

Factors influencing sustainability in inclusive education – Clinic-based surveys –

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Abstract

The Convention on the Rights of Persons with Disabilities proclaims that State Parties shall ensure an inclusive education system at all levels. Segregated education and inclusive education coexist, however, and the number of children educated in segregated settings continues to increase in Japan. Given these circumstances, to determine the conditions under which inclusive education is sustainable, we conducted one survey on children who had difficulties in their school life and another survey on children with autism who experienced school refusal. The results of our surveys suggest that developmental disorders are a risk factor for difficulties in school life and school refusal, and that support both inside and outside the school and pharmacotherapy are important for improvement. These results suggest that establishing a cooperative framework of doctors, schools, home, and community will lead to fewer problems at school, and will also provide clues for the successful continuation of inclusive education.

Key words:

Inclusive education, School non-attendance, Autism spectrum disorder, Developmental disorder, Clinic-based survey

Introduction

The Convention on the Rights of Persons with Disabilities proclaims that States Parties shall ensure an inclusive education system at all levels, and that persons with disabilities shall not be excluded from the general education system. The Japanese government signed this convention in 2007, and it was approved by the United Nations Secretariat in 2014. Segregated education and inclusive education (IE) coexist, however, and the number of children educated in segregated settings continues to increase in Japan.

Under the Enforcement Regulation of the School Education Law of the Japanese Ministry of Education, Culture, Sports, Science and Technology (MEXT) prior to 2013, it was stipulated that children with disabilities of a certain degree would attend school for special needs education (S-SNE) in principle. This law was subsequently revised so that children could be educated in regular classes¹⁾. These children are also provided special lessons following their individualized education program in a resource room (*tsukyu*) several times a month. According to MEXT statistics, the number of students receiving compulsory education in 2014 was 11,090,000, and the number of students receiving SNE was 340,000 (3.03%). The classification was as follows: 69,000 children in S-SNE, 184,000 children in class for SNE (C-SNE), and 84,000 children in regular class, i.e., IE class. Compared with statistics from 2004, the number of children educated at S-SNE increased by 1.3 times, the number of C-SNE increased by 2.1 times, and the number of IE classes increased by 2.3

times. Article 5 of the Enforcement Order of the School Education Law of Japan still has a statement suggesting segregated education: when a child is certified as appropriate for SNE, the parents must be advised to allow them to attend S-SNE. The aforementioned certification is carried out whilst taking into consideration the state of disability of the person, the contents of the support necessary for his or her education, the state of the education system in the area, etc.

Lange and Sletten (2002)²⁾ wrote that alternative education in the United States is classified into three types. The third type is designed with a remedial focus on academic and/or socioemotional matters. According to their definition, SNE in Japan can be considered equivalent to the concept of alternative education in the United States. They also pointed out that students with disabilities often struggle in traditional school systems, and that these students are at high risk of dropping out and can benefit from alternative education. McGregor and Mills (2012)³⁾ investigated the factors that influenced early exit from ordinary school and transfer factors to alternative schools for education and reported the results as follows: social and economic factors; family relationships; gender, language, and cultural barriers; aboriginal background, etc. Havik et al (2015)³⁾ investigated Norwegian ordinary schools and put forth that poor relationships with peers is an important risk factor for school refusal. They stated that teachers' classroom management could indirectly play a role in school refusal by preventing bullying and social exclusion by peers, and that poor support from teachers could increase the risk of school refusal. In Japan, Suzuki (2017)⁴⁾ examined 80 cases of children with school non-attendance who visited pediatric clinics, and reported that 57% of them have developmental disorders such as pervasive developmental disorder and attention-deficit/hyperactivity disorder (ADHD), and that 24% of them have psychiatric disorders. This report suggests that more attention should be paid to the involvement of developmental disorders as a background for school non-attendance.

As described above, segregated education and IE coexist in Japan. Given these circumstances, investigations into cases of students who have difficulties in IE settings and cases involving school refusal would contribute to our understanding of the conditions that make IE successful. In this study, therefore, we aimed to elucidate the aforementioned factors based on the medical records of children who visited pediatric or neuropsychiatric clinics because of problems relating to their school life.

Method

Among primary school pupils who visited Nouno Pediatric Clinic in 2017 due to difficulties at school, 24 cases whose clinical course was detected by both a pediatric neurologist and a clinical psychologist (both are authors of this paper) were surveyed in accordance with the aforementioned objectives. Of 24 cases, 18 (13 boys and 5 girls) were attending IE class and 6 (4 boys and 2 girls) were attending C-SNE.

We also conducted a survey of 101 children with autism spectrum disorder (ASD) aged 11 and 12 years old, who visited Oono Neuropsychiatric Clinic between January 2017 and December 2017. Of these cases, 20 had not attended school for over 6 months. Seventeen (10 boys and 7 girls) of these 20 cases were educated in an IE setting, and three (2 boys and 1 girl) were educated in C-SNE. The causes and factors of school non-attendance and clues relating to improvement were investigated in these cases.

Results

Table 1 presents the results of a survey of 24 primary school pupils who were having difficulties at school who visited Nouno Pediatric Clinic in 2017.

For diagnosis, the proportion of cases with developmental disorders, such as ASD, ADHD, and learning disorder (LD), was high in both IE and C-SNE. Fifteen cases (83.3%) were educated in IE and five cases (83.3%) were educated in C-SNE. As for the grade at onset of difficulties at school, the first grade was dominant, followed by the third and fourth grades. The diagnoses of eight cases who showed difficulties in the first grade in IE were as follows: one ASD, one ASD with ADHD, one ASD with obsessive compulsive disorder (OCD), one ADHD, one ADHD with LD, one LD with intellectual disorder (ID), one LD with anxiety disorder, and one Tourette syndrome. The diagnoses of six cases who showed difficulties in the third grade in IE were as follows: one ASD with LD, one ADHD, one ADHD with LD, two LDs, and one anxiety disorder.

As the chief complaint, prevalent manifestations of developmental disorders, such as hyperactivity, inattentiveness, emotional problems, and social problems, were dominant.

In terms of intervention at school and/or the child support institution, learning support was most common, followed by environmental adjustment and psychotherapy.

In terms of pharmacotherapy, 9 out of 18 patients in the IE class and all 6 cases in C-SNE were on medication. As for clues relating to improvement, support from family and neighbors, environmental adjustment, and learning support at school or the child support institution were reported.

In terms of current status, one male student who was educated in C-SNE shifted to IE class upon entering junior high school. He had exhibited highly compulsive behavior for many years, but after following regular advice from his doctor, his mother learned appropriate support methods and acknowledged a substantial improvement in his emotions and behavior. With this improvement, his transition to IE was approved.

Table 2 shows the results of a survey of children with school non-attendance who visited Oono Hagukumi Clinic in 2017 due to ASD.

In terms of diagnosis, in both IE and SNE, many cases of ASD were comorbid with ADHD and anxiety disorder.

As for the results of grade at onset of non-attendance, the fourth, fifth, and sixth grades were dominant. For inducement or cause, in both IE and SNE, emotional confusion/anxiety disorder was the most common, followed by bullying in IE, and apathy in SNE. The number of cases who experienced separation anxiety in early childhood was two in IE and none in SNE.

The types and effects of intervention are shown in Table 2 in the columns of “intervention-pharmacotherapy,” “effect of pharmacotherapy,” and “clues for re-school attendance.” Table 3 also presents the effects of intervention and pharmacotherapy.

The results shown in the above items indicate that although the support of school-based special measures alone was not sufficient, comprehensive support, including pharmacotherapy, psychotherapy, home visits by the teacher, and providing places to spend time in the school, were effective.

Table 1 Survey of children having difficulties at school

Educational setting	Inclusive Education/ Regularl class n=18			School / Class for SNE (S – SNE / C-SNE) n=6		
		n	%		n	%
Diagnosis	ASD	1	5.6	ASD	1	16.7
	ASD+AD/HD	2	11.1	ASD+AD/HD	4	66.7
	ASD, OCD	1	5.6	ASD, OCD	0	0.0
	ASD, ID	1	5.6	ASD, ID	0	0.0
	AD/HD	3	16.7	AD/HD	0	0.0
	AD/HD, ID	2	11.1	AD/HD, ID	0	0.0
	AD/HD, Comunication dis.	1	5.6	AD/HD, Comunication dis.	0	0.0
	LD	3	16.7	LD	0	0.0
	LD, ID	1	5.6	LD, ID	0	0.0
	Anxiety disorder, LD	1	5.6	LD, Anxiety disorder	0	0.0
	Others	2	11.1	Congenital anomaly, ID	1	16.7
Grade at onset	1st grade	8	44.4	1st grade	4	66.7
	2nd grade	1	5.6	2nd grade	0	0.0
	3rd grade	6	33.3	3rd grad	0	0.0
	4th grade	2	11.1	4th grade	2	33.3
	5th grade	1	5.6	5th grade	0	0.0
	6th grade	0	0.0	6th grade	0	0.0
Chief complaint (Plural answers)	Hyperactive/inattentive	6	33.3	Hyperactive/inattentive	1	16.7
	Emotional problems	2	11.1	Emotional problems	2	33.3
	Social problems	2	11.1	Social problems	4	66.7
	Anxiety	1	5.6	Anxiety	0	0.0
	Tendency to absenteeism	1	5.6	Tendency to absenteeism	0	0.0
	Difficulty of learning	8	44.4	Difficulty of learning	3	50.0
	Tic	1	5.6	Tic	0	0.0
Current status	IE	14	77.8	C-SNE	4	66.7
	IE+SNE	3	16.7	IE	1	16.7
	Transfer to C-SNE	1	5.6	S-SNE	1	16.7
Intervention at school or institution (Plural answers)	Learning support	7	38.9	Learning support	1	16.7
	Special measure of teacher	1	5.6	Special measure of teacher	0	0.0
	Environmental adjustment	2	11.1	Environmental adjustment	0	0.0
	After-school day service	1	5.6	After-school day service	0	0.0
	Psychotherapy	2	11.1	Psychotherapy	0	0.0
	No intervention	7	38.9	No intervention	5	83.3
Pharmacotherapy	Undergoing	9	50.0	Undergoing	6	100.0
	No medication	8	44.4	No medication	0	0.0
	Discontinued	1	5.6	Discontinued	0	0.0
Clues for improvement	Family/neighbor support	7	38.9	Family/neighbor support	3	50.0
	Environmental adjustment	3	16.7	Environmental adjustment	3	50.0
	Learning support	3	16.7	Learning support	0	0.0

Obsessive-compulsive disorder: OCD, Social communication disorder: Comunication dis.

Table 2 Survey of ASD children with school non-attendance

School setting	Inclusive Education (IE) n=17		Class for Special Needs Education (C-SNE) n=3			
	n	%	n	%		
Diagnosis	ASD	3	17.6	ASD	0	0.0
	ASD+AD/HD	6	35.3	ASD+AD/HD	0	0.0
	ASD, Social Anxiety dis.	7	41.2	ASD, Social Anxiety dis.	1	33.3
	ASD, ID	1	5.9	ASD, ID	2	66.7
Grade at inattendance	2nd grade of primary school	1	5.9	2nd grade of primary school	0	0.0
	3rd grade	2	11.8	3rd grade	0	0.0
	4th grade	5	29.4	4th grade	0	0.0
	5th grade	3	17.6	5th grade	1	33.3
	6th grade	6	35.3	6th grade	1	33.3
	1st grade of junior high school	0	0.0	1st grade of junior high school	1	33.3
Current status	Re-school attendance in IE	6	35.3	Re-school attendance in C-SNE	0	0.0
	Partial attendance in IE	2	11.8	Partial attendance in C-SNE	0	0.0
	Re-school attendance to C-SNE	3	17.6	Re-school attendance in C-SNE	1	33.3
	Under inattendance	6	35.3	Under inattendance	2	66.7
Inducement of school inattendance (Plural answers)	Emotional confusion/anxiety	11	64.7	Emotional confusion/anxiety	2	66.7
	Apathy	2	11.8	Apathy	1	33.3
	Parent-child relationship trouble	4	23.5	Parent-child relationship trouble	0	0.0
	Bullying	5	29.4	Bullying	0	0.0
	Social trouble other than bullying	3	17.6	Social trouble other than bullying	1	33.3
	Trouble with class teacher	2	11.8	Trouble with class teacher	1	33.3
Intervention · psychotherapy	Intervention	5	29.4	Intervention	1	33.3
	Psychotherapy	2	11.8	Psychotherapy	1	33.3
	Intervention and psychotherapy	0	0.0	Intervention and psychotherapy	0	0.0
	No intervention	11	64.7	No intervention	1	33.3
Effect of pharmacotherapy	Very effective	10	58.8	Very effective	1	33.3
	Partially effective	2	11.8	Partially effective	1	33.3
	Not effective	5	29.4	Not effective	1	33.3
Clues for re-school attendance	Home visit by teacher	2	11.8	Home visit by teacher	0	0.0
	Pick up/drop off by parent	3	17.6	Pick up/drop off by parent	0	0.0
	Provide place in the school	8	47.1	Provide place in the school	1	33.3
	Utilize the free school	2	11.8	Utilize the free school	0	0.0
	All are invalid	2	11.8	All are invalid	2	66.7
Anxiety during early childhood	Separation anxiety	2	11.8	Separation anxiety	0	0.0

Table 3 Effectiveness of intervention and pharmacotherapy

Support type	IE (n=17)		Class for SNE (n=3)	
	effective	not effective	effective	not effective
School	1	3	0	1
School + Pharmacotherapy	6 [1]	1	0	0
School + Intervention/Psychotherapy	1 [1]	0	0	0
Pharmacotherapy + Intervention/Psychotherapy	0	0	0	0
School + Pharmacotherapy + Intervention/Psychotherapy	5 [1]	0	2	0
None	0	0	0	0

School: school-based special measures []: transferred to Class for SNE italic number: partial effect

Discussion

In many countries, school non-attendance has been a serious issue for a long time. As discussed above, Suzuki (2017)⁴⁾ emphasized the significance of developmental disorders as a background for school non-attendance in Japan. Inoue⁵⁾ also described the importance of early diagnosis and appropriate intervention with the cooperation of schools, families, and specialized organizations in order to prevent secondary disorders and school refusal in children with autism. Ishizaki (2017)⁶⁾ explained the importance of cooperation between school teachers and doctors to prevent psychosomatic and behavioral problems that can cause school refusal among children and adolescents with developmental disorders. The results of our surveys also suggest that developmental disorders are a risk factor for difficulties at school and school non-attendance, and that support from both inside and outside the school and pharmacotherapy are important for improvement. These results suggest that establishing a cooperative framework among doctors, schools, home, and community can lead to solving problems at school, and provides clues for the successful continuation of IE.

In regard to the timing when difficulties at school develop, there were two peaks: grade 1 and grades 3 to 4 in both IE and C-SNE. Our survey on ASD showed that the onset of school refusal was dominant during grades 4 to 6. The Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5)⁷⁾ states that the symptoms of ASD may not fully manifest until social communication demands exceed limited capacities. Nine to ten year olds are in a critical period of psychological development, and the possibility of symptom exacerbation in autistic children is empirically known. Takeuchi (2009)⁸⁾ surmised that the turning point of cognitive development from a theory of mind perspective is as follows: the understanding of others is incomplete because it does not have an intuitive foundation and it is possible to misread signals from others; as a result, troubles with surroundings increase. This idea might explain the reasons why the non-attendance issue develops in the grade 4 to 6 period. For the sustainable success of IE, therefore, support that ensures the maintenance of good social relations during this period seems to be especially important.

The sampling of cases in our first survey for this study was not carried out by comprehensively extracting subjects from the total number of patients; instead, we extracted cases that were well understood by two of the authors. Although the possibility of sampling bias cannot be excluded, this method was considered advantageous as it guaranteed the quality of information. In this study, several factors that ensure the success of IE have been found, and these results seem to support further investigations with comprehensive extraction methods of subjects with a full understanding of clinical course.

Conclusion

We conducted two clinic-based surveys: one survey on children who had difficulties in their school life, and one survey on children with autism who experienced school refusal. The results indicate the importance of developmental disorders as a risk factor for these problems, and that support from both inside and outside the school, including medical treatment, are important for the improvement. These findings strongly suggest that establishing a cooperative system among doctors, schools, home, and community will serve to reduce problems at school, and will provide clues for the success of inclusive education.

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インクルーシブ教育の継続に影響をおよぼす要因
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障害者の権利に関する条約は、教育制度のすべての段階におけるインクルーシブ教育の構築を宣言している。しかし、我国では分離教育とインクルーシブ教育が共存し、前者の枠組みで教育される子どもの数が増加している。本研究では、インクルーシブ教育の継続が困難になる要因を明確にする目的で、学校生活上、問題をともなう子どもの実態と、不登校を経験した自閉症児を対象とした実態調査をおこなった。その結果、発達障害が学校生活上の困難や不登校の要因として留意すべきこと、学校内外の支援と薬物療法は状況改善のために重要であることが示され、医療機関、学校、家庭、地域社会の協力体制の確立がインクルーシブ教育の効果的な継続に重要であると考えられた。

キーワード

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