INFORMATION FOR INQUIRY INTO NATIONAL TREND OF SCHOOL REFUSAL AND RELATED MATTERS REQUEST:

- Additional information from Children's Health Queensland (CHQ) HSCE and Dr Stephen Stathis, Clinical Advisor, Mental Health, Alcohol and Other Drugs Branch, Clinical Excellence Queensland, Queensland Health following 20/04/2023 appearance at the Education and Employment References Senate Committee inquiry into the national trend of school refusal and related matters as per transcript regarding:

1. Information regarding overrepresentation of neurodiverse young people in school refusal, particularly students with an ASD or ADHD diagnosis and difficulty obtaining a suspected diagnosis.

a. What is the average time that it takes for a young person in Queensland to get that diagnosis?
b. How do they go about that?
c. What are the costs to families?
d. How do they access it?
e. What is the level of access, and how does that differ whether you are in Brisbane or across the regions?

RESPONSE:

- CHQ do not have the requested data to hand, as this would require coordination across multiple services including child development services, paediatric services and Child and Youth Mental Health Services. Education Queensland are best placed to provide the data on the numbers of children and adolescent who school refuse.

2. The number of GPs currently in schools.

RESPONSE:

- In October 2021, it was announced that GPs will be based in 50 schools across Queensland. Progress on this is a matter for Education Queensland as the Government agency responsible for the program.

3. Information relating to a review undertaken in June 2021 by the Child and Youth Mental Health Service (CYMHS) at Children's Health Queensland Hospital and Health Service regarding a literature review looking at contemporary models of practice and intervention for school refusal trends.

RESPONSE:

- CHQ CYMHS conducted an initial literature review scoping in June 2021 on contemporary models of practice/ collaboration /interventions, at risk indicators, definition, and evidence base in relation to school refusal trends particularly related to the global COVID-19 pandemic impacts. There is continued broad interest in working with key stakeholders to understand identification of the school refusal issue and collaborate on potential intervention trials which requires dedicated leadership, coordination and appropriate allocation of resources.
- The following updated overview of the relevant literature (note: this is not a formal literature review) as of June 2023 is from a mental health and specifically child and youth mental health service (CYMHS) perspective. It would be important to consider this alongside a similar literature overview from an education perspective, if available.

School refusal definition and incidence

- School refusal is a psychosocial problem characterized by a student's difficulty attending school and, in many cases, substantial absence from school[1]. It is often distinguished from truancy, in part because of the severe emotional distress associated with having to attend school and the absence of severe antisocial behaviour. Emotional distress is one of the main reasons students refuse to attend school.

Its presentation may take a variety of forms for different young people, including excessive fear, depressive moods, tantrums, and unexplained physical symptoms[2].

- As already noted at the inquiry into the national trend of school refusal and related matters, there are no data systems within Queensland Education or Health that currently captures information about school refusal or avoidance (see p.2 Queensland Catholic Education Commission Submission #13).
- The definition of school refusal/school avoidance varies across settings which makes the ability to capture consistent information very difficult with no nationally consistent definition for school refusal (including inclusion of pattern/duration and reasons for non-attendance i.e., learning issues, family issues, social phobia, school anxiety, separation, bullying etc) (see p.4 Triple P Submission #140).
- School refusal behaviour with anxiety factors peaks between the ages of 5-6 years and 11-13 years. It affects 1% to 2% of school-aged children, 1% to 7% of adolescents in the general population, and 5-16% of teenagers in clinical settings[3] [4] [5]. However, this estimation may inaccurate, given that the conceptualizations between school refusal and truancy are difficult to distinguish and remains controversial among non-attender groups[6]. Some children and young people exhibit the characteristics of both types of non-attendance behaviour (truancy and school refusal)[7].
- Current rates of school refusal are unknown internationally. Research suggest that rates have increased in the context of repeated school closures throughout the pandemic[8]. Although schools have returned to face-to- face teaching settings, research shows that some adolescents continue to struggle with COVID-19 related mental health concerns[9]. Recent studies show that adolescent depression, anxiety and sleep problems, which are known risk factors for school refusal, have increased significantly following COVID-19 lockdowns[9] [10]. In 2022, school refusal in India has almost tripled since the COVID-19 lockdown[11]. There are currently no studies directly addressing the effect of COVID-19 and school refusal on academic performance[12].
- School refusal is an international issue as UK February 2023 data from Attendance is everyone's business Children's Commissioner's submission to the persistent absence inquiry found that 2 out of every 9 pupils were persistently absent over UK autumn and spring terms in 2021/2022 meaning 1.6 million pupils missed at least 10% of possible school sessions with a highlight on the history of an absence where "pupils who had previously been persistently absent had a rate of persistent absence over three times that of those who had no history of persistent absence (51% persistently absent compared to 14% persistently absent in autumn and spring terms 2021/22)".
- In Queensland, anecdotally, there are growing concerns about the increasing numbers of students school refusing/ avoiding since the onset of the COVID-19 pandemic with the education sector reporting increases in emotional dysregulation of students and school refusal over last 2-3 years. Concerns about school refusal have also been raised by Headspace through Qld Be You.
- Statewide (Qld) Ed-LinQ Program data collected from Hospital and Health Service (HHS) Ed-LinQ Coordinators regarding number of consultation liaison requests and training delivered to school staff and stakeholders for 'school refusal' has been consistent across 2020-2022 calendar years as below:

Calendar Year	Consultation Liaison Requests for School Refusal	Training Sessions Delivered regarding School Refusal
2020	191	24
2021	215	22
2022	213	25

Adverse Consequences

- Significant adverse consequences due to school refusal may occur in the short- and long-term. In the absence of treatment, most youth with school refusal continue to display problematic school attendance and emotional distress[13]. Besides educational, mental health and social adjustment problems, the main short-term consequences also include missed employment opportunities, possible legal and financial problems, and the likely occurrence of many conflicts with family members and school officials[14].
- School refusal also harms adolescents' peer relations and social adjustment. One study revealed that more than one-third of youth who refuse to attend school had no friends and lacked the appropriate social connections[15]
- Chronic absenteeism has been shown to hurt both learning motivation and school achievement with an increased chance of dropping out of school early in adolescence[16]. Some of the major long-term consequences include increased crime rates, financial constraints, future employment problems, the

risk of marital conflict, and the need for further psychiatric assistance in adulthood[17]. School refusal has been identified as a key variable for the persistence of separation anxiety disorder into adulthood. Additionally, over a 10-year follow-up period, 30% of youths with school refusal continued to meet criteria for a psychiatric disorder[11].

- Family members and school staff are also affected by school refusal[18]. Parents may experience distress, due to the crisis-like presentation of school refusal and the challenge of resolving the problem, and family conflict may arise[17 19 20 21].
- School staff may incur stress displaced onto the school by family members and stress arising from their own uncertainty about management of the problem[20].

Aetiology

- School refusal is a complex problem that is multiply determined by a broad range of risk factors, which interact with each other and change over time[16 22 23 24]. A helpful way to organize the array of potentially relevant factors is to consider the domains of predisposing, precipitating and perpetuating factors. Within each domain, there is likely to be a confluence of individual, family, school and community factors. Of particular importance is that the heterogeneous nature of school refusal, with its varied presentations and numerous aetiological factors, points to the importance of a multi-source and multi-method approach to assessment[25]. In the 1990s, a functional analysis became more popular in understanding the problem; that is, examining the reasons why pupils fail to attend school[7].

Management

- Evidence indicates that improvements in school attendance occur for children and adolescents with school refusal who receive psychosocial treatment [18]. Reflective of the complexity involved, research into the various intervention programs available for tackling non-attendance has failed to find any conclusive evidence in favour of a particular approach[7] and very few controlled studies have been reported[16]. The aim of early return to school is usually emphasized in treatments as too long an absence sets in motion secondary factors that make treatment more difficult [26].
- The effectiveness of any intervention may depend upon an individual pupil's particular needs and their specific reasons for refusing to go to school. Research highlights the importance of involving school and family in responding to the problem as a potentially key factor. Several studies have pointed out the importance of involving parents as a part of the intervention process[7 17 27]. Consultation with school staff is also essential in the treatment of school-refusal behaviour, especially in cases of adolescent school refusers[28].
- The child-, parent- and school-based interventions involve the judicious selection of, and emphasis on, intervention components as indicated by the diagnostic profile and case formulation. This individualized approach rests on the complex array of possible factors involved in the development and maintenance of school refusal, together with the need to be sensitive to the individuality of each child, family and school situation[25].
- Of the psychosocial treatment approaches used with school refusal, Cognitive Behaviour Therapy (CBT) has been subjected to the most evaluation[29]. Studies have provided clear evidence that systematic exposure-based CBT is clinically effective[27].
- Child therapy involves the use of behavioural and cognitive procedures directly with the young person, helping them to acquire and then employ the necessary skills for coping with school return and regular attendance. Work with caregivers focuses on the role that parents and teachers can play in managing environmental contingencies at home and school; contingencies that are maintaining the school refusal problem and those that facilitate the young person's regular and voluntary school attendance. School-based strategies focus on preparatory work and behaviour management strategies that support the young person's reintegration into the school system.
- It appears that the most appropriate and effective method in dealing with chronic non-attendance is to design an individualised intervention programme, according to a pupil's particular needs, but involving a multi-systems approach (i.e., school, parents, and mental health clinician)[7].
- The overarching aim of interventions is the reduction of the young person's emotional distress and an increase in school attendance to help the young person follow a normal developmental pathway[1 above]. A finding of a 2015[30] review points to different effects on anxiety and attendance. The increased exposure to school, which is a key component to some of the interventions, may result in more immediate improvement in attendance. However, the increased exposure to school could, at least in the short term, result in an increase in anxiety. A decrease in anxiety may follow from a child's

continued attendance at school. There are few rigorous trials available to support any one CBT intervention for school refusal. The lack of evidence of short-term effects on anxiety points to the need for long-term follow-up studies to determine whether increased attendance ultimately leads to reduced anxiety.

- Future research in this area could benefit from more sophisticated and rigorous designs and analytic techniques. Moreover, independent replications of the manualized interventions examined in this review are needed, as are longer-term evaluations of effects of interventions[30].
- CBT's usefulness is limited, however, if youth displaying school refusal also refuse to attend treatment sessions. In these cases, parents and school staff may consider using school-based interventions that do not rely on face-to-face assessment and treatment with the young person[31]. There have been historic challenges in embedding closer interagency working[32]. There are several models that are showing promise to assist in interagency collaboration[33] [34].
- A growing number of interventions for school refusal are now incorporating more elements of multi-system interventions. Multi-systemic intervention strategies have been implemented with some degree of success, such as modular treatment, Link program, and In2School program. Although all of these multisystemic intervention approaches have gained attention and have proven to be largely effective, there is still considerable space for improvement[2].
- At a practical, front-line level, the CHQ HHS hosted Statewide Ed-LinQ program is coordinating a School Refusal and Avoidance (SAR) cross-agency working group which are developing capacity building materials to help support staff to support students with school attendance and considering how to identify and respond to school refusal and avoidance with a tool to support school staff members to identify students who are at risk of school disengagement due to school refusal/anxiety.
- There are also numerous local (Qld) opportunities to partner with other stakeholders with a range of new commonwealth and state initiatives being rolled out including:
    - Head to Health Kids hub in South Brisbane
    - Right Care, First Time, Where You Live Program occurring in Brisbane South PHN
    - Expansion of headspace initiative for dedicated Mental Health Alcohol and Other Drugs (MHAOD) consultation liaison
    - Project Air roll out through the Qld Department of Health Office of the Chief Psychiatrist (MHAOD Branch)
    - Expansion of existing Anna Freud Centre (UK) partnership with Queensland AMYOS for consideration of existing materials such as "Addressing emotionally-based school avoidance"- contains ideas to help education staff to address the issue Addressing emotionally-based school avoidance.

In conclusion

- It is important that there is an agreed definition of school refusal and there are systems in place to record the incidence. School refusal is a complex, multi faceted presentation with short and long term impacts. Evidence indicates that improvements in school attendance occur for children and adolescents with school refusal who receive psychosocial treatment though more research is required. An important aim is intervening as early as possible, though this may require child-, parent- and school-based interventions.
- As a final comment, because of the complexity of school refusal, many evidence-based "gold standards" have been judged to be ineffective for even 33% of young people[35]. Moreover, as a field that requires a great deal of individualization and contextualization, there is no research on school refusal that has been adapted and tailored to address the occurrence of COVID-19[36] [24]. Therefore, more empirical attempts based on different cultural contexts and era-specific characteristics need to be implemented in the field of school fefusal.

Background

- The Queensland Ed-LinQ Program aims to improve linkages and service integration between the education, primary care, community, and mental health sectors and complements the continuum of public mental health services responding to the needs of school-aged children and young people. The Ed-LinQ Program is delivered by Ed-LinQ Coordinators across 15 HHSs supported by a Statewide Ed-LinQ Coordinator hosted in CHQ CYMHS Specialist Teams.
- The geographical area covered by the local CHQ HHS Ed-LinQ program includes more than 330 schools with CHQ CYMHS Ed-LinQ Coordinators aiming to enhance the early detection and

collaborative care of primary and secondary school students with mental health problems through fostering strategic partnerships, enhancing capacity and providing consultation-liaison for the education, primary care and mental health sectors.

- The management of school refusal requires more a multi-stakeholder/agency approach co-designed with the child/young person and family due to range of factors potentially contributing. Hence, there are a range of CHQ CYMHS initiatives (occurring all CYMHS Program areas e.g., Ed-LinQ program, psychology discipline, community CYMHS, Jacaranda Place, etc) with a focus on enhancing capacity (health, education and other staff), supporting ongoing stakeholder engagement, and provision of evidence-based interventions.

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