Clinical Perspectives

Intensive School Avoidance Services for Youth in Higher Levels of Care

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School attendance problems (SAPs) are increasingly common in youth and often lead to poorer academic, social, and emotional functioning, family conflict, and referrals to psychiatric treatment. This paper highlights the unique benefits of intensive psychiatric treatment for SAPs and actionable steps for skills adaptation and implementation in a higher level of care, such as a partial hospital program. Four key components of evidence-based treatment for SAPs are reviewed: youth support, caregiver skills, school collaboration, and medication management. Strategies for increasing intrinsic motivation around school-related behaviors and supporting youth's executive functioning are highlighted as augmentations to traditional treatment. We emphasize the importance of school reentry using gradual exposure early in treatment paired with skills implementation and offer a sample exposure hierarchy as a template for practitioners. Finally, we provide guidance on collaboration between providers and school personnel to facilitate youth's successful return to school.

INTRODUCTION

Approximately 5% of youth presenting for mental health treatment struggle with SAPs, including long-term absences, periodic absences, frequent tardiness, class skipping, or noncompliance with schoolwork.[1] School avoidance is a complex problem correlated with multiple psychiatric diagnoses and historically requires significant resources with a record of poor treatment response.[2] Some patients require a higher level of psychiatric care, such as an intensive outpatient program (IOP) or partial hospitalization program (PHP), to improve their functioning and psychiatric symptoms. These intensive treatment settings are uniquely well suited to address school avoidance.

Intensive outpatient settings are designed to treat complex, transdiagnostic symptoms that cause severe functional impairment. Services that take commercial insurance or Medicaid provide access to care for families from underserved communities, which is a crucial need. Higher levels of care offer multiple modes of treatment, including intensive individual and group therapy, medication management, family support, and school collaboration; these components are critical to comprehensively treat SAPs. Additionally, an intensive treatment model where youth receive services multiple days a week leads to a robust treatment response with sustained outcomes,[3] which can reduce the amount of time a youth is absent from school. Importantly, caregivers are usually closely involved in the treatment process and receive support through family sessions, parenting groups, and sometimes peer-to-peer support. Further, PHPs/IOPs utilize a multidisciplinary treatment team approach, and school is often integrated into programming. This format provides opportunities for exposure to academics in a supportive environment and reduces stress about the return to school postdischarge.[4]

INTERVENTIONS

Intensive treatment for SAPs should include components of research-supported interventions like cognitive behavioral therapy, dialectical behavior therapy, and exposure therapy, and they can be applied in group and individual modalities. Strategies[5] should be tailored to the youth's specific needs based on assessment using empirically validated tools, such as the School Refusal Assessment Scale.[6]

COGNITIVE BEHAVIORAL THERAPY STRATEGIES

At the start of treatment, psychoeducation should be provided to youth and caregivers about school avoidance and associated symptoms, such as anxiety, depression, attention-deficit/hyperactivity disorder (ADHD), and learning

Table 1. Sample School Reentry Exposure Plan[a]

Step 1	Review assignments on virtual platform (eg, Google Classroom, Canvas) with support of PHP staff/teacher
Step 2	Complete one school assignment during PHP school, ask teacher for help when needed
Step 3	Go to school building on a weekend, walk around the outside for 10 min
Step 4	Do the morning school commute, walk to the front door, then go to program
Step 5	Text/call to a friend from school
Step 6	Have a Zoom meeting with school counselor
Step 7	Go in person to school to meet with advisor/counselor
Step 8	Attend school for 1–2 "easy" or preferred classes
Step 9	Attend school for a half day
Step 10	Attend school for the full day

PHP = partial hospitalization program.
[a]Plan should be based on anxiety/distress ratings, with early steps being easily tolerated and progressing to more challenging tasks. Repeat each step as needed until anxiety is reduced. School staff should be aware of exposure goals and how they can reinforce skills.

deficits. The interaction between avoidance and worsening psychiatric symptoms, social relationships, and academics should be emphasized. Additionally, cognitive restructuring can be used to identify and reframe distorted thoughts that exacerbate school anxiety and depression. Providers can also introduce social skills[7] to improve youths' assertiveness and skillful communication. For example, youth can role-play how to answer questions from peers and teachers about their prolonged absence to prepare for their return to school.

Behavioral activation and exposure are the cornerstones of effective treatment of SAPs. Exposure increases engagement with school-related stimuli, builds resilience, and reduces avoidance, and this should occur early on and throughout intensive treatment. School-related exposures include checking homework assignments, completing academic tasks, viewing the school website, attending a virtual meeting with a school counselor, and attending a class. Table 1 depicts an example of how to structure a gradual school reentry while youth are still enrolled in treatment.

MOTIVATION STRATEGIES

Motivation building and values-focused work are helpful additions to treatment in PHP/IOP. Adolescents often engage in school-related activities (eg, attending school, doing homework, joining clubs) due to external pressures such as threat of consequence or because they will feel guilty if they do not. Research shows that intrinsic motivation, or doing behaviors for reasons of inherent interest that align with personal values, is linked to adolescents' positive academic engagement and achievement. Problem-solving and implementing changes to the school environment that improve youths' competence, autonomy, and peer relationships are central to increasing intrinsic motivation for school attendance.[8]

EXECUTIVE FUNCTIONING SKILLS

Youth with school-related problems may experience deficits in executive functioning due to depression, anxiety, and/or ADHD. Executive functioning skills[9] can be adapted to address difficulty with prioritizing, completing large assignments, planning, scheduling, and catching up on missed work. Strategies include the following:

- utilizing the Eisenhower Matrix[10] for prioritization, which helps students organize and prioritize tasks based on level of importance and urgency
- creating a daily schedule
- developing a homework plan to break down large assignments
- creating a distraction-free workspace
- learning effective study techniques, such as the Pomodoro Method[11]

Many IOPs/PHPs integrate schooling into their programming, which creates opportunities for exposure to academics and executive functioning skills practice. Additionally, prior to transitioning out of the PHP/IOP, a support person at school should be identified who can reinforce use of these skills in the academic setting.

CAREGIVER SUPPORT

Support and skills coaching for caregivers should be prioritized in treatment and is pivotal for continued progress after the program. Caregivers can learn these skills in individual or group formats, with caregivers reporting positive, affirming experiences in groups with peers navigating similar SAPs. Psychoeducation about mental health symptoms and school engagement problems should be provided. Teaching caregivers about the skills youth are learning, especially executive functioning skills and exposures, can facilitate reinforcement and support outside of treatment. Caregivers also benefit from learning parenting strategies, such as using validation to improve the caregiver–child relationship and communication. Moreover, caregivers often need coaching on how to reduce accommodation of avoidant behaviors, such as removing access to behavioral reinforcers (eg, electronics, special meals, sleeping in) when their child stays home from school. Creating a behavior plan that concisely outlines rewards for approach behavior and consequences for avoidance provides struc-

ture and clarifies expectations. If aggression or safety concerns are present, crisis management tools should be implemented to identify common triggers, vulnerability factors, de-escalation strategies, and reengagement techniques to manage behavioral dysregulation. Last, a personalized coping plan should be developed with caregivers to support and promote their own mental health.

SCHOOL COLLABORATION

Close collaboration with school guidance counselors and staff is an important component of treating SAPs.[12] A staff member in the PHP/IOP can serve as a "point person" to facilitate this communication and coordinate the reentry plan. Permission should be obtained early in the youth's PHP/IOP admission to facilitate communication with the school and gather collateral information about any challenges that school personnel may have noticed. Providers can educate parents on the benefits of a 504 plan or Individualized Education Program, such as access to counseling, academic services, and tailored academic expectations based on the student's needs, and they can help facilitate these processes.

Ideally discharge from intensive treatment is coordinated with a graduated return to school plan. Stepwise reentry is consistent with the exposure model, promotes self-efficacy, and allows for youth and caregivers to continue receiving support from the treatment team throughout the transition (see Table 1).

PSYCHOPHARMACOLOGY

Many youth who present with significant school avoidance will have an underlying anxiety and/or depressive disorder. Although data regarding the pharmacological treatment of school avoidance is limited, psychotropic medications, particularly selective serotonin reuptake inhibitors (SSRIs), can play an important role in decreasing anxiety levels and enhancing motivation, allowing youth to engage in therapy more effectively. SSRIs can take 4-6 weeks to reach full therapeutic effect, underscoring the importance of timely titrations to a therapeutic dose. Acute settings allow for the rapid titration of medications in a monitored environment where youth are observed daily. SSRIs can be increased every 4–7 days depending on tolerability of side effects. Similarly, for those youth who have already trialed one SSRI, cross-titrations to other medications can be done safely and quickly. In some cases, youth presenting with severe anxiety or panic symptoms may benefit from a brief course of benzodiazepines while the SSRI achieves its therapeutic effect. Psychoeducation should be provided to youth and families about the risks and benefits of benzodiazepine use in this setting, including the potential for dependence and abuse. Generally, benzodiazepines should be used with caution in youth and are not recommended for long-term use.

In addition to anxiety and depressive disorders, some youth with school avoidance may present with a history of learning difficulties. The PHP/IOP allows for rapid evaluation, direct observation, and collaboration with school staff to diagnose neurodevelopmental disorders like ADHD. If a diagnosis seems likely, a stimulant trial may be initiated, and its impact can be directly assessed during the school portion of the treatment day.

CONCLUSIONS

The key components of effective treatment of SAPs are evidence-based therapeutic skills, caregiver support, school collaboration, and medication. Intensive outpatient treatment settings are well suited to address SAPs due to the model of intensive care and multidisciplinary support. This paper outlines strategies that have been shown to be feasible in an IOP/PHP setting. More research is always needed to verify effectiveness, efficacy, and safety; however, these interventions have a strong base of evidence in support of their use.

PLAIN LANGUAGE SUMMARY

Intensive outpatient program/partial hospitalization program settings are well suited to treat school attendance problems in youth. Intensive treatment offers frequent opportunities for exposure, skills coaching, school collaboration, and family support. Traditional outpatient interventions can be successfully adapted and augmented to fit acute care settings.

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REFERENCES

1. Rohrig SN, Bennett SM, Desai P, Zendegui EA, Chiu AW. A description of school refusal behavior in adolescents prior to acute care admission. *J Emot Behav Disord*. 2024;32(4):226-238. doi:10.1177/10634266231187369

2. Elliott JG, Place M. Practitioner review: School refusal: Developments in conceptualisation and treatment since 2000. *J Child Psychol Psychiatry*. 2019;60(1):4-15. doi:10.1111/jcpp.12848

3. Öst LG, Ollendick TH. Brief, intensive and concentrated cognitive behavioral treatments for anxiety disorders in children: A systematic review and meta-analysis. *Behav Res Ther*. 2017;97:134-145. doi:10.1016/j.brat.2017.07.008

4. McKay-Brown L, McGrath R, Dalton L, et al. Reengagement with education: A multidisciplinary home-school-clinic approach developed in Australia for school-refusing youth. *Cogn Behav Pract*. 2019;26(1):92-106. doi:10.1016/j.cbpra.2018.08.003

5. Kearney CA, Albano AM. *When Children Refuse School: Therapist Guide*. Oxford University Press; 2018. doi:10.1093/med-psych/9780190604059.001.0001

6. Kearney CA. Identifying the function of school refusal behavior: A revision of the School Refusal Assessment Scale. *J Psychopathol Behav Assess*. 2002;24:235-245. doi:10.1023/A:1020774932043

7. Rathus JH, Miller A. *DBT Skills Manual for Adolescents*. Guilford Publications; 2014.

8. Grolnick WS, Ryan R. Parent styles associated with children's self-regulation and competence in school. *J Educ Psychol*. 1989;81(2):143-154. doi:10.1037/0022-0663.81.2.143

9. Sibley MH, Altszuler AR, Ross JM, Sanchez F, Pelham WE Jr, Gnagy EM. A parent-teen collaborative treatment model for academically impaired high school students with ADHD. *Cogn Behav Pract*. 2014;21(1):32-42. doi:10.1016/j.cbpra.2013.06.003

10. Victorino RC. The Eisenhower Matrix: Prioritize your time on what matters most. Slab blog. September 23, 2020. Accessed July 21, 2025. https://slab.com/blog/eisenhower-matrix/

11. Cirillo F. *The Pomodoro Technique: The Acclaimed Time-Management System That Has Transformed How We Work*. Crown Currency; 2018.

12. Clemens EV, Welfare LE, Williams AM. Elements of successful school reentry after psychiatric hospitalization. *Preventing School Failure: Altern Educ Children Youth*. 2011;55(4):202-213. doi:10.1080/1045988X.2010.532521