Multi/Interdisciplinary teams for early school leaving prevention: Developing a European Strategy informed by international evidence and research

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1 Introduction

This paper seeks to examine evidence regarding the potential for multidisciplinary and interdisciplinary teams to play a key role in prevention of early school leaving. It is recognised that this is an emerging area for the context of early school leaving prevention across Europe. As part of developing a strategy for such multi/interdisciplinary teams, an important focus is on necessary and supportive conditions for their effectiveness, rather than a deterministic assumption of their inevitable effectiveness. Contextual conditions internal to the teams and regarding systemic needs for early school leaving prevention will need to be given recognition.

While a systems theory level focus has tended to be applied in health, youthwork and community psychology contexts (Behrens & Foster-Fishman, 2007; Tseng & Seidman 2007; Durlak et al., 2007)), there has been a comparative neglect of such a focus in educational contexts until recently (Ulicna et al., 2010; Downes 2011). In the US context, McLaughlin (2006) suggests that 'in part this lack of attention to system learning within education reflects the fact that only recently has the system been considered as a unit of change' (p.226). Examination of the opportunities and barriers to implementing a subsystem of a multi/interdisciplinary team within existing school and community systems in order to prevent early school leaving, will therefore interrogate lessons from empirical research on such teams in the areas of health and community mental health. A number of examples in European countries of multi/interdisciplinary teams which do engage with prevention of early school leaving will also be analysed, while being cognisant of the fact that though some have undergone independent evaluation, there is a dearth of international peer reviewed journal literature specifically on multi/interdisciplinary teams for early school leaving prevention. This applies *a fortiori* to the lack of randomised controlled trials assessing outcomes of multi/interdisciplinary teams on early school leaving prevention. Burkhart's (2004) review of selective prevention projects across Western Europe to engage with truancy, drug abuse and social marginalisation observed that in general the level of evaluation of projects was 'not very high, despite the potential for the creation of good evidence' (p.2).

The interplay between mental health promotion and early school leaving prevention is itself a rather newly emerging area in international research (Downes 2007). In the US context, Freudenberg & Ruglis (2007) strongly advocate the importance of interpreting early school leaving as a health related issue:

> Although evidence shows that education is an important determinant of health and that changes in school policy can improve educational outcomes, public health professionals have seldom made improving school completion rates a health priority…With a few important exceptions, health providers have not developed lasting partnerships with schools, nor have researchers provided the evidence needed to improve or replicate health programmes that can reduce school dropout rates (p. 3).

They continue:

> Simply reframing school dropout as a health issue has the potential to bring new players into the effort — parents, health institutions, young people, civil rights groups — and to encourage public officials to think of the dropout problem as central to community health
> and as a long-term solution beneficial to population health (p. 4).

Freudenberg & Ruglis (2007) cite a range of international studies finding that education helps people to acquire social support, strengthen social networks, and mitigate social stressors (Cutler 2006; Ross & Wu 1995; Ross & Mirowsky 1989). For a cause to have an effect it needs supporting conditions (Mill 1872; Rutter 1985); change to these conditions can negate the cause (Downes 2007a). Teams providing a range of mental health supports are protective conditions to potentially undermine risk factors for early school leaving. Reinke et al.'s (2009) focus in the US context on combining school and family interventions for the prevention of disruptive behaviour problems also bridges the gap between a public health approach and an educational one. They highlight the need for systemic, multidimensional interventions with regard to disruptive behaviours though not as part of an early school leaving strategy specifically:

> In addition to targeting malleable risk and protective factors, successful programs tend to be multifaceted ecological models aimed at multiple domains changing institutions and environments as well as individuals (p.34).

1a Definitions

Hall & Weaver (2001) summarise the following framework for distinguishing multidisciplinary, interdisciplinary and transdisciplinary teams. The multidisciplinary team allows each discipline to independently contribute its particular expertise to the client's needs. Team members work in parallel to each other and direct interdisciplinary communication is minimal exception through the team leader. In contrast, the interdisciplinary team members work closely together, with frequent communication organized around solving a common set of problems. Each member of the interdisciplinary team, in the words of Hall & Weaver (2001):

> Contributes his/her knowledge and skill set to augment and support the others' contributions. Each member's assessment must take into account the others' contributions to allow for holistic management of the patients' complex health problems. Team members preserve specialized functions while maintaining continuous lines of communication with each other (p.868).

In transdisciplinary work, roles of the individual team members are blurred as their professional functions overlap. Each team member must become sufficiently familiar with the concepts and approaches of his/her colleagues to be able to assume significant portions of the others' roles.

The roles of multi/interdisciplinary teams in the prevention of early school leaving needs to distinguish between three widely recognized prevention approaches in public health, namely, universal, selected and indicated prevention (Burkhart 2004; Reinke et al., 2009). Universal prevention applies to school, classroom and community-wide systems for all students. Selective prevention targets specialized group systems for students at risk of early school leaving. Indicated prevention engages in specialized, individualized systems for students with high risk of early school leaving.

A US wide three-tier model for providing a continuum of supports for positive behavioral interventions and supports (PBIS) estimates that 10-15% of students will not respond to universal school-wide interventions; 'these students will benefit from increased structure and contingent feedback' (Reinke et al., 2009). This US PBIS model across a range of over 6,000 schools, albeit focusing on disruptive behaviour rather than early school leaving, estimates that 5% of students do not respond favourably to universal or selected interventions and thereby require intensive intervention support, i.e., indicated prevention (Reinke et al., 2009). It is important to acknowledge that given the radical divergence in early school leaving figures across EU member states, that the percentages for each target group for selective and indicated prevention to be engaged with by multi/interdisciplinary teams will be expected to differ in a major way across different countries in the EU.

A preventive focus with regard to multi/interdisciplinary teams needs to be cognisant of two aspects, in particular, of the OECD ten steps to equity in education (Field, Kuczera & Pont 2007). These are:

- Step 6: Strengthen the links between school and home to help disadvantaged parents help their children to learn
- Step 9: Direct resources to students and regions with the greatest needs.

A selective and indicated prevention focus is important for early school leaving prevention, and a family support dimension to facilitate links between home and school implies an important outreach dimension on behalf of such multi/interdisciplinary teams and schools.

1b Scope of current research

This review does *not* purport to be one examining:
- the prevalence and scope of multi/interdisciplinary teams for early school leaving prevention across all EU member states;
- multi/interdisciplinary teams with regard to special education[2];
- transdisciplinary teams;
- multidisciplinary teams for *research* on early school leaving and related areas (such as in Haines et al., 2011);

[2] Cooper & Jacobs (2010) provide an impressive recent review of longitudinal RCT studies mainly from the US and Australia on interventions for emotional-behavioural disorders, with some focus on poverty related issues, though without an explicit focus on the composition of the teams engaged in the interventions.

- extracurricular activities which may involve engagement from diverse professionals, as part of an early school leaving prevention strategy (Ivers et al., 2010);
- specific, detailed 'off the shelf' programmes, such as for example, Incredible Years Programme (Webster-Stratton et al., 2001, 2004; McGilloway et al., 2011);
- alternative education programmes for those who have left initial education and who may also benefit from multi/interdisciplinary teams (van Veen 2011).

A focus of the current paper is on early school leaving prevention and mental health (Downes 2010); it is on emotional and behavioural support services at a systemic level across the school and community. It is notable that the Commission Staff Working Document on early school leaving (2010) explicitly recognises that early school leaving 'can be part of a situation of serious social, academic and/or emotional distress' (p. 36). Significantly, this is reiterated in the Commission Proposal for a Council Recommendation (2011) on early school leaving:

> Targeted individual support integrates social, financial, educational and psychological support for young people in difficulties. It is especially important for young people in situations of serious social or emotional distress which hinders them from continuing education or training (2011, p.13).

It is important also to retain a focus on substance abuse related issues as a key dimension to prevention of early school leaving (Downes 2003; EMCDDA 2003; Burkhart 2004).

2. Conditions for the effective *internal* functioning of multi/interdisciplinary teams

According to the review of Carpenter et al., (2003), there is 'some empirical evidence' (p.1083) about the effectiveness of community mental health teams in the UK context. They observe that work in the field of occupational psychology has established the ingredients of effective team working (Guzzo & Shea 1992) and Borrill et al., (1996) have used these factors to assess team functioning as part of a study of the NHS (National Health Service) workforce. Yet it is notable that effectiveness here does not necessarily pertain to outcomes for patients or individuals, but rather focuses on the internal functioning of the team and its own self-perceptions. A cautionary note must be made here as internal effectiveness cannot be assumed to be equated with external effectiveness. It is a notable feature of much of the research of multi/interdisciplinary teams that the preoccupation is with internal functioning more than with external outcomes. This is somewhat understandable given the methodological complexity of finding outcomes in a complex system of interacting factors, which go beyond a simple input-output model, as well as requiring analysis of supporting background mediating conditions for causal efficacy (Downes 2007a). Cooper & Jacobs (2010) similarly advert to multisystemic complexities as being 'difficult to unpick in terms of the discrete effects of each intervention element' though recognising that 'this unpicking is not entirely necessary in a developmental context where bio-psycho-social effects interplay in an organic and holistic manner, and also in a temporal and contextual, situated, manner' (p.136). A paradigm seeking inferences as to which team member contributed key causal

roles to outcomes in a complex system is methodologically questionable in a complex, dynamic system of holistic interactions.

This is quite apart from the well recognised methodological difficulties examining progress in relation to emotions (Cohen 2006; Downes 2007a; Desjardins 2008). Fichtner et al., (2001) also observe the difficulty in distinguishing between multidisciplinary teams' self-assessments and whether they were related to 'actual improvements or to the team's desire to appear more functional' through social desirability factors (Crowne & Marlowe 1960) and the well-known Hawthorne effect. Again they recognise that internal functioning improvements are not evidence of improved clinical outcomes. Stating that there is 'as yet no evidence' (p.1083) concerning whether team functioning can be promoted by greater integration of health and social care services, Carpenter et al., (2003) sought to test the hypothesis that well-established teams operating in districts where health and social services were integrated would be superior to those in non-integrated districts offering discrete services. However, they found no significant differences between integrated and discrete districts. Nevertheless, they did find 'widespread support' (p.1088) for a holistic approach to mental health care through improved communication for assessment of need, risk and the delivery of services. Furthermore, they conclude that 'the picture of community mental health teams presented by our data is generally positive. Team functioning was average or better than CMHTs in the NHS Workforce study' (p.1097). Another benefit was ''de-isolated' key workers' (p.1089). They also highlight that 'team members in the integrated districts considered their teams to be more innovative compared to other teams, and felt that there was stronger support for new ideas' (p.1098). Nevertheless, the authors also acknowledge the limitation that the study is a small sample in terms of professionals and districts.
Carpenter et al., (2003) noted that main problems of role conflict involved workload, increased bureaucracy and inter-professional and interpersonal conflict. They also observed that social workers were somewhat less positive about team functioning than other professionals in this study and experienced more role conflict. Onyett et al., (1997) also observed a dissatisfaction among social workers in multidisciplinary teams which they attribute at least in part to role blurring and a clash of values and beliefs between the 'medical' and 'social' models of mental health care. Carpenter et al., (2003) refer to the importance of a 'clear, shared, attainable vision' (p.1090) for the team, a point reiterated in the US context by Felkner et al., (2004) who observe the importance of addressing issues of communication, client expectation of care, and understanding of roles in the multidisciplinary team.

According to Carpenter & Barnes (2001), in the UK and internationally, integration between health and social services characterizes the future of mental health care. Community mental health teams are viewed as the core of specialist mental health services in England (Department of Health 1999, p.47). As noted by Carpenter et al., (2003), a survey by Onyett et al., (1994) demonstrated quite wide variation in the structure and composition of these teams. Community mental health teams share two main features in the English context, they are responsible for delivering and coordinating a specialized level of community-based care for defined populations and are multidisciplinary in composition (Carpenter et al., 2003). Hall & Weaver (2001) suggest

that interdisciplinary teams may help reduce costs by reducing service duplication and minimizing unnecessary interventions, while the 'interdependence and synergy of the team may also improve patient outcomes and team members' individual job satisfaction and performance' (p.872), citing studies of interdisciplinary teams on health and ageing (Clark et al., 1996) and palliative care (Elliott-Miller et al., 2002) as evidence of this. Multidisciplinary teams help ensure that idea generation and implementation are integrated (Jackson 1996). Moreover, they provide the potential to ensure that programmes seeking behavioural change are of sufficient intensity and duration to succeed (Morgan 2001), rather than being short term, ad hoc interventions which may even be counterproductive to vulnerable children's emotional needs and capacities to trust (Downes 2004).

In 1997, in the US context of healthcare, Beverley et al., commented on 'the paucity of information upon which to build an interdisciplinary framework' (p.38). Felkner et al.'s (2004) analysis of preliminary outcomes from an integrated mental health primary care team in Washington, US, stated that:

> The multidisciplinary mental health primary care team is a coordinated team intended to decrease fragmentation of care between mental health and primary care, improve collaboration between providers, and integrate specialist mental health care into the primary care setting. Our data suggest that the team can quickly evaluate and stabilize patients with psychiatric disorders and reduce the number of referrals to specialty mental health services (p.444).

However, they also recognise the need for prospective studies of longer duration to establish the team's effectiveness, as their data is only from the first year of operation of the team. The team consisted of a psychologist, a psychology intern, psychiatry residents, clinical social workers and a chaplain. Treatment options included individual or group psychotherapy, medication management, social worker support, and chaplain services.
Team building processes are necessary to avoid the formation and consequences of status hierarchies (Berger, Cohen & Zelditch 1966, 1972). Hall & Weaver (2001) offer 'key learning points' for interdisciplinary teamwork. These include education on how to function within a team, interdisciplinary education 'must address role blurring, group skills, communication skills, conflict resolution skills for team members' (p.868). Petrie's (1976) recommendation for 'idea dominance' if an interdisciplinary team is to succeed, is endorsed by Hall & Weaver (2001) and Hill (1998) in a medical context. Idea dominance means that a clear and recognizable idea must serve as a focus for teamwork, rather than the traditional focus of each member's domain of care. This would, for example, place the patient at the centre of the team's focus, or in an educational context, the child or student's needs would lead the direction of focus of the team. Petrie's (1976) idea dominance emphasises that the team members must be able to recognize their success and achievements in pursuing their goals; not only must the project succeed but each team member must perceive the he/she is personally achieving or contributing something.

Appleyard & Maden (1979) raise the concern that 'even if a team reaches some sort of conclusion an individual member can sabotage the whole concept by doing nothing' (p.1305) if they are not in agreement. They highlight the need to take preventive steps

to avoid diffusion of responsibility among team members in a medical context; the dangers of such diffusion of responsibility are arguably greater in a context of medical diagnosis and intervention than in devising and implementing steps to retain a student in school. A related issue is highlighted in a special issue of the *American Journal of Community Psychology* 2006 which points to the importance not only of the processes of collaboration but also of the structures that emerge from these interactional processes (Maton et al., 2006; Schensul et al., 2006).

A contextual focus on the organizational and societal histories and cultures which serve as a backdrop for team activities requires acknowledgment (McGrath, Berdahl & Arrow 1996; Nkomo 1996; Jackson 1996). This is especially relevant to the development of multi-interdisciplinary teams across different EU Member States. Yet as Jackson (1996) emphasises, appropriate leadership strategies, including inclusive communicative skills and conflict resolution skills, are key for the functioning of such teams, in any cultural context.

3 Beyond community based versus school based multi/interdisciplinary teams: Towards a both/and model

Field et al's (2007, p.97) OECD study illustrates the Finnish approach of adopting a multidisciplinary team as part of a continuum of interventions in schools. These include professionals from outside the school, such as a psychologist and social worker, together with the school's counsellor, the special needs teacher and classroom teacher. However, a major issue of the need for confidentiality has been highlighted in a range of student centred research in Ireland, with relevance for the needs of potential early school leavers in the context of multidisciplinary teams (Downes 2004; Downes et al., 2006; Downes & Maunsell 2007). It is of concern as to whether the privacy needs of students are respected in a multidisciplinary team that directly includes class teachers and special needs teachers. This issue of trust and confidentiality is particularly relevant for students whose families and even communities have experienced much alienation from the school system in the past.

A US nationwide survey of school-based service models and school-linked models involving 90 programmes suggested that the two models are not that different from each other (Shaw et al 1996). In the words of Reeder et al (1997):

> In general, the survey results suggest that the physical location of school health services is of minor importance with regard to the range of services provided and the types of health professionals affiliated with the program…Physical proximity of the clinic to educators does not guarantee that the more traditional educational functions of the school will be integrated with the enhanced health services offered by the clinic

Yet more recently, there is a growing recognition of what are in the words of Suldo et al.(2010), 'problems inherent to using schools as the site for service delivery' (p.362) in relation to mental health intervention and emotional supports for early school leaving prevention. These barriers include space constraints, scheduling problems, maintaining

student privacy, resistance from school personnel to students missing classes, a school accountability focus on academic success only (Suldo et al., 2010). Child and student-centred research in the Irish context (Downes 2004; Downes & Maunsell 2007) gave particular emphasis to students' concerns with privacy and confidentiality in relation to emotional support on the school site, with those most alienated from the school environment being consistently resistant to engaging in a relation of trust in the school building. Based on 342 questionnaire responses and 20 focus groups from 5 primary schools, and 173 questionnaire responses and 12 focus groups from 3 secondary schools in Ballyfermot, Dublin, Downes (2004) concluded that:

> there is a role for a person on-site in the school in whom students would confide regarding their problems, but usually only with late primary and the earlier years of secondary school students, especially girls. Yet even with this group at least half of the students state that they would not avail of such services on-site in the school. This suggests the need for availability of such emotional support services at other locations in the community in addition to the school (p 35).

Parents also reported concerns with privacy with regard to school based counselling in Downes' (2004) study, focusing on a traditionally socio-economically disadvantaged area of Dublin, Ireland. This may however be culture-specific.

Morgan & Hayes (2004) observed additional difficulties such as the primary school pupil returning to class after a therapeutic session and the clash in emotional climate between the therapeutic session and the classroom environment. Suldo et al., (2010) refer to 'a class of barriers that has been overlooked in prior research' (p.369), at least in the US context, and conclude:

> The high prevalence with which systemic issues pertinent to the school environment were described as problematic underscores the need for proactive attention to school-specific factors involving access to sufficient space and the students themselves, sufficient time and integration into a school site, and clearly defined responsibilities among the various school employees' providing social, emotional and behavioral support services (p.369).

Another such barrier observed in an Irish study across a number of schools in a socio-economically disadvantaged area was the perceived lack of parity of esteem between teachers and other professionals working onsite in the schools (Downes, Maunsell & Ivers 2006). This was especially the case at post-primary level rather than primary level. However, the small sample of schools invites caution regarding the generalization of such institutional resistance to external teams working onsite in schools. Nevertheless, Noell & Gansle's (2009) general emphasis on the inertia of school systems to resist change provides another cautionary note regarding potential resistance to external multi-interdisciplinary teams engaging with schools enhance school leaders' willingness and capacity to build strategic bridges with families and communities, including health and human services. From experience of a range of multidisciplinary teams engagements with Dutch primary and post-primary schools, Van Veen (2011, personal communication)

also emphasises the need for school leadership to be open to engage with such multiservice teams and recommends:

> *school leadership: making bridge-building a priority*
> - leadership is key to change and turnaround under-performing and under-resourced schools
> - from a building-centred, walled-in approach to leadership and management towards building leadership skills for engaging families, youngsters, organisations, communities and local authorities (outcomes-focused, collaborative, distributed and adaptive leadership)
> - resources for the preparation and use of school-family-community coordinators

He emphasises that 'learning and behaviour support teams (multidisciplinary teams in schools) are important to improve the support structure for children and teachers' (personal communication, June 2011).
The cross-cultural relevance of multidisciplinary teams working onsite in schools is evident from the following example of a support service in Russian schools:

> A team called 'Support Service' operates at the School. The members of the team are the educational psychologist, the school doctor, the school nurse, the person responsible for the pupils' nutrition, and the person responsible for art-therapy. There should also be the health care teacher but this position is not included into the list of members of the School staff. This team works in coordination with all other structures of the school (and can consult teachers on the psychological matters), and deals with children and their parents. The main target group of the Support Service is the pupils who miss classes and those with certain health problems (mainly alcohol and/or drug consumption). The responsibilities of the Support Service also cover the arrangement of all kinds of school events and activities: sport events, discussions, medical examinations; the psychologist and the social teacher carry out intervention programmes (Kozlovskiy, Khokhlova & Veits 2010).

Though Downes (2011) notes that there is a need for more information on the prevalence and effectiveness of such a multidisciplinary team in Russian schools, this example does highlight that schools can work in conjunction with such multidisciplinary teams and without obvious conflict of interests, cultures or priorities.

In the Netherlands context, van Veen (2011a) observes that multiservice schools are predominantly school linked (75%), i.e., community based, with only 15% being school-based. From research findings on multi-service schools in the Netherlands between 2002 and 2010, van Veen (2011a) concludes that

- services provided are inconsistent with objectives
- policies and practices are fragmented and do not effectively address barriers to learning
- few comprehensive, integrated programmes (including OST, school culture/climate, extended pupil services)
- few programmes for family support and youth care/mental health and for community development and adult education

- multi-service schools need to be supported by comprehensive policy planning at the local and provincial level: school boards/school leaders and local authorities need to provide a clear agenda, implementation support and resources
- tasks and responsibilities of key service providers need to be formulated realistically (resources)
- school-based and school network-based support structures need to be developed (from referral and co-location models towards integrated intervention models).

Van Veen (June 2011, personal communication) prioritises the importance of a community wide focus, as part of a systemic approach for such teams:

> develop and implement a national, city- and school systems-wide intervention plan that mobilizes and focuses community efforts and resources at the key points where students fall off the path to school graduation: from piecemeal and fragmented approaches towards a comprehensive, systematic approach
>
> make student success and dropout prevention a priority: support schools' and communities' efforts to eliminate dropping out as an option for students.

Summarising research in the Netherlands, van Veen (2011, personal communication) states, 'school factors explain less than 30% of achievement gains: families, peer networks and community systems cannot be ignored'.

4 Multi/interdisciplinary teams as a continuum of care: Including provision of mental health supports at various system levels

In US national surveys, at least two-thirds of schools reported providing the following services for students' mental health concerns: individual counselling, crisis intervention, assessment/evaluation, behaviour-management consultation, case management, referrals to specialized programs, group counselling, and substance use and/or violence prevention (Brener, Martindale & Weist 2001; Foster et al., 2005). Suldo et al., (2010) discuss the supports needed for provision of 'a continuum of tiered intervention services, including prevention and universal intervention (e.g., school wide positive behavioral supports, school climate promotion), targeted interventions for students at risk (e.g., social skills and anger management groups, classroom management strategies), and intensive individualized interventions with community support (e.g., therapy, implementation of behavior intervention plans) in schools' (p.354). However, despite this array of strategic intervention, they view school psychologists in the US context as being the appropriate deliverers of such service, following the National Association for School Psychologists 2006. The explanation for this is brief and is perceived as being due to their dual training in mental health and education (Suldo et al., 2010, p.354). This position follows on from the advocacy of Heathfield and Clark (2004) in the US for the prevention of mental health-related problems and subsequent poor educational outcomes as a priority for the field of school psychology via identification of risk factors and promotion of social-emotional functioning.

From Slovenia, Ivancic et al., (2010) provide a notable example of systemic mental health support for students in schools, prevalent across the educational system and supported by a legislative framework:

> The school has established a school counselling service which is funded by the Ministry of Education and Sport and regulated by the law on Organisation and Financing of Education, article 66, item 3 (Official Gazette, 98/2005, 07.11.2005). This is typical for the Slovenian education system. Following are main tasks:
>
> - vocational guidance and counselling before enrolment in school, at the time of enrolment
> and before enrolment in tertiary education,
> - analysing enrolment and following progress of pupils,
> - dealing with pupils of foreigners and organising Slovene language courses for these
> pupils,
> - various prevention activities related to drug abuse, aggressive behaviour; workshops on
> questions regarding sexuality,
> - workshops on independent learning and learning how to learn,
> - counselling on personal and social development,
> - Dealing with social issues of pupils and with other problems related to learning, discipline etc.

A Slovenian secondary school management interviewee in Ivancic et al., (2010) draws an explicit link between emotional counselling services and their role in prevention of early school leaving:

> A counselling service is established at school that deals with problems that may lead to early leaving of the education system but there is a belief that the class teacher is the one who is first responsible for dealing with such problems. He/she is the one creating the class climate, recognising early signs of individual problems and being able to react before their full escalation. The school thus heavily invests in class teachers. *I believe class teacher is a key person contributing to class climate… also other teachers are important but the centre is emotionally stable class teacher who takes care for good climate which significantly contributes to integration of individual pupils in the class environment* (Ivancic et al., 2010).

The counselling supports are perceived as complementary to the key role of the class teacher as a provider of social and emotional support to help prevent early school leaving:

> *You see that he needs help, he needs a hand…, a talk…however… If there were any one to talk to. … A single teacher may retain a pupil in school and this often happens* (Ivancic et al., 2010).

Yet significantly the Slovenian examples recognise that some emotional problems are sufficiently complex that there is a need to go beyond the role of the class teacher. It is important to distinguish a teacher's role in mental health promotion and stress prevention for students from that of therapy which requires professional supports (Downes 2003b).
In other words, it is important to introduce another layer of referrals, for more complex emotional support needs, such as to an external team (see also van Veen 2011a). An example from Flanders, Belgium, points to this key role of the educational institution in provision of referrals to services to meet some students' complex emotional needs:

> In case of other problems, such as psycho-social problems, issues concerning poverty,
> etc., the tutors and programme coordinators actively refer to other organisations and services (Vermeersch & Vandenbroucke 2010).

On this issue of referrals from school, evidence suggests that the emotional support needs of more withdrawn students tend to be missed by teachers compared with students displaying externalising problems such as aggression (Doll 1996; Downes 2004). Such withdrawn children may be equally at risk of early school leaving.

Referring to research on multidisciplinary behaviour and education support teams in Dutch schools, van Veen (2011a), observed:

- perceived positive outcomes on most indicators (70-89%)
- further improvements needed for:
  - intervention capacity (social work, mental health in particular) and quality services delivery (all sectors)
  - universal and selective prevention programmes (all sectors)
  - integrating BEST in the school's or school network's student support structure (in primary and further education in particular)
  - supporting frontline workers in schools (primary and further education)
- regional differences in policy support, leadership and implementation capacity
- need for models and quality indicators, technical assistance and implementation support.

Reinke et al., (2009) describe the US Behavioral Interventions and Supports (PBIS) school site based intervention programme across over 6,600 US State schools as a multilevel framework for the application of a behaviour-based systems approach to enhance the capacity of schools to design effective environments for implementing a continuum of services:

> All students receive school-wide support marked by consistent rules and consequences, encouragement, and clear expectations across all school settings. These prevention and intervention strategies target multiple systems within the school including classrooms and non-classroom settings (e.g., hallways, cafeteria, playground) and individual student and adult staff behaviour to increase positive outcomes (p.34).

They cite US studies showing that schools with a high level of implementation fidelity to the PBIS programme reduce out of class discipline referrals by 20-60% (Lohrman-O'Rourke et al., 2000; Taylor-Greene et al., 1997), while systematic evaluations have demonstrated functional relationships between implementation of school-wide strategies and reduction in problem behaviours in specific settings such as playgrounds (Lewis, Colvin & Sugai 2000) and common areas (Kartub, Taylor-Greene, March & Horner 2000).

Significantly, an overall reduction in suspensions through PBIS has also been observed in the US (Bradshaw, Mitchell & Leaf 2008), thereby indicating a direct benefit for early school leaving prevention. Multi/interdisciplinary teams can offer an important strategic dimension to prevention of suspension and expulsion from school, through providing social, emotional and behavioural support services, including teacher conflict resolution skills and diversity training, as well as alternative strategies to suspension. They can also offer supports for pupils' transitions (van Veen 2011a). Evidence from Lithuania and Ireland in particular highlights the serious scale of the problem of suspension and expulsion from secondary schools. Taljunaite et al.,(2010) provide the following example:

> According to [secondary school] management and the teacher interviewed approximately 10 percent of students are expelled from school in each year. The reasons are usually behaviour problems, bullying, harassment, and aggressiveness i.e. non-academic reasons prevail. The teacher mentioned that there were no expelled students for not attending classes. The statistics, according to the management can be collected, but this will not solve the problem

This figure seems to be in addition to their estimates of those who 'drop out' from school
which also reaches approximately 10% in Lithuania (Downes 2011). The Irish post-primary figure of 5% for suspension, applied to the total population of 332,407 students equates to well over 16,000 students suspended from post-primary schools in 2005/6 (ERC/NEWB 2010). Engel et al., (2010) in the English context also observe that:

> In one study (Rennison et al., 2005), for example, found that young people in the NEET [Not in Education, Employment or Training] group were over three times more likely previously to have been excluded from school than young people overall.

A systemic focus on social, emotional and behavioural support in the US context, contrasts with the following account from Norway, highlighted by Burkhart (2004). In June 2000, an expert group appointed by the Ministry of Education, Research and Church Affairs (KUD) and the Ministry of Children and Family Affairs conducted an assessment of programmes and initiatives aimed at reducing problem conduct and developing social skills (Report: Assessment of programme and initiatives aimed at reducing problem conduct and developing social skills; the Ministry of Education,

Research and Church Affairs and the Ministry of Children and Family Affairs 2000). The report states:

> The results from initiatives aimed at improving social skills indicate that if we want to address conduct disorders in children and young people, it is likely that every action should contain a component that is aimed explicitly at the social skills of children and young people, their conduct and understanding of how their own actions affect and are affected by others (p. 24).

The committee adds (p. 27) 'However, except for in alternative schools, it appears that concrete or practical skills training has been surprisingly little emphasised in such combined actions'. The need for provision of mental health supports has been reiterated more recently in qualitative research with educational management in the Norwegian context:

> 11 percent of the same group in SP3 stated that family related problems were a problem for participating in educational activity. We asked our informant how he thought public policy in this area could contribute to offering guidance services that go beyond the subjects taught at the institutions. Our informant responded: *Many students have mentally related problems and students have a high suicide rate. For many, being a student is a lonely affair. It goes without saying that the healthcare services must be equipped with a professional staff* (Stensen & Ure 2010).

Mental health support services in education, as a dimension of the need for prevention of risk of suicide, particularly in contexts of high stress associated with poverty and social exclusion, has also been highlighted (through qualitative research) in an Irish context for those at risk of early school leaving (Downes & Maunsell 2007). Lack of availability of such emotional support services are a clear strategic gap in Irish secondary school provision (Dooley et al., 2010; Downes 2008).

An Estonian qualitative report (Tamm & Saar 2010) also reveals both the need for emotional supports for those living in poverty and experiencing personal problems, as well as the availability of such supports across secondary schools:

> Some young learners (who have dropped out of their former school) come from problematic or disadvantaged families or have lost contact with their families and therefore lack elementary life skills, such as managing one's money, etc. They also need support to cope with personal problems – someone to talk to. Such support can be provided by teachers. All schools teach family studies but these are not enough. Such students need extra support and an opportunity to turn to somebody – the school head, a teacher, a psychologist, etc. – outside classes. Such conversations improve students' communication skills and the skill of solving problems…Many students need individual support and tutoring (Tamm & Saar 2010).

As school management interviewees in Tamm & Saar (2010) observe for Estonia:

> *Estonian larger schools, including adult secondary schools have a psychologist on their payroll. We also have counselling centres in counties offering the services of a psychologist and a career counsellor*

> *Sometimes they simply want to talk to somebody they trust, to pour out their heart. The teacher of family studies is in great demand also outside the curriculum: Sometimes the students come and ask: 'Has she come yet? I need to talk to her.' Even those who have no classes on that particular day come to school to talk to her*

Taljunaite et al., (2010) in Lithuania highlight the need for mental health supports due to official statistics on students with clinical level emotional, behavioural and social disorders:

Table 1
Students integrated into general schools: Lithuania

Beginning of the academic year				
	2005-2006	2006-2007	2007-2008	2008-2009
Emotional behavioural and social disorders	886	1237	877	899

(In Taljunaite et. al., 2010)

It is important however to emphasise that it is not simply those with clinical levels of emotional disorders who are particularly vulnerable to early school leaving and in need for system level emotional supports through multi/interdisciplinary teams (Downes 2011). This appears to be reasonably well recognised in the Russian context. This Russian educational system example illustrates an important commitment to emotional support provision:

> *First it's necessary to pay attention not to… the gaps in the knowledge but to prove that he CAN do something – and since he can, then he's a personality.* This work is conducted by the Support Service: they organise art-therapy and psychological trainings aimed at the realisation of the creativity potential, development of personal responsibility and to some extent to the promotion of active citizenship position.
> Art-therapy classes presume organising drama performances: interested students take part in the production of drama performances based on the scripts written by the head of this studio. The performances are devoted to the 'issues topical for students' (e.g. drug addiction, game addiction, suicide). During the production of the performances the participants and the head of the studio also discuss

> these topics; discussions are continued inside classes after the first show (Kozlovskiy, Khokhlova & Veits 2010).

This Russian report continues:

> The main goal of the psychological support service is to provide favourable conditions for all students, build up trustworthy relationships between them and the school and provide psychological help for those students who lack it in their families (Kozlovskiy, Khokhlova & Veits 2010).

Kozlovskiy, Khokhlova & Veits (2010) quote as follows from a secondary school interviewee:

> *They often come here with their spirit broken. They are offended at the world and intimidated, so it's very important for us to help them form a strong, stable and harmonious personality, who is fully aware of his/her desires and ambitions. We want to bring up a person who understands that s/he is not alone in the world and that there will be many problems on his/her life path so we teach them to be ready for those problems and be able to overcome them* (Kozlovskiy, Khokhlova & Veits 2010).

A different secondary school in Russia, a vocational school, however does not offer any emotional support service as such:

> There are 15 orphan students studying at the school at the moment. However, the school does not have its own Support Service for the students that would provide psychological help and consultations. Special measures aimed at the adaptation of students who belong to traditionally disadvantaged groups to the educational process and the student community are also not undertaken (Kozlovskiy, Khokhlova & Veits 2010).

A systemic focus on multi/interdisciplinary teams providing a continuum of care for prevention of early school leaving encompasses a) selective and indicated prevention approaches, b) developmentally appropriate interventions. It requires a multilevel focus on interventions at individual, group, family, teacher, school and community levels. This invites examination of the family-community dimension of outreach and the teacher-school systemic level for interventions regarding school climate in relation to European research and policy.

4a Multi/Interdisciplinary teams: Outreach to marginalized families and children

Facilitating service linkages may be critical given barriers that many families face, particularly those that are financially underprivileged (Flisher et al., 1997), in attempting to obtain needed treatments for their children. Youth who are low-income, and/or ethnic minority are even less likely to access health care—often related to lack of insurance or transportation, distance from providers, or stigma attached to seeking mental health treatment (Dey, Schiller,&Tai, 2004). In the context of implementation of the international right to the highest attainable standard of health, Hunt & Backman

(2008) refer to the key role of 'outreach programmes for disadvantaged individuals and communities' (p.11) and observe that 'a State has a core obligation to establish effective outreach programmes for those living in poverty' (p.12). Community outreach best practice also means that 'recruitment of health workers must include outreach programmes to disadvantaged individuals, communities and populations' (Hunt & Backman 2008, p.17). In a report of the UN Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, Paul Hunt (2006) observes international good practice as '7....Properly trained community health workers [who]...know their communities' health priorities...Inclusive, informed and active community participation is a vital element of the right to health'.

A selective and indicated prevention focus is important for early school leaving prevention, and a family support dimension to facilitate links between home and school implies an important outreach dimension on behalf of such multi/interdisciplinary teams and schools. Selective prevention targets specialized group systems for students at risk of early school leaving. Indicated prevention engages in specialized, individualized systems for students with high risk of early school leaving. Weist et al. (2009), who recently detailed a school mental health quality intervention that emphasized family engagement and empowerment, note that despite the widely acknowledged importance of family involvement in school mental health, actual practice typically does not reflect best practice in this dimension. Providing support to parents has been found to be very difficult and is rarely provided (Wagner et al., 2006). In 12 Irish schools, staff reported that they would like more supports in priority areas including psychological support, and in establishing links with students' homes and the local community (Smyth et al., 2004).

Mellin et al. (2011) conducted qualitative research in a US context on multidisciplinary teams. They engaged in focus groups interviews, using a semi-structured interview guide, conducted with school professionals (e.g., teachers, school-employed mental health professionals) and mental health professionals from a collaborating agency who are involved in a district-wide urban school mental health program in the mid-Atlantic region of he United States (N = 26). Participants included 20 women (77%) and 6 men (23%) ranging in age from 24 to 59, with a mean age of 33 (SD = 8.71). In terms of race and ethnicity, 16 (62%) identified as White (non-Hispanic), 8 (30%) identified as Black/African-American, and 2 (8%) identified as multiracial. A major theme that emerged was the need for Improved Access and Consistency for Youth and Families:

> Both community and school participants frequently commented on how the non-formal affiliation of community providers with schools helps provide attitudinal access (affirming positions, values, beliefs,) to services for youth and families. More specifically, participants commented on how it creates safety for youth and families; ''They [families] understand that I am not part of the school and that I can't tell the school what they are telling me. It's safe'' and ...the first thing I do is remind them [youth] that you are not in trouble when you are with me. I have no administrative power, I cannot give you detention or suspend you and that is not what I am here to do...9 times out of 10 the scowl goes away and they calm down because I can remind them of that. (Mellin et al. 2011, p.87)

Cultural barriers between home and a multidisciplinary team associated with school need to be anticipated, as is evident from Mellin et al's (2011) findings: 'several community providers also noted addressing the historical mistrust of schools and mental health systems that is a part of the experiences of many parents in this urban community. In particular, they discussed taking time to show families file cabinets and the keys. They explain to families that the files belong to the collaborating agency, not the school, and that the files will not follow their child to another school.' (p.87). These issues are arguably understated in this study as the sample did not include families and youth.

Based on 35 interviews, 27 with mental health clinicians, Langley et al. (2010) perceived that one of the main 'barriers' to the implementation of CBITS (cognitive behavioural intervention for trauma in schools) was parent engagement, with Lack of Parent Engagement (Ranked #1 by Implementers and #2–3 by Non-Implementers). Langley et al (2010) continue: 'Many clinicians described difficulties in contacting parents. One clinician described clear difficulty in ''reaching parents'' and working with parents of impoverished students... Clinicians who implemented CBITS also described challenges in engaging parents in treatment. For example, one clinician reported that ''It [the main barrier] was parent participation. We had only one parent session and parents did not help kids with getting their practice and homework done''' (p.109).

Langley et al (2011) conclude that, 'Parent engagement in school-based services has been a consistent challenge in the implementation of school mental health programs more broadly (Weist, Evans, & Lieber, 2003), and it is not surprising that parental involvement was a challenge here. The development of strategies for engaging parents in school based mental health services like CBITS may be a key element in increasing access to quality mental health services for youth in schools' (p.112). However, these findings also point to the need for both a community based team approach and not simply a school based team, in order to facilitate family involvement and gain greater credibility and trust. It also highlights the need for a family outreach dimension for such multi/interdisciplinary teams based in the community.

There is a need for a family outreach and family support approach to be one focusing on building on strengths of the family rather than concentrating on their deficits McKeown et al 2001). Models of comprehensive partnerships are characterized by family and community empowerment through decision making and addressing culturally relevant priorities for change (Fantuzzo & Mohr, 2000; Sheridan & Kratochwill, 2007). An emphasis on mutual respect and accountability contributes to sustained supports for families, schools, and communities to promote children's well-being across systems (Power, DuPaul, Shapiro & Kazak, 2003; Sugai & Horner, 2002). Fiks et al (2010) review states that 'Each of the partnership models includes key characteristics that foster collaboration across home, school, and community systems. These characteristics include an emphasis on strengths and assets (rather than problems or deficits), a focus on building trusting, long-term relationships, an emphasis on shared ownership across systems, an attempt to build capacity for sustainability over time, and use of participatory Action Research methods for model evaluation' (p.49); 'A few models have been examined within a case-study framework, but large scale systematic evaluation of model process and outcomes has rarely taken place' (p.49).

As Fiks et al (2010) note, community-based participatory research (CBPR) emphasizes the importance of partnering with community agencies to co-develop culturally sensitive assessment and intervention strategies involving important problems facing low-resource urban communities (Connor, Rainer, Simcox, & Thomisee, 2007; Minkler & Wallerstein, 2003). Spoth, Clair, Greenberg, Redmond, and Shin (2007), Spoth and Greenberg (2005), and Spoth, Greenberg, Bierman, and Redmond (2004) developed a multitiered partnership model called Promoting School-Community-University Partnerships to Enhance Resilience (PROSPER) that consists of a three-component structure including local community teams, a state-level university research team, and a coordination/liaison team. 'Partnerships operate at three levels within the state: (a) school community-level strategic teams of local, internal, and linking agents, (b) intermediate level coordinating teams of linking agents and regional technical assistants, and (c) state-level teams of external resource agents. Spoth et al. (2007) utilized the model to implement a family-based intervention designed to reduce youth substance use and improve parenting skills and youth social skills and peer resistance skills. Results indicated that even after controlling contextual variables at the community and school district levels, the functioning of the community team and technical assistance variables were related to higher recruitment rates' of participants (p.48). These community approaches echo the UN Rapporteur on the right to health regarding community participation.

Local community credibility of the multi/interdisciplinary team is facilitated by members of the team being in close cultural affinity with the families that are being sought to reach. Lieberman et al (2011) note that, 'The shortage of infant mental health providers from minority groups has a particularly negative impact on immigrant and minority children and families, who need interventions that are provided in their native language by practitioners who understand their cultural values and childrearing practices' (p.407).

As Stephan et al (2011) observe, school-based health centers (SBHCs) are a common site for collaborative school-based care in the US context. SBHCs employ a multidisciplinary team of student-care providers, including registered nurses, nurse practitioners, physicians, physician assistants, social workers, alcohol and drug counsellors, and other health professionals.19 SBHCs in six states: Colorado, Louisiana, Michigan, New Jersey, North Carolina, and West Virginia. However, no outreach dimension to families is described. Stephan et al (2011) conclude that 'In addition to an increased focus on family engagement, the MHET [Mental health and emotions] initiative would have benefited from evaluative feedback from families (and other stakeholders, including students and teachers) on the value and impact of the intervention' (p.79). Again a community based multi/interdisciplinary team rather than a school-based one offers an improved pathway into parental engagement, for families especially marginalized from the formal system and their children at heightened risk of nonattendance at school and early school leaving.

It certainly cannot be assumed that those most in need will access available services. This requires acknowledgement of the need for an outreach strategy from the Multi/inter disciplinary team to reach the more marginalized. The VaSkooli project in the

Turku and Salo regions of South-West Finland acknowledges the 'difficulties in reaching the youngsters and their families, who do not participate in any of the special services provided by the sub-projects' (Ahola & Kivela 2007, p.254). Similarly, Burkhart's (2004) EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) review of selective prevention programmes in the pre-enlargement EU, examined family intervention programmes for truancy, social exclusion and drug prevention (and not simply with an explicit drugs intervention focus). Burkhart's (2004) report made the following comments on outreach difficulties in Greece and Luxembourg:

- ***Greece:*** Although prevention professionals report that they have difficulties in approaching parents, universal family-based prevention is quite widespread in prevention practice in Greece. As the emphasis is put on the implementation of universal family interventions and there is little experience regarding targeted interventions, it suggested that the needs of families at risk must be assessed in order for targeted interventions to be gradually developed.

- ***Luxembourg:*** Parents who come to the parents meeting are glad to have an exchange. Parents have mostly the feeling of being alone with family conflicts or decisions concerning juveniles. In the exchange with the others, they get the understanding, that these conflicts are normal developments and concern also other families. The most difficult point is to motivate parents to come to a parent meeting. Therefore meetings with low thresholds concerning the topic and duration are needed at first to get them.

Burkhart's (2004) review and consultation process for the EMCDDA also observed that for Germany, compared to school intervention programmes, the family as a place for preventive measures is neglected. This statement is documented by Burkhart (2004) as being valid for research as well as for practice in the German context. More recently, it appears that at least in the region of Kessel in Germany, that multi/interdisciplinary teams are not prevalent for early school leaving prevention generally, nor for family outreach, though there are such teams for special educational needs and individual education plans (Uzerli, personal communication, June 2011). One exception in Kassel is the school, the Oscar von Miller Schule which has created a learning community in their school for teachers as well as for students, with such a multidisciplinary team[3]. Nor are there such multi/interdisciplinary supports for early school leaving prevention in Poland (Jerzy Wisniewski, former official, Polish Education Ministry, personal communication, June 2011). Burkhart's (2004) account of selective prevention in Denmark and the UK implies again the need for improved outreach support for marginalized families and for outreach for early intervention to engage children with school attendance:

[3] Thanks to Ursula Uzerli, EU Koordination / Internationales, Leiterin des Dezernats, Amt für Lehrerausbildung, Hessen, Germany for providing this information.

- ***Denmark:*** It seems that the knowledge and intervention from nursery teachers and school teachers at the earliest stage possible is crucial. These professionals often see very early signs of things starting to go wrong and have good knowledge of the abuse situations. Giving these professionals better possibilities for taking action might save some form getting into serious trouble later in life.
- ***UK*** Parents should be considered as a target group in their own right…There are some examples of successful work with families which is already taking place within UK but more needs to be done to ensure that the development of family based interventions is taken seriously.

O'Connell & Sheikh's (2009) analysis of a large US sample of over 25,000 eighth grade students from over 1,000 US schools, from the National Longitudinal Study (NELS) dataset, observed the relative importance of daily school preparation and smoking *inter alia* as variables associated with early school leaving. Daily school preparation was a composite measure based on with coming to school with necessary equipment and having home-work completed. Both of these aspects invite a solution-focused approach of outreach to the home and engagement of traditionally marginalized parents. As Reinke et al., (2009) highlight, traditionally in the US, family involvement in PBIS has been strongest within the selected and indicated tiers, where more intensive and individualized services are required to address more complex, escalated problems (Beckner 2007; Fox, Dunlop & Cushing 2002; Scott & Eber 2003). Extension of this logic of selected and indicated prevention strategies for family support for those most marginalized and living in poverty, requires a strategic priority for outreach dimensions to these families through multi/interdisciplinary teams.

As noted earlier, there is a dearth of research on multi/interdisciplinary teams focusing on outcome gains for early school leaving prevention. Though not the subject of a RCT trial, it is evident that the *Familiscope* interdisciplinary team, Ballyfermot, Dublin, Ireland, has however, been particularly successful in developing an outreach strategy to engage with children and families with backgrounds of addiction and nonattendance at school. Substantial gains in pupils' school attendance have been observed due to the intervention, one of the few examples of outcome gains from a multi or interdisciplinary team. The interdisciplinary team, funded originally through EU URBAN funding, comprises of outreach care workers, counsellors for emotional support and speech and language therapists working onsite in schools with both teachers and pupils, as well as with parents. The focus of this team is on prevention of early school leaving, provision of social and emotional support to children, young people and their families, availability of instrumental support to families, as well as promotion of a positive school climate across schools, anti-bullying approaches, and involving professional development of teachers. The approach is child-centred, while working at a system level with families and teachers. The community based aspect of the team is with a view for gaining more trust with families who have traditionally been alienated from the school system across generations.

Outreach Example: Familiscope Morning Programme and School Attendance Gains

The Familiscope Morning Programme is an intervention used to support children with chronic absenteeism. It involves supporting parents to implement appropriate morning and night time routines, monitoring and tracking children's attendance, offering practical support and advice to parents to overcome the issue, rewarding children for improved school attendance, promoting an awareness of the link between poor school attendance and early school leaving, resolving transport issues and engaging the necessary outside supports to benefit the child. The Child Welfare Worker will regularly call to the child's home to support the parent implement morning time routines, for example breakfast, uniform and schoolbag preparation, ensuring the child gets to school on time and supporting the parent to be firm and follow through when a child is school refusing. Work is also carried out with the parents to support them with night-time routines i.e. homework and bedtimes. The Child Welfare Worker will often transport the child to school or arrange for the child to take the school bus when available. The ultimate goal is to improve school attendance for children living in families that are often quite chaotic. Long term the goal is to pass these skills to the parents and children so they will no longer require support. Children who are consistently absent in their early school years rarely catch up.

It was observed that 16 out of 19 children on Familiscope's Morning Programme demonstrably improved their school attendance. 3 out of 19 did not improve attendance. The attendance gains are sizeable in a number of cases for those children who are most marginalized, as is evident from the following statistics in Table 2[4]. A number of cautionary notes must be added to this data. Firstly, though there was no obvious other mediating variable that affected these findings, this cannot be conclusively ruled out in the absence of a control group. Secondly, while these attendance gains occurred for pupils across a range of local schools in Ballyfermot, Dublin, the intervention approach may be limited to the Irish context. Thirdly, given the small sample of children and the small numbers of staff involved in the one interdisciplinary team, it is difficult to generalise as to whether this approach would work to improve school attendance for those most at risk of early school leaving in other cultural contexts. Nevertheless, this Familiscope outreach model through its morning programme offers a promising example of good practice for indicated prevention. It engages mainly with families experiencing intergenerational drug abuse, with chronic addictions, which impact on their children's learning and school attendance. A notable feature of the trust gained is that no member of the outreach team is from either the school itself or from the police/justice department, though strong partnership does exist with the National Education Welfare Board and local officer monitoring school attendance. The outreach approach combines a community based, social care and mental health approach with a child-centred focus on the educational goal of school attendance. In doing so, it provides what was noted above as an important dimension of interdisciplinary teamwork, namely, 'idea dominance' (Petrie 1976; Hall & Weaver 2001; Hill 1998).

[4] Thanks to Siobhan O'Reilly and Fiona Kearney, Familiscope, for providing this data.

Table 2. **Familiscope interventions and attendance figures**

Child A ***Pre Familiscope Intervention:*** 2007-2008: Absent 89 days ***Post Familiscope Intervention:*** 2008-2009: Absent 36 days 2009 to February 2010 : Absent 10 days	**Child B** ***Pre Familiscope Intervention:*** 2006 -2007: Absent 121 days ***Post Familiscope Intervention:*** 2007-2008: Absent 38 days 2008 – 2009: Absent 42 days 2009 to February 2010: Absent 9 days	**Child C** ***Pre Familiscope Intervention*** 2007 – 2008: Absent 42 days 2008 – 2009 Absent 56 days ***Post Familiscope intervention*** 2009 to February 2010: Absent 3 days	**Child D** ***Pre Familiscope Intervention*** 2006-2007: Absent 72 days ***Post Familiscope intervention*** 2007 – 2008: Absent 35 days 2008-2009: Absent 25 days 2009 to February 2010: Absent 10 days
Child E ***Pre Familiscope Intervention:*** Mar 2008 – Oct 2008: Absent 25 days in 4 month period (only stats available) ***Post Familiscope Intervention:*** Oct 2008 – June 2009: Absent 15 days 2009 to February 2010: Absent 13 days	**Child F** ***Pre Familiscope Intervention*** 2007 – 2008: Absent 15 days 2008 – 2009: Absent 28 days ***Post Familiscope intervention*** 2009 to February 2010: Absent 1 day	**Child G** ***Pre Familiscope Intervention*** 2008 – 2009: Absent 110 days ***Post Familiscope intervention*** 2009 – to February 2010: Absent 16 days	**Child H** ***Pre Familiscope Intervention*** Sept 2008 – Nov 2009: Absent 84 days ***Post Familiscope intervention*** Dec 2009- to February 2010: Absent 5 days

Child I ***Pre Familiscope Intervention*** 2008 – 2009: Absent 25 days ***Post Familiscope intervention*** 2009 to February 2010: Absent 2 days	**Child J** ***Pre Familiscope Intervention*** 2007 – 2008: Absent 21 days ***Post Familiscope intervention*** 2008 – 2009: Absent 8 days 2009 to February 2010: Absent 1 day	**Child K** ***Pre Familiscope Intervention*** 2007 – 2008: Absent 33 days 2008 – 2009: Absent 28 days ***Post Familiscope intervention*** 2009 February 2010: Absent 2 days	**Child L** ***Pre Familiscope Intervention:*** Case opened with the Education Welfare Officer in another area, attendance was flagged as a problem, statistics unavailable ***Post Familiscope Intervention:*** Nov 2009 to February 2010: Absent 10 days
Child M ***Pre Familiscope Intervention*** 2007 – 2008: Absent 50 days ***Post Familiscope Intervention*** 2008 – 2009: Absent 11 days	**Child N** ***Pre Familiscope Intervention*** 2007 – 2008: Absent 55 days ***Post Familiscope intervention*** 2008 – 2009 : Absent 28 days	**Child O** ***Pre Familiscope Intervention*** 2007 – 2008 : Absent 66 days ***Post Familiscope intervention*** 2008 -2009: Absent 25 days	**Child P** ***Pre Familiscope Intervention*** 2008 – 2009: Absent 26 days ***Post Familiscope Intervention*** 2009 to February 2010: Absent 7 days

4b Intervention of multi/interdisciplinary teams at a systemic level: Engagement with teachers' conflict resolution skills, diversity training, bullying prevention approaches, alternatives to suspension

In the EU Commission public consultation 'Schools for the 21st century', classroom management strategies were raised as an issue needing to be better addressed by teacher initial education (see also Commission staff working document 2008). The TALIS study (OECD 2009) observes an extremely wide variation in teacher participation in continuing professional development across countries. Non-attendance is attributed to obstacles such as lack of suitable programmes and clashes with work schedules.

However, the study identified beneficial effects associated with participation in continuing professional development, including increased use of more varied and versatile teaching methods, cooperation with colleagues and greater job satisfaction. Moreover, teacher consultation across participating TALIS countries raised the following priorities:

> The aspect of their work for which teachers most frequently say they require professional development is 'Teaching special learning needs students', followed by 'ICT teaching skills' and 'Student discipline and behaviour' (p.48). Student discipline issues is raised by 21% of teacher responses (OECD 2009, p.61).

It is notable also that professional development of teachers regarding student discipline and special needs students are both, in particular, central to early school leaving prevention. The OECD (2009) recognises that:

> Classroom discipline, aggregated to the school level, is a core element of instructional quality. In PISA, it is positively related to the school's mean student achievement in many participating countries (Klieme and Rakoczy, 2003). Also, it has been shown that – unlike other features of classroom instruction – there is a high level of agreement about this indicator among teachers, students and observers (Clausen, 2002) (p. 91).

Key results observed in TALIS (OECD 2009) include that:

> One teacher in four in most countries loses at least 30% of the lesson time, and some lose more than half, in disruptions and administrative tasks – and this is closely associated with classroom disciplinary climate, which varies more among individual teachers than among schools (p. 122).

In November 2007, the Council adopted Conclusions which constitute a commitment to improving the quality of teacher education. This theme is reiterated in the Commission staff working document (2009). However, the professional development focus gives little emphasis to the key issues of specifically developing teachers' conflict resolution skills, and their cultural diversity awareness training, including for different social classes. Rather, in the TALIS review (OECD 2009), it is construed as being largely in terms of student discipline and behaviour though it does invite focus on the interactional process between teacher and student in its recommendations for increased support for teachers' classroom management techniques:

> Several studies have shown that the classroom disciplinary climate affects student learning and achievement. TALIS supports this view by showing that disciplinary issues in the classroom limit the amount of students' learning opportunities. The classroom climate is also associated with individual teachers' job satisfaction. Thus a positive learning environment is not only important for students, as is often emphasised, but also for teachers. Across all participating countries it therefore seems advisable to work on enhancing teachers' classroom management techniques. The results suggest that in most schools at least some

> teachers need extra support, through interventions that consider teachers' individual characteristics and competences and the features of individual classes (OECD 2009, p.122-123).

This wider vision for professional development than simply classroom or behavioural management is given expression through the OECD's (2009) recognition that school climate of positive relation is also a key dimension:

> In addition to the environment at the classroom level, *school climate* is used as an indicator for the school environment. Here, school climate is defined as the quality of social relations between students and teachers (including the quality of support teachers give to students), which is known to have a direct influence on motivational factors, such as student commitment to school, learning motivation and student satisfaction, and perhaps a more indirect influence on student achievement (OECD 2009: 91).

The EU Commission Staff Working Paper on early school leaving (2010) echoes this theme of the need for development of teachers' relational and diversity approaches:

> School-wide strategies focus on improving the overall school climate and making schools places where young people feel comfortable, respected and responsible…While these schools usually rely on a handful of dedicated and committed teachers who choose to stay despite the difficulties, it is essential that teacher education prepares future teachers to deal with diversity in the classroom, with pupils from disadvantaged social backgrounds and with difficult teaching situations. It is also essential to improve school climate and working conditions - especially in disadvantaged areas - in order to have a more stable teaching force (p. 23).

The 2011 Commission Proposal for a Council Recommendation in relation to early school leaving further highlighted this issue of teacher professional development:

> Supporting and empowering teachers in their work with pupils at risk is a pre-requisite to successful measures at school level. Targeted teacher training helps them to deal with diversity in the classroom, to support pupils from socially disadvantaged backgrounds and to solve difficult teaching situations (p. 12).

Thus, there is a clear emerging European and international consensus – not only that teachers need more support regarding conflict resolution skills, classroom management techniques and assistance in fostering a positive classroom and school climate – but that these are key factors in both student performance and prevention of early school leaving. This level of focus on systemic communication in the class and across the school offers another level for potential intervention of multi/interdisciplinary teams as part of a systemic strategic focus on early school leaving.

Taljunaite et al.'s (2010) report offers conclusions which paint a stark picture about current practice in Lithuania and the need for progress in development of school climate:

> At the moment there is no unique strategy for solving this problem [of early school leaving]. The model of how to encourage school leavers to come back to school does not exist:
> • The system of monitoring early school leavers does not exist;
> • There is no data on how many school students do not attend schools and which proportion of them do not have a school leaving certificate;
> • There are no alternative schools for early school leavers and drop-outs;
> • Negative teachers' attitude towards students who do not attend school regularly;
> • Teachers lack of psychological and counselling skills when communication with those students;
> • The psychological support is unavailable. It is difficult to get this support, the quality and efficiency of support is insufficient (Taljunaite et al.,2010).

These gaps in the Lithuanian support system at school to help prevent early school leaving are of particular concern especially given the increasing recognition of alienation from school as an institutional and relational process where students feel 'eased out' (Smyth & Hattam 2004, p.165) from school (see also Fingleton 2003; Downes et al.,2006; Downes & Maunsell 2007; Hodgson 2007).

The need for a multi/interdisciplinary team to engage in targeted intervention for language development emerges from international research regarding language impairment as a risk factor for correlates of early school leaving, such as engagement in disruptive behaviour. Eigsti and Cicchetti (2004) found that preschool aged children who had experienced maltreatment prior to age 2 exhibited language delays in vocabulary and language complexity. The mothers of these maltreated children directed fewer utterances to their children and produced a smaller number of overall utterances compared to mothers of non-maltreated children, with a significant association between maternal utterances and child language variables. Rates of language impairment reach 24% to 65% in samples of children identified as exhibiting disruptive behaviours (Benasich, Curtiss, & Tallal, 1993),and 59% to 80% of preschool- and school-age children identified as exhibiting disruptive behaviours also exhibit language delays (Beitchman, Nair, Clegg, Ferguson, & Patel, 1996; Brinton & Fujiki, 1993; Stevenson, Richman, & Graham, 1985). In Irish contexts of urban designated disadvantaged schools, teachers and school principals consistently rated language support by speech and language therapists as a priority need for a strategic approach to early school leaving prevention and for improved academic performance for those at risk of poor school attendance at primary level (Downes 2004; Downes, Maunsell & Ivers 2006; Downes & Maunsell 2007). Again the issue of a language development dimension is not simply to target those at the level of a clinical speech and language disorder.

Based on 28 teacher responses across 4 schools designated as disadvantaged, an internal evaluation of the Dublin project, Familiscope's (2011) specifically focusing on the speech and language therapists working as part of a multidisciplinary team onsite in schools with children and teachers, as well as with parents, emphasised a range of benefits of this intervention. These included mental health benefits to give confidence to quiet,

withdrawn children, improving also their peer interaction, as well as facilitating their engagement in class and overcoming a fear of failure that stopped them trying to learn. Other benefits observed by teachers were an improved ability of pupils to follow '2-3 step directions' with consequent benefits for in-class behaviour, as well as improved phonemic and syllable awareness. This system level work focused also on developing teachers' language strategies. This occurred through child language groups, collaborative classroom delivery (speech and language therapist and teacher), informal advice consultation regarding language difficulties, informal teacher support in the classroom, teacher workshops, as well as direct speech support for the child.

A bullying prevention and intervention strategic focus as part of a mental health promotion and early school leaving prevention strategy through multi/interdisciplinary teams:

Significantly, Swearer et al.'s (2010) review of international research on bullying highlights that studies have demonstrated that children who are bullied are more likely to avoid school (e.g., Kochenderfer & Ladd, 1996; Olweus, 1992) or even leave school early (Fried & Fried, 1996). It is also notable that evidence suggests that the effects of bullying are exacerbated for those already at risk of early school leaving; Beran (2008) concluded that preadolescents who are bullied are at some risk for demonstrating poor achievement, although this risk increases substantially if the child also receives little support from parents and is already disengaged from school. Surveying 3,530 students in Grades 3 to 5, Glew, Fan, Katon, Rivara, and Kernic (2005) found that victims of bullying and bully-victims were less likely to be high achievers in school (measured by a composite score including reading, math, and listening) than students who were bystanders. In a study of 930 sixth graders, Nansel, Haynie, and Simons-Morton (2003) found significantly ($p < .01$) poorer school adjustment (e.g., doing well on schoolwork, getting along with classmates, following rules, doing homework) among students who were bullies, victims, or bully-victims, as compared with students who were not involved. Swearer et al.'s (2010) review also observes that bullies and victims are at risk for short-term and long term adjustment difficulties such as academic problems (Batsche & Knoff, 1994; Fonagy, Twemlow, Vernberg, Sacco, & Little, 2005), and psychological difficulties (Kaltiala-Heino, Rimpela, Rantanen, & Rimpela, 2000; Kumpulainen, Räsänen, Henttonen, Almqvist, et al., 1998; Swearer, Song, Cary, Eagle, & Mickelson, 2001).

In a report for the Swedish National Council for Crime Prevention, Ttofi, Farrington, and Baldry's (2008) meta-analysis evaluated 30 bullying intervention studies. Swearer et al., (2010) observe that 'This meta-analysis was noteworthy because of the rigorous study selection procedures used (i.e., focus on reducing school bullying, bullying defined clearly, bullying measured using self-report, studies that included both experimental and control conditions, inclusion of effect sizes, and sample sizes of 200 or larger). Results indicated that bullying and victimization were reduced by 17% to 23% in experimental schools compared with control schools...Ttofi et al. found that reductions in bullying were associated with parent training, increased playground supervision, disciplinary methods (dichotomized as punitive vs. nonpunitive), home–school communication, classroom rules, classroom management, and use of training videos'. (p.42). As Swearer

et al., (2010) observe, 'There was a dosage effect; the more elements included in a program, the greater the likelihood of reducing bullying. The researchers also noted that anti-bullying programs were more efficacious in smaller scale European studies and less effective in the United States' (p.42).

As noted by Swearer et al., (2010), Vreeman and Carroll (2007) examined the findings of 26 studies evaluating school-based anti-bullying efforts, distinguishing between classroom curriculum studies, whole-school/multidisciplinary interventions, and targeted social and behavioral skill training for bullies and victims. The most promising results were reported for whole-school anti-bullying efforts, including those to establish school-wide rules and consequences for bullying, teacher training, conflict resolution strategies, and classroom curricula and individual training. School-wide programs were found to be far more effective in reducing bullying and victimization than were classroom curriculum programs or social skills training strategies.

The need for the multi/interdisciplinary team to adopt a systemic approach to bullying prevention as a factor against early school leaving was also noted in a Canadian context by Lacharite & Marinii(2008): 'In keeping with the contextualizing of bullying as a multifaceted issue, there has been an increasing concern with the 'health' and 'democratic' deficits associated with the experience of bullying and victimization' (p.297); there is 'a critical need for multilevel intervention' (p.303). Downes (2009) highlights the need for continuity between school and community subsystems with regard to promotion of a positive school climate, as community level stresses will impact upon school climate unless a holistic approach to intervention occurs in contexts of social-economic disadvantage.

Swearer et al (2010) propose a systemic level of strategic intervention: 'the systems directly affecting children and adolescents include families, schools, peer groups, teacher–student relationships, parent–child relationships, parent–school relationships, neighborhoods, and cultural expectations.' (p.42). This applies to bullying prevention and intervention, but can equally apply to behavioural issues as a systemic strategic approach at individual, peer, school, family, and community contexts for early school leaving prevention (Downes 2004; 2009). Swearer et al (2010) conclude from their international review that: 'The research that has been conducted on bullying prevention and intervention suggests that anti-bullying initiatives should include individual, peer, family, school, and community efforts' (p.43). Swearer et al (2010) further conclude 'the research suggests that the majority of school-based bullying prevention programs have had little impact on reducing bullying behavior. Bullying will be reduced and/or stopped when prevention and intervention programs target the complexity of individual, peer, school, family, and community contexts in which bullying unfolds' (p.43). This need for a systemic focus on school-wide, family and community contexts is a key strategic focus for future multi/interdisciplinary teams in this area to engage in intervention for behavioural and bullying issues as part of an early school leaving prevention strategy.

Pyhältö et al. (2010) research in 6 schools in Finland of 518 students in 9th grade (Girls: 46% and Boys: 54%) highlights the importance of a peer interaction focus for factors associated with early school leaving, such as bullying prevention, and a sense of

belonging and satisfaction in school, 'collaborative investment in developing pupils' peer interactions within the class and school community is likely not only to promote the pupils' sense of belonging and satisfaction, but it may also provide a tool to promote more functional pupil–teacher relationships, hence facilitating teachers' work-related well-being as well' (p.218); 'Functional relationships with peers were reported to be a major source of satisfaction, while destructive friction in peer groups were considered a core source of anxiety and distress by the pupils.' (p.217-218). The interrelated nature of learning and well-being is referred to as experienced pedagogical well-being. Results showed that critical incidents for pedagogical well-being reported by the pupils were situated all along their school career.
From qualitative research with educational management in Estonia (Tamm & Saar 2010), the need for interventions and mental health supports emerges specifically regarding bullying prevention strategies at school:

> *Lower secondary students are younger than 17 years old. They are referred to us by the Department of Education; we cannot admit such students without the Department's approval. They could not cope in their old school. (...) Some schools (in particular those that have a social worker) refer their problematic students to us. The main problem is bullying. This year we have two such students and they are doing well. Our students are older and bullies cannot dominate* (Tamm & Saar 2010).

Child-centred research in designated disadvantaged primary and post primary schools in Ballyfermot, Dublin also drew an explicit link between bullying and non-attendance at school (Downes 2004).

In the EU Commission public consultation 'Schools for the 21st century', tackling bullying, violence and intolerance in schools was an emerging theme (see also Commission staff working document 2008). Moreover, van der Wal, de Wit & Hirasing's (2003) large scale research on 4,811 children aged 9 to 13 in schools in Amsterdam, observed that depression and suicidal ideation are common outcomes of being bullied in both boys and girls. There is a need for systemic supports to challenge such fatalism which is a risk factor for drug use and other self-harming behaviour, including a fatalism associated with early school leaving (Kalichman et al., 2000; Downes 2003; Ivers et al. 2010).

In a significant development, the Commission proposal for a Council Recommendation on early school leaving (2011) observes the need for 'developing anti-violence and anti-bullying approaches' (p. 12). Multi/interdisciplinary teams engaged with a range of schools can ensure that teachers and the wider school community can take a proactive preventive approach to bullying and violence in school (van Veen 2011). A systemic focus on bullying prevention is both necessary for effective bullying prevention and as a protective factor against early school leaving (Downes 2009). Rigby & Bauman (2010) highlight that internationally 'surprisingly little' (p.457) is known about what actions school personnel take to intervene in cases of bullying. From their summary of international research they conclude:

> Given the high level of acceptance among educators, both teachers and counsellors, of the use of punitive methods as the stock response in dealing with cases of bullying, it appears that the acceptance of alternative methods could come about through a recognition of the limitations of the traditional way of dealing with bullies and an increasing awareness of the merits of alternative approaches (p.461).

This points to the need not only for systemic change across schools on an issue relevant to early school leaving prevention. It also invites systemic intervention from a multi/interdisciplinary team to engage schools in changing practices across Europe and internationally, as part of a continuum of care interventions provided by such teams, for the key goal of early school leaving prevention.

5. Multi/interdisciplinary teams for early school leaving prevention: Analysis of four European examples

CLB, Flanders[5]

The CLB is the Pupil Guidance Centre. Every school in Flanders works with such a centre. A team of doctors, nurses, social workers, psychologists and pedagogues works in each CLB. Together with the school, the team ensures that each child can develop his/her knowledge, talents and competencies as much as possible. The parents and teachers, as well as the children or teenagers themselves, can go there directly for information, help and guidance. Some CLBs work with an intercultural official, who eases the way for people from other cultures. Every child in Flanders has to go to the CLB for a medical examination in the second year of kindergarten, in the fifth year of primary school and in the third year of secondary school. It is mandatory.

The CLB doctor tests the eyes and ears, and measures and weighs the child. S/he also looks at the child's teeth and posture, and determines whether s/he is developing normally. In this way, the doctor can quickly detect illnesses in the early stages and prevent them from worsening. If the school doctor sees a problem or suspects one, a more specialised examination carried out at a specialist is advised. The doctor also monitors children's vaccinations. The support and guidance for children by the CLB is free of charge.

The problems engaged with by the CLB

a) reading, writing, learning or studying difficulties;
b) questions about the choice of courses, study options, certificates and diplomas;
c) If a child does not feel comfortable at school: stress, fear of failing, bullying, violent behaviour, skipping school;
d) If a child might have health problems: vaccinations, growth problems, drug use, obesity, etc.

[5] Thanks to Martine Vranken, Coordination Inspector, Vlaams Ministerie van Onderwijs en Vorming, Brussels,Flanders, for providing this description of CLB.

Each CLB centre is open every school day. CLB officials are also available on certain days during the school holidays.

It is noticeable that the impressively wide scope of these centres engages with both primary and post-primary students, and is available across all areas of Flanders. The team integrates mental health, social care, medical and educational professionals. It adopts a universal and selective prevention approach, though it is unclear the extent to which it engages in intensive indicated prevention approaches. The teams appears not to engage in direct outreach to the most marginalized families, being focused on the individual child more than on family support. This systemic strategic focus does also appear to be somewhat lacking regarding change to school climate, with no systemic work with teaching staff engaged in, for example, on conflict resolution strategies or bullying prevention approaches.

SALAR, Sweden[6]

The SALAR project in Sweden seeks to develop integrated systems of mental health services for children and adolescents. It describes itself as a national development programme in Sweden in progress. Recognising that a holistic approach is needed to promote the mental health of children and adolescents, the work in the project's 14 geographical sites aims to find out:

- how children's mental health can be promoted and improved, and
- how children and adolescents gain early access to effective care and support according to their needs.

The project's twin aims are:

- to promote the mental health of children and adolescents with preventive work in which everyone concerned in local authorities and regions plays their part. The goal here is early efforts and good access to effective care and support in relation to need.
- to support a number of geographical sites to develop holistic strategies that can serve as national examples of solutions.

The purpose is thus to develop models for collaboration and working methods side by side. The project concerns individuals up to 18 years of age and all activities that cater for children and adolescents, e.g. health care for mothers and children, primary care, pre-schools, schools, school health care/pupils' health, paediatric medicine, habilitation for children and adolescents, youth clinics, family centres and child psychiatry.

Background – the need for comprehensive inter-sectoral strategies

[6] Thanks to Cecilia Goransson, International Coordinator, Education Administration, City of Stockholm, for providing this account of SALAR

According to the SALAR website, children and adolescents´ mental health is determined by a complex web of interacting factors. Services to address those with the highest need are required but so are also intervention strategies that may promote mental health, prevent mental ill-health and achieve early detection and intervention. If comprehensive strategies can be developed, children and adolescent can be helped earlier and thus need not be as highly struck by these problems as when the systems rely on only the highest level of specialized care. However, to be efficient, such systems need to be arranged with the involvement of a wide spectrum of sectors such as mental health care, social services and education.

"Model areas" – a national development programme in Sweden

In 2009 the Swedish government through its ministry of health and social welfare joined an agreement with the association of Swedish local authorities and regions to fund a three year national development programme to develop integrated systems of mental health services for children and adolescents. The programme has engaged 14 "model areas" (geographically bounded localities each including at least one regional authority and one or more municipalities). These areas were chosen as representatives for different types of localities throughout Sweden[7]. The funding provided to these areas intends to help those allocating extra resources to intensify their work to create sustainable inter-sectoral coordination from highest political level trough top management to managers and practitioners working closest to children and adolescents.

A central technical assistance team has been formed at the association of Swedish local authorities and regional to give appropriate support to the participating localities. Technical assistance has been given to local project leaders and steering groups at the top management and political levels. More than *75 specific* events targeting key areas such as the role of the education, social service and health care sectors as well as more generic competencies such as socioeconomic analysis, strategic collaboration and research & development have yet been run.

A recurrent finding noted on the SALAR website is that comprehensive strategies need mechanisms for strategic collaboration across all sectors as well as between the hierarchical levels. Socioeconomic analysis seem to be a viable strategy to illustrate the benefits of allocating funding to promotion, prevention and early intervention by showing with good data that appropriate work at these earlier levels can minimize the

[7] The sites in Sweden for the SALAR project are :
Dalarna – *Gagnef + Hedemora*
Gävleborg – *Hudiksvall*
Jönköping – *Jönköping + Eksjö*
Norrbotten – *Haparanda + Kalix + Överkalix + Övertorneå*
Skåne – *Helsingborg, Ystad + Simrishamn*
Stockholm – *Sollentuna, Farsta*
Uppsala – *Enköping + Håbo*
Värmland – *Hagfors*
Västerbotten – *Umeå + Vilhelmina*
Västra Götaland – *Vänersborg, Lärjedalen/Gunnared (Göteborg)*
Östergötland – *Norrköping*

risk of postponing problems that can be alleviated earlier at a lower cost to the society and to the affected family. It thus fulfils the dual interest to improve health and well-being while at the same time being a good investment for the societal economy.

It is noticeable that despite the impressively wide geographical spread of the project and its holistic focus, that the education system is not a site for emphasis in this project. Nor is early school leaving prevention itself a focus. This is somewhat surprising, especially given the association between early school leaving and mental health difficulties. The mental health implications for early school leaving and exclusion from the education system are evident from Kaplan et al's (1994) North American study of 4,141 young people tested in 7th grade and once again as young adults. They found a significant damaging effect of dropping out of high school on mental health functioning as measured by a 10-item self-derogation scale, a 9-item anxiety scale, a 6-item depression scale and a 6-item scale designed to measure coping.
This effect was also evident when controls were applied for psychological mental health as measured at 7th grade. Moreover, the significant damaging effect of dropping out of school was also evident even when controls were applied for gender, father's occupational status, and ethnic background. While it needs also to be acknowledged that early school leaving can have different effects across countries (Van Alphen 2009), this does not mean that holistic interdisciplinary team based approaches to mental health promotion and emotional support in the Swedish context need to operate as a parallel system to education and educational strategies for early school leaving prevention. State Departments of Health and Education need to develop interconnected strategies in this area (Downes 2008).

Gaps even in holistic interdisciplinary teams in Sweden and Flanders are particularly in relation to the need for combined community based and school site based interventions. The Flanders model of cooperation across mental health, social care disciplines, on the one hand, and medical and justice disciplines, on the other hand, would require further analysis as to whether the justice component (police members of the team) would hinder an outreach approach to gain the trust of individuals, families and communities who may be strongly alienated from the system - many of whom may also have family members with experience of being in trouble with the law and 'system'.

Familiscope, Dublin, Ireland, Child-centred family support service.

Familiscope is a community based interdisciplinary team which works also onsite in a range of primary and post-primary schools in an area of Dublin, Ballyfermot which has traditionally experienced high levels of poverty, social exclusion and early school leaving. It engages in the following system level interventions:

- Child Welfare Work—Child centred, community based interventions to address issues of child neglect i.e. emotional, educational and physical neglect
- Speech and Language work—school based therapy & language development work, partnerships with teachers, SNA s, parents, pre-schools, crèches
- Parenting work—Incredible Years, one to one support based on IY principles, Strengthening Families

- Family Support—child centred, practical, emotional, social, physical, therapeutic interventions
- Emotional support/interventions—key-working, individual therapeutic interventions
- Behavioural support/interventions—lunch time clubs, Incredible Years small group, individual therapeutic interventions
-

Objectives

- To provide child-centred family support interventions
- To provide a range of appropriate therapeutic responses—individual, couple, parent/child, family
- To provide speech and language therapy to children and young people experiencing difficulties
- To provide emotional and social support to children and young people experiencing difficulties
- To transfer skills to people living and working with children and young people
- To help build capacity within individuals, family and the local community

Guiding principles

- Familiscope is a community based organisation which is needs-led.
- Familiscope works from a child centred philosophy using family approaches in its work.
- Familiscope recognises the need to respond to and intervene directly with child/young person/family while also aiming to build capacity of others involved with the child/individual/young person/family.
- Familiscope believes in working in a way which incorporates all dimensions of the individual/family involved.
- Familiscope works in partnership with local agencies and organisations in meeting the needs
- Familiscope was evaluated as part of the Local Drugs Task Force interim project evaluation in 2007. Familiscope also commissioned an independent report on the work of the Child Welfare Programme with an emphasis on the voices of the children and the families in the service.

There are 4 kinds of evaluation of Familiscope which have taken place.

1) The external evaluation of Hogwarth (2007) was not a systematic evaluation, and provided some analytical description with some qualitative evidence.
2) The analysis of the speech and language dimensions to Familiscope for the National Economic and Social Forum (2009) report on Child Literacy and Social Inclusion engaged more with classifying and evaluating its strategic objectives and programmes for language development than in an outcome based data collection, whether qualitative or quantitative.
3) The third kind of evaluation pertained to gains in school attendance. This internal evaluation (2006-2010) provides quantitative data on school attendance outcomes but not as part of a control group study.
4) The fourth evaluation (2011) pertained to teacher responses to a questionnaire on the speech and language dimension to the multidisciplinary team, working onsite in schools with pupils, teachers and families. This questionnaire focused on

teacher perception of outcomes for pupils and on outcomes for their own teaching. This was also part of a self-evaluation process in Familiscope.

In the National Economic and Social Forum (NESF) report on Child Literacy and Social Inclusion (2009), Familiscope is cited as an example of good practice in a range of areas – as an example of projects a) incorporating broader developmental approaches of arts and culture activities, b) customized literacy-based approaches through speech and language therapy, and of projects c) driven by the public policy area of health, d) through systematic evidence-based planning and as an example of an e) innovative area-based cross-sectoral approach.

Internal evaluation by Familiscope (2011) of speech and language therapists work onsite in four local schools, based on questionnaire responses of 25 teachers and 3 school principals. This system level work focused also on developing teachers' language strategies. This occurred through child language groups, collaborative classroom delivery (speech and language therapist and teacher), informal advice consultation regarding language difficulties, informal teacher support in the classroom, teacher workshops, as well as direct speech support for the child. Key benefits observed by teachers and principals included:

- mental health benefits to give confidence to quiet, withdrawn children
- improving also their peer interaction, as well as facilitating their engagement in class and overcoming a fear of failure that stopped them trying to learn
- an improved ability of pupils to follow '2-3 step directions' with consequent benefits for in-class behaviour, as well as improved phonemic and syllable awareness
- continuity between home and school, 'parents able to help children at home offer learning strategies for speech and language'
- whole class benefits, extended range of language activities, developing strategies that can be applied in a variety of learning situation, including in-class support for small group work with children
- evidence of positive collaboration between teachers and the speech and language therapists
- call for more intensive support than that provided.

In the words of one school principal, 'on a school-wide basis, the significant improvement in our children's oral language skills helped to support our [national] targets for literacy. We have achieved significant gains in our standardised test scores. Our scores for the lower ability children are well above the national average/bell-curve...' The school principal attributes this specifically to the speech and language team members intervention, 'the intervention was very significant in helping the school achieve its specified [national] targets in literacy'.

The following excerpt from Evaluation of Local Drug Task Force (LDTF) Funded Projects, Self-Assessment Tool carried out by Hogwarth Consulting and Matrix Research and Consulting (2007) states:

> If Familiscope never existed the most at risk target group would continue to be marginalized from the very services that were initiated for them. They would also have negative school experiences due to the school system's inability to address their emotional/psychological and behavioural needs which creates an ongoing cycle of early school leaving. There would continue to be frustration in the schools in terms of their ongoing attempts to engage with this target group and it not being successful. This in itself creates a negative dynamic between the schools and the target group.

In contrast with the CLB, Flanders more universal and somewhat targeted selective intervention model, the Familiscope example concentrates more firmly on those most at risk of early school leaving, as a combination of an indicated intervention and selective intervention strategy. A feature of the Familiscope approach is its dual focus on both community and family interventions and school interventions. It also combines a language development focus with a mental health and family support focus, with speech and language therapists being part of the interdisciplinary team and working onsite in schools, not only with children but also with teachers, including classroom observation of teachers' literacy/language teaching skills for feedback to them on developing this area. Between 2006 and 2010, this speech and language therapists on the team have engaged with 220 teachers in school based workshops, 42 crèche/preschool workers, and directly with 307 children with at least one parent of each child always being involved in the contact and engagement process. The Familiscope model is a both/and one being community based and also working onsite across a range of schools in the Ballyfermot area of Dublin. It prioritises referrals of children based on need, rather than on a quota per school. In marked contrast to the CLB, Flanders, which operates across all of Flanders, a limitation of the Familiscope model is that it is restricted, as yet, to only one area of Dublin in Ireland.

The Hogwarth (2007) evaluation is not really a systematic analysis. Some user and practitioners discuss the benefits in terms of increased well- being, efficiency of service delivery. The NESF (2009) commentary on Familiscope is not a systematic evaluation, but is focusing more on strategic priorities for national level.

The question arises regarding the major gains in school attendance as improved outcomes for a range of children with chronic nonattendance issues - as to where these effects come from and whether they are attributable to the Familiscope outreach intervention, in the absence of a control group? The fact that the attendance gains were spread across a wide range of schools tends to exclude specific school related factors in these attendance gains. There were no other new agencies in the local area between 2006 and 2010 engaging with these children. This fact combined with the role of the Familiscope outreach team as a) first port of call in engaging with these families, the majority of whom previously refused to engage with statutory services, b) leading the case management of the families, and c) as being involved also directly with the families on a sustained basis, provides at least prima facie evidence that Familiscope's outreach team is the key factor leading to these major gains with a hard to reach group.

Regarding the internal evaluation of the speech and language therapists working onsite across four schools, with responses from 25 teachers and 3 principals to questionnaires, there was large consistency in the responses regarding the gains observed in the children's language development and subsequent behaviour. However, there is no direct evidence of norm-referenced language test scores as this was not part of this internal evaluation. Teacher observation of pupils' academic performance changes and behaviour change was largely consistent across different schools. There are no figures on refusals to respond which may have brought up more critique than the overwhelmingly positive feedback provided in the 28 responses. Nevertheless, a response rate of on average 7 teachers from the early primary years classes across four schools is a good response rate. The question also arises as to whether there were any social desirability factors in the teachers' responses. This is unlikely, not only because the questionnaire responses were anonymous. It is also improbable that social desirability factors influenced the positive feedback across the teachers' and principals' responses, as much of the focus of the questionnaires was on the supports in up-skilling teachers provided by the speech and language team members. It would be more likely that teachers would understate the level of support received rather than overstate how much they learned concerning the teaching of language development from another professional.

The Netherlands, Behaviour and education support teams (BEST) in schools (4-18+)[8]

- Objectives
  - early warning/diagnosis and intervention
  - integrating educational services and health and human services (instructional component, leadership component and addressing barriers to learning and development)
  - enhancing emotional well being, development, positive behaviour and educational attainment
  - consultation for schools/teachers and prevention programmes
- Multi-disciplinary teams
  - professionals from the school and health and human services
  - action and intervention oriented, not merely diagnostics, consultation and referrals
  - integrated in the school support structure
  - structural partnership in schools and networks of schools

According to van Veen (2011a), there has been successful implementation of this quality model in 21 pilot regions (primary schools networks, secondary schools, further education), with impact and positive outcomes in most regions (achievement, well-being, support/services delivery and school careers). Challenges include the quality of comprehensive youth policy planning (municipalities) and implementation, and collaboration with school boards; adequate resources (family support, social work, mental health and youth care services) and continuous reinforcement for improved social infrastructure (reduction of other networks); balancing primary prevention,

[8] Thanks to Professor Dolf van Veen, In Holland University, Netherlands, University of Nottingham, England, for providing this material

selective prevention and interventions; urgency to demonstrate positive outcomes on a large scale while conditions for quality implementation are sub-optimal; the need for a massive agenda for capacity building (leadership issues, case management, inter-professional programmes, Continuing Professional Development); need for quality combination programmes (education *and* health and human services programmes – one child/family, one plan. van Veen (2011a) also highlights the need to improve teaching and learning supports and integrate health and human services in the learning support structure (instructional, management and enabling component).

BEST professionals as part of these multi/interdisciplinary teams include: school student services coordinator (plus mentor, teacher and other school specialists), social worker, youth care office (youth care / youth mental health), school health care, truancy officer, police, including also special education, educational support services, family support services (pedagogical-medical) and substance abuse (drugs/addiction) services.

It is evident from Table 3 that these teams have expanded notably in scope between 2004 and 2009. The wide scope, scale and breadth of multi/interdisciplinary team members are impressive features of this Dutch programme, as is the evaluation of a number of positive outcomes, though not through randomised controlled trials. A concern raised earlier with regard to involvement of the police and truancy officers directly in these teams, rather than as partner groups, also applies to these Dutch models, with regard to issues of confidentiality, trust and privacy, especially for the outreach dimensions to such teams. It is a concern also that van Veen (2011a) observed 'few comprehensive, integrated programmes (including OST, school culture/climate, extended pupil services), few programmes for family support and youth care/mental health and for community development and adult education'.

Table 3. Behaviour and learning support teams
Developments in primary, secondary and further education 2004-09

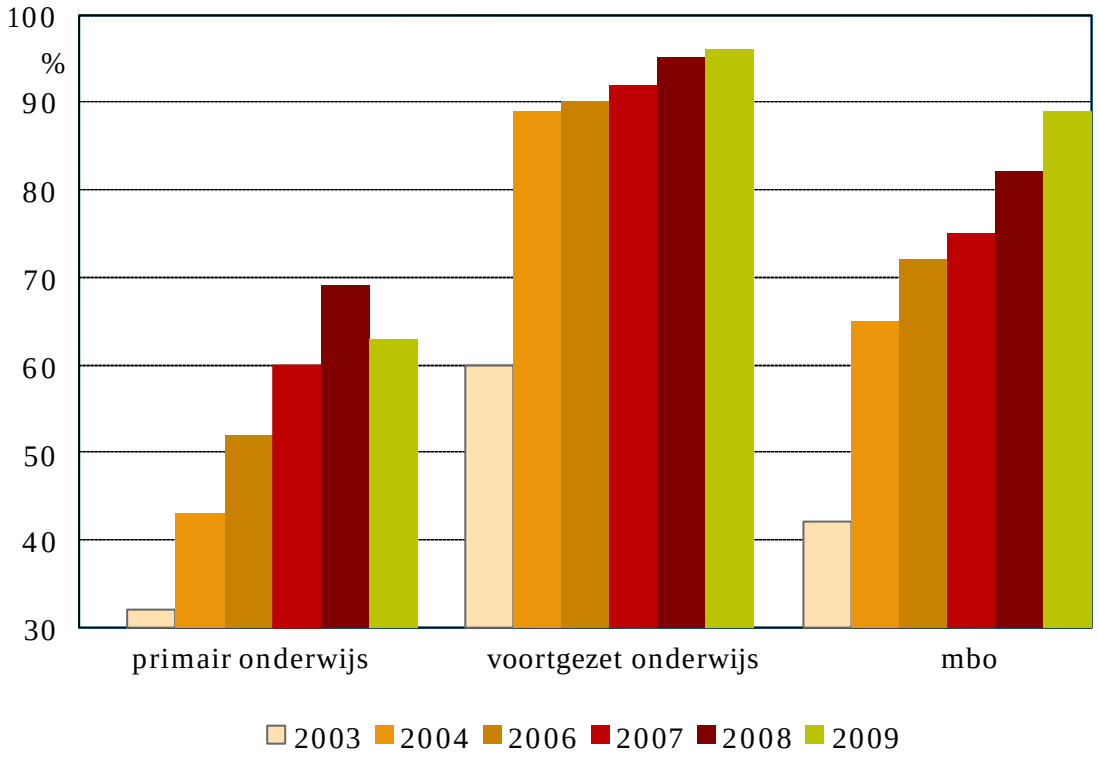
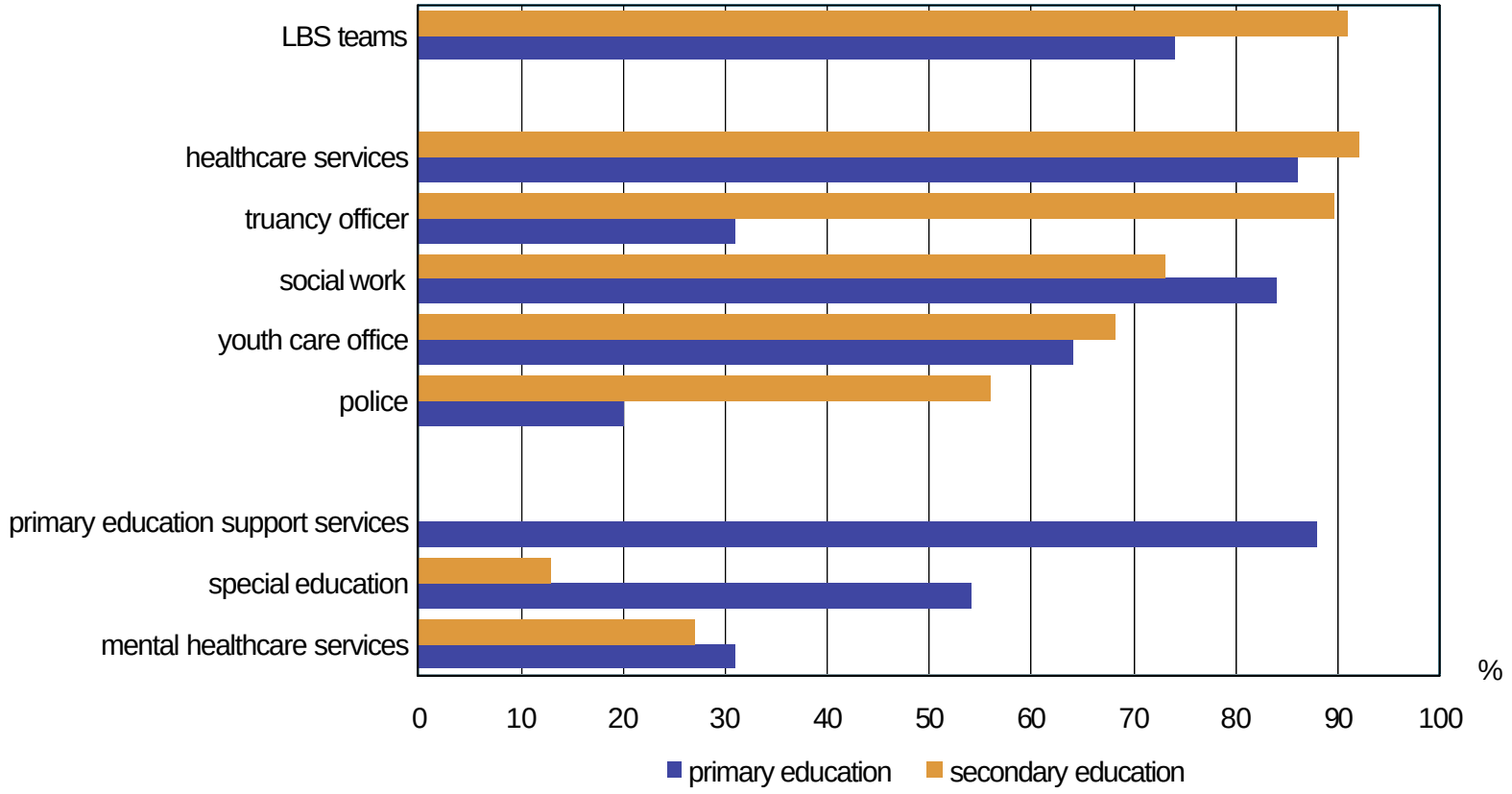
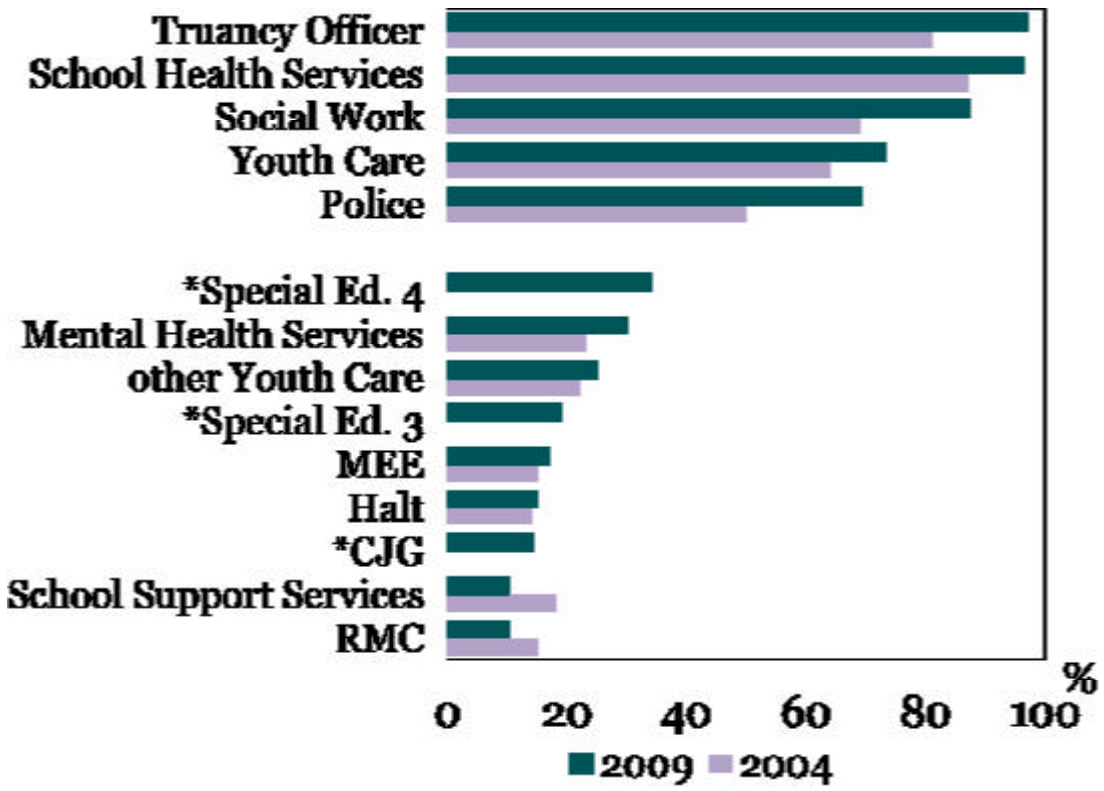


Table 4. and Table 5. BEST in primary and secondary schools, The Netherlands
Participating professionals 2004-2008 (van Veen, 2009)



Network of Experts on
Social Aspects of Education and Training


Truancy Officer
School Health Services
Social Work
Youth Care
Police
*Special Ed. 4
Mental Health Services
other Youth Care
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MEE
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School Support Services
RMC
0
20
40
60
80
100
%
2009
2004

Summary of the multi/interdisciplinary models from four European countries:

- Mental health, social care and education (though not school) team members (e.g., Ireland, Familiscope)
- Mental health, social care, education, medical and justice team members (e.g., Flanders, CLB; the Netherlands, BEST)
- Mental health, social care, medical team members (Sweden, SALAR)

6. Conclusions

This review illustrates that multi/interdisciplinary teams for early school leaving prevention constitute an element of at least some European countries' attempts to retain pupils and students in the school system. Examples observed are drawn from Sweden, Slovenia, Russia,Finland, the Netherlands, Flanders, and Ireland. This is not to state that there are not other examples in other European countries as well. While such teams are clearly absent in some countries such as Lithuania, Poland and at least some regions of Germany, there is a clear need and opportunity for the European Commission to support a more strategic approach to expand and evaluate such multi/interdisciplinary teams to sharpen their focus on early school leaving prevention strategies through mental health supports, family outreach approaches and school systemic change, including for alternatives to suspension, developing teachers' conflict resolution and bullying prevention skills (as factors relevant to early school leaving prevention) . Any such evaluations would need to go beyond ones in much of current research which tends to focus on the internal effectiveness of teams, while also recognising the systemic complexity of identifying and attributing outcome gains through multilevel interventions. Evaluation would need to encompass a range of structural, process and outcome indicators (Downes 2011). For multi/interdisciplinary teams, van Veen (2011, personal communication) recommends that countries 'develop and implement a regional, comprehensive policy and a resource coordination strategy and implementation supports'.

Any such European Commission support would need to provide strong strategic guidance to the teams on important issues to be engaged in by the teams such as mental health support, alternatives to suspension, marginalized families outreach, teacher conflict resolution and diversity training skills, bullying prevention skills, positive school climate promotion, engagement with parenting skills and a focus on children's language development etc. The teams would be required to engage in systemic level interventions across the individual, group, class, school, family and community. It would be important also to emphasise other key conditions from international research for the internal effectiveness of teams, such as idea dominance, awareness of the potential for role conflict, a distinct leadership role to avoid diffusion of responsibility, awareness of intra-team communication building and conflict resolution approaches. Concerns with confidentiality would need to be firmly addressed if members of the teaching staff are to be members of such teams, as distinct from working in partnership with these teams. Similarly, concerns with

family privacy and trust would tend to preclude police/justice officers from membership of teams with an outreach focus to the more marginalized. The outreach needs to be part of a child-centred care agenda rather than social control, punitive agenda. Beyond these confidentiality, privacy and trust issues, the composition of such multi/interdisciplinary teams would depend on different local and national emphases, with the caveat that some research points to particular role conflict between members of teams operating from both a mental health and social care model on the one hand, and a medical model on the other hand.

Empirical evidence from quantitative and qualitative sources highlights the need for interventions for the following priority areas:
a) at the individual child and family level:

- emotional support services for students to have someone to confide in, including therapeutic supports, as a protective factor for their mental health and to foster motivation and engagement in school and psychological supports in relation to the effects of bullying and traumatic events
- targeted language support services for children's language development, including systemic work with families
- emotional and behavioural support services to work with students displaying challenging behaviour and alienation from school
- outreach strategies in a culturally sensitive manner, to reach families marginalized from the education system

b) at the school system level:

- developing teacher conflict resolution skills and diversity awareness training for teachers
- developing whole school and in-class bullying prevention approaches
- developing alternatives to suspension
- developing a wider range of language development strategies in class.

International research suggests that community based teams working also onsite in schools offer a model of good practice to engage with the different systemic levels of intervention at individual, group/peer, school, family and community levels.

Outcome indicators as part of a strategic direction for such mental health multi/interdisciplinary teams are:
a) at an individual level

- gains in attendance at school
- improved behaviour in class
- decrease in bullying in class and school
- decreased anxiety and depression and improved mental health, including academic self-efficacy and global self-esteem
- increased academic motivation and performance
- increased language development

b) at a family level

- increased engagement of previously marginalized families with support services

- increased engagement of previously marginalized families with the school
- improved communication between child and parents

c) at the school system level
- decreased use of suspensions
- increased use of alternatives to suspension
- improved school and classroom climate
- decrease in bullying in class and school

It is recommended that the teams are to engage predominantly at the levels of selective and indicated prevention, with some universalism at whole class and whole school level for communities with a high proportion of early school leaving and/or poverty. Other key factors for success in the design and implementation of such actions for multi/interdisciplinary teams are that the intervention be of sufficient intensity and be over a time period of at least 4 years, where year 1 is design and recruitment, year 2 and 3 is the roll out of the full service and year 4 is its evaluation, based on evaluation aspects built into the programme for the team from the outset. The composition and ethos of the team needs to include a cultural affinity with marginalized families so that the outreach dimension is based on a trusting, culturally sensitive rather than punitive, social control or judgemental model. This does not mean that a relation of assumed connection and care between the outreach team members and each family would then preclude a cognitive-behavioural approach challenging and developing aspects of family communication centred on the needs of the child, including their educational and emotional needs.

It is essential that the team operates with a *systemic* vision of intervention and change rather than simply an individualistic one. In many situations, there is a need to establish these community based multi/interdisciplinary teams as a completely new team. In other cases, it may be advantageous to build these teams onto existing community structures, organisations and locations, depending on country and local area context. Within the proposed strategic framework, it is envisaged that each team's programme plans would draw upon the expertise of team members, in dialogue with children, youth, families, schools and other community organisations, to take ownership of pathways to best implement these strategic goals in the local context. Concerns with confidentiality and privacy for families and the goal of gaining their trust require that these particular multi/interdisciplinary care teams would not include members of the police, as they are essentially psychological, care teams rather than ones focused on social control issues. They are 'edu-care' teams. If these teams are to include teachers, as distinct from collaborating with teachers, very clear protocols for disclosure of the information given to the community based team by families would need to be developed, with regard to consent by the families and students for the availability of this information to be given to specific members of the school. In each country, there would be flexibility as to the exact professional composition of such mental-health-in-education teams. They could include, for example, any from the following range of professionals: family therapists, care outreach workers, youth workers, speech and language therapists, non-verbal therapists for younger children (e.g., art, play, music, sand therapists), emotional counsellors (as distinct from career guidance counsellors), nurses, occupational therapists, social workers, educational and clinical psychologists. For

the coordination of the teams there would need to be a clear role of team leader, as well as an administrator. As part of the community outreach, it could also involve recruitment of local parents as part of peer mentoring strategies, such as for language development approaches, emotional communication skills or lifelong learning classes. The focus of such 'edu-care' teams is recommended to be on prevention and early intervention rather than on diagnosis as such.

It is recommended that the areas for such teams would be targeted to community and school contexts with highest levels of poverty and early school leaving in each country. While the multi/interdisciplinary team may engage with children and young people manifesting emotional problems at a clinical level, it is envisaged that the majority of children and young people at risk of early school leaving and which are being targeted through such teams are in need of mental health supports that might be intensive, but do not require a medical model for intervention. These priority strategic issues being proposed for the multi/interdisciplinary teams are appropriate for all children and young people of school-going age. The particular age groups for targeting would be decided by each specific multi/interdisciplinary team, depending on local needs.

Promotion of multi/interdisciplinary teams for mental health interventions as part of early school leaving prevention is a strategic issue that is ripe for development through support at European level, given EU Council level commitment to targets of reducing early school leaving to 10% on average across Europe by 2020.

Promotion of multi/interdisciplinary teams for early school leaving prevention is a strategic issue that is ripe for development through support at European level, given EU Council level commitment to targets of reducing early school leaving to 10% on average across Europe by 2020. The next logical step is for the European Commission to invest Structural Funds in this issue as a matter of priority as a key part of an ET2020 strategy to reduce early school leaving across European States.

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