

Medication for School Refusal: What role does it play?

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School Refusal



- Severe difficulty attending school
- Severe emotional upset
- At home with parent's knowledge
- Absence of antisocial characteristics
- Reasonable efforts by parents to enforce attendance

(Berg, 1997)

The most evidence-based treatments for School Refusal are specifically adapted Cognitive Behavioural Therapy (CBT) interventions (e.g., Maynard et al., 2015; Heyne et al., 2011; Last et al. 1998)

Impact of Psychosocial Treatment on Attendance

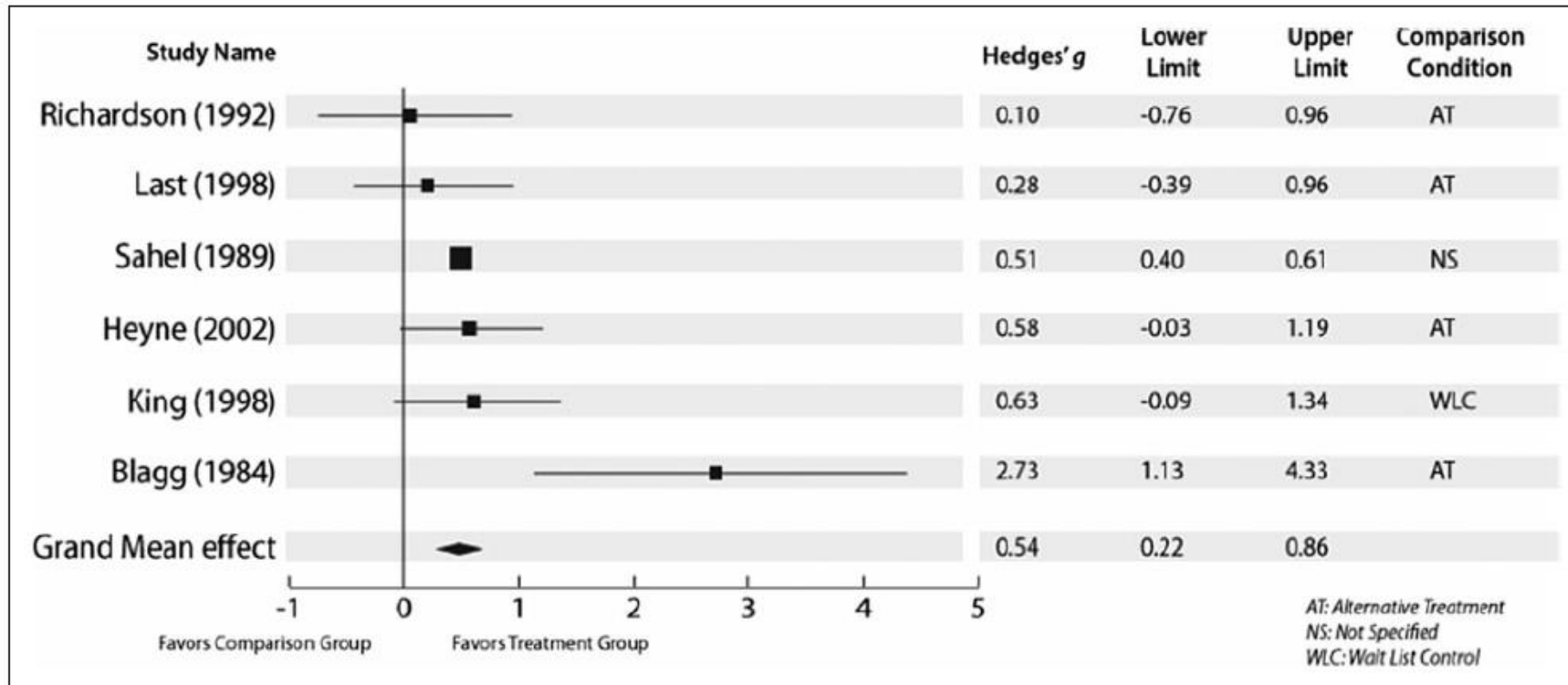


Figure 4. Effects of psychosocial treatments on attendance.

Maynard, Heyne et al., (2015)

Impact of Psychosocial Treatment on Anxiety

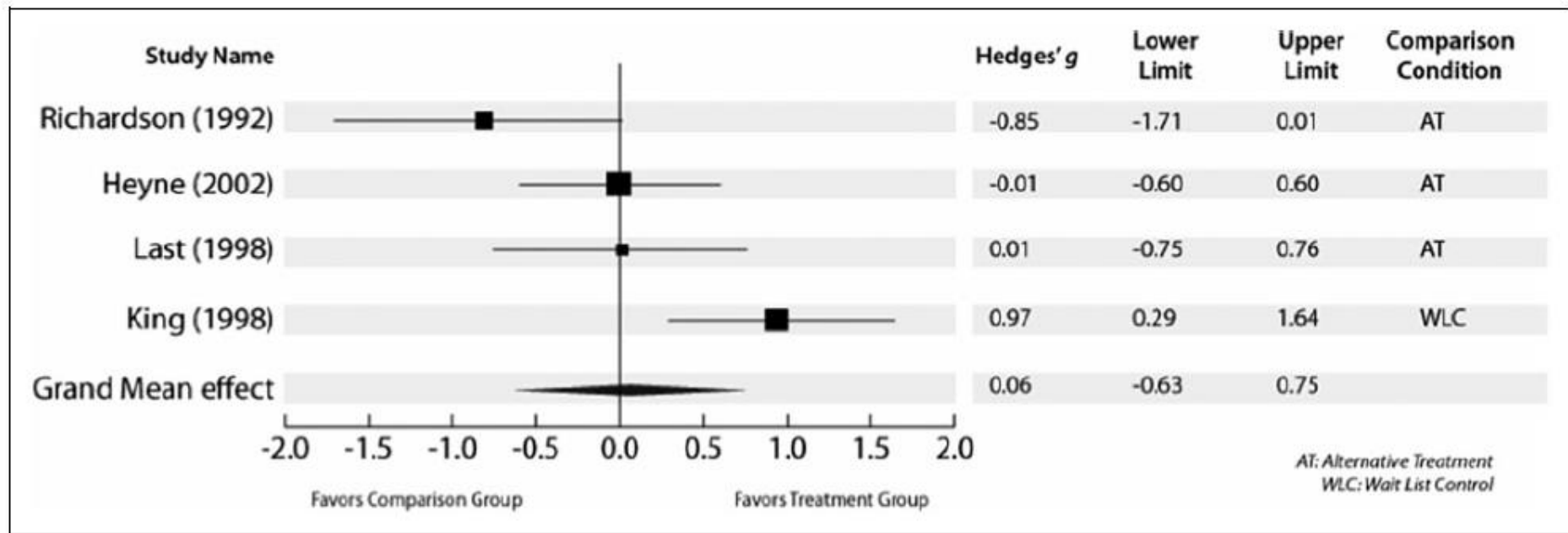


Figure 3. Effects of psychosocial treatments on anxiety.

- Psychosocial treatment leads to improvement in attendance but...
 - a substantial minority of students have inadequate attendance following treatment (8-40% Maynard Heyne et al., 2015);
 - others refuse to engage in 'talking therapies'
- Need for treatment innovation

Why Antidepressant medication?

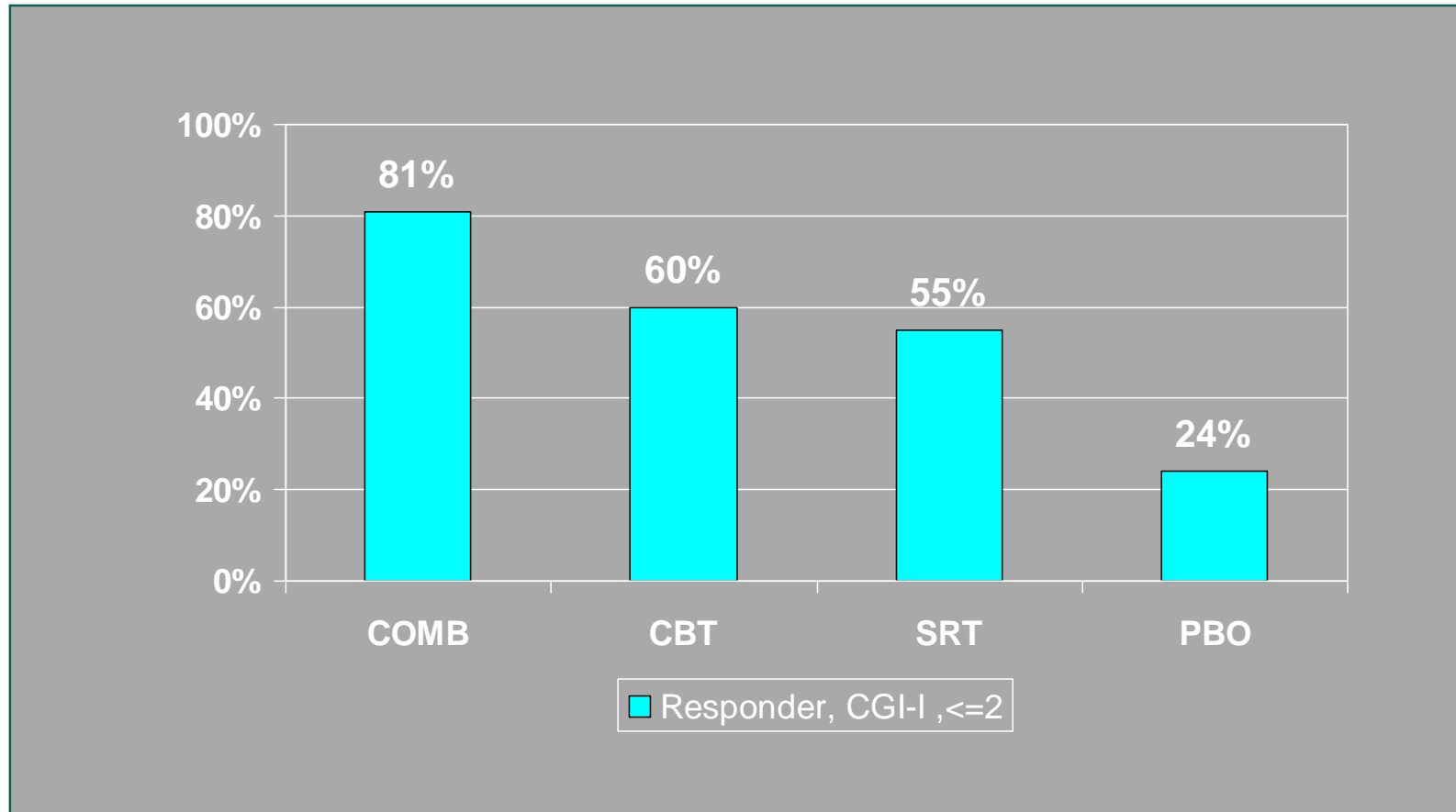


- Many students with school refusal experience anxiety disorders (Heyne, Sauter, & Maynard, 2015; McShane et al., 2001)
- Some evidence of efficacy of antidepressant medication for anxiety ($d=0.64$; Strawn et al., 2015), particularly in combination with CBT (Walkup et al 2008)

Treatment Response: Clinical Global Impressions -Improvement



COMB > CBT = SRT > PBO



Walkup et al., NEJM, 2008
Slide courtesy of Albano

Why Antidepressant medication?



- Many students with school refusal experience anxiety disorders (Heyne, Sauter, & Maynard, 2015; McShane et al., 2001)
- Some evidence of efficacy of antidepressant medication for anxiety ($d=0.64$; Strawn et al., 2015), particularly in combination with CBT (Walkup et al 2008)
- Accessible in the (some) community
- Newer antidepressants are relatively safe (Gordon & Melvin, 2014), though monitoring for suicidal adverse events is required (Posner et al., 2007)

Evidence for Antidepressants (+psychosocial intervention) for School Refusal



- Case Studies/Series
- Imipramine (Deltito & Hahn, 1993)
- Citalopram (Lepola, Leinonen & Koponen, 1996)
- Gabapentin & Hydroxyine (Durkin, 2002)
- Fluoxetine/risperidone, alprazolam (Oner, Yurtbasi, Er & Basoglu (2002))
- Open Trials
- Imipramine (Rabiner & Klein, 1969)
- Imipramine vs Alprazolam (Bernstein, Gerfinkel & Borchardt, 1990)
- Randomised Controlled Trials
- Imipramine vs placebo (Gittelman-Klein & Klein, 1971)
- Clomipramine vs placebo (Berney et al. 1982)
- Alprazolam vs Imipramine vs Placebo (Bernstein et al., 1990)
- Imipramine vs Placebo (Bernstein et al., 2000)
- Fluoxetine + CBT vs Placebo + CBT (Wu et al. 2013)
- Fluoxetine + CBT vs Placebo + CBT vs CBT (Melvin et al., 2017)

Safety and efficacy concerns raised about Tricyclic Antidepressants . (Hazell et al. 2002)
Generally not recommended in treatment guidelines.

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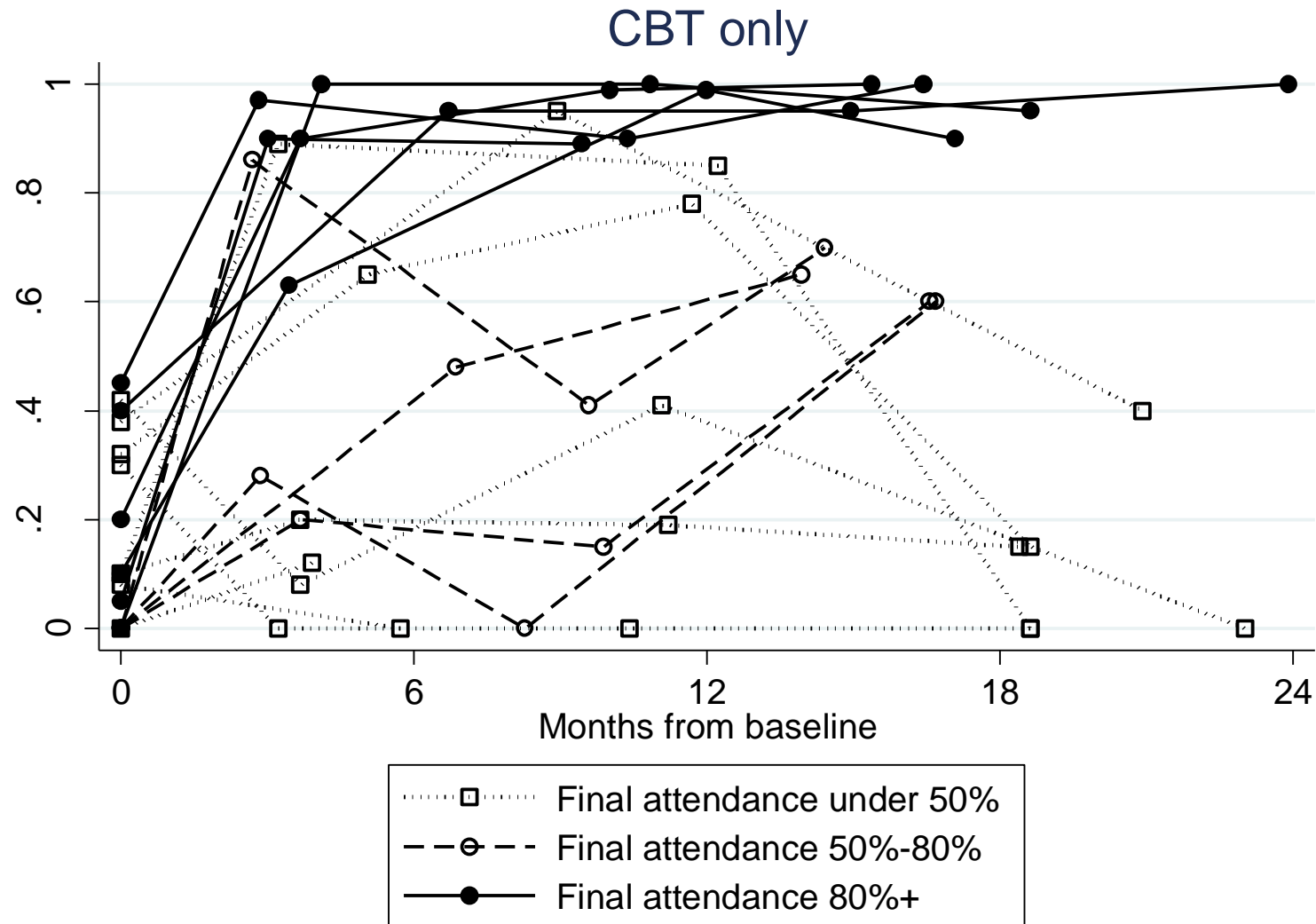
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Fluoxetine + CBT for School Refusal (Melvin et al., 2017)

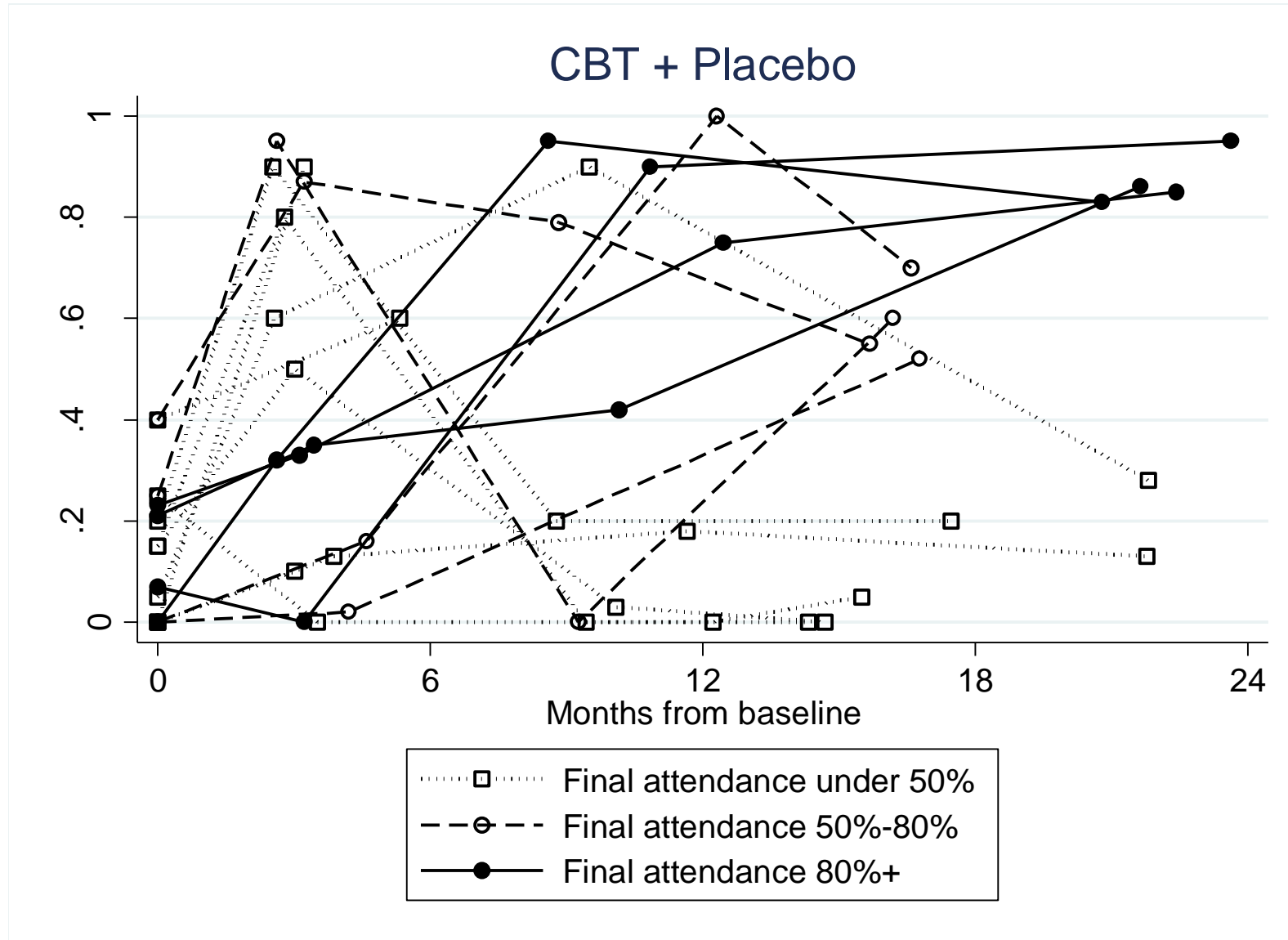


- Design
 - CBT+Fluoxetine vs CBT+Placebo vs CBT
- Sample
 - N=62 with anxiety disorder and < 50% school attendance for last 4 school weeks
 - 58% prior episode of school refusal
 - Age range 12-18 (m=13.5yrs)
- Intervention
 - CBT – 12 sessions dual clinician model
 - Fluoxetine – 10mg-60mg

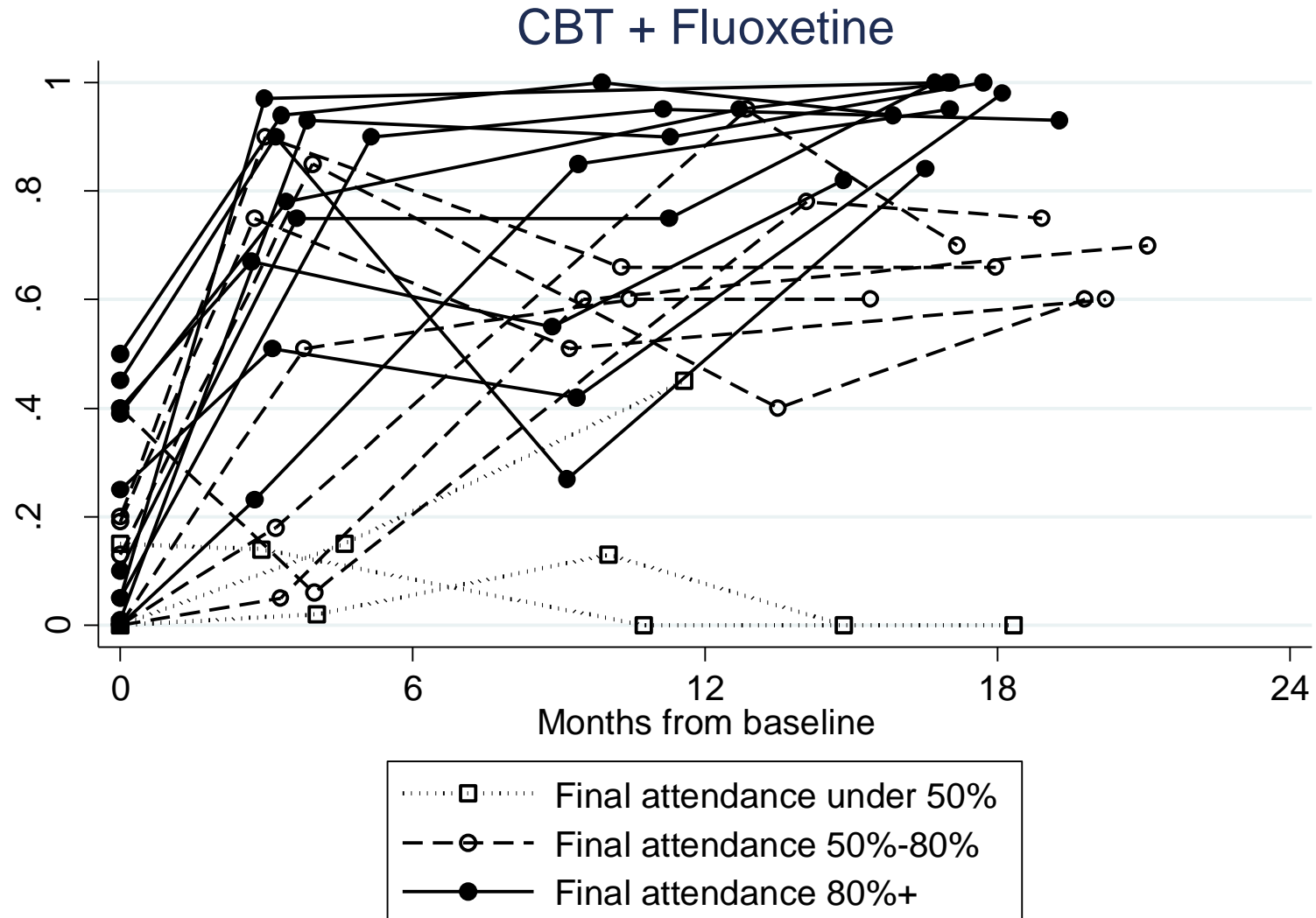
CBT: Attendance proportion over time



CBT + Placebo: Attendance proportion over time



CBT + Fluoxetine: Attendance proportion over time



- Consumer satisfaction rated on five point scale (0=not at all satisfied to 4 very much satisfied)
- Adolescents receiving CBT + Fluoxetine (mean score 3.1) reported significantly greater satisfaction ($p<.05$) with treatment than those receiving CBT alone (mean score 2.2)

(Adolescents were able to guess their treatment allocation better than chance)

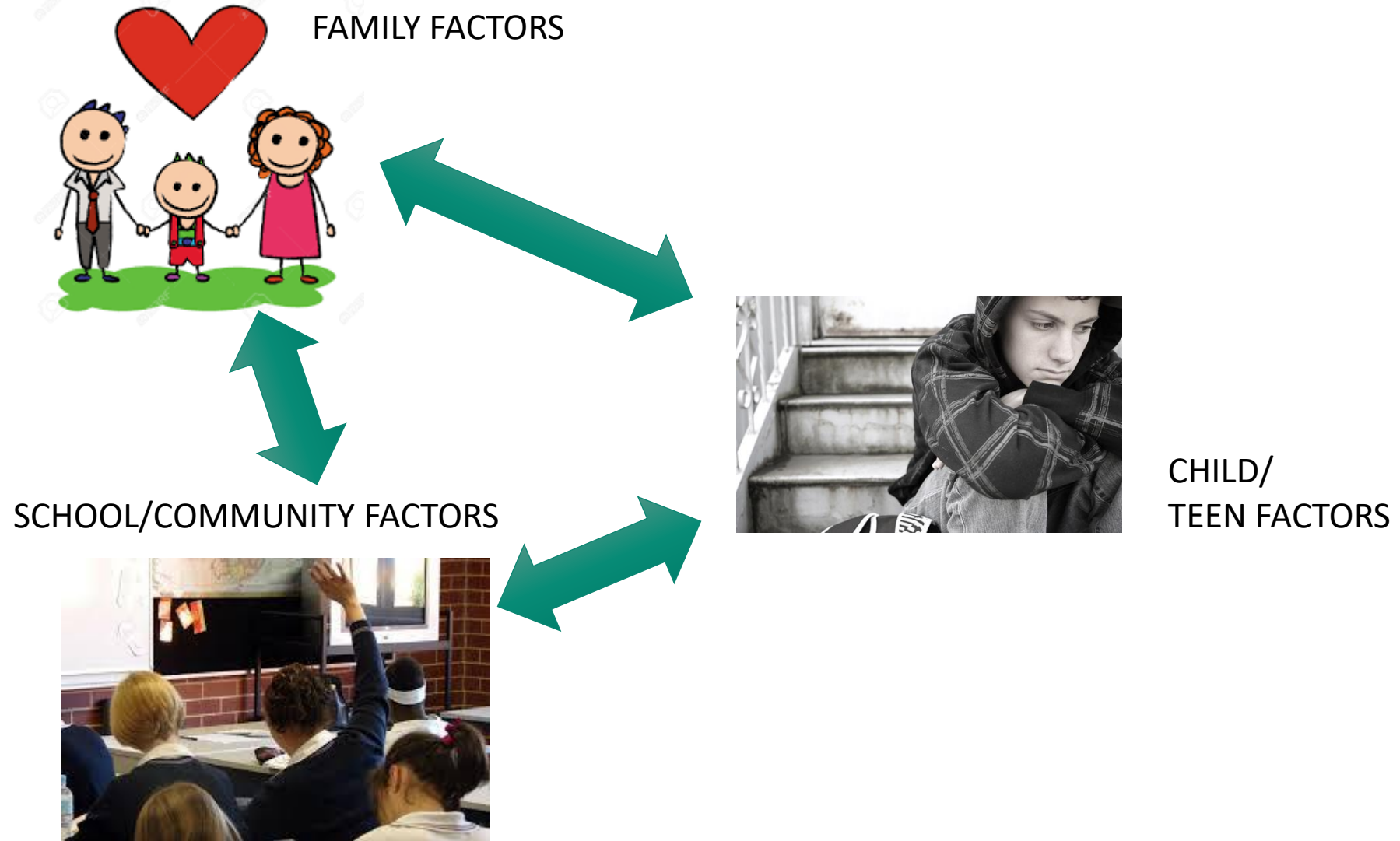
Side Effects



- Side effects were actively monitored in all groups across the trial
- All treatments were well tolerated. One suicide attempt (CBT+Placebo group) one withdrew to side effects (CBT+Fluoxetine)
- No difference between groups in the number of side effects – many were also symptoms of anxiety/depression
- The most common adverse events (after baseline)
 - difficulty falling asleep, difficulty arousing in the morning, outbursts of anger (all treatments),
- Nausea was the only side effect related to CBT+Fluoxetine

- Adding fluoxetine to CBT does not improve school attendance or clinical outcomes but does lead to greater treatment satisfaction
- All treatments were well tolerated
- Wu et al (2013) reached similar conclusions

Understanding School Refusal – Why no additive effect?



When to consider adding an Antidepressant



- Limited response to first line treatment CBT/psychosocial intervention
- Older age (adolescent, not child)
- Severe case of school refusal
- Child has an anxiety and/or depressive disorder
- Family preference for medication
- Supportive family that can monitor antidepressant use

(Melvin & Gordon, 2019)

- CBT remains the first line treatment for school refusal
- Few studies have investigated adding an antidepressant to CBT for school refusal and existing studies provide no clear evidence of benefit
- There is no evidence for antidepressants alone.
- Clinical judgement regarding whether an antidepressant should be tried can be informed by adolescent and family factors.

Thank you for your attention
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