

Reported sick from school

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Valorisation

In practice-based research valorisation is continually being addressed, for example in refining the intervention for reasons of practicability, suitability and acceptability, in arguing the roles of each stakeholder involved, and in presenting the challenges for implementation and dissemination, thus ensuring that the intervention will fit the needs and possibilities of professionals.

Ultimately, our study contributes to consensus in school absenteeism policy on absenteeism among students in cases of sickness reporting; firstly by stating that medical absenteeism is not primarily an issue for school attendance officers to deal with but mainly for schools and YHCPs. Schools and YHCPs are quite capable and appropriate partners for handling medical absenteeism. Our research also provides input on how to deal with actual medical absenteeism of individual students: a dialogue about medical absenteeism should be motivated by concern and not by the wish to enforce compulsory education. This more open attitude based on interest and concern allows school to look differently at medical absenteeism, leading to less frustration and better support for students. The consultation with a YHCP ensures a good relationship between school and parents. Moreover, schools are provided with a new standard for a medical absence rate which should be acted upon: well-defined and manageable criteria for intervening with the absence. In 2014, Hawkrigg and Payne [1] recommended that health professionals should intervene as soon as there is a pattern of 'sustained' school absence. They recognized that a standard for this pattern was lacking. Now an effective approach for addressing school absenteeism due to sickness reporting, including criteria for intervening with the absence, are finally available.

As mentioned before, our study is the first regarding effectiveness of an intervention to address medical absenteeism in secondary schools, and the effect study shows preliminary evidence that the intervention works in actual practice. Currently, evidence-informed policy is considered to be of great importance for the organization of efficient care. There is a growing awareness that it is necessary to use evidence to achieve more at less cost. Therefore, proving the effectiveness of an intervention has become a prerequisite for its implementation and widespread use. The preliminary evidence justifies the implementation of MASS on a wider scale, accompanied by further evaluation studies [2]. Our qualitative study provided insights in the main challenges for implementation and dissemination and will be helpful in improving commitment to and use of the intervention. Preliminary research on the cost-effectiveness already showed that the benefits of MASS are a fivefold of the costs [3].

Moreover, our study findings have led to a blueprint for the final version of MASS based on core elements. Defining these core elements is essential for monitoring the implementation and securing programme integrity of the intervention in case of widespread use. As mentioned before, the effectiveness of a public health programme is also influenced by its quality of implementation aspects and its impact by dissemination aspects [4]. Defining possibilities for local adjustments and thereby forging joint ownership is a key principle to ensure widespread adoption and feasibility of the implementation [5, 6]. And as mentioned by Rogers, to attain sustainability interventions must be adaptable to some extent [7], the so-called need for re-invention. In the case of MASS, local adjustments may be for example the physical location of the consultation with the YHCP

and determining which school professional will enter into conversation with students and their parents about the medical absence.

The intervention has been disseminated in several ways over the past years, mostly at the request of schools and youth health care organisations. In 2014 the needs to start implementing the intervention in other regions have been surveyed together with YHCPs and policy makers of other Regional Public Health Services. This survey was funded by ZonMw, the Dutch Organization for Health Research and Development, and resulted in a manual for YHC services to address medical absenteeism according to MASS, including support materials for schools to implement MASS. Our study and this manual ensure that MASS will be recognized as 'Functional intervention' by the intervention database of the RIVM [8]. In the same year, the RPH service West Brabant developed training courses for YHCPs about how to implement and carry out the MASS intervention and training courses for mentors and career counsellors about how to discuss the medical absenteeism with students and their parents. These courses have been developed with help of RIVM, the National Institute for Public Health and the Environment.

As stated before, agenda setting and funding are pre-exquisites for a sustainable implementation and widespread dissemination of an intervention. Regarding agenda setting, from 1 January 2015, 'absenteeism guidance' is officially included in the basic task package for YHC services (In Dutch: Basispakket JGZ). In addition it is possible now to use funding for preventive medical assessments in adolescence for implementing MASS in secondary and intermediate vocational schools [9], whereupon financial resources are accessible. Currently, the intervention is implemented in six RPHS-regions in the Netherlands. It is important to monitor the implementation and secure programme integrity of the intervention in case of widespread use. Unfortunately, in the Netherlands the development of and research on interventions is fragmented. There is no institution yet that is responsible to deploy and maintain an effective intervention nationally.

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