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Feasibility of a revised version of the Back2School intervention: a transdiagnostic cognitive-behavioral intervention for school attendance problems

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Abstract

School attendance problems (SAPs) are a heterogeneous clinical phenomenon with various associated etiologies, symptoms, and perpetuating factors. Most existing intervention manuals based on cognitive behavior therapy are specific to certain types of SAP. Due to this heterogeneity, transdiagnostic interventions have been recommended to address the entire spectrum of SAP with a single manual. This study aimed to evaluate the feasibility of Back2School (B2S), a transdiagnostic and modular cognitive behavior therapy intervention for SAPs in a Finnish context. The sample consisted of 16 families distributed among 5 clinicians who received training in the B2S intervention. We evaluated five distinct parameters: sample characteristics, data collection procedures and outcome measures, treatment satisfaction, acceptability, and study procedures, as well as treatment effects. The results showed an increase in school attendance after treatment, but a decrease back to pre-intervention levels at follow-up. However, the data indicated high treatment satisfaction among all respondent groups. We suggest some adaptations in data collection procedures and the recruitment process to enable B2S to be evaluated in a randomized controlled trial in the Finnish context for the treatment of SAPs.

Keywords: School attendance problems, Back2School, cognitive behavior therapy, feasibility study

Introduction

The prevalence, associated difficulties, and potential increase of school attendance problems (SAPs) have been subjects of concern in Finnish schools. According to one report, 2-3% of Finnish secondary school students exhibit a level of school absenteeism that significantly impairs their education and requires special arrangements from the school (Määttä et al., 2022). SAPs are linked to various complications, including socioemotional difficulties (Gottfried, 2014; Malcolm et al., 2003), poor academic performance (Gershenson et al., 2017;

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Gottfried, 2014), early school dropout (Carroll, 2010; Christle et al., 2007), future unemployment (Attwood & Croll, 2006), and psychopathology (Bools et al., 1990; Egger et al., 2003; Flakierska et al., 1988). The SAP intervention literature, particularly in Nordic countries, lacks best practice guidelines for psychosocial interventions, as evidenced by a limited number of intervention trials (Määttä et al., 2022). Given the growing concern about school attendance problems among Finnish students and the absence of validated interventions, there is a clear need for contributions to the literature on psychosocial interventions for SAPs.

A threshold of 10% has been considered the cutoff for problematic school absenteeism in several countries (Johnsen et al., 2024). Clinically, SAPs are a highly heterogeneous phenomenon (Heyne et al., 2019), characterized by a wide range of associated symptoms and various precipitating and perpetuating factors that contribute to the emergence and continuation of non-attendance (Heyne et al., 2019; Kearney, 2008).

The modern literature categorizes SAPs into four primary types: school refusal (SR), truancy (TR), school withdrawal (SW), and school exclusion (SE) (Heyne et al., 2019). Intervention research has primarily focused on the two most prevalent types of SAP—SR and TR—due to the distinct outcomes and developmental pathways associated with these forms, their links to internalizing and externalizing psychopathology, and the different clinical methods typically applied (Maynard et al., 2013, 2018). Distinguishing between SR and TR is important for the development of effective SAP interventions (Maynard et al., 2018).

Contemporary SR interventions are primarily based on cognitive behavior therapy (CBT) (Hannan et al., 2019; Heyne et al., 2008; King et al., 1998; Last et al., 1998). Six CBT manuals for school refusal are identified in the literature, differing in structure and outcome measures but consistently highlighting individualized case formulations and the involvement of both parents and school personnel (Heyne et al., 2008; Heyne & Rollings, 2002; Kearney & Albano, 2018; Last, 1993; Strömbeck et al., 2021; Tolin et al., 2009).

A meta-analysis evaluating six CBT-based interventions (Maynard et al., 2018) for SR suggested a positive effect on school attendance among school-refusing youths ($g = 0.46$). However, due to limited replication studies and variability in factors such as number of sessions, treatment course, and level of family involvement, the authors called for more evidence before CBT can be established as an empirically supported intervention for school refusal. Further reason for cautious optimism is provided by the recently published meta-analysis by Jakobsen et al. (2025) which demonstrated that CBT has a large effect on school absenteeism ($g = 1.02$), as well as small to moderate effects on anxiety ($g = -0.57$), depression ($g = -0.66$), and behavioral problems ($g = -0.40$) among school-aged youth with school refusal and broader forms of SAPs. Treatment response appears to be lower in adolescence, for whom CBT fails to produce satisfactory outcomes in one-third to two-thirds of referred cases (Heyne, 2022; Maric et al., 2013). Although the mechanisms of change in CBT for school refusal remain understudied, child self-efficacy appears to be a key cognitive mediator of improved school attendance and reduced psychiatric symptoms (Maric et al., 2013).

A systematic review of 16 indicated TR interventions demonstrated a moderate positive effect on school attendance ($g = 0.46$) (Maynard et al., 2013). The review revealed substantial heterogeneity among the included studies, with no single intervention standing out as consistently more effective than the others. A defining feature of truancy intervention has been the involvement of multiple stakeholders in the intervention process, including

parents or families, as well as representatives from the school and broader community (Johnsen et al., 2024).

As noted in the literature above, psychosocial interventions for SAPs have traditionally been type-specific, tailored to particular SAP subtypes, mainly SR and TR. However, given the symptom overlap among youth with SAPs (Heyne et al., 2019; Kearney & Albano, 2004) and the high rates of comorbid difficulties in this population (Heyne et al., 2019), transdiagnostic and modular treatment approaches have been proposed (Lomholt et al., 2020; Reissner et al., 2019). These approaches aim to address a broader range of psychosocial challenges using a single treatment framework. Modular interventions, which structure evidence-based procedures into modules selected based on the individual needs of each client, have shown superior outcomes for youth compared to usual care (Chorpita et al., 2013).

Back2School (Thastum et al., 2020) is a transdiagnostic CBT program that aims to improve school attendance and reduce mental health symptoms in children and youth with different forms of SAPs. One advantage of B2S, also compared to other transdiagnostic manuals (Reissner et al., 2019), is that its focus also encompasses parent- and school-initiated absenteeism (SW and SE), in addition to SR and TR. This is achieved through strong involvement of both parents and teachers in the intervention. B2S employs a modular approach, offering an individually tailored treatment course based on the maintaining factors contributing to each client's absenteeism. The original manual consists of 10 sessions and includes regular school meetings. Based on initial implementation experiences, a revised version of the manual was developed. Key modifications included increasing the number of sessions from 10 to 11, placing greater emphasis on parent training and incorporating motivational assessment into the background interview. The structure of the intervention was also revised, to extend the phase addressing transdiagnostic issues before initiating the problem-specific component of the intervention (anxiety, depression or behavior problems).

After the intervention was deemed feasible in a Danish context, the first randomized controlled trial of B2S was conducted (Johnsen et al., 2024), using the original manual. The study compared B2S to treatment as usual (TAU) on outcomes related to school attendance and mental health. Both the B2S group and the TAU group showed within-group improvements in school attendance. Although no significant group effect was found, the B2S group outperformed the TAU group in reducing emotional problems, conduct problems, problems with peers, as well as the overall impact of problems. Additionally, the B2S group showed greater improvements in self-efficacy among both youth and parents compared to the TAU group.

Aim

The present study aimed to conduct the first evaluation of the revised B2S manual through a feasibility study in the Finnish context. Using a single-group non-randomized design, the study collected both quantitative and qualitative data to assess feasibility.

The primary focus was on evaluating the feasibility of the B2S intervention in a Finnish context, assessed across five parameters, following Orsmond and Cohn's description of the distinctive features of a feasibility study (Orsmond & Cohn, 2015): sample characteristics, data collection procedures, treatment satisfaction, acceptability and study procedures, and

treatment effects. The goal was to inform future intervention studies aiming to test the efficacy of the B2S intervention in a Finnish context with more rigorous designs.

Methods

Participants

Our aim was to include 25 families, equally distributed among the 10 clinicians who participated in the B2S training. Of these 10 clinicians, 3 were ineligible due to changes in their workplace or other factors. Among the 7 eligible clinicians, 2 were unable to participate due to workplace regulations. The remaining 5 clinicians took part in the study.

The recruitment process and the four-day B2S training program were conducted during the summer of 2021 in the municipality of Lohja, located in southern Finland. The training was provided by the Danish developers of B2S as part of the KouluKunnossa project. Participants were professionals from the project municipalities, recruited through convenience sampling.

Recruitment of client families began in the fall of 2021. The final intent-to-treat sample consisted of 16 families, with each clinician treating between two and six families.

Inclusion criteria

Our inclusion criteria, based on the Danish feasibility study by Lomholt et al. (2020), were as follows: participating youth had to (1) be enrolled in one of seven public schools in southwestern Finland; (2) be aged 10–16 years in grades 4–9, excluding the second semester of ninth grade; (3) have more than 10% school absenteeism in the past three months, as reported by parent; (4) be fluent in either Finnish or Swedish; (5) be willing to participate in both assessment and intervention procedures together with at least one parent; and (6) have written informed consent from the parent with legal custody.

Ethical considerations

The study was approved by the Research Ethics Committee of Åbo Akademi University (8.9.2021).

Procedure

The study, a collaboration between Åbo Akademi University and the KouluKunnossa project, was conducted during the 2021–2022 and 2022–2023 academic years. Clinicians were recruited based on their commitment to the B2S program, clinical experience with families, and basic knowledge of CBT principles.

Participating families were recruited by the KouluKunnossa project from schools and family services within the municipality according to the inclusion criteria. All families received information about the intervention and the feasibility study prior to participation and provided written informed consent. Informed consent was also obtained from participating school staff. Ethical and legal procedures were managed by the KouluKunnossa project.

Data were collected at three time points: pre-intervention, post-information, and a three-month follow-up. Background questionnaires were administered prior to the intervention,



Figure 1. Overview of the data collection procedures.

Note. SA = Survey Analytics by Question Pro; Y = Youth; P = Parent; T = Teacher; C = Clinician

while treatment satisfaction and acceptability questionnaires were completed post-treatment. Outcome measures were collected from the child, parents, and teacher at each time point. Clinicians submitted data through secure channels, and all data were handled in accordance with encrypted and secure data management protocols. Microsoft Excel and Survey Analytics by Question Pro were used for data collection. See Figure 1 for an overview of the data collection procedure.

The Back2School intervention

The Back2School intervention is a manualized cognitive-behavior therapy program designed to address diverse school attendance problems. Prior to this study, the program was translated into Finnish and Swedish. The program draws on multiple existing interventions, including the @school program (Heyne et al., 2008), When Children Refuse School (Kearney & Albano, 2018) and the Cool Kids intervention (Lyneham et al., 2003). B2S is also influenced by the transdiagnostic MindMyMind program (Jeppesen et al., 2021), the Adolescent Behavioral Activation Program (McCauley et al., 2016), and the Parent Management Training - Oregon model (Forgatch & Kjøbli, 2016).

The pre-intervention assessment includes a semi-structured clinical interview that covers multiple domains, such as family functioning, the child's developmental and academic history, psychological and physiological health, and environmental factors. It also incorporates a semi-structured psychopathological interview to assess clinically significant psychopathology across a range of diagnostic categories.

For additional guidance in assessment, the School Refusal Assessment Scale—Revised (SRAS-R; Kearney, 2002) was used to create a descriptive functional analysis of the youth's school non-attendance. The SRAS is a 24-item self- and parent-report scale evaluating the primary function of a child's school refusal behavior: 1) avoidance of school-related stimuli (negative reinforcement); 2) escape from aversive school situations (negative reinforcement); 3) pursuit of attention (positive reinforcement); and 4) pursuit of tangible reinforcement outside school (positive reinforcement). Both the child- and the parent versions were used.

In addition, this study included the Inventory of School Attendance Problems (ISAP; Knollmann et al., 2019) to assess the presence and severity of various mental health symptoms, and their functional relationship to school absenteeism.

The B2S program delivers tailored cognitive-behavioral intervention procedures, with distinct treatment pathways for anxiety, depression, and behavioral problems. Techniques include exposure for anxiety, behavioral activation for depression, and contingency management for behavior problems. See Table 1 for an overview of the components of the revised B2S manual.

Table 1. Session-by-session summary of the revised Back2School program.

Session	Participants	Session topic
Assessment	C, Y, P	Semi-structured background interview and psychopathological interview. Questionnaires. Psychoeducation about the B2S program and SAP.
Session 1	C, Y, P	Case formulation, SMART goals, and behavioral reinforcement. Psychoeducation about SAP.
Session 2	C, P	Establishing good routines and introduction of positive feedback and reinforcement. Discussions about motivational aspects. Case formulation.
Session 3	C, P	Clear demands and deliberate disregard of negative behavior. Repetition of positive feedback and reinforcement. Principles for the extinction of unwanted behavior.
Session 4	C, Y, P	Return to school. The meaning and consequences of avoidance behavior. Psychoeducation about exposure therapy. Creation of an exposure hierarchy.
SM 1	C, Y, P, T	Planning school participation to increase the child's attendance at school. Psychoeducation about B2S to the school staff.
Session 5	C, Y, P	Psychoeducation, the cognitive model, and cognitive restructuring.
Session 6	C, Y, P	Return to school: follow-up and problem-solving. Continued exposure work.
Session 7	ANX & DEP: C, Y, P BEH: C, P	ANX: Focus on security behaviors and the exposure hierarchy. DEP: The vicious cycle of depression and behavioral activation. BEH: Rule-governed behaviors and the use of token economy.
SM 2	C, Y, P, T	Following up on the youth's return to school. Planning possible school efforts in helping the youth with academic struggles, anxiety, depression, and behavioral problems.
Session 8	C, P	ANX: Follow-up on the exposure hierarchy. Discussing the parents' role in the reinforcement and extinction of anxiety symptoms. DEP: Continued behavioral activation BEH: Problem-solving with the family. Token economy and the use of negative feedback.
Session 9	ANX & DEP: C, Y, P BEH: C, P	ANX: Exposure therapy DEP: Behavioural activation BEH: Problem-solving with the family. Token economy and the use of negative feedback.
Session 10	Optional	Summaries of homework. Optional techniques are suggested by the clinician.
Session 11	C, Y, P	Preparation for termination. Relapse prevention.
SM 3	C, Y, P, T	The role of the school in preventing relapse.
Booster session	C, Y, P	Follow-up. Maintenance of the treatment response.
SM 4	C, Y, P, T	How the school plans to secure the youth's school attendance. Relapse prevention

Note. C = Clinician; Y = Youth; P = Parent; T = Teacher; SM = School meeting; ANX = Anxiety; DEP = Depression; BEH = Behavioural problems.

Measures of feasibility

Sample characteristics

Baseline data were collected through comprehensive questionnaires to capture sample characteristics related to the child, the child's family, the treating clinician, and the schoolteacher. Parents provided information on demographic background, family structure, developmental history, medical conditions, and psychiatric history. Teachers reported on parent-school collaboration, academic performance, and the child's need for special support. Clinician characteristics, including educational background, were obtained through a pre-intervention questionnaire.

Data collection procedures and outcome measures

Outcome measures were assessed at each data collection point, along with response rates for questionnaire completion. School absenteeism data were collected weekly during each session and reported to the researchers *via* a session-by-session questionnaire. In addition, school attendance over the previous two weeks was recorded at each data point *via* a parent questionnaire. Response rates across data collection points and respondent groups are used in this study as an indicator of the feasibility of the data collection procedure.

Treatment satisfaction

Treatment satisfaction was assessed post-intervention using self-report questionnaires completed by the youth, parents, and the teacher, serving as subjective measures. Objective indicators included dropout rate, session attendance, and intervention duration. Qualitative feedback on treatment satisfaction was also collected from each informant (child, parent, and teacher).

Acceptability and study procedures

Post-intervention, clinician acceptability of the intervention and study procedures was assessed through a questionnaire. Self-report items addressed the treatment's utility and applicability, time management resources, adequacy of background knowledge, evaluation of the B2S training, and satisfaction with intervention outcomes. Qualitative insights were gathered through two open-ended questions, inviting clinicians to evaluate the usefulness of the included measures and to identify strengths and weaknesses of the B2S intervention.

Treatment effect

Treatment response was assessed by measuring changes in primary (absenteeism) and secondary (psychiatric symptoms and related psychosocial variables) outcomes from baseline to post-intervention. A three-month follow-up was conducted to evaluate the maintenance of treatment effects.

Measures regarding outcomes of the intervention

Primary outcome measures

Absenteeism. Absenteeism data were collected at each time point through parent reports provided to the clinician. For the preceding two weeks, both teachers and parents reported

the number of hours the child was expected to attend school and the number of hours actually attended. Absenteeism was thus operationalized as the percentage of expected school attendance over the last two weeks at baseline, post-intervention and three-month follow up.

Secondary outcome measures

Anxiety. The Revised Child Anxiety and Depression Scale (RCAD; Chorpita et al., 2000) is a 47-item self-report questionnaire used to assess anxiety and other internalizing symptoms in youth. Items are rated on a 4-point Likert scale ranging from “never” to “always.” In this study, both child- and parent-report versions were used. Two composite scores were calculated: the Total Anxiety scale (range: 0–111) and the Total Internalizing scale (scores 0–141). The RCADS has demonstrated acceptable to good internal consistency in both clinical ($\alpha = .78–.88$) (Chorpita et al., 2005) and non-clinical ($\alpha = .60–.96$) (Donnelly et al., 2019) samples, as well as adequate one-week test-retest reliability (.65–.80) (Chorpita et al., 2000).

Emotional, social, and behavioral difficulties. The Strengths, and Difficulties Questionnaire (SDQ; Goodman, 1997) was used to assess emotional, behavioral, and social difficulties. The SDQ consists of 25 statements rated on a 3-point Likert scale and was completed by the student, their parents and the class teacher. The SDQ includes five subscales: emotional problems, conduct problems, hyperactivity, peer problems, and prosocial behavior. Derived scales include externalizing symptoms (0–10), internalizing symptoms (0–10), and a total difficulties score (0–20). The Finnish version of the SDQ has shown acceptable internal consistency and adequate inter-rater reliability (Koskelainen et al., 2000).

Depression. The short version of the Mood and Feelings Questionnaire (SMFQ; Angold et al., 1995) was used to assess depressive symptoms. It consists of 13 items rated on a 3-point Likert scale and was completed by both the child and parent. The total score ranges from 0 to 26 and reflects depressive symptoms over the past 2 wk, aligning with the diagnostic criteria for major depressive disorder (APA, 2013). The SMFQ has demonstrated good internal consistency ($\alpha = .85$) and, using a cut-off score of 8 or higher, shows 60% sensitivity and 85% specificity for a psychiatric diagnosis of major depressive disorder (Angold et al., 1995).

Self-efficacy. Youth self-efficacy was measured using the 12-item Self-efficacy Questionnaire for School Situations (SEQ-SS; Heyne et al., 1998), rated on a 5-point Likert scale. The SEQ-SS yields two subscales: academic/social stress and separation/discipline stress—and a total score (12–60), with higher scores indicating greater self-efficacy. The SEQ-SS shows good internal consistency ($\alpha = .81–.85$) and strong test-retest reliability ($r = .79–.91$) (Heyne et al., 1998).

Parental self-efficacy in handling school attendance problems was assessed with the 25-item Self-efficacy Questionnaire for Responding to School Attendance Problems (SEQ-RSAP; Heyne et al., 2007), rated on a 4-point Likert scale (range 25–100). The SEQ-RSAP has demonstrated adequate internal consistency ($\alpha = .91$) and test-retest reliability ($r = .67$) (Lavooi, 2010).

Data analysis

The data included both quantitative and qualitative variables. Sample characteristics, treatment satisfaction, and clinician-rated acceptability were analysed using descriptive statistics (M, SD, %).

Qualitative data were collected through free-text sections in the treatment satisfaction questionnaires and the clinician post-intervention acceptability questionnaire. The qualitative analyses were done by the first author by coding and dividing the data into themes. The results are reported following the identified themes.

Treatment effects were assessed by examining changes in outcome variables over time. Effect sizes (Cohen's *d*) were calculated for changes from baseline to post-intervention, and to the three-month follow-up, interpreted according to conventional thresholds: 0.2 (small), 0.5 (medium), and 0.8 (large) (Cohen, 1988).

Changes in the primary and secondary outcomes were analysed using Mixed Linear Models (MLM), which allowed inclusion of the full intent-to-treat sample ($N=16$) despite missing data—offering a more ecologically valid representation of clinical practice. We used a two-level hierarchical structure with time (level 1) being nested within individuals (level 2), and with using a random intercept for each of the models.

Each model was tested with both fixed and random slopes. The slope that produced the best model fit was used for the final analysis. We used Hurvich and Tsai's criterion (AICC; Hurvich & Tsai, 1989) for evaluating the different models' goodness-of-fit, with models producing lower AICC values being chosen over models with higher AICC values. AICC is corrected for model complexity and specifically designed for smaller sample sizes. Variance components (VC) were used as the standard covariance structure in our models. We used First-Order Autoregressive structure [AR (1)] or Heterogeneous First-Order Autoregressive structure [ARH(1)] in case the model fit improved with either of these covariance structures.

All statistical analyses were made with the IBM SPSS Statistics software 24.

Results

Sample characteristics

Sixteen families formed the intent-to-treat sample and began the intervention. The mean age of the youth was 14.0 (SD= 1.7) with girls constituting the majority (69%). At baseline, 60% was absent 10%-50% of expected school attendance during the preceding two weeks prior to the start of treatment. Prior treatment for SAP was reported by 80% of the youth, most commonly involving consultation with a school psychologist (62%).

Seven participants (44%) had a prior psychiatric diagnosis, with anxiety disorders being the most common (37%). This pattern was reflected in the semi-structured psychopathological interview, where anxiety symptoms were most frequently reported (47%) followed by depressive (40%) and ADHD (33%) symptoms.

Based initial assessments, the most frequently selected treatment target was anxiety (50%), followed by behavior problems (25%) and depression (13%). For a detailed overview of sample characteristics, see [Table 2](#). Clinician demographics are presented in [Table 3](#).

Data collection procedures and outcome measures

All 16 youths and their parents in the intent-to-treat sample completed baseline measures, the background interview, and the semi-structured psychopathological interview, although

Table 2. Sociodemographic and clinical variables of the intent-to-treat sample ($N = 16$).

Variable	Participants
Age, mean (<i>SD</i>)	14.0 (1.7)
Gender, girl, <i>n</i> (%)	11 (69%)
School absenteeism, <i>n</i> (%)	
2 wk before the onset of treatment	
10% absenteeism	1 (7%)
11%–30% absenteeism	6 (40%)
31%–50% absenteeism	2 (13%)
51%–70% absenteeism	3 (20%)
71%–99% absenteeism	2 (13%)
100% absenteeism	1 (7%)
Lives with both parents, <i>n</i> (%)	
Yes	10 (62%)
No	6 (38%)
Siblings living at home, <i>n</i> (%)	
0	2 (12%)
1–3	7 (44%)
>3	4 (25%)
Missing value	3 (19%)
Chronic illness, <i>n</i> (%)	
Yes ^a	2 (13%)
No	14 (87%)
Developmental anomalies, <i>n</i> (%)	
Yes ^b	3 (19%)
No	12 (75%)
Can't say	1 (6%)
Academic level (teacher-reported), <i>n</i> (%)	
Significantly lower than average	1 (6%)
Lower than average	2 (13%)
Average	8 (50%)
Higher than average	2 (13%)
Significantly higher than average	0 (0%)
Missing value	3 (18%)
Receives special education (teacher-reported), <i>n</i> (%)	
Yes	7 (44%)
No	4 (25%)
Missing value	5 (31%)

(Continued)

Table 2. (Continued).

Variable	Participants
Mother education, <i>n</i> (%)	
Primary school	1 (6%)
High school/vocational education	12 (75%)
Academic/university of applied sciences	1 (6%)
Missing value	2 (13%)
Father education, <i>n</i> (%)	
Primary school	3 (19%)
High school/vocational education	8 (50%)
Academic/university of applied sciences	2 (13%)
Missing value	3 (18%)
Regular medication, <i>n</i> (%)	
Yes ^c	6 (38%)
No	10 (62%)
Disability related to learning, <i>n</i> (%)	
Yes	3 (19%)
No	11 (69%)
Can't say	2 (12%)
Parental self-reported mental health problems, <i>n</i> (%)	
Mother	4 (25%)
Father	5 (31%)
Prior treatment for SAP, <i>n</i> (%)	
Any treatment	13 (80%)
School psychologist	10 (62%)
Private psychologist	3 (19%)
Physician	9 (56%)
Specialist physician	2 (12%)
Psychiatrist	4 (25%)
Social worker	5 (31%)
No prior treatment	3 (19%)
Diagnosed psychiatric or developmental abnormality	
Learning difficulties	2 (12%)
Autism spectrum	1 (6%)
ADHD	2 (12%)
Depression	4 (25%)
Anxiety	6 (37%)
OCD	2 (12%)

(Continued)

Table 2. (Continued).

Variable	Participants
Clinically meaningful symptomatology reported in the psychopathological interview	
Anxiety symptoms	7 (47%)
Panic attacks	2 (13%)
Social anxiety	7 (47%)
Generalized anxiety	5 (33%)
Obsessive-compulsive symptoms	2 (13%)
Obsessions	2 (13%)
Compulsions	1 (7%)
PTSD symptoms	1 (7%)
Depressive symptoms	6 (40%)
Low mood/irritability	3 (20%)
Decreased interest or pleasure	4 (27%)
Fatigue or energy loss	5 (33%)
Hypomanic symptoms	2 (13%)
Use of alcohol	1 (7%)
Tic symptoms	1 (7%)
ADHD	5 (33%)
Conduct disorder	1 (7%)
Psychotic disturbances	3 (20%)
Auditory hallucinations	2 (13%)
Visual hallucinations	1 (7%)
Thought disorder	3 (20%)
Delusions	2 (13%)
Autism spectrum disorder	1 (7%)
No symptoms reported	2 (13%)
Interview data missing	1 (6%)
SRAS ^d	
Function 1: Avoidance of school-related stimuli provoking general negative affectivity (NR)	8 (50%)
Function 2: Escape from aversive social and/or evaluative situations at school (NR)	1 (6%)
Function 3: Pursuit of attention from others (PR)	4 (25%)
Function 4: Pursuit of tangible reinforcement outside of school (PR)	3 (19%)
Aim for intervention	
Anxiety	8 (50%)
Depression	2 (13%)
Behavior problems	4 (25%)

(Continued)

Table 2. (Continued).

Variable	Participants
Anxiety and behavior problems combined	1 (6%)
Missing value	1 (6%)

^aAsthma ($n = 1$), no answer ($n = 1$).

^bAutism spectrum disorder ($n = 1$), language impairment ($n = 1$), no answer ($n = 1$).

^cSertraline ($n = 3$), Methylphenidate ($n = 1$), Fluoxetine ($n = 1$), Quetiapine ($n = 1$), Hydroxyzine ($n = 1$), Salbutamol ($n = 1$).

^dHighest combined score by the youths and parents is considered the dominating factor.

Table 3. Clinician background variables, n (%).

Variable	Clinicians
Education,	
Psychologist	1 (20%)
Occupational therapist	1 (20%)
Bachelor of social services	1 (20%)
Nurse	1 (20%)
Special education teacher	1 (20%)
Experience of therapeutic/special education intervention work	
4–6 years	2 (40%)
7+ years	3 (60%)
Employment	
Municipality social services	2 (40%)
The private sector	2 (40%)
Other	1 (20%)

one family did not provide background interview data. Post-intervention completion rates dropped to 75% for both youths and parents, due to three dropouts and one family not returning questionnaires. At the three-month follow-up, completion rates were 56% for youths and 63% for parents. Teacher participation was 88% at baseline, declining to 56% post-intervention and to 25% at follow-up (see Fig 2 for an overview of the completed data collection process).

Treatment satisfaction

Three of the 16 families (18.8%) dropped out during the intervention. One family discontinued after the second session due to high family stress; another terminated after the third session citing time-management difficulties, despite motivation to continue. The third family withdrew after the second session due to high family stress and involvement with child protection services. Of the 13 families who completed the intervention, 12 attended all 11 sessions, and one completed nine sessions. The number of school consulting meetings varied: three families (23%) had two meetings, four (31%) had three, and six (46%) completed all four. The average duration from baseline to the 11th session was 99 days (range: 66–158).

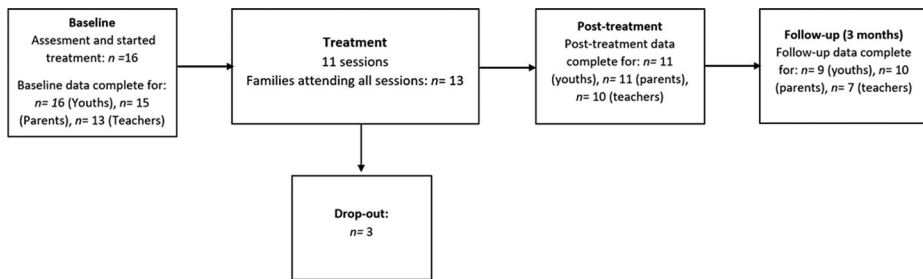


Figure 2. Overview of collected data by respondent group.

Table 4. Treatment satisfaction questionnaire results.

Item	Respondent [n]	Response options		
		Not true	Partly true	Certainly true
I got enough information about the content and purpose of Back2School.	Youth [12]	1 (8%)	5 (42%)	6 (50%)
	Parent [11]	0 (0%)	3 (27%)	8 (73%)
	Teacher [9]	1 (11%)	2 (22%)	6 (67%)
I trusted the therapist.	Youth [12]	0 (0%)	3 (25%)	9 (75%)
	Parent [11]	0 (0%)	0 (0%)	11 (100%)
	Teacher [9]	0 (0%)	0 (0%)	9 (100%)
The therapist understood our worries and concerns.	Youth [12]	0 (0%)	5 (42%)	7 (58%)
	Parent [11]	0 (0%)	0 (0%)	11 (100%)
	Teacher [8]	0 (0%)	0 (0%)	8 (100%)
We were helped by the Back2School program and the therapist.	Youth [12]	1 (8%)	5 (42%)	6 (50%)
	Parent [11]	0 (0%)	2 (18%)	9 (82%)
	Teacher [9]	0 (0%)	3 (33%)	6 (67%)
The meetings at the school were useful.	Youth [12]	1 (8%)	8 (67%)	3 (25%)
	Parent [11]	0 (0%)	1 (9%)	10 (91%)
	Teacher [9]	0 (0%)	3 (33%)	6 (67%)
I would recommend Back2School to others with similar problems.	Youth [11]	1 (9%)	2 (18%)	8 (73%)
	Parent [11]	0 (0%)	0 (0%)	11 (100%)
	Teacher [9]	0 (0%)	2 (22%)	7 (78%)

Treatment satisfaction questionnaires completed by youths, parents, and teachers indicated a high level of satisfaction across all groups. See [Table 4](#) for detailed results.

Acceptability and study procedures

Before treatment, all five clinicians reported high motivation (8–9/10) and moderate to high perceived ability (7–9/10) to adhere to the intervention manual. Qualitative feedback reflected positive impressions, particularly regarding the manualized and modular structure, as well as the intervention's relevance to clinical and societal needs.

Table 5. Acceptability questionnaire results (N = 5).

Item	Response options		
	Not true	Partly true	Certainly true
The B2S intervention was easy to implement	0 (0%)	3 (60%)	2 (40%)
The time and effort the program demands are in balance with its benefits	0 (0%)	0 (0%)	5 (100%)
I am satisfied with the help the client families received concerning:			
School absenteeism	0 (0%)	2 (40%)	3 (60%)
The psychological well-being of the youth	0 (0%)	2 (40%)	3 (60%)
Family functioning	0 (0%)	2 (40%)	3 (60%)
Was the one-week B2S training enough to use the program?	0 (0%)	1 (20%)	4 (80%)
Would you recommend B2S interventions to a colleague, acquaintance or family in need of support?	0 (0%)	0 (0%)	5 (100%)
	Poor	Moderate	Good
Evaluate your ability to work according to the intervention	0 (0%)	1 (20%)	4 (80%)

Post-intervention, the clinician acceptability questionnaire (N = 5) indicated high overall satisfaction with the manual. Notably, All clinicians agreed that the program offers a good balance between time and effort required and the benefits it provides. They also reported they would recommend B2S to others in need. Additional results are detailed in [Table 5](#).

Qualitative feedback

Theme 1: collaboration between multiple stakeholders (participant feedback)

Parents and teachers expressed satisfaction with the school-family collaboration during the intervention, emphasizing its importance for overall effectiveness. Both groups noted a positive impact on school attendance, and some described the collaboration as reassuring, enhancing their understanding of the child's situation. One parent, however, suggested that scheduling challenges due to conflicting timetables should be addressed in future implementations.

Theme 2: the clinicians' professional competence and working alliance (participant feedback)

Parents and teachers provided exclusively positive feedback regarding the clinicians, expressing satisfaction with their competence and professional skill set. One teacher described the therapist as an expert equipped with valuable tools to support the student's needs. A parent highlighted the clinician's judgment and case formulation, stating that they wouldn't have succeeded in improving the child's school attendance without the therapist's structured support. The therapeutic relationship was also emphasized, with parents identifying the working alliance as a key component of the intervention's effectiveness.

Theme 3: therapeutic techniques (participant feedback)

Many parents and teachers expressed satisfaction with the intervention, citing the helpfulness of its tools and strategies. Parents reported benefits for both their children and themselves, noting improvements in school performance and mood. Some youths, however, raised concerns about age appropriateness, with one suggesting the program might be better suited for elementary or early middle school students.

Theme 4: treatment effect (participant feedback)

Qualitative data reflected varied changes in school attendance during the intervention. While some improvements were noted, a substantial proportion of parents and teachers reported little to no effect. Reasons cited included external factors like the COVID-19 pandemic and the gradual nature of change. One parent reported a decline in the youth's well-being, citing the program's limited scope. Some participants identified potential mechanisms of change, including cognitive change, (as noted by a teacher) and improved mood and positive emotions (as reported by a parent).

Theme 5: assessment and outcome measures (clinician feedback)

Clinicians provided mixed feedback on the initial clinical assessment and outcome measures. While they acknowledged the extensive workload, they also recognized the assessments' clinical utility. One clinician valued the measures for research purposes but suggested streamlining them for treatment use. Concerns were raised about the validity of youths' self-reported responses. The ISAP and SRAS-R were identified as particularly useful and relevant for assessing SAPs. Clinicians recommended digital administration, greater involvement of families for accurate completion, and additional training in interpreting psychometric instruments.

Theme 6: strengths and weaknesses of B2S (clinician feedback)

Clinicians highlighted several strengths of the intervention, including its structured, manualized format, evidence base, and goal-oriented approach. One clinician noted that B2S appeared particularly effective for addressing anxiety in younger students. Although all clinicians criticized the extensive assessment process, they emphasized the value of case formulation and background interviews in informing treatment planning.

Treatment effects

As shown in [Figure 3](#), average school absenteeism decreased from 43% at baseline to 27% post-intervention but returned to near-baseline levels (42%) at the three-month follow-up. The effect of time on absenteeism was non-significant ($p = 0.842$).

At post-intervention, four youths (31%) no longer met the inclusion criteria of >10% absenteeism; however, this number decreased to one (10%) at follow-up. Three participants (23%) were absent more than 50% of expected school hours at post-intervention, compared to eight (53%) at baseline. At follow-up, two youths were absent 100% of the time during

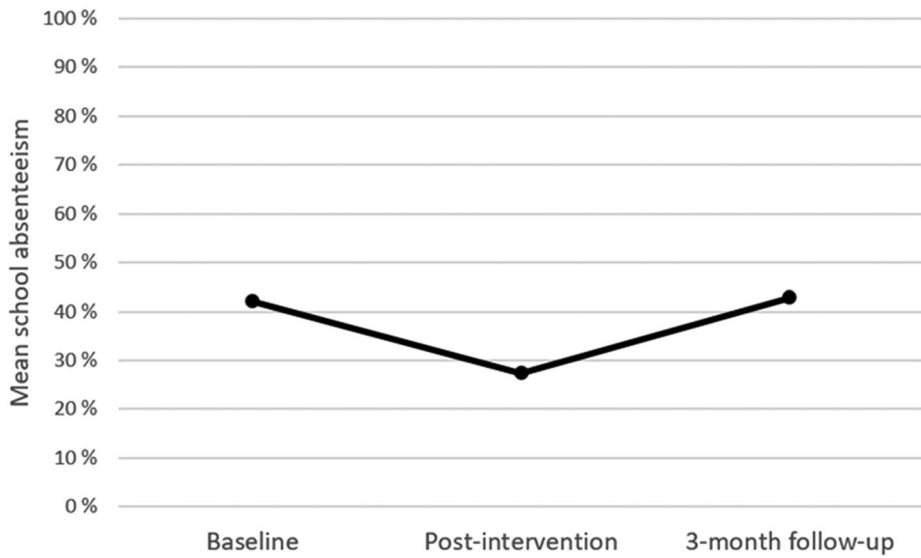


Figure 3. Mean school absenteeism by measurement point (%).

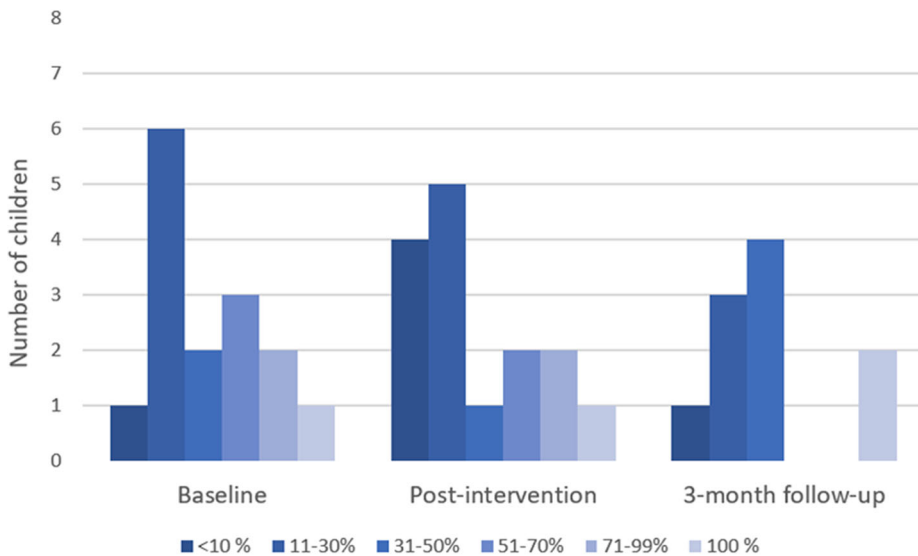


Figure 4. Levels of school absenteeism by data collection point.

the prior two weeks, while eight (80%) attended school more than 50% of the time. See [Fig 4](#) for further information.

Mixed linear models for the secondary outcome measures revealed significant time effects for three variables: teacher-reported hyperactivity, teacher-reported prosocial behavior, and parental self-efficacy. These changes over time demonstrated large effect sizes. A full summary of the mixed model results is provided in [Table 6](#).

Table 6. Primary and secondary outcome variables.

Outcome	Respondent	Baseline	Post-intervention	3-Month follow-up	Time x intervention effect
School absenteeism, %	Parent	43.12 (28.21) [15] ^a	27.38 (26.70) [11]	42.90 (33.39) [10]	$F = 0.040, p = 0.842, d_1^b = 0.463, d_2^c = 0.004$
RCADS anxiety	Youth	18.06 (20.17) [16]	23.27 (20.32) [11]	15.44 (10.69) [9]	$F = 0.803, p = 0.394, d_1 = 0.548, d_2 = 0.252$
	Parent	17.00 (13.60) [15]	16.18 (10.89) [11]	12.50 (7.55) [10]	$F = 2.115, p = 0.173, d_1 = 0.132, d_2 = 0.634$
RCADS depression	Youth	7.70 (6.03) [16]	10.45 (5.79) [11]	8.78 (4.74) [9]	$F = 0.001, p = 0.974, d_1 = 0.529, d_2 = 0.450$
	Parent	7.33 (4.10) [15]	6.82 (4.29) [11]	6.20 (4.54) [10]	$F = 0.436, p = 0.522, d_1 = 0.065, d_2 = 0.353$
RCADS Internalizing	Youth	25.75 (25.32) [16]	33.73 (25.90) [11]	24.22 (14.30) [9]	$F = 1.236, p = 0.280, d_1 = 0.566, d_2 = 0.126$
	Parent	24.33 (17.12) [15]	23.91 (15.01) [11]	18.70 (10.77) [10]	$F = 1.384, p = 0.253, d_1 = 0.044, d_2 = 0.599$
SDQ Emotional symptoms	Youth	3.38 (2.66) [16]	4.45 (2.21) [11]	4.33 (2.60) [9]	$F = 0.886, p = 0.357, d_1 = 0.486, d_2 = 0.413$
	Parent	3.67 (1.95) [15]	2.82 (2.04) [11]	2.80 (1.69) [10]	$F = 1.898, p = 0.183, d_1 = 0.405, d_2 = 0.483$
	Teacher	3.38 (2.26) [13]	3.70 (2.16) [10]	3.57 (2.76) [7]	$F = 0.082, p = 0.778, d_1 = 0.267, d_2 = 0.053$
SDQ Conduct problems	Youth	1.75 (1.30) [16]	2.45 (1.70) [11]	1.67 (1.00) [9]	$F = 0.219, p = 0.644, d_1 = 0.318, d_2 = 0.089$
	Parent	2.73 (2.87) [15]	1.73 (1.56) [11]	1.50 (1.58) [10]	$F = 0.551, p = 0.473, d_1 = 0.476, d_2 = 0.820$
	Teacher	0.85 (1.21) [13]	0.60 (0.97) [10]	1.00 (0.82) [7]	$F = 0.034, p = 0.855, d_1 = 0.208, d_2 = 0.083$
SDQ Hyperactivity/Inattention	Youth	4.31 (2.50) [16]	4.73 (2.10) [11]	5.11 (2.10) [9]	$F = 0.763, p = 0.402, d_1 = 0.233, d_2 = 0.615$
	Parent	3.53 (2.17) [15]	3.27 (1.79) [11]	2.60 (1.71) [10]	$F = 3.060, p = 0.095, d_1 = 0.217, d_2 = 0.344$
	Teacher	3.69 (2.96) [13]	2.80 (3.05) [10]	2.57 (3.21) [7]	$F = 6.408, p = 0.021, d_1 = 0.989, d_2 = 0.533$
SDQ Prosocial behavior	Youth	6.94 (1.44) [16]	7.27 (1.10) [11]	7.89 (0.78) [9]	$F = 3.551, p = 0.071, d_1 = 0.194, d_2 = 0.500$
	Parent	6.33 (2.77) [15]	6.82 (2.75) [11]	8.10 (1.97) [10]	$F = 3.569, p = 0.073, d_1 = 0.445, d_2 = 0.983$
	Teacher	4.38 (2.26) [13]	6.10 (2.64) [10]	6.57 (1.51) [7]	$F = 6.804, p = 0.018, d_1 = 1.147, d_2 = 1.217$

(Continued)

Table 6. (Continued).

Outcome	Respondent	Baseline	Post-intervention	3-Month follow-up	Time x intervention effect
SDQ Problems with peers	Youth	2.25 (1.57) [16]	2.36 (2.16) [11]	2.67 (2.50) [9]	$F = 0.208, p = 0.658, d_1 = 0.092, d_2 = 0.247$
	Parent	3.00 (2.42) [15]	2.18 (2.23) [11]	2.10 (1.45) [10]	$F = 1.804, p = 0.194, d_1 = 0.586, d_2 = 1.000$
	Teacher	2.62 (2.10) [13]	2.60 (1.96) [10]	2.00 (1.41) [7]	$F = 0.268, p = 0.611, d_1 = 0.018, d_2 = 0.413$
SDQ Total difficulties	Youth	11.69 (6.21) [16]	14.00 (5.08) [11]	13.80 (5.80) [9]	$F = 1.057, p = 0.316, d_1 = 0.471, d_2 = 0.515$
	Parent	12.93 (7.10) [15]	10.00 (5.40) [11]	9.00 (4.35) [10]	$F = 3.518, p = 0.076, d_1 = 0.698, d_2 = 1.092$
	Teacher	10.54 (5.17) [13]	9.70 (4.60) [10]	9.14 (4.63) [7]	$F = 0.540, p = 0.472, d_1 = 0.336, d_2 = 0.222$
SMFQ	Youth	6.81 (6.40) [16]	6.27 (4.69) [11]	5.11 (4.17) [9]	$F = 1.441, p = 0.242, d_1 = 0.075, d_2 = 0.293$
	Parent	4.67 (4.82) [15]	3.82 (4.64) [11]	2.70 (2.41) [10]	$F = 0.966, p = 0.337, d_1 = 0.202, d_2 = 0.410$
SEQ_SS Total	Youth	48.10 (7.45) [16]	47.18 (9.70) [11]	47.56 (6.62) [9]	$F = 0.009, p = 0.924, d_1 = 0.107, d_2 = 0.084$
SEQ-RSAP total	Parent	76.07 (9.52) [15]	84.00 (7.71) [11]	85.60 (10.06) [10]	$F = 15.969, p < 0.001, d_1 = 1.017, d_2 = 1.305$

Note. RCADS = Revised Children's Anxiety and Depression Scale; SDQ = The Strengths and Difficulties Questionnaire; SMFQ = Short Mood and Feelings Questionnaire; SEQ_SS = The Self-efficacy Questionnaire for School Situations; SEQ-RSAP = Self-Efficacy Questionnaire for Responding to School Attendance Problems.

^aData presented as mean (SD) [n].

^bEffect between baseline and post-intervention.

^cEffect between baseline and 3-month follow-up.

Discussion

The aim of this study was to evaluate the feasibility of the Back2School (B2S) intervention in the Finnish context across five parameters: 1) sample characteristics; 2) data collection procedures and outcome measures; 3) treatment satisfaction; 4) acceptability and study procedures; and 5) treatment effects.

Sample characteristics

The intent-to-treat sample ($N = 16$) fell short of the initial goal of 26 families. In contrast to studies such as Lomholt et al. (2020) where families proactively sought treatment, recruitment in the present study was initiated by schools, which directly contacted potential participants. The failure to achieve the desired sample size was due to the fact that the schools were unable to identify a sufficient number of families considered both suitable for the intervention and willing to participate, possibly due to limitations in the resources available for outreach efforts. This school-driven approach may have contributed to lower motivation and engagement among families compared to what might be expected with a more client-initiated recruitment process. Furthermore, the use of convenience sampling likely

influenced the sample characteristics, with higher-functioning families being included compared to what is typically observed in the SAP clinical population. To address this issue in a future randomized controlled trial, a similar recruitment strategy to that used in the Danish RCT (Johnsen et al., 2024) could be adopted: municipalities conduct media campaigns to inform the public about the study and its inclusion criteria, and families self-refer to the intervention. This approach could increase the likelihood of recruiting motivated families whose difficulties are well aligned with the scope of B2S.

Baseline data support this interpretation of a higher functioning sample: approximately 60% of participants missed 50% or fewer school days, compared to less than 40% in previous B2S studies (Johnsen et al., 2024; Lomholt et al., 2020). Similarly, psychometric data from baseline secondary outcome measures reflect relatively low symptom severity. For example, the mean scores of the RCADS internalizing scale (child-reported: $M = 25.75$, cut-off score: 48p-54p for boys & 58p-66p for girls), the SMFQ (child-reported: $M = 6.81$, cut-off score: 8p) and the SDQ total score (child-reported: $M = 11.69$, the cut-off for abnormal score: 16p-40p) all fell below clinical thresholds (Angold et al. 1995; Chorpita et al., 2005; He et al., 2013).

These indicators point to an atypically low level of mental health symptoms compared to clinical SAP samples described in the literature (Hannan et al., 2019; Heyne et al., 2011; Lomholt et al., 2020; Reissner et al., 2015; Strömbeck et al., 2021). As a result, the range of potential change and improvement was likely more limited than in prior SAP intervention trials.

Data collection procedures and outcome measures

Baseline questionnaire completion rates were excellent, with all respondents completing 100% of the measures. Post-intervention completion remained satisfactory, with 80% of both parents and youth submitting forms. However, response rates at the three-month follow-up were lower (youths: 60%, parents: 66%), likely due to several factors.

First, the data collection process was relatively complex. Participants completed questionnaires by hand, returned them to the clinician, who then transcribed responses into an Excel sheet and submitted them *via* an encrypted file-sender application. This multi-step process increased workload and organizational demands, likely contributing to missing data. One clinician suggested simplifying the procedure by allowing participants to complete digital forms together with the clinician, which may facilitate smoother data collection, and improve completion rates.

Second, feedback from both participants and clinicians indicated that the assessment battery was overly extensive. Future Finnish trials—particularly those involving control groups—could benefit from a shorter assessment package, similar to that used in the Danish RCT (Johnsen et al., 2024), which also incorporated monetary incentives for control participants. Additional strategies such as making baseline assessment completion an inclusion criterion and sending regular reminders to non-responsive families may further improve response rates.

Data on school absenteeism was collected weekly through a session-by-session questionnaire completed by clinicians and submitted to the research team. Due to technical limitations, data were not collected directly from school registries. At each measurement point,

parents also reported school attendance for the preceding two weeks. However, these responses were often incomplete or inconsistent with the clinician-reported session data. To ensure consistency, only data from the session-by-session questionnaires were used in the final analysis.

This discrepancy raises potential concerns about the validity of the absenteeism data, as different sources yielded conflicting percentages. For future trials, we recommend a more structured and streamlined approach to data collection—specifically, limiting absenteeism reporting to the two weeks preceding each measurement point. This would allow for feasible integration of school register data at three or four time points, which is more manageable than weekly reporting.

Treatment satisfaction

Despite a somewhat high attrition rate (18.8%), treatment satisfaction was high among parents, teachers, and youth, with a majority indicating they would recommend B2S (youth: 73%, parents: 100%, teachers: 78%). However, youths reported slightly lower satisfaction in areas such as the adequacy of intervention information and the usefulness of school meetings. The moderate youth satisfaction may be related to the higher baseline functioning observed in the sample compared to the target population, or to factors such as low motivation for change.

Although satisfaction with school meetings varied, 77% of families attended three or four meetings—a proportion that can be considered satisfactory given external constraints such as scheduling difficulties.

Acceptability and study procedures

Clinicians generally found B2S highly acceptable, with 100% expressing positive views on the program's time and effort balance and recommending it to others. Improvement suggestions mainly regarded the battery of measurement instruments, more specifically the extensive width of the battery, which is discussed above. Clinicians also expressed a need for guidelines on integrating other treatment entities, like family work, into B2S. This feedback is crucial for informing future modifications of the manual.

In this study, the ISAP was included as an additional component of the assessment package and was not part of the intervention manual itself. It was added because it represents a promising new instrument designed to assess symptomatology specifically in relation to SAP. The ISAP received positive feedback from the clinicians as a useful and informative tool. Given its ability to capture both the presence of symptoms and their functional relationship to SAP, future revisions of the manual might consider replacing the psychopathological interview with the ISAP to streamline the assessment procedure and reduce the workload associated with the pre-intervention assessment package.

Treatment effects

Time had a non-significant effect on absenteeism ($p = 0.842$), and only minimal effects were observed on secondary outcome measures. Although absenteeism decreased from 43% to 27% post-intervention, it returned to near-baseline levels (42%) at the three-month follow-

up. Interpretation of the follow-up data should take into account that two students reported 100% absenteeism at follow-up. When these outliers are excluded, average school attendance at follow-up appears notably improved.

Nonetheless, a decline in maintained treatment effects on school attendance is well-documented in the SAP intervention literature, with many clients reverting to problematic absenteeism levels between post-intervention and follow-up. One possible explanation for the modest treatment effects in this study may relate to the age group. Prior research suggests that younger children (ages 7–11) show stronger treatment responses to CBT for SAP compared to adolescents aged 14 and above (Heyne, 2022, 2023).

Evaluation of feasibility and further recommendations

The Back2School intervention demonstrates feasibility for implementation in a Finnish context, supported by adequate data collection, high participation rates, treatment satisfaction, clinician acceptability, positive qualitative feedback, and reduced school absenteeism from baseline to post-intervention. To support future randomized controlled trials with more robust designs, several modifications are recommended: revised inclusion criteria in B2S trials to mitigate floor effects (i.e., participants scoring at or near the lower end of measurement scales), participant-driven recruitment strategies, digital data collection to streamline procedures, a reduced set of outcome measures to lessen participant burden, and the inclusion of a 12-month follow-up to assess long-term treatment effects. These adjustments aim to improve sample representativeness, facilitate data management, and provide more comprehensive insights into the sustainability of intervention outcomes.

Limitations

This study has several limitations that affect the validity and generalizability of its findings. The most significant limitations regarding statistical power are the small sample size and the absence of a control group, which increase the risk of random findings and limit the representativeness of the sample. The non-randomized design also prevents attributing observed changes over time solely to the intervention. Additionally, the low response rate at follow-up - particularly among teachers - further weakens the strength of the conclusions. While these design constraints present statistical challenges, they are consistent with the study's primary aim: to assess the feasibility of the intervention as a precursor to a future randomized controlled trial, rather than to evaluate efficacy.

Another limitation is the lack of an explicit measure for negative effects of the intervention. Although some adverse reactions through open-ended responses and the treatment satisfaction questionnaire, no systematic method was employed to assess unintended or harmful outcomes. Future studies should consider including structured measures of negative effects to better align with best practices in intervention research.

Conclusions

The findings of this study indicate that the Back2School (B2S) intervention is feasible for implementation in a future randomized controlled trial in Finland. High levels of treatment satisfaction among participants, strong clinician acceptability, effective data collection

procedures, and a reduction in school absenteeism between baseline and post-intervention suggest B2S could help address the gap in literature on transdiagnostic interventions for school attendance problems. Key limitations of the study include the small sample size and relatively high baseline level of functioning among participants. Furthermore, suboptimal completion rates of outcome measures at follow-up likely reflect the complexity of the data collection procedures used. By refining recruitment strategies, streamlining data collection, and optimizing the intervention format based on these findings, future trials will be positioned to evaluate the treatment effects of B2S.

Declaration of generative AI and AI-assisted technologies in the writing process

During the preparation of this work the author(s) used [ChatGBT/OpenAi] in order to improve grammar and shorten some parts of the text. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the publication.

Disclosure statement

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Data availability statement

Data are available upon request from the corresponding author.

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