Addressing the Growing Problem of School Refusal

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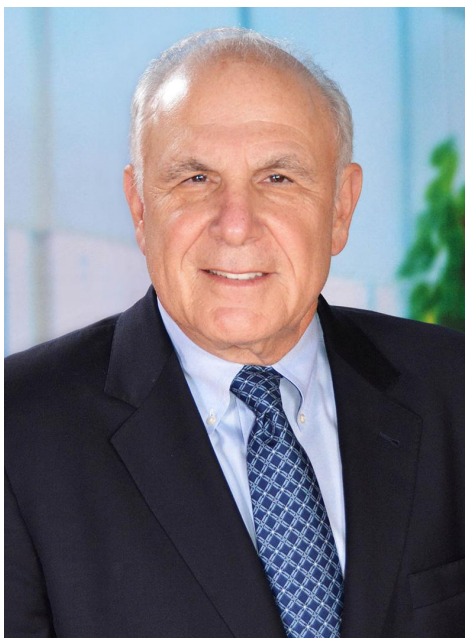

Howard Savin, PhD

Anxiety disorders have been plaguing America's children to a significant degree and are now one of the most common behavior health disorders of today's school age children. Anxiety, often in conjunction with depression, is found to be a key determinant of school refusal (historically diagnosed as School Phobia) which is now estimated to affect as much as 5% of all school children. (CDC, Data and Statistics on Children's Mental Health, 2015) Unlike truancy, which is largely a conduct disorder, school refusal encompasses children from kindergarten through high school who may be experiencing mild separation anxiety as well as more severe cases where a student may miss weeks or months of school because of debilitating anxiety or depression. (M. Wimmer, School Refusal: Information for Educators, 2010) There are serious long-term social and educational consequences associated with missing school, and school refusal has become a major concern for children, parents and schools alike. Effective programs are urgently needed to address critical underlying social, emotional and educational issues and serve to facilitate regular school attendance, which is the optimal outcome in most instances. Accordingly, this article describes the components of The Transitions Program at First Children Services and includes an illustrative case study.

Transitions Program Description

The Transitions Program at First Children Services enables parents and caregivers to begin confronting and resolving school refusal in their children. School refusal is addressed by moving home bound students into a center-based instruction team of professionals. The program serves students ranging from middle through high school grade levels. Meeting the mandates of the State core-curriculum, students are offered courses in every academic area, spanning ability levels from moderate to honors. Each of our State certified teachers follows a curriculum which changes our students' lives by nurturing a passion for learning within a therapeutic environment - a model which is designed to foster life-long academic skills, reflection and emotional stability. The program goal for middle school age children is reintroduction of our students to their home school's classroom setting in most cases. For high school age students entering the program, the targeted outcome is often to buoy their social-emotional growth and maximizing academic attainment, while guiding them through high school graduation and beyond.

At present, 25 New Jersey school districts send their students to our Transitions Program. Daily instruction is delivered in small group, limited to no more than six students in a class setting. The comprehensive program includes individual and group counseling, offered by a staff of licensed clinicians. Once enrolled in our program, each of our students is administered the Beck Youth Inventories-Second Edition (BYI-II). The BYI- II are five self-report scales that measure the student's experience of depression, anxiety, anger, disruptive behavior, and self-concept. The results help articulate the social-emotional status of each student, enabling staff clinicians to utilize specific therapeutic interventions while tracking clinical progress over their time in the program and prior to IEP or parent progress conferences. Our clinicians employ contemporary approaches to therapy based on individual needs. Interventions include mindfulness, cognitive-behavioral, and dialectical-behavior therapy. Each student receives a minimum of 40 minutes per week of individual therapy and 45 minutes per week of group counseling sessions. Additionally, our students attend a 45 minute weekly social skills group which employs the evidence-based Skillstreaming curriculum. This facilitates development of interpersonal competencies which enable the re-entry of our students to their sending school districts or to confidently pursue post-secondary education. Our academic and social skills programs, in sum, are crafted to prepare students to function independently in today's complex society.

Case Study

This 16-year old High School student had been homeschooled for 3 years prior to placement in our program. At that time, her diagnoses were severe mixed anxiety disorder with severe functional impairments, generalized anxiety disorder, separation anxiety (severe), school phobia and avoidance, somatic preoccupation, and agoraphobia. She was prescribed Zoloft and Intuniv. She was essentially a prisoner in her own home with a severe enmeshment with her mother. Her anxiety surfaced when she was

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organic. Or, maybe, as many people seem to think, it's social media and screen time.

A digression here about social media. 55% of Gen Z'ers reported that social media was a primary source of support when they are distressed. They also reported that it could be a source of distress, due to cyber bullying and the like. So, in their experience social media are a mixed bag.

Back to the question of whether world events are contributing to a decline of mental health. Possibly not, but if we use the usual simplistic model of mental illness as the outcome of innate vulnerability and social and psychological stressors, it would make sense that the state of the world is having an impact on the state of mental health—adolescent and adult.

And this would have important implications for mental health policy.

First, it raises doubt about whether increasing the availability of mental health services, improving their quality, promoting integration of service systems—all high on mental health policy agenda—will have a significant positive impact on the prevalence of mental disorders, suicide rates, overdose deaths, and so forth.

I am not suggesting that the elements of the current behavioral health policy agenda should be abandoned. I have been advocating for them for the past 40 years and will continue to do so. And I believe that mental health services can relieve the suffering of many individuals. Whether achieving our goals would result in widespread improvement of adolescent mental health is another question entirely.

Second, the probability that world events have a significant impact on mental health suggests that our current prevention agenda[6] does not go far enough. Again, I am not suggesting that we should abandon this agenda. It's important to mitigate the impact of poverty, violence, and adverse childhood events. It's important to provide support for parents who struggle to do what is right for their kids. It's important to provide early intervention and better education. But it may not be enough.

It may be that child and adolescent mental health advocates need to add **adverse world events** to their list of concerns, not just because the future of humanity may depend on the outcome of these issues, but more narrowly because the mental health of the next generations will fall, or hopefully rise, with the outcome.

Of course, taking on the flaws of the world we live in may be far too much to do. It takes enormous effort to pursue our current agenda. Our successes, and there are quite a few, have been hard won. Some advocates are called "tireless" because they are persistent. Most, I suspect, are in fact tired but dogged.

Nevertheless, long-term improvement of the mental health of our youngest generations may depend on entering the fray to fix the world and ensure that the generations to come will have the life we hope for them.

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in 6th grade and her grandmother died. Soon after, she had her first panic attack at school. This is when she stopped attending school. Her first visit to our program appeared unsuccessful. The student sat in the car for about an hour before entering the building, only to leave after five minutes. These five-minute visits went on for nearly two weeks before there was a breakthrough. Five minutes then became fifteen minutes. Fifteen minutes led to an hour - then, a half-day. To many, five minutes in class does not seem significant. However, her anxiety, present since the age of 11, affected not only her "refusal" to go school, but every aspect of her life. As a sixteen-year-old, she had never been left alone as she literally clung to her mother. The entire family was in her personal prison with her.

At the Transitions program, each plan is customized to meet a student's needs. In this case, her plan was layered with multiple supports. First, we gave her the tools to navigate overwhelming anxious moments. She was introduced to mindfulness coping strategies that created a path for her to control her emotions. In tandem with the mindfulness approach, the student met every morning with a clinician. The sessions were initially forty minutes and focused on developing and practicing coping skills, deep breathing, and positive affirmations. She was also permitted 5-minute breaks during the day as needed to practice her coping skills when her anxiety became overwhelming.

These sessions, over ensuing months, were faded to once per week morning check-in sessions along with "as needed" sessions for particularly anxious moments. She was also assigned a staff behavior technician to assist her with executive functioning that included hygiene, organization and socialization. She retained the support staff for the following school year.

During the summer of 2018, this student enrolled into a physical education course at her home high school. She was successful in completing her coursework and interacting with other students and teachers. In fact, it was the Transitions Program staff's recommendation that the student be enrolled for several courses at her sending school during the 2018-2019 academic year. Unfortunately, the sending high school was unable to accommodate this student's needs due to scheduling conflicts, so she opted to remain here at the Transitions Program as a full-time enrollee.

This Transitions Program participant is now an outgoing, happy teenager who has learned to manage what once was debilitating anxiety. She now mentors' new students, helping them to manage their catastrophic thoughts and proudly shares her story about starting in the parking lot. Her school attendance has improved to close to eighty percent. Academically, she exceeded the expectation of her sending district and is poised to complete the program in June, 2019. This student, once ridden with severe anxiety, now has friends, goes shopping, and even boasts of sleepovers!

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Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA

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The range of possibilities for action is considerable: individual engagement using a positive youth development model to solve problems that push TAYYA out of school; programmatic interventions to re-integrate students into school after an absence; and systems changes to implement a Multi-Tier System of Supports (MTSS) that reduces suspensions and expulsions by improving school climate and reserves intensive clinical services for those most in need.

Interventions that Work

Effective interventions for TAYYA build on positive youth development and person-centered planning that engages the young person around her/his strengths and interests.

Positive youth development is characterized by adaptive or mutually beneficial relationships between an individual and her/his life context, so that the individual contributes to the contacts that support her/him. The clinical element enters the framework when the goal of positive developmental interventions is to restore or enhance developmental processes that have been compromised by high levels of risk and challenge.[6]

Positive youth development approaches are useful for improving TAYYA education outcomes, for example by promoting positive perceptions of school which then leads to better school attendance, which is essential for academic achievement and graduation.[7] The ideal model will use mental health agency staff skills and knowledge of human development to engage a disconnected young person and strengthen their connections with school and long-term vocational goals.

Mental health providers can also collaborate with schools in program development, for example, by introducing mentoring programs that help the young person concentrate and handle pressures.

Providers can create "bridge" programs, such as BRYT (Bridge for Resilient Youth in Transition) developed by the Brookline Center for Community Mental Health for the local high school and now being tested in diverse districts across Massachusetts. BRYT helps students who have been absent due to behavioral health challenges to reintegrate with school. It places mental health staff in the school to provide clinical supports for returning students, academic case management on their behalf with school personnel, and liaison with families for students in both special and general education.[8]

Finally, systems change is an option for assisting TAYYA: Partnerships between schools and community agencies have often created a three-tier model, called a Multi-Tier System of Supports (MTSS) that invests in universal supports for all young people (Tier 1) to improve school climate and modify disciplinary practices that too often result in suspension or expulsion for students with behavioral health challenges. This model reserves Tier 3, the most clinical tier, for the minority of students with more intensive care requirements.

Reinforcing the Imperative to Focus on Education Issues

Serious mental health problems represent the largest burden of disease in young people. Yet, TAYYA between the ages of 16 or 18 and 21 with serious mental health conditions, who may have received services as children, discontinue services – either by dropping out or being forced out. Policy and funding barriers, unpleasant school experiences, lack of attractive treatment models, stigma and a desire to "be done" with mental health services, and poor coordination between mental health services and community institutions such as schools all contribute to this phenomenon.[9]

To reverse the trajectory leading to

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