PCUN Supports the Sustainable Development Goals

3 GOOD HEALTH AND WELL-BEING

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SCHOOL REFUSAL IN THE WAKE OF COVID-19: THE ROLE OF SCHOOL-FAMILY-COMMUNITY PARTNERSHIPS

School refusal (SR) poses significant risk to youth social, emotional, and academic development and creates notable distress and strain on schools and family systems (Sewell, 2008). Youth-facing providers have identified numerous psychosocial impacts of the COVID-19 pandemic that cause concern for a likely increase in the prevalence and severity of cases of SR. Effective prevention and treatment of SR requires close partnership between schools, families, mental health practitioners, and medical teams.

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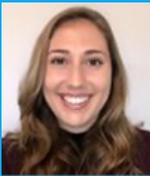
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Background

School refusal (SR) is a growing problem among youth. SR generally includes situations when 1) youth experience some type of increased emotion (e.g., worries, anger, stomachaches, etc.) that leads to a lack of school attendance that 2) is not due to antisocial behavior, and that 3) caregiver(s) know about and 4) have tried to resolve without success (Heyne et al., 2019). It includes missing either part of or the entire school day.

Understanding School Refusal

SR is always associated with some level of emotional distress in a young person, and may include depression and anxiety, somatic complaints, difficulty with emotional regulation, negative thinking, low self-efficacy, and/or poor problem-solving skills (Ingul et al., 2019; Heyne et al., 2015). SR is also multifactorial in nature with individual, family, school, and community factors each reciprocally contributing to the development and perpetuation of SR (Elliott & Place, 2019). SR behaviors arise out of attempts to meet needs or avoid undesired experiences, best conceptualized by Kearney's (2002) Functional/Contextual model of SR (Figure 1). These functions of SR can be readily assessed and quantified using a standardized 24-item instrument (School Refusal Assessment Scale – Revised; Kearney 2002).
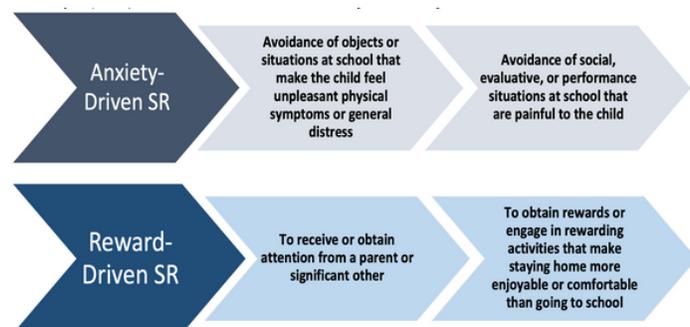

| Anxiety-Driven SR | Avoidance of objects or situations at school that make the child feel unpleasant physical symptoms or general distress | Avoidance of social, evaluative, or performance situations at school that are painful to the child |
| Reward-Driven SR | To receive or obtain attention from a parent or significant other | To obtain rewards or engage in rewarding activities that make staying home more enjoyable or comfortable than going to school |

Figure 1
Kearney's (2002) Functional/Contextual Model of School Refusal

Impact of COVID-19

The COVID-19 pandemic quickly and significantly changed many parts of daily living, including school attendance. Before the COVID-19 pandemic, estimated SR rates ranged from 0.4% to 5.4% of youth (Ingul et al., 2019), but appear to have steadily grown since. Overall rates of mental health challenges increased throughout the pandemic, suggesting a likely uptick in SR may follow as well. At the start of the pandemic, most schools implemented physical distancing and many switched to remote learning. New school-related stressors such as fears of getting sick or masking requirements fostered new territory for anxiety, phobia, and avoidance. Children already exhibiting or vulnerable to school refusal, likely experienced relief from school-related stressors and were reinforced by the rewarding elements of staying home, thus reinforcing avoidance of feared situations and priming them for greater SR upon return to in-person learning. For example, children who experience significant separation anxiety often fear harm coming to loved ones, particularly a caregiver, exacerbated by being away from them during the school day (Ingles et al., 2015). During the period of COVID-19 social distancing, children were rarely separated from caregivers, reducing opportunities to practice independence. Fears about caregiver health and wellbeing when apart may also have peaked beyond pre-pandemic levels given the salience of new potential health risks. Finally, caregiver accommodation of refusal behaviors is a key perpetuating factor of SR. Fears and uncertainty during this phase of the pandemic increased caregiver likelihood to choose to keep kids home or accommodate SR because of their own fears (Kroshus et al., 2020). These actions may have indirectly reinforced school avoidance and/or COVID-19 fears, resulting in the strengthening of patterns of refusal.

Recommendations

Given its multifactorial nature, treatment of SR requires a systemic and collaborative approach to treatment. Below are best practice recommendations for teamwork to support youth exhibiting SR (Figure 2).
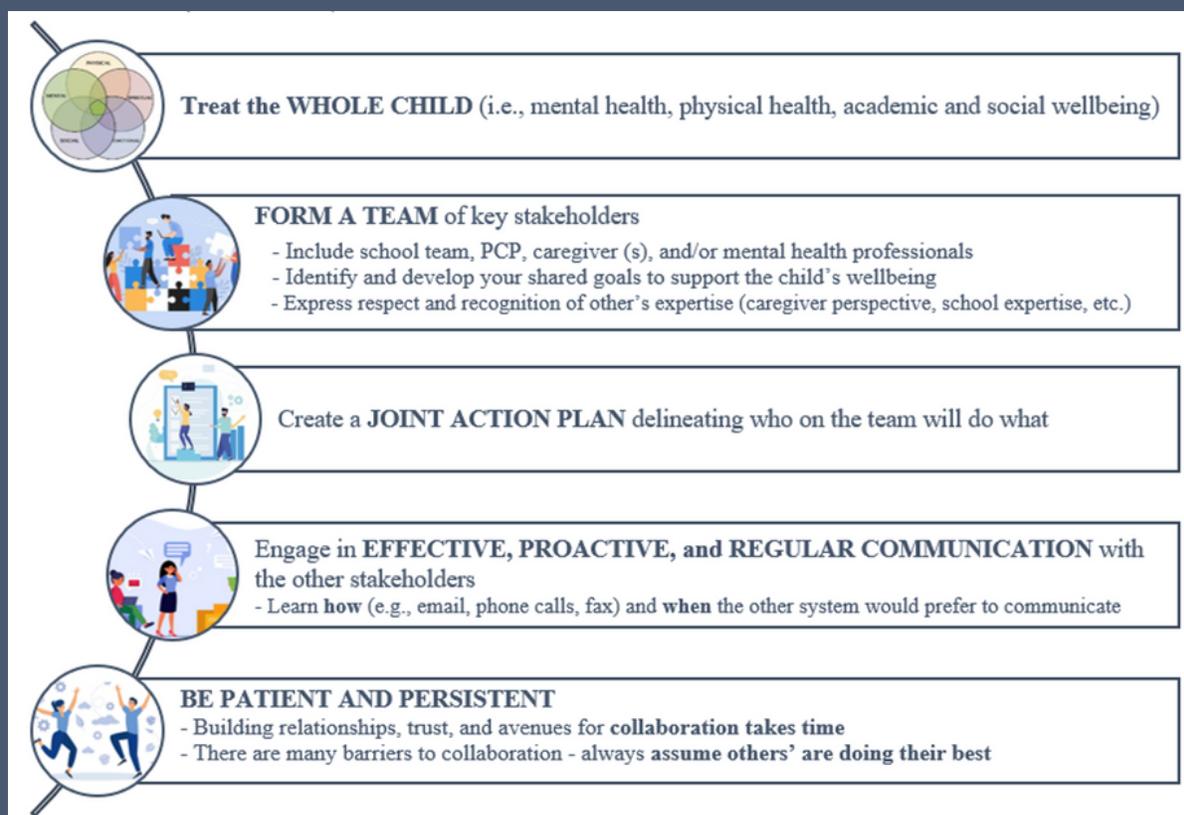

Figure 2
Best Practices for Multi-Systemic Collaboration

Best Practice for Schools

The multi-tiered system of support model (MTSS; Kearney & Graczyk, 2020) is a helpful framework for selecting school-based interventions based on individualized factors perpetuating the student's SR.This model focuses on prevention, early intervention for emerging absenteeism, and indicated interventions for severe and/or chronic attendance problems.

Prevention: *Foster relatedness and connectedness at school.*

- Promote supportive student-teacher relationships, parent involvement, and reduce any conflict with adults and peers
- Develop and utilize school attendance teams (Ingul et al., 2019) that regularly review attendance trackers and intervene early if concerning thresholds are reached (e.g., 5 or more tardies)

Early Intervention: *Empower educators to identify, communicate, and intervene early!*

- Collaborate with and involve parents to help identify the right supports to put into place
- Utilize attendance monitoring data to connect at-risk youth with mentoring (e.g., Check and Connect) and skill-based interventions (e.g, educational supports; social skills training) (Guryan et al., 2021; Kearney & Graczyk 2020)

Indicated Interventions: *Intensify and individualize interventions for youth with more significant SR.*

- Conduct a functional assessment of the student's SR using the SRAS-R (Kearney 2002) and use data to tailor in-school and at-home supports/interventions
- Employ targeted multi-modal strategies including school counseling, skill and educational supports, cognitive behavioral therapy, and medication management
- Form multidisciplinary teams with a focus on collaboration between home, school, primary care & mental health teams

Best Practices for Parents

Early intervention for SR is critical. Parents should act early and reach out for support (Kearney & Gracyk, 2020).

Prevention

- Notice early warning signs (e.g., physical complaints, calls home, requests to leave early, reluctance to go to school like bargaining, crying, tantrums, etc.)
- Validate your child's emotions (e.g., "A lot of kids feel nervous about school") and motivate with confidence and appropriate limits (e.g., "I know you can do this. You need to go to school to learn.")
- Reach out to partner & problem-solve with school if these concerns increase in frequency
- Support overall foundational health (e.g., sleep, exercise, nutrition)
- Support and model healthy coping strategies

Intervention

- Communicate concerns to school early to identify tailored supports (e.g., evaluation, counseling, small group work, addressing bullying)
- Let school know who is already on your child's care team (e.g., pediatrician, therapist)
- Make time at home as boring as possible (e.g., keep a "school schedule", no TV or technology, no naps or time in bed)
- Seek additional support from a mental health provider if SR lasts more than a few weeks, gets in the way of normal daily life (e.g., work schedule, child socializing) or if it begins to cause your child/family significant distress

Best Practices for Primary Care Providers

Primary Care Providers (PCPs) are often the first point of contact where families express concerns about SR. PCPs often have an established and trusting relationship with families. PCPs can easily support SR prevention during existing screening and psychosocial interviewing and can offer brief, effective education and intervention should they identify SR.

Prevention

- Include assessment of attitude toward school during your standard well child checks
- Provide anticipatory guidance when students are starting school or during natural school transitions (e.g., elementary to middle)
- Minimize letters excusing school absences unless there is a clear medical reason for missing school. If considering a letter, communicate with schools/behavioral health providers to keep treatment plans consistent
- When relevant, provide education about the mind-body connection and potential for manifestation of emotional distress as somatic responses (Fremont, 2003)

Intervention

- Be comfortable providing basic education about SR (e.g., helping parents understand the four functions of SR)
- Support timely referrals to mental health care and consider more frequent follow up while families get set up with services
- Leverage your relationship with the families to increase adherence with behavioral recommendations
- Support and collaborate care with schools and mental health professionals
- Support prescription of psychiatric medication as needed to support the child's participation in SR treatment

Best Practices for Mental Health Providers

Mental health providers may become engaged at various points in a child's journey with SR. Prevention efforts with all patients and effective evidence-based intervention with children exhibiting SR are important.

Prevention

- Assess attitudes toward school, bullying, and school engagement with both patients and caregivers in all intake evaluations
- Act as an advocate and liaison to support healthy school-family-community partnerships (e.g., encourage and facilitate communication between teams)

Intervention

- Consider utilizing an assessment form such as the SRAS-R (Kearney, 2002) to identify avoidance and reward structures underlying school refusal
- Work collaboratively with children, parents, and school professionals to develop a shared understanding of factors motivating the child's aversion to school or desire to stay home
- Utilize evidence-based treatments such as Cognitive Behavioral Therapy and Exposure and Response Prevention (Elliott & Place, 2019)
- Apply a systemic therapeutic approach that addresses avoidance, accommodation, and reinforcement at all levels of the child's context

CONTEXTUAL CONSIDERATIONS

Consideration of the sociocultural contexts of the child, family, school system, and community is necessary for effective treatment of SR.

- Acknowledge the resources available in the child's school; individuals in lower resourced schools may be prone to higher levels of environmental/community stressors
  - This may increase fears/avoidance urges for students
  - High demands on staff may make it harder for adults to identify early SR warning signs

- Acknowledge barriers and resources of the family; caregivers of students in low resourced areas may have more trouble dedicating time to supporting intervention and collaboration due to a greater impact of higher systemic stressors (e.g., school meetings during the work day with less job flexibility, facilitating return to school plans when there are also care demands for other children).

- Address the role of racism, culture, and prejudice in these processes through a lens of cultural humility.
  - Youth of color experience disproportional rates of missed school, and tend to be more often labelled as truant instead of experiencing SR (Lyon & Cotler, 2007).
  - Families of color may face structural racism/bias and have fewer socioeconomic or time resources to leverage toward addressing SR. Without appropriate acknowledgement and amelioration these factors can exacerbate prejudiced responses from schools.

- These problems intensify when considered in the context of increasing demands, changes, fatigue, and burnout parents, school teams, and medical teams may be experiencing from the COVID-19 pandemic. Further, the pandemic highlighted and worsened educational, social, and financial disparities, leaving lower resourced families and communities with even fewer resources. Appropriate conceptualization and intervention around SR involve understanding and addressing these stressors and disparities, while also highlighting and leveraging the individual and sociocultural strengths of each student and family.

Conclusion

SR is a systemic problem that has worsened since the COVID-19 pandemic and may be disproportionately affecting individuals in lower resourced schools and communities. When addressed collaboratively and systemically, intervention around SR is poised to promote good health and well-being (SDG 3), increase access to quality education (SDG 4), and reduced inequalities (SDG 10) for impacted youth.

References

Elliott, J. G., & Place, M. (2019). Practitioner review: school refusal: developments in conceptualisation and treatment since 2000. *Journal of Child Psychology and Psychiatry, 60*(1), 4-15.

Fremont, W. P. (2003). School refusal in children and adolescents. *American Family Physician, 68*(8), 1555-1561.

Guryan, J., Christenson, S., Cureton, A., Lai, I., Ludwig, J., Schwarz, C., ... & Turner, M. C. (2021). The effect of mentoring on school attendance and academic outcomes: A randomized evaluation of the Check & Connect Program. J*ournal of Policy Analysis and Management, 40*(3), 841-882.

Heyne, D. A., Sauter, F. M., & Maynard, B. R. (2015). Moderators and mediators of treatments for youth with school refusal or truancy. M*oderators and mediators of youth treatment outcomes*, 230-266.

Heyne, D., Gren-Landell, M., Melvin, G., & Gentle-Genitty, C. (2019). Differentiation between school attendance problems: Why and how? *Cognitive and behavioral practice, 26*(1), 8-34.

Inglés, C. J., Gonzálvez-Maciá, C., García-Fernández, J. M., Vicent, M., & Martínez-Monteagudo, M. C. (2015). Current status of research on school refusal. *European Journal of Education and Psychology, 8*(1), 37-52

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*(1), 46-62.

Kearney, C. A. (2002). Identifying the function of school refusal behavior: A revision of the School Refusal Assessment Scale. *Journal of Psychopathology and Behavioral Assessment*, 24, 235–245. https://doi.org/10.1023/A:1020774932043.

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.

Kroshus, E., Hawrilenko, M., Tandon, P. S., & Christakis, D. A. (2020). Plans of US parents regarding school attendance for their children in the fall of 2020: a national survey. *JAMA pediatrics, 174*(11), 1093-1101.

Lyon, A. R., & Cotler, S. (2007). Toward reduced bias and increased utility in the assessment of school refusal behavior: The case for diverse samples and evaluations of context. *Psychology in the Schools, 44*(6), 551-565.

Sewell, J. (2008). School refusal. *Australian Family Physician, 37*(6), 406.