**How does Multisystemic Therapy Impact on Educational Outcomes?**

Rachel Pulham

June 2022

*Submitted in partial fulfilment of the requirements for the degree of Doctor in Clinical Psychology (DClinPsy), Royal Holloway, University of London*

**Acknowledgements**

My first thanks are to everyone that has helped this thesis come to be, including my supervisors Dr Simone Fox and Dr Emily Glorney, as well as all fourteen people that have so kindly shared their experiences with me.

To the Royal Holloway DClinPsy 2019 Cohort, I’d like to say a massive thank you for their constant support (even at 3am), for making doctoral training the experience it has been and for being a constant source of hope and inspiration during the process of thesis and training.

To my home hens, I’d like to thank them for always being there, for creating a group that is empowering of one another and for bringing the loudness and laughter into any room.

To my lovely Mum, Dad, Brothers and the whole family, I am so thankful for their unwavering support, for their patience and understanding, and for teaching me there’s always a place for humour. Thank you for believing in me, even when I didn’t.

To my love Byron, thank you for being my biggest cheerleader. I will be forever thankful for the mammoth effort of living with someone completing a doctorate during a global pandemic. Thank you for always making me laugh, for noticing when I need a break and pushing me when energy was low. A final thanks to our little man Remi, who arguably should receive an honorary doctorate for all the hours spent sat on my lap, patiently waiting for a treat.

Contents Page

[Lay Summary 7](#_Toc113197044)

[Systematic review 7](#_Toc113197045)

[Chapter 1: Systematic Review 11](#_Toc113197046)

[A systematic review of psychological interventions aimed to improve school attendance amongst young people 11](#_Toc113197047)

[Abstract 12](#_Toc113197048)

[Background 14](#_Toc113197049)

[Prevalence of school refusal 15](#_Toc113197050)

[Causes and contributing factors of school refusal 18](#_Toc113197051)

[Interventions to promote school attendance 21](#_Toc113197052)

[Aims of systematic literature review 22](#_Toc113197053)

[Method 22](#_Toc113197054)

[Search strategy 23](#_Toc113197055)

[Data extraction and synthesis 27](#_Toc113197056)

[Risk of bias 27](#_Toc113197057)

[Results 35](#_Toc113197058)

[Synthesis of findings 35](#_Toc113197059)

[Quality appraisal 35](#_Toc113197060)

[Study characteristics 36](#_Toc113197061)

[Participant characteristics 36](#_Toc113197062)

[Intervention modalities 38](#_Toc113197063)

[Reports of effectiveness 42](#_Toc113197064)

[Discussion of findings 43](#_Toc113197065)

[Intervention modalities 43](#_Toc113197066)

[Effectiveness of interventions 45](#_Toc113197067)

[Beyond a one size fits all approach 46](#_Toc113197068)

[Review Limitations 47](#_Toc113197069)

[Future research 48](#_Toc113197070)

[Concluding synthesis 50](#_Toc113197071)

[Chapter 2: Empirical Paper 51](#_Toc113197072)

[How does Multisystemic Therapy impact on educational concerns? 51](#_Toc113197073)

[Abstract 52](#_Toc113197074)

[Introduction 53](#_Toc113197075)

[Multisystemic Therapy 53](#_Toc113197076)

[MST Theory of Change 54](#_Toc113197077)

[MSTtherapy overview 55](#_Toc113197078)

[MST principles 56](#_Toc113197079)

[MST and Education 56](#_Toc113197080)

[The importance of education 58](#_Toc113197081)

[Psychological interventions for educational concerns 59](#_Toc113197082)

[MST ultimate outcomes 61](#_Toc113197083)

[Purpose of the study 62](#_Toc113197084)

[Methodology 63](#_Toc113197085)

[Design 63](#_Toc113197086)

[Rationale for Constructivist Grounded Theory 63](#_Toc113197087)

[Epistemological stance 64](#_Toc113197088)

[Ethics 65](#_Toc113197089)

[Consultations with MST professionals and service-users to support co-design 66](#_Toc113197090)

[Sample criteria 67](#_Toc113197091)

[Materials 70](#_Toc113197092)

[Procedure 71](#_Toc113197093)

[Analysis 72](#_Toc113197094)

[Results 74](#_Toc113197095)

[Category 1: Understanding factors contributing to the problems in education 76](#_Toc113197096)

[Category 2: Building and aligning the system 79](#_Toc113197097)

[Category 3: Working on the home relationships 85](#_Toc113197098)

[Category 4: Flexibility of the MST model 89](#_Toc113197099)

[Category 5: Increasing responsibility 92](#_Toc113197100)

[Category 6: The legacy of MST 93](#_Toc113197101)

[Discussion 98](#_Toc113197102)

[Overview of results 98](#_Toc113197103)

[Relevance of the findings to the literature 98](#_Toc113197104)

[Research limitations 106](#_Toc113197105)

[Research strengths 107](#_Toc113197106)

[Suggestions for future research 108](#_Toc113197107)

[Conclusion 110](#_Toc113197108)

[Chapter 3 111](#_Toc113197109)

[Integration, Impact, and Dissemination 111](#_Toc113197110)

[Integration 112](#_Toc113197111)

[Synthesis of findings 112](#_Toc113197112)

[Challenges within the research 116](#_Toc113197113)

[Impact 118](#_Toc113197114)

[Dissemination 121](#_Toc113197115)

[References 123](#_Toc113197116)

[Appendices 144](#_Toc113197117)

[Appendix A: Quality assessment of literature 144](#_Toc113197118)

[Appendix B: Ethical approval confirmation 146](#_Toc113197119)

[Appendix C: Participant Debrief Sheet 147](#_Toc113197120)

[Appendix D: Demographic Information Forms 149](#_Toc113197121)

[Appendix D1: Demographic Information For (Caregivers) 149](#_Toc113197122)

[Appendix D2: Demographic Information Form (Education Professionals) 152](#_Toc113197123)

[Appendix D3: Demographic Information Form (MST Professionals) 154](#_Toc113197124)

[Appendix E: Interview schedules 156](#_Toc113197125)

[Appendix E1: Interview schedules (Caregivers) 156](#_Toc113197126)

[Appendix E2: Interview Schedule (Educational professionals) 159](#_Toc113197127)

[Appendix E3: Interview Schedule (MST Professional) 162](#_Toc113197128)

[Appendix F: Participant Information Sheets 165](#_Toc113197129)

[Appendix F1: Information Sheet (caregivers) 165](#_Toc113197130)

[Appendix F2: Educational Professional Information Sheet 169](#_Toc113197131)

[Appendix F3: MST Professional Information Sheet 173](#_Toc113197132)

[Appendix G: Consent Form 176](#_Toc113197133)

[Appendix H: Example transcript showing coding process 177](#_Toc113197134)

[Appendix I: Memo-ing extract 180](#_Toc113197135)

[Appendix J: Breakdown of theoretical, focused and initial codes 181](#_Toc113197136)

**List of tables**

[Table 1: Terms used to search databases 21](#_Toc105249659)

[Table 2: Summary of included studies 27](#_Toc105249660)

[Table 3: Caregiver demographics 65](#_Toc105249661)

[Table 4: Educational professional demographics 66](#_Toc105249662)

[Table 5: MST professional demographics 66](#_Toc105249663)

[Table 6: Grounded Theory model of MST’s addressing of Educational Concerns 71](#_Toc105249664)

**List of figures**

[Figure 1: PRISMA flow diagram summarising the stages of eligibility screening 25](#_Toc105249678)

[Figure 2: Bronfenbrenner’s ecological systems theory 43](#_Toc105249679)

[Figure 3: MST Theory of Change 54](#_Toc105249680)

[Figure 4: MST Analytical Process 54](#_Toc105249681)

[Figure 5: Grounded Theory model of MST’s addressing of Educational Concerns 73](#_Toc105249682)

# Lay Summary

Education has an important role in a young person’s social, academic, physical, and emotional development. Research has shown that difficulties attending school, have both short and long-term outcomes, such as being more likely to have employment difficulties, mental health difficulties, and more contact with forensic services. Additionally, research has explored the causes of school refusal, which have included family, school, friendship and individual related factors. With the studied causes and consequences, research has looked to evaluate psychological interventions to support young people engaging with school.

Multisystemic therapy is a successful family and community intervention, that supports young people who are at risk of going into care, being in custody or not being in education. Multisystemic therapy was developed to support the contributing factors of antisocial behaviour within a young person’s family, peer, school, and community system. Multisystemic therapy has three main outcomes, defined as a young person living at home, being in education and having no new criminal charges. Data from multisystemic services suggested that teams in the UK and Ireland were below service targets, and lower than international teams. Currently, there has been limited research investigating multisystemic therapy and education.

This thesis is formed of a systematic review which aimed to review existing empirical research of psychological interventions for school refusal, whilst a research study developed a theoretical model of how multisystemic therapy addresses educational concerns.

### Systematic review

Previous systematic reviews looking into psychological interventions for school refusal have found some support for cognitive behavioural therapy interventions. However, this research has been limited and requires more research attention. The current systematic review aimed to review research that had been completed since the previous review.

Research studies that were included in this review were papers that investigated the effectiveness of a psychological intervention to improve school attendance, for young people aged 11-17 and where attendance was measured as an outcome. Over 5900 studies were retrieved from four databases. After screening for duplicates and relevance, 12 studies were identified. The study intervention and outcomes were obtained, and each study was assessed using a 14-item quality appraisal tool.

#### Findings and conclusions of the systematic review

Compared to previous reviews, this review found more variance in the psychological interventions being researched. Five psychological interventions were found: cognitive behavioural therapy (n=4), whole school interventions (n=4), multimodal interventions (n=2), systemic structured family therapy (n=1) and mindfulness-based therapy (n=1). Most studies detailed that their interventions included members of the system, including a caregiver and the school as part of the intervention. Additionally, the interventions had different focuses, including young people that struggled to engage with psychological support, older young people and different experiences such as internalizing or externalising behaviours.

Reports of effectiveness were varied between and within the different psychological interventions. Only three studies found statistical evidence of their interventions improving school attendance. One of these studies was cognitive behavioural interventions and two were whole school interventions. Five studies reported no statistical evidence, including mindfulness-based, cognitive behavioural, multi-modal, and whole school interventions. Other studies did not complete statistical analysis but reported observed increases in attendance after their intervention, including structured family therapy, cognitive behavioural therapy, and whole school interventions.

#### Empirical paper

Findings from the systematic review showed some effective interventions but that further research was still needed. The systematic review highlighted the shift in interventions in the inclusion of the system around a young person. With the limited and inconclusive effectiveness of current psychological interventions, further exploration of psychological interventions is needed. Multisystemic therapy is known as a successful therapy that supports young people who are at risk of not being in education, employment, or training, however the role of multisystemic therapy and education has yet to be researched.

The current study therefore aimed to explore how multisystemic therapy helps young people and their families when there are educational problems. Fourteen interviews were completed with caregivers, educational professionals, and MST therapists, from three UK multisystemic teams. Interviews were recorded, transcribed, and then analysed. From the analysis six categories and thirteen subcategories were constructed, and a diagrammatic model was produced to show how these categories relate to one another.

#### Findings and conclusions of the empirical paper

Participants shared that the first role of multisystemic therapy is the therapist understanding the factors contributing to the educational problems. This included the understanding of difficulties from the family and the professionals involved, and then introducing the understanding of how these may relate to one another.

At the same time as developing that understanding, it was acknowledged that the therapist’s role was to build and align the system, by building relationships, breaking down the culture of blame, identifying strengths in the system, connecting and instilling hope in the value of education and working towards a shared goal.

A third category constructed was the importance of working on home relationships. Caregivers spoke of therapists creating a safe space for them to reflect to think about relationships and communication at home. The fourth category described the flexibility of the multisystemic therapy model, with creating and completing interventions for the family and the understood barriers of the system. The fifth category identified increasing the responsibility of the system throughout multisystemic therapy.

The final constructed category was the legacy of multisystemic therapy, which incorporated empowering the system to support and sustain the changes made, the continuous use of multisystemic therapy interventions after therapy has ended and the importance of interdisciplinary learning experiences between multisystemic therapy and educational professionals.

This research hoped to explore how multisystemic therapy addresses educational concerns. It has contributed the first model of multisystemic therapy and education, which describes the current process of multisystemic therapy which attends to the multiple parts of the system around a young person, that have influence in the reduction of educational concerns. The model aligns with theories underlying multisystemic therapy and multisystemic therapies core principles, as well as identifying new components when working with educational concerns. These findings offer a first step in understanding the role of multisystemic therapy in the reduction of educational concerns, that can be built upon by further research.

# Chapter 1: Systematic Review

# A systematic review of psychological interventions aimed to improve school attendance amongst young people

## Abstract

School plays an important role in a young person’s social, academic and emotional development. When there are difficulties in attending school, there are both short and long-term implications, such as falling behind at school and being more likely to have employment difficulties, mental health difficulties, and more contact with forensic services. With the potential impacts of school refusal in mind, much research to date has looked to explore effective interventions to increase school attendance. The aim of this review was to summarize the available evidence of the effectiveness of psychological interventions in increasing school attendance. A systematic literature search was conducted using PubMed, Medline, PsycINFO and Web of Science. Further grey literature searches were completed to include unpublished studies. A narrative synthesis approach was adopted. In total, 12 studies were selected for inclusion. Data were grouped into three themes: participant characteristics, psychological modalities, and effectiveness. In comparison to previous reviews, this review found more variability in psychological modalities with five being identified: cognitive behavioural therapy, whole school interventions, multimodal interventions, structured family therapy, and mindfulness-based therapy. Effectiveness varied within and between modalities, with only three studies finding statistical significance, notably in cognitive behavioural therapy and whole school interventions. Several studies did not complete statistical analysis but reported observed increases in school attendance and concluded that findings supported more methodologically rigorous studies in future. Additional findings were that most studies included members of the young person’s system as part of the intervention, and the identification of sub-groups within school refusal populations, including young people that had difficulties engaging with psychological support, older young people and different experiences and causes of school refusal. There are several limitations to this review, inclusive of methodological and conceptual weaknesses of the reviewed studies. Clinical implications and the need for additional research are discussed.

## Background

Education plays an important role in a broad range of aspects in a young person’s life; including their social and academic development, as well as on their physical, emotional, civil and economic outcomes in later life (Allison & Attisha, 2019; DePaoli et al., 2018; Dube & Orpinas, 2009; Fortin et al., 2006; Pellegrini, 2007; Rocque et al., 2017; Wilkins, 2008). With the gravity and longevity of these concerns in mind, attending school has been recognized as being a crucial component of a young persons’ success (Gottfried, 2014). Subsequently, school absences have been extensively researched; with a focus on understanding the causes, correlates and consequences, and ultimately to find effective interventions to minimize these impacts of a young person’s potential trajectory.

School refusal was first written about in a case study written by Jung in 1913 and has been a term used in much of this area of research since. School refusal is largely defined as a child’s or young person’s difficulty in attending school (Heyne & Sauter, 2013). Heyne (2019) reflected that at first glance school attendance problems look like a relatively straightforward phenomenon, but in fact lead to much debate and confusion, most notably in the breadth and lack of reference to causality of the term. In their review of the literature to date, Elliot (2019) reflected on the subsequent debates around terminology, with some research suggesting that any child-motivated problems in school attendance, no matter of their origin, should be termed ‘school refusal’ (Kearney, 1995). Other researchers have maintained the distinction between school refusal and truancy (Havik et al., 2015; Stein-hausen et al., 2008), with key differences arising with school refusal characterised by strong negative emotions, such as anxiety, and truancy characterized by poor motivation or negative attitude towards school. Kearney has since suggested the term ‘school refusal behaviour’ and has reported that this is one of the most common childhood behaviour problems (Kearney, 2018).

Early research found key factors that continue to be relevant today, with the most commonly used criteria for school refusal referring to four experiences; remaining at home with parents’ knowledge, an absence of severe anti-social behaviour (with exception of aggression), parents making attempts to get the young person in to school and the young person experiencing emotional upset at the prospect of school (Berg, 1969). Since this research, additional experiences have been described such as emotional difficulties: such as anxiety, depression and withdrawal; physical health complaints: such as stomach aches, headaches and disruptive behaviours, such as aggression, running away and family conflict (Kearney, 2004; 2008). Research to date has suggested that the peak age of onset of school refusal is in early adolescence (Heyne et al., 2014).

### Prevalence of school refusal

In England, pupil absences have been consistently reported as between 4.6-4.7% for the last four years (Department of Education [DofE]; Pupil absence in schools in England reports, 2018-2022). According to the Department of Education report, of that figure, unauthorised absences were reported as between 1.3-1.4% since 2017. There is a widely used binary understanding of absences; in that an absence is either authorised or unauthorised, with the most common authorised absences being documented as illness, medical appointments, or religious observance. Another figure reported in the government reports, in addition to pupil absences, are of ‘persistent absentees’, which is defined as a pupil missing 10% or more of their possible educational sessions, which are largely characterised by unauthorised absences (Kearney & Graczyk, 2014). Persistent absenteeism appears to correlate to research exploring school refusal, although research has reported slightly higher figures in that school refusal affects between 5-28% of all school-aged young people at some point during the course of their school career, which has been highlighted as a considerable challenge for schools (Kearney, 2001, 2007; Kearney et al., 2004). Additionally, with the emergence of the COVID-19 pandemic, there was a spike to 21.3% of young people absent, which included pupils self-isolating or shielding (DofE report, 2021). Despite schools being expected to provide immediate access to remote education in the Spring term 2021 (DofE report, 2021), 57.5% of all possible sessions were recorded as unattended. Other reports have suggested that over 30% of pupils in Years 7 to 11 were persistent absentees according to the DfE definition (Beynon & Thomson, 2021), which highlights the growing absence of young people in education over the last two years.

**Existing educational and clinical practice in the UK**

In the UK, the law “entitles every child of compulsory school age to an efficient, full-time education, suitable to their age, aptitude, and any special educational need they may have (Department of Education DoE Report, 2022; p.6). The report stipulates that parents or individuals with parental responsibility make sure that their child receives an education. Barriers and root causes of school attendance issues are acknowledged in the ‘Working together to improve attendance’ report (DoE, 2022) and outlines guidance to schools and its partners. The guidance outlines that for effective school attendance management, focus is required on three levels; in the prevention of school attendance through whole school management, early intervention to reduce absence before it becomes habitual and targeted interventions to re-engage persistent and severely absent pupils. The report outlines a six-step approach in promoting school attendance. The first step is described as aspiring to have high standards from all pupils and parents, and for schools to build a culture where all can and want to learn. Secondly, schools are expected to monitor and identify patterns of poor attendance early, before problems are entrenched. The third step is ‘listen and understand’ barriers to education and agree how all partners can work together to resolve. Following this, schools are guided to facilitate support in the removal of barriers in school and to support pupils and parents to access support to help overcome barriers outside of school. The report explores possible options and promotes a needs-based approach for each child and family. If absences persist, then ‘formalised support” is followed, which may look like a parenting contract or an education supervision order. The final step is to ‘enforce’ statutory interventions or prosecution to protect a pupil’s rights to an education. Under section 444 of the Education Act (1996) parents or people with parental responsibility can be issued with a fixed penalty notice by the local authority if a registered pupil of a compulsory school age fails to attend school regularly.

#### The impacts of non-school attendance

As aforementioned, school plays an important role in both a young person’s short and long-term well-being (Kearney, 2008c). Research has linked increasing disengagement in education, whether that be truancy, skipping classes or non-attendance, with immediate impacts such as falling behind with schoolwork, reduction of academic performance, disruptions to peer relationships and an increase in parent-child conflict (Epstein & Sheldon, 2002; Kearney & Ross, 2014). The more long-term impacts have seen non-attendance linked with being more likely to drop out of school altogether, have issues with employability, increased experiences of mental health difficulties and with increased contact with forensic services (Brandibas et al., 2004; Kearney & Bates, 2005; McCray, 2006; McCluskey et al., 2004; Smink & Reimer, 2005). In respect of mental health difficulties, in addition to possibly experiencing anxiety symptoms as previously mentioned, other mental health difficulties commonly present for young people with school refusal behaviour are separation anxiety, social phobia, panic attacks, post-traumatic stress disorder, depression and ‘adjustment’ disorder (Bernstein, 1991; Buitelaar et al., 1994; Fremont, 2003; Last & Strauss, 1990; McShane et al., 2001; Wanda, 2003).

### Causes and contributing factors of school refusal

Research has endeavoured to understand what may contribute to a young person not attending school. Reid (2005) identified four underlying factors that can explain school refusal behaviour, which they defined as family-related, school-related, peer-related, and individual-related factors, which map on to the considerable research to date.

#### Family related factors

Family related contributing factors towards school refusal behaviour have been detailed as parents education level, family work, health, and criminality (Henry, 2007; Gottfried, 2010; Ingul et al., 2012; Wilkins 2008). In addition to family conflict being an outcome of school refusal behaviour, much research to date has identified its role in school refusal triggers; these have been inclusive of family dynamics, parental marital discord, and family-based transitions (Kearney & Bates, 2006; Kearney & Silverman, 1995; Torma & Halsti, 1975). Highlighting one of the many possible stressors of family conflict, Goradr et al. (2012) noted the poverty gap’s influence on poorer educational and employment outcomes of young people. In their review they explored the interplay of attitude, aspirations and behaviours of young people and their families and the intergenerational impact on school refusal. More deeply, Tobias (2017) found that school refusal (which they termed ‘persistent school non-attendance’) was a ‘symptom’ of disordered familial relationships that the young person was expressing through their behaviour. They described this expression of the difficulties at home as raising the red flag. They went on to draw parallels with school refusal and other childhood difficulties, such as drug use, self-harm, and anorexia (Carr, 2014; Saito, 1992) and the possible systemic and familial contributions or underpinnings. Kearney (2004) also stated that young people may refuse school to pursue attention from significant others. Furthermore, Kearney (2008b) noted the systemic factors that families may reside within such as homelessness, financial difficulties, and poverty (Kearney, 2008b).

#### School related factors

In their research, which interviewed students attending alternative provisions in the context of not attending mainstream education, Wilkins (2008) found four themes, which students described as playing an important role in motivating them to attend school. These were school climate, academic environment, discipline, and relationships with teachers. Offering support to this, Havik et al. (2013) identified three major themes of school-related factors. In their interviews with parents, they identified demanding factors in school which included frightening teacher behaviour, such as harsh reprimands, unfair punishments and aggressive or cruel reactions, and the social and academic demands of educational institutions. The second theme was identified as teacher support, and had further subthemes of emotional support, organizational support, predictability and home-school communication. The final subtheme was friendship-related in the importance of the support from fellow students; notably feeling valued by others. Havik et al. (2013) also reported that parents had also shared concerns around insufficient adaption of schoolwork, the limited understanding from educationalists around school refusal behaviour and that a third of parents expressed concerns around their child being the victim of bullying. The role of bullying and victimisation has been long found to be associated with school refusal (Kearney, 2008b), in addition to the transition from primary to secondary education which has been viewed as one of the most stressful events in a young person’s life (Zeedyk, 2003).

#### Individual and peer related factors

In reference to individual-related factors, in his extensive research on school refusal, Kearney identified four common reasons that young people can refuse to attend school: (1) to avoid school-related situations that cause substantial distress, (2) to escape painful social and/or evaluative school-related situations, (3) as previously mentioned, to pursue attention from significant others, and (4) to pursue tangible rewards outside of school. Much research has noted the relationship of children with school, noting that school boredom, dislike of education, lack of expectations about education, school attitude and motivation for learning were key factors in student absenteeism (Devadoss & Foltz, 1996; Gump, 2006; Gökyer, 2012; Kottasz, 2005; Marburger, 2001; Paisey & Paisey, 2004; Pehlivan, 2006; Schwartz et al., 2009; Veenstra et al., 2010; Watkins & Watkins, 1994). Pehlivan (2006) also noted more systemic factors such as peer groups and their relationship with school, would have impacts on an individual’s motivation to learn. A further peer-related factor that is highlighted in other research is the draw from non-school peers and the more alluring activities outside of school (Kearney, 2008). Ek and Erikson (2013) reviewed the literature on psychological factors underpinning truancy and school refusal. In their review they identified that young people experiencing school refusal were more likely to be experiencing depression, social phobia and separation anxiety (Brandibas et al., 2004; Egger, 2003; Sánchez-Garcia & Olivares, 2009).

Importantly, much research has found difficulty differentiating between the causes and contributing factors of school refusal; and the consequences and impacts of school refusal. Reid (2005) reflected on the difficulties of young people and their families breaking free from the cycles of causes, contributing factors and consequences.

### Interventions to promote school attendance

From the extensive research on the contributions and impacts of school refusal, we can begin to build a picture of the complex nature of the seemingly simple phenomenon of school refusal. Research has helped bring to light the difficult experiences of young people and the potential trajectories and impacts it may have on their later life, and the possible intergenerational influence. With this in mind, there has been a wealth of research focusing on how education and mental health services can support school attendance.

There has been evidence to suggest that a range of therapies may reduce school refusal behaviour, and ultimately increase school attendance; inclusive of cognitive behavioural therapy, dialectical behavioural therapy, solution focussed therapy, narrative therapy and creative therapies (Ricard et al., 2013; Reddy et al., 2013; Tyson et al., 2010; Rapp-Paglicci et al., 2011; Brown et al., 2009; Jennings, 2008; Bender & Boas, 1941; Marken, 1997; Koshlan, 2010).

Two meta-analyses have been completed over the last 10 years, by Maynard et al. (2018) and Eklund et al. (2020) to review effective interventions for school refusal. Maynard et al. (2018) evaluated six psychosocial treatments and two psychosocial treatments combined with pharmacological interventions, that took place between 1980-2013. They reported that all but one of the interventions were a cognitive behavioural therapy intervention (CBT) or variant of such. They reflected on the dominance of CBT for school refusal being in line with prior narrative reviews, which had found positive effects of cognitive and/or behavioural intervention for school refusal (Elliott, 1999; King & Bernstein, 2001; King et al., 2000). They reported from their rigorous meta-analysis that whilst psychosocial interventions, particularly CBT, had some evidentiary support for improving attendance outcomes that it was premature to classify it as empirically supported due to the variability in CBT interventions conducted and that none of the studies included were a replication study. Eklund et al. (2020) completed a broader meta-analysis looking at interventions, inclusive of academic, behavioural and family partnership interventions. They summarized that despite the voluminous research on the causes, correlates and consequences of school refusal, their results suggested that most interventions were understudied, led to small effect sizes or both.

### Aims of systematic literature review

The literature above highlights both the clinical need for young people who are not attending school and promotes the importance of finding effective interventions to promote attendance. Two rigorous meta-analyses completed in the last decade (Eklund et al., 2020; Maynard et al., 2018) noted understudied and small effect sizes within the research to date. The aim of this systematic review was to present a narrative synthesis of research since 2013 (the end date for papers included in Maynard et al., 2018) focused on psychological interventions (outside the remit of Eklund et al. 2020, which explored non-psychological interventions) aimed at improving school attendance.

## Method

This review was conducted with reference to Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines (Moher, 2009).

### Search strategy

The literature search was conducted in February 2022. Searches were carried out for the terms shown in table 1, using the following databases: PubMed, Medline, PsycINFO, Web of Science. Databases were searched with four areas: (1) psychological interventions, (2) for secondary aged students, (3) within an education setting and (4) for educational concerns. Attention was paid to ‘grey’ literature in response to existing critiques (Littell et al., 2005; van der Stouwe et al., 2014) and was targeted through searching ProQuest Dissertations, PsychINFO, the Journal of School Psychology and research gate.

Table 1: Terms used to search databases

|  |  |  |
| --- | --- | --- |
| **Concept** | **Search Terms** | **Searched in** |
| Psychological Intervention | "psychological intervention" or "psychological treatment" or “psychological support” or “psychological approach” or “psychological therapy” or “cognitive behavioral therapy” or “cognitive behavioural therapy” or “CBT” or “systemic psychotherapy” or “systemic” or “psychotherapy” or “behavioural therapy” or “behavioral therapy” or “family therapy” or “multisystem” | All text |
| Secondary School Population | “adoles\*” or “young people” or “young person” or “child” or “teen” or “youth” or “pupil” or “student” or “caregiver” or “parent” or “famil\*” | Titles OR abstracts |
| Education Setting | “school” or “education” | Titles OR abstracts |
| Educational Concerns | “truan\*” or “absent” or “absence” or “absentee” or “school attend\*” or “school refus\*” or “school drop-out” or “school dropout” or “school drop out” or “anti-social behaviour” or “anti-social behaviour” or “school conduct” or “school phobia” or “school anxiety” or “family dysfunction” or “problem behavio\*” | All text |

#### Inclusion criteria

Article titles and abstracts were compared to specific inclusion criteria to identify whether they could be included in the study. The following seven inclusion criteria were used:

1. The article, dissertation or thesis was published after the literature search completed by Maynard et al. (2018) in 2013 and/or not included in their review.
2. The study investigated the effectiveness of a psychological intervention/s that aimed to improve school attendance. Psychological interventions were defined as being informed by psychological theorem and intervention conducted by psychologically informed practitioners. The study contained primary data or review of secondary data, and therefore not theory only papers. Studies were excluded if they focused on experiences, causes or prevalence of educational concerns or if the intervention was not psychological.
3. The study investigated psychological interventions on engagement in school, inclusive of truancy, school refusal or school absenteeism. Studies were excluded if the study only focused on behaviour, educational achievement or attainments.
4. The study intervention was focused on the reduction of school attendance prior to being permanently excluded. This is because another systematic review is currently being undertaken to explore post-exclusion psychological interventions (Gallagher et al., 2018).
5. The primary participants of the study were secondary school aged children or their parents/carers or family. In England and Wales this would identify children aged between 11-17 years of age, however there are national and international variations in secondary school ages and it was considered that setting a defined age period might discount useful interventions that would cover this population. Studies were excluded if they did not take place in a mainstream education setting, such as alternative educational provision or within inpatient contexts.
6. The study must have included data that measured student attendance rates (e.g., number of days absent from school, percentage of days present) in order to examine the effect of the psychological intervention on student absenteeism.
7. The manuscript was written in English

Initial searches identified 5937 papers across databases and alternative search methods. Similarly high number of papers were found in the two aforementioned reviews (Maynard et al., 2018; Eklund et al., 2020). Referencing software removed 866 duplicates, leaving 5071 papers remaining for screening. The titles and abstracts of these studies were reviewed, and 68 relevant papers were extracted. These papers were then reviewed in full against the eligibility criteria, leaving 12 studies included in the final sample. This process was completed by the study author, and a second doctoral student (H.C) who reviewed all eligible papers and 10% of excluded papers: research supervisors were consulted regarding a number of eligibility decisions. The overall process is illustrated in Figure 1.

Figure 1: PRISMA flow diagram summarising the stages of eligibility screening

Articles excluded (n=56)

Non-intervention study (n=14)

Non psychological intervention (n=10)

No attendance outcome (n=22)

Primary school aged (n=7)

Non-mainstream context (n=2)

No retrievable (n=1)

Included

Articles excluded

(n= 5003)

Screening

Eligibility

Final records (n=12)

Full texts articles extracted and assessed against eligibility criteria (n=68)

Titles and abstracts screened

(n=5071)

Records after duplicates removed

(n=866)

Additional records identified through other sources (n=5)

Identification

Records identified through searches (n=5932)

PsycINFO = 2297

PubMed/Medline = 3377

Web of Science = 258

### Data extraction and synthesis

Each of the studies that met inclusion criteria were reviewed and coded. The papers were reviewed in reference to the review aims, therefore only findings of relevance were extracted. A comprehensive spreadsheet was created inclusive of the following definitions, descriptions, and examples. Prior to coding articles, two of the authors who were doctoral students (R.P & H.C) met to define study constructs, describe and operationally define each category, and reach agreement on coding procedures. The following data extraction categories were agreed upon:

* Country of study
* Study design
* Number of students
* Type of psychological intervention
* Findings regarding attendance

The primary author (R.P) independently coded studies into the comprehensive spreadsheet. The second rater (H.C) used the same coding procedures so that each article was coded twice by two raters independently of each other. An initial review of 68 articles demonstrated 14 queries across coders. Of these, 7 discrepancies were reviewed by the research team and resolved through discussion amongst the authors. Discrepancies were found in determining whether an intervention was psychological in its nature and due to variances in participant ages; 100% agreement was noted across all categories.

### Risk of bias

To examine the risk of bias of included studies, the two raters (R.P and H.C) independently used the checklist for assessing the quality of quantitative studies (Kmet et al., 2004). This checklist comprised of 14 criteria; focusing on question, study design, method, subject characteristics, random allocation, blinding of investigators and subjects, outcome, and exposure measures, means of assessment, sample size, analytic methods, estimates of variance, confounding variables, results and conclusions. All studies included in the review were rated by the two raters on each domain as yes, partial, no or N/A. Each answer was given points, with an overall percentage calculable. Coders reviewed these ratings, and discrepancies were discussed and resolved by consensus.

Table 2: Summary of included studies

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Study** | **Design** | **N** | **Intervention** | **Findings regarding school attendance** | **Risk of bias (%)** |
| **Felver 2019**  USA | Randomised controlled pilot study | 29 | **Intervention: Learning to Breathe (L2B)**  ***Description*:** The L2B intervention includes six major thematic foci that are delivered across group sessions, including body awareness, understanding and working with feelings, increasing awareness of thoughts, feelings, and bodily sensations, reducing harmful self-judgments, cultivating positive emotions, and mindfulness training in daily life, and cultivating emotional balance and empowerment through meditation practice.  ***Intervention location:*** In school  ***Intervention time period:*** 7-week mindfulness intervention  ***Intervention delivered by*:** Licensed mental health providers  ***Ages of children*:** mean age of 16.39  ***Outcome measures:*** Unexcused student absences Compared to health education programming group  ***Intervention time points****:* Pre and during L2B period | Quarterly attendance throughout the intervention was analysed using repeated measures ANOVA.  Results indicated that there was not a statistically significant interaction between group assignment and attendance (ps> 0.05). | 71 |
| **Hannan 2019**  USA | Quasi Experimental | 25 | **Intervention: Intensive Cognitive Behavioural Therapy for School Refusal (CBT-SR)**  ***Description:*** CBT-SR included psychoeducation regarding school refusal and maintaining factors, consultation with the school regarding re-entry plan with necessary school accommodations, parent management training, and social skills training regarding school re-entry. School re-entry meant increasing the number of classes over 2–3 weeks. The re-entry plan was formulated by the student, the family, the clinician, and school.  ***Intervention location:*** In school (with some exceptions)  ***Intervention time period:*** 15 daily individual or family sessions of therapy (1.5–2 hours in length), over the course of 3 weeks.  ***Intervention delivered by:*** Licensed Psychologists  ***Ages of children:*** 9-18 years  ***Outcome measures:*** School attendance defined as 0% attendance, partial attendance and 90% or above  ***Intervention time points:*** Two time points | The change in attendance from pre- to post-treatment was significant (χ 2 (1) = 29.0, p < .001) At posttreatment, 60% of students were attending school above 90%. | 71 |
| **Heyne 2013**  The Netherlands | Single Case Study | 1 | **Intervention: The @School Program**  ***Description:*** Developmentally Sensitive Cognitive Behavioural Therapy. YP modules included putting problems in perspective, setting goals, managing stress, dealing with social situations and attending school. Parent modules include reducing maintenance factors, responding to behaviour, bolstering confidence, solving family problems and facilitating school attendance.  ***Intervention location:*** In school  ***Intervention time period:*** 12 modules for young person and parent over 30 sessions.  ***Intervention delivered by***: Psychologists  ***Ages of children:*** 16.5 years  ***Outcome measures:*** Attendance percentage  ***Intervention time points***: Three time points | Attendance was observed to increase from an average of 10 % at pre-treatment to an average of 90 % at post-treatment, remaining high at follow-up (95 %). | 80 |
| **Johnston 2018**  USA | Quasi-experimental design | 90 | **Intervention: Intensive Structural Family Therapy *Description:*** A systemic intervention designed to restructure the parental sub-system to support each other on a decision to help their youth.  ***Intervention location:*** In school  ***Intervention time period:*** 12 weeks  ***Intervention delivered by:*** School Counsellors  ***Ages of children:*** 14-18  ***Outcome measures:*** Attendance percentage. Compared to a Basketball Relationship Building intervention and a non-intervention group  ***Intervention time points:*** pre and post intervention. | Attendance increased with the students in the Intensive Structural Family Therapy condition. Attendance decreased slightly with students in the Basketball condition, while attendance in the control condition decreased the most out of the three groups, as mean scores suggest. | 71 |
| **Jones 2021**  USA | Mixed methods case study approach | 213 | **Intervention: COPE peer support groups**  ***Description:*** Curriculum included loneliness, loss, sadness, setting goals, fear & anxiety, frustration & anger, guilt & regret, forgiveness and encouragement & hope.  ***Intervention location****:* In school  ***Intervention time period*:** 16-week intervention  ***Intervention delivered by***: school psychologists/counsellors  ***Ages of children*:** 11-13  ***Outcome measures:***Attendance percentage.  ***Intervention time points:*** Pre and post intervention | Analysis revealed no statistically significant difference between school attendance rates from 2018-2019 to the 2019-2020 school year. | 68 |
| **Ledbetter 2018**  USA | Quasi-experimental causal-comparative design | 10970 | **Intervention: Positive Behaviour Interventions and Supports (PBIS)**  ***Description:*** PBIS is a proactive approach that allows school systems to effectively support student behaviour. PBIS is a whole school intervention that promote learning environments that are more engaging, responsive and productive, address classroom management and disciplinary issues, improve emotional support and maximize engagement and achievement.  ***Intervention location:*** In school  ***Intervention time period:*** Academic year  ***Intervention delivered by:*** Doctoral researcher  ***Ages of children:*** 11-13  ***Outcome measures:*** Number of school wide absences  ***Intervention time points:*** Pre and post | Attendance rates were compared for students participating in PBIS versus students not participating in PBIS.  χ2 analysis confirmed a significant difference in attendance rates for students who participated in PBIS, χ2 (1, N=6) = 84.92, p<.01. | 71 |
| **Lomholt 2020**  The Netherlands | Feasibility study and preliminary evaluation | 24 | **Intervention**: **Back2School Program (B2S)**  ***Description:*** The B2S intervention is based on a descriptive functional analysis obtained by the School Refusal Assessment Scale (SRAS) (Kearney and Silverman, 1993). CBT procedures include parent management, contingency management, and contracting to minimize incentives for school absenteeism and boost incentives for attendance. Also include cognitive restructuring and exposure-based practice to reduce the youth’s anxious or depressive physical sensations and thoughts.  ***Intervention location:*** In school  ***Intervention time period:*** 10-week manualized CBT program  ***Intervention delivered by:*** SchoolPsychologists & co-therapists (graduate psychology students)  ***Ages of children:*** 10-16 years  ***Outcome measures:*** Percentage of absence  ***Intervention time points:*** baseline, post intervention and follow up | The levels of school absenteeism were at 10 percent pre-intervention and increased from 45 percent at post-intervention to 54 percent at 3-month follow-up and 66 percent 1 year after the intervention. | 57 |
| **Maeda 2019**  Japan | Quasi-experimental | 62 | **Intervention: Rapid Return for School Refusal**  ***Description:*** A school intervention emphasizing a flooding approach, rather than graded exposure. An intervention offered to families, whose young people did not wish to attend individual support. Recruitment of parents to enforce school attendance.  ***Intervention location:*** In school  ***Intervention time period:*** Varied  ***Intervention delivered by:*** School Counsellor  ***Ages of children:*** Mean age of 13 years  **Outcome measures:** Attendance percentage. Results compared to a naturalistic comparison group, of parents and young people who did not take part.  ***Intervention time points:*** pre and post intervention | Twenty-eight of the 39 intervention cases (72%; 13 males and 15 females; χ 2 (1) = 0.14, p = 0.70) were classified as treatment responders. Adolescents achieved at least 85% attendance in the classroom within 3 months and for the next 6 months they were in class at least 85% of the time. | 61 |
| **Nwigwe 2020**  USA | Quasi-experimental | 74 | **Intervention: Check and Connect Intervention (C&C)**  ***Description:*** C&C is a comprehensive intervention designed to enhance student engagement at school and with learning for marginalized, disengaged students. C&C components are: support for students and families for two years, regular check ins, behavioural and educational progress, timely interventions; student connection to school, behavioural, social and academic competency, engagement with families  ***Intervention location:*** In school  ***Intervention time period:*** Academic year  ***Intervention delivered by:*** School/Guidance Counsellors  ***Ages of children:*** 17-18 years  ***Outcome measures***: Number of absences recorded. Compared between C&C treatment group and a control group receiving Behaviour Contract interventions.  ***Intervention time points:*** pre and post intervention | An independent-samples t-test was conducted to compare attendance in C&C and behaviour contract conditions. There was a statistically non-significant difference in the scores for enhanced modified C&C t(72)= 1.4, p = .162, 95% Confidence Interval for the Difference [-.778, 4.56], p > .05).  Although there was a statistically non-significant difference, the students in the C&C condition did have relatively better attendance when compared to students in the BAU condition, which was indicated by a lower mean score. | 68 |
| **Pas 2019**  USA | Quasi-experimental | 437 | **Intervention: Positive Behavioural Interventions & Supports (PBIS)**  ***Description:*** Scaled up PBIS includes systems and procedures to prevent and respond to disruptive behaviour, emphasis on clarity and consistency, clear behavioural expectations, implement a system to respond to the meeting of behavioural expectations and create and implement a consistent response system to behavioural infractions for all students across all school settings  ***Intervention location:*** In school  ***Intervention time period:*** Academic year  ***Intervention delivered by:*** School Coaches  ***Ages of children:*** 11-18 years  ***Outcome measures:*** Truancy rate, compared to non PBIS schools.  ***Intervention time points:*** Pre and post intervention | In secondary schools, there were statistically significant effects of PBIS. Specifically, PBIS schools showed greater declines in truancy rate. The effect sizes for truancy were medium. SW-PBIS did not improve truancy rates in elementary schools | 71 |
| **Reissner 2015**  Germany | Randomised controlled parallel group | 112 | **Intervention: Manual-based multi-modal treatment (MT)**  ***Description:*** MT compromises of four modules; cognitive behavioural therapy, family counselling, school related counselling and psychoeducational exercise program.  ***Intervention location:*** In school  ***Intervention time period:*** Mean number of sessions was 14, over 23 weeks  ***Intervention delivered by:*** Licensed Psychologists  ***Ages of children:*** 14.8 years (range 8.2–19.7 years)  ***Outcome measures:*** Attended school lessons. Comparisons were made to a treatment as usual control group.  ***Intervention time points:*** Baseline, 6 months and 12 months | The analysis of the treatment comparison manual-based multimodal treatment versus treatment as usual showed no difference for either treatment approach in terms of the regularity of school attendance for the observed time points. | 86 |
| **Strömbeck 2021**  Finland | Quasi-experimental | 84 | **Intervention: Hemmasittarprogrammet (HSP).**  ***Description:*** *Multi-modal CBT-based Treatment Program.* HSP includes individual components for young people (eg, skills training, social skills training, gradual school approach, behavioural activation, and problem solving). HSP includes components for the family (eg, regular meetings with the parents that focus on rules, agreements, daily routines, psychoeducation, and conflict reduction strategies).  ***Intervention location***: In school  ***Intervention time period***: The HSP intervention is about 12 months long and is divided into 3 phases: (1) assessment phase (3-4 weeks); (2) treatment phase (6-9 months); and (3) maintenance phase (around 3 months). Range was 4-20 months with average of 11.  ***Intervention delivered by***: School Therapist  ***Ages of children:*** 10-17 years  ***Outcome measures:*** Percentage of attendance  ***Intervention time points:*** Pre and post intervention and 6 month follow up | Before treatment, attendance was 6.2% of full-time, after treatment 18.1%, and at follow-up 30.3%. The proportions of participants who were totally absent from school were 76% before treatment, 41% after treatment, and 27% at follow-up.  In the present study, 5% reached the 80% cut-off after treatment and 19% at follow-up. School attendance of 90% or more was reached by 5% at post-treatment and 7% at follow-up. Before treatment (pre-treatment assessment), no one (0%) reached acceptable levels of school attendance | 68 |

## Results

### Synthesis of findings

A total of 12 articles were included in this systematic literature review. These articles came from fields of psychology and education. Table 2 summarises these studies according to their study design, number of participants, intervention, and key findings in reference to attendance. The 12 articles were synthesised based on the guidance specified by Baumeister & Leary (1997).

### Quality appraisal

A summary of quality appraisal scores can be seen in Table 2 (the full scores are in Appendix A). All papers scored above 55% which Kmet et al. (2006) notes as a ‘relatively liberal’ cut off point. Two research papers reached the ‘conservative cut off’ point of 75% or above (Heyne et al., 2013; Reissner et al., 2015). All papers outlined the theoretical framework, aims, objectives, settings and procedures. Most showed congruity between research questions and methodology, or situated their study within a protocol or feasibility study (Felver et al, 2019; Heyne et al, 2013; Lomholt et al., 2020). However very few studies justified their analytical method, with only two studies clearly stating randomisation. No study alluded to consideration of blinding, although most noted the limitation of non-randomisation. Very few studies referred to sample size or measuring of confounding variables (Hannan et al., 2019). Where sample size was mentioned, it was acknowledged as a limitation of the study (Reissner et al., 2015). Some studies were feasibility, pilot, single case study or secondary data designs, and therefore it is possible that other methodological aspects were noted in other papers they had written, such as the Heyne et al. (2011) study protocol. Where there was a control group, there were limits in this either in its description, in its relevance or definition of the treatment as usual (Johnston, 2018; Nwigwe, 2020). Outcome measures varied between studies, in looking at percentage of attendance, percentage of sessions attended and truancy rates. Additionally, several studies only observed increases and had limited statistical reporting (Heyne et al., 2013; Lomholt et al., 2020, Maeda & Heyne, 2019; Strömbeck et al., 2021). Furthermore, there was a limited report of effect sizes, with only Pas et al. (2019) reporting them.

### Study characteristics

Thirteen studies published between 2013 and 2021 were included in this review. Studies were conducted from across the world, but the majority were conducted in what would be considered western industrialised countries; Finland (n=1), Germany (n=1), The Netherlands (n=2) USA (n=7), Japan (n=1). Studies varied in their quantitative design with a randomised control pilot study (Felver et al., 2019), a single case study (Heyne et al., 2013), six studies with a quasi-experimental design (Hannan et al., 2019; Johnston, 2018, Maeda et al., 2019, Nwigwe, 2020, Pas et al., 2019, Strömbeck et al., 2021), a mixed methods case study (Jones, 2021), a quasi-experimental causal comparative design (Ledbetter, 2018), a feasibility study (Lomholt et al., 2020), a randomised controlled parallel group (Reissner et al., 2015).

The following studies were designed to inform a larger study; Felver et al. (2019), Heyne et al. (2013) and Lomholt et al. (2020).

### Participant characteristics

Sample sizes ranged extensively between the included studies, 24 (Lomholt et al., 2020) to 10970 (Ledbetter, 2018) – with the exception of the single case study design (Heyne et al., 2013). In reference to the gender of participants, studies again varied extensively from 31% female populations (Strömbeck et al., 2021) to Felver et al (2019) who had 67%. The distribution of gender is reported from all studies, again with the exception of Heyne et al. (2013) whose single case study was completed with a female participant. Studies differed in their reporting of ages, with some reporting means and others reporting ranges. Jones et al. (2021) and Strömbeck et al (2021) reported participants as young as 10 years, to 14 years and 17 years respectively. Lomholt et al. (2020) reported a mean age of 12, with Maeda et al. (2019) reporting a range from 12-15 years respectively. Hannan et al. (2019) reported participants between 9-18. Johnston (2018), Nwigwe (2020) and Pas et al. (2019) reported age ranges of 14-17 years. Reisnner et al. (2015) reported a mean age of 14.8 years, Felver et al. (2019) and Heyne et al. (2013) reported a mean age of 16. In summary participants ranged from 9-18 years, whilst the inclusion criteria noted secondary school aged children, in its applicability to the UK system, studies were included where populations where outside of this age range in acknowledgement of the variations in secondary school ages both nationally and internationally and to be able to include all useful interventions.

In reference to the ethnicities of participants, the majority of studies did not report the ethnicity of their sample (Heyne et al., 2013; Lomholt et al., 2020; Maeda et al., 2019; Nwgiwe et al., 2020; Reissner et al., 2015; Strömbeck et al., 2021). Studies that did include ethnicity demographic data reported that young people from black ethnicities made up between 0% (Hannan et al., 2019) and 58% (Johnston et al., 2018) of their sample. Studies reported young people from white ethnicities made up between 5% (Johnston et al., 2018) and 96% (Hannan et al., 2019). Other ethnicities were reported as Asian ethnicity which made up 1% (Johnston et al., 2018) to 15% (Felver et al., 2019); Hispanic ethnicities made up between 4% (Hannan et al., 2019) and 33.4% (Johnston et al., 2018) and American Indian ethnicities which were reported as between 0.1% (Johnston et al., 2018) and 4% (Felver et al., 2019).

In reference to referral behaviour, the majority of studies made reference to school refusal, such as frequent absences (Heyne et al., 2013; Johnston et al., 2018; Lomholt et al., 2020), meeting of Berg criteria (Berg, 2002; Berg et al., 1969) of school refusal (Maeda and Heyne, 2019), truancy rates (Pas et al., 2019). Alternatively for four studies, all students in a year were offered interventions without meeting criteria for school refusal.

### Intervention modalities

From the 12 studies included in this review, there were five guiding psychological modalities reported; cognitive behavioural therapy (CBT), multimodal interventions (MT), systemic structured family therapy (SFT), mindfulness-based therapy (MBT) and school-wide interventions, including positive behavioural intervention and support (PBIS).

Four studies included in this review, used a guiding modality of cognitive behavioural interventions (Hannan et al., 2019; Heyne et al., 2013; Lomholt et al., 2020; Maeda & Heyne, 2019), with a further two studies using CBT in addition to other psychological modalities (Reissner et al., 2015; Strömbeck, et al., 2021). Three of these studies shared at least one author (Heyne et al., 2013; Lomholt et al., 2020; Maeda & Heyne, 2019;). The four studies using CBT interventions ranged in their application of CBT, defining four intervention programs; intensive CBT for school refusal (CBT-SR) intervention (Hannan et al., 2019), the @school program (Heyne et al., 2013), the Back2School (B2S) intervention (Lomholt et al., 2020), and the Rapid Return for School Refusal program (Maeda & Heyne, 2019). In each of the CBT interventions presented, researchers noted that the intervention was systemically informed, with the inclusion of members in the system around the young person, whether that be directly working with the parents (Maeda & Heyne, 2019), working with the young person and their parents (Reissner et al., 2015) and working with the young person, parents and school (Hannan et al., 2019; Heyne et al., 2013; Lomholt et al., 2020; Strömbeck et al., 2021). Furthermore, Hannan et al. (2019) noted their lack of measures assessing family functioning as a limitation in their methodology and acknowledged that future assessment of CBT-SR should seek to adequately address issues related to family functioning.

Intensive CBT-SR was described as a daily intervention for either an individual or family sessions of therapy over the course of 3 weeks, and follows procedures outlined by Tolin et al. (2009) and previous literature using CBT-SR (Kearney, 2001; Kearney & Albano, 2007). The program incorporates psychoeducation, school consultation, parent management training and social skills training. The @school program was described as an intervention aimed at reducing internalizing behaviour to help young people to attend school (Heyne et al., 2013), which involved systemically encompassing CBT with the young person, their parents and offering CBT informed consultation to school staff. The B2S intervention (Lomholt et al., 2020) was informed by the @school program and the “When Children Refuse School program” (Kearney and Albano, 2007). The B2S program is defined as a modular transdiagnostic CBT intervention, which incorporated the family and school in the program. The Rapid Return for School Refusal approach (Maeda & Heyne, 2019) is described as drawing on CBT principles but reflected on the limitations of a graded exposure approach for young people who had difficulties engaging with psychological interventions. In their intervention method they drew on principles of flooding, in populations that found graded exposure CBT interventions ineffective. Maeda and Heyne (2019) reflected on the efficacy of the behavioural technique of flooding, noted in the review by Elliott and Pace (2019) however Maeda and Heyne also queried the efficacy of young people not attending school. Their intervention focuses on working with parents or carers of the young person.

A further two studies used a multimodal intervention. Reissner et al. (2015) described their multimodal treatment (MT) as compromising of four modules: cognitive behavioural therapy, family counselling, school-related counselling, and psychoeducational exercise program. The Hemmasittarprogrammet (HSP) was similarly defined as multimodal manual-based program but differentiated in its modules which included a focus on behavioural change, both at home and in the school environment, psychoeducation, gradual reintroduction to school, working with school staff, involvement of parents and to develop a plan for the return to school. They also acknowledged, based on the families’ goals, that additional aspects of treatment could be social skills training, exposure techniques and behavioural activation.

Outside of cognitive and behavioural modalities, in their doctoral research, Johnston (2018) explored the effectiveness of a structured systemic family therapy compared with a physical play & relationship building intervention and a control group. Johnston proposed that a complex systemic solution, in the role of family and school structure, would be required to support the complex systemic problem that is school refusal. Johnston’s approach was based on Minuchin’s Structural Family Therapy, which was designed to work with troubled family dynamics, with school refusal systemically formulated as a difficulty with externalizing behaviour and therefore lies in the domain of the family unit (Minuchin, & Montalvo, 1966; Minuchin et al., 1963 as cited in Johnston 2018).

One study explored mindfulness-based interventions (MBI) on school refusal (Felver et al., 2019). In their research they drew on research by Schoner-Reichl and Roeser (2016) who shared a growing body of empirical studies that highlighted the effectiveness of MBI in the promotion of positive mental health (Schoner-Reichl & Roeser, 2016; Tan & Martin, 2016) and more specifically an effective intervention within a school context (Felver et al., 2016). Felver et al. (2016) used a specific school-based MBI ‘Learning to Breathe’ (L2B) intervention (Broderick, 2013; Schonert-Reichl & Roeser, 2016) which was described as a mindfulness training and universal prevention program that can be integrated into secondary education settings. The L2B approach uses concepts from Kabat-Zinn’s (1990) program, and includes body awareness, understanding and working with feelings, increasing awareness of thoughts, feelings, and bodily sensations, reducing self-harmful self-judgements, cultivating position emotions and emotional balance and empowerment through meditation practice (Broderick, 2013; Schoner-Reichl & Roeser, 2016).

Four studies detailed their whole school or ‘school environment’ interventions (Jones et al., 2021; Ledbetter, 2017; Nwigwe, 2020; Pas et al., 2019). These four papers straddle the line between psychology and educational interventions. The similarities between these interventions, and in turn differences from the previous eight studies, is the proactive rather than reactive stance to educational difficulties. In addition, they situated their interventions as a collectivist and long-term intervention, rather than individual and time limited.

Pas et al. (2016) and Ledbetter (2017) both evaluated the effectiveness of positive behavioural interventions and support (PBIS) on the school attendance. PBIS is described as a three-tiered approach to behavioural management, a proactive approach to support student behaviour and looks to changing the organisational system at school. In contrast to a focus on presenting problems in most standardised psychological therapy, PBIS hopes to proactively create safe, engaging, and responsive environments within school (U.S. OSEP, 2009). Within the research to date on PBIS notes the many school-based and mental health service approaches for supporting with challenging behaviour are characterized by brief behavioural interventions that have no long-term sustainability after the intervention has been delivered. Nwigwe (2020) also looked at a whole school intervention called The Check and Connect intervention (C&C) which has been described as “a comprehensive intervention designed to enhance student engagement at school and with learning for marginalized, disengaged students in year 12, through relationship building, problem solving and capacity building, and persistence” (Christenson et al., 2012, p. 1). Additionally, Jones et al. (2021) had a more niche target population of all students that had been known to experiences adverse childhood experiences with the COPE Peer Support Group (COPE is a pseudonym). Similarly, to Pas et al. (2016) and Ledbetter (2017) they offered this proactively rather than when problems occurred or when at crisis point. COPE included a 16-week intervention supported by school psychologists, with a curriculum that included loneliness, loss, sadness, setting goals, fear and anxiety, frustration & anger, guilt & regret, forgiveness and encouragement & hope.

### Reports of effectiveness

Reports of effectiveness varied between and within differing psychological modalities. Studies also differed in their type of analysis of results with limited statistical testing. Of the 12 studies in this review, only three found statistically significant results following exposure to the intervention: Intensive CBT-SR (Hannan et al., 2019)and two PBIS interventions (Ledbetter et al., 2018; Pas et al., 2019). Studies that found no significant differences in school attendance were the MBI intervention (Felver et al., 2019), the COPE peer support (Jones et al., 2020), the Rapid Return for School Refusal intervention (Maeda & Heyne., 2019) the Check and Connect intervention (Nwigwe, 2020) and the manual based multi modal treatment intervention (Reissner et al., 2015). Overall significance was found in a CBT and two PBIS interventions, and ultimately not found in multi-model or other non-CBT studies.

Several studies reported observed differences in their data. In their single case design, Heyne et al. (2013) reported an increase of school attendance from 10% to 95% following their CBT intervention. Similarly, Lomholt et al. (2020) reported an observed increase of attendance from 10% attendance to 66% at a year follow up of their CBT intervention. Maeda and Heyne (2019) reported that 72% of students responded to their CBT treatment, with at least 85% attendance. Finally, Strömbeck (2021) reported observable increases in attendance following their HSP multimodal intervention, reporting student total absences were at 76% pre-intervention and dropped to 27% at follow-up.

## Discussion of findings

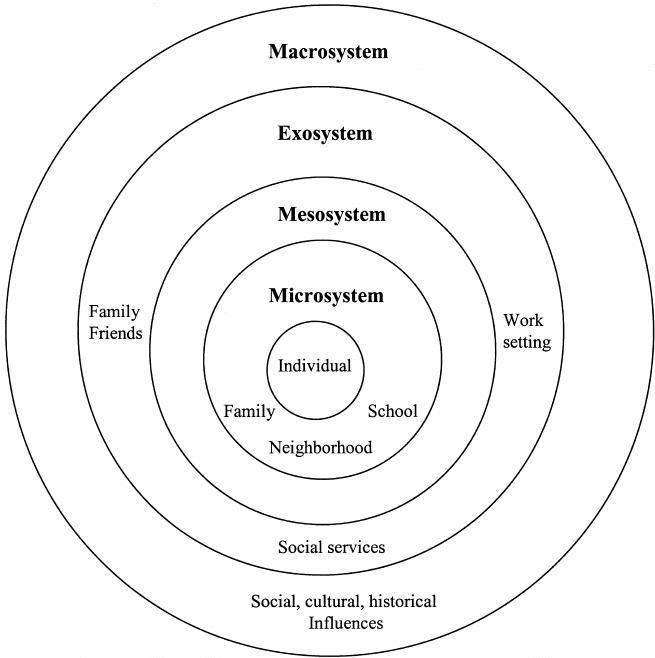
This review aimed to summarise the empirical evidence for psychological interventions to improve school attendance. This review sits within the wider context of two previous meta-analyses that reviewed psychological and pharmacological interventions between 1980-2013(Maynard et al., 2018) and non-psychological interventions (Eklund et al., 2020). This review was considered appropriate and timely to narratively review psychological interventions completed since these previous reviews. Overall, there has been a continuation of research exploring the role of CBT in the reduction of school refusal, however, there has been a shift to explore the effectiveness of other psychological modalities within the field, with emerging focus on systemically informed, multimodal and whole school interventions.

### Intervention modalities

This review included 12 studies, with five overarching psychological modalities, inclusive of CBT, multimodal approaches, MBI, structured family therapy and whole school interventions. In the meta-analysis by Maynard et al. (2018), they reflected on their findings suggesting the dominance of CBT for school refusal, which was in line with prior narrative reviews which had found positive effects of cognitive and behavioural intervention for school refusal (Elliott, 1999; King & Bernstein, 2001; King et al., 2000). A meta-analysis by Eklund et al. (2020) whom had a slightly different methodology in their wider scope of interventions, in that interventions were not completed by a psychologically informed practitioners, had found more variability, with interventions including behavioural, family partnership and academic. Similarly, this review found more variability in modality compared to the Maynard et al. (2018) review.

Over the last ten years, the psychological modalities being researched appear to have moved from a dominance in cognitive behavioural modalities towards a wider variety of psychological interventions being investigated. This could be seen as a direct response of the lack of empirically supported evidence found to date (Maynard et al., 2018), despite CBT’s dominance in the area. Eklund et al. (2020) also shared that despite the voluminous research on the causes, correlates and consequences of school refusal, their results suggested that most interventions were understudied, led to small effect sizes or both. Similarly, to the majority of Maynard’s findings, this review found that of the CBT interventions conducted, the studies had differing manuals and participants. Additionally, no studies were replication studies. Of the CBT informed interventions in this review, all appeared systemically influenced with the involvement of the system around the young person. Reflecting on Bronfenbrenner’s (1992) ecological system’s model , (seen in figure 2) each study, with the exception of the MBI intervention, involved members of the microsystem around a young person, inclusive of their parents or caregivers and members of school. This observable shift could also be understood to be situated in the acknowledgement of the complexity of the phenomenon of school refusal; with longstanding research proposing this as a complex systemic issue that requires a complex systemic approach (Johnston, 2018) with the relationship and cyclical causes, correlates and consequences. Additionally, it would appear that school refusal is being formulated with the systems contribution in mind.

Figure 2: Bronfenbrenner’s ecological systems theory



Moreover, there were two studies that incorporated CBT and behavioural interventions but were integrative in their approaches. This could be seen to demonstrate a further step on from single-modality dominance in CBT interventions being explored. There was also a step away from CBT, with exploring structured family therapy and mindfulness-based interventions. Another further shift is seeing an emerging field in whole school interventions that have been growing in evidence in the United States. This sees a wider shift towards proactive, collective, and structural interventions completed at a microsystem and mesosystem level.

### Effectiveness of interventions

Whilst the review was not able to be a more rigorous meta-analysis, the effectiveness of the five overarching modalities is inconclusive. Despite a wealth of continued research into CBT, the studies reviewed provide limited support for its effectiveness, with only one of the four finding statistically significant results (Hannan et al., 2019). It is however important to note the limited statistical analysis conducted. Despite observational increases in attendance for Heyne et al. (2013), Maeda & Heyne (2019) and Lomholt et al. (2020) these were not statistically supported. It is important to note that a number of these studies reviewed were feasibility, pilot, and single case study designs. Furthermore, with integrative multimodal interventions, no statistical evidence was found but again percentage increases were observed in the data (Reissner et al., 2015; Strömbeck et al., 2021).

In similarity with the Eklund meta-analysis, this review found that other modalities were emerging in the school refusal field. Although, there was no statistical evidence for mentalisation-based interventions, there was emerging statistical significance found for the CBT @school program when accounting for self-efficacy and whole school interventions, notably PBIS, as well as intensive CBT.

### Beyond a one size fits all approach

Another theme that can be seen amongst these papers is the tailoring of approaches to meet the needs of the family. In perhaps a nod towards the complexity of school refusal, whilst most of the interventions spoke of manualised approaches, often protocols alluded to tailoring this for the family’s needs and goals (Heyne et al., 2013, Johnston, 2018; Jones et al., 2021; Reissner et al., 2015; Strömbeck et al., 2021). This also appears to map onto the overall possible trend of bolstering CBT principles with incorporating more systemic mindedness. Additionally, therapeutic modules have incorporated a range of experiences, including internalizing behaviours, externalizing behaviours and family relationships. Two of the studies also make reference to self-efficacy, which refers to an individual's belief in his or her capacity to execute behaviours necessary to produce specific performance attainments (Bandura, 1977). With initial evidence it is a mediating factor to note for future research.

Another potential factor in a theme of not having a one size fits all approach, could be seen in the many differing populations within the wider population of young people who ‘refuse’ to attend school. Namely, older young people (Heyne et al., 2013; Lomholt et al., 2020), young people who have experienced adverse childhood experiences (Jones et al., 2021), young people who find it difficult to engage with individual support (Maeda & Heyne 2019) and non-school refusing populations (Pas et al., 2019; Ledbetter, 2018). Perhaps that also links with tailoring interventions to the family, and flexibility for goal orientated interventions and familial need.

### Review Limitations

There are several limitations of this review that should be considered. A main limitation of this study was that a more rigorous methodological approach was not completed, for instance completing a meta-analysis. The focus of this review was to identify psychological interventions that improve school attendance, and therefore a narrative synthesis methodology was conducted. This was in line with Centre for Reviews and Dissemination (CRD) guidelines due to the heterogeneity in the data reviewed. This methodology conducted however impedes the conclusions and interpretability of this review.

Secondly, there was a substantial number of papers found with the search terms. The findings of the search are similar to the search findings of previously similar systematic reviews, like Maynard et al. (2018) who found in excess of 8000. Whilst there is reasonable confidence that all relevant and available studies were found using the search strategy defined above, it is important to note that one researcher reviewed all papers in this review, which promotes consistency but also raises potential errors. Furthermore, another limitation is that there were potential missing search terms identified, such as ‘parent\*’, ‘child\*’, education\*, program\* and intervention\*. Additionally, whilst unpublished data was incorporated in this review, and two unpublished doctoral theses were included (Johnston, 2018; Nwigwe, 2019) it is possible that relevant unpublished data may not have been found through the search parameters. Therefore, this review cannot reliably assert a reduction in publication bias.

Thirdly, this review aimed to explore psychological interventions for school refusal in secondary school ages, based on the English education system. A number of studies recruited participants outside the age of secondary school, below the age of 11 and above the age of 17. No study controlled for the variable of age, and therefore it was not possible to remove children outside the age range for the purpose of this review. Therefore, this impedes the conclusions and interpretability of this review.

Finally, this review did not include moderator effects and other variables of the studies, as doing so was considered outside of the study aims. It is important to note that to interpret main effects appropriately, it would be necessary to include additional information, such as other variables and outcomes measured, which were outside the remit of this review. However, the possibility that some main effects were impacted by moderator effects and other variables, such as self-efficacy, anxiety, and fear, did not inform this review and therefore should be considered in this review’s interpretation.

### Future research

There are a number of recommendations for future research based on the findings of this review. Firstly, that despite a wealth of research there continues to be insufficient evidence to identify an empirically supported intervention modality, despite there being evidentiary support for CBT’s improvement of attendance outcomes, as found by Maynard et al. (2018). Additionally, a limit of the interpretability of this review, is the limited statistical analysis completed. Therefore, future research is warranted in focusing on psychological interventions including appropriate and rigorous methodologies and sample sizes. This appears to be in process, with a number of studies being single case, feasibility, protocol and pilot studies (Felver et al., 2019; Heyne et al., 2013; Lomholt et al., 2020).

Additionally, there does appear to be some trends in the research over the last decade. There is a lessening degree of CBT dominance, with under 50% of studies included being alternative interventions, more systemically informed CBT interventions, structural family therapy, mindfulness-based therapy, and whole school interventions. Currently, there is not a clear alternative to CBT but rather emerging evidence that research is looking into integrative modalities in its approach to school refusal and looking for other techniques and strategies to aid with different school refusal populations. In acknowledgement of the limits of the review, it could be helpful to understand the effectiveness of systemically informed interventions versus more traditional CBT interventions for school refusal.

#### Implications for practice

The findings from this review indicate that research is focussing in on the system complexities of the phenomenon that is school refusal, and that there is academic momentum in identifying interventions that respond appropriately. It should be noted that there are many limitations in this review, and whilst careful consideration of its findings and conclusions should be completed, it should not prohibit appropriate reflections on current clinical practices to support young people’s attendance and in future research to investigate evidence-based interventions. Trends in more integrative models, incorporation the system, tailoring interventions to the family and reviewing the possible ‘one size fits all’ approach, could be beneficial to be reflected upon. Research to date has shown limited empirical evidence for single-modality treatments such as CBT, and the focus of research can be seen to have opened up to consider the benefits of incorporating the system around a young person and including differing techniques, approaches and interventions, which this review has shown have findings worthy of consideration. It is already evident of collaborations of experts within the field, and perhaps this is conducive of sharing modalities and further exploring and defining populations within the school refusal field.

## Concluding synthesis

This review aimed to summarize the empirical research into effective psychological interventions for school refusal. The findings show that there is less of a cognitive behavioural therapy dominance in research around school refusal, and possible shifts of note of the systemic complexity of the school refusal difficulties, with more emerging of integrative, systemically informed, and whole school interventions. Other psychological modalities appear to be in their infancy compared to CBT research, however there is some initial and evidentiary support in intensive CBT-SR, the role of self-efficacy, and whole school interventions. Furthermore, a number of modalities had observable changes in school attendance and show support for future research with more rigorous methodologies. Additionally, this review demonstrates the systemic complexity, the inclusion of the wider system, a possible criticism of a ‘one size fits all’ approach and also leans towards proactive approaches to support prior to reaching crisis. Whilst many studies have attempted to investigate effective interventions, few provided methodological rigorous designs or analysis that could meaningfully inform clinical practice. Holding the consequences that school refusal has on a young person’s quality of life, this requires timely additional research.

# Chapter 2: Empirical Paper

# How does Multisystemic Therapy impact on educational concerns?

## Abstract

Existing research highlights the causes and consequences of young people who have educational difficulties, either in not attending school or being at risk of school exclusion. Much research has made attempts to explore effective interventions in increasing school engagement, with some evidentiary support but limited empirically supported interventions. Multisystemic therapy (MST) is an evidence-based family and community intervention, that has three ultimate outcomes: a young person being at home, having no new criminal charges and being in education, employment, or training. Currently there is limited research into how MST addresses educational concerns. This study aimed to explore how MST addresses educational concerns from the perspective of multiple stakeholders. A qualitative design using a constructivist version of Grounded Theory was used. Theoretical sampling was conducted to recruit 14 participants; four caregivers, three educationalists, five MST therapists and two MST supervisors. Data was collected using semi-structured interviews across three MST sites across the North and Midlands of England. Six categories and 13 subcategories emerged during the analysis and were used to build a theoretical model to understand the role and process of MST in addressing educational concerns. These included: understanding the factors contributing to the educational problem; building and aligning the system; working on the home relationships; flexibility of the MST model; increasing responsibility; and the legacy of MST. The model highlighted model fidelity with mapping onto theoretical underpinnings of MST and alignment with over half of the MST principles. Analysis also highlighted a number of novel findings inclusive of the MST process of deconstructing blame, the parallel process of working with the home environment and building and aligning the system and with aspects of the legacy of MST. Limitations and future research are discussed.

## Introduction

### Multisystemic Therapy

Multisystemic therapy (MST) is an intensive evidence-based family and community intervention, that supports young people who are at risk of going into care, being in custody or not being in education, due to antisocial behaviour (Henggeler et al., 2009a). MST was developed by Henggeler and his colleagues in the 1970s, in response to the limitations of services for this population. In the MST manual’s first edition, they described that the focus of MST was on ameliorating the known determinants of antisocial behaviour within the young person’s family, peer and school networks (Henggeler et al., 1998).

MST is underpinned by Bronfenbrenner’s (1979) theory of social ecology, that describes the nature of human behaviour being multidetermined. It understands that human behaviour is multi-causal, inclusive of antisocial behaviour, and that therefore effective interventions require holding in mind multiple sources of a young person’s social ecology, such as family, school, peer group and community. Henggeler et al. (2009) highlighted the ecological validity in that behaviour can be fully understood only when viewed within its naturally occurring context.Bronfenbrenner (1979, P3) described the ecological system around an individual as like “a set of nester structures, each inside the next, like a set of Russian dolls”. The theory of social ecology is noted as differing from other systems theorems in its focus on broader and contextual influences on a young person’s life. In their later work, Bronfenbrenner (1992) described the ecological systems theory, which depicts the five ecological systems nested within one another: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Neal & Neal, 2013). The microsystem is the immediate environment that a young person lives within and their family; the exosystem is the environment, which indirectly affects the individual; the macrosystem encompasses cultural and societal beliefs, decisions, and actions and the mesosystem captures the relationships between the microsystems (Bronfenbrenner, 1992).

### MST Theory of Change

Henggeler (1998) drew on Bronfenbrenner’s (1979) theory of social ecology, in his MST Theory of Change. The principal assumptions in MST Theory of Change (Henggeler et al., 2009) are that antisocial behaviour is driven by an interplay of risk factors associated with multiple systems in a young person’s life. Subsequently so, effective interventions should address the array of risk factors in the system, whilst in parallel building on and up the protective factors of the system. Additionally, a second assumption is that families are critical to achieving and importantly sustaining prosocial behaviour. The focus of MST therefore is seeing caregivers as the main conduits and facilitators of change; and that by empowering caregivers it is theorized that this will improve family functioning and behaviour throughout the family’s ecology. The MST Theory of Change is provided in figure 3. Henggeler et al. (2009) described the process of MST as collaborating with the family, to overcome barriers and increase caregiver effectiveness. The role of MST can be seen as MST therapists supporting caregivers to design and implement interventions for their young person in areas of peers, school and community, in order to improve functioning across the young person’s system to decrease antisocial behaviour. With all this in mind, the ultimate aim of MST can be seen as changing the system around a young person that may be seen as conducive to antisocial behaviour, to a system that surrounds a young person that encourages prosocial behaviour.

**Diagram

Description automatically generatedFigure 3:** MST Theory of Change (Henggeler et al., 2009)

### MSTtherapy overview

MST is considered a time limited intervention of between 3-5 months. MST therapists can see families several times a week and families have access to an on-call or in person support 24 hours a day (Ashmore & Fox, 2011). MST draws on intervention strategies from behavioural, parent management, cognitive behavioural and family therapy models. Figure 4 conceptualises the MST Analytical Process from referral behaviour to the desired outcomes and overarching goals, to the development of the MST Conceptualisation of “fit”. MST draws from a framework and the general ethos of doing ‘whatever it takes’ to engage families (Ashmore & Fox, 2011). This could position MST as particularly suited to the complex systemic issue that is school refusal (Johnston, 2018; Henggeler et al., 2009).

**Graphical user interface, application

Description automatically generatedFigure 4:** MST Analytical Process

### MST principles

There have been nine MST treatment principles identified that guide MST interventions (Henggeler & Schaeffer, 2016). Principle one is defined as ‘finding the fit’ which describes an assessment “to understand the ‘fit’ between identified problems and how they play out and make sense in the entire context of the family’s environment” (Henggeler & Schaeffer, 2016; P14). Principle two is defined as ‘focussing on positives and strengths’, with therapists emphasizing the positives they find, and using strengths as levers for positive change. Principle three is ‘increasing responsibility’ which speaks to promoting responsible behaviour. Principle four is that the interventions completed in therapy are ‘present focused, action orientated and well defined’. Principle five is ‘targeting sequences’ of behaviour in the interacting systems that sustain the identified problems. Principle six aims to ensure that therapy is ‘developmentally appropriate’ for the family, whilst Principle seven is the ‘continuous effort’ of MST contact. Principle eight speaks to evaluation and accountability and principle nine describes the ‘generalization’ of MST in that interventions should be designed to “invest the caregivers with the ability to address the family’s needs after the intervention is over” (Henggeler & Schaeffer, 2016; P15). Whilst these principles have been identified to be central to the completion of MST, their role and relevance in MST when there are educational concerns remain unexplored.

### MST and Education

In reference to MST’s role in education, Henggeler et al. (2009) reflected that by the time adolescents with antisocial behaviour are referred to MST services, many are already experiencing truancy, suspension, exclusion, and academic difficulties. In response, the systems around young people that are having educational difficulties, are often left feeling frustrated and hopeless, with trajectories thought to be set.

There has been extensive research to date on MST, but there has been limited research looking into the role of MST in relation to education or educational concerns. There has been some research to date that explored the sustainability of change following engagement with MST, that has noted the impact of MST on educational outcomes. In their research on young people’s perspectives of sustaining changes after MST, Paradisopoulos et al. (2019) identified seven theoretical codes. Two of these codes made reference to the school system, in ‘improving interpersonal and systemic awareness’ and ‘having alternatives: strategies and ideas for a preferred future’. They described the impact of the proactive approach of MST therapists meeting school staff to increase the systemic awareness of the difficulties for the young person, that appeared to encourage schools to share stories of progress with parents, rather than stories of difficulties, which are often cited as a source of concern and stress for families (Henggeler, 2009). Additionally, young people had made links between re-instating themselves into education and an increased sense of hope and noted the importance of generating goals for their future for which they could actively pursue and aim towards. Furthermore, other research exploring the long-term impacts of MST by Conroy et al. (2021) found that male adolescents who had received MST had more forward looking, hopeful and mature attitudes and experiences towards the world of work, than their peers who had not received MST. Conroy and colleagues concluded that working with MST during adolescence helped young men “cultivate more mature, forward-looking viewpoints and life activities 4 years later” when transitioning into adulthood (Conroy et al., 2021. P2)

### The importance of education

Education plays an important role on a broad range of aspects in a young person’s life. As previously discussed in the systematic review presented above, research has linked increasing difficulties and disengagement with school, with immediate impacts of falling behind with schoolwork, reduction of academic performance, disruptions to peer relationships and increase in parent-child conflict (Epstein & Sheldon, 2002; Kearney & Ross, 2014) and longer terms outcomes such as dropping out of education, employment difficulties, experiences of mental health difficulties and having more contact with forensic services (Brandibas et al., 2004; Kearney & Bates, 2005; McCray, 2006; McCluskey et al., 2004; Smink & Reimer, 2005 as cited in Balkas et al., 2015). Henggeler (2009) also has reflected on the high-stakes outcomes of young people in regard to educational concerns.

#### Causes and consequences of educational concerns

The causes and consequences of the educational concern of school refusal, have been extensively investigated in research over the last two decades. Research has noted the cyclical relationship between the causes and consequences and reflected on the difficulty for families in breaking these cycles (Reid, 2005). Four main factors have been identified in relation to school refusal, which includes the family, school, peers and the individual (Reid, 2005), which can be seen to map on to the microsystem of the Ecological Systems Theory (Bronfenbrenner, 1979). School refusal and more general educational concerns have also been compared with other childhood difficulties, such as drug-use, self-harm, and anorexia (Carr, 2014; Saito, 1992) in that school refusal can be understood as a ‘symptom’ of difficulties within the system, and a way in which young people have expressed this difficulty through their behaviour (Tobias, 2017).

Furthermore, Government and charity sector reports have highlighted some of the systemic impacts of school changes in the UK. Reports have noted a 60% increase of fixed and permanent exclusions over the last decade (Timpson Review, 2019; Marmot Report, 2020; Royal Society for the encouragement of Arts , 2020). In these reports, excluded young people were acknowledged as having worse trajectories than their non-excluded peers, with exclusion being a high indicator of being a victim or a perpetrator of crime (Serious Violence Strategy, 2018). Furthermore, a third of young people that have been excluded were found to be classified as ‘Not in Education, Employment or Training’ (NEET) later in life (Marmot, 2020). Reflecting on a young persons’ social graces and intersectionalities (Burnham, 2013), young people most impacted by exclusions were male, from black and mixed-race ethnicities, had special educational or additional needs, social care involvement and qualified for free school meals (Timpson, 2019). Young people who had more barriers, such as additional educational needs, family conflict, or poverty, or who were subject to racism, oppression and discrimination, were more likely to experience difficulties within education and were more likely to be excluded. Recommendations from these reports highlighted the need for multi-agency collaborations, funding for assessments of “whatever works” approaches, equipping schools with skills such as trauma-informed teaching and placing importance on safeguarding a young person’s education, and embedding that understanding with the later trajectories.

### Psychological interventions for educational concerns

Research has brought attention to the potential trajectories of young people who have difficulties with school engagement. The focus of subsequent research therefore has recognised the importance of finding effective interventions, with a wealth of research focus on how the system around a young person can intervene. Within the research to date, educational concerns have been conceptualised as school refusal and school behaviour.

#### School refusal interventions

In the meta-analysis by Maynard et al. (2018), the dominant intervention explored within school refusal research was Cognitive Behavioural Therapy (CBT), which has been supportive of prior narrative reviews, which had found positive effects of cognitive and/or behavioural intervention for school refusal (Elliott et al., 1999; King & Bernstein, 2001; King et al., 2000). Despite this, they found that there was only evidentiary support for CBT’s effectiveness in attendance outcomes, and that it was not empirically supported. In their meta-analysis Eklund and colleagues (2020), found more broad interventions inclusive of academic, behavioural and family partnership interventions. They summarized that despite the voluminous research on the causes, correlates and consequences of school refusal, their results suggested that most interventions were understudied, led to small effect sizes or both. The systematic review completed within this study saw the emergence of school-wide and organisational interventions, notably the Positive Behavioural Interventions and Support (PBIS) and CBT interventions finding statistical significance. It is discussed above that there was a trending shift in interventions that were systemically informed and interventions for particular populations within the school refusal area. Whilst there is some initial evidence, more research is needed.

#### School behaviour interventions

Public health and education policies have recognised the reduction of aggression, bullying and violence within schools in the UK as a consistent priority (Department for Education and Skills [DfES] 2003; Department for Children, Families and Schools [DfCDS], 2009). In similarity to evidence within the school attendance interventions literature, systematic reviews exploring psychological interventions for school behaviour have found that whole-school interventions have been particularly effective in the reduction of bullying experiences and victimisation (Vreeman & Carroll, 2007; Smith et al., 2004). Importance has been placed on the schools implementing organisational changes in the taking a socio-ecological approach to the understanding that behaviour is influenced by the wider social context and the need for non-stigmatising approaches towards anti-social behaviour within schools (Dahlgren & Whitehead, 1991; as cited in Bonell et al., 2014). There has also been emerging evidence of other psychological interventions; including a school-based acceptance and commitment therapy (ACT) that improved student wellbeing (Burckhardt, 2015), a group CBT intervention which improved externalizing and internalising ‘disorders’ within schools (Eiraldi et al., 2016) and Positive Behaviour Support and Interventions that were effective at reducing referrals for poor behaviour (Kelm & McIntosh, 2012).

### MST ultimate outcomes

The role of MST within school refusal and behaviour literature remains unexplored. However, the three ultimate outcomes of MST are defined as a young person living at home, having no new criminal charges and importantly being in education, training or employment. Data from MST Services in the UK and Ireland showed that at the time of discharge the percentages of young people living at home and having no further criminal offenses had been met, however percentages of young people in education were at 76.3%. This is considered nearly 14% lower than MST targets which are set at 90% and is 6-11% lower than International and U.S MST teams respectively (MST Data Report UK, 2019).

### Purpose of the study

Within the context of data suggesting that the UK and Ireland MST services are below targets, and lower than international outcomes, this research was conducted to explore the role of MST and educational concerns in the UK. This research aimed to explore the interface between MST and educational concerns in relation to MST referral behaviours. Referral behaviour refers to the behaviour/s that a young person has exhibited that has led to a referral. When thinking about the domain of education, behaviours may include school conduct issues, attendance issues and educational attainments. There has been no research to date (to the author’s knowledge), exploring this interface and therefore this research aimed to produce a model of MST’s role in educational concerns. This research hoped to produce a model to provide recommendations and guidance for MST developers, providers, and clinicians around how to improve current practice and additionally to be built upon with future research.

#### Research question

How does Multisystemic Therapy (MST) address educational concerns from the perspectives of caregivers and stakeholders?

## Methodology

### Design

An exploratory, qualitative method was favoured as this allows for a deeper understanding of an individual’s experiences, thoughts, and feelings of a particular process (Barker et al., 2002; Charmaz, 1995). A Grounded Theory method (Glaser & Strauss, 1967) was adopted due to its suitability in exploring areas of limited research (Chun Tie et al., 2019) and with its distinctive feature of developing theories to explain behaviours (Charmaz, 1995). A Constructivist Grounded Theory approach (Charmaz, 2014) was chosen.

### Rationale for Constructivist Grounded Theory

A Constructivist Grounded Theory was chosen as it was most consistent for the research aims of understanding the experience of how MST impacts educational concerns, in addition to the researchers’ epistemological stance. Grounded Theory methods allow the exploration of individual processes, interpersonal relations and reciprocal effects between individuals and larger social processes; imperative in a therapy, such as MST, situated within Ecological Systems Theory (Bronfenbrenner, 1992). Additionally, in contrast to other qualitative methods, Grounded Theory explores the social processes and searches for the relationships between these processes (Green et al., 2007) which are in line with the research aims. Compared to other qualitative methods such as Thematic Analysis, which identifies patterns in meaning across the data to derive themes (Braun & Clarke, 2006) or an Interpretative Phenomenological Analysis, which explores the meaning making of subjective experiences (Smith et al., 2009), Grounded Theory was selected as the most appropriate methodology.

Grounded Theory is an inductive and comparative methodology; used for collecting, synthesizing, analysing, and conceptualizing qualitative data for theory construction (Charmaz, 2014). A constructivist approach was favoured, over other main versions of Grounded Theory; traditional Grounded Theory (Glaser, 1967) and evolved Grounded Theory (Strauss & Corbin, 1990; 1994; 1998), due to its view of reality being constructed and not discovered (Charmaz, 2014). This contrasts with other approaches that have positivistic assumptions and do not note the epistemological position of the researchers.

Additionally, Constructivist Grounded Theory was chosen due to its recognition that the researcher has an impact on the work. Constructivist Grounded Theory methodology defines reflexivity as a critical element in ensuring the groundedness of a theory (Ramalho et al., 2015). Therefore, in an aim to acknowledge the researchers’ own assumptions and biases and how they shape constructions; inclusive of their own experiences of education and truancy, their own experiences of psychological theorems and values of social justice; a reflexive stance was considered important to prioritise (Charmaz, 2014). Reflexivity was instrumental in acknowledging times when the researcher’s preconceptions meant concepts were potentially overlooked (Vrasidas, 2001). This research endeavoured to provide constructions of individual’s accounts of experiences of MST when there are educational concerns, which honour the context in which they currently exist within and how they were constructed in the interviews (Fitzpatrick & Christian, 2006).

### Epistemological stance

Transparency around the epistemological stance of the researcher is important as it influences the research; in particular how the researcher understands the nature of reality (ontology) and how we gain knowledge from it (epistemology). This research will reside within a social constructionist stance (Berger & Luckmann, 1991) which has influenced constructivist Grounded Theory (Charmaz, 2000). Constructionists view knowledge and truth as created, and therefore not discovered by the mind (Schwandt 2003, as cited in Andrews, 2012), so that the description of an individual’s truths is mediated through language, meaning-making and social context (Houston, 2010). Adoption of a constructivist Grounded Theory approach allowed the researcher to contextualise aspects of the objective world and constructs from the social world that influence and at times determine the link of causation (Taylor, 2018).

### Ethics

Ethical approval was granted from Royal Holloway, University of London, Research Ethics Committee on the 15/10/2021 (Appendix B). The project was conducted outside of NHS settings and therefore ethical approval from the Health Research Authority within the NHS was not required. As caregivers were interviewed, MST Services UK and Ireland permission was sought, and local site ethics procedures were followed.

#### Ethical considerations

It was considered that interviews about people’s experiences of their child’s difficulties and subsequent therapy, could potentially be upsetting or distressing. Throughout the interviews, the researcher responded to any distress, expressed by participants, with compassion and validation. The researcher and the research team also proactively considered safeguarding measures to mitigate any risk that may present, inclusive of discussion of confidentiality in the information sheet and at interview and having a debrief sheet (Appendix C) which included appropriate services for participants to access, should they require it. The research team and MST therapy teams offered support to the researcher throughout the conduction of interviews.

### Consultations with MST professionals and service-users to support co-design

Consultations were firstly held with MST professionals, to familiarise the author with the MST model, to understand the different education systems across the UK and to understand ethical trust procedures. When meeting with UK MST sites, it was a shared intention to have a participatory informed design in this project, with MST therapists, educationalists and service-users informing the design and materials. Additionally, consultations with research supervisors, an MST therapist and a caregiver, who had engaged with MST and who worked as a teacher, supported the co-design of this research. Discussions had around the studies procedure informed the chosen methodology of individual interviews, instead of focus groups or mixed method designs previously used (Drew et al., 2019). This was chosen in an acknowledgement of this being a potentially difficult area to recruit and further ethical considerations such as feeling uncomfortable discussing experiences with other caregivers. Additionally, when reviewing content and language of the information sheets, consent forms, demographic forms, and interview schedules: feedback informing the final documents were the inclusion of follow up questions and altering language between the differing schedules, such as “drivers of behaviours” for “contributions to educational problems”.

### Sample criteria

#### Participants and setting

There are 22 UK ‘Standard’ MST teams, who supported over 600 young people in 2019 (MST Data Report UK, 2019). In addition, there are specialised MST teams, with the MST Child Abuse and Neglect (MST-CAN), MST Family Integrated Transitions (MST-FIT) and MST Problem Sexual Behaviour (MST-PSB), however this study was situated within MST Standard teams. A total of 14 individuals were recruited from three MST Standard teams across the Midlands and the north of England. There were four caregivers, three educational professionals and seven MST clinicians (five therapists, two supervisors). A further three educational professionals were identified, however despite initial agreement to take part, interview dates were postponed or never found. Demographic information from research demographic forms (Appendix D) is summarized in table 3-5 in order to situate the sample (Elliott et al., 1999), and to allow for transferability and relevance of the study.

#### Participant demographics

Table 3: Caregiver demographics

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Pseudonym | Described caregiver gender | Described caregiver ethnicity | Described relationship to the young person | Described gender of young person | Age of young person at referral |
| Andrew | Male | White British | Parent | Male | 17 |
| Becca | Female | White British | Parent | Female | 13 |
| Cecile | Female | Mixed Black Caribbean | Parent | Male | 16 |
| Davina | Female | White British | Parent | Female | 14 |

To preserve anonymity, geographical location was separated out from the demographic characteristics. Three parents were in the Midlands, and one in the North of England.

Table 4: Educational professional demographics

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pseudonym | Role | Described gender | Described ethnicity | How many families worked with |
| Evelyn | Educational Psychologist | Female | White British | 8+ |
| Frank | Headteacher | Male | White British | 2 |
| Gerard | SENCO | Male | White British | 2 |

To preserve anonymity, geographical location was separated out from the demographic characteristics. Three parents were in the Midlands, and one in the North of England.

Table 5: MST professional demographics

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Pseudonym | Role | Described gender | Described ethnicity | How many years working in MST? |
| Haima | MST Therapist | Female | Mixed British | 5-7 years |
| Isabel | MST Therapist | Female | White British | 2-4 years |
| Jade | MST Supervisor | Female | White British | 11-15 years |
| Kristen | MST Supervisor | Female | White British | 2-4 years |
| Lena | MST Therapist | Female | Mixed British | < 1 year |
| Marcel | MST Therapist | Male | Black African | 2-4 years |
| Nadiya | MST Therapist | Female | Asian British | 2-4 years |

To preserve anonymity, geographical location was separated out from the demographic characteristics. Three parents were in the Midlands, and one in the North of England.

#### Inclusion criteria

The inclusion criteria for caregivers were caregivers who had engaged with a Standard (non-adapted) MST team where there were concerns around education; over a period of three-five months within the two years prior to the interview and who had English language fluency. There was no criteria for age of children, as MST services works with children aged between 12-17. Exclusion criteria for caregivers were those that disengaged before completion, where education concerns were not a referral behaviour, and caregivers that engaged with adapted MST teams. The inclusion criteria for Educational Professionals were that they had been involved with or supervised work with a ‘Standard’ MST team. The exclusion criteria where when an educational professional had no awareness of or involvement with a family who had been involved with MST. Inclusion criteria for MST professionals were that they had been involved with a young person who had experienced problems within education, such as truancy, behavioural difficulties, or school refusal. Exclusion criteria for MST professionals were therapists or supervisors who have only worked in an adapted MST service, such as MST Child Abuse and Neglect (MST-CAN) or MST Family Integrated Transitions (MST-FIT).

#### Recruitment

A theoretical sampling approach was used, as is often used in Grounded Theory methodology (Charmaz, 2014). Recruitment was purposive, in order to identify and select individuals experiencing the phenomenon that was hoped to be explored (Cresswell & Plan Clark, 2011), in the experience of MST when there are educational concerns. There was not an identified sample size in this study, as is traditional in Grounded Theory, as this is superseded by data saturation (Charmaz, 2014). There is limited guidance on data saturation, and this concept is problematic within a constructivist methodology in the assumption of there being a knowing place of ‘saturation’. An alternative to data saturation is the aim for well-developed categories composed of depth and variability (Daniel & Poole, 2009). Therefore, this study aimed to recruit until a theory had been constructed, without adding any new categories.

### Materials

Three interview schedules were initially developed for caregivers, educational professionals and MST professionals (Appendix E). The schedules were based on the aims of this research, as well as being informed by previous literature (Kaur et al., 2017; Drew et al., 2019). Schedules were also influenced by Constructivist Grounded Theory methodology, particularly in the encouragement of the open-ended interview-style and questions in the aim to allow individual stories to emerge, and discussion of the processes in an individual’s experiences, thoughts, feelings and actions (Charmaz & Belgrave, 2012). The interview schedules were reviewed by the research team, an MST therapist, and a service-user.

The three interview schedules ranged from 25-34 questions. All schedules contained questions within the same themes; referral, focus of therapy, review of therapy, impacts of COVID, end of therapy and sustaining changes. Schedules differed in reference to language, for example in the caregiver interview schedule a question asked was “what do you think led to some of the difficulties within education?” In the educational professional schedule, the question was “what do you think are the contributions that led to difficulties within education?” In the MST professional schedule “What do you think are some of main drivers that have contributed to difficulties within education?”

Demographic information was collected via the demographic information sheets from all participants (Appendix F). The age, gender, ethnicity, relationship to the young person, age and gender of the young person and time since completing MST, were collected from caregivers. Role, how many years they had worked in MST (MST professionals) and how many young people they have worked with, known to MST (educational professionals) were collected from MST and educational professionals.

### Procedure

In respect of sampling procedures, MST professionals were recruited via responding to a research invite email sent to all MST teams. All 22 MST teams were contacted. In respect of the response rate, of the MST Therapists who responded to the research invite, 100% then took part in the interview. To recruit caregivers and educationalists, contact was made to three MST teams to inform them of the project and inclusion criteria. MST therapists and supervisors then contacted appropriate caregivers and educationalists about the study and shared the research poster. In respect of response rates, of the caregivers that consented to be contacted, 100% then took part in the interview. The response rate for educationalists was 50%. After consenting to be contacted, caregivers, MST professionals and education professionals were provided with an information sheet (Appendix F) and consent form (Appendix G) via email. After reading the information sheet, a suitable time was arranged over email. Consent was obtained via email, or verbally before an interview, as some participants were not able to sign electronically. Interviews were all conducted virtually, either over the phone or via video conferencing software of their choosing. Overall, 14 interviews were conducted with each approximately lasting between 30-120 minutes and were all audio recorded via video conferencing software. One interview with a caregiver was terminated, as it was mutually agreed to stop the interview after 30 minutes as the caregiver became distressed, when reflecting on their experiences in the COVID-19 pandemic. This interview data has been included in the analysis as the caregiver did not wish to withdraw consent.

#### Interview procedure

Before the interview started, the researcher framed the context and content of the project (Charmaz, 2014), reviewed anonymity, right to withdraw and shared the encouragement of taking breaks and welcomed stories and anecdotes. The interviews consisted of a dialogue between the researcher and the participant, which was guided by the interview schedule, but also supplemented by follow-up questions and comments (Dejonckheere & Vaughn, 2019) to ensure meaning and understanding were created in the interaction, which allows construction and reconstructions (Edward & Holland, 2013). Topics, themes and issues were built on from conversations with MST services, the service-user and also more widely from research around psychological intervention for school refusal.

### Analysis

Interviews were transcribed verbatim, and data was analysed using NVivo 12 software. Data collection and analysis co-occurred, which facilitated emergence of concepts directly from the data through consistent comparative analysis (Charmaz, 2014). Memos were used throughout as a form of primary analysis, and recorded thoughts, feelings, insights, and ideas of the study author concerning the research aims (Appendix I). Memoing was used to capture ideas about potential relationships between codes and categories. Data analysis followed the phases described by Charmaz (2014) of initial, focused, and theoretical coding.

*Initial coding* included the line-by-line method, that codes each line of a transcription (Ramalho, 2015), that reflects an action. *Focused coding* followed, which involved reviewing initial codes to identify codes frequent or significant in meaning. As focused codes were developed, they were combined into initial categories and subcategories, which involved clustering different focused codes under a higher conceptual category. This helped explain key ideas and crucial social processes and began to identify the theoretical direction of the results. The final phase is *theoretical coding* which consisted of refining the final categories and specifying the possible relationships between them (Charmaz, 2014). The researcher and research team reviewed and discussed the development of initial categories and sub-categories. This process was completed by reviewing sources and references through NVivo, memos, comprehensively going through transcripts to reflect on relationships between concepts and using supervision for reflexivity and objectivity. The outcome of this process was the formation of the Grounded Theory model, and its initial categories and subcategories. The initial Grounded Theory model was then shared with participants, in the process of member checking: to elicit feedback on the representativeness, credibility and accessibility of the model. Two follow up interviews were completed with an MST therapist and a caregiver, with three other responses from MST supervisors and an educationalist over email. Outcomes of this process was to amend the language of subcategories for example subcategory 4b “overcoming barriers to engaging in education” was developed with the MST therapist, as previously this was overcoming practical barriers. Example transcripts, coding procedures and previous models are shared in the appendices (Appendix H and J).

## Results

Six overarching categories were constructed from the data. These were ‘Understanding factors contributing to the educational problem’; ‘Working on the home relationships’, ‘Building and aligning the system’; ‘Flexibility of the MST model’; ‘Increasing responsibility’ and the ‘Legacy of MST’. These six categories encompass thirteen sub-categories, which are outlined in table 6. The Grounded Theory model constructed is shown in figure 5.

The model adds to the current understanding of MST, by informing its process within the context of educational concerns, which has previously not been understood. The model demonstrates that MST therapists are required to navigate and attend to multiple systems simultaneously, and what such processes are. Whilst there is a linear process presented, this differs with each family and the bi-directional arrows allow for the movement between parts of the process and highlight the fluidness of processing through the model.

Table 6: Grounded Theory model of MST’s addressing of Educational Concerns

|  |  |
| --- | --- |
| **Categories** | **Sub-categories** |
| 1. **Understanding factors contributing to the educational problem** | 1a. Understanding of difficulties from the system |
| 1b. Introducing how difficulties relate to the system |
| 1. **Building and aligning the system** | 2a. Building relationships with education and external agency |
| 2b. Breaking down the culture of blame, and identifying strengths across systems |
| 2c. Connecting, rebuilding and instilling hope in the value of education |
| 2d. Working towards a shared goal |
| 1. **Working on the home relationships** | 3a. Caregivers having a safe space to reflect |
| 3b. Spending time on relationships and communication |
| 1. **Flexibility of MST model** | 4a. Using behavioural FITs to inform interventions |
| 4b. Overcoming barriers to engaging education |
| 1. **Increasing responsibility** | |
| 1. **Legacy of MST** | 6a. Empowerment of the system to support and sustain |
| 6b. Continuous use of MST intervention after closure |
| 6c. Potential for interdisciplinary training and shared learning experiences of practice |

Figure 5: Grounded Theory model of MST’s addressing of Educational Concerns

**BUILDING & ALIGNING THE SYSTEM**

Building relationships with education and external agency

Breaking down the culture of blame, and identifying strengths across systems

Connecting, rebuilding and instilling hope in the value of education

Working towards a shared goal

**UNDERSTANDING FACTORS CONTRIBUTING TO THE PROBLEMS IN EDUCATION**

Understanding of the difficulties from the system

Introducing how difficulties relate to the system

**WORKING ON THE HOME RELATIONSHIPS**

Caregivers having a safe space to reflect

Spending time on relationships and communication

**INCREASING RESPONSIBILITY**

**FLEXIBILITY OF THE MST MODEL**

FIT formulations informing interventions

Overcoming barriers to engaging with education

**LEGACY OF MST**

Empowerment of the system to support and sustain

Continuous use of MST intervention after closure

Potential for Interdisciplinary training and share learning experiences of practice

### Category 1: Understanding factors contributing to the problems in education

This first category places the importance on the initial understanding and conceptualisation of the difficulties present within education and more widely in the system. These processes have been constructed in to two subcategories: ‘Understanding the difficulties from the system’ and ‘Introducing how difficulties relate to the system’.

#### Subcategory 1a: Understanding of the difficulties from the system

This subcategory speaks to MST gaining an understanding of what the difficulties are; both from the family and the wider system. The importance of understanding the problem by MST, was shared by Lena (Therapist) “It’s about really understanding and getting to know what is going on for them”. Practically this looked like getting to know “What is the frequency, intensity and duration?” (Jade, Therapist). Therapists also spoke to going beyond understanding in that the process of understanding meant bringing in empathy and “really validating how difficult it is” (Lena, Therapist). Therapists also shared widening the understanding by hearing how the wider systems made sense of problems, “I am really keen to get a really clear definition of what the issues look like, with the family and with other systems” (Jade, Therapist). There was a held view that understanding also appreciated that people make meaning out of behaviours and experiences differently, which impacts on how they may formulate or respond to the difficulty.

Kristen, Therapist: Trying to get a really good understanding of what ‘it’ is? So, making a FIT around to get all the drivers from everyone involved. What does school notice? What does mum and dad notice? What does the young person notice?

Lena, Therapist*:* What does them threatening actually look like? Is it a reaction? Are we acting out of fear or anxiety? Or is there a real concern around what this child might do? Because actually then our responses would look very different dependent on what that looks like.

Educationalists also spoke to the stuckness of the system with the present problems, and their appreciation of having someone new to join the system to help in the systems understanding of what the challenges are for the young person, the home, the school and the wider community. An educationalist spoke about how “MST was like having a fresh pair of eyes to look at everything, to look at what is going wrong? In the home. Here at the school. In the community” (Gerard, Educationalist).

#### Subcategory 1b: Introducing how difficulties relate to the system

The second subcategory describes the secondary process that takes place after understanding the problems within the system. Participants spoke to beginning to understand difficulties systemically. Therapists shared that “a lot of schools focus on the individual drivers, so we’re hoping to [help] schools to think more systemically” (Haima, Therapist). The introduction of systemic understandings or formulations, allowed to draw relationships between difficulties experienced within the system. This was also spoken to by educationalists, who shared that MST helped them see the problems within the system in which they had developed and the learning that they had from MST in “essentially just the very premise that we are not putting the problem within the children” (Evelyn, Educationalist). This subcategory speaks directly to building on the understanding of the problem from the system. Participants described the important part of understanding the difficulties within their context.

Jade, Therapist:[The system] clump the behaviour and the child [together]. You can love your child, but hate their behaviour, and it’s sitting with that, just that understanding that children are always communicating to us all the time. It would be great if they could say “you know what mum I find English incredibly difficult” – but they don’t. So, it’s up to [the system], to work and understand what is going on.

Participants also spoke to introducing the understanding of trauma and the concept of trauma informed approaches within MST. This further situates the problem within the system in which it resides, and by that concept that the problem is understandable within the experiences of the system. This appearing to promote further understanding the young persons’ behaviour and the issues within the system.

Haima, Therapist: helping staff to understand about trauma and using a trauma focused lens, because majority of the kids we work with either had some form of abuse or neglect when they were younger, so those early attachments have been disrupted. Sometimes I think schools can reinforce those negative cognitions around rejection, shame and so helping schools to understand using that trauma focused lens and how that could impact on the child's readiness to learn.

Participants also spoke to some of the wider potential misunderstandings within the system. Therapists spoke to situating the school within their context, in there seeming to be a “business model applied to education, policy and how you deal with behaviour” (Isabel, Therapist) and how that “one set approach doesn’t work for everyone”. With “schools’ priorities [being] very different to [MSTs]”, therapists spoke to understanding education within its system, “in the sense that they have 1000 children potentially that they are looking after” (Lena, Therapist). Furthermore, therapists placed importance in understanding the big investment MST requires for educational professionals, Haima (Therapist) shared that “If [a child is] in a mainstream school, it is asking them to put a lot of intervention specifically around one young person”. The importance of understanding the system in its entirety and from multiple perspectives was spoken about by most participants. The compassionate understanding of problems and challenges was seen from caregivers, in their developing understanding of their child’s behaviour within its context.

Davina, Caregiver: We were shouting at one another and then in the heat of the moment, I said, “I want you out, I am calling social services”. After some time, our daughter had come down and told us everything about what had been happening. I realised how much pressure she had been under. It was a heat of the moment thing, and that’s why I reacted like that. So, I gave her a big hug.

### Category 2: Building and aligning the system

Many therapists placed importance on the simultaneous processes of working with the family and building and aligning with the system. This category describes how MST builds and aligns with the system, that elicited four subcategories: ‘Building relationships with education and external agencies’, ‘Breaking down the culture of blame and identifying strengths across the system’, ‘Connecting, rebuilding and instilling hope in the value of education’ and ‘Working towards a shared goal’.

#### Category 2a: Building relationships with education and external agencies

Most participants spoke about the identification and engagement of people and professionals that could be fundamentally helpful in supporting the difficulties within the system; with most sharing in the view of its ultimate positive impact in creating a foundation for sustainability and longevity. Participants shared that in terms of embedding this as a “sustainable process” was “having and finding people, finding that group of people, [that are able to] support the kids at school, and also indirectly supports the parents at home” (Evelyn, Educationalist).Educationalists also spoke about MST bringing together “the whole package” (Frank, Educationalist). He went on to share that “the thing about MST is it’s starting to bring together a package around [the child] who bridges the school and home.” More specifically therapists spoke to the importance of identifying the “appropriate educational setting” in an acknowledgement of the learning needs that some young people who experience educational concerns may have, with these needs not being fully understood. Therapists shared how this is a “positive strength” of MSTs role in addressing educational concerns (Haima, Therapist). As the model has been constructed, Haima shared the importance of “getting that ball rolling from the start”, in that in having more appropriate settings and having a system that is able to help with the problems being experienced within it, is part of MSTs role. Moreover, participants placed emphasis on not only having the right services and settings involved, but also having the key decision makers of those systems involved.

Frank, Educationalist: MST creating that collaborative space... and with me was important. As the decision maker, at the top of the school, it needed me at that point to go “yes I will agree to that”. Whereas I think if the conversation had carried on taking place with just the head of year, they may not think they have the permissions to make that decision.

Participants had varied experiences of recruiting everyone necessary within the MST therapy. Caregivers reflected on the impact of when MST had not been able to engage and bring some of the key systems involved in the young person’s life.

Andrew, Caregiver: Everybody else could have got a lot more out of it. [My son] could have. His mum could have. The only person that has really benefitted from it is me. As much as I have gained from [MST], I just don’t see the point because I have got all this from it. I have all these tools, and then [my son] is going to go to [his mum], and she’s going to communicate with him the way she always has. Which is very much the way I was doing and getting it completely wrong.

#### Category 2b: Breaking down the culture of blame and identifying strengths across the system

The second subcategory constructed as part of MST building and aligning the system noted the impact of blame. Many participants spoke about blame, both in experiencing it towards themselves and in its application to other parts of the system. Participants noted blaming the young person, education, parents and more widely the government in not doing enough, and being, to some extent, responsible for the educational problems. Caregivers spoke to perceiving blame from school; “When you have a child that is playing up, [they may think that] it might come from home, because they’re not being looked after properly” (Davina, Caregiver).Blame was also placed on other parts of the system; “my daughter was in some really dangerous situations. I blamed social services, I blamed the government because of the funding” (Davina, Caregiver).Therapists also shared their experiences of school feeling blamed and not doing enough; “It can feel like people have that lack of appreciation that they are managing a whole school, with a lot of young people, and their focus is not on that one that we’re asking them to focus on”. (Jade, Therapist)

Challenges were apparent in the experience of blame within and by the system; however, participants spoke to the role of MST both in the acknowledgement of these experiences but also in the movement to a place of noticing the strengths of the parts of the system. Participants shared that MST had supported the deconstruction of blame, and the promotion of strengths, both of themselves but also in other parts of the system; “to have the support, from MST and everyone liaising with one another. It just felt like it was reinforcing, and what we wanted. It helped eliminate any self-doubt” (Davina, Caregiver).

Haima, Therapist: communicating to schools that you recognise their noble intent is important because for them they’re feeling that frustration, and it’s that transference of emotions you're feeling. We want to acknowledge how difficult it is. Being empathetic with them and validating really helps and then being strength focused with schools, is understanding that they are doing the best they can to support young people. Whilst drawing on the school's expertise, knowledge and experience.

Cecile, caregiver*:* [MST] really reminded me that I am a strong person. [My son] was diagnosed when he was four. They reflected on him still living with me, and not ending up in a foster care or something. I thought I was failing for finding it hard, but they really admired me as a strong woman. Well, I feel so good. You know that someone seen something in me.

Despite the impacts of feeling blamed or that others placed the problems responsibility on them, participants spoke of how MST had moved them from noticing the problems within the system to noticing of the strengths of the system. These contrasting positions demonstrate the complexity of MST’s role within educational concerns, in the process of breaking down the culture of blame for different members of the system, in order to create space for identifying strengths across the system.

#### Category 2c: Connecting, rebuilding, and instilling hope in the value of education

This subcategory describes the interaction between the system and their values towards education. Participants reflected on the historical relationships with education, the impacts of a persons’ intersectionality and the intergenerational value of education. Therapists reflected on their position of “appreciating from almost the social graces point of view” in that the system may “have different expectations and understandings around education” (Haima, Therapist).Others reflected on the impacts of social graces such as poverty or housing issues, and that if a family’s “basic needs are not being met, then education isn’t always a priority” (Nadiya, Therapist). Therapists also reflected on the intergenerational value of education, and that “Sometimes you get families were there have been generations that haven’t had a great experience of education and that is passed on to the next” (Marcel, Therapist).

Participants reflected that only on developing an understanding of an individual’s relationship with education and getting a better understanding of its history, could conversations move in to reconnecting with the potential value of education for the young person.

Jade, Therapist*:* Some of the work we have done is around aligning the parents with how much they value education. Some have had a really lousy experience themselves of education so they’re not really seeing the value to it. So, some of the work has been to shift their cognitions about education. One dad said to me recently he didn’t achieve in school, so he didn’t get their full potential, and they want their child to have a better future than what they’re doing.

Marcel, Therapist:reframing grandma’s outlook on school. Quite often she was getting stuck in thinking about that immediate day, and not thinking about the long run. If this continues, he will never get his education. He was an extremely bright kid. Where do you want him to be in five years?

Additionally, participants spoke to the relationships towards the safeguarding of a young person accessing education. Moreover, therapists reflected on the attitude of educationalists towards the young person and the safeguarding of education itself, and how that can be a barrier to accessing education. Similarly, towards connecting with a family members experience, therapists noted that MST’s role was to hear the relationship between the educationalist and whether education should be safeguarded for every child.

Isabel, Therapist: I think from schools’ point of view, we’ve definitely got an element of whether they like the young person or not. You know, and that makes sense, doesn’t it? It’s easier to invest if you find something appealing about somebody.

Striving to connect people and professionals from a young person’s system to the value of education for every young person, was something spoken about by most participants. Difficulties were found when members of the system had difficult experiences or where there was limited safeguarding of education for every young person. Therapists spoke to the reparation of hope for education, connecting them with the hopes of the future for the young person, and with the needs of the school. Marcel, therapist shared that schools have their “vested interest” in getting a young person attending school, and sometimes that is “about the kid, it is about the statistics, it is about money” but that the overarching concept “is about attendance”.

#### Category 2d: Working towards a shared goal

The final part of building and aligning with the system, speaks to working towards a shared goal. Participants reflected on the ‘different agendas’ that different members of the system had, but on the importance of having shared goals to work towards. Participants made reference to MST changing the language being used; “It is having the ‘we’ around this, rather than ‘us’ against ‘them’. So, it’s a ‘we’, we are working to the same goals” (Haima, Therapist). Many described the ease in connecting with the goal of getting the young person in to school, with benefits for education in meeting targets, the parents having access to ‘childcare’ and the young person being able to be with friends and reduce conflict, both at home and at school.

Frank, Educationalist*:* I think we were always advocates of one another which helped. Because it meant that the family and the pupil saw us as a united. We were united in working with the family. But it was that unification and that narrative that really helped.

Kristen, Therapist:getting that understanding that … ultimately everybody wants that young person to be doing well at school. No matter who they are. That’s the main goal so how can we work with you, to support you, to get you to that goal. It may not be particularly smooth, like we may want it to be. But that’s what we are there for. We are going to smooth those bumps out. To make it easier for everybody, so that we can get that goal at the end.

### Category 3: Working on the home relationships

Following the system developing an understanding of the difficulties, and situating them in the context, and amongst the simultaneous development and alignment of the system, participants spoke to the importance of focusing on the home. Therapists spoke of the importance of engaging two “powerful systems that are involved in that child’s life” and that “…as we work with a family, we should start right from day one, engaging the education system” (Jade, Therapist). This category relates to MST attending to the home and family systems, with two subcategories being constructed from the data; ‘Caregivers having a safe space to reflect’ and ‘Spending time on the foundations of home relationships’.

#### Subcategory 3a: Caregivers having a safe space to reflect

Many caregivers described one of the first processes for them in MST was the creation of a safe place to reflect on the difficulties that the family had been experiencing. Caregivers shared that prior to MST that often they had a number of experiences with other services that had tried to support their concerns for their child.

Andrew, Caregiver*:* The difference between [MST] and everyone that came through my door was that [the MST therapist] asked a question and I answered it, and it went from there. Whereas other people that came into my property where saying “have you tried this?” “Have you tried that?” and it were like “yes, I did that three month ago … or six month ago”.

Caregivers spoke to MST having a different approach than other services, in that other services had come with agendas and strategies; “he was reading from a piece of paper” (Andrew, Caregiver). Whereas MST came to understand how the problems had come to be. It was spoken about MST wanting to get to know families and appreciating that every family is different. MST’s understanding problems within the system, appeared to encourage caregivers to reflect on how they were trying to care for their child. Facilitation of a reflective space to think about the problem, rather than stepping into problem solving or following a scripted agenda, as other services had previously done, appeared to be an important role of MST.

Davina, Caregiver:[MST] wanted to know how we were communicating. At the time we thought we were doing everything right, putting down the rules [and] the boundaries. What we weren’t realising was that, and this is what we learned about MST, is that your children can pick up on your anxiety. She was so angry, and if we were seen to be upset or defensive, it didn’t help.

Andrew, Caregiver*:* [The MST therapist] changed my whole thought process, took emotion out of it, completely. I used to pre-judge my son before he’d open his mouth. I had already set myself up on a thought pattern that were never going to benefit me, neither him. She just showed me that the destination was the right place, but I was going down the wrong path. The destination was always the destination, but the journey were different. I had to retrain my brain after 17 years of being a parent and 17 years of parenting a certain way.

Data suggests that when MST approaches from a point of understanding, that it creates a space in which caregivers can reflect and making meaning on the problems that have been happening for them and their child. Caregivers spoke positively of MST asking questions about what had been happening, and this gave opportunities to reflect on what was happening at home.

#### Subcategory 3b: Spending time on relationships and communication

Building on from the safe space that MST creates for caregivers, participants spoke to the spending of time on the relationships and communication styles at home. This subcategory moves from acknowledgement and reflecting upon the challenges at home, into more action focused responses. Caregivers noted that relationships and communication at home was crucial in the addressing of educational concerns, as positive home relationships were important in setting the foundation for going into school.

Andrew, Caregiver: [Education] were always at the forefront, but there were no point the MST worker helping with this education thing if I were going to go up and take the covers off, and shout at [my son]. It were more important for us to get our relationship on track, as she said you start with one thing and other things start falling in to place.

Davina, Caregiver: It was all about, ‘connection not correction’. Because correction is like, right you’re not getting your pocket money this week, you’re grounded. What we were learning was, she was shouting at us, and before MST, at times I was defensive and I shouted back. But we learnt through MST, staying calm and saying, “how can I help?” “I want to help”. You know that kind of thing, it makes such a difference.

Therapists also reflected on the need to spend time on the home environment prior to engaging parents in supporting the difficulties within school. Emphasis was placed on how the home is a foundation to be built upon.

Isabel, Therapist:sometimes when we come in everything feels like they have gone so bad that I just try and find a way to be still again. Part of that is working with the parents. Quite a lot of the intervention does depend on you getting the parents to a place, where they can start to be more effective with the school stuff. You have to sit there, it’s that MST thing I can’t get there, without this thing here.

### Category 4: Flexibility of the MST model

The fourth category is defined as the ‘flexibility of the MST model’, which conceptualises two subcategories in ‘Using behavioural FITS to inform interventions’ and ‘Overcoming barriers to engagement in education’. Participants spoke to the relationship of this category and the previous categories of ‘Working on the home relationships’ and ‘Building and aligning the system’ as bi-directional, as these processes were not a one-time event or dormant process but something that was constantly navigated between throughout the course of therapy.

#### Category 4a: Using behavioural FITS to inform interventions

Participants spoke to MST interventions being “the ‘what works for XYZ plan’” and that interventions were “whatever works with this young person” (Haima, Therapist). It was acknowledged that interventions “look different for every family, because even if we have the same problem with two different families, the route you take to that outcome is massively different for both” (Kristen, Therapist). Flexibility was noted as a strength of MST and individualising interventions for the system and context that the problems resided within. Whilst drawing on lots of models and approaches, therapists also acknowledged there being a process to the flexibility; “I think that’s the beauty of MST, not only do we put plans in place, we review what’s worked and what hasn’t. And we keep going through the analytical process, that holds people and the process accountable” (Jade, Therapist). Caregivers also spoke to the experience of the ‘whatever work plans’; “Everything that was an issue, or a problem, or evidently flagged up by my MST worker would be concentrated on. She would zone in on those and we worked on those things specifically to get them nailed down as much as we could” (Andrew, Caregiver).

Additionally, it was shared that as well as being guided by the family and by the FIT formulations, MST is also informed by a range of evidence-based models. Therapists spoke about a range of differing models and approaches, including embracing facilitating communication, completing psychoeducation and then more widely drawing from behavioural, systemic, motivational interviewing and cognitive models. Participants reflected on the flexibility of MST being able to utilise a range of tools and strategies depending on the FITs.

Haima, Therapist: really breaking down into; these are the triggers; these are the warning signs. Making [difficulties] really behaviourally explicit, so instead of using quite woolly language, using examples that the teachers can see” […] “Breaking it down in like cognitive behavioural kind of aspect. What are the cognitions for the young person? What does the behaviour look like? Some of my de-escalation or what work plans looks at a systemic approach, so it looks at what the parents do? When did the teachers call on parents for example, early on in the sequence support with deescalating the child's behaviour, rather sending the child home. So it gets a combined collaborative approach again.

#### Subcategory 4b: Overcoming barriers to engaging in education

This second subcategory of the flexibility of the MST model was constructed as MST overcoming the barriers identified that impacted on education. Participants reflected on MST’s action-orientated stance; noting the practical, relational, and emotional barriers that were impacting education and pragmatically supporting the system to overcome them. Andrew (Caregiver) reflected on MST not only being about “counselling you” but that “[the MST therapist] actually phoned other agencies, charities and basically sorted out a laptop for [my son]. She got him the laptop, [and] bought him a memory stick. All he had to do was flip it open, and off he went.”Therapists also noted the practical barriers that got in the way for families that they had worked with.

Isabel, Therapist:I was working with a family, and they had such little money, that school had said we’ve got you a laptop, you just have to come and pick it up. [Dad] had to get the bus, like it wasn’t reasonable for him to walk. He had to wait for his benefits to be paid, so he could buy a mask so he could get on the bus. It’s just those small and really easily missed barriers, and for that man, school could have been like “why hasn’t he gone to fetch it?”

Whilst there were barriers in the relationships and communications in the system and educational provision, other barriers were noted as ‘getting the small things right’ (Kristen, Therapist). Therapists spoke of the impacts of identifying the small things and supporting caregivers to find ways to notice and overcome them.

Kristen, Therapist: the caregiver was working really hard with them after that. To make sure that they were getting up, leaving on time, had the right bus fare, had the right uniform. All those little things, that people don’t think make a big difference, but may make a massive difference.

In addition to the practical barriers, there were also barriers within education itself such as the young person experiencing additional needs that were not being supported. Participants reflected on young people having diagnoses and experiences suggestive of Autism Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD) and Dyslexia. Therapists reflected on meeting young people who were struggling and being able to “tell [the young person] had additional needs” and seeing their roles in asking “have you been assessed?”. Therapists shared that their role was “trying to support the parents […] and letting them know that they can [get their child assessed] and that’s their right” (Nadiya, Therapist)*.* Furthermore, therapists reflected on “supporting parents with moving through the [Educational Health Care Plan] processes, and you know applying that MST way, at looking at what’s needed here? And how do we meet this?” (Isabel, Therapist)

### Category 5: Increasing responsibility

This category refers to a process that takes place throughout MST. Data suggests that the increasing of the system’s responsibility happens from early on in therapy. This category is conceptualised as an arrow that comes directly from understanding, and runs throughout working with the home relationships, building, and aligning the system and the flexibility of the model. Therapists reflected that at the beginning of therapy, they work on problems with the system; offering to support members of the system in the actions that arose from FITS, such as communicating with other members of the system on their behalf or in the encouragement of enforcing consequences. Following the collaborative working, comes the process of increasing the responsibility of the system in continuing the ‘whatever work plans’.

Haima, Therapist: How can they take the lead on this? From the beginning, it’s getting them to think, so what will it take for the caregivers to do X Y and Z? Almost getting them to give us the steps, rather than telling them the steps they need to take to overcome the situation.

Jade, Therapist*:* a continual conversation that happens throughout, is that we are not going to be there. As soon as therapists say “I can get them [to school]” – that’s not sustainable, we are not going to be here forever. So right from the start of treatment, we should always be keeping on the family’s radar, about what might get in the way post MST.

During the work with MST, an Educationalist reflected on identifying their own ‘whatever work plans’ for their student and working collaboratively enabled the school to take the lead on the response.

Frank, Educationalist:There were then suggestions from the MST worker that were great in theory, but they couldn’t work in a live comprehensive school. But because we had demonstrated a willingness to think outside of the box, to compliment the MST workers work and desires moving forward, the MST worker was far more ready to accept that what we were saying that we get it, but actually practically that won’t work, but this may do. So, creating that collaborative space.

### Category 6: The legacy of MST

This final category refers to the legacy of MST, which incorporates the end of therapy and beyond MST. This category has three subcategories of ‘Empowerment of the system in support and sustainability’, ‘Continuing use of MST interventions after closure’ and the ‘Potential for interdisciplinary training and share learning experiences of practice’.

#### Subcategory 6a: Empowerment of the system to support and sustain

Participants spoke to the intensity of MST, and the need to be thinking about the end of therapy at the beginning, by empowering the system and navigating sustainability for as long as possible before MST comes to an end. This subcategory is impacted most by the unilateral arrow of ‘Increasing responsibility’. It speaks to the skilling up of the system in order for it to feel empowered to carry on with the journey and manage the inevitable issues in the future. Many participants reflected on the sustainability plan that was described as an “MST Bible” for families and schools (Haima, Therapist).

Davina, Caregiver: [There were] so many impacts because we kept practising what we had learnt. We were given a thing called a sustainability plan. It was almost like a manual of all the work we had done. It made up this book [of] everything that we covered, ideas, their suggestions, maybe somethings that my daughter would have liked. All the positive things throughout the work all in this book that we get to keep forever. As well as some certain steps that we can take, if or when the situation did arise again. She still has her moments, but nothing where it is a concern. It’s always remembering, in the “how can I help” “is there anything I can do” “I want to help”. That will always continue to help us, to continue to learn.

#### Category 6b: Continuing use of MST interventions after closure

In addition to empowerment and the sustainability plan, the second subcategory of the Legacy of MST was constructed as using MST interventions after closure. Participants spoke to the longer lasting sustainability and continuing use of MST techniques, understandings, and principles, when MST is no longer involved. Educationalists shared that “I still to this day do FITS with people. That kind of thing makes MST part of what our school does, and not just well we do [this and they do that]” (Evelyn Educationalist). Caregivers reflected on seeing the benefit of the changes made and living with the things that they had learnt from MST.

Andrew, Caregiver: Just not taking my eye off the ball and sliding back to my old routines basically. I’ve got a worksheet of all the work we have done, the key things that were important, what were the triggers, and the solutions. I haven’t had to open it up yet. Because I haven’t forgotten anything, I am just going with it. It worked. So, I am sticking with it, I am just rolling with it.

Davina, Caregiver: I am enjoying seeing my daughter being settled in herself. I am sure that’s through practising everything we learnt. I guess we’re not even practising anymore, we are just living it now. We’re not new to this. It becomes a learnt behaviour, you’re just used to doing it, it’s effective and it’s the right thing to do. Just compassionate and understanding.

Another participant shared a metaphor that a family had said in their comparison to other services that had supported the family, that described MST as identifying the problems, supporting them to find what works for them and empowering them to do it alone.

Jade, Therapist: One Mum described not only does MST give you the wings, they teach you how to fly, which I thought was just beautiful. Because what you’re saying is that no one else has put the flesh on the bones to me, so you gave me the wings, but you also taught me how to use them, which is just mind bending.

#### Subcategory 6c: Potential for interdisciplinary training and share learning experiences of practice

The final subcategory of the model speaks to the continuing connections between the wider systems. Participants reflected on the huge “investment MST needs from schools” (Evelyn, Educationalist) and that “[schools] are investing a lot of time, investing a lot of change and a lot of resource” in MST. With the acknowledgement of the kind of investment that MST requires from school, there was a shared view of how MST could invest proactively into schools.

Frank, Educationalist: [it is] how far MST could go in being a resource for staff CPD. MST could deliver some phenomenal training because of the backgrounds people have got and would be able to compliment schools in trauma informed awareness training, adverse childhood experiences or whatever it is that they are using in their approach. I think MST and the extent to their knowledge, to impart on school staff – that would be great, for staff to have some specialist input from colleagues from MST.

Participants from the multiple systems reflected on the importance of learning from one another and reflected on “investments leading to investments” (Frank, Educationalist). Educationalists reflected on the benefit in having more shared training and ability to support more young people before they experienced a crisis within education. Therapists reflected that MST completes “a lot of training with stakeholders, social services, and other professionals […] we could do the same things with school” (Nadiya, Therapist). Therapists also acknowledged the mutual benefit of shared learning experiences and having more of a presence within educational systems.

Marcel, Therapist: We had some training, about how to work with education, which was really good. It would be good to get some more on training around education. I did really find it quite challenging working with school. In that training that we had, the people from school were there, it was really good to speak to them as well, and work together.

An overarching theme was the value and appreciation of MST by educationalists and noting the potential opportunity to support more young people by having MST more integrated and accessible to schools. Educationalists reflected on ‘how far MST could go as a resource’ (Frank, Educationalist), whilst Therapists reflected on basing themselves within schools and the value of completing shared training and continually learning about the issues that are happening within the school system.

## Discussion

### Overview of results

This empirical study was completed to explore the role of MST in how it addresses the referral behaviours of educational concerns, due to the lack of previous research into MST and education. This Grounded Theory model is a first addition to the MST literature around its addressing of educational concerns and provides a process of how MST seeks to address them from the perspective of multiple stakeholders that form part of the work. The model constructed from the analysis exemplifies the complex social processes that educational challenges reside within, and the subsequent complex systemic approach required to support the young person and the people around them. The Grounded Theory model constructed identified six overarching categories in how MST addresses educational concerns, with thirteen subcategories. Participants in this study reflected on the processes of therapy when there were educational concerns, and whilst the model is presented linearly, participants spoke to navigating between the components of the Grounded Theory model throughout the course of therapy.

### Relevance of the findings to the literature

#### Understanding factors contributing to the educational problem

The eliciting of a clear and detailed understanding of the difficulties present for the young person and the wider systems, were conveyed by participants as an important role of MST at the beginning of therapy. There was an appreciation held that similar problems can be made sense of differently by different individuals; and therapists noted the assumptions within the system that needed to be deconstructed by gaining a clear understanding of what the pertinent issues and experiences are for the particular family in focus. Additionally, this process of appreciating that individuals experience the same problem differently can be understood within the social constructionist theory (Berger & Luckmann, 1966; 1991). Constructionism refers to an individual mentally constructing the world of experience through cognitive processes (Young & Colin, 2004) however social constructionism explains that people construct their world socially and within historical contexts. This process from constructionism to social constructionism appears to take place within the MST therapy, from the gaining of individual experiences of the problem to bringing to the forefront the multiple perspectives and experiences of the problems within the system, which allows for the production of systemic hypotheses of the problem.

The role of the MST therapists also was to acknowledge the pressures and difficulties with each member of the system, whether that be the young person, caregivers or educationalists. It then followed that MST therapists would bring together the individually constructed problems to produce an understanding of the problems within context and within the system. This category can be seen to link with the identified theme of ‘improving interpersonal and systemic awareness’ which have been connected to the process of sustainability (Paradisopoulos et al., 2019). Additionally, this first category of the Grounded Theory model can be seen to be in line with Principle one of the MST Nine principles (Henggeler & Schaeffer, 2016; referred to on page 52). Principle 1 refers to ‘finding the fit’ and is described as understanding the fit between the identified problems and how they play out and are made sense of in the entire context of a young person’s life. The reflections on this demonstrated a model fidelity within MST, in that all behaviours can be understood within their context (Henggeler, 2009).

#### Building and aligning the system

The relationships between members of the system were emphasised as being a crucial part in MST addressing the educational concerns. Therapists spoke of their motivation from the start of therapy to be bringing together professionals and services to start building the system around the young person, as has been recommended by previous charity sector reports (RSA, 2020). Participants spoke to having key services and decision makers as part of the work, and the detrimental impacts when parts of the systems had not engaged with MST, inclusive of the family, educational provisions and the young people themselves. In reference to the Ecological Systems Theory (Bronfenbrenner, 1979) therapists were focusing on building the microsystem around a young person. Following building the microsystem up to have key services and decision makers within it, this Grounded Theory model then noted the separate role of moving to the mesosystem, which captures the relationships between the microsystem (Bronfenbrenner, 1992).

The role of MST in attending to the mesosystem, refers to the aligning of the microsystem and development of better relationships between them. One of the ways in which MST begins attending to the mesosystem is in its reflection on their experiences of blame, whether in its recipience or in its projection on to other members of the system. The role of blame was noted to be a barrier in the relationship between parts of the system, which contributed to the sustaining of educational concerns. In philosophical research, blame’s primary function has been described as a social cognitive process that aims to publicly regulate a community member’s conduct that has violated a social norm within the system (Scanlon, 2008; Sher, 2006 as cited in Malle et al., 2014). Again, bringing the theory of social construction to the forefront, blame can be seen as a key mechanism in social-cultural regulation (Cushman, 2013). The concept of blame within MST is not new and has been acknowledged as something experienced by caregivers (Moore, 2015). Moore situated that MST seeks to help the microsystem understand that parents are not to blame and are in fact part of the solution. This Grounded Theory model demonstrates that blame is experienced by other members of the microsystem and even held within the exosystem, in the government, law and policies.

The role of MST was acknowledged as shifting from acknowledging blame to breaking down its culture in order for the microsystem to notice the strengths of other members of the system. Participants noted the barrier of parents blaming schools for not doing more, and rather placed importance on the noble intent of school trying to find ways to support the family, even when this had not helped. This focus on the positive and strengths of the system aligns with principle two of the nine principles of MST (Henggeler & Schaeffer, 2016) but this Grounded Theory model offers the value of the acknowledgement of blame and breaking this down, as part of the role of MST in addressing educational concerns.

Exploration of the history and the systems relationship on the value given to education was a further role of MST in aligning the system, and more widely to addressing of educational concerns. Participants reflected on both the intergenerational experiences of education within the family system and the attitude of the school towards the child deserving an education, having an impact on the young persons’ engagement with education. Considerable literature has acknowledged the impact of the value of education held in the family and school systems, on a young person’s engagement with education; inclusive of parental attitudes and aspirations as well as a young person’s dislike of education, lack of expectations about education, school attitude and motivation for learning on their educational engagement (Gump, 2006; Gökyer, 2012; Gorard, 2012; Kottasz, 2005; Marburger, 2001; Paisey & Paisey, 2004; Pehlivan, 2006; Veenstra et al., 2010). Therapists identified their role in connecting and rebuilding caregivers with the value of education for the young person, and the instilling of hope for the future of the young person. Similarly, therapists saw their role with educationalists to reconnect with the value of education for every child, and the impact on the school as a whole if a young person was not supported to engage. Following the connection with the value of education, participants reflected on the attuning of the system towards a shared goal. The relationship between instilling of hopes in the value of education and having a goal to pursue has been found previously by Paradisopoulos et al. (2019). Consolidating the alignment of the systems, could be seen in the recognition of external systems whose agendas were not explicitly compatible with those of MST, but identification of the overarching and shared goal for everyone in “getting the kid in to school”. Participants noted the benefits for the family system in not having to take care of the child at home during the day, for the education system of having better statistics and for the young person in not having conflict with people around them.

#### Working with the home relationships

The MST Theory of Change model **(**Henggeler, 2009) conceptualises the role of MST in improving the family functioning which impacts the wider school, peer and community systems. Whilst similarly participants emphasised the importance of working on the home relationships, they highlighted the parallel process of working with the home and education systems, to support the addressing of educational concerns. These separate categories spoke to the MST attending to the different systems around a young person in parallel.

Spending time on the familial foundations were reflected upon by most participants. Prior to interventions, MST therapists gave time to exploring relationships and communication at home, with caregivers experiencing MST as creating a safe space for them as parents to reflect on these relationships. Previous experiences of services had felt prescriptive and agenda-driven, whilst MST was led by the family and caregivers felt that MST wanted to know the experiences of familiess and experiences of the problems. Caregivers placed importance of MST focusing on home relationships first, prior to focusing on the educational system; with the held view that with better relationships and communication at home, the rest is likely to follow; which is in support of the MST Theory of Change model. Additionally, the action in response to reflections, were in line with principle four (Henggeler & Schaeffer, 2016) in which therapists look for the action that can be taken, targeting the specific and well-defined problems that arise during the course of MST.

#### The Flexibility of the Model

In the context of the interventions completed within MST’s addressing of educational concerns, participants noted the importance of MSTs flexibility and adaptability for the family and system in focus, in the doing ‘whatever works plan’. The explicit roles of MST therapists were identified as using ‘FIT’ formulations, which is the way in which therapists conceptualise behaviours, explore the factors that contribute to the behaviours in order to inform interventions that target the identified drivers to each behaviour. This process was aligned to principle five, in the targeting of sequences of behaviour within and between the various interacting elements of the young person’s life, including home, school and community, that sustain the identified problems. Psychological models used within the addressing of educational concerns were aligned with the models that MST incorporates, inclusive of behavioural, cognitive behavioural, parenting management and structured family therapy.

The barriers to engaging in education were emphasized as components often overlooked. Participants spoke to focusing on the ‘small things’ that were easily missed by the system. Reference was made to family’s social graces (Burnham, 2013) with particular reference towards socioeconomic hardships that had impacts on school attendance. Therapists and caregivers reflected on the small things having big impacts, not only in the identification but in the pragmatic response and action of the MST team. This subcategory also aligns with principle four; present focused, action oriented and well defined.

#### Increasing responsibility

A process running parallel to the previous three domains, was the reduction of involvement from the MST therapist and the increasing of the system’s responsibility to lead on interventions to promote educational engagement. The intensity of MST support when working with educational concerns was noted; with therapists reflecting that from the beginning they are looking for opportunities to increase the responsibility of the system. Therapists spoke to the collaborative working with the microsystem towards the beginning of therapy, but the need to explore the ability of the mesosystem to continue to sustain the changes made after MST therapy closure. This part of the Grounded Theory model aligns with principle three of the nine principles of MST; in the promotion of behaviour that increases responsible actions of the system.

#### The legacy of MST

A prominent theme that was elicited through the data was the encompassing of the immediate and long-term sustainability of MST practices. Participants placed importance on the empowerment of the system in its continued support of one another and the sustainability plan. A metaphor shared about the experiences of MST compared to other services, was that MST not only gave families wings (or skills) but that it taught them how to fly (embedment of skills), exemplifying MST providing skills and supporting the embedment of them in a young person’s life. Previous research by Kaur et al (2017) noted that caregivers identified improvements in their relationship with their child, shifts in how they viewed difficulties and solutions and feeling personally strengthened and resilient as contributing factors to sustaining changes from MST. These findings appear to map on to the categories developed within this Grounded Theory. Furthermore, research by Conroy et al (2021) found that adolescent males who had received MST had more forward looking, hopeful and mature attitudes and experiences towards the world of work, than their peers who had not received MST.

Empowerment and sustainability were described by participants, in the continuing use of MST strategies post closure. Caregivers spoke to the living of the values they learnt from MST, and not needing to consciously practice approaches and rather feeling better able to apply MST practices to the new and inevitable hiccups. For educationalists, they spoke to continuing to complete MST strategies with other young people. In his research, Reid (2005) acknowledged the cycles that can happen between the causes, correlates and consequences of school refusal behaviours, and the difficulties of breaking the cycle. The focus of MST in working with multiple members of the system, building the relationships within the mesosystem appears to allow for continuation of preferred behaviours and having foundations that can cope and respond to inevitable future difficulties.

Finally, the last category spoke to the hopes of where MST UK and Ireland teams could be in future. Participants shared that the major investment of MST and the potential resource MST could be prior to young people getting to a place of crisis within education. Both educationalists and therapists spoke to wanting to continue to build and align the relationship between the systems, building up the awareness of MST, MST sharing their expertise and knowledge to inform the educational set up. Charity sector reports appear to support this future hope and have previously highlighted the need for equipping schools with trauma informed approaches and the embedment of that understanding at the core of its organisation. (Marmot Report, 2020; RSA, 2020; Timpson Review, 2019). This also makes reference to an arrow between the ‘Legacy of MST’ and ‘Building and aligning the system’, as participants spoke to the importance of this, the benefits experienced from this in the pockets where it is happening but to this not being a formal part of the model at present.

### Research limitations

There are several limitations of this research. Firstly, whilst fourteen interviews would be considered a fair sample size, and the research team felt that data saturation had been met, there were small numbers of caregivers and educationalists that took part. As reflected on in the methodology section, three additional educationalists had been identified however despite the researcher’s flexibility, interviews were cancelled or missed on multiple occasions. This could be understood within the business of the educational system at present, particularly during the COVID-19 pandemic. Additionally, there were more voices from MST therapists and supervisors than caregivers. A larger sample size may have brought about further social process and provided additional diversity of experiences. Another limitation of the recruitment was that the research failed to recruit outside of England, this may therefore limit the interpretability or applicability of the model for other areas in the United Kingdom and Ireland. Additional limitations within the sample were possible selection biases. The procedure of MST therapists approaching possible caregivers and educationalists may raise the chance of selecting people with better relationships with and experiences of MST. It is possible that this model is not inclusive of families and professionals who have had negative experiences and outcomes in MST. Additionally, whilst response rates to interested participants are noted, it is not known how many MST therapists, caregivers and educationalists were approached and therefore an overall response rate is not known.

A further limitation that should be considered was the conduction of interviews over the phone and video conferencing software. All interviews with caregivers took place over the phone, whilst all interviews with MST professionals and educationalists took place over video conferencing. It is possible that interviews conducted face to face would have supported even richer information from the interviews, with telephone calls potentially reducing the rapport. A final limitation is that no quality guidelines for qualitative analysis were used.

### Research strengths

There are several strengths of this research. Firstly, this research is relevant, topical, and timely, in reference to the highlighted need by government and charity sector reports that place importance on keeping young people in education and finding ways for systems to work together, in addition to extensive literature and few effective psychological interventions rigorously evidenced. Another strength of this research is its incorporation of first-person accounts from a range of people that are invested in its processes. Lister (2004) noted the power of research that amplifies the voices of those who may not usually have the power or opportunity to share their views. This research also refers to the current socio-political landscape of education which has been shown to have huge impacts on the trajectories of young people. A further strength is the inclusion of experiences from a range of stakeholders, notably caregivers, MST professionals and educationalists, which is important in reference to an intervention that is embedded within an ecological systems theory. However as noted in the limitations previously, whilst having all voices informing this grounded theory, the voices of young people and the voices of caregivers and educationalists were fewer, and therefore impacting the representativeness of the model.

Another strength of this research is the rigorous methodology of the Constructivist Grounded theory design. This methodology requires a constant comparison of data throughout data collection and analysis, which encourages a thorough, and robust analysis to embed the theory developed from the data. Other strengths in the Constructivist Grounded Theory methodology are the advantages of keeping data memo-ing and reflecting diaries throughout recruitment, interviews and data analysis, which situate the researcher in the process of theory development and allow reflection on their contributions to the analytical process.

A further strength could be seen as constructing a theory from the data, rather than a methodology that looked to compare experiences from stakeholders to previously informed models, like MST Theory of Change. This allowed for a theory to be produced authentically and reduce risk of additional biases. Whilst similarities between this Grounded Theory and both the MST Theory of Change and the nine MST principles were found, this current methodology allowed for a full exploration of how the social processes that underpin MST interface with educational concerns. A final strength of this research was gaining insight and feedback from participants about the categories, subcategories and the Grounded Theory model produced. Their contributions helped further shape the model, check the relevance of the theory derived, enrich the researchers understanding, and further define the properties of emerging categories (Charmaz, 2014). Hearing the feedback of participants ensured that the model was accessible to multiple audiences and all potential stake holders.

### Suggestions for future research

This research explored the interface between MST and education within a UK population, at a time where the country is coming out of a global pandemic. It is possible that at a different point in time, that the model may change alongside changes in society, which is acknowledged in the research process by Charmaz (2014). With this in mind, future research could explore the influence and impact of COVID-19 on this model, and developments that come out after education and life as we know it becomes the new normal.

Another opportunity for future research could be to complete research exploring the effectiveness of MST with educational concerns outcomes and adding to the literature on psychological interventions for school refusal. As aforementioned, there is some evidentiary support for CBT approaches towards this population, however research over the last decade suggests a move towards systemically informed CBT approaches. With the Grounded Theory model presented of the MSTs addressing of educational concerns, it could possibly inform a research project into its effectiveness.

Reflecting on the importance of research that amplifies the voices of those who may not be in the receipt of power, a silent voice in this research is the experience of young people. This decision to not have the voices of young people, came from the clinical rationale that caregivers are the main conduit of MST therapy. However, it could be helpful in future to have this Grounded Theory model informed by young people.

Future research could also review the lasting legacy of MST with educationalists. Whilst research has explored sustainability within the familial system, it could be helpful to understand the impact of MST on the education system.

### Conclusion

This study has contributed the first model of Multisystemic therapy’s addressing of educational concerns and has widened the understanding of the roles of MST within the MST literature. The experiences of multiple MST stakeholders, including caregivers, educationalists and MST therapists and supervisors were explored through qualitative enquiry, and highlighted the social processes that are involved in the addressing of educational concerns. The model outlines the process of MST which attends to the multiple systems that have influence in the reduction of educational concerns, including gaining an understanding of the problem within the system, building and aligning the system, working on the home relationships, using behavioural FITS to inform and tailor interventions, the overcoming of barriers, increasing responsibility of the system and the legacy of MST after closure, which are all key components towards the delivery of MST when there are education concerns. Whilst previous research was limited into the interface and role of MST when there are educational concerns, the model constructed aligns with various parts of the underpinning theory of MST in Bronfenbrenners Ecological Systems Theory (1979) and the MST Theory of Change (Henggeler et al., 2009). Furthermore, this research suggests that the nine guiding principles of MST were also integral to MST addressing of educational concerns, with five of the nine principles elicited through the separated qualitative insight. Additionally, the Grounded Theory model also conceptualises additional processes that form part of the MST intervention when there are educational concerns, in the building and aligning of systems, exploration of blame and the historical relationships with the value of education. As well, as the potential furthering of MST’s role in the proactive alignment of MST and Education systems through shared experiences outside of therapy. These findings offer a first step in understanding the role and value of MST in the reduction of educational concerns, that can be built upon.

# Chapter 3

# Integration, Impact, and Dissemination

## Integration

The systematic review and the empirical paper were closely connected in their shared focus of investigating psychological interventions that support educational difficulties. The systematic review highlighted several gaps in the research completed in the field of psychological interventions for school refusal, which ultimately offered a rationale for the empirical paper in exploring an under researched therapeutic model in its addressment of educational concerns. As aforementioned, there is currently limited research into the role of MST in relation to educational concerns and as such, the empirical paper sought to better understand its role and processes from the point of view of multiple stakeholders, caregivers, MST therapists and supervisors and educationalists. Therefore, the systematic review offered support and a comprehensive literature review in underpinning the rationale for this empirical study.

### Synthesis of findings

As previously discussed, the systematic review noted limited empirically supported evidence in a range of current psychological interventions investigating their effectiveness in the amelioration of difficulties in school attendance. There was some statistical support in Positive Behavioural Interventions and Support, intensive Cognitive Behavioural Therapy for School Refusal and CBT when mediated by self-efficacy. Additionally, there were some observable increases in attendance in a range of CBT interventions, structured family therapy and multi-modal interventions, however similar to previous meta-analyses these results were not repeated, differences were not routinely statistically significant and statistical differences appeared in new and emerging fields. The findings of the systematic review however did show some shifts in research, perhaps on the back of the dominance in CBT interventions being investigated and the lack of empirically supported interventions over time. The shifts appear to be in systemically informed CBT interventions, multimodal or integrative approaches and whole school interventions including Positive Behavioural Interventions and Support (PBIS). Comparing the findings of this review with a previous review by Maynard et al. (2018) who found CBT dominance, there does seem to be a widening of approaches being explored.

The findings of this review in the limits of current psychological interventions effectiveness, appear to give a conceptual base for the exploration of other psychological modalities that build upon this information. Furthermore, with the appreciation of some effectiveness in cognitive and behavioural approaches, but a shift towards the inclusion of the system around a young person too, appears to provide further conceptual basis for this empirical study. Whilst MST has been extensively researched, to date there has been limited research into its interface with educational concerns.

Something that was important to reflect on throughout these two papers was my therapeutic leaning and the dominance of systemically informed services in my clinical experiences. Much attention was paid to the consideration of the research and my own meaning made and potential biases in my interpretations, with potentially more value paid to systemic models. It was therefore important to reflect on finding papers that noted systemic influences within their other psychological modalities, and objectively report them and share possible reflections. It was important for me to keep a reflective diary of my thought processes throughout each paper, to hold a reflexive stance and to be aware of the Critical Psychology approach (Parker, 2015) that I may have slipped in to. Noticing my tendencies was important so that I was reporting findings objectively but also not disregarding the noticing of potential shifts in intervention trends over time.

In reference to aspects of each paper that were potentially inconsistent with one another, the systematic review led to the emergence of unique findings in Positive Behaviour Interventions and Support approaches. Findings from the systematic review, included this approach which highlighted the role of psychologists and educationalists in their contributions to the educational system model, and making organisational changes from the top. This is different from the dominant models in school refusal evidence base to date, and with the multisystemic model. Whilst this appears a unique finding, integrating the data from the empirical study it does however relate to reflections shared by participants in the impacts felt from the ‘business model of schools’ and in government and charity sector calls for change. It is perhaps beyond the scope of this research to be able to join in the call for educational system revisions, however it raises thoughts around how far MST UK and Ireland services could go in terms of informing educational systems. Holding in mind the underpinning social ecology and ecological systems theory (Bronfenbrenner, 1979; 1992), whilst MST works on both a microsystem and mesosystem, the emerging evidence base of school refusal shows the Positive Behavioural Interventions and Support works at an exosystems level, informing at an organisational and policy level.

Another important reflection, especially from research conceptualised from social constructionist theory, was my own experiences of education and educational challenges. It was often helpful to reflect on what I was informed by and having my own experiences of truanting both myself and in the experiences of friends, whilst also working within an area of services where young people were often not attending school, I reflected that often my research and clinical roles were interchangeable. It was therefore important to be reflexive and informed in my approach and think about how these experiences were influencing the research process. Whilst I was initially formulating the purpose of reflecting on the meaning made of information through my own biases, I saw benefit in having these experiences and how they benefitted the dual role of this profession. Furthermore, Gair (2012) highlights the insider/outsider status as “the degree to which a researcher is located either within or outside a group being researched” (p. 137). The majority of participants I interviewed were from the North of England and the Midlands. I am from the North of England myself and reflected on lots of conversations about my accent with participants, and noticed the assumptions made about a researcher from a university situated in the South of England and notably the capital. I reflected though that I assumed I may have some insider status, “well you know what it’s like in the North…” but was more surprised when outsider status was felt “I’m not sure how much you know about difficulties within this area” for example. It made me think about my social graces and intersectionality (Burnham, 2013) more widely and how some could be seen as attributable to insider and some to outsider status, and that it is perhaps a more complex continuum and one to be reflecting on throughout. Reflecting on my gender, ethnicity, geography for example, but allowing time for the consideration of power and its impact on the research context (Johnstone & Boyle, 2018) and particular attention to the power of the ‘researcher’ and ‘service user’. It therefore felt more important to note the power, and to situate myself and acknowledge power within interviews and service-user involvement. Reflecting on these issues and processes demonstrated the complexity and multi-layered relational contributions that impacts on the research, and to note the importance of thorough and transparent reflections throughout. Reflecting on the power further, and the power afforded to ‘professionals’ as a whole who were possibly positioned as ‘experts’, inevitably shaped the lens through which caregivers shared their experiences. A potential counteraction to that was the involvement of individuals who used MST UK and Ireland services in the project, particularly in the co-design and the reviewing of categories and subcategories constructed, and so to root the relevancy of concepts and processes explored.

### Challenges within the research

Good practice in Grounded Theory approaches states the benefit of conducting the literature review after the completion of data analysis. This did not happen outwardly in this research with a brief literature review being required for the research proposal and research ethics. However, the majority of the literature review took place after data analysis had begun with additions such as the nine MST treatment principles being incorporated to underpin some of the findings. It is possible that previous literature unduly shaped the interview schedules and process, and the model itself. However, there is also a strength of this research in the construction of a new model, rather than adapting an existing model or guiding principles. This implicit shaping most likely impacted on the coding process; however, this was considered, and words of the participants were used as much as possible throughout initial and focussed coding analysis. With a second reviewer, this language was then reviewed in terms of its clarity. Reviewing the categories, subcategories and the model with participants was helpful in considering the relevance.

Linked to the previous reflection, another challenge of this research, but not exclusive to this research paper was the enormity of the Constructivist Grounded Theory approach. Throughout its process, I found this methodology overwhelming. Creating categories, and subcategories and the eventual emergence of the model was challenging in ensuring the capturing of the diversity of experiences, that would give justice to the time given by 14 individuals. It meant that I felt completely immersed in the data, often connecting things mentally, even when not analysing. The support given by my supervisory team was invaluable to grounding me in the aims of the research and what experiences spoke to concepts and processes within the research focus. It did mean however that a wealth of experiences were not conceptualised within this model, like the experiences of drivers in educational challenges, impacts of COVID-19 and the MST system that resides around the MST worker, to name a few. Upon reflection however, I have valued the immersive and iterative process of the methodology because it has widened the project’s possibilities. This Grounded Theory model captured connections, relations and processes between concepts that may not have been possible within other qualitative methodologies. This Grounded Theory model has highlighted the complexity of MST, the social processes taking place between the layers of the system, and it also highlighted how disparities are playing out on a relational and organisational level.

A further issue in this research was recruitment difficulties. There is much emphasis placed on recruiting the appropriate participants to maximise the value of research (Wright et al., 2010) and recruitment is acknowledged as one of the limitations of the empirical paper. In the recruitment of MST therapists and supervisors, caregivers and educationalists, I was reliant on MST teams to identify and put me in touch with members of their teams, caregivers and educationalists willing to take part in research. During recruitment, I had effectively over recruited MST therapists and supervisors who were keen to support my research, however I struggled to recruit equal numbers of caregivers and educationalists. As noted in my limitations, there were three additional educationalists recruited however after many postponements, cancellations and follow up emails, it was not possible to find a time to interview them prior to submission. It seems imperative to situate this research within its context in that the impacts of the COVID-19 pandemic continue to be felt, particularly by educationalists. The ongoing challenges of COVID-19 were often cited as reasons for postponement. When considering that this research aimed to explore multiple perspectives of MST’s addressment of educational concerns, having fewer voices of people outside of MST professionals constitutes a weakness in this research.

In further reflections on the difficulties in recruitment of educationalists and caregivers, other issues appeared two-fold. Following on from the previous reflection, two educationalists (one who took part and one who eventually did not take part) asked what the benefits for them was in taking part, in the hope of accessing some MST training. Although this was difficult to manage with a more research hat on, discussion with the research and MST team perhaps lent itself to the limited time, capacity and resources educationalists have. Furthermore, two caregivers shared that they were happy to take part in the interviews but were unsure of how helpful they would be. The apprehension felt by individuals less familiar with research is noted (Wright et al., 2010) and whilst attunement to their lack of confidence, the value placed on their experiences and reflections and normalising worries around taking part in research were completed, this perhaps would have had benefit to be considered and formulated earlier on. There are a range of recommendations that include brief guidance and training to support the apprehensions felt (Beresford, 2013; Wright et al., 2010). This however possibly offers an important missed opportunity in recruiting more individuals outside of MST teams.

## Impact

The findings of both the systematic review and the empirical paper have the potential to positively impact a range of beneficiaries including local MST professionals and teams, education provisions and local authorities, families and young people who are struggling to attend school and commissioners and policy makers (including MST UK and Ireland implementation service).

As highlighted previously, both papers have direct clinical impacts and implications in their review on the psychological interventions aimed at improving school attendance; both in their review of extensive literature and in their applicability of tangible approaches to be considered within therapy and research. Beneficiaries of this are likely to be MST UK and Ireland services, education providers, MST and Educational stakeholders and families. Whilst the findings of the systematic review did not provide empirically supported interventions it provided some evidentiary support for Positive Behavioural Interventions and Support and Intensive CBT-SR; showed observable improvements in school attendance in a range of CBT approaches structured family therapy and multimodal approaches and highlighted shifts in the modalities being focused in this area of research. Whilst the empirical paper noted the interface between MST and education, which incorporates CBT interventions, whilst being systemically informed; there seems to be an easy progression towards the findings of the systematic review and the notable urgency to review MST’s effectiveness.

In respect of the impact of the findings of the empirical paper, this Grounded Theory model offers the first construction of how MST addresses educational concerns. It not only maps onto the conceptual underpinnings of the social ecology theorem (Bronfenbrenner, 1979), but also the MST Theory of Change (Henggeler, 2009) and the nine principles of MST treatment (Henggeler & Scheaffer 2016); which provides support for model fidelity. It also offers a visual guiding model for MST therapist’s future work with families and educational systems that include a range of concepts to consider. Whilst this is not a linear model, with each section having bidirectional arrows, it offers processes of the intervention to be held in mind. Furthermore, it offers insight into a range of social processes such as acknowledgement of blame and shame, communication and relationships, as well as connection to strengths and professional esteem, and the role that MST therapists play in governing and attending to those social processes. Additionally, the clinical implications for professionals delivering MST offer the foundations for potential effectiveness and efficacy research.

More widely, clinical implications could be considered for services and clinicians, outside of MST. Clinicians and services working with young people and their families that may be having educational difficulties could consider this model or the concepts raised within it, in their therapeutic approaches. The model offers a range of concepts to be considered in working with young people and their families when there are concerns around the accessing and engagement with education.

It could be argued that clinical psychology and children services have unknowingly neglected the social, political and developmental role of educational institutions by focusing on the intra-psychic and interpersonal level (McClelland, 2013). Extensive literature highlights the significance of education on a large range of aspects of an individual’s wellbeing and quality of life. The potential clinical implications for policy makers, is the highlighted complex relational difficulties that are often present when there are educational concerns, and the complex systemic interventions required to respond to them. Government and charity sector reports state the growing rate of young people being excluded in educational settings, and further disparities to young people already at risk of multiple short- and long-term consequences. There is currently limited access to psychological interventions that support the system around a young person in order to improve school attendance and school engagement, despite the shift in focus observable in the interventions being investigated. Linking in with the empirical data, participants spoke to the ‘business of the school model’ and the limited funds, the high turnover of staffing and the prioritising of saving money and doing the same for less. This research offers the first model of MST and education, to be built upon as society changes and as new information comes to the forefront.

To further the impacts of this research, it would be important that this model be seen a first model within this moment in time, and to be developed as society changes and new processes are around. Future research could consider a range of avenues inclusive of effectiveness and efficacious research, inclusion of more voices from educationalists and caregivers, and for the first time include the voices of young people in their experiences of MSTs addressment of educational concerns. This would ensure that the model is representative of all the processes that happen within the MST intervention and acknowledge any new societal developments as they occur, such as changes with policy, government or impacts of COVID-19.

## Dissemination

To achieve and maximise this impact discussed above, a summary of the findings will be disseminated to all participants and across MST UK and Ireland services. Working with educational concerns was the only ultimate outcome not to be met in 2019, had had limited research attention and more anecdotally was considered less known about in discussions with participants. The former points rationalised the importance of the conduction of this research, and the latter point highlights its significance. Therefore, to maximise the impact, the theoretical model will feature in the summary. Additionally, a summary of the key findings will be presented to MST UK and Ireland teams. In reference to evaluating whether the impact has been met, or how the impact could be met further, a brief feedback questionnaire could help gather information about whether the audience has captured the concepts of the Grounded Theory model, and how the audience feels this may impact their work.

Attention needs to be paid to making information shared accessibly. It could be helpful to have multiple formats of the findings, such as summary of findings in essay form, but also having posters of the summary of findings and more quick reads. Any information would need to be accessible, in its clarity, simple prose and use of diagrams. It would also be important that whilst quick reads may disseminate the information to more people, that the findings are situated within their context and tentatively framed, even with an invite for individuals to discuss reflections and experiences, avoiding neglection of current and future issues and perspectives. The service users involved in this project will be provided with a summary of findings, and it may be useful to gain consultation from them about how to present and summarise the information aimed at families.

In reference to disseminating the findings more widely, publication would have the potential to achieve both national and international reach and support the academic impact of the work. Both the systematic review and empirical paper will be prepared for submission in relevant peer-reviewed academic journals in related fields, as two separate papers. In considering what journals to submit to, the Journal of Family Therapy is recognised in its publication of a number of qualitative MST studies. In addition, topic specific journals such as The Journal of School Psychology, could have both clinical and academic target audiences. The impact of the potential submission to relevant journals will be considered and discussed with the research team prior to submission.

The research findings have already been presented to staff and students at Royal Holloway University of London and it is hoped the findings will have provided understanding about multisystemic therapy and educational concerns for a range of clinicians. Additionally, the research findings will be presented at both the MST UK and Ireland network team meeting, which is attended by the MST programme lead and all consultants working within teams in the UK and Ireland. Additionally, findings will be presented at the next MST European Conference.

# References

Allison, M. A., & Attisha, E. (2019). The link between school attendance and good health. Pediatrics, 143, e20183648. https://doi. org/10.1542/peds.2018-3648.

Andrews, T (2012) What is Social Construcionism? Grounded theory review. *An international journal*. *1*(11) <http://groundedtheoryreview.com/2012/06/01/what-is-social-constructionism/>

Ashmore, Z., & Fox, S. (2011). How does the delivery of Multisystemic therapy to adolescents and their families challenge practice in traditional services in the Criminal Justice System? *The British Journal of Forensic Practice,* 25-31. DOI: [10.5042/bjfp.2011.0047](http://dx.doi.org/10.5042/bjfp.2011.0047)

Balfanz, R. & Byrnes V. (2018). Using data and the human touch: Evaluating the NYC inter-agency campaign to reduce chronic absenteeism. *Journal for Education Students Placed at Risk,* *23*(1-2) 107-121. https://www.tandfonline. com/doi/full/10.1080/10824669.2018.1435283

Balkis, M., Arslan, G., & Duru, E. (2016) The School Absenteeism among High School Students: Contributing Factors. *Educational sciences, theory and practice*, *16*(6) 1819-1831. DOI 10.12738/estp.2016.6.0125

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioural change. *Psychological Review*, *84*(2), 191-215. [https://doi.org/10.1037/0033-295X.84.2.191](https://psycnet.apa.org/doi/10.1037/0033-295X.84.2.191)

Barker, C., & Pistrang, N. (2002) Psychotherapy and social support: Integrating research on psychological helping. *Clinical Psychology Review,* *22*(3) 361-379 <https://doi.org/10.1016/S0272-7358(01)00101-5>

Beck, A. T & Clark, D., A (1988) Anxiety and depression: An information processing perspective. *Anxiety Research*, *1*(1), 23-36, DOI: [10.1080/10615808808248218](https://doi.org/10.1080/10615808808248218)

Beresford, P. (2013). From ‘other’ to involved: User involvement in research: an emerging paradigm. *Nordic Social Work Research*, *3*(2), 139–148. <https://doi.org/10.1080/2156857X.2013.835138>

Berg, I., Nichols, K., & Pritchard. (1969) School phobia – its classification and relationship to dependency. *Journal of Child Psychology and Psychiatry,* *10*(2) 123-141. <https://doi.org/10.1111/j.1469-7610.1969.tb02074.x>

Berg, I. (2002). School avoidance, school phobia, and truancy. In Lewis, M. (Ed.), *Child and adolescent psychiatry: A comprehensive textbook* (3rd ed., pp. 1260–1266). Sydney, Australia: Lippincott Williams & Wilkins.

Berger P, L., & Luckmann, T. (1966). The social construction of reality. *A Treatise in the Sociology of Knowledge*. <http://perflensburg.se/Berger%20social-construction-of-reality.pdf>

Berger, P. & Luckmann, T. (1991). The social construction of reality. London: Penguin Books.

Bernstein GA. (1991) Comorbidity and severity of anxiety and depressive disorders in a clinic sample. *Journal of American Academic Child and Adolescent Psychiatry*, 30. p43–50. DOI: [10.1097/00004583-199101000-00007](https://doi.org/10.1097/00004583-199101000-00007)

Beynon, K., & Thomson, D., (2021) How many secondary school pupils have been persistently absent so far this year? *Fischer Family Trust Education Datalab*. <https://ffteducationdatalab.org.uk/2021/11/how-many-secondary-school-pupils-have-been-persistently-absent-so-far-this-year/>

Bonell, C., Allen, E., Christie, D., Elbourne, D., Fletcher, A., Grieve, R., LeGood, R., Mathiot, A., Scott, S., Wiggins, M., & Viner, R. M. (2014) Initiating change locally in bullying and aggression through the school environment (INCLUSIVE): study protocol for a cluster randomised controlled trial. *Trials*, *15*(381). [www.trialsjournal.com/content/15/1/381](http://www.trialsjournal.com/content/15/1/381)

Brandibas, G., Jeunier, B., Clanet, C., & Fouraste, R. (2004) Truancy, School Refusal and Anxiety*. School Psychology International,* *25*(1):117-126. DOI: [10.1177/0143034304036299](http://dx.doi.org/10.1177/0143034304036299)

Braun, V. and Clarke, V. (2006) Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.  DOI: [10.1191/1478088706qp063oa](https://doi.org/10.1191/1478088706qp063oa)

Broderick, P.C., & Metz, S. (2013) Learning to BREATHE: A Pilot Trial of a Mindfulness Curriculum for Adolescents. *Advances in School Mental Health Promotion*, *2*(1)35-46 DOI: [10.1080/1754730X.2009.9715696](http://dx.doi.org/10.1080/1754730X.2009.9715696)

Bronfenbrenner, U (1979) The Ecology of Human Development: Experiments by Nature and Design. Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. (1992). Ecological systems theory. In R. Vasta (Ed.), Six theories of child development: *Revised formulations and current issues* (pp. 187–249). Jessica Kingsley Publishers.

Brown, D. W., Riley, L., Burchart A., Meddings, D. R., Kann, L., & Harvey, A. P. (2009). Exposure to physical and sexual violence and adverse health behaviours in African children: results from the Global School-based Student Health Survey. *Bulletin of the World Health Organisation*, *87*(6) 447-455. DOI: [10.2471/blt.07.047423](https://doi.org/10.2471/blt.07.047423)

Browne, N., Zlotowitz, S., Alcock, K., & Barker, C. (2020). Practice to policy: Clinical psychologists’ experiences of macrolevel work. Professional Psychology: Research and Practice, 51(4), 371–382. [https://doi.org/10.1037/pro0000301](https://psycnet.apa.org/doi/10.1037/pro0000301)

Buitelaar, J. K., van Andel, H., Duyx, J. H., & van Strien, D. C. (1994). Depressive and anxiety disorders in adolescence: a follow-up study of adolescents with school refusal. *Acta paedopsychiatrica*, *56*(4), 249–253.

Burckhardt, R., Manicavasagar, V., Batterham, P. J., Miller, L. M., Talbot, E., & Lum, A. (2015) A Web-Based Adolescent Positive Psychology Program in Schools: Randomized Controlled Trial. *Journal of Medical Internet Research, 28*;17(7): e187. doi: 10.2196/jmir.4329

Burnham, J. (2013) Developments in Social GGRRAAACCEEESSS: Visible invisible, voiced-unvoiced. In I. Krause (ed.) *Culture and Reflexivity in Systemic Psychotherapy: Mutual Perspectives*. London: Karnac.

Camoirano A. (2017). Mentalizing Makes Parenting Work: A Review about Parental Reflective Functioning and Clinical Interventions to Improve It. *Frontiers in psychology*, *8*(14). <https://doi.org/10.3389/fpsyg.2017.00014>

Carr, A. (2014). The evidence base for family therapy and systemic interventions for child-focused problems. *Journal of Family Therapy*, *36*(2) p.107–157. <https://doi.org/10.1111/1467-6427.12032>

Charmaz, K. (1995a). Between positivism and postmodernism: Implications for methods. *Studies in Symbolic Interaction*, *17*, 43–72.

Charmaz, K. (1995b). Grounded theory. In Smith, J., Harré, R., Langenhove, L. (Eds.), *Rethinking methods in psychology* (pp. 27–65). London: Sage.

Charmaz, K. (2000). Grounded theory objectivist and constructivist method. In Denzin, N. and Lincoln, Y. (Eds.), *Handbook of Qualitative Research* (pp. 509-535). Thousand Oaks, CA: Sage

Charmaz, K., & Belgrave, L. (2012). Qualitative interviewing and grounded theory analysis. *The SAGE handbook of interview research: The complexity of the craft*, 2, 347-365.

Charmaz, K. (2014). Constructing grounded theory. London: Sage.

Christenson, S. L., Stout, K., & Pohl, A. (2012). Check & Connect: A comprehensive student engagement intervention: Implementing with fidelity. Minneapolis, MN: University of Minnesota, Institute on Community Integration. <http://checkandconnect.umn.edu/contactus/About_and_SelfAssessment.pdf>

Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *SAGE open medicine*, 7. P 1-8. [https://doi.org/10.1177/2050312118822927](https://doi.org/10.1177%2F2050312118822927)

Conroy, D., Smith, J. A., Butler, S., Byford, S., Cotrell, D., Kraa,. A., Fonagy, P., Ellison, R., Simes, E., & Anokhina, A. (2021) The Long-Term Impact of Multisystemic Therapy: an experiential study of the adolescent young adult life transition. *Journal of Adolescent Research.* P1-34. <https://doi.org/10.1177/07435584211025323>

Cresswell, J. W., & Plano Clark, V. L. (2011). Designing and conducting mixed method research. 2nd Sage. Thousand Oaks, CA, 201.

Cushman, F. (2013) Action, outcome and value: a dual-system framework for morality. *Personality and Social Psychology Review*, *17*(3) 273-292 DOI: 10.1177/1088868313495594

Dahlgren G, Whitehead M: Policies and Strategies to Promote Social Equity in Health: Institute for Future Studies. Stockholm, Sweden: 1991.

Daniel, D. B., & Poole, D. A. (2009) Learning for Life: An Ecological Approach to Pedagogical Research. *Perspectives on Psychological Science*, *4*(1) DOI:

[10.1111/j.1745-6924.2009.01095.x](http://dx.doi.org/10.1111/j.1745-6924.2009.01095.x)

Dansereau, D. F., Knight, D. K., & Flynn, P. M. (2013). Improving adolescent judgment and decision making. *Professional Psychology: Research and Practice,* *44*(4), 274–282. [https://doi.org/10.1037/a0032495](https://psycnet.apa.org/doi/10.1037/a0032495)

Dejonckheere, M., & Vaughn, L. M., (2019) Semistructured interviewing in primary care research: a balance of relationship and rigour. *Family medicine and community health*. 7: e000057. doi:10.1136/ fmch-2018-000057

DePaoli, J. L., Balfanz, R., Atwell, M. N., & Bridgeland, J. (2018). Building a grad nation: Progress and challenge in raising high school graduation rates. Washington, D.C. Retrieved from https ://new.every1graduates.org/wp-content/uploads/2018/06/18930 \_Civic\_BGN\_v7.pdf.

Department for Education and Skills (DfES). (2003) White Paper: The Future of Higher Education. London: DfES. <https://publications.parliament.uk/pa/cm200203/cmselect/cmeduski/425/425.pdf>

Department for Education Report (2022).Working together to improve school attendance. Guidance for maintained schools, academies, independent schools, and local authorities. London

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/1099677/Working\_together\_to\_improve\_school\_attendance.pdf

Department for Children, Families and Schools (DfCFS). (2009) Your child, your schools, our future: building a 21st century schools’ system. London: TSO.

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/344452/21st_century_schools.pdf>

Devadoss, S., & Foltz, J., (1996) Evaluation of Factors Influencing Student Class Attendance and Performance. [*American Journal of Agricultural Economics*](https://econpapers.repec.org/article/oupajagec/), *78*(3), 499-507 <https://doi.org/10.2307/1243268>

Drew, H., Holmes, L., Dunn, V., & Harrison, N. (2019) Evaluation of the Multisystemic Therapy Service in Essex. Department of Education, University of Oxford.

Dube, S.R., & Orpinas, P. (2009). Understanding excessive school absenteeism as school refusal behavior. *Children & Schools, 31*(2), 87–95. [https://doi.org/10.1093/cs/31.2.87](https://psycnet.apa.org/doi/10.1093/cs/31.2.87)

Eiraldi, R., Power, T. J., Schwarts, B. S., Keiffer, J. N., McCurdy, B. L., Mathen, M., & Jawad, A. F. (2016) Examining Effectiveness of Group Cognitive-Behavioral Therapy for Externalizing and Internalizing Disorders in Urban Schools. *Behavioural modifications,* *40*(4):611-39. doi: 10.1177/0145445516631093.

Ek, H., & Eriksson, R. (2013). Psychological factors behind truancy, school phobia, and school refusal: A literature study. *Child & Family Behavior Therapy* 35(3), 228-248.

<https://doi.org/10.1080/07317107.2013.818899>

Eklund, K., Burns, M. K., Oyen, K., de Marchena S. L., & McCollom, E. M (2020). Addressing Chronic Absenteeism in Schools: A Meta-Analysis of Evidence-Based Interventions. *School Psychology Review*. DOI: 10.1080/2372966X.2020.1789436

Ekstrand, B. (2015). What It Takes to Keep Children in School: A Research Review. *Educational Review*, *67*(4), 459-482. <https://doi.org/10.1080/00131911.2015.1008406>

Elliott, R., Fischer, C. T., & Rennie, D. L., (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British journal of Clinical Psychology, 38*(3):215-29. doi: 10.1348/014466599162782

Epstein, J. L., & Sheldon, S. B. (2002). Present and accounted for: Improving student attendance through family and community involvement. *The Journal of Educational Research 95*(5), 308–318. [https://doi.org/10.1080/00220670209596604](https://psycnet.apa.org/doi/10.1080/00220670209596604)

Felver, J. C., Celis-De Hoyos, C. E., Tezanos, K. M., & Singh, N. N., (2016). A Systematic Review of Mindfulness-Based Interventions for Youth in School Settings. *Mindfulness,* 7 (1) DOI: [10.1007/s12671-015-0389-4](http://dx.doi.org/10.1007/s12671-015-0389-4)

\* Felver, J. C., Clawson, A. J., Morton, M. L., Brier-Kennedy, E., Janack, P., & DiFlorio, R. A. (2019). School-based mindfulness intervention supports adolescent resiliency: A randomized controlled pilot study. *International Journal of School & Educational Psychology*, *7*(1), 111–122. [https://doi.org/10.1080/21683603.2018.1461722](https://psycnet.apa.org/doi/10.1080/21683603.2018.1461722)

Fitzpatrick, S., & Christian, J. (2006) Comparing homelessness research in the US and Britain. *European Journal of Housing Policy*, *6*(3) 313-333. DOI:

[10.1080/14616710600973151](http://dx.doi.org/10.1080/14616710600973151)

Fortin, L., Marcotte, D., Potvin, P., Royer, E., & Joly, J. (2006). Typology of students at risk of dropping out of school: Description by personal, family and school factors. *European Journal of Psychology of Education,* *21*(4), 363–383. https://www.jstor.org/stable/23421387

Fremont, W. P. 2003. School Refusal in Children and Adolescents. *American Family Physician*, *15;68*(8):1555-1561. <https://www.aafp.org/afp/2003/1015/p1555.html>

Gair, S. (2012). Feeling their stories: Contemplating empathy, insider/outsider positionings, and enriching qualitative research. *Qualitative Health Research,* *22*(1), 134–143. <https://doi.org/10.1177/1049732311420580>

Gallagher, L., Taylor, L., Neophytou, E., & Johnston, K. A systematic review of the needs of the excluded from school population and the psychological interventions trialled with this vulnerable group of young people. *PROSPERO* 2018 <https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42018093950>

Glaser, B. and Strauss, A. (1967). The Discovery of Grounded Theory: Strategies for qualitative research. New York: Aldine De Gruyter.

Glaser, B. (1978). Theoretical sensitivity: Advances in the methodology of grounded theory. Mill Valley, CA: Sociology Press.

Glaser, B. (1992). Basics of grounded theory analysis: Emergence vs. forcing. Mill Valley, CA: Sociology Press.

Gorard, S., See, B. H., & Davies, P. (2012) The impacts of attitudes and aspirations on educational attainment and participation. *Joseph Rowntree Foundation.* <https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/education-young-people-parents-full.pdf>

Gottfried, M. A. (2009). Excused versus unexcused: How student absences in elementary school affect academic achievement. *Educational Evaluation and Policy Analysis*, 31(4), 392–415. [https://doi.org/10.3102/0162373709342467](https://doi.org/10.3102%2F0162373709342467)

Gottfried, M. A. (2014). Chronic absenteeism and its effects on students’ academic and socioemotional outcomes. *Journal of Education for Students Placed at Risk. 19*(2), 53-75. <https://doi.org/10.1080/10824669.2014.962696>

Gökyer, N. (2012). The views of students on the causes of absenteeism at high schools. *Kastamonu Eğitim Fakültesi*, *20*(3), 913–938.

Green, D. O., Creswell, J. W., Shope, R. J., & Plano Clark, V. L. (2007) Grounded Theory and Racial/Ethnic Diversity. *The SAGE handbook of grounded theory.* https://dx.doi.org/10.4135/9781848607941.n22

Gump, S. E. (2006). Guess who’s (not) coming to class: Student’s attitudes as indicators of attendance. *Educational Studies*, *32*(1), 39–46. <https://doi.org/10.1080/03055690500415936>

Haight, C. M., Chapman, G. V., Hendron, M., Loftis, R., & Kearney, C. A. (2014). Evaluation of a truancy diversion program at nine at‐risk middle schools. *Psychology in the Schools,* 51(7), 779-787. <https://doi.org/10.1002/pits.21775>

\*Hannan, S., 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*(1), 89-101, DOI: 10.1080/23794925.2019.1575706

Havik, T., Edvin, B., & Ertesvåg, S. K. (2014) Parental perspectives of the role of school factors in school refusal, *Emotional and Behavioural Difficulties*, *19*(2\_, 131-153, DOI: 10.1080/13632752.2013.816199

Henggeler. S.W., Schoenwald, S. K., Borduin, C.M., et al (1998) Multisystemic Treatment of Antisocial Behaviour in Children and Adolescents. *Treatment Manuals for Practitioners.* New York: The Guilford Press.

Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., & Swenson, C.C. (2006) Methodological critique and meta-analysis as Trojan Horse. *Children and Youth Services Review, 28*(4) 447–57.

Henggeler SW, Schoenwald SK, Borduin CM, Rowland MD & Cunningham PB (2009) Multisystemic Therapy for Children and Adolescents (2nd edn). New York & London: The Guilford Press.

Henggeler, S. W. (2012). Multisystemic Therapy: Clinical Foundations and Research Outcomes. *Psychosocial Intervention*, *21*(2), 181–193. <https://doi.org/10.5093/in2012a12>

Henggeler, S. W., & Schaeffer, C. M. (2016) Multisystemic Therapy: Clinical overview, outcomes, and implementation research. *Journal of Family Proc*ess. 1-15. doi: 10.1111/famp.12232

Henry, K. L. (2007). Who’s skipping school: Characteristics of truants in 8th and 10th grade? *Journal of School Health*, *77*(1), 29–35. DOI: [10.1111/j.1746-1561.2007.00159.x](https://doi.org/10.1111/j.1746-1561.2007.00159.x)

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*(1)870–878 DOI: [10.1016/j.janxdis.2011.04.006](https://doi.org/10.1016/j.janxdis.2011.04.006)

\*Heyne, D., Sauter, F. M., Ollendick, T. H., van Widenfelt, B. M. & Westenberg, P. M. (2013) Developmentally sensitive cognitive behavioral therapy for adolescent school refusal: rationale and case illustration. *Clinical Child and Family Psychology Rev*, *17*(2):191-215. DOI: [10.1007/s10567-013-0160-0](https://doi.org/10.1007/s10567-013-0160-0)

Heyne, D., Sauter, F. M., Ollendick, T. H., Van Widenfelt, B. M., & Westenberg, P. M. (2014). Developmentally sensitive cognitive behavioural therapy for adolescent school refusal: Rationale and case illustration. *Clinical Child and Family Psychology Review*, *17*(2), 191-215. DOI: [10.1007/s10567-013-0160-0](https://doi.org/10.1007/s10567-013-0160-0)

Heyne, D., Gren-Landell, M., Melvin, G., & Gentle-Genitty, C. (2019). Differentiation between school attendance problems: Why and how? *Cognitive and Behavioural Practice*, *26*, 8–34. <https://doi.org/10.1016/j.cbpra.2018.03.006>

Houston, S. (2010). Prising open the black box: Critical realism, action research and social work. *Qualitative Social Work*, *9*(1), 73-91. [https://doi.org/10.1177/1473325009355622](https://doi.org/10.1177%2F1473325009355622)

Ingul, J.M., Klockner, C.A., Silverman, W.K. and Nordahl, H.M. (2012) Adolescent School Absenteeism: Modelling Social and Individual Risk Factors. Child and Adolescent Mental Health, *17*(1), 93-100. <http://dx.doi.org/10.1111/j.1475-3588.2011.00615.x>

\*Jones, T., Plummer, C., & Lamb, L. (2021) The Effectiveness of Peer Support Groups among Middle School Students. Thesis Lipscomb UniversityProQuest Dissertations Publishing.<https://www.proquest.com/openview/6694382b4df9e2c7bcf2a6669a0e5646/1?pq-origsite=gscholar&cbl=18750&diss=y>

\*Johnston, P. (2018). Absent parents absent kids: increasing attendance in high school students identified as school refusing. PhD Thesis. *Department of marriage and family therapy through Texas Wesleyan University.* <https://eric.ed.gov/?id=ED591651>

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). The Power Threat Meaning Framework: Overview. Leicester: *British Psychological Society*.

Jung, C. G., Adler, G., & Hull, R. F. C. (1913) Collected Works of C.G. Jung, Volume 7: Two Essays in Analytical Psychology. *Princeton University Press.* https://www.jstor.org/stable/j.ctt5hhr7s

Kaur, P.[, Pote, H.](https://pure.royalholloway.ac.uk/portal/en/persons/helen-pote(fe0a0884-8ca4-4a2a-a98a-af75b5b7dd41).html)[, Fox, S.](https://pure.royalholloway.ac.uk/portal/en/persons/simone-fox(4e9024bc-56c5-4cf9-beda-f92ab311f96a).html), & Paradisopoulos, D. (2017). [Sustaining change following multisystemic therapy: caregiver's perspectives](https://pure.royalholloway.ac.uk/portal/en/publications/sustaining-change-following-multisystemic-therapy(f14a9146-3ed5-4559-ac9c-368395bf2811).html). *Journal of Family Therapy*, *39*(2), 264-283. <https://doi.org/10.1111/1467-6427.12093>

Kearney, C.A. (2008) School Absenteeism and School Refusal Behavior in Youth: A Contemporary Review. *Clinical Psychology Review*, *28(1),* 451-471.  
<http://doi:10.1016/j.cpr.2007.07.012>

Kearney, C. A. (2001). School refusal behavior in youth: A functional approach to assessment and treatment. *American Psychological Association.* [https://doi.org/10.1037/10426-000](https://psycnet.apa.org/doi/10.1037/10426-000)

Kearney, C. A., & Albano, A. M. (2007). When children refuse school: A cognitive-behavioral therapy approach, therapist guide, (2nd ed.). Oxford University Press.

Kearney, C. A., Lemos, A., & Silverman, J. (2004). The functional assessment of school refusal behaviour. *The Behaviour Analyst Today*, *5*(3), 275-283. <http://dx.doi.org/10.1037/h0100040>

Kearney, C. A., & Bates, M. (2005). Addressing School Refusal Behavior: Suggestions for Frontline Professionals. *Children & Schools*, *27*(4), 207–216. [https://doi.org/10.1093/cs/27.4.207](https://psycnet.apa.org/doi/10.1093/cs/27.4.207)

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*(1), 57-65. [https://doi.org/10.1037/0735-7028.34.1.57](https://psycnet.apa.org/doi/10.1037/0735-7028.34.1.57)

Kearney, C. A., & Ross, E. (2014). Problematic school absenteeism. In C. A. Alfano & D. C. Beidel (Eds.), Comprehensive evidence-based interventions for children and adolescents (pp. 275-286). Hoboken, NJ, US: John Wiley & Sons Inc.

Kearney, C. A., & Silverman, W. K. (1993). Measuring the function of school refusal behaviour: The School Assessment Scale. *Journal of Clinical Child Psychology*, *22*(1), 85-96. 203. <https://doi.org/10.1207/s15374424jccp2201_9>

Kearney, C. A., Spear, M., & Mihalas, S. (2014). School refusal behavior. In L. Grossman & S. Walfish (Eds.), Translating psychological research into practice (pp. 83-88). New York, NY, US: Springer Publishing Co.

Kearney, C. A. (2008a). An interdisciplinary model of school absenteeism in youth to inform professional practice and public policy. *Educational Psychology Review*, *20*, 57–282. <http://dx.doi.org/10.1007/s10648-008-9078-3>

Kearney, C. A. (2008b). School absenteeism and school refusal behaviour in youth: A contemporary review. *Clinical Psychology Review*, *28*, 451–471. DOI: [10.1016/j.cpr.2007.07.012](https://doi.org/10.1016/j.cpr.2007.07.012)

Kelm, J. L., & McIntosh, K. (2012). Effects of school‐wide positive behaviour support on teacher self‐efficacy. *Psychology in the Schools, 49*(2), 137–147. [https://doi.org/10.1002/pits.20624](https://psycnet.apa.org/doi/10.1002/pits.20624)

King, N.J., & Bernstein, G.A. (2001). School refusal in children and adolescents: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry,* *40*(2), 197–205. DOI: [10.1097/00004583-200102000-00014](https://doi.org/10.1097/00004583-200102000-00014)

King, N.J., Heyne, D., Tonge, B., Gullone, E., & Ollendick, T.H. (2001). School refusal: Categorical diagnoses, functional analysis and treatment planning. *Clinical Psychology & Psychotherapy, 8*(5), 352–360. [https://doi.org/10.1002/cpp.313](https://psycnet.apa.org/doi/10.1002/cpp.313)

Kmet, L. M., Lee, R. C., & Cook, L. S. (2004) Standard quality assessment criteria for evaluating primary research papers from a variety of fields. Edmonton: Alberta Heritage *Foundation for Medical Research* (AHFMR). AHFMR - HTA Initiative #13.

Kottasz, R. (2005) Reasons for student non-attendance at lectures and tutorials : an analysis. I*nvestigations in university teaching and learning, 2*(2). pp. 5-16. ISSN 1740-5106

\*Lomholt, J. J., Johnsen, D. B., Silverman, W. K., Heyne, D., Jeppesen, P. & Thastum, M. (2020) Feasibility Study of Back2School, a Modular Cognitive Behavioral Intervention for Youth With School Attendance Problems. *Frontier Psychology*. *6*(11):586.

  doi: 10.3389/fpsyg.2020.00586

Last, C. G., & Strauss, C. C. (1990). School refusal in anxiety-disordered children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *29*(1), 31–35. [https://doi.org/10.1097/00004583-199001000-00006](https://psycnet.apa.org/doi/10.1097/00004583-199001000-00006)

\*Ledbetter Gill, A. (2017). The impact of positive behaviour interventions and supports on attendance rates and office discipline referrals at the middle school level. Thesis. *Doctorate of Education Liberty University*, Lynchburg, VA

Lister, R. (2004). Poverty. Chichester: Wiley.

Littell, J. H., Campbell, M., Green, S. & Toew, B. (2005) Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10‐17. *Cochrane Database of Systematic Reviews, 4* (4) DOI: [10.1002/14651858.CD004797.pub4](http://dx.doi.org/10.1002/14651858.CD004797.pub4)

\*Maeda, N. & Heyne, D. (2019) Rapid Return for School Refusal: A School-Based Approach Applied With Japanese Adolescents. *Frontiers in Psychology*. 10:2862 DOI:

[10.3389/fpsyg.2019.02862](http://dx.doi.org/10.3389/fpsyg.2019.02862)

Malle, B. F., Guglielmo, S., & Monroe, A. E. (2014). A theory of blame. Psychological Inquiry, 25(2), 147–186. [https://doi.org/10.1080/1047840X.2014.877340](https://psycnet.apa.org/doi/10.1080/1047840X.2014.877340)

Marmot Report, (2020) Health equity in England: the Marmot review 10 years on. *British Medical Journal.* doi: <https://doi.org/10.1136/bmj.m693>

Marburger, D. R. (2001). Absenteeism and undergraduate exam performance. *Journal of Economic Education, 32*(2), 99–109. DOI: [10.1080/00220480109595176](https://doi.org/10.1080/00220480109595176)

Maynard, B. R., Heyne, D., Brendel, K. R., 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* (1) p 56-67 <https://doi.org/10.1177/1049731515598619>

McClelland, L. (2013). Reformulating the impact of social inequalities: Power and social justice. *Formulation in Psychology and Psychotherapy: Making Sense of People’s Problems*. London: Routledge, 121-44.

McCluskey, C. P., Bynum, T. S., & Patchin, J. W. (2004). Reducing chronic absenteeism: An assessment of an early truancy initiative. *Crime & Delinquency*, 50, 214–234.

McCray, E. D. (2006). It’s 10 a.m.: Do you know where your children are? The persisting issue of school truancy. *Intervention in School and Clinic*, *42*(1), 30–33. [https://doi.org/10.1177/10534512060420010501](https://doi.org/10.1177%2F10534512060420010501)

McShane, G., Walter, G., & Rey, J. M. (2001) Characteristics of adolescents with school refusal. *Australia and New Zealand Journal of Psychiatry*. *35*(6) p 822–826.

DOI: [10.1046/j.1440-1614.2001.00955.x](https://doi.org/10.1046/j.1440-1614.2001.00955.x)

Minuchin, S., & Montalvo, B. (1967). Techniques for working with disorganized low socioeconomic families. *American Journal of Orthopsychiatry*, *37*(5), 880–887. [https://doi.org/10.1111/j.1939-0025.1967.tb00532.x](https://psycnet.apa.org/doi/10.1111/j.1939-0025.1967.tb00532.x)

Minuchin, S., Auerswald, E., King, C. H., & Rabinowitz, C. (1964). The study and treatment of families that produce multiple acting-out boys. *American Journal of Orthopsychiatry*, *34*(1), 125–133. [https://doi.org/10.1111/j.1939-0025.1964.tb02200.x](https://psycnet.apa.org/doi/10.1111/j.1939-0025.1964.tb02200.x)

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *British Medical Journey*. 339. doi: <https://doi.org/10.1136/bmj.b2535>

Moore, L. (2015) [Multisystemic Therapy Empowers Parents To Be The Solution](https://info.mstservices.com/blog/multisystemic-therapy-parents-solution). *MST Services blogs*. <https://info.mstservices.com/blog/multisystemic-therapy-parents-solution>

MST Data Report UK. (2019) http://www.mstuk.org/evidence-outcomes

Neal, J. W., & Neal, Z. P. (2013) Nested or Networked? Future Directions for Ecological Systems Theory. *Social development,* *22*(3) 722-736

<https://doi.org/10.1111/sode.12018>

\*Nwigwe, U. (2020) The Effectiveness of the Check & Connect Intervention: On Chronic Absenteeism in an Urban High School. Fairleigh Dickinson University.

Paisey C., & Paisey, N. J. (2004) Student attendance in an accounting module – reasons for non-attendance and the effect on academic performance at a Scottish University. *Accounting Education,* *13*(1) 39-53. DOI: [10.1080/0963928042000310788](https://doi.org/10.1080/0963928042000310788)

Paradisopoulos D., Pote H., Fox S., Kaur P. (2015). Developing a model of sustained change following multisystemic therapy: Young people’s perspectives. *Journal of Family Therapy*, *37*(4), 471–491. doi: 10.1111/1467-6427.12070

Parker, I. (2015) Towards critical psychotherapy and counselling: what can we learn from critical psychology (and political economy)? Critical psychotherapy, psychoanalysis and counselling.  In: Loewenthal, D. (eds) *Critical Psychotherapy, Psychoanalysis and Counselling.* Palgrave Macmillan, London. https://doi.org/10.1057/9781137460585\_3

Patridge, L., Strong, F. L., Lobley, E., & Mason, Danni. (2020) Pinball Kids. Preventing School Exclusions. *Royal Society for the encouragement of Arts (RSA)* https://www.thersa.org/globalassets/reports/2020/the-rsa-pinball-kids-preventing-school-exclusions.pdf

\*Pas, E. T., Ryoo, J. H., Musci, R. J., & Bradshaw, C. P. (2019) A state-wide quasi-experimental effectiveness study of the scale-up of school-wide Positive Behavioral Interventions and Supports. [*Journal of School Psychology*](https://yonsei.pure.elsevier.com/en/publications/a-state-wide-quasi-experimental-effectiveness-study-of-the-scale-),*73(1).* 41-55

DOI: [10.1016/j.jsp.2019.03.001](https://doi.org/10.1016/j.jsp.2019.03.001)

Pehlivan, Z. (2006) Absenteeism at state high schools and related school management policies in Turkey. [*Social and Behavioral Sciences*](https://www.sciencedirect.com/journal/procedia-social-and-behavioral-sciences),*15*(1). 3121-3126 <https://doi.org/10.1016/j.sbspro.2011.04.257>

Pellegrini, D.W. (2007). School non-attendance: Definitions, meanings, responses, interventions. *Educational Psychology in Practice,* *23*(1), 63–77. <https://doi.org/10.1080/02667360601154691>

Ramalho, R., Adams, P., Huggard, P., & Hoare, K. et al. (2015) Literature Review and Constructivist Grounded Theory Methodology. Forum: *Qualitative social research*. 16 (3) DOI: <https://doi.org/10.17169/fqs-16.3.2313>

Rapp-Paglicci, L., Stewart, C., & Rowe, W. (2011). Can a self-regulation skills and cultural arts program promote positive outcomes in mental health symptoms and academic achievement for at-risk youth? Journal of Social Service Research, 37(3), 309-319. [https://doi.org/10.1080/01488376.2011.564067](https://psycnet.apa.org/doi/10.1080/01488376.2011.564067)

Reddy, D. S., Negi, L., Dodson-Lavelle, B., Ozawa-de Silva, B. R., Pace, T. W.W., Cole, S. A., Raison, C. L., & Craighead, L. W. (2013) Cognitive-based compassion training: a promising prevention strategy for at-adolescents. I*. 22*(2) DOI: [10.1007/s10826-012-9571-7](http://dx.doi.org/10.1007/s10826-012-9571-7)

Reid, K. (2005). The causes, views and traits of school absenteeism and truancy: An analytical review. *Research in Education,* 74, 59–82. http://dx.doi.org/10.7227/RIE.74.6

\*Reissner, V., Jost, D., Krahn, U., Knollmann, M., Weschenfelder, A., Neumann, A., Wasem, J., & Hebebrand, J. (2015). The treatment of school avoidance in children and adolescents with psychiatric illness: A randomized controlled trial*. Deutsches Arzteblatt International*, *112*(39), 655-662. doi: [10.3238/arztebl.2015.0655](https://doi.org/10.3238%2Farztebl.2015.0655)

Ricard, R. J., Lerma, E., & Heard, C. C. C. (2013) Piloting a Dialectical Behavioural Therapy infused skills group in a Disciplinary Alternative Education Program. *Journal for specialists in group work.* 38(4), 285– 306. [https://doi.org/10.1080/01933922.2013.834402](https://psycnet.apa.org/doi/10.1080/01933922.2013.834402)

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 lifecourse efects of truancy. *Crime and Delinquency*, *63(1),* 592–612. <https://doi.org/10.1177/0011128716660520>

Saito, T (1992). Systemic family therapy of a junior high student with school refusal and suspected borderline personality disorder*. Japanese Journal of Family Psychology*, *6*(2), 81-94.

Schoner-Reichl, K. A., and Roeser, R. W. (2016) Handbook of Mindfulness in Education: *Integrating Theory and Research into Practice. Springer*, New York, NY. Pp 394

Schwandt, T. A. (2003). Three epistemological stances for qualityative inquiry: Interpretivism, hermeneutics, and social constructionism. In: N. K. Denzin, & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (2nd ed., pp. 292-331). Thousand Oaks, CA: Sage.

Schwartz, L. A., Radcliffe, J., & Barakat, L. P. (2009). Associates of school absenteeism in adolescents with sickle cell disease. *Pediatric blood & cancer*, *52*(1), 92–96. <https://doi.org/10.1002/pbc.21819>

Scanlon, T. (2008) Moral dimensions: permissibility, meaning, blame. *Belknap Press of Harvard University Press.* [10.4159/9780674043145](https://philpapers.org/go.pl?id=SCAMDP&proxyId=&u=https%3A%2F%2Fdx.doi.org%2F10.4159%2F9780674043145)

Sher, G (2006) In Praise of Blame. *Oxford University Press.*

Serious Violence Strategy (2018) HM Government. <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/698009/serious-violence-strategy.pdf>

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, Article 17. [https://doi.org/10.1186/1753-2000-2-17](https://psycnet.apa.org/doi/10.1186/1753-2000-2-17)

Smink, J. & Reimer, M. S. (2005) Fifteen effective strategies for improving student attendance and truancy prevention. *National dropout prevention center network. 1-28*

<https://eric.ed.gov/?id=ED485683>

Smith, J.A. Flower, P. & Larkin, M. (2009), Interpretative Phenomenological Analysis: Theory, Method and Research. Taylor Francis. London: Sage

Smith, J. D., Schneider, B. H., Smith, P. K., & Ananiadou, K. (2004) The effectiveness of whole-school antibullying programs: a synthesis of evaluation research. *School of Psychology Review*, *33* (4) pp547–560. <https://doi.org/10.1080/02796015.2004.12086267>

Strauss, A., & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage.

Strauss, A., & Corbin, J. (1994). Grounded theory methodology: An overview. In N. Denzin & Y. Lincoln (Eds.), Handbook of qualitative research (pp. 273-285). Thousand Oaks, CA: Sage.

Strauss, A., & Corbin, J. (1998). Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd ed.). Thousand Oaks, CA: Sage.

\*Strömbeck, J., Palmér, R., Lax, I.S., Fäldt, J., Karlberg, M., & Bergström, M. (2021) Outcome of a multi-modal CBT based treatment program for chronic school refusal. *Global Paediatric Health*. 30 (8) DOI: [10.1177/2333794X211002952](https://doi.org/10.1177/2333794x211002952)

Tan, L. B. G., & Martin, G. (2016) Taming the adolescent mind: a randomised controlled trial examining clinical efficacy of an adolescent mindfulness-based group programme. *Child and Adolescent Mental Health, 20* (1) DOI: [10.1111/camh.12057](http://dx.doi.org/10.1111/camh.12057)

Taylor, S. P. (2018). Critical realism vs social constructionism & social constructivism: application to a social housing research study. *International Journal of Sciences: Basic and Applied Research*, *37*(2), 216-222. <http://insight.cumbria.ac.uk/id/eprint/3596>

Timpson, E. (2019) The Timpson Review of School Exclusion. www.gov.uk <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/807862/Timpson_review.pdf>

Torma, S., & Halsti, A. (1975). Factors contributing to school phobia and truancy. Psychiatria Fennica, 209–220.

Tobias, A. (2017). Raising a ‘red flag’ by not going to school: A grounded theory study of family coach intervention with persistent school non-attenders. Doctoral Thesis; *Department of Education and Training University of Essex* <http://repository.tavistockandportman.ac.uk/1714/1/Tobias%20-%20Raising.pdf>

Tyson, E., Baffour, T.S., & Duong-Tran, P. (2010). Gender comparisons of self-identified strengths and coping strategies: A study of adolescents in an acute psychiatric facility. *Child Adolescent Social Work Journal*, *27(1),* 161-175.

DOI:10.1007/s10560-010-0196-7

van der Stouwe, T., Asscher, J. J., Stams, G. J. J. M., Dekovic, M., & van der Laan, P. H. (2014) The effectiveness of Multisystemic Therapy (MST): a meta-analysis. *Clinical Psychology Review, 34*(6) 468-481.  DOI: [10.1016/j.cpr.2014.06.006](https://doi.org/10.1016/j.cpr.2014.06.006)

Veenstra, R., Lindenberg, S., Tinga, F., & Ormel, J. (2010). Truancy in late elementary and early secondary education: The influence of social bonds and self-control—The TRAILS study. International Journal of Behavioral Development, 34(4), 302–310. [https://doi.org/10.1177/0165025409347987](https://psycnet.apa.org/doi/10.1177/0165025409347987)

Vrasidas, C. (2001). Making the familiar strange-and interesting-again: Interpretivism and symbolic interactionism in educational technology research. *Methods of evaluating educational technology*, 85-103.

Vreeman, R. C., & Carroll, A. E. (2007) A systematic review of school-based interventions to prevent bullying. *Arch Pediatr Adolesc Med*, *161*(1):78-88. Doi:10.1001/archpedi.161.1.78

Watkins, R., & Watkins, E. (1994). At-risk: A local study of a national issue. *Journal of Instructional Psychology, 21(*1), 290–297. <https://doi.org/10.1111/j.2044-8279.1992.tb01004.x>

Wright, D., Foster, C., Amir, Z., Elliott, J., & Wilson, R. (2010). Critical appraisal guidelines for assessing the quality and impact of user involvement in research. *Health Expectations,* 13(4), 359–368. https://doi.org/10.1111/j.1369-7625.2010.00607.x

Wilkins, J. (2008). School characteristics that influence student attendance: Experiences of students in a school avoidance program. In P.J. Graham (Ed.), *The high school journal,* 91(1). pp. 12–24. Wilmington, NC: University of North Carolina Press

Young, R. A., & Colin, A. (2004) Introduction: constructivism and social constructionism in the career field. *Journal of vocational behaviour,64* (3) 373-388. <https://eric.ed.gov/?id=EJ730146>

Zeedyk M. S., Gallacher J., Henderson M., Hope G., Husband B., Lindsay K. (2003). Negotiating the transition from primary to secondary school: perceptions of pupils, parents and teachers. *School Psychology International, 24*(1) 67–79. 10.1177/0143034303024001010

# Appendices

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Quality criteria**  **(2, 1 or 0 or NA)** | **Study number (list below)** | | | | | | | | | | | | |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** |
| 1. Question / objective sufficiently described? | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 1. Study design evident and appropriate? | 2 | 2 | 1 | 1 | 2 | 2 | 2 | 2 | 1 | 1 | 2 | 2 | 2 |
| 1. Method of subject/comparison group selection or source of information/input variables | 2 | 1 | 1 | 1 | 1 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 2 |
| 1. Subject (and comparison group, if applicable) characteristics sufficiently described? | 2 | 2 | 2 | 1 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| 1. If interventional and random allocation was possible, was it described? | 1 | 0 | NA | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 0 |
| 1. If interventional and blinding of investigators was possible, was it reported? | 0 | 0 | NA | NA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| 1. If interventional and blinding of subjects was possible, was it reported? | 0 | 0 | NA | NA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1. Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/misclassification bias? Means of assessment reported? | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 1 |
| 1. Sample size appropriate? | 1 | 2 | NA | 2 | 2 | 2 | 1 | 1 | 1 | 2 | 2 | 2 | 2 |
| 1. Analytic methods described/justified and appropriate? | 2 | 2 | 1 | 1 | 2 | 2 | 2 | 1 | 2 | 2 | 1 | 2 | 2 |
| 1. Some estimate of variance is reported for the main results? | 0 | 2 | NA | 2 | 2 | 1 | 1 | 0 | 0 | 0 | 2 | 2 | 2 |
| 1. Controlled for confounding? | 2 | 1 | NA | 1 | 0 | 2 | 0 | 1 | 2 | 1 | 1 | 2 | 0 |
| 1. Results reported in sufficient detail? | 2 | 2 | 1 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 2 |
| 1. Conclusions supported by the results? | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| **Total score** | 20/28 | 20/28 | 12/16 | 17/24 | 19/28 | 20/28 | 16/28 | 17/28 | 18/28 | 19/28 | 20/28 | 22/28 | 20/68 |
| **Percentage score** | **71** | **71** | **71** | **83** | **68** | **71** | **57** | **61** | **64** | **68** | **71** | **86** | **68** |

## Appendix A: Quality assessment of literature

1. Felver (2019)
2. Hannan (2019)
3. Heyne (2013)
4. Johnston (2018)
5. Jones (2021)Ledbetter (2018)
6. Lomholt (2020)
7. Maeda (2019)
8. Maric (2013)
9. Nwigwe (2020)
10. Pas (2019)
11. Reissner (2015)
12. Strömbeck (2021)

## Appendix B: Ethical approval confirmation

**From:** Ethics Application System <ethics@rhul.ac.uk>

**Sent:** 15 October 2021 12:44  
**To:** Pulham, Rachel Anne (2019) <Rachel.Pulham.2019@live.rhul.ac.uk>; Glorney, Emily <Emily.Glorney@rhul.ac.uk>; Ethics <Ethics@rhul.ac.uk>  
**Subject:** Result of your application to the Research Ethics Committee (application ID 2905)

PI: Dr Emily Glorney  
Project title: How does Multisystemic Therapy impact on educational outcomes?  
  
REC ProjectID: 2905  
  
Your application has been approved by the Research Ethics Committee.  
Please report any subsequent changes that affect the ethics of the project to the University Research Ethics Committee ethics@rhul.ac.uk

This email, its contents and any attachments are intended solely for the addressee and may contain confidential information. In certain circumstances, it may also be subject to legal privilege. Any unauthorised use, disclosure, or copying is not permitted. If you have received this email in error, please notify us and immediately and permanently delete it. Any views or opinions expressed in personal emails are solely those of the author and do not necessarily represent those of Royal Holloway, University of London. It is your responsibility to ensure that this email and any attachments are virus free.

## Appendix C: Participant Debrief Sheet

**[](https://www.royalholloway.ac.uk/)**Department of Psychology Royal Holloway,

University of London

Egham, Surrey TW20 0EX

www.royalholloway.ac.uk/psychology

**Debrief Sheet**

**Project title:** How does Multisystemic Therapy impact on educational outcomes?

**Name of Researcher:** Rachel Pulham

**Email of Researcher**: rachel.pulham.2019@live.rhul.ac.uk

**Thank you for taking the time to take part in this project.**

**Reasons for the project**

The reason for undertaking this project is that there has been limited research to date focusing on how Multisystemic Therapy (MST) supports educational concerns, such as school conduct, attendance, exclusion, and attainments. Data from MST teams across the UK suggest that the outcomes at discharge for young people engaging in education, employment or training are below the target of 90%.

Therefore, this project aims to:

* Gain insight into how MST supports the educational concerns.
* Explore the experience of undertaking MST to address educational concerns.
* Develop a model of the process of MST when supporting educational concerns, in the hope to aid MST teams and developers in clinical practice.

By taking part in the interview, you have helped gain insight and explore experiences. This will ultimately help develop a model of the process of how multisystemic therapy supports educational concerns.

**Support**

Talking about potentially sensitive and personal experiences can be distressing. If it could be helpful to talk to someone following this interview, please consider the following options:

**The Samaritans**- A charity which provides anonymous emotional support over the telephone, which is available 24 hours a day.  
*Telephone:* 116 123 (free)

*Website:* [https://www.samaritans.org](https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.samaritans.org%2F&data=04%7C01%7CRachel.Pulham.2019%40live.rhul.ac.uk%7C0132697aefa24e1ff5d208d97e7feb5d%7C2efd699a19224e69b601108008d28a2e%7C0%7C0%7C637679910142870779%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=PRGnR94%2FV%2FZddgQC2RhD1wLBQrTPDrejhCpHw3EgaUE%3D&reserved=0)

**Barnardo’s**– A charity which supports young people and families with mental health and wellbeing.

*Website*: [https://www.barnardos.org.uk](https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.barnardos.org.uk%2F&data=04%7C01%7CRachel.Pulham.2019%40live.rhul.ac.uk%7C0132697aefa24e1ff5d208d97e7feb5d%7C2efd699a19224e69b601108008d28a2e%7C0%7C0%7C637679910142880736%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=tK3acDOmizjIw%2BK%2Bj2xfgZ14zFKyup6Jdn6NgLBIU3U%3D&reserved=0)

**Young minds** – A charity which offers support to young people and their parents

Parents telephone helpline: 0808 802 5544 (Mon-Fri 9.30m-4pm)

*Website:* [https://youngminds.org.uk/](https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fyoungminds.org.uk%2F&data=04%7C01%7CRachel.Pulham.2019%40live.rhul.ac.uk%7C0132697aefa24e1ff5d208d97e7feb5d%7C2efd699a19224e69b601108008d28a2e%7C0%7C0%7C637679910142890690%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=oFHB7L1sYvVBqDlHPMi12BajmKucHIxcHTMD1kHvjHA%3D&reserved=0)

**Catch 22** – A service which delivers a wide range of support services to help resolve complex difficulties experienced by young people and their families/carers.

Website: [https://www.catch-22.org.uk/expertise/young-people-and-families/](https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.catch-22.org.uk%2Fexpertise%2Fyoung-people-and-families%2F&data=04%7C01%7CRachel.Pulham.2019%40live.rhul.ac.uk%7C0132697aefa24e1ff5d208d97e7feb5d%7C2efd699a19224e69b601108008d28a2e%7C0%7C0%7C637679910142890690%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=exwvcgq9JMIYMK%2BBDTtJ7VjsmMhfrZszfXpBA1XdJ20%3D&reserved=0)

**Confidentiality**

All personal details, consent forms and interview audio-recordings will be stored electronically on a password protected laptop, that only I have access to. The recordings will be transcribed and made anonymous at the point of typing. I will refer to anything said during the interview using a pseudonym rather than your name, and nothing that could identify you will be included in any documents produced from this project.

**Withdrawal from the project**

Participation in this study is completely voluntary and therefore you can withdraw your participation should you wish to, without giving a reason. Your decision to not take part will not affect your care in any way. You can request to withdraw your data by contacting me or my supervisor Dr Emily Glorney over email on the contact details below. However, data can only be withdrawn up to when the transcript has been included in analysis, which would be three weeks after the interview has been completed due to the data being anonymous following this.

**Feedback of results**

If you would like to be notified of the results of this research, you can request this at any point after taking part by emailing me to be added to the distribution list when the project has finished.

**Further questions**

If you would like further information or would like to discuss anything about the project, please do get in touch with me, or get in contact with my supervisor Dr Emily Glorney.

**Complaints**

If you are unhappy with any aspect of the project and wish to complain, please contact my supervisor Dr Emily Glorney or the Royal Holloway Ethics Committee.

**Contact details**

Rachel Pulham Dr Emily Glorney

Trainee Clinical Psychologist Senior Lecturer in Forensic Psychology

Royal Holloway, University of London Royal Holloway, University of London

[rachel.pulham.2019@live.rhul.ac.uk](mailto:rachel.pulham.2019@live.rhul.ac.uk) [emily.glorney@rhul.ac.uk](mailto:emily.glorney@rhul.ac.uk)

Royal Holloway, University of London Ethics Committee: [ethics@rhul.ac.uk](mailto:ethics@rhul.ac.uk)

**Please keep this debrief sheet for reference, and feel free to contact me if you have any questions or would like any additional information at any point.**

Thank you.

**Rachel Pulham**

**Trainee Clinical Psychologist**

## [Royal Holloway, University of London logo](https://www.royalholloway.ac.uk/)Appendix D: Demographic Information Forms

### Appendix D1: Demographic Information For (Caregivers)

**Demographic information form - Caregivers**

**NAME:**

1. How would you describe your gender?
2. How would you describe your ethnicity?

|  |  |  |
| --- | --- | --- |
| **White** | English/Welsh/Scottish/Northern Irish/British |  |
| Irish |  |
| Gypsy or Irish Traveller |  |
| Another other White background. Please describe: | |
| **Black** | English/Welsh/Scottish/Northern Irish/British |  |
| African |  |
| Caribbean |  |
| Any other Black background, please describe: | |
| **Asian** | English/Welsh/Scottish/Northern Irish/British |  |
| Indian |  |
| Pakistani |  |
| Bangladeshi |  |
| Chinese |  |
| Any other Asian background. Please describe: | |
| **Multiple ethnic groups** | White and Black Caribbean |  |
| White and Black African |  |
| White and Asian |  |
| Any other multiple ethnic background, please describe: | |
| **Any other ethnic group** | Arab |  |
| Any other ethnic background. Please describe | |

1. What area of the United Kingdom do you live?

|  |  |
| --- | --- |
| **Scotland** |  |
| **Northern Ireland** |  |
| **Wales** |  |
| **North East** |  |
| **North West** |  |
| **Yorkshire and the Humber** |  |
| **West midlands** |  |
| **East Midlands** |  |
| **South West** |  |
| **South East** |  |
| **East of England** |  |
| **London/Greater London** |  |

1. What is your relationship with the young person (e.g. parent, grandparent, carer etc.)?
2. How would you describe the gender of the young person referred for MST?
3. What age was the young person when they were referred to the Multisystemic team?
4. At the time of referral and at the point of discharge, please tick whether the following were an issue or concern:

|  |  |  |
| --- | --- | --- |
| **Attendance** | At Referral | At Discharge |
| * Not going into school |  |  |
| * Truanting in school |  |  |
| * Skipping school |  |  |
| * Other: | |  |
| **School Conduct** |  |  |
| * Aggression |  |  |
| * Disruptive behaviour |  |  |
| * Anti-social behaviour |  |  |
| * Other: | |  |
| **Performance** |  |  |
| * Issues with homework |  |  |
| * Below target |  |  |
| **Exclusions/Suspensions** |  |  |
| * Fixed exclusion/suspension |  |  |
| * Permanent exclusion |  |  |
| Other: | |  |

1. How long was the work with the Multisystemic Team?

**1-2 months 3-4 months 5-6 months 6-7 mothers 8-9months 10 months+**

1. How long ago did you work with the Multisystemic team?

**<6 months 6-12 months 12-24 months 24-36 months 36+ months**

1. Did the work with the Multisystemic Team take place during the COVID-19 pandemic?

**No Part of the work All of the work**

1. Is the young person in education, employment or training currently? **Yes/No**

### [Royal Holloway, University of London logo](https://www.royalholloway.ac.uk/)Appendix D2: Demographic Information Form (Education Professionals)

**Demographic information form – Education Professionals**

**NAME:**

1. How would you describe your gender?
2. How would you describe your ethnicity?

|  |  |  |
| --- | --- | --- |
| **White** | English/Welsh/Scottish/Northern Irish/British |  |
| Irish |  |
| Gypsy or Irish Traveller |  |
| Another other White background. Please describe: | |
| **Black** | English/Welsh/Scottish/Northern Irish/British |  |
| African |  |
| Caribbean |  |
| Any other Black, please describe: | |
| **Asian** | English/Welsh/Scottish/Northern Irish/British |  |
| Indian |  |
| Pakistani |  |
| Bangladeshi |  |
| Chinese |  |
| Any other Asian background. Please describe: | |
| **Multiple ethnic groups** | White and Black Caribbean |  |
| White and Black African |  |
| White and Asian |  |
| Any other Multiple ethnic background, please describe: | |
| **Any other ethnic group** | Arab |  |
| Any other ethnic background. Please describe | |

1. What area of the United Kingdom do you work?

|  |  |
| --- | --- |
| **Scotland** |  |
| **Northern Ireland** |  |
| **Wales** |  |
| **North East** |  |
| **North West** |  |
| **Yorkshire and the Humber** |  |
| **West Midlands** |  |
| **East Midlands** |  |
| **South West** |  |
| **South East** |  |
| **East of England** |  |
| **Greater London** |  |

1. What is your job role?
2. How many families have you worked with, who have been involved with Multisystemic Therapy?

|  |  |
| --- | --- |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |
| 5 |  |
| 6 |  |
| 7 |  |
| 8+ |  |

1. Please tick whether the following were a concern for the young person/people you have worked with:

|  |  |
| --- | --- |
| **School Conduct** |  |
| * Aggression |  |
| * Disruptive |  |
| * Anti-social behaviour |  |
| * Other: | |
| **Attendance** |  |
| * Punctuality |  |
| * Internal Truancy |  |
| * Skipping school |  |
| * Other: | |
| **Educational attainments** |  |
| * Issues with homework |  |
| * Below target |  |
| **Exclusions** |  |
| * Fixed exclusion/suspension |  |
| * Permanent exclusion |  |
| Other: | |

### Appendix D3: Demographic Information Form (MST Professionals)[Royal Holloway, University of London logo](https://www.royalholloway.ac.uk/)

**Demographic information form – MST Professionals**

**NAME:**

1. How would you describe your gender?
2. How would you describe your ethnicity?

|  |  |  |
| --- | --- | --- |
| **White** | English/Welsh/Scottish/Northern Irish/British |  |
| Irish |  |
| Gypsy or Irish Traveller |  |
| Another other White background. Please describe | |
| **Black** | English/Welsh/Scottish/Northern Irish/British |  |
| African |  |
| Caribbean |  |
| Any other Black background, please describe: | |
| **Asian** | English/Welsh/Scottish/Northern Irish/British |  |
| Indian |  |
| Pakistani |  |
| Bangladeshi |  |
| Chinese |  |
| Any other Asian background. Please describe | |
| **Multiple ethnic groups** | White and Black Caribbean |  |
| White and Black African |  |
| White and Asian |  |
| Any other Multiple ethnic background, please describe | |
| **Any other ethnic group** | Arab |  |
| Any other ethnic background. Please describe: | |

1. What area of the United Kingdom do you work?

|  |  |
| --- | --- |
| **Scotland** |  |
| **Northern Ireland** |  |
| **Wales** |  |
| **North East** |  |
| **North West** |  |
| **Yorkshire and the Humber** |  |
| **West midlands** |  |
| **East Midlands** |  |
| **South West** |  |
| **South East** |  |
| **East of England** |  |
| **Greater London** |  |

1. What is your job role?
2. How long have you worked within or with the Multisystemic Team?

|  |  |
| --- | --- |
| <1 year |  |
| 2-4 years |  |
| 5-7 years |  |
| 8-10 years |  |
| 11-15 years |  |
| 16 years + |  |

1. Please tick the educational concerns that you have experienced when working with young people and families.

|  |  |
| --- | --- |
| **School Conduct** |  |
| * Aggression |  |
| * Disruptive |  |
| * Anti-social behaviour |  |
| * Other: | |
| **Attendance** |  |
| * Punctuality |  |
| * Internal Truancy |  |
| * Skipping school |  |
| * Other: | |
| **Educational attainments** |  |
| * Issues with homework |  |
| * Below target |  |
| **Exclusions** |  |
| * Fixed exclusion/suspension |  |
| * Permanent exclusion |  |
| Other: | |

## Appendix E: Interview schedules

### Appendix E1: Interview schedules (Caregivers)

**Interview Schedule - Caregivers**

*Introductions*

Introduce self, role, project, rationale

Timings

Ground rules

Discuss/recap consent form (anonymity, right to withdraw, stop interview)

Welcome stories, anecdotes, and examples of the work

**Referral**

1. How did you come to be involved with the Multisystemic Therapy team?
   1. *Prompt: What was the journey to MST?*
   2. *Prompt: How long did you wait to work with MST?*
   3. *After the assessment, how long was it until the therapist started to help?*
2. What was your experience of being referred for multisystemic therapy?
   1. *Prompt: feelings, thoughts, fears, relationship with referrer and with family*
3. Could you expand on some of the difficulties the young person was having in relation to education, that you mentioned in the demographic form?
4. What do you think led to some of the difficulties within education?

**Focus of Therapy**

1. In reference to education, what was focused on or prioritised during the work with the MST team?
   1. *Prompt; school conduct, attendance issues, educational attainments, exclusions*
   2. *Prompts: communication; relationships; the drivers/contributions*
2. How did you and the therapist work together to address these concerns?
   1. *Prompt: What did the work first focus on?*
   2. *Prompt: What did this involve for you? Young person? Educational professionals?*
3. To what extent do you think the work with MST supported these concerns?
4. How did the MST therapist support the relationship with educational professionals?

**Review of Therapy**

1. In your experience, what didn’t work well, in addressing the educational concerns?
   1. *Prompt; school conduct, attendance issues, educational attainments, exclusions*
2. From your experience, were there things that could have been done differently within the work completed to support the concerns had around education?
3. Were there any barriers to addressing educational concerns?
   1. *Prompts: engagement, relationships*
4. What was done to try and overcome these challenges during therapy?
   1. *Prompt: what did you and the therapist do to overcome the barriers?*
5. In your experience, what worked well, in relation to addressing the educational concerns?
   1. *Prompt; school conduct, attendance issues, educational attainments, exclusions*
6. \*What did you and the therapist do that worked well?
   1. *Prompt: what strategies or interventions did you use?*
7. \*Was there anything that helped engagement with the MST process when addressing educational concerns?
8. \*What between you and the therapist had the biggest impact, on educational concerns?
   1. *Prompt: What did this involve?*
9. \*In relation to educational concerns, what did the MST therapist do to empower you?
   1. *Prompt: How did the MST therapist do that?*
   2. *Prompt: increasing responsibility, having difficult conversations with school.*
   3. *Prompt: being the young person’s advocate*
10. What were some of the impacts of the work completed?
    1. *Prompt; school conduct (aggressive, disruptive or anti-social behaviour)*
    2. *attendance issues (punctuality, internal truancy, skipping school)*
    3. *educational attainments (completing schoolwork, meeting targets)*
    4. *school exclusions (fixed or permanent)*

**Impacts of COVID**

1. Did any part of the therapy take place during the COVID-19 pandemic – from March 2020 onwards?
   1. *What was the time period?*
2. \*What was the impact of COVID-19 on education?
   1. *Prompt: home-schooling*
3. \*How did you overcome these impacts and challenges on education with MST?
4. \*What did the work look like with the MST therapist?
5. \*How were educational concerns managed?

**End of therapy**

1. What were the outcomes of the MST work, in relation to the concerns around education?
   1. *Prompt; school conduct (aggressive, disruptive or anti-social behaviour)*
   2. *attendance issues (punctuality, internal truancy, skipping school)*
   3. *educational attainments (completing schoolwork, meeting targets)*
   4. *school exclusions (fixed or permanent)*
2. What work was completed, potentially towards the end of therapy, to continue the progress or improvements after therapy ended?
3. What was your experience of ending therapy with the MST team?
   1. *Prompts: what were your thoughts, feelings, fears, hopes*
4. What have been the impacts of MST since the referral on the young person’s engagement and experience of education?
5. What was the impact of MST on you as a caregiver, in managing educational concerns?
6. What was your experience of the end of therapy?
   1. *Prompt: what did you do in the work to support ending and sustain changes?*

**Sustaining changes**

1. How are thing now in regards to education since MST has finished?
2. Has anything hindered sustaining changes made?
3. What helped sustain changes made?
   1. *Prompt: what helped maintain the relationship with school?*

**End of interview**

1. Is there anything that you were expecting to come up, that has not?
2. Is there anything else you would like to add?

Debrief

Voucher

### Appendix E2: Interview Schedule (Educational professionals)

**Interview Schedule – Educational Professional**

*Introductions*

Introduce self, role, project, rationale

Timings

Ground rules

Discuss/recap consent form (anonymity, right to withdraw, stop interview)

Welcome stories, anecdotes and examples of work

**General**

1. How many young people have you worked with that have been involved with the Multisystemic therapy team?
2. In your experience what has been the journey for a young person getting support from the MST team for educational concerns?
3. In your experience, what are some of the educational concerns that young people and their families are referred to MST for?
   1. *Prompt; school conduct, attendance issues, educational attainments, school*
4. What do you think are the contributions that led to difficulties within education?
   1. *Prompts: communication, relationships*

**Focus of therapy**

1. How much do you know about what MST involved and what the therapist was doing with the family?
2. What has been your experience of being involved with MST with families?
3. Can you tell us a bit about your contact with the MST therapist and what that involved?
   1. *To what extent were you involved with the work?*
   2. *Prompt: What did you involvement look like?*
4. What educational concerns were being focused on during MST?
   1. *Prompt; school conduct, attendance issues, educational attainments, exclusions*
   2. *Prompts: communication; relationships; the drivers/contributions*
5. How did you and the MST therapist align in reference to your goals of education?
6. To what extent do you think that MST addressed the educational concerns?

**Review of therapy**

1. What role did you see MST as playing to support the difficulties around education for the young person?
2. In your experience what didn’t work well in addressing the educational concerns that the work focused on?
   1. *Prompt; school conduct (aggressive, disruptive or anti-social behaviour)*
   2. *attendance issues (punctuality, internal truancy, skipping school)*
   3. *educational attainments (completing schoolwork, meeting targets)*
   4. *school exclusions (fixed or permanent)*
3. What factors, if any, got in the way of addressing the concerns?
   1. *What were the challenges?*
   2. *Prompts: Relationships with other professionals, relationship with the family members attendance/communication, therapeutic alliance*
   3. *How were these challenges overcome during the course of therapy?*
4. In your experience, what worked well, in relation to addressing the educational concerns?
   1. *Prompt; school conduct, attendance, attainments, exclusions*
5. How did MST support with building up the relationship with the family?
   1. *Prompt: What did this look like/involve?*
6. What between you and the therapist had the biggest impact, on educational concerns?
   1. *Prompt: What did this involve?*
7. What were some of the impacts of the work completed with the MST team?
   1. *Prompt; school conduct (aggressive, disruptive or anti-social behaviour)*
   2. *attendance issues (punctuality, internal truancy, skipping school)*
   3. *educational attainments (completing schoolwork, meeting targets)*
   4. *school exclusions (fixed or permanent)*

**COVID-19**

1. Were you involved with the young person engaging with MST during the COVID-19 pandemic?
2. \*What was the impact of COVID-19 on education for the young person?
3. \*What were the challenges of these impacts on education?
4. \*How were these challenges managed during the MST work?

**End of therapy**

1. What was your experience of the therapy ending with the MST team?
   1. *Prompts: what were your thoughts, feelings, fears, hopes*
2. What was your involvement with the young person when the therapy was coming to an end and then completed?
3. What helped with the end of therapy?
   1. *Prompt: what particular strategies, interventions, techniques*
4. What have been some of the outcomes of the MST work, in relation to the concerns that were had about education?
   1. *Prompt; school conduct, attendance, attainments, exclusions*
5. Were there things that could have been done differently within the MST work to support the educational concerns?
6. What have been the impacts of MST since the referral on the young person’s engagement and experience of education?
7. \*What have been the longer-term outcomes of engaging with MST?

**Sustaining change**

1. In your experience, what do you think has hindered sustaining changes made after MST has finished?
2. What do you think has helped sustaining changes made after MST has finished?

**End**

1. Is there anything that you thought may come up in the interview today, that hasn’t?
2. Is there anything that you would like to add?

**Debrief**

### Appendix E3: Interview Schedule (MST Professional)

**Interview schedule - MST Professionals**

*Introductions*

Introduce self, role, project, rationale – MST Standard!

Timings

Ground rules

Discuss/recap consent form (anonymity, right to withdraw, stop interview)

Welcome stories, anecdotes, and examples of work

**General**

1. How much of your work focuses on supporting young people’s education?
2. What are some of the journeys for families who have been referred to MST for educational concerns?
3. In your experience, what educational concerns are young people and their families referred to MST with?
   1. *Prompt; school conduct (aggressive, disruptive or anti-social behaviour)*
   2. *Prompt; attendance issues (punctuality, internal truancy, skipping school)*
   3. *Prompt; educational attainments (completing schoolwork, meeting targets)*
   4. *Prompt; school exclusions (fixed or permanent)*
4. What do you think are some of main drivers that have contributed to difficulties within education?
   1. *Prompts: causes of difficulties, contributions*
   2. *Prompts: maintaining/perpetuating factors*

**Focus of Therapy**

1. Can you speak to the work you have completed or supervised with families to address educational concerns?
   1. *Prompt; for school conduct, attendance, attainments and school exclusions*
   2. *Prompt; What did that work look like or involve? Where did work start?*
   3. *Prompt; Who in the system did this involve?*
2. In your own experiences, what educational concerns have you focused on during therapy?
3. What may therapy focus on at the start of the work when there are educational concerns?
   1. *Prompt: what does this involve?*
   2. *Who does this involve?*

**Review of the therapeutic work**

1. What have been some of the parts of the work that have gone well?
2. What specific strategies, techniques and interventions do you feel have been most useful to address educational concerns?
   1. *Prompts: empowering parents, motivational interviewing*
3. Can you tell me about some examples of when some specific educational goals have managed to be achieved?
   1. *What do you think enabled this to happen?*
   2. *What worked well about the work in order for this to happen?*
4. In your experience*, w*hat are some of the factors that promote engagement when addressing educational concerns in MST?
   1. *Prompt: with family, young person, professionals and all together*
5. In your experiences, what hasn’t worked well when addressing educational concerns?
   1. *Prompt; school conduct, attendance issues, educational attainments, school exclusions*
6. What clinical skills have you used to overcome barriers?
7. What were the barriers to supporting young people with educational concerns?
   1. *Prompts: where there any alignment difficulties with young people, caregivers or educational staff?*
8. How did you try and overcome these issues?
   1. *Prompt: What worked? What didn’t work?*
   2. *Prompt: With whom?*
9. How did you use supervision to support you with challenges for barriers in education?
10. Can you tell me about some of the difficulties you have had when working with a family around educational concerns?
    1. *Prompt: How did you try and overcome these issues?*
11. Can you tell me about some of the difficulties you have had when working with educational professionals?
    1. *Prompt: How did you try and overcome these issues?*
12. In your experiences, are there any specific regional challenges that may contribute to the educational concerns experienced by families you have worked with?
13. \*How has the work tried to overcome these challenges?
    1. *Prompts: how may they be overcome?*

**Impacts of COVID**

1. How has the COVID-19 pandemic impacted specifically on educational concerns for young people and their families that you have worked with?
   1. *Prompt: what about the impacts with working with educational professionals?*
2. What additional challenges did COVID-19 bring?
3. How have these been managed or overcome?
   1. *Prompt: what did you have to do differently to adapt? What did this look like?*

**End of Therapy**

1. Thinking about the work you have completed with families around educational concerns, when has the end of therapy been thought about with families?
   1. *Prompts: What would indicate this in terms of education?*
   2. *Prompts: reviews, do-loops*
2. When preparing to end therapy, what work has been completed to continue the progress or improvements in relation to educational concerns?
   1. *Prompts: what did this involve?*
3. How did you support the family and the educational professionals for closure?
   1. *Prompt: sustainability planning*
   2. *Prompt: what particular strategies, interventions, techniques*
4. What have been some of the outcomes of the MST work, in relation to the concerns that were had about education?
   1. *Prompt; school conduct (aggressive, disruptive or anti-social behaviour)*
   2. *attendance issues (punctuality, internal truancy, skipping school)*
   3. *educational attainments (completing schoolwork, meeting targets)*
   4. *school exclusions (fixed or permanent)*
5. Can you tell me about some of the impacts of MST since the referral on the young person’s engagement with and experience of education?

**Ending**

1. Is there anything that you were expecting to come up, that hasn’t?
2. Anything you would like to add?

**Debrief**

## [Royal Holloway, University of London logo](https://www.royalholloway.ac.uk/)Appendix F: Participant Information Sheets

### **Appendix F1: Information Sheet (caregivers**)

Department of Psychology Royal Holloway,

University of London

Egham, Surrey TW20 0EX

www.royalholloway.ac.uk/psychology

**Participant Information Sheet**

**Project title**: How does Multisystemic Therapy (MST) impact on educational outcomes?

**Consent to participate in a research project**

Thank you for considering taking part in this research project. My name is Rachel Pulham, I am a Clinical Psychology Trainee at Royal Holloway, University of London. The purpose of this document is to provide you with the information you need to decide whether or not you would like to take part in this project. Please take time to consider the information carefully, to discuss it with family or friends if you wish and to ask the researcher any questions you may have.

**Project** **description**

I am interested in exploring the process and experience of undertaking multisystemic therapy (MST) in addressing concerns around education. There is currently limited research focusing on how MST supports educational concerns, such as school conduct, attendance, exclusion, and attainments. Data from MST teams across the UK suggest that the outcomes at discharge for young people engaging in education, employment or training are below the target of 90%. Alongside this, government and charity sector reports have identified that there has been a 60% rise in exclusions since 2015.

**The key aims of the project are:**

* To gain insight into how MST supports the educational concerns.
* To explore the experience and process of undertaking MST to address educational concerns.
* To develop a model of the process of MST when supporting educational concerns, in the hope to aid MST teams and developers in clinical practice.

**What would taking part involve?**

1. You would be asked to complete a brief questionnaire about your demographic information. This can be done any time before the interview.
2. You would be asked to take part in a semi-structured interview with me. This would be held via the most familiar video conferencing software to you and would last for approximately 45 – 90 minutes. You would be offered various dates and time options with the hope to find a mutually convenient time for the interview.

If you decided to take part in this study, you would have the opportunity to ask any questions or share any thoughts you have regarding any aspect of the project both before the interview, at the start and at the end of the interview.

In the interview you would be asked several open questions about:

* Your experience of engaging with MST for concerns around education.
* What the interventions addressing educational concerns involved, and what that was like.
* Any strengths, limitations or difficulties involved with completing work around educational concerns.
* Your overall experience of MST, and its impacts and outcomes on education.

To ensure that the information gathered is an accurate representation of the interview, the interview would be audio-recorded. You would not be expected to talk about anything you do not wish to speak about.

**Confidentiality & anonymity**

All personal details, consent forms and audio-recordings from the interview will be stored electronically on a password protected laptop, that only I have access to. The audio-recordings will be transcribed and typed up and made anonymous at the point of typing. I will refer to anything you say using a pseudonym rather than your name, and nothing that reveals who you are will be included in any documents produced from this project. I will keep a list of participants’ names and pseudonyms in a password protected document, kept separate from the interview transcripts. Additionally, consent forms will be kept separately. As soon as the recordings have been transcribed, the recordings will be deleted securely. Any direct quotes would be presented anonymously in the final research report and any publication. The anonymised transcript of what you say will be kept securely for a period of five years after the study has been completed, in compliance with the university guidance. After this date, all data will be securely destroyed. All information you provide will be kept confidential unless you disclose information regarding risk to yourself or others. In such an event, you would be informed of the action that would be necessary in order to ensure your safety and that of others.

**What are the possible benefits of taking part?**

There would be a compensation of £10 for the time you would give to completing this interview. Other benefits of taking part in this research project would be indirect. One of the benefits is that your experiences may help future young people and families. You would also be helping inform a model of how MST addresses educational concerns, in the hope that this will inform clinical practice.

**What are the possible disadvantages of taking part?**

Talking about experiences of difficulties and of therapy can be difficult. You would not have to answer any questions you are not comfortable with. If you find any parts of the interview stressful, upsetting or uncomfortable, you would be welcome to ask for a break or to reschedule the interview. Additionally, the interview would require you to sit down and look at a computer screen for a long period of time, there may be a risk of physical discomfort, pain or eye strain/dryness. Again, you would be welcome to take breaks at any point by letting the researcher know, or discussing this at the start of the interview to schedule this in.

**What will happen if I don't want to carry on with the study?**

Participation in this study is completely voluntary. If you decide to take part, you can end your participation, without giving a reason. Your decision whether or not to take part will not affect your care in any way. You could request to withdraw your data in person, email or through telephone. However, data can only be withdrawn up to when the transcript has been included in analysis, which would be three weeks after the interview.

**What will happen to the results of this study?**

It is intended for the results of this study to be disseminated in academic publications, conferences and to stakeholders of UK Doctorate in Clinical Psychology courses, such as clinical psychologists, trainee clinical psychologists and policy makers. Interested participants would be sent an email about the overall findings and implications when the research project has been completed.

**Royal Holloway University Research Ethics Committee**

This study has received ethical approval by Royal Holloway, University of London (application ID 2905).

**Further information and contact details**

If you would like further information or would like to discuss anything about the project, please do get in touch with me, the researcher of this project, or get in contact with my supervisor Dr Emily Glorney.

Rachel Pulham Dr Emily Glorney

Trainee Clinical Psychologist Senior Lecturer in Forensic Psychology

Royal Holloway, University of London Royal Holloway, University of London

[rachel.pulham.2019@live.rhul.ac.uk](mailto:rachel.pulham.2019@live.rhul.ac.uk) [emily.glorney@rhul.ac.uk](mailto:emily.glorney@rhul.ac.uk)

Although, it is hoped that this would not be the case, if you are unhappy with any aspect of the project and wish to complain, please contact my supervisor Dr Emily Glorney.

**GDPR statement**

Important General Data Protection Information (GDPR) Royal Holloway, University of London is the sponsor for this study and is based in the UK. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Any data you provide during the completion of the study will be stored securely on hosted on servers within the European Economic Area’. Royal Holloway is designated as a public authority and in accordance with the Royal Holloway and Bedford New College Act 1985 and the Statutes which govern the College, we conduct research for the public benefit and in the public interest. Royal Holloway has put in place appropriate technical and organisational security measures to prevent your personal data from being accidentally lost, used or accessed in any unauthorised way or altered or disclosed. Royal Holloway has also put in place procedures to deal with any suspected personal data security breach and will notify you and any applicable regulator of a suspected breach where legally required to do so. To safeguard your rights, we will use the minimum personally identifiable information possible (i.e., the email address you provide us). The lead researcher will keep your contact details confidential and will use this information only as required (i.e., to provide a summary of the study results if requested and/or for the prize draw). The lead researcher will keep information about you and data gathered from the study, the duration of which will depend on the study. Certain individuals from RHUL may look at your research records to check the accuracy of the research study. If the study is published in a relevant peer-reviewed journal, the anonymised data may be made available to third parties. The people who analyse the information will not be able to identify you. You can find out more about your rights under the GDPR and Data Protection Act 2018 by visiting <https://www.royalholloway.ac.uk/about-us/more/governance-and-strategy/data-protection/> and if you wish to exercise your rights, please contact [dataprotection@royalholloway.ac.uk](mailto:dataprotection@royalholloway.ac.uk)

**Please keep this sheet for reference, and feel free to contact me if you have any questions or would like any additional information at any point.**

Thank you.

**Rachel Pulham**

**Trainee Clinical Psychologist**

### [Royal Holloway, University of London logo](https://www.royalholloway.ac.uk/)Appendix F2: Educational Professional Information Sheet

Department of Psychology Royal Holloway,

University of London

Egham, Surrey TW20 0EX

www.royalholloway.ac.uk/psychology

**Participant Information Sheet – Education Professionals**

**Project title:** How does Multisystemic Therapy (MST) impact on educational outcomes?

**Consent to participate in a research study**

Thank you for considering taking part in this research project. My name is Rachel Pulham, I am a Clinical Psychology Trainee at Royal Holloway, University of London. The purpose of this document is to provide you with the information you need to decide whether or not you would like to take part in the research. Please take time to consider the information carefully, to discuss it with your colleagues or managers if you wish and to ask me any questions you may have.

**Project description**

I am interested in exploring the process and experience of undertaking multisystemic therapy (MST) in addressing concerns around education. There is currently limited research focusing on how MST supports educational concerns, such as school conduct, attendance, exclusion, and attainments. Data from MST teams across the UK suggest that the outcomes at discharge for young people engaging in education, employment or training are below the target of 90%. Alongside this, government and charity sector reports have identified that there has been a 60% rise in school exclusions since 2015.

**The key aims of the project are**:

* To gain insight into how MST supports the educational concerns.
* To explore the experience and process of undertaking MST to address educational concerns.
* To develop a model of the process of MST when supporting educational concerns, in the hope to aid MST teams and developers in clinical practice.

**What would taking part involve?**

1. You would be asked to complete a brief questionnaire about you. This can be done any time before the interview.
2. You would then take part in a semi-structured interview with me at a mutually convenient time. This would be held via video conference (e.g. Zoom, MS Teams, WhatsApp) and would last for approximately 45 – 90 minutes.

If you decided to take part in this study, you would have the opportunity to ask any questions or share any thoughts you have regarding any aspect of the project both before the interview, at the start and at the end of the interview.

In the interview you would be asked questions about:

* Your experience of being involved with MST with a young person and family who have concerns around education.
* Your involvement with the work completed with MST.
* Any strengths, limitations or difficulties involved with completion work around addressing educational concerns.
* Your overall experience of MST, and it’s impacts and outcomes on education.

To ensure that the information gathered is an accurate representation of the interview, the interview would be audio-recorded.

**Confidentiality** **& anonymity**

All personal and professional details, consent forms and audio-recordings from the interview will be stored electronically on a password protected laptop, that only I have access to. The audio-recordings will be typed up and made anonymous at the point of typing. Any direct quotes would be presented anonymously in the final research report and any publication. I will not include your name in the transcript and nothing that could identify who you are will be included in any documents produced from this project. As soon as the recordings have been typed up, the recordings will be deleted securely. The anonymised transcript of what you say will be kept securely for a period of five years after the study has been completed, as is the university guidance for research data. After this date, all data will be securely destroyed. All information you provide will be kept confidential, unless there is a disclosure of risk to yourself or others. In such an event, you would be informed of the action that would be necessary in order to ensure your safety and that of others.

**What are the possible benefits of taking part?**

By talking to me, your experiences may help future young people and families that have concerns around education. You would also be helping inform a model of how MST addresses educational concerns, in the hope that this will inform clinical practice.

**What are the possible disadvantages of taking part?**

Taking part in an interview can be stressful or uncomfortable. Therefore, you would be welcome to ask for a break or to reschedule the interview at any point. Additionally, the interview would require you to sit down and look at a computer screen for over 45 minutes, which may increase risk of physical discomfort, pain or eye strain/dryness. Again, you would be welcome to take breaks at any point by letting me know, or discussing this at the start of the interview to schedule this in.

**Can I say no?**

Participation in this study is completely voluntary. If you decide to take part, you can end your participation, without giving a reason. You could request to withdraw your data in person, email or through telephone. However, data can only be withdrawn up to when the transcript has been included in analysis, which would be three weeks after the interview.

**What will happen to the results of this study?**

It is intended for the results of this study to be published in the academic field and communicated directly with practitioners and policy makers. If you would like to read the summary of the findings and implications of the research then please give your email address to me and I will send on a summary, once the research project has been completed.

**Royal Holloway University Research Ethics Committee**

This study has received ethical approval by Royal Holloway, University of London (application ID 2905).

**Further information and contact details**

If you would like further information or would like to discuss anything about the project, please do get in touch with me, the researcher of this project, or get in contact with my supervisor Dr Emily Glorney.

Rachel Pulham Dr Emily Glorney

Trainee Clinical Psychologist Senior Lecturer in Forensic Psychology

Royal Holloway, University of London Royal Holloway, University of London

[rachel.pulham.2019@live.rhul.ac.uk](mailto:rachel.pulham.2019@live.rhul.ac.uk) [emily.glorney@rhul.ac.uk](mailto:emily.glorney@rhul.ac.uk)

Although, it is hoped that this would not be the case, if you are unhappy with any aspect of the project and wish to complain, please contact my supervisor Dr Emily Glorney.

**GDPR statement**

Important General Data Protection Information (GDPR) Royal Holloway, University of London is the sponsor for this study and is based in the UK. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Any data you provide during the completion of the study will be stored securely on hosted on servers within the European Economic Area’. Royal Holloway is designated as a public authority and in accordance with the Royal Holloway and Bedford New College Act 1985 and the Statutes which govern the College, we conduct research for the public benefit and in the public interest. Royal Holloway has put in place appropriate technical and organisational security measures to prevent your personal data from being accidentally lost, used or accessed in any unauthorised way or altered or disclosed. Royal Holloway has also put in place procedures to deal with any suspected personal data security breach and will notify you and any applicable regulator of a suspected breach where legally required to do so. To safeguard your rights, we will use the minimum personally identifiable information possible (i.e., the email address you provide us). The lead researcher will keep your contact details confidential and will use this information only as required (i.e., to provide a summary of the study results if requested and/or for the prize draw). The lead researcher will keep information about you and data gathered from the study, the duration of which will depend on the study. Certain individuals from RHUL may look at your research records to check the accuracy of the research study. If the study is published in a relevant peer-reviewed journal, the anonymised data may be made available to third parties. The people who analyse the information will not be able to identify you. You can find out more about your rights under the GDPR and Data Protection Act 2018 by visiting <https://www.royalholloway.ac.uk/about-us/more/governance-and-strategy/data-protection/> and if you wish to exercise your rights, please contact [dataprotection@royalholloway.ac.uk](mailto:dataprotection@royalholloway.ac.uk)

**Please keep this sheet for reference, and feel free to contact me if you have any questions or would like any additional information at any point.**

Thank you.

**Rachel Pulham**

**Trainee Clinical Psychologist**

### [Royal Holloway, University of London logo](https://www.royalholloway.ac.uk/)Appendix F3: MST Professional Information Sheet

Department of Psychology Royal Holloway,

University of London

Egham, Surrey TW20 0EX

www.royalholloway.ac.uk/psychology

**Participant Information Sheet – MST Professional**

**Project title:** How does Multisystemic Therapy (MST) impact on educational outcomes?

**Consent to participate in a research study**

Thank you for considering taking part in this research project. My name is Rachel Pulham, I am a Clinical Psychology Trainee at Royal Holloway, University of London. The purpose of this document is to provide you with the information you need to decide whether or not you would like to take part in the research. Please take time to consider the information carefully, to discuss it with your colleagues or managers if you wish and to ask the researcher any questions you may have.

**Project description**

I am interested in exploring the process and experience of undertaking multisystemic therapy (MST) in addressing concerns around education. There is currently limited research focusing on how MST supports educational concerns, such as school conduct, attendance, exclusion, and attainments. Data from MST teams across the UK suggest that the outcomes at discharge for young people engaging in education, employment or training are below the target of 90%. Alongside this, government and charity sector reports have identified that there has been a 60% rise in school exclusions since 2015.

**The key aims of the project are**:

* To gain insight into how MST supports the educational concerns.
* To explore the experience and process of undertaking MST to address educational concerns.
* To develop a model of the process of MST when supporting educational concerns, in the hope to aid MST teams and developers in clinical practice.

**What would taking part involve?**

1. You would be asked to complete a brief questionnaire about you. This can be done any time before the interview.
2. You would then take part in a semi-structured interview with me at a mutually convenient time. This would be held via video conference (e.g. Zoom, MSTeams, Whats App) and would last for approximately 45 – 90 minutes.

If you decided to take part in this study, you would have the opportunity to ask any questions or share any thoughts you have regarding any aspect of the project both before the interview, at the start and at the end of the interview.

In the interview you would be asked questions about:

* Your experience of undertaking MST for concerns around education.
* What the interventions addressing educational concerns involved.
* Any strengths, limitations or difficulties involved with completing work around educational concerns.
* Your overall experience of undertaking MST; its impacts and outcomes on education.

To ensure that the information gathered is an accurate representation of the interview, the interview would be audio-recorded.

**Confidentiality** **& anonymity**

All personal and professional details, consent forms and audio-recordings from the interview will be stored electronically on a password protected laptop, that only I have access to. The audio-recordings will be typed up and made anonymous at the point of typing. I will not include your name in the transcript and nothing that could identify who you are will be included in any documents produced from this project. Any direct quotes would be presented anonymously in the final research report and any publication. As soon as the recordings have been typed up, the recordings will be deleted securely. The anonymised transcript of what you say will be kept securely for a period of five years after the study has been completed, as is the university guidance for research data. After this date, all data will be securely destroyed. All information you provide will be kept confidential, unless there is a disclosure of risk to yourself or others. In such an event, you would be informed of the action that would be necessary in order to ensure your safety and that of others.

**What are the possible benefits of taking part?**

By taking part, your experiences may help future young people and families that have concerns around education. You would also be helping inform a model of how MST addresses educational concerns, in the hope that this will inform clinical practice.

**What are the possible disadvantages of taking part?**

Taking part in an interview can be stressful or uncomfortable. Additionally, you would be required to be looking at a computer screen for around 60 minutes, which may cause physical discomfort and/or eye strain. Therefore, you would be welcome to ask for a break at any point.

**Can I say no?**

Participation in this study is completely voluntary. If you decide to take part, you can end your participation, without giving a reason. You could request to withdraw your data in person, email or through telephone. However, data can only be withdrawn up to when the transcript has been included in analysis, which would be three weeks after the interview.

**What will happen to the results of this study?**

It is intended for the results of this study to be published in the academic field and communicated directly with practitioners and policy makers. If you would like to read the summary of the findings and implications of the research then please give your email address to me and I will send on a summary, once the research project has been completed.

**Royal Holloway University Research Ethics Committee**

This study has received ethical approval by Royal Holloway, University of London (application ID 2905).

**Further information and contact details**

If you would like further information or would like to discuss any details personally, please get in touch with me, the researcher of this project or my supervisors Dr Emily Glorney.

Rachel Pulham Dr Emily Glorney

Trainee Clinical Psychologist Senior Lecturer in Forensic Psychology

Royal Holloway, University of London Royal Holloway, University of London

[rachel.pulham.2019@live.rhul.ac.uk](mailto:rachel.pulham.2019@live.rhul.ac.uk) [emily.glorney@rhul.ac.uk](mailto:emily.glorney@rhul.ac.uk)

Although, it is hoped that this would not be the case, if you are unhappy with any aspect of the project and wish to complain, please contact my supervisor Dr Emily Glorney.

**GDPR statement**

Important General Data Protection Information (GDPR) Royal Holloway, University of London is the sponsor for this study and is based in the UK. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Any data you provide during the completion of the study will be stored securely on hosted on servers within the European Economic Area’. Royal Holloway is designated as a public authority and in accordance with the Royal Holloway and Bedford New College Act 1985 and the Statutes which govern the College, we conduct research for the public benefit and in the public interest. Royal Holloway has put in place appropriate technical and organisational security measures to prevent your personal data from being accidentally lost, used or accessed in any unauthorised way or altered or disclosed. Royal Holloway has also put in place procedures to deal with any suspected personal data security breach and will notify you and any applicable regulator of a suspected breach where legally required to do so. To safeguard your rights, we will use the minimum personally identifiable information possible (i.e., the email address you provide us). The lead researcher will keep your contact details confidential and will use this information only as required (i.e., to provide a summary of the study results if requested and/or for the prize draw). The lead researcher will keep information about you and data gathered from the study, the duration of which will depend on the study. Certain individuals from RHUL may look at your research records to check the accuracy of the research study. If the study is published in a relevant peer-reviewed journal, the anonymised data may be made available to third parties. The people who analyse the information will not be able to identify you. You can find out more about your rights under the GDPR and Data Protection Act 2018 by visiting <https://www.royalholloway.ac.uk/about-us/more/governance-and-strategy/data-protection/> and if you wish to exercise your rights, please contact [dataprotection@royalholloway.ac.uk](mailto:dataprotection@royalholloway.ac.uk)

**Please keep this sheet for reference, and feel free to contact me if you have any questions or would like any additional information at any point.**

Thank you.

**Rachel Pulham, Trainee Clinical Psychologist**

## [Royal Holloway, University of London logo](https://www.royalholloway.ac.uk/)Appendix G: Consent Form

Department of Psychology Royal Holloway,

University of London

Egham, Surrey TW20 0EX

www.royalholloway.ac.uk/psychology

**Consent form**

**Project title:** How does Multisystemic Therapy impact on educational outcomes?

**Name of Researcher:** Rachel Pulham

**Email of Researcher**: rachel.pulham.2019@live.rhul.ac.uk

*Please read the following statements and if you are in agreement, please write your initials in the box next to the statement.*

|  |  |
| --- | --- |
| 1. I confirm that I have read the information sheet for the above study, and I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. |  |
| 1. I understand that my participation is voluntary and that I am free to withdraw without giving a reason; up until three weeks after the interview. At which point the interview will be transcribed and anonymised. |  |
| 1. I understand that the interview will be recorded. The recording will be transcribed and securely deleted, and I agree to this. |  |
| 1. I understand that all data will be kept confidential, and that no personal identifying information will be disclosed in any reports on the project, or to any other party. |  |
| 1. I understand that maintaining strict confidentiality is subject to the following limits: information will be kept confidential unless I disclose information regarding risk of harm to myself and others, in which case I will be informed of the action that would be necessary to ensure my safety and that of others. |  |
| 1. I agree to take part in the above study. |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Name Participant Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Researcher Name Researcher Signature Date

If you have any concerns about this research, please email [ethics@rhul.ac.uk](mailto:ethics@rhul.ac.uk)

## Appendix H: Example transcript showing coding process

|  |  |  |
| --- | --- | --- |
| **Extract** | **Initial Codes** | **Focused Codes** |
| MST Therapist 15: Exactly, really understanding and getting to know what is going on for them and really validating how difficult it is. You know, I haven’t got all of the answers, you are absolutely a partner in this. You know your family inside out and I have basically just rocked up on your doorstep. I don’t know anything about you. You know some families will go, “well I just want you to give me an answer” and you know I am kind of like do you know what? I could give you an answer, I could tell you “Try this and try that” but actually you’ve had lots of service involvement before, and it hasn’t worked. I don’t even understand what’s happening right now, so I can give you an answer, but I can’t tell you that it is going to work. And then you might get really frustrated if it doesn’t, so you know how do we spend some time really understanding what is going on. | Understanding the problems for the family  Validating how difficult it is  MST not knowing position  Families wanting the answers  MST reflecting on unhelpfulness of giving strategies  Trying this and trying that  Families having lots of previous experiences  Starting at understanding | Every family is different  The flexibility of MST  Gaining a real understanding of what is going on |
| Caregiver 11: “The difference between [MST Worker] and everyone that came through my door was [MST worker] asked a question and I answered it and it went from there. Whereas other people that came into my property where “have you tried this?” “Have you tried that?” and it were like “yes I did that three month ago” “yes I did that six months ago”. And I spoke to them about my son missing school, and things like that and there were one gentleman that were in my house and after I had spoken to him about everything, he had a piece of paper and he kept referring to it to this piece of paper, rather than talking to me. He were basically working off a piece of paper. To his own agenda, to his own questions. … Not everyone is the same, every family is different and that is one of the good things about MST, she dealt with us. Without problem. And she didn’t come in, saying “all families are this way” and “all families are that way”. She dealt with us. Me with the way that I was, and the way I reacted to things and to my son. The way that my son was when he reacted to me, and she just went from there.” | Reflecting on the differences between MST and other services  Other services problem solving  Other services giving parenting advice  Other services reading from a script  MST dealing with the family  Not a one size fits all  MST knowing every family is different  Reflecting on communication with son  Reflecting on relationships  MST dealing with ‘them’ | MST not having a script  The flexibility of MST  Reflecting on communication at home |
| Educationalist 11: I think MST’s strength are undoubtedly, to this day, I love it, it is purely magic. The strength of MST are it is sustainable within families and although we failed a lot I know in educationally, over the years, sometimes in placements too. Essentially just the very premise that we are not putting the problem within the children, the notion we are saying it’s the carer that needs the support because we are not important and we as psychologists have been saying this for years, we don’t have the legal reach, we don’t have that emotional power that a parent or carer does. Even were the relationship is broken down, and it is completely dreadful and even when it is abusive there is still a power within that relationship. Which they don’t have with me. They don’t give a monkey’s what I do. So just tapping into that power, of a parent or carer and I see it in my own work. That’s why I am interested in MST in the first place I see it in my own work – and I want to do it in my own work. And I just don’t have the capacity to do that. To actually be able to say I am going to go and talk to this parent, for four hours this week. I am going to talk to them on a daily basis, I am going to be coaching them through what they are going to do. That is where sustainable change happens. That drip, drip, drip, drip feed. And we know anyway, psychological models tell us that, very clearly, in such that has been done in the past. It’s the message we try and keep giving out, in other spheres of our work. You know I keep saying, I don’t want someone with communication difficulties to have a one week hour session with your communication specialist – I need them to have two-three small 10 minute sessions every single day. Focusing only very narrowly on something very very specific and tangible, that we can all see, and touch. You know? And then we can celebrate when it works, and we can move on to the next thing. So I know that in terms of children’s development and how they are able to change and how parents and adults can change and adapt and learn, it’s got to be that slow. And I love it, that the model that it works alongside the parents. The parent is the person with expert. We are not the experts. The parents aren’t either, but they hold the expert knowledge of the child. They are the people who know them best. And because they know them best, and they are able to vocalise and shape what we do around those children, jointly with the therapist. It is massively power, and the power of the relationship – which is something else we know, and we do it all the time in mental health. | Appreciating MST  MST being sustainable  Not putting the problem within the child  Caregivers needing support  Caregivers being in a powerful relational position  Tapping into the emotional power  Using MST in education  Not having the capacity in education  The intensity of MST is where the sustainability happens  The drip drip drip feed  Reflecting on the benefits of intensive support  MST focussing on one problem  MST being tangible and specific to the family  Celebrating when MST works  Moving on to the next thing  Caregivers being the expert  Caregivers being in the best position to advocate  Caregivers working jointly with therapists | Understanding problems systemically  Using MST strategies after closure  The intensity of MST  Focusing on problems Doing whatever works  Caregivers expertise |

## Appendix I: Memoing extract

*04/02/2022*

Therapists, caregivers, and educationalists have all brought up the concept of blame. In reference to experiencing it, assuming it or feeling it towards other. There is also something about everyone feeling blamed and shamed. Parents feel blamed, the child is blamed, the school is blamed, the government is blamed. Possible projections of blame too. Therapists are bringing up the relationship between blame and reframing to strengths. Rather than the system being responsible for what is happening, it is responsible for finding the ways forward. It is a core relationship, moving from blame to seeing noble intent. But that first there needs to be attendance to blame and its deconstruction.

*07/02/2022*

I am hearing a lot about the process of understanding. There is something about understanding what is going on for the system, that is about language, the meaning made, the assumptions, the biases. I hear the role of MST is breaking things down, going back to what actually happened before the meaning was made. What does it look like? What does “dangerous” or “violent” behaviour mean? How is the system making meaning or making assumptions? There is an appreciation of the system running on empty, and people jumping to conclusions more. Everyone is in threat mode, and is under resourced, heavily stressed, and trying make their lives easier? Therefore, a good understanding of what is actually happening, slowing down the process.

*09/02/2022*

A theme coming out in the interviews is that there is benefit of settling the home environment, thinking about relationships, communications, and routines. It’s thinking about communication on a level of, the matching of energies. Child kicks off and parent is triggered in some way. There is something about the “relearning” or “redoing” the parenting thing. It seems to be the process of reflecting on the changes from childhood to adolescence and the difficulties that come at that part of life.

There also appears to be parallel processes of attending to the familial system and building the system around the child/family, simultaneously. Recruiting the right people, the right services and the decision makers within the different systems. When MST hasn’t worked or perhaps has needed more than 20 weeks, is when these processes have not been synchronized, when they have been speaking to the wrong person in the school or at home, or not engaging a parent in the work. So there seems to be something about having everyone necessary around, understanding.

## Appendix J: Breakdown of theoretical, focused and initial codes

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Theoretical Codes** | **Focused Codes** | **Example Initial Codes** | **Sources\*** | **References\*\*** |
| 1. **Understanding factors contributing to the educational problem** | Building an understanding of the issues | * Breaking down referral behaviours * Every family is different * Negative experiences of previous services | 3  5  8 | 6  10  13 |
| Understanding problems systemically | * Helping school understand child’s behaviour * The system understanding difficulties systemically | 6  9 | 12  23 |
| 1. **Building and aligning the system** | Building the system | * MST collaborating with schools * Getting the right support in place * Recruiting the right people to the system | 8  8  12 | 26  27  36 |
| Working with blame and bringing in strengths | * Blaming chaos of home for educational concerns * Recognising the schools contribution | 5  5 | 5  13 |
| The systems value of education | * Reconnecting with value of education | 4 | 12 |
| The system being aligned with goals | * Working as an aligned team * Aligning with goals | 5  7 | 13  16 |
| 1. **Working on the home relationships** | Reflecting on how to do the parenting thing | * Parents feeling able to express * Reflecting on parenting | 4  4 | 7  20 |
| Same destination, different journey | * Changing approaches at home * Focusing on relationships and communication at home | 3  3 | 9  6 |
| 1. **Flexibility of MST model** | Formulating the whatever works plan | * Constantly conceptualising using FITS * Doing whatever works | 7  4 | 16  8 |
| Not underestimating the barriers | * Getting the practical things right * MST supporting routines | 8  5 | 18  10 |
| 1. **Increasing responsibility** | Preparing for closure | * Parents taking responsibility back from MST * Thinking about sustainability from the beginning | 5  7 | 10  14 |
| 1. **Legacy of MST** | Sustainability planning for closure | * Thinking about what is realistic * Making sustainability plans detailed | 5  5 | 9  9 |
| Practising the living of MST values | * Feeling more confident after MST * Using MST strategies after closure | 2  5 | 5  8 |
| MST going beyond just therapy | * The system needing a drip drip drip approach * Investment leading to investment | 6  8 | 13  16 |

\*NVivo sources is the collective term for interview. Therefore 8 means that this initial code was present in 8 interviews

\*\*NVivo references is the count of selections within that source that have been coded to any node. Therefore 16 means that this initial code was referred 16 times.