Knowing What Works

A Roadmap for School Refusal Interventions Based on the Views of Stakeholders

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NRO NATIONAAL REGIEORGAAN ONDERWIJSONDERZOEK

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Summary

School attendance offers substantial short-term and long-term benefits for youths. Too many youths in the Netherlands are absent from school, posing a risk to their development and a challenge for professionals who seek to support these youths. School refusal, the focus of this report, is one type of school attendance problem which has a negative impact on the young person, family, school, and the broader community.

This report presents findings from the Knowing What Works [*Weten Wat Werkt*] project conducted by a consortium of four partners, co-funded by the NRO, and supported by the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*]. The aim of the project was to identify best practices for the development and delivery of interventions for school refusal. Four questions were addressed: (1) Which organisations provide an intervention for school refusal?; (2) What is offered during intervention for school refusal?; (3) Why do interventions for school refusal work?; and (4) How do organisations collaborate in interventions for school refusal?

Twenty-one organisations across 9 of the 12 Dutch provinces participated in the project, including 76 professionals from education and/or support services, 39 youths who participated in intervention for school refusal, and 86 parents. They shared their views on 'what works' in existing school refusal interventions. Qualitative data was gathered via focus group interviews with professionals and questionnaires for youths and parents. Quantitative data was also gathered via the questionnaires for youths and parents, and a questionnaire for professionals.

Most youths participating in interventions for school refusal had been absent from school for between 3 months and 1 year prior to intervention. According to professionals, anxiety disorder is the most common problem among these youths, and approximately one-half have been bullied, one-half have an autism spectrum disorder, one-third have a depressive disorder, and one-quarter have chronic unexplained physical symptoms. According to the vast majority of youths and parents, it was difficult for the young person to attend school due to stress or anxiety. Other commonly reported reasons for difficulty attending school were sad mood and somatic complaints.

A key finding is that interventions are more likely to work when adequate attention is paid to both organisational matters and content matters associated with the intervention. The organisation providing the intervention needs to attend to the intervention's viability and the qualities of personnel delivering the intervention. The intervention itself needs to address, among other things, the relationship with youths and parents, the contents of the intervention (e.g., safe environment, creating movement), and collaboration across education and support services.

Key findings were used to prepare a roadmap which supports the development, delivery, and review of interventions for school refusal. The 14 signposts in the roadmap represent important conditions for effective intervention. The roadmap was prepared for the benefit of professionals addressing school refusal, whether in an education and/or support services setting, as well as management teams responsible for ensuring intervention can be developed and delivered. It may also be informative for policymakers and for youths and parents seeking support. We hope it will contribute to a better future for the many youths who find it difficult to attend school.

This report differs from prior reports in three ways. First, it zooms in on one type of school attendance problem, namely school refusal. Second, it is the first project to elicit the voices of large numbers of professionals, together with youths and parents, with respect to factors that help and hinder intervention for school refusal. Importantly, the voices of each stakeholder group are reported separately from the other stakeholder groups, permitting a nuanced understanding of 'what works' according to different stakeholders. Third, the recommendations for intervention flow directly from the results about 'what works', in contrast to reports which include assumptions about what might work based on descriptions of youths with school attendance problems.

Glossary (English to Dutch)

English term	Dutch equivalent	Explanation
Authorised absenteeism	Geoorloofd schoolverzuim	Also referred to as 'excused' and 'justified'.
Contact person	Contactpersoon	The contact person is the professional who participated in the telephone screening during recruitment and arranged for completion of the First Impressions Questionnaire.
Education professionals	Onderwijsprofessionals	'Education professionals' is sometimes used to refer to personnel in the school setting involved in intervention for school refusal, and sometimes to refer to education professionals outside of the school setting who consult to personnel in the school setting.
Educational intervention	Onderwijsinterventie	We use this term to refer to interventions which are conducted by education professionals, typically although not exclusively in educational settings.
Interdisciplinary collaboration	Interdisciplinaire samenwerking	Professionals from different disciplines work interactively, analysing, synthesising, and harmonising the links between their respective disciplines into a coherent whole.
Long-term absenteeism	Thuiszitten Langdurig thuiszitten Langdurig relatief verzuim	Dutch policy: > 1 month Dutch policy: > 3 months
Mainstream education	Regulier onderwijs	Mainstream education is distinguished from special education. The terms 'regular school' and 'conventional school' are sometimes used in the literature to refer to mainstream education.
Mental health intervention	Geestelijke gezondheidsinterventie	We use this term to refer to interventions which are conducted by mental health professionals, typically although not exclusively in mental health settings.
Meta school facility	Bovenschoolse voorziening	This refers to an educational facility which, at an organisational level, is above the level of individual schools. Youths may participate in a meta school facility for some time before returning to a mainstream school or other suitable educational facility.
Multidisciplinary collaboration	Multidisciplinaire samenwerking	Professionals from different disciplines work alongside each other.
Multiple disciplinary collaboration	Meerdere disciplinaire samenwerking	Collaboration between professionals of different disciplines which is either multidisciplinary in nature and/or interdisciplinary in nature.

Organisations	Organisaties	The institutions providing an intervention for school refusal. Sometimes the intervention is provided by a single institution, and sometimes by a number of institutions working together.
Participants	Participanten	'Participants' is used in two main ways in the report: (i) to refer to youths and parents participating in the 21 interventions for school refusal; and (ii) to refer to professionals, youths, and parents participating in the Knowing What Works project.
Practice tasks (or home tasks, between-session tasks, therapy-related homework assignments)	Oefeningen (ofwel opdrachten tussen de sessies door, huiswerk voor therapie)	This term refers to activities that youths and/or parents are asked to engage in, outside of the intervention setting. The activities might be intended to strengthen and generalise skills, and to effect change in one's everyday life.
Program	Programma	'Program' is more general than 'intervention'. 'Intervention' is typical in mental health settings, less typical in school settings.
School absenteeism	Schoolverzuim	This is a broad construct which includes arriving late to school, departing school during the school day, and not being at school for a day, days, weeks, months, or years.
School attendance problems	Problematisch schoolverzuim	A threshold of school absenteeism has been reached which is deemed to pose a problem. Many different thresholds are reported in the literature (e.g., > 25% in two weeks). Evidence also suggests that even one day of absence can be problematic.
School dropout	Uitval	The school-aged young person discontinues school-based education prior to graduation.
School exclusion	Schooluitsluiting	One of the four types of school attendance problems.
School refusal	Schoolweigering	One of the four types of school attendance problems.
School withdrawal	Schoolonthouding	One of the four types of school attendance problems.
School personnel	Schoolpersoneel	School personnel generally refers to professionals working in the school setting who can assist with school refusal intervention (e.g., teachers, mentors, counsellors). Sometimes the term 'education professionals' is used.
Severe and/or chronic school refusal	Ernstige en/of chronische schoolweigering	The literature provides no clear operationalisation of 'severe' and 'chronic', except that 'chronic' has been used to refer to more than 10% absenteeism in a given period. We use the term to exclude cases of emerging, mild, or moderate school refusal.
Student	Leerling	A young person of school-age.
Support services	Hulpverlening	Support services as a translation for 'hulpverlening' is a broad term intended to subsume mental health services ('GGZ') and youth care ('jeugdzorg'). We have not adopted the recent trend of using 'youth help' to refer to all support for youth.

Truancy	Spijbelen	One of the four types of school attendance problems.
Unauthorised absenteeism	Ongeoorloofd schoolverzuim	Also referred to as 'unexcused' and 'unjustified' school absenteeism.
Young people / youths	Jongeren	Inclusive of children and adolescents. The terms 'young people' and 'youths' are used interchangeably throughout the report.
Youth care	Jeugdzorg	Services for youths outside of the mental healthcare system.

Glossary (Dutch to English)

Dutch term	English equivalent	Toelichting
Bovenschoolse voorziening	Meta school facility	Hiermee wordt een onderwijsvoorziening bedoeld die op organisatieniveau boven het niveau van individuele scholen staat. Jongeren kunnen enige tijd deelnemen aan een bovenschoolse voorziening voordat ze terugkeren naar een reguliere school of een andere passende onderwijsvoorziening.
Contactpersoon	Contact person	De contactpersoon is de professional die tijdens de werving heeft deelgenomen aan de telefonische screening en het invullen van de Eerste Blik Vragenlijst heeft verzorgd.
Ernstige en/of chronische schoolweigering	Severe and/or chronic school refusal	De literatuur geeft geen duidelijke operationalisering van 'ernstig' en 'chronisch', behalve dat 'chronisch' soms verwijst naar meer dan 10% verzuim in een bepaalde periode. We gebruiken de term om gevallen van opkomende, milde of matige schoolweigering uit te sluiten.
Geestelijke gezondheidsinterventie	Mental health intervention	We gebruiken deze term om te verwijzen naar interventies die worden uitgevoerd door professionals van de geestelijke gezondheidszorg, meestal, hoewel niet uitsluitend, in instellingen voor geestelijke gezondheidszorg.
Geoorloofd schoolverzuim	Authorised absence	Onder geoorloofd schoolverzuim valt onder de Nederlandse wet onder andere afwezigheid door ziekte of het bijwonen van bijvoorbeeld een begrafenis (Brouwer-Borghuis, Heyne, Vogelaar, et al., 2019).
Hulpverlening	Support services	'Hulpverlening' als vertaling voor 'support services' is een brede term die bedoeld is om de geestelijke gezondheidszorg (GGZ) en jeugdzorg onder te brengen. We hebben niet de recente trend overgenomen om met 'jeugdhulp' te verwijzen naar alle hulp aan jongeren.
Interdisciplinaire samenwerking	Interdisciplinary collaboration	Professionals uit verschillende disciplines werken interactief, analyseren, synthetiseren en harmoniseren de verbinding tussen hun respectievelijke disciplines tot een samenhangend geheel.
Interventie in een geestelijke gezondheidszorg instelling	Mental health intervention	We gebruiken deze term om te verwijzen naar interventies die worden uitgevoerd door professionals in de geestelijke gezondheidszorg, meestal, hoewel niet uitsluitend, in instellingen voor geestelijke gezondheidszorg.
Jeugdzorg	Youth care	Diensten voor jongeren buiten de GGZ.
Jongeren	Young people / youths	Inclusief kinderen en adolescenten. De termen 'young people' en 'youths' worden in het rapport door elkaar gebruikt.
Langdurig relatief verzuim (Thuiszitten)	Long-term absenteeism	Het Nederlandse beleid:> 1 maand = thuiszitten Het Nederlandse beleid:> 3 maanden = langdurig thuiszitten

Leerling	Student	Een jongere van leerplichtige leeftijd.
Meerdere disciplinaire samenwerking	Multiple disciplinary collaboration	Samenwerking tussen professionals van verschillende disciplines die ofwel multidisciplinair van aard en/of interdisciplinair van aard is.
Multidisciplinaire samenwerking	Multidisciplinary collaboration	Professionals uit verschillende disciplines werken naast elkaar.
Oefeningen (ofwel opdrachten tussen de sessies door, huiswerk voor therapie)	Practice tasks (or home tasks, between-session tasks, therapy-related homework assignments)	Dit verwijst naar activiteiten die jongeren en/of ouders gevraagd worden te ondernemen, buiten de interventiesetting. Ze kunnen bedoeld zijn om vaardigheden te versterken en generaliseren, en om verandering teweeg te brengen in het dagelijks leven.
Onderwijsinterventie	Educational intervention	We gebruiken deze term om te verwijzen naar interventies die worden uitgevoerd door onderwijs professionals, meestal, hoewel niet uitsluitend, in onderwijsomgevingen.
Onderwijsprofessionals	Education professionals	'Onderwijsprofessionals' wordt soms gebruikt om te verwijzen naar personeel in de schoolomgeving dat betrokken is bij interventie voor schoolweigering, en soms om te verwijzen naar onderwijsprofessionals buiten de schoolomgeving die overleg plegen met personeel in de schoolomgeving.
Ongeoorloofd schoolverzuim	Unauthorised absence	Ongeoorloofd verzuim omvat 'absoluut schoolverzuim' (niet ingeschreven zijn op een school) en 'relatief schoolverzuim' (weg van school om andere redenen dan geoorloofd verzuim, zoals gezinsvakanties tijdens de schoolperiode) (Brouwer-Borghuis, Heyne, Vogelaar, et al., 2019).
Organisaties	Organisations	De organisaties die een interventie voor schoolweigering aanbieden. Soms wordt de interventie verzorgd door één organisatie, soms door meerdere organisaties die samenwerken.
Participanten	Participants	'Deelnemers' wordt in het rapport op twee manieren gebruikt: (i) om te verwijzen naar jongeren en ouders die deelnemen aan de 21 interventies voor schoolweigering; en (ii) om te verwijzen naar professionals, jongeren en ouders die deelnemen aan het project Weten Wat Werkt.
Problematisch schoolverzuim	School attendance problem	Er is een drempel van schoolverzuim bereikt die als een probleem wordt beschouwd. In de literatuur worden veel verschillende drempels gerapporteerd (bijv.> 25% in twee weken). Er zijn ook aanwijzingen dat zelfs één dag schoolverzuim problematisch kan zijn.
Programma	Program	'Programma' is algemener dan 'interventie'. 'Interventie' is typisch voor instellingen voor geestelijke gezondheid, minder typisch voor scholen.
Regulier onderwijs	Mainstream education	Het reguliere onderwijs onderscheidt zich van het speciaal onderwijs. De termen 'reguliere school' en 'conventionele school' worden in de literatuur soms gebruikt om te verwijzen naar het reguliere onderwijs.
Schoolonthouding	School withdrawal	Een van de vier soorten problematisch schoolverzuim.
Schoolpersoneel	School personnel	Schoolpersoneel verwijst over het algemeen naar professionals die in de schoolomgeving werken en die kunnen helpen bij de aanpak van schoolweigering (bijv. leraren, mentoren, begeleiders). Soms wordt de term 'onderwijsprofessionals' gebruikt.

Schooluitsluiting	School exclusion	Een van de vier soorten problematisch schoolverzuim.
Schoolverzuim	School absenteeism	Dit is een brede constructie die omvat: te laat op school komen, tijdens de schooldag van school vertrekken, en een dag, dagen, weken, maanden of jaren niet op school zijn.
Schoolweigering	School refusal	Een van de vier soorten problematisch schoolverzuim.
Spijbelen	Truancy	Een van de vier soorten problematisch schoolverzuim.
Thuiszitten (Langdurig relatief verzuim)	Long-term absenteeism	Het Nederlandse beleid:> 1 maand = thuiszitten Het Nederlandse beleid:> 3 maanden = langdurig thuiszitten
Voortijdig schoolverlaten	School dropout	'Voortijdig schoolverlaters' verwijst naar jongeren tot 23 jaar die zonder startkwalificatie het onderwijs verlaten. Ook wel schooluitval genoemd.

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Chapter 1 – Introduction

When youths are engaged in education – which commonly entails being at school – they stand to reap benefits in the here-and-now, in the short-term, and in the long-term. Moreover, being at school and successfully completing school are indicators of successful development (Kearney & Graczyk, 2020).

Many youths have substantial difficulty attending school and engaging in education. This jeopardises their access to the benefits of education, and thus their development. Large numbers of youths are absent from school and do not complete schooling, as noted in national and international reports.

Dutch policies and practices have been oriented towards ensuring all youths receive an education. The Knowing What Works [*Weten Wat Werkt*] project aims to support practice and policy in the Netherlands, by shedding light on interventions that are effective in helping youths who find it difficult to attend school, to re-engage with education.

Section 1.1 of this report elaborates on the benefits of school attendance, the magnitude of school absenteeism, and Dutch policy and practice as it relates to school attendance and absenteeism. This is the general context for the Knowing What Works project. Thereafter, Section 1.2 zooms in on the specific rationale for the project.

1.1 The Broad Context for Knowing What Works

1.1.1 The Benefits of School Attendance

Being at school evokes many different responses. For some youths, the response is positive because of the here-and-now benefits of spending time with friends, learning something new, getting a good grade, or feeling cared for by a teacher.

Among professionals, school attendance is understood to be "an important foundational competency" (Kearney et al., 2019a, p. 1) and "a critical developmental benchmark" (Kearney & Graczyk, 2020, p. 316). By being at school, a young person demonstrates social and emotional competencies, and can further develop these competencies. The competencies include, but are not limited to, self-regulation skills, relationship skills, and decision-making skills (Collie, 2020). For example, school attendance fosters routines and responsibilities such as getting up in the morning to arrive at school on time and observing the norms for behaviour during school time (Heyne, Gentle-Genitty, et al., 2020).

School attendance is also "a primary mechanism for improving student achievement" (Allensworth & Balfanz, 2019, p. x). Being at school increases exposure to instructional time, benefitting intellectual development, academic achievement, and educational outcomes (Allensworth & Balfanz, 2019; Ginsburg et al., 2014; Keppens & Spruyt, 2020). Higher levels of attendance in the early school years – sometimes measured dimensionally, sometimes measured categorically based on attendance above 90% – are linked to higher academic achievement in both the early years (Gershenson et al., 2017; Gottfried, 2009, 2014; Rhoad-Drogalis & Justice, 2018) and in secondary school (Ansari & Pianta, 2019).

Health outcomes are also influenced by the academic, social, and emotional functioning that develop during the school years (Okano et al., 2019). Specifically, school attendance can buffer against mental health problems (Bonell et al., 2019; Lawrence et al., 2019). Depending on the curriculum, school attendance can also influence identity, passions, morals, and ethics (Eccles & Roeser, 2015).

Youths more likely to graduate from secondary school are those with better attendance (Schoeneberger, 2012; Smerillo et al., 2018) and better school performance (Allison et al., 2019), the latter influenced by the former. The long-term benefits associated with graduation from secondary school have their roots not in graduation per se, but in school attendance during the years prior to graduation (Rocque et al., 2017).

Long-term benefits include being prepared for successful transition to adulthood (Fredricks et al., 2019), such as social and economic participation in society (Zaff et al., 2017). Youths who complete secondary school are at lower risk for negative outcomes such as criminal behaviour and unemployment (Lansford et al., 2016; Maynard et al., 2015) and early dependence on disability pension (Myhr et al., 2018). There is broad agreement that educational attainment is also associated with longer life expectancy (Rocque et al., 2017).

1.1.2 The Magnitude of School Absenteeism

Around the globe, school absenteeism is a major concern (e.g., New Zealand Ministry of Education, 2019; United Kingdom Department of Education, 2018; United States Department of Education, 2019). Longitudinal studies show that rates of absenteeism remain at high levels or are increasing (e.g., Chang et al., 2018; Danish Ministry of Education, 2018; Japanese Ministry of Education, Culture, Sports, Science and Technology, 2017; Maynard et al., 2017). Statistics which suggest that absenteeism is increasing will be due, in part, to improved reporting of absenteeism (Chang et al., 2018). Nonetheless, absenteeism rates are cause for great concern. An international report estimated that 61 million youths of primary school age and 202 million youths of secondary school age were out of school, meaning that they did not complete schooling or were not enrolled in school despite being of school age (UNICEF and UIS, 2016). Federal mandates regarding absenteeism have fuelled an increasing sense of urgency about this problem (Gottfried & Hutt, 2019).

The situation in the Netherlands is equally concerning. How do we know this? Every year, all municipalities in the Netherlands provide the Ministry of Education, Culture and Science [*Ministerie van Onderwijs, Cultuur en Wetenschap*] with an overview of absenteeism in the previous school year. This is a legal obligation as prescribed in the Compulsory Education Act of 1969 (Tweede Kamer der Staten-Generaal, 1992). Two categories of absenteeism employed by the Ministry are absolute absenteeism [*absoluut verzuim*] and long-term relative absenteeism [*langdurig relatief verzuim*]. Absolute absenteeism applies when students of compulsory education age[1] are not enrolled in a school. Long-term relative absenteeism applies when a student is enrolled in a school but is absent for more than four consecutive school weeks (youths in this category are also referred to as 'thuiszitters'). Sometimes reports are based on long-term relative absenteeism that occurs for more than three months, rather than four weeks. Absolute absenteeism and long-term relative absenteeism are both regarded as unauthorised absence [*ongeoorloofd schoolverzuim*]; the absence is without a valid reason and in violation of the Compulsory Education Act.

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[1] In the Netherlands, compulsory education begins at age five (although most children begin at age four) and finishes at the end of the school year in which the young person turns 16, or once they complete the Dutch equivalent of Year 12, whichever occurs first. The age limit is extended to 18 years if the young person has not reached a certain level of education, namely a diploma at level 2 or above in vocational education, a diploma at havo level (higher general education), or a diploma at vwo level (preuniversity education) (adapted from Brouwer-Borghuis, Heyne, Vogelaar, et al., 2019).

In January 2020 a report prepared by Ministers Slob[2], de Jonge[3], and Dekker[4] (Slob et al., 2020) indicated that the total number of youths fulfilling the criteria for some of these categories in school year 2018-2019 had risen in comparison with school year 2017-2018, and in fact the numbers increased every school year since 2013-2014. For example, in the 2013-2014 school year there were 3,023 cases of absolute absenteeism and 1,843 cases of long-term relative absenteeism (more than three months), totalling 4,866 students. In the 2019-2020 school year there were 2,478 cases of absolute absenteeism and 2,712 cases of long-term relative absenteeism, totalling 5,190, a 9 percent increase.

It is important to note that these numbers only represent the extremes of absenteeism (i.e., not enrolled at school; away from school for at least three consecutive months). Many youths who are enrolled in school, and who are not absent for at least three consecutive months, will also miss many days of school. Even lower levels of absenteeism can have a negative impact (see Section 1.2.1). This applies to authorised absences [*geoorloofd schoolverzuim*] (i.e., with a valid reason, and not in violation of the Compulsory Education Act, such as being sick or attending a funeral) and unauthorised absences such as luxury absenteeism [*luxeverzuim*] (e.g., a family holiday during school term without the school's permission). School principals are obliged to report unauthorised absenteeism to DUO[5] when: (a) it is luxury absenteeism; (b) the young person has accumulated 16 hours[6] of unauthorised absence in four consecutive school weeks; and (c) there is continued unauthorised absenteeism for four or more school weeks.

The increase in absenteeism in the Netherlands has occurred despite all the efforts to reduce absenteeism (see Section 1.1.3). Reducing and preventing absenteeism is a current, complex, and challenging issue. Reports released in the Netherlands in the last few years attest to this. They include 'The story behind the numbers: Long-term absenteeism in secondary education' (INGRADO, 2018), 'The power to continue: How can we break the deadlock around long-term absenteeism?' (Dullaert, 2019), 'This is me: Portraits of youth with long-term absenteeism' (Van der Ree, 2019), 'Don't give up: School drop-out from the perspective of youth with long-term absenteeism' (Van Binsbergen et al., 2019), 'Impulse approach to long-term absenteeism: Research into the story behind the numbers and the ambitions of the Absenteeism Pact' (Lubberman et al., 2019), 'Authorised absenteeism: From insight to intervention' (Maarsingh et al., 2020), and 'Understanding long-term absenteeism: Disputes about admission, removal or developmental perspectives of (imminent) absentees' (Krijnen et al., 2021).

A primary reason for the difficulty addressing absenteeism is that factors associated with absenteeism are many, diverse, and interactive (Melvin et al., 2019). For example, at school there may be problems in the interaction between students, in the way school professionals respond to students, and in other facets of school climate. For the young person, neurodevelopmental conditions, learning problems, and problems with physical or mental health may contribute to absenteeism. Parent attitudes to school, parent psychopathology, family functioning, socio-economic status, and housing instability might play a role. In the

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[2] The Minister for Primary and Secondary Education and Media.
[3] The Minister for Health, Welfare and Sport.
[4] The Minister for Legal Protection.
[5] DUO stands for Dienst Uitvoering Onderwijs [*Education Implementation Service*], a national service for the administration of education department regulations.
[6] Primary and vocational schools report the number of missed hours; secondary schools report missed lessons.

Netherlands, a study by Van Binsbergen et al. (2019) explored factors associated with long-term absenteeism among youths with a behavioural problem. Various factors were identified, including individual factors (internalising problems, being overweight, problematic cannabis use, and excessive stress), family factors (significant problems in the home situation), and broader systemic factors (complexities in the delivery of care).

In short, many youths are absent from school and there are many factors associated with absenteeism. It could be said that the combinations of factors associated with absenteeism are as numerous as the number of youths who do not attend school regularly. Policy and practice for addressing absenteeism need to account for this complexity.

1.1.3 The Efforts of Dutch Policy and Practice

In 2014 the Appropriate Education Act [*Wet Passend Onderwijs*] focused considerable attention on school absenteeism. Indeed, reduced absenteeism is a standard via which the success of the Act is judged. At the time the Act was introduced there was broad recognition that too many youths were not participating in education. For example, in 2013 the Social Domain Supervision Department[7] [*Toezicht Sociaal Domein*] reported findings of a survey into absenteeism.[8] Work to address absenteeism was conducted by INGRADO[9], Behavioural Work [*Gedragswerk*],[10] The Educational Consultants [*De Onderwijsconsulenten*],[11] and the Children's Ombudsman [*Kinderombudsman*][12]. However, the number of absent youths was not decreasing, and some categories of absenteeism have been increasing (Section 1.1.2). Absenteeism is a complex problem for which even the Appropriate Education Act does not provide quick solutions. In the meantime, various approaches have been developed in education and in youth care, often in collaboration between the two, to help absent youths attend school. In the Netherlands, the number and diversity of interventions for school attendance problems mirror what is seen in the international literature (e.g., Maynard et al., 2013, 2018). It is quite likely that, at national and international levels, the development of interventions for school absenteeism occurs with minimal knowledge of what already exists, or of what works well.

In October 2015 the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*] commenced; this was a response to the need for a coordinated approach to school refusal. It started as a collaborative initiative between Attendiz (special education, represented by Marije Brouwer-Borghuis) and the AT Group (mental health care, represented by Jan Vermue), supported and facilitated by LECSO (National Expertise Centre for Special Education, represented by Corine van Helvoirt) and the University of Leiden

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[7] This Department is within the Ministry of Health, Welfare and Sport.
[8] www.reikthuiszittersdehand.nl
[9] INGRADO is the national association for school attendance officers and related professionals.
[10] Gedragswerk is commissioned by the Ministry of Education, Culture, and Science. It focuses on youths who have been absent from school for long periods.
[11] Onderwijsconsulenten
[12] De Kinderombudsman

(represented by David Heyne). The National Expertise Team focuses on school refusal, a specific type of absenteeism. Youths displaying school refusal can be described as those who no longer dare to go to school (see Section 1.2.1 for a fuller description of school refusal). In the international literature this is often referred to as school refusal, and in Dutch literature it has been referred to as 'schoolweigering' (school refusal), 'schoolfobie' (school phobia), and 'schoolangst' (school anxiety). Youths displaying school refusal often experience other problems (e.g., anxiety, depression, autism), and they may have experienced bullying. A main aim of the National Expertise Team is to facilitate the exchange of knowledge among professionals providing interventions for school refusal, including professionals in educational settings and (mental) healthcare settings. Another aim is to identify, prioritise, and answer research questions arising from the daily practice of these professionals.

In June 2016 the Absenteeism Pact[13] [*Thuiszitterspact*] was initiated, with the aim of reducing long-term absenteeism. The Ministry of Education, Culture and Science [*Ministerie van Onderwijs, Cultuur en Wetenschap*] and the Ministry of Health, Welfare and Sport [*Ministerie van Volksgezondheid, Welzijn en Sport*] entered into this pact with the Council for Primary Education [*PO-Raad*], the Council for Secondary Education [*VO-Raad*], the Ministry of Justice and Security [*Ministerie van Veiligheid en Justitie*], and the Association of Dutch Municipalities [*Vereniging van Nederlandse Gemeenten*], with Marc Dullaert as the driving force. The Absenteeism Pact was established to ensure that by 2020 no school-aged young person would be at home for longer than three months without appropriate education or care. Agreements were made about definitions, better registration of long-term absenteeism, connection with the justice system, and better cooperation between education and care. As noted in Section 1.1.2, the goal of the Absenteeism Pact has not yet been achieved.

In June 2017 the research consortium[14] responded to a call for research proposals issued by the National Directorate for Educational Research [*Nationaal Regieorgaan Onderwijsonderzoek (NRO)*].[15] The NRO works to improve education by coordinating and financing educational research, and by improving the connection between practice and research, and the connection between policy and research. One of the NRO programs is Behaviour and Appropriate Education [*Gedrag en Passend Onderwijs*]. In this program the NRO provides subsidies for practice-oriented research and reviews because teachers in primary and secondary education often experience the provision of appropriate education as a burden. They find it particularly difficult to respond to students with problem behaviour. In the 2017 call for submissions, the topic of Behaviour and Appropriate Education could be investigated from one of four main perspectives: (1) the perspective of school culture; (2) the perspective of the student's future; (3) the teacher's perspective on the special educational needs of these students; and (4) the perspective of the student with special learning needs. The proposal submitted by the research consortium focused on the second perspective, namely the student's future. Youths who display school refusal are at risk of

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[13] https://www.rijksoverheid.nl/documenten/publicaties/2016/06/13/thuiszitterspact
[14] The research consortium comprises the four co-founders of the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*], namely the first four authors of this report.
[15] The NRO is part of the Netherlands Organisation for Scientific Research [*NWO*].

lower academic achievement, their broader development is threatened, and they may drop out of school completely and experience social adjustment problems later in life (see Section 1.2.1). Effective intervention is needed to help these youths feel comfortable to engage with education and attend school regularly. In the lead up to the NRO's call for proposals, members of the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*] increasingly expressed the desire to establish national guidelines for school refusal intervention, by systematically mapping out the operative elements in existing interventions. In other words, they sought to know 'what works'. This is how the Knowing What Works [*Weten Wat Werkt*] project started.

In October 2018 the research consortium commenced the project presented in this report. All consortium members have been involved in the development, implementation, and report-writing for the project. The National Expertise Team [*Landelijk KennisTeam Schoolweigering*] was an important source of input and served as valued sounding board during the Knowing What Works project. The Expertise Team has existed for six years now, meeting three to four times a year to share knowledge on various topics as well as to create new knowledge. The meetings have both a practical character (presentations and discussion about interventions) and a scientific character (discussion of recent research results and theoretical issues).[16] Since 2021, the Netherlands Youth Institute [*Nederlands Jeugdinstituut*] has supported the activities of the National Expertise Team. Recently, the team has been considering a broader focus: (1) from school refusal to the wider field of school attendance and absenteeism; and (2) from interventions for severe, chronic, and complex cases, to early intervention, prevention, and the promotion of school attendance. In 2022, the name of the team will change to the Expertise Network for School Attendance [*Kennisnetwerk Schoolaanwezigheid*] to reflect the team's decision to broaden its focus. Members of the Expertise Team work closely with the International Network for School Attendance (INSA: www.insa.network) and closer ties will be fostered with this international body of practitioners, researchers, and policymakers.

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[16] An overview of the activities of the National Expertise Team for School Refusal can be found via this link.

1.2   The Specific Rationale for Knowing What Works

Knowing What Works is a response to national and international concerns about absenteeism. Section 1.1. of this report reveals that, more than ever, it is important to know 'what works' with respect to improving school attendance, and to share knowledge and develop expertise.

The National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*] contributes to this knowledge through the project Knowing What Works, by focusing on the school refusal component of the complex problem of school absenteeism. Professionals in the Netherlands encounter youths and parents who need help in connection with school refusal. Effective intervention is essential because school refusal can have a large impact on the young person and their family, as well as an impact on education and mental health professionals (Section 1.2.1). This is especially true of severe and/or chronic cases, which are increasingly conceptualised as Tier 3 absenteeism (Section 1.2.2).

Schools and support services in the Netherlands are developing different interventions. What is still missing is a roadmap for developing and implementing school refusal interventions. Despite almost 100 years of international research on school refusal and interventions, there is still a great need to better understand what works, why, and for whom. There are few examples of collaboration between mental health and education for school refusal intervention (Section 1.2.3). Furthermore, there are few examples of school refusal research and practice being informed by the voices of different stakeholders, including professionals delivering intervention for school refusal, as well as youths and parents participating in these interventions (Section 1.2.4).

Knowing What Works provides rich insights into 21 Dutch interventions for severe and/or chronic school refusal, along with the views of youths and parents who have participated in many of these interventions. The project provides answers to the key questions: (1) Which organisations provide an intervention for school refusal?; (2) What is offered during intervention for school refusal?; (3) Why do interventions for school refusal work?; and (4) How do organisations collaborate in interventions for school refusal?

The results (presented in Chapter 3) form the basis for a roadmap for effective school refusal interventions, a bundling of 'good practices' (presented in Chapter 4). Currently there is no roadmap, which can result in unnecessarily diverse views among professionals and between organisations, and insufficient insight into what is appropriate for these youths and their parents. It is our intention that the insights derived via the Knowing What Works project be available for current and future professionals and organisations – locally, nationally, and internationally – who plan to provide an intervention for school refusal or fine-tune an

existing intervention. A roadmap relieves professionals and organisations of the time-consuming task of developing an intervention from scratch, reduces the risk of different organisations re-inventing the wheel and thus squandering precious time, and may improve the effectiveness of interventions for school refusal. In this way Knowing What Works can help reduce school absenteeism and school dropout, thereby increasing adaptive development and positive futures for young people.

Knowing What Works represents the first project, nationally and internationally, to draw together information about the elements in interventions offered for Tier 3 school refusal. It is also the first project to combine the voices of youths, parents, and professionals from education and mental health, with respect to the elements of school refusal interventions perceived to contribute most to positive outcomes. For the Dutch context, this report also contributes to the very small body of literature on interventions for youths whose absenteeism from school is associated with emotional distress (i.e., school refusal).

1.2.1 School Refusal and Its Negative Effects

Definition

Put simply, school refusal is the type of school attendance problem whereby a young person experiences emotional distress around going to school and/or being at school, often leading to absenteeism. Working definitions for school refusal have varied across the decades, and the most recent review of definitions defines school refusal in the following way:

> School refusal is said to occur when: (1) a young person is reluctant or refuses to attend school, in conjunction with emotional distress that is temporal and indicative of aversion to attendance (e.g., excessive fearfulness, temper tantrums, unhappiness, unexplained physical symptoms) or emotional distress that is chronic and hindering attendance (e.g., depressive affect; sleep problems), usually but not necessarily manifest in absence (e.g., late arrivals; missing whole school days; missing consecutive weeks, months, or years); and (2) the young person does not try to hide associated absence from their parents (e.g., they are at home and the parents are aware of this), and if they previously hid absence then they stopped doing so once the absence was discovered; and (3) the young person does not display severe antisocial behaviour, beyond resistance to parental attempts to get them to school; and (4) the parents have made reasonable efforts, currently or at an earlier stage in the history of the problem, to secure attendance at school, and/or the parents express their intention for their child to attend school full-time. (Heyne et al., 2019, p. 22).

Researchers often differentiate between school refusal and three other types of absenteeism, referred to as truancy, school withdrawal, and school exclusion (Heyne et al., 2019). Truancy is said to occur when the young person is absent from school or from the

proper location at school (e.g., they are in the schoolyard rather than in class), the absence occurs without the permission of school authorities, and the young person typically tries to conceal this absence from their parents. School withdrawal is said to occur when absence from school is related to the effort of the parent(s) to keep the young person home, or little effort by the parent(s) to get the young person to school. Thus, unlike truancy, absence is not concealed from the parents. School exclusion is said to occur when absence from school or from specific school-related activities stems from school-based actions such as the inappropriate use of disciplinary exclusion, inability or unwillingness to accommodate the needs of the young person, or discouraging a young person from attending, beyond legally acceptable school policy.

Terminology

Two considerations regarding the term 'school refusal' warrant highlighting. First, the term is used to describe the phenomenon characterised by a young person's difficulty going to school, not to ascribe causation to the young person. A broad range of risk factors and processes at the level of the individual, family, school, and community can predispose a young person to the development of school refusal, precipitate its onset, and perpetuate the problem, accompanied by a broad range of protective factors and processes that can attenuate the severity of the problem and facilitate progress during intervention (Heyne, 2006; Heyne et al., 2014; Ingul et al., 2019). Like Devenney and O'Toole (2021), we contend that the responsibility for addressing school refusal does not lie at the feet of the young person, nor the family. Rather, professionals work together with youths, families, schools, and support services in the community to address the broad range of risk factors and processes.

Second, like Tobias (2019), we eschew the notion that school refusal is a psychiatric condition. Tobias (2019) described persistent school non-attendance as a way that youths "can raise a red flag to show their distress" as a rational response to feeling unsafe (p. 30). In the same way, school refusal signals the young person's difficulty going to school. Youths experiencing this difficulty may also fulfil criteria for a specific mental health problem, but this is not inherent to school refusal. For example, while some youths displaying school refusal show signs of separation anxiety, and others show signs of social anxiety and/or depression (e.g., Heyne et al., 2002), yet others do not meet criteria for any mental health problem (Egger et al., 2003).

Prevalence

Depending on the sample studied and the definition used, school refusal occurs among 1-7% of youths in the general population. More specifically, Heyne and King's (2004) narrative synthesis indicated a prevalence rate of 1-2% across all school-aged youth, Egger et al.'s

(2003) community study of 9-16 year-olds yielded a similar rate across a three-month period, Havik et al. (2015) found that 3.6% of 11-15 year-olds reported absence from school in the last three months that was quite often because of 'school-refusal related reasons', and 6.9% of the 11-17-year-olds in Steinhausen et al.'s (2008) community sample reported fear of going to school.[17] A small Dutch study among a community sample of primary school youths yielded a prevalence rate of around 3% (Vuijk et al., 2010). Rates of school refusal among youths seen in clinical settings range from 5-16% (Al Husni Al Keilani & Delvenne, 2021; Burke & Silverman, 1987; Hersov, 1985; Honjo et al., 1992; McShane et al., 2001).

Age-related patterns in samples of youths referred for intervention for school refusal seem to suggest that school refusal is more prevalent among preadolescent and adolescent youths relative to those in early or middle childhood (Heyne et al., 2002; King et al., 1998; Last et al., 1987; Last & Strauss, 1990; McShane et al., 2001; Morgan, 1959; Wu et al., 2013). However, it is difficult to know whether school refusal is more common among adolescents per se, or whether adolescents are simply more likely to be referred for school refusal intervention, perhaps because of its complexity in this developmental period (Heyne, 2021a). A community study by Egger et al. (2003) was conducted among non-referred youths aged 9-16 years, some of whom displayed school refusal. It revealed that the mean age of onset of school refusal was 10.9 years, and that school refusal was significantly more prevalent among younger youths. It should be noted, however, that youths in this study may have displayed emerging or mild school refusal, as opposed to severe and chronic school refusal. In sum, it seems that mild or emerging school refusal may be more common among younger children, and that referral for severe and chronic school refusal is clearly more common among adolescents.

Negative effects

School refusal is an indicator of current difficulties for the young person, and it can impact their quality of life (Torrens Armstrong et al., 2011). It also has the potential to lead to various short and long-term negative effects for the young person, the family, the school, and the broader community.

Negative effects for youths

For the young person, many negative effects can stem from the absenteeism associated with school refusal. When school refusal is just emerging, it may be associated with late arrival at school, leaving school early, or missing school for some days. Once it has become established it is often associated with weeks, months, or years of absence (e.g., Brouwer-Borghuis, Heyne, Sauter, et al., 2019). Reduced learning time due to absence contributes to lowered school attainments (e.g., Aucejo & Romano, 2016; Carroll, 2020; Filippello et al.,

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[17] A further 0.5% of youths reported fear of going to school together with truancy.

2019), even when there is a small amount of lost learning time (Hancock et al., 2013). The impact of absence on achievement is particularly strong among youths from disadvantaged populations (Hancock et al., 2013). Absenteeism is also a predictor of school drop-out (Schoeneberger, 2012), which is associated with unemployment (Attwood & Croll, 2006) and lower life expectancy (Rogers et al., 2013).

Alongside the negative effects due to missed learning, lowered school attainment, and school drop-out, is the potential negative effect on the young person's mental health. Absenteeism has been associated with impairment in social-emotional development (Malcolm et al., 2003), even from an early age (Gottfried, 2014). One-half of youths referred for the treatment of school refusal have a mental health problem in the form of an anxiety and/or depressive disorder (Heyne et al., 2015) and one-quarter of non-referred youths who display school refusal meet criteria for a mental health disorder (Egger et al., 2003). In some of these cases the mental health problem will have contributed to the onset and maintenance of school refusal, such as the child with separation anxiety disorder refusing to attend school because of an excessive fear of separation from parents (e.g., Bagnell, 2011) and the adolescent with social anxiety disorder who avoids school because of the intense anxiety about being judged or humiliated by peers (McShane et al., 2007). In other cases, absence from school could contribute to the development of mental health problems. Clinical experience indicates that youths presenting with school refusal can berate themselves for their inability to attend school 'like all the other kids do', as they themselves say (Heyne & Sauter, 2013). This sense of being different or abnormal because of one's difficulty attending school, and the social withdrawal associated with school refusal (Berg, 2002), may contribute to depressive experiences.

The causal relationship between mental health problems and school refusal is not clear in each case, but what is clear is that researchers regard psychopathology and absenteeism as important risk factors for each other. Lawrence et al. (2019) suggested that absence can perpetuate poor mental health because of reduced social connection and lower academic achievement, which in turn leads to more absenteeism. Wood et al. (2012) argued that, for some youth, absenteeism is an outcome of problems such as anxiety or depression and that subsequent absenteeism exacerbates symptoms which can lead to worsening absenteeism, whereas for other youths absenteeism is initially unrelated to psychopathology but mental health deteriorates as a result of absence. Using longitudinal data to understand the reciprocal influences between absenteeism and psychopathology over time, these researchers found some support "that a higher level of one of these factors in one year tended to presage the onset of increases in the other factor in the following year" (p. 362). Among children (below fifth to sixth grade), a longitudinal path in which absenteeism led to psychopathology was not observed, and among adolescents there was more evidence (compared to children) of psychopathology leading to absenteeism. According to Heyne et al. (2022), although absenteeism may not lead to psychopathology for some groups of youth, it is probably a risk for recovery among those youths who already experience a mental health problem. Regarding self-harm and suicidal ideation, a review of cross-sectional and longitudinal studies by Epstein et al. (2020) led to the conclusion that there is emerging evidence of associations between absenteeism, self-harm, and suicidal ideation.

The direction of influence was unclear, and the researchers noted that in a few studies, absenteeism was associated with a lower risk of suicidal thoughts. Interpreting this latter result, Heyne et al. (2022) suggested that a decline in suicidal thoughts might occur among youths who stay home to avoid bullying. In short, school absenteeism and mental health problems are intertwined, each presenting an obstacle to optimal development (Heyne et al., 2022).

The previous paragraph describes some of the longitudinal outcomes associated with absenteeism, but not with school refusal specifically. There are just a few studies which have documented outcomes in late adolescence (Buitelaar et al., 1994) and adulthood (Berg & Jackson, 1985; Flakierska-Praquin et al., 1997; McCune & Hynes, 2005) among youths who displayed school refusal during their school years. The studies point to longer-term mental health problems and adjustment difficulties for youths who had displayed school refusal, although the designs of the studies do not permit the conclusion that it was the presence of school refusal during the school years that was responsible for the problems in late adolescence and adulthood. Maeda and Heyne (2019) argued that school refusal may become prolonged and more difficult to treat in the absence of appropriate intervention, based on various reports in the literature (i.e., Glaser, 1959; Hersov, 1972; King et al., 1998; Okuyama et al., 1999; Sonoda et al., 2008). They noted that the prolongation of school refusal increases a young person's anxiety about school return (Terada, 2015; Warnecke, 1964) and probably reduces the young person's motivation for resolving an aversion to school attendance. A study by King et al. (1998) controlled for the effects of intervention for school refusal using a wait-list control condition in a randomised trial of cognitive-behavioural therapy (CBT) for school refusal. Approximately four months after initial assessment, school attendance continued to be poor and anxiety disorders were still common across youths in the wait-list condition. Less than one-third of youths on the waitlist had a 'normal' level of school attendance (i.e., 90% or more) after waiting for intervention. In other words, very few of the youths displaying school refusal showed spontaneous recovery in the short-term, in the absence of appropriate intervention.

Negative effects for parents and families

Parents also experience negative effects. A qualitative study addressing school non-attendance generally (rather than school refusal specifically) indicated that parents feel embarrassed, blamed by school staff or helping professionals, misunderstood, isolated, and anxious about their responses to absenteeism (Gregory & Purcell, 2014). A qualitative study which focused on school refusal identified frustration and helplessness among parents (Dannow et al., 2020). These parents experienced a dilemma: "how to strike the right balance between how much the child is capable of and how much the parents should challenge the child" (p. 31). Also writing about school refusal, Berry and Lizardi (1985) explained that the family is under great stress because the young person's distress about attending school usually begins in the home environment (e.g., complaints, anxiety, acting-out behaviours), and school refusal is compounded by the stress that occurs in the family.

The emotional impact on parents is often accompanied by the practical impact of school refusal on their lives. For example, once school refusal begins parents may stay home to be with their child, and during intervention they often take time off work to manage absenteeism. In a study of intervention for school attendance problems, Johnsen (2020) reported that 51% of parents arrived late to work and 43% left work early, due to the school attendance problem. In a study focused on school refusal, Gallé-Tessonneau and Heyne (2020) noted that parents spent time communicating regularly with the school (e.g., writing notes about absence; asking for help) and addressing other consequences of school refusal (e.g., planning private lessons; arranging visits to the doctor).

Increased levels of family stress and conflict are also likely to be a consequence of school refusal (Christogiorgos & Giannakopoulos, 2014; McAnanly, 1986). Conflict can occur between parents who have different ideas about how to respond to their child's refusal to attend school, and between the young person and their parents. For example, an adolescent's increasing autonomy potentiates family conflict around 'who gets to decide what' about the adolescent attending school (Heyne, 2021a). Tolin et al. (2009) described a case in which an adolescent's antagonistic relationship with his mother made it hard for her to implement contingency management procedures recommended during intervention for school refusal.

In turn, family conflict may negatively impact the outcome of treatment for school refusal. Valles and Oddy (1984) reported higher levels of conflict among families of non-successfully treated cases relative to those that were successfully treated. Fornander and Kearney (2019) noted that family conflict as reported by parents was less typical in cases involving higher levels of absenteeism (10% absence) than in cases involving lower absenteeism (5% absence). It was suggested that some families may become so frustrated that they disengage from efforts to solve the school attendance problem. Whether family conflict is a negative effect of absenteeism or precedes absenteeism, it very likely has a negative impact on the resolution of absenteeism.

If absenteeism leads to school dropout, as it often does (Schoeneberger, 2012), there can be further negative effects for the family. A study by Gausel and Bourguignon (2020) suggested that family members would be angry at the young person who dropped out of school, due to concern about the family's self-image (e.g., school dropout reflects a moral failure in the family), and angry at others due to concern about social image (e.g., loss of respect in the eyes of others). The study also suggests that family members might be angrier about dropout from vocational education than general education.

Negative effects for the community

The task of managing absenteeism is complex and time-consuming (Reid, 2006a). According to practitioners who work with youth displaying school attendance problems, these problems are resource intensive and emotionally challenging (Finning et al., 2018). They negatively impact teacher morale (Wilson et al., 2008) and put a strain on education

professionals (McAnanly, 1986), with the added burden of helping students catch up on missed learning (Balu & Ehrlich, 2018). Time is also required to plan, implement, and evaluate strategies for providing the social and emotional support the young person needs as they return to school. Support is provided by professionals located in the school, as well as professionals consulting to the school. For example, community-based family coaches help parents of youths with persistent absenteeism build confidence and capacity for asserting authority, and they help school professionals make adaptations to the school environment to help the young person feel safe when back at school (Tobias, 2019). Another potential negative impact for the school is a reduction in funding because of high absenteeism (Epstein & Sheldon, 2002).

As noted earlier, school attendance helps prepare youths for successful transition to adulthood (Fredricks et al., 2019), enhancing social and economic participation in society (Zaff et al., 2017). Conversely, lower rates of school completion contribute to reduced productivity and increased social support costs for society (Evans, 2000).

Conclusion

School refusal is a complex problem. The factors that predispose, precipitate, and perpetuate school refusal include those at the level of the individual, family, school, and community. There is discussion about the suitability of the term 'school refusal', but one thing is clear: the difficulty that youths have with attending school can have far-reaching negative consequences. A school attendance problem represents a serious disruption to the young person's growth process (Kearney & Graczyk, 2020), and there are negative consequences for the family and community. Effective intervention is needed, to reduce negative effects and ensure the short- and long-term well-being of the young person.

1.2.2 Interventions for School Refusal and Their Effectiveness

The numerous negative effects associated with school refusal underscore the need for effective interventions. In the first part of Section 1.2.2 we describe a framework that helps organise interventions according to three levels – or tiers – which represent different levels of need for intervention and thus different levels of intensity of intervention. In the second part of Section 1.2.2 we present an overview of interventions used when school refusal is severe and/or chronic, akin to Tier 3 school refusal. The third part of Section 1.2.2 summarises current knowledge about the effectiveness of interventions for severe and/or chronic school refusal.

The multi-tiered system of supports model

A multi-tiered system of supports (MTSS) model is a framework for service delivery. It has previously been used to organise a range of assessment and intervention strategies for students with academic or behavioural challenges, whereby tiers represent increasing levels of needed support (Kearney & Graczyk, 2020). An example is 'Schoolwide Positive Behaviour Support' to promote appropriate student behaviour and address disruptive and other inappropriate behaviour in schools (Sugai & Horner, 2002). In the field of school attendance, the tiers in the framework represent assessment and intervention strategies to promote school attendance and prevent school attendance problems (Tier 1); early intervention for school attendance problems which are emerging, mild, or moderate (Tier 2); and intensive intervention to address severe and/or chronic school attendance problems (Tier 3). The framework is broad because it encompasses prevention, early intervention, and treatment, and because it is relevant to all types of school attendance problems, not just school refusal.

A version of the multi-tiered approach was introduced to the field of school attendance and absenteeism by Kearney and Graczyk (2014). It was referred to as a 'Response to Intervention' model, which is one type of MTSS framework. The authors built on the success of the tiered model for learning problems and behavioural problems, applying the model to promote school attendance and reduce school attendance problems. The three tiers of the model were depicted as the bottom third of a triangle, the middle third, and the top third, each representing different levels of need for support. The higher tiers represent greater amounts of absenteeism and thus the need for more intensive interventions. For each tier, there are recommended interventions, together with assessment strategies for identifying those in need of interventions and to evaluate the effectiveness of the interventions employed (Kearney & Graczyk, 2020). A key benefit of a model like this is that it helps to organise the vast number of interventions for promoting attendance and reducing absenteeism, so that stakeholders are less overwhelmed (Heyne et al., 2022). A detailed account of intervention and assessment strategies relevant to each tier of the model was published in a book by Kearney (2016).

The 'Response to Intervention' model was recently expanded from a two-dimensional triangle depicting three tiers, to a three-dimensional pyramid in which the three tiers are depicted on each side of a multi-sided pyramid (see Figure 1). The expanded model is referred to as a 'multidimensional, MTSS pyramid model for school attendance and school absenteeism' (Kearney et al., 2019a, 2019b; Kearney & Graczyk, 2020). The sides of the pyramid represent 'domain clusters' which allow for the application of nuanced strategies. To illustrate, a professional may choose to work with the domain cluster 'type of attendance problem', and each side of a four-sided pyramid would represent one of the four domains within this cluster, namely school refusal on one side of the pyramid, truancy on the second side, school withdrawal on the third side, and school exclusion on the fourth side. Interventions applied in each tier of the pyramid, especially the second and third tiers, would vary somewhat depending on which side of the pyramid the professional was addressing (Kearney & Graczyk, 2020). For example, Tier 2 interventions for school refusal may include

anxiety management strategies and exposure-based practices to gradually increase the young person's time at school, whereas Tier 2 interventions for truancy may address parenting and supporting youth to develop self-control and conflict resolution skills (Kearney & Graczyk, 2020). The three-dimensional model contrasts with the two-dimensional 'flat triangle' model because the latter implied that youths experience the same problems and that interventions at Tier 2 would be the same for all cases, and interventions at Tier 3 would also be the same for all cases (Kearney & Graczyk, 2020).

For professionals inside and outside the education system, the MTSS model for delivering services to promote school attendance and reduce absenteeism can facilitate efficiency and effectiveness. It does this by encouraging data-based decision-making about needs, evidence-based assessment and intervention strategies relevant to each tier, and timely delivery of services before problems become more intractable and time-consuming (Kearney & Graczyk, 2020). The model counteracts a 'wait to fail' approach by encouraging a proactive approach to identifying and responding to school attendance problems (Kearney & Graczyk, 2014). It aims to ensure that as few cases[18] as possible require intensive Tier 3 interventions for severe and/or chronic attendance problems, by highlighting the importance of Tier 1 preventive interventions to reduce the likelihood of attendance problems emerging in the first place, and Tier 2 interventions to respond efficiently and effectively to emerging absenteeism. In other words, the model increases the likelihood that the right amount and type of intervention is provided at the right time.

Figure 1
Kearney and Graczyk's (2020) Multidimensional, Multi-Tiered System of Supports Pyramid Model for School Attendance and School Absenteeism

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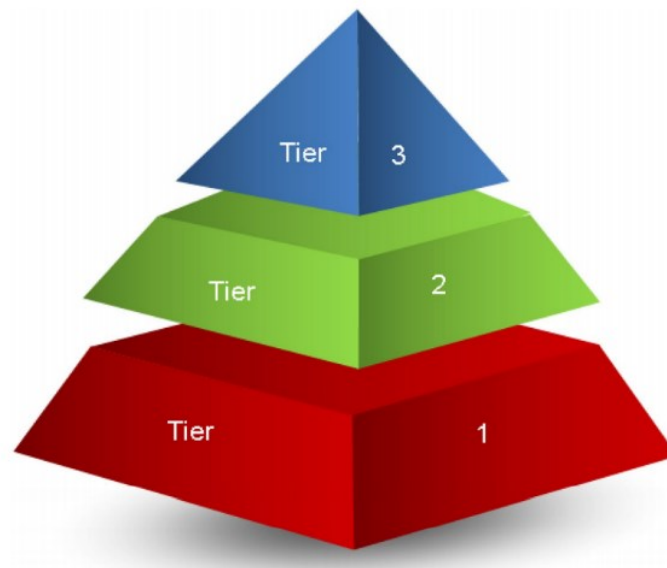
[18] We use the word cases rather than youth, in a nonpejorative way, simply to indicate that it is not only youth, or not always youth, who are the recipients of interventions for school attendance problems.

Overview of interventions for severe and/or chronic school refusal

A summary of interventions for school refusal is found in a review by Heyne, Strömbeck, et al. (2020). Across the last 40 years there have been 51 published studies on the evaluation of treatment for school refusal, including group-based studies (37%), case studies (47%), and follow-up studies (16%). Most of these studies were conducted in the USA (37%), with others conducted in Europe (25%), Australia (20%), and Asia (18%). Three of the 51 studies (6%) were based on work conducted in the Netherlands (Buitelaar et al., 1994; Heyne et al., 2011, 2014). It is not clear how many youths in the 51 studies displayed severe/chronic school refusal (Tier 3) rather than emerging/mild/moderate school refusal (Tier 2) because study authors did not employ this distinction, which is unsurprising because the tiered model was only introduced in 2014 (Kearney & Graczyk, 2014). However, information about the youths included in the group-based studies indicates that some, and perhaps many, exhibited severe or chronic school refusal. For example, the average duration of school refusal was 56 weeks in the study by Last et al. (1998); the average amount of school-time missed in the last month was 70 percent in the study by Bernstein et al. (2000) and 85 percent in the study by Melvin et al. (2017); and 64 percent of youths in the study by Heyne et al. (2002) had experienced multiple episodes of school refusal. The most evaluated interventions across the 51 studies in Heyne, Strömbeck, et al.'s (2020) review were cognitive and/or behavioural: 24 percent were cognitive-behavioural therapy (CBT), and 20 percent were behavioural intervention. This corresponds with Elliott and Place's (2019) assertion that the most popular approach to treatment for school refusal continues to be CBT, "often incorporating exposure-based behavioural programmes" (p. 7).

CBT manuals for school refusal

Five CBT manuals have been developed to target school refusal (i.e., Heyne & Rollings, 2002; Heyne et al., 2008; Kearney & Albano, 2007, 2018b; Last, 1993; Tolin et al., 2009). Table 1 presents the components of the manuals, including interventions with youths, parents, and in school settings. It also summarises the studies in which the manuals have been evaluated. As noted in Heyne et al. (2015), similarities across the manuals include treatment delivery on a case-by-case basis (rather than group therapy), consultation to school staff, and practice tasks (also called between-session tasks and home tasks). Family work on communication and problem solving between the young person and parents is incorporated in all but Last's (1993) manual. Graded exposure to attendance at school is evident in all manuals but it receives less attention in Kearney and Albano's (2007) interventions for positively reinforced school refusal behaviour. The five manuals are also similar in that they refer to interventions conducted with youths and with parents, but in varying amounts and for varying reasons.

The five CBT manuals also differ in some ways. The first manual published by Last (1993) was standardised, meaning that all cases received the same intervention. Since then, manuals encourage individualised treatment which may be based on the main function(s) served by the young person's behaviour (e.g., Kearney & Albano, 2007) or a broader case formulation

Table 1

Scope and Components of CBT Manuals for the Treatment of School Refusal

CBT as a stand-alone treatment [a]				
Authors (year) / Publication type / Target group / Evaluation	Scope of treatment	CBT components with the young person	CBT components with the parents	Other components
Last (1993) / Unpublished treatment manual / Target group not specified, but 'anxiety-based school refusal' is implied / Evaluated in trial comparing CBT and Educational Support Therapy (Last et al., 1998); 23 received CBT (mean age 11.7 years, range 6-17). Inclusion: 'anxiety-based school refusal'; anxiety disorder; current enrolment in school; at least 10% absence for at least 1 month. Exclusion: depressive disorder. Racial composition CBT group: White (92%), Black (4%), Hispanic (4%).	• 12 weekly sessions with YP (60 min for first 2 sessions, then 45-60 min) + HW for YP + telephone contact to monitor progress and provide reinforcement. • Unspecified amount of contact with parents ('Mother'). • Telephone contact with school contact person + visit to the school if required. • All cases receive the same intervention.	• Psychoeducation about treatment elements as each is introduced during treatment. • Graduated in vivo exposure (session 1 focuses on construction of an individualised 'Fear and Avoidance Hierarchy'; in each session the YP receives an exposure-based homework assignment). • Cognitive self-statement training to identify maladaptive thoughts and replace them with coping self-statements, to assist with initiation/completion of homework assignments (introduced in session 2 and reviewed thereafter in each session). • Discuss follow-up care (session 12).	• Advised of the importance of graduated exposure and allowing the child to be in control of treatment. • Rating YP's fear/avoidance hierarchy. • Asked to provide 'physical support' for the YP's exposure assignments (e.g., driving to school).	**School staff:** • Informed about YP's exposure assignments. • Informed about value of verbal reinforcement to promote attendance. • Informed about the problem of drawing undue attention to the YP. **Physician:** • Consulted if YP frequently reports somatic complaints.
Heyne and Rollings (2002) / Published treatment manual / For youths displaying school refusal and not attending school at all, attending sporadically, or attending regularly but with excessive reluctance / Evaluated in trial comparing CBT and Wait-List (King et al., 1998); 17 received CBT (mean age 10.6 years, range 5-15). Inclusion: SR following Berg et al. (1969) criteria; most had an anxiety disorder. Exclusion: intellectual or physical disability, psychotic symptoms, suicidal behaviour; parents' acute marital breakdown. Racial composition: not reported. Also evaluated in trial comparing youth-focused CBT, parent/school-focused CBT, or both (Heyne et al., 2002); 61 YP (mean age 11.5 years, range 7-14). Inclusion: less than 85% attendance in the last 2 weeks; anxiety disorder; parent commitment to child returning to regular schooling. Exclusion: CD, mental retardation, severe psychiatric disturbance. Racial composition: 92% 'born in Australia'. Also evaluated in trials of multimodal treatments reported by Wu et al. (2013) and Melvin et al. (2017).	• 8 sessions (60 min) with YP, usually 2 sessions/week + HW. • 8 sessions (60 min) with parents, usually 2 sessions per week (emphasis on both parents being involved) + HW + telephone contact as required. • Consultation with school staff + regular telephone contact. • Occasional joint sessions between YP and parents. • Treatment components are selected, sequenced, and paced as indicated by the case formulation. • Dual practitioner model.	• Psychoeducation (SR, anxiety, CBT for SR). • Goal setting. • Relaxation training. • Cognitive therapy (detecting cognition, determining whether it is helpful or unhelpful, discrediting unhelpful cognition, discovering alternative helpful cognition, doing HW related to cognitive therapy). • Problem solving. • Enhancement of social competence (social skills training) as required. • Exposure, usually graded (imaginal exposure might proceed in vivo exposure). • Relapse prevention.	• Psychoeducation (SR, anxiety and behaviour problems, CBT for SR). • Preliminary considerations (school placement, child's physical health). • Establishing household routines • Preliminary exposures (prior to school return). • Clarifying date and process for increasing school attendance. • Behaviour management strategies (minimising home-based reinforcement during school hours, instruction-giving, planned ignoring, modeling confidence, positive reinforcement). • Escorting the child to school. • Cognitive therapy. • Collaboration between parents and school staff. • Relapse prevention.	**School staff:** • Information about plans for YP's return to school. • Preparing the class for the YP's return (contingent upon YP's wishes). • Helping the YP settle in upon arrival at school. • Accommodating the YP academically, socially, and emotionally. • Planned ignoring. • Positive reinforcement. • Close monitoring. • Collaboration between school staff and parents. • Relapse prevention.

Kearney and Albano (2007, 2018b) / Published treatment manual / For youths aged 5 to 17 years displaying SRB and without primary difficulties such as learning disorder, developmental disorder, depression, hyperactivity, conduct disorder, and substance abuse. Kearney and Albano (2018) suggest that the programs are more suited to Tier 2 SRB (emerging, mild, moderate) than Tier 3 SRB (severe, chronic, complex). / An earlier version of the manual was trialed in a case series (Kearney & Silverman, 1990) with 7 YP (mean age 12.5 years, range 9-16) who had SRB for less than one year. Racial composition: All 'white'. The earlier version of the manual was also evaluated in a comparison between prescriptive CBT and non-prescriptive CBT (Kearney & Silverman, 1999) conducted with 8 YP (mean age 11.2 years, range 6-16 years) with 'acute SRB' (no longer than 15 months). Inclusion: those with complete or partial absence, and those with complete attendance but with morning problems or undue distress. Exclusion: primary depression or learning disorder. Racial composition: Caucasian = 6, African American = 1, Anglo-Hispanic = 1.	• The manual comprises four CBT programs. The 1st and 2nd programs focus predominantly on work with the YP. The 3rd program focuses predominantly on work with the parents. The 4th program focuses predominantly on work with the YP and parents together. • The choice of program(s) is contingent upon the main function(s) served by the YP's SRB. • 8 sessions (of 50 mins or longer if required) in a 4- to 8-week period (may be more or fewer sessions as required) + HW for the YP and/or parents + frequent contact between sessions + booster sessions as required. • In two-parent families, both parents are involved.	**All programs:** • Discuss form, function, treatment, and treatment rationale for SRB. • Adherence to a regular school-day schedule. • Preparing for termination. **Program 1:** • Psychoeducation (anxiety). • Relaxation training. • Systematic desensitisation, imaginal and in vivo. • Eliminating safety signals. **Program 2:** • Psychoeducation (social anxiety). • Cognitive therapy (identify negative thoughts, challenge and change anxious thoughts, use coping self-talk). • Graduated exposure (role-play and in vivo). • Processing exposure experiences. • Social skills training as required. **Program 3:** • YP comes to the treatment sessions and is told what will happen and may ask questions. • YP can think about punishments and rewards to be used by parents. • YP can be asked to comment on the daily routines. • Social problem solving if YP is asked questions about part-time attendance.	**All programs:** • Discuss form, function, treatment, and treatment rationale for SRB. • Adherence to a regular school-day schedule. • Preparing for termination. **Program 1:** • Participate in last part of each session to provide input, review the session, and learn how to help YP engage in desensitisation and anxiety management. • Support YP in conducting HW. • Facilitate adherence to a regular school-day schedule. **Program 2:** • Participate in last part of each session to provide input, review material, plan HW, and learn how to coach the YP. • Support YP in conducting and processing HW. • Implement a normal school-day routine when YP is at home. • Help the YP get to school. **Program 3:** • Restructure parent commands. • Establish regular routines. • Implement punishments for school refusal behaviour. • Implement rewards for attendance. • Ignoring inappropriate behaviours. • Forced school attendance if required.	**Program 1:** • Teachers assist with in vivo desensitisation to schoolwork as required. **Program 2:** • Teachers assist with school-based exposures as required. **Program 3:** • Inform siblings about the treatment plan as required. • Broader treatment is required if there is extreme over-protectiveness (e.g., focus on parental resistance, paranoia). • Engage siblings, ex-spouse, or school officials in command-giving and taking the YP to school, as required. • Resolve family/parent problems as required. • Help the teacher employ contingency management strategies as required. • Daily behaviour report sent home by teacher, as required. • Refer YP for physical examination if there are physical symptoms.

		Program 4: - Negotiate initial contract with YP alone. - Together with parents, develop/ implement contracts around non-SRB problems and later around SRB (specifying problem, solutions, rewards, and punishments). - Communication skills training as required. - Peer refusal skills training as required. - Cognitive restructuring procedures (related to the use of peer refusal skills) as required.	**Program 4:** - Negotiate initial contract with parents alone. - Together with YP, develop/implement contracts around non-SRB problems and later around SRB (specifying problem, solutions, rewards, and punishments). - Communication skills training as required. - Escort YP to school / from class to class, as required. - Strategies for helping a YP get out of bed, as required.	**Program 4:** - May include other children in the family in the contract process. - Improving academic performance or considering alternative academic programs as required. - Structural, strategic, transgenerational, or experiential family therapy as required. - Liaise with school officials about partial attendance, as required. - Interventions for sleep problems, as required.
Heyne et al., (2008) / Unpublished treatment manual / Applicable for YP displaying SR as defined by Berg and colleagues (Berg, 1997, 2002; Berg et al., 1969; Bools et al., 1990); the school refuser's emotional distress may be manifest in clinical or sub-clinical levels of fear, anxiety, and depression; externalising problems in the form of oppositional and defiant behaviour may also be observed at clinical or sub-clinical levels. It was not designed for youths with conduct disorder, autism spectrum disorder, or intellectual disability. / Evaluated in a non-randomised trial (Heyne et al., 2011) with 20 YP (mean age 14.6 years, range 11-17). Inclusion: 10-18 years; SR following Berg and colleagues (Berg, 2002; Berg et al., 1969); less than 80% attendance last 2 weeks; anxiety disorder (excluding obsessive-compulsive disorder & posttraumatic stress disorder); parent commitment to child returning to regular schooling. Exclusion: CD, autism spectrum disorder, severe psychiatric disturbance. Racial composition: 'Dutch origin'.	10 to 14 sessions (60 min) with YP and 10 to 14 sessions (60 min) with parents, including 2 to 3 sessions (90 min) with YP and parents together if indicated + HW for YP and parents + telephone contact as required + a monthly booster session as required for 2 months. - Treatment is usually closer to 14 sessions with the YP and parents in cases of adolescent SR. - Treatment is divided into a preparation phase (usually 2 sessions/week) and an implementation phase (usually 1 session/ week). - In two-parent families, both parents are involved. - Consultation with school staff during assessment and during two treatment-related school visits (90 min) + regular telephone and email contact. - Treatment modules are selected, sequenced, and paced as indicated by the case formulation. - Dual practitioner model.	**Standard Modules** - Reviewing the Overall Plan (presentation/discussion of case formulation & general treatment targets). - Putting Problems in Perspective (psychoeducation about SR, anxiety/depression as required, treatment components, & the treatment process). - Setting Goals (considering goals related to the presenting problems & broader goals of the YP; training in goal-setting as required). - Solving Problems (training/application of problem solving skills; fostering a positive problem orientation as required). - Managing Stress (exploring current stress management strategies; training in relaxation procedures as required). - Dealing with Cognition (training/ application of skills for detecting/ discrediting unhelpful cognition & discovering/using helpful cognition). - Attending School (development/implemen-tation of 'attendance plan'; other exposure strategies as required). - Promoting Progress (review progress regarding goals, knowledge, skills; discuss strategies to maintain gains & manage lapses). **Optional Modules** - Thinking About the Teenage Years (exploring the impact of developmental transitions & tasks; psychoeducation as required). - Dealing with Social Situations (enhancing social competence; e.g., micro-/macro-skills,	**Standard Modules** - Reviewing the Overall Plan (presentation/discussion of case formulation & general treatment targets). - Putting Problems in Perspective (psychoeducation about SR, anxiety/depression as required, treatment components, & the treatment process). - Setting Goals (considering goals related to the presenting problems, including parents' own treatment-related goals). - Reducing Maintenance Factors (exploring factors maintaining SR; problem solving discussion to determine ways to manage the factors). - Giving Effective Instructions (exploring parental instruction-giving; training in effective instruction-giving as required). - Responding to Behaviour (fostering positive reinforcement of desirable behaviour and planned ignoring of undesirable behaviour). - Bolstering a Young Person's Confidence (planning/implementing preliminary engagement tasks, e.g., increasing social contact before increasing attendance). - Facilitating School Attendance (fostering parent use of a supportive and/or steering role to facilitate school attendance). - Promoting Progress (review progress regarding goals and YP's/parents'	**Standard Modules for School Staff** - Orientation to Intervention (reviewing the case formulation; reviewing the relevance of selected CBT modules for treating SR in this case; reviewing the role of the young person, parents, school staff, & practitioners during treatment). - Organisational Issues (reviewing the 'attendance plan'; identifying a coordinator). - Emotional Issues (problem solving discussion about reducing & responding to the young person's emotional distress on arrival at school or during the day). - Promoting Progress (review progress; discuss strategies to maintain & build upon current gains, & to manage lapses). **Optional Modules for School Staff** - Behavioural Issues (problem solving discussion about strategies for dealing with externalising behaviour that may be associated with SR). - Academic Issues (problem solving discussion about ways to accommodate the young person's academic strengths and difficulties). - Social Issues (problem solving discussion about ways to address social difficulties). **Physician:** - Consulted to rule out organic basis for illness complaints.

		social-cognitive skills, increased peer involvement). • Dealing with Depression (training/ application of activity scheduling; application of skills for dealing with depression-related cognition). • Solving Family Problems (fostering the development/use of skills for effective communication and problem solving between parents and adolescent).	knowledge/skills; discuss strategies to maintain gains & manage lapses). **Optional Modules** • Thinking About the Teenage Years (exploring the impact of developmental transitions & tasks; psychoeducation as required). • Bolstering a Parent's Confidence (helping parents manage their own distress via cognitive/behavioural interventions, to better assist their child). • Solving Family Problems (fostering the development/use of skills for effective communication and problem solving between parents and adolescent).	**General:** • Promoting collaboration between school staff and parents. • Therapist consults with others (e.g., district attendance officer) to ensure a united approach across all involved in the intervention.
Tolin et al. (2009) / Journal article / adolescents displaying SR, severity warranting referral by school district / Evaluated in a case series with 4 youths aged 13 to 16 years who displayed SRB defined by Kearney and Albano (2000), all of whom had an anxiety disorder and two had a depressive disorder. A case with autism spectrum disorder and a case with anorexia nervosa were excluded. Racial composition: Caucasian = 3, Hispanic = 1. Also evaluated in an open clinical (Hannan et al., 2019); 25 received CBT (mean age 14.3 years, range 9-18). Inclusion: less than 90% attendance last 2 weeks; SR related to anxiety or depression; anxiety disorder, major depressive disorder, dysthymia, somatoform disorder, or adjustment disorder with anxious or depressed mood; family agreement to participate in intensive CBT for SR. Exclusion: substance use disorder, psychotic disorder, conduct disorder, intellectual disability, autistic disorder, safety concerns (e.g., suicidal plan or intent), psychosis, mania. Racial composition: 'All identified as Caucasian, one also identified as Hispanic.'.	• 15 sessions (90-120 min) across 3 weeks + HW for parents and YP. • CBT tailored to the function of the SRB and to the co-occurring psychopathology. • Case formulation indicates interventions to use alongside the central features of treatment. • Parents in the room with the YP for a part of every session; sometimes parents attend without the YP; in the vast majority of sessions the YP is present even when session is focused on the parents.[b]	• Central feature of treatment is graded in vivo exposure with the YP (exposure to school-related stimuli, social interactions, or feared internal sensations). • Imaginal exposure as required. • Record daily school attendance. • Cognitive restructuring as required. • Social problem solving as required. • Social skills training and behaviour rehearsal as required. • Relaxation training as required. • Motivational interviewing as required. • Sleep hygiene as required. • Establishing a daily routine as required. • Communication / conflict resolution training together with the parent, as required.	• Central feature of treatment is contingency management training with parents (e.g., use of reinforcement; making privileges contingent upon attendance targets). • Record daily school attendance. • Establishing a daily routine as required. • Facilitate graded exposure as required. • Communication / conflict resolution training together with the YP, as required. • Parent contact with police to pick up a child who has left school, as required.	**Educational specialist** • Provides recommendations for school-based modifications (e.g., YP may spend time in the school library or be tutored in an empty classroom) and liaises with school staff. **Therapist** • Consultation to school staff (e.g., to modify school schedule; to discuss ways to maintain gains) as required. • Family counseling as required (working with parents alone, modifying parent-child interaction patterns). • May accompany the child to school as required. **General** • Sessions can occur in the clinic, in the home, or at school.

Note: CBT = cognitive-behavioural therapy; YP = young person (children, adolescents, or both); SR = school refusal; SRB = school refusal behaviour, referring to the group of young people often regarded as truanting and the group of young people often regarded as displaying school refusal; HW = home-work assignments or 'between-session tasks'; CD = conduct disorder.

[a] Treatments which focus on behaviour therapy alone or in combination with other treatments (besides cognitive therapy) are not included in the Table (i.e., Berg & Fielding [1978]; Blagg & Yule [1994]).

[b] D. Tolin (2013, personal communication)

(e.g., Heyne & Rollings, 2002; Heyne et al., 2008). The standard number of treatment sessions and the duration of treatment vary, as follows: an average of 8 sessions across approximately 1 month in Heyne and Rollings (2002), 8 sessions across 1 to 2 months in Kearney and Albano (2007, 2018b), 12 sessions across 3 months in Last (1993), 10 to 14 session across approximately 2 months in Heyne et al. (2008), and 15 sessions across 3 weeks in Tolin et al. (2009). This may signal differences in thinking about how quickly the young person is likely to return to school. In some manuals, problem solving training with the young person is included routinely (Heyne & Rollings, 2002; Heyne et al., 2008), whereas in others it is included as required (Kearney & Albano, 2007; Tolin et al., 2009) or not at all (Last, 1993). Similarly, cognitive therapy interventions are employed with all youths (e.g., Heyne et al., 2008) or as required (e.g., Tolin et al., 2009). When cognitive therapy is used routinely, it might comprise training in coping self-statements to help the young person engage in exposure tasks (e.g., Last, 1993) or broader cognitive restructuring (e.g., Heyne et al., 2008; Kearney & Albano, 2007). Other CBT components commonly employed with the young person are psychoeducation, relaxation training, and social skills training, but these are not standard elements in all the manuals.

Other interventions for school refusal

Interventions other than CBT were also identified in Heyne, Strömbeck, et al.'s (2020) review of studies evaluating outcome following treatment for school refusal. Twenty-five percent of the studies evaluated some form of psychosocial intervention in addition to or instead of CBT or behavioural intervention, such as narrative therapy, multimodal treatment, parent counselling, collage therapy, and hypnosis. Sixteen percent of studies evaluated medication, either as a stand-alone intervention (4%), combined with CBT (4%), or combined with other interventions (8%) such as individual psychotherapy for the young person and casework with the parents. Studies of school refusal that did not meet criteria for inclusion in the review of Heyne, Strömbeck, et al. (2020) describe yet other forms of intervention such as psychodynamic psychotherapy (e.g., Malmquist, 1965); family therapy (e.g., Bryce & Baird, 1986); and components from acceptance and commitment therapy (ACT) alongside adaptations to account for chronic medical illness (Rohrig & Puliafico, 2018).

The use of medication in the treatment of school refusal warrants further attention because it is a contentious issue for some professionals. Melvin and Gordon (2019) published a narrative review of the last 50 years of research on the use of antidepressant medication for school refusal, the most common form of medication used with this group. Their review drew on evidence from randomised controlled trials, open trials, small case series, case studies, and an observational study. They concluded that there is no compelling evidence for the use of antidepressant medication as a monotherapy, and insufficient evidence for the adjunctive use of medication, but the combination of CBT and medication can be considered for those youths for whom psychosocial treatments have not been effective. Melvin and Gordon also presented issues to be considered when deciding about adding

psychopharmacological intervention to CBT for school refusal, such as the severity of school refusal, the age of the young person, and youth and family preferences.

Interventions focusing on anxiety and depression

Interventions for school refusal often target youth anxiety and/or depression (Johnsen et al., 2021). This is to be expected based on findings from community and clinical samples revealing that youths who display school refusal often experience symptoms of anxiety and/or depression, also at the disorder level (Maynard et al., 2018). By helping these youths manage emotional distress and increase school attendance, the broader aim of treatment for school refusal can be achieved: academic and social-emotional development (Heyne & Sauter, 2013). Youth-focused interventions for school refusal are often accompanied by interventions to help parents make it easier for the young person to attend school (e.g., how to respond to avoidant or oppositional behaviour) and interventions to help school professionals do the same (e.g., Heyne & Rollings, 2002). See Section 1.2.3 for further discussion of interventions conducted with parents and in school settings.

Professionals working with youths displaying school refusal sometimes base their intervention on CBT manuals developed for the treatment of anxiety disorders (e.g., Barrett & Turner, 2000; Kendall & Hedtke, 2006) or depressive disorders (e.g., Lewinsohn et al., 1990; TADS Team, 2003), but this practice is questionable. Heyne and Sauter (2013) presented anecdotal reports from clinical researchers indicating that treatments for anxiety or depressive disorders fail to adequately address school refusal. It was argued that manuals focused on anxiety or depression do not adequately address variations in the factors that give rise to school refusal and in how it presents. Further, while parents are suggested to have an important role during intervention for school refusal (Heyne et al., 2014; Reynolds et al., 2012; Tolin et al., 2009), there is less clarity about the need to involve parents in the treatment of anxiety disorders (Breinholst et al., 2012; Reynolds et al., 2012) and depressive disorders (Clarke et al., 1999), underscored in a recent review by Lawrence et al. (2021).

Kearney et al. (2008) similarly argued that treatment for anxiety-based school refusal involves considerations that do not necessarily apply when treating anxious youths without school refusal, including the urgency of school return, the need to consult with school personnel during assessment and treatment, and the requirement for daily monitoring of progress. Compton et al. (2010) excluded youths displaying school refusal from a study of CBT and medication for youth anxiety disorders because school refusal "may require additional or different treatments" (p. 8). Reissner et al. (2015) employed CBT to target "school avoidance *and* the underlying psychological disorder in equal measure" (p. 656, emphasis added), implying that treatment of an anxiety or depressive disorder alone would be insufficient. Manassis (2016) presented the case of a depressed child avoiding school, arguing that it would be inappropriate to simply employ a manual for the treatment of depression. According to Manassis, the parent needs to be supported to help the child return to school.

These anecdotal reports are supported by the research on treatment outcome. When an anxiety-focused manual was applied to the treatment of school refusal, the dropout rate was very high (56%; Beidas et al., 2010). This rate is higher than the dropout rates reported in studies using a treatment manual for school refusal, namely 0-27 percent (Bernstein et al., 2000; Hannan et al., 2019; Heyne et al., 2002, 2011; King et al., 1998; Last et al., 1998; Melvin et al., 2017). Beidas et al. (2010) suggested that the high dropout from general CBT treatment might occur because of a failure to specifically target school refusal. The notion that treatment specific to school refusal is likely to yield superior outcomes finds indirect support from the field of youth anxiety. The treatment of anxiety via protocols targeting a range of anxiety disorders yields smaller effects than disorder-specific treatments (Ingul et al., 2014; Reynolds et al., 2012). In addition, Hudson et al. (2015) speculated that their treatment for anxious youths was less effective for socially anxious youths because it failed to adequately address characteristics specific to social anxiety. In the same way, a treatment focused on anxiety may yield inferior outcomes relative to a treatment specific to school refusal.

Technological developments

Several technological developments in the treatment for school refusal were recently summarised by Johnsen et al. (2021). These include: the use of virtual reality in which school-related virtual environments were used to enhance youths' motivation to participate in treatment for school refusal and to enhance their cooperation during exposure tasks associated with school attendance (Gutiérrez-Maldonado et al., 2009); web-based coaching that enables the therapist to observe and support youths and parents in the home setting (Chu et al., 2015); and a mobile game that supplements early intervention and treatment for school refusal by allowing youths, parents, and professionals to work together to address problems associated with school refusal (Høiseth et al., 2020). The summary by Johnsen et al. (2021) was based on published literature about technological developments. It is very likely that there are other developments taking place around the world which are not yet published in the literature.

Effectiveness of interventions for school refusal

There is a need to know 'what works', to better help youth displaying school refusal to continue their educational and social-emotional development. Empirical studies and anecdotal reports contribute to our understanding of the effectiveness of interventions, the former via robust scientific support and the latter by shedding additional light on 'what works'. Below, we summarise findings from four reviews of empirical studies of interventions for school refusal. In Section 1.2.4 we include anecdotal accounts of 'what works' based on the reports of youths, parents, and professionals.

In 2005, King et al. published a narrative review of studies of CBT for school refusal. This was presented in the context of a broader review of behavioural or CBT interventions for anxiety and phobic disorders among youths. It thus excluded studies of other forms of intervention for school refusal. Studies published from 1980 onwards were included. They identified seven studies of CBT for school refusal, five of which were group-design studies. Based on their review of these seven studies, the authors concluded that CBT for school refusal "appears to be useful" (p. 241).

In 2008 Silverman et al. published a review of psychosocial treatments for anxiety and phobic disorders among youths, including a section dedicated to studies of treatment for school refusal. Only group-design studies were included, and stricter criteria were used for the inclusion of studies, relative to the review by King et al. (2005). For example, studies were only included if they had used structured diagnostic interviews and included at least 12 participants per treatment condition. Three group-design studies of treatment for school refusal were included (i.e., Heyne et al., 2002; King et al., 1998; Last et al., 1998). Silverman et al. (2008) employed the criteria of Chambless and colleagues (Chambless & Hollon, 1998; Chambless et al., 1996) to determine the level of empirical support for treatments. They concluded that CBT for school refusal was "possibly efficacious" (p. 109). More specifically, the classification "possibly efficacious" was applied to child/adolescent-focused CBT (Heyne et al., 2002; Last et al., 1998), parent-focused CBT (Heyne et al., 2002), and the combination of child/adolescent-focused CBT and parent-focused CBT (Heyne et al., 2002; King et al., 1998). However, these classifications appear to be based on youth- and parent-reported data about anxiety and other symptoms (e.g., fear, depression), and not in relation to amount of attendance at school.

In 2009 Pina et al. published a review focused solely on school refusal. They conducted a narrative synthesis of eight single-case experimental design studies and six group-design studies[19] of psychosocial interventions for school refusal, excluding 44 anecdotal case studies and 8 studies of pharmacological intervention. The single-case design studies focused on behavioural interventions with the young person and/or parents, and one incorporated additional cognitive therapeutic techniques with the young person. Two of the group design studies evaluated CBT (Heyne et al., 2002; King et al., 1998), one evaluated behavioural intervention alone or in combination with cognitive intervention (Kearney & Silverman, 1999), one evaluated the combination of supportive psychotherapy, social skills training, milieu therapy, and family therapy delivered in a hospital (Berg & Fielding, 1978), one compared behaviour therapy, hospitalisation, and the combination of home tuition and psychotherapy (Blagg & Yule, 1984), and one compared CBT with educational-support therapy (Last et al., 1998).

There were significant increases in school attendance and reductions in various symptoms associated with school refusal (e.g., anxiety, fear, depression, disruptive behaviour), leading

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[19] The authors referred to seven group design studies but one of these (i.e., King et al., 2001) was a long-term follow-up of subjects included in another of the studies (i.e., King et al., 1998).

Pina et al. (2009) to describe behavioural strategies alone or in combination with cognitive strategies as "promising lines of intervention" (p.11). Their review included an evaluation of effect sizes based on five of the group-design studies. Two specific conclusions were based on the analysis of effect sizes. First, they concluded that current treatments yield significant increases in school attendance and reductions in symptoms, but there is room for improving the efficacy of treatments. Second, effects can be achieved by working directly with the young person, and/or by working directly with parents and teachers.

In 2018 Maynard et al. reported the most robust evaluation of psychosocial interventions for school refusal. Their systematic review and meta-analysis only included studies with: (1) a pre-post design in the context of a randomised controlled trial (i.e., random allocation to treatment conditions) or quasi-experimental design (i.e., non-random allocation to treatment conditions); and (2) studies which reported baseline data on outcomes or used statistical controls. Furthermore, studies were rated for risk of bias in the estimates of an intervention's effects. Different to earlier reviews, the authors included unpublished dissertations alongside the published studies, which provides a more comprehensive view of available evidence. Eight studies were included, and seven of these evaluated CBT for school refusal (with the young person alone, with minimal parent involvement, or with substantial involvement of parents and teachers). The one study which was not an evaluation of CBT for school refusal was non-directive Rogerian group-based counselling in a school setting. Altogether, outcomes for 399 youths displaying school refusal were analysed, including youths from Australia, the United States, Canada, England, Kuwait, and China.

Across the eight studies there was a positive and significant effect for school attendance, and this effect was described as a robust finding. Based on the effect for school attendance, the authors suggested that there is "tentative support for CBT for the treatment of children and adolescents with school refusal" (Maynard et al., 2018, p.61). Most of the reviewed studies included several risks of bias, which could have increased effect sizes. At the same time, the comparison treatment in two of the six studies of psychosocial treatment[20] was a variant of CBT (Heyne et al., 2002; Richardson, 1992), which may have reduced the overall mean effect. Across the six studies that measured youths' anxiety, there was no significant effect at post-treatment. The authors suggested that increased exposure to school by virtue of increased attendance could lead to an increase in anxiety, at least in the short-term (i.e., at posttreatment). They called for studies with long-term follow-up to determine whether increased school attendance among youths is, in the longer term, also accompanied by decreased anxiety.

Authors of recent narrative reviews have similarly pointed out the need for long-term follow-ups (Elliott & Place, 2019; Johnsen et al., 2021). To date, the strongest support for the durability of treatment gains following CBT for school refusal comes from the study of King et al. (2001). Thirteen of the sixteen families who participated in the treatment study of King et al. (1998) were able to be located at long-term follow-up, three to five years after

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[20] Six of the eight studies focused on psychosocial treatment; the two other studies involved use of medication.

treatment. Improvements in school attendance were maintained and no new psychological problems were reported.

Conclusion

Interventions to promote school attendance and reduce school attendance problems can be organised according to three tiers in the MTSS model: Tier 1 interventions to promote attendance and prevent absenteeism, Tier 2 interventions to respond efficiently to emerging, mild, or moderate school attendance problems, and Tier 3 interventions for severe and/or chronic school attendance problems. The Knowing What Works project has a specific focus on school refusal interventions in Tier 3.

Diverse interventions have been employed to address school refusal. CBT is the most evaluated intervention in treatment outcome studies. Variations of CBT have been employed (e.g., varying according to the number of sessions, duration of treatment, and the extent to which parents and school staff are involved), but treatment manuals usually include recommendations for intervention with the young person, parents, and school staff (Heyne et al., 2015). The positive impact of CBT on school attendance is supported by narrative reviews and a meta-analysis. The narrative reviews also suggest a positive impact on symptoms such as anxiety and depression, but this is yet to be supported via robust evaluation in a meta-analysis of studies including longer-term follow-up. Despite the promise of CBT, a sizable group of youths is not helped by current interventions, and there is still a great need to improve interventions (Heyne, 2019).

Research needs to address the factors that account for or 'explain' change when interventions for school refusal are employed (Maynard et al., 2018; Pina et al., 2009). According to Pina and colleagues, "knowledge of mediators could be key for exporting evidence-based school refusal behavior interventions from research settings to community settings and into the hands of service providers" (p. 18). The Knowing What Works project addresses the question of 'what works', not through robust evaluation of mediating factors measured during the implementation of interventions, but by asking professionals, youths, and parents to reflect upon those elements in intervention that they regard as important and helpful.

The question of 'for whom' interventions work also needs to be addressed (Elliott & Place, 2019; Maynard et al., 2018), for example, based on sociodemographic or clinical characteristics. The Knowing What Works project also addresses this question of 'for whom' interventions for school refusal work. Professionals were asked about the young people and families who respond most and least to their interventions.

1.2.3 Collaboration Between Professionals in Education and Mental Health

Previously, there was a lack of collaboration across disciplines

For more than a century, the efforts of practitioners and researchers to understand and respond to absenteeism usually occurred within – rather than across – different disciplines. Some of these disciplines included child development, education, psychology, medicine and psychiatry, social work, sociology, criminal and juvenile justice, cultural politics, and public and educational policy (Heyne, Gentle-Genitty et al., 2020; Kearney et al., 2019a).

Historically, many interventions for school refusal have been psychological in nature (see Johnsen et al., 2021). Indeed, the interventions included in the reviews described in Section 1.2.2 were often psychological in nature and they were provided in clinical settings. For example, seven of the eight studies in Maynard et al.'s (2018) review evaluated a variant of CBT, and five of the eight were conducted in clinical settings. The tradition of understanding and responding to school refusal as a predominantly psychological problem likely has its roots in the tendency to characterise school refusal by the presence of emotional distress associated with school attendance. Heyne et al.'s (2019) inventory of the terms used to refer to school refusal across the last 90 years illustrates the tendency to understand school refusal as a psychological problem, evident in terms such as 'stay-at-home neuroses' (Partridge, 1939), 'phobia' (Johnson et al., 1941), 'separation anxiety' (Estes et al., 1956), 'school anxiety' (Morgan, 1959), 'emotional absenteeism' (Frick, 1964), and 'internalising school refusal disorder' (Young et al., 1990, as cited in Kearney, 2003). A focus on interventions conducted in clinical settings may also be explained by the tradition of not providing mental health interventions in school settings, until quite recently (Heyne et al., 2022).

CBT is a psychological intervention often argued to be the therapy of choice for school refusal (e.g., Elliott & Place, 2019). At the same time, it is understood that cognitive and behavioural interventions with the young person need to be supplemented "by working closely with family and school staff" (Elliott & Place, 2019, p.11), thereby addressing the multicausality of school refusal. To be sure, practitioners working with youths to address the mental health issues associated with school refusal have often included an emphasis on family influences and school influences in their interventions for school refusal.

In the sections that follow, we illustrate the attention that has been paid to family influences in interventions for school refusal, and to school influences. Respectively, these suggest a focus on mental health interventions, and a focus on educational interventions. Thereafter, we draw attention to reports of professionals from different disciplines working together to develop and/or deliver intervention for school refusal. When professionals from different

disciplines work together, it may be multidisciplinary or interdisciplinary (Choi & Pak, 2006). The multidisciplinary approach is an 'additive' approach because professionals from multiple disciplines share knowledge with each other, but they stay within their boundaries. The following three examples could be regarded as multidisciplinary collaboration: (1) various professionals (e.g., a teacher, school administrator, social worker, and psychologist) meet to share their perspectives on a youth's absenteeism; (2) a mental health professional develops and implements a fundamentally psychological intervention for school refusal and invites education professionals to participate; and (3) education professionals implementing strategies in educational settings such as 'alternative educational programs' invite mental health professionals to support the intervention. The interdisciplinary approach, on the other hand, is an 'interactive' approach in which professionals analyse, synthesise, and harmonise the links between their respective disciplines into a coherent whole (Choi & Pak, 2006). For example, when mental health and education professionals work together to develop and deliver an integrated intervention for absenteeism, this could be regarded as interdisciplinary (Heyne et al., 2022). As another example, when a psychologist consulting to school personnel about a particular young person engages the school personnel in the conceptualisation of the youth's difficulty attending school and the development of an intervention plan, the intervention for that young person can be considered interdisciplinary. In this report we refer to collaboration which is multidisciplinary or interdisciplinary as 'multiple disciplinary', following Choi and Pak (2006). Multiple disciplinary collaboration is held to be important for advancing both knowledge and practice in the field of school attendance and absenteeism (Heyne, 2019; Kearney, 2019).

Mental health interventions

Interventions that have a positive impact on mental health can be provided by different types of practitioners and in different settings. For the purposes of this report, we use the term 'mental health interventions' to refer to interventions which are provided by mental health practitioners, typically although not exclusively in a mental health setting.

Mental health interventions include those conducted with the young person (e.g., the psychological interventions noted in Section 1.2.2), but mental health practitioners also employ interventions with parents and families. According to Elliott and Place (2019), "the influence of the family is a key factor to consider in developing a treatment plan" (p. 9). There are numerous reports of family therapy in cases of school refusal (e.g., Bryce & Baird, 1986; Conoley, 1987; Richardson, 2016; Wetchler, 1986), although evidence that family therapy is as effective as individually focused therapies is lacking (Elliott & Place, 2019). Behavioural and cognitive-behavioural interventions also promote attention to family influences and parenting practices associated with school refusal. For example, of the five CBT manuals developed for school refusal, four include family work on communication and problem solving (Heyne & Rollings, 2002; Heyne et al., 2008; Kearney & Albano, 2007; Tolin et al., 2009). These manuals also emphasise work with parents on practices such as the

establishment of regular household routines, minimisation of home-based reinforcement during school hours, effective instruction-giving, consequences for attendance and absence, and increasing confidence for managing school refusal. More recently, Minamitani and Matsumoto (2018) reported a six-session group-based CBT parent support program. Because of the role parents need to play in supporting their child by helping them confront and cope with anxiety-provoking situations, the program includes stress management and cognitive restructuring, to benefit the parents' well-being and parenting practices.

There are several published reports of mental health professionals conducting interventions for school refusal in educational settings. In the USA, school-based group therapy was conducted with six adolescents displaying school refusal (Contessa & Paccione-Dyszlewski, 1981). Prior to the group therapy, individual therapy focused on insight and desensitisation to the school setting. The subsequent group therapy was non-directive, whereby the counsellor used restatement, reflection, and indirect questioning. During 8 months of weekly group sessions of 50 minutes, the topic often turned to school-related issues of fear of failure, inability to cope, and frustration. Strong, supportive relationships and deep levels of trust developed among the group members, and there was increased school attendance for five of the six adolescents. In Japan, Maeda (Maeda, 2012, 2016; Maeda et al., 2012) employed a school-based behavioural intervention for school refusal among adolescents. He as psychologist consulted to school staff and parents to support them in implementing a rapid return to school. No individual therapy was provided to adolescents because of their refusal to accept support.

Educational interventions

Interventions for school refusal include those conducted by education professionals, typically in educational settings (e.g., a school or educational service). In this report we refer to these as 'educational interventions'.

School influences on the development or maintenance of school refusal need to be accounted for in interventions for school refusal. A young person displaying school refusal may only feel comfortable and confident enough to re-engage with education when school staff 'lower the hurdles' for school attendance by reducing the factors that 'push' a young person away from school and increasing the factors that draw or 'pull' them towards school. The five CBT manuals for school refusal introduced in Section 1.2.2 all encourage the practitioner to attend to school influences, such as: modifications at school to accommodate the young person academically, socially, and emotionally (Heyne & Rollings, 2002); using positive reinforcement in the school setting to promote attendance (Last, 1993); daily communication between the teacher and parents (Kearney & Albano, 2007); helping school personnel consider the ways in which therapeutic gains can be maintained in the school setting (Tolin et al., 2009); and increasing understanding and motivation among school staff by collaboratively reviewing the case formulation (Heyne et al., 2008). This last point is

underscored by Elliott and Place (2019) in their review of developments in the conceptualisation and treatment of school refusal. They argued that the practitioner needs to assess the perspectives of school personnel regarding the reasons for a youth's refusal to attend school, because these perspectives "may impact on the willingness of school staff to be maximally supportive to the child" (p. 7). For an illustration of why and how school influences were addressed in the context of a psychological intervention for school refusal, see Heyne et al. (2014).

Other school influences that may warrant attention during intervention for school refusal are found in Ingul et al.'s (2019) review of characteristic of the school setting which have been associated with school refusal. These include: aspects of the classroom situation (e.g., problematic student-teacher relationship; lack of teacher support; feeling disbelieved, blamed, and punished; fear of the teacher; lack of classroom monitoring; noisy and unpredictable classrooms; transition moments such as moving between rooms or changing from individual work to group-based work); aspects of the school more generally (e.g., fear of less structured aspects of school such as break times; the sense of attending a dangerous school); social aspects (e.g., peer victimisation, difficulty making friends, feeling isolated); and educational aspects (e.g., academic difficulties, learning disorders, anxiety about academic performance, and a mismatch between the young person's ability and the academic demands of school). Brouwer-Borghuis, Heyne, Sauter, et al. (2019) also signalled the need to account for school-related influences when providing intervention for school refusal, drawing on Zullig et al.'s (2010) framework of school climate and its five domains: (1) order, safety, and discipline; (2) academic outcomes (including academic performance and perceptions of the academic program); (3) social relationships, including contact with peers and contact with teachers and other school personnel; (4) school facilities; and (5) school connectedness (including eagerness to learn, feeling valued, and having positive feelings about school).

Educational interventions for school refusal can be particularly important for adolescents. Adolescence is the period in which school-related factors are held to play a greater role in school attendance problems (Galloway, 1985). Educational interventions can also be important for youths with developmental disorders. Youths who have developmental disorders need special educational methodologies (Nishida et al., 2004). Alternative educational programs (AEPs) for youths displaying school refusal provide a setting in which methodologies such as these can be implemented, helping autistic youths displaying school refusal to re-engage with education (Brouwer-Borghuis, Heyne, Sauter, et al., 2019).

Attention to both educational interventions and mental health interventions

Collaboration between professionals in education and mental health can be expected for multiple reasons. First and most obvious, education professionals and mental health professionals both encounter school refusal. Second, school refusal "intersects with both

education and public health policies because of its potentially serious academic, social, and psychiatric consequences" (Sibeoni et al., 2018). Third, there are multiple influences on school refusal (Heyne, 2006), as there are on school attendance problems more generally (Melvin et al., 2019). The family influences that have been associated with school refusal include maladaptive family functioning and parent psychopathology (Heyne et al., 2015), indicating the value of involvement by mental health professionals. The school influences noted above point to the value of intervention by education professionals. Fourth, real-world problems, like school refusal, are often complex and not confined to the artificial boundaries of disciplines, calling for the perspectives of professionals who see things differently, achieve sophisticated understanding, derive consensus definitions and guidelines, and provide comprehensive services (Choi & Pak, 2006). The provision of a palette of interventions for school refusal is more likely to meet the needs of complex cases (Heyne, 2019), and the broader the range of professionals involved, the broader the palette can become.

The literature reveals various examples of multiple disciplinary work to meet the needs of youths with severe and/or chronic school attendance problems. These are multimodal interventions, comprising diverse interventions conducted by mental health and education professionals, among others. Following, we provide a short overview of seven programs we identified, noting the ways in which education and mental health interventions were incorporated in the program.

McShane et al. (2007) reported on the 'Sulman Program' in Australia, an adolescent mental health and education program located at a special education high school adjoining a psychiatric unit. It was designed to better meet the needs of socially anxious adolescents with anxiety-based school attendance problems. Adolescents participated in a multimodal program tailored to their individual needs (e.g., graded exposure to public transport and various social situations), three days per week across the school year. A mental health professional was available within the school setting, engaging the adolescents in activities and responding to their social, emotional, and practical needs. According to McShane and colleagues, the controlled nature of the school environment was instrumental to positive outcome, as was the provision of taxi transport to the facility. The provision of transport helped increase the adolescents' motivation for attendance, partly by reducing uncontrolled social situations that can occur on public transport and lead to non-attendance.

Walter et al. (2010) reported on an inpatient mental health service in Germany, which included access to a school for special education. The intervention was designed to provide support to adolescents with chronic anxious-depressive absenteeism, including adolescent, parent-, and teacher-focused interventions. In severe cases (i.e., complete school absence for more than 3 months), intervention included attendance at the special school. The school was located near the inpatient unit and employed teachers with expertise in educating youths with psychiatric disorders. The aim was that adolescents would return to mainstream education as soon as possible. In a subsequent report, Walter et al. (2014) described outcomes for adolescents in the treatment program, nearly 70 percent of whom had been

enrolled in the special school. According to the authors there is a small group of adolescents with chronic absenteeism who "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).

Grandison (2011) reported on a 'Short Stay School' program in England. The program was for youths with medical and mental health needs, most of whom were adolescents displaying school refusal. It was staffed by professionals from education and health services and jointly funded by both services. Progress evaluations every six weeks involved a meeting with the young person, their parents, the head teacher and learning mentor from the Short Stay School, and personnel from the mainstream school. The meetings were conducted prior to the adolescent's transition back to mainstream education and involved making plans for the reintegration. School-related anxiety was addressed via graded exposure to the Short Stay School and then to mainstream education (Thambirajah et al., 2008). All five youths included in the report of Grandison (2011) had contact with Child and Adolescent Mental Health Services, although the nature of the interventions was not described. The factors held to positively influence the transition back to mainstream school were the phased and personalised approach to reintegration, and the collaboration between parents, school staff, and staff of the Short Stay School (Grandison, 2011). According to the authors, viewing school refusal as principally the work of mental health professionals contributes to a feeling of disempowerment for education professionals and parents. School staff may feel "disempowered and ill-equipped to deal with what may appear to them to be mental health problems," but this is not the case according to the authors (p. 182). For example, school-based mentors helped the youths explore and understand their emotions, and this was supportive of reintegration to mainstream school. According to Grandison, "school refusal behaviour has a mental health dimension that needs to be addressed although this work is probably not the sole domain of Child and Adolescent Mental Health Specialists," because parents, mentors, and perhaps peers may have useful roles to play as well (p. 185).

Another intervention in England is an alternative educational program for adolescents with autism spectrum disorder (ASD) and anxiety-based absenteeism, described by Preece and Howley (2018). 'The Centre' was located in a small school building and managed within a service for students not attending mainstream school because of complex medical or mental health conditions. It was staffed by a full-time class teacher, supplemented with specialist subject teachers as appropriate, and supported by a senior colleague. To help adolescents prepare for re-engagement with formal education, attention was devoted to their wellbeing, relationship building, frequent face-to-face communication between Centre staff and families, and an autism-friendly surrounding (e.g., structured classroom layout and clarity about the functions of the different areas). By and large the intervention appears to be an educational intervention (i.e., intervention in a school classroom, facilitated by education professionals) but there was also attention to youths' social-emotional needs, and additional support for parents via external professionals (e.g., group training in anxiety management). The seven adolescents with ASD and anxiety-based absenteeism showed improved attendance, engagement with an educational curriculum, increased psychological wellbeing,

and decreased psychological distress. Parents felt supported because staff responded to their needs (e.g., referral for other external support such as befriending schemes). A range of factors were believed to have contributed to the positive outcomes, including: an adapted learning environment (e.g., small class size, individual work); individual goals for curriculum, transition, personal/social goals, and attendance; flexibility and creativity in adopting good practice approaches for ASD and school refusal; consistency across all staff involved (e.g., using common terminology, clear criteria for inclusion); open communication with parents and other professionals; and close collaboration with all persons involved. According to the authors, "the Centre's collaborative approach and effective communication were identified by team members, external professionals and parents alike, and contributed to the development of effective partnership working, with shared goals and a shared focus" (p. 477).

The 'Multimodal Treatment' in Germany is described in detail in Reissner et al. (2019). It was developed for youth referred to a mental health setting who display school refusal, truancy, or both. Funded by a mental health service, it targets a wide range of mental health problems characterised by internalising and externalising behaviour and it seems well suited to addressing the diversity and complexity inherent to school attendance problems. The intervention was developed by a multidisciplinary team (i.e., psychotherapists, psychiatrists, psychiatric nurses, social workers, teachers, and a sports scientist) which also delivers the intervention and engages in regular case conferences. CBT for the young person is the central module, but the family-, school-, and peer-related aspects of school attendance problems are addressed via modules on family counselling, school counselling, and a psychoeducational physical exercise program for youths to address physical exercise, team building, social competency, and motivation. Motivational interviewing is included in all four Multimodal Treatment modules. There is the possibility to conduct home visits because they can increase therapeutic engagement among unmotivated youths and families.

'The Link'[21] program in the Netherlands is for adolescents displaying school refusal (Brouwer-Borghuis, Heyne, Sauter, et al., 2019). In most of the cases described by Brouwer-Borghuis and colleagues, youths included in the program were fully absent from school for half a year. The Link relies on education-based funding but fosters close collaboration with mental health services. For example, therapists from mental health services with an established alliance with The Link attend the Link classroom. The classroom provides an intermediary schooling experience, which serves as a link between prior absenteeism and subsequent engagement with a more typical educational setting. This adapted educational setting is one of three main emphases in the intervention, the other two being the adoption of a CBT orientation by Link staff and collaboration between everyone involved (i.e., youth, parents, Link staff, staff from the original school, and therapists). According to Brouwer-Borghuis and colleagues, collaboration is time-intensive but the consistency of intervention that is achieved via multidisciplinary meetings seems imperative to successful outcomes.

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[21] 'The Link' intervention is offered by various organisations included in the current Knowing What Works project.

Like the Multimodal Treatment in Germany, there is also provision for home visits by Link staff.

The 'In2School' intervention in Australia is described in detail in McKay-Brown et al. (2019). Designed specifically for youths displaying school refusal, In2School is housed in a special education facility located at a mental health service and provided in kind by the mental health service. Researchers, teachers, and mental health clinicians developed the intervention because of the range of problems that youths displaying school refusal can experience. The education- and health-focused partnership is underscored by the collaboration between the two teachers and a clinician (across time the clinician role has been fulfilled by a social worker, psychiatric nurse, or psychologist). The team shares knowledge, they develop individualised mental health 'care and recovery plans' and educational 'individual learning plans,' and they collaborate in outreach to youths, parents, and teachers at the youths' mainstream school. Table 2 lists the broad range of interventions undertaken by the clinician, the teachers, and the clinician and teachers in partnership. Like in The Link (Brouwer-Borghuis, Heyne, Sauter, et al., 2019), the young person spends time in a transitional classroom before returning to mainstream education. The transitional classroom provides opportunities for students to build resilience and help-seeking skills (L. McKay-Brown, personal communication, September 25, 2018). There is a gradual increase in the amount of time the young person spends in the transitional classroom and the number of classmates present. There is also a closely supervised gradual return to the mainstream school. Therapeutically, narrative-informed work with the young person is provided alongside cognitive-behavioural interventions.

Conclusion

Multiple disciplinary collaboration is important for advancing knowledge and practice in the field of school attendance and absenteeism (Heyne, 2019; Kearney, 2019). However, the research literature indicates that widespread uptake of multiple disciplinary models of school attendance problems is elusive (Heyne et al., 2022). Perhaps the practice of responding to school refusal in the Netherlands is different, reflecting considerable collaboration between education and mental health services to address the multiple influences on school refusal. In the Knowing What Works project, collaboration between professionals from education and mental health may well be identified as a key element of 'what works' in intervention for school refusal.

The complexity associated with school refusal and its management suggests that additional forms of collaboration – other than between professionals from education and mental health – may also be identified as important. 'Multiple partners' may signal the importance of collaboration between professionals and teams from numerous disciplines and settings,

Table 2

Summary of Key Tasks Undertaken During Each Phase of the In2School Interdisciplinary Intervention for School Refusal

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. From McKay-Brown et al., 2019, p. 97. Copyright 2019 by Elsevier. Reprinted with permission.

such as school staff, education services such as INGRADO, and mental health services, but also community services offering resource-based support (e.g., Sugrue et al., 2016). 'Teamwork' may signal the importance of collaboration between professionals providing an intervention for school refusal, irrespective of their disciplines (e.g., Chu et al., 2015). 'Comprehensive intervention' may signal the importance of collaboration between professionals, the young person, and the family, to effect change (e.g., Anderson et al., 1998; Chhabra & Puar, 2016; Conoley, 1987; Gosschalk, 2004; Heyne et al., 2014). 'Scientist-practitioner partnerships' may signal the importance of practitioners and researchers working together to gain a better understanding of what works in real-world settings, and for whom (Johnsen et al., 2021). The Knowing What Works project explores the nature and perceived importance and helpfulness of various forms of collaboration in the context of school refusal interventions in the Netherlands.

Just because collaboration is considered important for effective intervention for school refusal, it does not mean it is easy to achieve. Kearney (2019) noted that "mental health professionals sometimes see attendance problems as solely within the realm of school-based professionals, and school-based professionals sometimes see attendance problems as solely within the realm of mental health professionals" (p. 1). Elliott and Place (2019) referred to the challenging practicalities of developing and delivering interventions across professional borders. According to Sibeoni et al. (2018), the lack of established guidelines for collaborating on intervention for school refusal makes it difficult to coordinate efforts between education professionals, mental health professionals, and families. Organisational and policy issues may hinder rather than help collaboration. For example, inadequate collaboration may stem from a school team's difficulty gaining sufficient or timely consultation from professionals in a mental health service, and professionals in the mental health service may be restricted in the extent to which they can provide regular consultation to education professionals. Consultation by mental health practitioners to school staff may be more challenging when school refusal occurs in adolescence, because adolescents have contact with a greater number of teachers than children, perhaps making it more difficult to gain the co-operation of multiple school staff in an intervention for school refusal (Heyne et al., 2008). The Knowing What Works project explores professionals' perspectives on the challenges associated with collaboration.

1.2.4 Listening to the Voices of Stakeholders in School Refusal Interventions

Increasingly, the voices of multiple stakeholders are considered important in the development and delivery of interventions for school attendance problems, including school refusal. The International Network for School Attendance (INSA) noted that "contemporary models for understanding and reducing absenteeism will be enhanced by the voices of all stakeholders: youth who display little or no absenteeism, youth who are absent, parents,

education and helping professionals, policy-makers, and representatives of specific cultural and indigenous (first nation) groups" (Heyne, Gentle-Genitty et al., 2020). According to Johnsen et al. (2021), attention to these diverse voices becomes even more important as we experience rapid changes in educational and social landscapes, such as educational reform, online learning, and social media. Following, we summarise studies addressing stakeholder experiences and views related to intervention for school absenteeism, including the small number of studies focused on school refusal in particular.

The experiences and views of professionals

Intervention for absenteeism

Ground-breaking work eliciting the voices of professionals was conducted by Reid, in the UK. He reported on interviews conducted with head teachers from primary, junior, infant, and nursery schools, including special schools, with a focus on attendance issues in primary school (Reid, 2004). He also conducted interviews with head teachers, deputy heads, middle managers, and form tutors about attendance issues in secondary schools (Reid, 2006a). For these professionals, the management of absenteeism was complex, time consuming, and sometimes non-systematic. In another study by Reid (2006b), social workers and welfare officers from education support services shared their views about the management of absenteeism, via questionnaires and during interviews. Many of these professionals held views about the management of absenteeism that were at variance with government strategies. They emphasised the need for greater access to alternative or vocational curriculum schemes, including out-of-school centres for absentee youths, which contrasts with legislation oriented towards penalties for persistently absent youths and their parents.

More recently, two other UK studies addressed the voices of professionals. Finning et al. (2018) conducted interviews with 16 education professionals from across three secondary schools in the south-west of England. They were asked about their experience of working with students displaying school attendance problems, and their experience of interventions for these problems. Regarding the former, practitioners spoke about difficulty understanding the causes of school attendance problems, how resource-intensive school attendance problems are, and how emotionally challenging it is to address these problems. When asked about interventions, the practitioners spoke about the need to provide emotional support. This includes nurturance, building students' resilience, and providing mental health support. They also spoke about making adaptations to the school context. Adaptations include personalised learning in an alternative educational program, reduced timetabling, supporting reintegration back into school via virtual classrooms accessible from home, and providing a calm environment at school. Home visits were also regarded as helpful in the process of helping students return to school.

Tobias (2019) used interviews to elicit the experiences and views of 19 family coaches working in a single local authority in south-east England, to understand factors that help and hinder return to school after persistent school non-attendance. A grounded theory emerged, with implications for coaching work to address absenteeism. According to the author, interventions need to help the young person feel safe, by addressing environmental stressors such as the lack of a secure base for the young person in the home environment. A relationship-based intervention addresses the young person's need to be seen and supported, by listening to and caring about the young person, identifying and addressing difficulties, and supporting the young person via changes to the educational environment (e.g., a quiet space at lunchtime for a socially anxious young person; changes to educational provision so the young person feels they can fit in better).

Coaches who were interviewed suggested that the greatest success occurs when emphasis is placed on building parent confidence and capacity. Coaches come "alongside parents" to help them feel safe and secure, provide constant reassurance, be sensitive towards their needs and readiness to make changes, and help them care for themselves and become empowered, allowing the parents to think longer term and be better able to set boundaries and assume a more authoritative role (p. 25). According to the coaches, the effectiveness of intervention is threatened when systems are inflexible and resistant to change or sabotaging the change process. This can occur when there is conflict between organisations (e.g., overstretched services moving responsibility for management of a case onto another service), and when the school system is restrained by a focus on educational targets and unaware of circumstances in the home. Tobias suggested that "intervention is more likely to be successful where all the relevant systems are cooperating, and share aims and values" (p. 29). Other factors held to hinder change were the young person's rejection of support (e.g., refusing to come out of their room or to talk), and parents' sabotaging efforts to bring about changes in the family, sometimes because parents themselves are in an unsafe place and unable to accept help. According to the coaches, the biggest factor impacting success was whether change could be made in the family home, bringing about sufficient change "within a backdrop of wider adversity" (p. 28).

In the USA, Sugrue et al. (2016) interviewed 23 community agency staff from nine agencies in an urban-suburban county. The agencies provided a program to address chronic school absenteeism (≥10% absence in a school year) among elementary school-age children (kindergarten to 5th grade). The professionals were asked about the common interventions and services provided during the part of the program that involved 90 days of community-based case management offered to families when a child reaches nine unexcused absences from school. Thematic analysis of the responses yielded three main categories of supports and services provided to families: resource-based (e.g., food, clothing, mental health counselling), relationship-based (e.g., between school and family, or child and teacher), and information-based (e.g., school policies on attendance). The professionals were also asked which services and supports they regarded as most and least helpful, although responses to this question were not reported as main themes. Sugrue and colleagues presented incidental accounts of difficulties caseworkers experienced when providing services to address

absenteeism. For example, one caseworker reported difficulties getting housing support for families while others noted that school staff displayed varying levels of cooperation when effort was made to improve the relationship between the family and school. There was no thematic analysis of the qualitative data related to these difficulties.

Intervention for school refusal

The studies summarised thus far addressed professionals' voices on interventions for school absenteeism in general. Very few studies have addressed professionals' voices on intervention for school refusal. The only study to address this directly was conducted by Kljakovic and Kelly (2019). They elicited the views of 14 professionals working with youths displaying school refusal (i.e., youths who were extremely socially withdrawn and unable to attend mainstream education) in England.[22] The professionals worked in the Pupil Referral Unit (an alternative educational program), the Child and Adolescent Mental Health Service, and the Social Inclusion Panel (comprising multi-agency professionals who coordinate care for vulnerable youths). The researchers sought to understand the needs of these youths, factors contributing to their withdrawal from school, and what is needed for them to reintegrate in school. Three group interviews yielded qualitative data analysed using thematic analysis.

The three main themes that emerged in the study of Kljakovic and Kelly (2019) were: "(1) the varied and complex nature of the problem, (2) barriers to helping these young people and (3) the need to hold on to hope" (p. 926). Regarding the first theme, the recurring features of cases encountered by professionals included the complexity of the youths' needs and presentation, parent-child relationship issues, and difficulty in the relationship between services and parents. Professionals also spoke about the lack of clarity about what causes these youths to withdraw. Regarding the second theme, professionals spoke about system factors (e.g., the ineffectiveness of standard practices within services), incongruent goals (e.g., difficulty engaging the young person and family due to limited staffing resources, which then makes it difficult to work towards a shared goal; the different agencies involved work towards competing goals), and societal pressure (e.g., youths and their families are faced with unrealistic expectations). Regarding the third theme, professionals described three areas that are important if change is to occur. These included 'intensive and hopeful' (e.g., intervention needs to be intensive; professionals need to build strong relationships and remain hopeful to instil hope in youths and families), 'gradual change' (e.g., creating a supportive environment in which there are opportunities for youths to gradually socialise with others in a similar position), and 'sharing the workload' (e.g., positive outcomes rely on a collective approach between professionals and the family). When discussing the results, the authors argued that an "intensive approach to supporting vulnerable young people on

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[22] The authors appear to use the term school refusal in the broader sense of withdrawal from school. However, the specification that youths were extremely socially withdrawn and unable to attend school, and the finding that 48 percent of youths were in the clinical or borderline range for separation anxiety disorder, suggests that many of the youths may have met the criteria for school refusal as reported in Heyne et al. (2019).

the edge of society" calls for "an integrated and multi-agency approach that spans health, local authority and education" (p. 932). They also called for further research to better understand how to intervene effectively.

Most recently, Devenney and O'Toole (2021) addressed the experiences and views of 17 education professionals working in secondary schools in Ireland, with a focus on school refusal. Although the study did not directly focus on intervention, a theme that arose relates to school responses. The theme included responses about monitoring student attendance, linking with outside agencies as needed, working closely with each young person and their family, promoting cooperation between the family and school, fostering positive attitudes to lifelong learning, trying to get youths back into school, and supporting students who feel overwhelmed by making sure school is perceived as a safe and calm space (e.g., providing a personal time-out pass and access to a relaxation room in the school). There was also reference to parents feeling "as if they have been cast adrift," with minimal support from school personnel (p. 38). Youths' mental health and wellbeing were addressed via weekly wellbeing programs, but some professionals reported that these strategies were often ineffective. According to some professionals, medication for managing anxiety helped youths cope with worries related to school and to actually make it into the school building. Most professionals also spoke about the "difficult and strained relations between school personnel and students/parents and between school and support services," as well as the impact of school refusal on the relationship between the student and teacher (p. 36). This issue of relationships connects with the topic of collaboration, presented in Section 1.2.3.

The experiences and views of youths

In research on school absenteeism, "the voice of the child is barely represented" (Baker & Bishop, 2015, p. 356). Some studies have explored youths' experiences of, and reasons for absence from school (e.g., Baker & Bishop, 2015; Gregory & Purcell, 2014; Keppens & Spruyt, 2017; Kljakovic et al., 2021; Malcolm et al., 2003). Sometimes this yielded spontaneous reports about responding to absenteeism, such as the school's response, and authors then made suggestions about intervention (e.g., Gregory & Purcell, 2014). However, very few studies have intentionally elicited youths' voices regarding intervention for school attendance problems. Following, we summarise a study focused on youths' perspectives on the support they received, and a second study indirectly addressing this topic.

Baker and Bishop (2015) interviewed four secondary school-aged youths from one Local Education Authority in the South of England. These youths had been absent from school for at least one year.[23] During semi-structured interviews, the youths were asked about the support they received and their thoughts on what could have been done differently. All four

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[23] Baker and Bishop (2015) used the term 'extended non-attendance'. Some of the characteristics of the absenteeism displayed by these youths are reminiscent of what is often referred to as school refusal.

youths mentioned a delay in the school's response, and they spoke negatively about the pressure they felt to return to school quickly. All four had experience with mental health services, one youth mentioning that this was helpful "until the worker [I] had a relationship with left," and one mentioning that medication helped (p. 361). Suggestions made by the youths about what could have been done differently included the school responding sooner, offering more support and understanding, and using a more phased approach to school return. According to Baker and Bishop, the study points to the need for "a swift but individually tailored response" to absenteeism, and for improved multi-agency work which provides a response that is appropriate, speedy, and coordinated, with particular attention to early intervention (p. 366).

O'Brien and Dadswell (2019) conducted a study which, while not focused on interventions to remediate school attendance problems, touched on the topic of things that could have made life at school easier for youths who had self-excluded from school.[24] Focus group interviews were conducted with 13 youths who had self-excluded from mainstream education and now attended a UK charity-based learning centre providing educational and therapeutic support to youths who self-excluded due to severe bullying or other trauma. The three themes that emerged when the youths were asked what could have made life at mainstream easier were: (1) teacher awareness of changes in behaviour or mood that might indicate that bullying is occurring; (2) promoting a feeling of security for students; and (3) promoting empathy and compassion among students. We propose that the themes are suggestive of interventions that would be relevant to the prevention of self-exclusion from school, early intervention for youth who are showing signs of emerging self-exclusion, and helping youth return to school after self-exclusion. O'Brien and Dadswell's (2020) subsequent report underscored the importance of involving youths in research "to develop support that better fits the needs of bullied young people and reduce the incidences of self-exclusion" (p. 225). They also emphasised the need to act on the voices of youths, and not just to include youths in research to support adult assumptions or agendas.

The experiences and views of parents

Researchers have explored the views of parents of youths displaying school attendance problems, or displaying school refusal specifically, but the focus is seldom on the parents' views on intervention. Place et al. (2000) interviewed the families of 17 adolescents who displayed school refusal. Based on the responses, the authors drew implications for intervention. However, the interviews addressed the influences acting upon youths fearful of attending school, and not stakeholder views on effective intervention for school refusal. Havik et al. (2014) interviewed 17 parents of youths displaying school refusal, but the focus was on the parents' perspectives on school factors associated with school refusal, not on

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[24] O'Brien and Dadswell (2019) defined self-exclusion from school as follows: "when a child or young person decides themselves to permanently stop going to school" (p. 7). Their writing suggests that there is overlap between self-exclusion from school, and school refusal.

intervention. The implications for school-based changes (e.g., adapting schoolwork; increasing teacher knowledge about school refusal; using a coordinated team approach) were largely presented in the context of prevention, or early intervention for emerging school refusal, and not as interventions for severe and chronic school refusal.

The experiences and views of multiple stakeholders

Youths', parents', and professionals' experiences and views on school refusal intervention

The first study of youths', parents', and professionals' voices regarding factors perceived to promote successful intervention for school refusal[25] was reported by UK researchers Nuttall and Woods (2013). Using an explanatory case study approach, the authors interviewed two youths with whom intervention was delivered (aged 13 and 14 years), their parents, and the professionals involved in intervention (school staff, family support worker, health practitioners, attendance officer). Numerous themes emerged, although the results were not reported for each stakeholder group separately.

Individual factors perceived to be associated with successful intervention included: 'Developing feelings of safety, security and belonging' (e.g., a consistent teacher in the alternative provision; access to a small welcoming place with reduced social pressure), 'confidence, self-esteem, and value' (e.g., being given responsibilities; being treated as an individual), 'aspiration and motivation' (e.g., making learning meaningful), 'positive, nurturing ethos of the school' (e.g., person-centred approach; solution-focused approach; welcoming staff on return to school); 'positive experiences at home and school' (e.g., developing friendships; building upon the young person's strengths and interests; professionals encouraging the family to engage in enjoyable activities), 'encouragement and positive attention' (e.g., mentor encouraging peers to contact the young person when they were away from school), 'taking an interest in the young person as a whole' (e.g., regular personalised contact), 'making a positive contribution' (e.g., the young person has the opportunity to express their views), 'flexible and individualised approach to learning' (e.g., reduced timetable around difficult subjects; allowing sufficient time for reintegration), 'supporting social interaction and communication' (e.g., support for problem solving with peers), and 'developing an understanding of thoughts, feelings, and behaviour' (e.g., reframing negative thoughts to reduce anxiety).

Family factors associated with successful intervention included: 'positive relationships between home and school' (e.g., a change in attendance officer, whereby the new one adopted a more nurturing approach towards the parent; school staff were flexible in arranging meetings with the parent; professionals communicated progress); and 'increasing

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[25] The authors used the term 'school refusal behaviour' but the cases they describe fit the common criteria for 'school refusal' due to the presence of anxiety.

the effectiveness of parenting skills' (e.g., visiting the family home; developing family routines; encouraging a parent to set clear boundaries). Professionals suggested that 'parent openness to support and change' would have contributed to earlier success, and 'further development of parenting skills' may have led to more success.

Factors associated with successful intervention that relate to professionals and systems included: 'early identification and assessment of need' (e.g., effective systems for monitoring attendance to quickly follow up when the young person was absent; holistic assessment via the Common Assessment Framework), 'collaboration between professionals' (e.g., professionals from different agencies working towards a common goal; identify the lead professional to chair meetings), 'discussions about the impact of not going to school' (e.g., attendance officer discusses parents' legal obligations, but avoids harsh consequences and prosecution), 'regular monitoring, reviewing, and celebrating progress' (e.g., provide regular updates on progress; positive feedback and rewards), 'a key adult who is available' (e.g., a mentor responds to the young person's needs; young person knows how to access the support person), 'personality, knowledge, skills, and experience of professionals' (e.g., holistic understanding of the young person's needs), 'persistence and resilience of professionals' (e.g., communicating that the young person was not forgotten about; realising that it takes time and strategies may need to be adapted over time), and 'a whole school approach' (e.g., communication between staff about strategies; support from team leadership).

Youths' and parents' experiences and views on school refusal intervention

A second qualitative study of stakeholder voices regarding intervention for school refusal was reported by Sibeoni et al. (2018). These researchers investigated adolescents' and parents' experiences of psychiatric care provided for adolescents displaying anxiety-based school refusal. The focus was on the global experience of care (which ranged from 14 to 79 months) as opposed to the experience of specific interventions. Semi-structured interviews were conducted with 20 adolescents (13-18 years) who had been away from school for at least a month before treatment started, and with 21 parents. The interviews included questions about the elements of treatment that were regarded as helpful and effective, as well as the elements that did not help and were harmful. Two main themes emerged from the qualitative analysis, namely 'goals of psychiatric care' and 'the therapeutic levers identified as effective'.

The main theme 'goals of psychiatric care' comprised two sub-themes: 'self-transformation' and 'problem solving'. Regarding 'self-transformation', adolescents considered that they needed to change and develop (e.g., reduction of psychiatric symptoms; increase in self-confidence). Most adolescents recognised that they had changed during the time they received care, but they were uncertain about how the change occurred. Regarding 'problem solving', parents were principally concerned about academic consequences for their child, so solutions that directly addressed school problems were considered relevant and helpful

(e.g., adapting schooling; distance education). For all parents, support for return to school was associated with treatment effectiveness. Parents and adolescents identified social isolation and difficulty interacting with others as problematic. For parents, the solution was the social life offered in the context of inpatient or day care. Adolescents found that the therapy context enabled them to fit into a peer group.

The main theme 'the therapeutic levers identified as effective' also comprised two sub-themes: 'time and space' and 'relationships'. Regarding 'time and space', adolescents reflected on the time that is needed for intervention to be effective (e.g., time to develop trust in the professional team; time to develop personally). Parents wished that effective treatment could have been found sooner (e.g., the right professional or right treatment from the beginning). Parents also reflected on the space in which intervention occurred (e.g., more welcoming than school). For the adolescents, the people they met in the psychiatric facility were valued more than the place itself. Regarding 'relationships', being able to speak, being heard, and developing trusting relationships with staff in the facility were essential therapeutic levers according to adolescents and parents. The adolescents also considered changes in their relationship with their parents to be helpful (e.g., more autonomy), as well as having relationships with peers (e.g., being able to talk about your problem with someone your own age). Other incidental relationships were also regarded as effective and helpful (e.g., with an art therapist; with the taxi driver who brought them to the facility). Parents also regarded their child's relationships with teachers at the facility as decisive.

Reflecting on the results of their study, Sibeoni and colleagues argued that "treatment must last long enough, in a place dedicated to care, to allow these youth to become involved in their care and to reflect on the personal changes they need, but also to offer them the possibility of multiple human encounters, some of which — expected or unexpected — will turn out to be determinant in their development" (p. 47). They also called for similar studies to be conducted with mental health professionals, to learn about their perspectives on the goals of intervention and what it is that makes intervention effective.

Conclusion

Stakeholder's voices on 'what works' to reduce school refusal, and to promote school attendance and engagement, are needed to enrich and advance research and practice. There are numerous stakeholders with experiences and views to share, but only three studies have explicitly examined stakeholder perspectives on intervention for school refusal. Nuttall and Woods (2013) interviewed youths, parents, and professionals; Sibeoni et al. (2018) interviewed youths and parents; and Kljakovic and Kelly (2019) interviewed professionals. The only other study to examine stakeholder perspectives about factors that help and hinder successful intervention was Tobias' (2019) study of professionals' perspectives on intervention for persistent absenteeism, and not school refusal specifically. Each of these studies relied on relatively small samples: 2 youths, their parents, and involved

professionals in the study of Nuttall and Woods (2013); 20 youths and 21 parents in the study of Sibeoni et al. (2018); 14 professionals in the study of Kljakovic and Kelly (2019), and 19 professionals in Tobias' (2019) study. Moreover, the geographic representativeness of the samples in three of these studies was rather limited: Kljakovic and Kelly (2019) and Tobias (2019) selected professionals from single regions in the UK (i.e., one borough in East London, and a single local authority in the UK, respectively), and Nuttall and Woods reported on just two young people. By contrast, Sibeoni et al. (2018) included adolescents and parents drawn from three adolescent psychiatry departments across France.

In short, no study has simultaneously elicited the voices of large numbers of professionals, youths, and parents with respect to factors that help and hinder intervention for school refusal. The Knowing What Works project explicitly elicits the voices of each of these stakeholder groups, directly addressing the recent call to incorporate the voices of youths and parents in research on how to help youths who refuse to attend school (Kljakovic & Kelly, 2019). Importantly, the voices of each stakeholder group are reported separately from the other stakeholder groups, permitting a more nuanced understanding of 'what works' according to youths, parents, and professionals. Large numbers of each stakeholder group are included, recruited from across 9 of the 12 provinces in the Netherlands. This is also the first project to simultaneously elicit the voices of stakeholders associated with interventions conducted in different settings, namely mental health settings and educational settings.

1.3   Aim and Research Questions

Members of the research consortium heard incidental accounts of Dutch organisations providing intervention for school refusal, via associates in the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*]. The Knowing What Works project was established to conduct a more systematic review of existing interventions in the Netherlands. The main aim of the project was to identify the elements in interventions that are held to be instrumental; that is, what is it about the interventions that makes them effective. Specifically, we sought the views of professionals, youths, and parents regarding best practices within existing interventions.

Knowledge about these best practices would inform the development of a roadmap for school refusal interventions. It is our belief that a roadmap for developing new services or refining existing services provides direct support to service providers. That is, the availability of a roadmap reduces the likelihood that separate services or regions spend precious time and money working 'in the dark', independent of each other, perhaps re-inventing the wheel when this is not necessary or strategic. This direct benefit for service providers would have an indirect benefit for families affected by school refusal, because families are more likely to encounter services providing interventions which comprise effective elements.

Four main research questions were addressed in the Knowing What Works project. These main questions included subsidiary questions.

Question 1: Which organisations provide an intervention for school refusal?

1a. **Which education and mental health organisations in the Netherlands offer an intervention specifically focused on school refusal?**
1b. **Who participates in these interventions?**

Responses to Question 1 provide context for the project. For example, if it were found that most interventions were provided by mental health organisations (Question 1a), or that youths with specific characteristics are under- or overrepresented in the interventions currently offered (Question 1b), that could help us understand why certain elements are employed or not (Question 2), for whom interventions are held to be most effective (Question 3), and why collaboration to address school refusal occurs in the way that it does (Question 4).

Question 2: What is offered during intervention for school refusal?

2a. **How many organisations provide a comprehensive intervention that involves participation of the young person, parents, and school?**
2b. **What do organisations do to address school refusal?**
2c. **Which difficulties do professionals experience in delivering interventions?**

Question 2 sheds lights on what is being done to address school refusal. It illuminates the nature and extent of educational interventions for school refusal, as well as the nature and extent of mental health interventions. In addition, it explores the extent to which organisations' interventions are flexible [*maatwerk*] vis-à-vis standardised [*gestandaardiseerd*]. Like Question 1, Question 2 provides context for understanding responses to the subsequent research questions, and for viewing Dutch interventions against the backdrop of the international literature. For example, if it were found that intervention elements that are commonly employed internationally are seldom identified in Dutch interventions, that could help explain stakeholder views on the important elements in intervention and desired adjustments to intervention (Question 3). Furthermore, if it were found that many organisations include both education and mental health interventions, that could help explain a finding that collaboration between services is intense and highly valued (Question 4).

Question 3: Why do interventions for school refusal work?

3a. **In which ways do youths and parents benefit from the intervention?**
3b. **Which elements are perceived to be most important for an effective intervention for school refusal, according to professionals, youths, and parents?**
3c. **For whom do the interventions work best and worst?**
3d. **What adjustments do professionals wish to make to improve their intervention?**

Question 3 is directly related to the main aim of the Knowing What Works project: to identify which of all the elements in interventions for school refusal are perceived to be most important. As noted in Section 1.2.2 (Interventions for School Refusal and Their Effectiveness), there are numerous calls to understand why interventions for school refusal are effective (e.g., Elliott & Place, 2019; Heyne et al., 2015; Nuttall & Woods, 2013; Pina et al., 2009). An empirically robust analysis of the mechanisms via which interventions have their effect calls for intervention trials conducted with large samples and multiple measures of potentially mediating variables. In the interim, the current project provides qualitative perspectives from multiple stakeholders about what makes an intervention for school refusal effective.

Question 4: How do organisations collaborate in interventions for school refusal?

4a. What do professionals say about collaboration in intervention for school refusal?
4b. What do youths and parents say about collaboration in intervention for school refusal?

Question 4 addresses issues raised in Section 1.2.3 (Collaboration Between Professionals in Education and Mental Health) about multiple disciplinary work to address multiple influences associated with school attendance problems. Responses to Question 4 shed light on the extent and nature of collaboration between education, mental health, and other services, and the possible impediments to collaboration. In effect, these responses allow us to zoom in on the 'process' via which effective interventions for school refusal can be developed and delivered, alongside what is learned about the 'elements' of effective intervention at Question 3.

Chapter 2 – Method

2.1 Research Design and Ethics Approval

The Knowing What Works project employed a mixed methods design, combining the advantages of qualitative and quantitative methodologies. Qualitative data was gathered via focus group interviews and open-ended questions in questionnaires, to gain a deeper understanding of 'what works' in interventions for school refusal. Qualitative methods are "a tool of choice" when focusing on the perspectives of service users (Sibeoni et al., 2018, p. 40). Quantitative data was gathered via closed questions in questionnaires, permitting empirical investigation of the characteristics of interventions, those who participate in the interventions, and outcomes. In this report, both the qualitative data and quantitative data is reported descriptively. Details of the data analysis method are found in Section 2.5.

Research activities associated with the Knowing What Works project were approved by the Psychology Ethics Committee of the Institute of Psychology at Leiden University on January 21st, 2019. An amendment to the research procedure was approved on February 20th, 2020, whereby questionnaires for youths and parents would be implemented online rather than via pencil-paper format, and a digital consent form would be used. No financial compensation was made to any parties for their participation (i.e., organisations, professionals, parents, and youths).

2.2 Participants and Recruitment

2.2.1 Overview of Participants

Three primary stakeholder groups participated in the Knowing What Works project:
(1) professionals working in organisations that provide an intervention for school refusal;
(2) youths who participated in one of these interventions; and (3) parents of youths who participated in one of these interventions. The recruitment of professionals, youths, and parents is described in the next sections. In all, 76 professionals participated in the group interviews conducted at 21 organisations from across 9 of the 12 provinces in the Netherlands.[26] Appendix A presents information about the organisations. Fifty-two youths from 14 of these organisations responded to an invitation to complete an online questionnaire, along with 96 parents. Descriptive data pertaining to the stakeholder groups is presented in Appendix B.

2.2.2 Recruitment of Professionals

Professionals were recruited to the Knowing What Works project via the recruitment of their respective organisations, beginning in November 2018. An administrative assistant from the National Expertise Centre for Special Education [*Landelijk Expertisecentrum Speciaal Onderwijs*] sent a recruitment letter to all special education schools (Appendix C); to the Support Centre for Appropriate Education [*Steunpunt Passend Onderwijs*] for forwarding to all regional partnerships [*samenwerkingsverbanden*] of primary and secondary education; to the senior secondary vocational education council [*MBO Raad*] for forwarding to senior secondary vocational education schools; and to Youth Care Netherlands [*Jeugdzorg Nederland*] and Mental Health Care Netherlands [*GGZ Nederland*] for forwarding to mental health care organisations. Due to the limited response from mental health care organisations, information about the project was also distributed via the newsletters of the Knowledge Centre for Child and Adolescent Psychiatry [*Kenniscentrum Kinder- en Jeugdpsychiatrie*] and the Association for Behavioural and Cognitive Therapies [*Vereniging voor Gedrags- en Cognitieve therapieën*], via the websites of at.groep Zorg and the National Expertise Centre for Special Education, and via the extranet of the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*].

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[26] The nine provinces are Friesland, Gelderland, Groningen, Noord-Brabant, Noord-Holland, Overijssel, Utrecht, Zeeland, and Zuid-Holland.

The recruitment letter invited a representative from the organisation (hereafter referred to as the contact person) to contact the Knowing What Works Project Coordinator (Marije Brouwer-Borghuis) if the organisation had an intervention for school refusal and wished to participate in the project, or if they were unsure whether their intervention was relevant for the project. Organisations could respond to the recruitment call until the end of September 2019. Contact persons from 55 organisations expressed interest in the Knowing What Works project. They were advised that a research assistant would contact them to gain additional information about the intervention during a screening interview. They were also sent an email which provided information about the research process (Appendix D).

The research assistant telephoned the contact person from each organisation to conduct the screening interview of about 20 minutes (Appendix E), to determine the intervention's suitability for inclusion in the Knowing What Works project. The contact person was also invited to provide the research team with additional information about the intervention (e.g., brochure, website, manual).

Of the 55 organisations expressing interest, 38 participated in a screening interview between March and September 2019. Seventeen organisations did not participate in the screening interview for one or more of the following reasons: the organisation indicated that they did not wish to participate due to lack of time; the intervention was temporarily inactive; the intervention was not yet underway; there was no response to calls from the research assistant.

Using the information gathered during the screening interview and the other information made available by the organisation's contact person (e.g., brochure, manual, website links), authors DH, MBB, and GA discussed the suitability of each school refusal intervention according to four inclusion criteria. If needed, extra information was requested from the contact person by telephone. The four criteria were:

1. Type of organisation: The intervention was provided by an educational organisation (po, vo, so, vso, or mbo until 18 years of age) and/or a mental health care organisation.
2. Focus on school refusal: The organisation's intervention aimed to address school refusal, operationalised by the research team as 'more than 80% of youths participating in the intervention display school refusal'. The contact person from the organisation had been asked to estimate the percentage of youths in their intervention who fulfilled the criteria for school refusal, as presented during the screening interview (Appendix E).
3. Severity of school refusal: The intervention focused on youths surpassing a legal limit of absenteeism (i.e., 16 hours in 4 weeks).
4. Number of youths participating in the intervention: The intervention was provided to at least 10 cases in the prior 12 months. This criterion was included because each organisation would be asked to invite at least 10 participating youths and their parents to complete a questionnaire, and the research team did not wish to gather data from youths and parents who had completed the intervention more than a year earlier.

Regarding Criterion 1: By default, this criterion led to the exclusion of organisations providing an intervention for youths over 18 years of age and enrolled in mbo, and youths enrolled in HBO and WO. Criterion 1 also excluded interventions offered via private practitioners, for two reasons. First, it was beyond the scope of this project to include the multitude of private services likely providing intervention for school refusal. Second, the project aimed to yield a roadmap for mainstream service providers in education and mental health, drawing on current practice in these settings.

Regarding Criterion 2: The 80% threshold meant that the intervention did not need to be limited solely to youths displaying school refusal. Furthermore, interventions that focused on somatic symptoms would be included if at least 80% of the youths displayed school refusal. The research team was prepared to relax the 80% criterion if needed, to include up to 24 interventions (the upper limit determined by project financing and timeframe). Thus, if there were fewer than 24 interventions reaching the 80% threshold, the threshold would be reduced to 50%. Ultimately, all included interventions met the 80% threshold.

Regarding Criterion 3: This was an approximate operationalisation of Tier 3 school refusal (i.e., severe and chronic school refusal), the focus of the Knowing What Works project. We sought to exclude early intervention for Tier 2 emerging, mild, or moderate school refusal, and Tier 1 interventions to prevent school refusal. Because different criteria are presented in the literature for differentiating between Tier 2 school attendance problems and Tier 3 school attendance problems (e.g., Hobbs et al., 2018; Skedgell & Kearney, 2018), we included interventions targeting so-called severe school refusal based on Dutch law, policy, and practice (Brouwer-Borghuis, Heyne, Vogelaar, et al., 2019). The criterion of at least 16 hours absence across four consecutive school weeks corresponds with 16-18%[27] of missed school time. This exceeds the thresholds of 10% or 15% absenteeism sometimes recommended for the identification of Tier 3 absenteeism (e.g., Skedgell & Kearney, 2018) and it approaches the threshold of 20% recommended by others (e.g., Hobbs et al., 2018).

Regarding Criterion 4: Because the research team wished to include up to 24 organisations, we were also prepared to partially loosen this criterion, including interventions that were delivered to less than 10 cases in the past 12 months if there were not 24 interventions that fulfilled the first three criteria.

Of the 38 interventions screened, 21 were included.[28] Of these 21, 17 fulfilled all four criteria, and the other 4 fulfilled all but Criterion 4. All but one intervention specifically addressed school refusal. The other intervention addressed somatic symptoms but at least 80% of youths participating in the intervention displayed school refusal.

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[27] The variation stems from differences in yearly minimum total hours of education per level and type of education.

[28] Three organisations employ a similar intervention, namely Link Amsterdam, Link Almelo, and Link Ambelt in Zwolle. These were treated as three separate interventions because they are delivered by different organisations, and the organisations deliver their own variation of the Link program.

Of the 17 organisations that were not included, 11 (65%) had fewer than 50% youth displaying school refusal, 3 (18%) elected not to participate, 2 (12%) were private organisations, and 1 (6%) did not respond to further contact after screening. The contact person from these 17 organisations received an email thanking them for their interest and explaining why various interventions had not been included in the Knowing What Works project (Appendix F).

The 21 included organisations were contacted via e-mail to notify of inclusion (Appendix G) and to gain written informed consent for the professionals delivering the interventions to participate in the project (Appendix H).

2.2.3 Recruitment of Youths and Parents

Youths who participated in a school refusal intervention provided by one of the 21 organisations were the prospective participants in the Knowing What Works project, as were their parents. Youths eligible to participate were those between 4 and 18 years of age (i.e., primary school level to secondary/vocational school level, but not older than 18 years, the age at which compulsory education finishes in the Netherlands). Youths between 10 and 18 years would be invited to complete a questionnaire, as well as their parent(s)/ caregiver(s).[29] When youths were between 4 and 9 years of age, only the parents would be invited to complete the questionnaire. Appendices I and J present the materials used to gain written informed consent from youths and parents, respectively.

Youths and parents were recruited via the contact persons associated with the 21 interventions included in the project. Recruitment via the contact persons protected the youths' and parents' privacy, because the research team would not need to have access to their names and email addresses to gather data.

The contact person at each organisation was asked to email an invitation to the 15 youths and their parents who had most recently completed the intervention, but only going back as far as January 2019. Following Nuttall and Woods (2013), the specification 'completed the intervention since January 2019' was designed to ensure that youths and parents would have sufficient recall of their experience of the intervention and its outcomes. The contact person was asked to invite the last 15 youths and their parents irrespective of the outcome of the intervention, and irrespective of whether the contact person suspected the youths or parents would or would not respond to the invitation (see the email in Appendix K). The aim was to gather data from at least 10 youths and their parents, per organisation. By approaching 15 youths and parents, the research team took account of a 33% non-response rate. It was also anticipated that some organisations would have fewer than 15 youths who had completed the intervention between January 2019 and the moment the questionnaire

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[29] Henceforth, 'parent(s)/caregiver(s)' will be written simply as 'parents'.

was available online (i.e., March 2020). In these cases, the organisation would simply invite any and all youths and parents who had completed the intervention since January 2019, rather than inviting youths and parents who had completed the intervention more than a year earlier.

An item in the questionnaire completed by youths and parents asked how long it was since their participation in the intervention ended. The question was answered by 37 youths and 85 parents (one parent per youth = 45, two parents per youth = 40).[30] In Table 3 it can be seen that the vast majority of youths (90%) completed the intervention in the year prior to completing the questionnaire, corresponding with the recruitment criteria mentioned above (i.e., completed intervention at some time since January 2019). For a small number of youths (10%), parents reported that it had been longer than a year since intervention ended. These participants were nevertheless included in the project because there may have been some delays in the distribution of the questionnaires and in the return of questionnaires by youths and parents.

Table 3
Length of Time Since Participants Completed the Intervention (Parent Report)

Length of time	Percentage of youths
Between 0 and 1 month ago	8.6%
Between 1 and 3 months ago	15.5%
Between 3 and 6 months ago	19.0%
Between 6 and 12 months ago	46.6%
Between 12 and 18 months ago	6.9%
More than 18 months ago	3.4%

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[30] Youths and parents did not always give the same answer to this question; 9 of the 37 youths (24.3%) gave a different response to their parents, and 7 of the 20 parent pairs gave a different response to each other. To analyse the data, we used the responses of parents who answered alone or where both parents gave the same response. This includes 71 parents who reported on 58 youths.

2.3   Instruments for Data Gathering

Data was gathered from professionals via the First Impressions Questionnaire [*Eerste Blik Vragenlijst*] and the Focus Group Interview. Data was gathered from youths via the Knowing What Works Questionnaire for Youth [*Weten Wat Werkt Vragenlijst voor Jongeren*], and from parents via the Knowing What Works Questionnaire for Parents [*Weten Wat Werkt Vragenlijst voor Ouders*]. These instruments are described below. The process for implementing the instruments is described in Section 2.4.

2.3.1 First Impressions Questionnaire

The First Impressions Questionnaire [*Eerste Blik Vragenlijst*] was designed for the current project to gain a first impression of the organisation and its intervention. This served numerous functions. First, it provided data directly relevant to Research Questions 1a and 1b (i.e., Which education and mental health organisations in the Netherlands offer an intervention specifically focused on school refusal?; Who participates in these interventions?) and other contextual information for interpretation of results from the Knowing What Works project. Second, it reduced the need to ask these questions during the focus group interview, thereby reducing the length of the interview. Third, it provided context for the interviewer(s) before they met with the professionals during the focus group interview.

The questionnaire comprises six parts. Part 1 includes a transcription of the responses given by the organisation's contact person during the telephone screening (e.g., the name of the intervention; the specified age range of youths who may participate in the intervention). The person completing the First Impressions Questionnaire [*Eerste Blik Vragenlijst*] was invited to provide corrections and additional information as needed. Parts 2 to 5 comprise questions primarily eliciting factual information around the 'Origin and organisation of the program' [*Ontstaan en organisatie van het programma*] (e.g., when the intervention started; how the intervention is financed; how many professionals are involved in the intervention), 'Target group' [*Doelgroep*] (e.g., indications and contra-indications for participation in the intervention; estimation of the percentage of youths with specific disorders; estimation of the percentage of youths who had been away from school for more than a year prior to starting the intervention), 'Education content' [*Inhoud van het onderwijs*] (e.g., whether home-schooling is offered during the intervention; whether the intervention is oriented toward a return to mainstream education; level of education provided during the intervention), and 'Evaluating the intervention' [*Evalueren van de interventie*] (e.g., whether

youths are followed up after they complete the intervention; whether the intervention is evaluated in any way). Part 6 was an open question inviting other comments. The full questionnaire is found in Appendix L.

The First Impressions Questionnaire [*Eerste Blik Vragenlijst*] was developed by two authors (MBB, DH) and reviewed by the other three authors (GA, JV, CvH). During piloting of the Focus Group Interview Schedule (see Section 2.3.2) it became evident that the interview schedule needed to be shortened. For this reason, some questions were moved from the interview schedule and incorporated in the First Impressions Questionnaire. For example, questions about education (e.g., type of educational setting youths attend before and after the intervention) and the organisation's evaluation of their intervention were moved from the interview schedule to the First Impressions Questionnaire.

2.3.2 Focus Group Interview Schedule

To achieve the project's main aim of identifying best practices for the development and delivery of interventions for school refusal, focus group interviews were conducted with professionals associated with the 21 interventions. The interviews revolved around the professionals' experiences and views concerning their intervention. The interviews constitute 'focus groups' according to Morgan's (1996) definition: "a research technique that collects data through group interaction on a topic determined by the researcher" (p. 130). An important aspect of this process is the active role of the researcher in creating discussion among the professionals.

A semi-structured interview schedule was developed by the two members of the research team with substantial experience in developing, delivering, and evaluating interventions for school refusal (DH, MBB). Input was also received from researchers experienced in qualitative research in the field of school attendance and absenteeism (Finning et al., 2018; Havik et al., 2014). The interview comprises a series of open questions presented in a relatively standard order. This semi-structured format permits the gathering of specific information while allowing flexibility for exploration (Nuttall & Woods, 2013). The questions were designed to address Research Questions 2, 3, and 4, with most emphasis given to Questions 3 and 4. Some questions were inspired by the literature on school refusal (e.g., a question about common treatment elements) and others by the developers' familiarity with interventions for school refusal (e.g., a question about the extent to which the intervention is individualised versus standardised). The interview schedule includes prompts for the interviewer to seek clarification or further elaboration.

The first version of the interview schedule was reviewed by two other members of the team (JV, CvH), leading to a reduction in the number of questions. It was then piloted, as

described below, and modified. The final interview schedule is presented in Appendix M. The seven main topics addressed in the interview are:

(1) Opening the interview (i.e., invitation for each person to introduce themselves and their role in the intervention);

(2) Scope of the intervention (e.g., the aim of the intervention);

(3) Therapeutic aspects of the intervention (e.g., the therapeutic elements offered to youths and to parents);

(4) Education aspects and return to school (e.g., how return to school is achieved; difficulties providing the educational aspects of the intervention);

(5) Collaboration (e.g., the ways in which education and mental health work together; characteristics of a good collaboration);

(6) Professionals' views about their intervention (e.g., why the intervention works as well as it does; which elements of the intervention are considered most important); and

(7) Closing the interview (i.e., what is necessary, to tackle school refusal effectively).

At three points during the interview the professionals were invited to independently provide written responses to questions presented in a booklet. This served numerous functions: it allowed professionals to reflect upon and respond to a list of school refusal interventions identified in the literature; it ensured each professional participating in the interview could share a view on the topics in the booklet; it provided a springboard for further group discussion; it added variability to the process during the 2.5 hour interview, to maintain professionals' engagement; and it yielded additional qualitative and quantitative data directly relevant to the research questions. Examples of questions in the booklet are 'Which of these common treatment elements are present in your intervention?' and 'What two changes would you make to the intervention if you had a magic wand or a lot of money?' The booklet is presented in Appendix N.

In qualitative research it is ideal to conduct pilot interviews and adjust the interview as needed (Baarda et al., 2018). The Focus Group Interview Schedule was thus piloted in January 2019 by the two researchers who developed the schedule. It was piloted with two organisations known to the research team via the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*] and supportive of the Knowing What Works project. Intentionally, the organisations chosen for piloting provided substantially different interventions for school refusal: one operated within a mental health service and the other operated within an educational setting. In line with Torrens Armstrong et al. (2011), piloting confirmed the importance of there being sufficient room for discussion between the participants as experts. Thus, the main modification following piloting was to shorten the schedule by removing questions and placing them in the First Impressions Questionnaire, and removing some topics altogether (e.g., discussion about the way school-related factors associated with school refusal are addressed in the intervention). Data gathered during the 2 piloting interviews was retained for analysis together with data from the subsequent 19 interviews, because the subsequent interviews comprised a subset of questions in the pilot interviews, and not different questions.

2.3.3 Knowing What Works Questionnaire for Youths

The Knowing What Works Questionnaire for Youths was developed for the current project by authors MBB and DH. It was developed with a view to addressing four domains from the perspective of the young person as stakeholder: (1) satisfaction; (2) outcomes; (3) the experience of collaboration between professionals; and (4) helpful elements in the intervention for school refusal.

In the initial phase of development, a research assistant reviewed the literature on these domains. Regarding the first domain (satisfaction), various questionnaires were identified. The research team gained permission to use the 4-item Process [*Verloop*] scale from the Exit Questionnaire [*Exit-vragenlijst*] (Jeugdzorg Nederland et al., 2018). According to the Alexander Foundation (Stichting Alexander, 2008) this subscale has good internal consistency (α = .85). Two satisfaction items were also identified in the youth and parent versions of the Rating Scale for Satisfaction and Impact [*Beoordelingsschaal voor Tevredenheid en Effect*], also referred to as BESTE (De Meyer & Veerman, 2016). These two items were adapted slightly for the current project.

No questionnaires were found that adequately addressed the other three domains. Thus, in the middle phase of development, authors MBB and DH generated item content based on: (1) a review of items in the BESTE scale that are related to the second domain (outcomes); (2) a review of questions in the Focus Group Interview Schedule with Professionals which addressed the third domain (experience of collaboration) and the fourth domain (helpful elements); (3) the authors' experience of delivering and evaluating interventions for school refusal, and their familiarity with the literature on evaluation of school refusal (e.g., Heyne, Strömbeck, et al., 2020); (4) a discussion with members of the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*] during one of its meetings; and (5) consultation with youths. Regarding these last two points, 15 professionals were presented with a list of the domains to be addressed in the Knowing What Works Questionnaire for Youths and invited to generate questions related to these domains, adopting the perspective of youths and parents. Four professionals offered further assistance by inviting youths at their organisation to help generate questions, using a semi-structured format to engage youths in discussion (see Appendix O). This step was particularly helpful for determining how best to ask youths about their experience of collaboration between services. Based on the input from professionals and youths, authors MBB and DH developed a set of items for the questionnaire. A decision was made to apply the response scale used for the Process [*Verloop*] items to the other items developed for the questionnaire.

In the final phase of development, the Knowing What Works Questionnaire for Youths was sent to the same four professionals who engaged youths in item development. They were asked to comment on whether they thought youths would be able to understand and respond to the items, and to indicate which items they regarded as less essential. Items

were deleted so the questionnaire would not be too taxing, and the final version comprised 42 questions.

The questions in the final Knowing What Works Questionnaire for Youths are divided across seven topics:
(1) demographics (5 closed questions);
(2) difficulties with school attendance prior to intervention (3 closed questions);
(3) experience of the intervention (6 closed questions);
(4) changes occurring for the child during or after the intervention (14 closed and 5 open questions);
(5) experience of collaboration between professionals (4 closed and 2 open questions);
(6) helpful elements in intervention (2 open questions); and
(7) other information (1 open question which was optional).

The questions in Topic 3 are those drawn from the Exit Questionnaire and the BESTE scale. The Knowing What Works Questionnaire for Youths is found in Appendix P. Administration time was approximately 20 minutes.

2.3.4 Knowing What Works Questionnaire for Parents

The Knowing What Works Questionnaire for Parents was developed after the Knowing What Works Questionnaire for Youths. The question generation phase thus involved the development of questions that paralleled the questions in the Knowing What Works Questionnaire for Youths, but which were worded from the perspective of the parent. Additional items were developed to assess outcomes for the parents themselves. A parent representative at author MBB's workplace was also invited to suggest items. The final version of the questionnaire comprised 48 questions.

Questions in the Knowing What Works Questionnaire for Parents are divided across the same seven topics appearing in the Knowing What Works Questionnaire for Youths. However, parents were also asked about changes that occurred for them during or after the intervention (Topic 4i), and there were small variations in the number of questions per topic, as follows:
(1) demographics (6 closed questions);
(2) child's difficulties with school attendance prior to intervention (3 closed questions);
(3) experience of the intervention (7 closed questions; unlike youths, parents were also asked whether they were informed about how their child was going during the intervention);
(4i) changes occurring for the child during or after the intervention (12 closed and 5 open questions);
(4ii) changes occurring for the parent during or after the intervention (5 closed questions);

(5) experience of collaboration between professionals (4 closed and 2 open questions);

(6) helpful elements in intervention (3 open questions; parents were not only asked what had benefited them most, but also what has benefited their child most); and

(7) other information (1 open question which was optional).

The questions in Topic 3 include those drawn from the Exit Questionnaire and the BESTE scale. The Knowing What Works Questionnaire for Parents is found in Appendix Q. Administration time was approximately 20 minutes.

2.4 Procedures for Data Gathering

2.4.1 Implementing the First Impressions Questionnaire

The First Impressions Questionnaire [*Eerste Blik Vragenlijst*] and an Informed Consent Form were e-mailed to a contact person for each of the 21 interventions included in the project. The contact person was asked to ensure that the questionnaire was completed (whether on their own or together with colleagues), arrange for the relevant person in the organisation to sign the consent form, and return the questionnaire and consent form to the research team at least two weeks prior to the Focus Group Interview at their organisation. This provided sufficient time for the research team to follow-up on any non-returned documents prior to the date of the interview, and review the information in the First Impressions Questionnaire prior to conducting the interview.

2.4.2 Conducting the Focus Group Interviews with Professionals

The research assistant contacted the contact person for each intervention, to discuss the process and date for the group interview which would be conducted at the location where the intervention is provided. The contact person was invited to identify which professionals would be in attendance during the interview, with the understanding that at least two or three professionals would participate in the group interview. There was no upper limit applied to the number of professionals in attendance at an interview. It was suggested to the contact person that professionals participating in the interview would include those who understand the implementation of the intervention (e.g., what is done with the young person) and those who understand the foundations of the intervention (e.g., aims, policies, financing). Ultimately, the number of professionals who participated in an organisation's focus group interview ranged from two to eight. Ahead of the interview, the research assistant provided the nominated interviewer (MBB and/or DH) with the names and roles of the professionals who would participate in the interview.

A few days prior to the interview, the interviewer emailed the contact person to introduce themselves; confirm the time, location, and people anticipated at the interview; remind about the use of a recording device; remind about the time usually taken to conduct the interview, and ask that the email be forwarded to the professionals who will be participating

in the interview. The following was communicated about the time taken to conduct the interview: "I trust the research assistant asked you and your colleague to reserve 2.5 hours for the meeting. This sounds like a lot of time, and for busy professionals it is indeed a lot of time. At the same time, our experience suggests that the time flies once we start engaging in discussion about your valuable work to address school refusal."

The group interviews were conducted by authors MBB and DH, the two authors with most experience in developing, delivering, and evaluating interventions for school refusal (12 years and 24 years, respectively). MBB's experience is primarily from within the education sector and DH's experience is primarily from within the mental health sector, although both authors have familiarity with both sectors. Where possible, MBB conducted interviews about interventions offered in educational settings and DH conducted interviews about interventions offered in mental health settings.[31]

The first three interviews were conducted by MBB and DH together. These included the first two interviews in which the Focus Group Interview Schedule was piloted, and a third interview in which the final version of the schedule was used for the first time. Thereafter, interviews were conducted by either MBB or DH, except for the 5th, 8th, and 16th interviews which were conducted by both MBB and DH. This was done to protect against interviewer drift across the course of the 21 interviews, ensuring greater consistency in the use of the semi-structured interview schedule. When interviews were conducted by both interviewers, the seven topics in the interview were divided across the two interviewers.

At the beginning of each interview, the interviewer(s) highlighted key points about the interview process (e.g., to learn about the participants' experiences and views about their intervention for school refusal; participants can respond to each other's comments rather than waiting to be asked directly). For more information about the introduction to the interview, see Appendix M. At the end of the interview, the interviewer(s) provided the participants with a package of the latest national and international materials on school attendance problems and school refusal. The 2 pilot interviews were conducted in January 2019, and the other 19 interviews were conducted between April 2019 and January 2020.

2.4.3 Implementing the Knowing What Works Questionnaires

The research assistant e-mailed the contact person at each of the 21 interventions to determine: (1) how many youths had completed the intervention between January 2019 and February 2020; (2) which person associated with the intervention would be responsible for managing the distribution of questionnaires to youths and parents (hereafter referred to as

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[31] It was decided that author DH would be in attendance for the interviews with three organisations providing Link interventions (i.e., Link Amsterdam, Link Almelo, Link Ambelt in Zwolle) because author MBB was associated with the development of the original Link intervention.

the 'administrator'); and (3) whether there were special circumstances the research team should account for with respect to the distribution or receipt of questionnaires. Ultimately, 17 of the 21 organisations (81%) sent questionnaires to youths and parents.

The questionnaires and consent forms were implemented online.[32] Unique links were developed by the research assistant so that each young person and parent approached by the administrator could have online access to the Informed Consent Form and the uniquely numbered version of the relevant questionnaire (i.e., Knowing What Works Questionnaire for Youths or Knowing What Works Questionnaire for Parents). This enabled tracking of the completion of questionnaires. In families with two parents, both parents were provided with unique links so that they could independently complete the questionnaire.

Between February 28th and March 11th, 2020, each administrator was sent the set of links they would use to invite youths and parents to complete the questionnaire, together with an email explaining the procedure for forwarding respective links to youths and parents (see Appendix K). The administrator was asked to email the links within three successive days, and to notify the research assistant of the date on which the final email was sent, as a benchmark for sending reminders. Two weeks after the administrators had been asked to send the links, they received a request from the research assistant to send a reminder to youths and parents who had not yet completed the questionnaire.[33] Around this time the COVID-19 pandemic started having an impact on families and services, and it became evident that some organisations had not yet been able to email the links to youths and parents. A new email was sent to the administrators in the middle of April 2020 (see Appendix R), asking that the links to the questionnaires be sent by the end of April, giving youths and parents up to six weeks (until mid-June) to complete their questionnaire before the online system would be closed.

Each time a questionnaire was completed by a young person or parent, the data and signed consent form were automatically sent to the research team via Qualtrics. The only identifying information available to the research team was the name provided by the young person or parent in the consent form. The research team saved the data in coded form, meaning that the name provided in the consent form was stored separately from the data derived from the questionnaires. Administrators were not able to access the responses of youths and parents to whom they had sent a link.

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[32] The items in the questionnaire were only visible once the consent form had been completed.
[33] The research assistant simply advised the administrator about which of the unique numbers ascribed to each questionnaire was not yet associated with a completed questionnaire.

2.5   Data Analysis

2.5.1 Qualitative Data Analysis

Qualitative data from the focus group interviews with professionals was used to address Research Question 2 (What is offered during intervention for school refusal?), Question 3 (Why do interventions for school refusal work?), and Question 4 (How do organisations collaborate in interventions for school refusal?).

Audio recordings of the focus group interviews were transcribed verbatim by five research assistants[34] and reviewed by author MBB. More than 50 hours of interviews across 21 interventions yielded 1,250 pages of transcribed text. The text was uploaded into the 9th version of the ATLAS.ti program for qualitative data analysis. Analysis of the data was based on a bottom-up 'inductive' approach, whereby themes emerged from the data rather than themes being identified based on theory or the researchers' preconceptions. It is acknowledged, however, that the researchers' knowledge and experience in the field of school refusal could influence the identification and reporting of themes.

Following Nuttall and Woods (2013), thematic analysis was conducted in relation to specific research questions. The steps employed in the analysis of the quantitative data were drawn from Braun and Clarke's (2006) description of thematic analysis: (1) familiarising oneself with the data (reading and re-reading the data, noting down initial ideas); (2) generating initial codes (systematically coding interesting features of the data); (3) searching for themes (collating codes into possible themes); (4) reviewing themes (checking if the themes work in relation to the coded extracts and working towards a thematic 'map' of the analysis); (5) defining and naming themes (an ongoing process of refining the themes and the overall story they tell, applying distinctive labels to each theme); and (6) preparing the report, including interview extracts which are clear, compelling examples of the themes they represent.

The qualitative data analysis was conducted chiefly by author MBB, with support from authors DH and GA. The first three interviews to be coded were chosen to include diversity in setting (mental health, education, and both) and in the person who conducted the interview (MBB and DH together, MBB alone, and DH alone). This led to the selection of interviews 4, 5, and 7. MBB and DH independently coded these three interviews, generating

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[34] The research assistants signed a confidentiality agreement before starting their activities.

initial codes and using memos in the ATLAS.ti program to register ideas and uncertainties about codes. After the coding of each of these first three interviews, a meeting was held to discuss each person's codes, identify differences in coding, and refine the coding system. MBB then coded another two interviews, chosen from among the last interviews conducted (interviews 18 and 21). After the five interviews had been coded, MBB and DH discussed a possible network of themes, looking for connections across themes and deriving broader themes (main themes) and narrower themes (sub-themes). MBB continued coding the interviews, and MBB and DH met after 10 interviews has been coded, and after 15 interviews had been coded, to review and refine the emerging network of main themes and sub-themes, adapting codes as needed. No new themes or sub-themes emerged during the coding of the last 6 interviews. Rather, the codes identified in the last 6 interviews helped confirm the existence of themes emerging from the coding of the first 15 interviews. After the coding of the 21st interview, MBB and DH finalised the network. Sub-themes that were very similar were merged into a single sub-theme. Sub-themes with few codes were preserved as separate sub-themes because they added to the explanation of the main theme. Inspection of the codes associated with the main themes revealed that most main themes included responses from at least one-half of the organisations interviewed. The sub-themes, on the other hand, included responses from as few as two organisations, or more than one-half of the organisations, depending on the sub-theme.

Different to Braun and Clarke (2006), at Step 3 we did not review the whole transcript to gather data relevant to a potential theme. Rather, we limited our review to those parts of the transcripts in which the professionals responded to the questions of interest as posed by the interviewers. Similarly, at Step 4, we did not check whether the themes worked in relation to the entire data set. The digression from Braun and Clarke's (2006) steps occurred because of time constraints associated with coding 1,250 pages of text.

Two points about the analysis of data related to Research Question 3 (Why do interventions for school refusal work?) warrant attention. First, an assumption was made that responses to the first two questions in Part 6 of the Focus Group Interview Schedule (i.e., 'Why do you think your program works as well as it does?' and 'Which elements of your program do you see as most important?) would reflect working elements in the professionals' intervention for school refusal, and an assumption was made that responses to the first question in Part 7 (i.e., 'What do you think is necessary to properly address school refusal?) would reflect general working elements associated with interventions for school refusal (i.e., irrespective of whether it is an element in the professionals' intervention). At first, separate networks were derived, but overlap between the material in the two networks led to the preparation of a single network about working elements. However, in Chapter 3 we indicate whether emerging main themes and sub-themes were only based on responses to the two questions in Part 6 of the Focus Group Interview Schedule, only based on responses to the question in Part 7, or based on responses to questions in both parts. Second, one of the questions in the booklet accompanying the Focus Group Interview Schedule was 'Which two adjustments would you like to make to the intervention if you had a magic wand or a lot of money?'

When professionals wrote about more than two adjustments, the additional adjustments were included in the coding of this qualitative data.

Qualitative data gathered from youths' and parents' responses in the Knowing What Works Questionnaire for Youths and the Knowing What Works Questionnaire for Parents was also analysed. Specifically, their responses to the item 'Describe what helped you / your child most during the intervention' were coded and organised according to emerging sub-themes and main themes.

Excerpts from the qualitative data are presented throughout Chapter 3. Via email communication with the contact person at each intervention, professionals were given the opportunity to review the excerpts to be included in this report. Professionals from one intervention were uncomfortable with three excepts and these were not included in the report.

2.5.2 Quantitative Data Analysis

Qualitative data was augmented with quantitative data gathered via the First Impressions Questionnaire [*Eerste Blik Vragenlijst*], via several items in the booklet used during the focus group interviews with professionals, and via the Knowing What Works Questionnaire for Youths and Knowing What Works Questionnaire for Parents. The quantitative data helps address Research Question 1 (Which organisations provide an intervention for school refusal?), Research Question 2 (What is offered during intervention for school refusal?), Research Question 3 (Why do interventions for school refusal work?), and Research Question 4 (How do organisations collaborate in interventions for school refusal?). The quantitative data was entered in SPSS version 25 for analysis. The statistics used to analyse the data included in this report were mean, mode, range, standard deviation, and Fisher's exact tests.

Chapter 3 – Results

3.1 Organisations Providing Interventions for School Refusal

The results presented in Section 3.1 relate to Research Question 1a (Which education and mental health organisations in the Netherlands offer an intervention specifically focused on school refusal?). Section 3.1.1 addresses the types of organisations providing school refusal interventions, Section 3.1.2 addresses the financing of the interventions, Section 3.1.3 addresses how long the interventions have been operating, and Section 3.1.4 presents the number of youths participating in the interventions. Appendix A contains a Social Services Directory, providing an overview of the 21 interventions in the Knowing What Works project.

3.1.1 Types of Organisations

Thirteen of the 21 interventions (62%) are fully or partially situated within special education. Of these 13 interventions, 7 are situated within secondary special education [*voortgezet special onderwijs (vso)*] and 1 in special education [*special onderwijs (so)*]. The other 5 interventions are a collaboration between secondary special education and support services (youth care [*jeugdzorg*], mental health services [*GGZ*]). In 3 of these 5 interventions, all youths participating in the secondary special education intervention receive support services from the same organisation. In 1 intervention the education professional and support services professional work together in the class, although a specific support services intervention as such is not offered. In 1 intervention an external support services professional is involved at the beginning of the secondary special education intervention.

Five of the 21 interventions (24%) are fully or partially situated in mainstream secondary education. These interventions are either mainstream secondary education within a meta school facility [*bovenschoolse voorziening*] of the regional partnership [*samenwerkingsverband*], or a separate facility of a secondary school. Two of the 5 interventions involve a combination of mainstream secondary education and mental health services. In 1 of these 2 interventions, all youths who attend the educational intervention participate in day treatment provided by mental health services. The other intervention involves a permanent support services partner, although not all youths are supported by this partner.

One of the 21 interventions focuses on both mainstream education and special education. This intervention was originally developed by an external teaching support service for secondary special education, and it is used in secondary special education, secondary education, and senior secondary vocational education [*mbo*].

Two of the 21 interventions are situated entirely within mental health services and/or youth care. One of these is an outpatient program in a mental health service and the other is a combination of youth care and mental health services, including education professionals.

In all, 20 of the 21 interventions studied in this project involve an education organisation or education professionals. Of these 20 interventions, 8 involve a permanent collaboration between education and support services (i.e., youth care and/or mental health services).

3.1.2 Financing of the Interventions

The financing of interventions depends largely on the type of organisation in which the intervention is situated. Four main sources of financing were identified: (1) financing from (secondary) special education based on a special education needs statement [*toelaatbaarheidsverklaring (TLV)*]*,* residential place funding [*plaatsbekostiging (RP)*], or another arrangement with (secondary) special education; (2) financing from mainstream secondary education via the school of origin and/or the regional partnership [*samenwerkingsverband*]; (3) financing from support services based on a youth care or mental health services indication; and (4) additional funding, such as grants and project funds from the organisation itself or from an external organisation.

Table 4 indicates that 10 of the 21 interventions are financed via just one of these sources. The other 11 interventions are financed via a combination of different types of financing. Seven of the 11 interventions with combined financing receive funding from both education and support services.

Table 4
Financing of the Interventions

Source of financing	Number of interventions
Single source of financing	
(Secondary) special education	6
Mainstream secondary education	2
Support services	2
Multiple sources of financing	
Secondary special education + support services	5
Secondary special education + additional financing	2
Mainstream secondary education + support services	2
Mainstream secondary education + additional financing	2

Further to the data in Table 4, it should be noted that the educational part of one of the interventions is financed via support services funding. The support services offered via

another intervention are financed via education funding.[35] A number of the interventions that are financed via (secondary) special education require a needs statement [*TLV*] category that is higher than 'low'.[36] It appears that organisations providing an intervention for school refusal actively seek ways to offer and finance both education and support services for youths participating in the intervention.

3.1.3 How Long the Interventions Have Operated

The First Impressions Questionnaire included a question about how long the intervention has been running. On average, interventions have been running for just under six years (*M*=5.7; *SD*=4.2). The longest-running intervention was in operation for 16 years at the time of data gathering. More than one-third (*n*=8) of the 21 interventions were established in the three years prior to data gathering.

3.1.4 Number of Youths Supported Per Year

During the telephone screening, the contact person for the intervention was asked whether there are at least 10 youths per year who complete the intervention. Subsequently, the First Impressions Questionnaire included an item inviting professionals to estimate the number of youths displaying school refusal who participate in their intervention each year. Responses were obtained from 19 of the 21 interventions. Professionals from some interventions (*n*=5) reported the intervention's capacity per year, and professionals from other interventions (*n*=4) reported the number of youths currently participating in the intervention. For the remaining interventions (*n*=10), the professionals estimated the number youths participating per year. When professionals stated a range, the average was taken as the response. Overall, responses indicated that the number of youths participating in each intervention varies from 10 to 96 per year. The average across all interventions is 36 youths per year (*SD*=25). Based on an average of 36 youths per intervention, the 21 interventions studied in the current project are estimated to serve a total of 756 youths per year.

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[35] This intervention is not included within the 8 interventions that are a combination of education and support services because it involves professionals employed in education and offering support services.

[36] There are three categories within the special education needs statement for (secondary) special education: low, medium, and high. The category selected depends on the youth's support needs.

3.2 Characteristics of Youths Participating in Interventions

The results presented in Section 3.2 relate to Research Question 1b (Who participates in these interventions?). Section 3.2.1 addresses the age of youths participating in intervention, Section 3.2.2 addresses their background, Section 3.2.3 addresses their absence from school prior to intervention, and Sections 3.2.4 and 3.2.5 address the type and level of the youths' education prior to participating in intervention. Section 3.2.6 addresses school refusal characteristics and other problems experienced by these youths, based on the reports of professionals, youths, and parents.

3.2.1 Age

Data about the youths' age was gathered during telephone screening and via the First Impressions Questionnaire. Information about the age group served by each intervention is also found in the Social Services Directory (Appendix A). Most of the interventions (*n*=16) focus on secondary school-aged youths. The reported age range was often 12-18 years, or up to 20 years in connection with the age limit for secondary special education. A lower limit of 10 or 11 years was mentioned in relation to a few interventions. Of the other 5 interventions that do not specifically focus on secondary school-aged youths, 3 focus on both primary and secondary school-aged children/youths, with ages ranging from 4 to 20 years. Of the other 2 interventions, 1 focuses explicitly on primary education (4-13 years) and 1 focuses on secondary education and senior secondary vocational education [*mbo*] (up to 21 years). Some professionals reported that even though their intervention is available for youths within a specified age range, they tend to see youths of a specific age, as seen in the following extracts.

"The age group is 12 to 18 years, but we actually see that it's mainly youths aged 15 and 16 who participate."

"Most of them are aged around 15 or 16 years."

"In principle, from 5 to 18 years. We have hardly any very young children, it's more in secondary education, with a peak of students who run into problems in the first two years of secondary school. Or students aged late 16 or 17."

Overall, most youths participating in the 21 interventions studied in this project are of secondary school age (12 to 16 years). The interventions less often serve children who are in primary school or youths who have already started senior secondary vocational education.

3.2.2 Background

The First Impressions Questionnaire asked professionals to indicate whether the youths participating in their intervention have an immigrant or refugee background and, if so, to estimate the percentage of youths for whom this applies. As shown in Table 5, only a small proportion of youths have an immigrant or refugee background.

Table 5
Estimated Percentage of Youths with an Immigrant or Refugee Background

Background	Number (%) of interventions (out of 21) that provide intervention to youths with an immigrant or refugee background	Average % (minimum-maximum) of youths with an immigrant or refugee background, across interventions that indicated this applies to their population	Average % of youths with an immigrant or refugee background, across the 21 interventions
Immigrant	10/21 (47.6%)	14.0% (2%-50%)	6.7%
Refugee	4/21 (19.0%)	6.3% (5%-10%)	1.2%

3.2.3 Length of Absence Prior to Referral

Recall that one of the criteria for an intervention to be included in the project was that it focused on youths surpassing a legal limit of absenteeism (i.e., 16 hours in 4 weeks). Via the First Impressions Questionnaire, professionals were also asked to estimate the percentage of youths in their intervention who are absent from school for four weeks or more prior to being referred to the intervention. Data was available for 19 of the 21 interventions.[37] The estimates ranged from 50% to 100%, with an average of 91% (*SD*=13). Based on the estimate that 756 youths participate in the 21 interventions each year (see Section 3.1.4), it would seem that 688 youths (i.e., 91% of 756 youths) are absent from school for four weeks or more, due to school refusal, prior to intervention.

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[37] For 2 of the 19 interventions, the percentages did not add up to 100%; these numbers were recalculated and corrected for the analysis.

An additional question asked professionals to estimate what percentage of youths absent for more than four weeks fall into the following three categories:

1. *Absent for between four weeks and three months prior to the start of the intervention.*
2. *Absent for between three months and one year prior to the start of the intervention.*
3. *Absent for more than one year prior to the start of the intervention.*

Data was available for 16 of the 21 interventions. The mean of estimates for category 2 was the highest (*M*=44.0%), followed by category 1 (*M*=39.3%) and category 3 (*M*=16.7%). For eight interventions the highest estimate applied to category 2, for seven interventions the highest estimate applied to category 1, and for one intervention the highest estimate applied to category 3. In all, it seems that most youths are absent from school for between four weeks and one year prior to participation in the intervention.

3.2.4 Type of Education Prior to Referral

The First Impressions Questionnaire invited professionals to indicate the type of education youths were engaged in prior to referral to the intervention (i.e., school of origin). Data was available for 20 of the 21 interventions.[38]

Table 6 indicates that most youths (63%) are enrolled in mainstream primary school or secondary school prior to participation in intervention. The second most common type of education prior to intervention was special education (28% of youths). In all, 91% of youths are enrolled in a mainstream school or a school for special education prior to participation in intervention. When professionals responded with 'other, namely ….', they mainly reported day-time activities (*dagbesteding*) or intensive treatment.

3.2.5 Level of Education Prior to Referral

The First Impressions Questionnaire included a question about the youths' education level prior to participation in intervention. Complete data was available for 19 of the 21 interventions,[39] and there were 20 valid responses for the item about 'primary education learning materials'.

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[38] For 1 of the 20 interventions, the percentages did not add up to 100%; these numbers were recalculated and corrected for the analysis.
[39] For 3 interventions the total scores did not add up to 100%. This was not corrected because there was no option for 'other, namely' which may have applied to some of the youths.

Table 6

Estimated Percentage of Youths in Each Type of Education Prior to Participation in Intervention

Type of education	Number (%) of interventions indicating that youths are enrolled in this type of education	Average % (minimum-maximum) of youths in each type of education, across the interventions indicating that youths are enrolled in this type of education	Average % of youths in each type of education across 20[a] interventions
Mainstream primary or secondary education	16/20 (80.0%)	78.9% (30%-100%)	63.2%
Special education or secondary special education	15/20 (75.0%)	36.9% (2%-100%)	27.7%
Other, namely …	6/20 (30.0%)	16.7% (3%-52%)	5.0%
Senior secondary vocational education (mbo)	4/20 (20.0%)	10.3% (5%-15%)	2.1%
Home education	5/20 (25.0%)	5.6% (3%-10%)	1.4%
No education	2/20 (10.0%)	7.5% (5%-10%)	0.8%

[a] Data was unavailable for one of the interventions.

Table 7 indicates that almost 90% of all youths are at the vmbo (pre-vocational secondary education), havo (senior general secondary education), vwo (pre-university education), or gymnasium (grammar school) education level prior to participation in intervention. All of these are learning pathways offered within mainstream secondary education. The 'practical training' [*praktijkonderwijs*] pathway in secondary education and the 'route to work' [*route arbeid*] pathway in secondary special education are less common among secondary school-aged youths.

The 'primary education learning materials' option was not only endorsed by professionals delivering intervention focused (partly) on primary school-aged youths, but also by professionals delivering intervention within secondary special education.

Table 7

Estimated Percentage of Youths at Each Educational Level Prior to Participation in Intervention

Educational level	Number (%) of interventions indicating that youths were at this educational level prior to referral	Average % (minimum-maximum) of youths at each level, across interventions indicating this educational level	Average % of youths at each level across 20 (or 19)[a] interventions
Vmbo (vmbo-bb, vmbo-kb, vmbo-gl, vmbo-tl)	18/19 (94.7%)	48.5% (9%-90%)	46.0%
Havo/vwo/gymnasium	19/19 (100%)	43.7% (5%-90%)	43.7%
Primary education learning materials	5/20 (25.0%)	28.4% (2%-95%)	7.1%
'Route to work', day-time activities and 'practical training' pathways	4/19 (21.1%)	10.8% (1%-30%)	2.2%
Mbo (level 1, 2, 3 or 4)	3/19 (15.8%)	5.7% (2%-11%)	0.9%

[a] For some categories of educational level, data was unavailable for one or two interventions.

3.2.6 Characteristics of School Refusal and Other Problems

Recall that one of the criteria for an intervention to be included in the current project was that at least 80% of youths participating in the intervention display school refusal. This was assessed during telephone screening and followed up in the First Impressions Questionnaire. Professionals from 19 interventions included an estimate of the percentage of youths displaying school refusal, via the First Impressions Questionnaire. Responses ranged from 81% to 100%, with 100% being the most common response (i.e., 13 of the 19 interventions). The average estimate across the 19 interventions was 97% (*SD*=6).

The First Impressions Questionnaire asked professionals to indicate whether youths participating in their intervention experience specific disorders or difficulties. Professionals were also asked to estimate the percentage of youths in the intervention across the last 12 months who experienced each disorder or difficulty. Professionals from all 21 interventions responded to these questions, except for the questions about autism spectrum disorder, attention deficit hyperactivity disorder, and learning disorder, which were responded to by professionals from 20 of the 21 interventions.

Table 8 indicates that professionals from nearly all interventions reported that there are youths in their intervention who have an anxiety disorder (95% of interventions), an autism spectrum disorder (100% of interventions), or an experience of being bullied (95% of

interventions). Averaged across the interventions, these disorders and difficulties apply to more than one-half of the youths: 58% of youths have an anxiety disorder, 54% have an autism spectrum disorder, and 55% have experienced bullying.

Professionals from most interventions also reported that there are youths in their intervention who have a depressive disorder (81% of interventions), chronic unexplained physical symptoms (86% of interventions), learning disorder (70% of interventions), and attention deficit hyperactivity disorder (70% of interventions). Averaged across the interventions, more than one-third of youths (35%) have a depressive disorder, one-quarter (25%) have chronic unexplained physical symptoms, and one-fifth (20%) have a learning disorder. According to professionals, very few youths have an externalising disorder (3%) or intellectual disability (3%).

Table 8

Estimated Percentage of Youths Experiencing Specific Disorders and Difficulties

Disorder/difficulty	Number (%) of interventions indicating that this is experienced by participating youths	Average % (minimum-maximum) of youths experiencing this, across interventions indicating it applies to their population	Average % of youths experiencing this, across 21 (or 20)[a] interventions
Anxiety disorder	20/21 (95.2%)	60.8% (10-95)	57.9%
Experience of being bullied	20/21 (95.2%)	57.5% (11-90)	54.7%
Autism spectrum disorder	20/20 (100%)	53.5% (10-100)	53.5%
Depressive disorder	17/21 (81.0%)	43.8% (9-100)	35.4%
Chronic unexplained physical symptoms	18/21 (85.7%)	29.1% (3-100)	24.9%
Learning disorder	14/20 (70.0%)	28.5% (10-75)	20.0%
Attention deficit hyperactivity disorder	14/20 (70.0%)	21.9% (4-95)	15.4%
Externalising disorder	6/21 (28.6%)	9.7% (2-29)	2.8%
Intellectual disability	7/21 (33.3%)	8.4% (1-20)	2.8%

[a] For some disorders or difficulties, data was unavailable for one intervention.

The Knowing What Works Questionnaire for Youths and the Knowing What Works Questionnaire for Parents invited youths and parents to indicate whether they recognised specific characteristics of school refusal in themselves or their child, prior to participation in the intervention. The focus was on anxiety, mood problems, and somatic complaints,

because these are specified in the definition of school refusal included in Appendix E. The following three statements were presented to youths and parents:

- *Prior to participation in the intervention, I/my child found it difficult to go to school due to stress or anxiety.*
- *Prior to participation in the intervention, I/my child found it difficult to go to school due to sad mood.*
- *Prior to participation in the intervention, I/my child found it difficult to go to school due to somatic complaints.*

Eighty-four parents (*n*=44 instances when just one of the youth's parents responded, and *n*=40 instances when two of the youth's parents responded) and 37 youths responded to these statements. For the 40 instances where two parents responded, we used the average of the two parents' responses, assigning a weighting factor,[40] to calculate the total average score across all parents. This procedure was used because the basic unit for analysis was the number of youths. As such, parent data pertains to 64 youths. Relevant appendices, indicated throughout the text, present the data for instances when just one of the youth's parents responded, and when two of the youth's parents responded.

Appendix S1 indicates that most youths (79%) and parents (90%) reported difficulties with attending school due to anxiety/stress. More than one-half of youths (59%) and parents (60%) indicated that school attendance was hindered by sad mood. More than one-third of youths (35%) and almost one-half of parents (46%) indicated that somatic complaints had an impact on school attendance.

For 20 instances where two parents completed the questionnaire, the answers of both parents were compared to determine the extent to which they agreed upon the presence or absence of the forementioned characteristics. Response categories were collapsed from four categories to two: 1 = completely disagree or disagree; 2 = agree or completely agree. These categories identify whether a specific characteristic of school refusal was applicable or not. We examined whether both parents gave responses that fell into the same category, from among the two categories. Correspondence between the reports of both parents was highest for the statement about anxiety/stress (85% correspondence), followed by somatic complaints (75%) and sad mood (65%).

We also examined the degree of correspondence between youths' and parents' reports. Here again, response categories were collapsed from four categories to two. The results are presented in Appendix S2. They indicate that the correspondence between youths and

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[40] The weighting factor was determined as follows: if one parent completed a questionnaire for a young person, this questionnaire counted once; if two parents completed a questionnaire for a young person, those questionnaires counted as 0.5 each. This was calculated separately for each part of the questionnaire. For example, a parent could have a different weighting factor for 'Characteristics of School Refusal' than for 'Youths' and Parents' Satisfaction', depending on whether one or two parents completed that part of the questionnaire, because not all parents responded to all parts of the questionnaire.

parents was 78% for the statement about whether anxiety/stress was present prior to the intervention. This correspondence (i.e., 78%) is higher than the correspondence for somatic complaints (70%) and sad mood (62%).[41]

Recall, the definition of school refusal does not require the presence of all three characteristics (i.e., anxiety/stress, sad mood, and somatic complaints). More than 90% of youths reported that they experienced at least one of the three characteristics, and 62% experienced two or three of these characteristics. Only 8% of youths reported that they experienced none of the three characteristics prior to participation in intervention. However, one or both parents of these three youths reported the presence of at least one of the characteristics. Across all parents (without the weighting factor), 99% reported one or more characteristics. One parent did not recognise any of the characteristics, but in this case the young person reported that at least one characteristic was present. Overall, all youths experienced at least one characteristic of school refusal, according to the reports of youths and/or parents.

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[41] Not tested statistically.

3.3 Characteristics of School Refusal Interventions

The results presented in Section 3.3 relate to Research Question 2a (How many organisations provide a comprehensive intervention that involves participation of the young person, parents, and school?), Research Question 2b (What do organisations do to address school refusal?), and Research Question 2c (Which difficulties do professionals experience in delivering interventions?). Section 3.3.1 addresses the extent to which comprehensive interventions are provided, Section 3.3.2 addresses the length of the interventions, and Section 3.3.3 addresses the role of screening within the interventions. Section 3.3.4 addresses how education is arranged during intervention, and Section 3.3.5 addresses the therapeutic elements offered, together with the difficulties professionals experience in delivering therapeutic elements. Section 3.3.6 addresses the extent to which interventions are flexible or standardised, and Section 3.3.7 addresses the ways in which professionals evaluate the impact of their intervention.

3.3.1 Comprehensiveness of Interventions

To learn about the extent to which professionals consider their intervention to be comprehensive, the First Impressions Questionnaire included the following question:

> *Who participated in the intervention? Indicate whether the following are never, sometimes, or always involved in the intervention:*
>
> - *The young person*
> - *Parents/carers*
> - *School personnel*

Professionals from all 21 interventions reported that they always work with the young person and always work with school personnel. Professionals from 2 interventions reported that they sometimes work with parents, while the other 19 interventions (91%) always involve work with parents. It appears that most interventions can be regarded as comprehensive interventions.

3.3.2 Length of Interventions

To gain insight into the length of the interventions, the First Impressions Questionnaire included the following question:

> *What is the average length in weeks (estimation) that youths participate in your intervention?*

For some interventions, the estimation was given in number of weeks, or as an average length of time. For other interventions a range was given. To enable comparison with the responses of youths and parents, professionals' responses were converted to categories corresponding with those used in the questionnaires for youths and parents. If the response fell on the upper limit of one category and the lower limit of another category (e.g., one year), it was included in the higher of these categories. The data presented in Table 9 is based on information from professionals at 20 interventions.

Table 9

Length of Interventions According to Professionals

Average length of the intervention	Percentage (number) of interventions with an estimated average length of intervention falling within the specified timeframe
Between 0 and 3 months	5% (*n*=1)
Between 3 and 6 months	25% (*n*=5)
Between 6 months and 1 year	35% (*n*=7)
Between 1 year and 2 years	30% (*n*=6)
Longer than 2 years	5% (*n*=1)

Table 9 indicates that almost all interventions (95%) are longer than 3 months, and around two-thirds (65%) last between 6 months and 2 years. Only one intervention lasts longer than 2 years, as reflected in the response: *"That's difficult to say; students are here on average for a number of years."*

Youths and parents were also asked how long the intervention lasted. This question was answered by 37 youths and 85 parents. Youths and parents from the same family did not always give the same response to this question: 10 of the 37 youths (27%) gave a different response than their parents. Further, when two parents responded, they did not always agree with each other. In 7 of 20 instances (35%), parents gave different responses. For the analysis, we used the responses of parents who answered alone and the responses of parents when both parents agreed. This resulted in 71 parents reporting on 58 youths.

Table 10 indicates that parents reported that most of the youths (93%) participated in intervention for three months or longer. A little less than one-third of youths (29%) participated in intervention for one year or longer, according to parents.

Table 10

Length of Interventions According to Parents

How long did the intervention last?	Percentage of youths completing intervention within the specified timeframe
Between 0 and 3 months	6.9%
Between 3 and 6 months	37.9%
Between 6 months and 1 year	25.9%
Between 1 and 2 years	25.9%
Longer than 2 years	3.4%

3.3.3 Screening

The First Impressions Questionnaire included a question about the use of a process to screen for school refusal. Ten of the interventions (48%) include screening. In some cases, screening appears to be related to the definition of school refusal, and in other cases it is linked to the indications and contra-indications associated with the intervention. Among the other 11 interventions (52%), professionals from 6 interventions indicated that they do not have a screening process, and the responses from professionals associated with 5 interventions were scored as missing (because a response was not given, or it was unclear). If professionals indicated that screening for school refusal did occur, they were also asked whether the intervention used specific screening criteria or questionnaires. Of the 10 interventions that do involve screening, 4 make use of screening criteria or questionnaires (e.g., the School Refusal Assessment Scale - Revised). The other 6 interventions do not make use of screening criteria, or the response was missing or unclear. Professionals from some of the interventions that do not engage in screening or do not use questionnaires stated that they are considering or currently developing a screening process.

3.3.4 Education During Intervention

The First Impressions Questionnaire included questions about how education is organised for youths participating in intervention. One of the questions was whether the intervention aims to help youths return to mainstream education. This was reported to be the case for 9 of the 21 interventions (43%), sometimes the case for 8 interventions (38%), and never the

case for 4 interventions (19%). Regarding how education is organised, professionals were asked whether home education is offered within the intervention. A response to this question was provided for 20 interventions. Of these 20 interventions, 9 (45%) sometimes offer home education. The professionals associated with these 9 interventions further reported that, in principle, home education is not the goal, but it is sometimes used as a prelude to youths attending an education setting.

"Because we work with IVIO [institute for individual education, which offers remote learning options], a student can sometimes work on a course at home. We're not in favour of this because it can be counterproductive and take away the need to go to school. So, in principle, no, unless ... ."

"Sometimes at the beginning. We try to do this for only a short time because our experience is that students then find it difficult to go to school."

"Only as a very limited intervention to build up a relationship with the student."

Professionals from 8 of the 20 interventions (40%) reported that they do not offer home education during the young person's participation in intervention. In some of the interventions, it is because they are not an education organisation and are therefore not able to facilitate home education. Other interventions do not involve home education because it is not in keeping with the aims of the intervention.

"No, we work towards classroom-based diploma-oriented education, which should therefore be the perspective for the participating youths after completing the intervention. For this reason, we do not offer home education."

"No, we don't want to encourage home education because the threshold for going to school then becomes even higher. We offer an alternative education setting, so that nearly all students manage to take the step to [name of intervention]."

Professionals from 3 of the 20 interventions (15%) indicated that they do offer home education. For 2 of the 3, it is not standard, but it is an option sometimes used as a step towards youths attending an education setting in person. The other intervention is a support services intervention, where teachers are members of the team and provide educational support at home. For most of the youths in this intervention, home education is the first step back to school.

"Education in the home situation is intended to re-connect youths with educators and educational materials, so that they can take the step from there to a school environment, or so that we can gain extra insight into the youths and their home situation. We do not provide home education as the ultimate goal."

Despite differences across interventions regarding the provision of home education, an aim of all interventions is to ultimately help youths participate in an education setting or an alternative setting outside the home.

The First Impressions Questionnaire included a question about where youths pursue their education while participating in the intervention. Professionals were asked to provide estimates for the following options:

- *School of origin*
- *Temporary placement in a school for special education*
- *Temporary placement in a meta school facility* [*bovenschoolse voorziening*]
- *Home education*
- *No education*
- *Other, namely:*

This question was answered by professionals from 20 of the 21 interventions. Most of these interventions (60%) arrange a (temporary) placement in a school for special education. For these interventions it was reported that all, or nearly all (90%) of the youths in the intervention are accommodated in a school for special education. In some cases, this is a temporary placement with a view to reintegration in mainstream education or another appropriate (educational) program. In other cases, the aim is to prepare youths for placement in one of the other secondary special education classes of the special school.

Three of the 20 interventions (15%) include temporary placement in a meta school facility. For these interventions it was reported that all, or nearly all (80%) of the youths in the intervention temporarily participate in a meta school facility.

Two of the 20 interventions (10%) arrange for youths to pursue education at the school of origin. One of these is an educational intervention on the site of a secondary school. All youths participate in education in the secondary school, with temporary specialist support and assistance on-site. The other intervention is an external educational intervention, which is offered fully or partly at the youths' school, and youths participate in education at the school of origin.

Two interventions do not have a fixed location where most youths pursue education. In both interventions, youths either pursue education in the school of origin or they (temporarily)

participate in special education. One of the two interventions also offers home education, while the other regularly arranges for youths to (temporarily) pursue education in a meta school facility.

In one intervention, around 80% of youths commence with home education as the first step, leading to education at the school of origin, or another secondary school, secondary special education, meta school facility, adult education, or senior secondary vocational education [*mbo*].

In short, most interventions include an alternative education setting as part of the intervention.

3.3.5 Therapy During Intervention

The interviews with professionals included questions about the therapeutic elements included in the interventions. One question invited professionals to individually report on their use of the following common treatment elements reported in Heyne et al. (2015), via the booklet used in the interview:

1. *Individual treatment (as opposed to group treatment)*
2. *Consultation with the school (providing support, working with teachers)*
3. *Homework for therapy (exercises/assignments between sessions)*
4. *Graduated in vivo exposure to school*
5. *Working with the family on communication and problem solving*

This question was answered by 57 of the 76 professionals. All respondents indicated that their intervention includes graduated in vivo exposure to school. Nearly all respondents (95%) indicated that therapy is offered individually, and the intervention includes consultation with the school. Around four-fifths of professionals (81%) reported that the intervention includes work with the family on communication and problem solving, and three-quarters (75%) indicated that participants are given therapy-related homework.

When professionals' written responses were subsequently discussed during the interview, it became evident that professionals working in educational interventions found this question difficult to answer. Many of these interventions do not offer therapy, but the professionals recognised the common treatment elements as aspects of their own intervention.

"You see, we provide coaching and that is actually a form of treatment."

"We also engage in graduated exposure to school on the basis of a build-up program."

"Yes, and within our education setting we can't call it treatment. But what we do, everything that we've just listed, naturally falls under individual treatment. It's just that it's called coaching."

"Going to the school, walking through the school with the young person. That's all exposure."

"If you see this as real therapy in the family, giving real systemic therapy, we don't do that. But if it's about working with the family on communication, when you read what it says here, then yes, we do that."

"We don't have that, I mean homework as homework, yes, but this is about homework as therapy. So, this is about … the skills for everyday life, which you need to practise."

In addition to the closed question about common treatment elements, professionals were asked several open questions about offering therapeutic elements, namely:

- *Describe the therapeutic elements of your program.*
- *What is the theoretical background for the interventions?*
- *Are interventions offered for the youths? If so, what are they?*
- *Are interventions offered for the parents? If so, what are they?*
- *Are interventions offered for professionals at the school? If so, what are they?*
- *Are there group interventions in your program? If so, what are they?*

In most interviews it became evident that the intervention includes some form of individual therapy, guidance, or coaching, connecting with the question about the extent to which individual therapy takes place in education.

"But also individually, I often see her speaking with a student individually: 'It's really good that you're here'. And you know, motivational interviewing is also, of course, a form of, yes, of just providing support."

Table 11 lists the theoretical underpinnings of interventions as reported by professionals, together with the therapeutic elements offered to youths, parents, and school personnel. The interventions offered are internal (i.e., provided by professionals within the organisation offering the intervention) and/or external (i.e., provided by professionals from other organisations).

Table 11

Professionals' Reports of the Theoretical Underpinnings of the Therapeutic Interventions and the Specific Therapeutic Elements

Theoretical underpinnings of therapeutic interventions
Cognitive-behavioural
Systemic
Solution-focused
(Social) competence model
Positive psychology
Self-determination theory
Recovery approach
Non-violent resistance
Motivational interviewing
Positive behaviour support
Specific interventions with youths - individual
Cognitive-behavioural therapy (e.g., Thinking + Doing = Daring, schema therapy)
Eye movement desensitisation and reprocessing
Psychoeducation
Non-verbal therapy: psychomotor therapy / movement, creative therapy, music therapy, drama therapy / role playing, rock and water, heart coherence, mindfulness
Exposure (in vivo)
Pharmacotherapy (medication)
Career counselling (e.g., talent talks)
Brain blocks
Solution-focused work
Motivational interviewing
New authority and non-violent resistance
Support with education (learning to learn, executive functions, teaching methods)
Paramedical therapy: physiotherapy, speech therapy
Mentalisation-based treatment
Pivotal response treatment
Specific interventions with youths - group
Group activities (e.g., playing group games, cooking, drinking tea)
Group interviews and discussion (e.g., variation classes)
Social skills training (e.g., TOPs!)
Girls group (still to be started)
Boys group (still to be started)
Emotion regulation training
Psychotherapy group
Anxiety therapy group
Recovery work group
Self-image group
Cognitive-behavioural therapy (FRIENDS program)
Resilience training

Specific interventions with the parents or family
Family-based treatment (e.g., systemic therapy, family and schools together, multidimensional family therapy, new authority, non-violent resistance)
Parent interviews and coordination (e.g., evaluation interviews, weekly reports)
Parent guidance
Parent sessions (e.g., parent evening, parent training)
Psychoeducation
Home visits
Treatment for parents (e.g., emotion focused therapy, cognitive-behavioural parent module)
Parent mediation
Specific interventions for schools
Further training for (one's own) school and teachers (e.g., workshops, consultation, teacher coaching)
Maintaining contact and coordination
Intervision (peer feedback) and supervision within one's own school
Formulating advice on action (e.g., feedback on assessment)
Psychoeducation
Guidance when youths return to school

Note: Table entries that were mentioned in relation to four or more interventions are in bolded font, and entries mentioned in relation to three or fewer interventions are not bolded.

As seen in Table 11, cognitive-behavioural therapy (CBT) is commonly employed with youths, and a common group-based intervention is group activities. The most common interventions with parents are family-based treatment and support for parents in the form of meetings, updates, guidance, and training. For schools, the most common interventions are training for education professionals and maintaining contact. The following quotations elucidate the professionals' responses:

CBT as a therapeutic approach

"Yes, to put it simply, we use the Think-Feel-Do model. … We always actually assume that the easiest to change is your Do, so you wake up and you feel nauseous, you can just turn over and think: 'Oh it's going to be one of those days again' and I'm going to stay in bed'. But you can also, you can do something different and then your thoughts and your feelings automatically change at the same time."

"What we mainly do is cognitive-behavioural therapy."

"We do actually have a bit of starter CBT, I'd like to call it, challenging of negative thoughts. What else can you do, then? … How do you feel if you don't immediately hear anything when you put your hand up? What are alternatives for what you're showing at the moment?"

Group activities for youths

"We have times when we play games together."

"The group interventions naturally also happen during gym classes and cooking classes."

Family treatment

"They receive a systemic therapist linked to the family. So, there's a systemic therapist who conducts interviews with the parents, about once every two weeks while the young person is here."

Parent contact

"We have weekly reports that we share every week, from day to day. Well, yes, about how things have gone. And we address those weekly reports to the student personally, so we address the student, and it is sent to all the people involved, so the support services, parents."

"We have parents that we speak with nearly every day. I have parents that I [educational remedialist within the intervention] briefly speak with every week in any case, in addition to the contact they have with the mentor."

Parent sessions

"For the period that the young person is here … parents get three sessions, parent sessions … elements of the 'new authority' are shared there and discussed with one another, but also just contact with other people in the same situation. Because you also notice that this is a question that parents have. Having a discussion with one another on 'how is it going for you at home about the school refusal?' Because you can see that they really appreciate this."

Further training for (one's own) school and teachers

"All the teachers have been trained. Trained in school refusal. That's already done before the project has started."

"So, guidance of teachers is done by me and my school psychologist colleague, and it mainly relates to coaching."

Professionals were asked about the difficulties they experience when delivering the therapeutic elements of their intervention, as follows:

> *What difficulties do you experience in providing therapeutic elements when addressing school refusal?*

Figure 2 presents the difficulties professionals experience in delivering therapeutic elements, summarised as main themes and sub-themes. For this network, the sections of the transcripts that were coded were those sections where professionals had responded to this specific question.[42] The content of the sub-themes is clarified via quotations from the interviews.

Figure 2

Difficulties in Delivering Intervention – Views of Professionals

Difficulties related to the characteristics of participants	Difficulties related to delivery of therapy elements	Difficulties related to the collaboration with support services
Willingness and involvement	Room to help	Organising (timely) additional help
Being present and keeping appointments	Arrange group interventions	Communication
Family factors	Generalising to daily practice	The grey area between education and support services

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[42] In contrast to most of the other qualitative analyses presented in this report, author GA conducted the coding and author MBB developed the network.

Main theme: Difficulties related to the characteristics of participants

The main theme 'difficulties related to the characteristics of participants' [*moeilijkheden gerelateerd aan kenmerken van participanten*] comprises sub-themes referring to specific characteristics and behaviours of youths, parents, and/or the family. These difficulties were mentioned by professionals in approximately one-half of the interventions.

Willingness and involvement

The sub-theme 'willingness and involvement' [*bereidwilligheid en betrokkenheid*] refers to the attitude and commitment of parents and youths with respect to the therapeutic intervention. Difficulties can occur if participants are resistant or distrustful.

> " ... it's difficult to bring in the support services, a kind of distrust on the part of the parents, student, or both, towards support services, because they've tried everything and still nothing works."
>
> " ... I think the resistance they sometimes have. Especially at the beginning, that students say: I don't want to talk, I don't want that hassle. Because sometimes they're already so worn down ... But yes, then we do something with this."

Being present and keeping appointments

The sub-theme 'being present and keeping appointments' [*aanwezig zijn en afspraken nakomen*] refers to actually showing up, being present at the times when therapeutic elements are offered, and following through on agreed tasks, such as doing homework related to the therapeutic elements.

> "The biggest problem is always that they don't show up. How do you make contact with a young person who doesn't show up?"
>
> "When we're talking about hindering factors, then trust in therapy is the thing that comes up most. And once they're there, then it actually goes fine."
>
> "Every week it's 'Oh yeah, I'm going to do it!' and the week after it's 'No, I haven't done it'."

Family factors

The 'family factors' [*gezinsfactoren*] sub-theme draws together codes related to parenting and to family functioning.

> *"Changing your role from protector to educator is … for some parents … really very difficult to take that step. Your child is vulnerable, so you're still in the protective role."*
>
> *"I encounter those systemic problems. Where you think: well, that young person actually wants to, the home system wants to as well, but they aren't able to."*

Main theme: Difficulties related to the delivery of therapeutic elements

This main theme 'difficulties related to delivery of therapeutic elements' [*moeilijkheden gerelateerd aan het uitvoeren van therapeutische elementen*] comprises sub-themes about difficulties with actually delivering therapeutic interventions. The theme emerged in approximately one-third of the interviews.

Room to help

Codes included in the sub-theme 'room to help' [*ruimte om hulp te bieden*] refer to the professionals' sense of having insufficient time and space to provide the young person and/or parents with therapeutic interventions.

> *"When I'm standing in front of the class, then I don't always have the opportunity to be doing therapeutic things with a student one-to-one."*
>
> *"I think that something I sometimes encounter with focused coaching is finding that bit of time, but then really finding the time, to be able to offer support as well as the school things."*
>
> *"It's sometimes so very complex that you think, well, we don't have any time to treat this properly, even though it's actually needed."*

<u>Arrange group interventions</u>

The sub-theme 'arrange group interventions' [*groepsinterventies regelen*] draws together codes referring to the difficulties that are experienced when providing and implementing group interventions.

> *"That they sometimes don't always dare to join in, to go to those shared social occasions. Or don't want to."*
>
> *"I think there's a power in the group interventions, or in the group therapy that you provide. It's seeing and feeling and sensing a tremendous recognition together, but sometimes one person has already had a lot of treatment and another not so much yet, and sometimes as the group leader it's difficult to find ways …. That you notice yourself thinking 'how can you connect individually with each young person?' That's really a challenge."*

<u>Generalising to daily practice</u>

The sub-theme 'generalising to daily practice' [*generaliseren naar de dagelijkse praktijk*] comprises codes that refer to the transfer of therapeutic elements to functioning in everyday life.

> *"What's sometimes missing is that transfer into practice, so we'd like to have more of that."*
>
> *"A difficulty that I've encountered is the transfer into the home and the young person's own setting."*
>
> *" ... the insufficient link between the treatment and everyday life … ."*

Main theme: difficulties related to the collaboration with support services

Sub-themes within the main theme 'difficulties related to the collaboration with support services' [*moeilijkheden gerelateerd aan de samenwerking met hulpverlening*] pertain to difficulties experienced in the collaboration between the intervention and (additional) support services. Difficulties related to this main theme were mentioned by professionals in more than one-half of the interventions.

Organising (timely) additional help

The sub-theme 'organising (timely) additional help' [*realiseren van (tijdig) aanvullende hulp*] comprises codes referring to the availability of appropriate (specialist) help alongside the help provided by professionals working in the intervention.

> *"A student sometimes needs specific things, but there are usually waiting lists in the care sector."*
>
> *"Looking for the right type of support, which is often not immediately available, is something that hinders us in the steps, or at least hinders the student in the steps that they can take here."*

Communication

The 'communication' [*communicatie*] sub-theme refers to communication and coordination between professionals working in the interventions, and external professionals who provide additional therapeutic elements.

> *"It really depends, in fact, on the collaboration. It's actually happened to me that I just didn't hear anything, for months, and it's also happened that I got a phone call immediately. So that's evidently a very big difference in terms of coordination."*
>
> *"I always try to make it clear during the intake that we really need each other and that, naturally there's the privacy laws, but sometimes you have to tell each other about things in order to have a discussion to find a good approach for the student. And with some people that still causes quite a lot of tension."*

The grey area between education and support services

The sub-theme 'the grey area between education and support services' [*het grijze gebied tussen onderwijs en hulpverlening*] refers to the difficulty professionals have in determining whether interventions are an aspect of education or support services.

> *"When is what I'm doing still actually education? And when is it providing support services, what I'm doing, when does it become treatment?"*

3.3.6 Flexibility Versus Standardisation

Professionals were asked the following question during the interviews:

> *Some interventions are completely standardised/protocolised (that is to say, there is a fixed program/intervention that is provided to everyone) while others are completely flexible (that is to say, there are no fixed elements). Where is your intervention located on this scale between 'completely standardised or protocolised' and 'completely flexible'?*

Professionals individually rated their intervention from 0 (completely flexible) to 8 (completely standardised). The minimum, maximum, and average scores for 19 of the 21 interventions are presented in Table 12.

Table 12
Professionals' Ratings of the Extent to Which Their Intervention is Flexible or Standardised, On a Scale From 0 (Fully Flexible) to 8 (Fully Standardised)

Intervention	Minimum score, as indicated by at least one of the interviewed professionals	Maximum score, as indicated by at least one of the interviewed professionals	Average score of the professionals per intervention (and rounded average scores)
1[a]	-	-	-
2	3.5	5	4.3 (4)
3	2	5	3.7 (4)
4	1	4	2.5 (3)
5	2	3	2.5 (3)
6	3	6	4.3 (4)
7	3	6	5.0 (5)
8	4	5	4.5 (5)
9[b]	-	-	-
10	1	3	2.0 (2)
11	2.5	6	4.0 (4)
12	4	4	4.0 (4)
13	0	0	0.0 (0)
14	0.5	1	0.8 (1)
15	0	3	1.3 (1)
16	2	4	3.0 (3)
17	0	6	2.1 (2)
18	2	3	2.5 (3)
19	6	6	6.0 (6)
20	2.5	3	2.9 (3)
21	0	2	1.0 (1)

[a] This intervention was part of the pilot interview and a different procedure was used.
[b] In the case of this intervention, the question was formulated differently during the interview.

Table 12 shows that the average score per intervention ranges from 0 to 6. The average across the 19 interventions is 2.9. When the average scores for the interventions are rounded off to whole numbers, the most common scores are 3 and 4. This means that the scores are around the middle of the scale, with a slight leaning towards flexibility. The lowest and highest scores per intervention (0 and 6) occur infrequently. Very few interventions are completely flexible and very few are almost completely standardised. Overall, most interventions are partly standardised and partly flexible.

After professionals independently gave their ratings, they were invited to discuss their responses. The text in the transcripts relating to this discussion was coded.[43] Four themes emerged: clarification of the ratings given, concrete examples, advantages and disadvantages, and desires. The meaning of each theme is explained below, with corresponding quotations to illustrate the themes.

Theme: Clarification of the ratings given

This theme encompasses the explanations professionals provided for their ratings, as they described the flexibility and standardisation in their interventions. Although the interventions vary in the extent to which they are more flexible or standardised, professionals from most interventions said that their intervention includes standard elements, frameworks, and structure.

"Yes, we do have a kind of framework."

"We do very many standard elements, of course."

"We have a very strict step-by-step plan."

In one-third of the interviews, professionals reported a difference between how the intervention is organised (more fixed) and how it is delivered (more flexible). This was one reason why many professionals found it difficult to provide a single rating on the scale.

"On the one hand we have a lot of structure in the phases in which we work, and on the other hand we have the work with individuals."

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[43] In contrast to most of the other qualitative analyses conducted for this report, this coding was conducted by author MBB alone. Thematic analysis was performed, comparable to the analyses for the other networks.

> *"The process is fairly standardised, and we have a number of very clear agreements here. And what we do with the young people is much more flexible."*

A few professionals said that their intervention involves a combination of more standardised interventions and completely flexible interventions.

> *"If you look at the treatment, then the training is almost completely standardised, it only includes a few optional elements. And individually it's completely flexible."*

The professionals often said that standardisation within the intervention is not seen as a 'straitjacket'. Rather, there is flexibility within the standard approach of the intervention. Several professionals said, for example, that if certain elements in their intervention are not appropriate for a young person, they are not provided. A few professionals said that the modules within their protocolised intervention are chosen based on the individual young person's needs.

> *"There is flexibility in what we provide within the framework."*
>
> *"You need to have a fixed method for how you work, but you should also look at the person in front of you and what that person needs."*
>
> *"We never do something with a young person just because that's what we do."*
>
> *"Yes, if a student says I don't want to go to music, I want to do gym or whatever, then I have to think of something different."*

Several professionals emphasised the power of flexibility in relation to the population served by the intervention, with the frequent comment that every case is different and that school refusal calls for flexibility and thinking 'out of the box'.

> *"I actually think that the strength lies in the fact that we're so flexible."*
>
> *"Our students are all so different, and have such different educational needs, that you need to be able to make adjustments."*

> *"And on the other hand, every young person, every family, every system, and especially every school, is different. So that requires a certain amount of flexibility."*
>
> *" ... within that we're flexible. And we dare to make decisions that perhaps aren't quite so obvious."*

A number of professionals described flexibility and standardisation as something that changes over time during the course of their work with the young person. A more flexible approach is taken at the beginning, and after a while this is reduced, based on the principle that youths will ultimately have to re-integrate into existing systems and society at large.

> *"We gradually work towards being increasingly structured and increasingly in line with what's expected of students."*

Theme: Concrete examples

This theme refers to the professionals' concrete examples of working in a flexible or standardised manner.

Professionals in numerous interventions said that the intake process is standardised. Frequently, professionals mentioned that the standard elements in their intervention include working in phases, providing group activities, using standardised training sessions or treatments, and periodically consulting with all parties involved. A few professionals also mentioned that their intervention has been or is currently being documented.

> *"Every 5 or 6 weeks we have meetings attended by everyone involved: student, parents, support services, mentor and someone from our organisation."*
>
> *"At the moment we're working on a manual, to document everything we do."*

The flexible aspects of intervention that were often mentioned are the individual guidance and treatment provided for youths, and the individual approach towards youths.

> *"I see a great deal of flexibility in how we approach the youths."*

> " ... this large amount of freedom in the social-emotional aspects."

Several professionals described the education part of their intervention as flexible, while others described it as the more standardised part of the intervention.

> " ... because we're tied to the frameworks of education, how we have to organise it and all the requirements we have to fulfil."
>
> "You take a close look at what that student wants, what you want to work towards, and you actually adjust the education, the educational pathway to that."
>
> "When you're looking at the didactic package for a child, then that's completely flexible ... ."

Building up the young person's school attendance was described as flexible in several interviews, although a few professionals regarded it as more standardised.

> " ... everything that we still really need to arrange with the student, that's completely flexible: will he go there on Monday, Wednesday, Friday, or an hour or so every day, or ... ."

Theme: Advantages and disadvantages

The codes related to this theme largely pertain to the advantages and disadvantages of standardisation. Some disadvantages of flexibility were also mentioned. A frequently mentioned advantage of standardisation is that frameworks and guidelines offer direction, reducing the likelihood that professionals work in an overly ad hoc fashion. A few professionals said that standardisation also provides clarity for youths and parents.

> "I think it's important that there's a bit of structure in it, in the sense that it's also clear what you're working towards."
>
> "You can't do it unless there's a format, because otherwise, if you had to devise everything on-the-spot, then I think it would be very confusing."
>
> " ... standardisation also gives you some guidelines in interviews with parents and students."

A few professionals mentioned that standardisation makes an intervention transferable.

> *"It means that when a new colleague arrives you can inform them about the basic things ... ."*

A disadvantage of a high degree of standardisation, according to numerous professionals, is that you can lose the opportunity to respond appropriately to individual youths.

> *" ... if your approach is too standardised, then you'll lose your personal response to the student ... ."*

A few professionals suggested that a disadvantage of flexibility is that there is a risk that what is done is too dependent on the specific professional.

> *"I think one of the pitfalls of the regional/national approach to school absenteeism is that you make it so exclusive by constantly saying that we provide a completely flexible intervention for everyone ... ."*

A flexible approach is also very demanding, presenting obstacles for professionals. They frequently reported that there are limits to flexibility.

> *"But it's not actually the case that everything can be done, right?"*

A few professionals said that options for flexibility are limited by finances or the search for the right support services for a young person.

> *"I gave a 'two' [on the rating scale] because I would really like to deliver complete flexibility, but that isn't possible within the budget."*
>
> *"But it's sometimes frustrating that searching for support services sometimes means that you can't deliver as much flexibility as you'd like ... ."*

Additionally, a few professionals said that flexibility is time-intensive; it takes time to think about what the flexible intervention will be.

> *"I really need time to be creative, all those standard things haven't worked for our families."*

Theme: Desires

This theme encapsulates what it is that professionals desire with respect to flexibility vis-à-vis standardisation. Numerous professionals expressed satisfaction with the rating they gave on the scale (from 'completely standardised or protocolised' to 'completely flexible'), while others expressed the desire for their intervention to move in a particular direction on this scale. Several of them would like their intervention to move as far as possible towards flexibility, while several others would like it to move more towards standardisation. A few professionals would like their intervention to be more in the middle of the scale.

> *"Then you'd naturally prefer to be as low [on the rating scale] as possible."*
>
> *"So, I think that you should actually be somewhere around the middle [of the rating scale]. And I think that we're now moving a bit towards that and at first we were more on this side and now rather more towards the middle."*

3.3.7 How Professionals Evaluate the Impact of Their Intervention

The First Impressions Questionnaire asked professionals about the extent to which youths are followed up after participating in the intervention, and whether the intervention is evaluated in any way. Twelve interventions (57%) include structural follow-up with youths. For some interventions this is standard practice based on consolidation [*bestendiging*], as is customary within (secondary) special education. Other interventions use a questionnaire sent after a specific period, transfer guidance, booster sessions, or discussion of the youth's current development during a fixed number of meetings with the Care and Advice Team [*Zorg- en adviesteam*]. In some cases, youths are followed up because they remain in the school for (secondary) special education. Professionals from yet other interventions said that they sometimes have contact with the youths, or with specific groups of youths (such as

those in the examination track). Some professionals did not answer this question, and in one case it was explicitly stated that youths are not followed up after completing the intervention.

With respect to evaluation of the interventions, professionals from five interventions (24%) said that quantitative data is collected for specific parameters, such as information about intake and leaving, and characteristics of the youths. Professionals from seven interventions (33%) reported that a satisfaction survey is implemented, that participants are invited to give 'grades' for care and education, or that standardised questionnaires are administered. In some cases, the effects of the intervention are evaluated via standard routine outcome monitoring (ROM). These are interventions that are (partly) situated within mental health services/youth care. Only one intervention conducts scientific research on the effectiveness of the intervention by means of questionnaires at pre-intervention, post-intervention, and follow-up. Professionals in numerous interventions expressed the wish to conduct a better evaluation of the effects of their intervention or said that they were in the process of developing a system to evaluate the impact of their intervention.

3.4 Outcomes Following Interventions

The results presented in Section 3.4 relate to Research Question 3a (In which ways do youths and parents benefit from the intervention?). Section 3.4.1 addresses the youths' and parents' satisfaction with the intervention. Sections 3.4.2 to 3.4.7 address the changes that occurred for youths, according to youths and parents. These changes relate to characteristics associated with school refusal, school attendance, the experience of school, problem solving skills and social skills, quality of life, and confidence in the future. Changes for parents and families are also reported. Section 3.4.8 addresses the types of education youths attend after completing intervention, according to professionals.

Most of the results reported in this section are based on the Knowing What Works Questionnaire for Youths and the Knowing What Works Questionnaire for Parents. The number of youths and parents who answered specific items in the respective questionnaires is reported in each subsection, along with how many questionnaires were completed by just one parent of the young person, or by both parents. When a questionnaire was completed by two parents, we took the average of their responses (by assigning a weighting factor, see section 3.2.6). Percentages shown in the text are based on the whole group of parents, unless otherwise stated. For the purposes of reporting results in the text, we combined the two agreement categories (i.e., "completely agree" and "agree") and the two disagreement categories (i.e., "completely disagree" and "disagree"). The disaggregated data is found in Appendix S.

3.4.1 Youths' and Parents' Satisfaction

The 4-item Process [*Verloop*] scale was used to measure youths' and parents' satisfaction with the intervention. This scale was completed by 37 youths and 83 parents (one parent *n*=43, two parents *n*=40). The average score for youths was 3.48 (*SD* = 0.64). The average score for parents was 3.59 (*SD* = 0.54) for one parent, and 3.35 (*SD* = 0.67) for two parents. According to the manual associated with this scale, a score above 3 is designated a good rating, and a score between 2.75 and 3.00 is a satisfactory rating. On average, youths and parents scored well above 3, signalling overall positive evaluations of the interventions.

Parents and youths were also asked the following question, derived from the BESTE scale:

- *For youths: Would you recommend this intervention to others who need help with school attendance?*

- *For parents: Would you recommend this intervention to others whose child needs help with school attendance?*

Table 13 indicates that most youths (92%) and parents (92%) would probably or definitely recommend the intervention to others.

Table 13
Percentage of Youths and Parents Reporting That They Would, Or Would Not, Recommend the Intervention to Others

Recommend or not	% (and number) of youths	% (and number) of one parent	% (and number) of two parents	% parents total
Definitely would not	2.7% (1)	4.7% (2)	2.5% (1)	4.0%
Probably would not	5.4% (2)	4.7% (2)	2.5% (1)	4.0%
Probably would	43.2% (16)	32.6%(14)	45.0% (18)	36.5%
Definitely would	48.6% (18)	58.1% (25)	50.0% (20)	55.6%

Parents were asked whether they were kept informed by the professionals delivering the intervention. Table 14 indicates that almost all parents (92%) felt that they were kept informed by the professionals with respect to their child's progress.

Table 14
Percentage of Parents Reporting That Professionals Updated Them About Their Child's Progress During the Intervention

Informed by professionals	% (and number) of one parent	% (and number) of two parents	% parents total
Completely disagree	2.3% (1)	5% (2)	3.1%
Disagree	6.8% (3)	-	4.7%
Agree	34.1% (15)	52.5% (21)	39.8%
Completely agree	56.8% (25)	42.5% (17)	52.3%

Youths and parents were asked what they thought about the length of the intervention. Table 15 indicates that approximately one-half of the parents and youths thought the intervention was the right length. Around one-fifth of youths and one-third of parents had no opinion on this.

In sum, the scores on the Process [*Verloop*] scale and the other questions about satisfaction with the intervention indicate that, on average, youths and parents were highly satisfied with the interventions.

Table 15

Youths' and Parents' Views on the Length of the Intervention

Opinion on length	% (and number) of youths	% (and number) of one parent	% (and number) of two parents	% parents total
Too short	16.2% (6)	9.1% (4)	15.0% (6)	10.9%
Exactly long enough	45.9% (17)	47.7% (21)	65.0% (26)	53.1%
Too long	16.2% (6)	6.8% (3)	5.0% (2)	6.3%
No opinion	21.6% (8)	36.4% (16)	15.0% (6)	29.7%

3.4.2 Youths' Anxiety, Mood, and Somatic Complaints

Youths and parents were asked about changes in the young person's experience of anxiety, mood problems, and somatic complaints. The following statements were presented to youths and parents:

- *As a result of participating in the intervention, I/my child suffered less from stress or anxiety.*
- *As a result of participating in the intervention, my/my child's mood has improved.*
- *As a result of participating in the intervention, I/my child suffered fewer somatic complaints.*

Responses to these statements were provided by 37 youths and 80 parents (one parent *n*=46, two parents *n*=34). Appendix S3 indicates that some of the youths and parents responded with "not applicable," suggesting that the topic of the item (e.g., mood problems) did not occur for them prior to participation in the intervention. Nevertheless, when youths for whom "not applicable" was reported were included in the analyses, two-thirds of youths (68%) and parents (67%) reported that the young person suffered less from stress or anxiety as a result of participation in the intervention, approximately two-thirds of youths (65%) and parents (70%) reported that the young person's mood had improved, and approximately one-third of youths (30%) and parents (33%) reported that the young person suffered fewer somatic complaints.

In Appendix S4 we present responses only for those youths and parents who did not answer "not applicable". The responses in Appendix S4 indicate that most youths and parents reported an improvement in the specified areas. Specifically, about three-quarters of the youths (76%) and parents (74%) reported that the young person's anxiety or stress had decreased, and three-quarters of youths (75%) and more than four-fifths of parents (83%) reported that the young person's mood had improved. With respect to somatic complaints, approximately three-fifths of youths (61%) and parents (59%) reported that there were fewer somatic complaints as a result of participating in the intervention.

3.4.3 Youths' School Attendance

Youths and parents were asked about school attendance via the following two statements:

- *As a result of participating in the intervention, I/my child was able to go to school more often.*
- *As a result of participating in the intervention, I/my child found it easier to go to school.*

Responses to these statements were provided by 37 youths and 83 parents (one parent *n*=45, two parents *n*=38). Appendix S5 shows that a little more than three-quarters of youths (78%) and parents (77%) reported that the young person was able to go to school more often. Around three-quarters of youths (76%) and almost four-fifths of parents (79%) reported that it was easier for the young person to go to school as a result of participation in the intervention.

3.4.4 Youths' Experience of School

Youths and parents were asked about changes in the young person's experience of school, as a result of participation in the intervention. They were presented with the following statements:

- *As a result of participating in the intervention, I/my child had more fun at school.*
- *As a result of participating in the intervention, I/my child saw more value in education.*
- *As a result of participating in the intervention, there was an improved relationship between me/my child and the teachers.*

Response to these statements were provided by 37 youths and 82 parents (one parent *n*=44, two parents *n*=38). Appendix S6 shows that just over two-thirds of youths (68%) and one-half of the parents (50%) reported that the young person had more fun at school. Just over three-fifths of the parents (62%) and just under three-fifths of the youths (57%) reported that the relationship between the young person and teachers had improved. With respect to seeing more value in education, almost one-half of the parents (45%) and youths (46%) reported that this was the case.

3.4.5 Youths' Problem Solving Skills and Social Skills

Youths and parents were asked about changes in the young person's skills as a result of participating in the intervention. They were presented with the following statements:

- *As a result of participating in the intervention, I/my child improved in problem solving.*
- *As a result of participating in the intervention, I/my child could get along better with peers.*

A response to these statements was obtained from 37 youths and 82 parents (one parent *n*=44, two parents *n*=38). Appendix S7 shows that more than four-fifths of youths (83%) and just over three-fifths of parents (63%) reported that the young person improved in problem solving. Approximately one-half of the youths (51%) and just over two-fifths of the parents (43%) reported that the young person could get along better with peers.

3.4.6 Youths' Quality of Life and Confidence in the Future

Youths and parents were asked about changes in the young person's life satisfaction and confidence in the future, as a result of participation in the intervention. They were presented with the following statements:

- *As a result of participating in the intervention, I have / my child has greater satisfaction in life.*
- *As a result of participating in the intervention, I have / my child has more confidence in the future.*

Responses to these statements were provided by 37 youths and 82 parents (one parent *n*=44, two parents *n*=38). Appendix S8 shows that nearly three-quarters of youths (70%) and two-thirds of parents (66%) reported that the young person was more satisfied with life, and nearly three-quarters of youths (70%) and parents (70%) reported that the young person had more confidence in the future, as a result of participation in the intervention.

3.4.7 Parent and Family Functioning

Parents were asked to respond to the following statements:

- *As a result of participating in the intervention, I was better able to understand why my child had difficulties going to school.*
- *As a result of participating in the intervention, I became more confident in my ability to respond to my child's difficulties going to school.*
- *As a result of participating in the intervention, I was better able to support my child in going to school.*
- *As a result of participating in the intervention, I experienced less tension and stress regarding my child's school attendance.*

Responses to these statements were provided by 81 parents (one parent *n*=43, two parents *n*=38). Appendix S10 indicates that just over two-thirds of the parents considered that, as a result of participation in the intervention, they could support their child better (70%), they experienced less tension and stress regarding their child's school attendance (67%), and they were more confident in their ability to respond to their child's difficulties going to school (68%). Fewer than two-thirds of parents (60%) reported that, as a result of participation in the intervention, they were better able to understand why their child had difficulties going to school.

To gain insight into possible improvements in family functioning, the following statements were presented to youths and parents:

- *For youths: As a result of participating in the intervention, there were fewer difficulties at home between me and my parents/carers.*
- *For parents: As a result of participating in the intervention, there were fewer difficulties at home between me and my child.*

Responses to these statements were provided by 37 youths and 81 parents (one parent *n*=43, two parents *n*=38). Appendix S9 shows that just over three-fifths of the youths (62%) and parents (61%) experienced fewer difficulties at home.

3.4.8 Education Subsequent to Participation in Intervention

The First Impressions Questionnaire invited professionals to estimate the percentage of youths who return to the school of origin after participation in the intervention. Data was available for 17 of the 21 interventions. Professionals estimated that just over one-fifth of youths (21%) returned to their school of origin. Professionals were also asked about the type of education youths follow after participation in the intervention. Data was available for 19 of the 21 interventions,[44] and data related to day-time activities (*dagbesteding*) was available for 18 interventions.

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[44] For 3 of these 19 interventions, the estimates provided by professionals did not add up to 100%. Their estimates were recalculated for the purpose of the analysis.

As seen in Table 16, professionals estimated that almost one-half of youths (48.8%) participate in special education or secondary special education after intervention for school refusal. This percentage might actually be higher, because we observed that some professionals involved in interventions within (secondary) special education appeared to have read the question as 'after leaving (secondary) special education' instead of 'after leaving the school refusal intervention'. Transfer to a different secondary special education class would then actually be 'leaving the intervention'. The 'other, namely' category mostly referred to therapy or intensive therapy in combination with education. One intervention refers many youths to a meta school facility, increasing the percentage for the 'other, namely' category. One-third of youths (32.9%) return to mainstream education, when considering only those interventions for which professionals indicated that they make use of a transition back to mainstream education. Viewed across all the interventions, referral back to mainstream education applies to approximately one-fifth of youths (20.8%).

Table 16

Estimated Percentage of Youths in Each Type of Education Following Participation in the Intervention

Type of education	Number (%) of interventions (out of 19, or 18) indicating that youths go to this type of education	Average % (minimum-maximum) of youths in each type of education, across interventions that indicated this applies to their population	Average % of youths across all 19 (or 18)[a] interventions
Special education or secondary special education	17/19 (89.5%)	48.8% (5%-95%)	43.6%
Mainstream primary or secondary education	12/19 (63.2%)	32.9% (7%-90%)	20.8%
Senior secondary vocational education (mbo)	13/19 (68.4%)	14.9% (2%-53%)	10.2%
Other, namely:	5/19 (26.3%)	26.8% (3%-67%)	7.1%
Day-time activities	10/18 (55.6%)	12.8% (1%-35%)	7.1%
Work placement / work-related skills	8/19 (42.1%)	9.5% (1%-29%)	4.0%
Adult education	7/19 (36.8%)	8.6% (1%-20%)	3.2%
No education	5/19 (26.3%)	7.4% (5%-10%)	2.0%
Home education	6/19 (31.6%)	5.2% (1%-13%)	1.6%

[a] For some types of education, data was unavailable for two or three interventions.

3.5 Working Elements in the Interventions

The results presented in Section 3.5 relate to Research Question 3b (Which elements are perceived to be most important for an effective intervention for school refusal, according to professionals, youths, and parents?), Research Question 3c (For whom do the interventions work best and worst?), and Research Question 3d (What adjustments do professionals wish to make to improve their intervention?). Section 3.5.1 addresses the elements in intervention that professionals view as most important. Sections 3.5.2 and 3.5.3 address the elements in intervention that youths and parents view as most helpful. Section 3.5.4 addresses for whom interventions are most and least effective according to professionals, and Section 3.5.5 addresses the changes that professionals would like to make to their interventions.

3.5.1 Working Elements According to Professionals

Figure 3 presents the most important elements in intervention according to professionals, organised in domains, main themes, and sub-themes. For this network, the parts of the transcripts that were coded were those in which professionals responded to the following questions:

- *Why do you think your intervention works as well as it does?*
- *Which elements in your intervention do you view as most important?*
- *What do you think is needed to properly address school refusal?*

In Figure 3, a '1' shown after a main theme or sub-theme indicates that the theme was only mentioned in relation to the first two questions, and a '2' indicates that the theme was only mentioned in relation to the third question. Bold typeface indicates that the theme emerged in response to either of the first two questions, and in response to the third question.

The ordering of the sub-themes in Figure 3 is not determined by the frequency with which the themes were mentioned. Rather, the ordering is based on the process of intervention; some themes seem to be conditional for other themes (e.g., 'the arrangements' must be in order before 'the content' can be determined). Some themes are closely related, so they are positioned together (e.g., a 'safe environment' and 'adapted educational environment'). The meaning of the themes is elucidated via quotations from the interviews.

Figure 3

Most Important Elements in Intervention – Views of Professionals

The arrangements		The intervention			
Structural conditions	Personnel	Relationship with participants	The content	Collaboration between those involved	Attention to prevention and timely intervention[2]
physical environment[1]	**Heartfelt commitment to this population**	**Transparent and reliable**	**Clarifying the problem(s)**	**Collective effort**	
Financial arrangements	Vision[1]	**Available**	**Safe environment**	Communication[1]	
Support from management[1]	**Team composition and teamwork**	**Accepting**	**Adapted educational environment**	**Respect and trust**	
	Knowledge, experience, and curiosity	**Connected**	**Room for customisation**		
	Patience and persistence	**Positive approach**	**Easy beginning**		
		Humour and putting things in perspective[1]	**Rhythm and structure**		
		Flexible and creative	**Creating movement**		
			Success experiences[2]		
			Psycho-education		
			Involve parents[1]		
			Systemic approach		
			Creating perspective		

Main theme: Structural conditions

The main theme 'structural conditions' [*structurele voorwaarden*] includes sub-themes related to the arrangements that make it possible to carry out the intervention. Professionals associated with around one-half of all interventions mentioned an important element that falls under this main theme.

> *"The arrangements have to be in good order."*

Physical environment

The 'physical environment' [*fysieke omgeving*] sub-theme is about location and logistics; in other words, where an intervention is located and how this location facilitates the logistics of cooperation between different organisations.

> *"I think that's the most important factor, that we have education and support services so close together, in one building."*
>
> *"I think the location is also an important element."*

Financial arrangements

The 'financial arrangements' [*financiële arrangementen*] sub-theme relates to the financing of the intervention; that financing is secured and supported by other parties.

> *"Sustained by the partnership that is willing to invest in it."*
>
> *"Yes, then it's about time and money again? That you can just invest in it."*
>
> *"I also think that the regional partnerships and schools can be more creative in outsourcing."*

Support from management

The 'support from management' [*steun van* management] sub-theme is about the support that is offered by the organisation and its management, making it possible to carry out the intervention.

> " … the support from the organisation. Helping to think about and, yes, being able to facilitate the whole process."
>
> "For me, [name of professional in management] is very important, so that you have someone in management who gives you lots of support."

Main theme: Personnel

The main theme 'personnel' [*personeel*] is based on codes relating to the quality of the staff in the team, which is seen as an important condition for addressing school refusal. Responses related to this main theme were made by professionals from almost all interventions.

Heartfelt commitment to this population

The sub-theme 'heartfelt commitment to this population' [*hart voor de doelgroep*] is about the connection professionals have with the target group.

> "We started the program out of a sincere feeling of commitment to youths with prolonged school absenteeism, not with a mindset of 'Let's do something that will be nice for us', because, of course, it wasn't always nice to press on with it."
>
> "Really believing in what you are doing and what you stand for … ."

Vision

The 'vision' [*visie*] sub-theme is about having a clear vision for the school refusal population and the intervention provided for them.

> *"Yes, but it also comes from the vision. I also think that, that you have explained it very clearly: this is what we are going to do, this is what we are not going to do."*
>
> *"I think another reason why it works is that we have a particular view of young people, a particular idea about their development."*

Team composition and teamwork

The sub-theme 'team composition and teamwork' [*samenstelling team en teamwork*] is about having a balanced team, and about people within the team working well together.

> *"We're quite well balanced, I would say."*
>
> *" … always making use of one another's strengths."*
>
> *"What I think is a really important basis is that we have peer review, that we have one another; you can't do it alone. It's just that you have to keep one another in the loop: why do you do what you do?"*
>
> *"I believe that this team can handle anything together. Because of what they have built up together. I really believe that."*

Knowledge, experience, and curiosity

The sub-theme 'knowledge, experience, and curiosity' [*kennis, ervaring en leergierigheid*] relates to specific knowledge that professionals working in the intervention have, and their curiosity to learn more. It is also about the experience of professionals and the way an intervention has developed over time, with professionals becoming more proficient in working with this population.

> *"I think that everyone really understands how anxiety, mood and ASD problems work."*
>
> *"I think, in any event, professionals who have a lot of know-how about school refusal."*

"And, of course, you have to look critically at your own project. It's with good reason that I say that we have to make adjustments again. You have to keep on looking at whether it is still progressing as you want."

"The network around us, too, all people who help us who have a lot of knowledge about the subject. The Expertise Team for School Refusal. We're constantly being raised to a new level … ."

"We've also looked at other programs. We want to do that again and then look to see: What do they do? And what could we adopt from how they are doing things? So, you can draw inspiration from other people."

Patience and persistence

The sub-theme 'patience and persistence' [*geduld en volharding*] includes codes related to professionals having patience and being persistent. It is about not giving up and being prepared for it to take more time to achieve change with youths and their parents.

"Because we are so persistent … ."

"I also think that people give up on youths too quickly."

Main theme: Relationship with participants

The main theme 'relationship with participants' [*de relatie met deelnemers*] is about the way professionals approach and work with youths and parents. Professionals from almost all interventions mentioned important elements that fall within one or more of the sub-themes within this main theme.

Transparent and reliable

The sub-theme 'transparent and reliable' [*transparent en betrouwbaar*] is about providing clarity and being transparent towards youths and parents. It is also about being trustworthy; doing what you have said you will do.

" … that it is properly structured and clear; that the goal is very clear."

"You say what you will do, and you do what you have said, every single time."

Available

The sub-theme 'available' [*beschikbaar*] includes codes related to being available both in a physical sense and in relational sense. It is about spending time with the youths and their parents, and about physical availability. It is about paying attention, listening, and making time and space to build a relationship with youths and parents.

" … and the accessibility, our availability too, I think. That if things aren't working out, if they're not successful, or if things are stressful, then they know who they can call and we also expect them to call, so to speak."

"Plus, the availability; you are always accessible, and the students know that too; for me that's the cement in the program. And it can also mean being available at a distance, or available when you're very close by, in a manner of speaking, even almost beside the student. But that means available in the personal space of the student who can then say, 'This is what I need.' "

"Paying attention to students. Really seeing students, that is it."

" … and we listen really well."

Accepting

The sub-theme 'accepting' [*acceptatie*] includes codes that relate to having an open and accepting attitude towards youths, showing them that they are OK just the way they are, and as a professional, not judging them.

"I think what matters is that they know they are OK as they are."

"Not passing judgement."

Connected

The sub-theme 'connected' [*aansluiten*] is about connecting with the young person. This theme is also about youths being able to have a say and make decisions. A young person can think together with the professional about the steps that are to be taken, fitting with what the young person can do and wants to do.

> *"I also think it helps that students are able to have a say in what happens here … ."*
>
> *" … influence on your own learning process."*
>
> *"Having a good relationship with the student, looking at what is possible and building further on that."*

Positive approach

The sub-theme 'positive approach' [*positieve benadering*] includes codes related to professionals being kind, caring, and optimistic. It is about focusing on the positive things and on talents; looking at what works rather than what does not work or has not worked yet."

> *"I also think that having a positive approach on all fronts is really important."*
>
> *" … and looking at the things that are going well and not at all the things that have gone wrong."*
>
> *"That people are pleased to see you, pleased that you are there that day."*

Humour and putting things in perspective

The sub-theme 'humour and putting things in perspective' [*humor en relativering*] is about professionals using humour and putting problems in perspective, making problems less serious and daunting for the young person.

> *"There has to be a balance, between how serious it is, and how to handle it. And there are also times when we simply have fun together."*

Flexible and creative

The sub-theme 'flexible and creative' [*flexibel en creatief*] is about professionals being flexible and being able to think 'outside the box'; being able to think of something that is just a bit different from the norm.

> " … you start the morning here with the idea that every day will be different. Well, every day is a new day. And yes, adjusting, to what is to come."
>
> "You shouldn't have a teacher here who can't think 'out of the box' or who thinks only in terms of rules, because you need all the available options here to be able to do the work."

Main theme: The content

This main theme 'the content' [*de inhoud*] is about the 'what' of the intervention. It is about what is offered to youths while they are taking part in the intervention. Professionals from all interventions spoke about important elements that fall within one or more of the sub-themes within this main theme.

Clarifying the problem(s)

The sub-theme 'clarifying the problem(s)' [*verheldering problematiek*] is about having or gaining a clear picture of what is going on and what the young person needs.

> " … I also think the analysis that we make at the start: why is it that things aren't working?"
>
> "That you really try to find out: what is the real problem? Because then you know what the problem is and what you can do about it."

Safe environment

The sub-theme 'safe environment' [*veilig klimaat*] is mainly about the environment being pleasant and familiar, so that young people feel safe. It is also about the atmosphere and a sense of security, not only in terms of the physical environment, but also about what the professionals do, for example by being an anchor for the young person.

> *"The safe environment is something you hear a lot, also from young people, that when they come in, the secretary already says: 'Hi, nice to see you. I'll walk you over'."*
>
> *"For me feeling safe is the most important thing … ."*

Adapted educational environment

The 'adapted educational environment' [*aangepaste onderwijsomgeving*] sub-theme is mainly concerned with the fact that there is an alternative educational environment appropriate for youths displaying school refusal. Many of the codes mention small scale.

> *" … small scale, with mini-classes."*
>
> *" … then you do have to re-arrange the classes completely, and have small classes everywhere."*
>
> *"We also pay a lot of attention to adapting the educational environment. You hear so often from the parents: what a calm classroom, not too busy, not too many other children."*

Room for customisation

The sub-theme 'room for customisation' [*ruimte voor maatwerk*] is about opportunities to adapt things so that you can be flexible and meet the wishes and capabilities of youths.

> *" … that flexible approach that you can easily say: okay, now we'll add a day or an hour."*
>
> *"Everything is possible in education; we can adapt everything. We can adapt everything to the student, to the student's educational needs."*
>
> *" … schools should be able to offer more flexibility … ."*

Easy beginning

The sub-theme 'easy beginning' [*lage insteek*] is about making few demands at the start of the intervention, going along with what a young person thinks they can handle and lowering hurdles.

"Starting easy. Not too many 'musts' in the beginning."

"And that working together is at first, most of all, getting them motivated to start. I think that's an element that is very important."

" … knowing what he can expect when he comes to school again so that the hurdle to going to school is as low as possible. That means knowing that there are no high demands, simply being at school is the first step, and that's enough."

Rhythm and structure

The 'rhythm and structure' [*ritme en structuur*] sub-theme is about the (daily) rhythm that is re-established, and the structure offered by the intervention in various ways.

"Time and what you do in a day, the fact that that's set."

"It's also largely about predictability … ."

Creating movement

'Creating movement' [*beweging creëren*] is about small or big steps, breaking through avoidance, exposure, activating young people, and getting back into education.

"And I think you can see the 12 weeks [length of the intervention] as a restriction, but I also see it as a strength, that you see that the movement is there. You have to get down to work when you come here."

"Breaking through patterns."

"Continuing with education, that that is picked up again. So, education itself."

" … breaking through the avoidance. Exposure, exposure, exposure. Yes, and not over-talking. We do that too much, I think, in our treatments. Now, you're close to the shopping centre, go into the shop and pay the bill."

Success experiences

The sub-theme 'success experiences' [*succeservaringen*] addresses the things that young people can succeed in.

" … I've already said it, but experiences of success, I think it's really important that things start going well again."

"Start with a positive experience at school."

Psychoeducation

The sub-theme 'psychoeducation' [*psycho-educatie*] is about offering psychoeducation as an intervention as well as talking regularly about what young people find difficult and letting them experience that other young people have similar difficulties.

"And we say you're not the only person, that is a real eye-opener, that you'll meet a lot of youths with long-term school absenteeism here."

" … what we do with these young people, psychoeducation, is something that should also be done in schools."

Involve parents

'Involve parents' [*ouders betrekken*] is about actively involving parents in the intervention in which their child is taking part.

"Yes, I think the parent training is an important element. A lot of positive experiences with this, or have heard that parents have had positive experiences."

> **"*Parents go into the treatment with their own goals.*"**

Systemic approach

A 'systemic approach' [*systemische aanpak*] refers to taking the family system into account during intervention to address school refusal.

> " *… there is always something in the systemic dynamics. So I also think it is a prerequisite to have someone there who can look at things systemically.*"
>
> "*Being able to work in the home situation, with the parents. Because without the parents, the children don't go to school, and it's not going to work. So, yes, a systemic approach.*"

Creating perspective

'Creating perspective' [*perspectief creëren*] is about offering (alternative) possibilities for the future, offering hope and clarity. It shows what young people can work towards.

> " *… offering prospects, in fact. Yes, not destroying that little bit of hope, but expanding it, which allows them to take some steps.*"
>
> "*So actually, that perspective is also important, that you have the conversation about where do you see yourself in the long run and what is the route to that, and do you want that? Are you motivated?*"
>
> "*I think talking about future prospects is important because school is often seen as a monolithic structure, while it leads to something else. It's actually only a short period in your life and after that you want something different, but you need the school for that. Then it acquires a different meaning.*"

Main theme: collaboration among those involved

The main theme 'collaboration among those involved' [*samenwerking tussen betrokkenen*] is about collaboration between professionals from the intervention, youths, parents, and other

professionals who are involved. Professionals from about two-thirds of the interventions mentioned collaboration in general, or they mentioned more specific aspects that fall within one of the three sub-themes below.

> *"What I think is most important is the teamwork between youth-care and education."*
>
> *"I can answer that straight away: it's the teamwork between support services and education. If you treat these as two separate paths, it doesn't work. It's the fact that they work together that makes it work."*

Collective effort

The sub-theme 'collective effort' [*gezamenlijke inspanning*] includes codes about close collaboration between all those involved, jointly developing and delivering the support for youths and parents.

> *"Also working closely together with support services. You can't do without that."*
>
> *"Another quality is togetherness. Starting together, ending together."*
>
> *"Very close collaboration, with absolutely everyone. Not working alongside one another."*

Communication

The sub-theme 'communication' [*communicatie*] is about the communication between all those involved in intervention; it needs to be clear, and it has to take place in a structural way.

> *"We are able to continuously communicate with each other."*
>
> *"Having structural contact and evaluation: 'Where are we now?'"*

Respect and trust

The sub-theme 'respect and trust' [*respect en vertrouwen*] is about the way in which the relationship between all those involved is shaped, that this is done respectfully and that there is equality and mutual trust.

> *" … support service professionals who don't dictate from a sort of lofty position about how everything should be done, that we say, well, the school has to do this or that."*
>
> *"Trust is also very important. Expressing trust in one another, parents about school, and school about parents, and the support services too, of course."*

Attention to prevention and timely intervention

The main theme 'attention to prevention and timely intervention' [*aandacht preventive en tijdige interventie*] is based on responses made by professionals from about one-half of the interventions, at the point when professionals were asked about what is needed to properly address school refusal. This main theme is about preventing severe and chronic school refusal via better recognition within regular schools and intervening in a timely manner when school refusal is recognized among young people.

> *"A part of this prevention, more generally in schools, is making sure that you intervene before it happens."*
>
> *" … if they can recognise and discuss this earlier at school, action might be taken earlier."*
>
> *"Intervening promptly, because the longer the child is at home, the bigger the barrier to returning will be."*

3.5.2 Working Elements According to Youths

Figure 4 presents the main themes and sub-themes that emerged from youths' written responses to the following item in the questionnaire:

> *Describe what was most helpful for you during the intervention. You can mention more than one thing.*

Figure 4

Most Helpful Elements in Intervention – Views of Youths

The professionals	The content	The changes
Kind and caring	Tranquility and safety	Increase in self-confidence and perseverance
Understanding and trust	Working on anxiety	Decrease in anxiety
Connected	Easy beginning	
	Building up school attendance	
	Rhythm, structure, and clarity	
	Social contact and contact with peers with similar difficulties	
	Flexibility and support in learning	

Youths generally gave brief answers. Of the 39 youths who completed the questionnaire, 37 (95%) gave one or more responses to this question. Two youths indicated that they had not benefited from the intervention, and one young person stated that: *"All the help they offered me was important and formed a whole, and that's what made the difference."* The answers of the remaining 34 youths were used to develop the network presented in Figure 4. The emerging sub-themes are elucidated using quotations from the youths' responses.

<u>Main theme: The professionals</u>

The main theme 'the professionals' [*de professionals*] is based on responses from almost one-half of the youths. Some youths mentioned that the professionals were generally helpful, as seen in the first set of quotations below. Other youths mentioned specific aspects of the professionals' approach that were helpful, described in the specific sub-themes.

"Support workers."

"The teachers."

"The guidance."

"The good contact between me and the mentor."

<u>Kind and caring</u>

The sub-theme 'kind and caring' [aardig, zorgzaam] is about professionals who are kind, caring, and friendly.

"Kind, friendly, caring, enthusiastic support service professionals."

"Some nice mentors."

<u>Understanding and trust</u>

The sub-theme 'understanding and trust' [*begrip en vertrouwen*] is about youths feeling understood and trusted.

"Understanding teachers."

"You feel more understood."

"You can explain your situation in confidence."

<u>Connected</u>

The sub-theme 'connected' [*aansluiten*] is about youths being taken seriously, their wishes being taken into account, them being encouraged to have a say, and matching steps in intervention to their wishes.

"That they really look together with you at what is best."

"Things were changed to suit how I felt."

Main theme: the content

The previous main theme focused on the quality of contact with professionals, whereas the main theme 'the content' [*de inhoud*] is about what is offered during intervention and the intervention setting. Approximately three-quarters of youths mentioned helpful elements that fall within this main theme.

<u>Tranquillity and safety</u>

The sub-theme 'tranquillity and safety' [*rust en veiligheid*] includes codes relating to a calm and safe environment, as well as taking moments of rest.

"Calm groups."

"Moments of peace."

"Creating security."

<u>Working on anxiety</u>

'Working on anxiety' [*werken aan angst*] refers to the help and opportunities youths receive throughout intervention to learn to handle their anxiety.

"Keeping on repeating things. Because I kept on repeating it, my anxiety got less."

> *"Help with stress and anxiety symptoms."*

Easy beginning

The sub-theme 'easy beginning' [*lage insteek*] refers to there being low demands on the young person, not asking too much of them in the beginning, and ensuring that steps that are taken are successful.

> *"That I could make shorter days and therefore be able to go to school every day instead of the occasional whole day."*
>
> *"The small/careful steps made in discussion together."*
>
> *"Setting achievable goals."*

Building up school attendance

The sub-theme 'building up school attendance' [*opbouwen schoolgang*] is about building up the hours at school and the hours engaged in school-related activities (such as schoolwork).

> *"Building up schoolwork."*
>
> *"Slowly building up the hours at school."*

Rhythm, structure, and clarity

The sub-theme 'rhythm, structure, and clarity' [*ritme, structuur, duidelijkheid*] is about the clarity and structure within the intervention, as well as the daily routine that is re-established as a result of taking part in the intervention.

> *"Calm and structure."*

> *"Going somewhere every day, so that I didn't spend the whole day sitting at home, and that I had a daily routine."*

Social contact and contact with peers with similar difficulties

The sub-theme 'social contact and contact with peers with similar diffciulties' [*sociale contacten en lotgenoten*] includes codes about dealing with peers and having contact with young people with similar difficulties.

> *"Also, the contact with peers and the social side of things."*
>
> *"Hearing that other youths also have the same problems and hearing other youths' solutions."*

Flexibility and support in learning

The sub-theme 'flexibility and support in learning' [*flexibiliteit en ondersteuning bij het leren*] refers to the possibilities youths have to make progress in education, and the didactic support they are offered during their participation in the intervention.

> *"Still being able to get my diploma with the help of a modified program that was suitable for me."*
>
> *"Good teachers who thought up mnemonics and presented their subject in an interesting way."*

Main theme: the changes

The main theme 'the changes' [*de veranderingen*] refers to the changes youths say have taken place during the intervention, and which have benefited from. These changes were mentioned by about one in seven young people.

Increase in self-confidence and perseverance

The sub-theme 'increase in self-confidence and perseverance' [*toename zelfvertrouwen/doorzettingsvermogen*] is based on codes indicating that there were increases in self-confidence and perseverance that were important to youths.

> *"Building up more self-confidence."*
>
> *"Having more confidence in myself, discovering that I do have the ability to persevere."*

Decrease in anxiety

The sub-theme 'decrease in anxiety' [*afname angst*] refers to the reductions in anxiety or stress experienced by youths.

> *"Less anxiety."*
>
> *"That I had less stress."*

3.5.3 Working Elements According to Parents

Figure 5 presents the main themes and sub-themes that emerged from parents' written responses about the most helpful elements in intervention, based on the following items in the questionnaire:

- *Describe what you think was most helpful for your child during the intervention. You may mention more than one thing; it's about what helped your child.*
- *Describe what was most helpful for you during the intervention. You may mention more than one thing; it's about what helped you.*

Of the 86 parents who completed the questionnaire, 77 (90%) provided one or more responses to the first question. Of these, 1 parent responded with 'not applicable', 1 responded with 'don't know', and 2 indicated that the intervention was not successful. Regarding the second question, 69 parents (80%) provided one or more responses. Of these, 2 parents responded with 'don't know' or 'no idea' and 3 indicated that the intervention was

Figure 5

Most Helpful Elements in Intervention – Views of Parents
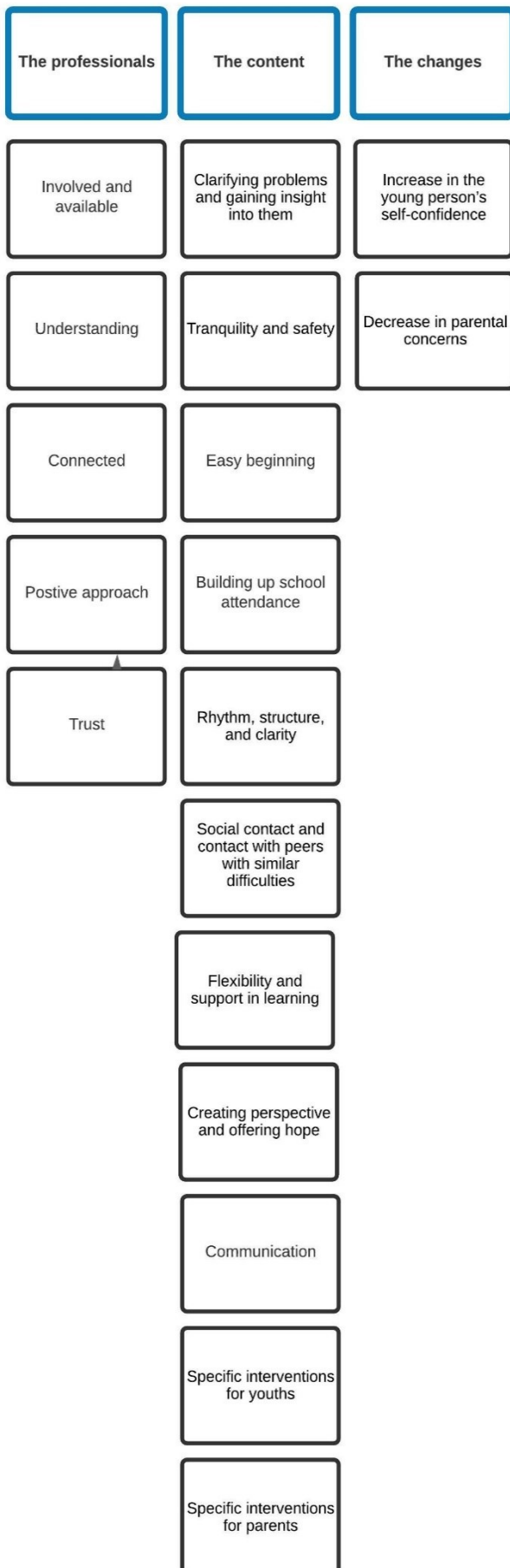
not effective or not helpful. Thus, the network presented in Figure 5 is based on 73 parents' responses to the first question, and 64 parents' responses to the second question. Below the headings used to introduce the sub-themes indicate whether the intervention element was helpful for the child, for the parent, or for both. Quotations taken from the questionnaires are used to clarify the content of the main theme and sub-themes.

Main theme: the professionals

The main theme 'the professionals' [*de professionals*] was based on responses from almost three-quarters of the parents. Parents indicated that various aspects of the professionals' support were helpful during intervention, for their children and for themselves.

For the young person: *"Contact with the counsellor."*

For the young person: *"[Name of child] was very happy with the team from [name of intervention] and felt very comfortable with them."*

For the parent: *" … that throughout the whole process the right people were there for us and our daughter."*

Involved and available (for young people and parents)

The sub-theme 'involved and available' [*betrokken en beschikbaar*] is about the professionals' involvement with youths and parents, and their availability in person and in the relationship they have with youths and parents.

For the young person: *"Personal attention."*

For the young person: *"Sincere involvement."*

For the parent: *"Attention paid to your child."*

For the parent: *"Listening carefully to [name child] and to us."*

Understanding (for young people and parents)

The sub-theme 'understanding' [*begrip*] refers to youths' and parents' feelings of being understood by the professionals.

For the young person: *"That he doesn't need to explain the whole thing to everyone."*

For the young person: *"School … understanding medically unexplained physical symptoms."*

For the young person: *"It was important for the child to feel understood and accepted."*

For the parent: *"The understanding shown by the school psychologist."*

Connected (for young people and parents)

The sub-theme 'connected' [*aansluiten*] refers to professionals taking the young person and their parents seriously and making sure they have a say in what happens and the steps to be taken.

For the young person: *"That she was heard and taken seriously. They worked with her, at her pace."*

For the young person: *"Having a say in what is decided."*

For the young person: *"Being able to decide himself how the build-up in his program would look."*

For the parent: *"I could tell that they took him seriously."*

Positive approach (for young people and parents)

The sub-theme 'positive approach' [*positieve benadering*] is about the positive attitude professionals have towards youths and parents.

For the young person: *"The positive approach of the program as well."*

For the young person: *"Positivity of the staff."*

For the parents: *"She [professional] stayed positive, which gave me strength at times when I was finding things difficult."*

Trust (for young people and parents)

The sub-theme 'trust' [*vertrouwen*] is about youths and parents having trust in the professionals, and the professionals having trust in them.

For the young person: *"Trusting the teacher, and receiving trust from the teacher."*

For the young person: *"The trust he gained during the talks."*
For the parents: *"We were really able to entrust our child to them."*

For the parents: *"The fact that [name of child] was very well looked after gave me peace of mind. That's how I knew he was in good hands."*

Main theme: the content

In the previous main theme (i.e., 'the professionals'), the quality of contact was the central topic. The current main theme is about 'the content' [*de inhoud*] of the intervention. It refers to what was actually offered to youths and parents. About seven-eighths of the parents mentioned intervention elements that fall within this main theme, either because they were helpful elements for their child and/or for themselves.

Clarifying problems and gaining insight into them (for young people and parents)

The sub-theme 'clarifying problems and gaining insight into them' [*verheldering en inzicht*] is about gaining clarity about the experiences of youths and parents, and gaining deeper insight into what is needed.

For the young person: *"Discovering what is going on with him."*

For the young person: *"He learned what is important for him, and what he needs in order to be able to cope at school."*

For the parent: *"The information gave me insight into what autism is and what it means for [name of child] and for me."*

For the parent: *"Insight into why things went wrong at school and what he needs."*

Tranquillity and safety (particularly for young people)

The sub-theme 'tranquillity and safety' [*rust en veiligheid*] is about providing a safe, calm, and small-scale environment at school, or elsewhere.

For the young person: *"The space to temporarily withdraw / calm down / compose himself without outside stimuli and the need to be alert."*

For the young person: *"An environment with limited stimuli (small group)."*

For the young person: *"It was a safe place for him."*

Easy beginning (particularly for young people)

The sub-theme 'easy beginning' [*lage insteek*] is based on codes about not putting a lot of pressure on young people, and letting them get used to being at school without having too many obligations.

For the young person: *"There was no compulsory homework."*

For the young person: *"Not having to work, but just being there."*

For the young person: *"Not being pressured."*

Building up school attendance (particularly for young people)

The sub-theme 'building up school attendance' [*opbouwen schoolgang*] is about stepwise increases in time spent at school and doing schoolwork.

> For the young person: *"Daring to go back into school, step by step."*
>
> For the young person: *"Calm build-up in the number of subjects, gradually increasing doing homework, and gradually increasing the number of days at school."*
>
> For the parent: *"The gradual build-up of the program."*

Rhythm, structure, and clarity (particularly for the young people)

The sub-theme 'rhythm, structure, and clarity' [*ritme, structuur, duidelijkheid*] is mainly about bringing structure into the day, getting back into the routine of school, and providing the young person with structure and clarity in general.

> For the young person: *"Creating structure."*
>
> For the young person: *"Going to school gave and gives some structure/stability."*
>
> For the young person: *"The clarity that was provided about school. What is expected."*
>
> For the young person: *"Getting back into the routine of going to school, in a playful way."*

Social contact and contact with peers with similar difficulties (particularly for young people)

The sub-theme 'social contact and contact with peers with similar diffculties' [*sociale contacten en lotgenoten*] includes codes about contact with peers and youths with similar problems. Parents indicated that this was important for their child, and one parent said it was an important factor for themselves, that there was contact with other parents who were having the same experience with their child.

> For the young person: *"Being with other people."*
>
> For the young person: *"Very important: peers with similar difficulties!!! Knowing, hearing, and seeing that you are not alone. Being together for some months."*
>
> For the young person: *"Recognition from equals. 'I'm not mad, nor am I the only one,' I can just be myself."*

For the parent: *"Parents' evenings to share that you aren't alone in this difficult time."*

Flexibility and support in learning (for young people and parents)

The sub-theme 'flexibility and support in learning' [*flexibiliteit en ondersteuning bij het leren*] is about the (flexible) opportunities that are offered to youths so they can make progress in terms of their education, and the support that is offered with schoolwork.

For the young person: *"Making the schoolwork clear and providing clear guidance."*

For the young person: *"Flexible approach to help me understand schoolwork."*

For the parent: *"Our daughter didn't in any event fall far behind with her schoolwork."*

For the parent: *"Choosing and starting with an exam subject."*

Creating perspective and offering hope (for young people and parents)

The sub-theme 'creating perspective and offering hope' [*perspectief creëren en hoop bieden*] is about creating a broader perspective for youths, a goal that they can work towards. This could be acquiring a diploma (with some modifications), but it could also be about leaving education and looking for a different, more fitting way to participate in society. Codes that generally relate to offering hope also fall within this sub-theme.

For the young person: *"Again, having prospects for achieving his ambitions (to live a more normal life and become a computer programmer)."*

For the young person: *"The most decisive thing (in addition to all the good interventions) was that my daughter again had the prospect of completing school. The [name of intervention] has clearly seen that she cannot do this in the regular way, and they have actively thought about how this could be done."*

For the parent: *"When she went to [name of the location of the intervention], there was hope and a future again."*

For the parent: *"After having tried everything, none of which worked, there was agreement with everyone to go off the beaten track and look for what is possible from the child's viewpoint."*

Communication (particularly for the parents)

The sub-theme 'communication' [*communicatie*] is about the provision of information to parents and youths, and some responses were about agreements between all those involved.

For the young person: *"The collaboration between all the parties involved, particularly those who were most closely involved."*

For the parent: *"I found it particularly helpful to receive the weekly reports."*
For the parent: *"If he didn't feel well that day, or something happened, this was communicated straight away or later that day."*

For the parent: *"And I could always mail/phone if I had questions and I generally received a rapid and honest response."*

Specific interventions for youths (specifically for young people)

Codes included in the sub-theme 'specific interventions for youths' [*specifiek aanbod voor jongeren*] are about the range of specific interventions offered to youths.

For the young person: *"In particular the talks helped her, together with the medication, once it became apparent that the program alone was not enough."*

For the young person: "*In addition to that insight, the therapies have also made him stronger, more balanced.*"

For the parent: *"It was particularly good that they collected our child from home and went to the new school together."*

<u>Specific interventions for parents (particularly for parents)</u>

Codes included in the sub-theme 'specific interventions for parents' [*specifiek aanbod voor ouders*] are about the support offered specifically to parents.

For the parent: *"The weekly hour together with my daughter and the psychologist. It helped us understand one another better."*

For the parent: *"The help at home; also, after he had finished this program, we still had some help at home for him."*

For the parent: *"Discussions with guidance if things did not go well for our daughter at home."*

For the parent: *"The course on how to cope with the behaviour."*

Main theme: the changes

The main theme 'the changes' [*de veranderingen*] includes the changes that, according to parents, occur for youths and parents because of the intervention. Approximately one-quarter of the parents mentioned such changes.

<u>Increase in the young person's self-confidence (for the young people)</u>

The sub-theme 'increase in the young person's self-confidence' [*toename zelfvertrouwen*] is based on parents' responses indicating that it was helpful that their child's self-confidence had increased.

For the young person: *"Gaining more self-confidence."*

For the young person: *"That she became more sure of herself."*

<u>Decrease in parental concerns (for parents)</u>

The sub-theme 'decrease in parental concerns' [*afname zorgen ouders*] is about alleviating parents' concerns, parents having to do less themselves, and receiving more help.

For the parent: *"The worry that she could not meet obligations was removed, which meant I could show more understanding."*

For the parent: *"That I could be a mum again rather than a helper (desperately) looking for a solution to help a child."*

For the parent: *"My child was away from home. I had some time for myself/the other children."*

For the parent: *"Having someone else take over control. Agreements were made with my child rather than via me, and me then having to agree to things with my child. Taking us as parents 'out of the mix' was a relief."*

3.5.4 Those for Whom Intervention Seems to Have Most/Least Effect

Figure 6 presents the professionals' perspectives on factors that influence the effectiveness of intervention. The parts of the transcripts that were coded for this network were those where professionals responded to the following questions:

- *Which young people/families seem to respond best to the intervention?*
- *Which young people/families seem to respond worst to your intervention?*

The ordering of the sub-themes in Figure 6 is not based on the frequency of responses related to each sub-theme. The main themes and sub-themes are illustrated via quotations from the interviews.

Main theme: Presenting problems for the young person

The main theme 'presenting problems for the young person' [*huidige problemen voor de jongere*] includes sub-themes related to the symptoms and problems experienced by youths. Responses related to this main theme were made by professionals from approximately one-half of all the interventions.

Figure 6

For Whom Interventions Have Most/Least Effect – Views of Professionals
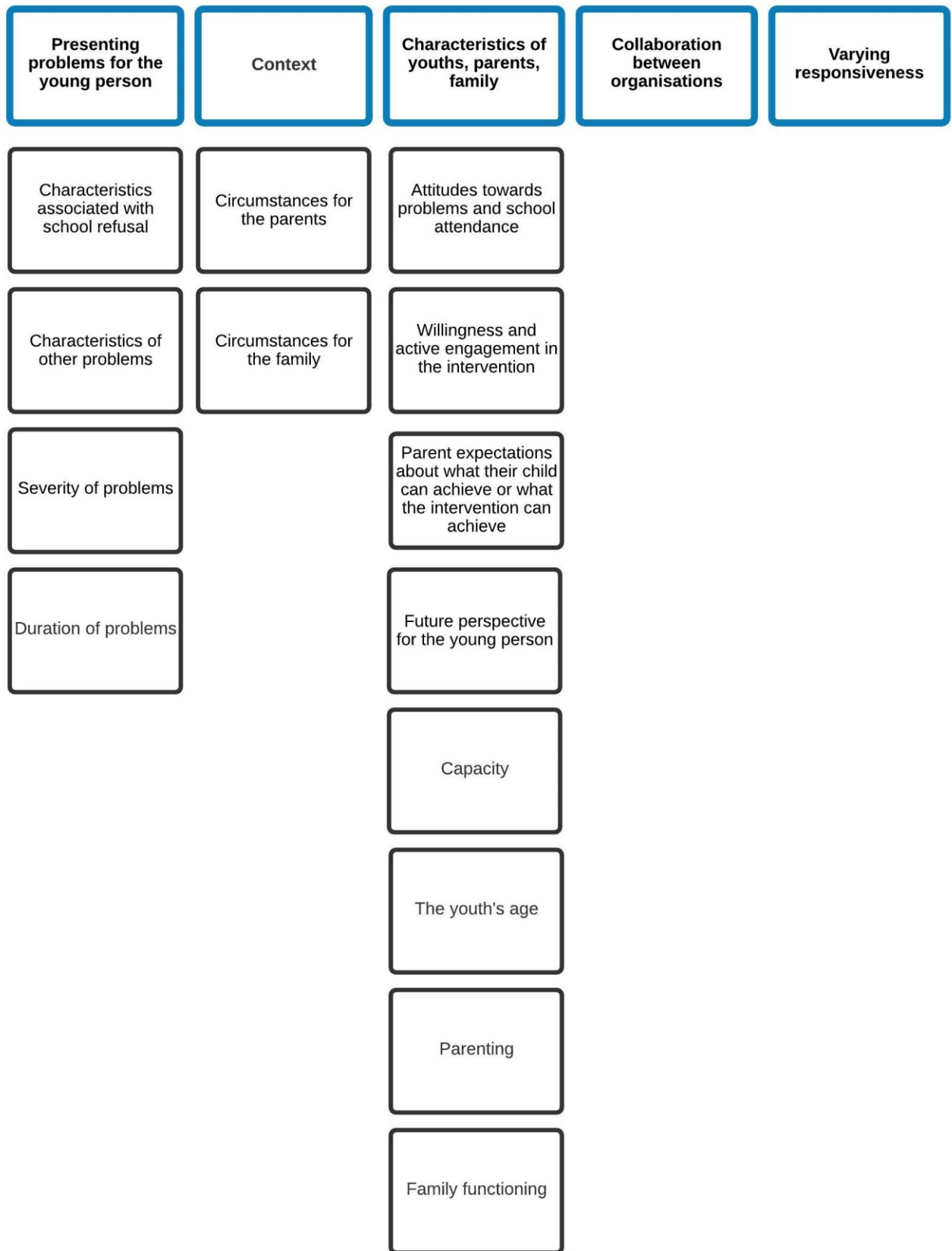
Characteristics associated with school refusal

The sub-theme 'characteristics associated with school refusal' [*kenmerken schoolweigering*] emerged from responses reflective of school refusal characteristics. Codes related to a better response to intervention are about symptoms of anxiety and having little concern about falling behind at school. Codes related to an inferior response to intervention are about such things as social inactivity, depression, social anxiety, and somatic complaints.

"But that's something we notice now, that it is indeed, the anxiety really has to be the main complaint."

"There is a very complicated part of the target group and that is the young people who stay in bed in the morning, totally inactive, and really not able to be prompted to do anything."

"I do find that the really depressed students are difficult to get back on track."

Characteristics of other problems

The sub-theme 'characteristics of other problems' [*kenmerken van andere problemen*] is based on codes related to additional problems for youths, apart from school refusal. Almost all codes included in this sub-theme relate to inferior response to intervention (i.e., additional issues such as externalising problems, identity problems, sleep problems, and excessive gaming). With respect to better response to intervention, professionals from one intervention mentioned that the intervention works best if autism is the only factor present.

"We focus on anxiety, and if anxiety is not the only issue, because it's always there as well, but there is also a 'lack of willingness' component, or a behavioural component, sometimes also an inability component … but in any case, if there is a behavioural component, this project is less suitable."

"I also think it will work less well for young people with aggression issues."

"Attachment issues are also very difficult for us."

" … lot of gaming, a huge lot of gaming."

Severity of problems

The codes related to the sub-theme 'severity of problems' [*ernst van de problemen*] are about the severity of school refusal and any additional problems. Almost all the codes are related to inferior response to intervention, indicating that professionals perceive that the intervention works less well if there are serious complaints and difficulties.

> " …maybe then the problem is too big, that they aren't ready for it."
>
> " …that the issues are so serious that much more intensive support was needed than this."

Duration of problems

The sub-theme 'duration of problems' [*duur van de problemen*] includes codes related to the duration of the school refusal and any additional problems. The codes are mainly related to inferior response to intervention. Professionals perceive that there is better response to their intervention when problems have not endured for a long time.

> " … who have also not been staying at home for very long."
>
> "I think, but that is also an assumption, that the less time the student has been staying at home, the sooner he can return full-time to school. And the longer a child is at home, and the more that support services are involved, or the more that has been tried: yes, that is difficult."

Main theme: Context

The main theme 'context' [*context*] includes codes related to circumstances in the young person's direct environment. Such circumstances were mentioned by professionals from one-third of the interventions.

Circumstances for the parents

Codes within the sub-theme 'circumstances for the parents' [*omstandigheden voor ouders*] were often about the parents' own problems, such as psychiatric problems and addictions,

and the presence of such problems was perceived to be associated with inferior response to intervention.

"Parents having psychiatric problems often makes things difficult too."

"Actually, those parents that have the same kinds of problems as … the young person."

"If the parents are addicted… ."

<u>Circumstances for the family</u>

The sub-theme 'circumstances for the family' [*omstandigheden voor gezin*] is about circumstances such as poverty and divorce, and the presence of such circumstances was perceived to be associated with inferior response to intervention.

"But big financial problems can also cause complications."

"Or that you have a brother or sister for whom things are also not going well … ."

"Having divorced parents is also a serious restrictive factor."

Main theme: Characteristics of youths, parents, family

The main theme 'characteristics of youths, parents, family' [*eigenschappen jongeren, ouders, gezin*] is based on codes about certain characteristics and behaviours of youths, parents, and/or the family. Responses related to this main theme were mentioned by professionals from almost all the interventions.

<u>Attitude towards problems and school attendance</u>

The sub-theme 'attitude towards problems and school attendance' [*houding ten opzichte van de problemen en de schoolgang*] is about the experience of being distressed and the acceptance by both youths and parents that there is a problem. It also relates to how youths and parents feel about the young person going to school, the tendency of a young person to stay at home, and the tendency of parents to keep a young person at home. Being distressed

and accepting that there is a problem were perceived to be associated with better response to intervention.

"The people who experience a lot of suffering … ."

"We also have students who sit at home and don't see it as a problem."

" … who just keep the children at home."

<u>Willingness and active engagement in the intervention</u>

There were many responses related to the sub-theme 'willingness and active engagement in the intervention' [*bereidwilligheid en betrokkenheid bij de interventie*], coming from professionals in about two-thirds of the interventions. The responses are about daring to be vulnerable, and about motivation and openness to change on the part of youths and parents. The sub-theme is also about playing an active part in the intervention and being committed. Willingness and commitment on the part of youths and/or parents was perceived by professionals to be associated with better response to intervention.

"In any case the young people and parents who show commitment from the start."

" … if parents themselves also want to work on goals."

"The willingness to face difficult situations."

"If the communication doesn't go well, we know, this is going to be very difficult."

"[Parents] who respond and want to engage with you. Who dare to show vulnerability."

<u>Parent expectations about what their child can achieve or what the intervention can achieve</u>

The sub-theme 'parent expectations about what their child can achieve or what the intervention can achieve' [*verwachtingen ouders ten aanzien van hun kind of ten aanzien van de interventie*] refers to qualities (e.g., realistic expectations) associated with a better response to intervention.

> *"So, no extreme expectations such as we're going to work miracles and within three weeks Johnny will be back at school. But also not: 'Oh, he's never going to be able to do that.'"*
>
> *"That they expect an awful lot of us in the four hours a week that they are here."*
>
> *" … parents who have an open view and have few expectations, such as: my child is going to get a diploma here now."*
>
> *"I believe the crux is that you have the same view of the development of that child."*

Future perspective for the young person

'Future perspective for the young person' [*toekomstperspectief voor de jongere*] is a small sub-theme about having, or not having, direction for the future. Not having direction is perceived by professionals to be associated with inferior response to intervention.

> *"…seeing no chance of a diploma or anything, if they already have to go to a lower level anyway."*
>
> *"…not having a follow-on study program that interests them."*

Capacity

'Capacity' [*capaciteiten*] refers to the potential for youths, parents, and families to benefit from the intervention. According to professionals, having certain capacities seems to have a positive impact on the effectiveness of intervention.

> *"I think that if you want to reach your potential here, you also need to be able to look at yourself in a positive way, at least to a certain extent."*
>
> *" … that the family has the capacity to embark on such an intensive course of action."*
>
> *"I do think that for young people with a lower level of cognition, for what we offer, we should invest more, or just have more knowledge. We know too little about it."*
>
> *" … youths who are unable to reflect."*

<u>The youth's age</u>

The sub-theme 'the youth's age' [*leeftijd van de jongere*] simply relates to the age of the young person in intervention. There is no clear direction here. Some professionals indicated that younger youths in secondary education benefit more from the intervention, while others indicated that older youths benefit more.

"My experience is that we achieve a lot with youths who are a bit older because at a certain point you are more able to discuss things with them."

"We're more likely to be able to get the younger children back on their feet a little faster than those who come in at 17 and have been struggling for years."

<u>Parenting</u>

The sub-theme 'parenting' [*opvoeding*] relates to the way parents raise their child. This includes parenting style, parents' availability, and agreements between parents. According to professionals, an over-protective parenting style and differences of opinion between parents are associated with inferior response to intervention.

" … that there is space within the system for the individuation-separation process."

"Parents who disagree with one another; that's something that doesn't work well for us."

"What is a success factor? Well, for me it's good if there are two people present that are raising the child."

"Unfortunately, we sometimes have a situation where the parents are physically there, but not available and then these children have to do it on their own. And that's often just not possible for them."

<u>Family functioning</u>

The sub-theme 'family functioning' [*gezinsfunctioneren*] indicates that professionals consider that substantial problems within the family are associated with inferior response to intervention.

> " … if youths come from a very harmonious family."
>
> "If it is very systemic and the problem is completely embedded."

Main theme: collaboration between organisations

The main theme 'collaboration between organisations' [*samenwerking tussen organisaties*] has no sub-themes. This is a small main theme, based on responses from professionals in one-seventh of the interventions. It is included as a main theme because it is qualitatively different from the other main themes. The codes within this main theme are almost all related to collaboration between those delivering the intervention and those from external support services. Positive coollaboration, where there is room for the intervention to reach its full potential, was associated with better response to intervention.

> " … if everyone works together and if there are good support service professionals who help."
>
> "In fact, we all want the same, but sometimes things interfere and that can mean that we have to halt the program, maybe because we think that we are making things worse for the student rather than better."

Main theme: Varying responsiveness

The main theme 'varying responsiveness' [*wisselende responsiviteit*] reflects the fact that professionals found it hard to say who benefits most and least from the intervention. Responsiveness is variable and sometimes surprising. Responses related to this theme were made by professionals from just under one-half of the interventions.

> "No, we can't actually say that yet."
>
> "But it isn't easy to say, that's the most important thing, I think."
>
> "No, because we have also had parents or children who were very resistant or about whom you thought, this is not going to work out, and then at some point in time something happens, and the child starts to move. Then you also see movement in the parents, so, I can't specify a type."

3.5.5 Adjustments Professionals Wish to Make to Improve Intervention

Figure 7 presents the adjustments professionals would like to make to their intervention if there were no restrictions. The following question was asked during the interviews:

> *What two adjustments would you like to make to the intervention if you had a magic wand or a lot of money?*

This question was answered independenly by professionals, in writing, and subsequently discussed. During coding of the written responses, the transcripts based on discussion about the adjustments were consulted to gain clarity about the meaning of the written responses. If a professional wrote down more than two adjustments, these were also coded and included in the qualitative data analysis. The quotations used to illustrate the emerging sub-themes were drawn from the written responses as well as the transcript of discussion about the written responses.

The ordering of the domains, main themes, and sub-themes shown in Figure 7 was not based on the frequency of responses. Rather, the structure of the network shown in Figure 3 (important elements in intervention) was used as a guide for ordering the components of the network shown in Figure 7.

Main theme: Structural conditions

The main theme 'structural conditions' [*structurele voorwaarden*] includes sub-themes about conditions that are ideally in place to effectively carry out the intervention. Professionals from about three-quarters of the interventions mentioned adjustments that fall within this main theme.

Financial arrangements

The sub-theme 'financial arrangements' [*financiële arrangementen*] includes codes related to a desire to ensure there is always room for youths to participate in intervention, and the desire for the intervention's continuity to not be jeopardised by a lack of funding.

"Being able to accept every young person rather than looking at money, so that every young person has a chance for good prospects in the future."

Figure 7

Adjustments to Improve Intervention – Views of Professionals
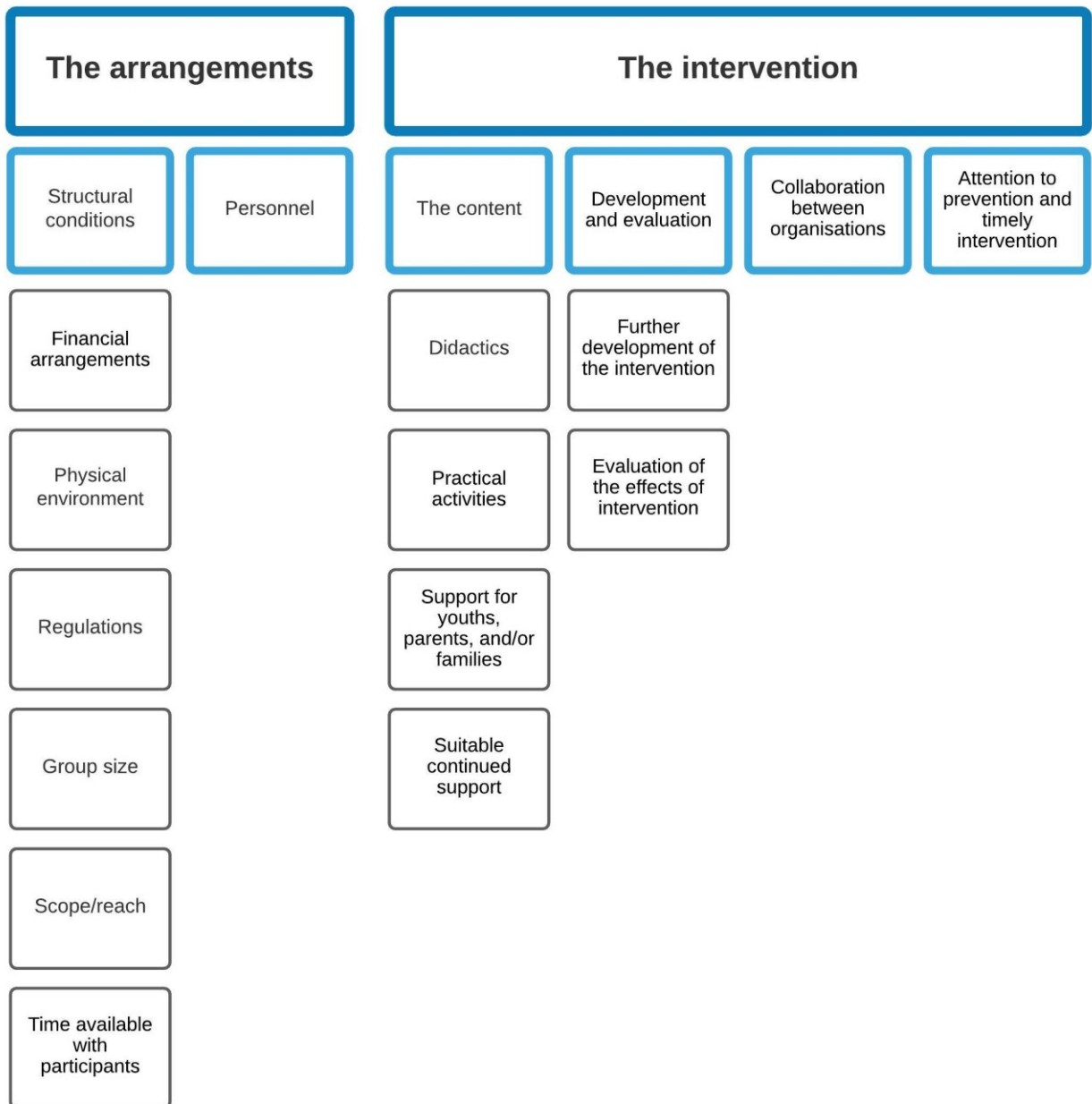
"Schools should not be struggling with the dilemma of whether they should or want to put money into the students [to participate in the intervention]. Now, this is holding schools back. It costs money, and that can be spent differently."

Physical environment

The sub-theme 'physical environment' [*fysieke omgeving*] is about adapting and improving the physical environment in which the intervention is offered.

" … wanting to have a place where mothers can bring their children and drink a cup of coffee together."

"Homely atmosphere with a canteen, ping pong table, for arrival and relaxing. Ideally with room for pets (rabbit)."

"A permanent treatment room. At the moment, we have to reserve meeting rooms in the school, which are not always well suited for treatment appointments."

Regulations

The sub-theme 'regulations' [*regelgeving*] is about the desire to be less restricted by regulations and bureaucracy in the planning and implementation of the intervention.

"Being able to think outside the box and not sticking to how the inspectorate of education sees things."

"Thinking in terms of performance and efficiency as a yardstick is less prominent. The thinkers, inventors, professionals are given room to experiment."

Group size

The sub-theme 'group size' [*groepsgrootte*] includes codes related to keeping class sizes small or reducing class sizes, specifically in relation to interventions situated within the educational system.

> *"Keeping groups to a maximum of 10 students."*
>
> *"Smaller classes."*

Scope/reach

The sub-theme 'scope/reach' [*omvang*] is about increasing the scope or reach of the intervention in a broad sense. It includes the ability to offer more students a place, increase the number of half-day sessions, and further roll out the intervention.

> *"More places! We have a waiting list."*
>
> *"The possibility of offering whole days to students who can handle that."*
>
> *"The program is a standard part of the school program and regional collaboration for students who have dropped out for more than 10% [of school time]."*

Time available with participants

The sub-theme 'time available with participants' [*beschikbare tijd met participanten*] includes codes about wanting to have more time to work with youths and parents.

> *"More time for personal contact with the young person."*
>
> *"Having more time, dividing treatment into different phases."*

Main theme: Personnel

The main theme 'personnel' [*personeel*] is largely about the composition and expertise of the team delivering intervention. Codes relate to the desire to expand the intervention team with more professionals and with professionals with specific expertise. Responses related to this main came from professionals from more than two-thirds of the interventions.

> *"Expanding the team with specific expertise (psychotherapist / clinical psychologist / psychiatrist / mental health psychologist)."*
>
> *"An extra assistant in the class for every mentor."*
>
> *"Sufficient personnel that have good or adequate skills."*
>
> *"Appointment of subject teachers."*

Main theme: The content

The main theme 'the content' [*de inhoud*] refers to the content of the intervention. The desired changes that fall within this main theme are about improving the support offered to youths, parents, or the school. Professionals from about two-thirds of the interventions mentioned a desired change related to this main theme.

Didactics

The 'didactics' [*didactiek*] sub-theme includes responses about adapting the content of the teaching material as well as the way in which the content is offered.

> *"Interactive teaching methods aimed at differentiation."*
>
> *"Having a more differentiated educational program."*

Practical activities

The sub-theme 'practical activities' [*praktische activiteiten*] reflects the desire to go out-and-about more with youths and focus more on practical learning in terms of educational content and goals.

> *"Visits to museums, interesting places, etc."*
>
> *"Funding for pets and mountain bikes and someone who integrates this into our educational program."*

> *"Set up internships/work skills, give students (the opportunity to) learn skills other than learning from books."*

Support for youths, parents, and/or families

The sub-theme 'support for youths, parents, and/or families' [*ondersteuning voor jongeren, ouders en/of families*] relates to what is offered to youths, parents, and their families, such as specific therapeutic elements. According to professionals, desired adjustments include the use of other expertise (other professionals/organisations, or other services provided by professionals already involved) and the ability to offer more of what is already available.

> *"Someone who can collect students from home in the start-up period, who can be deployed flexibly."*
>
> *"More opportunities to practise with exposure."*
>
> *"A permanent parent counsellor for parents in the school who can also train groups of parents if they wish, and provide individual counselling."*
>
> *"More possibilities to work with the system."*

Suitable continued support

The sub-theme 'suitable continued support' [*passend vervolg*] reflects the desire to provide aftercare, interventions, or facilities that meet the needs of youths after they have participated in the intervention.

> *"Being able to offer aftercare programs more intensively after the transfer to the next school."*
>
> *"Good follow-up program, for example group therapy for young people, something between outpatient support and part-time."*
>
> *"Easier transition to the next location: more creative customisation options."*

Main theme: Development and evaluation

The main theme 'development and evaluation' [*ontwikkeling en evaluatie*] includes responses about further development and evaluation of the intervention method. It is also about the desire to work out exactly what is done, and what the effects are. This is a smaller main theme, based on responses from professionals in about one-quarter of the interventions.

Further development of the intervention

The sub-theme 'further development of the intervention' [*doorontwikkeling interventie*] refers to professionals' desire to be able to (continuously) develop the intervention.

> *"More time/money to develop evidence-based programs."*
>
> *" … refine or further develop the methodology."*

Evaluation of the effects of intervention

The sub-theme 'evaluation of the effects of intervention' [*evaluatie effecten*] is principally about the desire to measure the effects of the intervention.

> *"Effectiveness study."*
>
> *"And being able to measure the effects so we understand better what works and why."*

Main theme: Collaboration between organisations

The main theme 'collaboration between organisations' [*samenwerking tussen organisaties*] is about collaboration among professionals delivering the intervention, and collaboration with professionals from other organisations. Almost all the preferred adjustments relate to the desire for collaboration with external support services, especially the desire to collaborate more intensively. This main theme emerged from the responses of professionals in just under one-half of the interventions.

Professionals were asked to indicate which two recommendations they would like to see implemented in their intervention, either because it is not yet included or because they think it should receive more attention than it currently does. After the professionals independently responded to the list of ten recommendations, their choices were discussed in the group.

Of the 76 professionals participating in the 21 interviews, 57 (75%) answered this question in writing. Of these 57, 44 nominated one or two adjustments, 10 nominated three adjustments, and 3 nominated four or more adjustments. The responses of these last 3 professionals were not included in the analysis. Table 17 shows how often the various recommendations were endorsed.

Recommendation 10 (More access to alternative educational programs before return to regular education) was the most frequently endorsed recommendation. Many of the interventions included in the current project already constitute an alternative educational program (i.e., a temporary, adapted educational setting to re-engage youths displaying school refusal). Despite this, almost 60% of the professionals endorsed this recommendation. This might be interpreted to mean that the professionals perceive a need for more alternative educational programs as an intervention for school refusal, and/or as an option for youths after completing intervention.

Table 17

The Adjustments Professionals (N=54) Would Like to Make to Their Intervention

Adjustment	Percentage (number) of professionals endorsing the recommendation
1. Spending more time working with the young person	9.3% (5)
2. Spending more time working with the parents	13.0% (7)
3. Spending more time working with the parents and young person together	18.5% (10)
4. Spreading the program over a longer period	13.0% (7)
5. Intensifying the program	13.0% (7)
6. More attention to social factors	35.2% (19)
7. More attention to the role of parents in managing their child's behaviour	11.1% (6)
8. More attention to parent-youth communication and family problem solving	35.2% (19)
9. More use of supplementary medication	0.0% (0)
10. More access to alternative educational programs before return to regular education	59.3% (32)

Recommendation 6 (More attention to social factors) and Recommendation 8 (More attention to parent-youth and family problem solving) were the next most commonly endorsed recommendations. Several quotations illustrate the professionals' thoughts about Recommendations 10, 6, and 8.

Recommendation 10: *"My own wish is for more access to alternative educational programs, not that there should be a [name of the intervention] somewhere else, but rather that there should be, for example, a support class within the mainstream school where the young person can first build up and then just be in the classroom."*

Recommendation 6: *"And also for social skills. We work on these, but I think that if I had to choose, this is where we could develop further."*

Recommendation 8: *"More attention to the communication between parent and child and problem solving in the family. Yes, because I think this is where a lot of the problem is, and there's a lot to be gained if we focus more on this."*

3.6 Collaboration Between Professionals from Different Organisations

The results presented in Section 3.6 relate to Research Question 4a (What do professionals say about collaboration in intervention for school refusal?) and Research Question 4b (What do youths and parents say about collaboration in intervention for school refusal?). The views of professionals are presented in Section 3.6.1 and the views of youths and parents in Section 3.6.2.

3.6.1 Perspectives of Professionals

Professionals' views on collaboration arise at numerous points throughout Chapter 3. It is evident in Section 3.1.1 (about types of organisations providing intervention for school refusal) and Section 3.1.2 (about financing of the interventions) that a structural collaboration between education and support services occurs in about one-third of the interventions studied in this project. Collaboration also emerged as a main theme in all the networks based on professionals' reports, as follows.

Section 3.3.5 presents the network 'Difficulties in Delivering Intervention – Views of Professionals' (Figure 2). Difficulties related to the collaboration with support services is a main theme. Related sub-themes are organising (timely) additional help, communication, and the grey area between education and support services.

Section 3.5.1 presents the network 'Most Important Elements in Intervention – Views of Professionals' (Figure 3). Collaboration between those involved is a main theme in the domain 'the intervention'. Related sub-themes are collective effort, communication, and respect and trust.

Section 3.5.4 present the network 'For Whom Interventions Have Most/Least Effect – Views of Professionals' (Figure 6). Collaboration between organisations emerged as a main theme.

Section 3.5.5 presents the network 'Adjustments to Improve Intervention – Views of Professionals' (Figure 7). Collaboration between organisations is a main theme in the domain 'the intervention'.

3.6.2 Perspectives of Youths and Parents

The questionnaires administered to youths and parents included a question about which professionals had been involved during the intervention. Youths and parents were also asked to share their experience of the collaboration between these professionals, and the impact of collaboration, as follows:

- *All these people worked well together (rated on a 4-point scale from totally disagree to totally agree).*
- *Because of the collaboration between all these people, things improved for me/my child (rated on a 4-point scale from totally disagree to totally agree).*

Thirty-six youths and 82 parents (one parent n=44, two parents n=38) responded to these questions. Appendix S11 indicates that around four-fifths of youths (81%) and parents (81%) reported that everyone worked well together. About two-thirds of youths (64%) and parents (69%) reported that things had improved for the young person because of the collaboration. Looking at the cross-tabulated data for these two questions it appears that there is a relationship between responses to the two questions, for youths' responses (Appendix T) and for parents' responses (Appendix U). Post hoc Fisher's exact tests revealed a statistically significant association between responses to the two questions ($p < 0.001$, two-sided) for both youths and parents. In other words, youths and parents who reported that there was good collaboration, also reported that collaboration had a positive effect on the young person.

Chapter 4 – Discussion

4.1   Summary of Findings

4.1.1 Organisations and the Participants in their Interventions

The findings summarised below relate to Research Question 1a (Which education and mental health organisations in the Netherlands offer an intervention specifically focused on school refusal?) and Research Question 1b (Who participates in these interventions?).

Organisations

The 21 interventions studied in this project are situated in 9 of the 12 Dutch provinces. There are four types of organisations involved in the provision of intervention for school refusal: special education, mainstream education, mental health services, and youth services.

Twenty of the interventions include representation from education: special education (n=13), mainstream education (n=5), and education support services (n=2). These interventions run independently of other organisations (n=12) or together with mental health services / youth care (n=8). The one organisation without representation from education is an outpatient program in a mental health service. In total, 9 interventions include representation from mental health / youth care.

Approximately one-half of the interventions offered by organisations are financed via one source (i.e., only mental health funding, only special education funding, or only mainstream education funding). The other interventions are funded via multiple sources (e.g., special education funding and mental health funding).

On average, the interventions have been running for 5 to 6 years; one intervention has been running for 16 years, and around one-third were established within the three years prior to data collection.

Youths participating in interventions for school refusal

It is estimated that the 21 interventions serve approximately 750 youths and families per year. This is based on an average of 36 cases per intervention per year. Over three-quarters

of the interventions focus on secondary school-aged youth. Several focus on primary school-aged youth and secondary school-aged youth, while just one focuses solely on primary school-aged youth. No vocational schools expressed interest in participating in the project, but one of the 21 interventions provides intervention for youths in secondary school and in vocational education.

Most youths participating in the interventions have been absent from school for between 3 months and 1 year prior to intervention. Many others have been absent from school for between 1 and 3 months. On average, 9 out of 10 youths participating in the interventions have been away from school for at least 1 month.

Prior to participation in intervention, almost two-thirds of youths were enrolled in mainstream education, and almost one-third in special education. Fewer than 10% of youths participated in other forms of education or activities prior to intervention: 5% were in healthcare funded day-time activities [*dagbesteding*] such as care farms, or in intensive treatment; 2% were engaged in vocational education; 1.5% in home education; and 1% were either not enrolled in education or they had not attended school for a long time despite being enrolled. Among youths of secondary school age, almost one-half were at the vmbo or mbo education level, and almost one-half were at the havo, vwo, or gymnasium level.

Anxiety disorder is the most common problem among youths participating in intervention for school refusal. Further, approximately one-half of youths have been bullied and one-half have an autism spectrum disorder. Around one-third of youths have a depressive disorder, one-quarter have chronic unexplained physical symptoms, and one-fifth have a learning disorder. Very few youths have an externalising disorder or intellectual disability. According to the vast majority of youths and parents, it was difficult for the young person to attend school due to stress or anxiety. The next most common reason given for difficulty attending school was sad mood, mentioned by more than one-half of parents and youths. Somatic complaints were associated with difficulty attending school by nearly one-half of parents and around one-third of youths. Moreover, for every young person, there was a report from the young person and/or parents that the young person had difficulty attending school due to anxiety and/or stress and/or mood problems and/or somatic complaints.

As few as 7% of all youths participating in the interventions have an immigrant background. This is considerably lower than the 25% of the Dutch population with an immigrant background (CBS, n.d.). Further, 1.2% of youths have a refugee background.

4.1.2 What the Organisations Do

The findings summarised below relate to Research Question 2a (How many organisations provide a comprehensive intervention that involves participation of the young person,

parents, and school?), Research Question 2b (What do organisations do to address school refusal?), and Research Question 2c (Which difficulties do professionals experience in delivering interventions?).

Comprehensive intervention

Using the First Impressions Questionnaire [*Eerste Blik Vragenlijst*], professionals reported on the extent to which their intervention involves youths, parents, and school personnel, according to 'never', 'sometimes', or 'always'. All 21 interventions always involve work with the young person and with school personnel. Furthermore, 19 interventions also involve work with parents. The other two interventions sometimes involve work with parents. Data derived from the focus group interviews with professionals support the data derived from the First Impressions Questionnaire, whereby the codes used to form sub-themes shown in Figure 3 regularly included references to interventions with youths, parents, and school personnel.

What organisations do to address school refusal

Screening

Almost one-half of the interventions involve a screening process for school refusal, whereby participants are accepted into the intervention based on criteria related to school refusal or other indications and contra-indications relevant to the intervention (see the Social Services Directory in Appendix A). Four of the 21 interventions use questionnaires as part of the screening for school refusal. Professionals from some of the interventions not engaged in screening or not using questionnaires during screening volunteered that they are working on a screening process.

Education elements

Almost one-half of the interventions sometimes involve the provision of home education. In these cases, home education is not included as a standard element of intervention but as an option sometimes used in the early phase of intervention and for a short time. Two-fifths or interventions do not provide home education. Reasons given were that it is not in keeping with the aims of the intervention (e.g., it would make it more difficult for youths to return to an educational setting), or the team is not in a position to facilitate home education. Less than one-fifth indicated that they offer home education. In these interventions, home education is offered as a prelude to youths attending an educational setting, perhaps via the work of education professionals from mental health services that provide educational

support at home. Reasons given were that the provision of home education helps re-connect youths with educators and educational materials, and it offers extra insight into a youth's home situation. Despite differences across organisations with respect to the provision of home education, an aim of all interventions is to help youths participate in an educational setting or alternative setting for learning. Home education is not the goal, but a means to an end.

This raises the question of which other provisions are made for education, other than home education. Three-fifths of the organisations arrange a (temporary) placement in special education for most or all of the youths, sometimes with a view to reintegration in mainstream education and sometimes with a view to a permanent placement in special education. Three organisations arrange a temporary placement in a meta school facility [*bovenschoolse voorziening*] associated with the intervention, two organisations arrange for youths to pursue education via the school of origin [*school van herkomst*], two organisations do not have a fixed arrangement for the provision of education, and at one organisation most youths commence home education followed by education at the school of origin. In short, most interventions make use of an alternative educational setting in special education or a meta school facility.

The First Impressions Questionnaire asked whether the intervention aims to help youths return to a mainstream educational setting. This is the case for nine organisations, sometimes the case for eight organisations, and not the case for four organisations. After intervention, 21% of youths across all interventions are estimated to return to the school they were enrolled in prior to intervention [*school van herkomst*]. Specifically, the settings to which youths return include special education (44%), mainstream education (21%), vocational education (10%), healthcare funded day-time activities [*dagbesteding*] (7%), apprenticeship (4%), adult education (3%), home education (2%), no education (2%), or other (7%).

Therapy elements

During the interview, professionals were asked to describe the theoretical background of their intervention and the therapy elements in their intervention. The theoretical backgrounds most frequently mentioned included CBT, systemic, and solution-focused work. Therapeutic elements in the work with youths were most frequently CBT (via a manual such as 'Thinking and Doing = Daring' [*Denken + Doen = Durven*] or in an ad hoc fashion), exposure, eye movement desensitisation and reprocessing (EMDR), psychoeducation, non-verbal therapies (e.g., creative therapy, music therapy, drama therapy), pharmacotherapy, and group interventions (e.g., cooking). Other therapeutic elements were mentioned infrequently (see Table 11). Therapeutic elements in the work with parents were frequently family-based treatment such as Family and Schools Together (FAST), Multidimensional Family Therapy (MDFT), and Non-Violent Resistance (NVR), as well as parent sessions (e.g., to communicate progress; guidance in parenting) and group-based meetings with parents.

Elements frequently mentioned in relation to working with school staff included coaching teachers and maintaining regular contact.

Professionals were also asked to indicate via the booklet used during the interview whether their intervention reflects characteristics common to protocols for the treatment of school refusal, namely: individual treatment as opposed to group treatment; consultation with the school; homework assignments between sessions; graded exposure to school; and working with the family on communication and problem solving (see Section 1.2.2). All professionals indicated that their intervention includes graded exposure to school and nearly all indicated that intervention is offered individually and includes consultation with school personnel. Four-fifths indicated that they work with the family on communication and problem solving and three-quarters indicated that practice tasks (also called between-session tasks and home tasks) are part of their intervention.

Flexibility vis-à-vis standardisation

There was considerable variability in professionals' ratings of the extent to which their intervention is flexible or standardised. A small number indicated that their intervention is 'completely flexible', while a small number from the same or another organisation indicated that their intervention is 'highly but not completely standardised'. When considering the average response per intervention, the range is 'completely flexible' to 'highly but not completely standardised'. However, the average score for flexibility-standardisation per intervention was most commonly around the middle of the scale, with a slight leaning towards flexibility. In short, no organisations offer a fully standardised intervention, a small number offer a predominantly or fully flexible intervention, and most offer an intervention which is both flexible and standardised.

Professionals were also invited to discuss their ratings of the flexibility-standardisation of their intervention. Four themes emerged from analysis of their discussion.[45] The first is 'clarification of the ratings given'. Professionals in most organisations noted that their intervention includes a framework and standard elements, and in one-third of organisations they noted that the structure or process of the intervention is more fixed while the delivery for each young person is more flexible. Flexibility was described as important and powerful, with the frequent comment that every young person is different. The second theme was 'concrete examples'. Professionals in numerous organisations cited standardisation in relation to the intake process, working in phases, using a standardised training with youths, and periodically consulting with all parties involved. Only a few organisations mentioned that their intervention is documented. The third theme was 'desires'. Numerous professionals expressed satisfaction with the flexibility-standardisation of their intervention, while others expressed the desire for their intervention to be more flexible, or more standardised, or more of a balance between flexible and standardised. The fourth theme

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[45] The themes are based on qualitative analysis by one researcher; they are not presented in a network.

was 'advantages and disadvantages'. An often-mentioned advantage of standardisation is that a framework offers support and direction, reducing the likelihood that professionals work in ad hoc fashion. A few professionals suggested that flexibility runs the risk that what is done by a professional is too dependent on that specific professional.

Length of intervention

The First Impressions Questionnaire asked for an estimation of the length of the intervention provided, averaging across all cases participating in the intervention. One-third of interventions last between 6 and 12 months, one-third last longer than 12 months, one-quarter last between 3 and 6 months, and just one intervention is shorter than 3 months. In sum, intervention was not short-term, when short-term is understood to mean less than three months. For almost all youths (93%), intervention lasted at least 3 months.

When parents were asked about the length of the intervention their child participated in, more than one-third reported 3 to 6 months, one-quarter reported 6 to 12 months, one-quarter reported 12 to 24 months, and small numbers of parents indicated less than three months or longer than 24 months.

Approximately one-half of parents and one-half of youths regarded the length of intervention as appropriate. Opinions were evenly split among the remaining youths as to whether intervention was too short or too long, and among the remaining parents there was a slight tendency for parents to regard the intervention as too short.

Difficulties professionals experience when providing intervention

During the interview, professionals were asked about difficulties they may experience in providing therapeutic elements when addressing school refusal, whether it be therapy elements they provide themselves, or therapy elements made available via external organisations. Their responses are represented in three main themes in Figure 2.

The first main theme is 'difficulties related to the characteristics of participants' [*moeilijkheden gerelateerd aan kenmerken van participanten*]. It comprises three sub-themes. First, 'willingness and involvement' [*bereidwilligheid en betrokkenheid*] refers to the difficulty professionals experience when participants seem distrustful and resistant towards the therapy process. Second, 'being present and keeping appointments' [*aanwezig zijn en afspraken nakomen*] indicates that professionals find it difficult when youths do not show up for appointments or do not follow through on agreed tasks. Third, 'family factors' [*gezinsfactoren*] indicates that parenting and family functioning can present a challenge, such as when parents are overprotective.

The second main theme is 'difficulties related to the delivery of therapy elements' [*moeilijkheden gerelateerd aan het uitvoeren van therapeutische elementen*]. The sub-theme 'room to help' [*ruimte om hulp te bieden*] refers to the sense of having insufficient time to provide the help that is needed. The sub-theme 'arranging group interventions' [*groepsinterventies regelen*] indicates that it is difficult to carry out group interventions, in part because of the different needs of each young person in the group, in part because it is difficult to engage youths who are anxious being in a group, and in part because youths are at different stages of readiness for participating in a group. The sub-theme 'generalising to daily practice' [*het generaliseren naar de dagelijkse praktijk*] indicates that some professionals find it difficult to help youths employ what they have learned in therapy, in their daily lives.

The third main theme is 'difficulties related to the collaboration with support services' [*moeilijkheden gerelateerd aan de samenwerking met hulpverlening*]. The sub-theme 'organising (timely) additional help' [*het realiseren van (tijdig) aanvullende hulp*] refers to the difficulty professionals experience in securing appropriate external (specialist) help, unhindered by waiting lists. The sub-theme 'communication' [*communicatie*] refers to difficulties professionals experience when there is limited open and timely communication from external professionals who provide therapy for the youths in the intervention. The sub-theme 'the grey area between education and support services' [*het grijze gebied tussen onderwijs en hulpverlening*] indicates that education professionals sometimes find themselves wondering whether what they are doing is, or should be, regarded as therapy.

4.1.3 Working Elements in Interventions for School Refusal

This section begins with a summary of youths' and parents' experiences of the intervention and their views on the impact of intervention, addressing Research Question 3a (In which ways do youths and parents benefit from the intervention?). The section continues with a summary of professionals', youths', and parents' views on the working elements in intervention, addressing Research Question 3b (Which elements are perceived to be most important for an effective intervention for school refusal, according to professionals, youths, and parents?). Thereafter, we summarise professionals' views on who responds most and least to the intervention, addressing Research Question 3c (For whom do the interventions work best and worst?). The section concludes with a summary of the adjustments professionals would like to make to their intervention, addressing Research Question 3d (What adjustments do professionals wish to make to improve their intervention?).

Youths' and parents' experience of intervention, and how intervention benefitted them

Satisfaction with intervention

Youths and parents responded to the Process [_Verloop_] scale of the Exit Questionnaire [_Exit-vragenlijst_], which comprises questions about how well the intervention went, how much the professionals included them in decision-making, how much they were taken seriously by the professionals, and how well the professionals did their work. The average subscale scores for youths and parents were 3.5 and 3.6 respectively (on a scale of 1 to 4), exceeding the cut-off of 3 which designates a good rating of the intervention process.

Almost all parents (92%) indicated that they were informed by professionals about how their child was doing during intervention, and almost all youths (92%) and parents (92%) would recommend the intervention to others who need help with school attendance. As few as 3% of youths and 4% of parents said they definitely would not recommend the intervention to others.

Effects of intervention

Among youths who reported anxiety or stress prior to intervention, three-quarters reported reduced anxiety or stress as a result of the intervention. Among those reporting mood problems prior to intervention, three-quarters reported reduced mood problems, and among those reporting somatic complaints prior to intervention, well over one-half reported a reduction in these complaints. A high percentage of parents also reported reductions in these problems for their child; three-quarters reported reductions in anxiety or stress, four-fifths reported improvement in mood, and well over one-half reported that their child suffered from fewer somatic complaints as a result of the intervention.

Regarding school attendance, three-quarters of youths reported being able to go to school more often as a result of the intervention, and three-quarters of parents reported that their child was able to go to school more often. Participation in the intervention made it easier to go to school, according to three-quarters of youths and almost four-fifths of parents.

Intervention was also responsible for changes in the extent to which youths had fun at school (according to two-thirds of youths and one-half of parents), had an improved relationship with teachers (well over one-half of youths and one-half of parents), saw more value in education (approaching one-half of youths and parents), improved in their problem solving (four-fifths of youths and almost two-thirds of parents), and could get along better with peers (one-half of youths and approaching one-half of parents). Youths' confidence in the future increased as a result of the intervention, according to over two-thirds of youths and over two-thirds of parents. Greater satisfaction in life, as a result of the intervention, was reported by more than two-thirds of youths.

Parents reported improvements for themselves. Two-thirds reported that they experienced less tension and stress regarding their child's school attendance, had become more confident in their ability to respond to their child's difficulties going to school, and were better able to support their child. Three-fifths reported that participation in the intervention helped them understand why their child had difficulties attending school.

There were fewer difficulties at home between the young person and their parents, as a result of the intervention, according to three-fifths of youths and parents.

The working elements in intervention

Professionals' views on the most important elements in intervention

Professionals' views on 'what works' in intervention for school refusal were drawn from their verbal responses to three questions: Why their intervention works as well as it does; Which elements in their intervention are most important; and What is needed to address school refusal. Six main themes emerged, as shown in Figure 3. These are grouped under two domains.

The domain 'the arrangements' [_de regelingen_] comprises two main themes. The main theme 'structural conditions' [_structurele voorwaarden_] includes: (1) the 'physical environment' [_fysieke omgeving_] such as education and mental health located in one building; (2) 'financial arrangements' [_financiële arrangementen_] such as investment from the regional partnership [_samenwerkingsverband_]; and (3) 'support from management' [_steun management_].

The main theme 'personnel' [_personeel_] includes: (1) having a 'heartfelt commitment to this population' [_hart voor doelgroep_]; (2) having a 'vision' [_visie_] for how to help; (3) paying attention to 'team composition and teamwork' [_samenstelling team and teamwork_]; (4) team members having 'knowledge, experience, and curiosity' [_kennis, ervaring en leergierigheid_], including an openness to learning about addressing school refusal; and (5) 'patience and persistence' [_geduld en volharding_], whereby professionals do not give up on these youths.

The domain 'the intervention' [_de interventie_] comprises four main themes. The main theme 'relationship with participants' [_de relatie met deelnemers_] includes: (1) being 'transparent and reliable' [_transparant en betrouwbaar_], for example being open about what intervention involves and reliable by doing what you say you will do; (2) being physically and emotionally 'available' [_beschikbaar_], such as participants being able to call professionals when things get tough, and being very attentive to the young person; (3) being 'accepting' [_acceptatie_], including being non-judgemental; (4) being 'connected' [_aansluiten_], including taking the young person seriously, and inviting input from them; (5) having a 'positive approach'

[*positieve benadering*], such as paying attention to what is going well; (6) using 'humour and putting things in perspective' [*humor en relativering*]; and (7) being 'flexible and creative' [*flexibel en creatief*] in response to issues that arise.

The second main theme, 'the content' [*de inhoud*], refers to what is done during intervention. It includes: (1) 'clarifying problems' [*verheldering problematiek*]; (2) creating a 'safe environment' [*veilig klimaat*]; (3) offering an 'adapted educational environment' [*aangepaste onderwijsomgeving*] such as smaller class size; (4) 'room for customisation' [*ruimte voor maatwerk*] such as adjustments to how long the young person is present at the intervention each day; (5) an 'easy beginning' [*lage insteek*] with minimal expectations at the start of the intervention; (6) providing 'rhythm and structure' [*ritme en structuur*]; (7) facilitating change by breaking old patterns and 'creating movement' [*beweging creëren*]; (8) creating 'success experiences' [*succeservaringen*]; (9) offering 'psychoeducation' [*psycho-educatie*], (10) 'involve parents' [*ouders betrekken*], for example to address parenting strategies as part of the intervention; (11), using a 'systemic approach' [*systemische aanpak*] to account for family factors; and (12) 'creating perspective' [*perspectief creëren*], about building the youth's perspective for the future (e.g., discussing life after the school years).

The third main theme is 'collaboration between those involved' [*samenwerking tussen betrokkenen*]. It includes: (1) 'collective effort' [*gezamenlijke inspanning*]; (2) clear and regular 'communication' [*communicatie*] between all involved; and (3) the demonstration of 'respect and trust' [*respect en vertrouwen*] between all involved in the intervention.

The fourth main theme is 'attention to prevention and timely intervention' [*aandacht preventie en tijdige interventie*]. It reflects professionals' views on the need to reduce severe and chronic school refusal (i.e., Tier 3 cases) by doing work in Tier 1 and 2 of the multi-tiered system of supports model to promote school attendance and reduce absenteeism, as well as timely referral for Tier 3 work.

Youths' views on the most helpful elements in intervention

Youths' written responses about the most helpful elements in intervention were grouped according to three main themes. The first main theme 'the professionals' [*de professionals*] includes sub-themes about the professionals being 'kind and caring' [*aardig, zorgzaam*], creating an atmosphere of 'understanding and trust' [*begrip en vertrouwen*], and being responsive to the young person and their input as seen in the sub-theme 'connected' [*aansluiten*].

The second main theme 'the content' [*de inhoud*] includes sub-themes referring to 'tranquillity and safety' [*rust en veiligheid*]; 'working on anxiety' [*werken aan angst*]; an 'easy beginning' [*lage insteek*] referring to minimal expectations in the early phase of intervention; helping youths with gradually 'building up school attendance' [*opbouwen schoolgang*]; the 'rhythm, structure, and clarity' [*ritme, structuur, duidelijkheid*] offered during the

intervention; supporting 'social contact and contact with peers with similar difficulties' [*sociale contacten en lotgenoten*]; and the provision of 'flexibility and support in learning' [*flexibiliteit en ondersteuning bij het leren*].

The third main theme 'the changes' [*de veranderingen*] includes sub-themes that reflect the changes the youths noticed in themselves, and which they attributed to the intervention. These changes included an 'increase in self-confidence and perseverance' [*toename zelfvertrouwen / doorzettingsvermogen*] and a 'decrease in anxiety' [*afname angst*]. The changes suggest that elements in the intervention were helpful for the youths.

Parents' views on the most helpful elements in intervention

Parents' responses about the most helpful elements in intervention were grouped according to the same main themes, namely 'the professionals' [*de professionals*], 'the content' [*de inhoud*], and 'the changes' [*de veranderingen*]. Their responses sometimes referred to what they themselves benefitted from most during intervention, and sometimes to what they believe their child benefitted from most.

The first main theme 'the professionals' [*de professionals*] includes sub-themes referring to professionals being 'involved and available' [*betrokken en beschikbaar*]; their 'understanding' [*begrip*]; the fact that professionals were 'connected' [*aansluiten*], such as taking parents seriously and inviting shared decision-making; the professionals' 'positive approach' [*positieve benadering*]; and the fact that there was 'trust' [*vertrouwen*], whereby professionals were trusting and trustworthy.

The second main theme 'the content' [*de inhoud*] includes sub-themes referring to the room for 'clarifying problems and gaining insight into them' [*verheldering en inzicht*]; 'tranquillity and safety' [*rust en veiligheid*]; an 'easy beginning' [*lage insteek*] referring to minimal expectations in the early phase of intervention; helping youths with gradually 'building up school attendance' [*opbouwen schoolgang*]; 'rhythm, structure, and clarity' [*ritme, structuur en duidelijkheid*]; supporting youths' 'social contact and contact with peers with similar difficulties' [*sociale contacten en lotgenoten*]; the provision of 'flexibility and support in learning' [*flexibiliteit en ondersteuning bij het leren*]; 'creating perspective and offering hope' [*perspectief creëren en hoop bieden*]; 'communication' [*communicatie*]; 'specific interventions for youths' [*specifiek aanbod voor jongeren*]; and 'specific interventions for parents' [*specifiek aanbod voor ouders*].

The third main theme 'the changes' [*de veranderingen*] includes sub-themes reflecting parents' sense that there was an 'increase in the young person's self-confidence' [*toename zelfvertrouwen jongere*] and a 'decrease in parental concerns' [*afname zorgen ouders*]. These changes suggest that elements in the intervention were helpful for youths and parents.

For whom interventions have most/least effect, according to professionals

Professionals spoke about factors that seem to influence the effectiveness of their intervention. Five main themes emerged.

The first main theme is 'presenting problems for the young person' [*huidige problemen voor de jongere*]. It includes sub-themes referring to 'characteristics associated with school refusal' [*kenmerken van schoolweigering*] such as poorer outcome when the young person stays in bed the whole morning; 'characteristics of other problems' [*kenmerken van andere problemen*] such as poorer outcome if there is aggression; 'severity of problems' [*ernst van de problemen*] such as poorer outcome when the problem is so severe that more intensive help is needed; and the 'duration of problems' [*duur van de problemen*] such as better outcome if the young person has not been away from school for a long time.

The second main theme is 'context' [*context*]. It includes sub-themes referring to 'circumstances for the parents' [*omstandigheden voor ouders*] such as poorer outcome if parents have psychiatric problems, and 'circumstances for the family' [*omstandigheden voor gezin*] such as poorer outcome if the family has financial problems.

The third main theme is 'characteristics of youths, parents, and family' [*eigenschappen jongeren, ouders, gezin*]. It includes eight sub-themes that refer to 'attitudes towards problems and school attendance' [*houding ten opzichte van problemen en van de schoolgang*] such as better outcome when participants experience some level of distress and poorer outcome if parents keep a child at home; 'willingness and active engagement in the intervention' [*bereidwilligheid en betrokkenheid bij de interventie*] such as better outcome when youths and parents are committed from the start, and when they are willing to confront difficult situations; 'parent expectations about what their child can achieve or what the intervention can achieve' [*verwachtingen van ouders ten aanzien van hun kind of ten aanzien van de interventie*] such as poorer outcome if parents believe their child will never be able to achieve change; 'future perspective for the young person' [*toekomstperspectief van de jongere*] such as poorer outcome if the young person is not excited by any options for further training or education; 'capacities' [*capaciteiten*] such as better outcome if youths or parents are able to view themselves more positively, and poorer outcome if participants have low self-reflection; 'the youth's age' [*leeftijd van de jongere*] such as better outcome with older youths, but also better outcome with younger youths; 'parenting' [*opvoeding*] such as better outcome when there is room in the family for individuation, and poorer outcome when parents do not agree with each other; and 'family functioning' [*gezins functioneren*] such as better outcome if youths come from a harmonious family and poorer outcome if the problem is woven into the family system.

The fourth main theme is 'collaboration between organisations' [*samenwerking tussen organisaties*]. There were no sub-themes. The professionals' responses refer to qualities of professionals from external support services (e.g., better outcome when they are

cooperative) and the quality of the relationship between those who offer a school refusal intervention and the professionals from external services (e.g., poorer outcome when there is miscommunication).

The fifth main theme, 'varying responsiveness' [*wisselende responsiviteit*], includes responses from professionals indicating that it is difficult to specify who is more or less likely to respond well to the intervention (e.g., we cannot yet say; it is not easy to say).

Adjustments professionals wish to make to improve their intervention

Professionals were asked an open question about adjustments they would like to make to their intervention. Six main themes emerged, grouped under two domains, one representing organisational matters and the other representing the intervention itself.

The domain 'the arrangements' [*de regelingen*] comprises two main themes. The first main theme 'structural conditions' [*structurele voorwaarden*] includes 'financial arrangements' [*financiële arrangementen*] such as sufficient funding to continue the intervention; the 'physical environment' [*fysieke omgeving*] such as a permanent therapy room and a space where parents can gather to speak with one another after bringing their child to the intervention; 'regulations' [*regelgeving*] such as not being constrained by the requirements of the education inspection; 'group size' [*groepsgrootte*] such as a maximum of 10 youths per group; 'scope/reach' [*omvang*] such as reducing the waiting list by having capacity to serve more youths; and the amount of 'time available with participants' [*beschikbare tijd met participanten*]. The second main theme 'personnel' [*personeel*] includes responses which predominantly rerefer to team composition (e.g., expand the team with professionals with specialist expertise such as a healthcare psychologist or specialist teachers).

The domain 'the intervention' [*de interventie*] comprises four main themes. The first main theme 'the content' [*de inhoud*] includes the following sub-themes: 'didactics' [*didactiek*], referring to the content of teaching material and the way it is presented, such as being able to offer more subjects; 'practical activities' [*praktische activiteiten*] such as excursions to museums; 'support for youths, parents, and/or families' [*ondersteuning voor jongeren, ouders, en/of families*] such as someone who can meet the young person at home during the initial phase of intervention, and a permanent parent advisor; and 'suitable continued support' [*passend vervolg*], such as more intensive support after youths return to school. The second main theme 'development and evaluation' [*ontwikkeling en evaluatie*] includes sub-themes referring to 'further development of the intervention' [*doorontwikkeling interventie*] such as having more time and money to develop evidence-based programs; and 'evaluation of the effects' of intervention [*evaluatie effecten*]. The third main theme 'collaboration between organisations' [*samenwerking tussen organisaties*] includes the desire to have a permanent working relationship with one specific mental health service, and the desire to have excellent mental health workers on standby. The fourth main theme

'attention to prevention and timely intervention' [*aandacht preventie en tijdige interventie*] includes the desire to have a better system for early identification, to provide some form of intervention before there is a need for referral to the organisation's intervention, and timely referral for intervention by the organisation.

After the open question, professionals were asked to indicate which of 10 intervention elements they would like to incorporate in their intervention or pay more attention to (see Appendix N). Most commonly, professionals nominated a desire to have more access to alternative educational programs, endorsed by nearly 60% of professionals. This is despite the fact that professionals who nominated this were often providing an alternative educational program already. It suggests that alternative educational programs are needed not only as a temporary route back into education, but as a more permanent setting in which some youths can gain an education. The next most common adjustments professionals would like to make, endorsed by 35% of professionals, were more attention to social factors (such as social anxiety, social skills, or social isolation) and more attention to family communication and problem solving.

4.1.4 Collaboration Between Organisations

This section summarises stakeholders' views on collaboration in intervention for school refusal. The professionals' views reported here are those that arose spontaneously during the focus group interview.[46] They are used to address Research Question 4a (What do professionals say about collaboration in intervention for school refusal?). The youths' and parents' views on collaboration were solicited via closed questions in the Knowing What Works Questionnaire for Youths and the Knowing What Works Questionnaire for Parents. They are used to address Research Question 4b (What do youths and parents say about collaboration in intervention for school refusal?).

Professionals' views on collaboration in intervention for school refusal

Collaboration emerged as a main theme in all four networks based on professionals' reports during the focus group interviews.

First, when professionals were asked about the most important elements in intervention for school refusal (Figure 3), one of the main themes that emerged was 'collaboration between those involved' [*samenwerking tussen betrokkenen*]. Specifically, professionals indicated

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[46] Professionals' spontaneous reports about collaboration were drawn from those parts of the interview that were analysed to address the other research questions presented in this report. The analysis of professionals' responses to specific questions about collaboration will be published in a forthcoming scientific article.

that there needs to be a 'collective effort' [*gezamenlijke inspanning*] such as between education and mental health services; there needs to be regular and clear 'communication' [*communicatie*] between all professionals; and there needs to be 'respect and trust' [*respect en vertrouwen*] between all involved in the intervention.

Second, when professionals were asked about factors that seem to influence the effectiveness of their intervention (Figure 6), one of the main themes that emerged was 'collaboration between organisations' [*samenwerking tussen organisaties*]. Their responses indicate that intervention is more likely to be effective when professionals from external support services are cooperative, and less likely to be effective when there is problematic communication between professionals from different organisations.

Third, professionals' reports about difficulties experienced while delivering intervention for school refusal yielded the main theme 'difficulties related to the collaboration with support services' [*moeilijkheden gerelateerd aan de samenwerking met hulpverlening*] (Figure 2). The three sub-themes refer to difficulty 'organising (timely) additional help' [*het realiseren van (tijdig) aanvullende hulp*], such as extra specialist services for the young person and without long waiting lists; the 'communication' [*communicatie*] from professionals at other services, which is sometimes slow and not always open; and 'the grey area between education and support services' [*het grijze gebied tussen onderwijs en hulpverlening*], when interventions are not clearly education-based interventions or mental health-based interventions (e.g., an education professional engages a young person in exposure to the school setting, but this is not referred to as treatment).

Fourth, when professionals were asked about adjustments they would like to make to their intervention (Figure 7), a main theme that emerged was, again, 'collaboration between organisations' [*samenwerking tussen organisaties*]. Specifically, they wish to have a permanent working relationship with one specific mental health service, and to have excellent mental health workers on standby.

Youths' and parents' views on collaboration in intervention for school refusal

Youths and parents had a positive experience of collaboration between all professionals involved in the intervention. Four-fifths of youths and parents rated the collaboration positively. At the same time, nearly one-fifth of youths and parents moderately disagreed with the statement that there was good collaboration. Importantly, no youth and only a few parents (3%) strongly disagreed with the statement that there was good collaboration.

Collaboration was accountable for positive change according to almost two-thirds of youths and a little more than two-thirds of parents. One-quarter of youths and parents moderately disagreed with the statement that collaboration contributed to positive change. Only a few

youths (8%) and parents (6%) strongly disagreed with the statement that collaboration contributed to positive change for the young person.

Post-hoc tests revealed a positive association between responses to the question about how well professionals collaborated, and responses to the question about whether the collaboration had a positive impact on outcomes. In other words, youths and parents who reported that collaboration was good, generally also reported that the collaboration had a positive effect on the young person.

4.2 Integration and Interpretation of Findings

Key findings from the Knowing What Works project are integrated and interpreted in the light of existing literature. Specifically, we address findings related to the needs of youths and parents dealing with school refusal (Section 4.2.1), the interventions provided by organisations (Section 4.2.2), the working elements in those interventions (Section 4.2.3), and collaboration between education and support services to deliver intervention for school refusal (Section 4.2.4).

4.2.1 Reflections on the Needs of Youths and Parents

There are many youths displaying severe and chronic school refusal

The Knowing What Works project was not an epidemiological study of the prevalence of school refusal in the Netherlands. The project does, however, provide a snapshot of the extent to which organisations are currently supporting youths and parents dealing with school refusal. It is estimated that school refusal interventions are provided for 750 youths per year, across the 21 interventions included in the project.

This is likely to be a substantial underrepresentation of the number of youths in the Netherlands who display school refusal, for four main reasons. First, project criteria for recruiting organisations required that: (a) the intervention be predominantly focused on school refusal (i.e., more than 80% of youths in the intervention display school refusal); (b) youths in the intervention have a minimum amount of absence (i.e., at least 16 hours absence in 4 weeks); and (c) the minimum number of youths participating in the intervention was 10 per year, at least in the early stages of project recruitment. If the inclusion criteria had been more relaxed, more organisations may have participated, increasing the estimate of Dutch youths displaying school refusal. Second, two organisations fulfilling recruitment criteria did not participate. Third, many youths displaying school refusal are likely to be supported in other settings (e.g., by private practitioners). Fourth, there will be a group of youths who are not receiving any form of help.

One indicator of the severity of school refusal is the amount of absence from school (Heyne, 2021a). On average, 9 out of 10 youths participating in the 21 interventions studied in the Knowing What Works project had been away from school for at least 4 weeks, suggestive of severe school refusal. For many youths, it seems school refusal was also chronic. There was

no data about when each youth started having difficulty attending school, but most organisations indicated that youths participating in their intervention had been away from school for between 3 months and 1 year prior to participation.

Because many youths participating in the 21 interventions experienced severe and chronic school refusal, it is highly likely that they and their families experienced the negative effects associated with school refusal. Section 1.2.1 summarises the potential impact of absenteeism and school refusal upon youths, families, professionals, and the community. The impact includes, but is not limited to, lowered academic achievement, interruption in the youth's social adjustment, and family conflict. There is longer-term risk for school dropout and social adjustment problems later in life.

Internalising problems are common among these youths

According to professionals, anxiety disorder was the most common problem among youths participating in intervention for school refusal. Averaging across the 21 interventions, it is estimated that more than one-half of youths had an anxiety disorder. This estimate matches the suggestion based on international studies that approximately 50% of youths referred for school refusal meet criteria for one or more anxiety disorders (Heyne et al., 2015). As such, the sample of youths served by interventions in the current project seems typical of samples described in international studies. Around one-third of youths had a depressive disorder. This also corresponds with international studies of school refusal which indicate that depression is significantly associated with school refusal (e.g., Egger et al., 2003), particularly among adolescents displaying school refusal (Heyne, 2021a). One-quarter of the youths had chronic unexplained physical symptoms. International literature suggests that somatic complaints occur among 50-80% of referred youths with established school refusal (Berg, 1980; Honjo et al., 2001) and 25% of non-referred youths with emerging or mild school refusal (Egger et al., 2003).

It is unsurprising that youths presented with internalising problems such as anxiety, depression, and somatic complaints, given that: (a) the criteria for school refusal require the presence of emotional distress (Heyne et al., 2019); and (b) organisations were only invited to participate in the project if their intervention focused on youths displaying school refusal. Similarly, it is unsurprising that very few youths had an externalising disorder because school refusal is defined in part by the absence of severe antisocial behaviour, and externalising problems such as oppositional defiant disorder are not highly prevalent among youths displaying school refusal (Heyne et al., 2015).

Youths' and parents' reports correspond with the picture derived from the professionals' reports. That is, the vast majority of youths and parents reported that school attendance was difficult due to stress or anxiety for the young person, and the next most common reasons were mood problems and somatic complaints.

Autism and the experience of bullying are common among these youths

Averaging across the 21 interventions, one-half of all youths have an autism spectrum disorder. This is in keeping with the few studies available that suggest that school refusal is indeed common among autistic youths (Bitsika, Heyne, et al., 2021). For example, Kurita (1991) reported that 27% of Japanese youths with autism or another pervasive developmental disorder met full criteria for school refusal, and other youths in the sample showed unwillingness to attend school while still attending, which may be conceptualised as emerging school refusal. In a study among English youths with autism, the most common reason given by parents for absence from school was the youths' reluctance or refusal to attend, which was more common even than absence due to illness or due to other attendance problems such as school withdrawal or school exclusion (Totsika et al., 2020).

Approximately one-half of youths participating in the 21 interventions had been bullied. This is unsurprising when viewed in the context of international literature on school refusal. Being bullied is a risk factor for school refusal (Ingul et al., 2019), and in an English study of teachers' and other professionals' perceptions of the causes of school refusal, bullying and friendship problems were identified as contributing factors (Archer et al., 2003). One-third of parents in a Norwegian study reported bullying in relation to their child's school refusal (Havik et al., 2014) and one-third of school refusal cases in an Australian study involved conflict with peers (McShane et al., 2001). A study conducted in the USA revealed that youths with emerging or mild school refusal were significantly more likely than regular school attenders to experience victimisation and conflict with peers (Egger et al., 2003). In the Netherlands, Van Binsbergen et al. (2019) reported that youths with long-term absenteeism [*thuiszitters*] often spoke about being bullied. The only Dutch study addressing bullying and school refusal indicated that one-third of adolescents participating in a school refusal intervention experienced bullying at primary or secondary school (Brouwer-Borghuis, Heyne, Sauter, et al., 2019).

Many autistic youths report bullying at school. In two Australian studies of youths with autism, just over one-half of those who were bullied at school asked their parents if they could stay home from school, suggestive of emerging school refusal (Bitsika, Heyne, et al., 2021; Bitsika, Sharpley, et al., 2021). It is possible that many of the autistic youths represented in the current project experienced bullying, given that most youths were enrolled in mainstream education prior to participation in intervention and autistic youths attending mainstream schools are more likely to be bullied than those in special schools (Humphrey & Hebron, 2015).

The experience of bullying is likely to complicate a return to school among youths displaying school refusal (Grandison, 2011; Place et al., 2000). This is likely to apply to youths with and without an autism spectrum disorder.

Learning disorders and intellectual disability are less common among these youths

According to the professionals, learning disorders and intellectual disability are not highly prevalent among youths participating in the interventions. This is compatible with reports in international studies. For example, Prabhuswamy et al. (2007) identified learning disorder among 15% of youths displaying school refusal in a study conducted in India. A Norwegian study conducted by Havik et al. (2015) revealed that special educational needs were more characteristic of youths with truancy-related absence than absence related to school refusal.

Nonetheless, barriers to learning warrant attention in the prevention of school refusal and intervention for school refusal. Naylor et al. (1994) argued that language impairments and learning disabilities can lead to frustration in the school setting, and result in an inability to meet academic and social demands, potentially contributing to the development of school refusal. Ingul et al. (2019) asserted that a mismatch between a youth's ability and the academic demands of school poses a risk for school refusal, citing Havik et al.'s (2014) study in which parents reported that their child's school refusal may have arisen due to insufficient adaptation of academic requirements. McShane et al. (2001) noted that academic difficulties (not specified) were one of the major stressors among one-third of youths displaying school refusal who were participating in inpatient or outpatient treatment. Filippello et al. (2020) found that, relative to youths with high academic achievement, youths with low academic achievement and youths with specific learning disorders reported a greater desire to escape from aversive social or evaluative situations at school, reminiscent of school refusal. Anxiety about academic performance is another barrier to learning among youths displaying school refusal. Egger et al. (2003) found higher performance anxiety among youths displaying school refusal than among youths displaying truancy or no attendance problem.

The parents of youths displaying school refusal also experience distress

The challenges and distress experienced by parents were not a primary focus of this project but they are very relevant to the topic of intervention for school refusal. Qualitative data from parents about the most helpful elements in intervention (Figure 5) yielded a sub-theme referring to a 'decrease in parental concerns' [*afname zorgen ouders*]. For example, parents referred to the stress they experienced because their child was at home all day, and the relief that was provided once their child returned to school. They also spoke about being allowed to be parents again, instead of being in the role of a professional helping the child. Quantitative data from parents sheds more light on the decrease in parental concerns. For two-thirds of parents, the intervention helped reduce tension and stress regarding their child's school attendance. Almost two-thirds of parents reported fewer difficulties at home as a result of the intervention, and slightly more than two-thirds had become more confident in their ability to respond to difficulties surrounding school attendance. Parents' qualitative reports about the most helpful elements in intervention also yielded sub-themes

indicating that parents valued the 'understanding' [*begrip*] shown by professionals, and that professionals were instrumental in 'creating perspective and offering hope' [*perspectief creëren en hoop bieden*]. These aspects of intervention were probably regarded as helpful because of the challenges and distress the parents had experienced in relation to their child's difficulty attending school.

Professionals' reports about factors that influence the outcome of intervention for school refusal (Figure 6) yielded sub-themes referring to 'circumstances for the parents' [*omstandigheden voor ouders*] such as mental health problems, and 'circumstances for the family' [*omstandigheden voor gezin*] such as poverty and divorce. These sub-themes highlight challenges for parents and the negative impact these challenges can have on the outcome of intervention. Professionals' reports about difficulties delivering intervention (Figure 2) also yielded a sub-theme referring to 'family factors' [*gezinsfactoren*], such as the difficulty parents have in relinquishing an overprotective parenting style when they see their child as vulnerable. When professionals spoke about the most important elements in intervention, an emerging theme was 'involve parents' [*ouders betrekken*]. Specific reports from professionals suggest that parents valued the support they experienced when intervention focused on parenting, and that parents participated in intervention because they had their own specific goals.

The literature underscores the challenges and distress experienced by parents of youths with school attendance problems. A Dutch study on long-term absenteeism [*thuiszitten*] supports the notion that problems on the home-front increase the likelihood of absenteeism, such as financial problems and broken homes (Van Binsbergen et al., 2019). International literature on the experience of parents is found in Section 1.2.1. In short, parents of youths with school attendance problems may experience embarrassment, blame, being misunderstood, and anxiety (Gregory & Purcell, 2014), as well as interruption to their work schedules due to a child's absenteeism (Johnsen, 2020). The literature on school refusal points to stress for the family (Berry & Lizardi, 1985; Christogiorgos & Giannakopoulos, 2014; McAnanly, 1986) and sometimes trauma (Devenney & O'Toole, 2021); parents' experiences of frustration and helplessness, and uncertainty about how much to challenge a child who finds it difficult to attend school (Dannow et al., 2020); conflict between parents about managing school refusal (Heyne, 2021a); and parent psychopathology (Heyne et al., 2015).

4.2.2 Reflections on the Interventions Provided

Much work is being done in many parts of the Netherlands to support youths displaying school refusal and their parents. One-third of the interventions included in this project were established in the last three years, suggesting an increase in the perceived need for interventions. This is very likely in response to government reports about the continuing high number of youths fulfilling the criteria for long-term absenteeism [*thuiszitters*].

There is a focus on youths in secondary school

Most interventions in the current project focus on youths in secondary school. This might be explained by a combination of factors. First, school refusal among adolescents is more severe and complex, which probably explains higher referral for adolescents relative to children (Heyne, 2021a). In the Dutch study of youths with long-term absenteeism [*thuiszitters*] conducted by Van Binsbergen et al. (2019), it was noted that problems had occurred for some time, often during primary school and even earlier, but that school dropout [*het feitelijke thuiszitten*] started after the transition to secondary school. Second, organisations are probably tasked with responding to the needs of youths with more severe school refusal, which, as noted, often occurs among youths in secondary school. Third, when organisations respond to the needs of more severe and complex cases, they then have less capacity to focus on early intervention among primary school youths displaying emerging school refusal. This third point is supported by the finding in the current project that professionals spoke about the need for more 'attention to prevention and timely intervention' [*aandacht preventie en tijdige interventie*] (see Figure 3 and Figure 7).

Choosing to focus on secondary school youths is understandable, and commendable, given that intervention for school refusal among adolescents often appears to be less effective than among children (Heyne, 2021a). Even when preventive interventions and early interventions are provided for children and adolescents displaying emerging school refusal, it is inevitable that some youths will still experience severe and chronic school refusal for which effective intensive interventions are needed (Kearney & Graczyk, 2014).

Because most organisations participating in this project focus on youths in secondary school, the results of the project are largely, but not solely, based on the views of professionals working with adolescents. Thus, the results are more readily generalisable to work with adolescents than work with children. Professionals who work predominantly with children displaying school refusal are encouraged to keep this in mind. That is, while the findings are likely to be relevant for all professionals working with youths displaying school refusal, they are more immediately relevant for those working with adolescents.

There is a preponderance of educational interventions

The vast majority of interventions in the Knowing What Works project are educational interventions whereby youths (temporarily) participate in an adapted educational environment to help them re-engage with education. Most of these are situated within special education, although five are situated within mainstream education. It is striking that so many educational interventions were included in the project, because the literature mainly includes reports of psychological interventions for school refusal (Johnsen et al.,

2021; Maynard et al., 2018) and only recently have school-related factors associated with school refusal received increasing attention (Brouwer-Borghuis, Heyne, Sauter, et al., 2019).

The preponderance of educational interventions may have resulted from a recruitment bias. Interventions were recruited through support services [*hulpverlening*] including mental health care [*GGZ*], and through education channels such as regional partnerships [*samenwerkingsverbanden*] and special education. However, the educational interventions may have been reached more readily. For example, it was possible to reach all regional partnerships [*samenwerkingsverbanden*] via the Support Centre for Appropriate Education [*Steunpunt Passend Onderwijs*], whereas support services such as mental health care and youth care are less easily reached as an entire group. Furthermore, the Knowing What Works project was supported by the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*] which is perhaps more familiar to professionals within special education than within support services, partly because the expertise team was initially facilitated by the National Expertise Centre for Special Education [*LECSO*].

It is also possible that the preponderance of educational interventions included in this project reflects the actual situation in the Netherlands, whereby interventions for school refusal are mainly located in educational settings, with few interventions provided by support services [*hulpverlening*]. Assuming this to be the case, three factors might explain it. First, youths and families may receive assistance through support services, but the assistance offered may focus on symptoms of anxiety or depression rather than specifically on school refusal, despite the suggestion in Chapter 1 that protocols specific to school refusal be used to address school refusal. As a result, there may be fewer programs within mental health services that specifically address school refusal. A second factor may be the difficulty support services have in providing youths and families with appropriate timely support. Long waiting lists and challenges engaging youths and families with support services may motivate schools to develop and provide interventions themselves. A third factor builds on the previous point. Over one-third of interventions in the Knowing What Works project were established in the three years prior to the start of the project. This could be related to the arrival of the Appropriate Education Act in 2014 [*Passend Onderwijs 2014*] which created a focus on long-term absenteeism [*thuiszitters*], and the arrival of subsequent initiatives such as the Absenteeism Pact [*Thuiszitterspact*] in 2016 (Ministerie van Onderwijs, Cultuur en Wetenschap, et al., 2016). The emphasis within regional partnerships [*samenwerkingsverbanden*] on providing suitable support for all youths with long-term absenteeism may have resulted in the new initiatives within education.

As noted above, educational interventions are less common in the scientific literature, relative to mental health interventions. Even if educational interventions are more commonly used, it may be less common to evaluate them than it is to evaluate protocol-based interventions used in mental health services. The educational interventions in the Knowing What Works project are often in the form of special classes within secondary special education [*vso*], involving programmatic work together with customised interventions per student and family, which can complicate the scientific research process.

Nevertheless, professionals in the current project often expressed the wish to evaluate their intervention. This might be a positive spin-off from the project: as the spotlight was shone on working elements in school refusal interventions, those delivering the interventions became more conscious of the value of refining, describing, and evaluating their intervention. To our knowledge, just one intervention included in this project is presented in the scientific literature (Brouwer-Borghuis, Heyne, Sauter, et al., 2019), one is described in a submitted article (De Groot et al., 2021), and another is currently being evaluated for its effectiveness (Karel et al., 2021).

Half of the interventions are funded by one source

Around one-half of the interventions are funded via a single source: education funding or support services [*hulpverlening*] funding. The other interventions have access to both education funding and support services funding, or other sources of funding (e.g., subsidies from philanthropic trusts; project funds from within the organisation). The fact that funds are pooled from various sources might be explained by the complexity of school refusal which requires intensive, multi-faceted care (see Section 4.2.1).

Even when interventions have just one source of funding, additional support may be required for some youths and this support needs to be financed. For example, an educational intervention may not have a permanent collaboration with a mental health service, but a youth participating in the educational intervention may receive additional assistance via a mental health service. Conversely, youths participating in an intervention provided by a mental health service that has no permanent collaboration with an education service may require special adjustments in their education (e.g., placement within special education). When there is no structural arrangement for funding from both education and mental health, extra burden can be experienced by those delivering intervention in terms of finding ways to cover the costs of additional support required for some youths.

It is important that funding issues do not stand in the way of youths' and families' access to appropriate intervention. The reports of professionals interviewed for the Knowing What Works project clearly indicate how important it is that funding is secure, and that there is sufficient time and resources to provide appropriate interventions for school refusal. Numerous professionals indicated that they wish to improve the collaboration between education services and support services [*hulpverlening*] and to have a permanent collaboration between these two services.

Financing is rarely discussed in the scientific literature. An exception is Hannan et al.'s (2019) study of an intervention for school refusal at a mental health service. Participants were referred by schools and funding was arranged via the school district. The authors described their intervention as one that works in conjunction with school systems with sufficient

finances to fund therapy for youths, adding that "the motivation of a school system should be taken into account when assessing how well a program works" (p. 98).

The elements in intervention are similar, but there are also differences

It is to be expected that the 21 interventions share similar characteristics because they all focus on school refusal. At the same time, the interventions differ in a number of ways. Following, we highlight key similarities and differences and offer explanations.

Comprehensive intervention

Almost all of the interventions are comprehensive, whereby youths, parents, and school personnel are always involved in the intervention. It appears that the comprehensive approach to intervention is perceived to be necessary, presumably to address individual, family, and school-related factors known to be associated with the development and/or the maintenance of school refusal (Heyne, 2006).

Length of intervention

Almost all interventions span at least 3 months. This is longer than most manualised interventions summarised in Table 1, which last for 3 weeks (Tolin et al., 2009), approximately 1 month (Heyne & Rollings, 2002), between 1 and 2 months (Kearney & Albano, 2007, 2018b), approximately 2 months (Heyne et al., 2008), and 3 months (Last, 1993). As noted above, there was a preponderance of educational interventions among the 21 interventions studied in the Knowing What Works project. Educational interventions in the form of alternative educational programs presumably require more time than manualised CBT interventions, in large part due to the emphasis on providing education alongside the provision of specific mental health interventions with youths and parents. If a project similar to Knowing What Works was conducted in other countries, whereby professionals were asked about the nature and length of their interventions, it might also be found that interventions in those countries are longer than what is typical among manualised interventions for school refusal.

There is also variability in the length of the Dutch interventions, whereby one-third span 3 to 6 months, one-quarter span 6 to 12 months, and one-third continue for more than 12 months. Variation in the length of intervention raises a question about whether some interventions are too short, maybe due to under-resourcing, or other interventions are perhaps unnecessarily long? Indeed, one-half of youths and parents indicated that the length of intervention was, in their view, too short or too long.

Various interpretations of the variability among Dutch interventions are plausible. First, the severity, chronicity, and/or complexity of school refusal among youths participating in some interventions may be greater than among youths participating in other interventions. With respect to complexity, there was indeed large variability in the percentage of youths presenting with additional problems (see Table 8). For example, all youths participating in some interventions were reported to experience depression, while in other interventions there were no youths who experienced depression. Variability in the extent to which youths experienced additional problems was also noted in relation to anxiety, chronic unexplained physical symptoms, attention deficit hyperactivity disorder, autism, and bullying. Second, differences in funding arrangements are likely to impact how much time each organisation can make available to support youths refusing to attend school. Third, if educational interventions are delivered in the absence of a permanent collaboration with mental health services, considerable time may be required to engage needed mental health services. Fourth, the tendency for some organisations to be flexible in their approach to intervention, discussed next, can impact the length of intervention offered. Fifth, longer interventions may intentionally target youths' broader development, helping them develop perspective for the future [*toekomstperspectief*], on top of the more immediate goal of helping them re-engage with school to facilitate their academic and social-emotional development. Specification of the goals, objectives, and methods associated with an intervention would help shed more light on the reasons for variability in the length of interventions (see Signpost 12 in Section 4.4.1).

Flexibility and standardisation

Most interventions in the current project include some standardisation, but there is also flexibility in the delivery of intervention. Standardisation is seen in the use of an intake process, working in phases, including a standardised training with participants, and periodically consulting with all parties involved. Professionals noted that standardisation provides them with support and direction, and it reduces an ad hoc approach to working with families. A small number of interventions are predominantly or fully flexible. Professionals noted that flexibility serves the unique needs of each case. Of the five school refusal treatment manuals described in Section 1.2.2, one is highly standardised and the other four encourage flexibility with respect to what is offered or how much emphasis is given to specific elements in the intervention. Variations are based on the function(s) of the young person's refusal to attend school and/or the case formulation. For example, social skills training with the young person may be indicated for some youths but not others, and in some families extra attention might be given to communication and problem solving between the young person and parents. In the Knowing What Works project, variation in the extent to which interventions are flexible or standardised may be explained by the preferred working method of team members, and the extent to which theory is used to determine the essential and thus standard elements in intervention. Variation may also be related to how long an intervention has existed. Perhaps the teams providing newer interventions are yet to discern and document the key elements in their intervention. Once documented, these

elements may be implemented more consistently, increasing the extent to which the intervention is standardised. When a team has insufficient time to document their intervention, the intervention may acquire a more flexible character. The topic of documentation is addressed in Signpost 12 (see Section 4.4.1).

Education elements

All interventions included in the Knowing What Works project aim to re-connect youths with some form of learning. Understandably, the options available to achieve this vary, due in large part to the nature of the organisation providing the intervention. For example, some organisations offer temporary placement in an educational setting that is provided by the organisation itself, while others need to arrange for youths to pursue education via the school of origin [*school van herkomst*]. When professionals were asked about adjustments they would like to make to their intervention, the most common response was to have more access to alternative educational programs as a bridge back to mainstream education. Thus, the difference currently observed with respect to providing temporary placement in an educational setting seems to be more about a difference in resourcing than a difference in perspective about the value of alternative educational programs in intervention for school refusal. While it is expensive to provide alternative educational programs, they may be necessary for some youths displaying severe and chronic school refusal, especially those who have social difficulties (Heyne, 2021b).

A key difference across interventions is the use of home education. One-half of the interventions sometimes incorporate home education as a prelude to the young person engaging in education within an educational setting, while other interventions explicitly exclude the use of home education. The diversity in perspectives on home education mirrors the diversity observed in the literature (e.g., Havik & Ingul, 2021; Neuman, 2020; Wray & Thomas, 2013). There is a pressing need to understand the indications and contra-indications for home education, including an examination of individual, family, and school factors that predict poorer or better outcome following a period of home education.

Therapy elements

The manualised CBT interventions for school refusal described in Chapter 1 share various characteristics: individual delivery of intervention rather than group format, graded exposure to school, attention to family communication and problem solving, and practice tasks (also called between-session tasks and home tasks). We reflect upon these characteristics in relation to the 21 interventions included in the current project. Thereafter, we reflect on the large diversity of therapeutic elements in the interventions in the project.

Individual support is provided in all 21 interventions. Certainly, some interventions include elements delivered in group format such as skills training with youths and group activities

such as cooking, but on the whole the professionals reported that their intervention is conducted individually for each young person. This could be expected, given the diversity of influences that may predispose a young person to the development of school refusal, precipitate its onset, perpetuate the problem, and serve as protective factors that are drawn upon during intervention (Heyne, 2006; Heyne et al., 2014; Ingul et al., 2019).

Graded exposure is included in all interventions studied in this project. When school refusal is severe and chronic, as it is for many youths in the studied interventions, it is likely that professionals choose to gradually re-engage youths with education to help them feel more secure in the process. The steps involved in re-engagement are chosen to be mildly challenging but not overwhelming, with respect to the amount of time spent at school and the types of activities the young person engages in. The sense of urgency about increasing school attendance for emerging, mild, or moderate school refusal (i.e., Tier 2) seems to be less present among professionals addressing severe and chronic school refusal (i.e., Tier 3). Perhaps professionals hold the view that 'slow progress is better than no progress at all', based on the assumption that rapid re-engagement would not be successful. From an empirical perspective, no study has compared part-time increase in school attendance (i.e., graded exposure) with full-time increase (i.e., rapid return, or flooding). Maeda and Heyne's (2019) study of rapid school return among Japanese adolescents suggests that the rapid approach is more effective than no intervention, but the authors noted many contra-indications for using the approach such as the presence of mental health problems for the young person and the experience of bullying. Indeed, many youths in the interventions in this project have been bullied at school. The experience of bullying may contribute to trauma, which is an underlying factor in the experience of school refusal according to professionals interviewed by Devenney and O'Toole (2021). According to these authors, "coercive, confrontational and controlling strategies will trigger painful memories and potentially re-traumatise young people" (p. 41). Trauma is understudied with respect to school refusal, and treatment outcome studies often excluded youths with posttraumatic stress disorder (e.g., Heyne et al., 2011; Melvin et al., 2017). When trauma events are studied, it is usually in relation to absenteeism in general (e.g., Siriwardhana et al., 2013) or truancy (e.g., Dembo et al., 2012), but not school refusal. Numerous professionals in the current project indicated that they incorporate eye movement desensitisation and reprocessing (EMDR) in their work with youths, presumably to address a trauma component.

Family communication plus family problem solving is addressed in four-fifths of the interventions. Furthermore, one-third of professionals indicated that they would like to devote more attention to family communication and problem solving. Thus, there is substantial agreement that this is an important part of intervention for school refusal. This corresponds with the literature on school refusal indicating that one-half to two-thirds of families experience maladaptive family functioning (Bernstein et al., 1999; Kearney & Silverman, 1995), that alteration in family interaction patterns is advocated (Bernstein et al., 1999; Hansen et al., 1998; Place et al., 2000), and that communication training and problem solving are important for families characterised by conflict or detachment (Kearney & Silverman, 1995). Helping youths and parents develop and use skills for effective

communication and problem solving has various benefits, as outlined in Heyne and Sauter (2013) and Heyne (2021b). In short, these skills help modify family-based factors associated with the development or maintenance of school refusal (e.g., conflict; detachment / disengagement; rigidity / insufficient independence) and help improve family relationships more generally. Regarding the former, parents and youths are empowered to discuss the process for increasing school attendance in a more calm and confident manner (e.g., whether to change schools; the roles of the young person and parents in helping the young person get out of bed and ready for school). A reduction in tension and conflict during such discussions can increase the youth's willingness and ability to follow through with plans for attending school. Involving youths in decision-making during family discussions can also increase their motivation for participating in intervention. Regarding the latter, improved family communication and problem solving enhances positive experiences in the family which helps modify disengagement, and it increase family members' capacity to develop and use creative and flexible solutions which helps modify rigidity. Finally, when professionals engage families in the practice of communication and problem solving, other factors associated with the development or maintenance of school refusal may come to light, such as maladaptive family beliefs like 'anxiety should be avoided at all costs because it is unpleasant'.

Practice tasks (also called between-session tasks and home tasks) are to be distinguished from school-related homework. Practice tasks are a core feature of CBT, used to gather information, test beliefs, and generalise skills to everyday life (Kazantzis et al., 2005). In the manualised CBT interventions for school refusal described in Chapter 1, examples of such tasks are the practice of a relaxation technique at home (Heyne & Rollings, 2002), engaging in graded exposure (Last, 1993), and parents practising contingency management (e.g., restricting a child's access to television and computer during school-time; Tolin et al., 2009). The quantity and quality of compliance with practice tasks is significantly related to treatment outcome (Kazantzis et al., 2000, 2016). In the current project, practice tasks are included in three-quarters of the interventions. We suggest three reasons why such tasks are not utilised in all interventions. First, there was a preponderance of educational interventions in this project. Almost by definition, therapy-related practice tasks are applicable to interventions provided by mental health professionals. Professionals in educational settings will be less inclined to conceptualise the practice tasks they prescribe as therapy-related practice tasks, even though they may in fact be encouraging youths to engage in tasks which benefit re-engagement with education (e.g., modifying their sleep-wake routine to be better able to get up and ready for school in the morning). In addition, education professionals who deliver an intervention independent of mental health services may be less focused on the value of practice tasks, relative to education professionals working closely with professionals from mental health services. Second, it is likely that education professionals provide prompts for youths to engage in therapy-related tasks during their daily contact with youths (e.g., encouragement to initiate contact with peers), whereas mental health practitioners often meet with youths once or twice a week, in the confines of a therapy room, and thus without access to situations in which skills can be practiced, accentuating the need to asks youths to engage in practice tasks between

sessions. Third, the theoretical orientation of some interventions may not emphasise practice tasks. In line with this, Kazantzis et al. (2005) found that practitioners with a psychodynamic/analytic or interpersonal orientation reported less use of practice tasks than CBT practitioners.

Other CBT components commonly employed in the five manualised CBT interventions for school refusal as described in Chapter 1 are psychoeducation, social skills training, and relaxation training. Numerous professionals in the Knowing What Works project reported that they engage youths in psychoeducation, and some mentioned the use of psychoeducation in their consultation with teachers at the young person's school. Social skills training was mentioned, but less commonly. Relaxation training was not mentioned by name, but it is presumably incorporated in the CBT or group work on anxiety that professionals did mention by name. Other therapy elements that professionals named may also have benefit for youths' relaxation and stress management (e.g., mindfulness and psychomotor therapy).

The large diversity in therapeutic interventions for school refusal is evident in Heyne, Strömbeck, et al.'s (2020) review of the evaluation of treatment for school refusal. Alongside the cognitive and behavioural interventions were narrative therapy, multimodal treatment, parent counselling, collage therapy, hypnosis, medication, psychodynamic psychotherapy, family therapy, and components from acceptance and commitment therapy. Of these, the ones mentioned by numerous professionals in the current project were parent counselling, family therapy, and medication. The ones mentioned by just a few professionals were creative therapy and psychotherapy, both in the context of group work with youths. Interventions that did not arise in Heyne, Strömbeck, et al.'s review (2020), but which were mentioned by a small number of professionals, were mindfulness, motivational interviewing, mentalisation-based treatment, emotion regulation training, and work on self-esteem.

Summary

There is considerable overlap across the 21 interventions. Interventions are almost always comprehensive (involving youths, parents, and school personnel), therapy is principally delivered per individual rather than in group format, re-engagement with school is gradual, and the temporary provision of alternative educational programs is valued. Family communication plus problem solving is also valued, although the process for addressing communication and problem solving is unclear because this was not investigated. Most, but not all interventions incorporate practice tasks, but it is unclear whether this applies only to youths, or also to parents. Differences between the interventions include the length of intervention, the extent to which intervention is flexible or standardised, the use of home education, and the use of elements infrequently mentioned by professionals (e.g., motivational interviewing and mentalisation-based treatment).

4.2.3 Reflections on the Working Elements in Intervention

Much of the data gathered during the current project addresses the working elements in the interventions that were studied. We begin by reflecting upon youths' and parents' experience of the interventions and their views on the outcomes of intervention. We then reflect upon the working elements in intervention, firstly drawing on professionals' reports about the most important elements, then drawing on youths' and parents' reports about the most helpful elements for them. Thereafter, we integrate the views of professionals, youths, and parents regarding the working elements in intervention. The final parts of Section 4.2.3 integrate professionals' reports about difficulties delivering intervention, adjustments they would like to make to their intervention, and who responds most and least to intervention.

The interventions were evaluated positively by a majority of youths and parents

Data from youths and parents indicate that the interventions were viewed positively and were held to contribute to positive outcomes.[47] Specifically, youths' and parents' ratings of the intervention process were very favourable, and almost all participants would recommend the intervention to others. Many youths and parents reported improvements in numerous areas of the young person's life as a result of the intervention. The improvements include, but are not limited to, reduced anxiety or stress, reduced mood problems, increased school attendance, finding it easier to go to school, enjoying school more, increased sense of the value of education, and increased confidence in the future. The interventions also yielded improvements for parents and families. The improvements include, but are not limited to, less stress regarding a child's going to school, more confidence about responding to a child's difficulties going to school, being better able to support a child's attendance at school, and experiencing fewer difficulties at home between the young person and parents.

Taken together, the positive responses about the interventions suggest that the interventions 'work'. We can thus have more confidence that professionals', youths', and parents' views on the working elements in interventions are about the elements in interventions that indeed work.

However, two points deserve comment. First, the closed questions posed to youths and parents about changes they experienced included the specification that change was a result of participation in the intervention. This means that we can be more certain that the changes were indeed related to the intervention, but we do not know which elements in intervention contributed to the change. Data about the most helpful elements in intervention was only derived from the open questions. Second, although a majority of youths and parents reported changes, some youths and parents did not report changes. One

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[47] Responses from youths and parents were collapsed across interventions.

possibility is that the questions asked did not tap into the kinds of changes these youths and parents experienced. An alternative possibility is that these are the youths and parents who respond less well to intervention according to professionals (Figure 6). If this is the case, it suggests that current interventions need to be enhanced in some way to increase the likelihood that youths and parents who currently report little to no benefit may also benefit from intervention for severe and chronic school refusal.

The most important elements in intervention according to professionals

Professionals' reports of the most important elements in intervention yielded many sub-themes (Figure 3). The large number of sub-themes provides a nuanced picture of what is important when supporting youths and families dealing with school refusal. In our view, the large number of sub-themes also reflects the broad expertise and commitment of the professionals who were interviewed.

The sub-themes are grouped according to main themes, themselves grouped according to two key domains: 'the arrangements' [*de regelingen*] that permit effective intervention, and 'the intervention' [*de interventie*] itself. The two domains are inter-connected: being able to deliver an effective intervention requires that certain organisational issues have been arranged, but the arrangements alone are insufficient if not paired with effective elements in intervention.

The domain 'the arrangements' [*de regelingen*] includes the main theme 'structural conditions' [*structurele voorwaarden*] necessary for the delivery of an intervention, namely conditions represented by the sub-themes 'physical environment' [*fysieke omgeving*], 'financial arrangements' [*financiële arrangementen*], and 'support from management' [*steun management*]. It is self-evident that these structural conditions are necessary for the delivery of intervention. However, the professionals who were interviewed have experienced difficulties arranging appropriate funding and a suitable physical environment. For example, professionals across several interventions noted that there was uncertainty about the continuation of their funding. Further, there is often a need for multiple sources of funding because many youths require intensive support from both education and support services [*hulpverlening*]. Ideally, referrers such as regional partnerships [*samenwerkingsverbanden*] are willing and able to cover the costs associated with the referral of a specific young person. 'Financial arrangements' would thus involve agreements between the parties that purchase and provide the interventions. The 'physical environment' [*fysieke omgeving*] is also related to funding. For example, if education and support services collaborate in the delivery of an intervention, a suitable physical environment needs to be available. Usually this will involve providing more than a single classroom or therapy room.

The other main theme in the domain 'the arrangements' [*de regelingen*] is 'personnel' [*personeel*]. According to the professionals interviewed, this involves appointing professionals with the appropriate expertise, experience, inquisitiveness, persistence, and passion for those affected by school refusal. It is important that these professionals function well as a team and have a joint vision for addressing school refusal. This main theme is best viewed as dynamic rather than static because professionals accrue much knowledge and expertise across the years that an intervention is delivered, and this is passed on to new colleagues in the team and to professionals outside the team (e.g., via the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*]).

The domain 'the intervention' [*de interventie*] includes the main theme 'relationship with participants' [*de relatie met deelnemers*]. The attention professionals gave to the relational aspects of their work, above and beyond specific interventions, underscores the importance of having suitable personnel. Seven sub-themes describe how professionals interact with youths and parents. The importance of these non-specific aspects of intervention is evidenced in the literature indicating that non-specific factors such as the therapeutic alliance between client and therapist impact upon response to treatment (e.g., Palpacuer et al., 2017). In the area of school refusal, professionals interviewed in Kljakovic and Kelly's (2019) study indicated that it is important for professionals to build strong relationships and remain hopeful, to instil hope among youths and families. Youths and parents interviewed in Sibeoni et al.'s (2018) study similarly spoke about the importance of being heard and developing trusting relationships with professionals.

Another main theme in this domain is 'the content' [*de inhoud*]. The 12 sub-themes describe what it is that professionals do for youths and parents. A number of the sub-themes will be familiar to those working in support services [*hulpverlening*], such as clarifying the problem, providing psychoeducation, and employing a systemic approach. Other sub-themes will be more familiar to those working in education, such as creating a safe environment and offering an adapted educational environment. This emphasises the importance of collaboration between education and support services in addressing school refusal; the knowledge and expertise of professionals in both sectors is required.

One of the sub-themes within 'the content' [*de inhoud*] is 'creating movement' [*beweging creëren*]. Many of the interviewed professionals spoke about this. Movement refers to activating youths and helping them face fears and difficulties. School refusal often involves fear and avoidance linked to the school setting or specific situations within school (Heyne & King, 2004), and movement towards the feared and avoided situation via a gradual increase in school attendance can be regarded as graded exposure. The sub-theme thus corresponds with Elliott and Place's (2019) observation that CBT is the most common treatment for youths displaying school refusal, an approach that often includes exposure. Indeed, CBT and exposure are therapeutic elements employed by professionals in the current project (see Table 11), and graded exposure to school is incorporated in all of the interventions in the project (see Section 3.3.5). At the same time, gradual return to school may be very challenging for youths with a high level of fear. According to Preece and Howley (2018), this

is especially true for youths with autism because of the complexity of autism spectrum disorder characteristics, resultant anxiety, and difficulty attending school and engaging with learning (Preece & Howley, 2018). Alternative educational settings like those included in the Knowing What Works project play an important role in providing a safe environment for a gradual return to school, especially for the many youths with autism who display school refusal. For all youths, those with and without autism, a delicate balance needs to be found between providing support in a safe environment on the one hand, and creating movement on the other hand. This is discussed further in Section 4.4.1.

A third main theme in this domain is 'collaboration between those involved' [*samenwerking tussen betrokkenen*]. The sub-theme 'collective effort' [*gezamenlijke inspanning*] suggests that professionals view it as important that professionals from different disciplines work together, in a multidisciplinary or interdisciplinary way (Choi & Pak, 2006). The more frequent and intensive the collaboration, the more it becomes a part of the intervention rather than it being an ad hoc arrangement. Collaboration between all involved with intervention for school refusal is one of the three pillars of intervention as described by Brouwer-Borghuis, Heyne, Sauter, et al. (2019).

The fourth main theme is 'attention to prevention and timely intervention' [*aandacht preventie en tijdige interventie*]. It is about deploying preventive or curative interventions in a timely fashion, resonating with the multi-tiered system of supports framework for service delivery which aims to ensure the right level of intervention is delivered at the right time, to promote school attendance and prevent school attendance problems (see Section 1.2.2). The 'timely intervention' part of this main theme also captures professionals' reports about the need for timely referral to their intervention, so that they are better placed to satisfactorily address school refusal.

The most helpful elements in intervention according to youths and parents

Youths' and parents' views on the most important elements in intervention are presented in Figure 4 and Figure 5, respectively. There are three main themes in both networks: 'the professionals' [*de professionals*], 'the content' [*de inhoud*], and 'the changes' [*de veranderingen*]. These themes can be thought of in terms of who delivers intervention, what is done during intervention, and the impact of intervention.

The main theme 'the professionals' [*de professionals*] comprises youth and parent views on various helpful characteristics of professionals and their way of working. The sub-themes 'understanding and trust' [*begrip en vertrouwen*] and 'connected' [*aansluiten*] emerged from the reports of youths and parents alike.[48] The latter sub-theme reflects the professionals' ability and willingness to account for the wishes and needs of youths and parents.

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[48] 'Understanding' and 'trust' are two separate sub-themes in the network showing parents' reports.

Understanding, trust, and being connected align with the work of Sibeoni et al. (2018), whereby adolescents displaying school refusal, and their parents, indicated that being able to speak, being heard, and developing trusting relationships were important therapeutic elements. For parents, the importance of being understood is seen in the work of Gregory and Purcell (2014) who noted that parents of youths absent from school often felt misunderstood by education professionals. For youths, the importance of being understood is seen in the work of Baker and Bishop (2015), whereby youths with severe school absenteeism indicated that it would have been helpful if they had been offered more support and understanding.

The other sub-themes related to 'the professionals' [*de professionals*] are somewhat different for youths and parents, given the emphases that emerged in their respective reports. Whereas youth responses were grouped in a sub-theme 'kind and caring' [*aardig, zorgzaam*], parent responses were grouped in the sub-themes 'positive approach' [*positieve benadering*] and 'involved and available' [*betrokken en beschikbaar*]. Collectively, youths and parents valued warm and committed professionals who were present physically and emotionally. These characteristics likely form the basis for the characteristics described in the previous paragraph, namely understanding, trust, and being connected. According to Van Binsbergen et al. (2019), youths displaying long-term absenteeism often have a complex history of contact with social services, and parents are often overburdened. Assuming this is equally applicable to youths and parents dealing with school refusal, then the relationships professionals establish with youths and parents are ideally characterised by kindness, caring, positivity, involvement, and availability.

The main theme 'the content' [*de inhoud*] comprises youths' and parents' views on the important activities conducted during intervention. Six sub-themes are identical across the two networks representing youths' and parents' views: 'tranquillity and safety' [*rust en veiligheid*], 'easy beginning' [*lage insteek*], 'building up school attendance' [*opbouwen schoolgang*], 'rhythm, structure, and clarity' [*ritme, structuur en duidelijkheid*], 'social contact and contact with peers with similar difficulties' [*sociale contacten en lotgenoten*], and 'flexibility and support in learning' [*flexibiliteit en ondersteuning bij het leren*].

The sub-themes 'building up school attendance' [*opbouwen schoolgang*] and 'flexibility and support in learning' [*flexibiliteit en ondersteuning bij het leren*] are directly related to helping youths increase school attendance and engage in learning. Responses that yielded the sub-theme 'flexibility and support in learning' were not only about offering academic support, but also about tailoring suitable educational pathways to the needs of youths, perhaps via an adapted educational program. Indeed, when youths have been absent from school for a substantial time, it is difficult for them to participate in the standard curriculum. Research by Van Binsbergen et al. (2019) attests to this, inasmuch as youths indicated that there was not enough flexibility at school at those times when they had (temporarily) stopped attending school. The sub-themes 'tranquillity and safety' [*rust en veiligheid*], 'easy beginning' [*lage insteek*], and 'rhythm, structure, and clarity' [*ritme, structuur en duidelijkheid*] are not

directly related to school attendance and learning, but they likely create the conditions in which youths can be helped to attend school and engage in learning.

The sub-theme 'social contact and contact with peers with similar difficulties' [*sociale contacten en lotgenoten*] refers to the process of increasing youths' capacity to connect with other youths, perhaps firstly via contact with youths experiencing similar difficulties. Youths in Sibeoni et al.'s (2018) study of school refusal similarly indicated that it was helpful to have contact with peers. Professionals in the school refusal study by Kljakovic and Kelly (2019) suggested that there needs to be an environment in which youths have opportunities to gradually socialise with others in a similar position. For many youths who display school refusal, the process of (re)establishing social contact is likely to be complicated by social anxiety (Blöte et al., 2015), bullying (Bitsika et al., 2022), and autism (Preece & Howley, 2018). In an alternative educational setting where most youths are familiar with school refusal, re-establishing social contact will probably be less difficult. Compared to youths in a mainstream school setting, these youths can better understand each other and are probably less likely to ignore or reject each other. In addition, the alternative setting provides a very safe environment in which to gradually engage with others socially. As a result, youths may be better prepared for the return to a more typical educational environment and the social dynamics therein. A case illustration in Brouwer, Heyne, Sauter, et al. (2019) offers an example of the process via which a young person prepared for return to a mainstream school setting through participation in an alternative educational program. When interventions do not include an alternative educational setting, special attention would need to be given to the ways in which youths participating in individual therapy can be helped to build social competence and confidence (see Heyne, 2021b).

Six sub-themes in the main theme 'the content' [*de* inhoud] are not consistent across youths and parents. Only youths' reports yielded a sub-theme about 'working on anxiety' [*werken aan angst*], very likely because professionals conducted this work directly with the youths and not via the parents. The five sub-themes that emerged only in the reports of parents are 'clarifying problems and gaining insight into them' [*verheldering en inzicht*], 'creating perspective and offering hope' [*perspectief creëren en hoop bieden*], 'communication' [*communicatie*], 'specific interventions for youths' [*specifiek aanbod voor jongeren*], and 'specific interventions for parents' [*specifiek aanbod voor ouders*]. It is to be expected that parents, more than youths, would value insight, perspective, and communication about the intervention process with their child.

The main theme 'the changes' [*de veranderingen*] encapsulates the helpful effects of the intervention, alluding to the existence of working elements in the interventions. A similar sub-theme emerged from the reports of youths and parents, namely 'increase in self-confidence/perseverance' [*toename zelfvertrouwen/doorzettingsvermogen*] according to youths, and 'increase in the young person's self-confidence' [*toename zelfvertrouwen jongeren*] according to parents. These sub-themes are reminiscent of Bandura's (1977) concept of self-efficacy; one's belief in one's ability to do something. Self-efficacy is an important construct in relation to the development or maintenance of school refusal (Heyne

et al., 1998; Ingul et al., 2019), cognitive-behavioural treatment for school refusal (Heyne & Sauter, 2013), and the outcome of treatment for school refusal (Heyne, Strömbeck et al., 2020). For example, a youth's belief in their ability to handle school-related situations such as answering peers' questions about absence from school may impact upon their efforts to attend school. In addition, youths who participated in CBT for school refusal reported increases in self-efficacy for handling challenging school-related situations (Heyne et al., 2002, 2011; King et al., 1998), and increased self-efficacy appears to be an important factor for reducing anxiety and increasing school attendance (Maric et al., 2013). It is thus not surprising that youths and parents participating in the Knowing What Works project indicated that increased confidence was an important element of intervention.

Two other sub-themes in the main theme 'the changes' [*de veranderingen*] are 'decrease in anxiety' [*afname angst*] according to youths, and 'decrease in parental concerns' [*afname zorgen ouders*] according to parents. The latter emerged from reports indicating that the intervention allowed parents to breathe again, to be parents again rather than therapists, and to devote time and attention once again to other children in the family. It seems that intervention helped reduce the burden for parents, despite the potential burden of participating in intervention.

The design of the current project does not permit an analysis of the changes reported by youths and parents in relation to specific sub-themes about the professionals or the content in the interventions. Youths and parents spontaneously wrote about changes that occurred, in the context of the question about what was most helpful during intervention. They had not been asked to write about which elements in the intervention were, in their view, responsible for the changes they wrote about. Studies of factors that mediate the outcome of intervention are warranted, as described in Section 4.4.3 ('Robust evaluation of the mechanisms of change in interventions for school refusal').

Integrating professionals', youths', and parents' views on the working elements

Professionals are a key aspect of 'what works' in intervention for school refusal, according to the reports of professionals, youths, and parents. The reports of professionals yielded the main themes 'personnel' [*personeel*] and the 'relationship with participants' [*de relatie met deelnemers*]. The reports of youths and parents yielded the main theme 'the professionals' [*de professionals*]. Sub-themes that emerged across the reports of professionals and participants (i.e., youths, parents, or both) refer to professionals being 'available' [*beschikbaar*], 'connected' [*aansluiten*], and having a 'positive approach' [*positieve benadering*]. In other words, when professionals are physically and emotionally available, positive and warm, and attending to the needs and capacities of youths and parents, intervention is more likely to be effective.

Specific elements of intervention also constitute 'what works' with respect to school refusal intervention. The main theme 'the content' [*de inhoud*] emerged from the reports of professionals, youths, and parents, and the sub-themes that emerged across the reports of professionals and participants were 'clarifying problems and gaining insight into them' [*verheldering en inzicht; verheldering problematiek*], 'tranquillity and safety' [*rust en veiligheid; veilig klimaat*], 'easy beginning' [*lage insteek*], 'rhythm, structure, and clarity' [*ritme, structuur en duidelijkheid; ritme en structuur*] and 'perspective' [*perspectief creëren en hoop bieden; perspectief creëren*]. Overlap is also seen across the sub-themes 'room for customisation' [*ruimte voor maatwerk*] which emerged from the reports of professionals, and 'flexibility and support in learning' [*flexibiliteit en ondersteuning bij het leren*] which emerged from the reports of youths and parents. In other words, it is important that professionals spend time gaining good insight into the specific difficulties and experiences of the young person and parents, offer hope and perspective, foster a safe environment in which youths can tackle difficulties in small steps, establish rhythm and structure in the life of the young person, and develop tailor-made solutions as needed.

We also observed differences in the three networks representing professionals', parents', and youths' views on 'what works' in intervention. This is to be anticipated because each stakeholder group has a different experience of intervention. Moreover, the questions that were asked of each stakeholder group were not identical. To recap, the network representing professionals' views on the most important elements in intervention is based on their responses to three questions during the interview: 'Why do you think your program works as well as it does?', 'Which elements in your program do you see as most important?', and 'What do you think is necessary to address school refusal properly?' Youths provided written responses to one item in a questionnaire: 'Describe what you most benefitted from in the program'. Parents provided written responses to two items in a questionnaire: 'Describe what you think your child most benefited from in the program', and 'Describe what you most benefitted from in the program'. Even though we would not anticipate identical networks across the three stakeholder groups, we wish to reflect upon four differences.

First, the domain 'the arrangements' [*de regelingen*] only emerged in the network based on professionals' reports. Clearly, professionals delivering interventions for school refusal have far more insight into what is needed to be able to deliver an intervention, such as financing and support from management. At the same time, many of the sub-themes emerging from the reports of youths and parents will be conditional upon 'the arrangements' mentioned by professionals. For example, parents reported that it is important that professionals are 'involved and available' [*betrokken en beschikbaar*], an element that is less likely to be present if professionals do not have enough time for their work. As another example, youths and parents reported that 'tranquillity and safety' [*rust en veiligheid*] are important, and these conditions are more likely to be present when professionals have been able to arrange an appropriate 'physical environment' [*fysieke omgeving*].

Second, the sub-theme 'creating movement' [*beweging creëren*] emerged from the reports of professionals, but it did not emerge as an explicit sub-theme in the reports of youths and parents. It is, however, implicit in the youth and parent sub-theme 'building up school attendance' [*opbouwen schoolgang*]. It is important to note that the names of the sub-themes were chosen to best reflect the word choice of the stakeholder groups. For example, professionals used expressions like "you have to get on with it" [*je moet aan de bak*], "breaking habits" [*patronen doorbreken*], and "exposure, exposure, exposure, not too much talking" [*exposure, exposure, exposure. Ja en niet te veel praten*]. In these responses, 'creating movement' seems to be the essence. Youths and parents, on the other hand, spoke about the value of being helped to gradually increase attendance at school. They used expressions like "slowly building up hours at school" [*het langzaam opbouwen van uren op school*] and "gradually increase the number of days at school" [*geleidelijk aantal dagen naar school opvoeren*]. The difference in emphasis – 'create movement' according to professionals, and 'building up school attendance' according to youths and parents – may occur because professionals feel the responsibility for effecting change by initiating the change process with youths and parents. Professionals' sense of a need to create movement may be especially pertinent in cases involving long-term absenteeism and thus entrenched avoidance of school, which was true for many youths in the current project. The ideal speed of change is unclear. Maeda and Heyne (2019) highlighted the fact that there has been no systematic evaluation of a graded return to school (graded exposure) relative to rapid school return (flooding). They summarised numerous single-case studies and other authors' views on the issue of speed of school return, noting that "it seems that taking pressure off the young person to attend school is not an effective intervention" (p. 3). What is clear from the current project is that youths and parents value a gradual approach, as well as being consulted during intervention, as suggested by the sub-themes 'connected' [*aansluiten*] and 'communication' [*communicatie*]. Professionals voiced the importance of 'psychoeducation' [*psycho-educatie*], which is important when engaging youths and parents in the process of increasing school attendance (e.g., psychoeducation about the role of avoidance in maintaining anxiety, or the role of inactivity in maintaining depression).

Third, the sub-theme 'social contact and contact with peers with similar difficulties' [*sociale contacten en lotgenoten*] emerged from the reports of youths and parents, but it did not emerge in the reports of professionals. However, professionals spoke about aspects of intervention which are surely beneficial for youths' social interaction, seen in the sub-themes such as 'safe environment' [*veilig klimaat*], 'adapted educational environment' [*aangepaste onderwijsomgeving*], 'rhythm and structure', [*ritme en structuur*], and 'success experiences' [*succeservaringen*] when those experiences are focused on social situations.

Fourth, a main theme that emerged from professionals' reports but not the reports of youths or parents was 'attention to prevention and timely intervention' [*aandacht preventie en tijdige interventie*]. This theme emerged from responses to the question about what is generally needed to properly address school refusal, not from the question about what is effective within professionals' current interventions. This can be understood as follows: professionals regard the prevention of school refusal as an activity that needs to take place

prior to referral to their intervention. It is important to note that the question about what is generally needed to properly address school refusal is broader than the question asked of youths and parents, namely, which aspects of intervention were most beneficial for them. If youths and parents were also asked the broader question, they may have shared a similar view to that of professionals: that prevention and early intervention are needed so that youths and parents are not burdened with the problem of severe and chronic school refusal.

In conclusion, the similarities observed across the reports of professionals, youths, and parents underscore the importance of including those specific intervention elements in the roadmap for school refusal interventions. The differences do not suggest that elements emphasised by one stakeholder group but not another should be excluded from the roadmap. Rather, the different perspectives of each stakeholder group serve to enrich the composition of the roadmap.

Difficulties delivering intervention, viewed alongside important elements in intervention

The difficulties professionals face in delivering intervention for school refusal can shed further light on the important elements in intervention. In this section we synthesise the results presented in Figure 2 and Figure 3.

The network about difficulties delivering intervention (Figure 2) comprises three main themes, two of which inform thinking about 'what works' in intervention for school refusal. 'Difficulties related to the delivery of therapy elements' [*moeilijkheden gerelateerd aan het uitvoeren van therapeutische elementen*] comprises sub-themes suggesting, indirectly, that interventions are more likely to be effective when youths can be helped to participate in group interventions, when there are strategies for helping youths transfer learnings to their daily lives, and when professionals have sufficient time to provide needed help. 'Difficulties related to the collaboration with support services' [*moeilijkheden gerelateerd aan de samenwerking met hulpverlening*] comprises sub-themes which also suggest, indirectly, that interventions are more likely to be effective when there is a permanent collaboration with external help, because this may reduce waiting times and ensure there is open and timely communication between collaborating professionals.

The preceding suggestions about what might be important in intervention are supported by sub-themes in the network about important elements in intervention (Figure 3). The sub-theme 'knowledge, experience, and curiosity' [*kennis, ervaring en leergierigheid*] refers to the characteristics of professionals which could help in the process of engaging youths in group interventions and assisting them in transferring learnings to their daily lives. The sub-themes 'financial arrangements' [*financiële arrangementen*] and 'support from management' [*steun management*] are conditions which could increase the likelihood that professionals have sufficient time to provide needed support. 'Financial arrangements' and 'support from management' will also help achieve a permanent collaboration with external

help. Lastly, the sub-theme 'communication' [*communicatie*] underscores the importance of open and timely communication with external help.

Adjustments to intervention, viewed alongside important elements in intervention

The adjustments professionals would like to make to their intervention can provide insight into the important elements in intervention. In this section we synthesise the results presented in Figure 3 and Figure 7, along with results presented in Table 17.

Professionals' responses to the question about adjustments to their intervention covered two domains: 'the arrangements' [*de regelingen*] and 'the intervention' [*de interventie*] (Figure 7). These are the same domains that emerged from their responses to questions about the most important elements in intervention (Figure 3). Moreover, there are many similarities in the main themes emerging in the network about adjustments and the network about important elements. Specifically, of the six main themes in the network about adjustments, five were identical or nearly identical to main themes in the network about important elements, namely: 'structural conditions' [*structurele voorwaarden*]*,* 'personnel' [*personeel*]*,* 'the content' [*de inhoud*]*,* 'collaboration between organisations' [*samenwerking tussen organisaties*]*,* and 'attention to prevention and timely intervention' [*aandacht preventie en tijdige interventie*]*.* The similarity in main themes across these two networks points to the importance of these elements for effective intervention. That is, the elements that professionals wish to enhance within their intervention are often the same elements they regard as important for intervention, presumably because they have already found those elements to be helpful. It is also possible that professionals who expressed a desire to adjust their intervention currently work with an intervention that includes some, but not all of the elements shown in the network about important elements. It was often unclear in professionals' reports whether an adjustment was suggested because the intervention does not currently include that element, or because they want to increase attention given to an existing element in their intervention.

As noted in the preceding paragraph, a main theme that emerged in both networks is 'structural conditions' [*structurele voorwaarden*]. In the network about adjustments, it is the most prominent main theme inasmuch as it is the main theme with the most sub-themes (i.e., 6 of the 14 sub-themes in the whole network), and the sub-themes were based on the responses of many professionals. This was not the case in the network about most important elements, whereby the main theme 'structural conditions' comprises just 3 of the 30 sub-themes in that network. This could be interpreted to mean that professionals still seek considerable support from those who have an influence on the structural conditions, in order to provide a more effective intervention.

Another main theme that emerged in both networks is 'personnel' [*personeel*]. When asked about adjustments to the intervention, professionals indicated the desire for colleagues with

specific expertise, and for more colleagues. Having more colleagues would likely address the desired adjustments represented by the sub-themes 'time available with participants' [*beschikbare tijd met participanten*] and 'scope/reach' [*omvang*], which are incorporated in the main theme 'structural conditions' [*structurele voorwaarden*]. Numerous professionals wish to expand their intervention in terms of the number of places available and via roll-out in other settings. If more professionals were recruited, interventions could indeed be more intensive and more wide-reaching.

There are two differences in the main themes in the network about important elements and the network about adjustments. First, the network about important elements included the main theme 'relationship with participants' [*de relatie met deelnemers*], but this did not emerge in the network about adjustments. It appears that professionals are content with the manner in which they currently establish working relationships with youths and parents. It is also possible that the question about adjustments was more likely to elicit concrete adjustments (e.g., financial arrangements) than abstract adjustments (e.g., the relationship with youths and parents) because it was worded this way: 'Which two adjustments would you like to make to the intervention if you had a magic wand or a lot of money?' The wording of the question might also explain why some of the sub-themes in the network about important elements did not emerge in the network about adjustments, such as passion for this group of youths, and teamwork, because these are things money cannot buy.

The second difference is that the main theme 'development and evaluation' [*ontwikkeling en evaluatie*] only emerged in the network about adjustments. Perhaps this did not emerge as a main theme in the network about important elements because further development and evaluation are not elements in an intervention per se, but broader processes associated with providing an intervention. Indirect reference to further development of the intervention can be seen in two sub-themes in the network about important elements, namely the professionals' 'knowledge, experience, and curiosity' [*kennis, ervaring en leergierigheid*] and their 'vision' [*visie*]. It is as if the main theme 'development and evaluation' [*ontwikkeling en evaluatie*] in the network about adjustments is an extension of these sub-themes in the network about important elements. That is, professionals believe that it is not just a matter of having knowledge and vision, but it is also important to record what is known and envisaged (i.e., writing down the goals and methodology of the intervention) and to take the next step in enhancing an intervention by evaluating it. Indeed, professionals associated with various interventions voiced a desire to take this next step.

A sub-theme that appeared in the network about adjustments but not in the network about important elements is 'suitable continued support' [*passend vervolg*]. The need for continued support is also seen in professionals' responses when asked which of 10 intervention elements they would like to incorporate in their intervention or pay more attention to (Table 17). Most professionals (almost 60%) indicated that they would like to have greater access to alternative educational programs for youths, as part of the process of helping youths re-engage with education. This suggests that some youths presenting with

severe and chronic school refusal need longer-term support than can be offered through the current interventions. Longer-term support might be needed to continue the process of re-engaging youths with education, to maintain their re-engagement with education, and/or to address other issues such as social-emotional difficulties.

Another common response among professionals when asked to indicate which of 10 intervention elements they would like to incorporate in their intervention or pay more attention to was social factors (social anxiety, social skills, or social isolation). As noted above, the sub-theme 'social contact and contact with peers with similar difficulties' [*sociale contacten en lotgenoten*] emerged in the networks based on youths' and parents' reports about helpful elements in intervention. However, it did not emerge as a sub-theme when professionals were asked about the most important elements in intervention. The different data-gathering processes might explain this. That is, questions about important elements were open and could be answered by anyone, whereas all professionals completed a forced choice question in the booklet about 10 possible adaptations to their intervention. The forced choice question may have brought social factors to the attention of professionals.

A third common response to the list of 10 intervention elements was to pay more attention to family communication and problem solving. The network based on professionals' views on important elements in intervention included the sub-themes 'involve parents' [*ouders betrekken*] and 'systemic approach' [*systemische aanpak*], but there was no specific reference to family communication and problem solving. Professionals may have had family communication and problem solving in mind when they spoke about the importance of a systemic approach in intervention for school refusal, even though they did not formulate their responses in terms of family communication and problem solving. Another possibility is that professionals are less inclined to incorporate training in these specific skills when working with youths and parents. As noted in Section 1.2.2, working with the young person and parents together on communication skills and family problem solving is incorporated in four of the five CBT manuals addressing school refusal. Specific indications for working in this way are presented in Heyne and Sauter (2013).

Integrating difficulties delivering intervention, adjustments to intervention, and important elements in intervention

A number of themes are evident in multiple networks. These themes include the time required to deliver intervention for school refusal, youths' social involvement, and collaboration. We address each theme in turn.

Time required to deliver intervention

Three networks based on professionals' reports include a sub-theme that relates to spending time with youths and their parents. In the network about difficulties delivering intervention (Figure 2), it is seen in the sub-theme 'room to help' [*ruimte om hulp te bieden*]. In the network about important elements in intervention (Figure 3), it is seen in the sub-theme about being 'available' [*beschikbaar*]. In the network about adjustments to intervention (Figure 7), it is seen in the sub-theme 'time available with participants' [*beschikbare tijd met participanten*]. Evidently, there is not always enough time to provide the support that professionals deem necessary. The need for professionals to have sufficient time, physically and emotionally, is apparent in the Finning et al. (2018) study based on interviews with professionals. The authors concluded that working with youths displaying school absenteeism is intensive and emotionally challenging.

Youths' social involvement

Professionals expressed the wish to pay more attention to social factors (Table 17), and their responses to the question about adjustments to intervention yielded a sub-theme about more 'practical activities' [*praktische activiteiten*] (Figure 7). The desire to offer more practical activities may stem from the difficulty some professionals experience in 'arranging group interventions' [*groepsinterventies regelen*] (Figure 2). For some youths, engaging in a practical activity may be an easier first step, before joining in with group-based therapy. This would depend on the nature of the group therapy that is offered; some group therapy processes will be less intimidating for youths relative to other processes. The overview of therapeutic interventions (Table 11) indicates that group activities are indeed included in some of the interventions studied in this project.

Collaboration

Another theme evident in numerous networks is collaboration. The network about important elements in intervention includes the main theme 'collaboration between those involved' [*samenwerking tussen betrokkenen*] (Figure 3), the network about difficulties delivering intervention includes the main theme 'difficulties related to the collaboration with support services' [*moeilijkheden gerelateerd aan de samenwerking met hulpverlening*] (Figure 2), and the network about adjustments to intervention includes the main theme 'collaboration between organisations' [*samenwerking tussen organisaties*] (Figure 7). Many responses associated with these main themes are about education professionals seeking collaboration with professionals from support services [*hulpverlening*], or via versa. It seems that professionals desire an intensive (frequent) and full (multiple disciplinary) collaboration between education and support services, but this is not easy to achieve and there are difficulties in coordination, among other things. The topic of collaboration is discussed further in Section 4.2.4.

***For whom intervention works, viewed alongside important and helpful elements in
intervention, adjustments to intervention, and difficulties delivering intervention***

In this section we reflect upon professionals' reports about who seems to benefit most and
least from intervention (Figure 6), in the light of their reports about the most important
elements in intervention (Figure 3), difficulties delivering intervention (Figure 2), and
adjustments they would like to make to their intervention (Figure 7). We also draw upon
youths' and parents' reports about helpful elements in intervention (Figures 4 and 5,
respectively). By considering 'what works' in the light of for whom it works, we stand to gain
a more nuanced understanding of intervention for school refusal. Three points are to be
kept in mind when reading the discussion below. First, professionals' reports about who
benefits most and least refer to factors that can complicate the delivery of intervention, such
as family problems. The factors are not necessarily the cause of school refusal; they may be
correlates or even consequences of school refusal. Second, while professionals' reports
about who benefits most and least may help inform the development of a roadmap for
school refusal interventions, they predominantly shed light on the extra needs of specific
youths and families rather than signalling the needs of most or all youths and families.
Related to this, some of the sub-themes presented below are based on the responses of
professionals associated with just a small number of interventions. Nonetheless,
consideration needs to be given to how these extra needs can best be met. Third, we
combined professionals' reports about who benefited most and least within main themes
and sub-themes with non-valanced labels. For example, the sub-theme 'duration of
problems' [*duur van de problemen*] comprises reports indicating that youths who had
difficulties for a long time tended to respond less well to intervention, along with reports
indicating that youths who had difficulties for a short time tended to respond well to
intervention.

The first main theme in Figure 6 is 'presenting problems for the young person' [*huidige
problemen voor de jongere*]. Sub-themes suggest intervention is more effective when: school
refusal is predominantly associated with anxiety, has had limited impact on academic
progress, and is not complicated by depression, inactivity, social anxiety, and physical
symptoms; other problems are not present, such as aggression, sleeping problems, and
excessive gaming; the severity of presenting problems is not high; and the duration of
presenting problems is not long.

The sub-themes in 'presenting problems for the young person' [*huidige problemen voor de
jongere*] yield various implications for 'what works' in intervention for school refusal. First,
interventions which address youth anxiety, re-activate youths, and provide academic
support are more likely to be effective. These are intervention elements which were
nominated by professionals, parents, and/or youths as being important or helpful (e.g., the
sub-themes 'working on anxiety' [*werken aan angst*], 'creating movement' [*beweging
creëren*], and 'flexibility and support in learning' [*flexibiliteit en ondersteuning bij het leren*]).
Second, interventions need to account for co-occurring problems such as aggression,

sleeping problems, and excessive gaming. Third, because the severity and duration of presenting problems impacts effectiveness, an effective strategy for addressing school refusal is one which pays due attention to prevention and early intervention. Indeed, the sub-theme 'attention to prevention and timely intervention' [*aandacht preventie en tijdige interventie*] emerged from professionals' reports about important elements in intervention (Figure 3) and adjustments to improve intervention (Figure 7). When severe and chronic school refusal already exist (i.e., prevention and early intervention were not employed or were not effective), intervention may need to be more intensive or longer. This connects with professionals' reports about the important elements in intervention (the sub-theme 'patience and persistence' [*geduld en volharding*]) and adjustments to improve intervention (the sub-theme 'time available with participants' [*beschikbare tijd met participanten*]). It also connects with difficulties delivering effective intervention, namely the sub-theme 'room to help' [*ruimte om hulp te bieden*], which focuses on an incapacity to offer intensive support when needed.

The second main theme in Figure 6 is 'context' [*context*]. It includes sub-themes which suggest that intervention is more effective when: circumstances for the parents do not include mental health problems and addictions; and circumstances for the family do not include poverty and divorce. Working with parents and families is important, according to professionals' reports about important elements (the sub-themes 'involve parents' [*ouders betrekken*] and 'systemic approach' [*systemische aanpak*]) and parents' reports about helpful elements (the sub-themes 'specific interventions for parents' [*specifiek aanbod voor ouders*] and 'decrease in parental concerns' [*afname zorgen ouders*]). Professionals also referred to work with parents and families when discussing adjustments to improve intervention (the sub-theme 'support for youths, parents, and/or families' [*ondersteuning voor jongeren, ouders en/of families*]). The question becomes, what kind of support is needed in order for intervention to be as effective as possible? According to Devenney and O'Toole (2021), professionals need to take time to understand the social context related to school refusal to best understand the kind of support that parents and families need, per case. The 'context' [*context*] main theme in Figure 6 suggests that some parents will need extra support in addressing their own mental health problems and relationship distress. Families affected by poverty need practical support, often provided through social services.

The third main theme in Figure 6 is 'characteristics of youths, parents, and family' [*eigenschappen jongeren, ouders, gezin*]. Its sub-themes suggest that intervention is more effective when: attitudes towards problems and school attendance include acceptance that there is a problem and recognition that staying home rather than going to school is not OK; there is willingness and active engagement in the intervention whereby youths and parents are motivated, committed, and open to change; there are realistic parent expectations about what their child can achieve or what the intervention can achieve; the young person has future perspective for themselves, with respect to interest in further education or training; there are capacities for benefitting from intervention, such as self-refection and positive self-regard; parenting allows room for the youth's individuation, and there is a united approach between the parents; and family functioning is characterised by harmony

and the absence of systemic influences on school refusal. Many of these characteristics are likely to be addressed by the intervention elements regarded as important and helpful. For example, in the network based on professionals' views on the important elements in intervention, sub-themes include 'psychoeducation' [*psycho-educatie*], 'involve parents' [*ouders betrekken*], 'creating perspective' [*perspectief creëren*], and 'systemic approach' [*systemische aanpak*]. In the network based on youths' reports about helpful elements, sub-themes refer to the characteristics of professionals that may help increase their willingness and engagement, namely 'kind and caring' [*aardig, zorgzaam*], 'understanding and trust' [*begrip en vertrouwen*], and 'connected' [*aansluiten*]. Parents' reports of helpful elements similarly referred to characteristics of professionals that may help increase parents' willingness and engagement, along with 'clarifying problems and gaining insight into them' [*verheldering en inzicht*], 'creating perspective and offering hope' [*perspectief creëren en hoop bieden*], and 'specific interventions for parents' [*specifiek aanbod voor ouders*].

Thus, interventions that include elements regarded as important and helpful are likely to account for many of the characteristics of youths, parents, and families which could otherwise interfere with effective intervention. In some cases, however, youths' or parents' unhelpful attitudes towards problems and school attendance, and their lack of active engagement, may call upon professionals to focus even more on building a working relationship and promoting commitment to change. Efforts to build motivation among youths displaying school attendance problems are seen in Walter et al.'s (2010, 2014) use of self-management therapy, and Reissner et al.'s (2019) use of motivational interviewing. Targeted psychoeducation will be important to address parents' unrealistic or underdeveloped expectations about what their child can achieve or what intervention can achieve. Youths' and parents' capacities for benefitting from intervention may warrant extra attention, such as the capacity for self-refection. This might involve scaffolding cognitive therapy interventions with youths. Sauter and colleagues describe the process of priming cognitive capacities in youths prior to engagement in cognitive-behavioural interventions (Sauter et al., 2009) and the assessment of readiness for participation in cognitive therapy (Sauter et al., 2010). Extra attention is paid to family-based intervention when there is family disharmony. Section 1.2.3 includes examples of work with the family (e.g., Bryce & Baird, 1986; Richardson, 2016). Behavioural and cognitive-behavioural interventions attend to family influences by working with youths and parents on family communication and problem solving (Heyne & Rollings, 2002; Heyne et al., 2008; Kearney & Albano, 2007; Tolin et al., 2009). This may help address conflict, detachment, disengagement, rigidity, or insufficient independence for family members (Heyne & Sauter, 2013).

The fourth main theme in Figure 6 is 'collaboration between organisations' [*samenwerking tussen organisaties*]. It suggests that intervention is more effective when there is collaboration with external services, and when the collaboration is characterised by a cooperative attitude and clear communication. The importance of collaboration is reflected in the three other networks based on professionals' views, namely the network about most important elements in intervention (main theme 'collaboration between those involved' [*samenwerking tussen betrokkenen*]), the network about difficulties delivering intervention

(main theme 'difficulties related to the collaboration with support services' [*moeilijkheden gerelateerd aan de samenwerking met hulpverlening*]), and the network about adjustments to intervention ('collaboration between organisations' [*samenwerking tussen organisaties*]). Collaboration is thus an important aspect of intervention for school refusal, especially when school refusal is severe and chronic. As noted by Kearney (2016), "close association between school officials and … other professionals is often necessary at Tier 3" (p. 108). When other professionals are invited to collaborate in intervention, they are ideally well-versed in intervention for attendance problems and willing to consult regularly (Kearney, 2016). In the current project, the vast majority of youths and parents (four-fifths) rated the collaboration between everyone involved in the intervention positively, and many youths and parents (two-thirds) indicated that collaboration was accountable for the positive change observed in youths. It thus seems that the difficulties professionals experience with respect to collaboration are not noticed by youths and parents.

The fifth main theme in Figure 6 is 'varying responsiveness' [*wisselende responsiviteit*]. It indicates that for some professionals it is difficult to specify who benefits most and least from intervention. This might be because very few of the interventions included in the Knowing What Works project are systematically evaluated. We consider this point from the perspectives of research and practice.

From a research perspective, there is a need to better understand the factors that moderate the outcome of intervention for school refusal. Recall from Section 1.3 the suggestion that information about which youths and families are under- or overrepresented in interventions in this project helps us better understand for whom interventions are most and least effective. Evidently most interventions serve secondary school youths (Section 4.2.2). This helps explain why professionals reported that youths with co-occurring problems such as depression are less likely to benefit from intervention, given that depression is more common among adolescents displaying school refusal relative to children (Baker & Wills, 1978; Kearney, 1993). The fact that most interventions were educational interventions helps explain why professionals reported that a lack of collaboration with mental health services contributes to poorer outcome. Suggestions for research on factors that moderate the outcome of intervention for school refusal are found in Section 4.4.3.

From a practical perspective, professionals need sufficient time, resources, and collegial support to systematically monitor and record progress, and to reflect upon this data so as to be well informed about the youths and families for whom intervention is – or is not – yielding positive outcomes. A questionnaire similar to the one used with youths and parents in the current project may be a helpful tool for monitoring progress. When information about responsiveness is readily available, teams addressing school refusal can better identify and address the strengths and soft spots in their intervention. The emphasis on approaching each young person and family individually, via flexibility, does not nullify the value of discerning themes in youths' and families' responsiveness to intervention

4.2.4 Reflections on Collaboration Between Organisations

The Knowing What Works project explored the nature and perceived importance and helpfulness of collaboration in intervention for school refusal. Collaboration is a broad term that can be understood in many ways, but in Chapter 1 (Section 1.2.3) the literature focuses on collaboration between professionals from different disciplines and thus from different sectors, such as education and mental health. Data gathered during the current project predominantly focuses on this collaboration between professionals from education and support services [*hulpverlening*], including mental health. In this section we reflect upon and integrate key findings derived from the interviews conducted with professionals and the questionnaires completed by youths and parents.

Professionals' views on collaboration

Collaboration emerged as a main theme in all four networks based on professionals' reports (Figures 2, 3, 6, and 7). The associated sub-themes are summarised in Section 4.1.4. Clearly, collaboration is in the minds of professionals providing intervention for school refusal. It is spoken about as an important element in intervention, and as a factor which influences the outcome of intervention. Professionals spoke about the difficulty they have with respect to collaborating with support services, and about their desire to improve collaboration such as having a permanent support services partner.

Many interventions in the current project are educational interventions. This may help explain why collaboration emerged as a main theme in multiple networks. That is, professionals in educational settings may commonly rely on collaboration to adequately address the needs of youths in their care, especially collaboration with support services [*hulpverlening*]. Indeed, school refusal among youths referred for intervention is often associated with mental health problems like anxiety and depression (Heyne et al., 2015), so support services will often be needed.

The network about difficulties delivering intervention reveals 'the grey area between education and support services' [*het grijze gebied tussen onderwijs en hulpverlening*]. For example, professionals in educational settings address issues broader than youths' educational needs, such as improving their social-emotional well-being. Other forms of support offered in educational interventions include (social) activation, dealing with school-related fears, and parent counselling. Professionals in educational interventions are disinclined to refer to this work as therapy because of professional demarcations between education and support services. A related issue emerged in Devenney and O'Toole's (2021) study of the views and experiences of education professionals addressing school refusal, whereby "some participants grappled with what the role and duty of schools should be, asking are we 'care providers' or 'education providers'?" (p. 38). During the interviews in the

current project, it became clear that some professionals in educational interventions seek an answer to the question of whether they can offer, or should be offering therapeutic elements even though they do not work in support services [*hulpverlening*]. On the one hand it is customary in education to support youths' social-emotional well-being, especially in special education, and there are team members such as behaviour specialists [*gedragswetenschappers*] who can fulfil this role (see Appendix B1). On the other hand, these are educational settings and not specialised support services.

Within a permanent collaborative relationship between education and support services, the grey area may become less confusing. There can be regular discussions about who will do what and when, yielding clearer demarcations between the respective roles of partners working in education and partners working in support services. When professionals from different sectors do not know each other so well due to the lack of a permanent collaborative relationship, the grey area is likely to be more complex. This necessitates discussion about what professionals from different sectors can expect from each other in terms of their respective roles and how they can best support each other. This is particularly important when professionals in special educational settings provide an intervention for school refusal, because they are likely to offer more specialised help than support services professionals are accustomed to when working with professionals from mainstream education.

The question arises: how often do professionals delivering school refusal interventions have a permanent relationship with external professionals? Just over one-third of interventions studied in the current project have a permanent arrangement for collaboration between education and support services. Some professionals expressed the desire to intensify this collaboration while others expressed the desire to have a permanent arrangement. When there is permanent and intensive collaboration, collaboration becomes part of the intervention instead of it being something that is done alongside the intervention. Examples of permanent and intensive collaboration between education professionals and support services professionals can be found in the literature in Section 1.2.3, including one funded by a mental health service (Reissner et al., 2019), one which relies on education-based funding (Brouwer-Borghuis, Heyne, Sauter, et al., 2019), and one which is housed in a special education facility located at a mental health service and provided in kind by the mental health service (McKay-Brown et al., 2019). In these interventions, mental health professionals and education professionals work side-by-side within the same team.

Youths' and parents' views on collaboration

Youths and parents were asked about their experience of collaboration between all professionals involved in the intervention, via closed questions. The questions were about the quality of the collaboration and whether the collaboration was responsible for improvements for the young person.

Around four-fifths of youths and parents reported that all people involved in the intervention worked well together. This pertains to collaboration between professionals from education and support services [*hulpverlening*], as well as other professionals such as the school attendance officer [*leerplichtambtenaar*] and the doctor from youth health care [*jeugdgezondheidszorg*]. Furthermore, around two-thirds of youths and parents reported that things had improved for the young person as a result of the collaboration. A post-hoc test revealed a significant positive association between youths' responses to the question about how well professionals collaborated, and their responses to the question about whether the collaboration had a positive impact on outcomes (see Appendix T). The same was found for parents' reports (see Appendix U). In other words, among those who agreed with the statement that there was good collaboration between professionals, the majority indicated that the collaboration contributed to positive outcomes for the young person. There was a small group of youths (21%) and parents (15%) who agreed with the statement that there was good collaboration but disagreed with the statement that the collaboration contributed to positive outcomes. This suggests that good collaboration may not be a necessary condition for positive outcome. Another interpretation is that the collaboration that did occur was not prominent enough in the minds of youths and parents for them to attribute the positive outcomes to it.

Following the closed questions about collaboration, youths and parents were asked an open question about the most important elements in intervention. Parent reports yielded the sub-theme 'communication' [*communicatie*] between parents and professionals delivering the intervention. These responses are mainly about the frequency or speed with which professionals updated the parents about how things were going, or how easily the professionals could be contacted. Thus, the sub-theme does not refer to collaboration in the broader sense of professionals from various sectors working together.

In sum, youths' and parents' responses indicate that, at a minimum, collaboration occurs and is often helpful. Further analysis of the data will permit greater understanding of the exact nature of collaboration (i.e., which professionals are often involved).

Integrating professionals', youths', and parents' views on collaboration

Various networks based on professionals' reports include a sub-theme associated with collaboration, that being 'communication' [*communicatie*]. This sub-theme is also seen in the network based on parents' reports of important elements in intervention. Collectively, the sub-themes refer to communication between parents and professionals delivering intervention, between all those involved in intervention, and specifically between education and support services [*hulpverlening*]. The presence of the sub-theme 'communication' in various networks across multiple stakeholders points to the importance of collaboration in the roadmap for school refusal interventions. The report by INGRADO (2018) draws specific attention to the need for improved collaboration between education and support services.

It is self-evident that communication is an essential ingredient of collaboration; it is necessary to know who is doing what, when, why, and how. This is especially true in the area of school refusal which requires detailed planning and coordination to be able to implement (gradual) steps for increasing engagement with education. For example, daily communication between the teacher and parents is part of Kearney and Albano's (2007, 2018b) treatment protocol, and open communication with parents and other professionals is an important aspect of Preece and Howley's (2018) school refusal intervention for youths with an autism spectrum disorder. According to INGRADO (2018), intervention for school attendance problems in the Netherlands is complicated when professionals from education and support services "speak a different language" (p. 5).

While communication is an important component of collaboration, collaboration is broader than communication alone. Recall from Section 1.2.3 that multidisciplinary interventions are those in which professionals from different disciplines work alongside each other (an additive approach to intervention); interdisciplinary interventions are those in which professionals from different disciplines work interactively, by analysing, synthesising, and harmonising the links between their respective disciplines into a coherent whole (an interactive approach to planning and delivering intervention); and multiple disciplinary practice is an umbrella term used to refer to interventions which are multidisciplinary or interdisciplinary (Choi & Pak, 2006). Results of the Knowing What Works project suggest that school refusal interventions in the Netherlands tend towards being multiple disciplinary, reflected in the sub-theme 'collective effort' [*gezamenlijke inspanning*] which emerged from professionals' responses about important elements in intervention, and in the desire expressed by numerous education professionals to have a permanent collaboration with support services [*hulpverlening*]. When professionals spoke about 'team composition and teamwork' [*samenstelling team and teamwork*] in relation to important elements in intervention, and when they spoke about 'personnel' [*personeel*] in relation to adjustments they would like to make to their intervention, they may also have had multiple disciplinary practice in mind. With respect to funding, it might seem like only one-half of the school refusal interventions in the Netherlands are multiple disciplinary in nature, inasmuch as one-half of the interventions are financed via just one source (i.e., only mental health funding, only special education funding, or only mainstream education funding). However, there was often diversity in the disciplines of professionals participating in each interview, and thus among the team of professionals delivering each intervention.

As an aside, we observed that when interventions are characterised by intense collaboration across disciplines, the name given to the intervention regularly refers to both the educational partner and the support services partner. In these cases, the intervention probably looks and feels to parents like one intervention delivered by one team, even though the intervention involves contributions from education and support services. This might explain why collaboration between organisations did not emerge as a separate sub-theme in the responses of parents, even though it did in the networks based on professionals' responses.

Whereas professionals see scope for improvements in collaboration (as seen in the networks about 'difficulties delivering intervention' and 'adjustments to intervention'), youths and parents were generally positive about their experience of collaboration between all those involved. This difference likely emerges from the different vantage points of these stakeholders. Professionals who were interviewed have been delivering intervention for school refusal for around 4 years, on average. They are thus likely to see more opportunities for the enhancement of collaboration than are parents, who presumably have experienced intervention just once.

4.3 Strengths and Limitations of the Knowing What Works Project

4.3.1 Strengths

Broad representation of provinces and professionals

Twenty-one organisations across 9 of the 12 Dutch provinces participated in the Knowing What Works project. In this way, there is rather broad geographical representation of school refusal interventions. Based on an average interview length of 2.5 hours, more than 50 hours of conversation were conducted with 76 professionals across the 21 interventions. This number of hours, with this number of professionals, increases confidence in the representativeness of the views gained from professionals. Furthermore, the settings in which these professionals deliver interventions included special education, mainstream education, and mental health, even though most were special education settings.

This is only the third sample of professionals interviewed about intervention for school refusal. The current sample is considerably larger than the sample of 14 professionals in Kljakovic and Kelly's (2019) study, and Nuttall and Woods' (2013) study was conducted with professionals associated with just two youths displaying school refusal. The geographic representativeness of the samples in these two studies was limited: Kljakovic and Kelly (2019) selected professionals from a single region in the UK (i.e., a single local authority in the UK) and Nuttall and Woods (2013) reported on intervention with just two youths. Moreover, the current sample of 76 professionals is at least three times larger than recent studies with professionals interviewed about school absenteeism more generally (i.e., Finning et al., 2018; Sugrue et al., 2016; Tobias, 2019).

Attention to youths' and parents' views

The Knowing What Works project makes a substantial contribution to the literature on youths' and parents' views on intervention for school refusal. We are aware of just two studies that explicitly addressed these stakeholders' views on intervention for school refusal (i.e., Nuttall & Woods, 2013; Sibeoni et al., 2018). These studies relied on small samples: 2 youths and their parents in the Nuttall and Woods (2013) study, and 20 youths and 21 parents in Sibeoni et al.'s study (2018). Two other studies that included youths were not explicitly about intervention for school refusal: Baker and Bishop (2015) interviewed 4

youths displaying extended non-attendance but only some characteristics of school refusal were evident in the sample, and O'Brien and Dadswell (2019) interviewed 13 youths who self-excluded from school but the study was not focused on interventions to remediate school attendance problems.

In the current project, 52 youths across 14 of the 21 interventions completed an online questionnaire with open and closed questions, along with 96 parents. Importantly, the responses of youths and parents were used alongside the responses of professionals to inform the development of the roadmap for school refusal interventions. In this way, the current project responds to O'Brien and Dadswell's (2020) call to not simply conduct research with youths with attendance problems to support adults' assumptions or agendas, but to deliberately act on the voices of these youths. In addition, our inclusion of youths, parents, and professionals is a response to the call from the International Network for School Attendance (INSA) to enhance models for reducing absenteeism by including the voices of all stakeholders (Heyne, Gentle-Genitty et al., 2020).

The Knowing What Works project also enriches the Dutch literature on youths' and parents' views on school attendance problems and intervention for these problems. Research conducted in the Netherlands has included interviews with youths about what helped them get back on track (Van der Ree, 2019) and interviews with parents about reducing absenteeism (Lubberman et al., 2019), but not about school refusal per se. Another study focused on a sub-group of youths displaying absenteeism, namely those with behavioural problems (Van Binsbergen et al., 2019), but the interviews principally addressed factors associated with absenteeism and school drop-out, and not the working elements in intervention to address absenteeism. Similarly, Maarsingh et al. (2020) administered a questionnaire to a sub-group of youths with absenteeism, namely those with authorised absenteeism, but the focus was on factors associated with this type of absenteeism. Knowing What Works provides a new focus on the experiences and views of Dutch youths and parents who participated in intervention for school refusal.

The intention to focus on school refusal was achieved

The focus on one type of school attendance problem – school refusal – was motivated by the practical and scientific interests of the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*]. Organisations providing a school refusal intervention were included in the project if more than 80% of youths participating in the intervention displayed school refusal. During screening, a contact person from the organisation was asked to estimate the percentage of youths fulfilling the school refusal criteria presented during the screening interview (see Appendix E). Contact persons' responses during screening were checked via their responses to the First Impressions Questionnaire which was administered a little later. All 21 interventions fulfilled the project inclusion criterion that at least 80% of youths in the intervention fulfilled criteria for school refusal. Twenty of the interventions

intentionally addressed school refusal and one addressed somatic symptoms, but in this latter intervention at least 80% of youths displayed school refusal. Across the 21 interventions, the average estimate of the percentage of youths fulfilling the school refusal criteria was 97%. In short, based on information from the contact persons, it seems the interventions included in the Knowing What Works project were provided almost exclusively for youths displaying school refusal.

Data gathered from youths and parents increases our confidence in the estimates provided by contact persons. Seventy-eight percent of youths and 90% of parents reported that it was difficult for the young person to attend school prior to intervention due to anxiety or stress. Based on these reports alone, which align with the definition of school refusal (Heyne et al., 2019), it seems the vast majority of youths presented with school refusal. In addition, some youths and parents reported that the young person had difficulty going to school due to mood problems (59% of youths and 60% of parents) or somatic complaints (35% of youths and 46% of parents), also characteristic of school refusal. Collectively, the reports of youths and/or parents indicate that 100% of youths had difficulty attending school to anxiety and/or stress and/or mood problems and/or somatic complaints.

Taken together, the reports of the contact persons, youths, and parents indicate that the interventions studied in this project were focused on youths displaying school refusal. This suggests that the results related to 'what works' in interventions for school refusal can be generalised to the work of other professionals focusing on school refusal.

The method for identifying themes in the qualitative data was robust

Qualitative data gathered from professionals, youths, and parents was thematically analysed following Braun and Clarke's (2006) widely used six-step method. This involved a bottom-up inductive approach whereby themes emerged from the data rather than being identified on the basis of theory or the researchers' preconceptions. Furthermore, in vivo coding was conducted whereby labels were assigned to short passages of text using a word or phrase from that passage. This contrasts with open coding whereby portions of text are summarised using a label created by the researcher.

By using in vivo coding, the researchers remained as close as possible to what had been said. This is a time-consuming process but it helped build a detailed model of the data. Researchers independently coded the first three interviews and meetings were held after the coding of each interview to refine the coding system. As coding continued, meetings were held at regular intervals to discuss emerging networks and refine coding as needed.

The method for analysing the qualitative data means that the networks are likely to be a faithful reflection of what professionals, youths, and parents said about intervention for school refusal. We recognise that the knowledge and professional experience that the two

researchers brought to the analysis of the qualitative data could have influenced the identification and reporting of themes. At the same time, the roadmap for school refusal interventions, based largely but not solely upon the networks arising from analysis of the qualitative data, was developed by four authors, two of whom were not associated with the qualitative data analysis.

Readers are reminded that although the themes emerging from professionals' reports represent key issues for school refusal intervention, the emergence of a theme does not mean that an issue represented by a theme was discussed by professionals from each of the 21 interventions. For example, a few sub-themes are based on two or three different codes, which may represent points made by professionals associated with four or five interventions. At the same time, there were sub-themes which were based on codes emerging from the responses of professionals from across a large number of interventions. In Chapter 3 we have indicated how representative the main themes and sub-themes are (e.g., "professionals from about two-thirds of the interventions mentioned that collaboration is important").

4.3.2 Limitations

Some types of organisations and some youths are under-represented

Seventeen organisations expressed interest in participating in the Knowing What Works project but did not take part in a screening interview. Reasons given included lack of time, temporary discontinuation of the intervention, and not having started the intervention. It is possible that the organisational matters experienced by these organisations with respect to developing and delivering intervention, differ from the organisational matters ('the arrangements' [*de regelingen*]) that arose from the interviews with professionals associated with the 21 interventions included in the project. Thus, there may be organisational matters that were not identified in the current project.

Relatively few of the interventions included in the project are interventions delivered in mental health settings or jointly with mental health services. Of the 21 interventions studied, 9 involve mental health services. The low number of interventions offered by, or in conjunction with mental health services, relative to the number of interventions offered in educational settings, may accurately represent the broader situation in the Netherlands. That is, there may be relatively few mental health services in the Netherlands that provide an intervention focused on school refusal, perhaps because these services address school refusal via teams focused on anxiety disorders or depressive disorders, but not specifically school refusal. On the other hand, there may have been a bias during recruitment. For example, professionals from educational settings may have been more inclined to respond

to recruitment materials because they are more directly and frequently confronted with the problem of school refusal. The use of the term 'school refusal' [*schoolweigering*] may have made the project more appealing to those in educational settings relative to mental health settings, because of its immediate relevance for those in school settings. It is also possible that recruitment materials were distributed more widely within educational settings than within mental health settings, more often catching the attention of education professionals in a position to decide to participate. In any case, the preponderance of interventions provided by education organisations is likely to have accentuated 'what works' in education organisations relative to mental health settings.

A difference between school refusal in childhood vis-à-vis adolescence it that emerging or mild school refusal may be more common among children, and referral for severe and chronic school refusal is more common among adolescents (Section 1.2.1). Most interventions included in the project focus on youth in secondary school and several explanations were offered in Section 4.2.2, such as higher referral for school refusal occurring in adolescence. This means that relatively few of the 76 professionals interviewed have experience in developing and delivering interventions for school refusal occurring in childhood. Thus, the results of the current project may have more direct relevance for interventions focused on school refusal in adolescence, although the results probably have some relevance for interventions addressing school refusal in childhood as well.

A group which is under-represented in the interventions studied in this project is youths with an immigrant background. Across the interventions, this group represented 7% of all youths participating in the interventions, considerably lower than the 25% of the Dutch population with an immigrant background (CBS, n.d.). It is thus unsurprising that cultural issues relevant to intervention for school refusal did not emerge as a theme in the responses of professionals. International data indicate that minority groups have higher levels of absenteeism (e.g., Hancock et al., 2013) and truancy (Maynard et al., 2017). Dutch data similarly reveal higher levels of truancy among immigrant relative to non-immigrant youths (Stevens et al., 2018), and a higher rate of school dropout among ethnic minority youths compared with native Dutch youths (Cabus & De Witte, 2015). Currently there is no data on the relative risk for school refusal among minority groups. Further work is required to determine whether the signposts in the roadmap presented in Section 4.4.1 work equally well for youths with and without an immigrant background.

Shortcomings in the data gathering with professionals

The First Impressions Questionnaire [*Eerste Blik Vragenlijst*] was used to gather descriptive information about the organisations delivering an intervention for school refusal (see Appendix L). All 21 organisations returned the questionnaire but in some cases data was missing for specific items. For example, only 16 of the 21 organisations completed the question about how long the youths participating in their intervention had been away from

school prior to intervention. In addition, numerous items in the questionnaire asked for estimates. For example, Question 19 asked the contact person to estimate the percentage of youths who had a diagnosed anxiety disorder. This form of questioning was deemed suitable in view of the aim of the Knowing What Works Project: to learn about 'what works' according to professionals, youths, and parents, and not to study the prevalence of school refusal or characteristics associated with school refusal. Thus, the findings in the current project that are based on the First Impressions Questionnaire should not be regarded as scientifically robust data on the prevalence of school refusal or its associated characteristics. Rather, findings from the questionnaire provide context for interpreting the key findings related to 'what works' in interventions for school refusal.

A booklet was used to obtain written responses to several questions during the focus group interviews with professionals (see Appendix N). One of the questions asked professionals to write about two adjustments they would like to make to their intervention and the reasons for the nominated adjustments. One advantage of asking professionals to write this down is that the ideas of every professional could be gathered. If the question was asked verbally, fewer professionals may have engaged in discussion about this topic. A shortcoming of asking for written responses is that the interviewers did not have an opportunity to ask follow-up questions to seek clarification. Sometimes it was unclear whether a professional's written response referred to an adjustment they would like to make or to the reason for making an adjustment. Written responses that were clearly about 'what could be adjusted' were coded for analysis while the responses about 'why' were not coded, and in many cases no reason was given for a specific adjustment. For example, if a professional wrote about "having more team members so the intervention can be tailored more to the needs of the young person", then the part about "having more team members" was coded as the desired adjustment while the part about "so the intervention can be tailored more to the needs of the young person" was not coded as a desired adjustment because it was understood to be the reason for the adjustment. When it was not clear if the written response was about an adjustment, or the reason for an adjustment, the material was coded as if it were about an adjustment. For example, "Having more time, dividing treatment into different phases" was coded to reflect the desire to have more time. Thus, results related to desired adjustments to interventions should be viewed as global impressions rather than a detailed analysis of why adjustments need to occur.

Shortcomings in the data gathering with youths and parents

It is unclear to what extent the responses gathered from youths and parents are representative of the larger number of youths and parents who participate in the 21 interventions. Two issues related to this are selection bias and sample size.

Regarding selection bias, 17 of the 21 organisations (81%) agreed to distribute the questionnaires to youths and parents who participated in their intervention. The four

organisations not distributing questionnaires may have been hindered by time constraints or may have been reluctant for data about the intervention's effectiveness to be made available to the researchers. Recall, it was not possible for the researchers to be directly involved in distributing the questionnaires to youths and parents out of respect for their anonymity. It is also important to note that clear instructions were provided to organisations about how families were to be selected by them, to reduce a potential bias towards distributing questionnaires to families thought to have responded best to intervention. However, there was no check on the organisations' selection of families. Of the 17 organisations that did distribute the questionnaires, responses were received from youths associated with 14 of these organisations (82%), and from parents associated with 15 of these organisations (88%). Thus, while not all organisations were represented in the reports of youths and parents, youth and parent data was available for a fairly high proportion of organisations that distributed questionnaires. Another source of potential bias is self-selection bias, whereby families more satisfied with the outcome may have been more inclined to respond to the organisation's request to complete the questionnaires. On the other hand, it is the authors' experience that a high proportion of parents who are unsatisfied with services provided will also respond to requests to share their experiences.

Regarding sample size, the current sample of youths and parents is large, relative to other studies of youths' and parents' views on intervention for school refusal or school attendance problems (Section 4.3.1). At the same time, data was only available for a small proportion of youths and parents participating in the interventions offered by the 15 organisations from which youth and parent data was gathered. The small sample size per intervention means it was not possible to analyse youth and parent data for each intervention separately. Moreover, this was not the aim of the current project.

Due to the issues of potential selection bias and sample size, it is unknown whether the views of youths and parents in each intervention are representative of the larger group of youths and parents who participated in that intervention. For example, is what we learned about youths' and parents' satisfaction with intervention representative of all participants in that intervention. Moreover, is it representative of youths and parents who participate in all 21 interventions studied in this project? What can be seen in the data is that there was variability in youths' responses and parents' responses (e.g., some youths indicated that they definitely would not recommend the intervention to others), so if there was a self-selection bias stemming from satisfaction with the outcomes of intervention, it was not a ubiquitous bias.

The qualitative data gathered via written responses in youth and parent questionnaires was sometimes ambiguous. Because the data was not gathered via interview, it was not possible for researchers to ask follow-up questions or to use the context of an interview transcript to clarify what the young person or parent meant.

4.4   Implications

The reports of youths and parents participating in the Knowing What Works project suggest that current interventions for school refusal are having a positive effect. A majority of youths and parents attributed positive changes to the intervention, including reduced anxiety and stress, reduced mood problems, reduced somatic complaints, reduced difficulty attending school, increased school attendance, increased fun at school, improved relationships with teachers and peers, improved problem solving, increased sense of the value of education, increased confidence in the future, and greater life satisfaction.

While these retrospective reports of youths and parents do not constitute robust scientific support for the effectiveness of the interventions, they do suggest that elements in the current interventions are working. At the same time, the reports of professionals suggest that there are youths and families who respond less well to their intervention. This is supported by the fact that some youths and parents did not indicate that there were positive changes attributable to the intervention. For some youths and parents, and in some interventions, there is likely room for improvement.

Bearing in mind the strengths and limitations of the Knowing What Works project (Section 4.3), we present a roadmap for developing and delivering intervention for school refusal (Section 4.4.1). Some signposts in the roadmap are more relevant for those who work with youths and families, while other signposts are more relevant for those in a management role. We present implications for practice, including implications for school personnel and practitioners (4.4.2), as well as implications for research (4.4.3). Key points are highlighted in the conclusion (4.4.4).

4.4.1 A Roadmap for Developing and Delivering School Refusal Interventions

A key outcome of the Knowing What Works project is the roadmap for school refusal interventions. It comprises 14 signposts that represent essential conditions for effective intervention for school refusal. The intended audience for the roadmap is those who develop and deliver school refusal interventions. This includes professionals who work with youths and families [*uitvoerders*] and management teams responsible for ensuring that it is possible to develop and deliver an intervention [*bestuurders*]. Other stakeholders who may be interested in the roadmap include policymakers, parents, and youths.

The roadmap was prepared by authors DH, MBB, JV, and CvH, the four authors with experience in developing and delivering services for youths and families. Their experience spans the fields of education, mental health, management, and policymaking. The roadmap was developed on the basis of the key findings in this report, existing knowledge about school refusal and intervention (Chapter 1), and the list of recommendations about preparation of the roadmap derived during a panel meeting with stakeholders. The plan for the panel meeting is found in Appendix V and the emerging recommendations are found in Appendix W. The panel meeting was facilitated by authors MBB and DH in November 2019 and attended by eight members of the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*], shown in Appendix X.

The process used to develop the roadmap was as follows. The four authors reviewed this report and the recommendations made by the panel, then independently nominated 10 signposts to be included in the roadmap for developing and delivering intervention for severe and chronic school refusal. Next, a consensus meeting was held to derive a uniform set of signposts to be included in the roadmap. There was substantial overlap across the 10 signposts nominated by each author. Specifically, of the 15 signposts identified across the four authors, 11 had been nominated by at least two authors. During a second consensus meeting, the team discussed the relevance of: (a) the 11 signposts identified by at least two authors; and (b) the 4 signposts identified by a single author. One signpost ('attention to prevention and early intervention') was excluded from the roadmap because the roadmap intentionally focuses on signposts for Tier 3 school refusal. The final roadmap, which comprises 14 signposts, is presented in Table 18.

The signposts are numbered from 1 to 14. To some extent this ordering reflects a common process for delivering intervention for school refusal. For example, professionals customarily begin by determining who will be served by the intervention (Signpost 1), understanding the difficulties experienced by youths and families and the context for these difficulties (Signpost 2), and investing in the quality of contact with youths and parents (Signpost 3). Later in the process, professionals help youths, parents, and school personnel create movement towards the young person's re-engagement with education (Signpost 10). In short, signposts 1 to 10 are directly relevant for professionals delivering intervention. Signposts 11 and 12 require the attention of professionals delivering intervention as well as the attention of management teams. When developing an intervention, management teams pay attention to establishing a committed team with knowledge and experience (Signpost 13) and securing necessary resources (Signpost 14).

Because information provided by professionals was used in constructing the roadmap, many of its elements – the signposts – will be familiar to professionals. For those familiar with the work associated with each signpost, the roadmap provides a checklist for reviewing an existing intervention. In this case, the ordering of the signposts is less relevant. Rather, attention is given to those signposts deemed to warrant most attention.

The roadmap focuses on severe and chronic school refusal. Thus, it applies to Tier 3 of the multi-tiered system of supports model to promote school attendance and address school absenteeism. The reader is reminded of the importance of interventions to promote attendance and prevent school refusal (Tier 1 interventions) and to respond efficiently when school refusal is emerging, mild, or moderate (Tier 2 interventions). Indeed, many professionals interviewed during the project spoke about the importance of prevention and early intervention. The need for Tier 1 and Tier 2 interventions is discussed in Section 4.4.2.

It should be noted that the roadmap is not intended as a prescription for how to deliver intervention on a case-by-case basis, nor as a prescription for which strategies or techniques should be used in relation to each signpost. Rather, as an extension of the Knowing What Works project, forums can be held to support those who develop and deliver interventions for school refusal. For example, the signpost 'Promote the willingness and involvement of youths and parents' could be the theme for a meeting of the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*] or a webinar facilitated by the International Network for School Attendance. Forums such as these provide opportunities to consider the details associated with specific signposts, via presentations, in-depth discussion, and training. Other ways in which the roadmap can be used are presented in Section 4.4.2 (see 'Tips from the field').

Following, we present each signpost, including: the justification for the signpost based on the results in this report and supporting literature; the essence of the signpost; connections with other signposts; and additional points and literature to consider when working with the signpost.

Table 18
Signposts in the Roadmap for School Refusal Interventions

1	Provide an integrated approach, including youth, parents, and school
2	Pursue insight into the integrative picture
3	Invest in your availability and the quality of your contact with youths and parents
4	Promote the willingness and involvement of youths and parents
5	Create a safe environment
6	Lower the hurdles in the beginning
7	Provide rhythm and structure
8	Broaden educational options and adjust educational tasks
9	Facilitate social contact with peers
10	Create movement
11	Work together as education and support services
12	Specify your method
13	Gather a committed team with knowledge and experience
14	Provide sufficient resources to implement the intervention
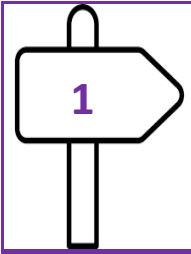
Signpost 1: Provide an integrated approach, including youth, parents, and school

1

Justification

Results from this project

Professionals' reports about the important elements in intervention yielded a main theme about the 'relationship with participants' [*de relatie met deelnemers*] (Figure 3). Numerous sub-themes refer to the ways in which professionals provide support, such as being 'available' [*beschikbaar*], being 'accepting' [*acceptatie*], and being 'connected' [*aansluiten*]. The main theme about 'the content' of intervention [*de inhoud*] includes sub-themes about working with youths (e.g., creating 'success experiences' [*succeservaringen*]), a sub-theme that specifically refers to the need to 'involve parents' [*ouders betrekken*], and a sub-theme implying family-related work, namely 'systemic approach' [*systemische aanpak*]. Professionals' reports about preferred adjustments to intervention yielded sub-themes about providing extra support to youths via 'practical activities' [*praktische activiteiten*] and providing (more) 'support for youths, parents, and/or families' [*ondersteuning voor jongeren, ouders, en/of families*] (Figure 7). Professionals also endorsed the following items from a list of possible adjustments: more attention to social factors for the young person, and more attention to family communication and problem solving.

Information from professionals via the First Impressions Questionnaire indicates that all organisations always work with the young person, and almost all interventions always provide support to parents. All 21 interventions involve working with youths on graded exposure to school attendance, necessitating the provision of support to youths, and most interventions work on family communication and problem solving, necessitating the additional involvement of parents.

Indirect support for Signpost 1 is found in professionals' reports about which youths and families benefit most and least from intervention (Figure 6). The effectiveness of intervention can be compromised by contextual factors such as 'circumstances for the parents' [*omstandigheden voor ouders*], as well as the characteristics of youths and parents, such as their 'attitude towards problems and school attendance' [*houding ten opzichte van problemen en van de schoolgang*]. These sub-themes suggest the need to provide even more support for some parents and youths.

The need to provide support for youths is evident in the youths' reports of the most helpful elements in intervention (Figure 4). Sub-themes related to the content of intervention refer to 'working on anxiety' [*werken aan angst*], helping youths with gradually 'building up school attendance' [*opbouwen schoolgang*], helping them with 'social contact and contact with peers with similar difficulties' [*sociale contacten en lotgenoten*], and providing 'flexibility and support in learning' [*flexibiliteit en ondersteuning bij het leren*]. Sub-themes related to changes that occurred as a result of the intervention also point to the value of working with youths, such as intervention to support an 'increase in self-confidence and perseverance' [*toename zelfvertrouwen / doorzettingsvermogen*].

The parents' reports about the most helpful elements in intervention were similar (Figure 5). Sub-themes related to the content of intervention refer to the delivery of 'specific interventions for youths' [*specifiek aanbod voor jongeren*], increasing youths' 'social contact and contact with peers with similar difficulties' [*sociale contacten en lotgenoten*], and providing them with 'flexibility and support in learning' [*flexibiliteit en ondersteuning bij het leren*]. Like youths, parents also wrote about an 'increase in the young person's self-confidence' [*toename zelfvertrouwen jongere*], reinforcing the value of working with youths. Youths' and parents' responses to other items in the questionnaire also point to the value of providing support to youths, inasmuch as many youths reported positive changes as a result of the intervention (e.g., reduced anxiety and stress, reduced mood problems, improved problem solving, increased school attendance) and many parents reported that they observed the same changes in their child.

The need to provide support to parents is evident in the parents' reports about the most helpful elements in intervention (Figure 5). They indicated that 'specific interventions for parents' [*specifiek aanbod voor ouders*] are helpful, and that the intervention led to a 'decrease in parental concerns' [*afname zorgen ouders*]. Parents' responses to other items in the questionnaire indicate that the intervention helped them become more confident in their ability to respond to their child's difficulties going to school, and better able to support their child, and that there were fewer difficulties at home between them and their child.

The need for intervention at the school level is seen in youths' and parents' reports that a helpful element of intervention is the provision of 'flexibility and support in learning' [*flexibiliteit en ondersteuning bij het leren*]; professionals' reports that an 'adapted educational environment' [*aangepaste onderwijsomgeving*] is an important element of intervention; professionals' preferred adjustments to intervention, which include adjustments to 'didactics' [*didactiek*]; and professionals' reports in the First Impressions Questionnaire that all interventions involve work with school personnel, and most arrange education via special education, a meta school facility [*bovenschoolse voorziening*], the school of origin [*school van herkomst*], or home education.

Supporting literature

The literature included in this report underscores the importance of Signpost 1. Section 1.1.2 indicates that youth, parent, family, and school factors are associated with absenteeism. In the words of Sugrue et al. (2016), "results demonstrate that chronic absenteeism is related to a multilevel ecology of factors and suggest that an equally complex ecologically based intervention model is needed" (p. 137).

Section 1.2.1 describes the negative impact school refusal has on youths and parents, and the challenge it presents for education professionals, pointing to the importance of providing support for all three stakeholder groups during intervention.

Section 1.2.2 highlights the support provided to youths, parents, and school personnel in five CBT treatment protocols for school refusal, and in numerous case examples of comprehensive intervention (e.g., Anderson et al., 1998; Chhabra & Puar, 2016; Conoley, 1987; Gosschalk, 2004; Heyne et al., 2014).

Section 1.2.3 indicates that practitioners who work with youths to address the mental health issues associated with school refusal often emphasise family influences and school influences in their interventions. Preece and Howley (2018) observed that parents felt supported because their needs were responded to (e.g., group training in anxiety management; referral for other external support such as befriending schemes). The authors attributed the positive outcomes of their intervention to open communication with parents, and to school-related interventions such as an adapted learning environment (e.g., small class size, individual work) and individual goals for curriculum.

Section 1.2.4 summarises stakeholders' reports about interventions for absenteeism and for school refusal. These reports point to the benefit of involving youths and parents (e.g., focus on parenting skills; build strong relationships and remain hopeful, to instil hope in youths and families) and the benefit of consulting to school personnel (e.g., school personnel were flexible in arranging meetings with parents). The professionals in Tobias' (2019) study suggested that the greatest success occurs when emphasis is placed on building parent confidence and capacity, and when change can be made in the family home.

Essence

Signpost 1 points to the need for intervention to be comprehensive. Time is spent with the young person and with parents, and there is attention to school-related matters. As well as it being comprehensive, intervention is integrated in the sense that there is coherence between the work conducted with the young person, the parents, and school personnel. Time would be spent with the young person and parents individually, but also together, especially to address family communication and problem solving. Attention is also given to

the extra support needed to address parent-related problems and broader contextual issues for the family (e.g., poverty), whether it be support be provided by the organisation delivering the school refusal intervention or a collaborating service.

School personnel are closely supported in their role in intervention, whether they be personnel from the original school [*school van herkomst*], a new school identified for the young person, or an alternative educational program that serves as the intervention for school refusal. If professionals delivering intervention for school refusal work in clinical settings, consultation is provided to school personnel. Professionals working within an educational intervention for school refusal deliver school-related interventions themselves.

To address the relationship between school personnel on the one hand, and the young person and parents on the other hand, the intervention would also specify the frequency and nature of time spent together with the young person, parents, and school personnel.

Links with other signposts

Signpost 1 relies upon the work associated with Signpost 13 (Gather a committed team with knowledge and experience). A team of professionals who are experienced in, and enthusiastic about supporting youths, parents, and school personnel are most suited to the work of Signpost 1. Signpost 1 also relies upon the work associated with Signpost 11 (Work together as education and support services). The needs of youths and parents, including education and mental health needs, are most efficiently and effectively addressed via collaboration between education professionals and mental health professionals.

Signpost 1 lays the groundwork for implementing many other signposts. The work associated with Signpost 2 (Pursue insight into the integrative picture) is advanced by learning from the young person, parents, and school personnel about the challenges they face, and their needs. It is self-evident that Signpost 3 (Invest in your availability and the quality of your contact with youths and parents) relies upon meeting with youths and parents. It is also important to invest in the quality of contact with school personnel, which is facilitated by including relevant personnel in the intervention from the beginning. Signpost 4 (Promote the willingness and involvement of youths and parents) is only achieved by having direct and regular contact with youths and parents. Signpost 5 (Create a safe environment) may apply to the establishment of a safe environment in the school setting, which relies upon consultation with committed school personnel, as does Signpost 8 (Broaden educational options and adjust educational tasks). The work associated with Signpost 9 (Facilitate social contact with peers) benefits from contact with youths to help them build confidence and competence for social situations. Parents and school personnel can also be helped to create opportunities for the young person to re-engage socially. Signpost 10 (Create movement) is best addressed when youths, parents, and school personnel are helped to develop and collaboratively implement plans for increasing school attendance.

Additional information

Consideration can be given to the use of a dual practitioner model, whereby different practitioners work with the young person and with the parents, but they liaise closely with each other (Heyne & Rollings, 2002). The model serves important therapeutic functions as described in Heyne and Sauter (2013). For example, the young person may perceive a greater alliance between themselves and their own practitioner, instead of seeing the practitioner as someone simply aligned with the parents. This may enhance the young person's openness and collaboration. The family also benefits from the knowledge, expertise, and ideas of two practitioners, and the practitioners can consult with and support each other.

Some youths are reluctant to participate in intervention and may even refuse to attend initial meetings with professionals. Flexibility may be required to engage these youths (e.g., initial home visits to form a connection; supporting parents in the process of helping their child attend an appointment; using motivational interviewing). Parents may also be ambivalent about investing time to address school refusal, especially if they are burdened with other personal or family issues, or have lost hope in their ability to effect change. It may require time to build a supportive relationship and foster hope for change, perhaps with the help of motivational interviewing. Further discussion about engagement of youths and parents is presented in Signpost 4.

Occasionally it will take time to gain the commitment of busy school personnel. It is likely to be helpful to visit school personnel in their workplace, and to encourage them to share their views on the factors associated with the young person's difficulty attending school.

Further reading

The following articles provide an account of comprehensive intervention for school refusal, conducted with the young person, parents, and school personnel.

Anderson, J., King, N., Tonge, B., Rollings, S., Young, D., & Heyne, D. (1998). Cognitive-behavioural intervention for an adolescent school refuser: A comprehensive approach. *Behaviour Change*, *15*, 67-73.

Heyne, D., Sauter, F. M., Ollendick, T. H., Van Widenfelt, B. M., & Westenberg, P. M. (2014). Developmentally sensitive cognitive behavioral therapy for adolescent school refusal: Rationale and case illustration. *Clinical Child and Family Psychology Review*, *17*, 191-215.

<u>The following article provides the practitioner with recommendations that can be made to parents, youths, and school-based personnel when intervention has not yet begun.</u>

Hendron, M., & Kearney, C. A. (2011). Bridging the gap between assessment and treatment of youths with school refusal behavior: What to do when clients ask "What now?" *Journal of Clinical Psychology Practice*, *2*, 14-21.

<u>The following book is a practical, user-friendly resource for practitioners in clinical and school settings.</u>

Kearney, C. A. (2019). *Helping families of youth with school attendance problems: A practical guide for mental health and school-based professionals.* New York: Oxford University Press.

<u>The following book is a parent guide to solving common school attendance problems.</u>

Kearney, C. A. (2021). *Getting your child back to school: A parent's guide to solving school attendance problems, revised and updated edition*. New York: Oxford University Press.

<u>The following Dutch-language article outlines how parents are encouraged to play a role in addressing school refusal.</u>

Scharree, C. (2007). Schoolweigering? Ouders aan de slag [School refusal? Parents get to work]. *Kind en Adolescent Praktijk*, *6*, 8-13.
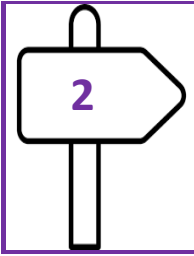
Signpost 2: Pursue insight into the integrative picture

Justification

Results from this project

Professionals' reports about important elements in intervention (Figure 3) yielded sub-themes that signal the importance of Signpost 2. These include a sub-theme about 'clarifying problems' [*verheldering problematiek*] and a sub-theme about being 'connected' [*aansluiten*], the latter referring to professionals' ability and willingness to account for the wishes and needs of youths and parents. The sub-theme 'communication' [*communicatie*] refers to clear and regular communication between all those involved, which benefits the process of learning about the needs of youths, parents, and others involved in intervention. Professionals value 'room for customisation' [*ruimte voor maatwerk*], which implies differential intervention based on differential needs, underscoring the importance of understanding the unique needs in each case. The network about who benefits most and least from intervention (Figure 6) includes main themes about 'presenting problems for the young person' [*huidige problemen voor de jongere*], the 'context' [*context*], and 'characteristics of youths, parents, and family' [*eigenschappen jongeren, ouders, gezin*]. When professionals take time to understand presenting problems, contextual factors (e.g., mental health problems for parents), and participant characteristics (e.g., attitudes towards school attendance), they are better placed to account for these during intervention.

Information from professionals gathered via the First Impressions Questionnaire highlights the complex and long-term nature of school refusal: anxiety disorder was common; one-half of youths had an autism spectrum disorder; around one-half had been bullied; other difficulties included depressive disorder, chronic unexplained physical symptoms, and learning disorders; and most youths had been absent from school for between 3 months and 1 year prior to the intervention. The complexity and longevity of school refusal signal the need for professionals to develop a good understanding of issues contributing to, co-occurring with, and/or arising from school refusal.

Other data from the First Impressions Questionnaire indicates that professionals from 4 of the 21 interventions use questionnaires as part of their screening for school refusal, and that professionals from some of the other interventions are working on a screening process. Information obtained during screening can be used to develop the integrative picture.

The importance of gaining insight into the integrative picture is seen in parents' reports that a helpful element of intervention is 'clarifying problems and gaining insight into them' [*verheldering en inzicht*] (Figure 5). Indirect support for Signpost 2 is seen in youths' and parents' reports that it was helpful for them when professionals demonstrated 'understanding and trust' [*begrip en vertrouwen*] and were 'connected' [*aansluiten*]. This indicates that professionals were attentive and engaged during the process of understanding the youths' and parents' experiences and needs. To illustrate, a youth's response linked to the sub-theme 'connected' was: "they really work with you to look at what is best."

Supporting literature

The literature included in this report underscores the importance of Signpost 2. Section 1.2.1 describes the possible role of youths' mental health problems in school refusal, the impact of school refusal on youths, the emotional and practical impact of school refusal on parents, conflict that can occur between parents, and conflict between parents and their child, among other things. These numerous influences on school refusal, and outcomes of school refusal, contribute to the integrative picture. For example, the integrative picture may refer to the embarrassment, blame, anxiety, and sense of being misunderstood that parents can experience when a child has a school attendance problem.

Section 1.2.3 describes school refusal programs that include educational interventions and mental health interventions. In the In2School intervention for example, professionals share knowledge with each other in order to develop individualised mental health 'care and recovery plans' and educational 'individual learning plans' (McKay-Brown et al., 2019). When professionals from mental health and education share their respective knowledge about the young person's and family's needs, a more integrated picture is achieved.

Section 1.2.4 includes the voices of stakeholders. A study incorporating the voices of youths, parents, and professionals suggests that successful intervention for school refusal is associated with early identification and assessment of need, and with a holistic understanding of youths' needs (Nuttall & Woods, 2013). According to professionals, it is difficult to understand the causes of school attendance problems (Finning et al., 2018), including school refusal (Kljakovic & Kelly, 2019), making it more difficult to address these problems. According to coaches, education professionals ought not be restrained by a focus on educational targets, and would ideally be aware of circumstances in the home (Tobias, 2019). Youths reported that life at school would have been easier if teachers had been aware that bullying was occurring, based on observed changes in the youths' behaviour and mood (O'Brien & Dadswell, 2019). According to Devenney and O'Toole (2021), paying attention to the social context "plays an important role in understanding young people and their difficulties relating to school refusal," underscoring the need to understand school refusal "less in terms of a medical condition (as suggested by a biomedical model), and more in terms of young people's life experiences" (p. 41). The mismatch between a youth's ability and the academic demands of school was suggested to pose a risk for school refusal (Ingul et

al., 2019), and problems on the home-front were suggested to play a role in increasing the likelihood of absenteeism (e.g., financial problems and broken homes). In short, time is needed to understand which of many possible factors may be contributing to school refusal, and the impact of school refusal on all concerned.

Essence

Signpost 2 signals the need to take the time, prior to intervention, to understand which of the factors associated with absenteeism generally, and school refusal more specifically, contribute to difficulties for the young person and family, as well as difficulties that may be encountered by school personnel. This necessitates discussion with youths, parents, and school personnel, and more broadly with others who know the young person and the family situation (e.g., current and prior helping professionals). Understanding the young person and their social context prior to intervention supports the tailoring of intervention to the needs of the young person, family, and school. For example, how does a young person's autism influence the manner in which intervention is conducted with the young person, what are the parents' concerns and expectations regarding their autistic child's education, and which educational environment is most suited to the needs of the young person? The integrative picture is embellished during the course of intervention, as the situation changes and as more information becomes available.

Links with other signposts

Signpost 2 relies upon the work associated with Signpost 1 (Provide an integrated approach, including youth, parents, and school) because it is only via close contact with youths, parents, and school personnel that professionals are able to develop a fuller understanding of the causes and consequences of school refusal from all three perspectives. It also relies upon the work associated with Signpost 3 (Invest in your availability and the quality of your contact with youths and parents) and Signpost 4 (Promote the willingness and involvement of youths and parents) because, as the working relationship strengthens and youths and parents become more engaged, they are likely to feel more comfortable and motivated to share their experiences and views, which benefits the integrative picture. Signpost 13 (Gather a committed team with knowledge and experience) ensures that those responsible for pursuing insight into the integrative picture are adept in doing so, and Signpost 11 (Work together as education and support services) increases access to the insight of professionals from education and support services, which informs the integrative picture.

Signpost 2 lays the groundwork for implementing other Signposts. Specifically, having insight into the integrative picture informs the kinds of adjustments that need to be made to the school program during work associated with Signpost 8 (Broaden educational options and

adjust educational tasks). Similarly, work associated with Signpost 9 (Facilitate social contact with peers) is informed by a good understanding of the young person's strengths and difficulties with respect to social contact, as well as an understanding of family and school contexts that may be helping or hindering the young person's social contact. Work associated with Signpost 5 (Create a safe environment) and Signpost 6 (Lower the hurdles in the beginning) is also informed by a thorough understanding of the young person's needs.

Additional information

In clinical settings intervention is usually preceded by assessment. The authors of this report intentionally avoided the term 'assessment', choosing instead for 'pursuing insight into the integrative picture' so that Signpost 2 is equally relevant for professionals in education and mental health settings.

Keeping in mind the next signpost (Signpost 3: Invest in your availability and the quality of contact with youths and parents), it is often advisable to build connection with youths and parents via conversation, before implementing questionnaires that help inform the integrative picture. However, flexibility is required. For example, a less responsive or highly anxious young person may be offered the chance to firstly complete some questionnaires. Some parents may put pressure on professionals to 'solve the problem' before the necessary time has been taken to understand the factors contributing to school refusal. In this situation, professionals may find it helpful to consult Hendron and Kearney (2011).

Professionals interviewed in the current project sometimes visit the family at home because it helps them gain insight in a youth's home situation. The Multimodal Treatment for school attendance problems includes scope to conduct home visits, to increase therapeutic engagement among unmotivated youths and families (Reissner et al., 2019). Web-based coaching has similarly been used to enable practitioners to observe and support youths and parents in the home setting (Chu et al., 2015).

Further reading

Chapter 2 of the following Dutch-language book outlines the development of school refusal.

Nienhuis, B. (2012). *Schoolangst en schoolweigering bij kinderen* [School anxiety and school refusal in children]. Lannoo Campus.

The following Dutch-language article describes school refusal, how it differs from other school attendance problems, and the role of family factors and organisations.

Van Geffen, M., & Engelen, H. (2004). Systeembenadering bij schoolweigering [Systemic approach to school refusal]. *Systeem Therapie*, *16*, 197-214.

The following article reviews the range of factors and processes associated with school attendance and absenteeism.

Melvin, G. A., Heyne, D., Gray, K. M., Hastings, R. P., Totsika, V., Tonge, B. J., & Freeman, M. M. (2019). The Kids and Teens at School (KiTeS) Framework: An inclusive bioecological systems approach to understanding school absenteeism and school attendance problems. *Frontiers in Education*, *4*:61.

Chapter 7 of the following book describes contextual variables associated with school attendance problems.

Kearney, C. A. (2008). *Helping school refusing children and their parents: A guide for school-based professionals*. Oxford University Press.

The following article reviews the psychometric properties of instruments developed to understand school attendance problems.

Gonzálvez, C., Kearney, C. A., Vicent, M., & Sanmartín, R. (2021). Assessing school attendance problems: A critical systematic review of questionnaires. *International Journal of Educational Research*, *105*, 101702.

Part 1 of the following book focuses on assessment for school refusal.

Heyne, D., and Rollings, S. (2002). *School refusal*. Oxford: BPS Blackwell.

The resources menu on the website below includes access to questionnaires used to understand school attendance problems.

International Network for School Attendance (INSA) website: www.insa.network

The following book includes chapters on assessment procedures.

Kearney, C. A. (2016). *Managing school absenteeism at multiple tiers: An evidence-based and practical guide for professionals*. New York: Oxford University Press.
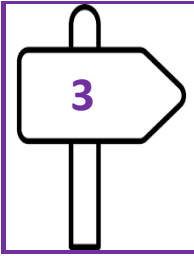
3 | Signpost 3: Invest in your availability and the quality of contact with youths and parents

Justification

Results from this project

Professionals' reports about important elements in intervention (Figure 3) support the need for professionals to invest in the quality of their contact with those participating in intervention. The main theme about 'personnel' [*personeel*] includes sub-themes that refer to a 'heartfelt commitment to this population' [*hart voor doelgroep*] and 'patience and persistence' [*geduld en* volharding]. The main theme about the 'relationship with participants' [*de relatie met deelnemers*] comprises seven characteristics, including but not limited to professionals being 'accepting' [*acceptatie*], 'connected' [*aansluiten*], and having a 'positive approach' [*positieve benadering*]. Professionals' reports about adjustments they would like to make to their intervention (Figure 7) yielded the sub-theme 'group size' [*groepsgrootte*]. According to professionals, having smaller groups of youths (e.g., maximum of 10 per group) is preferable, perhaps because it would increase their availability and the quality of contact they have with each participant. Indeed, professionals' reports about adaptations to their intervention yielded the sub-themes 'time available with participants' [*beschikbare tijd met participanten*] and 'support for youths, parents, and/or families' [*ondersteuning voor jongeren, ouders en/of families*]. Professionals' reports about difficulties delivering intervention for school refusal (Figure 2) yielded a sub-theme about participants' 'willingness and involvement' [*bereidwilligheid en betrokkenheid*], referring to participants' unhelpful attitude towards the therapy process and inadequate involvement in the process. Similar sub-themes emerged when professionals were asked for whom their intervention has most and least effect (Figure 6), namely 'attitude towards problems and school attendance' [*houding ten opzichte van problemen en van de schoolgang*] and 'willingness and active engagement in the intervention' [*bereidwilligheid en betrokkenheid bij de interventie*]. This suggests, indirectly, that professionals' investment in the quality of their contact with youths and parents is important because it enables professionals to foster helpful attitudes towards therapy and the participants' investment in therapy.

Information gathered via the First Impressions Questionnaire indicates that around one-fifth of interventions offer home education as a prelude to youths attending an educational setting. It was suggested by a few professionals that the provision of educational support at home helps re-connect youths with educators and educational materials. Other

professionals suggested that visiting youths in the home setting may be essential to engaging some youths who have been isolated for a long time.

Youths' and parents' responses to the Process [*Verloop*] scale of the Exit Questionnaire [*Exit-vragenlijst*] were positive, with average scores of 3.5 and 3.6 (on a scale of 1 to 4), respectively. This suggests that they felt included by professionals in decision-making, and taken seriously, which surely enhanced the quality of professionals' contact with youths and parents. When youths were asked about helpful elements in intervention (Figure 4), an emerging main theme was 'the professionals' themselves [*de professionals*]. All three sub-themes refer to characteristics that enhance the quality of the contact, namely 'kind and caring' [*aardig, zorgzaam*], 'understanding and trust' [*begrip en vertrouwen*], and 'connected' [*aansluiten*]. Similarly, when parents were asked about helpful elements in intervention (Figure 5), the main theme about professionals included sub-themes referring to professionals being 'involved and available' [*betrokken en beschikbaar*], being 'understanding' [*begrip*], being 'connected' [*aansluiten*], having a 'positive approach' [*positieve benadering*], and 'trust' [*vertrouwen*]. In addition, nearly all parents indicated that they were informed by professionals about how their child was doing during intervention, an important aspect of quality contact.

Supporting literature

The literature included in this report underscores the importance of Signpost 3. Section 1.2.1 presents the negative effects of absenteeism, and of school refusal more specifically, including parents' sense of being blamed by school staff and other helping professionals, feeling misunderstood and isolated, being anxious about how they respond to absenteeism, feeling frustrated and helpless, and feeling like they have been cast adrift. There may also be increased stress and conflict in the family. Family members are thus in great need of supportive professionals. Support also needs to be provided to school personnel, in view of the negative impact absenteeism can have upon them.

Section 1.2.3 includes accounts of professionals' investment in the quality of contact with youths and parents. For example, Multimodal Treatment includes scope for professionals to conduct home visits to increase therapeutic engagement among unmotivated youths and families (Reissner et al., 2019). The team of professionals working in the In2School intervention also conduct outreach to youths, parents, and teachers at the young person's school (McKay-Brown et al., 2019). Elliott and Place (2019) suggested that the willingness of school personnel to be maximally supportive of the young person displaying school refusal may be influenced by the perspectives of school personnel. Thus, quality contact between the professional and school personnel will be important for learning about and broadening the perspectives of school personnel, as well as gaining their collaboration in developing and implementing an intervention plan.

In Section 1.2.4, stakeholders' voices highlight the importance of professionals' investment in quality contact with youths, parents, and school personnel. Professionals spoke about strained relationships between school personnel and youths and parents, and between school personnel and support services (Devenney & O'Toole, 2021). Some parents are at risk of sabotaging professionals' efforts to bring about changes in the family, sometimes because they themselves are in an unsafe place (Tobias, 2019), pointing to the importance of a primary focus on quality contact. Other professionals spoke about the provision of nurturance and emotional support; using a relationship-based intervention that addresses the youth's need to be seen and supported, in part by listening to and caring about them; and coming alongside parents to help them feel safe and secure, providing constant reassurance, and being sensitive towards their needs and readiness to make changes (Finning et al., 2018). Relationship-based support was a main category of support offered by some professionals, alongside resource-based support and information-based support (Sugrue et al., 2016). According to some professionals, one of three things important for change to occur, is being intensive and hopeful, whereby professionals build strong relationships with youths and families (Kljakovic & Kelly, 2019).

Section 1.2.4 also includes the voices of youths and parents. Youths suggested that professionals could offer more support and understanding (Baker & Bishop, 2015), and youths, parents, and/or professionals reported that the relationship factors associated with successful intervention for school refusal include feelings of safety, security, and belonging; value; the positive, nurturing ethos of the school; positive attention; having an interest in the young person as a whole, for example with regular personalised contact; positive relationships between home and school; a key adult who is available; and communicating that the young person was not forgotten about (Nuttall & Woods, 2013). Effective therapeutic levers identified by adolescents and parents included time for adolescents to develop trust in the professional team; being able to speak, be heard, and develop trusting relationships with staff in the intervention facility; relationships with teachers in the facility; and other incidental relationships such as with an art therapist (Sibeoni et al., 2018). According to Sibeoni et al. (2018), intervention for school refusal must occur "in a place dedicated to care" and with the possibility for "multiple human encounters, some of which – expected or unexpected – will turn out to be determinant in [the youth's] development" (p. 47).

Essence

Signpost 3 signals the need for professionals to pay close attention to the relational aspects of their work. The quality of a professional's contact with youths, parents, and school personnel needs to be given at least as much attention as the nature and quality of the specific interventions employed. The contact is characterised by empathy, a non-judgemental stance, patience, understanding, and care. The people with whom professionals have contact need to feel safe, seen, and supported. Professionals' attention to the

relational aspects of their work is important at the outset, when youths and parents who are distressed and discouraged are most in need of comfort, support, and understanding. The working relationship continues to be important throughout the intervention.

Links with other signposts

Signpost 3 relies upon the work conducted in Signpost 1 (Provide an integrated approach, including youth, parents, and school). It is only when youths, parents, and school personnel have been invited to participate in intervention that the professional can work on the quality of the contact with them. Signpost 3 also benefits from the work associated with Signpost 5 (Create a safe environment). That is, when youths and parents feel safe (in the intervention setting, and when they are visited in their homes), they are more likely to respond to the professional's efforts to connect with them. Signpost 6 (Lower the hurdles in the beginning) is not essential for Signpost 3, but lowering expectations during the early phase of intervention is likely to make it easier for professionals to develop a connection with the young person and parents.

Signpost 3 supports the work conducted in Signpost 2 (Pursue insight into the integrative picture), Signpost 4 (Promote the willingness and involvement of youths and parents), and Signpost 5 (Create a safe environment). That is, a good working relationship with youths, parents, and school personnel can help them feel more comfortable and motivated to share their experiences, thoughts, and feelings; it lays a foundation for promoting their involvement in intervention; and it is essential to helping them feel safe. Signpost 3 is also important for the work associated with Signpost 10 (Create movement). Because professionals invite youths, parents, and school personnel to engage in difficult tasks associated with creating movement (e.g., to start facing feared situations), these participants in intervention need to have confidence in, and respect for the professional and their suggestions. In addition, the quality of contact established with everyone involved in intervention will benefit the collaboration inherent to Signpost 11 (Work together as education and support services).

Additional information

Tier 3 school refusal is usually severe, chronic, and complex. When youths have been away from school for some time they often regard themselves as 'not normal' because they have not been able to attend school regularly 'like all the other kids do' (Heyne & Sauter, 2013). They may have developed entrenched unhelpful habits around sleeping and gaming. Parents experience considerable stress due to the crisis-like presentation of school refusal and other challenges for the family, and because they have invested substantial time and effort to address school refusal and to get appropriate help, often in the absence of success (Heyne &

Rollings, 2002; Kearney, 2001). Some parents may grow sceptical of the helping profession. Ultimately, youths and parents may have lost hope for change. This is the context in which professionals need to be available, and to invest heavily in the quality of their working relationship with youths and parents.

Professionals will also need to focus on the quality of contact with school personnel and other professionals involved in the intervention, because they may also need moral support in their roles, and it is essential that they are willing to be engaged in delivering elements in the intervention.

Further reading

Chapter 6 of the following book is about working with parents and youths when addressing school refusal.

Thambirajah, M. S., Grandison, K. J., & De-Hayes, L. (2008). *Understanding school refusal: A handbook for professionals in education, health, and social care*. Jessica Kingsley Publishers.

A section in the following chapter is dedicated to 'considering the role of empathy' when working with youths and parents to address school refusal.

Heyne, D., & Sauter, F. M. (2013). School refusal. In C. A. Essau, and T. H. Ollendick (Eds.), *The Wiley-Blackwell handbook of the treatment of childhood and adolescent anxiety* (pp. 471-517). Chichester: John Wiley & Sons Limited.

The following book focuses on strengths-based approaches when working with children, adolescents, parents, caregivers, and supportive adults. Specific chapters address empathic connection and working with youths with many presenting concerns.

Byrd, R., & Luke, C. (2020). *Counseling children and adolescents: Cultivating empathic connection*. Routledge.
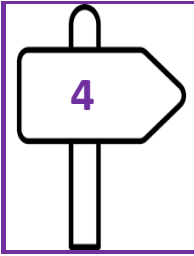
4 | Signpost 4: Promote the willingness and involvement of youths and parents

Justification

Results from this project

Professionals' reports about difficulties delivering intervention (Figure 2) yielded the main theme 'difficulties related to the characteristics of participants' [*moeilijkheden gerelateerd aan kenmerken van participanten*]. Two of the sub-themes are directly related to Signpost 4. These are 'willingness and involvement' [*bereidwilligheid en betrokkenheid*] and 'being present and keeping appointments' [*aanwezig zijn en afspraken nakomen*]. A similar main theme emerged when professionals were asked about for whom their intervention has most and least effect (Figure 6), namely 'characteristics of youths, parents, family' [*eigenschappen jongeren, ouders, gezin*]. Two of the sub-themes related to Signpost 4 are 'attitudes towards problems and school attendance' [*houding ten opzichte van de problemen en schoolgang*] and 'willingness and active engagement in the intervention' [*bereidwilligheid en betrokkenheid bij de interventie*]. These are related to Signpost 4 in the sense that acknowledging problems is a pre-requisite for being willing to address them and being involved in the process of addressing them. Professionals' reports about the important elements in intervention (Figure 3) also support the importance of Signpost 4. Multiple sub-themes emerged in the main theme 'relationship with participants' [*de relatie met deelnemers*] and the two that are most closely connected to Signpost 4 are being 'accepting' [*acceptatie*] and being 'connected' [*aansluiten*]. These sub-themes are about connecting with the experiences and needs of youths and parents, and refraining from judgement. When professionals connect with participants in this way, participants are more likely to have the sense that they are taken seriously, which could promote their willingness to participate in intervention.

The sub-theme about professionals being 'connected' [*aansluiten*] also emerged from youths' and parents' reports about helpful elements in intervention (Figures 4 and 5). For youths and parents, this sub-theme is part of the main theme 'the professionals [*de professionals*], indicating that the relationship that professionals have with participants is helpful for youths and parents. A good working relationship is likely to contribute positively to youths' and parents' willingness and involvement. For parents, another sub-theme in the main theme about 'the professionals' is 'involved and available' [*betrokken en beschikbaar*]. When participants notice that professionals are involved and available, their own willingness and involvement stand to increase. Finally, youths' and parents' responses to the Process

[*Verloop*] scale of the Exit Questionnaire [*Exit-vragenlijst*] indicate that they were satisfied with the course of the intervention, and more than 90% of youths and parents reported that they would recommend the intervention to others. Ratings of satisfaction might be interpreted as an indicator of youths' and parents' close involvement in intervention, because if they had remained resistant to intervention they are unlikely to have been satisfied with the assistance they received.

Supporting literature

The literature included in this report supports the importance of Signpost 4. The definition presented in Section 1.2.1 indicates that school refusal involves reluctance or refusal to attend school (Heyne et al., 2019). Even though many youths displaying school refusal want to be able to attend school, the emotional stress associated with school attendance holds them back. This points to the importance of promoting youths' willingness to participate in intervention, especially when they start to re-engage with school because this is often a very difficult step. Promoting willingness and involvement is particularly important when school refusal is prolonged, because anxiety about returning to school increases, and this can reduce the young person's motivation for addressing school refusal (Maeda & Heyne, 2019). Section 1.2.1 also addresses the relationship between family factors and school absenteeism. Fornander and Kearney (2019) found that family conflict was less typical among youths with higher levels of absenteeism relative to youths with lower levels of absenteeism. They explained this by suggesting that some families get so frustrated that they stop investing in efforts to solve the school attendance problem. Signpost 4 is especially important for such families.

In Section 1.2.2 and Section 1.2.3, multiple interventions for severe and/or chronic school refusal are described. Some of these explicitly address the enhancement of youths' motivation. For example, in the In2School intervention, engagement and rapport building are explicitly addressed in phase one (McKay-Brown et al., 2019). Tolin et al.'s (2009) CBT manual includes scope for conducting motivational interviewing, and all four modules in Reissner et al.'s (2019) Multimodal Treatment include motivational interviewing. This latter intervention includes scope to conduct home visits to increase engagement among unmotivated youths and families (Reissner et al., 2019), as does the Link program (Brouwer-Borghuis, Heyne, Sauter, et al., 2019). According to Gutiérrez-Maldonado et al. (2009), virtual reality is a means to enhance youths' motivation for participation in treatment for school refusal, and McShane et al. (2007) noted that taxi transport to their intervention raised youths' motivation to participate.

Section 1.2.4. addresses stakeholders' views, some of which relate to the willingness and involvement of youths and parents. For example, professionals suggested that parents' greater openness to support and change would have contributed to earlier success (Nuttall & Woods, 2013). Professionals in Tobias's (2019) study stressed the importance of addressing parents' readiness for change and their needs, and professionals in Kljakovic and

Kelly's (2019) study suggested that it is important for professionals to instil hope in youths displaying school refusal, and their families.

Essence

Signpost 4 stresses the importance of promoting youths' and parents' engagement with intervention, referring to their willingness to participate in an intervention and their active involvement throughout the intervention. Professionals' efforts to enhance youths' and parents' willingness and involvement often occur in the early phase of intervention. Such efforts are also important throughout intervention to sustain youths' and parents' willingness to participate in successively challenging steps associated with increasing school attendance.

Helping youths and parents appreciate the relevance and importance of intervention, via psychoeducation, can increase engagement in intervention. The working relationship that professionals establish with youths and parents (Signpost 3) can also promote participants' willingness and involvement in intervention. In some instances, additional interventions will be needed such as motivational interviewing.

This signpost is particularly pertinent when youths or parents display minimal willingness and involvement in intervention. At the same time, it signals the need for professionals to consider the level of engagement of each young person and parent who is offered intervention.

Links with other signposts

Signpost 4 relies upon the work associated with Signpost 3 (Invest in your availability and the quality of your contact with youths and parents). The quality of the contact between professionals on the one hand, and youths and parents on the other hand, is especially important when youths or parents have come to mistrust education or support services. Signpost 4 also benefits from the work associated with Signpost 5 (Create a safe environment) and Signpost 6 (Lower the hurdles in the beginning). Youths and parents are more likely to be willing and able to take small steps within a safe environment than they are to engage in bigger steps in a more discomforting environment. To some extent the work at Signpost 4 will benefit from the work associated with Signpost 2 (Gain insight into the integrative picture) because professionals have a better understanding of the factors that may contribute to a young person's or parent's minimal engagement in intervention. For example, if youths or parents feel compelled to participate in intervention, there is less intrinsic motivation to engage in intervention.

Signpost 4 supports the work associated with Signpost 8 (Facilitate social contact with peers) and Signpost 10 (Create movement) because re-connecting with peers and moving towards regular school attendance will prove to be difficult if youths are not engaged in intervention.

Additional information

The importance of prevention and early intervention for school refusal is reflected in various networks presented in Chapter 3. It is conceivable that youths and parents will be more willing and involved in intervention when difficulties related to school attendance are emerging, rather than entrenched, because they are likely to experience more hope and scope for change. When school refusal is already severe and chronic, professionals need to ensure there is ample attention to youths' and parents' engagement, prior to increasing school attendance, because youths and parents are likely to have made efforts to address school refusal without the desired effect, potentially affecting willingness and involvement in intervention.

Signpost 4 is predominantly focused on youths' and parents' engagement, but it may be important to also address the willingness and involvement of professionals external to the intervention. Working with youths with school attendance problems can be emotionally challenging for education professionals (Finning et al., 2018). Professionals' investment in providing support may wane if they have witnessed limited progress during intervention for school refusal. The professionals delivering intervention for school refusal need to consider ways in which external professionals such as teachers and mentors can best be supported in their roles.

Further reading

The following article includes a description of intrinsic and extrinsic motivational stimulation to reduce truancy.

Enea, V., & Dafinoiu, I. (2009). Motivational/solution-focused intervention for reducing school truancy among adolescents. *Journal of Cognitive and Behavioral Psychotherapies*, *9*, 185-198.

The following article refers to the use of self-management therapy for youths displaying school attendance problems.

Walter, D., Hauptmann, C., Rizk, S., Lehmkuhl, G., & Doepfner, M. (2014). Short- and long-term effects of inpatient cognitive-behavioural treatment of adolescents with anxious-

depressed school absenteeism: A within-subject comparison of changes. *Child and Family Behavior Therapy*, *36*, 171-190.

The following article includes a section on 'fostering a motivational therapeutic attitude' among youths displaying school attendance problems.

Reissner, V., Knollmann, M., Spie, S., Jost, D., Neumann, A., & Hebebrand, J. (2019). Modular Treatment for children and adolescents with problematic school absenteeism: Development and description of a program in Germany. *Cognitive and Behavioral Practice*, *26*, 63-74.

The following article addresses youths' readiness for participation in cognitive therapy.

Sauter, F. M., Heyne, D., Blote, A. W., Van Widenfelt, B. M., & Westenberg, P. M. (2010). Assessing therapy-relevant cognitive capacities in young people: Development and psychometric evaluation of the Self-Reflection and Insight Scale for Youth. *Behavioural and Cognitive Psychotherapy*, *38*, 303-317.

Signpost 5: Create a safe environment

5
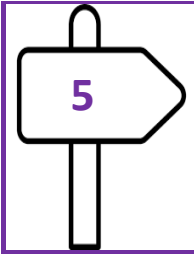
Justification

Results from this project

Professionals spoke about the provision of an adapted educational environment in response to various questions in the interview and in the First Impressions Questionnaire. First, 'adapted educational environment' [*aangepaste onderwijsomgeving*] emerged as a sub-theme in the network about important elements in intervention (Figure 3). Second, the most commonly endorsed adjustment to intervention was about having more access to alternative educational programs for youths before they return to conventional education (Table 17). Third, most interventions already involve the provision of an alternative educational setting in special education or in a meta school facility. Fourth, almost one-half of youths in interventions for school refusal move on to special (secondary) education after the intervention (Table 16), which is by definition an adapted educational environment. The adapted educational environments spoken about by professionals are more likely to provide a sense of safety for youths, relative to conventional educational settings.

The value of Signpost 5 is supported by other responses from professionals. The sub-theme 'safe environment' [*veilig klimaat*] emerged as an important element of intervention, and 'physical environment' [*fysieke omgeving*] emerged as a sub-theme about structural conditions for delivering intervention (Figure 3). Reports about adjustments to intervention include 'physical environment' [*fysieke omgeving*] and 'group size' [*groepsgrootte*], the latter referring to smaller groups (Figure 7). Sub-themes about the way professionals relate to participants also connect with the notion of safety, such as showing 'acceptance' [*acceptatie*] and having a 'positive approach' [*positieve benadering*] (Figure 3). The importance of Signpost 5 is also supported by the high rates of having been bullied among youths who participate in school refusal interventions (55% by professionals' reports).

Youths' and parents' reports about the helpful elements in intervention similarly indicate the need for a safe environment (Figures 4 and 5). The subtheme 'tranquillity and safety' [*rust en veiligheid*] emerged from the responses of both youths and parents. Youths and parents reported that it is helpful when professionals are kind and positive, reflected in the sub-themes 'kind and caring' [*aardig, zorgzaam*] and 'positive approach' [*positieve benadering*]. This mirrors the sub-theme 'positive approach' [*positieve benadering*] that emerged from professionals' reports about what is important in intervention. Parents also spoke about

'trust' [*vertrouwen*], referring to the trustworthiness of professionals and the trust that professionals place in youths. Professionals' kindness, positivity, and trustworthiness will contribute to the sense of being in a safe environment.

Supporting literature

The literature included in this report underscores the importance of Signpost 5. In Section 1.2.1 it was noted that school refusal is not a psychiatric condition, but that persistent school absenteeism can be viewed as a sign that a young person is feeling unsafe (Tobias, 2019). Parents of youths who are absent from school may feel blamed by school staff and helping professionals, and feel anxious about their response to absenteeism (Gregory & Purcell, 2014), pointing to the need for intervention to be a safe space for parents as well as youths.

Section 1.2.3 includes reports of interventions for youths displaying absenteeism or school refusal. Some of these highlight the importance of adapting the school environment. For example, McShane et al. (2007) suggested that arranging a controlled school environment contributed to positive outcomes for youths. According to Walter et al. (2014), a sub-group of youths with chronic school attendance problems will need access to an adapted educational environment over a longer period of time in order to be able to achieve a good level of school attendance. The article by Brouwer-Borghuis, Heyne, Sauter, et al. (2019) presents an example of an adapted educational program to address school refusal. The authors described the educational setting where intervention takes place according to the five domains of Zullig et al.'s (2010) school climate framework. One of the domains is 'order, safety, and discipline', stressing the importance of a safe environment within school.

The stakeholder perspectives presented in Section 1.2.4 underscore the importance of a safe environment when providing intervention for school attendance problems and school refusal. Various environments were mentioned, including the school setting, the home environment, and the clinical setting. For example, practitioners interviewed for Finning et al.'s (2018) study spoke about personalised learning in an alternative educational program, and creating a calm environment at school. Tobias (2019) interviewed family coaches and concluded that interventions need to be set up in such a way that youths feel safe, by addressing safety in the home environment as well as making changes to the educational environment. Tobias also wrote about the need for professionals to help parents feel safe and secure. According to Tobias, time is required to help youths and parents build confidence again, and to help school personnel adapt the school environment so the young person feels safe once back at school. Education professionals in Devenney and O'Toole's (2021) study on school refusal identified the need for school personnel to ensure that youths view school as a safe and calm space. Youths and parents in the studies by Nuttall and Woods (2013) and Sibeoni et al. (2018) reflected upon intervention for school refusal. They regarded safety and belonging as important elements in successful intervention. Parents in Sibeoni et al.'s study also reflected on the therapeutic space in which intervention occurred (a psychiatric facility), noting that it was more welcoming than school. In O'Brien and

Dadswell's (2019) study, youths who self-excluded from school suggested that life at school would have been easier if school personnel had promoted a feeling of security.

In Section 4.2.1, the experience of bullying is connected with absenteeism and school refusal, including among autistic youths (e.g., Bitsika, Heyne, et al., 2021; Egger et al., 2003; Van Binsbergen et al., 2019). By extension, bullied youths who display school refusal may be better able to engage in intervention, especially intervention in an educational setting, when it offers an environment that feels safe.

Essence

Signpost 5 signals the need to provide an intervention environment in which the young person and parents feel safe. Youths and parents who participate in intervention for school refusal are likely to have experienced considerable discomfort, distress, and sometimes trauma as a result of school refusal or associated experiences (e.g., bullying for youths; embarrassment and confusion for parents). Interventions in the form of alternative educational programs represent a key opportunity to provide youths with a safe environment in which to re-engage with schooling. During, after, or instead of participation in an alternative educational program, many youths will be helped to re-engage with a conventional school setting. This signals the need to consult with personnel at the conventional school about ways in which the young person can be helped to feel safe there. When intervention for school refusal is delivered in a clinical setting, attention is also given to the ways in which youths and parents are helped to feel safe. Results from this project and the supporting literature indicate that safety is promoted via attention to the physical setting (e.g., small group size increases tranquillity and safety) and via the professional's approach when meeting with youths and parents (e.g., acceptance, trustworthiness).

Links with other signposts

Signpost 5 relies upon a good understanding of the young person's needs, addressed at Signpost 2. Signpost 5 profits from the work associated with Signpost 3 (Invest in your availability and the quality of your contact with youths and parents) and Signpost 7 (Provide rhythm and structure). The quality of contact can help participants feel more secure in the working relationship, and rhythm and structure will contribute to youths' sense of safety as they engage with intervention, whether it be in a clinical or educational setting. When intervention is provided in an educational setting, Signpost 5 will rely heavily upon the work associated with Signpost 8 (Broaden educational options and adjust educational tasks) and Signpost 14 (Provide sufficient resources to implement the intervention). Adaptations to the educational program and the availability of a comfortable setting will contribute to a sense of safety, mentally and physically. Signpost 13 (Gather a committed team with knowledge

and experience) is important inasmuch as professionals who are experienced in a trauma-informed approach to working with youths and parents can enrich the sense of safety.

Signpost 5 and Signpost 6 (Lower the hurdles in the beginning) are related. By lowering the hurdles, introducing few expectations of youths and parents in the beginning, some youths and parents will feel safer in the help-giving situation. Similarly, focusing on the creation of a safe environment for youths and parents means that the hurdle is lowered with respect to them engaging with the help-giving process.

Signpost 5 supports the work associated with Signpost 4 (Promote the willingness and involvement of youths and parents). It will be easier for youths and parents to engage with intervention and become actively involved when the intervention itself feels safe. In a similar way, the work associated with Signpost 9 (Facilitate social contacts with peers) and Signpost 10 (Create movement) will be easier when youths feel at ease. For example, it will be easier for youths to interact with peers in the safe environment of a small classroom in an alternative educational program where social interaction is closely monitored and there is little risk of negative peer interaction such as bullying.

Additional information

As mentioned, the provision of a safe environment (Signpost 5) can be a condition for subsequently creating movement (Signpost 10). There is also a potential incongruity between these two signposts. The provision of a safe environment can be very helpful towards the start of intervention, but the prolonged provision of an 'overly safe' environment which is devoid of developmentally appropriate challenges can hinder the process of youths taking steps towards school attendance. In other words, youths' coping skills and self-efficacy stand to benefit from graded exposure to new experiences. The fact that almost all educational interventions in the current project make temporary use of an adapted educational setting and commonly include graded exposure to school could be understood to mean that professionals delivering these interventions are aware of the tension between providing a safe environment on the one hand, and creating movement on the other hand. The extent to which professionals focus on safety vis-à-vis movement is likely to differ between interventions, due to differences in the goals of intervention and the population served. For example, it is conceivable that more emphasis will be placed on providing safety when a large proportion of youths have an autism spectrum disorder or have been at home for an extended time prior to participation in intervention.

Bullying warrants special attention at Signpost 5. According to Place et al. (2000) and Grandison (2011), youths displaying school refusing have often been bullied and fear that this will happen again once they re-engage with school. Given this, Brouwer-Borghuis, Heyne, Sauter, et al. (2019) underscored the importance of bullying interventions at the school level (e.g., preventing and responding to bullying) as well as the individual level (e.g.,

social skills related to assertiveness) to prevent relapse when youths transition from the Link alternative educational setting to a different school setting. Consultation to school personnel at the new setting is aimed at ensuring that supports are in place to protect the young person from bullying.

Further reading

The following article describes an adapted educational environment for youths displaying school refusal.

Brouwer-Borghuis, M., Heyne, D., Sauter, F. M., & Scholte, R. H. J. (2019). The Link: An alternative educational program in the Netherlands to reengage school-refusing adolescents with schooling. *Cognitive and Behavioral Practice*, *26*, 75-91.

The following article addresses the tension between creating safety and creating movement, discussing harmful safety behaviours vis-à-vis helpful coping behaviours.

Hoffman, J. L., & Chu, B. C. (2019). When is seeking safety functional? Taking a pragmatic approach to distinguishing coping from safety. *Cognitive and Behavioral Practice*, *26*, 176-185.

The following article summarises the views of youths with autism spectrum disorder, and their parents, with recommendations for dealing with bullying in schools.

Carrington, S., Campbell, M., Saggers, B., Ashburner, J., Vicig, F., Dillon-Wallace, J., & Hwang, Y.-S. (2017). Recommendations of school students with autism spectrum disorder and their parents in regard to bullying and cyberbullying prevention and intervention. *International Journal of Inclusive Education*, *21*, 1045-1064.

The following article includes opportunities for intervention in relation to the bullying of youths with autism spectrum conditions.

Humphrey, N., & Hebron, J. (2015). Bullying of children and adolescents with autism spectrum conditions: A 'state of the field' review. *International Journal of Inclusive Education*, *19*, 845-862.
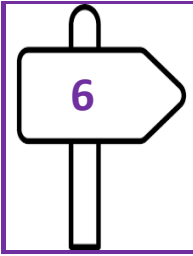
6 | Signpost 6: Lower the hurdles in the beginning

Justification

Results from this project

Professionals' reports about the important elements in intervention (Figure 3) yielded a sub-theme about helping participants ease into the intervention via an 'easy beginning' [*lage insteek*], which directly supports the importance of Signpost 6. Other reports from professionals provide indirect support for the value of lowering the hurdles in the beginning. When asked about the difficulties experienced in delivering intervention (Figure 2), professionals nominated various characteristics of participants that make it more difficult. These responses yielded sub-themes about participants showing 'willingness and involvement' [*bereidwilligheid en betrokkenheid*] and 'being present and keeping appointments' [*aanwezig zijn en afspraken nakomen*]. In other words, participants' unhelpful attitudes towards the therapy process and their limited investment in the process hampers intervention, as does the fact that some youths do not show up for appointments or do not follow through on agreed tasks. If professionals lower the hurdles at the start of intervention, this may enhance participants' engagement in intervention.

Professionals' reports in the First Impressions Questionnaire provide indirect support for Signpost 6. Most youths participating in the intervention had been absent from school for between 3 months and 1 year. On the face of it, it might seem beneficial for youths' academic development if they are helped to quickly re-engage with education. However, the length of time away from school is probably a contra-indication for moving too quickly because it may cause youths and some parents to become disengaged from the intervention process. It was also reported that anxiety disorder was common among the youths, one-half of youths had been bullied, one-half had an autism spectrum disorder, and around one-third had a depressive disorder. Again, in these cases, moving too quickly towards a return to education may be counterproductive. A small number of organisations offer home education as a prelude to youths attending an educational setting. Professionals suggested that the provision of home education helps re-connect youths with educators and educational materials. Efforts to help youths re-connect in a stepwise manner can be seen as an example of lowering the hurdles in the beginning of the intervention.

The reports of youths and parents provide support for Signpost 6. When asked about helpful elements in intervention, youths' and parents' responses independently yielded sub-themes

suggestive of lowering the hurdles in the beginning, namely minimal pressure in the early phase via an 'easy beginning' [*lage insteek*] and the need for 'tranquillity and safety' [*rust en veiligheid*] (Figures 4 and 5, respectively).

Supporting literature

The literature included in this report underscores the importance of Signpost 6. In Section 1.2.3 it was suggested that youths may only feel comfortable and confident enough to re-engage with education when school staff 'lower the hurdles' for school attendance by reducing the factors that 'push' the young person away from school and increasing the factors that draw or 'pull' them towards school. As noted in Table 1, the five CBT manuals for school refusal encourage professionals to attend to school influences, such as modifications at school to accommodate the young person academically, socially, and emotionally. Lowering the hurdles in these ways helps youths re-connect with the educational setting.

Lowering the hurdles also applies to the process of engaging youths in intervention, in advance of helping them re-connect with an educational setting. Interventions described in Section 1.2.3 allow time for relationship-building and enhancing youths' readiness for return to school. Specific examples include helping youths develop insight (Contessa & Paccione-Dyszlewski, 1981); helping them prepare for re-engagement with formal education by firstly attending to their wellbeing and building relationships in an autism-friendly setting (Preece & Howley, 2018); and providing opportunities for youths to build resilience and help-seeking skills before returning to mainstream education (McKay-Brown et al., 2019). The @school program for school refusal makes an explicit demarcation between the preparation phase of intervention, and the subsequent implementation phase which includes the process of increasing school attendance (Heyne & Sauter, 2013).

In Section 1.2.4, professionals' views on intervention point towards the importance of lowering the hurdles. The professionals interviewed by Finning et al. (2018) spoke about providing emotional support, building youths' resilience, providing mental health support, and making adaptations to the school context (e.g., reduced timetabling). Based on the reports of family coaches, Tobias (2019) suggested that interventions for absenteeism need to help youths feel safe by addressing environmental stressors (e.g., the lack of a secure base for the young person in the home environment), and interventions need to be relationship-based to address youths' need to be seen and supported. Professionals interviewed by Kljakovic and Kelly (2019) suggested that for change to occur, it needs to be gradual (e.g., creating a supportive environment in which there are opportunities for youths to gradually socialise with others in a similar position). Youths in Baker and Bishop's (2015) study had been absent from school for at least a year, and they spoke negatively about the pressure they felt to return to school quickly. They suggested that a more phased approach to school return could have helped. Youths in Sibeoni et al.'s (2018) study reflected on the time needed for intervention to be effective, including time to develop trust in the professional team, and time for youths to develop personally. According to Sibeoni and

colleagues, "treatment must last long enough … to allow these youth to become involved in their care and to reflect on the personal changes they need" (p. 47). In Nuttall and Woods' (2013) study, one of the many factors perceived to be associated with successful intervention for school refusal was allowing sufficient time for reintegration.

Essence

Signpost 6 signals the need to lower expectations for a rapid return to school. Instead, time is taken to build relationships (between the professional and the young person and parents, and between the young person and their peers), to address environmental stressors, to help youths develop personally, and to help them develop skills they can draw on to cope with attendance at school. Time is also needed to understand which factors 'push' a young person away from school and which 'pull' them towards school, and to arrange modifications in the school setting accordingly (e.g., modified curriculum for the young person; peer support at school).

Lowering the hurdles is more broadly applicable for all new experiences, not just the experience of increasing school attendance. For example, professionals consider ways in which expectations can be lowered when the young person first commences intervention, the first time they join in a group activity, and the first time they re-engage with academic tasks.

Links with other signposts

Signpost 6 benefits from the work associated with Signpost 2 (Pursue insight into the integrative picture). A full understanding of the factors associated with school refusal helps to determine which hurdles need to be lowered in the beginning. To some extent, the success of Signpost 6 also depends on Signpost 11 (Work together as education and support services). That is, reduced expectations in the early phase of intervention will only be felt when all of the professionals involved in the intervention are 'working from the same page' with respect to reduced expectations.

Signpost 6 and Signpost 5 (Create a safe environment) are related. By virtue of lowering the hurdles, with limited expectations, some youths and parents will feel safer in the help-giving situation. Similarly, focusing on the creation of a safe environment for youths and parents means that the hurdle is lowered with respect to engaging with the help-giving process. Signpost 6 and Signpost 8 (Broaden educational options and adjust educational tasks) are also related. Signpost 8 represents a lowering of the academic hurdles for the young person. However, whereas Signpost 6 applies largely to the early phase of intervention, adjustments to the school program may need to apply for the duration of intervention, and thereafter.

Signpost 6 supports the work associated with Signpost 4 (Promote the willingness and involvement of youths and parents). Lowered expectations in the early phase of work with youths and parents likely facilitates their willingness and involvement. In other words, it is easier to become engaged in a process which is not overly demanding. For a similar reason, lowering the hurdles may benefit the quality of professionals' contact with youths and parents (i.e., Signpost 3). Importantly, Signpost 6 lays the groundwork for Signpost 10 (Create movement), because lowering the hurdles is not an end in itself. Specifically, benefits associated with Signpost 6 (e.g., quality of contact; willingness and involvement; feeling safe) provide the context for the professional to work with youths and parents on creating movement.

Additional information

A key question for professionals is 'when' to start raising the hurdles again, in the interests of creating movement. The data gathered in the context of the Knowing What Works project does not yield guidelines for this. The general impression gained from interviewing professionals is that the timing of re-engagement with school is highly flexible, which probably helps explain why so many interventions involve considerable flexibility. Factors that likely contribute to a longer transition between 'lowering the hurdles' and 'creating movement' include: the length of time the young person has been away; the number and severity of associated problems for the young person (e.g., depression); the young person's engagement in intervention and motivation for increasing school attendance; and the extent to which school personnel are willing and able to make accommodations for the young person in the school setting.

Kearney et al. (2008) wrote about the urgency of school return, but this is usually applied in the context of Tier 2 school refusal (emerging, mild, or moderate cases), not Tier 3 school refusal which is the focus of this report. As noted in Section 1.2.2, the standard number of treatment sessions and the duration of treatment vary across the five CBT manuals for school refusal (e.g., an average of 8 sessions across 4 to 8 weeks in Kearney and Albano [2007, 2018b]; 10 to 14 session across approximately two months in Heyne et al. [2008]; 15 sessions across 3 weeks in Tolin et al. [2009]). This underscores the variation in how quickly a young person is likely to return to school. The relatively low number of sessions in Kearney and Albano's (2007, 2018b) manual may be because the manual is oriented more towards Tier 2 school refusal, as opposed to Tier 3 school refusal.

It is important for managers to appreciate the distinction between Tier 2 and Tier 3 school refusal, in order to adapt expectations about the speed with which professionals help youths return to school. Understanding the difference between Tier 2 and Tier 3 school refusal can help managers appreciate the importance of creating a safe environment and initially lowering the hurdles for the young person and parents.

Further reading

<u>The following chapter describes the separation between a preparation phase in intervention for school refusal, and an implementation phase.</u>

Heyne, D. A., & Sauter, F. M. (2013). School refusal. In C. A. Essau, & T. H. Ollendick (Eds.), *The Wiley-Blackwell handbook of the treatment of childhood and adolescent anxiety* (pp. 471-517). Chichester: John Wiley & Sons Limited.

<u>The following manual describes the phases of intervention for school attendance problems in terms of starting treatment, intensifying treatment, the maturing of treatment, the advanced maturing of treatment, and completing treatment and preparing for termination.</u>

Kearney, C. A., & Albano, A. M. (2018b). *When children refuse school: A cognitive-behavioral therapy approach/therapist guide* (3rd ed.). Oxford University Press.
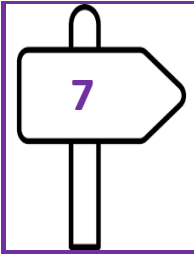
Signpost 7: Provide rhythm and structure

Justification

Results from this project

Professionals' reports about important elements in intervention yielded three sub-themes relevant to Signpost 7 (Figure 3). The sub-themes 'rhythm and structure' [*ritme en structuur*] and 'safe environment' [*veilig klimaat*] are about the content of intervention, and the sub-theme 'transparent and reliable' [*transparant en betrouwbaar*] is about the relationship between professionals and participants. The predictability that stems from an intervention's rhythm and structure is likely enhanced by the provision of a safe environment and professionals' reliability.

The extent to which an intervention is flexible vis-à-vis standardised will also have a bearing on the extent to which there is rhythm and structure. Most interventions in the current project are both flexible and standardised. Professionals' anecdotal reports indicate that numerous interventions are standardised with respect to working in steps or phases, incorporating a specific protocolised (group) training program with youths, and having regular meetings with everyone involved. Some professionals described the process for increasing school attendance as flexible, and others described it as more standardised.

Youths' reports about the most helpful elements in intervention yielded two sub-themes directly related to Signpost 7 (Figure 4). The first is 'rhythm, structure, and clarity' [*ritme, structuur, duidelijkheid*]. In the words of one young person, what was helpful was "going somewhere every day, that I no longer sat at home all day, and really had a daily rhythm." The second is 'building up school attendance' [*opbouwen schoolgang*]. Slowly building up the number of hours at school represents a structured process. A sub-theme indirectly related to Signpost 7 is 'tranquillity and safety' [*rust en veiligheid*]. Interventions with rhythm and structure likely contribute to youths' sense of tranquillity and safety.

Parents' reports about the most helpful elements in intervention yielded the same three sub-themes, namely 'rhythm, structure, and clarity' [*ritme, structuur, duidelijkheid*], 'building up school attendance' [*opbouwen schoolgang*], and 'tranquillity and safety' [*rust en veiligheid*] (Figure 5). In the words of parents, there was "slow build up in the number of subjects, gradually increasing homework, gradually increasing the number of days at school," and "going to school gave and gives structure, support."

Supporting literature

The literature included in this report underscores the importance of Signpost 7. In Section 1.1.1, school attendance was linked to the development of self-regulation skills, in part because it fosters routines and responsibilities such as getting up in the morning to arrive at school on time (Heyne, Gentle-Genitty, et al., 2020).

Section 1.2.1 describes the potential impact of absenteeism on a youth's view of themselves (Heyne & Sauter, 2013) and on the development or persistence of poor mental health (Lawrence et al., 2019; Wood et al., 2012). Accordingly, the rhythm associated with school attendance may mitigate such problems. Parents' routines are also disrupted when a child is at home instead of school, such as arriving late to work or leaving work early (Johnsen, 2020). Indirectly, rhythm and structure associated with youths' participation in an intensive intervention for school refusal can contribute to more structure in the parents' lives.

Many of the interventions described in Section 1.2.2 include graded exposure to school attendance, a structured approach to increasing school attendance. Parents are also helped to establish routines at home, such as a sleep-wake routine and a school-day routine when youths are at home prior to full-time school attendance (Heyne & Rollings, 2002; Heyne et al., 2008; Kearney & Albano, 2007; Tolin et al., 2009). These routines help prepare youths physically and mentally for the upcoming increase in school attendance (Heyne & Sauter, 2013).

School-related influences on absenteeism and attendance, described in Section 1.2.3, reflect the importance of rhythm and structure. In the case of school refusal, school-related influences include unpredictable classrooms and fear of the less structured aspects of school (Ingul et al., 2019). Conversely, school-related influences to be addressed in school refusal intervention include order, safety, and discipline (Brouwer-Borghuis, Heyne, Sauter, et al., 2019); structured classroom layout, clarity about the functions of the different areas, and consistency across all staff involved, particularly for youths with autism (Preece & Howley, 2018); and a gradual increase in the amount of time the young person spends in the classroom and the number of classmates present (McKay-Brown et al., 2019).

The voices of stakeholders are presented in Section 1.2.4. Some of their experiences and views underscore the importance of predictability, and thus structure, when helping youths re-engage with school. Professionals addressing school attendance problems spoke about the need to help parents set boundaries and assume a more authoritative role (Tobias, 2019). Youths who self-excluded from school shared that life at school would have been easier if teachers promoted a feeling of security for students (O'Brien & Dadswell, 2019). Youths who displayed school refusal suggested that school personnel could have used a more phased approach to school return (Baker & Bishop, 2015). Similarly, professionals addressing school refusal suggested that change needs to be gradual, such as creating a supportive environment in which there are opportunities for youths to gradually socialise with others (Kljakovic & Kelly, 2019). The same professionals suggested that unrealistic

expectations on youths and families form a barrier to helping youths who display school refusal. Nuttall and Woods' (2013) study of the views of professionals, parents, and youths indicates that youths' sense of safety and security arises in part from the predictability of a consistent teacher in the educational setting; that family routines and boundary-setting are important; and that youths need to know how to access key adults who are available to support them.

Essence

Rhythm essentially refers to youths' and parents' experience of routines and predictability. Structure essentially refers to the arrangements made by professionals to promote rhythm. Increasing rhythm and structure increases predictability and security, helpful for participants' engagement in intervention and the development of confidence and competencies. Rhythm and structure are also inherent to the process of gradually increasing school attendance.

There are two main reasons why rhythm and structure are important in intervention for school refusal. First, in cases of severe and chronic school refusal, youths' and families' routines have often become disrupted. This includes disruption to routines for youths (e.g., sleeping in on school mornings, not showering or dressing until later in the day, engaging in excessive gaming during the day) and parents (e.g., arriving late to work or leaving work early). The youth's engagement in educational activities is also disrupted. These disruptions serve to maintain school refusal: youths find it harder to attend school and parents find it harder to manage school refusal. Second, many youths displaying school refusal experience anxiety, depression, and/or autism, necessitating rhythm and structure to provide extra predictability and security (see 'Additional information').

Rhythm and structure can be achieved at a macro level and a micro level. At the macro level, participants experience predictability and security when they participate in interventions which have a broad structure, such as working in phases (e.g., settling into the intervention, then developing coping skills, then engaging in more demanding activities such as increasing school attendance). The structure associated with daily participation in an alternative educational program also provides participants with an experience of rhythm. At the micro level, rhythm is achieved via the specific routines that occur during the day, both in the intervention setting (e.g., morning check-in with the mentor) and in the home environment (e.g., improved evening and morning routines). Clarity is another micro level aspect of predictability and security. For example, professionals help youths and parents understand the process associated with a stepwise increase in school attendance.

Professionals also increase a sense of predictability and security for participants via their reliability when working with youths and parents. In the words of one of the professionals in the current project, "You say what you do and you do what you say, every day."

Links with other signposts

Signpost 7 relies upon the work associated with Signpost 1 (Provide an integrated approach, including youth, parents, and school) and Signpost 2 (Pursue insight into the integrative picture). Professionals who work with youths, parents, and school personnel, learning about specific needs for predictability and security, are better placed to make arrangements that provide structure and thus rhythm.

There is a close link between Signpost 7 and Signpost 8 (Broaden educational options and adjust educational tasks). Adjustments to the school program will account for the young person's need for predictability and security in the academic realm.

Signpost 7 supports the work associated with Signpost 5 (Create a safe environment) and Signpost 6 (Lower the hurdles in the beginning). Providing rhythm and structure increases youths' and parents' sense of security and safety, and it may make it easier for them to engage in the initial phase of intervention. Signpost 7 also supports the work associated with Signpost 9 (Facilitate social contact with peers). For youths uncomfortable with social contact with peers, providing rhythm and structure will be helpful in the process of increasing their social competencies and social contact.

Importantly, Signpost 7 lays the groundwork for Signpost 10 (Create movement). When youths and parents have been helped to achieve more predictability in their daily routines, they are better placed to create movement in other areas, such as increasing the youth's social contact and increasing school attendance.

Additional information

Many youths participating in interventions for school refusal experience depression, anxiety, and/or autism. Rhythm and structure are indicted for all three problem areas.

For youths who are depressed, behavioural activation is a potentially active ingredient in intervention (Malik et al., 2021). Rhythm and structure facilitate the systematic increase in youths' participation in overt activities. Behavioural activation may also be important to address withdrawn and avoidant behaviours associated with youth anxiety, although there is less evidence for its effectiveness among anxious youths (Malik et al., 2021). A promising school-based behavioural activation intervention for anxious or depressed youths emphasises anti-avoidance exposure in the real-life situation of school, conducted by school personnel (Chu et al., 2016). Even if behavioural activation is not employed for the treatment of anxiety, the predictability and security that flow from rhythm and structure can alleviate worry among anxious youths participating in intervention for school refusal.

For youths with autism, intervention needs to be delivered in an autism-friendly way, including rhythm and structure to increase predictability and security. Chapter 1 presents Preece and Howley's (2018) intervention for autistic youths displaying school refusal. As part of the preparation for youths' re-engagement with formal education, youths are provided with an autism-friendly surrounding (e.g., structured classroom layout and clarity about the functions of the different areas). Another school refusal intervention suited to youths with autism was reported by Brouwer-Borghuis, Heyne, Sauter, et al. (2019). The educational setting is explicitly predictable and structured (e.g., fixed schedules; consistency in teaching staff; minimal movement between different classrooms during the school day; engaging in a preferred activity on arrival in the classroom).

Somatic complaints are also typical among youths displaying school refusal (Berg, 1980; Egger et al., 2003; Honjo et al., 2001). In these cases, it is important to have a clear and concrete plan regarding physical exertion and other activities, as noted in the NHG guideline on medically unexplained symptoms (Olde Hartman et al., 2013). Rhythm and structure are also suggested in a recent review of somatic symptoms experienced by youths displaying school refusal (Li et al., 2021). Studies included in the review point to the potential benefit of a short bath in the morning to soothe abdominal pain; regular exercise, good sleep, and healthy eating; graded exposure to school while learning to cope with somatic symptoms; and prompt and predictable responses from school personnel when youths experience somatic symptoms at school.

Rhythm and structure may also help address one of the difficulties professionals experience when delivering intervention, namely 'generalising to daily practice' [*het generaliseren naar de dagelijkse praktijk*] (Figure 2). Compliance with practice tasks (also called between-session tasks and home tasks) is indeed one of the difficulties inherent to working with youths (Hudson & Kendall, 2002). When practice tasks are administered and followed up in a predictable fashion, youths may be more inclined to practise learned skills outside of the intervention setting. For example, professionals need to begin by setting simple tasks, and routinely explore the reasons why practice tasks were not completed or only partially completed (Hudson & Kendall, 2002).

Lastly, professionals suggested that they would like to work with smaller groups of youths (Figure 7). Working with smaller groups may make it easier for professionals to increase rhythm and structure in an intervention.

Further reading

The following article about an alternative educational program for school refusal presents characteristics of the setting that increase rhythm and structure for youths.

Brouwer-Borghuis, M., Heyne, D., Sauter, F. M., & Scholte, R. H. J. (2019). The Link: An alternative educational program in the Netherlands to reengage school-refusing adolescents with schooling. *Cognitive and Behavioral Practice*, *26*, 75-91.

Chapter 6 of the following book helps parents set up regular routines, in the service of helping their child attend school regularly.

Kearney, C. A., & Albano, A. M. (2018a). *When children refuse school: A cognitive-behavioral therapy approach/parent workbook* (3rd ed.). Oxford University Press.

Chapter 4 of the following book includes a section (Special Topic 4.5) on gradually increasing school attendance.

Kearney, C. A., & Albano, A. M. (2018b). *When children refuse school: A cognitive-behavioral therapy approach/therapist guide* (3rd ed.). Oxford University Press.
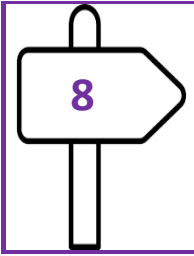
Signpost 8: Broaden educational options and adjust educational tasks

Justification

Results from this project

Professionals' reports about the important elements in intervention yielded two sub-themes that are closely related to Signpost 8, namely having 'room for customisation' [*ruimte voor maatwerk*] and being 'flexible and creative' [*flexibel en creatief*] (Figure 3). The need to tailor the school program is seen in the fact that most interventions make use of an alternative educational setting in special education or a meta school facility, the fact that about one-half of interventions sometimes provide home education, and the fact that professionals viewed their interventions as both customised and standardised, with a slight tendency towards customisation (Table 12). Professionals often remarked that there is a tailor-made approach to meeting the needs of youths, within the broader framework of the intervention. Multiple sub-themes related to Signpost 8 emerged when professionals were asked about adjustments they would like to make to their intervention (Figure 7). Professionals would like to be less restricted by (formal) rules and bureaucracy when planning and delivering intervention, which is reflected in the sub-theme 'regulations' [*regelgeving*]. Professionals would also like to offer more 'practical activities' [*praktische activiteiten*] and to adapt the learning program so it better suits the group of youths they support, reflected in the sub-theme 'didactics' [*didactiek*]. The need to develop individual educational pathways is also seen in professionals' reports that about one-fifth of youths participating in interventions have a learning disorder, and the vast majority of youths participating in intervention are completely absent from school for at least four weeks prior to participating in intervention.

Youths' and parents' reports about helpful elements in intervention yielded the sub-theme 'flexibility and support in learning' [*flexibiliteit en ondersteuning bij het leren*] (Figure 4 and Figure 5). This sub-theme resonates with professionals' reports about having 'room for customisation' [*ruimte voor maatwerk*] and being 'flexible and creative' [*flexibel en creatief*]. Another sub-theme that emerged from the reports of parents is 'creating perspective and offering hope' [*perspectief creëren en hoop bieden*], which includes reference to creative solutions to ensure youths are ready for participation in society.

Supporting literature

Literature included in this report supports the relevance of Signpost 8. Section 1.2.1 addresses the negative effects of school refusal for the young person, including reduced learning time due to the absenteeism associated with school refusal. This negatively impacts school attainment (e.g., Aucejo & Romano, 2016; Carroll, 2020; Filippello et al., 2019) and places youths at risk for school drop-out (Schoeneberger, 2012).

In section 1.2.2, five CBT manuals for the treatment of school refusal are outlined (Table 1). In three of these manuals academic issues are explicitly addressed as part of the intervention (Heyne et al., 2008; Heyne & Rollings, 2002; Kearney & Albano, 2007). Section 1.2.2 includes the suggestion that treatment manuals for school refusal are preferable to manuals for anxiety disorders or depressive disorders (Heyne & Sauter, 2013; Kearney et al., 2008). Manuals that are not specific to school refusal fail to address issues inherent to school refusal like increasing school attendance, and they do not address academic issues associated with school refusal.

Section 1.2.3 includes descriptions of various educational and multidisciplinary interventions that address school-related factors relevant to Signpost 8. For example, the adapted learning environment and individual curriculum goals that form part of the alternative educational program described by Preece and Howley (2018) were held to contribute to improved attendance and engagement with an educational curriculum. Another example is the multidisciplinary In2School intervention (McKay-Brown et al., 2019). Teachers and a clinician work together to provide therapeutic and educational interventions (Table 2), and the educational interventions signal the importance of Signpost 8. In addition, Ingul et al. (2019) summarised school-related influences that warrant attention during intervention for school refusal. Two of the influences closely related to Signpost 8 are 'aspects of the classroom situation' (e.g., lack of teacher support) and 'educational aspects' (e.g., academic difficulties, learning disorders, and a mismatch between the young person's ability and the academic demands of school).

Stakeholders' views presented in section 1.2.4 also support the importance of Signpost 8. According to Sibeoni et al. (2018), parents found it very helpful when solutions for school-related problems were offered during intervention for school refusal, such as adapted schooling and distance education. Based on interviews with youths, parents, and professionals, Nuttall and Woods (2013) indicated that a flexible and individualised approach to learning seems to be associated with successful intervention for school refusal. Furthermore, professionals interviewed by Finning et al. (2018) and Reid (2006b) stressed the importance of educational adaptations such as an alternative curriculum and reduced timetabling.

Essence

Signpost 8 signals the need to identify and implement necessary changes to the young person's education. The changes may be broad, in terms of increasing educational options available to the young person (e.g., referral to an alternative educational program; implementation of a curriculum better suited to the young person), or they may be narrow (e.g., reduced expectations or scheduling for school-based assignments or testing). The specific changes are contingent upon a thorough understanding of the young person's capacities and potential, as well as the impact of educational requirements on the development and maintenance of their difficulty attending school. Changes to the young person's education may be short-term or longer-term, and they are enacted in the interests of the young person's prospects for future education.

Developing individual educational pathways for youths relies on collaboration with youths and parents, and it will often involve collaboration with other professionals. For example, if a young person is temporarily attending an alternative educational program as part of the intervention for school refusal, the youth's education ought to be discussed with personnel from the original school [*school van herkomst*] and the school to which the young person will transition after the alternative educational program. In addition, education professionals and mental health professionals involved in intervention need to communicate with each other about the most appropriate educational options and tasks for the young person, and about educational progress made during intervention.

Links with other signposts

Signpost 8 relies upon the work associated with Signpost 1 (Provide an integrated approach, including youth, parents, and school) and Signpost 2 (Pursue insight into the integrative picture). First, the delivery of an individualised educational program requires contact with the young person, whether the contact occurs via education professionals in the team that provides school refusal intervention, or via a consultant to the team, as might occur during intervention provided in a mental health setting. Second, the development of the educational program requires a good understanding of the young person's strengths, difficulties, and needs. Thus, Signpost 8 also relies upon the work associated with Signpost 11 (Work together as education and support services) because professionals from both sectors might contribute to the development and delivery of the educational program.

There is a close link between Signpost 8 and Signpost 10 (Create movement). Youths are helped to take steps towards achievement of educational goals, and in the process of taking steps, professionals learn more about the support that is needed to help them achieve new educational goals. Signposts 8 and 10 are also linked inasmuch as the steps that youths take towards increased school attendance will also increase their exposure to educational

opportunities, and the increased familiarity and comfort with educational activities can make it easier to increase school attendance.

Signpost 8 can support the work associated with Signpost 4 (Promote the willingness and involvement of youths and parents). When youths see that effort has been made to provide an adapted, realistic educational program, their motivation for participating in intervention and working to increase school attendance may be enhanced. Signpost 8 also supports the work done at Signpost 6 (Lower the hurdles in the beginning) and Signpost 7 (Provide rhythm and structure). Adjusting a youth's educational program is one way to reduce the expectations placed on them in the early phase of intervention, and simplification of the educational program may enhance the young person's sense of structure and clarity.

Additional information

Many youths who display Tier 3 school refusal have been absent from school for an extended time, and this often leads to falling behind academically. These youths need help to re-engage with educational activities and, where possible, to catch up on missed schoolwork. School refusal is also associated with performance anxiety (Egger et al., 2003), another influence on learning that needs to be considered when developing an individual educational pathway for a young person.

Youths who fall behind academically, for whatever reason, may ultimately transfer to another school or to a lower educational level. Professionals in the current project indicated that most youths who participate in their intervention attend mainstream education before the intervention, and that almost one-half of youths transfer to special education after the intervention. Two Dutch studies reflect a change in educational level among youths with school attendance problems. Van Binsbergen et al. (2019) found that a considerable number of youths with severe school attendance problems were engaged in lower levels of education when they participated in intervention, relative to earlier in their school life. Brouwer-Borghuis, Heyne, Sauter, et al. (2019) found that 62% of adolescents who participated in the Link intervention for school refusal were in higher rather than lower levels of education[49] at the start of their secondary schooling, whereas only 30% were in higher levels by the time they participated in the intervention. Clearly, youths displaying school attendance problems experience changes in educational setting and/or level. This is to be valued, to the extent that the change yields a more suitable educational pathway for the young person. However, if the absenteeism associated with school refusal leads to a change in educational setting or level, then it is important that these youths have access to an individual educational pathway as soon as possible.

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[49] High levels of education included 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).

Further reading

The following article addresses school influences that warrant attention during intervention for school refusal.

Ingul, J. M., Havik, T., & Heyne, D. (2019). Emerging school refusal: A school-based framework for identifying early signs and risk factors. *Cognitive and Behavioral Practice*, *26*, 46-62.

The following articles address the relationship between learning disorders and school refusal.

Naylor, M. W., Staskowski, M., Kenney, M. C., & King, C. A. (1994). Language disorders and learning disabilities in school refusing adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, *33*, 1331-1337.

Prabhuswamy, M., Srinath, S., Girimaji, S., & Seshadri, S. (2007). Outcome of children with school refusal. *The Indian Journal of Pediatrics*, *74*, 375-379.

Signpost 9: Facilitate social contact with peers

9
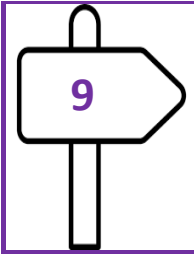
Justification

Results from this project

Professionals were asked to nominate which of 10 aspects of intervention they would like to change in their own intervention. One-third indicated that they would like to pay more attention to social factors (e.g., social anxiety, social skills, social isolation), and this was among the top three changes nominated by professionals. Professionals' responses to an open question about adjustments to their intervention are represented in Figure 7. A sub-theme that emerged was 'practical activities' [*praktische activiteiten*] such as excursions to museums, perhaps because activities like these could help facilitate social contact among youths. A difficulty for professionals in making therapeutic interventions available is seen in the sub-theme 'arranging group interventions' [*groepsinterventies regelen*] (Figure 2), in some cases because youths do not yet dare to join a group treatment or group activity. These youths require extra support to feel comfortable being with other youths. Another difficulty professionals face in delivering intervention is seen in the sub-theme 'family factors' [*gezinsfactoren*], including the difficulty some parents have in relinquishing an overprotective parenting style. Given that overprotective parenting may result in less social involvement for some youths, interventions which facilitate social contact with peers may be indicated. When professionals were asked about for whom their intervention has most and least effect, an emerging sub-theme was 'characteristics associated with school refusal' [*kenmerken van schoolweigering*], such as poorer outcome when the young person is staying in bed the whole morning (Figure 6). Interventions to help youths engage with peers may be instrumental in curbing this avoidance behaviour.

Via the First Impressions Questionnaire, professionals described characteristics of the youths participating in the interventions. Absence from school was often long-term, so many youths are likely to need help re-connecting with peers at school. Interventions to facilitate social contact are likely to be important for youths who have been bullied (one-half of all youths according to professionals) and youths who have an autism spectrum disorder (one-half of all youths). Youths experiencing a depressive disorder (one-third of all youths in the current project) can also benefit from interventions that facilitate social contact if the depression is associated with social withdrawal.

Direct support for Signpost 9 is found in the reports of youths and parents. When youths were asked about the most helpful elements in intervention, the sub-theme 'social contact and contact with peers with similar difficulties' [*sociale contacten en lotgenoten*] emerged (Figure 4). Likewise, parent reports about the most helpful elements yielded a sub-theme about their child having 'social contact and contact with peers with similar difficulties' (Figure 5). The fact that one-half of youths and almost one-half of parents said that the youths could get along better with peers as a result of the intervention, also suggests that facilitating social contact is an important signpost in interventions for school refusal.

Supporting literature

The literature included in this report underscores the importance of Signpost 9. Section 1.2.1 indicates that absenteeism is associated with impairment in youths' social-emotional development and it may contribute to social adjustment problems later in life. School refusal in adolescence may be more complex than in childhood due to increased social anxiety. In Section 1.2.2, the description of school refusal interventions indicates that attention to social skills and social competence is common in CBT interventions. Section 1.2.3 presents a summary of school-related influences on school refusal that warrant attention during intervention, including social aspects (e.g., peer victimisation; difficulty making friends; feeling isolated). The transitional classroom described by McKay-Brown et al. (2019) involves a gradual increase in the number of classmates present, alongside the gradual increase in the amount of time the young person spends in the classroom. The focus on individual social goals in Preece and Howley's (2018) alternative educational program for adolescents with autism spectrum disorder and anxiety-based absenteeism was held to be partly responsible for the program's effectiveness.

Section 1.2.4 presents the voices of stakeholders in interventions for absenteeism as well as interventions for school refusal. Professionals addressing absenteeism spoke about the need to help the young person feel safe, in part by making changes to the social environment at school such as creating a quiet space at lunchtime for a socially anxious youth (Tobias, 2019). Professionals addressing school refusal spoke about the need for change to be gradual, including in the social sphere, such as creating a supportive environment in which there are opportunities for youths to gradually socialise with others in a similar position (Kljakovic & Kelly, 2019). When youths were asked about what could have made life at mainstream school easier for them, their responses yielded a theme about promoting empathy and compassion among students (O'Brien & Dadswell, 2019). According to youths, parents, and professionals, individual factors associated with successful intervention for school refusal are positive experiences at home and school (e.g., developing friendships), the mentor encouraging peers to contact the young person when they are away from school, and supporting social interaction and communication, such as support for problem solving with peers (Nuttall & Woods, 2013). Youths and parents participating in a school refusal intervention in a psychiatric care facility identified social isolation and difficulty interacting with others as problematic for the young person. Factors they associated with the

intervention's effectiveness included the social life offered in the context of inpatient or day care (parent report), and being able to fit into a peer group, such as being able to talk about your problem with someone your own age (youth report) (Sibeoni et al., 2018).

In Section 4.2.1 we reflected on the fact that many youths participating in the 21 interventions studied in the Knowing What Works project had experienced bullying, which corresponds with a considerable body of literature linking bullying and school refusal, including among youths with ASD (Archer et al., 2003; Bitsika, Heyne, et al., 2021; Bitsika, Sharpley, et al., 2021; Brouwer-Borghuis, Heyne, Sauter, et al., 2019; Egger et al., 2003; Havik et al., 2014; McShane et al., 2001; Place et al., 2000). Clearly, the social environment at school needs to be addressed, alongside youths' social skills.

Essence

School refusal is often associated with social problems for youths. These problems will sometimes contribute to the development of school refusal, sometimes co-occur with school refusal, and sometimes arise out of the young person's absence from school. Irrespective of whether social problems are a cause, correlate, or consequence of school refusal, they warrant close attention in many cases.

Signpost 9 has a simple title – 'Facilitate social contact with peers' – but the process of facilitating social contact can be far more complex than the title suggests. Usually, it is not just a simple matter of creating opportunities for youths to spend time with other youths. Rather, youths typically require substantial support before, during, and following an increase in social contact. Issues to address can include low motivation for social interaction (e.g., when youths are also depressed), social anxiety, and the acquisition of micro-skills, macro-skills, social perspective-taking skills, and social problem solving skills. School personnel and parents are also helped to support the young person's social involvement inside and outside of school. The data and literature included in this report point to the added value of youths having social contact with peers with similar difficulties [*lotgenoten*], and the value of increasing social contact in a gradual fashion.

On account of the relationship between school refusal and bullying, interventions are likely required at the school level (e.g., preventing and responding to bullying) and the individual level (e.g., social skills related to assertiveness).

Links with other signposts

Signpost 9 relies upon the work associated with Signpost 1 (Provide an integrated approach, including youth, parents, and school), Signpost 2 (Pursue insight into the integrative picture),

Signpost 3 (Invest in your availability and the quality of your contact with youths and parents), and Signpost 4 (Promote the willingness and involvement of youths and parents). Signpost 1 ensures that there is scope to work directly with the young person to address social contact, Signpost 2 sheds light on the specific needs of the young person in the social sphere, Signpost 3 helps the young person feel more comfortable to be open regarding their fears and desires related to social contact, and Signpost 4 increases the likelihood that the young person will engage in tasks related to social contact. Signpost 5 (Create a safe environment) can also benefit efforts to enhance social contact, when that safe environment is a setting where the young person comes in contact with other youths (e.g., in an alternative educational program). Likewise, Signpost 13 (Gather a committed team with knowledge and experience) can benefit efforts to enhance social contact, when the team comprises members skilled at helping youths connect with one another.

Signpost 9 supports the work associated with Signpost 10 (Create movement). When 'movement' is understood to mean an increase in school attendance, this is more likely to be achieved when the young person is feeling more competent and confident socially, given the inherently social nature of school.

Additional information

Group-based intervention

Group-based interventions have natural appeal for addressing social problems. However, data from the current project did not provide direct support for the importance of group-based intervention. Indirect support might be seen in youths' and parents' reports about the benefits of youths' social contact with peers, if youths' contact with peers occurred in a group context such as group-based intervention.

The literature in Chapter 1 provides various examples of group-based intervention. Often, an intervention was group-based by virtue of it being an alternative educational program comprising a classroom with a small group of youths. A rare exception was the group-based therapy reported by Contessa and Paccione-Dyszlewski (1981). As noted by Heyne (2021b), a key opportunity provided by group-based intervention for school refusal is increased social involvement within a supportive context, including social-related exposure exercises followed by cognitive restructuring. This may increase the young person's capacity to cope with school return and with the social challenges that will arise during ongoing school attendance.

Intervention for socially anxious youths displaying school refusal

Intervention for school refusal appears to be less effective for adolescents with social anxiety disorder (Bernstein et al., 2001; Heyne et al., 2011; Layne et al., 2003; McShane et al., 2004). The 'double dilemma' of concurrent social anxiety disorder and school refusal might help explain the inferior response, whereby social anxiety and school refusal serve to reinforce each other (Heyne, 2021b). In the current project, anxiety disorder was the most common problem among youths participating in the interventions for school refusal. It is possible that many of these youths experiencing anxiety were dealing with social anxiety in particular.

Albano (1995) recommended group-based intervention following individual intervention for socially anxious adolescents displaying school refusal. McShane et al. (2007) developed an intervention specifically to address the needs of socially anxious adolescents with anxiety-based school attendance problems. They noted that adolescents with social anxiety disorder may avoid school because of intense anxiety about being judged or humiliated by peers. The program was tailored to adolescents' individual needs (e.g., graded exposure to public transport and various social situations). A mental health professional available within the school setting engaged the adolescents in activities and responded to their social, emotional, and practical needs. According to McShane and colleagues, the controlled nature of the school environment was instrumental to positive outcome, as was the provision of taxi transport to the facility because it increased adolescents' motivation for attendance, in part by reducing uncontrolled social situations that can occur on public transport and lead to non-attendance. When Hannan et al. (2019) worked with youths with social anxiety and school refusal, they facilitated exposure to social interactions related and unrelated to school, maximising generalisation and lowering the hurdle for school return. Heyne (2021b) observed that interventions for school refusal include behavioural interventions (e.g., social skills training; social-related exposures) and cognitive interventions (e.g., cognitive therapy for social anxiety), and that these may need to be more intensive when working with youths with social anxiety. It is important that cognitive interventions for socially anxious youths address processes associated with social anxiety, such as self-focused attention (Blöte et al., 2014) and post-event rumination (Spence et al., 2017).

Participation in prosocial activities is also important, such as organised sports or clubs for drama, music, and academic interests (Fredricks & Eccles, 2005; Homel et al., 2020). These could be helpful for socially anxious adolescents displaying school refusal if groups are small and well supervised. Beyond the benefits for youths experiencing social anxiety, participation in organised sports and clubs can of course have broader benefits for youths' psychosocial adjustment (Fredricks & Eccles, 2005).

Further reading

Chapter 5 of the following book addresses intervention for youths refusing school to escape aversive social and/or evaluative situations.

Kearney, C. A., & Albano, A. M. (2018b). *When children refuse school: A cognitive-behavioral therapy approach/therapist guide* (3rd ed.). Oxford University Press.

The following article is an evaluation of an intervention in a specialist adolescent educational and mental health program providing educational assistance and social skills development.

McShane, G., Bazzano, C., Walter, G., & Barton, G. (2007). Outcome of patients attending a specialist educational and mental health service for social anxiety disorders. *Clinical Child Psychology and Psychiatry*, *12*, 117-124.

The following article focuses on the assessment of social skills and social competence, and methods to increase the use of social skills.

Spence, S. H. (2003). Social skills training with children and young people: Theory, evidence and practice. *Child and Adolescent Mental Health*, *8*, 84-96.

The following article describes a study of the benefits of youths' participation in extracurricular activities.

Fredricks, J. A., & Eccles, J. S. (2005). Developmental benefits of extracurricular involvement: Do peer characteristics mediate the link between activities and youth outcomes? *Journal of Youth and Adolescence*, *34*, 507-520.

Signpost 10: Create movement

10
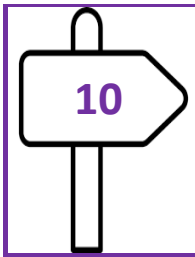
Justification

Results from this project

Professionals reported that 'creating movement' [*beweging creëren*] is an important element in intervention (Figure 3). Furthermore, all 21 interventions in the Knowing What Works project include graded exposure. This is a key CBT intervention for creating movement, and CBT is one of the frequently mentioned theoretical underpinnings of interventions studied in this project. Implicit references to creating movement are seen in professionals' reports about the importance of creating 'success experiences' [*succeservaringen*] and 'creating perspective' [*perspectief creëren*] for youths. The importance of creating perspective is also seen in professionals' responses to the question about for whom intervention has most and least effect (Figure 6). Specifically, professionals indicated that outcome is poorer if the young person is not excited by any options for further training or education, seen in the sub-theme 'future perspective for the young person' [*toekomstperspectief van de jongere*]. Professionals' reports that they would like their intervention to include more 'practical activities' [*praktische activiteiten*] might also be interpreted as a desire to facilitate youths' movement (Figure 7). Movement, in the form of participation in activities, may constitute exposure for youths with anxiety disorders (the most common problem among youths participating in the interventions studied in this project), and behavioural activation for youths with depressive disorders (one-third of youths had a depressive disorder).

Youths' reports provide direct and indirect support for the need to create movement. Direct support is seen in youths' reports that helpful elements in intervention are 'working on anxiety' [*werken aan angst*] and 'building up school attendance' [*opbouwen schoolgang*] (Figure 4). Indirect support is seen in the youths' reports that another helpful element of intervention is having 'social contact and contact with peers with similar difficulties' [*sociale contacten en lotgenoten*]. Re-connecting socially is an important aspect of movement, even if it is not yet accompanied by movement back into the school setting.

Parents' reports also provide direct and indirect support for the need to create movement. Helpful elements in intervention according to parents include 'building up school attendance' [*opbouwen schoolgang*] and 'creating perspective and offering hope' [*perspectief creëren en hoop bieden*] (Figure 5). Like youths, parents also spoke about the

value of youths' 'social contact and contact with peers with similar difficulties' [*sociale contacten en lotgenoten*]. As noted above, re-connecting socially can be understood as initial yet very important movement.

Supporting literature

The literature included in this report underscores the importance of Signpost 10. In Section 1.2.1 it was noted that school refusal may become prolonged and thus more difficult to overcome in the absence of appropriate intervention. Furthermore, disruption to school attendance represents a serious disruption to the young person's growth process (Kearney & Graczyk, 2020), with negative consequences for the family and community as well. Movement towards re-engagement with education – not stagnation – is needed.

Section 1.2.2 provides an overview of interventions for school refusal, the most common approach being CBT. CBT for school refusal usually emphasises graded exposure to school attendance. Graded exposure is about movement; it requires change from the status quo of avoidance, and movement towards the situation that has been avoided. Practice tasks (also called between-session tasks and home tasks) are also common in CBT for school refusal, providing opportunities for youths and parents to effect change outside of the space where intervention occurs. Importantly, a meta-analysis of the effects of interventions for school refusal, almost all CBT, revealed that intervention contributes to an increase in school attendance (Maynard et al., 2018).

The review of educational and mental health interventions in Section 1.2.3 provides examples of professionals creating movement, such as graded exposure to public transport and various social situations (McShane et al., 2007); desensitisation to the school setting (Contessa & Paccione-Dyszlewski, 1981); and a phased, personalised approach to the transition from an alternative educational program back into formal education [*school van herkomst*] (Grandison, 2011).

Section 1.2.4 includes stakeholders' experiences and views on the process of creating movement. In the Finning et al. (2018) study, education professionals spoke about supporting reintegration back into school via virtual classrooms accessible from home. In the study of Kljakovic and Kelly (2019), professionals spoke about the need for change, with an emphasis on gradual change (e.g., creating a supportive environment in which there are opportunities for youths to gradually socialise with others in a similar position). Some of the education professionals in Devenney and O'Toole's (2021) study reported that medication for managing anxiety helped some youths cope with worries related to school and to actually make it into the school building. All parents in the study of Sibeoni et al. (2018) reported that the effectiveness of intervention was associated with support for return to school. Collectively, these stakeholder views point to the value of movement, however that may be achieved.

Essence

Signpost 10 points to the need to create movement towards re-engagement with school. In essence, it is about breaking entrenched avoidance patterns. Re-engagement with the school setting is usually gradual, especially for Tier 3 school refusal which is typically severe, chronic, and complex. There are various ways in which the gradations of re-engagement can be conceptualised, such as increased time at school, increased time in favoured and then lesser favoured classes, and increased engagement with school-related work. Gradual re-engagement with the school setting is likely to be preceded by gradual change in other parts of the young person's life related to school, such as increased social involvement prior to increased school attendance, and establishing healthy morning and evening routines. The process of creating movement is not limited to work with the young person. Rather, parents and school personnel are helped to acquire and use strategies that support the young person's re-engagement with school.

Links with other signposts

The work associated with Signpost 10 relies upon the work of many other signposts. Signpost 1 (Provide an integrated approach, including youth, parents, and school) enables professionals to have direct contact with youths to help them re-engage with school. Signpost 2 (Pursue insight into the integrative picture) informs the planning for gradual return. For example, understanding the multiple influences on a specific young person's refusal to attend school reveals areas that need to be considered such as the role parents will play in supporting an increase in school attendance, and which 'push' and 'pull' factors in the school setting need to be addressed prior to the young person increasing attendance. The severity and chronicity of school refusal are also likely to impact the rate at which re-engagement occurs. Signpost 3 (Invest in your availability and the quality of your contact with youths and parents) and Signpost 4 (Promote the willingness and involvement of youths and parents) are pre-requisites to working together on re-engagement with school. They increase the likelihood that youths will be motivated to engage with the professional to develop and implement plans for creating change, such as increased social involvement and increased school attendance.

School-based preparations to support the youth's re-engagement with school are inspired by Signpost 5 (Create a safe environment), Signpost 7 (Provide rhythm and structure), Signpost 8 (Broaden educational options and adjust educational tasks), and Signpost 9 (Facilitate social contact with peers). These signposts draw professionals' attention to factors that can 'push' a young person away from school and the factors that can 'pull' a young person towards school. For example, Signpost 9 facilitates movement when socially anxious and/or isolated youths are helped to enhance the quality and quantity of social contact, making it easier to move towards school attendance.

The work associated with Signpost 13 (Gather a committed team with knowledge and experience) ensures that youths, parents, and school personnel are guided through the process of increasing school attendance by professionals who are experienced in planning and supporting reintegration. Signpost 11 (Work together as education and support services) is essential to the work at Signpost 10. All professionals supporting the family, including those from education and from support services, need to stand behind the plan for increased school attendance, be familiar with its contents, and collaborate in the implementation of the plan.

There is a close link between Signpost 6 (Lower the hurdles in the beginning) and Signpost 10. Lowering the hurdles in the initial phase of intervention is in the service of being in a better position to create movement in the subsequent phase.

The work associated with Signpost 10 can enhance the work of Signpost 2 (Pursue insight into the integrative picture). That is, our understanding of a young person's difficulties, strengths, and needs is further informed by their response to the process of re-engaging with school. The work associated with Signpost 10 can also benefit the work associated with Signpost 9 (Facilitate social contact with peers). Return to the social context of school provides opportunities for youths to practice re-engaging socially.

Additional information

All 21 interventions include a focus on increased school attendance. This does not mean that increased school attendance is the main goal of intervention. Rather, increased school attendance may be conceptualised as progress towards social-emotional and academic development, which in turn contribute to future perspectives for the young person.

For youths anxious about being at school, increasing school attendance can be conceptualised as exposure. As noted in Section 1.2.2, CBT is the most popular approach to intervention for school refusal and it often incorporates exposure-based work (Elliott & Place, 2019). For youths not attending school in association with depression, increasing school attendance can be conceptualised as behavioural activation, a stand-alone treatment for depression (Veale, 2008) and a component of CBT for depression (Curry et al., 2000). Even though many professionals in educational settings intentionally refrain from conducting therapy for anxiety or depression, the many ways in which they help youths increase school attendance very likely contribute to reductions in youths' anxiety and/or depression.

Transitional classrooms and alternative educational programs are themselves interventions which create movement back to the school of origin [*school van herkomst*] or a new school. They do this by virtue of helping youths become familiar and comfortable with aspects of

schooling (e.g., a classroom, peers, schoolwork), but in a safe environment (e.g., routines with high levels of predictability, few other youths, teachers who are experienced in working with youths displaying school refusal), before taking the step of moving into a more traditional educational setting. The provision of home education can be seen in a similar light. Around one-fifth of the interventions in the Knowing What Works project offer home education as a prelude to youths attending an educational setting. It was suggested by some professionals that the provision of home education helps re-connect youths with educators and educational materials. This can be regarded as the commencement of movement towards school attendance and participation in education.

A key question for professionals is when to start raising the hurdles again, in the interests of creating movement and achieving school attendance. This point is discussed in the 'Additional information' section in the description of Signpost 6 (Lower the hurdles in the beginning).

Another question, albeit a contentious one, is the role medication might play in helping create movement. According to some of the professionals in the study by Devenney and O'Toole (2021), medication for managing anxiety helped youths cope with worries about school and to actually make it into the school building. The topic of medication was introduced in Section 1.2.2 about interventions for school refusal, and it is taken up again in Section 4.4.3 on research (The use of medication and its impact).

The use of technology to help create movement is likely to be a non-contentious issue for stakeholders. Section 1.2.2 describes a small number of technological developments in the treatment of school refusal. One of these, virtual reality, has been used to enhance youths' motivation to participate in treatment and to enhance their cooperation during exposure tasks associated with school attendance (Gutiérrez-Maldonado et al., 2009). During the course of the Knowing What Works project we did not encounter examples of Dutch interventions for school refusal making use of technological developments.

Practice tasks (also called between-session tasks and home tasks) are an important mechanism for creating movement. They are an essential component of intervention for school refusal, providing the young person with opportunities to practice skills in the real-life setting, facilitating the generalisation of skills beyond the therapy context, and increasing the likelihood that gains made during intervention will be maintained (Heyne & Rollings, 2002). As noted in Section 1.2.2, all five CBT manuals for school refusal include the use of practice tasks. Seventy-five percent of all professionals in the current project indicated that they engage youths in practice tasks. It may be less typical for professionals in educational settings to engage youths in non-academic practice tasks relevant to intervention for school refusal. Nevertheless, it is important for professionals from education and support services to communicate about practice tasks recommended by the mental health practitioner, to increase consistency in the young person's practice of key skills across different settings. If education professionals delivering intervention for school refusal work independently of

support services, it would be helpful to consider using 'out of school' practice tasks to help create movement.

Further reading

The following book about intervention for school refusal describes strategies that parents can use to facilitate school attendance.

Heyne, D., & Rollings, S. (2002). *School refusal*. Oxford: BPS Blackwell.

The following book about interventions for school attendance problems includes sections on 'gradually increasing school attendance' and different forms of exposure.

Kearney, C. A., & Albano, A. M. (2018b). *When children refuse school: A cognitive-behavioral therapy approach/therapist guide* (3rd ed.). Oxford University Press.

The following articles describe the background and process of behavioural activation.

Martin, F., & Oliver, T. (2019). Behavioral activation for children and adolescents: A systematic review of progress and promise. *European Child and Adolescent Psychiatry*, *28*, 427-441.

Veale, D. (2008). Behavioural activation for depression. *Advances in Psychiatric Treatment*, *14*, 29-36.

The following article provides examples and discusses issues associated with home tasks that are designed to help anxious youths practice skills in their natural environment.

Hudson, J. L., & Kendall, P. C. (2002). Showing you can do it: homework in therapy for children and adolescents with anxiety disorders. *Journal of Clinical Psychology*, *58*, 525-534.

The following chapter discusses the practicalities of homework, including a step-by-step guide to systematically using homework.

Robinson, P. (2008). Putting it on the street: Homework in cognitive behavioral therapy. In W. T. O'Donohue & J. E. Fisher (Eds.), *Cognitive behavior therapy: Applying empirically supported techniques in your practice* (pp. 260-271). John Wiley & Sons, Inc.

Signpost 11: Work together as education and support services

11
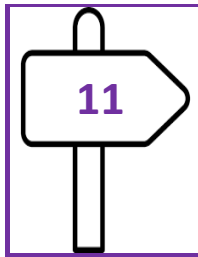
Justification

Results from this project

Professionals' reports indicate that eight interventions (just over one-third) have a permanent collaboration between education and support services. Seven of these eight interventions receive funding from both education and support services (Table 4). Collaboration emerged as a main theme in all networks based on professionals' reports. Their reports about important elements in intervention yielded the main theme 'collaboration between those involved' [*samenwerking tussen betrokkenen*] (Figure 3). The sub-themes include: 'collective effort' [*gezamenlijke inspanning*], 'communication' [*communicatie*], and 'respect and trust' [*respect en vertrouwen*]. A similar main theme emerged from professionals' reports about which youths and families benefit most and least from intervention, namely 'collaboration between organisations' [*samenwerking tussen organisaties*] (Figure 6). Professionals explained that intervention is negatively impacted when collaboration between themselves and professionals from external services is problematic. This is also seen in the main theme 'difficulties related to the collaboration with support services' [*moeilijkheden gerelateerd aan de samenwerking met hulpverlening*] emerging from professionals' reports about difficulties delivering intervention (Figure 2). The sub-themes within this main theme are: 'organising (timely) additional help' [*het realiseren van (tijdig) aanvullende hulp*], 'communication' [*communicatie*], and 'the grey area between education and support services' [*het grijze gebied tussen onderwijs en hulpverlening*]. With regard to 'communication' for example, it is difficult when professionals from external support services are negligent in maintaining regular contact. When professionals were asked about preferred adjustments to their intervention (Figure 7), they expressed the desire to strengthen their relationship with other services (e.g., by having a permanent support services partner).

Around four-fifths of youths and parents reported that the professionals involved in the intervention seemed to work well together. In addition, about two-thirds of youths and parents reported that things had improved for the young person as a result of the collaboration between professionals. Collaboration did not emerge as a main theme based on youths' and parents' reports about helpful elements in intervention. However, parents expressed the importance of communication with professionals involved in the intervention, reflected in the subtheme 'communication' [*communicatie*] (Figure 5).

Supporting literature

The literature included in this report underscores the importance of Signpost 11. In Section 1.2.1, the point was made that professionals need to work together with youths, families, the school, and support services to address the broad range of risk factors associated with school refusal.

Section 1.2.3 outlines the need for collaboration between education and mental health. It was noted that complex cases of school refusal are likely to benefit from a palette of interventions (Heyne, 2019), which likely applies to severe and chronic school refusal too. By extension, a palette of interventions becomes broader when professionals from multiple disciplines work together to address school refusal. Numerous examples of multiple disciplinary intervention are found in Section 1.2.3, most of which focus on the collaboration between professionals in education and mental health. Education is usually provided in an alternative educational setting (e.g., special school, transitional classroom, meta school facility), and mental health support varies from participation in an inpatient mental health service to consultation by mental health professionals to youths in an educational setting. Another model of collaboration, presented in Section 1.2.4, is community-based management offered to families of youths displaying absenteeism, including consultation by community agency staff to school personnel (e.g., Sugrue et al., 2016).

Section 1.2.4 presents stakeholder views on collaboration. Education professionals interviewed by Finning et al. (2018) spoke about the need to provide mental health care as well as adapting the school environment. Family coaches interviewed by Tobias (2019) suggested that the effectiveness of intervention for absenteeism is threatened when there is conflict between organisations, and when the school system is restrained by a focus on educational targets, neglecting attention to the home environment. The author suggested that intervention will be successful when all relevant systems cooperate and have the same values and aims. Kljakovic and Kelly (2019) interviewed education and mental health professionals working with youths displaying school refusal, as well as professionals from other agencies. A barrier to helping these youths was observed in professionals' reports that professionals from different sectors had different goals. According to the authors, an integrated multi-agency approach is warranted, spanning health, education, and the local authority. Based on interviews with youths displaying long-term absenteeism, Baker and Bishop (2015) also pointed to the need for multi-agency collaboration that yields a prompt and coordinated response. Interviews with professionals, youths, and parents led Nuttall and Woods (2013) to conclude that a factor associated with successful intervention for school refusal is collaboration between professionals (e.g., professionals from different agencies working towards a common goal; identifying the lead professional to chair meetings).

Essence

Signpost 11 underscores the need for professionals from education and support services such as mental health, to establish close, effective, and efficient collaboration, to best meet the multiple needs of youths displaying school refusal and their families. In short, there is a need for joint effort from all involved; collaboration is a key condition for effective intervention. At an individual level, collaboration refers to the working relationship between two or more professionals. At an organisational level, collaboration refers to arrangements between sectors, services, or agencies associated with the delivery of intervention for school refusal. The collaboration may be incidental, such as when professionals or organisations come together to address the needs of a specific young person and their family. Ideally, collaboration between professionals or organisations has a permanent structure. A permanent or structural collaboration implies that there is an understanding via verbal or written agreement that the collaborating parties can rely upon each other, on an ongoing basis, to address the needs of youths displaying school refusal and their families. It may take time to develop such an understanding and agreement, as is the case for most types of relationships. When there is no permanent collaboration and professionals find themselves collaborating on a case-by-case basis, there is still a need to become familiar with each other and each other's area of work, given that education and support services can often seem like different worlds (e.g., terminology, expertise, pace of working). Whether a collaboration is incidental or permanent, it is imperative that there be clear and regular communication about goals, roles, and progress, to ensure optimal support for youths and families.

Links with other signposts

Signpost 11 benefits from Signpost 12 (specify your method). When the overarching goal(s) and specific objectives of intervention are clear, then the need for collaboration with professionals from other disciplines and services becomes clearer.

There is a link between Signpost 11 and Signpost 4 (Promote the willingness and involvement of youths and parents). On the one hand, youths' and parents' involvement in intervention is a pre-requisite to the provision of support to youths and parents via professionals from other disciplines or services. On the other hand, the involvement of other professionals may enhance the willingness and involvement of youths and their parents.

There is also a link between Signpost 11 and Signpost 13 (Gather a committed team with knowledge and experience). When professionals from education and support services collaborate closely over time, their respective knowledge and expertise are enhanced.

Signpost 11 enhances options for providing support and services at Signpost 1 (Provide an integrated approach, including youth, parents, and school). For example, parents may

require practical support via social services or emotional support via mental health services, and these may be provided by professionals external to the school refusal intervention. Signpost 11 supports the work associated with Signpost 2 (Gain insight into the integrative picture), inasmuch as the involvement and perspectives of professionals external to the intervention can contribute to the development and refinement of the integrative picture.

When the school refusal intervention is provided in a mental health setting or another non-education setting, Signpost 11 supports the work associated with Signpost 8 (Broaden educational options and adjust educational tasks) because it draws attention to the need to consult with education professionals about appropriate educational options and tasks for the young person.

Additional information

There is potential for youths and parents to feel overwhelmed when various services and professionals are involved in intervention for school attendance problems and other challenges facing the family (Van Binsbergen et al., 2019). Education professionals addressing school refusal also feel the pressure of liaising with many different services (Devenney & O'Toole, 2021). It is important that the process of collaboration is streamlined, with frequent and clear communication, so that youths and parents can understand the respective roles of different professionals and how that work best serves their needs. In particular, it is essential that youths, parents, education professionals, and professionals from support services are clear about the details of the plan for re-engagement with school.

Section 4.2.4 includes our reflections on collaboration between organisations. There, we noted Devenney and O'Toole's (2021) comment that some education professionals addressing school refusal "grappled with what the role and duty of schools should be, asking are we 'care providers' or 'education providers'?" (p. 38). One education professional in Devenney and O'Toole's study is quoted as saying "there is a point where we say CAMHS [Child and Adolescent Mental Health Services] will have to take over, the medical services have to take over, this is not our job" (p. 38). Professionals in the current project similarly spoke about 'the grey area between education and support services' [*het grijze gebied tussen onderwijs en hulpverlening*]. In particular, professionals in educational interventions wonder whether they should be offering therapeutic elements even though they do not work in support services [*hulpverlening*]. We noted in Section 4.2.4 that a permanent collaboration between education and support services may render the so-called grey area less confusing.

In the Netherlands, INGRADO[50] (2018) conducted research on prolonged absenteeism [*thuiszitters*]. Interviews were conducted with professionals associated with all 75 regional

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[50] INGRADO is the national association for school attendance officers and related professionals.

partnerships [*samenwerkingsverbanden*] for secondary education. Professionals reported various challenges in the collaboration between education and support services, including waiting lists for support services, a different pace of work, and difficulties combining funding from education and support services. Professionals also spoke about the developments they foresee for the future, such as improved communication and clarification of expectations between professionals from different disciplines, working closely with community partners to address sickness-related absenteeism, and investment in getting to know each other (e.g., gaining insight into each other's work and professional language). The report by Peeters et al. (2018) describes what needs to be done to speed up collaboration between education and support services, to better support youths whose needs span multiple areas of work. That report represents the start of a broader project in which multiple regions in the Netherlands have been named inspiration regions, to experiment with and learn about multidisciplinary collaboration within childcare and education.

During the 2019 conference of the International Network for School Attendance (INSA), a symposium was dedicated to the topic of collaboration between education and mental health care when addressing school attendance problems. Permanent collaborations that exist in three different interventions (i.e., Brouwer-Borghuis, Heyne, Sauter, et al., 2019; McKay-Brown et al., 2019; Reissner et al., 2019) were described via a marriage metaphor. For example, an education professional and a mental health professional associated with the Link Almelo described the characterises of their marriage in this way: they live together under the roof of education, they know each other well, they keep working on their communication, they have overlapping chores and responsibilities, and they are really passionate about their work (Brouwer-Borghuis, Bonthuis, et al., 2019). The same marriage metaphor was used during the interviews with professionals for the Knowing What Works project, whereby professionals were asked to discuss the collaboration between education and support services by making use of the metaphor. The researchers conducting the interviews gained the impression that it was helpful for the professionals to think about collaboration in this way. A forthcoming publication incorporates the professionals' responses.

Further reading

<u>The following two articles describe multiple disciplinary interventions that address school refusal.</u>

Brouwer-Borghuis, M., Heyne, D., Sauter, F. M., & Scholte, R. H. J. (2019). The Link: An alternative educational program in the Netherlands to reengage school-refusing adolescents with schooling. *Cognitive and Behavioral Practice*, *26*, 75-91.

McKay-Brown, L., McGrath, R., Dalton, L., Graham, L., Smith, A., Ring, J., & Eyre, K. (2019). Reengagement with education: A multidisciplinary home-school-clinic approach

developed in Australia for school-refusing youth. *Cognitive and Behavioral Practice*, *26*, 92-106.

The following article describes a multiple disciplinary intervention that addresses school attendance problems.

Reissner, V., Knollmann, M., Spie, S., Jost, D., Neumann, A., & Hebebrand, J. (2019). Modular Treatment for children and adolescents with problematic school absenteeism: Development and description of a program in Germany. *Cognitive and Behavioral Practice*, *26*, 63-74.

The following book contains a section about a joint system approach to address school refusal.

Thambirajah, M. S., Grandison, K. J., & De-Hayes, L. (2008). *Understanding school refusal: A handbook for professionals in education, health, and social care*. Jessica Kingsley Publishers.

The following reports address challenges and changes for multiple disciplinary collaboration in the Netherlands.

INGRADO. (2018). *Het verhaal achter de cijfers: Thuiszitters in het voortgezet onderwijs* [The story behind the numbers: Long-term absenteeism in secondary education]. Retrieved November 26, 2021, from https://ingrado.nl//media/files/kennisbank/participatie_in_het_onderwijs/thuiszitters/literatuur_en_onderzoek/Het_verhaal_achter_de_cijfers.pdf.

Peeters, R., Zunderdorp, M., Lamers, M., & Rats, E. (2018). *Met andere ogen. Advies voor versnelling en bestendiging van de samenwerking onderwijs-zorg-jeugd* [With different eyes. Advice for accelerating and perpetuating the collaboration between education-care-youth]. Retrieved November 19, 2021, from https://www.aanpakmetandereogen.nl/media/filer_public/0e/c3/0ec3407b-0533-45c2-8324-5cf93511e7df/rapport-met-andere-ogen.pdf.

Signpost 12: Specify your method

12

Justification

Results from this project

Professionals' reports provide support for the importance of Signpost 12. Professionals from just a few organisations mentioned that their intervention is documented. When professionals discussed the flexibility vis-à-vis standardisation inherent to their intervention, they often mentioned that an advantage of standardisation is that a framework offers support and direction, reducing the likelihood that professionals work in an ad hoc fashion. Related, a few professionals reported that flexibility is disadvantageous because it runs the risk that what is done by a professional is too dependent on that specific professional.

When professionals rated the extent to which their intervention is flexible or standardised, there was considerable variability in responses, even among members in the same team. The average rating of flexibility vis-à-vis standardisation, per intervention, ranged from 'completely flexible' to 'highly but not completely standardised'. No organisations offer a fully standardised intervention, a small number offer a predominantly or fully flexible intervention, and most offer an intervention which is both flexible and standardised. Professionals in most organisations noted that their intervention includes a framework and standard elements (e.g., an intake process, working in phases, and periodically consulting with all parties involved), and in one-third of organisations it was noted that the structure or process of the intervention is more fixed while the delivery for each young person is more flexible. Flexibility was regarded as important and powerful, with the frequent comment that every young person is different. Numerous professionals expressed satisfaction with the amount of flexibility and standardisation in their intervention while others expressed a desire for the intervention to be more flexible, or more standardised, or more of a balance between flexible and standardised. In sum, there is broad diversity in the flexibility vis-à-vis standardisation of interventions, which calls for the specification of methods to better understand when flexibility is applied and why, and when standardisation is applied and why.

Professionals' reports in the First Impressions Questionnaire signal various uniformities in the organisations' interventions, but explanations for why professionals work in the way they do was not gathered systematically. For example, all 21 interventions always involve work with the young person, nineteen also always involve work with parents, and two

sometimes involve work with parents. It is unclear, however, about the process professionals use to determine whether or not parents would be included in the intervention. Almost one-half of the organisations have a screening process for school refusal, whereby participants are accepted into the intervention based on criteria related to school refusal or other indications and contra-indications. Four of these organisations use a questionnaire as part of the screening process. Some of the organisations that do not conduct screening or do not use questionnaires during screening are currently working on a screening process. The length of the interventions varies (i.e., one-third last more than 12 months, one-third last between 6 and 12 months, one-quarter last between 3 and 6 months, and just one lasts for less than 3 months), but again, the rationale for the length of each intervention is unclear. We did learn about the organisations' justification for whether or not they use home education. For example, two-fifths of the organisations do not provide home education because it is not in keeping with the aims of the intervention (e.g., it would make it more difficult for youths to return to an educational setting), or because the team is not in a position to facilitate home education. Less than one-fifth of organisations routinely offer home education as a prelude to youths attending an educational setting, to help youths re-connect with educators and educational materials. In sum, there are explanations for some elements in intervention but not for others, and written specification of methods is warranted.

The reports of youths and parents did not address the issue of specifying the method for intervention, as would be expected.

Supporting literature

The literature included in this report underscores the importance of Signpost 12. In Section 1.1.3 it was noted that the Absenteeism Pact [*Thuiszitterspact*] included agreements about definitions of absenteeism and better registration of long-term absenteeism. This suggests that at the highest levels there are efforts to pursue clarity, and where appropriate, to promote systematic ways of working. The same can be achieved at the organisational level, with specification of the method for intervening in school refusal. In Section 1.1.3 it was also noted that members of the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*] expressed a desire for national guidelines for school refusal intervention, by systematically mapping out the operative elements in existing interventions.

Section 1.2.2 introduced the multi-tiered system of supports (MTSS) model, a framework for service delivery. This is a recent example of efforts to systematise work in the field of school attendance and absenteeism, with a view to facilitating efficiency and effectiveness. It does this by encouraging data-based decision-making about how to respond to youths' and families' needs, and specifying evidence-based assessment and intervention strategies for each tier of the model (Kearney & Graczyk, 2020). Section 1.2.2 also includes examples of

treatment manuals for school refusal which specify methods used when working with youths, parents, and school personnel (see Table 1).

In Section 1.2.3 we shared Sibeoni et al.'s (2018) point that the lack of established guidelines for collaborating on intervention for school refusal makes it difficult to coordinate efforts between education professionals, mental health professionals, and families. We contend that the absence of specified methods for school refusal interventions in the Netherlands similarly complicates coordination among professionals associated with those interventions.

Section 1.2.4 summarises the voices of stakeholders. Reid (2006a) interviewed professionals in secondary schools and reported that the management of absenteeism is sometimes non-systematic, which might explain the professionals' sense that the management of absenteeism is complex and time consuming. Coaches interviewed in Tobias' (2019) study suggested that the effectiveness of intervention is threatened when systems are inflexible and resistant to change, or sabotaging the change process, which may arise when there is conflict between organisations (e.g., overstretched services moving responsibility for management of a case onto another service). The clear specification of methods might alleviate such conflict. Professionals interviewed in Kljakovic and Kelly's (2019) study similarly spoke about barriers to helping youths who display school refusal, including incongruent goals (e.g., different agencies worked towards competing goals). Specification of the method, including the goals of the method, may reduce this problem. Indeed, in Nuttall and Woods' study (2013) based on the voices of youths, parents, and professionals, one of the factors associated with successful intervention was a whole school approach (e.g., communication between staff about strategies; support from team leadership). Presumably, the specification of methods facilitates a whole school approach to addressing school refusal.

Essence

Signpost 12 points to the importance of specifying the method used to address school refusal. A description of the method would be prefaced by a statement of the overarching goal(s) of intervention, along with the specific objectives of intervention. It would also describe or display the hypothesised links between the method, the objectives, and the overarching goal(s).

Specifying the method would help shed light on when, and how, professionals employ flexibility in their work, and when, and how, standardisation is employed. Results of this project suggest that flexibility and standardisation are both important, and it is our belief that greater specification of when flexibility is applied and when standardisation is applied will enhance the implementation of an intervention, and thus benefit the youths and families participating in the intervention. The calls made to tailor intervention for each young person do not mean that each professional needs to 'start from scratch' in planning

intervention for a specific young person and family. A framework, in the form of specified goals, objectives, and methods, would provide direction in the process of tailoring intervention.

Links with other signposts

Signpost 12 relies upon the work associated with Signpost 14 (Provide sufficient resources to implement the intervention), Signpost 13 (Gather a committed team with knowledge and experience), and Signpost 11 (Work together as education and support services). Teams delivering school refusal interventions require time to reflect upon and record the goals, objectives, and methods associated with their intervention. A committed team, with knowledge and experience in intervention for school refusal, is well placed to prepare such documentation. When the team comprises members from multiple disciplines, the established goals, objectives, and methods are more likely to meet more of the needs of more of the families dealing with school refusal.

Signpost 12 informs the work that is done in relation to all other Signposts. For example, if one of the objectives is to provide appropriate support to parents and not only to youths, it points to the importance of Signpost 1 (Provide an integrated approach, including youth, parents, and school) and Signpost 3 (Invest in your availability and the quality of your contact with youths and parents). As another example, if one of the objectives is to help youths re-engage with education, this points to the importance of Signpost 8 (Broaden educational options and adjust educational tasks).

Additional information

The 21 interventions in the Knowing What Works project are somewhat similar with respect to their theoretical underpinnings and therapeutic elements, such as the use of CBT, systemic work, and solution-focused work. At the same time, there is great diversity in the therapeutic elements employed (see Table 11). When methods are specified, including justification for the use of specific methods, it will be easier to understand the origins of this diversity. Is it perhaps due to the fact that different interventions are serving different needs among youths and families? This could explain, for example, why some interventions include EMDR, creative therapies, and MDFT, while others do not.

Only a few organisations have documented their intervention. This likely slows down orientation and training for new team members, and it hinders dissemination and implementation of the intervention in other settings or regions. When the method is specified and thus more easily shared, it reduces the likelihood that organisations will inadvertently 're-invent the wheel', developing their own intervention 'from scratch'.

Specification of the method also makes it easier to identify the effective elements in intervention. Even when a comparison between pre-intervention and post-intervention measurements indicates improvements for youths and parents, it will be unclear what contributed to the improvements if the method has not been specified (see Section 4.4.3 on 'Robust evaluation of the mechanisms of change in interventions for school refusal'). Specifying the methods inherent to an intervention will not only facilitate robust evaluation in scientific studies, but it will also facilitate routine evaluation in the setting where the intervention is delivered (see 'Routine evaluation of outcome' in Section 4.4.2).

The roadmap for school refusal interventions in Section 4.4.1 offers a higher-order framework for specifying which of the important conditions for effective intervention are accounted for in an organisation's intervention. In addition to this higher-order framework, teams need to specify the goals, objectives, and methods of their intervention. For example, if group training is offered for youths, specification would include what is done, with which youths, for how long, in the service of which objective, and how the objective relates to the broader goal(s) of the intervention.

There are numerous examples of the specification of goals and methods in interventions for school refusal, and for school attendance problems more broadly (see 'Further reading' below). A recent example based on work in the Netherlands is seen in Brouwer-Borghuis, Heyne, Sauter, et al.'s article (2019). The article presents the three pillars – or methods – of an intervention for school refusal, and the various ways in which each method is implemented. For example, one of the pillars is the provision of an alternative educational setting. The authors drew upon Zullig et al.'s (2010) framework for school climate to conceptualise and document their method. It is not necessary that specified methods be prepared for publication, but when methods are easily accessible it benefits research and practice because the methods gain broader attention in the field of school attendance and absenteeism. The main point, however, is that the methods are specified for the benefit of all team members working together in the delivery of an intervention.

Further reading

The following articles, chapter, and book provide examples of the specification of methods for intervention focused on school refusal.

Brouwer-Borghuis, M., Heyne, D., Sauter, F. M., & Scholte, R. H. J. (2019). The Link: An alternative educational program in the Netherlands to reengage school-refusing adolescents with schooling. *Cognitive and Behavioral Practice*, *26*, 75-91.

Heyne, D., & Rollings, S. (2002). *School refusal*. Oxford: BPS Blackwell.

Heyne, D. A., & Sauter, F. M. (2013). School refusal. In C. A. Essau, and T. H. Ollendick (Eds.), *The Wiley-Blackwell handbook of the treatment of childhood and adolescent anxiety* (pp. 471-517). Chichester: John Wiley & Sons Limited.

McKay-Brown, L., McGrath, R., Dalton, L., Graham, L., Smith, A., Ring, J., & Eyre, K. (2019). Reengagement with education: A multidisciplinary home-school-clinic approach developed in Australia for school-refusing youth. *Cognitive and Behavioral Practice*, *26*, 92-106.

The following book and articles provide examples of the specification of methods for intervention focused on school attendance problems.

Kearney, C. A., & Albano, A. M. (2018b). *When children refuse school: A cognitive-behavioral therapy approach/therapist guide* (3rd ed.). Oxford University Press.

Reissner, V., Knollmann, M., Spie, S., Jost, D., Neumann, A., & Hebebrand, J. (2019). Modular Treatment for children and adolescents with problematic school absenteeism: Development and description of a program in Germany. *Cognitive and Behavioral Practice*, *26*, 63-74.

Thastum, M., Johnsen, D. B., Silverman, W. K., Jeppesen, P., Heyne, D. A., & Lomholt, J. J. (2019). The Back2School modular cognitive behavioral intervention for youths with problematic school absenteeism: Study protocol for a randomized controlled trial. *Trials*, *20*, 29. doi:10.1186/s13063-018-3124-3

13 Signpost 13: Gather a committed team with knowledge and expertise
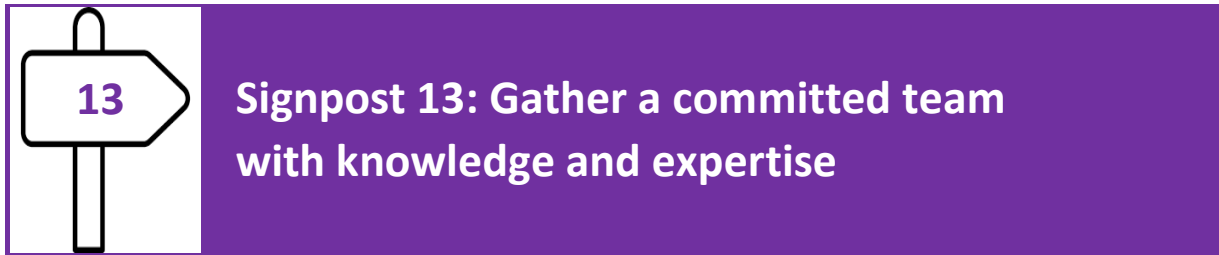
Justification

Results from this project

Professionals frequently referred to the characteristics of the team delivering intervention. 'Personnel' [*personeel*] is a main theme in the network about important elements in intervention (Figure 3). Responses related to this theme yielded five sub-themes: 'heartfelt commitment to this population' [*hart voor doelgroep*], 'vision' [*visie*], 'team composition and teamwork' [*samenstelling team en teamwork*], 'knowledge, experience, and curiosity' [*kennis, ervaring en leergierigheid*], and 'patience and persistence' [*geduld en volharding*]. The first and second sub-themes directly relate to the team's commitment, and the fourth sub-theme directly relates to the team's knowledge and expertise. Another main theme in this network is about the content of the intervention, comprising 12 sub-themes. For example, elements considered important include 'clarifying problems' [*verheldering problematiek*], providing a 'safe environment' [*veilig klimaat*], 'creating movement' [*beweging creëren*], and 'systemic approach' [*systemische aanpak*]. It is easy to imagine that this diverse array of elements requires knowledgeable professionals with experience and expertise. 'Personnel' [*personeel*] is also a main theme in the network about adjustments professionals would like to make to their intervention (Figure 7). This main theme is comprised of responses that mainly refer to team composition (e.g., expand the team with professionals with specialist expertise such as a healthcare psychologist or specialist teachers). There are also incidental references to team members' knowledge and expertise (e.g., the desire to have excellent mental health workers). Professionals' reports about difficulties they experience in delivering intervention (Figure 2) lend indirect support to Signpost 13. The main theme about 'difficulties related to the collaboration with support services' [*moeilijkheden gerelateerd aan de samenwerking met hulpverlening*] includes reference to the difficulty arranging extra (specialist) services appropriate for youths.

Information gathered via the First Impressions Questionnaire indicates that youths experience diverse difficulties (e.g., anxiety disorders, depressive disorders, autism). The interviews with professionals indicated that there are also difficulties for parents and families. The diversity of difficulties experienced by youths, parents, and families points to the need for a team with broad knowledge and expertise. Furthermore, just 8 of the 20 organisations that have representation from education work together with mental health

services / youth care. When collaboration with external services is difficult to arrange, it is ideal that teams comprise professionals with knowledge and expertise in the areas normally addressed via collaboration with external services.

Youths and parents wrote about the helpful elements in intervention from their perspective. A main theme that emerged in the network for youths (Figure 4) and parents (Figure 5) was 'the professionals' [*de professionals*]. Some of the characteristics of professionals that are helpful include 'kind and caring' [*aardig, zorgzaam*], creating an atmosphere of 'understanding and trust' [*begrip en vertrouwen*], and having a 'positive approach' [*positieve benadering*]. These are the characteristics of committed professionals with expertise in developing quality contact with youths and parents.

Supporting literature

The literature included in this report underscores the importance of Signpost 13. In Section 1.1.3 we noted that the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*] was established to facilitate the exchange of knowledge among professionals providing interventions for school refusal. There is a thirst among the members of the Expertise Team to acquire and share knowledge and to develop expertise for supporting youths and families affected by school refusal.

Section 1.2.3 describes the multiple influences on school refusal, including family influences and school influences. The breadth of influences underscores the need for teams to comprise members who are knowledgeable about school refusal and have varied expertise. We underscored the fact that Tier 3 school refusal is often complex, and therefore not confined to the artificial boundaries of single disciplines. Like other complex real-world problems, intervention for school refusal calls for the perspectives of professionals who achieve sophisticated understanding and provide comprehensive services (Choi & Pak, 2006).

Section 1.2.3 also presents numerous examples of multiple disciplinary work to meet the needs of youths with severe and/or chronic school attendance problems. The interventions comprise diverse elements conducted by mental health and education professionals, among others, which is testament to the need for teams with diverse expertise. Further, Section 1.2.3 draws attention to challenges in working together as a team. For example, Kearney (2019) noted that "mental health professionals sometimes see attendance problems as solely within the realm of school-based professionals, and school-based professionals sometimes see attendance problems as solely within the realm of mental health professionals" (p. 1). Elliott and Place (2019) referred to the challenging practicalities of developing and delivering interventions across professional borders. The implication is that the expertise of team members need to extend beyond skills and knowledge in their respective areas of work, to include their commitment and capacity to work across disciplines.

Section 1.2.4 summarises the voices of professionals, parents, and youths. Sugrue et al. (2016) presented caseworkers' accounts of the difficulties experienced when providing services to address absenteeism, such as difficulties getting housing support for families. Devenney and O'Toole (2021) reported on education professionals' work addressing school refusal, mentioning the need for professionals to link with outside agencies. Baker and Bishop's (2015) study similarly referred to the need for improved multi-agency work. Together, these studies point to the need for teams to comprise professionals who are committed to working together, and who come from different services, or at the very least have good connection with outside agencies. Other qualities of team members who deliver successful intervention for school refusal are found in the studies of Nuttall and Woods (2013) and Sibeoni et al. (2018), including a nurturing approach towards parents by the school attendance officer; a dedication to care; personality, knowledge, skills, and experience (e.g., developing a holistic understanding of the young person's needs); persistence and resilience; and communication.

Essence

Signpost 13 points to the need for teams addressing school refusal to comprise members with diverse expertise, with knowledge and experience in addressing school refusal, and with commitment and capacity to work across disciplines and services. Because of the challenges inherent to addressing severe and chronic school refusal, team members will ideally possess characteristics that supplement their specific expertise in delivering interventions with youths, parents, and school personnel, such as creativity and persistence.

Links with other signposts

Signpost 13 relies upon the work associated with Signpost 11 (Work together as education and support services) and Signpost 14 (Provide sufficient resources to implement the intervention). Regarding Signpost 11, close collaboration between education and youth care effectively broadens the expertise of the team addressing school refusal. For example, a professional from youth care may not be employed within the team but serve as consultant to the team. Regarding Signpost 14, management ensures that the team is well-resourced with respect to experienced and expert professionals.

Signpost 13 is the basis for many other Signposts in the roadmap for school refusal interventions. For example, knowledgeable and experienced team members are adept at developing a full understanding of a young person's refusal to attend school (Signpost 2: Pursue insight into the integrative picture), developing quality contact with youths and parents (Signpost 3: Invest in your availability and the quality of your contact with youths and parents), knowing which hurdles to lower and how to lower them (Signpost 6: Lower the

hurdles in the beginning), facilitating youths' social contact (Signpost 9: Facilitate social contact with peers), and facilitating an increase in school attendance (Signpost 10: Create movement).

Additional information

An additional characteristic of the team that is committed to effective intervention for school refusal is a willingness to engage in quality control. This can take the form of routine evaluation of outcome (see 'Routine evaluation of outcome' in Section 4.4.2). Ongoing professional development also plays a role in the quality of services provided.

Further reading

The following article includes the views of youths, parents, and professionals about the characteristics of professionals that are regarded as important for school refusal intervention, together with an ecological model of successful reintegration.

Nuttall, C., & Woods, K. (2013). Effective intervention for school refusal behaviour. *Educational Psychology in Practice*, *29*, 347-366.

Signpost 14: Provide sufficient resources to implement the intervention

14
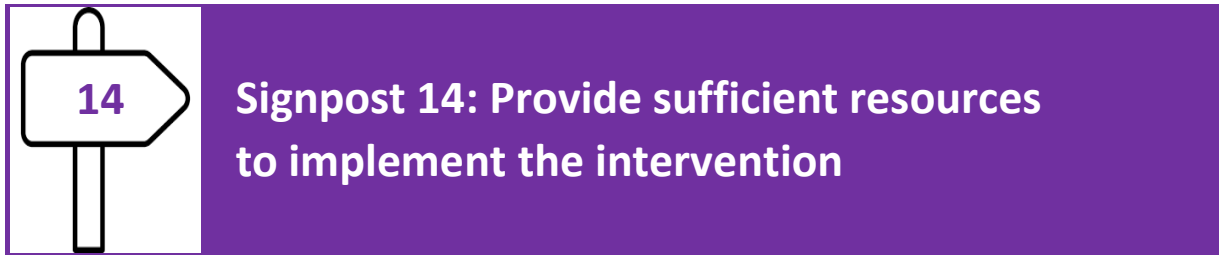
Justification

Results from this project

Professionals' reports about important elements in intervention yielded the main themes 'structural conditions' [*structurele voorwaarden*] and 'personnel' [*personeel*], grouped under the domain 'the arrangements' [*de regelingen*] (Figure 3). This domain is clearly related to Signpost 14, with many references to arrangements that need to be in place so that the intervention can be well executed. In particular, 'structural conditions' includes a sub-theme about the 'physical environment' [*fysieke omgeving*] such as education and mental health being located in one building, a sub-theme about 'financial arrangements' [*financiële arrangementen*] such as investment from the regional partnership [*samenwerkingsverband*], and a sub-theme about 'support from management' [*steun management*]. The main theme 'personnel' includes a sub-theme about team members having 'knowledge, experience, and curiosity' [*kennis, ervaring en leergierigheid*], suggesting the resourcing of professional development. There are sub-themes in the domain 'the intervention' [*de interventie*] which also align with Signpost 14. They refer to professionals being 'available' [*beschikbaar*] and providing an 'adapted educational environment' [*aangepaste onderwijsomgeving*]. In professionals reports' about preferred adjustments to intervention (Figure 7), the domain 'the arrangements' [*de regelingen*] emerged once again, incorporating the main themes 'structural conditions' [*structurele voorwaarden*] and 'personnel' [*personeel*]. The main theme 'structural conditions' includes multiple sub-themes, including 'group size' [*groepsgrootte*], 'scope/reach' [*omvang*], and 'time available with participants' [*beschikbare tijd met participanten*], all reliant on sufficient resourcing. When professionals were asked about difficulties they have in delivering intervention (Figure 2) they spoke about the lack of time available to conduct intervention with youths and parents, reflected in the sub-theme 'room to help' [*ruimte om hulp te bieden*].

Youths' and parents' reports about helpful elements in intervention yielded the main theme 'the professionals' [*de professionals*] (Figures 4 and 5). Parents' reports yielded the sub-theme 'involved and available' [*betrokken en beschikbaar*], closely connected to Signpost 14 and mirroring professionals' reports about their need to be 'available' [*beschikbaar*].

Data about the characteristics of youths participating in intervention and the length of intervention underscore the importance of Signpost 14. Professionals estimated that 90% of youths are at home for at least 4 weeks prior to referral for intervention, and the majority are absent from school for between 3 months and 1 year prior to intervention. Many youths face additional challenges such as anxiety, depression, autism, and/or bullying. The severity, chronicity, and complexity of the challenges facing these youths points to the need for sufficient resources to ensure that their needs are well met. According to parents, more than 90% of youths participate in intervention for at least 3 months, and almost one-third of youths participate in intervention for at least 1 year. Professionals similarly indicated that almost all interventions last longer than 3 months, and about two-thirds last between 6 months and 2 years. In short, the interventions are time consuming.

According to professionals, more than one-half of the 21 interventions studied are financed by multiple sources, perhaps suggesting that the regular funding available to organisations is insufficient. Funding sources included education, support services, and additional funding such as grants and project funds (Table 4).

Supporting literature

Literature included in this report supports the relevance of Signpost 14. In Section 1.2.1 we noted Maeda and Heyne's (2019) point that school refusal is likely to continue and become more difficult to address if adequate intervention is not available. This argument was based on numerous reports in the literature (i.e., Glaser, 1959; Hersov, 1972; King et al., 1998; Okuyama et al., 1999; Sonoda et al., 2008). In the absence of adequate intervention, a young person's anxiety about returning to school increases (Terada, 2015; Warnecke, 1964) and may reduce motivation for resolving the aversion to school attendance.

In section 1.2.2 we described the multidimensional, multi-tiered system of supports (MTSS) pyramid model for school attendance and school absenteeism (Kearney et al., 2019a, 2019b; Kearney & Graczyk, 2020). According to this model, all interventions included in the Knowing What Works project are Tier 3 interventions because they target youths with extensive school attendance problems. According to Kearney and Graczyk (2020), youths in Tier 3 of the MTSS model need intensive support. Thus, there need to be sufficient resources to adequately respond to the needs of these youths and their families.

Section 1.2.4. present stakeholders' voices. Professionals included in the studies conducted by Finning et al. (2018) and Reid (2006a) indicated that the process of intervening with school attendance problems is complex and resource intensive. If adequate resources are not available, the work conducted with youths and parents can be severely hindered. Kljakovic and Kelly's (2019) study focused on the reports of professionals working with youths displaying school refusal. One of the main themes that emerged from the interviews with professionals was barriers to helping youths and their parents, such as limited staffing resources which makes it difficult to engage the young person and family. Sibeoni et al.'s

(2018) study focused on the experiences of youths displaying school refusal and the experiences of their parents, with respect to the psychiatric care that was provided. Youths spoke about the time that is needed for intervention to be effective (e.g., time to develop trust in the professional team and time to develop personally). According to Sibeoni and colleagues, "treatment must last long enough, in a place dedicated to care, to allow these youth to become involved in their care and to reflect on the personal changes they need" (p. 47).

Essence

Signpost 14 requires the attention of management teams [*bestuurders*] responsible for ensuring professionals can develop and deliver an effective intervention, one that is ongoing, and ideally one that can be duplicated across settings. In essence, Signpost 14 signals the need for management teams to provide sufficient resources so professionals can adequately address the multiple needs of youths and parents participating in intervention. Funding is an essential resource that makes it possible to provide adequate physical resources, human resources, and time. Examples of physical resources include a well-equipped classroom or other location for intervention, options for relaxation moments for youths (e.g., a table-tennis table), and a comfortable space for parents to meet. The physical proximity of education and mental health services was also valued by professionals in the current project. Examples of human resources include the recruitment of professionals with knowledge and expertise related to school refusal, opportunities for their professional development, and having a sufficient number of professionals so that more intensive support can be offered to youths and parents, and so there is scope to offer intervention to more youths and parents than is currently the case. Time is needed to develop the intervention and document the method, to deliver the intervention (including sufficient time to 'be available' to youths and parents, establish and implement a flexible educational program, and collaborate with other professionals involved in the intervention), to ensure the intervention is long enough for enduring change to occur, to conduct routine evaluation of outcome, and to share accumulated knowledge and expertise with other professionals in the field.

Links with other signposts

Signpost 14 is essential to the work associated with all other signposts. If there is insufficient resourcing, interventions cannot be delivered as intended, and youths and parents will not receive the full support they need.

For example, Signpost 3 (Invest in your availability and the quality of your contact with youths and parents) requires that professionals have sufficient time to be 'available' for youths and parents, which is a helpful element of intervention according to youths and

parents, and an important element according to professionals. It takes time to establish a close working relationship during face-to-face contact with youths and parents, and to provide support between the face-to-face contacts. Signpost 5 (Create a safe environment) requires sufficient resources to provide a setting supportive of the young person (e.g., an alternative educational setting with a small number of youths). Signpost 8 (Broaden educational options and adjust educational tasks) requires time to identify and implement necessary changes to the young person's education (e.g., a curriculum better suited to the young person). Signpost 11 (Work together as education and support services) requires professionals to dedicate time to nurturing the relationship with professionals from other services. When there is insufficient time for close collaboration, it is conceivable that communication will be pared down to the sharing of basic information only, jeopardising the effectiveness of interventions that require intensive planning and implementation by multiple professionals across disciplines and services.

The signposts not directly related to the daily practice of delivering intervention might be at most risk of receiving less attention when professionals have insufficient time. For example, Signpost 12 (Specify your method) requires time to reflect upon and document the goals, objectives, and methods associated with the intervention, and to update the documentation over time. If professionals do not have sufficient time for this, the intervention they deliver may be less likely to yield positive outcomes for youths and families. Similarly, Signpost 13 (Gather a committed team with knowledge and experience) indicates that professionals require sufficient time to engage in ongoing professional development (e.g., arranging team meetings to discuss a specific topic, participating in meetings of the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*]). Overly busy professionals may pay less attention to this signpost.

Additional information

Funding for school refusal interventions needs to account for the collaboration between education and support services that is inherent to addressing severe and chronic school refusal. For example, when a mental health professional conducts intervention with a young person displaying school refusal, it is very likely – and highly desirable – that the professional consults with personnel at the young person's school (see Table 1). When this kind of collaboration is incidental (e.g., the professionals collaborate on a single case), the mental health professional's work is most likely funded by the mental health service for whom he or she works, and the work of education professionals at the school is funded by the school. When there is an ongoing, structural collaboration between a mental health service and a school or collection of schools (e.g., school district, regional partnership [*samenwerkingsverband*]), arrangements are made to fund the collaborative intervention, and this is sometimes complicated. Fortunately, projects like 'With Different Eyes' [*Met*

Andere Ogen] are underway in the Netherlands to explore and advance intensive collaboration between education, support services, and other organisations.

It is easy to argue that the cost associated with developing and delivering intervention for severe and chronic school refusal is more than compensated for by the improvements in the future perspectives of youths participating in intervention. At the same time, it is important that services also invest in prevention and early intervention. Indeed, the reports of professionals yielded the main theme 'attention to prevention and timely intervention' [*aandacht preventie en tijdige interventie*] in the context of important elements in intervention and preferred adjustments to intervention (Figure 3 and Figure 7). Timely intervention is the core message of the MTSS model to promote school attendance and address school absenteeism (Kearney & Graczyk, 2020). When there is timely assessment and intervention to promote school attendance and prevent school attendance problems (Tier 1), and to intervene early when school attendance problems are emerging, mild, or moderate (Tier 2), fewer youths require access to intensive intervention for severe and/or chronic school attendance problems (Tier 3) (Kearney & Graczyk, 2014). By that very fact, fewer resources would be needed to address Tier 3 school refusal.

Drawing on professionals' estimates of the number of youths participating in their intervention each year, we estimated that the 21 interventions in the current project serve approximately 750 youths each year. In Section 4.2.1 we explained why this is likely to be a substantial underrepresentation of the yearly number of youths displaying severe and chronic school refusal. It is imperative that sufficient resources are available to provide intervention to all youths displaying school refusal, including those not currently receiving intervention of any kind.

Further reading

The following articles describe the multi-tiered system of supports model to promote school attendance and address school absenteeism.

Kearney, C. A., & Graczyk, P. A. (2014). A Response to Intervention model to promote school attendance and decrease school absenteeism. *Child and Youth Care Forum*, *43*, 1-25.

Kearney, C. A., & Graczyk, P. A. (2020). A multidimensional, multi-tiered system of supports model to promote school attendance and address school absenteeism. *Clinical Child and Family Psychology Review*, *23*, 316-337.

The following report is about supporting multidisciplinary work within education.

Peeters, R., Zunderdorp, M., Lamers, M., & Rats, E. (2018). *Met andere ogen. Advies voor versnelling en bestendiging van de samenwerking onderwijs-zorg-jeugd* [With different eyes.

Advice for accelerating and perpetuating the collaboration between education-care-youth].
Retrieved November 19, 2021, from
https://www.aanpakmetandereogen.nl/media/filer_public/0e/c3/0ec3407b-0533-45c2-8324-5cf93511e7df/rapport-met-andere-ogen.pdf.

4.4.2 Implications for Practice

The Knowing What Works project focused on the elements in school refusal interventions that 'work' according to key stakeholders, namely professionals delivering interventions and youths and parents participating in interventions. The project was not focused on the details of 'how' to deliver the elements that work, and it does not yield prescriptions for what to do with a specific young person and their family. However, Section 4.4.2 offers implications for school personnel, for prevention and early intervention, and for routine evaluation of interventions. The section concludes with 'tips from the field'; these are ideas from members of the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*] about how the roadmap for school refusal interventions can be used.

How school personnel can work with the roadmap for school refusal interventions

The roadmap for school refusal interventions comprises 14 signposts. It is intended for use by professionals who develop and/or deliver intervention for Tier 3 school refusal, including professionals in education settings, mental health services, and other support services. In this section we comment on the relevance of the signposts for professionals in educational settings, specifically those professionals at a school to which the young person will return after absence related to school refusal (i.e., the school of origin [*school van herkomst*]), and professionals at a school which the young person will attend for the first time (i.e., the new school). It was not written for professionals whose school refusal intervention is conducted in an educational setting (e.g., an alternative educational program), but the points included here likely have relevance for this group of professionals too. More information about each signpost can be found in Section 4.4.1.

Signpost 1 – Provide an integrated approach, including youth, parents, and school

A comprehensive and integrated approach to intervention for school refusal relies upon the involvement of the young person, parents, and school personnel. School personnel should identify a school-based contact person who, among other things, supports communication between the young person, the parents, other school personnel, and any professionals consulting from external services. For example, the contact person liaises with other school personnel to ensure that recommendations to help the young person re-engage with school are implemented (e.g., arranging a comforting place for the young person when they feel distressed at school; temporary concessions for specific classes). The contact person is ideally someone who is familiar to the young person and parents, liked by them, highly motivated to identify and implement ways to support the young person and parents, and able to engender the support of other school personnel.

Signpost 2 – Pursue insight into the integrative picture

School personnel at the school of origin [*school van herkomst*] will have knowledge of the young person and parents which can be drawn upon to achieve a good understanding of the factors associated with the development and maintenance of school refusal. They may also have knowledge of previous efforts to support the young person and parents, and the outcome of those efforts. School personnel based in the new school which the young person will attend are less likely to be able to contribute to the integrative picture, but they are encouraged to become familiar with the needs of the young person and parents, in preparation for the young person's commencement at the school.

Signpost 3 – Invest in your availability and the quality of your contact with youths and parents

The school-based contact person identified at Signpost 1 may also serve as the school-based support person for the young person and their parents. Alternatively, someone else in the school will take on the role of support person (e.g., 'mentor'). This necessitates having time available to meet with the young person and parents and to maintain contact by telephone and electronic media. The support person's role is most intensive prior to and during the process of helping the young person increase school attendance. They are also available longer-term as needed.

Signpost 4 – Promote the willingness and involvement of youths and parents

School personnel will identify ways to reduce the factors that 'push' a young person away from school and increase the factors that 'pull' them towards school (e.g., supporting the young person socially and academically). Increasing the young person's and parents' hope for change and for a positive future will bolster their willingness and involvement during intervention, in part via motivational interviewing techniques. It will be helpful for school personnel to be familiar with the characteristics of youths and parents that can hinder and help intervention (see Figures 2 and 6).

Signpost 5 – Create a safe environment

School personnel's efforts to create a safe school environment for all students will also have benefits for individual youths working to increase their attendance at school. Specific arrangements for youths increasing attendance should also be made (e.g., provision of a comfortable space the young person can visit when feeling distressed; permitting the young person to have a locker in a quieter part of the school). Trauma-informed approaches in schools will be of great benefit to youths who have experienced bullying at school (see, for example, Thomas et al., 2019). The many youths who display school refusal and have autism

will also need to be accommodated in an autism-friendly environment (see examples in Brouwer-Borghuis, Heyne, Sauter, et al., 2019).

Signpost 6 – Lower the hurdles in the beginning

Tier 3 school refusal is often chronic, whereby youths have been away from school for a long time. Therefore, the plan for increasing school attendance is usually gradual (e.g., starting with just 1 or 2 hours per day, or 1 or 2 favourite classes per day). Before the plan for increasing attendance commences, sufficient time needs to be spent with the young person, parents, and school personnel to ensure all stakeholders are adequately prepared for successful implementation of the plan. The school-based contact person helps all relevant school personnel understand and work with the plan for increasing the young person's school attendance.

Signpost 7 – Provide rhythm and structure

The predictability that comes from rhythm and structure in daily routines provides a sense of security for youths. Rhythm and structure applies to the way in which intervention for school refusal is delivered by professionals, and to the youth's experience of the educational setting once they start attending school again. The plan for increasing attendance needs to be clear, including how much time the young person will spend at school, where they will be, and what they will and will not be asked to do. It is imperative that all relevant personnel at the school are familiar with the plan, and are willing and able to follow through with the plan.

Signpost 8 – Broaden educational options and adjust educational tasks

School personnel need to understand and respond to the educational needs of the young person, whether they be personnel at the school of origin [*school van herkomst*] to which the young person will return during the course of intervention, or personnel at the new school the young person will attend. In some cases, the success of intervention for school refusal relies upon the extent to which school personnel are willing and able to tailor the academic program to the young person's current capacities. This may involve broad adjustments (e.g., implementing a curriculum better suited to the young person) or narrow adjustments (e.g., reduced expectations for school-based assignments).

Signpost 9 – Facilitate social contact with peers

In some cases, the success of intervention will rely upon the extent to which school personnel help the young person feel comfortable in the social context of school. Initiatives can be employed prior to the increase in school attendance (e.g., identify several supportive

students who contact the young person before they return to school), once the increase in school attendance commences (e.g., ensuring the young person has social support in the classroom and during break times), and well into the future (e.g., there is a permanent process for the young person to gain support when social challenges arise, such as bullying).

Signpost 10 – Create movement

This signpost is a necessary companion to Signpost 6 (Lower the hurdles in the beginning). At the time agreed upon between all involved (i.e., the professional overseeing delivery of the intervention, the young person, parents, and school personnel), the young person will start increasing school attendance. School personnel will be careful to implement the plan as agreed, refraining from adding any expectations that fall outside the plan until a new plan has been agreed upon by all. School personnel are in a unique position to observe and report on progress at each step of the plan for increasing attendance, ensuring that progress and set-backs are discussed with the professional overseeing the delivery of intervention, and that youths and parents are valued for their efforts towards achieving the plan.

Signpost 11 – Work together as education and support services

Members of the team addressing school refusal ideally include professionals from education (e.g., mentors; care coordinators; educational psychologists), support services (e.g., mental health; youth care; social welfare), and community partners (e.g., student attendance officers). Short of this ideal, school personnel will establish close working relationships with professionals in these areas of work to help them carry out tasks relevant to the signposts. A key issue for school personnel is to ensure there is efficient and effective communication between the members of the team.

Signpost 12 – Specify your method

The method referred to at this signpost is the broader intervention for school refusal, not only the role that school personnel play. However, school personnel can establish and document their approach to addressing school refusal, including how they collaborate with external professionals. For example, the suggestions for school personnel that are included at each signpost can be made accessible for all school personnel, current and incoming. Documentation of the school's approach to addressing school refusal might be undertaken by that member of school personnel who participate in a school's School Attendance Team (see below). This document might form part of the school's broader policy on promoting school attendance and preventing absenteeism (see below, 'The need for Tier 1 and Tier 2 interventions, to reduce the need for Tier 3 interventions').

Signpost 13 – Gather a committed team with knowledge and experience

The team referred to at this signpost is the broader intervention team involved in developing and delivering an intervention for school refusal (e.g., the team of professionals at a mental health service or in an alternative educational setting). However, school personnel might also establish a School Attendance Team. The School Attendance Team comprises those members of staff with a passion for helping youths engage with all that school has to offer. Diversity in the roles and experiences of members of the School Attendance Team is desirable, including professionals from the broader community. This helps ensure, for example, that the young person's educational and social-emotional needs are addressed, along with the needs of the family. The School Attendance Team may determine which school personnel are best suited to supporting individual youths presenting with school refusal, and their parents.

Signpost 14 – Provide sufficient resources to implement the intervention

The provision of resources to address school refusal is a matter often addressed by those in management. At a structural level, school-based managers are encouraged to support the establishment and ongoing work of the school-based School Attendance Team to promote attendance and respond to absenteeism (see the following section on 'The need for Tier 1 and Tier 2 interventions, to reduce the need for Tier 3 interventions'). On a case-by-case basis, school personnel need to determine which resources are required (e.g., who will meet the young person on arrival at school, who is the school-based contact person specified at Signpost 1).

The need for Tier 1 and Tier 2 interventions, to reduce the need for Tier 3 interventions

The Knowing What Works project focused on Tier 3 school refusal which is typically severe and chronic, and often complex. School personnel, together with other professionals and the broader community, also need to address Tier 1 and Tier 2 of the multi-tiered system of supports (MTSS) framework (Kearney & Graczyk, 2020). Tier 1 refers to the promotion of school attendance and prevention of school attendance problems, and Tier 2 refers to early intervention for emerging, mild, and moderate school attendance problems. Prevention and early intervention help reduce the need for Tier 3 intervention for school refusal, which is often challenging and certainly costly. By devoting resources to prevention and early intervention, fewer resources will be needed to address the smaller group of youths presenting with severe and chronic school refusal.

The importance of reducing the number of youths presenting with severe and chronic school refusal is underscored by data from the Knowing What Works project. Professionals reported that the outcome of their intervention is poorer among youths with more severe

and chronic problems (Figure 6). Conversely, youths who have not been away from school for a long time seem to respond better to intervention. Furthermore, a main theme that emerged in professionals' reports about important elements in intervention (Figure 3) and their reports about preferred adjustments to intervention (Figure 7) was 'attention to prevention and timely intervention' [*aandacht preventie en tijdige interventie*]. Education professionals and support services professionals committed to working at Tier 1 and Tier 2 of the MTSS framework are encouraged to read about Tier 1 and 2 interventions described in Kearney (2016). School Attendance Teams are likely to play a key role in the implementation and evaluation of these interventions. An article by Ingul et al. (2019) presents considerations for members of the School Attendance Team as they work to identify youths with emerging school refusal.

In the Netherlands, Care and Advice Teams [*Zorg- en adviesteams*] include school attendance officers [*leerplichtambtenaren*] and professionals representing student guidance [*leerlingbegeleiding*], school social work [*schoolmaatschappelijk werk*], and youth health care [*jeugdgezondheidszorg*]. Thus, there is a structure available for multiple professionals to work together in response to youths identified as in need. The question is whether a School Attendance Team is ideally established alongside or within the existing structure to expand the focus of Care and Advice Teams. Because Care and Advice Teams focus on youths with existing problems, it may be advantageous to establish a School Attendance Team alongside a Care and Advice Team so that attention is also given to the promotion of school attendance and the identification of those in need of early intervention. In this way, emerging, mild, or moderate school refusal is less likely to become severe and chronic school refusal.

A project is underway in the Netherlands, with partners in Norway, Germany, and the United States, to develop and evaluate a model for supporting schools as they address school attendance at Tiers 1, 2, and 3 of the MTSS framework. A key component of the model is the establishment and functioning of the School Attendance Team. For information, consult the MY COUNTRY space for the Netherlands, on the website of the International Network for School Attendance (www.insa.network).

The need for timely Tier 3 interventions

When youths display Tier 3 school refusal, presumably because Tier 2 interventions were not sufficient or were not implemented, it is imperative that Tier 3 intervention be provided in a timely fashion so that the problem does not become even more entrenched and intractable. Professionals in the Knowing What Works project referred to this in the context of the main theme about 'attention to prevention and timely intervention' [*aandacht preventie en tijdige interventie*] (Figure 3 and Figure 7). Research presented in Section 1.2.4 underscores the importance of timely Tier 3 intervention. In Baker and Bishop's (2015) study, four youths who had been away from school for at least a year and who displayed characteristics of

school refusal were asked about what could have been done differently with respect to the support they received. All four youths mentioned that there had been a delay in the school's response, and suggested that the school should have responded sooner. In the Sibeoni et al. (2018) study, 20 adolescents and 21 parents were asked about their experience of psychiatric care provided for anxiety-based school refusal. Parents expressed the wish that effective treatment had been found sooner (e.g., the right professional or right treatment from the beginning).

Routine evaluation of outcome

During the Knowing What Works project it became evident that professionals are sometimes unaware of the impact of their intervention, and for whom the intervention has most and least effect. In addition, many professionals reported that they would like to have a system in place to evaluate their work.

Professionals delivering intervention for school refusal will ideally establish a process to routinely evaluate their intervention. Kearney's (2016) book on managing absenteeism at multiple tiers includes chapters dedicated to the evaluation of interventions implemented at Tier 1, Tier 2, and Tier 3 of the multi-tiered system of supports (MTSS) framework. There are many methods and instruments for evaluating the impact of interventions at each tier, so an initial task in establishing routine evaluation is to consider which of these methods and instruments is most suited to the needs of a team, whether it is a team located within education, in a support service, or across education and support services. A scoping review of constructs measured following intervention for school refusal provides leads regarding methods and instruments that can be used (Heyne, Strömbeck, et al., 2020). The materials presented in the Appendices of the current report may also be helpful. For example, the interview with professionals (Appendix M) and the questionnaires used with youths and parents (Appendices P and Q) could be adapted for routine evaluation of interventions for school refusal and other attendance problems (e.g., truancy or school withdrawal).

The four-stage 'Plan, Do, Check, and Act' cycle (PDCA; Dahlgaard-Park, 2015) is a simple yet powerful method for improvement that ought to be considered when planning for routine evaluation of outcome. It places routine evaluation in the broader context of modifying an intervention based on what is learned about the effectiveness of the intervention.

Tips from the field

During the June 2021 meeting of the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*], members reviewed the roadmap for school refusal

interventions and made suggestions for its use. These 'tips from the field' are presented hereunder.

1. Use the roadmap as a checklist,
    a. whereby team members independently rate each signpost in terms of: (i) how important the signpost is; and (ii) the attention currently given to each signpost.
    b. to identify areas of focus for further training.
    c. to help teams specify their current methodology, focusing on what is done, how it is achieved, and which signposts are considered essential or optional.

2. Use the roadmap as a discussion document,
    a. to provide a connecting perspective among professionals currently delivering or planning to develop an intervention for school refusal.
    b. to facilitate structured dialogue about the content of an existing intervention, focusing on 'what has been learned' about the intervention in the light of the roadmap, and 'where improvements can be made'.
    c. to help regional partnerships [*samenwerkingsverbanden*] and healthcare partners [*zorgpartners*] address service gaps and build consensus on how funding is spent.
    d. to facilitate regional, national, and international exchange of ideas and expertise related to school refusal intervention.

3. Use the roadmap as a springboard,
    a. to consider the role of the school attendance officer [*leerplichtambtenaar*].
    b. to consider what one does as the care coordinator [*zorgcoördinator*].
    c. to identify topics for discussion between mentors and students [*mentorgesprekken*].
    d. to identify what is needed when youths move between primary and secondary school, or between special education and mainstream education.

4.4.3 Implications for Research

The Knowing What Works project provides 'a sneak peak in the kitchen' [*een kijkje in de keuken*] of 21 interventions for school refusal. The project enabled us to explore educational and mental health interventions to address severe and chronic school refusal; ways in which education and mental health services collaborate; and what professionals, youths, and parents perceive to be the most important and helpful elements in the interventions. Data was gathered via interviews with 76 professionals from across 21 interventions, and via questionnaires completed by youths and parents who participated in 15 of the 21 interventions. This data was used to develop 14 signposts in a roadmap for school refusal interventions.

The findings from the project are global impressions. That is, the views of professionals associated with the 21 interventions were analysed collectively, yielding main themes and sub-themes as shown in the networks in Chapter 3. Likewise, the responses of youths and parents who had participated in different interventions were analysed collectively, and not for each intervention separately. The project was not designed to identify interventions that appear to have better outcomes relative to other interventions, hence it was titled Knowing What Works [*Weten Wat Werkt*] and not Knowing Which One Works [*Weten Welke Werkt*].

A subsequent step for research would be to analyse what is done within specific interventions, in relation to youths' and parents' reports of the acceptability and effectiveness of those specific interventions. This would permit a more robust evaluation of the mechanisms of change in interventions for school refusal. A second research question is the extent to which a youth's age, as a proxy for developmental level, influences the outcome of intervention. Other variables which potentially predict the outcome of intervention could also be investigated. A third question relevant to severe and chronic school refusal relates to the role that medication might play in intervention. Finally, an examination of 'what works' in interventions for other school attendance problems could be conducted. These four research topics are addressed next.

Robust evaluation of the mechanisms of change in interventions for school refusal

The current project made use of qualitative data from multiple stakeholders about what it is that contributes to effective intervention for school refusal. The project does not permit conclusions about the mechanisms of change in specific cases or in a specific intervention. Empirical investigation of the mechanisms of change in specific interventions requires standardised measurement of key variables at pre-intervention, during intervention, post-intervention, and ideally at various follow-up points (e.g., 6 months and 12 months after the end of intervention). Examples of outcome variables that could be measured at pre-intervention, post-intervention, and follow-ups include school attendance, anxiety, depression, and overall wellbeing. For an overview of outcome variables included in studies of treatment for school refusal, see Heyne, Strömbeck, et al. (2020). The decision about which variables to measure during intervention would be guided by the theory of change associated with the intervention under investigation. For an overview of variables that may mediate the outcome of intervention for school refusal, see Heyne et al. (2015). Examples of variables that might mediate outcome are youth self-efficacy, relationships with peers and teachers at school, parent self-efficacy, and family functioning. With respect to family functioning, controlled studies could evaluate relative outcomes when interventions do and do not include family-related work.

A finding in the current project is that the 21 interventions studied involve considerable flexibility. No organisations offer a fully standardised intervention, a small number offer a predominantly or fully flexible intervention, and most offer an intervention which is both

flexible and standardised. The flexible way of working is understandable because these are real-world interventions being provided to youths and families with diverse backgrounds and needs. However, robust empirical investigation of the mechanisms of change will benefit from greater standardisation in the delivery of intervention across participants. To the extent that organisations are able to specify the key elements in their intervention and increase the standard delivery of those elements, without sacrificing the flexibility deemed important to successful intervention, the effective elements in these interventions can be studied.

A main theme that emerged from the reports of professionals was 'development and evaluation' [*ontwikkeling en evaluatie*]. More specifically, when professionals were asked about adjustments they would like to make to their intervention they spoke about the desire to develop evidence-based interventions and to evaluate the effects of intervention. It is encouraging to note this desire among professionals delivering interventions. Organisations less accustomed to evaluating interventions may require support to develop and implement processes for measuring key variables at pre-intervention, during intervention, at post-intervention, and at follow-ups. Collaboration can be sought with other organisations more accustomed to routine outcome measurement, and with researchers from higher education or commercial agencies. The youth and parent questionnaires included in Appendix P and Appendix Q of this report may be helpful for measuring outcomes and consumer satisfaction from the perspective of youths and parents. However, these should be accompanied by other instruments which have sound psychometric properties (see Gonzálvez et al., 2021; Heyne, Strömbeck, et al., 2020). If different organisations employ the same instruments to measure outcome, non-randomised comparisons of the interventions provided by the different organisations can be conducted.

The effects of age and other variables on the outcome of interventions for school refusal

In the current project, professionals were asked about factors that seem to influence the effectiveness of their intervention. An emerging sub-theme was 'the youth's age' [*leeftijd van de jongere*], based on responses indicating that outcome is better for younger youth, but also responses indicating that outcome is better for older youth. Qualitative research cannot robustly ascertain moderators of outcome. Robust statistical analysis is required to gain a better understanding of whether, and to what extent, age is a moderator of the outcome of intervention, with age used as a proxy for youths' developmental level. This requires a large sample of youths across a wide age range, along with the use of standardised measurements at pre-intervention and post-intervention as outlined in the previous topic.

The importance of robust examination of age effects is supported by findings in the literature. Two studies of CBT for school refusal included children and adolescents and examined age effects, and both studies pointed to inferior outcomes among older youths

(Heyne, 1999; Last et al., 1998). These outcomes are consistent with the inferior outcomes observed among older youths in studies of school refusal interventions other than CBT (Goh, 1989; Prabhuswamy et al., 2007; Rodriguez et al., 1959; Valles & Oddy, 1984). Furthermore, age is likely to influence intervention outcomes in a moderated mediation model of change. To illustrate, the effect of a mediator (e.g., a change in family functioning mediates the relationship between intervention and the outcome of intervention) may be moderated by another variable (e.g., the age of the young person influences the extent to which a change in family functioning mediates the relationship between intervention and the outcome of intervention).

Some professionals in the current project found it difficult to specify which youths and families were more or less likely to respond to the intervention provided. This may reflect the fact that few organisations conduct systematic evaluation of their intervention, and thus there is little scientific insight into 'for whom' the intervention has most effect. Thus, in addition to investigating age, researchers might study other pre-intervention variables that could influence the outcome of intervention, including the severity and chronicity of school refusal, co-occurring psychopathology such as social anxiety and depression, academic functioning, family functioning, and parent psychopathology (Heyne et al., 2015).

The use of medication and its impact

Pharmacological intervention for school refusal is a contentious issue for some professionals. Because school refusal is a complex problem, especially when it is severe and chronic, medication is unlikely to be an effective stand-alone intervention because it does not address the multiple factors contributing to school refusal at the individual, family, school, and community levels (Heyne, 2006). However, medication may be used in a multi-modal intervention to address symptoms of anxiety or depression while other interventions address additional factors contributing to school refusal such as bullying, learning problems, and psychosocial adversity (Londono Tobon et al., 2018). Indeed, multi-modal interventions for school refusal or truancy (Reissner et al., 2019) and for chronic absenteeism with anxiety or depression (Walter et al., 2010) include the possible use of medication. Multidisciplinary guidelines for the use of medication can be found online.

In the Knowing What Works project, professionals were directly asked about medication via a closed question. The question invited professionals to indicate which of 10 intervention elements, including medication, they would like to pay more attention to in their own intervention. None of the professionals indicated that they would like to make more use of medication. However, medication was mentioned by professionals associated with 5 of the 21 interventions during an open question about the mental health services provided during intervention for school refusal. For example, a mental health professional explained that medication is not instigated in the first six weeks of intervention but if a young person had already been prescribed medication then there is consultation with a medical practitioner to

discuss dosage. Professionals from educational settings also commented that medication is often used, resonating with reports from education professionals in Devenney and O'Toole's (2021) study that medication sometimes helped anxious youths get "over the threshold of the door of the school" (p. 40). None of the professionals participating in the Knowing What Works project mentioned medication when asked about effective elements in their intervention. Youths and parents were not asked directly about the use of medication. One parent spontaneously mentioned medication in response to the question about effective elements. Specifically, this parent explained that their child was helped via the discussion that occurred during psychosocial intervention, but that medication was also needed when it became clear that the psychosocial intervention was not sufficiently effective.

Taken together, there is evidence that medication is used, professionals did not perceive it to be a working element of their intervention, and they did not prioritise the use of medication when reflecting on adjustments they would like to make to their intervention. The fact that minimal attention was paid to medication might be explained by various factors, such as the preponderance of educational interventions in the project relative to mental health interventions, and the likelihood that professionals associated with educational interventions do not consider questions of medication to be part of their core business.

Melvin and Gordon (2019) presented a narrative review of 50 years of research on antidepressant medication for school refusal, the most common medication used with youths displaying school refusal. They argued for the need to consider medication as an adjunct to CBT because some youths do not respond to psychosocial interventions, especially when school refusal is severe and chronic. At the same time, they concluded that there is insufficient evidence to automatically assume that the additional use of medication will be beneficial. Furthermore, they noted that there is no compelling evidence for using antidepressant medication as a stand-alone intervention. Similar conclusions were reached by Londono Tobon et al. (2018) in their systematic review of various pharmacological interventions for school refusal. Antidepressants and anxiolytics were found to reduce school refusal, depression, and anxiety, but there was no evidence that medications were superior to placebo. The authors suggested that professionals firstly consider psychosocial interventions to address school refusal and concurrent problems such as anxiety or depressive disorders, or combine psychosocial and pharmacological interventions when a young person presents with an anxiety or depressive disorder and professionals believe there is an urgent need to help the young person return to school because prognosis worsens as school refusal continues.

Further research is needed to better understand the role and benefits of medication in intervention for severe and chronic school refusal. As noted by Londono Tobon et al. (2018), data about pharmacological interventions for school refusal is sparse, and there is a need for more studies with newer medications and larger samples. In addition to conducting large-scale quantitative studies as suggested by Londono Tobon et al., research can include single case experimental designs to better understand the impact of combining medication with

psychosocial intervention. Future qualitative research can also shed more light on the scope of medication use (e.g., how many and which youths displaying Tier 3 school refusal are prescribed medication) and the impact of medication, via interviews with professionals, youths, and parents.

What works in interventions for other school attendance problems?

Recall from Section 1.2.1 that some researchers differentiate between school refusal and three other types of absenteeism, namely truancy, school withdrawal, and school exclusion (Heyne et al., 2019). The primary reason for differentiation is that different factors are associated with the development and maintenance of different types of attendance problems, necessitating different interventions. The Knowing What Works project focused on school refusal, but the research model and the instruments included in the Appendices of this report could be adapted to learn more about 'what works' in interventions for truancy, school withdrawal, and school exclusion. A question arises as to the extent to which an emerging roadmap for truancy intervention, for example, would be similar to and different from the roadmap for school refusal intervention as presented in this report. A related question concerns the role that school attendance officers [*leerplichtambtenaren*] ideally serve in interventions for school attendance problems (e.g., in which cases, in what ways, and at which points in the intervention process).

4.4.4 Conclusion

Many interventions in the Netherlands are dedicated to supporting youths and families confronting severe and chronic school refusal. The number of interventions is testament to the work being done to address school refusal and the great need to support these youths and their families. Intervention is needed to help youths gain confidence to re-engage with school and further develop the academic and social-emotional skills that contribute to a fulfilling future. The common co-occurrence of school refusal and autism highlights the need for interventions that respond to the special needs and competencies of youths with an autism spectrum disorder. For bullied youths, a restored sense of safety at school and positive social experiences are needed to facilitate school attendance. Parents also need support to reduce their distress and help them provide optimal support to their child as he or she engages with school.

The Knowing What Works project focused on 21 school refusal interventions, synthesising the experiences and views of professionals, youths, and parents associated with these interventions. This is the first effort, nationally and internationally, to synthesise the voices of key stakeholders from across multiple school refusal interventions. The project is

testament to the efforts of the National Expertise Team for School Refusal [*Landelijk KennisTeam Schoolweigering*] to advance research and practice in this area. Data derived during the project contributes to knowledge about key conditions for school refusal interventions, encapsulated in 14 signposts in the roadmap for school refusal interventions. Professionals in education and support services [*hulpverlening*] can draw upon this knowledge as they develop and deliver interventions for school refusal. The availability of a roadmap reduces the likelihood that professionals will spend precious time and resources simply 're-inventing the wheel'. The National Expertise Team for School Refusal – soon to be the Expertise Network for School Attendance [*Kennisnetwerk Schoolaanwezigheid*] – will support professionals' use of the roadmap by facilitating meetings dedicated to discussion and training in those parts of the roadmap that professionals identify as warranting most attention. This will help translate the 'what' of intervention for school refusal into the 'how' of intervention for school refusal.

Two areas of enquiry in the Knowing What Works project deserve special comment. First, one of the research questions was about how many organisations provide a comprehensive intervention that involves the participation of the young person, parents, and school. Virtually all of the interventions studied in this project are comprehensive, meaning that they include work with the young person, parents, and school personnel. Descriptive information about youths and families points to the complexity of school refusal, including individual factors (e.g., autism) and family factors (e.g., parent mental health problems). School factors emerged in the reports of professionals, youths, and parents (e.g., the need for flexibility and support in learning). The complexity associated with school refusal and with intervention for school refusal likely explains the finding that most interventions last at least 6 months. It is important that intervention is not only comprehensive, but also integrated. Intervention is integrated to the extent that there is coherence between the work conducted with the young person, parents, and school personnel.

Second, there were research questions about what professionals, youths, and parents say about collaboration in intervention for school refusal. Professionals provided many examples of multiple disciplinary collaboration, but they also expressed a desire for improved collaboration. Youths and parents were generally positive about their experience of collaboration. Many youths displaying school refusal require educational and mental health support, evidenced in all six networks presented in this report. This underscores the value of permanent collaboration between education and support services [*hulpverlening*]. Complex real-world problems like school refusal are not confined to the artificial boundaries of a single professional discipline such as education, or mental health. Rather, they require the different perspectives of professionals who can achieve sophisticated understanding and provide comprehensive services (Choi & Pak, 2006). We suggest that comprehensive and integrated multiple disciplinary intervention is the gold standard for addressing school refusal when it is severe, chronic, and complex. Widespread uptake of multiple disciplinary models of school attendance problems is elusive (Heyne et al., 2022), but the practice of responding to school refusal in the Netherlands appears to involve considerable collaboration between education and mental health services.

Regional policy should ensure that school refusal interventions are available for youths and families affected by school refusal. The signposts in the roadmap presented in this report can guide policymaking at the regional level and within organisations that provide an intervention for school refusal. For example, Signposts 10 to 14 refer to the need to work together as education and support services, to specify the goals and method for intervention, to gather a committed team with knowledge and experience, and to provide sufficient resources to implement the intervention. National policy can be guided by the findings in this report that many youths displaying school refusal require access to alternative educational programs and/or concessions within the standard educational pathways, in order to be able to remain engaged with education, perhaps preventing early school leaving. The clear need for collaboration between education and support services can also inform national policy on the provision of services for youths. This necessitates resolution of the currently complex funding issues (e.g., which funds and how much funding is available to enable professionals from social services to provide support to a young person in the school setting) and enhancing knowledge exchange between professionals from these sectors.

In conclusion, the Knowing What Works project contributes to the growing body of research on intervention for school refusal. We identified four topics for continued research, and refer readers to other questions relevant to school refusal intervention (Johnsen et al., 2021). Researchers are encouraged to collaborate with key stakeholders including professionals, youths, and parents, to determine the relative importance of new research questions.

References

Albano, A. M. (1995). Treatment of social anxiety in adolescents. *Cognitive and Behavioral Practice*, *2*, 271-298.

Al Husni Al Keilani, M., & Delvenne, V. (2021). Inpatient with an Anxious School Refusal: A Retrospective Study. *Psychiatria Danubina*, *33*(Suppl 9), 69-74.

Allensworth, E., & Balfanz, R. (2019). Foreword. In M. Gottfried & E. L. Hutt (Eds.), *Absent from school: Understanding and addressing student absenteeism* (p. ix-xi). Harvard Education Press.

Allison, M. A., Attisha, E., & AAP COUNCIL ON SCHOOL HEALTH (2019). The link between school attendance and good health. Pediatrics, *143*, e20183648.

Anderson, J., King, N., Tonge, B., Rollings, S., Young, D., & Heyne, D. (1998). Cognitive-behavioural intervention for an adolescent school refuser: A comprehensive approach. *Behaviour Change*, *15*, 67-73.

Ansari, A., & Pianta, R. C. (2019). School absenteeism in the first decade of education and outcomes in adolescence. *Journal of School Psychology*, *76*, 48-61.

Archer, T., Filmer-Sankey, C., & Fletcher-Campbell, F. (2003). *School phobia and school refusal: Research into causes and remedies LGA research report 46*. Retrieved May 10, 2021, from https://www.nfer.ac.uk/media/2078/pho01.pdf.

Attwood, G., & Croll, P. (2006). Truancy in secondary school pupils: Prevalence, trajectories and pupil perspectives. *Research Papers in Education*, *21*, 467-484.

Aucejo, E. M., & Romano, T. F. (2016). Assessing the effect of school days and absences on test score performance. *Economics of Education Review*, *55*, 70-87.

Baarda, B., Bakker, E., Boullart, A., Fischer, T., Julsing, M., Peters, V., & van der Velden, T. (2018). *Basisboek kwalitatief onderzoek: Handleiding voor het opzetten en uitvoeren van kwalitatief onderzoek* [All you need in qualitative research: Manual for setting up and conducting qualitative research]. Noordhof Uitgevers.

Bagnell, A. L. (2011). Anxiety and separation disorder. *Pediatrics in Review*, *32*, 440-445.

Baker, H., & Wills, U. (1978). School phobia: Classification and treatment. *British Journal of Psychiatry*, *132*, 492-499.

Baker, M., & Bishop, F. L. (2015). Out of school: A phenomenological exploration of extended non-attendance. *Educational Psychology in Practice*, *31*, 354-368.

Balu, R., & Ehrlich, S. B. (2018). Making sense out of incentives: A framework for considering the design, use, and implementation of incentives to improve attendance. *Journal of Education for Students Placed at Risk*, *23*, 93-106.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84,*191-215.

Barrett, P. M., & Turner, C. (2000). *FRIENDS for Children: Group Leader's Manual.* Bowen Hills, Australia: Australian Academic Press.

Beidas, R. S., Crawley, S. A., Mychailyszyn, M. P., Comer, J. S., & Kendall, P. C. (2010). Cognitive-behavioral treatment of anxious youth with comorbid school refusal: Clinical presentation and treatment response. *Psychological Topics*, *19*, 255-271.

Berg, I. (1980). School refusal in early adolescence. In L. Hersov & I. Berg (Eds.), *Out of school: Modern perspectives* (pp. 231-249). Wiley.

Berg, I. (1997). School refusal and truancy. *Archives of Disease in Childhood*, *76*, 90-91.

Berg, I. (2002). School avoidance, school phobia, and truancy. In M. Lewis (Ed.), *Child and adolescent psychiatry: A comprehensive textbook* (3rd ed., pp. 1260-1266). Sydney: Lippincott Williams & Wilkins.

Berg, I., & Fielding, D. (1978). An evaluation of hospital in-patient treatment in adolescent school phobia. *British Journal of Psychiatry*, *132*, 500-505.

Berg, I., & Jackson, A. (1985). Teenage school refusers grow up: A follow-up study of 168 subjects, ten years on average after in-patient treatment. *British Journal of Psychiatry*, *147*, 366-370.

Berg, I., Nichols, K., & Pritchard, C. (1969). School phobia: Its classification and relationship to dependency. *Journal of Child Psychology and Psychiatry*, *10*, 123-141.

Bernstein, G. A., Borchardt, C. M., Perwien, A. R., Crosby, R. D., Kushner, M. G., Thuras, P. D., & Last, C. G. (2000). Imipramine plus cognitive-behavioral therapy in the treatment of school refusal. *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 276-283.

Bernstein, G. A., Hektner, J. M., Borchardt, C. M., & McMillan, M. H. (2001). Treatment of school refusal: One-year follow-up. *Journal of the American Academy of Child and Adolescent Psychiatry*, *40*, 206-213.

Bernstein, G. A., Warren, S. L., Massie, E. D., & Thuras, P. D. (1999). Family dimensions in anxious-depressed school refusers. *Journal of Anxiety Disorder, 13,* 513-528.

Berry, G. L., & Lizardi, A. (1985). The school phobic child and special services providers: Guidelines for early identification. *Special Services in the Schools*, *2*, 63-72.

Bitsika, V., Heyne, D. A., & Sharpley, C. F. (2021). Is bullying associated with emerging school refusal in autistic boys? *Journal of Autism and Developmental Disorders, 51,* 1081-1092.

Bitsika, V., Heyne, D. A., & Sharpley, C. F. (2022). The inverse association between psychological resilience and emerging school refusal among bullied autistic youth. *Research in Developmental Disabilities*, *120*. doi.org/10.1016/j.ridd.2021.104121

Bitsika, V., Sharpley, C., & Heyne, D. A. (2021). Risk for school refusal among autistic boys bullied at school: Investigating associations with social phobia and separation anxiety. *International Journal of Disability, Development and Education*. DOI: 10.1080/1034912X.2021.1969544

Blagg, N., & Yule, W. (1984). The behavioural treatment of school refusal: A comparative study. *Behaviour Research and Therapy*, *22*, 119-127.

Blagg, N., & Yule, W. (1994). School phobia. In T. H. Ollendick, N. J. King & W. Yule (Eds.), *International handbook of phobic and anxiety disorders in children and adolescents* (pp. 169-186). New York: Plenum Press.

Blöte, A. W., Miers, A. C., Heyne, D. A., Clark, D. M., & Westenberg, P. M. (2014). The relation between social anxiety and audience perception: examining Clark and Wells' (1995) model among adolescents. *Behavioural and Cognitive Psychotherapy*, *42*, 555-567.

Blöte, A. W., Miers, A. C., Heyne, D. A., & Westenberg, P. M. (2015). Social anxiety and the school environment of adolescents. In K. Ranta, A.M. La Greca, L.-J. Garcia-Lopez, and

M. Marttunen (Eds.), *Social anxiety and phobia in adolescents: Development, manifestation and intervention strategies* (pp. 151-181). Springer International Publishing.

Bonell, C., Blakemore, S.-J., Fletcher, A., & Patton, G. (2019). Role theory of schools and adolescent health. *The Lancet Child and Adolescent Health*, *3*, 742-748.

Bools, C., Foster, J., Brown, I., & Berg, I. (1990). The identification of psychiatric disorders in children who fail to attend school: A cluster analysis of a non-clinical population. *Psychological Medicine*, *20*, 171-181.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77-101.

Breinholst, S., Esbjørn, B. H., Reinholdt-Dunne, M. L., & Stallard, P. (2012). CBT for the treatment of child anxiety disorders: A review of why parental involvement has not enhanced outcomes. *Journal of Anxiety Disorders, 26*, 416-424.

Brouwer-Borghuis, M., Bonthuis, C., & Singer, J. (2019, October 16-18). *The Link: An educational facility for school-refusing adolescents, and its mental health spouse(s)* [Paper presentation]. 2019 INSA Conference, Oslo, Norway.

Brouwer-Borghuis, M., Heyne, D., Sauter, F. M., & Scholte, R. H. J. (2019). The Link: An alternative educational program in the Netherlands to reengage school-refusing adolescents with schooling. *Cognitive and Behavioral Practice*, *26*, 75-91.

Brouwer-Borghuis, M., Heyne, D., Vogelaar, B., & Sauter, F. M. (2019). Early identification of school attendance problems: How helpful are Dutch laws, policies, and protocols? *European Journal of Education and Psychology*, *12*, 47-62.

Bryce, G., & Baird, D. (1986). Precipitating a crisis: Family therapy and adolescent school refusers. *Journal of Adolescence*, *9*, 199-213.

Buitelaar, J. K., van Andel, H., Duyx, J. H. M., & van Strien, D. C. (1994). Depressive and anxiety disorders in adolescence: A follow-up study of adolescents with school refusal. *Acta Paedopsychiatrica*, *56*, 249-253.

Burke, A. E., & Silverman, W. K. (1987). The prescriptive treatment of school refusal. *Clinical Psychology Review*, *7*, 353-362.

Byrd, R., & Luke, C. (2020). *Counseling children and adolescents: Cultivating empathic connection*. Routledge.

Cabus, S. J., & De Witte, K. (2015). Does unauthorized school absenteeism accelerates the dropout decision?: Evidence from a Bayesian duration model. *Applied Economics Letters, 22,* 266-271.

Carrington, S., Campbell, M., Saggers, B., Ashburner, J., Vicig, F., Dillon-Wallace, J., & Hwang, Y.-S. (2017). Recommendations of school students with autism spectrum disorder and their parents in regard to bullying and cyberbullying prevention and intervention. *International Journal of Inclusive Education*, *21*, 1045-1064.

Carroll, H. C. M. (2020). The relative effect of pupil absenteeism on literacy and numeracy in the primary school. *Educational Studies*, DOI: 10.1080/03055698.2020.1793302

CBS. (n.d.). *Hoeveel mensen met een migratieachtergrond wonen in Nederland?* Retrieved May 12, 2021, from https://www.cbs.nl/nl-nl/dossier/dossier-asiel-migratie-en-integratie/hoeveel-mensen-met-een-migratieachtergrond-wonen-in-nederland-

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66,* 7-18.

Chambless, D. L., Sanderson, W. C., Shoham, V., Johnson, S. B., Pope, K. S., Crits-Christoph, P., Baker, M. J., Johnson, B., Woody, S. R., Sue, S., Beutler, L. E., Williams, D. A., & McCurry, S. M. (1996). An update on empirically validated therapies. *The Clinical Psychologist*, *49*, 5-18.

Chang, H. N., Bauer, L., & Byrnes, V. (2018). *Data matters: Using chronic absence to accelerate action for student success*. Retrieved April 2, 2020, from https://www.attendanceworks.org/wp-content/uploads/2019/01/Attendance-Works-Data-Matters_010919.pdf.

Chhabra, T., & Puar, S. (2016). Social support in psychotherapy of panic disorder with agoraphobia in school setting. *Indian Journal of Health and Wellbeing*, *7*, 648-650.

Choi, B. C., & Pak, A. W. (2006). Multidisciplinarity, interdisciplinarity and transdisciplinarity in health research, services, education and policy: 1. Definitions, objectives, and evidence of effectiveness. *Clinical and Investigative Medicine*, *29*, 351-64.

Christogiorgos, S., & Giannakopoulos, G. (2014). School refusal and the parent-child relationship: A psychodynamic perspective. *Journal of Infant, Child, and Adolescent Psychotherapy*, *13*, 182-192.

Chu, B. C., Crocco, S. T., Esseling, P., Areizaga, M. J., Lindner, A. M., & Skriner, L. C. (2016). Transdiagnostic group behavioral activation and exposure therapy for youth anxiety and depression: Initial randomized controlled trial. *Behaviour Research and Therapy*, *76*, 65-75.

Chu, B. C., Rizvi, S. L., Zendegui, E. A., & Bonavitacola, L. (2015). Dialectical behavior therapy for school refusal: Treatment development and incorporation of web-based coaching. *Cognitive and Behavioral Practice*, *22,* 317-330.

Clarke, G. N., Rohde, P., Lewinsohn, P. M., Hops, H., & Seeley, J. R. (1999). Cognitive-behavioral treatment of adolescent depression: Efficacy of acute group treatment and booster sessions. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*, 272-279.

Collie, R. J. (2020). The development of social and emotional competence at school: An integrated model. *International Journal of Behavioral Development*, *44*, 76-87.

Compton, S. N., Walkup, J. T., Albano, A. M., Piacentini, J. C., Birmaher, B., Sherrill, J. T., Ginsburg, G. S., Rynn, M. A., McCracken, J. T., Waslick, B. D., Iyengar, S., Kendall, P. C., & March, J. S. (2010). Child/Adolescent Anxiety Multimodal Study (CAMS): Rationale, design, and methods. *Child and Adolescent Psychiatry and Mental Health*, *4*, Article 1. https://doi.org/10.1186/1753-2000-4-1.

Conoley, J. C. (1987). Strategic family intervention: Three cases of school-aged children. *School Psychology Review*, *16*, 469-486.

Contessa, M. A., & Paccione-Dyszlewski, M. R. (1981). An application of a group counselling technique with school-phobic adolescents. *Adolescence, 16*, 901-904.

Curry, J. F., Wells, K. C., Brent, D. A., Clarke, G. N., Rohde, P., Albano, A. M., Reinecke, M. A., Benazon, N., & March, J. S. (2000). *Cognitive behavior therapy manual: Introduction, rationale, and adolescent sessions*. Duke University Medical Center, The TADS Team.

Dahlgaard-Park, S. (2015). Plan, do, check, act (pdca) cycle. In *The Sage Encyclopedia of Quality and the Service Economy* (Vol. 1, pp. 497-498). SAGE Publications. https://www.doi.org/10.4135/9781483346366.n141

Danish Ministry of Education. (2018). *Student absence for primary school pupils.* Retrieved June 12, 2019, from https://www.uvm.dk/statistik/grundskolen/elever/elevfravaer.

Dannow, M. C., Esbjørn, B. H., & Risom, S. W. (2020). The perceptions of anxiety-related school absenteeism in youth: A qualitative study involving youth, mother, and father. *Scandinavian Journal of Educational Research*, *64*, 22-36.

De Groot, C., Heyne, D., & Boon, A. (2021). *Personality traits among adolescents displaying severe school refusal and the influence on treatment outcome* [Manuscript submitted for publication]. Parnassia Group, Youz, Centre for Youth Mental Healthcare Haaglanden.

Dembo, R., Briones-Robinson, R., Ungaro, R. A., Gulledge, L. M., Karas, L. M., Winters, K. C., Belenko, S., & Greenbaum, P. E. (2012). Emotional psychological and related problems among truant youths: An exploratory latent class analysis. *Journal of Emotional and Behavioral Disorders, 20,* 157-168.

Devenney, R., & O'Toole, C. (2021). 'What kind of education system are we offering': The view of education professionals on school refusal. *International Journal of Educational Psychology, 10,* 27-47.

Dullaert, M. (2019). *De kracht om door te zetten: Hoe kunnen we de impasse rondom thuiszitten doorbreken?* [The power to continue: How can we break the deadlock around long-term absenteeism?]. Retrieved January 20, 2021, from https://www.rijksoverheid.nl/documenten/rapporten/2019/01/29/de-kracht-om-door-te-zetten.

Eccles, J. S., & Roeser, R. W. (2015). Schools as developmental contexts during adolescence. *Journal of Research on Adolescence*, *21*, 225-241.

Egger, H. L., Costello, E. J., & Angold, A. (2003). School refusal and psychiatric disorders: A community study. *Journal of the American Academy of Child and Adolescent Psychiatry*, *42,* 797-807.

Elliott, J. G., & Place, M. (2019). Practitioner review: School refusal: Developments in conceptualisation and treatment since 2000. *Journal of Child Psychology and Psychiatry*, *60*, 4-15.

Enea, V., & Dafinoiu, I. (2009). Motivational/solution-focused intervention for reducing school truancy among adolescents. *Journal of Cognitive and Behavioral Psychotherapies*, *9*, 185-198.

Epstein, J. L., & Sheldon, S. B. (2002). Present and accounted for: Improving student attendance through family and community involvement. *Journal of Educational Research*, *95*, 308-318.

Epstein, S., Roberts, E., Sedgwick, R., Polling, C., Finning, K., Ford, T., Dutta, R., & Down, J. (2020). School absenteeism as a risk factor for self-harm and suicidal ideation in children and adolescents: A systematic review and meta-analysis. *European Child and Adolescent Psychiatry*, *29*, 1175-1194.

Estes, H. R., Haylett, C. H., & Johnson, A. M. (1956). Separation anxiety. *American Journal of Psychotherapy*, *10*, 682-695.

Evans, L. D. (2000). Functional school refusal subtypes: Anxiety, avoidance, and malingering. *Psychology in the Schools*, *37*, 183-191.

Filippello, P., Buzzai, C., Costa, S., & Sorrenti, L. (2019). School refusal and absenteeism: Perception of teacher behaviors, psychological basic needs, and academic achievement. *Frontiers in Psychology, 10*:1471.

Filippello, P., Buzzai, C., Messina, G., Mafodda, A. V., & Sorrenti, L. (2020). School refusal in students with low academic performances and specific learning disorder: The role of self-esteem and perceived parental psychological control. *International Journal of Disability, Development and Education*, *67*, 592-607.

Finning, K., Harvey, K., Moore, D., Ford, T., Davis, B., & Waite, P. (2018). Secondary school educational practitioners' experiences of school attendance problems and interventions to address them: A qualitative study. *Emotional and Behavioural Difficulties*, *23*, 213-225.

Flakierska-Praquin, N., Lindström, M., & Gillberg, C. (1997). School phobia with separation anxiety disorder: A comparative 20- to 29-year follow-up study of 35 school refusers. *Comprehensive Psychiatry*, *38*, 17-22.

Fornander, M. J., & Kearney, C. A. (2019). Family environment variables as predictors of school absenteeism severity at multiple levels: Ensemble and classification and regression tree analysis. *Frontiers in Psychology*, *10*:2381. doi: 10.3389/fpsyg.2019.02381

Fredricks, J. A., & Eccles, J. S. (2005). Developmental benefits of extracurricular involvement: Do peer characteristics mediate the link between activities and youth outcomes? *Journal of Youth and Adolescence*, *34*, 507-520.

Fredricks, J. A., Parr, A. K., Amemiya, J. L., Wang, M.-T., & Brauer, S. (2019). What matters for urban adolescents' engagement and disengagement in school: A mixed-methods study. *Journal of Adolescent Research*, *34*, 491-517.

Frick, W. B. (1964). School phobia: A critical review of the literature. *Merrill-Palmer Quarterly Review of Behavior and Development*, *10*, 361-373.

Gallé-Tessonneau, M., & Heyne, D. (2020). Behind the SCREEN: Identifying school refusal themes and sub-themes. *Emotional and Behavioural Difficulties*, *25*, 139-154.

Galloway, D. (1985). *Schools and persistent absentees*. Pergamon Press.

Gausel, N., & Bourguignon, D. (2020). Dropping out of school: Explaining how concerns for the family's social-image and self-image predict anger. *Frontiers in Psychology*, *11*:1868.

Gershenson, S., Jacknowitz, A., & Brannegan, A. (2017). Are student absences worth the worry in U.S. primary schools? *Education Finance and Policy*, *12*, 137-165.

Ginsburg, A., Jordan, P., & Chang, H. (2014). *Absences add up: How school attendance influences student success*. Attendance Works. Retrieved January 26, 2021, from https://www.attendanceworks.org/wp-content/uploads/2017/05/Absenses-Add-Up_September-3rd-2014.pdf.

Ginsburg, G. S., & Schlossberg, M. C. (2002). Family-based treatment of childhood anxiety disorders. *International Review of Psychiatry*, *14*, 143-154.

Glaser, K. (1959). Problems in school attendance: school phobia and related conditions. *Pediatrics*, *23*, 371-383.

Goh, C. W. (1989). School refusal: Clinical features and treatment outcome. *Singapore Medical Journal*, *30*, 550-552.

Gonzálvez, C., Kearney, C. A., Vicent, M., & Sanmartín, R. (2021). Assessing school attendance problems: A critical systematic review of questionnaires. *International Journal of Educational Research*, *105*, 101702.

Gosschalk, P. O. (2004). Behavioral treatment of acute onset school refusal in a 5-year old girl with separation anxiety disorder. *Education and Treatment of Children*, *27*, 150-160.

Gottfried, M. A. (2009). Excused versus unexcused: How student absences in elementary school affect academic achievement. *Educational Evaluation and Policy Analysis*, *31*, 392-415.

Gottfried, M. A. (2014). Chronic absenteeism and its effects on students' academic and socioemotional outcomes. *Journal of Education for Students Placed at Risk*, *19*, 53-75.

Gottfried, M. A., & Hutt, E. L. (2019). Introduction. In M. A. Gottfried & E. L. Hutt (Eds.), *Absent from school: Understanding and addressing student absenteeism* (pp. 1-12). Harvard Education Press.

Grandison, K. J. (2011). *School refusal and reintegration from short stay school to mainstream* [Unpublished master's thesis]. University of Birmingham.

Gregory, I. R., & Purcell, A. (2014). Extended school non-attenders' views: Developing best practice. *Educational Psychology in Practice*, *30*, 37-50.

Gutiérrez-Maldonado, J., Magallón-Neri, E., Rus-Calafell, M., & Peñaloza-Salazar, C. (2009). Virtual reality exposure therapy for school phobia. *Anuario de Psicología*, *40*, 223-236.

Hancock, K. J., Shepherd, C. C. J., Lawrence, D., & Zubrick, S. R. (2013). *Student attendance and educational outcomes: Every day counts*. Report for the Department of Education, Employment and Workplace Relations, Canberra.

Hannan, S. E., Davis, E., Morrison, S., Gueorguieva, R., & Tolin, D. F. (2019). An open trial of intensive cognitive-behavioral therapy for school refusal. *Evidence-Based Practice in Child and Adolescent Mental Health*, *4*, 89-101.

Hansen, C., Sanders, S. L., Massaro, S., & Last, C. G. (1998). Predictors of severity of absenteeism in children with anxiety-based school refusal. *Journal of Clinical Child Psychology*, *27*, 246-254.

Havik, T., Bru, E., & Ertesvåg, S. K. (2014). Parental perspectives of the role of school factors in school refusal. *Emotional and Behavioural Difficulties*, *19*, 131-153.

Havik, T., Bru, E., & Ertesvåg, S. K. (2015). Assessing reasons for school non-attendance. *Scandinavian Journal of Educational Research*, *59*, 316-336.

Havik, T., & Ingul, J. M. (2021). Does homeschooling fit students with school attendance problems?: Exploring teachers' experiences during COVID-19. *Frontiers in Education*, *6*:720014.

Hendron, M., & Kearney, C. A. (2011). Bridging the gap between assessment and treatment of youths with school refusal behavior: What to do when clients ask "What now?" *Journal of Clinical Psychology Practice*, *2*, 14-21.

Hersov, L. (1972). School refusal. *British Medical Journal*, *3*, 102-104.

Hersov, L. (1985). School refusal. In M. Rutter & L. Hersov (Eds.), *Child and adolescent psychiatry: Modern approaches,* (2nd ed*., pp. 382-399). Oxford: Blackwell Scientific Publications.

Heyne, D. (1999). *Evaluation of child therapy and caregiver training in the treatment of school refusal* [Unpublished doctoral dissertation]. Faculty of Education, Monash University.

Heyne, D. (2006). School refusal. In J. E. Fisher and W. T. O'Donohue (Eds.), *Practitioner's guide to evidence-based psychotherapy* (pp. 599-618). New York: Springer.

Heyne, D. (2019). Developments in classification, identification, and intervention for school refusal and other attendance problems: Introduction to the special series. *Cognitive and Behavioral Practice*, *26*, 1-7.

Heyne, D. (2021a). *Practitioner review: Examining developmental factors in adolescent school refusal* [Manuscript submitted for publication]. Institute of Psychology, Leiden University.

Heyne, D. (2021b). *Practitioner review: Signposts for enhancing cognitive-behavioural therapy for adolescent school refusal* [Manuscript submitted for publication]. Institute of Psychology, Leiden University.

Heyne, D., Gentle-Genitty, C., Gren Landell, M., Melvin, G., Chu, B., Gallé-Tessonneau, M., Askeland, K. G., Gonzálvez, C., Havik, T., Ingul, J. M., Johnsen, D. B., Keppens, G., Knollmann, M., Lyon, A. R., Maeda, N., Reissner, V., Sauter, F., Silverman, W. K., Thastum, M., . . . Kearney, C. A. (2020). Improving school attendance by enhancing communication among stakeholders: Establishment of the International Network for School Attendance (INSA). *European Child and Adolescent Psychiatry*, *29*, 1023-1030.

Heyne, D., Gren Landell, M., Melvin, G., & Gentle-Genitty, C. (2019). Differentiation between school attendance problems: Why and how? *Cognitive and Behavioral Practice*, *26*, 8-34.

Heyne, D., Kearney, C. A., & Finning, K. (2022). Mental health and attendance at school: Setting the scene. In T. Ford, K. Finning, and D. Moore (Eds.), *Mental health and attendance at school* (Chapter 1). Cambridge University Press.

Heyne, D., King, N., Tonge, B., Pritchard, M., Young, D., Rollings, S., & Myerson, N. (1998). The Self-Efficacy Questionnaire for School Situations: Development and psychometric evaluation. *Behaviour Change*, *15*, 31-40.

Heyne, D., King, N., Tonge, B., Rollings, S., Young, D., Pritchard, M., & Ollendick, T. (2002). Evaluation of child therapy and caregiver training in the treatment of school refusal. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*, 687-695.

Heyne, D., & King, N. J. (2004). Treatment of school refusal. In P. M. Barrett & T. H. Ollendick (Eds.), *Handbook of interventions that work with children and adolescents: Prevention and treatment* (pp. 243-272). Chichester: Wiley.

Heyne, D., & Rollings, S. (2002). *School refusal*. Oxford: BPS Blackwell.

Heyne, D., & Sauter, F. M. (2013). School refusal. In C. A. Essau, & T. H. Ollendick (Eds.), *The Wiley-Blackwell handbook of the treatment of childhood and adolescent anxiety* (pp. 471-517). Chichester: John Wiley & Sons Limited.

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

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

Heyne, D., Sauter, F. M., Ollendick, T. H., Van Widenfelt, B. M., & Westenberg, P. M. (2014). Developmentally sensitive cognitive behavioral therapy for adolescent school refusal: Rationale and case illustration. *Clinical Child and Family Psychology Review*, *17*, 191-215.

Heyne, D., Sauter, F. M., & Van Hout, R. (2008). *The @school program: Modular cognitive behaviour therapy for school refusal in adolescence* [Unpublished manuscript]. Faculty of Social and Behavioral Sciences, Leiden University.

Heyne, D., Sauter, F. M., Van Widenfelt, B. M., Vermeiren, R., & Westenberg, P. M. (2011). School refusal and anxiety in adolescence: Non-randomized trial of a developmentally-sensitive cognitive behavioral therapy. *Journal of Anxiety Disorders*, *25*, 870-878.

Heyne, D., Strömbeck, J., Alanko, K., Bergström, M., & Ulriksen, R. (2020). A scoping review of constructs measured following intervention for school refusal: Are we measuring up? *Frontiers in Psychology*, *11*:1744.

Hobbs, A., Kotlaja, M., & Wylie, L. (2018). Absenteeism interventions: An approach for common definitions in statewide program evaluations. *Justice Evaluation Journal*, *2*, 215-232.

Hoffman, J. L., & Chu, B. C. (2019). When is seeking safety functional? Taking a pragmatic approach to distinguishing coping from safety. *Cognitive and Behavioral Practice*, *26*, 176-185.

Høiseth, M., Holme, S., Ek, S., Gabrielsen, C., & Alsos, O. (2020). Teen evaluations of a game targeting school refusal. *Proceedings of the 2020 ACM Interaction Design and Children Conference, Extended Abstracts*, 175-180.

Homel, J., Thompson, K., & Leadbeater, B. (2020). Changes in positive and negative peer influences and depressive symptoms from adolescence to young adulthood. *Journal of Adolescence*, *84*, 113-122.

Honjo, S., Kasahara, Y., & Ohtaka, K. (1992). School refusal in Japan. *Acta Paedopsychiatrica*, *55*, 29-32.

Honjo, S., Nishide, T., Niwa, S., Sasaki, Y., Kaneko, H., Inoko, K., & Nishide, Y. (2001). School refusal and depression with school attendance in children and adolescents: Comparative assessment between the Children's Depression Inventory and somatic complaints. *Psychiatry and Clinical Neurosciences*, *55*, 629-634.

Hudson, J. L., & Kendall, P. C. (2002). Showing you can do it: homework in therapy for children and adolescents with anxiety disorders. *Journal of Clinical Psychology*, *58*, 525-534.

Hudson, J. L., Rapee, R. M., Lyneham, H. J., McLellan, L. F., Wuthrich, V. M., & Schniering, C. A. (2015). Comparing outcomes for children with different anxiety disorders following cognitive behavioural therapy. *Behaviour Research and Therapy*, *72*, 30-37.

Humphrey, N., & Hebron, J. (2015). Bullying of children and adolescents with autism spectrum conditions: A 'state of the field' review. *International Journal of Inclusive Education, 19*, 845-862.

INGRADO. (2018). *Het verhaal achter de cijfers: Thuiszitters in het voortgezet onderwijs* [The story behind the numbers: Long-term absenteeism in secondary education]. Retrieved November 26, 2021, from https://ingrado.nl//media/files/kennisbank/participatie_in_het_onderwijs/thuiszitters/literatuur_en_onderzoek/Het_verhaal_achter_de_cijfers.pdf.

Ingul, J. M., Aune, T., & Nordahl, H. M. (2014). A randomized controlled trial of individual cognitive therapy, group cognitive behaviour therapy and attentional placebo for adolescent social phobia. *Psychotherapy and Psychosomatics*, *83*, 54-61.

Ingul, J. M., Havik, T., & Heyne, D. (2019). Emerging school refusal: A school-based framework for identifying early signs and risk factors. *Cognitive and Behavioral Practice, 26,* 46-62.

Japanese Ministry of Education, Culture, Sports, Science and Technology. (2017). *Futoukou jidouseitosuu no suii* [Changes in the number of students not in school]. Retrieved June 12, 2019, from https://www.mext.go.jp/b_menu/houdou/30/10/icsFiles/afieldfile/2018/10/25/14103_92_2.pdf.

Jeugdzorg Nederland, Stichting Alexander, & Praktikon. (2018). *Exit Vragenlijst Jeugdhulp 2018* [Exit Questionnaire Youth Care 2018] [Unpublished manuscript]. Stichting Alexander, Jeugdzorg Nederland en Praktikon.

Johnsen, D. B. (2020). *The Back2School Project: Introducing transdiagnostic cognitive behavioral therapy for youths with school attendance problems* [Unpublished doctoral dissertation]. Aarhus University.

Johnsen, D. B., Heyne, D., & Karel, E. R. (2021). Psychological interventions for school refusal and truancy. In M. Gren Landell (Ed.), *School attendance problems: A research update and where to go* (pp. 125-137). Jerringfonden.

Johnson, A. M., Falstein, E. I., Szurek, S. A., & Svendsen, M. (1941). School phobia. *American Journal of Orthopsychiatry*, *11*, 702-711.

Karel, E. R., Hermes, H., Defourny, C., & Heyne, D. (2021). *Effectiveness of the @school protocol when employed in a real-world setting* [Manuscript in preparation]. De Berkenschutse.

Kazantzis, N., Deane, F. P., & Ronan, K. R. (2000). Homework assignments in cognitive and behavioral therapy: A meta-analysis. *Clinical Psychology: Science and Practice*, *7*, 189-202.

Kazantzis, N., Lampropoulos, G. K., & Deane, F. P. (2005). A national survey of practicing psychologists' use and attitudes toward homework in psychotherapy. *Journal of consulting and clinical psychology*, *73*, 742-748.

Kazantzis, N., Whittington, C., Zelencich, L., Kyrios, M., Norton, P. J., & Hofmann, S. G. (2016). Quantity and quality of homework compliance: A meta-analysis of relations with outcome in cognitive behavior therapy. *Behavior Therapy*, *47*, 755-772.

Kearney, C. A. (1993). Depression and school refusal behavior: A review with comments on classification and treatment. *Journal of School Psychology*, *31*, 267-279.

Kearney, C. A. (2001). *School refusal behavior in youth: A functional approach to assessment and treatment*. Washington, DC: American Psychological Association.

Kearney, C. A. (2003). Bridging the gap among professionals who address youths with school absenteeism: Overview and suggestions for consensus. *Professional Psychology: Research and Practice*, *34*, 57-65.

Kearney, C. A. (2008). *Helping school refusing children and their parents: A guide for school-based professionals*. Oxford University Press.

Kearney, C. A. (2016). *Managing school absenteeism at multiple tiers: An evidence-based and practical guide for professionals*. Oxford University Press.

Kearney, C. A. (2019). *Helping families of youth with school attendance problems: A practical guide for mental health and school-based professionals*. New York: Oxford.

Kearney, C. A. (2021). *Getting your child back to school: A parent's guide to solving school attendance problems, revised and updated edition*. New York: Oxford University Press.

Kearney, C. A., & Albano, A. M. (2000). *When children refuse school: A cognitive-behavioral therapy approach (Therapist guide)*. Psychological Corporation.

Kearney, C. A., & Albano, A. M. (2007). *When children refuse school: A cognitive-behavioral therapy approach/therapist's guide* (2nd ed.). Oxford University Press.

Kearney, C. A., & Albano, A. M. (2018a). *When children refuse school: A cognitive-behavioral therapy approach/parent workbook* (3rd ed.). Oxford University Press.

Kearney, C. A., & Albano, A. M. (2018b). *When children refuse school: A cognitive-behavioral therapy approach/therapist guide* (3rd ed.). Oxford University Press.

Kearney, C. A., Gonzálvez, C., Graczyk, P. A., & Fornander, M. J. (2019a). Reconciling contemporary approaches to school attendance and school absenteeism: Toward promotion and nimble response, global policy review and implementation, and future adaptability (Part 1). *Frontiers in Psychology*, 10:2222. doi:10.3389/fpsyg.2019.02222

Kearney, C. A., Gonzálvez, C., Graczyk, P. A., & Fornander, M. J. (2019b). Reconciling contemporary approaches to school attendance and school absenteeism: Toward promotion and nimble response, global policy review and implementation, and future adaptability (Part 2). *Frontiers in Psychology*, 10:2605. doi: 10.3389/fpsyg.2019.02605

Kearney, C. A., & Graczyk, P. A. (2014). A Response to Intervention model to promote school attendance and decrease school absenteeism. *Child and Youth Care Forum, 43,* 1-25.

Kearney, C. A., & Graczyk, P. A. (2020). A multidimensional, multi-tiered system of supports model to promote school attendance and address school absenteeism. *Clinical Child and Family Psychology Review*, *23*, 316-337.

Kearney, C. A., & Silverman, W. K. (1990). A preliminary analysis of a functional model of assessment and treatment for school refusal behavior. *Behavior Modification*, *14*, 340-366.

Kearney, C. A., & Silverman, W. K. (1995). Family environment of youngsters with school refusal behavior: A synopsis with implications for assessment and treatment. *The American Journal of Family Therapy, 23,* 59-72.

Kearney, C. A., & Silverman, W. K. (1999). Functionally based prescriptive and nonprescriptive treatment for children and adolescents with school refusal behavior. *Behavior Therapy*, *30*, 673-695.

Kearney, C. A., Stowman, S., Haight, C., & Wechsler, A. (2008). Manualized treatment for anxiety-based school refusal behavior in youth. In C. LeCroy (Ed.), *Handbook of evidence-based child and adolescent treatment manuals* (pp. 286-313). Oxford University Press.

Kendall, P. C., & Hedtke, K. (2006). *Cognitive-behavioral therapy for anxious children: Therapist manual* (3rd ed.). Ardmore, PA: Workbook Publishing.

Keppens, G., & Spruyt, B. (2017). The development of persistent truant behaviour: An exploratory analysis of adolescents' perspectives. *Educational Research*, *59,* 353-370.

Keppens, G., & Spruyt, B. (2020). The impact of interventions to prevent truancy: A review of the research literature. *Studies in Educational Evaluation*, *65*, 100840.

King, N. J., Heyne, D., & Ollendick, T. (2005). Cognitive-behavioral treatments for anxiety and phobic disorders in children and adolescents: A review. *Behavioral Disorders*, *30*, 241-257.

King, N. J., Tonge, B. J., Heyne, D., Pritchard, M., Rolling, S., Young, D., Myerson, N., & Ollendick, T. H. (1998). Cognitive-behavioural treatment of school-refusing children: A controlled evaluation. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*, 395-403.

King, N. J., Tonge, B. J., Heyne, D., Turner, S., Pritchard, M., Young, D., Rollings, S., Myerson, N., & Ollendick, T. (2001). Cognitive-behavioural treatment of school-refusing children: Maintenance of improvement at 3- to 5-year follow-up. *Scandinavian Journal of Behaviour Therapy*, *30*, 85-89.

Kljakovic, M., & Kelly, A. (2019). Working with school-refusing young people in Tower Hamlets, London. *Clinical Child Psychology and Psychiatry*, *24*, 921-933.

Kljakovic, M., Kelly, A., & Richardson, A. (2021). School refusal and isolation: The perspectives of five adolescent school refusers in London, UK. *Clinical Child Psychology and Psychiatry*. https://doi.org/10.1177/13591045211025782

Krijnen, E., Vaessen, A., Pater, C. J., & Ledoux, G. (2021). *Zicht op thuiszitten: Geschillen over toelating, verwijdering of ontwikkelingsperspectief van (dreigende) thuiszitters* ['Understanding long-term absenteeism: Disputes about admission, removal or developmental perspectives of (imminent) absentees]. Kohnstamm Instituut.

Kurita, H. (1991). School refusal in pervasive developmental disorders. *Journal of Autism & Developmental Disorders, 21*, 1-15.

Lansford, J. E., Dodge, K. A., Pettit, G. S., & Bates, J. E. (2016). A public health perspective on school dropout and adult outcomes: A prospective study of risk and protective factors from age 5 to 27. *Journal of Adolescent Health*, *58*, 652-658.

Last, C. G. (1993). *Therapist treatment manual for NIMH school phobia study: Exposure therapy program* [Unpublished manuscript]. Nova University.

Last, C. G., Francis, G., Hersen, M., Kazdin, A. E., & Strauss, C. C. (1987). Separation anxiety and school phobia: A comparison using DSM-III criteria. *American Journal of Psychiatry*, *144*, 653-657.

Last, C. G., Hansen, C., & Franco, N. (1998). Cognitive-behavioral treatment of school phobia. *Journal of the American Academy of Child and Adolescent Psychiatry, 37,* 404-411.

Last, C. G., & Strauss, C. C. (1990). School refusal in anxiety-disordered children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, *29*, 31-35.

Lawrence, D., Dawson, V., Houghton, S., Goodsell, B., & Sawyer, M. G. (2019). Impact of mental disorders on attendance at school. *Australian Journal of Education*, *63*, 5-21.

Lawrence, P. J., Parkinson, M., Jasper, B., Creswell, C., & Halligan, S. L. (2021). Supporting the parents of children and young people with anxiety and depressive disorders is an opportunity not to be missed: A scoping review. *The Lancet Psychiatry*, *8*, 909-918.

Layne, A. E., Bernstein, G. A., Egan, E. A., & Kushner, M. G. (2003). Predictors of treatment response in anxious depressed adolescents with school refusal. *Journal of the American Academy of Child and Adolescent Psychiatry, 42,* 319-326.

Lewinsohn, P. M., Clarke, G. N., Hops, H., & Andrews, J. (1990). Cognitive-behavioral group treatment of depression in adolescents. *Behavior Therapy, 21,* 385-401.

Li, A., Guessoum, S. B., Ibrahim, N., Lefèvre, H., Moro, M. R., & Benoit, L. (2021). A systematic review of somatic symptoms in school refusal. *Psychosomatic Medicine*, *83*, 715-723.

Londono Tobon, A., Reed, M. O., Taylor, J. H., & Bloch, M. H. (2018). A systematic review of pharmacologic treatments for school refusal behavior. *Journal of Child and Adolescent Psychopharmacology*, *28,* 368-378.

Lubberman, J., Bertling, L., & Duysak, S. (2019). *Impuls thuiszittersaanpak: Onderzoek naar het verhaal achter de cijfers en de ambities van het Thuiszitterspact* [Impulse approach to long-term absenteeism: Research into the story behind the numbers and the ambitions of the Thuiszitterspact]. Retrieved January 20, 2021, from https://docplayer.nl/171784168-Impuls-thuiszittersaanpak-onderzoek-naar-het-verhaal-achter-de-cijfers-en-de-ambities-van-het-thuiszitterspact.html.

Maarsingh, H., de Tiège, E., Kaper, M., & Holman, I. (2020). *Geoorloofd verzuim: Van inzicht naar aanpak* [Authorised absenteeism: From insight to intervention]. Sociaal Planbureau Groningen.

Maeda, N. (2012). The effects of active parental intervention on school refusal behavior. *Progress in Social Welfare Research*, *7*, 15-25.

Maeda, N. (2016). School-based behavioural consultation for school refusal behaviour. *International Journal of Psychological Studies*, *8*, 40-52.

Maeda, N., Hatada, S., Sonoda, J., & Takayama, I. (2012). School-based intensive exposure therapy for school refusal behavior. *Clinical Case Studies*, *11*, 299-311.

Maeda, N., & Heyne, D. (2019). Rapid return for school refusal: A school-based approach applied with Japanese adolescents. *Frontiers in Psychology*, *10*:2862.

Malcolm, H., Wilson, V., Davidson, J., & Kirk, S. (2003). *Absence from school: A study of its causes and effect in seven LEAs*. Queen's Printers: Nottingham.

Malik, K., Ibrahim, M., Bernstein, A., Venkatesh, R. K., Rai, T., Chorpita, B., & Patel, V. (2021). Behavioral activation as an 'active ingredient' of interventions addressing depression and anxiety among young people: A systematic review and evidence synthesis. *BMC Psychology*, *9*, 150.

Malmquist, C. P. (1965). School phobia a problem in family neurosis. *Journal of the American Academy of Child Psychiatry*, *4*, 293-319.

Manassis, K. (2016). *Cognitive behavioral therapy with children: A guide for the community practitioner* (2nd ed.). Routledge.

Maric, M., Heyne, D. A., MacKinnon, D. P., Van Widenfelt, B. M., & Westenberg, M. P. (2013). Cognitive mediation of cognitive-behavioural therapy outcomes for anxiety-based school refusal. *Behavioural and Cognitive Psychotherapy*, *41*, 549-564.

Martin, F., & Oliver, T. (2019). Behavioral activation for children and adolescents: A systematic review of progress and promise. *European Child and Adolescent Psychiatry*, *28*, 427-441.

Maynard, B. R., Heyne, D., Brendel, K. E., Bulanda, J. J., Thompson, A. M., & Pigott, T. D. (2018). Treatment for school refusal among children and adolescents: A systematic review and meta-analysis. *Research on Social Work Practice*, *28*, 56-67.

Maynard, B. R., McCrea, K. T., Pigott, T. D., & Kelly, M. S. (2013). Indicated truancy interventions for chronic truant students: A Campbell systematic review. *Research on Social Work Practice*, *23*, 5-21.

Maynard, B. R., Salas-Wright, C. P., & Vaughn, M. G. (2015). High school dropouts in emerging adulthood: Substance use, mental health problems, and crime. *Journal of Community Mental Health*, *51*, 289-299.

Maynard, B. R., Vaughn, M. G., Nelson, E. J., Salas-Wright, C. P., Heyne, D. A., & Kremer, K. P. (2017). Truancy in the United States: Examining temporal trends and correlates by race, age, and gender. *Children and Youth Services Review*, *81*, 188-196.

McAnanly, E. (1986). School phobia: The importance of prompt intervention. *Journal of School Health*, *56*, 433-436.

McCune, N., & Hynes, J. (2005). Ten year follow-up of children with school refusal. *Irish Journal of Psychological Medicine*, *22*, 56-58.

McKay-Brown, L., McGrath, R., Dalton, L., Graham, L., Smith, A., Ring, J., & Eyre, K. (2019). Reengagement with education: A multidisciplinary home-school-clinic approach developed in Australia for school-refusing youth. *Cognitive and Behavioral Practice, 26,* 92-106.

McShane, G., Bazzano, C., Walter, G., & Barton, G. (2007). Outcome of patients attending a specialist educational and mental health service for social anxiety disorders. *Clinical Child Psychology and Psychiatry*, *12*, 117-124.

McShane, G., Walter, G., & Rey, J. M. (2001). Characteristics of adolescents with school refusal. *Australian and New Zealand Journal of Psychiatry*, *35*, 822-826.

McShane, G., Walter, G., & Rey, J. M. (2004). Functional outcome of adolescents with school refusal. *Clinical Child Psychology and Psychiatry*, *9*, 53-60.

Melvin, G. A., Dudley, A. L., Gordon, M. S., Klimkeit, E., Gullone, E., Taffe, J., & Tonge, B. J. (2017). Augmenting cognitive behavior therapy for school refusal with fluoxetine: A randomized controlled trial. *Child Psychiatry and Human Development, 48*, 485-497.

Melvin, G. A., & Gordon, M. S. (2019). Antidepressant medication: Is it a viable and valuable adjunct to cognitive-behavioral therapy for school refusal? *Cognitive and Behavioral Practice*, *26*, 107-118.

Melvin, G. A., Heyne, D., Gray, K. M., Hastings, R. P., Totsika, V., Tonge, B. J., & Freeman, M. M. (2019). The Kids and Teens at School (KiTeS) Framework: An inclusive

bioecological systems approach to understanding school absenteeism and school attendance problems. *Frontiers in Education*, *4*:61.

Minamitani, N., & Matsumoto, Y. (2018). Developmental trial of a cognitive behavior therapy program for parents of junior high students exhibiting school refusal: Evidence based on a small sample from a metropolitan area in Japan. *School Health*, *14* , 1-11.

Ministerie van Onderwijs, Cultuur en Wetenschap, Ministerie van Volksgezondheid, Welzijn en Sport, PO-Raad, VO-Raad, Ministerie van Veiligheid en Justitie, & VNG. (2016). *Thuiszitterspact*.
https://www.rijksoverheid.nl/documenten/publicaties/2016/06/13/thuiszitterspact

Morgan, D. L. (1996). Focus groups. *Annual Review of Sociology*, *22*, 129-152.

Morgan, G. A. V. (1959). Children who refuse to go to school: Observations on school anxiety. *The Medical Officer*, *102*, 221-224.

Myhr, A., Haugan, T., Lillefjell, M., & Halvorsen, T. (2018). Non-completion of secondary education and early disability in Norway: Geographic patterns, individual and community risks. *BMC Public Health*, *18*:682.

Naylor, M. W., Staskowski, M., Kenney, M. C., & King, C. A. (1994). Language disorders and learning disabilities in school refusing adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, *33*, 1331-1337.

Neuman, A. (2020). Ask the young: What homeschooled adolescents think about homeschooling. *Journal of Research in Child Education*, *34*, 566-582.

New Zealand Ministry of Education. (2019). *New Zealand Schools Attendance Survey: term 2, 2018.* Retrieved June 12, 2019, from
https://www.educationcounts.govt.nz/publications/series/2503/new-zealand-schools-attendance-survey-term-2,-2018.

Nienhuis, B. (2012). *Schoolangst en schoolweigering bij kinderen* [School anxiety and school refusal in children]. Lannoo Campus.

Nishida, A., Sugiyama, S., Aoki, S., & Kuroda, S. (2004). Characteristics and outcomes of school refusal in Hiroshima, Japan: Proposals for network therapy. *Acta Medica Okayama*, *58*, 241-249.

Nuttall, C., & Woods, K. (2013). Effective intervention for school refusal behaviour. *Educational Psychology in Practice*, *29,* 347-366.

O'Brien, N., & Dadswell, A. (2019). *Working with young people to explore bullying and self-exclusion from school: Final report*. Anglia Ruskin University Chelmsford. Retrieved January 5, 2021, from http://arro.anglia.ac.uk/id/eprint/704884.

O'Brien, N., & Dadswell, A. (2020). Reflections on a participatory research project exploring bullying and school self-exclusion: Power dynamics, practicalities and partnership working. *Pastoral Care in Education*, *38,* 208-229.

Okano, L., Jeon, L., Crandall, A., Powell, T., & Riley, A. (2019). Developmental cascades of social competence, achievement in school, and achievement on standardised assessments during the transition to adolescence and secondary school. *Journal of Adolescence*, *74*, 91-102.

Okuyama, M., Okada, M., Kuribayashi, M., & Kaneko, S. (1999). Factors responsible for the prolongation of school refusal. *Psychiatry and Clinical Neurosciences*, *53*, 461-469.

Olde Hartman, T., Blankenstein, N., Molenaar, B., Bentz van den Berg, D., Van der Horst, H., Arnold, I., Burgers, J., Wiersma, T., & Woutersen-Koch, H. (2013). NHG-standaard somatisch onvoldoende verklaarde lichamelijke klachten (SOLK) [NHG Guideline on medically unexplained symptoms]. *Huisarts en Wetenschap*, *56*, 222-230.

Palpacuer, C., Gallet, L., Drapier, D., Reymann, J. M., Falissard, B., & Naudet, F. (2017). Specific and non-specific effects of psychotherapeutic interventions for depression: Results from a meta-analysis of 84 studies. *Journal of Psychiatric Research*, *87*, 95-104.

Partridge, J. M. (1939). Truancy. *British Journal of Psychiatry*, *85*, 45-81.

Peeters, R., Zunderdorp, M., Lamers, M., & Rats, E. (2018). *Met andere ogen. Advies voor versnelling en bestendiging van de samenwerking onderwijs-zorg-jeugd* [With different eyes. Advice for accelerating and perpetuating the collaboration between education-care-youth]. Retrieved November 19, 2021, from https://www.aanpakmetandereogen.nl/media/filer_public/0e/c3/0ec3407b-0533-45c2-8324-5cf93511e7df/rapport-met-andere-ogen.pdf.

Pina, A. A., Zerr, A. A., Gonzales, N. A., & Ortiz, C. D. (2009). Psychosocial interventions for school refusal behavior in children and adolescents. *Child Development Perspectives*, *3*, 11-20.

Place, M., Hulsmeier, J., Davis, S., & Taylor, E. (2000). School refusal: A changing problem which requires a change of approach? *Clinical Child Psychology and Psychiatry*, *5*, 345-355.

Prabhuswamy, M., Srinath, S., Girimaji, S., & Seshadri, S. (2007). Outcome of children with school refusal. *The Indian Journal of Pediatrics*, *74*, 375-379.

De Meyer, R. E., & Veerman, J. W. (2016). *Beoordelingsschaal voor Tevredenheid en Effect (BESTE)* [Rating Scale for Satisfaction and Impact]. Nijmegen: Praktikon.

Preece, D., & Howley, M. (2018). An approach to supporting young people with autism spectrum disorder and high anxiety to re-engage with formal education: The impact on young people and their families. *International Journal of Adolescence and Youth*, *23*, 468-481.

Reid, K. (2004). The views of head teachers and teachers on attendance issues in primary schools. *Research in Education*, *72*, 60-76.

Reid, K. (2006a). An evaluation of the views of secondary staff towards school attendance issues. *Oxford Review of Education*, *32*, 303-324.

Reid, K. (2006b). The views of education social workers on the management of truancy and other forms of non-attendance. *Research in Education*, *75*, 40-57.

Reissner, V., Jost, D., Krahn, U., Knollmann, M., Weschenfelder, A. K., Neumann, A., Wasem, A., & Hebebrand, J. (2015). The treatment of school avoidance in children and adolescents with psychiatric illness: A randomized controlled trial. *Deutsches Ärzteblatt International, 112,* 655.

Reissner, V., Knollmann, M., Spie, S., Jost, D., Neumann, A., & Hebebrand, J. (2019). Modular Treatment for children and adolescents with problematic school absenteeism: Development and description of a program in Germany. *Cognitive and Behavioral Practice, 26,* 63-74.

Reynolds, S., Wilson, C., Austin, J., & Hooper, L. (2012). Effects of psychotherapy for anxiety in children and adolescents: A meta-analytic review. *Clinical Psychology Review*, *32*, 251-262.

Rhoad-Drogalis, A., & Justice, L. M. (2018). Absenteeism in Appalachian preschool classrooms and children's academic achievement. *Journal of Applied Developmental Psychology*, *58*, 1-8.

Richardson, G. (1992). *School refusal: Two counselling interventions*. Simon Fraser University. Retrieved November 28, 2021, from http://summit.sfu.ca/system/files/iritems1/3665/b14217697.pdf.

Richardson, K. (2016). Family therapy for child and adolescent school refusal. *Australian and New Zealand Journal of Family Therapy*, *37*, 528-546.

Robinson, P. (2008). Putting it on the street: Homework in cognitive behavioral therapy. In W. T. O'Donohue & J. E. Fisher (Eds.), *Cognitive behavior therapy: Applying empirically supported techniques in your practice* (pp. 260-271). John Wiley & Sons, Inc.

Rocque, M., Jennings, W. G., Piquero, A. R., Ozkan, T., & Farrington, D. P. (2017). The importance of school attendance: Findings from the Cambridge Study in Delinquent Development on the life-course effects of truancy. *Crime & Delinquency*, *63*, 592-612.

Rodriguez, A., Rodriguez, M., & Eisenberg, L. (1959). The outcome of school phobia: A follow-up study based on 41 cases. *American Journal of Psychiatry*, *116*, 540-544.

Rogers, R. G., Hummer, R. A., & Everett, B. G. (2013). Educational differentials in US adult mortality: An examination of mediating factors. *Social Science Research*, *42*, 465-481.

Rohrig, S. N., & Puliafico, A. C. (2018). Treatment of school refusal in an adolescent with comorbid anxiety and chronic medical illness. *Evidence-Based Practice in Child and Adolescent Mental Health*, *3*, 129-141.

Sauter, F. M., Heyne, D., Blöte, A. W., Van Widenfelt, B. M., & Westenberg, P. M. (2010). Assessing therapy-relevant cognitive capacities in young people: Development and psychometric evaluation of the Self-Reflection and Insight Scale for Youth. *Behavioural and Cognitive Psychotherapy*, *38*, 303-317.

Sauter, F. M., Heyne, D., & Westenberg, P. M. (2009). Cognitive behavior therapy for anxious adolescents: Developmental influences on treatment design and delivery. *Clinical Child and Family Psychology Review*, *12*, 310-335.

Scharree, C. (2007). Schoolweigering? Ouders aan de slag [School refusal? Parents get to work]. *Kind en Adolescent Praktijk*, *6*, 8-13.

Schoeneberger, J. A. (2012). Longitudinal attendance patterns: Developing high school dropouts. *The Clearing House: A Journal of Educational Strategies, Issues and Ideas*, 85, 7-14.

Sibeoni, J., Orri, M., Podlipski, M.-A., Labey, M., Campredon, S., Gerardin, P., & Revah-Levy, A. (2018). The experience of psychiatric care of adolescents with anxiety-based school refusal and of their parents: A qualitative study. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *27*, 39-49.

Silverman, W. K., Pina, A. A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child and Adolescent Psychology, 37,* 105-130.

Siriwardhana, C., Pannala, G., Siribaddana, S., Sumathipala, A., & Stewart, R. (2013). Impact of exposure to conflict, tsunami and mental disorders on school absenteeism: Findings from a national sample of Sri Lankan children aged 12-17 years. *BMC Public Health, 13,* 560. doi.org/10.1186/1471-2458-13-560

Skedgell, K., & Kearney, C. A. (2018). Predictors of school absenteeism severity at multiple levels: A classification and regression tree analysis. *Children and Youth Services Review*, *86*, 236-245.

Slob, A., de Jonge, H. M., & Dekker, S. (2020). *Brief van de Ministers voor Basis- en Voortgezet Onderwijs en Media, van Volksgezondheid, Welzijn en Sport en voor Rechtsbescherming* [Letter from the Ministers for Primary and Secondary Education and Media, Health, Welfare and Sport and Legal Protection]. Retrieved January 20, 2021, from https://www.tweedekamer.nl/kamerstukken/detail?id=2020Z01665&did=2020D035 01.

Smerillo, N. E., Reynolds, A. J., Temple, J. A., & Ou, S. R. (2018). Chronic absence: Eighth-grade achievement, and high school attainment in the Chicago Longitudinal Study. *Journal of School Psychology*, *67*, 163-178.

Sonoda, J., Hashimoto, K., Ishibashi, C., & Kamohara, Y. (2008). Futoukoushien no gendaiteki kadai: Koudoukagaku no tachiba kara [Contemporary subjects to support of school non-attendance: from viewpoints of behavioral science]. *Journal of Kibi International University Research Institute of Clinical Psychology*, *5*, 1-22.

Spence, S. H. (2003). Social skills training with children and young people: Theory, evidence and practice. *Child and Adolescent Mental Health*, *8*, 84-96.

Spence, S. H., Donovan, C. L., March, S., Kenardy, J. A., & Hearn, C. S. (2017). Generic versus disorder specific cognitive behavior therapy for social anxiety disorder in youth: A randomized controlled trial using internet delivery. *Behaviour Research and Therapy*, *90*, 41-57.

Steinhausen, H.-C., Müller, N., & Metzke, C. W. (2008). Frequency, stability and differentiation of self-reported school fear and truancy in a community sample. *Child and Adolescent Psychiatry and Mental Health, 2*, 17.

Stevens, G. W. J. M., Van Dorsselaer, S., Boer, M., De Roos, S., Duinhof, E. L., Ter Bogt, T. F. M., Van Den Eijnden, R. J. J. M., Kuyper, L., Visser, D., Vollebergh, W. A. M., & De Looze, M. (2018). *HBSC 2017. Gezondheid en welzijn van jongeren in Nederland [Health and well-being of young people in the Netherlands].* Universiteit Utrecht.

Stichting Alexander. (2008). *Pilot Exit-vragenlijst jeugdzorg-zorgaanbieders: Procesbeschrijving, evaluatie en aanpassing* [Pilot Exit Questionnaire Youth Care / Care Providers: Process description, evaluation and adaptation] [Unpublished manuscript]. Stichting Alexander, the Netherlands.

Sugai, G., & Horner, R. (2002). The evolution of discipline practices: School-wide positive behavior supports. *Child and Family Behavior Therapy*, *24*, 23-50.

Sugrue, E. P., Zuel, T., & LaLiberte, T. (2016). The ecological context of chronic school absenteeism in the elementary grades. *Children & Schools*, *38*, 137-145.

TADS (Treatment for Adolescents With Depression Study) Team. (2003). Treatment for Adolescents With Depression Study (TADS): Rationale, design, and methods. *Journal of the American Academy of Child and Adolescent Psychiatry, 42,* 531-542.

Terada, M. (2015). Futoukou no kodomo no rikai to soukitaisho II: Gakkou ni okeru taisho no wakugumi [The Treatment of non-attendance children: The framework of the treatment in school]. *Journal of Tokai Gakuen University*, *9*, 101-118.

Thambirajah, M. S., Grandison, K. J., & De-Hayes, L. (2008). *Understanding school refusal: A handbook for professionals in education, health, and social care*. Jessica Kingsley Publishers.

Thastum, M., Johnsen, D. B., Silverman, W. K., Jeppesen, P., Heyne, D. A., & Lomholt, J. J. (2019). The Back2School modular cognitive behavioral intervention for youths with problematic school absenteeism: Study protocol for a randomized controlled trial. *Trials*, *20*, 29. doi:10.1186/s13063-018-3124-3

Thomas, M. S., Crosby, S., & Vanderhaar, J. (2019). Trauma-informed practices in schools across two decades: An interdisciplinary review of research. *Review of Research in Education, 43*, 422-452.

Tobias, A. (2019). A grounded theory study of family coach intervention with persistent school non-attenders. *Educational Psychology in Practice*, *35*, 17-33.

Tolin, D. F., Whiting, S., Maltby, N., Diefenbach, G. J., Lothstein, M. A., Hardcastle, S., Catalano, A., & Gray, K. (2009). Intensive (daily) behavior therapy for school refusal: a multiple baseline case series. *Cognitive and Behavioral Practice*, *16*, 332-344.

Torrens Armstrong, A. M., McCormack Brown, K. R., Brindley, R., Coreil, J., & McDermott, R. J. (2011). Frequent fliers, school phobias, and the sick student: School health personnel's perceptions of students who refuse school. *Journal of School Health, 81,* 552-559.

Totsika, V., Hastings, R. P., Dutton, Y., Worsley, A., Melvin, G., Gray, K., Tonge, B., & Heyne, D. (2020). Types and correlates of school non-attendance in students with autism spectrum disorders. *Autism*, *24*, 1639-1649.

Tweede Kamer der Staten-Generaal. (1992). *Wijziging van de Leerplichtwet 1969 en enkele andere wetten.* Retrieved January 9, 2019, from http://resolver.kb.nl/resolve?urn=sgd%3Ampeg21%3A19921993%3A0005960

UNICEF and UIS. (2016). *Monitoring education participation: Framework for monitoring children and adolescents who are out of school or at risk of dropping out.* UNICEF Series on Education Participation and Dropout Prevention (Vol 1). Geneva: UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States.

United Kingdom Department of Education. (2018). *Pupil absence in schools in England: autumn 2017 and spring 2018.* Retrieved June 12, 2019, from https://www.gov.uk/government/statistics/pupil-absence-in-schools-inengland-autumn-term-2017-and-spring-term-2018.

United States Department of Education. (2019). *Chronic absenteeism in the nation's schools: A hidden educational crisis.* Retrieved June 12, 2019, from https://www2.ed.gov/datastory/chronicabsenteeism.html.

Valles, E., & Oddy, M. (1984). The influence of a return to school on the long-term adjustment of school refusers. *Journal of Adolescence*, *7*, 35-44.

Van Binsbergen, M. H., Pronk, S., Van Schooten, E., Heurter, A., & Verbeek, F. (2019). *Niet thuisgeven. Schooluitval vanuit het perspectief van thuiszitters* [Don't give up: School drop-out from the perspective of youth with long-term absenteeism]. Kohnstamm Instituut. Retrieved May 10, 2021, from https://kohnstamminstituut.nl/wp-content/uploads/2019/12/1030-niet-thuisgeven.pdf.

Van der Ree, Y. (2019). *Dit ben ik: Portretten van thuiszitters* [This is me: Portraits of youth with long-term absenteeism]. Retrieved January 20, 2021, from https://www.nji.nl/nl/Download-NJi/Publicatie-NJi/Dit-ben-ik-Portretten-van-thuiszitters-PDF.pdf.

Van Geffen, M., & Engelen, H. (2004). Systeembenadering bij schoolweigering [Systemic approach to school refusal]. *Systeem Therapie*, *16*, 197-214.

Veale, D. (2008). Behavioural activation for depression. *Advances in Psychiatric Treatment*, *14*, 29-36.

Vuijk, P., Heyne, D., & van Efferen-Wiersma, E. (2010). @school project: Prevalentie en functies van problematisch schoolverzuim in het Rotterdamse basisonderwijs [@school project: Prevalence and functions of problematic absenteeism in primary education in Rotterdam]. *Kind en Adolescent*, *31*, 29-40.

Walter, D., Hauptmann, C., Rizk, S., Lehmkuhl, G., & Doepfner, M. (2014). Short- and long-term effects of inpatient cognitive-behavioural treatment of adolescents with anxious-depressed school absenteeism: A within-subject comparison of changes. *Child and Family Behavior Therapy, 36*, 171-190.

Walter, D., Hautmann, C., Rizk, S., Petermann, M., Minkus, J., Sinzig, J., Lehmkuhl, G., & Doepfner, M. (2010). Short term effects of inpatient cognitive behavioral treatment of adolescents with anxious-depressed school absenteeism: An observational study. *European Child and Adolescent Psychiatry*, *19*, 835-844.

Warnecke, R. (1964). School phobia and its treatment. *British Journal of Medical Psychology*, *37*, 71-79.

Wetchler, J. L. (1986). Family therapy of school-focused problems: A macrosystemic perspective. *Contemporary Family Therapy*, *8*, 224-240.

Wilson, V., Malcolm, H., Edward, S., & Davidson, J. (2008). 'Bunking off': The impact of truancy on pupils and teachers. *British Educational Research Journal*, *34*, 1-17.

Wood, J. J., Lynne-Landsman, S. D., Langer, D. A., Wood, P. A., Clark, S. L., Eddy, J. M., & Ialongo, N. (2012). School attendance problems and youth psychopathology: Structural cross-lagged regression models in three longitudinal data sets. *Child Development*, *83*, 351-366.

Wray, A., & Thomas, A. (2013). School refusal and home education. *Journal of Unschooling and Alternative Learning*, *7*, 64-85.

Wu, X., Liu, F., Cai, H., Huang, L., Li, Y., Mo, Z., & Lin, J. (2013). Cognitive behaviour therapy combined fluoxetine treatment superior to cognitive behavior therapy alone for school refusal. *International Journal of Pharmacology*, *9*, 197-203.

Zaff, J. F., Donlan, A., Gunning, A., Anderson, S. E., McDermott, E., & Sedaca, M. (2017). Factors that promote high school graduation: A review of the literature. *Educational Psychology Review*, *29*, 447-476.

Zullig, K. J., Koopman, T. M., Patton, J. M., & Ubbes, V. A. (2010). School climate: Historical review, instrument development, and school assessment. *Journal of Psychoeducational Assessment*, *28*, 139-152.

Appendices

Appendix A: Social Services Directory

The Social Services Directory presented in the next 21 pages provides an overview of the 21 organisations participating in the Knowing What Works project, and their interventions. These organisations provided consent to be included in the Social Services Directory and were given an opportunity to review the description of their organisation and its intervention prior to inclusion in this report. The information provided by the organisations was current at the time of preparation of the report. For updates, visit the websites of the respective organisations.

Back On Track Successfully (BOTS)

Locatie:	Bergen op Zoom
Organisatietype:	Voortgezet Speciaal Onderwijs
Betrokken organisatie(s):	Aventurijncollege en GGZ (FACT)

Doelgroep

Leeftijden:	Tussen de 12 en 18 jaar.
Geschikt voor:	Indicaties zijn:

- o Langdurig verzuim (>2 maanden) vanwege schoolgang belemmerende psychiatrische klachten (o.a. beperkt energieniveau, suïcidaliteit, beperkte fysieke/mentale gesteldheid), dan wel motivatie/gezinsproblemen.
- o Een veranderingsgericht traject op eigen school, welke niet gelukt is.
- o Onderwijsbehoeften zijn niet middels andere trajecten vanuit het SWV uit te voeren.
- o TIQ > 80, indien sprake van een lager TIQ wordt op basis van het klinische beeld gekeken naar de mogelijkheden.

Minder geschikt voor:	(Forse) externaliserende problematiek.
Gemiddelde programmaduur:	+/- 30 weken.

Korte omschrijving programma

Financiering:	Inzet vanuit onderwijs is op TLV-basis of via een arrangement vanuit het samenwerkingsverband. Inzet vanuit de zorg is vanuit een arrangement voor FACT, afgegeven door het CJG.
Doelen:	Terugkeer naar school. Wanneer mogelijk school van herkomst, anders instroom op een andere passende onderwijslocatie, bijv. het Aventurijncollege. Ook willen we dat de leerlingen weer lekker in hun vel komen te zitten en bagage meekrijgen waardoor ze steviger in hun schoenen staan. Daarnaast willen we het gezinssysteem sterker maken.
Aanbod:	Een veilige omgeving creëren waarin leerlingen stap voor stap het plezier en de veiligheid terugvinden om weer naar school te gaan en bestaande patronen rondom schoolverzuim doorbreken. Dit wordt gedaan door middel van gezinsbegeleiding vanuit FACT, therapieën vanuit GGZ en begeleiding en coaching op school.
Disciplines:	Docenten, intern begeleider en gedragswetenschapper, FACT medewerkers en regiebehandelaar FACT.

Contact

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Beter pASSend (Altra)

Locatie:	Amsterdam
Organisatietype:	Voortgezet Speciaal Onderwijs
Betrokken organisatie(s):	Altra VSO

Doelgroep

Leeftijden:	Tussen de 12 en 18 jaar.
Geschikt voor:	Jongeren bij wie ASS is gediagnosticeerd en sprake is van angstproblematiek die het, ondanks speciale zorg, niet lukt om naar school te gaan.
Minder geschikt voor:	Externaliserende gedragsproblematiek niet voortkomend uit ASS. Jongeren die niet in staat zijn om in een klaslokaal te functioneren of niet aanspreekbaar zijn.
Gemiddelde programmaduur:	+/- 1,5 schooljaar.

Korte omschrijving programma

Financiering:	Vanuit onderwijs en jeugdzorg.
Doelen:	Het eerste doel is dat de leerling m.b.v. intensieve begeleiding in kleine klassen weer regelmatig naar school gaat. Uiteindelijk wordt er gezocht naar een passende vervolgplek. De Beter pASSend klas is een schakelvoorziening.
Aanbod:	De leerling start na een wenperiode met een dagdeel per week, dit wordt langzaam uitgebouwd naar vier dagdelen per week. Naast hun individuele zorgprogramma kunnen leerlingen de kern schoolvakken op eigen niveau volgen, dit kan uitgebreid worden met andere vakken en activiteiten. Er wordt regelmatig contact gehouden met het netwerk. Op verzoek van ouders wordt er ook ondersteuning thuis geboden.
Disciplines:	Onderwijs en jeugdzorg.

Contact

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Beter pASSend klas (PI de Pionier)

Locatie:	Duivendrecht (2 Beter pASSend klassen en 2 Beter pASSend taalklassen) en Amsterdam Noord (2 Beter pASSend klassen binnen de Prof. Waterinkschool)
Organisatietype:	Speciaal Onderwijs
Betrokken organisatie(s):	PI-school De Pionier

Doelgroep

Leeftijden:	Tussen de 6 en 13 jaar.
Geschikt voor:	Diagnose binnen het autistisch spectrum; minimaal beneden gemiddelde cognitieve mogelijkheden hebben of aantoonbaar leerbaar zijn; leerlingen die ondanks extra begeleiding toch binnen so uitvallen; beschikken over een compleet aanmelddossier inclusief TLV so; ouders die bereid zijn mee te denken met het onderwijsteam van deze klas.
Minder geschikt voor:	Als een leerling niet kan functioneren binnen een groep van vier leerlingen (dus 1-1 leeromgeving nodig heeft) of niet leerbaar is op cognitief gebied.
Gemiddelde programmaduur:	1,5 tot 2 jaar (waarbij per leerling wordt gekeken wat nodig is en verlenging soms mogelijk is).

Korte omschrijving programma

Financiering:	TLV so laag en daarop aanvullend arrangement van het samenwerkingsverband of TLV so hoog.
Doelen:	Kinderen weer naar school laten gaan, plezier laten ervaren in school, zich veilig laten voelen, samenbrengen met leeftijdsgenootjes, weer 'normaal' mee kunnen laten doen in de maatschappij en de leerontwikkeling weer op gang brengen d.m.v. maatwerk.
Aanbod:	Vier dagdelen onderwijs per week in een kleine, veilige setting in de aanwezigheid van een leerkracht en een autismespecialist. Binnen het onderwijs wordt er begeleiding en ondersteuning geboden aan de hand van onder andere competentie vergrotend werken, geweldloos verzet en PRT training. Binnen de taalklas wordt daarnaast thematisch onderwijs geboden waarbij handelend leren een plaats heeft.
Disciplines:	Docenten, autismespecialisten, schoolpsycholoog en een intern begeleider. Er kan daarnaast gebruik worden gemaakt van logopedie, fysiotherapie en begeleiding door Prodeba (max. 2 dagdelen naast de Beter pASSend klas) bij de Pionier of van de zorgklas van Carehouse (max. 4 dagdelen) bij de Prof. Waterinkschool.

Contact

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Bijzonder Interventie Team Schoolgang (B!TS)

Locatie:	Rotterdam
Organisatietype:	Voortgezet Speciaal Onderwijs
Betrokken organisatie(s):	Het B!TS project is een initiatief van Het Passer College in samenwerking met IVIO@School

Doelgroep

Leeftijden:	Tussen de 12 en 20 jaar.
Geschikt voor:	Leerlingen met internaliserende problemen. Hierbij kan gedacht worden aan leerlingen met ASS, depressieve klachten en/of een angststoornis. Leerling heeft langer dan vier weken geen onderwijs gevolgd, heeft een TLV en is onderwijsontvankelijk.
Minder geschikt voor:	Externaliserende gedragsproblematiek, psychiatrische problematiek zoals schizofrenie en psychose.
Gemiddelde programmaduur:	+/- 50 weken.

Korte omschrijving programma

Financiering:	De financiering is op TLV-basis.
Doelen:	Het doel van dit project is het opbouwen van de volledige schoolgang.
Aanbod:	Door middel van onderwijs op maat wordt ervoor gezorgd dat de leerling geen verdere leerachterstand oploopt. Daarnaast leert de docent aan de leerling hoe hij of zij 'het leren' het beste kan aanpakken. Naast de lesstof wordt o.a. gewerkt aan het vergroten van het zelfvertrouwen. Stap voor stap leert de leerling weer te functioneren in de klas en in groepsverband met leeftijdgenoten.
Disciplines:	Docenten, pedagogisch medewerkers, psychologen, orthopedagogen en jeugdhulpverleners vanuit een externe organisatie.

Contact

Contactpersoon:	
E-mail:	infobits@hetpassercollege.nl
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Website:	www.bitsrotterdam.nl

De Combi

Locatie:	Ede
Organisatietype:	Voortgezet Onderwijs en Christelijke GGZ
Betrokken organisatie(s):	Eleos, GGZ de Hoop en het RefSVO

Doelgroep

Leeftijden:	Tussen de 12 en 18 jaar.
Geschikt voor:	Internaliserende problematiek passend bij DSM-5 diagnose, ernstige problemen bij bezoeken van school, jongeren zitten thuis en verbergen het schoolverzuim niet, ouders hebben pogingen gedaan om hun kind naar school te krijgen, jongeren en ouders zijn gemotiveerd om zich in te zetten voor behandeling.
Minder geschikt voor:	IQ lager dan 80 of forse verslavingsproblematiek, per jongere bespreekbaar in hoeverre de deeltijdbehandeling toch iets kan bieden.
Gemiddelde programmaduur:	12 tot 16 weken.

Korte omschrijving programma

Financiering:	Het onderwijs wordt bekostigd door de school van herkomst, de behandeling door de gemeente.
Doelen:	Jongeren die gestagneerd zijn in hun ontwikkeling weer helpen om tot ontwikkeling te komen, zodat ze weer onderwijs kunnen gaan volgen in een passende onderwijssetting, waar mogelijk op de school van herkomst. Daarnaast diagnostiek naar en behandeling bij psychiatrische problematiek die bij de jongeren speelt.
Aanbod:	Er wordt voor thuiszittende jongeren een veilige omgeving gecreëerd waarbinnen onderwijs, groepstherapie en individuele therapie aangeboden wordt. Hierbij is sprake van een intensieve samenwerking tussen de jeugd-GGZ en het onderwijs waarbij aandacht is voor diagnostiek en behandeling. Door de veilige sfeer kunnen de jongeren succeservaringen opdoen en durven ze steeds weer een stapje verder te zetten, waarbij het doel is terug te keren naar een passende onderwijssetting. Daarnaast wordt gewerkt aan het inzicht krijgen en verminderen van de klachten.
Disciplines:	Kinder- en jeugdpsychiater, GZ-psycholoog, orthopedagogen, systeemtherapeuten, sociaal pedagogisch hulpverleners, non-verbale therapeut, bewegingsagoog, docenten en onderwijsassistenten.

Contact

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De Doorstroomklas

Locatie:	Haarlem
Organisatietype:	Voortgezet Speciaal Onderwijs
Betrokken organisatie(s):	VSO Daaf Geluk

Doelgroep

Leeftijden:	Van 12 t/m 21 jaar.
Geschikt voor:	Complexe internaliserende ontwikkelingsproblematiek, thuiszittende leerling of leerling die dreigt thuis te komen zitten, gemotiveerde leerling en ouders, leervermogen op vmbo-k, vmbo-tl, havo of vwo niveau, passende en betrokken hulpverlening.
Minder geschikt voor:	ontbreken van hulpverlening, onvermogen van leerling en/of ouders bepaalde verplichtingen aan te gaan, externaliserende problematiek, onvermogen diagnose(s) vrij te bespreken.
Gemiddelde programmaduur:	+/- 1 schooljaar.

Korte omschrijving programma

Financiering:	Vanuit onderwijsgelden van het samenwerkingsverband Zuid-Kennemerland.
Doelen:	Langdurige thuiszitters stap voor stap helpen bij het aanleren van de vaardigheden die ze nodig hebben om deel te kunnen nemen aan ons vso onderwijs.
Aanbod:	Aan de hand van didactische en (ortho)pedagogische ondersteuning/begeleiding wordt gewerkt aan het hertstellen van de schoolgang. Hierbij kunnen cognitieve gedragstherapeutische technieken, psychodiagnostiek, psycho-educatie en schoolse- en emotionele vaardigheidstraining ingezet worden om de leerlingen te leren omgaan met bijvoorbeeld spanningsopbouw, emotieregulatie, trauma's, angsten, negatieve gedachtes, etc. De Doorstroomklas blijft een onderwijssetting, er wordt geen behandeling geboden. Alle ondersteuning en begeleiding die wordt geboden, staat in dienst van de ontwikkeling van de leerling richting het diplomagerichte onderwijs.
Disciplines:	Orthopedagogen en didactisch ondersteuners.

Contact

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De Schakelklassen

Locatie: Arnhem
Organisatietype: Voortgezet Speciaal Onderwijs
Betrokken organisatie(s):   Mariëndael VSO

Doelgroep

Leeftijden: Tussen de 12 en 20 jaar.
Geschikt voor: Thuiszitters, psychische stoornissen (zeer divers), internaliserende problematiek.
Minder geschikt voor: Externaliserende problematiek.
Gemiddelde programmaduur: +/- 8 maanden/35 weken.

Korte omschrijving programma

Financiering: Vanuit SWV wordt een TLV toegekend.
Doelen: De schakelklas bestaat uit twee fases. In de eerste fase, die 8 weken duurt, komen de leerlingen 3 dagen per week naar school. Er wordt gewerkt aan de terugkeer naar school. De doelen zijn het vergroten van zelfvertrouwen, het zich weer veilig voelen in de groep, het opbouwen van een realistisch zelfbeeld, het accepteren van beperkingen en het (her)formuleren van het toekomstperspectief. In de tweede fase wordt het aantal dagdelen op school opgebouwd en wordt verder onderzocht welke onderwijs- en ondersteuningsbehoeften de leerling heeft en welke plek hiervoor het best passend is.
Aanbod: In de eerste fase volgen de leerlingen speciaal ontwikkelde modules, die grotendeels door de eigen mentoren worden gegeven. Zij worden geobserveerd en worden didactisch in kaart gebracht om achterstanden en hiaten op te sporen, waarop waar mogelijk passende interventies kunnen worden ingezet. In de tweede fase zullen zaken als studievaardigheden en leren omgaan met druk op de voorgrond komen te staan. Fasegewijs zal een leerling doorstromen naar een andere afdeling binnen school. Indien aan de orde zal uitstroom naar een andere school, of een ander uitstroomtraject, worden onderzocht en begeleid.
Disciplines: Mentoren, vakdocenten, didactische ondersteuning, maatschappelijk werk, GZ-psycholoog, teamleider, klassenondersteuning, trajectbegeleider.

Contact

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Individueel Leertraject Zuiderbos

Locatie: Vught
Organisatietype: Voortgezet Speciaal Onderwijs
Betrokken organisatie(s):   Stichting Speciaal Onderwijs Zuiderbos

Doelgroep

Leeftijden: 11 tot 18 jaar.
Geschikt voor: Bestaan van integrale vraagstukken in combinatie met (vermoedens van) psychiatrische problematiek/belastbaarheid.
Minder geschikt voor: Leerlingen waarbij (een vermoeden van) bestaan van psychiatrische problematiek niet aanwezig is.
Gemiddelde programmaduur: Sommige leerlingen stromen na 3 weken door naar een meer reguliere vorm van onderwijs, andere leerlingen na 1,5 jaar.

Korte omschrijving programma

Financiering: Plaatsbekostigd
Doelen: Samen met de leerling kijken wat hij/zij nodig heeft om weer terug te kunnen stromen naar een zo regulier en passend mogelijke vorm van onderwijs of wanneer meer passend naar een vorm van arbeid of dagbesteding.
Aanbod: Het vanuit een veilige leersituatie in kaart brengen van ondersteuningsbehoefte van een leerling via participerende observaties, stapsgewijs opbouwen schoolconditie, vergroten weerbaarheid door inzet modellen voor gedrag, belastbaarheid en didactiek en door het bieden van veiligheid en voorspelbaarheid door de dag heen.
Disciplines: leerkrachten, leraar ondersteuners, orthopedagogen, ondersteuningscoördinatoren, behandelcoördinatoren (binnen de zorg) van de desbetreffende leerling.

Contact

Contactpersoon: Bas van Spaendonk
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Leerlingen Allemaal Naar School! (LANS)

Locatie:	Heeze
Organisatietype:	Voortgezet Speciaal Onderwijs
Betrokken organisatie(s):	De Berkenschutse

Doelgroep

Leeftijden:	Tussen de 10 en 17 jaar.
Geschikt voor:	Leerlingen met schoolverzuim en onderliggende angst- en/of stemmingsproblemen. Minder dan 80% aanwezigheid op school gedurende de afgelopen 2 schoolweken, ouders zijn op de hoogte van het verzuim van de jongere, klinische scores van angst en/of stemmingsproblemen.
Minder geschikt voor:	IQ lager dan 80, contra-indicatie door externe medicus en/of externe behandelaar, psychotische stoornis volgens DSM-5, onvoldoende communicatiemogelijkheden, persoonlijkheidsstoornis in ontwikkeling, verslavingsproblematiek, eetstoornis, sprake van ernstige suïcidaliteit, families volgen intensieve hulpverleningstrajecten, actuele echtscheiding tussen ouders, verandering van psychofarmaca gedurende behandeling, aanwezigheid van DSM-classificatie norm-overschrijdend gedragsstoornis, vermoeden van trauma.
Gemiddelde programmaduur:	+/- 16-20 weken.

Korte omschrijving programma

Financiering:	Voor de toekomst wordt bekeken of er een onderwijszorgarrangement gecreëerd kan worden.
Doelen:	Re-integratie in het onderwijs. Middels behandeling wordt gewerkt aan onderliggende copings-vaardigheden van leerling en ouders waardoor emotionele stress vermindert en schoolgang kan worden opgebouwd.
Aanbod:	Een assessment en een evidence-based behandeling (@schoolbehandelprotocol Heyne & Sauter, 2013). Er wordt begonnen met het verkrijgen van een uitgebreide beeldvorming door samen met ouders en kind in gesprek te gaan en vragenlijsten af te nemen. Vanuit daar wordt ingeschat of het @schoolprotocol geïndiceerd is. Het gaat hierbij om een ontwikkelingsgerichte behandeling die modulair is opgebouwd waarbij zowel de leerling als zijn ouders middels een apart therapietraject behandeld worden.
Disciplines binnen de school:	Gedragswetenschappers, mentoren en teamleiders.

Contact

Contactpersoon:	Hilde Hermes, Evelyne Karel en Cynthia Defourny
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Website:	www.berkenschutse.nl

Link Almelo

Locatie:	Almelo
Organisatietype:	Voortgezet Onderwijs
Betrokken organisatie(s):	Samenwerkingsverband 23-01 VO

Doelgroep

Leeftijden:	Ongeveer 12 tot 18 jaar.
Geschikt voor:	Jongeren met schoolweigering, jongeren uit het voortgezet onderwijs
Minder geschikt voor:	Externaliserende problematiek.
Gemiddelde programmaduur:	6 maanden tot een jaar.

Korte omschrijving programma

Financiering:	Vanuit onderwijsgelden. Naast het plaatsen op De Link zijn individuele hulpverleningstrajecten vaak noodzakelijk om leerlingen weer in ontwikkeling te krijgen. Wij hebben hiervoor een samenwerking met at. Zorg. Echter, wanneer leerlingen bij binnenkomst al hulpverlening ontvangen van een andere organisatie gaan wij hier de samenwerking ook mee aan. Hulpverlening wordt bekostigd vanuit de jeugdwet.
Doelen:	Allereerst wordt er gewerkt aan het normaliseren van de schoolgang, waarbij doelen worden gesteld op zowel onderwijstijd, didactiek als sociaal-emotionele ontwikkeling. Vervolgens wordt er gekeken wat de onderwijsbehoeften zijn van leerlingen en welke onderwijssetting hierbij uiteindelijk het best aansluit.
Aanbod:	In een kleinschalige onderwijssetting wordt intensieve begeleiding geboden bij het stapsgewijs vergroten van vaardigheden die nodig zijn binnen het onderwijs. Dit doen we door exposure en elementen uit de cognitieve gedragstherapie die gericht zijn op het verlagen van angst en spanning, het reguleren van stress en het leren omgaan met deze stress (aanleren coping strategieën). Daarnaast wordt er ouderbegeleiding en psycho-educatie geboden, allemaal met als doel het normaliseren van de schoolgang.
Disciplines:	Docenten/ onderwijsbegeleiders, orthopedagogen, schoolmaatschappelijk werker en management. Intensieve samenwerking met ouders, leerplichtambtenaar en hulpverleners.

Contact

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Link Amsterdam

Locatie: Amsterdam
Organisatietype: Voortgezet Onderwijs
Betrokken organisatie(s):   Expertisecentrum Stichting Orion

Doelgroep
Leeftijden: Tussen de 12 en 18 jaar.
Geschikt voor: Angst- en stemmingsproblematiek, leerling staat ingeschreven op een school in Amsterdam/Diemen, leerling zit thuis, er is hulpverlening GGZ in het gezin en voor het kind, ouders zijn bereid om deel te nemen aan begeleiding.
Minder geschikt voor: Leerling heeft geen TLV, externaliserend gedrag.
Gemiddelde programmaduur: +/- 3-4 maanden volledig, daarna in combinatie met regulier onderwijs.

Korte omschrijving programma
Financiering: Vanuit het samenwerkingsverband Amsterdam/Diemen.
Doelen: Het eerste doel is het krijgen van een dagritme en gemotiveerd raken voor school, voor schoolse taken en voor het sociaal omgaan met anderen. Daarna is het hoofddoel om leerlingen weer perspectief te geven voor onderwijs en de stappen voor te bereiden om weer deel te nemen op de school van herkomst.
Aanbod: Leerlingen krijgen een individueel lesaanbod in een veilige omgeving. Daarnaast is er aandacht voor sociaal-emotionele aspecten en groepsactiviteiten.
Disciplines: Orthopedagoog, transfer begeleider, docenten, externe hulpverlening (GGZ), accounthouder SWV, docenten uit poule die flexibel ingezet kunnen worden.

Contact
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Link- en Schakelklassen

Locatie:	Zwolle
Organisatietype:	Voortgezet Speciaal Onderwijs
Betrokken organisatie(s):	De Ambelt - VSO Zwolle - Herfte

Doelgroep

Leeftijden:	Van 12 tot 21 jaar.
Geschikt voor:	(langdurig) thuiszitter, psychische en/of psychiatrische problematiek, internaliserende problematiek.
Minder geschikt voor:	Externaliserende problematiek, IQ <85.
Gemiddelde programmaduur:	Gemiddeld een aantal jaren.

Korte omschrijving programma

Financiering:	Op basis van TLV.
Doelen:	Leerlingen stromen in in een instroomgroep waar het weer op school zijn en het meedoen aan activiteiten op de voorgrond staat. Activatie, sociale interactie, jezelf leren kennen en daarbij mondjesmaat werken aan schoolvakken. Hier kan je één to twee jaar blijven en gedurende die tijd wordt gekeken of je door kan stromen naar een linkklas, waarbij het werken aan schoolvakken en aanwezig zijn volgens een normaal weekrooster al mogelijk is. Mocht je in staat zijn om een diploma te halen dan stroom je door naar een trajectklas binnen de Ambelt. Een andere optie is om verder te gaan in een schakelklas waarbij de uitstroombestemming arbeid wordt. Hierbij is het mogelijk is om certificaten voor bepaalde vakken te halen.
Aanbod:	Leraarondersteuners werken in groepjes of individueel aan bepaalde thema's die spelen, zoals angst of sociaal contact. Dit wordt gedaan a.d.h.v. gesprekken. Daarnaast wordt er SOVA training en Rots en Water training gegeven en psycho-educatie.
Disciplines:	Locatie directeur, behandelcoördinator, gedragswetenschapper, intern-begeleider, maatschappelijk werker, mentoren, leraar ondersteuners, klassenassistenten, vakdocenten.

Contact

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Onderwijs Zorg Centrum

Locatie:	Odijk
Organisatietype:	Voortgezet Speciaal Onderwijs
Betrokken organisatie(s):	Beukenrode Onderwijs (vso school) en Timon

Doelgroep

Leeftijden:	Tussen 12 en 20 jaar.
Geschikt voor:	Leerlingen die gedragsmatige en/of sociaal-emotionele belemmeringen hebben. Zij kunnen om die reden niet aan de eisen en verwachtingen van het reguliere onderwijs voldoen. Ook volledige plaatsing binnen een vso school behoort (nog) niet tot de mogelijkheden. De gedragsproblemen zijn vaak gediagnosticeerd als stoornissen binnen het autisme spectrum, de oppositioneel-opstandige gedragsstoornis, ADHD of verschillende vormen van bedreigde persoonlijkheidsontwikkelingen. Plaatsbekostiging o.b.v. een Jeugdhulp en/of WMO indicatie en/of Passend Onderwijs met een Toelaatbaarheidsverklaring (TLV).
Minder geschikt voor:	Als er met een leerling niet gecommuniceerd kan worden.
Gemiddelde programmaduur:	Gemiddeld 6 maanden.

Korte omschrijving programma

Financiering:	Onderwijs vanuit TLV, hulpverlening vanuit beschikking van de gemeente.
Doelen:	Samen met de jongere kijken wat hij/zij nodig heeft, waar hij/zij voor gemotiveerd is en waar zijn/haar krachten liggen, om zo leerlingen weer zin in het leven te geven en op weg te helpen naar een passende school, werk of dagbesteding.
Aanbod:	Een competentie- en systeemgerichte aanpak. De jongeren ontwikkelen praktische vaardigheden, voeren individuele gesprekken met de trajectbegeleider en doen groepsactiviteiten gericht op samenwerking en (psycho)educatie en sociale vaardigheden. Dit in combinatie met Beukenrode onderwijsprogramma's op maat. Het doel is dat jongeren weer uitstromen naar een passende onderwijsplek binnen regulier of speciaal onderwijs.
Disciplines:	Onderwijs, wijkteam of CJG, leerplicht, samenwerkingsverbanden, andere hulpverleners (GGZ), school van herkomst.

Contact

E-mail:	toegang@timon.nl
Telefoon:	0800 – 9008
Website:	www.timon.nl/hulpaanbod/ouders/hulp-thuis-en-op-school/onderwijs-zorg-centrum/
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Re-Fit

Locatie:	Zwolle
Organisatietype:	Voortgezet (Speciaal) Onderwijs
Betrokken organisatie(s):	Regionaal Expertiseteam, Onderwijscentrum De Twijn

Locatie:	Friesland
Organisatietype:	Ambulante Onderwijsbegeleiding
Betrokken organisatie(s):	Steunpunt Onderwijs Noord

Doelgroep

Leeftijden:	Jongeren in vo en mbo, doorgaans 12 tot 21 jaar.
Geschikt voor:	Onvoldoende verklaarde lichamelijke klachten die leiden tot schoolverzuim (of risico op schoolverzuim), jongere en ouders accepteren de medische diagnose en vinden de klachten voldoende onderzocht, jongere en ouders zijn gemotiveerd voor het programma, jongere kan fysiek deelnemen aan activiteiten zonder toename van klachten, jongere functioneert minimaal 8u per week in de onderwijspraktijk.
Minder geschikt voor:	Sprake van ernstige psychopathologie, jongere kan niet binnen een groep functioneren.
Gemiddelde programmaduur:	+/- 16 weken.

Korte omschrijving programma

Financiering:	Vanuit middelen die beschikbaar gesteld worden door de samenwerkingsverbanden vanuit tripartite afspraken na afschaffing van LGF. Scholen die niet binnen deze afspraken vallen, kunnen dit bekostigen uit eigen middelen passend onderwijs.
Doelen:	Leerlingen komen, binnen hun mogelijkheden, weer tot functioneren op school. Daarnaast gaan leerlingen bij Re-Fit weg met een plan voor de toekomst, zodat ze handvatten hebben hoe om te gaan met een eventuele terugval.
Aanbod:	Re-Fit biedt een groepstraining gecombineerd met een coachingstraject wat gericht is op het bieden van erkenning, herkenning en psycho-educatie. Deze training is gebaseerd op het oplossingsgericht werken.
Disciplines:	Consulent (ambulant begeleider CL3), orthopedagoog, ergotherapeut, maatschappelijk werker, jeugdarts.

Contact

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Website:	www.steunpuntonderwijsnoord.nl/expertise/aanpak-ziekteverzuim/

REstart

Locatie: Goes
Organisatietype: Voortgezet (Speciaal) Onderwijs
Betrokken organisatie(s):   OdyZee College, Stichting Respont

Doelgroep

Leeftijden: Van 12 tot 18 jaar.
Geschikt voor: Internaliserende problematiek, meer dan 6 weken schoolverzuim, gemiddeld of hoger IQ.
Minder geschikt voor: Laag IQ, externaliserend gedrag.
Gemiddelde programmaduur: +/- 42 weken.

Korte omschrijving programma

Financiering: Grotendeels door onderwijs, categorie 1 bekostiging, voor verdere financiering is er een aanvraag gedaan bij het transformatiefonds.
Doelen: Het kind weer naar school laten gaan en zorgen voor rehabilitatie op zowel cognitief als op sociaal-emotioneel gebied.
Aanbod: Binnen een veilige schoolomgeving wordt er begeleiding geboden aan de hand van cognitieve gedragstherapie en oplossingsgerichte therapie. Daarnaast wordt er systeemtherapie geboden binnen het gezin.
Disciplines: Leerkrachten, orthopedagoog, leidinggevende, systeemtherapeut, CGT therapeut.

Contact

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Schoolfobieprogramma

Locatie:	Den Haag
Organisatietype:	Specialistische GGZ, Voortgezet Speciaal Onderwijs
Betrokken organisatie(s):	Youz en Pleysier College Zefier

Doelgroep

Leeftijden:	12 tot 18 jaar.
Geschikt voor:	Schoolweigering door angstklachten en/of persoonlijkheidsproblematiek. Ambulante begeleiding achter de rug welke ontoereikend bleek te zijn om de schoolgang te herstellen.
Minder geschikt voor:	Stoornis in het autistische spectrum, LVB, gameverslaving of drugsverslaving.
Gemiddelde programmaduur:	1,5 tot 2 jaar.

Korte omschrijving programma

Financiering:	De jongeren die deelnemen aan het programma krijgen een behandeling binnen Youz. Behandelingen onder de 18 jaar worden gefinancierd door de gemeente.
Doelen:	Herstel van de schoolgang binnen passend vervolgonderwijs en het leren omgaan met stress en spanning.
Aanbod:	De jongeren gaan in kleine stapjes weer terug naar school en krijgen daarbij individuele behandeling aan de hand van cognitieve gedragstherapie, MBT (Mentaliseren Bevorderende Therapie) en schematherapie. Na een tijdje wordt dit groeps- behandeling. Daarnaast wordt er ook altijd systeembehandeling en ouderbegeleiding geboden.
Disciplines:	GZ-psycholoog, systeemtherapeut, mentor, ouderbegeleiding, schoolfobiedocent en een gedragswetenschapper.

Contact

Contactpersoon:	Lucienne Smout
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Telefoon:	088-3588888

Team Thuiszitters

Locatie:	Amsterdam
Organisatietype:	Jeugdzorg, Onderwijs en GGZ
Betrokken organisatie(s):	Samenwerkingsverband, Altra, De Opvoedpoli en Care Express

Doelgroep

Leeftijden:	5 tot 18 jaar.
Geschikt voor:	Jongeren die langdurig uitgevallen zijn of die zo goed als thuis zitten met een hele voorgeschiedenis van schooluitval (langere perioden, meerdere scholen).
Minder geschikt voor:	Zwakbegaafde jongeren.
Gemiddelde programmaduur:	+/- 75 weken.

Korte omschrijving programma

Financiering:	Jeugdzorgbeschikking.
Doelen:	De leerling weer aan te laten haken bij het onderwijs en het onderwijs weer aan te laten haken bij de leerling.
Aanbod:	Het team bundelt kennis van onderwijs, jeugdhulp en GGZ en werkt buiten de gebaande paden. Ze zijn gestart als hoog specialistisch aanbod maar gaan zich ook richten op dreigende uitval (niet met het gehele multidisciplinaire team, maar op maat) met als doel om de opgebouwde expertise ook beschikbaar stellen aan het voorveld, onderwijs etc.
Disciplines:	Ambulant hulpverleners, docenten, regiebehandelaar, systeemtherapeut, orthopedagoog, gedragswetenschapper/projectleider.

Contact

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Thuiszittersteam (TZT)

Locatie:	Utrecht
Organisatietype:	Voortgezet Speciaal Onderwijs
Betrokken organisatie(s):	Professor Fritz Redlschool

Doelgroep

Leeftijden:	Tussen 12 en 20 jaar.
Geschikt voor:	Door psychiatrische problematiek niet in staat om naar school te gaan. Wel in staat om in contact te gaan met het TZT, intrinsieke motivatie, wens of idee om met onderwijs aan de slag te gaan, de jongere kan zich begeleidbaar opstellen, ouders en betrokkenen zijn bereid om in gesprek te gaan met het TZT.
Minder geschikt voor:	Externaliserend gedrag, aangaan van contact en samenwerking met gezin is niet mogelijk, drugs- en/of alcoholverslaving, gezinnen/leerlingen waarbij geen ritme of dagstructuur is.
Gemiddelde programmaduur:	De begeleidingstrajecten duren tussen de 6 en 9 maanden.

Korte omschrijving programma

Financiering:	Vanuit onderwijs.
Doelen:	Jongeren verbinden met onderwijs in de breedste zin van het woord. Beweging en herstel zijn hierin kernwoorden, op meerdere leefgebieden. Er wordt gewerkt op het snijvlak van onderwijs en zorg. Jongeren weer laten aanhaken bij een vorm van onderwijs of dagbesteding. Het resocialiseren en weer reactiveren als beschermende factor om niet nog meer geïsoleerd te raken. Normaliseren waar kan.
Aanbod:	Begeleiding op maat met als doel: opbouw richting onderwijs/ dagbesteding in de breedste zin van het woord. Stapje voor stapje de jongere onder begeleiding laten wennen aan het naar school gaan en het op school zijn door middel van exposure en daarnaast een 'schoolvorm' van cognitieve gedragstherapie om helpende gedachtes te creëren en patronen te doorbreken. Daarnaast wordt behandeling verder geboden vanuit de (specialistische) GGZ. In gezamenlijkheid wordt er een Integraal plan onderwijs en zorg opgesteld. Samenwerken en de gelederen sluiten staan centraal. Er wordt gewerkt vanuit o.a. de presentie theorie, d.w.z. naast de jongere staan, de verbinding zoeken en proberen een vertrouwensband te krijgen, als eerste belangrijke stappen. Het kan goed zijn dat het in de eerste fase juist niet over school of boeken gaat. Met in acht nemen van competentie, autonomie en relatie.
Disciplines:	Schoolpsycholoog K&J NIP, pedagoog, docent, ambulant begeleider, sportbegeleider, coach.

Contact

Contactpersonen:	Gezina Topper, Esther Melaard en Mariëtte van Hemert
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Traject Thuiszitters Voortgezet Onderwijs

Locatie: Groningen
Organisatietype: Voortgezet Onderwijs
Betrokken organisatie(s):   Openbare onderwijsgroep Groningen

Doelgroep

Leeftijden: Tussen 12 en 18 jaar.
Geschikt voor: Jongeren die langer dan 4 weken thuis zitten, afkomstig van een school vallend onder ons samenwerkingsverband, hulpverlening moet betrokken zijn, liefst ook met casemanager.
Minder geschikt voor: Verslaving, externaliserend gedrag.
Gemiddelde programmaduur: +/- 49 weken (exclusief vakanties).

Korte omschrijving programma

Financiering: School van herkomst en het samenwerkingsverband.
Doelen: Leerlingen krijgen weer onderwijs, leren schoolse vaardigheden, worden sociaal vaardiger en kunnen zo snel mogelijk weer terug naar een reguliere school. Dit wordt bereikt door per leerling te kijken wat hij/zij nodig heeft.
Aanbod: Binnen een klein klasje krijgen de leerlingen onderwijs en begeleiding aangeboden, om zo te werken aan de persoonlijke leerdoelen. De begeleiding wordt gedaan op basis van gesprekken en coaching. Daarnaast krijgen de leerlingen behandeling vanuit de GGZ.
Disciplines: Docenten, VO-WIJ team, gedragswetenschappers, outreachend docent, onderwijsassistent, conciërge, leerplicht, RMC, casemanager, GGZ, jeugdhulpverlening en school van herkomst.

Contact

Contactpersoon: Marinda Hagen
E-mail: m.hagen@o2g2.nl
Telefoon: 06-12161949
Website: www.opdcstadgroningen.nl

Villa Revius

Locatie:	Doorn
Organisatietype:	Voortgezet Onderwijs
Betrokken organisatie(s):	Revius Lyceum en Gemeente Utrechtse Heuvelrug

Doelgroep

Leeftijden:	Tussen 12 en 18 jaar.
Geschikt voor:	Dreigende thuiszitters, veel verzuim, jeugdarts is ingeschakeld.
Minder geschikt voor:	Externaliserende problematiek.
Gemiddelde programmaduur:	+/- 26 weken.

Korte omschrijving programma

Financiering:	Docenten, coördinator en huisvestiging door de school, coördinerend begeleider passend onderwijs door de gemeente.
Doelen:	Terugkeer naar de school van herkomst of wanneer niet mogelijk ander passend onderwijs. Daarnaast wordt er gestreefd naar persoonlijke groei door middel van ondersteuning op bijvoorbeeld sociaal-emotioneel gebied of opvoedingsondersteuning.
Aanbod:	Per kind wordt er gekeken naar wat het kind nodig heeft om zichzelf persoonlijk te kunnen ontwikkelen en uiteindelijk de stap naar de school van herkomst (of ander passend onderwijs) weer te kunnen maken. Dit wordt gedaan door het stap voor stap opbouwen van onderwijs in combinatie met coaching en hulpverlening.
Disciplines:	Leerplicht, jeugdarts, dorpsteam, vakdocenten, eventuele externe hulpverlening, orthopedagoog als begeleider passend onderwijs.

Contact

Contactpersoon:	Henriëtte Hopman
E-mail:	h.hopman@reviusdoorn.nl
Telefoon:	0343-412145
Website:	www.revius.nl

Weer naar School

Locatie:	Zwolle Noord Nederland
Organisatietype:	Gespecialiseerde jeugd GGZ, poliklinisch
Betrokken organisatie(s):	Accare, kinder- en jeugdpsychiatrie

Doelgroep

Leeftijden:	Tussen 6 en 18 jaar.
Geschikt voor:	Het behandelprotocol richt zich primair op schoolweigering en schoolonthouding. In een enkel geval ook op spijbelen omdat hier soms ook psychische klachten aan ten grondslag liggen.
Minder geschikt voor:	Ernstige verslavingsproblematiek is een contra-indicatie. Wanneer de cliënt niet op kantoor (en ook niet op school) durft te komen, is dat tevens een contra-indicatie. De angst lijkt te groot en er zal eerst een voorliggende interventie plaats moeten vinden.
	Bij langer dan 6 weken volledig verzuim, moet het protocol met meer ruimte/flexiliteit benaderd worden. Diagnostiek lijkt dan een grotere rol te moeten krijgen en er moet vooraf kritisch gekeken worden of "weer naar school" haalbaar is.
	Bij jongeren ouder dan 18 jaar kan er minder gebruik gemaakt van worden van een gedwongen kader. Jongeren moeten een startkwalificatie hebben behaald, maar er kan minder of geen druk uitgeoefend worden door de leerplicht.
Gemiddelde programmaduur:	6 weken en soms nog 12 weken met een lage frequentie.

Korte omschrijving programma

Financiering:	Beschikking vanuit de gemeente.
Doelen:	Na 6 weken moet duidelijk zijn wat de belemmerende factoren zijn die maken dat er sprake is van schoolverzuim. Die factoren worden vervolgens aangepakt om de schoolgang uiteindelijk te herstellen.
Aanbod:	Tijdens het programma wordt er gekeken naar wat voor problematiek er bij de jongere speelt, welke systemische factoren of mogelijke onderliggende psychiatrie een rol speelt. Op basis van deze informatie wordt er een plan gemaakt om samen met de jongere en de ouders, aan de hand van systemische ondersteuning, psycho-educatie, therapie of andere vormen van hulpverlening terug te werken naar volledige schoolgang.
Disciplines:	Regiebehandelaar (GZ-psycholoog, orthopedagoog-generalist), systeemtherapeut, HBO behandelaar.

Contact

Website:	www.accare.nl/behandelingen/weer-naar-school

Appendix B: Descriptive Data

Appendix B1
Characteristics of the 76 professionals who participated in the focus group interviews

Characteristic	
Gender (*N*=76)	**Number (%)**
Female	61 (80.3%)
Male	14 (18.4%)
Unspecified	1 (1.3%)
Age (*N*=75)	
Mean	45 years (SD=11)
Minimum	20 years
Maximum	63 years
Years of experience with the intervention (*N*=74)	
Average	3.8 years (SD=3.1)
Minimum	0.5 years
Maximum	15 years
Field of work (*N*=76)	**Number (%)**
Education	57 (75.0%)
Support services [*hulpverlening*]	16 (21.1%)
Paramedical care	1 (1.3%)
Unspecified	2 (2.6%)
Function (*N*=76)	**Number (%)**
Psychologist / educational remedialist[51]	25 (32.9%)
(Specialised) teachers / classroom supervisor	22 (28.9%)
Counsellor[52] / coach / therapist	10 (13.2%)
Management	7 (9.2%)
Provide support within school[53]	7 (9.2%)
Education professional from outside the school	3 (3.9%)
Unspecified	2 (2.6%)

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[51] 'Gedragswetenschappers'
[52] 'Hulpverlener'
[53] For example, 'zorgcoördinator'

Appendix B2
Characteristics of the 52 youths who opened the online questionnaire

Characteristic	
Response across 17 organisations sending questionnaires	
Organisations with a response from young people	14[a] (82.4%)
Organisations without a response from young people	3 (17.6%)
Response rate per organisation	
Minimum number of young people	1
Maximum number of young people	9
Young person and parent response to invitation (*N*=52)	
Youth and parent consent, questionnaire done	39[b]
Youth consent, questionnaire done, missing parent consent	8
Youth consent, no questionnaire done	4
Questionnaire done, missing youth consent	1
Young person's gender (*N*=37)	**Number (%)**
Female	19 (48.7%)
Male	20 (51.3%)
Young person's age when questionnaire completed (*N*=37)	
Mean	16 years (SD=1.8)
Minimum	12 years
Maximum	20 years
Parent responses for 37 youth completing the questionnaire	
One parent completed a questionnaire	24
Two parents completed a questionnaire	15

[a] Responses from youths participating in interventions associated with 13 organisations could be used in the analysis. For one young person from one organisation, no permission was received from the parent. [b] Quantitative data analyses were conducted with data from 37 of the 39 youths, because data from two youths was not yet available when quantitative data analysis was undertaken.

Appendix B3
Characteristics of the 96 parents who opened the online questionnaire

Characteristic	
Response across 17 organisations sending questionnaires	
Organisations with response from parents	15 (88.2%)
Organisations without response from parents	2 (11.8%)
Response rate per organisation	
Minimum number of parents	2
Maximum number of parents	13
Parent response to the invitation (*N*=96)	
Parent consent, questionnaire done	86
No parent consent for parent or youth questionnaire	5
Parent consent, no questionnaire done	4
Questionnaire done, missing parent consent	1
Parent gender (*N*=86)	**Number (%)**
Female	55 (64.0%)
Male	31 (36.0%)
Parent age when completing the questionnaire (*N*=86)	
Mean	49 years (SD=5.4)
Minimum	37 years
Maximum	65 years
Parent relationship to child (*N*=86)	
Biological parent	85 (98.8%)
Adoptive parent	1 (1.2%)
Per child, number of parents completing questionnaire (*N*=86)	
One parent	44 [a]
Two parents about the same child	42 [a]

[a] This means that the 86 questionnaires completed by parents pertained to 65 young people (i.e., 44 + 42/2 = 65)

Appendix C: Recruitment Letter

Geachte collega,

U kent ze vast; kinderen en jongeren die het moeilijk vinden om naar school te gaan. Veel organisaties zoeken naar een efficiënte en effectieve manier om deze kinderen en jongeren te helpen. Heeft uw organisatie ook een aanbod? Dan komen wij graag met u in contact.

In een nieuw onderzoeksproject richten we ons specifiek op kinderen en jongeren die door angst- of stemmingsklachten (schoolweigering) niet of zeer beperkt naar school gaan. Hoewel er binnen onderwijs en hulpverlening wel programma's hiervoor ontwikkeld zijn en worden, zijn er momenteel geen duidelijke richtlijnen voor dergelijke interventies.

Het is daarom noodzakelijk dat we weten wat er gedaan wordt en welke aspecten het meest effectief lijken. De NRO onderstreept dit en heeft ons consortium een subsidie verleend voor het onderzoek: Weten Wat Werkt: Ontwikkeling van een interventie blauwdruk voor schoolweigering. Wij gaan interventies onder de loep nemen en bouwstenen genereren voor programma's voor schoolweigering.

Indien uw organisatie over een dergelijke interventie beschikt, verzoeken we u om contact op te nemen met Marije Brouwer-Borghuis (coördinator van het onderzoek) via m.brouwer@swv2301.nl of 06-38086446. Ook als u twijfelt of uw aanbod bij het onderzoek past horen wij graag van u. Wij zullen vervolgens contact met u opnemen om het onderzoek verder toe te lichten.

Een belangrijk onderdeel van het onderzoek is dat we langskomen om betrokken professionals te interviewen. Hoewel dit u als organisatie tijd zal kosten, zal het onderzoek ook nieuwe inzichten opleveren. Tevens zullen alle projecten terug te vinden zijn op een sociale kaart, en dus meer zichtbaar zijn in de discussie rondom "thuiszitters".

We danken u alvast voor uw medewerking,
David Heyne, Marije Brouwer-Borghuis, Corine van Helvoirt en Jan Vermue

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Een gangbare definitie van schoolweigering
(Heyne et al., *Cognitive and Behavioral Practice,* 2019)

Verzet of weigeren om naar school te gaan i.c.m. tijdelijke (o.a. onverklaarde lichamelijke klachten) of chronische (o.a. depressie) emotionele stress, vaak leidend tot schoolverzuim

Het kind/de jongere probeert het schoolverzuim niet te verbergen voor ouders

Afwezigheid van antisociaal gedrag (met uitzondering van het verzet richting ouders gerelateerd aan het naar school gaan)

Ouders hebben op een moment actief geprobeerd hun kind naar school te krijgen en/of geven een duidelijke intentie aan om hun kind naar school te krijgen.

Appendix D: Further Information for Organisations About the Research Process

Beste…

Bedankt voor de interesse in dit belangrijke onderzoek.

In het kort ziet het onderzoek er als volgt uit:

- Werving: We werven nu middels de wervingsbrief op programma's voor schoolweigering. Hier hebben jullie op gereageerd, waarvoor dank. Indien mogelijk zouden we graag alvast wat informatie over jullie programma ontvangen, zouden jullie dit misschien aan mij willen mailen? (bvb een handleiding of webpage). Dit zorgt ervoor dat we de face-to-face interviews niet te lang hoeven te laten duren.
- Screening: We bellen alle contactpersonen van de programma's voor een screening, dit duurt ongeveer 20 minuten. We stellen vragen zoals: binnen welk werkveld (onderwijs, hulpverlening) is de interventie gesitueerd? Hoeveel schoolweigeraars worden er ongeveer per jaar gezien?
- Ethiek: Voor de daadwerkelijke start ontvangen jullie nog een informatiebrief, waarin jullie organisatie ook om 'informed consent' wordt gevraagd; we voeren het onderzoek op een ethische manier uit .
- Bezoek: We bezoeken de programma's die we includeren. We komen dus op locatie voor een face-to-face interview dat ongeveer 2,5 uur gaat duren. Om het interview tot 2,5 uur te kunnen beperken wordt er vooraf een vragenlijst gestuurd met alle vragen die niet per se face to face hoeven te worden afgenomen.
- Vragenlijsten: Tijdens ons bezoek nemen we vragenlijsten mee voor ouders/jongeren met het verzoek aan de contactpersonen van het programma om die te versturen. De ingevulde lijsten gaan rechtstreeks terug naar ons. We zijn dit deel van de procedure nog nader aan het uitwerken, dit kan dus nog veranderen.

Wat zijn de opbrengsten voor jullie organisatie en de maatschappij?:

- De organisaties die we bezoeken worden door ons, als tegenprestatie, van recente literatuur rondom schoolweigering voorzien.
- De programma's worden opgenomen op een sociale kaart, die van jullie ook als dat jullie wens is.
- Het onderzoek levert voor het werkveld een blauwdruk op voor interventies voor schoolweigering.
- De verzamelde data zullen gebruikt worden voor meerdere nationale en internationale artikelen rondom de inrichting/werkzame factoren van interventies voor schoolweigering

Appendix E: Telephone Screening Interview

Naam:
Functie:
Datum:
Duur:

1. **Wat is de naam van het programma dat kinderen/jongeren met schoolweigering ondersteunt?**
2. **Tot welke organisatie behoort het programma?**
3. **Wat leuk dat jullie je aangemeld hebben. Wat is jullie motivatie voor deelname aan het Weten Wat Werkt onderzoek?**
4. **Binnen welk werkveld is jullie programma gesitueerd?**
   - Basis GGZ
   - Gespecialiseerde GGZ: ambulant
   - Gespecialiseerde GGZ: dagbehandeling
   - Gespecialiseerde GGZ: klinische opname
   - Jeugdzorg
   - Onderwijs: primair onderwijs
   - Onderwijs: voortgezet onderwijs
   - Onderwijs: speciaal onderwijs of voortgezet speciaal onderwijs
   - Onderwijs: mbo
   - Overig, namelijk:
5. **Wat is de leeftijdsgroep van kinderen/jongeren die deelnemen?**
6. *Uitleg aan professional:* **Ons onderzoek is gericht op programma's voor kinderen en jongeren met schoolweigering. Een gangbare definitie van schoolweigering is:**

   a) *verzet of weigeren om naar school te gaan i.c.m. tijdelijke (o.a. onverklaarde lichamelijke klachten) of chronische (o.a. depressie) emotionele stress, vaak leidend tot schoolverzuim;*
   b) *het kind/de jongere probeert het schoolverzuim niet te verbergen voor ouders;*
   c) *afwezigheid van antisociaal gedrag (met uitzondering van het verzet richting ouders gerelateerd aan het naar school gaan);*
   d) *ouders hebben op een moment actief geprobeerd hun kind naar school te krijgen en/of geven een duidelijke intentie aan om hun kind naar school te krijgen (Heyne et al., 2019).*

   Nu u de definitie gehoord heeft zou ik graag het volgende willen vragen*:*
     i. **Behoren jongeren met schoolweigering tot de doelgroep van jullie programma?**
     ii. **Ongeveer welk percentage van de jongeren in jullie programma voldoet aan de genoemde criteria voor schoolweigering?**
7. **Hoeveel jongeren met schoolweigering volgen jaarlijks ongeveer jullie programma?**
8. **Ongeveer welk percentage van de jongeren met schoolweigering die deelnemen aan jullie programma, had voor de verwijzing naar het programma, een minimale afwezigheid van 16 uur in 4 opeenvolgende weken?**
9. **Zijn er meer dan tien jongeren, waarbij sprake was van schoolweigering, uitgestroomd in de afgelopen 12 maanden.**
10. **Is de opzet van het onderzoek duidelijk voor jullie? Hebben jullie nog vragen?**

Appendix F: Notification of Non-Inclusion

Beste [Naam],

Graag willen wij u bedanken voor uw medewerking aan onze telefonische screening. Wij hebben een grote waardering voor het werk dat jullie vanuit [PROJECTNAAM] doen om thuiszittende kinderen en/of jongeren te begeleiden.

Naar aanleiding van de telefonische screening die heeft plaatsgevonden op [DATUM], is er besloten dat we uw interventie helaas niet kunnen includeren in ons Weten Wat Werkt onderzoek naar interventies tegen schoolweigering.

Een mogelijke reden voor exclusie uit het onderzoek is dat uw interventie of programma niet specifiek is opgezet is voor de begeleiding van kinderen en jongeren met schoolweigering. Andere mogelijke redenen voor exclusie zijn:

- Jongeren met schoolweigering behoren tot de doelgroep van jullie programma, maar er is (in vergelijking met de geïncludeerde programma's) een minder groot percentage schoolweigeraars dat deelneemt aan jullie programma
- Jongeren met schoolweigering behoren tot de doelgroep van jullie programma, maar er is (in vergelijking met de geïncludeerde programma's) een minder grote deelnemersgroep.

Mocht u specifiekere informatie willen over waarom uw programma niet is geïncludeerd, schroom dan vooral niet om contact met ons op te nemen.

Wij willen u in ieder geval van harte bedanken voor uw medewerking aan het Weten Wat Werkt onderzoek.

Met vriendelijke groet,

Namens het Weten Wat Werkt Team

Georgine Aerts
Onderzoeksassistent

Appendix G: Notification of Inclusion

Beste [Naam],

Allereerst willen wij u graag bedanken voor uw deelname aan het Weten Wat Werkt onderzoek en voor uw medewerking aan onze telefonische screening. Naar aanleiding van deze screening, is er besloten dat uw interventie voor jongeren met schoolweigering [Projectnaam] geïncludeerd kan worden in het Weten Wat Werkt onderzoek naar interventies tegen schoolweigering.

De volgende stappen in het onderzoek zijn als volgt:

- **Informed consent:** Bijgaand ontvangen jullie het informed consent. Graag ontvangen wij deze vóór aanvang van het interview ondertekend retour via g.j.w.aerts.leidenuniv@gmail.com of per post via de contactgegevens zoals opgenomen in het consent formulier.
- **Eerste blik:** Om het face-to-face interview tot 2,5 uur te kunnen beperken ontvangt u van ons nog een zogenaamde *Eerste Blik Vragenlijst* met alle vragen die niet per se face-to-face hoeven te worden afgenomen. Deze zullen we u begin mei toesturen.
- **Bezoek:** We komen op locatie voor een face-to-face interview dat ongeveer 2,5 uur gaat duren. Er wordt gewerkt middels een focusgroep, waarin we graag 3-6 professionals die betrokken zijn bij het project tegelijk interviewen.
- **Mogelijke data** voor dit interview zijn (op dit moment) wat ons betreft op: [Datum] of op [Datum].
- **Vragenlijsten:** Tijdens ons bezoek zullen we vragenlijsten meenemen voor ouders/jongeren met het verzoek aan jullie om die naar de tien laatst uitgestroomde jongeren te sturen. De ingevulde lijsten gaan rechtstreeks terug naar ons. We zullen dit tijdens ons bezoek nog nader toelichten.

Graag horen we van u terug of een van de voorgestelde data mogelijk is.

Met dank alvast voor de medewerking,

Namens het Weten Wat Werkt Team

Georgine Aerts
Onderzoeksassistent

Appendix H: Informed Consent – Organisations

Aan de coördinator van [INSERT NAME OF PROGRAM]

Middels deze brief willen we u graag informeren over het project Weten Wat Werkt: Ontwikkeling van een handleiding met interventie-bouwstenen voor schoolweigering. Dit onderzoeksproject wordt uitgevoerd door de Universiteit Leiden, in samenwerking met SWV 23-01, LECSO, en AT-ZORG. U heeft aangegeven hieraan te willen deelnemen, dank daarvoor. Wij stellen uw medewerking zeer op prijs. Als blijk van onze waardering zullen we u, indien u dit op prijs stelt, als wij langskomen voorzien van een pakket met recentelijke literatuur rondom schoolweigering. Tevens zullen we uw project, indien u dit wenst, opnemen in de sociale kaart die we opstellen. Hierin zullen alle projecten kort beschreven worden (o.a. doelgroep en type organisatie) inclusief contactgegevens. We zullen u vooraf de beschrijving laten lezen.

In het onderzoek zullen we ons richten op de kenmerken en werkwijzen van verschillende interventies voor jongeren met schoolweigering in ons land. We zijn geïnteresseerd in de manier waarop gewerkt wordt aan het oppakken van de schoolgang, welke aanpak er richting jongeren gehanteerd wordt, op welke manier ouders betrokken worden, hoe de samenwerking met andere professionals vormgegeven wordt en welke elementen als werkzaam worden gezien.

Om deze aspecten in beeld te krijgen, zullen we uw organisatie bezoeken voor een interview van ongeveer 1,5 uur. Wij verzoeken u om vanuit de organisatie te bepalen welke professionals aansluiten bij dit interview. Het is wenselijk dat er betrokkenen aanwezig zijn die zicht hebben op de concrete uitwerking van de interventie in de praktijk (dus hoe wordt er concreet met de jongeren gewerkt) als ook betrokkenen die zicht hebben op hoe het project georganiseerd is (o.a. financiering) en wat de visie en onderbouwing van het project is. Het interview zal opgenomen worden middels opname apparatuur. De verkregen gegevens zullen vervolgens geanonimiseerd verwerkt worden, waarna de opname verwijderd zal worden.

Om de afname van het interview te kunnen beperken tot 1,5 uur sturen we u met deze brief een vragenlijst mee gericht op de meer feitelijke kenmerken van uw interventie (zoals financiering, doelgroep). Het verzoek is om deze vragenlijst in te vullen en terug te sturen naar: Dr. D. Heyne, Ontwikkelings- en Onderwijspsychologie, Postbus 9555 2300 RB Leiden. De vragenlijst kan ook naar u ge-e-maild worden, zodat u deze digitaal kunt invullen. Als dit uw voorkeur heeft, verzoeken wij u om dit te melden bij Marije Brouwer-Borghuis via m.brouwer@swv2301.nl. De vragenlijst ontvangen wij graag uiterlijk twee weken voor het interview terug, zodat wij ons goed voor kunnen bereiden op het interview.

We willen ook de ervaringen van een aantal ouders en jongeren meenemen in ons onderzoek, aangezien op een NRO bijeenkomst andere professionals de meerwaarde van deze input benadrukten. Wanneer wij langskomen voor het interview zullen wij daarom vragenlijsten meenemen, met het verzoek aan u om deze naar de tien jongeren en hun ouders te sturen, die het laatst zijn uitgestroomd uit uw programma. De vragenlijsten en bijbehorende toestemmingsverklaringen zullen door de jongeren en hun ouders rechtstreeks teruggestuurd worden naar ons.

Het onderzoek is goedgekeurd door de Commissie Ethiek Psychologie van de Universiteit Leiden. Professionals, ouders en jongeren kunnen ervan verzekerd zijn dat alle gegevens, die we tijdens dit onderzoek verkrijgen, vertrouwelijk behandeld worden en dat niet bevoegde buitenstaanders geen

inzage zullen hebben in hun gegevens. Wanneer er gegevens uit dit onderzoek gepubliceerd worden, dan zullen persoon-gerelateerde gegevens op geen enkele wijze herleidbaar zijn tot de families of uw organisatie.

De medewerking van uw organisatie aan dit onderzoek is geheel vrijwillig. Wanneer u zich bereid verklaard heeft om aan dit onderzoek deel te nemen, hebt u te allen tijde de vrijheid om op die beslissing terug te komen en alsnog besluiten niet mee te doen. U hoeft hiervoor geen verklaring of reden te geven. Mocht u ontevreden zijn over hoe het onderzoek wordt afgenomen, dan kunt u hierover contact opnemen met de voorzitter van de afdeling Ontwikkelings- en Onderwijspsychologie Prof. dr. Michiel Westenberg (bereikbaar via e mail: Westenberg@fsw.leidenuniv.nl).

We willen de directeur van uw organisatie vragen om onderstaande toestemmingsverklaring te tekenen en deze met de bijgevoegde vragenlijst naar ons terug te sturen. Mocht u naar aanleiding van deze informatie nog vragen hebben met betrekking tot dit onderzoek, dan kunt u contact opnemen met projectleider Dr. David Heyne (bereikbaar op tel: 071-5273644 of via e-mail: heyne@fsw.leidenuniv.nl) of de coördinator van het onderzoek Marije Brouwer-Borghuis, MSc. (bereikbaar op tel: 06-38086446 of via e-mail: m.brouwer@swv2301.nl).

Toestemmingsformulier

Ik* heb de informatie in de brief over het onderzoeksproject gelezen en ik heb de kans gehad om vragen te stellen. Indien ik vragen heb gesteld, dan heb ik daar naar tevredenheid antwoord op gekregen.

Ik geef **wel / geen**** toestemming dat onze organisatie, nl………………………………………. mee zal werken aan dit onderzoek.

Ik* geef **wel / geen**** toestemming dat onze organisatie, nl……………………………………… opgenomen zal worden in de sociale kaart.

Naam: ………………………………………………………………………………………

Functie:…………………………………………………………………………………..

Datum:…………………………………………………………………………………..

Handtekening:……………………………………………………………………………..

* laten tekenen door bevoegd gezag

** doorhalen wat niet van toepassing is

Appendix I: Informed Consent – Youths

Version 03-02-2020

Beste jongere,

Bedankt voor het openen van deze vragenlijst. Graag willen we je informeren over het onderzoeksproject: Weten Wat Werkt. Dit onderzoek richt zich op programma's die kinderen en jongeren helpen die niet of met moeite naar school gaan als gevolg van angst- of stemmingsklachten (ook wel schoolweigering genoemd).

Het programma/de klas [NAME OF PROGRAM INSERTED] van [NAME OF ORGANISATION INSERTED] neemt hier aan deel. We hebben professionals werkzaam bij [NAME OF PROGRAM INSERTED] geïnterviewd over hun programma in het algemeen. Na dit interview hebben wij de professionals gevraagd om vragenlijsten te versturen naar de laatste 15 jongeren die [NAME OF PROGRAM INSERTED hebben afgerond en hun ouders/verzorgers. Jij bent een van die 15 jongeren en vandaar dat jij en je ouders/verzorgers de uitnodiging voor deze vragenlijst hebben gekregen.

Wij willen graag weten hoe de verschillende programma's er uitzien en wat volgens professionals, jongeren en ouders/verzorgers wel en niet helpend is. Op basis daarvan zullen we een handleiding opstellen voor de praktijk. Jouw informatie is daarbij erg belangrijk. Deze informatie willen wij verkrijgen middels deze vragenlijst. Meer informatie zal er bij jou niet worden opgevraagd. In de vragenlijsten noemen we [NAME OF PROGRAM INSERTED] "het programma".

Het onderzoek is goedgekeurd door de Commissie Ethiek Psychologie van de Universiteit Leiden. Jij en je ouder(s)/verzorger(s) kunnen ervan verzekerd zijn dat alle gegevens, die we middels de vragenlijsten verkrijgen, vertrouwelijk behandeld worden en dat niet bevoegde buitenstaanders geen inzage zullen hebben in de gegevens. De personen die werken bij het programma waar jij aan deelgenomen hebt, kunnen jouw antwoorden ook niet zien. Jouw antwoorden worden rechtstreeks naar de Universiteit Leiden gestuurd. Bij het analyseren van de vragenlijsten berekenen we de gemiddelde scores over meerdere jongeren en ouders, en zoeken we naar veel genoemde thema's bij de open vragen. We beschrijven geen individuele uitkomsten. Wanneer er gegevens uit dit onderzoek gepubliceerd worden, dan zullen deze gegevens op geen enkele wijze tot jou of je ouder(s)/verzorger(s) herleidbaar zijn. Aangezien het versturen van de codes voor de vragenlijsten door het programma is gedaan, hebben wij niet de beschikking over jullie adresgegevens of andere herleidbare gegevens. Bij de start van deze vragenlijst vragen we wel om je naam en je handtekening. Dit is benodigd voor de toestemming, echter de gegevens afkomstig uit de vragenlijsten zullen anoniem verwerkt worden en de persoonlijke informatie verkregen door de toestemmingsverklaringen zullen apart worden opgeslagen.

De medewerking van jou en je ouder(s)/verzorger(s) aan dit onderzoek is geheel vrijwillig. Wanneer jullie je bereid verklaard hebben om aan dit onderzoek deel te nemen, hebben jullie te allen tijde de vrijheid om op die beslissing terug te komen en alsnog te besluiten niet mee te doen. Jullie hoeven hier dan geen reden voor op te geven. Mochten jullie ontevreden zijn over hoe het onderzoek wordt afgenomen, dan kunnen jullie hierover contact opnemen met de voorzitter van de afdeling Ontwikkelings- en Onderwijspsychologie Prof. dr. Michiel Westenberg (bereikbaar via e-mail: Westenberg@fsw.leidenuniv.nl).

Mochten jullie naar aanleiding van deze informatie nog vragen hebben met betrekking tot dit onderzoek, dan kunnen jullie contact opnemen met projectleider Dr. David Heyne (bereikbaar op tel: 071-5273644 of via e-mail: heyne@fsw.leidenuniv.nl) of de coördinator van het onderzoek Marije Brouwer-Borghuis, MSc. (bereikbaar op tel: 06-38086446 of via e-mail: m.brouwer@swv2301.nl).

We willen je alvast heel hartelijk bedanken voor de medewerking.

Namens het Weten Wat Werkt team,

Dr. David Heyne
Marije Brouwer-Borghuis, MSc.
Georgine Aerts, MSc.

Toestemming

Ik heb bovenstaande informatie over het onderzoeksproject gelezen en ik heb de kans gehad om vragen te stellen. Indien ik vragen heb gesteld, heb ik daar naar tevredenheid antwoord op gekregen. Ik geef toestemming om mee te werken aan dit onderzoeksproject.

o   Ik geef toestemming

o   Ik geef geen toestemming

N.B. Bij toestemming gaat de jongere door naar de volgende vraag. Bij geen toestemming eindigt de vragenlijst

Vul de volgende informatie in

Mijn naam:

Datum van vandaag:

N.B. Met gedwongen respons, deze vragen kan de jongere niet overslaan.

Plaats je handtekening in onderstaande ruimte

In Qualtrics is een leeg invulveld waarin middels de muis een handtekening kan worden geplaatst. Indien dit niet gebeurt wordt de vragenlijst verlaten

Akkoord ouder(s)/verzoger(s)

Mijn ouder(s)/verzorger(s) gaan ermee akkoord dat ik deelneem aan dit onderzoek en zullen in hun vragenlijst hier ook voor tekenen.

- o   Ja
- o   Nee

N.B. Bij ja gaat de jongere door naar de volgende vraag. Bij nee wordt de jongere gevraagd om zijn ouder(s)/verzorger(s) om toestemming te vragen en daarna door te gaan met de vragenlijst. Deze vraag kan niet overgeslagen worden.

Appendix J: Informed Consent – Parents

Version 03-02-2020

Beste ouder/verzorger,

Bedankt voor het openen van deze vragenlijst. Graag willen we u informeren over het onderzoeksproject: Weten Wat Werkt. Dit onderzoek richt zich op programma's die kinderen en jongeren helpen die niet of met moeite naar school gaan als gevolg van angst- of stemmingsklachten (ook wel schoolweigering genoemd).

Het programma/de klas [NAME OF PROGRAM INSERTED] van [NAME OF ORGANISATION INSERTED] neemt hier aan deel. We hebben professionals werkzaam bij [NAME OF PROGRAM INSERTED] geïnterviewd over hun programma in het algemeen. Na dit interview hebben wij de professionals gevraagd om vragenlijsten te versturen naar de laatste 15 jongeren die [NAME OF PROGRAM INSERTED] hebben afgerond en hun ouders/verzorgers. Uw zoon/dochter is een van die 15 jongeren en vandaar dat u en uw zoon/dochter de uitnodiging voor deze vragenlijst hebben gekregen.

Wij willen graag weten hoe de verschillende programma's er uitzien en wat volgens professionals, jongeren en ouders/verzorgers wel en niet helpend is. Op basis daarvan zullen we een handleiding opstellen voor de praktijk. Uw informatie is daarbij erg belangrijk. Deze informatie willen wij verkrijgen middels deze vragenlijst. Meer informatie zal er bij u niet worden opgevraagd. In de vragenlijst refereren we naar [NAME OF PROGRAM INSERTED] als "het programma".

Het onderzoek is goedgekeurd door de Commissie Ethiek Psychologie van de Universiteit Leiden. U en uw zoon/dochter kunnen ervan verzekerd zijn dat alle gegevens, die we middels de vragenlijsten verkrijgen, vertrouwelijk behandeld worden en dat niet bevoegde buitenstaanders geen inzage zullen hebben in de gegevens. De personen die werken bij het programma waar uw kind aan deelgenomen heeft, kunnen uw antwoorden ook niet zien. Uw antwoorden worden rechtstreeks naar de Universiteit Leiden gestuurd. Bij het analyseren van de vragenlijsten berekenen we de gemiddelde scores over meerdere jongeren en ouders, en zoeken we naar veel genoemde thema's bij de open vragen. We beschrijven geen individuele uitkomsten. Wanneer er gegevens uit dit onderzoek gepubliceerd worden, dan zullen deze gegevens op geen enkele wijze tot u of uw zoon/dochter herleidbaar zijn. Aangezien het versturen van de codes voor de vragenlijsten door het programma is gedaan, hebben wij niet de beschikking over jullie adresgegevens of andere herleidbare gegevens. Bij de start van deze vragenlijst vragen we wel om uw naam, de naam van uw zoon/dochter en uw handtekening. Dit is benodigd voor de toestemming, echter de gegevens uit de vragenlijst zullen anoniem verwerkt worden en de persoonlijke informatie verkregen door de toestemmingsverklaring zal apart worden opgeslagen.

De medewerking van u en uw zoon/dochter aan dit onderzoek is geheel vrijwillig. Wanneer jullie je bereid verklaard hebben om aan dit onderzoek deel te nemen, hebben jullie te allen tijde de vrijheid om op die beslissing terug te komen en alsnog te besluiten niet mee te doen. Jullie hoeven hier dan geen reden voor op te geven. Mochten jullie ontevreden zijn over hoe het onderzoek wordt afgenomen, dan kunnen jullie hierover contact opnemen met de voorzitter van de afdeling Ontwikkelings- en Onderwijspsychologie Prof. dr. Michiel Westenberg (bereikbaar via e-mail: Westenberg@fsw.leidenuniv.nl).

Mochten jullie naar aanleiding van deze informatie nog vragen hebben met betrekking tot dit onderzoek, dan kunnen jullie contact opnemen met projectleider Dr. David Heyne (bereikbaar op tel:

071-5273644 of via e-mail: heyne@fsw.leidenuniv.nl) of de coördinator van het onderzoek Marije Brouwer-Borghuis, MSc. (bereikbaar op tel: 06-38086446 of via e-mail: m.brouwer@swv2301.nl).

We willen u alvast heel hartelijk bedanken voor de medewerking.

Namens het Weten Wat Werkt team,

Dr. David Heyne
Marije Brouwer-Borghuis, MSc.
Georgine Aerts, MSc.

Toestemming

Ik heb bovenstaande informatie over het onderzoeksproject gelezen en ik heb de kans gehad om vragen te stellen. Indien ik vragen heb gesteld, heb ik daar naar tevredenheid antwoord op gekregen. Ik geef toestemming om mee te werken aan dit onderzoeksproject. Ik geef bij deze ook toestemming voor de deelname van mijn kind.

- o Ik geef toestemming
- o Ik geef geen toestemming

N.B. Bij toestemming gaat de ouder door naar de volgende vraag. Bij geen toestemming eindigt de vragenlijst

Vul de volgende informatie in

Uw naam:

Naam van uw kind:

Datum van vandaag:

N.B. Met gedwongen respons, deze vragen kan de ouder niet overslaan.

Plaats uw handtekening in onderstaande ruimte

In Qualtrics is een leeg invulveld waarin middels de muis een handtekening kan worden geplaatst. Indien dit niet gebeurt wordt de vragenlijst verlaten

Appendix K: Email About Distributing Questionnaires to Youths and Parents

Beste [Naam],

Hartelijk dank voor het toesturen van de informatie over het aantal jongeren dat in 2019 jullie programma afgerond hebben. De vragenlijsten voor ouders en jongeren behorende bij het Weten Wat Werkt onderzoek zijn nu klaar om verstuurd te worden. Het betreft een digitale afname. Bij deze sturen we jullie informatie over de procedure en jullie beoogde rol in het verspreiden van de vragenlijsten aan ouders en jongeren. De procedure is als volgt:

1. Selecteer de laatste 15 jongeren die het programma tussen januari 2019 en nu (februari 2020) hebben afgerond. Zijn het er 15 of minder, selecteer ze dan allemaal. Let op, door de verlenging van 2 tot 3 maanden in 2020, zijn dit er mogelijk meer of andere jongeren dan jullie in eerste instantie aan ons hebben doorgegeven. Indien er casussen tussen zitten die jullie absoluut niet willen benaderen, tel die dan wel in de 15 mee en registreer dat jullie die niet hebben benaderd. Het is namelijk niet de bedoeling dat jullie een selectie maken in wie jullie wel graag zouden zien meedoen en wie niet. Dit zou een negatieve impact hebben op de betrouwbaarheid van het onderzoek.
2. In het document "overzicht jongeren onderzoek Weten Wat Werkt" dat als bijlage meegestuurd is, zijn voor 5 jongeren en hun ouders weblinks te vinden. Vul de rode delen van de tekst aan met de naam van de jongere en indien er twee ouders in beeld zijn geef dan aan voor wie welke link is (bijvoorbeeld moeder, vader benoemen). Dit document is voor eigen gebruik en hoeven wij niet te ontvangen. In onze afstemming met jullie over de vragenlijsten (bijvoorbeeld lijsten die we missen of waar iets aan ontbreekt) zullen we de codes gebruiken om te communiceren. Jullie weten dan welke jongere/ouders daarbij horen.
3. Als bijlage bij deze mail is een standaard e-mail voor ouders en een standaard e-mail voor jongeren bijgevoegd:

   - **E-mail voor ouders: Bewerk de e-mail door:**
   - In de rode delen van de tekst in te vullen wat de naam van de jongere is en of het hun zoon of dochter betreft. Daarna dit graag zwart maken.
   - De rode tekst: *Wij hebben uw zoon/dochter ook een mail gestuurd met de eigen unieke link* zwart maken indien er ook een mail naar de jongere zelf is verstuurd, en zoon of dochter weghalen.
   - De tekst over twee weblinks voor beide ouders, zwart maken indien er voor beide ouders/verzorgers een link wordt meegestuurd. Deze tekst weghalen indien er slechts 1 ouder in beeld is.
   - Onderaan de e-mail voor de ouders kunnen de weblinks geplakt worden die te vinden zijn in het document "Overzicht jongeren onderzoek Weten Wat Werkt". Indien er twee ouders in beeld zijn, dan specificeren voor wie welke link is (bijvoorbeeld moeder, vader benoemen).

   - **E-mail voor jongere: Bewerk de e-mail door:**
   - De naam van de jongere in te vullen. Daarna dit graag zwart maken.
   - Onderaan de e-mail voor de jongeren kunnen de weblinks geplakt worden die te vinden zijn in het document "Overzicht jongeren onderzoek Weten Wat Werkt".

4. Stuur de bewerkte e-mail naar beide ouders, indien jullie van beide ouders het e-mailadres hebben. Stuur de email voor de jongere naar het e-mailadres van de jongere indien jullie dit hebben. Het versturen naar beide ouders en de jongere heeft tot doel om de respons te verhogen. Om te kunnen deelnemen moet er in ieder geval naar 1 ouder gemaild kunnen worden, het kan niet alleen via het e-mailadres van de jongere.
5. Stuur bij de e-mail voor de ouders de twee informatiebrieven voor ouders en jongeren als bijlagen mee. Stuur bij de e-mail voor de jongere alleen de informatiebrief voor de jongeren mee. Deze brieven hebben wij meegestuurd bij deze e-mail.
6. Noteer in de laatste kolom van het document "overzicht jongeren onderzoek Weten Wat Werkt" naar wie de e-mails gestuurd zijn en wanneer ze verstuurd zijn.
7. Het is de bedoeling dat alle e-mails naar ouders/jongeren binnen drie aaneengesloten dagen verstuurd worden. Als de laatste e-mail verzonden is horen wij graag terug dat dit gebeurd is en op welke datum. Deze datum houden wij dan aan voor onze follow up.
8. Twee weken na het verzenden van de e-mails laten wij weten welke codes/weblinks niet gebruikt zijn. Aan jullie dan het verzoek om terug te zoeken welke jongeren/ouders dit zijn en hen eenmalig een herinnering te sturen.

Als bijlagen bij deze mail hebben we ook de vragenlijsten toegevoegd, die digitaal door de jongeren en hun ouders zullen worden ingevuld. Op die manier weten jullie ook welke vragen er gesteld zullen worden over naam project. Wij verzoeken jullie om de vragenlijsten niet te delen buiten de eigen organisatie.

We hopen dat bovenstaande duidelijk is, zo niet dan horen we dat graag terug van jullie.
Nogmaals hartelijk dank voor jullie medewerking met ons onderzoek, wij waarderen dit zeer.

Namens het Weten Wat Werkt team,

Dr. David Heyne
Marije Brouwer-Borghuis, MSc.
Georgine Aerts, MSc.

7 bijlagen
20200228 - Vragenlijst Weten Wat Werkt - Jongeren.pdf
20200228 - Vragenlijst Weten Wat Werkt - Ouders.pdf
20200228 - E-mail voor jongeren - [Naam programma].docx
20200228 - E-mail voor ouders - [Naam programma].docx
20200228 - Informatiebrief Weten Wat Werkt - [Naam programma] - Jongeren.pdf
20200228 - Informatiebrief Weten Wat Werkt - [Naam programma] - Ouders.pdf
20200228 - Overzicht jongeren voor Weten Wat Werkt - [Naam programma].docx

Appendix L: First Impressions Questionnaire

'Eerste Blik Vragenlijst'

Naam   :

Functie   :

Project   :

Datum   :

Beste [naam],

Graag willen wij u nogmaals bedanken voor uw deelname aan het onderzoeksproject Weten Wat Werkt: Ontwikkeling van een handreiking met bouwstenen voor interventies bij schoolweigering.

Bijgaand ontvangt u de 'eerste blik' vragenlijst. Het doel van deze vragenlijst is om aanvullende informatie omtrent uw interventie te verkrijgen, naast de informatie die we al hebben verkregen tijdens de telefonische screening. De aanvullende informatie helpt ons om een goede 'eerste blik' te kunnen vormen voordat we het interview bij u gaan afnemen. Op deze manier kunnen we de interviews ook zo efficiënt mogelijk laten verlopen.

In deze vragenlijst vindt u met name vragen die gericht zijn op feitelijke informatie met betrekking tot uw project. Deze vragen hoeven dus ook niet per se in de interviews uitgevraagd te worden.

De antwoorden die door u gegeven zijn tijdens de telefonisch screening, zijn ook in de huidige vragenlijst opgenomen (vragen 1 t/m 9). Aan u de vraag om deze antwoorden te controleren en zo nodig aan te vullen.

Wanneer er gevraagd wordt naar percentages dan willen we u vragen om deze te beantwoorden over de afgelopen 12 maanden. Alle andere vragen gaan over hoe het *op dit moment* binnen jullie programma geregeld is.

Met dank alvast voor de medewerking,

Namens het Weten Wat Werkt Team
Marije Brouwer, David Heyne en Georgine Aerts

Deel 1. Vragen gesteld tijdens telefonische screening

De antwoorden zijn al ingevuld, graag controleren en indien nodig aanvullen.

1. **Wat is de naam van het programma dat kinderen/jongeren met schoolweigering ondersteunt?**

   Antwoord uit telefonische screening:

2. **Tot welke organisatie behoort het programma?**

   Antwoord uit telefonische screening:

3. **Wat is jullie motivatie voor deelname aan het Weten Wat Werkt onderzoek?**

   Antwoord uit telefonische screening:

4. **Binnen welk werkveld is jullie programma gesitueerd?**

   Antwoord uit telefonische screening:

   - Basis GGZ
   - Gespecialiseerde GGZ: ambulant/poliklinisch
   - Gespecialiseerde GGZ: dagbehandeling
   - Gespecialiseerde GGZ: klinische opname
   - Jeugdzorg
   - Onderwijs: primair onderwijs
   - Onderwijs: voortgezet onderwijs
   - Onderwijs: speciaal onderwijs of voortgezet speciaal onderwijs
   - Onderwijs: mbo
   - Overig, namelijk:

5. **Wat is de leeftijdsgroep van kinderen/jongeren die deelnemen?**

   Antwoord uit telefonische screening:

6. **Ons onderzoek is gericht op programma's voor kinderen en jongeren met schoolweigering. Een gangbare definitie van schoolweigering is:**

(Heyne et al., Cognitive and Behavioral Practice, 2019)
- *Verzet of weigeren om naar school te gaan i.c.m. tijdelijke (o.a. onverklaarde lichamelijke klachten) of chronische (o.a. depressie) emotionele stress, vaak leidend tot schoolverzuim*
- *Het kind/de jongere probeert het schoolverzuim niet te verbergen voor ouders*
- *Afwezigheid van antisociaal gedrag (met uitzondering van het verzet richting ouders gerelateerd aan het naar school gaan)*
- *Ouders hebben op een moment actief geprobeerd hun kind naar school te krijgen en/of geven een duidelijke intentie aan om hun kind naar school te krijgen.*

a. **Behoren jongeren met schoolweigering tot de doelgroep van jullie programma?**

   Antwoord uit telefonische screening:

b. **Ongeveer welk percentage van de jongeren in jullie programma voldoet aan de genoemde criteria voor schoolweigering?**

   Antwoord uit telefonische screening:

7. **Hoeveel jongeren met schoolweigering volgen jaarlijks ongeveer jullie programma?**

   Antwoord uit telefonische screening:

8. **Ongeveer welk percentage van de jongeren met schoolweigering die deelnemen aan jullie programma, had voor de verwijzing naar het programma, een minimale afwezigheid van 16 uur in 4 opeenvolgende weken?**

   Antwoord uit telefonische screening:

9. **Zijn er meer dan tien jongeren, waarbij sprake was van schoolweigering, uitgestroomd in de afgelopen 12 maanden?**

   Antwoord uit telefonische screening:

Deel 2. Ontstaan en organisatie van het programma

Graag antwoorden op dit formulier. (N.B.: waar jongeren staat kunt u ook kinderen lezen)

10. **Sinds wanneer bestaat het programma?**

11. **Hoe is het programma gefinancierd?**

12. **Beantwoord de volgende vragen over de grootte van het programma:**

    a. **Hoe groot is de formatie (in totale FTE) van het programma?**

    b. **Welke disciplines zijn betrokken bij het programma?**

    c. **Hoeveel verschillende mensen zijn betrokken bij het programma?**

13. **Beantwoord de volgende vragen over de samenwerking met andere organisaties / professionals:**

    a. **Zijn leerplichtambtenaren betrokken bij het programma?**

        i. Indien ja: op welke manier?
        ii. Indien niet: waarom niet?

    b. **Is de Jeugd Gezondheidszorg (JGZ) betrokken bij het programma?**

        i. Indien ja: op welke manier?
        ii. Indien niet: waarom niet?

    c. **Is de school van herkomst betrokken bij het programma?**

        i. Indien ja: op welke manier?
        ii. Indien niet: waarom niet?

    d. **Is het samenwerkingsverband betrokken bij het programma?**

        i. Indien ja: op welke manier?
        ii. Indien niet: waarom niet?

14. **Beantwoord de volgende vragen over het vervoer gedurende het programma:**

    a. **Op welke manier(en) komen jongeren op school gedurende het programma?**

    b. **Worden jongeren ook thuis opgehaald door professionals van het programma?**

Deel 3. Doelgroep

15. Met wie wordt er in jullie programma gewerkt?

Kruis aan wat van toepassing is

	Nooit	**Soms**	**Altijd**
De jongere			
Ouders/verzorgers			
Schoolpersoneel			
Iemand anders, namelijk: ………………………………………………			
Iemand anders, namelijk: ………………………………………………			
Iemand anders, namelijk: ………………………………………………			

16. Beantwoord de volgende vragen over de indicaties voor deelname:

   a. Wat zijn indicaties voor deelname aan het programma?

   b. Wat zijn contra-indicaties voor deelname aan het programma?

   c. Waar zijn de indicaties en contra-indicaties gespecificeerd?

17. Wordt er gescreend op schoolweigering?

   Omcirkel wat van toepassing is

   Ja / nee

   a. Indien ja: Gebruiken jullie screeningscriteria of vragenlijsten?

   i. Ja, namelijk:
   ii. Nee

   b. Indien niet: waarom niet?

18. Beantwoord de volgende vragen over de werving :

    a.   Hoe werven jullie jongeren voor het programma?

    b.   Wie zijn de belangrijkste verwijzers?

N.B. Bij vraag 19, 20 en 21 dient u de __afgelopen 12 maanden__ als referentiekader te nemen

19. Welk percentage (schatting) van de jongeren met schoolweigering in jullie programma wordt gekenmerkt door (vink aan wat van toepassing is):

- **Een gediagnosticeerde neurobiologische ontwikkelingsstoornis**
  - ☐ Autisme spectrum stoornis   Geschat percentage:
  - ☐ ADHD   Geschat percentage:
  - ☐ Leerstoornis (zoals dyslexie)   Geschat percentage:
  - ☐ Verstandelijke beperking   Geschat percentage:

- **Een gediagnosticeerde internaliserende stoornis**
  - ☐ Angststoornis   Geschat percentage:
  - ☐ Stemmingsstoornis   Geschat percentage:

- ☐ **Een gediagnosticeerde externaliserende stoornis**   Geschat percentage:
- ☐ **Chronische onverklaarde lichamelijke klachten**   Geschat percentage:
- ☐ **Ervaringen met gepest worden**   Geschat percentage:
- ☐ **Een achtergrond als vluchteling**   Geschat percentage:
- ☐ **Een allochtone afkomst**   Geschat percentage:

20. Beantwoord de volgende vragen over de tijd die jongeren thuiszaten:

    a. Welk percentage (schatting) van de jongeren met schoolweigering die deelnemen aan jullie programma zaten tenminste 4 weken volledig thuis voorafgaand aan de verwijzing naar het programma?

    b. Hoe lang zaten deze jongeren thuis voordat zij startten met het programma?
      i.   Tussen 4 weken en 3 maanden   Geschat percentage:
     ii.   Tussen 3 maanden en 1 jaar   Geschat percentage:
   iii.   Langer dan een jaar   Geschat percentage:

21. Wat is de gemiddelde duur in weken (schatting) dat jongeren deelnemen aan jullie programma?

    Schatting aantal weken:

Deel 4. Inhoud van het onderwijs

*N.B. Vraag 22 tot en met 25 dient u alleen in te vullen **<u>als onderwijs onderdeel van het programma is.</u>***

22. **Wordt er thuisonderwijs geboden binnen jullie programma?**

    a. Zo ja: op welke manier en hoe lang?

    b. Indien niet: waarom niet?

23. **Is het programma gericht op terugkeer naar regulier onderwijs?**

    a. Zo ja: op welke manier?

    b. Indien niet: waarom niet?

24. **Welke onderwijsniveaus bieden jullie aan *gedurende* jullie programma en kunnen alle onderwijsniveaus geboden worden?**

25. **Welk lesprogramma/curriculum wordt gebruikt *gedurende* jullie programma? (IVIO, programma school van herkomst, eigen programma etc.)**

*N.B. Bij vraag 26 tot en met 30 dient u de **<u>afgelopen 12 maanden</u>** als referentiekader te nemen*

26. **Naar welke vorm van onderwijs gaan de jongeren *voor* verwijzing naar jullie programma, met andere woorden; aan welke vorm van onderwijs worden ze *geacht* te participeren?**

    ☐ Regulier basis of voortgezet onderwijs   Geschat percentage:
    ☐ Speciaal onderwijs of voortgezet speciaal onderwijs Geschat percentage:
    ☐ Mbo   Geschat percentage:
    ☐ Thuisonderwijs   Geschat percentage:
    ☐ Geen onderwijs   Geschat percentage:
    ☐ Anders, namelijk: Geschat percentage:

27. **Welk onderwijsniveau volgen de jongeren *voor* verwijzing naar jullie programma?**

    ☐ Leerstof basisschool   Geschat percentage:
    ☐ Route dagbesteding, route arbeid, praktijkonderwijs   Geschat percentage:
    ☐ Vmbo (basis, kader, gemengd en theoretisch)   Geschat percentage:
    ☐ Havo/Vwo/Gymnasium   Geschat percentage:
    ☐ Mbo (niveau 1, 2, 3 of 4)   Geschat percentage:

28. Welke vorm van onderwijs volgen de jongeren *gedurende* jullie programma?

☐ School van herkomst   Geschat percentage:

☐ Tijdelijke plaatsing op school voor speciaal onderwijs   Geschat percentage:

☐ Tijdelijke plaatsing op bovenschoolse voorziening   Geschat percentage:

☐ Thuisonderwijs   Geschat percentage:

☐ Geen onderwijs   Geschat percentage:

☐ Anders, namelijk: Geschat percentage:

29. Ongeveer welk percentage van de jongeren keert na deelname aan jullie programma terug naar de school van herkomst?

Geschat percentage:

30. Naar welke vorm van onderwijs gaan de jongeren *na* deelname aan jullie programma:

☐ Regulier basis of voortgezet onderwijs   Geschat percentage:

☐ Speciaal onderwijs of voortgezet speciaal onderwijs   Geschat percentage:

☐ Volwassenonderwijs   Geschat percentage:

☐ Mbo   Geschat percentage:

☐ Leerwerktraject/arbeidstoeleiding   Geschat percentage:

☐ Dagbesteding   Geschat percentage:

☐ Thuisonderwijs   Geschat percentage:

☐ Geen onderwijs   Geschat percentage:

☐ Anders, namelijk: Geschat percentage:

Deel 5. Evalueren van de interventie

31. Volgen jullie de jongeren na het afronden van het programma?

    a. Zo ja: hoe, hoe vaak, en tot wanneer?

    b. Indien niet: waarom niet?

32. Wordt de interventie op de een of andere manier geëvalueerd?

    a. Zo ja:
        i. Wat wordt geëvalueerd (bijv. cliënttevredenheid)
        ii. Worden er kwantitatieve data verzameld? Zo ja: Welke meetinstrumenten / vragenlijsten worden gebruikt?
        iii. Worden er kwalitatieve data verzameld? Zo ja: welke en op welke manier?
        iv. Op welke momenten wordt er geëvalueerd (start, tussentijds, direct na afronding, follow-up)?
    b. Indien niet: waarom niet?

Deel 6. Overige opmerkingen/aanvullingen

Appendix M: Focus Group Interview Schedule for Professionals

WETEN WAT WERKT (versie 17-07-2019)
Op Zoek Naar Gangbare Bouwstenen
Voor Interventies Gericht Op Schoolweigering

Interview - Inleiding – 5 Minuten

Project: _____

Datum interview: _____

Geïnterviewden: _____

Interviewer(s): _____

1. **INTRODUCTIE:** Ik ben / wij zijn …….
2. **PROJECT DOEL:** Zoals jullie misschien weten, het WwW project heeft als primaire doel …
3. **PROJECT PROCESS:** Om dit te bereiken, gaan we langs programma's met een interview
4. **DANK:** Dank voor de achtergrond informatie (bvb email, telefoon, vragenlijst vooraf). We zijn heel blij om vandaag hier te mogen zijn, om meer over jullie programma te horen. We zijn dankbaar voor de tijd die jullie vrij gemaakt hebben voor dit interview …..
5. **OPEN DISCUSSIE:** Dit groepsinterview is bedoeld om jullie ervaringen en meningen te horen over interventies voor schoolweigering. Hoewel er vragen gesteld worden, hoeft het niet continu via vraag en antwoord te verlopen. Je mag op elkaars antwoorden reageren en hoeft niet te wachten totdat je om een antwoord gevraagd wordt. We vinden vooral de discussie belangrijk en dat jullie zeggen wat jullie echt denken. Er zijn geen goede of foute antwoorden.
6. **TIER 3:** We focussen in dit onderzoek op 'Tier 3' interventies (voor jongeren met ernstige en chronisch schoolverzuim die meer dan 16 uur in 4 weken afwezig waren). We willen jullie daarom vragen om jullie Tier 3 interventie in je achterhoofd te houden bij het beantwoorden van de vragen en niet de Tier 1 en 2 interventies die jullie inzetten.
7. **TIJD:** We moeten ook realistisch blijven, we hebben 2,5 uren samen……..
8. **BEPERKING:** Dat lijkt veel, maar onze ervaring is dat dit zo voorbij is. Misschien zijn er momenten dat we een onderwerp toch moeten afronden, om ervoor te zorgen dat we het over de andere onderwerpen kunnen hebben.
9. **INTERVIEW PROCESS:** Delen van het interview worden begeleid door [naam], en andere delen door [naam] …
10. **OPNAME:** Zoals eerder aangegeven, wordt het interview opgenomen; op die manier kan onze onderzoeksassistent een transcript maken voor ons ….. Hoe klinkt dit? ….
11. **START:** Dan, om te beginnen …. [begin met eerste vraag in interview]

Interview – Checklist & Richtlijnen

Checklist voor de interviewer:

1. Haal consent form en EBV op, als niet eerder opgestuurd
2. Check regelmatig dat de 'recording device' werkt.
3. Schrijf initialen van de geïnterviewden op wanneer ze iets inbrengen, zodat dit voor de quotes gebruikt kan worden

Onderzoeksvragen voor het Weten Wat Werkt project:

1. Hoeveel en welke onderwijs- en hulpverleningsorganisaties in Nederland bieden een interventie aan die specifiek gericht is op schoolweigering?
2. Hoeveel van deze programma's hanteren een integrale aanpak van schoolweigering, waarbij zowel het kind/jongere, ouders als school betrokken worden?
3. Welke interventies worden ingezet bij het kind/jongere, ouders en school?
4. Welke elementen van de ingezette interventies worden gezien als meest belangrijk voor een effectieve aanpak van schoolweigering?
5. Welke praktische moeilijkheden ervaren de organisaties met betrekking tot het aanbieden van interventies voor schoolweigering?
6. Op welke manier werken onderwijs- en hulpverleningsorganisaties samen bij het terugleiden naar school van kinderen/jongeren met schoolweigering?
7. Welke rol dient het onderwijs te spelen in de interventies voor schoolweigering?

Richtlijnen voor de interviewer:

- Wat doen ze in dit programma? – meer gesloten
  - Welke interventies zijn voorzien (RQ3) – meer gesloten (16 vragen)
  - In hoeverre is wat ze doen 'integraal'? (RQ2) – meer gesloten (4 vragen)
  - Gaat het over het 'huwelijk' en hoe? (RQ6) – meer open (5 vragen)
- Waarom doen ze wat ze doen? – meer open
  - Belangrijkste elementen volgens hen (RQ4) – meer open (9 vragen)
  - Praktische moeilijkheden (RQ5) – meer open (4 vragen)
- Hoe zij denken over de rol van onderwijs in interventies voor schoolweigering (RQ7) – meer open (3 vragen)

1. Start van het interview (10 m)

a. Voorstellen: kun je vertellen wie je bent en wat je rol in het programma is?

2. Strekking van het programma (25 m)

KAART HET ONDERWERP AAN ….

   a. Hoe bepalen jullie welke jongeren jullie toelaten?

     NB: bij twijfel over aandacht over schoolweigering, hier op doorvragen

   b. Wat is het doel van jullie programma?

[Verwijs iedereen naar de schaal in de bijlage]

   c. 1. Soms zijn programma's volledig gestandaardiseerd/geprotocolleerd (dat wil zeggen een vast programma/aanbod dat iedereen aangeboden krijgt), andere programma's bieden volledig maatwerk (dat wil zeggen zonder vaste elementen). Waar bevindt jullie programma zich op deze schaal tussen 'volledig gestandaardiseerd of geprotocolleerd ' en 'volledig maatwerk'? Willen jullie dit omcirkelen?

     2. Kunnen jullie dit toelichten?
     [Even pauzeren voordat de volgende vraag wordt aangeboden: "Wat vinden jullie ervan dat het programma zich daar op de schaal bevindt?"]

[Verwijs iedereen naar de schaal in de bijlage]

   d. 1. Sommige programma's voor jongeren met schoolweigering worden volledig vanuit onderwijs aangeboden en aangestuurd, andere programma's worden volledig vanuit hulpverlening aangeboden en aangestuurd. Waar bevindt jullie programma zich op deze schaal tussen 'volledige focus op onderwijs' en 'volledige focus op hulpverlening'? Willen jullie dit omcirkelen?

     2. Kunnen jullie dit toelichten?
     [Even pauzeren voordat de volgende vraag wordt aangeboden: "Wat vinden jullie ervan dat het programma zich daar op de schaal bevindt?"]

e. Schrijven jullie een probleemanalyse en/of behandelplan/ontwikkelingsperspectief plan per jongere?

      i. Zo ja: hoe vaak wordt deze geraadpleegd en bijgesteld?

      ii. Indien niet: hoe bepalen jullie de interventie en de voortgang?

f. In hoeverre is de inhoud van het programma hetzelfde voor jongeren met schoolweigering <u>en</u> ASS als voor jongeren met schoolweigering <u>zonder</u> ASS?

g. Is jullie werkwijze beschreven?

      i. Zo ja: mogen we die ontvangen en/of bekijken?

      ii. Indien niet: hoe weten teamleden hoe te handelen?

CONTROLEER NOGMAALS
OF OPNAME APPARATUUR WERKT

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3. Therapeutische elementen (20 m)

KAART HET ONDERWERP AAN ….

a. Beschrijf eens de therapeutische elementen van jullie programma:

b. Wat is de theoretische achtergrond voor de interventies?

[Even pauzeren voordat de volgende voorbeelden worden aangeboden]
Bijvoorbeeld: CGT, oplossingsgericht, psychodynamische, …?

c. 1. In de literatuur staat een samenvatting van 'common treatment elements' *[vaak voorkomende behandelelementen]* in interventies voor schoolweigering.[54] Welke van deze 'vaak voorkomende behandelingselementen' zijn aanwezig in jullie programma. Omcirkel deze.

> *[Verwijs iedereen naar de lijst van elementen in de bijlage]*

> 1. Individuele behandeling (in plaats van groepsbehandeling)
>
> 2. Consultatie met school (ondersteunen van school en het werken met de docenten)
>
> 3. 'Huiswerk' voor therapie (oefeningen/opdrachten tussen de sessies door)
>
> 4. In vivo graduele exposure (stapsgewijs blootstellen aan school)
>
> 5. Werk met het gezin aan communicatie en problem solving (probleem oplossend vermogen)

> 2. Kunnen jullie dit toelichten?

> [Even pauzeren voordat de volgende vraag wordt aangeboden: "Wat is de reden om de andere therapeutische elementen niet te includeren?"]

d. Worden er interventies aangeboden voor de jongeren?

> i. Zo ja: welke interventies, voor welke jongeren en hoe intensief zijn deze?
>
> ii. Indien niet: kun je iets meer vertellen over waarom deze niet aangeboden worden?

e. Worden er interventies aangeboden voor de ouders?

> i. Zo ja: welke interventies, voor welke ouders en hoe intensief zijn deze?
>
> ii. Indien niet: kun je iets meer vertellen over waarom deze niet aangeboden worden?

f. Worden er interventies aangeboden aan professionals van school?

> i. Zo ja: welke interventies, voor welke professionals van school en hoe intensief zijn deze?
>
> ii. Indien niet: kun je iets meer vertellen over waarom deze niet aangeboden worden?

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[54] Heyne, Sauter, and Maynard (2015)

g. Bestaan er groepsinterventies in jullie programma?

    i.   Zo ja: welke, voor wie en hoe intensief zijn deze?

    ii.   Indien niet: kun je iets meer vertellen over waarom deze niet aangeboden worden?

h. Hoe wordt er besloten welke interventie er ingezet wordt bij een specifieke casus?

i. Welke moeilijkheden ervaren jullie met betrekking tot het bieden van therapeutische elementen rondom schoolweigering?

4. Onderwijs elementen & terugkeer naar school (20 m)

KAART HET ONDERWERP AAN …

a. Welke rol dient het onderwijs (of onderwijsinstelling) volgens jullie te vervullen, m.b.t. de aanpak van schoolweigering?

b. 1. Beschrijf eens hoe de terugkeer naar school wordt vorm gegeven in jullie programma.

    2. Hoe snel na de start van het programma starten jongeren met school/onderwijs?

    NB: Dan binnen jullie programma/als dat geldt of dan de school van herkomst (als geen onderwijs door jullie programma gegeven wordt).

    3. Hoe snel of langzaam wordt het verwacht dat de jongeren volledig naar school gaan?

c. In hoeverre wordt er druk gelegd en doorgepakt met betrekking tot het naar school gaan?

    [Even pauzeren voordat de volgende voorbeelden worden aangeboden]
    Bijvoorbeeld ouders worden gevraagd om streng te zijn, er wordt op enige wijze fysieke dwang toegepast.

d. Welke moeilijkheden ervaren jullie m.b.t. het vormgeven van het onderwijs gedurende het programma?

5.Samenwerking (20 min.)

KAART HET ONDERWERP AAN ….

a. Beschrijf eens hoe onderwijs en zorg samenwerken in jullie project.

   [Even pauzeren voordat de volgende vraag gesteld wordt]
   Is er sprake van een structurele samenwerking tussen onderwijs en zorg (dat wil zeggen vaste partijen)?

b. Wat draagt bij aan een goede samenwerking?

c. Welke moeilijkheden ervaren jullie in de samenwerking?

d. Welke moeilijkheden ervaren jullie in de samenwerking met andere partijen? (zoals de partijen genoemd in de EBV: leerplicht, samenwerkingsverband, school van herkomst, JGZ, etc.)

   Inleiding op huwelijks metafoor
   Leg uit: voor het INSA congres beschrijven wij de samenwerking tussen onderwijs en zorg vanuit de huwelijksmetafoor. De thema's die aan bod komen zijn thema's als 'hoe verliep de datingfase', 'wie doet wat binnen de relatie', en 'hoe houd je het goed met elkaar'.

e. 1. Zouden jullie ook eens vanuit die metafoor willen denken en willen beschrijven hoe, volgens jullie, in jullie programma het huwelijk tussen onderwijs en zorg eruitziet?

   2. Zouden jullie ook willen denken en beschrijven hoe het ideale huwelijk eruit zou zien?

CONTROLEER NOGMAALS

OF OPNAME APPARTUUR WERKT

6. Eigen mening over jullie programma (25 min.)

KAART HET ONDERWERP AAN ….

a.   Waarom werkt volgens jullie jullie programma zo goed als het doet?

b.   Welke elementen van jullie programma zien jullie als meest belangrijk?

c.   Kunnen jullie aangeven welke jongeren/families het beste lijken te reageren op het programma?

   [Even pauzeren voordat de volgende voorbeelden worden gegeven: Dat wil zeggen: oudere of
   jongere jongeren, jongeren uit bepaalde families]

d.   Welke jongeren/families lijken het slechtst te reageren op jullie programma?

e.   1. *[Verwijs iedereen naar de juiste bijlage]* Welke twee aanpassingen zouden jullie aan het
   programma willen doen als jullie een toverstaf of heel veel geld hadden? Wil iedereen dit voor
   zichzelf invullen?

      a.   Aanpassing een, en de reden daarvoor:
      b.   Aanpassing twee, en de reden daarvoor:

   2. *[Als iedereen het ingevuld heeft]*? Kunnen jullie in 5 minuten tot een gezamenlijke keuze
      komen voor twee aanpassingen voor het project?

f.   1. Een aankomend review artikel over interventies voor schoolweigering doet aanbevelingen
   m.b.t de verbetering van interventies voor jongeren met schoolweigering.[55] Mogelijk doen jullie
   al een aantal van die aanbevelingen. Wij willen je graag vragen om twee verbeteringen te
   omcirkelen die je ook in jullie programma aan zou willen brengen, omdat jullie dat nog niet doen
   of omdat je vindt dat jullie dat meer zouden moeten doen.

      [Verwijs iedereen naar de lijst met aanbevelingen in de bijlage]

      1. Meer tijd besteden aan het werken met de jongere
      2. Meer tijd besteden aan het werken met de ouders
      3. Meer tijd besteden aan het werken met ouders en jongere samen
      4. Het programma uitspreiden over langere tijd
      5. Intensiveren van het programma (bijvoorbeeld 15 bijeenkomsten in 3 weken in plaats
         van 15 bijeenkomsten in 15 weken)
      6. Meer aandacht voor sociale factoren (zoals sociale angst, sociale vaardigheden of
         sociale isolatie)
      7. Meer aandacht voor de rol van ouders m.b.t. het managen van het gedrag van hun kind

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[55] Heyne, D. (2021b). *Practitioner review: Signposts for enhancing cognitive-behavioural therapy for adolescent
school refusal* [Manuscript submitted for publication]. Developmental and Educational Psychology Unit, Leiden
University.

8. Meer aandacht voor de communicatie tussen ouder-kind en problem solving in het gezin
9. Meer gebruik van aanvullende medicatie
10. Meer toegang tot alternatieve onderwijstrajecten voor terugkeer naar regulier onderwijs

2. *Als iedereen het ingevuld heeft:*

Kunnen jullie jullie aanpassingen toelichten?

7. Conclusie (15 minuten)

KAART HET ONDERWERP AAN ….We zijn aan het einde van dit interview. Na veel te hebben uitgewisseld en nagedacht over jullie programma willen we jullie nog een paar afsluitende vragen stellen.

a.   Wat is nodig volgens jullie om schoolweigering goed aan te pakken?

b.   Hebben jullie het idee dat dit interview jullie denken heeft beïnvloed over interventies voor jongeren met schoolweigering.

Zo ja, wat is er veranderd?

Appendix N: Booklet Used During the Focus Group Interview

Bijlagen bij het Interview

Gegevens professionals

Naam :

Datum :

Project :

1. **Wat is uw leeftijd?**

2. **Wat is uw functie/beroep?**

3. **Heeft u een opleiding gevolgd die aansluit bij uw huidige functie, en zo ja welke?**

4. **Hoeveel jaar werkervaring heeft u in deze functie/in dit werkveld?**

5. **Hoelang bent u al betrokken bij het huidige project?**

Overige opmerkingen/aanvullingen

Vaak voorkomende behandelelementen ('Common Treatment Elements')

Welke van onderstaande vaak voorkomende behandelelementen in interventies voor schoolweigering zijn aanwezig in jullie programma? Omcirkel deze.

1. **Individuele behandeling** (in plaats van groepsbehandeling)

2. **Consultatie met school** (ondersteunen van school en het werken met de docenten)

3. **'Huiswerk' voor therapie** (oefeningen/opdrachten tussen de sessies door)

4. **In vivo graduele exposure aan school** (stapsgewijs blootstellen aan school)

5. **Met het gezin werken aan communicatie en problem solving** (probleem oplossend vermogen)

Gewenste aanpassingen

Welke twee aanpassingen zouden jullie aan het programma willen doen als jullie een toverstaf of heel veel geld hadden?

Aanpassing een, en de reden daarvoor:

Aanpassing twee, en de reden daarvoor:

Aanbevelingen voor verbetering van interventies voor jongeren met schoolweigering

1. **Meer tijd besteden aan het werken met de jongere**

2. **Meer tijd besteden aan het werken met de ouders**

3. **Meer tijd besteden aan het werken met ouders en jongere samen**

4. **Het programma uitspreiden over langere tijd**

5. **Intensiveren van het programma** (bijvoorbeeld 15 bijeenkomsten in 3 weken in plaats van 15 bijeenkomsten in 15 weken)

6. **Meer aandacht voor sociale factoren** (zoals sociale angst, sociale vaardigheden of sociale isolatie)

7. **Meer aandacht voor de rol van ouders m.b.t. het managen van het gedrag van hun kind**

8. **Meer aandacht voor de communicatie tussen ouder-kind en problem solving in het gezin**

9. **Meer gebruik van aanvullende medicatie**

10. **Meer toegang tot alternatieve onderwijstrajecten voor terugkeer naar regulier onderwijs**

Appendix O: Guide for Professionals Engaging Youths in the Generation of Questions for the Knowing What Works Questionnaire for Youths

Uitleg over het Weten Wat Werkt onderzoek

[NAAM PROGRAMMA] neemt deel aan het onderzoeksproject: Weten Wat Werkt – Op weg naar een handreiking voor interventies bij schoolweigering.

In dit onderzoeksproject willen we erachter komen wat werkt als jongeren veel moeite hebben om naar school te gaan. Dit is belangrijk om te weten bij het vormgeven van nieuwe programma's en het verbeteren van bestaande programma's, zoals [NAAM PROGRAMMA].

De mening van jongeren is erg belangrijk voor ons. We willen graag weten hoe zij over de programma's denken en wat volgens hen helpt. Om daarachter te kunnen komen zullen wij in ons onderzoek jongeren, die het programma al hebben afgerond, een vragenlijst sturen. Bij het opstellen van deze vragenlijst zouden we graag jouw hulp gebruiken. Hoewel we zelf al een aantal vragen bedacht hebben, willen we ook graag weten welke vragen er volgens jou gesteld kunnen worden. Wanneer er gesproken wordt over programma, dan bedoelen we projecten zoals [NAAM PROGRAMMA].

Onderstaand geven we over drie thema's kort wat uitleg met daarna aan jou het verzoek om aan te geven welke vragen we volgens jou zouden kunnen stellen. Je mag jouw vragen en ideeën op het formulier schrijven. Dit gebeurt volledig anoniem; je hoeft jouw naam niet in te vullen en we krijgen je naam ook niet te horen.

We willen je alvast hartelijk danken voor jouw hulp!

David Heyne en Marije Brouwer-Borghuis

Thema 1: Opbrengsten

Door het onderzoek willen we graag te weten komen wat deelname aan de verschillende programma's de jongeren en hun families heeft opgeleverd. Wat is er volgens hen nu anders dan voor deelname aan het programma?

Welke vragen zouden we volgens jou kunnen stellen om hier een goed beeld van te krijgen? Met andere woorden: als jij straks [NAAM PROGRAMMA] hebt afgerond, wat zouden we je dan moeten vragen om erachter te kunnen komen wat er voor jou en je familie veranderd is doordat jij naar [NAAM PROGRAMMA] bent geweest?

....
....
....
....
....
....
....

Thema 2: Samenwerking

Wij weten dat er vaak meerdere professionals betrokken zijn als jongeren het moeilijk hebben om naar school te gaan. Bijvoorbeeld hulpverleners, mensen uit onderwijs, artsen, en leerplichtambtenaren. We willen graag weten hoe de jongeren de samenwerking tussen die professionals hebben ervaren. Weten ze wie er allemaal betrokken waren en waarom? Werd er volgens hen goed samengewerkt? Mochten ze zelf ook meedenken?

Denk jij dat jongeren hier ons wat over kunnen vertellen? Waarom wel of niet?

....
....
....
....
....

Weet jij welke professionals er allemaal bij jou betrokken zijn?

....
....
....
....
....

Welke vragen zouden we volgens jou kunnen stellen om te weten te komen hoe de jongeren over de samenwerking denken?

....
....
....
....
....

Thema 3: Werkzame factoren

Ons onderzoek heet Weten Wat Werkt; wij willen er namelijk vooral graag achter komen wat "echt" werkt als het voor een jongere moeilijk is om naar school te gaan.

Welke vragen zouden we volgens jou kunnen stellen om erachter te komen wat in het programma de jongeren het meest heeft geholpen? Met andere woorden, met welke vragen komen wij er achter wat jou bij [NAAM PROGRAMMA] het meest geholpen heeft?

……

……

……

……

……

……

……

……

Appendix P: Knowing What Works Questionnaire for Youths

Onderdeel 1

Inleidende vragen

<u>1a</u>
<u>Datum van vandaag:</u>

<u>1b</u>
<u>Ik ben:</u>
-jongen
-meisje
-anders, namelijk…..

<u>1c</u>
<u>Wat is je leeftijd in jaren?</u>
-ik ben nu…….jaar

<u>1d</u>
<u>Hoe lang is het geleden dat jouw deelname aan het programma gestopt is?</u>
-tussen 0 en 4 weken geleden
-tussen 1 en 3 maand geleden
-tussen 3 maanden en 6 maanden geleden
-tussen 6 maanden en 1 jaar geleden
-tussen 1 jaar en 1,5 jaar geleden
- langer dan 1,5 jaar geleden

<u>1e</u>
<u>Hoe lang heeft jouw deelname aan het programma in totaal geduurd?</u>
-tussen 0 en 3 maanden
-tussen 3 en 6 maanden
-tussen 6 maanden en een 1 jaar
-tussen 1 en 2 jaar
-langer dan 2 jaar

Onderdeel 2

De volgende zinnen gaan over hoe het met je ging <u>voordat</u> je deelnam aan het programma.

2a
<u>Voor</u> deelname aan het programma vond ik het moeilijk om naar school te gaan door spanning of angst.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

2b
<u>Voor</u> deelname aan het programma vond ik het moeilijk om naar school te gaan door somberheid.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

2c
<u>Voor</u> deelname aan het programma vond ik het moeilijk om naar school te gaan door lichamelijke klachten.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

Onderdeel 3

Denk terug aan jouw deelname aan het programma.
De volgende zinnen gaan over hoe jij vindt dat het programma is verlopen.

3a [56]
De hulp van het programma is goed verlopen.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

3b
De mensen van het programma beslisten met mij, in plaats van over mij.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

3c
Ik voelde me serieus genomen door de mensen van het programma.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

3d
De mensen van het programma deden hun werk goed.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

3e [57]
Wat vond jij van de duur van het programma?
O te kort
O precies lang genoeg
O te lang
O geen mening

---

[56] Items 3a to 3d inclusive were drawn from the Process [*Verloop*] scale in the Exit Questionnaire [*Exit-vragenlijst*].
[57] Item 3ᵉ was adapted from an item in the BESTE scale which read: What do you think about the length of the intervention? [*Wat vind jij van de periode die de behandeling heeft geduurd?*].

3f [58]

Als iemand anders hulp nodig zou hebben met het naar school gaan, zou jij dit programma dan aanraden?

O beslist niet
O waarschijnlijk niet
O waarschijnlijk wel
O beslist wel

---

[58] Item 3f was adapted from an item in the BESTE scale which read: Suppose that one of the children in your extended family or among acquaintances would experience the same as you did at the time (before you came into contact with the treatment). Would you recommend this treatment to them? [*Stel dat familie of kennissen met één van hun kinderen hetzelfde zouden meemaken als jij destijds (voor je in contact kwam met de behandeling). Zou jij hen deze behandeling dan aanraden?*].

Onderdeel 4

De volgende zinnen gaan over wat er voor jou veranderd is door deelname aan het programma.
Het gaat hierbij om veranderingen tijdens het programma, en/of na het programma.

4a
Door deelname aan het programma lukte het me vaker om naar school te gaan.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

Indien het antwoord mee eens of helemaal mee eens is:
Wat heeft geholpen om vaker naar school te gaan?
Indien het antwoord niet mee eens of helemaal niet mee eens is:
Wat had kunnen helpen om vaker naar school te gaan?

4b
Door deelname aan het programma vond ik het makkelijker om naar school te gaan.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

4c
Door deelname aan het programma kreeg ik meer plezier in school.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

Indien het antwoord mee eens of helemaal mee eens is:
Wat heeft geholpen om meer plezier in school te krijgen?
Indien het antwoord niet mee eens of helemaal niet mee eens is:
Wat had kunnen helpen om meer plezier in school te krijgen?

4d
Door deelname aan het programma zag ik meer het nut van onderwijs.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

4e

Door deelname aan het programma is de relatie tussen mij en leerkrachten beter geworden.

O helemaal niet mee eens

O niet mee eens

O wel mee eens

O helemaal wel mee eens

4f

Door deelname aan het programma kreeg ik minder last van spanning of angstklachten.

O niet van toepassing; ik had geen angstklachten voor deelname aan het programma

O helemaal niet mee eens

O niet mee eens

O wel mee eens

O helemaal wel mee eens

Bij niet van toepassing wordt er doorgegaan naar vraag 3g

Indien het antwoord mee eens of helemaal mee eens is:

Wat heeft geholpen om minder last van spanning of angstklachten te krijgen?

Indien het antwoord niet mee eens of helemaal niet mee eens is:

Wat had kunnen helpen om minder last van spanning of angstklachten te krijgen?

4g

Door deelname aan het programma is mijn stemming beter geworden.

O niet van toepassing; ik was niet somber voor deelname aan het programma

O helemaal niet mee eens

O niet mee eens

O wel mee eens

O helemaal wel mee eens

Bij niet van toepassing wordt er doorgegaan naar vraag 3h

Indien het antwoord mee eens of helemaal mee eens is:

Wat heeft geholpen om je stemming te verbeteren?

Indien het antwoord niet mee eens of helemaal niet mee eens is:

Wat had kunnen helpen om je stemming te verbeteren?

4h

Door deelname aan het programma kreeg ik minder last van lichamelijke klachten.

O niet van toepassing; ik had geen last van lichamelijke klachten voor deelname aan het programma

O helemaal niet mee eens

O niet mee eens

O wel mee eens

O helemaal wel mee eens

Bij niet van toepassing wordt er doorgegaan naar vraag 3i

Indien het antwoord mee eens of helemaal mee eens is:

Wat heeft geholpen om minder last van lichamelijke klachten te krijgen?

Indien het antwoord niet mee eens of helemaal niet mee eens is:
Wat had kunnen helpen om minder last van lichamelijke klachten te krijgen?

<u>4i</u>
Door deelname aan het programma werd ik beter in het oplossen van problemen.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

<u>4j</u>
Door deelname aan het programma werd ik beter in het omgaan met leeftijdsgenoten.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

<u>4k</u>
Door deelname aan het programma werd ik meer tevreden met mijn leven.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

<u>4l</u>
Door deelname aan het programma kreeg ik meer vertrouwen in de toekomst.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

<u>4m</u> [59]
Door deelname aan het programma ontstonden er thuis minder moeilijkheden tussen mij en mijn ouders/verzorgers.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

<u>4n</u>
Op een schaal van 0-10, hoe trots ben jij op wat je hebt bereikt door deelname aan het programma?

---

[59] Item 4m was based on an item in the BESTE scale which read: Has the treatment changed the way the family functions? [*Is er door de behandeling in het functioneren van het gezin iets veranderd?*].

Onderdeel 5

Wij weten dat er vaak meerdere personen betrokken zijn als jongeren het moeilijk hebben om naar school te gaan. Bijvoorbeeld hulpverleners, mensen uit onderwijs, artsen en leerplichtambtenaren. De volgende vragen gaan over zulke personen.

Welke personen uit onderstaande lijst waren volgens jou allemaal betrokken gedurende jouw deelname aan het programma? Wat vond je van de hulp van deze personen?

<u>5a</u>
Geef in de eerste kolom aan welke personen betrokken waren.
O wel betrokken
O niet betrokken
O ik weet het niet

<u>5b</u>
En in de tweede kolom wat je van de hulp van die personen vond.
O wel helpend
O niet helpend
O ik weet het niet

In de digitale versie staan er twee kolommen naast elkaar met de professionals genoemd in de rijen; jongeren kunnen dan in 1 rij aangeven of iemand betrokken was en of die hulp als helpend is ervaren of niet.

Geef in de eerste kolom aan welke personen betrokken waren en in de tweede kolom wat je van de hulp van die personen vond.
O hulpverlener(s)
O docent(en)
O iemand van het zorgteam op school (zoals een orthopedagoog, zorg coördinator, counselor)
O leerplichtambtenaar
O schoolarts
O medisch specialist (zoals een kinderarts)
O iemand van de jeugdreclassering
O een (gezins)voogd
O anders, namelijk………
O anders, namelijk……..
O anders, namelijk……..

<u>5c</u>
Al die personen hebben goed samengewerkt.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

5d

Door de samenwerking tussen al die personen ging het beter met mij.

O helemaal niet mee eens

O niet mee eens

O wel mee eens

O helemaal wel mee eens

5e

Beschrijf eens wat je fijn vond aan de samenwerking tussen al die personen.

………

………

5f

Beschrijf eens wat je niet fijn vond aan de samenwerking tussen al die personen.

……….

………

Onderdeel 6

Dit onderzoek heet Weten Wat Werkt. Wij willen graag weten wat maakt dat jongeren weer naar school kunnen gaan, na een periode van niet of heel weinig op school te zijn geweest. De volgende vragen gaan daar over.

<u>6a</u>
Beschrijf eens waar jij het meeste aan hebt gehad in het programma. Je mag meer dan 1 ding noemen; het gaat om wat jou heeft geholpen.

………
………
……….

<u>6b</u>
Ook als programma's goed helpen kunnen er nog dingen verbeterd worden. Vanuit jouw ervaring met het programma, welke aanpassingen zou je willen aanraden en waarom?

o Aanpassing 1, en de reden daarvoor:

_____

_____

_____

_____

o Aanpassing 2, en de reden daarvoor:

_____

_____

_____

_____

Onderdeel 7

Afsluiting

We zijn aan het einde van deze vragenlijst. We hebben veel vragen gesteld, maar mogelijk is er nog iets dat je ons wilt laten weten wat nog niet of onvoldoende aan bod is gekomen. Geef in onderstaande vraag aan of dit het geval is en zo ja wat je nog graag zou willen aanvullen.

O nee
O ja, namelijk
………
……….

We willen je heel hartelijk bedanken voor het invullen van de lijst. Mocht je naar aanleiding van het invullen van de lijst nog graag met ons hierover willen spreken dan mag je een mail sturen naar Marije-Brouwer-Borghuis via m.brouwer@swv2301.nl, zij neemt dan contact met je op.

Appendix Q: Knowing What Works Questionnaire for Parents

Onderdeel 1

Inleidende vragen

<u>1a</u>
<u>Datum van vandaag:</u>

<u>1b</u>
<u>Wat is uw geslacht</u>
-man
-vrouw
-anders, namelijk

<u>1c</u>
<u>Wat is uw leeftijd in jaren?</u>

<u>1d</u>
<u>Wat is uw relatie tot de jongere die deelgenomen heeft aan het programma?</u>
-biologische ouder
-stiefouder
-pleegouder
-anders, namelijk

<u>1e</u>
<u>Hoe lang is het geleden dat de deelname van uw kind aan het programma gestopt is?</u>
-tussen 0 en 4 weken geleden
-tussen 1 en 3 maand geleden
-tussen 3 maanden en 6 maanden geleden
-tussen 6 maanden en een jaar geleden
-tussen 1 jaar en 1,5 jaar geleden
-langer dan 1,5 jaar geleden

<u>1f</u>
<u>Hoe lang heeft de deelname van uw kind aan het programma in totaal geduurd?</u>
-tussen 0 en 3 maanden
-tussen 3 en 6 maanden
-tussen 6 maanden en een 1 jaar
-tussen 1 en 2 jaar
-langer dan 2 jaar

Onderdeel 2

De volgende zinnen gaan over hoe het met uw kind ging <u>voor</u> deelname aan het programma.

2a
<u>Voor</u> deelname aan het programma vond mijn kind het moeilijk om naar school te gaan door spanning of angst.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

2b
<u>Voor</u> deelname aan het programma vond mijn kind het moeilijk om naar school te gaan door somberheid.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

2c
<u>Voor</u> deelname aan het programma vond mijn kind het moeilijk om naar school te gaan door lichamelijke klachten.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

Onderdeel 3

Denk terug aan deelname aan het programma.
De volgende zinnen gaan over hoe u vindt dat het programma is verlopen.

3a [60]
De hulp van het programma is goed verlopen.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

3b
De mensen van het programma beslisten met mij, in plaats van over mij.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

3c
Ik voelde me serieus genomen door de mensen van het programma.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

3d
De mensen van het programma deden hun werk goed.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

3e
Ik werd door de mensen van het programma geïnformeerd over hoe het met mijn kind ging.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

---

[60] Items 3a to 3d inclusive were drawn from the Process [*Verloop*] scale in the Exit Questionnaire [*Exit-vragenlijst*].

3f [61]

Wat vond u van de duur van het programma?

O te kort

O precies lang genoeg

O te lang

O geen mening

3g [62]

Als het kind van iemand anders hulp nodig zou hebben met het naar school gaan, zou u dit programma dan aanraden?

O beslist niet

O waarschijnlijk niet

O waarschijnlijk wel

O beslist wel

---

[61] Item 3f was adapted from an item in the BESTE scale which read: What do you think about the length of the intervention? [*Wat vindt u van de periode die de behandeling heeft geduurd?*].

[62] Item 3g was adapted from an item in the BESTE scale which read: Suppose that one of the children in your extended family or among acquaintances would experience the same as you did at the time (before you came into contact with the treatment). Would you recommend this treatment to them? [*Stel dat familie of kennissen met één van hun kinderen hetzelfde zouden meemaken als u destijds (voor u in contact kwam met de behandeling). Zou u hen deze vorm van behandeling dan aanraden?*].

Onderdeel 4i

De volgende zinnen gaan over wat er voor uw kind veranderd is door deelname aan het programma. Het gaat hierbij om veranderingen tijdens het programma, en/of na het programma.

4i - a
Door deelname aan het programma lukte het mijn kind vaker om naar school te gaan.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

Indien het antwoord mee eens of helemaal mee eens is:
Wat heeft uw kind geholpen om vaker naar school te gaan?
Indien het antwoord niet mee eens of helemaal niet mee eens is:
Wat had uw kind kunnen helpen om vaker naar school te gaan?

4i - b
Door deelname aan het programma vond mijn kind het makkelijker om naar school te gaan.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

4i - c
Door deelname aan het programma kreeg mijn kind meer plezier in school.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

Indien het antwoord mee eens of helemaal mee eens is:
Wat heeft uw kind geholpen om meer plezier in school te krijgen?
Indien het antwoord niet mee eens of helemaal niet mee eens is:
Wat had uw kind kunnen helpen om meer plezier in school te krijgen?

4i - d
Door deelname aan het programma zag mijn kind meer het nut van onderwijs.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

<u>4i - e</u>
Door deelname aan het programma is de relatie tussen mijn kind en leerkrachten beter geworden.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

<u>4i - f</u>
Door deelname aan het programma kreeg mijn kind minder last van spanning of angstklachten.
O niet van toepassing; mijn kind had geen angstklachten voor deelname aan het programma
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

Bij niet van toepassing wordt er doorgegaan naar vraag 3g
Indien het antwoord mee eens of helemaal mee eens is:
Wat heeft uw kind geholpen om minder last van spanning of angstklachten te krijgen?
Indien het antwoord niet mee eens of helemaal niet mee eens is:
Wat had uw kind kunnen helpen om minder last van spanning of angstklachten te krijgen?

<u>4i - g</u>
Door deelname aan het programma is de stemming van mijn kind beter geworden.
O niet van toepassing; mijn kind was niet somber voor deelname aan het programma
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

Bij niet van toepassing wordt er doorgegaan naar vraag 3h
Indien het antwoord mee eens of helemaal mee eens is:
Wat heeft geholpen om de stemming van uw kind te verbeteren?
Indien het antwoord niet mee eens of helemaal niet mee eens is:
Wat had kunnen helpen om de stemming van uw kind te verbeteren?

<u>4i - h</u>
Door deelname aan het programma kreeg mijn kind minder last van lichamelijke klachten.
O niet van toepassing; mijn kind had geen last van lichamelijke klachten voor deelname aan het programma
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

Bij niet van toepassing wordt er doorgegaan naar vraag 3i
Indien het antwoord mee eens of helemaal mee eens is:
Wat heeft uw kind geholpen om minder last van lichamelijke klachten te krijgen?
Indien het antwoord niet mee eens of helemaal niet mee eens is:
Wat had uw kind kunnen helpen om minder last van lichamelijke klachten te krijgen?

4i - i
Door deelname aan het programma werd mijn kind beter in het oplossen van problemen.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

4i - j
Door deelname aan het programma werd mijn kind beter in het omgaan met leeftijdsgenoten.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

4i - k
Door deelname aan het programma werd mijn kind meer tevreden met zijn/haar leven.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

4i - l
Door deelname aan het programma kreeg mijn kind meer vertrouwen in de toekomst.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

Onderdeel 4ii

De volgende zinnen gaan over wat er voor u veranderd is door deelname aan het programma.
Het gaat hierbij om veranderingen tijdens het programma, en/of na het programma.

4ii - a [63]
Door deelname aan het programma kon ik beter begrijpen waarom mijn kind moeite had met het naar school gaan.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

4ii - b
Door deelname aan het programma kreeg ik meer vertrouwen dat ik weet hoe te reageren als mijn kind het moeilijk vindt om naar school te gaan.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

4ii - c [64]
Door deelname aan het programma lukte het mij beter om mijn kind te ondersteunen bij het naar school gaan.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

4ii - d
Door deelname aan het programma kreeg ik minder last van spanning en stress rondom de schoolgang van mijn kind.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

---

[63] Item 4ii-a was based on an item in the BESTE scale which read: Has the treatment clarified your view of your child's behaviour? [*Is door de behandeling uw zicht op het gedrag van uw kind verhelderd?*].
[64] Item 4ii-c was based on an item in the BESTE scale which read: Has the treatment changed anything in the way you raise your child? [*Is er door de behandeling iets veranderd in de manier waarop u uw kind opvoedt?*].

4ii - e [65]

Door deelname aan het programma ontstonden er thuis minder moeilijkheden tussen mij en mijn kind.

O helemaal niet mee eens

O niet mee eens

O wel mee eens

O helemaal wel mee eens

---

[65] Item 4ii-e was based on an item in the BESTE scale which read: Has the treatment changed the way the family functions? [*Is er door de behandeling in het functioneren van het gezin iets veranderd?*].

Onderdeel 5

Wij weten dat er vaak meerdere personen betrokken zijn als jongeren het moeilijk hebben om naar school te gaan. Bijvoorbeeld hulpverleners, mensen uit onderwijs, artsen en leerplichtambtenaren. De volgende vragen gaan over zulke personen

Welke personen uit onderstaande lijst waren volgens u allemaal betrokken gedurende deelname aan het programma? Wat vond u van de hulp van deze personen?

<u>5a</u>
Geef in de eerste kolom aan welke personen betrokken waren.
O wel betrokken
O niet betrokken
O ik weet het niet

5b
En in de tweede kolom wat u van de hulp van die personen vond.
O wel helpend
O niet helpend
O ik weet het niet

In de digitale versie staan er twee kolommen naast elkaar met de professionals genoemd in de rijen; ouders kunnen dan in 1 rij aangeven of iemand betrokken was en of die hulp als helpend is ervaren of niet.

O hulpverlener(s)
O docent(en)
O iemand van het zorgteam op school (zoals een orthopedagoog, zorg coördinator, counselor)
O leerplichtambtenaar
O schoolarts
O medisch specialist (zoals een kinderarts)
O iemand van de jeugdreclassering
O een (gezins)voogd
O anders, namelijk………
O anders, namelijk……..
O anders, namelijk……..

<u>5c</u>
Al die personen hebben goed samengewerkt.
O helemaal niet mee eens
O niet mee eens
O wel mee eens
O helemaal wel mee eens

5d

Door de samenwerking tussen al die personen ging het beter met mijn kind.

O helemaal niet mee eens

O niet mee eens

O wel mee eens

O helemaal wel mee eens

5e

Beschrijf eens wat u fijn vond aan de samenwerking tussen al die personen.

……

……

5f

Beschrijf eens wat u niet fijn vond aan de samenwerking tussen al die personen.

…….

…….

Onderdeel 6

Dit onderzoek heet Weten Wat Werkt. Wij willen graag weten wat maakt dat jongeren weer naar school kunnen gaan, na een periode van niet of heel weinig op school te zijn geweest. De volgende vragen gaan daar over.

<u>6a</u>

Beschrijf eens waar uw kind volgens u het meeste aan heeft gehad in het programma. U mag meer dan 1 ding noemen; het gaat om wat uw kind heeft geholpen.

……

……

……

<u>6b</u>

Beschrijf eens waar u het meeste aan hebt gehad in het programma. U mag meer dan 1 ding noemen; het gaat om wat u heeft geholpen.

……

……

……

<u>6c</u>

Ook als programma's goed helpen kunnen er nog dingen verbeterd worden. Vanuit uw ervaring met het programma, welke aanpassingen zou u willen aanraden en waarom?

     o Aanpassing 1, en de reden daarvoor:

_____

_____

_____

     o Aanpassing 2, en de reden daarvoor:

_____

_____

_____

Onderdeel 7

Afsluiting

We zijn aan het einde van deze vragenlijst. We hebben veel vragen gesteld, maar mogelijk is er nog iets dat u ons wilt laten weten wat nog niet of onvoldoende aan bod is gekomen. Geef in onderstaande vraag aan of dit het geval is en zo ja wat u nog graag zou willen aanvullen.

O nee
O ja, namelijk

……
…….

We willen u heel hartelijk bedanken voor het invullen van de lijst. Mocht u naar aanleiding van het invullen van de lijst nog graag met ons hierover willen spreken dan kunt u een mail sturen naar Marije-Brouwer-Borghuis via m.brouwer@swv2301.nl, zij neemt dan contact met u op.

Appendix R: Email Reminding About Distribution of the Questionnaires

Beste [Naam],

Onder andere naar aanleiding van de omstandigheden rondom het Corona-virus is het nog niet alle programma's gelukt om de vragenlijsten voor het Weten Wat Werkt onderzoek te verzenden naar de jongeren en hun ouders. Wij begrijpen ook heel erg goed dat dit momenteel niet de grootste urgentie heeft.

Toch zouden we jullie willen vragen om aan te geven of het jullie lukt om voor eind april de vragenlijsten te verzenden. Jongeren en hun ouders hebben vervolgens tot eind mei de mogelijkheid om de vragenlijsten in te vullen. Eind mei willen we de dataverzameling namelijk stoppen, zodat we voldoende tijd hebben om de resultaten te verwerken in de handreiking.

Mochten jullie specifieke problemen/moeilijkheden ervaren bij het uitsturen van de lijsten dan horen we het graag en denken we graag mee in oplossingen. We willen jullie nogmaals hartelijk bedanken voor jullie medewerking met het onderzoek, wij waarderen dit zeer.

Met vriendelijke groet,

Het Weten Wat Werkt Team

Georgine Aerts
Marije Brouwer-Borghuis
David Heyne

Appendix S: Tables Supplementary to the Results

Appendix S1
Percentage (and number) of youths and parents who reported that youths did, or did not, experience anxiety, mood, or physical symptoms before participating in the intervention.

	Found it difficult to go to school due to stress or anxiety	Found it difficult to go to school due to sad mood	Found it difficult to go to school due to somatic complaints
Totally disagree	16.2% (6) youths 6.8% (3) one parent 0.0% (0) two parents 4.7% parents total	18.9% (7) youths 11.4% (5) one parent 7.5% (3) two parents 10.2% parents total	48.6% (18) youths 22.7% (10) one parent 25.0% (10) two parents 23.4% parents total
Disagree	5.4% (2) youths 4.5% (2) one parent 7.5% (3) two parents 5.5% parents total	21.6% (8) youths 29.5% (13) one parent 30.0% (12) two parents 29.7% parents total	16.2% (6) youths 31.8% (14) one parent 27.5% (11) two parents 30.5% parents total
Agree	27.0% (10) youths 20.5% (9) one parent 27.5% (11) two parents 22.7% parents total	32.4% (12) youths 29.5 (13) one parent 42.5% (17) two parents 33.6% parents total	13.5 (5) youths 25.0% (11) one parent 30.0% (12) two parents 26.6% parents total
Totally agree	51.4% (19) youths 68.2% (30) one parent 65.0% (26) two parents 67.2% parents total	27.0% (10) youths 29.5% (13) one parent 20.0% (8) two parents 26.6% parents total	21.6% (8) youths 20.5% (9) one parent 17.5% (7) two parents 19.5% parents total

Appendix S2

Level of agreement between youths and their parents about the presence of youth anxiety, mood, and physical symptoms before participating in the intervention.

	Found it difficult to go to school due to stress or anxiety	Found it difficult to go to school due to sad mood	Found it difficult to go to school due to somatic complaints
Young people endorsed the same category as the only parent who responded	19 (51.4%)	17 (45.9%)	19 (51.4%)
Young person endorsed the same category as both parents	10 (27.0%)	6 (16.2%)	7 (18.9%)
Young person endorsed a different category compared to one of the two parents	2 (5.4%)	6 (16.2%)	4 (10.8%)
Young person endorsed a different category as the only parent who responded	4 (10.8%)	6 (16.2%)	4 (10.8%)
Young person endorsed a different category compared to both parents	2 (5.4%)	2 (5.4%)	3 (8.1%)

Appendix S3

Percentage (and number) of youths and parents who reported that there was, or was not, a reduction in the young person's anxiety, mood, or physical symptoms.

	Less stress or anxiety	Improved mood	Fewer somatic complaints
Not applicable	10.8% (4) youths 10.9% (5) one parent 5.9% (2) two parents 9.5% parents total	13.5% (5) youths 17.4% (8) one parent 11.8% (4) two parents 15.9% parents total	51.4% (19) youths 47.8% (22) one parent 32.4% (11) two parents 43.7% parents total
Totally disagree	10.8% (4) youths 8.7% (4) one parent 2.9% (1) two parents 7.1% parents total	2.7% (1) youths 6.5% (3) one parent 2.9% (1) two parents 5.6% parents total	5.4% (2) youths 6.5% (3) one parent 0.0% (0) two parents 4.8% parents total
Diasgree	10.8% (4) youths 17.4% (8) one parent 14.7% (5) two parents 16.7% parents total	18.9% (7) youths 10.9% (5) one parent 2.9% (1) two parents 8.7% parents total	13.5% (5) youths 21.7% (10) one parent 8.8% (3) two parents 18.3% parents total
Agree	40.5% (15) youths 54.3% (25) one parent 41.2% (14) two parents 50.8% parents total	40.5% (15) youths 52.2% (24) one parent 55.9% (19) two parents 53.2% parents total	13.5% (5) youths 17.4% (8) one parent 41.2% (14) two parents 23.8% parents total
Totally agree	27.0% (10) youths 8.7% (4) one parent 35.3% (12) two parents 15.9% parents total	24.3% (9) youths 13.0% (6) one parent 26.5% (9) two parents 16.7% parents total	16.2% (6) youths 6.5% (3) one parent 17.6% (6) two parents 9.5% parents total

Appendix S4
Percentage of youths and parents who reported that there was, or was not, a reduction in the young person's anxiety, mood, or physical symptoms, from among the group that did not indicate that this was not the case before the intervention (i.e., excluding the "not applicable" responses).

	Less stress or anxiety	Improved mood	Fewer somatic complaints
Totally disagree	12.1% youths 7.9% parents total	3.1% youths 6.6% parents total	11.1% youths 8.5% parents total
Diasgree	12.1% youths 18.4% parents total	21.9% youths 10.4% parents total	27.8% youths 32.4% parents total
Agree	45.5% youths 56.1% parents total	46.9% youths 63.2% parents total	27.8% youths 42.3% parents total
Totally agree	30.3% youths 17.5% parents total	28.1% youths 19.8% parents total	33.3% youths 16.9% parents total

Appendix S5
Percentage (and number) of youths and parents who reported that there was, or was not, an improvement in school attendance.

	Able to go to school more often	Found it easier to go to school
Totally disagree	8.1% (3) youths 8.9% (4) one parent 10.5% (4) two parents 9.4% parents total	10.8% (4) youths 8.9% (4) one parent 5.3% (2) two parents 7.8% parents total
Diasgree	13.5% (5) youths 15.6% (7) one parent 10.5% (4) two parents 14.1% parents total	13.5% (5) youths 17.8% (8) one parent 15.8% (6) two parents 17.2% parents total
Agree	18.9% (7) youths 35.6% (16) one parent 50.0% (19) two parents 39.8% parents total	40.5% (15) youths 46.7% (21) one parent 50.0% (19) two parents 47.7% parents total
Totally agree	59.5% (22) youths 40.0% (18) one parent 28.9% (11) two parents 36.7% parents total	35.1% (13) youths 26.7% (12) one parent 28.9% (11) two parents 27.3% parents total

Appendix S6

Percentage (and number) of youths and parents who reported that there was, or was not, improvement in the young person's experience of school.

	Had more fun at school	Saw more value in education	Improved relationship between the young person and teachers
Totally disagree	10.8% (4) youths 9.1% (4) one parent 13.2% (5) two parents 10.3% parents total	18.9% (7) youths 13.6% (6) one parent 18.4% (7) two parents 15.1% parents total	16.2% (6) youths 11.4% (5) one parent 10.5% (4) two parents 11.1% parents total
Disagree	21.6% (8) youths 45.5% (20) one parent 26.3% (10) two parents 39.7% parents total	35.1% (13) youths 43.2% (19) one parent 31.6% (12) two parents 39.7% parents total	27.0% (10) youths 29.5% (13) one parent 21.1% (8) two parents 27.0% parents total
Agree	54.1% (20) youths 36.4% (16) one parent 39.5% (15) two parents 37.3% parents total	29.7% (11) youths 34.1% (15) one parent 44.7% (17) two parents 37.3% parents total	40.5% (15) youths 45.5% (20) one parent 52.6% (20) two parents 47.3% parents total
Totally agree	13.5% (5) youths 9.1% (4) one parent 21.1% (8) two parents 12.7% parents total	16.2% (6) youths 9.1% (4) one parent 5.3% (2) two parents 7.9% parents total	16.2% (6) youths 13.6% (6) one parent 15.8% (6) two parents 14.3% parents total

Appendix S7
Percentage (and number) of youths and parents who reported that there was, or was not, improvement in the young person's problem-solving skills and social skills.

	Improved problem solving	Could get along better with peers
Totally disagree	5.4% (2) youths 6.8% (3) one parent 2.6% (1) two parents 5.6% parents total	21.6% (8) youths 13.6% (6) one parent 7.9% (3) two parents 11.9% parents total
Disagree	10.8% (4) youths 34.1% (15) one parent 26.3% (10) two parents 31.7% parents total	27.0% (10) youths 40.9% (18) one parent 55.3% (21) two parents 45.2% parents total
Agree	62.2% (23) youths 54.5% (24) one parent 57.9% (22) two parents 55.6% parents total	35.1% (13) youths 43.2% (19) one parent 36.8% (14) two parents 41.3% parents total
Totally agree	21.6% (8) youths 4.5% (2) one parent 13.2% (5) two parents 7.1% parents total	16.2% (6) youths 2.3% (1) one parent 0.0% (0) two parents 1.6% parents total

Appendix S8
Percentage (and number) of youths and parents who reported that there was, or was not, improvement in the young person's quality of life.

	Greater satisfaction in life	More confidence in the future
Totally disagree	8.1% (3) youths 6.8% (3) one parent 5.3% (2) two parents 6.3% parents total	8.1% (3) youths 4.5% (2) one parent 7.9% (3) two parents 5.6% parents total
Disagree	21.6% (8) youths 31.8% (14) one parent 18.4% (7) two parents 27.8% parents total	21.6% (8) youths 29.5% (13) one parent 13.2% (5) two parents 24.6% parents total
Agree	56.8% (21) youths 52.3% (23) one parent 52.6% (20) two parents 52.4% parents total	35.1% (13) youths 50.0% (22) one parent 52.6% (20) two parents 50.8% parents total
Totally agree	13.5% (5) youths 9.1% (4) one parent 23.7% (9) two parents 13.5% parents total	35.1% (13) youths 15.9% (7) one parent 26.3% (10) two parents 19.0% parents total

Appendix S9:

Percentage (and number) of youths and parents who reported that there were, or were not, changes in family functioning following intervention.

	Fewer difficulties at home between the young person and parent(s)
Totally disagree	13.5% (5) youths 14.0% (6) one parent 10.5% (4) two parents 12.9% parents total
Disagree	24.3% (9) youths 30.2% (13) one parent 18.4% (7) two parents 26.6% parents total
Agree	35.1% (13) youths 41.9% (18) one parent 50.0% (19) two parents 44.4% parents total
Totally agree	27.0% (10) youths 14.0% (6) one parent 21.1% (8) two parents 16.1% parents total

Appendix S10:
Percentage (and number) of parents who reported that there were, or were not, changes in parent functioning following intervention.

	Better able to understand why my child had difficulties going to school	Less tension and stress regarding my child's school attendance
Totally disagree	14.0% (6) one parent 2.6% (1) two parents 10.5% parents total	9.3% (4) one parent 5.3% (2) two parents 8.1% parents total
Disagree	27.9% (12) one parent 34.2% (13) two parents 29.8% parents total	25.6% (11) one parent 23.7% (9) two parents 25.0% parents total
Agree	41.9% (18) one parent 50.0% (19) two parents 44.4% parents total	44.2% (19) one parent 47.4% (18) two parents 45.2% parents total
Totally agree	16.3% (7) one parent 13.2% (5) two parents 15.3% parents total	20.9% (9) one parent 23.7% (9) two parents 21.8% parents total

	Became more confident in my ability to respond to my child's difficulties going to school	Better able to support my child in going to school
Totally disagree	11.6% (5) one parent 5.3% (2) two parents 9.7% parents total	9.3% (4) one parent 7.9% (3) two parents 8.9% parents total
Disagree	18.6% (8) one parent 31.6% (12) two parents 22.6% parents total	18.6% (8) one parent 26.3% (10) two parents 21.0% parents total
Agree	58.1% (25) one parent 52.6% (20) two parents 56.5% parents total	60.5% (26) one parent 50.0% (19) two parents 57.3% parents total
Totally agree	11.6% (5) one parent 10.5% (4) two parents 11.3% parents total	11.6% (5) one parent 15.8% (6) two parents 12.9% parents total

Appendix S11
Percentage (and number) of youths and parents who reported that there was, or was not, good collaboration between all professionals, and that this collaboration helped.

	All these people worked well together	Because of the collaboration, things improved for the young person
Totally disagree	0.0% (0) youths 2.3% (1) one parent 5.3% (2) two parents 3.2% parents total	8.3% (3) youths 4.5% (2) one parent 7.9% (3) two parents 5.6% parents total
Disagree	19.4% (7) youths 15.9% (7) one parent 15.8% (6) two parents 15.9% parents total	27.8% (10) youths 29.5% (13) one parent 15.8% (6) two parents 25.4% parents total
Agree	61.1% (22) youths 54.5% (24) one parent 44.7% (17) two parents 51.6% parents total	44.4% (16) youths 50.0% (22) one parent 52.6% (20) two parents 50.8% parents total
Totally agree	19.4% (7) youths 27.3% (12) one parent 34.2% (13) two parents 29.4% parents total	19.4% (7) youths 15.9% (7) one parent 23.7% (9) two parents 18.3% parents total

Appendix T: Association Between Youths' Reports About How Well Professionals Collaborated and Whether Collaboration Had a Positive Impact on Outcomes

		All these people worked well together		
		Totally disagree / Disagree	Totally agree / Agree	Total
Because of the collaboration between all these people, things improved for me	Totally disagree / Disagree	100.0% (7)	20.7% (6)	36.1% (13)
	Totally agree / Agree	0.0% (0)	79.3% (23)	63.9% (23)
	Total	100.0% (7)	100.0% (29)	100.0% (36)

Appendix U: Association Between Parents' Reports About How Well Professionals Collaborated and Whether Collaboration Had a Positive Impact on Outcomes

		All these people worked well together		
		Totally disagree / Disagree	Totally agree / Agree	Total
Because of the collaboration between all these people, things improved for my child	Totally disagree / Disagree	87.5% (14)	15.2% (10)	29.3% (24)
	Totally agree / Agree	12.5% (2)	84.8% (56)	70.7% (58)
	Total	100.0% (16)	100.0% (66)	100.0% (82)

Appendix V: Plan for the Panel Meeting with Stakeholders

Panelbijeenkomst - Weten Wat Werkt
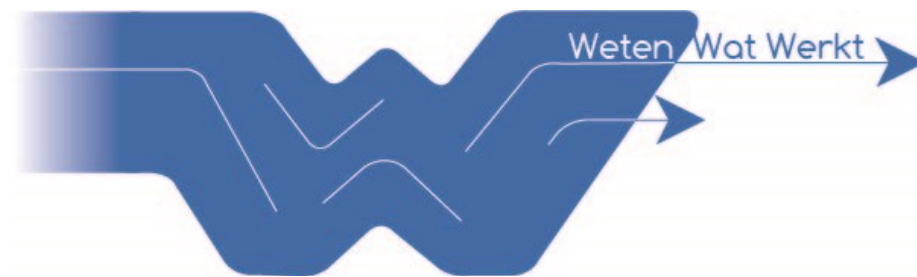
Marije Brouwer-Borghuis, m.brouwer@swv2301.nl
David Heyne, heyne@fsw.leidenuniv.nl

Beschrijving

Schoolverzuim en daarmee ook schoolweigering is "hot" in Nederland, resulterend in nieuwe projecten en beleid die op nationaal en lokaal niveau ontwikkeld worden. Om te voorkomen dat iedereen opnieuw "het wiel moet uitvinden," heeft ons onderzoek als doel om zicht te krijgen op al bestaande interventies en deze kennis bruikbaar te maken voor het werkveld. Hiertoe bestuderen we een twintigtal interventies voor jongeren met schoolweigering in Nederland. Middels interviews in focus groepen en vragenlijsten willen we zicht krijgen op de kenmerken en werkwijzen van de verschillende interventies en verhelderen wat volgens professionals, ouders en jongeren de belangrijkste bouwstenen oftewel werkzame factoren zijn. Uiteindelijk zal dit leiden tot een handreiking voor het werkveld met daarin een soort routekaart voor interventies bij schoolweigering. Tevens zal het onderzoek resulteren in meerdere wetenschappelijke publicaties.

Discussiepunten

1. Wat zou je geïncludeerd willen zien in zo'n routekaart?
2. Hoe zou zo'n routekaart ondersteunend kunnen zijn voor de praktijk?
3. Hoe sturend/niet sturend kan en zou zo'n routekaart moeten zijn?
4. Zijn jullie bekend met dergelijke routekaarten?

Appendix W: Recommendations Made by Stakeholders in Attendance at the Panel Meeting

- Clarify that the roadmap is a framework for the development and delivery of interventions, not a recommendation about how to work with specific cases.
- Be concrete/informative (based on data), as well as suggestive/stimulating (based on interpretation, e.g., include questions at the end of the roadmap).
- Include conclusions drawn from analysis of the data.
- Identify four key pillars.
- Identify 'necessary' and 'contingent' conditions for intervention (e.g., 'because 75% of participants spoke about this, it seems necessary').
- Include themes: therapy elements, education elements, instrumental elements.
- Indicate the amount of time needed to address school refusal.
- Indicate the conditions needed for successful intervention for school refusal (e.g., the bridge between education and healthcare).
- Considerations for developing a new intervention vis-à-vis connecting with existing interventions.
- Considerations for short- or long-term interventions.
- Considerations for specifying expectations about a young person's return to school.
- Considerations for preventive interventions that can be offered in school settings.
- Considerations for provision of facilities within schools.
- Considerations for collaboration between professionals in a team, not only between education and mental health services more generally.
- Considerations for achieving consensus about return to school.
- Considerations for the 'click' between professionals and the young person.
- Considerations for the cost-benefit analysis; in the long-term, is it really as expensive as it seems in the short-term?
- Decide whether the roadmap will also be written for parent groups.
- Encourage readers to seek space to create change.
- Account for regional differences.

Appendix X: Professionals Who Participated in the Panel Meeting

- Ellen Starke (Projectleider bij Stichting Orion Amsterdam)
- Rachel Scheurwater (Orthopedagoog bij Erve Olde Meule in Hengelo, Attendiz)
- Thyrza Hylkema (Adjunct-directeur bij Erve Olde Meule in Hengelo, Attendiz)
- Sara Steijn (Adviseur onderwijs-jeugdhulp bij de NJI)
- Rinke Verheij (IB-er RSG Tromp Meesters)
- Anne Galama (Leerplichtambtenaar Gemeente Amersfoort)
- Auke van Breemen
- Rolien de Haan (Coordinator schoolondersteuningsteam & Verzuim bij Reggesteijn)