FOR MENTAL HEALTH PROFESSIONALS

CLINICAL PRACTICE POINT

A COLLABORATIVE APPROACH TO SUPPORTING YOUNG PEOPLE EXPERIENCING SCHOOL REFUSAL

THIS RESOURCE WILL HELP YOU

1. **Define school refusal**
2. **Recognise factors that contribute to school refusal**
3. **Identify how to engage young people experiencing school refusal**
4. **Identify how to work collaboratively with schools, families, and carers, when working with young people experiencing school refusal**

INTRODUCTION

School refusal sits within a spectrum of challenges that young people may experience when it comes to school attendance.(1-2) These challenges present differently and may occur due to a number of individual and higher-order contextual risk factors.(1-2) This clinical practice point will focus solely on the challenge of 'school refusal'.

For more information on the whole spectrum of school attendance challenges, please see Orygen's guide on supporting young people experiencing school attendance challenges.

SCHOOL REFUSAL

While there is variation in the literature, this document will refer to school refusal as school non-attendance that parents/carers are aware of, that is driven by the young person, and which is associated with emotional distress, primarily anxiety.(3-5)

School refusal is characterised as:

- Reluctance or refusal to attend school, often leading to prolonged absences;
- Staying at home during school hours with parents' knowledge rather than concealing the problem from parents;
- Experience of emotional distress, particularly anxiety symptoms, at the prospect of attending school;
- Absence of severe antisocial behaviour (for example, aggression or destructive behaviour); and
- Parental efforts to secure their child's attendance at school.(4)

Approximately one to two per cent of young people in the general population are estimated to experience school refusal, with rates increasing to between five and 15 per cent of young people referred for mental health services. (4) Young people with autism spectrum disorder (ASD) are at higher risk of school refusal. (6) This may be due to a number of reasons including school environments that are not inclusive for neurodivergent young people, difficulty with peer relationships, and bullying.

If not addressed early, school refusal can become chronic and difficult to change, potentially impacting the young person's social, emotional, educational, and occupational trajectories. However, early warning signs often go unaddressed because they are not recognised as potential risk factors for school refusal. There may also be barriers to communication between families and schools, or a lack or poor understanding of resources to address school refusal.

Research shows school refusal intervention is less likely to be effective when the school refusal has persisted for more than two years.(3) There is also emerging evidence that one-third of young people who present with school refusal are likely to experience serious adjustment difficulties in adulthood (for example, social learning phobia and learning difficulties), and that this could result in reduced future employment and/or education.(3) This highlights the importance of prevention and early intervention to mitigate the onset of school refusal.

FACTORS THAT INFLUENCE SCHOOL REFUSAL

There are many factors across a young person's life which can contribute to the development of school refusal.(7) These factors may include:

- Bullying;(5,8)
- diagnosed and undiagnosed mental ill-health, especially anxiety and depression which may present through psychosomatic concerns, such as headaches and dizziness;(5)
- neurodiversity, including ASD;(6,8)
- academic and/or learning difficulties;(9-10)
- experiences of exclusion from school (suspension or expulsion);(5)
- social isolation;
- difficult or disharmonious student-teacher interactions or relationships;(11) and/or
- parent/carer factors, for example finding it difficult to enforce school attendance.(3)

These factors can also interact, with some young people experiencing a compounding effect of multiple factors, increasing the risk of school refusal.

A MODEL OF SCHOOL REFUSAL BEHAVIOUR

Kearney and Silverman developed a functional model of assessing school refusal behaviours.(12-14) This model proposed four functions for school refusal behaviour and highlighted the impact of positive or negative reinforcement.(12-14)

These functional categories are:

- **Function 1:** Avoiding negative affect, for example wanting to avoid school due to specific fears, including of teachers.
- **Function 2:** Escaping from aversive social and evaluative situations, for example difficulties within the social domain, including with peers.
- **Function 3:** Avoiding separation anxiety and getting needs for parental or carer attention met.
- **Function 4:** Tangible positive reinforcement, for example wanting to engage in activities other than school that are deemed to be more exciting and interesting.

This model includes tangible positive reinforcement (function four), a function which commonly underlies truancy, a specific typology of school attendance challenge. As this resource focuses on school refusal (school absenteeism that is related to distress and anxiety), functions one to three will be of more relevance.

IDENTIFYING YOUNG PEOPLE AT RISK

Young people may be referred specifically with school refusal, or early warning signs may be identified during an initial psychosocial assessment or at any point during engagement. It is therefore important that clinicians have a good understanding of school refusal and be alert to the emergence of early warning signs especially for young people who may be at risk of school refusal, such as those with anxiety disorders.

Due to the importance of prevention and early intervention, it is vital that families and schools are also aware of the early warning signs of emerging school refusal. The sharing of information between families and/or carers and schools is key to assisting with identification. Families and carers will likely be the first to notice the early warning signs of school refusal and should be encouraged to share these with school staff members so all parties can work together to address school refusal behaviours before they become chronic.(5)

EARLY SIGNS OF SCHOOL REFUSAL

Early signs at home	Early signs at school
Struggling to get out of bed, leave the house or get out of the car	Unexplained absences or often running late to school
Disrupted sleep cycle, for example, oversleeping or not getting enough sleep	Absences on significant days such as tests, speeches, physical education classes
Feeling sick before school, for example, waking up with a headache, sore throat or stomach-ache	Learning difficulties
Tearfulness, clinginess and dawdling before school	Decreased participation in class
Complaints about attending school and reluctance to talk about school	Frequent visits to the sick bay or the wellbeing office
Difficulty attending school after weekends and holidays	Frequent requests to go home early
Difficulty separating from caregivers	Excessive worry about a parent when at school
Panic symptoms, threats of self-harm	Social isolation or withdrawal
Isolating behaviours at home	Peer relational problems
Excessive screen time	Avoiding particular classes

Clinicians working with schools can encourage schools to be proactive and use attendance tracking data, for example, non-attendance, lateness, visits to wellbeing and sick bay, to identify students who are at risk of school refusal. By aligning the collection of reasons for non-attendance with measures such as the School Non-Attendance Checklist (SNACK), schools can improve identification of students with emerging school refusal. Additional information is provided in the **Working with Schools section** below.

Clinicians working with young people, especially those presenting with anxiety and depression who may be at elevated risk, should regularly ask about their school attendance and any distress or anxiety related to attending school. This can allow the clinician to explore and help to address any barriers to school attendance early.

Supporting young people at key transitions and stressful life events

It is important to support young people during key transitions (for example, moving from primary to secondary school or changes in the family) and other stressful times (for example, examinations and bullying). Transitions during early high school also coincide with a cascade of pubertal changes, including increasing self-awareness, and changes in friendship groups. This can result in young people developing more awareness of their differences to peers and experience of isolation or alienation. This can be particularly challenging for young people with autism spectrum disorder (ASD).

Through these periods, clinicians can support young people to learn effective coping strategies, structured problem-solving and build a network of supports.

ASSESSMENT

When working with a young person experiencing school refusal, clinicians should conduct a thorough assessment of the young person's presenting concerns, experience of distress or anxiety relating to attending school and school refusal. It is important to gather information on the predisposing, precipitating, perpetuating and protective factors for the school refusal. This assessment may include the use of measures, such as:

- the SChool REfusal EvaluatioN (SCREEN) SCREEN_English.pdf.; and
- School Refusal Assessment Scale Revised (SRAS-R; parent and child version).(15)

DISTINGUISHING SCHOOL REFUSAL FROM OTHER ABSENTEEISM

Within the body of literature examining school non-attendance, psychological distress is argued to be a distinguishing factor between school refusal and other school attendance challenges. Young people experiencing school refusal commonly experience anxiety symptoms or disorders. Depression may also contribute; however, the association isn't as strong (3). Therefore, the presence of significant distress related to school can help differentiate school refusal from school attendance challenges which require different interventions.

FORMULATION

Effective intervention for school refusal requires a collaborative, developmentally informed formulation, integrating both the young person and their family's understanding of the predisposing, precipitating, perpetuating, and protective factors. (16) Specifically, there is a need to explore young peoples' views and to seek to understand their difficulties at the earliest stage possible.

Within formulation and treatment planning, clinicians should ensure consideration has been given to the following factors:

- neurodiversity;
- disability and learning needs;
- social skills (including any challenges in this domain);
- language and culture;
- mental health difficulties; and
- belonging and sense of safety at school, including bullying and experiencing discrimination such as racism and/or exclusion.

Clinicians can also use the results from SRAS-R to understand the possible functions of the school refusal. Results can be integrated with information provided by the young person and family/carers to inform the clinician's formulation and treatment plan. The table below reviews the functions proposed in the Kearney and Silverman model and treatment components for consideration.(12)

Function	Treatment components for consideration
Function one: avoid negative affect/distress	• Somatic management skills such as controlled breathing or progressive muscle relaxation training. • Graded exposure to school. • Self-reinforcement and building self-efficacy.
Function two: escape from aversive social and evaluative situations	• Cognitive restructuring of negative self-talk. • Role play. • Graded exposure tasks involving real-life situations. • Building coping skills.
Function three: avoiding separation anxiety and getting needs for parental or carer attention met	• Parent training in contingency management. • Effective parent instructions and consequences. • Establishing routines. • Use of rewards for school attendance.
Function four: tangible positive reinforcement	• Increase incentive for school attendance. • Curtail social and other activities because of non-attendance. • Family problem solving strategies to reduce conflict. • Communication skills and peer refusal skills.

Clinicians should be mindful that some young people may have more difficulties verbalising why they do not want to attend school, such as young people with ASD. Integrating information from multiple sources and using screening measures can assist in clarifying reasons for school refusal. An assessment of social and executive functioning can help clinicians to tailor interventions for young people with ASD who experience school refusal.(17) Information about sensory processing differences can also be important for tailoring interventions, for example, introducing sensory toolkits to use at school or working with the young person's teacher on where they should sit in the classroom may help to minimise sensory overload.

THERAPEUTIC APPROACHES

When considering therapeutic interventions for school refusal, there should be **shared decision-making** with the overarching aim of empowering the young person to take steps to improve their school attendance, which in turn can help them to resume a more adaptive developmental pathway. (3,16) A range of intervention approaches have been considered and are discussed below.

COGNITIVE BEHAVIOURAL THERAPY

Cognitive behavioural therapy (CBT) has the strongest evidence-base of any treatment in addressing school refusal.(18) CBT is a treatment form that typically draws upon a combination of psychoeducation, relaxation training, social skills training, gradual exposure to the emotion-provoking circumstance and cognitive restructuring.

Recent CBT interventions advocate for more individualised treatment based on the young person's functions causing school refusal, for example, anxiety or distress related to academic pressure or difficulty socialising with peers, alongside assessment of predisposing, precipitating, perpetuating, and protective factors (both with the young person, school staff, and family members).(16). This combined approach has also been found to be effective in alleviating a range of anxiety symptoms for young people – a key factor in the presence of school refusal.(16)

Recent research suggests that CBT programmes of this kind, when supplemented with support from school staff and family members, can reduce school refusal.(4)

BEHAVIOURAL THERAPY

Behavioural approaches for young people experiencing school refusal are primarily exposure-based and draw upon techniques such as systematic desensitisation (which incorporates graded exposure and relaxation training), imaginal exposure, and contingency management.(19)

Peterman et al. provide helpful practical guidance for operating exposure techniques, including in work with young people whose school refusal is driven by an avoidance of anxiety-provoking situations.(20) A major challenge is that for exposure to prove effective, there needs to be close, ongoing collaboration with school staff who may sometimes find the extensive time requirements of organising and monitoring individualised school return programmes onerous. The young person and clinician may also be able to draw on the young person's support networks, for example, taking public transport together, having a friend meet the young person at the school gate or walking into the classroom together.

Example of an exposure hierarchy

Clinicians can work with young people and their families and carers to develop a personalised exposure hierarchy. This uses a Subjective Units of Distress scale (SUDs) to rate situations or activities according to their anticipated level of anxiety. An exposure hierarchy should include a range of activities at different SUDs ratings from 0-10 (with zero meaning no anxiety and 10 meaning extreme anxiety). An example of an exposure hierarchy is provided below. For more information about creating an exposure hierarchy see Creating an Exposure Hierarchy (Guide) | Therapist Aid

Situation or activity	Subjective units of distress (SUDs)
Spending a whole day at school	10
Staying at school until lunchtime	8
Going to arts and maths and spending the rest of the day in the library	7
Going to school in the morning and sitting in the library	7
Meeting homeroom teacher at school	5
Going to the school gates	4
Emailing teacher to ask about work that has been missed	3

FAMILY-BASED INTERVENTIONS

The involvement of the family is a key factor to consider in developing a treatment plan. Research suggests it is only when the young person realises that parents or carers are determined to assist their child in returning to school that real progress tends to be made by the young person.(21) Involving the family in the intervention, alongside school staff, is essential in most cases.(22) While family therapy has long been advocated for in the treatment of school refusal, (23 - 25) there is insufficient evidence that family therapy in isolation is effective for treatment of school refusal. However, family inclusion or participation more broadly is now seen as a vital component of holistic and integrated treatments for school refusal, through embedding it alongside individual psychological intervention and systems work with the school. For example, creating opportunities for families to actively participate in monitoring and evaluating goals around attendance.

OTHER PSYCHOLOGICAL INTERVENTIONS

There are several other interventions which may be helpful for school refusal including dialectical behaviour therapy (DBT) (26) and narrative informed practice.(11) However, evidence for the efficacy of these interventions in treating school refusal is still developing.

Trauma-informed care is also a key approach to supporting young people who experience school refusal.(27) This approach recognises that adaptive responses can occur because of trauma (for example, attachment, regulation, and trust challenges) and may provide validation to support learning safer and more effective coping strategies. When selecting appropriate interventions, it is important to keep wider systemic factors in mind, including if there are school-wide issues.(13) For more information on trauma informed care please see Orygen's **What is trauma-informed care and how is it implemented in youth healthcare settings?**

WORKING WITH FIRST NATIONS YOUNG PEOPLE

When working with First Nations young people experiencing school refusal, it is important to consider social, cultural, and contextual factors, such as experiences of discrimination including racism, connection to family and community.

It is also important to celebrate successes and support First Nations young people to engage in education in a meaningful way by incorporating cultural knowledge systems. Work in a strengths-based approach by listening to the individual and exploring their aspirations and what success looks like on their terms. It is vital to provide pathways to help First Nations young people to incorporate culture and language into their learning and to challenge the pro-colonial narratives embedded in our national curricula.

> "Celebrate the success [of First Nations young people] ... don't write people off too early because they are not good at school."
>
> **OLIVER, FIRST NATIONS STATEMENT OF COMMITMENT COORDINATOR, ORYGEN**

Mental health clinicians can work with First Nations young people to understand barriers to attending school, explore family/carer experiences or expectations of school attendance and explore solutions to potential barriers. Ensure that any intervention is:

- trauma-informed;
- strengths-based;
- culturally responsive;
- family/carer and community inclusive wherever possible; and
- is considerate of the range of historical factors.

Wherever possible, clinicians should support schools to improve their cultural responsiveness and engage in holistic interventions which allow First Nations young people to achieve their greatest potential. This might include First Nations young people connecting with Elders and providing opportunities to be on Country.

For more information see section 'Working to build a supportive school environment' and 'Related resources'.

WORKING WITH FAMILY AND CARERS

> "The family system needs to be held in mind all the time."
>
> **CHRISTINA, CLINICAL LEAD, HEADSPACE**

Working with families and carers is central to addressing school refusal. However, families and carers may experience several barriers to communicating their concerns with schools at an early stage and working with schools and mental health clinicians to intervene early. For example, one study reported carers experiencing feelings of hopelessness, helplessness and guilt when supporting a young person experiencing school attendance challenges.(7) Actively communicating in a compassionate, supportive way, giving information as soon as possible about what might be involved, and providing support through family peer workers, for example, can help to empower parents and reduce feelings of helplessness and guilt.

Other factors that should be considered when working with families and carers include:

- clarifying the pathway of support for young people, families, carers, and school staff about what to do, to reduce possible confusion and distress;
- relationship factors, including family/carer separation, conflicting parenting styles and negative comments about school, (5) comparisons to siblings and their achievements;
- trauma experiences for the young person or their family and/or carers including domestic violence or substance use, (30) or wanting to keep the young person at home due to concerns that the school environment will not be safe for the young person;(5)
- language differences, including English as a second language;
- busy or chaotic home environments where families and/or carers may be overwhelmed, and the young person is required to be at home to assist; (5) and
- parent mental health concerns.(5)

Clinicians can play a significant role in supporting family and/or carers to help them to continue to support the young person.(31) Outreach programs where supports and other services come to the home, rather than requiring the carers to try to get the young person out of the home, can also be of benefit to parents/carers. Family and/or carer-specific sessions parallel to work with the young person, which addresses their needs and builds their skills, as well as including information about communication skills and contingency planning, should also be offered.(31) Including parents and carers when developing an exposure hierarchy with the young

person, can ensure that it is realistic, recruits a range of supports (extended family, neighbours, parents of the child's friends) and can allow for problem solving of practical issues, for example, public transport, lunch, school uniform and catching up on homework.

Keeping a non-blaming and constructive approach is important for all involved and clinicians may be able to assist in establishing and maintaining this positive process. Understanding the families' and/or carers' background and experiences of school and other systems or services/organisations can also be useful for clinicians, given the range of contributing factors to school refusal. These family or carer experiences could include coming from different cultural backgrounds and migrant or refugee experiences. Emerging research suggests it is important to consider how various cultural groups perceive school attendance challenges, such as school refusal.(32)

Varied understandings of school attendance challenges can also be held by all involved in the care and support of a young person. Mental health clinicians should acknowledge how family and carer mental health, especially anxiety, can naturally exacerbate stress and distress for themselves and often their young person, too. It may be helpful to assist families and carers to access their own mental health and other supports as necessary.

WORKING WITH SCHOOLS

Ultimately, reducing school refusal and other school attendance challenges is a whole school responsibility and requires a consistent whole school approach, with multiple levels of intervention from universal prevention, target intervention to intensive support. Clinicians can play a valuable role in supporting schools to develop their whole school approach and meet their obligations under the Disability Standards for Education.

Disability Standards for Education

Schools have an obligation under the Disability Standards for Education (2005) to support students with a disability including mental health conditions. This can include working with the young person and their parent or carer to develop reasonable adjustments which allow the young person to participate in school and learn, as well as taking steps to prevent harassment and victimisation.

Further information can be found on **the Australian Department of Education's website**.

It is important for schools to have clear guidelines and policies about how to support a young person experiencing school refusal. These guidelines should include how to identify early warning signs, for example, arriving late at school, leaving school early, requests to go home, as well as identifying which staff member is responsible for making the initial contact (31).

For more information on how schools can use a multidimensional, multitiered system of supports to reduce school attendance challenges (including school refusal) see **Orygen's guide on supporting young people experiencing school attendance challenges**

COLLABORATING WITH SCHOOLS TO ADDRESS SCHOOL REFUSAL

When collaborating with schools to address school refusal, it is helpful to build on protective factors wherever possible, including reinforcing any existing supportive student-parent/carer-staff relationships, especially when school refusal is entrenched (31).

> "Tap into what it is about school that gives them meaning. Most of the time, it's connection...I ask, "What gets you to school?" and it is usually a teacher ... a really friendly teacher. It's usually someone looking at them and thinking "wow, you're here" ... "well done", "good work"."

CHRISTINA, CLINICAL LEAD, HEADSPACE

Clinicians may also want to explore a range of strategies and adjustments with young people, families/carers, and schools, including:

- staggered start and finish times;
- flexibility to prioritise subjects the young person has a connection to or confidence to participate in;
- the opportunity for young people to meet with the teacher from each subject;
- prioritising strategies that focus equally on relational engagement at school and not only performance outcomes;
- a contact person who can ensure clear lines of communication between the school, the young person, and their family and/or carers to avoid confusion and disconnection. Wherever possible, involve a staff member that the young person has a positive relationship with;
- suggesting the young person has company on the journey to and from school, for example, a friend meeting them to catch public transport together;
- reducing hours on campus (for example, more frequent but shorter days); and
- options to complete other work at home or in alternative places such as the library.

WORKING TO BUILD A SUPPORTIVE SCHOOL ENVIRONMENT

Not all young people will experience their school environment as safe, supportive, and inclusive, including some neurodivergent young people and young people with additional learning needs. When formulating collaborative intervention strategies, it is important to consider whether the environment is inclusive of the young person's needs. This includes factors such as class size, learning profiles, sensory processing profiles and opportunities for social engagement with supportive peers. Further considerations should include the emotional safety of LGBTQIA+ young people, First Nations young people and young people from migrant and refugee communities.

Given the complexities and demands on staff time, schools may not always be fully aware of a young person's risk factors or vulnerabilities. There may also be barriers or challenges to creating a safe and supportive culture for some individuals or groups of students. Working wherever possible with the school wellbeing team and other staff who have leadership and curriculum level responsibilities is important to continue to discuss how this can be achieved.

Clinicians can also be proactive by providing brief education or organising training and support, in conjunction with other professionals and services. School-based mental health clinicians can assist teachers and leadership staff to organise professional development opportunities to increase the cultural safety of the educational setting. They can also support staff to become aware of and engage with community-based supports that are relevant to specific diverse groups such as First Nations young people and those from migrant and refugee backgrounds.

Clinicians can also play a role in modelling non-blaming approaches to supporting young people and communicating with parents. Taking opportunities to challenge and provide alternatives to punitive approaches, which can create tension between families and schools, can be helpful.

TEAM-BASED APPROACH

Working with school refusal is complex and requires more than a single clinician to engage the young person, their family, and the school. An interdisciplinary team, including a mental health clinician, family worker, peer worker and psychiatrist, is ideal for a comprehensive approach to supporting a young person, their family or carers and their school. Having someone to coordinate the team is also key to the success of the intervention.

CONCLUSION

For sustainable and effective interventions, clinicians should collaborate with school staff members and families and carers of the young person who is experiencing school refusal. As part of this collaboration, it is important that support and intervention is offered as early as possible and that systematic plans are put into place.

Mental health professionals can use general clinical skills and expertise with the young person, including assisting them to understand barriers to engaging in school and developing more effective coping strategies. Clinicians can also engage with appropriate services and other professionals to ensure that holistic support is provided and that re-engagement into the school setting on a more frequent and ongoing basis can occur.

CASE SCENARIO

The following case study is to help illustrate ways that mental health clinicians, families and/or carers and schools can work collaboratively to support a young person experiencing school refusal.

Max is a 13-year-old, cisgender male student in year seven. He has a history of school attendance behaviours and a diagnosis for autism spectrum disorder (ASD) with underlying social anxiety, which he has psychological support for. The primary school wellbeing and leadership teams supported Max at primary school and provided high school staff with handover information.

Engagement strategies for high school that were implemented included:

- meeting with Max and his carers at the end of primary school to discuss his concerns for starting high school;
- creating plans for a morning routine; and
- introducing Max to key high school staff members and other strategies including access to the wellbeing/sensory space when needed.

Max was also able to share his ideas on what he would like to happen, which included:

- being able to walk around the school when other students were not present;
- meeting his new homeroom teacher again prior to school starting; and
- having a locker away from other students to avoid loud areas.

Despite the above, Max continues to experience school refusal and is at risk of missing 10 per cent of his classes. As per school policy, his parents receive near-daily SMS messages advising that he has not attended school entirely or is missing certain classes.

The school was aware that Max's parents have been working hard to support him but feel at a loss. The school counsellor contacted the family and met with them to offer support, including arranging a meeting with them, Max and appropriate school staff members. At this meeting a mental health service was suggested to the family so that they could have access for themselves and for Max. Max was also asked to share his concerns and he expressed that he was having difficulties in his English class with persuasive text writing and did not know where to sit in each class. A seating plan was devised outlining where Max can sit in each class/subject, and it was organised that Max's English teacher would meet with him to discuss his English concerns. A communication book was also provided to allow Max to write down his concerns when they arise, and then problem-solve how to overcome these with the school's wellbeing coordinator. Max was also supported to build a sensory toolkit that he could bring to class to help him self-regulate in class.

The mental health service was contacted by the family as they were struggling with their own anxiety for Max, feeling stressed and unsure what else they could do to assist. The service included family peer support, direct mental health support to young people, and a case manager who could liaise with the school. Regular and ongoing meetings were organised, which occurred more frequently initially to ensure that plans were made, and any actions were followed up on.

RELATED RESOURCES

- In My Blood It Runs: a film developed as part of a campaign to make schools in Australia more culturally safe for Aboriginal and Torres Strait Islander young people.
- Beyond Blue: anxiety, depression, and suicide prevention support.
- eheadspace: online and phone support.
- Kids Helpline.
- Raising Children Network.
- Travancore School.
- Be You: School refusal (Beyond Blue).
- Child Family Community Australia Publications: CFCA Paper | Child Family Community Australia (aifs.gov.au)
- SafeSchools.

ORYGEN RESOURCES

See Orygen's resource library for evidence, workforce development and skills material relating to:

- Anxiety
- Perfectionism
- Brief interventions (BIT) toolkit
- Toolkits - Schools resources
- Cognition
- COVID-19
- Cultural diversity and mental wellbeing
- Depression
- Neurodevelopmental disorders
- Schools
- Trans and gender diverse young people
- Trauma

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