

**Raising a 'red flag' by not going to school:
A grounded theory study of family coach intervention
with persistent school non-attenders**

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Abstract

Persistent school non attendance (PSNA) is a widely acknowledged problem. Outcomes for persistent absentees are poor in the long term. Children and young people (CYP) who are often absent from school are more likely than others to leave with few or no qualifications, to suffer mental health difficulties and to become criminal offenders in adult life. Family coaches work with families where a child has persistently poor or no school attendance, alongside adult unemployment or anti-social behaviour. Uniquely, their work extends across different systems: school; family; professional services and the wider community. As a team, they have extensive experience of casework, having worked with several hundred families in the local authority. This grounded theory study draws upon the unique perspective and experience of this team in order to understand what factors they perceive to induce and constrain the successful reintegration of CYP, from coaching families, to school after a period of PSNA. A theoretical framework, based upon their combined experiences, is set out in order to help inform future work within the local context and beyond. This emphasises the importance of ensuring that CYP feel safe in their family home, as the key focus of successful coaching intervention.

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1.0 Introduction

School attendance is currently a hotly-debated topic. In the national media, and on social networks, the penalties for parents who take their children out of school for term time holidays are fiercely debated. One thread on the site *netmums.com* has been ongoing since 27.01.13, and continues to the present day, with parents arguing about their right to take children on holidays during term time to avoid the inflated prices during school holidays (netmums.com, 2017). One side of the debate takes the view that every school day is important; thirteen-weeks holiday and fifty-two weekends each year is ample time for families to spend quality time together, and any absence is detrimental to the child, school systems, and to the delivery of the curriculum. The other side views the fine system as draconian and an unnecessary infringement of the right to take a holiday when it is convenient and within budget constraints. Parents, who have been subject to hefty fines for doing this, even where their children's attendance is otherwise excellent, argue that a week skiing during the spring term will not affect the life chances of their offspring. What possible harm could a week off school have?

Recently, there has been a high-profile case in the media where a local authority fine for term time absence was contested by a father through the courts (Gye, 2015). The case of Mr Platt, who refused to pay a fine for taking his six-year-old daughter on a family holiday during term time, has been closely watched by both parents and the media. A High Court judge ruled last summer that Mr Platt's daughter's overall attendance record was satisfactory and he had no case to answer. In April 2017, the Supreme Court ruled against him, following a new challenge by his local authority.

A BBC investigation into the impact of Mr Platt's case last year, reported that ten councils had dropped similar cases, while six had suspended issuing fines and twelve others were reviewing their policies (Bulman, 2016). Now that the Supreme Court ruling has been announced, it is likely that freshly-legitimised councils will begin to reverse this movement towards leniency. The outcome of Mr Platt's case has significantly impacted school attendance policy and has set a precedent for other parents wishing to contest fines, who had been increasing significantly in number. More than 90,000 parents in England and Wales were fined a total of £5.6m over the 2014-15 academic year for taking their children out of school for holidays during term time. This is an almost four-fold increase since 2012-13 (Cockburn, 2016).

Other parents, buoyed by Mr Platt's initial success, had begun to challenge fines in growing numbers. Despite the Supreme Court ruling, this parent-led movement of dissent remains resolute. A petition to end school penalty fines, has now attracted over 195,700 signatures. Battle lines are being drawn. But Mr Hedley, the creator of the petition, himself makes the distinction between local authorities, "fining parents who are wanting to go to family events or have affordable quality time together rather than tackling the huge issue of truancy" (Bulman, 2016). Mr Hedley makes a valid point. Whilst some parents wage a vocal, high-profile and indignant campaign against current policy, is this merely a distraction from the true issue of persistent school absence? What is the justification for such an increased drive on enforcing attendance at school, and is it helpful for those families with children who are persistently absent through truancy or anxiety?

The tightening of attendance rules is justified by the Department for Education (DFE) as a response to evidence that missing even a single day of school can lead to a negative impact upon results. A spokesperson on behalf of the DFE sums this up: “The evidence shows that every extra day of school missed can affect a pupil's chances of achieving good GCSEs” (British Broadcasting Corporation (BBC) 2017).

The most recent statistical information provided by the DFE does indeed show a strong correlation between school attendance and achievement (Department for Education, 2016a). The report, which is based upon a national database of individually-reported school census data, sets out an argument for overall absence having a statistically significant negative link to attainment. The key findings include:

- Pupils with no absence are 1.3 times more likely to achieve level 4 or above, and 3.1 times more likely to achieve level 5 or above, than pupils that missed 10-15 percent of all key stage two (KS2) sessions.
- Pupils with no absence are 2.2 times more likely to achieve 5 or more GCSEs or equivalent at grades A*-C including English and mathematics and 4.7 times more likely to achieve the English Baccalaureate than pupils missing 10-15 percent of Key stage four (KS4) sessions.

The DFE statistics make interesting reading. In the cohort of pupils described in the report, there were 27,150 who had missed more than 10 percent of their KS2 schooling (5.6 percent of the 482,264 pupils in total) and 73,150 who had missed more than 10 percent of their KS4 schooling (14.5 percent of the 503,775 pupils in total). If these figures are reflective of cohorts generally, this would suggest that by KS4,

approximately 14.5 percent of pupils are persistent absentees, as defined by the DFE as those missing more than 10 percent of schooling. Even at first glance this is certainly a bigger and more complex issue than that of term time holidays. A problem which appears to increase significantly with the age of the child and to affect one seventh of the entire school population by the end of KS4.

Further scrutiny of the report highlights that those pupils with the highest 5 percent of overall absence were far more likely to be eligible for free school meals (FSM) or to have a special educational need (SEN). 44.2 percent of the KS2 pupils with the highest 5 percent of overall absence were also eligible for FSM, compared to 7.6 of the pupils with the lowest 5 per cent of overall absence. Similarly, 35.7 percent of the KS4 pupils with the highest 5 percent of overall absence were eligible for FSM, compared to 7.6 percent of the pupils with the lowest 5 percent of overall absence. The percentages of pupils with SEN showed a similar pattern: 41.4 versus 11.5 percent at KS2 and 40.6 versus 11.6 percent at KS4. This certainly suggests that there are other factors involved and the picture that is painted is not as straightforward as initially suggested. That low socio-economic status and SEN are significant contributing factors in persistent school absence and subsequent low academic attainment, is also no surprise to me in terms of my own professional experience.

At the time of writing I am about to complete my thirteenth year working as a local authority Educational Psychologist (EP). Since qualifying, the role has presented many challenges and has provided experience of supporting children, young people, their families and schools with many different areas of need. One issue, however, has presented itself time and again to be most difficult to resolve; that of individuals with

persistently poor or no school attendance. Mirroring the wider ongoing debate about definition and terminology, which I will discuss in depth in the next chapter, this issue has come to my attention variously labelled as *school refusal*, *emotionally-based school refusal*, *truancy* and *separation anxiety*.

In each individual case, it has been difficult to pinpoint with confidence the causes, and there have always been multiple factors to consider. Solutions have not been simple or easy to formulate. Often, at the point where I have become involved, professionals and family members have told me that they feel *stuck* and unaware of how best to help. I too have felt *stuck*, conducting conversations with young people variously: through the crack under their closed bedroom door; entirely through family members; one-sidedly, whilst they remain silent; whilst they are wrapped in a blanket or wearing a woolly hat in a warm room; whilst they are sweating and pale because of self-reported drug use and whilst they are shaking and tearful. I have had lengthy telephone conversations or meetings with parents who are desperate for help and feel powerless to support their child, and have worked hard to understand young people whom I have never been able to meet with in person because they have refused to see me at all.

Four years ago, I had the privilege in my work to link regularly for a period of three years with a team called The Integrated Team for Families (ITF). The ITF Family Coaches (hereafter referred to as ‘coaches’ for brevity) worked with families who met their criteria through two or more factors: adult unemployment; poor school attendance and anti-social behaviour. Funding for this team was performance-related and they

were constantly looking for new and creative approaches to use with children and young people (CYP) with poor school attendance, who formed a great proportion of their work. These CYP included those who could be classed as intermittently truant as well as those who might fall into the category of anxiety-based non-attenders, and who may have been completely absent from school for several months. My role mainly involved providing training and individual consultations to the staff, as well as some casework with CYP, where school attendance was an issue. It was through my work with this team that I came into close contact with a number of families for whom school attendance was a significant issue, and was privy to the stories of many more through the medium of consultation; families from a range of backgrounds and in a variety of different circumstances, all of whom were struggling to address the issue of school attendance for one or more of their children. Linking closely with this team also led me to realise the extent to which CYP and their families could become marginalised within the wider educational system.

At that time, coaches became involved with families like these at different levels of intensity and in a variety of ways. Where a family required a high level of support, coaches were allocated to work with them for several hours each week and for more than a year in some cases. Once allocated to a family, coaches might: attend the home regularly and work with all family members including parents, siblings and extended family; meet with CYP individually; liaise with schools often becoming the lead professional at multi-disciplinary meetings, and liaise with a range of other professionals from health, education, crime and social services, including those from the voluntary sector. They might, for example: attend GP or court appointments in an advocacy or support role; provide practical help to a family to improve their living

space or manage the household budget; provide parenting training; or make a referral for support in cases of domestic abuse. This created a situation whereby their involvement would span all the different systems in which a CYP existed; they had the opportunity to get to know and understand a family better than other professionals, who may only meet them on a few occasions in a clinical environment for example. However, many of the coaches found the school attendance aspect of their work challenging, finding it to be most difficult to support families to make lasting changes leading to successful school attending for the CYP involved. Despite no longer being linked to the team, I still retain good relationships with many of the coaches with whom I collaborated, and I remain a point of contact whenever coaches feel they would benefit from discussion about casework. I am still, therefore, frequently asked for my opinion on the best way forward.

Turning to the academic literature for help in addressing this problem, I have found this to be lacking, despite there being a substantial body of work published over the last century. General conclusions from the literature indicate that persistent non-attenders are a heterogeneous group and that causal factors can be rooted in a CYP's school, family, mental health and peer context, often spanning all of these to some extent (Carroll, 2015; Ek & Eriksson, 2013; Kearney, 2003; Kearney & Graczyk, 2014). The phenomenon appears to be highly complex and without a single unifying theory that can be drawn upon in deciding how to intervene. It is suggested that support must therefore be bespoke, collaborative and multi-factorial (Kearney & Graczyk; Lyon & Cotler, 2009; Nuttall & Woods, 2013). From a practical perspective in my local authority role, starting with a completely blank slate each time a case is presented, may

not be the most efficient use of time. This is especially true in the context of public sector cuts and a growing scarcity of local authority resources.

Thus, came the idea to explore the unique experiences and perspectives of the family coaches themselves; to understand what factors they perceived to help and to hinder the reintegration of a child, from a coaching family, to school where there was persistent school non-attendance (PSNA). This would be research specific to the local context, with professionals very well positioned to understand the causes and constraints; channelling years of experience working with multiple families where PSNA was an issue. It was hoped that this would lead to the development of a theoretical framework from their combined experiences that would be helpful in guiding future work within the local context.¹

¹ Use of the pronoun 'they' has been used in the singular throughout this thesis in accordance with the movement towards non-gendered language in academic publishing.

2.0 Literature review

2.1 Introduction

In considering how to conduct the research in this study, a thorough review of the existing literature was carried out. The purpose of this review was to examine prior work in the broad area of PSNA. The questions that guided the review were:

- What is the wider context in which PSNA exists and what bearing does this have on current practice?
- What does the existing body of research say about the importance of school attendance and how PSNA can best be addressed?
- What are the gaps in the research and what would be a helpful addition to the research base?

This chapter therefore, will examine the literature on PSNA. It will look first at the national context and the impact of this on current practice. It will then consider the issue of terminology and definition, before moving into a discussion of the demographics, including some of the research about risk factors and outcomes. Following this, it will present some of the key theoretical models that have been proposed, including some of the guidance that has been produced by local authority Educational Psychology Services (EPSs), and examine the main treatment and intervention approaches in the literature. Finally, it will discuss the Troubled Families Programme, from which ITF evolved, and the local context from which this research emerges.

2.2 Details of sources and searches

In conducting this review, a series of searches were carried out, details of which can be found in the table in Appendix A. For section 2.3.6, it was felt that a systematic review of the literature on intervention approaches was warranted in order to gain a clear overview of how PSNA intervention has already been researched and what might constitute a helpful addition to the subject. The tables in Appendix B give a comprehensive summary of this systematic review.

2.3 Reviews

2.3.1 The national context

To understand fully the issue of PSNA, it is necessary to look at how this sits within a wider political and cultural context. This section examines the complex factors surrounding PSNA in the UK and how these have an impact upon practice.

Prior to the 1860s, education was not compulsory in the UK. The National Education League, an organisation set up to campaign for free, compulsory, and non-religious education for all children, was instrumental in the formation of the 1870 Education Act. This is the earliest piece of legislation regarding the provision of education in Britain, establishing a system of *school boards* to build and manage schools in areas where they were needed. In 1880 a further Education Act made school attendance compulsory between the ages of five and ten. Education became free in 1891. Since this time there has been a series of further legislation each time extending the age of

compulsory attendance and establishing the system of local education authorities (Parliament, 2017).

In recent years, the government has prioritised the importance of school attendance through a commitment to reduce levels of absence. Compulsory school age is now from 5 to 16 years. In England, 16-18-year olds must also either stay in full-time education, start an apprenticeship or traineeship, or work or volunteer (for 20 hours or more a week) while in part-time education or training. Section 1:7 of the Education Act 1996 (which remains statutory despite having been superseded by the 2002 Act) states:

The parent of every child of compulsory school age shall cause him to receive efficient full-time education suitable—

(a) to his age, ability and aptitude, and

(b) to any special educational needs he may have, either by regular attendance at school or otherwise (Education Act 1996).

Section 6:2 states that failure to comply with this statutory duty can lead to the local authority serving the parent with a school attendance order. Non-compliance with this order is an offence, unless the parent can prove that the child is receiving a suitable education out of school. If convicted, parents are liable to a fine “not exceeding level 3 on the standard scale”. (At the time of writing this would specifically mean up to £1000). If a child is registered at a school and fails to attend

regularly, this is also considered an offence on the part of the parent. A parent who is aware that their child is not attending school regularly but does not take reasonable steps to address this may be liable to a fine “not exceeding level 4 on the standard scale” (£2500), or “imprisonment for a term not exceeding three months”. In an escalating penalty-based process, local authorities may prosecute parents through the court system, ultimately resulting in the possibility of an education supervision order.

The DFE published a document in November 2013 (revised in May 2015) entitled: *Children missing education: statutory guidance for local authorities* (DFE, 2015).

This document sets out the statutory duties of local authorities in identifying and returning children who are not regularly attending school. Schools have a legal duty to monitor pupil attendance daily and to inform the local authority of any pupil who is regularly absent from school or who misses 10 or more school days without authorisation. They are also required to investigate any unexplained absences as part of their legal safeguarding duty.

The DFE recognises certain groups as being at greater risk of not attending school, including: pupils at risk of harm/neglect; children of Gypsy, Roma and Traveller families; families of Armed Forces; missing children/runaways; CYP supervised by the Youth Justice System; and *children who cease to attend a school*. The latter category is not further defined in the document.

Currently all of this sits within the wider context of further school reform. The recent government white paper, *Educational Excellence Everywhere* (DFE, 2016b), sets out

the objective that all schools will become academies by 2022. This is broadly opposed by teaching unions, such as the National Union of Teachers (NUT), who state that the changes are a “threat to the most vulnerable children” because schools will manage their own admissions procedures (National Union of Teachers, 2016). Academies are outside local authority control, and are both their own admissions authority and responsible for their own appeal systems (DFE, 2014a). Of course, many academies work hard to be inclusive, but there have been several accounts in the media of some “flouting admission rules” to select pupils from more privileged backgrounds (Garner, 2013), or “gaming the system” and redirecting children to other schools if they have special needs or are not predicted high enough grades (Goddard, 2016). These concerns are echoed in the most recent Academies Commission report (Academies Commission, 2013).

Schools are under increasing pressure to demonstrate their outcomes statistically and to show measurable *value-added* via individual pupil achievement targets, examination results and attendance data. School data is widely publicised online (Government digital service, 2017), and is used to inform judgements by the Office for Standards in Education, Children's Services and Skills (Ofsted). Emphasis on pupils attaining educational targets in core subjects may lead to resources being channelled away from competing priorities in schools, such as promoting mental health or emotional well-being. This can also cause schools to feel less willing to accommodate pupils with additional needs or vulnerabilities. Certainly, there is a tension, when using finite resources, to include and support a minority of pupils, who are likely to have a negative effect on overall school *success* statistics.

Schools may also feel a pressure to move on pupils with PSNA or indeed to using creative registering to cause the problem to disappear from their statistics. Marking a child with a code B in the school register to denote *education off site*, or a code C to denote *leave of absence authorised by the school* (DFE, 2016c) could be an alternative way to register CYP with PSNA, which avoids prosecution of families. Schools may justify this coding by sending nominal amounts of school work home to be completed. This is a practice used by some schools within the locality where this research takes place, but there is no evidence of this in the literature. It is perhaps an inevitability that where a system's success is measured statistically, those inputting the data have an incentive to find any loop hole that will help their numbers look the best they can.

As well as school reform, the current government is in the process of reducing the size and scope of local government. The past several years has seen a reduction in delegated funding to local authorities and the cessation of multiple government grants, forcing councils to reduce their staff and sell assets. This has had an impact upon the amount of support that local authorities have been able to offer to schools and families (National Audit Office (NAO), 2014a).

In parallel with this is the rising profile of children's mental health needs in the UK. The recently published government report, *Future in Mind* (Department of Health, 2015), sets out to make comprehensive improvements in provision for CYP with mental illness. The report states that one in ten children needs support or treatment for mental health problems, which can affect educational attainment and physical

health, and that 75% of mental health problems in adult life (excluding dementia) start by the age of 18. There are implications for universal services, such as schools, which need to play a part in early identification and intervention.

In summary, the wider contextual situation has four key features. Firstly, the punitive culture in which the blame for absence is ascribed to parents, with associated penalties. Secondly, the pressure on schools to demonstrate statistically that they are improving attendance and attainment, leading to the potential marginalisation of CYP with additional needs. Thirdly, diminishing local authority resources and support services. Fourthly, a competing high-profile mental health agenda. This combination of factors has led to a context where CYP with similar underlying needs might be treated inconsistently depending upon the lens through which they are viewed. One pathway, for example may involve a sympathetic GP leading to a diagnosis of anxiety as a medical need, provision from the local authority of an Education Health and Care Plan, leading to home tuition or a small school environment. Another pathway may result instead, in a series of increasingly punitive measures through the court system.

2.3.2 Terminology and definition

The issue of CYP with similar underlying needs being treated inconsistently, depending upon how they are perceived, relates to the issue of classification. When reviewing the literature on PSNA it quickly becomes apparent that there are several issues that require careful consideration with regard to terminology and definition.

The earliest literature on PSNA tends to link this with juvenile delinquency, “feeble-mindedness” or to frame it as a medical problem (Dayton, 1928; Goddard, 1914;

Harkavy, 1937). In the more recent literature, CYP who have persistently poor school attendance are described under a number of different terms, each with its own conceptual emphasis. This section will give an overview of the key terminology and discuss some of the issues around definition.

The first issue for debate is which behaviours are included under the umbrella heading of PSNA. The government currently define CYP as *persistent absentees* where their percentage of registered attendance is less than 90% overall (DFE, 2016d). These same children are variously described as *children missing in education* and *children who cease to attend a school* depending upon the government report. In the book *School Refusal Behaviour* (Kearney, Spear, & Mihalas, 2014), a range of additional behaviours are included, that may not impact overall registered attendance but certainly impact upon educational engagement. CYP may for example: be persistently late for school in the morning; walk out part way through the school day; or be fully registered for the day but refuse to attend classes. The range of behaviours that might be encompassed by the overarching term PSNA are summarised in figure 2.1.

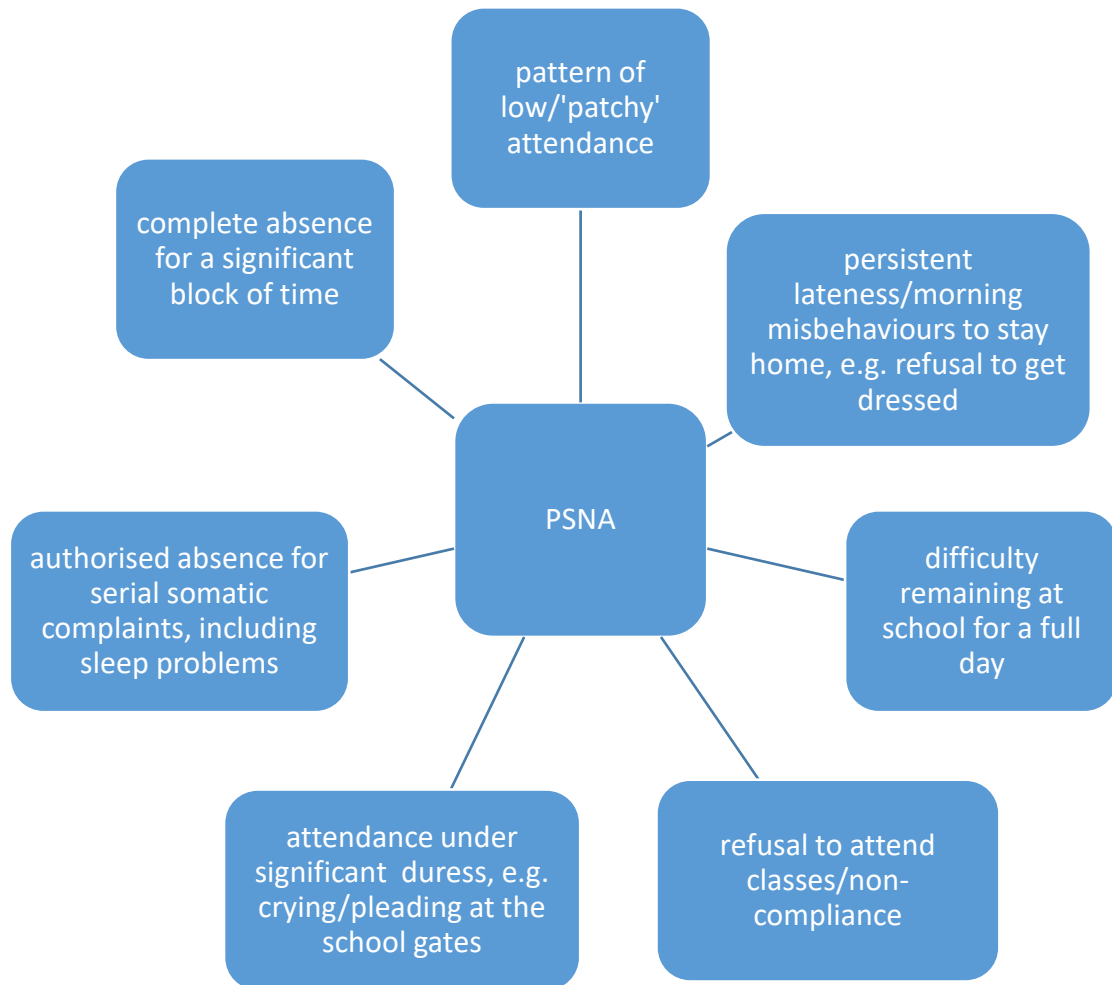


Figure 2.1: The range of behaviours noted in PSNA

The second issue is the terminology used to describe these behaviours. The diagram in figure 2.2 is one way of illustrating the multiple subsets of terms, and their relationships, as set out in the majority of the existing literature.

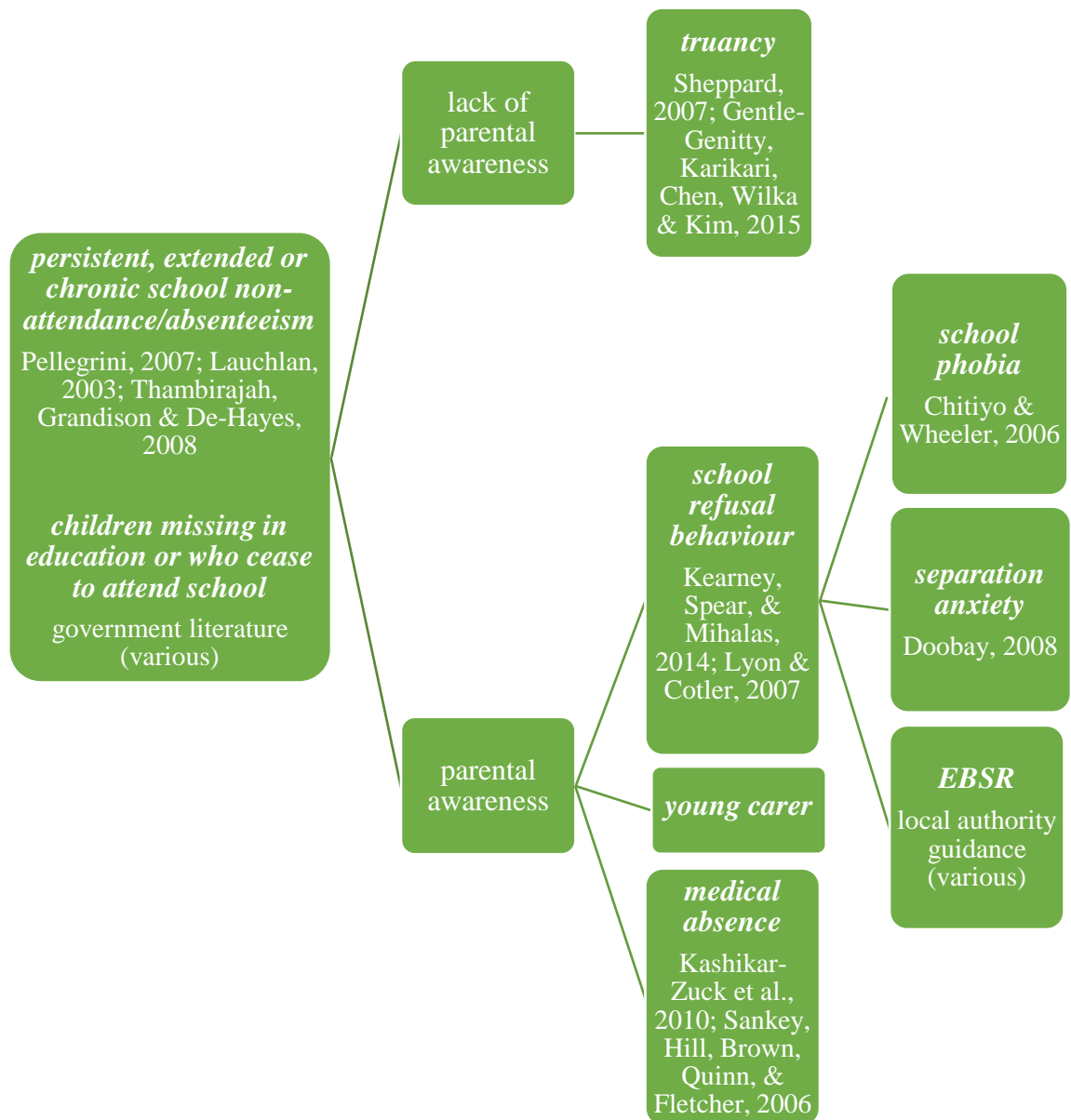


Figure 2.2: An overview of the terminology used in PSNA

Pellegrini (2007) describes the dichotomy that is well established in the literature between students who, “suffer from forms of anxiety about school and do not attend with their parents’ knowledge” versus those who “are believed to stay away from school due to lack of interest and motivation, in the absence of any clinically significant characteristics, and without their parents’ knowledge” (p.64). He argues for the use of the broad umbrella term *extended school non-attendance* to describe the behaviour without suggesting cause or attributing blame, noting semantic difficulties with some of the more specific commonly used terms.

Other proponents of the use of broad terms such as *chronic non-attendance* (Lauchlan, 2003); and *school non-attendance* (Thambirajah, et al, 2008) agree, discussing that more specific definitions wrongly attribute the issue as singularly *within-child* or are overly pathologizing, failing to recognise that there can be a myriad of overlapping contributing factors. Gregory and Purcell (2014) argue that more specific labels can act as a barrier to understanding the issue and can deflect attention away from some of the important environmental elements at play.

Within these broader defining terms are the two major subcategories of *truancy* and *school refusal behaviour*. Like Pellegrini, Sheppard (2007) uses the term *truant* to define CYP that are absent without parental knowledge. However, there is no shortage of debate around this definition. Several recent studies (Gentle-Genitty et al, 2015; Sutphen, Ford, & Flaherty, 2010) have attempted to review the literature on truancy, concluding that many operational definitions exist; some of which define truancy as part of a spectrum of conduct disorders (such as stealing, destructiveness,

drug and alcohol use, anti-social behaviour and avoiding home), others which describe it as a pattern of intermittent rather than continuous school absence and others still which highlight the involvement of peers who are also absent from school or the desire to keep the behaviour hidden from adults as much as possible.

School refusal behaviour in contrast is generally defined as being underpinned by anxiety and emotional upset (Doobay, 2008). The assumption here appears to be that the truant is in control of their behaviour, choosing to miss school for purposes of misbehaviour, whereas the school refuser is overwhelmed by the emotions of fear or anxiety and thus physically unable to attend. Lyon and Cotler (2007) consider this to be an “undesirable effect” of distinguishing between truancy and what they term *anxiety-based school refusal*. They illustrate a scenario of school refusers eliciting sympathy whilst truants are seen as deserving of admonishment.

School refusal behaviour is further subcategorised in the literature as (or sometimes used interchangeably with) the terms *school phobia* and *separation anxiety*. School phobia involves the diagnostic medical term *phobia* and has been defined as a persistent, irrational fear or anxiety about attending school (Chitiyo & Wheeler, 2006), implying that something or somebody within the school environment is provoking anxiety. Some of the literature asserts that this fear is not of school itself, but of the loss of an attachment figure or security base to whom children would normally turn for comfort, hence the distinction *separation anxiety* (Doobay, 2008). Separation Anxiety Disorder is a clinical diagnosis within the fifth and most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSMV) (DSM

Library, 2016). It is defined in terms of “persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation” and “recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.” (p.190-195)

In practice, the two terms appear to be indistinct. A local government report (Archer, Filmer-Sankey, & Fletcher-Campbell, 2003) examined definitions of school phobia and school refusal among local authority and school staff across England and found there to be no clear distinction between the two. A third, related, term is also in use. *Emotionally-based school refusal*, or EBSR, is a further term used to describe school refusal behaviour which has anxiety at its root. This term is generally used in local authority guidance papers that will be discussed further in section 2.3.5, but is not found in use more generally within the literature.

Close examination of the literature demonstrates that there is a significant overlap between CYP described as truants and those described as school refusers.

Commonalities exist in terms of both risk factors and outcomes (Chen, Culhane, Metraux, Park, & Venable, 2016; Havik, Bru, & Ertesvåg, 2015) that indeed suggest this may be a false dichotomy. Lauchlan (2003) also disputes the usefulness of this distinction on the grounds that some children may exhibit characteristics of both truancy and school refusal, and suggests that drawing a line between the two is to oversimplify. Indeed, due to the level of ongoing debate regarding the terminology, several commentators in the field suggest that CYP with PSNA are such a heterogeneous group, a better approach would be to perform a functional analysis of

the purpose served by non-attending on a case by case basis, avoiding the semantic difficulties of labelling completely (Gulliford, 2015; Kearney & Ross, 2014).

In defining the terms of PSNA, mention should also be made of the category of CYP who may be described as *young carers* (Cox & Pakenham, 2014). These are CYP for whom a parent or sibling has major needs with ill-health or disability and much more responsibility than would be usual falls upon their shoulders (Kavanaugh, Noh, & Studer, 2015). There are CYP who could be described as unofficial young carers in that the responsibilities they shoulder are hidden or unrecognised outside the home because a parent may have undiagnosed mental health needs. For example, a CYP with a functionally agoraphobic single mother may have to take their younger siblings to school in the morning before getting themselves to school and may have responsibility for grocery shopping and such in the afternoons. This could have a significant impact upon school attendance.

A note should also be made of the additional category of CYP for whom PSNA is an issue but may be described as suffering from a chronic medical complaint. CYP with clinical diagnoses of Juvenile Primary Fibromyalgia Syndrome (Kashikar-Zuck et al, 2010) and Chronic Fatigue Syndrome (Sankey et al, 2006) were found to experience difficulties with regular school attendance both during the illnesses and following recovery. Additionally, premenstrual symptoms (Tadakawa, Takeda, Monma, Koga, & Yaegashi, 2016), obesity (Pan, Sherry, Park, & Blanck, 2013), migraine (Arvans & LeBlanc, 2009) and recurrent headache (Breuner, Smith, & Womack, 2004) are all found to be associated with persistent absence. In several of the studies the school

non-attendance appeared to be linked to mental health symptoms, like depression or anxiety, rather than to the specific manifestations of the illness, such as pain. It is also discussed whether aspects of these medical diagnoses could be somatic expressions of underlying mental distress, which would suggest some overlap with school refusal behaviour (Tanaka, Terashima, Borres, & Thulesius, 2012).

In summary, the issue of terminology and definition in the area of PSNA is complex and contradictory. Perhaps this is symbolic of the complexity that can exist at the level of the individual, and the heterogeneity of the group as a whole. Certainly, it reflects the variety of different lenses through which these CYP are viewed, as well as the evolution of dominant psychological discourses over time. PSNA is variously seen as an educational, medical, social, criminal, and psychological issue, each lens defining the problem according to its own values and labels. Over time, the dominant psychological discourse has moved from an emphasis on behaviourism to a current focus on mental health, which has led to a wider shift in how PSNA is perceived and treated. It may be more likely now, for example, that the focus is the underlying anxiety that the CYP is experiencing, which might be addressed with cognitive behavioural therapy (CBT) and medication. Previously the formulation and intervention might have centred around removing tangible rewards at home and reconditioning a CYP to reduce their fear of school, through repeated exposure.

In practice, this lack of agreement across time and discipline, may lead to CYP with PSNA being categorised and treated inconsistently, according to which system they happen to have become a part. Additionally, there is an impact upon research, as it

becomes difficult to obtain a clear overview of the issue, joining up the disparate pieces of research across time and discipline coherently. This issue will be further examined in the later sections of this review. For further reading on the matters of terminology and definition, Pellegrini (2007) provides an excellent discussion of the factors acting as an obstacle to attaining a shared definition.

2.3.3 Demographics, risk factors and outcomes

It is well-established in the literature that there are CYP who are persistent school non-attenders. This section of the review will look at the extent of the problem, who might, most likely, be affected, and what the impact might be upon those missing school. Reviewing these aspects of PSNA aims to answer the question about whether it should be considered a problem of importance, and one worthy of further exploration and research.

2.3.3.1 Prevalence

In the literature, prevalence rates are hugely varied, both geographically and between surveys, because of the differing classifications and criteria applied. Specific UK prevalence rates are also difficult to find for this group because the presentation of absence is varied and sometimes statistically hidden; for example, high anxiety may sometimes be diagnosed and subsequently registered as authorised medical absence, but because of a scarcity of community mental health resources, a child with a similar presentation may be registered as having unauthorised absence. A similar underlying issue may also be statistically camouflaged by schools registering with a *B code* as

discussed in section 2.3.1, being viewed in terms of an associated health issue, or resulting in a CYP being taken off role completely and home educated.

In England, the percentage of CYP in state-funded primary and secondary schools that were classified as persistent absentees (where attendance is less than 90%) in autumn 2015 was 10.3% (DFE, 2016d). In 2013, Ofsted reported that 1,400 pupils across 15 local authorities were not participating in full-time education (Ofsted, 2013). The British Psychological Society (BPS) estimates that if this pattern was replicated across all local authorities in England, it would mean that more than 10,000 children at any one time were missing full-time education for extended periods (Apter, 2013).

2.3.3.2 Risk Factors

The risk or causal factors found in the literature are numerous. Figure 2.3 is a summary of the multiple factors that have been found to be associated with PSNA. These range diversely from family dynamics to peer group bullying, and sexual orientation to socio-economic status. It is of course difficult to say with certainty that any of these factors have a direct causal link to PSNA. The problem with combining studies in this way is that it paints a false picture of certainty, failing to consider the great range of different studies included and whether their results can be considered valid or reliable. The knowledge-base on risk factors is drawn from enormously variable and disparate sources; both in terms of their location (geographically and historically) and methodology. The studies in figure 2.3, for example, took place variously in the USA, Japan, UK, Sweden and Israel, with significant variations in their wider societal and cultural environments. Sample sizes

varied from single case studies to large scale online questionnaires with upwards of a thousand participants. The methods involved were sometimes quantitative and sometimes qualitative, examining in detail the perspectives of a small groups of people. It is unsurprising therefore, that the results can sometimes be contradictory.

The concept of causality itself is problematic. A correlation between variables does not automatically mean that one is the *cause* of the other. Causation indicates that one factor is the *result* of the other; the majority of the studies cited in figure 2.3 have examined *associated* factors, which suggests correlation but not cause. Where a study has declared a more causal stance, thought must be given to *direction* as well as whether a methodology is appropriately mindful of biases that might exist within a sample of participants. For example, finding parenting self-efficacy to be a predictor of school refusal (Carless et al, 2015) does not take into account the potential effect of school refusal upon parent self-efficacy. Equally, focusing upon parent perceptions may falsely locate blame within school, not family (Havik et al, 2014; Havik et al, 2015).

Symbols are included in figure 2.3 to denote numbers of participants (L: > 100), (M: 10 to 100), or (S: < 10). Symbols are also used to denote whether a study was quantitative (QN) or qualitative (QL), self-report (SR), parent report (PR), teacher report (TR) or observational (O). The location of the study is also stated so that judgements can be made about how culturally similar, and therefore appropriate, the setting might be when considering relevance to the UK.

Family factors

- Low level of parental support (Virtanen, Lerkkanen, Poikkeus, & Kuorelahti, 2014) [L, QN, SR, Finland]
- Low parental education level and working mother (Park et al, 2015) [L, QN, SR&PR, South Korea]
- Low parental self-efficacy (Carless, Melvin, Tonge & Newman, 2015) [L, QN, SR&PR, Australia]
- Parental separation (Pflug & Schneider, 2016) [L, QN, SR, Germany]
- Conflict and stress in family life (Place, Hulsmeier, Davis, & Taylor, 2000) [M, QL, PR, UK]
- Parental anxiety or depression (Bahali, Tahiroglu, Avci, & Seydaoglu, 2011) [M, QN, PR, Turkey]
- Smoking household (Levy, Winickoff, & Rigotti, 2011) [L, QN, PR, US]

Within-child factors

- Low level of self-control (Nakhaie, Silverman, & LaGrange, 2000) [L, QN, SR, Canada]
- Learning difficulties (Strand & Granlund, 2014) [M, QN, O, Sweden]
- Obesity (Li et al, 2012) [L, QN, O, US]
- Emotional disturbance (Chen et al, 2016) [L, QN, O, US]
- Lesbian, gay or bisexual identity (Bui, 2010; Burton, Marshal, & Chisolm, 2014) [L, QN, SR, US]
- Aspects of gender and ethnicity that are relevant to 'social capital' (Nakhaie et al, 2000) [L, QN, SR, Canada]
- Adolescence (Mabey, 2012) [L, QN, O, UK]

School factors

- General level of disruptive or violent behaviour in class (Havik, Bru & Ertesvåg, 2014) [M, QL, PR, Norway]
- Methods of attendance data collection (Boden, 2013) [S, QL, SR&O, Sweden]
- Perceptions of low teacher support (Havik, Bru & Ertesvåg, 2015) [L, QN, SR, Norway]
- Low teacher attachment (Virtanen et al, 2014) [see above]
- Poor communication with/involvement of parents (Claes, Hooghe, & Reeskens, 2009) [L, QN, O, UK, US, Hong Kong, Australia, Europe, South America, Cyprus]
- Transition points (primary to secondary, KS3 to 4, following holidays) (Bealing, 1990; Havik et al, 2015; Mabey, 2012) [L, QN, SR&O, UK; see above]

Societal factors

- Non-equitable public health policy (Yeung, Gunton, Kalbacher, Seltzer, & Wesolowski, 2011) [L, QN, O, US]
- Lower socio-economic status (Pflug & Schneider, 2016; Place et al, 2000) [see above]
- Poverty (Wilson, 2014) [Descriptive peice by a teacher, UK]
- Lack of wider support in the community (Coulter, 1995) [S, QL, PR&O, UK]
- Authoritative governmental style (Gesinde, 2005) [L, QN, SR, Nigeria]
- Marginalisation (Hoyle, 1998) [L, QL, O, UK]

Health factors

- Psychosomatic illness (Honjo, Nishide, Niwa, Sasaki, Kaneko, Inoko & Nishide, 2001) [M, QN, SR&O, Japan]
- Low mood and depression (Gren-Landell, Ekerfelt, Bradley, Andersson, & Andersson, 2015) [L, QN, TR, Sweden]
- Anxiety, including separation anxiety disorder (Christogiorgos & Giannakopoulos, 2014) [S, QL, O, Greece]

Social factors

- Bullying (Berkowitz & Benbenishty, 2012; Havik et al, 2014) [; see above]
- Difficulties with peer relationships (Place et al, 2000) [see above]
- Drug use (Henry, 2010) [L, QN, SR, US]

Figure 2.3: Associated risk factors in PSNA

2.3.3.3 Outcomes

Outcomes for persistent absentees are consistently described as poor in the long term. CYP who are often absent from school are more likely than others to leave with few or no qualifications and are more likely to be unemployed, suffer mental illness and become homeless (Apter, 2013). PSNA is closely associated with crime, specifically non-violent crime (Rocque, Jennings, Piquero, Ozkan, & Farrington, 2017). The Audit Commission (1996) found that a quarter of school-age offenders have significant school non-attendance records and that the majority of school-age offenders progress to become adult offenders. Statistics from the first quarter of 2016 showed that 6.5% of 16-18 year olds and 14% of 19-24 year olds were not in education, employment or training (*NEET*) (DFE, 2016e).

The literature has additionally reported links with levels of lifetime alcohol consumption (Wormington, Anderson, Schneider, Tomlinson, & Brown, 2016), “problem drinking” (Rocque et al, 2017), drug abuse (Dembo et al, 2016), poor social engagement, and low levels of attainment in Maths and English (Gottfried, 2014). Associated factors such as loneliness have also been found to have an impact upon health and sleep cycles (Iwamitsu et al, 2007; Tanaka et al., 2012).

Despite methodological differences, it is widely agreed in the literature that PSNA is a predictor of a myriad of difficulties in later life and therefore a useful early marker of a range of potentially chronic life problems. It would seem entirely pertinent, given the evidence, for professionals to try to research, intervene and support CYP affected by this.

2.3.4 Key theoretical models that describe PSNA

To try to make sense of the multiple casual factors and manifestations of PSNA outlined in the previous sections, there have been various theoretical models proposed. A good theoretical model should provide a coherent picture of the relevant factors in PSNA and increased clarity about how best to address this. This section will review some of the key models that can be found within the literature and look critically at how helpful these might be in practice.

One of the strongest voices within the literature on PSNA is Christopher Kearney, who has published many articles and books on the subject, frequently together with his colleague, Wendy Silverman. Within this body of work several theories and models have been presented that attempt to describe the reasons for PSNA and how best to intervene.

One of Kearney and Silverman's most cited models is the four-factor functional model of school refusal behaviour (Kearney & Silverman, 1993). In this model, four primary forms of school refusal are conceptualised. The School Refusal Assessment Scale (SRAS) is used to perform a functional analysis, to help categorise the form of school refusal behaviour and choose the best treatment option. The four categories of school refusal behaviour are defined thus:

1. Avoidance of negative affectivity-provoking objects or situations
2. Escape from aversive social or evaluative situations

3. Attention-getting behaviour
4. Positive tangible reinforcement

Category one would be where elements of the school environment habitually cause a fearful and anxious reaction in the CYP, who systematically seeks to avoid school.

Category two locates the problem more specifically within difficult peer relationships (which might include feeling bullied or isolated) or individual teaching styles.

Category three would be commensurate with the term *separation anxiety*. The CYP is seeking attention from an attachment figure, with whom their relationship is insecure.

Category four is an echo of the term *truancy*. Non-attendance at school might be experienced as a rewarding experience, reinforced by activities undertaken with peers whilst out of school, or by rewarding activities at home (such as access to computer games).

The analysis recognises that individuals do not fall neatly into one category, but behave in accordance with a range of overlapping factors. The model suggests that one category might have overall dominance over the others and should therefore be the main focus for intervention. Suggestions for intervention vary according to the four categories, but are generally behaviourist or cognitive behaviourist in nature. For example, for a fear of the school environment, a strategy such as *flooding* (Blagg & Yule, 1984), might be employed. Rewards might also be used to reinforce attendance, whilst any rewarding activity outside school is removed.

The authors state that the four-factor model is informed by the researchers' own clinical experience and knowledge of the literature. The subsequent formulation of the SRAS is based upon research undertaken by the authors with 42 children demonstrating school refusal behaviour, and their parents, in two states in the USA. The authors report adequate inter-rater reliability, test-retest reliability, construct validity and concurrent validity. However, this evidence must be taken with caution. Small numbers are involved in the study (fewer than 40 individual inter-rater and test-retest measures) and concurrent measures are those that measure related, but not precisely correlate, concepts; the Children's Depression Index and the Fear Survey Schedule, for example. The authors themselves discuss the need for a larger sample size to be employed.

The benefit of this model is that it provides a structured and methodical approach to identifying the causes of PSNA, and addressing these systematically. The model begins with a functional analysis of the underlying causal factors, rather than ascribing a label based on the dominant, but potentially misleading, presenting behaviours. This approach would be beneficial where practitioners, such as school-based staff, have little prior knowledge or experience, as there is a helpful emphasis in taking time to assess and analyse the roots of the problem before considering what approach will be most useful.

From a critical perspective, practical experience and case studies in the literature suggest that the lines between each category tend to be fluid and interconnected, with causal factors acting upon a CYP from several directions simultaneously. One also

needs to consider that once a CYP is not attending school, whatever the initial reasons, secondary and maintenance factors from other categories will come into effect. For example, a CYP who stays away from school ostensibly attracted by a peer group who are socially active during the school day (category four), will subsequently fall behind academically and may feel reluctant to put themselves into the position of judgement by peers or teachers by returning to school (category two). Cases may not always fall into one clearly dominant category and several factors may need to be addressed simultaneously.

A later key model presented by Kearney in conjunction with a different colleague, Patricia Graczyk, is the *response to intervention model to promote school attendance and decrease school absenteeism* (Kearney & Graczyk, 2014). This is a theoretical framework, guided by a systematic literature search covering the past twenty-five years. Kearney and Graczyk's model emphasises early identification and intervention, and presents a three-tiered system for practitioners to draw upon.

The model is hierarchical, setting out an approach to PSNA that begins in school as a universal strategy, and progresses in intensity in response to the CYP's need. As can be seen from the overview in figure 2.4, tier one might simply involve regular screening and monitoring. Tiers two and three act as a natural extension of increasingly more targeted strategies, such as small-group work or therapeutic intervention, where CYP are identified as being at risk or requiring increasingly complex intervention.

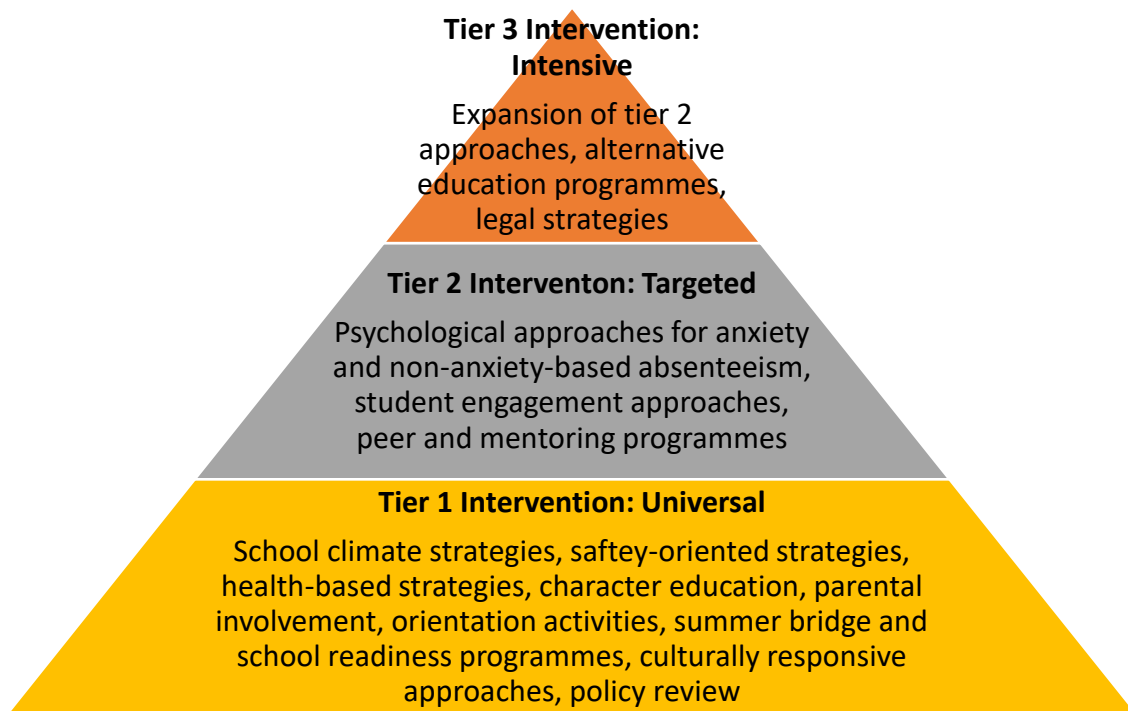


Figure 2.4: A Response to intervention model for problematic school absenteeism

Kearney and Graczyk state that their rationale for this model is based upon five requirements emerging from the literature. These are: early identification and intervention with progress monitoring; functional assessment; empirically supported procedures and protocols; compatibility with other multi-tier approaches and a team-based approach for implementation. For each tier, they outline a list of strategies that have had proven success in the reviewed research literature. The paper is comprehensive and well-referenced, with multiple and varied intervention approaches to draw from.

Kearney and Graczyk present their model as a general blueprint for professionals but state:

The intricacy of problematic absenteeism, however, means that modifications will be necessary to more specifically tailor these guidelines to the demands of a given case and to a certain geographic location or school district. Researchers, educational and mental health professionals, and parents must collaborate to develop this model and further enhance its utility for all youths with absenteeism (p.17).

They suggest several critical points to adhere to in developing their model for use at local level. These include: reaching a consensus in defining the key terms related to school attendance and absenteeism, based upon the local data; monitoring attendance in the locality at all three tiers in their model; performing a functional analysis of the factors acting upon the propensity for absenteeism and researching the key academic, social, and behavioural indicators as well as mental health and vocational outcomes for students. As set out by the authors, this model provides a useful overview of how to approach PSNA that lacks in specificity, needing to be adapted to the local situation in which it is applied. The model cannot be taken and applied at face value, which limits its usefulness in practice as a stand-alone tool, without additional work to identify the factors and constructs at play in a particular context.

Recently within the UK context, Nuttall and Woods (2013) outlined their *ecological model of successful reintegration* following their work exploring two case studies of school refusal behaviour. This model, influenced by Bronfenbrenner's (1979) ecological systems theory, describes the multiple components of school refusal behaviour and views this as a system embedded within a specific context. A simplified illustration can be found in figure 2.5.

Their model was developed to conceptualise successful reintegration from school refusal. It described the five main areas they identified within their research as *systems* surrounding the child. These were: psychological factors; support for psychological factors; factors supporting the family; the role of professionals and systems and the wider socio-legislative and cultural context within which the systems existed. The model recognises how changes within these systems led to positive outcomes for both case studies. The researchers set out their findings as themes within each system.

At the core of the model are psychological factors at the level of the child: *developing feelings of safety, security and a sense of belonging; increasing confidence, self-worth and value and aspiration and motivation*. Surrounding this are factors that support these key components, including: *encouragement and positive attention and supporting social interaction and communication*. Wrapped around this are factors that support the family, including: *positive relationships and developing parenting skills*. Around this layer is the role of professionals, including: *flexibility and availability of key adult; personality, skills and experience and collaborative, multi-agency working*. Finally, the model sits within a contextual setting, which includes: *avoidance of the prosecution route and harsh consequences*.

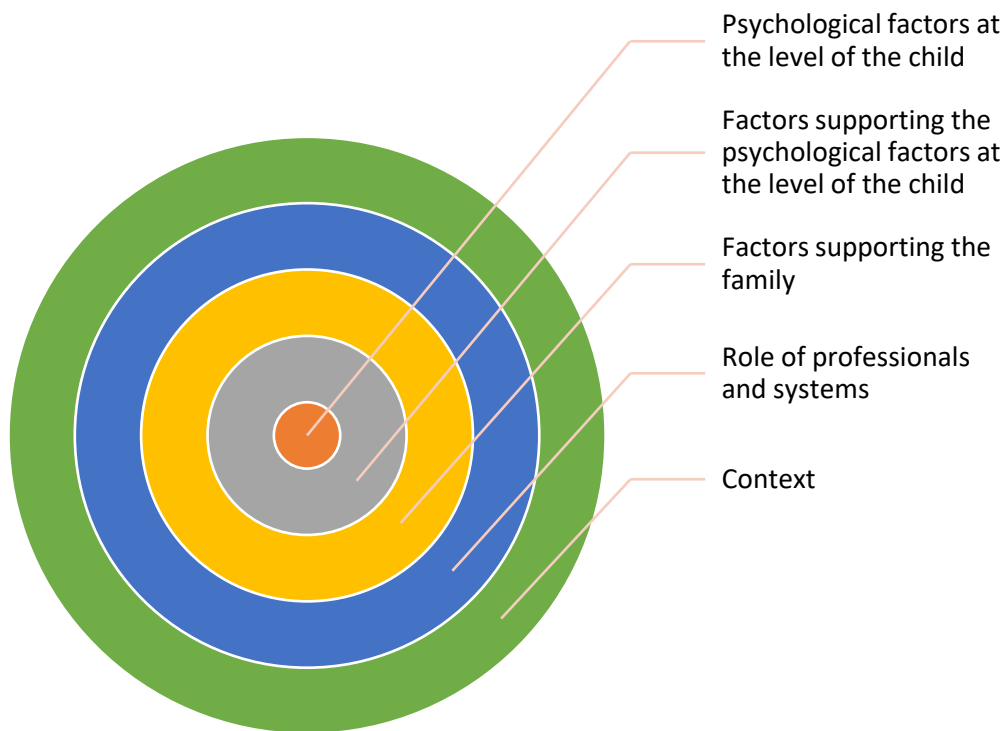


Figure 2.5: A simplified version of the ecological model of successful reintegration.

The model is a useful conceptualisation of the systems that act around a CYP and how intervention must span all these systems in order to be effective. The authors describe their research as exploratory; their findings are based upon two case studies within one authority, which limits their generalisability. However, they present their model as one which can be used to populate findings from other research studies, and as a useful framework for conceptualising other cases. In terms of practical application, it could be used in individual casework to examine the factors at each level that are relevant for the CYP in question. It presents a promising development but one which is in its infancy and needs further evidencing.

Finally, the BPS also present a four-factor model, whereby any single case of PSNA might include elements of one or more of the following factor-categories of causation (Apter, 2013):

1. Emotionally-based: where there are mental health issues affecting the student or other family members, for example, where the student is a young carer of a parent with a mental health condition or a drug habit.
2. Physical health related: ranging from unusually frequent coughs and colds to chronic conditions such as cystic fibrosis that necessitate episodic in-patient treatment.
3. Attitudinal/systemic: absenteeism that becomes significant when it is habitual or too frequently a pragmatic solution, for example term-time family holidays.
4. School behaviour-related: for example, exclusion, managed moves, alternative provision and part-time timetables.

The BPS describes PSNA as unique to each individual, and persisting due of the complexity of the interrelationship of these four factors. They describe the factor weightings as dynamic and varying in the degree to which they contribute to the problem from day to day. They devised a table to illustrate how psychology might seek to intervene in accordance with the four factors outlined, provided in figure 2.6. Some of the treatment and intervention approaches referred to in this table, will be discussed in section 2.3.6.

Factor-Categories	Psychology	Evidence-based Interventions
1. Emotional/ mental health- based non- attendance	Social cognitive theory	Psycho-education; solution circles; CBT; consultation
	Behavioural theory	Behavioural teaching; token economies
	Counselling psychology	Individual client-centred work; consultation support, training and development groupwork;
	Psychodynamic	Individual and family psychotherapy
	Cognitive behavioural	CBT for fearfulness of school; depression and anxiety
	Attachment theory	Parent-training; parent support and development groups; systemic family therapy; consultation groups
	Learning difficulties	Instructional psychology; assessment through teaching; precision-teaching; self-efficacy training; dynamic and formative assessment; consultation
2. Physical health related non-attendance	Cognitive behavioural	Health management, pain and discomfort management via mental health and well-being interventions, e.g. CBT for depression, anxiety and improved well-being; team around the child meetings; consultation
3. Attitudinal/ systemic non-attendance	Positive psychology	Solution-focused family work; systemic family therapy; consultation; motivational interviewing; CBT; mediation meetings
4. School- behaviour related nonattendance and exclusion	Social-cognitive theory	Teacher training (INSET); individual student work; multi-agency work, e.g. working with social workers and parents; CBT/behavioural experiments;
	Behavioural theory	Behaviour management systems; systematic classroom observation; token economies; mediation meetings; consultation

Figure 2.6: BPS table describing some of the applied psychological interventions used by psychologists, and their theoretical foundations

The BPS model provides a descriptive overview or aide-memoire for psychologists, describing the types of intervention that are employed by applied psychologists in the field, rather than a theoretical model of intervention. The four categories do not represent four underlying causes that are scientifically valid as distinct from each other. They are constructed for ease of presenting the quantity of information and it could be argued that they are therefore arbitrary. The evidence referred to in section 2.3.2 regarding the overlap between medical conditions and emotional well-being, for example, makes the distinction between categories one and two less clear.

The usefulness of this model in practice is therefore limited. It may be helpful, at a service level, to use this overview to decide which interventions to offer to the wider community, or to individual psychologists for whom it might be useful to know what interventions exist whilst they are formulating a treatment programme for an individual. However, it does not offer help with the process of formulation.

In summary, the four key models presented are helpful ways to attempt to make sense of the area of PSNA, but each has limitations in terms of its usefulness in practical application, without significant adaptation to a specific context or case. The models do not provide full answers about the best ways to proceed in PSNA, leaving room for further development in the area.

2.3.5 Local authority guidance

Alongside the key theoretical models that exist, there are several examples of guidance that have been published by local authority EPSs in England. In this section, three examples of published guidance are reviewed, once again looking critically at how helpful these might be in practice and where they might fall short.

West Sussex (2004), North Somerset (2010) and Derbyshire (2013) have produced booklets which set out some of the research into what they term *Emotionally-Based School Refusal* or *EBSR*. All three of these publications were produced by working groups of EPs in collaboration with school staff and other professionals in their local areas. Their stated purpose is to provide clear and concise information to school staff and agencies about EBSR, share and celebrate the good practice that already exists in relation to EBSR, support schools in managing pupils at risk of EBSR, and clarify the roles of different agencies in relation to EBSR.

The North Somerset and Derbyshire models both draw from the earlier West Sussex model, which makes the firm distinction between *wilful* non-attendance or truancy, and that which is anxiety-based, thus reinforcing this division. The West Sussex model involves carrying out a functional analysis of the underlying cause of the school refusal behaviour, providing a framework of questions to ask the young person and their parent. This framework, referred to as the Attendance Risk Monitoring Schedule (ARM), codes the responses into four categories:

- A – Negative emotion (involves avoidance of a specific stimulus in the school setting)
- B – Situation avoidance (involves unsatisfactory peer relationships and social anxiety)
- C – Need for parental attention and contact (involves attention-receiving behaviour designed to result in staying at home with a specific parent or caregiver)
- D – Tangible reinforcement (involves tangible reinforcement for staying at home, e.g. watching television, playing on the computer, or in the community)

It draws heavily from Kearney & Silverman's model (1993), outlined in section 2.3.4, attempting to identify the primary function of the behaviour and linking interventions accordingly. Predisposing, precipitating and maintenance factors are helpfully also discussed. Interestingly, twelve years after its publication, the link to the West Sussex guidance has now been removed by West Sussex County Council from its website, suggesting perhaps that the information is no longer felt to be up to date or useful.

The North Somerset and Derbyshire documents are set out as more general guides for intervention, with practical suggestions for what to look out for and how different professionals and agencies can support. They move away from the West Sussex model of ascribing categories through functional analysis, suggesting that it is a complex combination of overlapping factors and triggers.

All three sets of guidelines are embedded in their own specific local context. For professionals working in other authorities they provide a helpful starting point but must be adapted to fit with the systems and structures in place elsewhere. Each provides a general overview of the background context and a model of good practice in assessment and identification. The guidance booklets are primarily concerned with setting up systems around the child, where EBSR can be identified early and appropriate referrals can be made. However, they have limited information about specific interventions that can be employed to address the problem and these tend to focus heavily on behaviourist techniques. The guidelines would have limited practical application in the local context where this research takes place and it is not always clear what the evidence-base is for any treatment approaches suggested. This evidence-base will be examined comprehensively in the next section.

2.3.6 Treatment and intervention approaches

This section considers the specific ways in which the problem of PSNA can be addressed, systematically reviewing the existing body of research for evidence. It was felt that a systematic literature review was warranted for this section, for the purpose of carefully identifying whether there were any gaps in the research, and what study would therefore be a helpful addition to the research base.

Intervention for PSNA spans a range of disciplines. Figure 2.7 gives an overview of the treatment approaches described within the literature in the last decade, showing the wide variety of perspectives that exist.



Figure 2.7: An overview of the approaches to treatment and intervention

As can be seen from figure 2.7, PSNA intervention is approached from many different standpoints. Under these broader headings, PSNA has been variously addressed with: anti-anxiety medications, such as fluoxetine (Melvin et al, 2016); steroids (Iwata, 2012); hypnosis (Aviv, 2006); exposure (Maeda et al, 2012); virtual reality exposure (Gutiérrez-Maldonado et al, 2009); hospitalisation (Walter et al, 2014); solution-focused brief therapy (Thompson et al, 2012); a national children's health insurance programme (Yeung et al, 2011); screening programmes (Korematsu et al, 2016); parent training (Kearney et al, 2007); family check-ups (Stormshak et al, 2009); social skills training, sports participation and moral character classes (Marvul, 2012); academic tutoring (Haight et al, 2014); CBT (Heyne et al, 2014) and web-based CBT (Chu, Rizvi, Zendegui, & Bonavitacola, 2015). This list is not comprehensive, but gives a flavour of the wide variety of approaches employed.

A systematic review of the literature was undertaken to try to generate unbiased and critically synthesised conclusions about the treatment and intervention of PSNA, through systematically exploring the empirical evidence. This was felt to be warranted to identify gaps in the research literature about intervention, given the immense volume of available literature. The review asked the question, *what evidence exists that PSNA can be successfully improved?* Full details of this can be found in Appendix B, including information on the review method and inclusion and exclusion criteria.

The review generated several conclusions:

- A large amount of literature exists in this area of research. A carefully constructed search of work published specifically about intervention approaches generated 125 articles from just the past ten years.
- Much of this literature is not reporting original research, but is some form of secondary reporting. 47 of the 125 articles were discarded because of this. Secondary reporting included text books and book reviews, editorials, literature reviews, opinion pieces and advisory texts.
- Part of this literature is concerned with the causal, co-existing or resulting factors of non-attendance. This provides useful additional information about the possible circumstances surrounding PSNA, but not direct evidence about how this can be specifically or successfully addressed. A small section of the literature looks at assessment methods or the lived experience of PSNA. Whilst useful to read, this does not help to directly answer the review question about evidence of successful intervention. A further 38 papers were discarded for these reasons.
- Of the 31 papers selected for review, 18 were studies carried out in the USA. The remaining papers originated from Japan, Israel, The Netherlands, Australia, Romania, Turkey, Germany and Spain. Only one article was of work carried out in the UK. This is reflective of the wider literature, the vast majority of which also originates from the USA, with additional work variously and thinly scattered throughout Western Europe and the wider world. Generalising to the UK context is difficult because of the cultural and systemic differences that exist. Differing educational systems, political models, cultural norms, family practices and welfare arrangements all act to create differences in the world of the school non-attender. In Nuttall and Woods' ecological model of successful reintegration (2013), outlined in section 2.3.4, the impact of the wider cultural and political context is

considered to be a key factor of influence. This in itself creates a gap in the literature for more work to be carried out within the UK context.

- The literature originates from a range of professional disciplines. Of the 31 studies reviewed, the background was variously: social work; criminal justice; psychiatry; various branches of psychology; youth work; education; public health; nursing; and counselling. Once again, this reflects the wider literature and makes comparison difficult. Success criteria from an educational perspective may differ broadly from that of a nursing or criminal justice perspective. Terminology is also variant, as are inclusion criteria. Participants in the psychiatry based studies tended to have co-occurring symptoms of clinical depression or anxiety (Heyne et al, 2011; Melvin et al, 2016), whereas those in the criminal justice based studies tended to have associated anti-social behaviours (Strand et al, 2014).
- Related to this, there are several different theoretical and methodological standpoints. Many of the studies apply a positivist lens, attempting to measure the impact of pharmacological or behavioural interventions quantitatively, using trials and statistical analysis (Melvin et al, 2016; Reissner et al, 2015). Others take a more relativist ontology, using detailed case studies or interviews to qualitatively review therapeutic or systemic interventions (Heyne et al, 2014; Oner et al, 2014). Others still take a pragmatic view, using mixed methods to examine whether community-based schemes in a specific school or local area have been effective (Dietter et al, 2016; Sugrue et al, 2015). One study approached the issue phenomenologically, exploring the experiences and perspectives of the CYP, parents and professionals involved (Robinson, 2010). This further confounds comparison. Importantly, almost all the studies view the phenomenon through a single lens, viewing the problem as an educational, criminal or medical one.

- In addition to the wide variability in the papers' inclusion criteria, methodology, and measurement of success, the quality of the design of many of the studies was either weak or only moderate in quality. According to the criteria used to rate the design in each of the 31 studies, which can also be found in Appendix B, only one study was able to achieve a strong rating (Melvin et al, 2016). The others were flawed in terms of either recruitment strategy, lack of comparison group, poor triangulation, or analysis. Anomalies were not always adequately addressed.
- Outcomes were varied. 17 of the studies achieved a rating of 0 or 1 because the evidence of any effect was either weak or non-existent. 9 of the studies showed promising evidence of success and 5, strong evidence, such as a significant effect-size. However, because the design of these studies was flawed, caution must be exercised before extrapolating.

Due to the wide variation in ontological perspectives, cultural contexts, disciplines, inclusion criteria and methodologies, and the inadequate research designs in many of the studies, it is difficult to draw any general conclusions about what actually works. Only very tentative statements can be made from systematically reviewing the literature: some CYP with persistent non-attendance respond well to anti-anxiety medication and CBT for up to twelve months following treatment (Melvin et al, 2016); some CYP, who have co-occurring depressive symptoms or a phobia, respond well to a period of treatment whilst hospitalised (Walter et al, 2010); 20 CYP in one setting responded well to thorough attendance-monitoring, inclusion in team sports and sessions on *moral character* (Marvul, 2012); two case studies showed that success occurred when the CYP felt confident and safe, positive relationships were developed between home and school, and the needs of the families were met (Nuttall

et al, 2013); and one case study demonstrated success up to two-months following intensive CBT sessions with a girl and her parents (Heyne et al, 2014). These tentative conclusions are quite inadequate for professionals wishing to know how to proceed with new casework.

Several other meta-analyses have been published. These have also sought to apply consistent criteria to evaluate the many studies in existence and to draw more general conclusions. One such systematic review was undertaken by Maynard (2011). She comprehensively searched the literature to find 33 individual studies, which were coded and analysed to account for differences in methodology. Significant heterogeneity was found between studies, as was significant variability in effect sizes. Her meta-analysis saw some positive effects of behavioural, parent-based and school-based interventions. It did not find support for the specific use of collaborative interventions. Significantly, Maynard found that the majority of interventions did not result in regular attendance for the participants. She also describes how many of the studies also had significant “methodological shortcomings”.

Kearney and Graczyk (2014) describe undertaking a systematic review of 25 years of literature in this area. They summarise the issues thus:

School absenteeism is prevalent and debilitating but educational, mental health, and other professionals who address this problem must navigate a diverse literature of varying conceptualizations. Researchers in several disciplines cover this area, including education, psychology, criminal justice,

law, social work, nursing, medicine, and sociology. As such, various terms have been devised historically to describe problematic absenteeism. These terms are usually ensconced in a particular field and have thus led to a fractured literature. As a result, standardized terminology is lacking and a common framework to define a continuum of support based on student attendance patterns and related needs has been elusive (p.2).

These meta-analyses are highly consistent with the findings from the systematic review carried out for the purposes of this study. As well as the literature being *fractured* as described above, much of it uses a narrow lens to view the phenomenon, approaching it from a medical, criminal or educational perspective but rarely from all angles at once. Figure 2.7 is a helpful illustration of this tendency. Additionally, no single approach has been consistently successful with all CYP and very few studies revisit a CYP beyond a few months post-intervention, which makes it impossible to know whether there was any longer-term success.

Two studies have approached the subject from a slightly different angle, drawing upon the knowledge and experience of professionals working multi-systemically to address the problem, who might therefore be able to view the issue through several lenses simultaneously. Sugrue, Zuel and LaLiberte (2016), and Blackmon and Cain (2015), conducted research with caseworkers working intensively with CYP with PSNA and their families. Both studies carried out individual interviews with caseworkers, analysing these to try to gain a better understanding of the factors underlying PSNA and how this could inform intervention work.

Sugrue et al, (2016), interviewed 24 community agency staff working in a truancy intervention program based in Minnesota, over a two-month period, and found that “chronic absenteeism is related to a multilevel ecology of factors”, including: societal issues, such as poverty and housing; community issues, such as cultural barriers and parent work schedules; relational issues of school and family, such as lack of understanding of illness policies and of compulsory education laws as well as historical mistrust of schools; and personal/family issues, such as language barriers, transportation, lack of structure, mental health, parental substance abuse, large family size, relationship between child & school staff and family conflict. They concluded that an “equally complex ecologically based intervention model” was needed to adequately address the PSNA. Caseworkers needed to address issues that arose in all the systems in operation around the CYP to experience any hope of success.

Blackmon and Cain (2015), conducted in depth interviews with six caseworkers working within a successful truancy programme based in Louisiana. They concluded that the caseworker was the “main agent of change” as it was necessary to build a committed, trusting and persistent relationship with the wider family. They also found that intervening by building a support network around the family was the most effective form of longer-term success.

Both models take the field of literature forward by attempting to look at PSNA as multi-factorial, rather than single-factor. They are community, rather than clinic based and so view the CYP in their typical environment and within multiple systems. They also begin to take a longer-term view, interviewing caseworkers who have

worked with multiple families over a considerable period of time (90 days in the former study, and without an official limit in the latter) and who therefore have some awareness of progression. However, both studies are based in the USA, with cultural and environmental situations that differ significantly from the local authority where this research took place. Additionally, both interventions are primary-based and fall short of identifying the issues and success factors that might be in effect with secondary-aged students with PSNA.

In the wider literature, where models have been drawn up, the authors have pointed out that these must be adapted according to locally specific patterns and systems. It would not be possible for a local authority in the UK to develop a robust set of guidelines for its schools and professionals based solely upon what can be found in the literature. The gap identified in the research, therefore, is for understanding the issue at a local level, with a coherent perspective that would be relevant to all disciplines. Exploring the experiences and perspectives of caseworkers in the UK context, whose work extends across the different ecosystems in which the CYP exists, and who therefore have a unique, multi-factored perspective on the phenomenon, would make a helpful contribution to the knowledge-base. Additionally, caseworkers who have worked with CYP with PSNA at both primary and secondary age, over a significant length of time, would extend the scope of the study further.

2.3.7 The Integrated Team for Families (ITF)

One example of an intervention in the UK to address the issue of PSNA in a multi-systemic way, is the Integrated Team for Families. ITF began as the Family Intervention Project (FIP) in 2009 as part of the government's Troubled Families Programme, a strategy to address antisocial behaviour (The National Archives, 2010). This local authority was one of those funded to set up as an early pilot scheme in 2005 following the great success of a one-off intensive residential intervention in Dundee in the mid-1990s. The theory behind the Troubled Families Programme was that targeted support to a number of high profile families causing problems in one local setting, would have a beneficial impact for the whole area (Department for Communities and Local Government, 2012). These families were felt to be disproportionate users of government funded resources and services (for example, social services, health services including mental health, court and probation services, housing associations, welfare benefits, drug/alcohol cessation clinics). Historically, a family with multiple problems living on one housing estate may have been relocated several times, shifting the problems without any thought to addressing the route of these.

These families almost always have other often long-standing problems which can lead to their children repeating the cycle of disadvantage. One estimate shows that in over a third of troubled families, there are child protection problems. Another estimate suggests that over half of all children who are permanently excluded from school in England come from these families, as do one-in-five young offenders (Department for Communities and Local Government, 2012, p. 1).

ITF caseworkers are termed *Family Coaches*. They tend to be from a diverse range of backgrounds including: probation; policing; housing; youth offending; social care and teaching. Historically, families have met the criteria for a coach through two or more factors:

1. Crime or anti-social behaviour. Persistent anti-social behaviour or a proven offence of an under eighteen-year old in the family in the previous twelve months.
2. Education. One or more children in the family: have been permanently excluded; have experienced several fixed term exclusions in the previous three terms; attend a Pupil Referral Unit (PRU); **are not on a school roll; or have had ten percent unauthorised absences or more across the previous three terms.**
3. Work. One or more adults in the family are on Department of Work and Pension (DWP) *out of work* benefits (including Employment and Support Allowance, Incapacity Benefit, Carer's Allowance, Income Support and/or Jobseekers Allowance, Severe Disablement Allowance).

Since May 2016, ITF has merged with the local authority parenting team and the criteria for eligible families has broadened and sits under six headline areas. A comprehensive overview of these criteria can be found in the table in Appendix C. Education concerns continue to be one of the main criteria.

Coaches become involved at different levels of intensity (up to several hours per week) and for up to 9 months in duration, though historically involvement could continue for up to two years if an extension was agreed by management. The table in Appendix D gives an overview of the three possible levels of engagement, and a comprehensive list of interventions offered can be found in the table in Appendix E. The range of work

undertaken by coaches places them in an unusual position for professionals; they work multi-systemically, involvement spanning all the different systems in which a CYP exists.

FIP, the intervention from which ITF grew, was a well-evaluated project with a sound evidence-base for its impact (Action for Children, 2011). However, since 2011, it has risen dramatically in profile and has been part of a wider political agenda. On the 15th December 2011, the incumbent prime minister, David Cameron, delivered a speech, in which he addressed the London riots that had taken place earlier that year, placed the blame on *troubled families* and declared a commitment to government spending by extending the already successful FIP programmes across the country. He praised the more personal approach to welfare that a family worker could bring:

For a long time I was criticised for talking about the broken society. But I believe that it's only by recognising the problem that we can fix what's gone wrong. And this summer we saw, beyond doubt, that something has gone profoundly wrong. The riots were a wake-up call - not a freak incident but a boiling over of problems that had been simmering for years. (...) we've known for years that a relatively small number of families are the source of a large proportion of the problems in society. Drug addiction. Alcohol abuse. Crime. A culture of disruption and irresponsibility that cascades through generations (Cabinet Office, 2011).

Cameron pledged £448 million to “turning around the lives of 120,000 troubled families by the end of this Parliament.” The offer to local councils was to fund 40% of the cost if they match this with 60%, and demonstrated results. Services had to prove, in measurable terms, that the children were attending school significantly more, adults were in work and anti-social behaviour had been reduced. It was a high-profile act, the catalyst for which was the need to take action after a summer marred by civil disobedience. In June 2013, the government announced an expansion of the Troubled Families Programme, delegating £200 million to work with 400,000 additional families, and greater scope for local authorities to identify the criteria for involvement.

In March 2015, pre-empting the publication of the official evaluation, a government press release was made stating that, more than 105,000 troubled families had been “turned around,” saving taxpayers an estimated £1.2 billion (Department for Communities and Local Government, 2015). However, in October 2016, with a new prime minister incumbent, a government report was published, evaluating the Troubled Families Programme (Department for Communities and Local Government, 2016). The report prompted the headline in the Guardian: *The troubled families programme was bound to fail – and ministers knew it* (Portes, 2016).

The report was based on multiple data sources, which would suggest that it is both thorough and well-triangulated. Analysis used: outcomes data from national administrative datasets; a large-scale face-to-face survey of families, comparing families going through the programme with a matched comparison group; qualitative

case study research with a purposive sample of 20 local authorities, conducted longitudinally; telephone interviews with a further 50 local authorities; monitoring data collected on a self-report basis from 143 local authorities at three points in time during the evaluation; and a quantitative survey of local authorities conducted during the early stages of the programme to map the broad characteristics of local Troubled Families programmes.

The research was unable to find consistent evidence that the programme had any significant impact upon employment or school attendance, 12 to 18 months after families joined the programme. In the qualitative data, families did report that they were managing better financially and felt more confident, positive about the future, and in control of their lives, compared to the matched comparison group. Pertinent to this study, school attendance was slightly improved but not to a statistically significant extent.

The report itself declares that the timing of the data collection may have been too early to capture the full impact of the intervention and that there were “major limitations in data quality” (p.71). Specifically, they note difficulties with school attendance data, citing this as the least reliable. They also note that the comparison group was not well-matched in terms of school attendance prior to intervention, children in the programme having worse attendance than those in the comparison group. There was also noted to be significant regional variation in outcomes but only overall national figures are reported. They therefore rightly conclude that no piece of evidence collected can be regarded as conclusive. The programme continues, and it

has been recommended that a follow-up evaluation takes place to examine the impact of the second phase.

2.3.8 The Local Situation

The local authority, where this research took place, is currently* aware of 174 CYP overall who are being home educated. The authority has a service which monitors home education and provides tutors for those children with a medical need. This service, is currently providing home tuition for 25 CYP with a tier 3 Child and Adolescence Mental Health Service (CAMHS) diagnosis, which would indicate a mental health need. Additional to this there are CYP who are categorised as *school refusers* by the authority but who do not have any specific diagnosis. Any school-aged CYP with attendance less than 30% is identified from data reports and discussed at the Children Missing from Education (CME) panel which takes place half-termly. Currently the authority is aware of 26 CYP whose attendance is less than 30%.

**figures reflect the status in October 2016*

No published local guidance exists in the authority and practice between schools is variable as each school has its own policy or process. Some schools employ an Inclusion, Home School Liaison, or Education Welfare Officer. Others do not have a nominated member of staff for attendance.

The local ITF numbers twenty-eight coaches. The team is well-established and several coaches were also members of the local FIP, from which ITF evolved. The

team is currently situated in three regional offices in the city, each with an operational manager and sits within the Children and Families arm of the local authority.

2.4 Research aims and questions

This review has led to the following conclusions:

- PSNA exists within a complex political and cultural situation, which can affect the equity of how CYP are viewed, assessed and treated.
- The existing body of research confirms the importance of school attendance on the future outcomes of CYP. How PSNA can best be addressed remains inconclusively researched.
- The gap identified in the research is understanding the issue at a local level, in the UK context, with a coherent perspective that would be relevant across disciplines. Exploring the experiences of caseworkers who have worked with a subset of CYP with PSNA at both primary and secondary-age, across all the systems within which a CYP exists, and over a significant length of time, would make a helpful contribution to the knowledge-base.

This study therefore attempts to contribute to the literature on PSNA, by exploring the experiences and perspectives of caseworkers in the UK context (in this case coaches), whose work extends across the different ecosystems in which the CYP exists, and who therefore have a unique, multi-factored perspective on the phenomenon. The aim is to focus within the local context and to develop a framework for successful intervention based specifically on this data, for use with the local population. A grounded theory approach will help to do this through collecting data

about local casework and attempting to build a theory for successful intervention around this. It might be described as *practice-based evidence* as it is developed through the experience of what works.

In this thesis, the broad term PSNA is used, to be inclusive of the full range of behaviours that are linked with this (please refer to figure 2.1) and to recognise the complex range of overlapping subdivisions (please refer to figure 2.2). The use of the term *persistent* as opposed to *extended* or *chronic* is to ensure that this does not just describe CYP who are absent for long periods of time, but also those for whom attendance is poor or variable. Coaches are involved with CYP who might fall into all the subcategories described in figure 2.2. Given that this is a study based on grounded theory, the aim is not to restrict discussion of any casework on the grounds that this does not meet a predefined definition, and to be as open as possible to any line of enquiry that presents itself from the ground, without pre-formed value-laden judgements about the cause.

The purpose of this study, therefore, is to explore the unique perspective of the coaches working in the local authority; to better understand what factors they perceive to help and hinder the reintegration of a child, from a coaching family, to school after a period of PSNA. The overall aim is to develop a theoretical framework from their combined experiences that will be helpful in guiding future work within the local context. The research will be guided by the following questions:

- 1.** What are the perspectives of coaches on their work with persistent school non-attenders?

- 2a.** What do coaches perceive to be the factors influencing the successful reintegration of CYP to school following a period of PSNA?

- 2b.** What do coaches perceive to be the constraints operating to prevent the successful reintegration of CYP to school following a period of PSNA?

- 3.** How can the theory that explains the process of successful coach intervention in the local authority inform future intervention and policy development?

The next chapter will describe in detail the methodology employed to answer these questions.

3.0 Methodology

3.1 Introduction

As set out at the end of chapter 2.0, the purpose of this study was to explore the unique perspective of coaches working in one local authority; to better understand what factors they perceived to help and hinder the reintegration of a child, from a coaching family, to school after a period of PSNA. The overall aim was to develop a theoretical framework from their combined experiences that would be helpful in guiding future work within the local context.

A research strategy was adopted that was felt to provide the best opportunity to answer the guiding research questions. This chapter sets out the details of the methodology employed, as well as why this was felt to be the most appropriate tool.

3.2 Research purpose

The research was felt to be primarily exploratory; seeking to elicit the unique experiences and perspectives of the coaches and to uncover new issues and themes in the area of PSNA. It aimed to illuminate the phenomenon from a unique point of view that had little precedent in the literature. Secondary to this it was explanatory; seeking to uncover reasons why some CYP supported by ITF successfully reintegrate and some fail to do so.

3.3 Research strategy

It was felt that a qualitative strategy would be most appropriate for this study. The qualitative approach supported the exploratory nature of the research as it could build a rich picture of the coaches' experiences of PSNA; to draw out as many novel themes as possible, without restricting the data collection through rigid adherence to structured questionnaires, the selection of which might have been influenced by the researcher's own pre-held assumptions or pre-existing theoretical frameworks.

The research does not claim to be objective or to be able to generalise its findings more widely than the local context, though these may be pertinent to other contexts that are similar; its function was to explore and understand the subjective experiences of the coaches to illuminate the complex phenomenon of PSNA, in coaching families, in one UK local authority.

A qualitative approach was also felt to increase the trustworthiness of the data in relation to its stated aims; coaches were asked for their personal perceptions about their *experiences* in the local context, with a subset of CYP from coaching families, and not *absolute truths* about school non-attendance more generally.

3.4 Research orientation

The ontology of this research was therefore relativist. A relativist ontology would assert that our understanding of the world is constructed. Constructs are relative and not fixed; there are no truths, only subjective understandings that differ according to

perspectives. Relativism would assert that meaning is created through experiences and interactions. The epistemology of this research was therefore social constructionism; which attempts to generate meaning through shared discourse and constructions.

In the context of PSNA, experiences are unique and individual to each CYP, family and professional involved. However, because coaches, as a team, have the experience of several hundred locally-based cases, it was felt that some overarching themes could be drawn out to highlight collectively constructed *truths* about the factors that support or hinder the successful reintegration of CYP to school, within this specific local context. A social constructionist approach, allowed the coaches to make sense of their personal experiences with PSNA and to construct collective ideas about what factors *generally* increase or decrease the likelihood of a successful return to school in coaching families.

3.5 Research participants

As this was qualitative research, the sample was a non-probability one and purposive. The participants were all coaches. The whole team of twenty-eight coaches was invited to volunteer. Exclusion criteria was applied to four of the coaches because they were new to the team. Other than this, all experiences and perceptions were felt to be valid. An overview of the inclusion and exclusion criteria can be found in table 3.1.

Inclusion criteria	Exclusion criteria
A family coach with experience of work with CYP with PSNA for 6 months or more	Less than 6 months' experience

Table 3.1: Participant inclusion and exclusion criteria

Initial contact was through email correspondence with one of the operational managers followed by a talk at one of their regular team meetings in July 2016 to explain the purpose and procedure of the study. A total of twenty-one of the twenty-four eligible coaches volunteered to participate. Due to sickness absence, nineteen of these actually participated.

Demographic information about gender and age, is set out in table 3.2. The average number of years' employment as a coach was 3.13 years, ranging from eight months to six years. Prior to employment as coaches, participants had worked in a wide variety of occupations including: play therapy; social work; youth work; academic research, counselling, policing, teaching; health visiting; crime prevention; housing and rough sleeping work; and substance misuse work.

Gender			Age range (years)				
Male	Female	Total	Under 25	25-34	35-44	45-54	Over 55
5	14	19	0	3	6	8	2

Table 3.2: Participant gender and age

3.6 Research method

The method of inquiry felt to be most appropriate for this study was Grounded Theory (GT). In GT, the researcher develops a theoretical model grounded in the views of the participants (Creswell, 2009). This was felt to be the most fitting way to capture a range of perspectives from the team of coaches (as per the research questions 1, 2a and 2b), and to develop these into a theoretical model that could help to answer research question 3. A detailed overview of the procedure followed in this study, and how this fits with a GT approach, is set out in sections 3.6.1 to 3.6.4.

The GT method is most closely aligned with the alternative methodology of Thematic Analysis (TA). TA aims to systematically analyse data for key themes and the relationships between them, and to report these descriptively. It differs from GT by stopping short of developing a *theory*. This research was concerned with developing a theoretical model that could explain the process of successful coaching intervention in order to inform planning in the local authority. It was felt that TA would fall short of enabling a model to emerge, which described this process adequately and completely in terms of context, activities, systems and outcomes.

3.6.1 GT: Origins

The GT methodology originated in the 1960s from a series of studies about dying in hospitals, conducted by the sociologists Barney Glaser and Anslem Strauss (Glaser & Strauss, 1968). The dominant methodological paradigm at this time was positivism, through which lens qualitative research appeared “impressionistic, anecdotal, unsystematic and biased” (Charmaz, 2006). Glaser and Strauss challenged the

methodological consensus by developing a systematic strategy for conducting qualitative research.

3.6.2 GT: Principles

GT does not start with a theory or hypothesis and then seek to verify or prove this via the evidence of the data. Instead, it is a tool for generating theory from messy, real life situations (Sutcliffe, 2016). The critical realist approach to GT assumes that there is a world independent of our individual or socially constructed perceptions, and that this reality is experienced and interpreted through context (Bhaskar, 1975). Critical realist GT aims to explore the possible mechanisms working in a context, that might help to explain a process or a phenomenon.

Charmaz (2006) sets out the defining features of grounded theory practice as follows:

- a) Simultaneous involvement in data collection and analysis;
- b) Constructing analytic codes and categories from data, not from preconceived logically deduced hypotheses;
- c) Using only the constant comparative method, which involves making comparisons during each stage of the analysis;
- d) Advancing theory development during each step of data collection and analysis;
- e) Memo-writing to elaborate categories, specify their properties, define relationships between categories, and identify gaps;
- f) Sampling aimed toward theory construction, not for population representativeness;

g) Conducting the literature review *after* developing an independent analysis.

This study adheres to the above principles, though there are caveats with the final two. Sampling in this small study was constrained to the team of coaches. In order to follow the principle of *sampling to follow theory construction*, the research would have had to extend to elicit the views of CYP, families and other professionals. This could not be done within the scope of this study, but could be carried out in the future as an extension of the initial study. This is discussed further in chapter 5.0.

The principle of waiting until after the analysis to review the literature is so that the researcher comes to the area as a “blank slate”; without pre-existing hypotheses and biases (Charmaz, 2006). Thornberg (2012) points out that this is impossible in educational research because, in practice, a researcher must have some knowledge of the literature in order to present their idea to the ethics board and justify the study to any sponsors. He therefore recommends undertaking “informed grounded theory”, whereby the literature is examined, but the researcher remains open to the concepts that emerge from the data. New hypotheses may therefore emerge that better explain the data than any existing theory or model. The literature review may therefore be carried out prior to and throughout the process of data collection and analysis.

The way in which this study adheres to the other principles listed above will be described in terms of the procedure in the following section.

3.6.3 GT: Procedure

GT is a non-linear approach. The data gathered should be rich and detailed, using a data collection technique which promotes the use of open questioning and follows new lines of thinking generated by the participants. Coding begins tentatively and is refined in several stages, with frequent referral back to the original data and theoretical sampling to check out emerging theories. There are three levels of coding: open coding (broad themes); axial coding (connections between themes); and selective coding (systematically exploring how a core concept relates to others). The process continues until the point of *saturation*; when gathering fresh data no longer reveals new theoretical insights. Table 3.3 outlines this process in detail.

GT Procedure	Associated principle	Application in this study
1. Employ a data collection technique that is rich and detailed and explores new lines of thought.	<i>b</i>	Data was collected over a series of four focus groups; each of between four and six volunteer coaches. The focus group technique is described in section 3.5.4. Each group was tape recorded and transcribed for analysis. Open questioning was used. [The outline of questions and prompts used within these focus groups can be found in Appendices F, G and H.]
2. Refine theory development in several stages, referring back to original data and checking emerging theories with new samples of participants.	<i>a, b, c, d</i>	The focus groups were spread out over a period of four months, ideas and theories developed between carrying these out. Any tentative theories generated were brought back to the subsequent focus group for feedback. The process continued until a comprehensive set of theoretical themes had been established.
3. Data analysis is carried out in stages, whilst constantly referring back to the original data.	<i>a, b, d</i>	Max QDA was employed as a research tool. This allowed several versions of the data analysis to be saved simultaneously and data to be easily retrieved and compared throughout the process.
4. Open coding: create simple and precise codes, closely matching the language used by participants, sometimes verbatim; word the codes to reflect actions, rather than concepts;	<i>b, c</i>	A detailed analysis of the first two transcripts produced approximately 1400 initial codes. The focus group transcripts were read line by line and all segments of text relevant to the research questions were assigned with a simple label in the active voice (e.g. CYP feeling anxious). The length of these segments varied from a few words to several paragraphs and more than one code was applied to a

remain open and analytical, avoid jumping to theoretical or conceptual thinking too early.		segment if it was felt that this demonstrated more than one concept. Sometimes codes overlapped segments.
5. Memo writing	<i>e</i>	Memo-writing was used throughout, to jot down any conceptual thoughts as they arose, and to be referred to at other stages in the analysis. Memos were written using the Max QDA software.
6. Axial coding: from initial codes, develop emerging themes, and connections between them; evolving to a higher level of abstraction and interpretation.	<i>a, c, d</i>	Initial codes that were observed to be the most significant or frequent were used to categorise others. Categories were formed, within which were several sub-categories. These emerging themes were taken back to be checked out with the participants of the third focus group. During the course of discussion, previously undisclosed topics were raised, so that some new initial codes were subsequently created.
7. Selective coding: look at how core themes relate to one another. As the theory develops, use constant comparison to review the coding of the previous transcripts in light of this.	<i>a, b, c, d</i>	The themes were further developed, connected and categorised; referring back to all three transcripts, and taking into account the reactions from the third group. A tentative theory was developed.
8. Saturation: continue the process until no additional information is forthcoming that would provide fresh insights.		The tentative theory was taken to a fourth focus group for comment. As very few new initial codes could be created from this final transcript, and there was a high degree of consensus, it was felt that the point of saturation had been reached.
9. Theory development	<i>b, c</i>	A final grounded theory was developed, referring back to all four transcripts. Themes were drawn together to form theoretical models and these were formed into a coherent explanatory model.

Table 3.3: Outline of the research procedure

3.6.4 The focus group technique

The focus group technique of data collection was chosen as it was felt to have several benefits in light of the GT approach. Where individual interviews might be strongly influenced by the interviewer in terms of direction of questioning, the focus group is more likely to find its own direction of travel. It might be argued that interviewees are heavily influenced by the questioning, body language, interest and knowledge of the interviewer in a one to one situation. In a focus group, the direction of conversation is also influenced by the interest, body language and additional enquiries of the other participants. It fits well with the idea that theory is being generated from the ground, without being influenced by the potential biases or preconceptions of the researcher, because alternative lines of enquiry and tangents are more likely to be followed in this setting.

A review was carried out of several pieces of research that used focus groups to elicit the ideas and perceptions of participants (Vaughn, Schumm, & Sinagub, 1996). The authors concluded that the advantages of focus groups over individual interviews are:

- possible reduction in social desirability effects, as the presence of peers may reduce the need to impress the interviewer;
- greater anonymity of the group environment, which can help individuals to disclose more freely;
- more genuine responses, as each individual is not required to respond to every question, and participants are able to see that a diverse range of views is valued.

Additionally, arguments have been put forward that being in a group situation with familiar peers, people are able to prompt one another and are likely to feel more at ease than in an individual interview (Costley & Armsby, 2007).

3.7 Validity

Lincoln and Guba (1985) suggest that there are four features of qualitative research that help to ensure that it is trustworthy. The validity of this research is addressed under the headings of these features:

3.7.1 Sensitivity to context

The research focused on a specific group working within a specific context. The methodology was systematic and all interpretations have been evidenced so that these can be checked by referring back to the original data.

3.7.2 Commitment and rigour

The participants knew the researcher through a history of joint working. Several of the coaches had expressed a desire to communicate their views on this issue and to participate in the research. Measures were taken to ensure that the study adhered to high ethical standards (for further details please refer to section 3.9). The thematic way that the data was intended to be used was made explicit and some ground rules on confidentiality within each focus group were established to help the participants to feel more at ease and free to say what they felt. The researcher was aware of the need to be reflexive about her own role during the research and to critically examine any

potential bias and influence upon the formulation of the research questions, data collection and analysis of data.

3.7.3 Transparency and coherence

An audit trail was produced at each stage of the analysis so that the themes generated could be shown to be grounded in the original data and were open to outside scrutiny. The computer sorting package, MAX QDA was used for extra rigour, within which it is made explicit, through a series of memos, how themes were arrived at and the underlying reasoning involved.

To provide *consensus replication*, following the first two focus groups, a section of the data and initial coding was taken to a tutorial session, where it was subjected to the scrutiny of four other doctoral students and three supervisors. The group were asked to comment on whether the initial codes generated appeared to be in line with the associated text and labelled in a way that was considered appropriate. The unanimous consensus was that this was the case. Following the final development of the grounded theory, the four transcripts and the full coding system on Max QDA was sent to the researcher's supervisor for comment. The feedback was that the themes developed were felt to be grounded in the data.

For the research to have *testimonial validity*, participants in the third and fourth focus groups were asked to indicate whether interpretations based on the data from the previous groups, accurately described their experience or not.

3.7.4 Impact and importance

PSNA is a well-documented and internationally-recognised phenomenon, not unique to the local context. As set out in chapter 2.0, the research has few answers regarding what constitutes a consistent, successful intervention and the factors that increase the likelihood of reintegration to school. Themes that arose through this research were felt to be important in the local context, within coaching work, as well as to be able to contribute to discussions about how support is organised in the wider national context and possibly further.

In the local context, no authority-wide policy or guidance existed, and support services were difficult to engage with any immediacy due to their long waiting lists and selective criteria for casework. Schools did not necessarily prioritise these CYP for support because they were not presenting an immediate issue at school, for example disrupting classes. The CYP could become marginalised and miss education for very long periods of time whilst support was being engaged, which could be stressful for them and for their parents. Subsequently, a range of professionals in the authority were keen for some research to be done and felt that it was important for some coherent and evidence-based guidance to be put together.

3.8 Relevance

In deciding upon final research questions, the views of a range of relevant professionals within the local authority were drawn upon. The researcher attended a Children Missing in Education meeting and a Pupils with Medical Needs Panel, which were, between them, attended by all the major stakeholders in the authority

regarding school attendance (Head of the service supporting children educated outside school, Vulnerable Children Manager, Attendance Lead, Acting Principal EP, Access and Inclusion Performance Manager, School Admissions Manager, Education Safeguarding Officer, Acting Head of CAMHS, Behaviour Improvement Advisor, Head of NHS Paediatric Services, Head of ITF). These panels review cases of CYP who are persistently not attending school and decide what provision they will receive, including home tuition for those with medically diagnosed health needs (including mental health). The researcher also met with the Home School Liaison Officer for a specialist provision in the authority for Year 11 students who have struggled with attendance throughout secondary school. Finally, consultation was made with the operational managers of ITF and the coaches themselves at a team meeting, to better understand what direction of research would be most helpful and relevant to them. The aim was that the research reflected questions that were being asked more widely within the authority.

Following the research, a report was made back to ITF at a team meeting, and a written summary of the project was provided to the local authority. It is hoped that the research can ultimately help to inform future intervention through local authority policy development and the production of a guidance document and an assessment tool by the EPS. The *catalytic validity* of the research process, in its ability to reorient, focus and energise participants, remains to be seen.

3.9 Ethics

This study was considered to meet appropriate ethical standards by the Tavistock Research Ethics Committee (TREC) and a copy of the approval letter can be found in Appendix I.

A request was made to the manager of ITF and the coaches themselves by e-mail and subsequently at a team meeting. At this team meeting, the coaches were asked about their opinions on the direction of the research and were invited to contribute to this. The final research questions were therefore guided by what the coaches themselves felt they would like to explore. An arrangement was made to feedback the results at the end of the research. This allowed an element of reciprocity and mutual benefit in participating.

All participants were provided with an information sheet which included information about: the researcher; the sponsoring institution; the purpose of the research; a guarantee of confidentiality; assurance that participants could withdraw at any time; contact details for any questions; and information about the level and type of participant involvement and the benefits of participating. Participation was voluntary. All participants signed a consent form and were reminded of the right to withdraw participation at any point. The information sheet and consent form can be found in Appendix J and K, respectively.

All discussions about individuals were anonymised by coaches to protect the identity of the CYP involved. All the collected data was anonymised, treated as confidential and has not been made available to anyone except the researcher and the research

supervisor. Once collected, all data has been held on an encrypted laptop and will continue to be kept for a period of 10 years as recommended by Sieber (1998).

There was an indirect risk that the identity of the CYP and their families might be known through reading the contextual information. However, once the data analysis was performed, the findings were organised generally and thematically, to minimise the risk of identification of individuals and their specific contributions. A summary of these findings can be found in the following chapter.

4.0 Findings

4.1 Introduction

This chapter will describe the grounded theory of family coach intervention in PSNA that emerged from this study. The theory aims to answer the first two research questions that were set out in chapter 2.0:

- 1.** What are the perspectives of coaches on their work with persistent school non-attenders?
- 2a.** What do coaches perceive to be the factors influencing the successful reintegration of CYP to school following a period of PSNA?
- 2b.** What do coaches perceive to be the constraints operating to prevent the successful reintegration of CYP to school following a period of PSNA?

A grounded theory is defined as, "...an explanatory scheme comprising a set of concepts related to each other through logical patterns of connectivity" (Birks and Mills, 2014, p. 112-113).

Strauss and Corbin (1990) specify that the "theory" is expressed through a storyline that employs "descriptive narrative about the central phenomenon of the study." They proposed a coding paradigm consisting of five elements:

1. The central phenomenon that is the focus of the study.
2. The causal conditions that contribute to the phenomenon.

3. The context in which the phenomenon is embedded.
4. The actions and interactions taken by people in response to the phenomenon.
5. The consequences of those actions and interactions.

(Strauss and Corbin, 1990)

The grounded theory that emerged from this research is organised in terms of these five interacting elements, and can be found illustrated diagrammatically in figure 4.1. Figure 4.2 summarises this theory in the form of a brief descriptive narrative. The theory is then described in detail, taking each element in turn, and illustrated with direct quotes from the transcripts. Where an axial code is referred to, this is highlighted in bold.

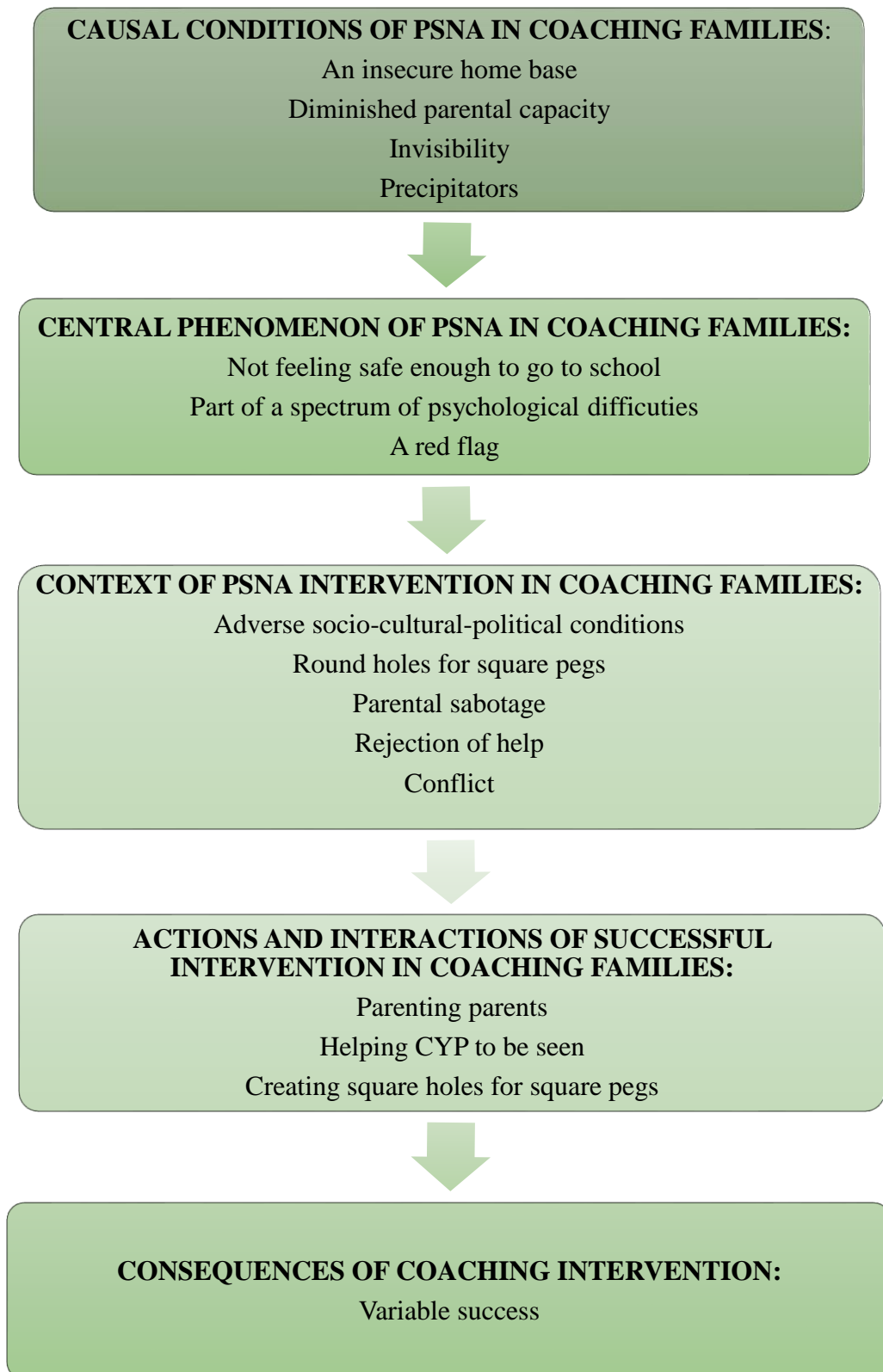


Figure 4.1: The theory of family coach intervention in PSNA (diagrammatic representation)

In coaching families, PSNA is felt to be a ‘red flag’ and occurs when a CYP feels unsafe. It is one of many associated signs that the wellbeing and physical and mental health of the CYP is suffering. In the majority of cases, this feeling of being unsafe is a product of the home environment not providing a secure base, parents having a diminished capacity and the CYP feeling that their situation is invisible to others. Additional precipitating factors, such as problematic peer relationships, adolescence, secondary transition, and having ASC exacerbate this, but are not enough to cause PSNA on their own.

Successful intervention occurs when the CYP is helped to feel safe. Family coaches have done this by parenting parents to build their capacity. They have also carefully noticed CYP and made their needs visible; including helping to make adaptations to the CYP’s educational provision to create a ‘square hole for a square peg’.

Intervention must overcome inflexible systems that are resistant to change. Socio-cultural-political systems, such as the class system, may be averse to the CYP feeling safe, because of inequities or limitations in the distribution of power and resources. The school system may rigidly adhere to policy or prioritise a conflicting agenda. Parents may sabotage the coaches’ efforts to make changes to the family system. CYP themselves often reject support. Conflict between diverging systems must be managed for intervention to be successful.

Due to the powerful resistance to change, coaches are not always able to sufficiently support lasting change and success is variable.

Figure 4.2: The theory of family coach intervention in PSNA (narrative representation)

4.2 The Central Phenomenon of PSNA in coaching families: *Not feeling safe enough to go to school*

In coaching families, PSNA is felt to be a ‘red flag’ and occurs when a CYP feels unsafe. It is one of many associated signs that the wellbeing and physical and mental health of the CYP is suffering.

The central phenomenon in PSNA is that CYP in coaching families are **not feeling safe enough to go to school**. Coaches described young people who were “*incredibly fearful*” [FG1:13]; for their own well-being, that of a parent, or of the family as a whole. The fear manifested in different ways; one child was scared of “*being left alone*” and “*just afraid cause he knows something’s wrong*” [FG1:13], another of “*being sick at school*” [FG3:193]. One young man was afraid of “*big groups of people, loud noises*” [FG1:17] and a second was “*frightened of what might happen if he’s left (alone)*” [FG1:67]. Another young man had talked openly with one of the coaches about his experiences of “*being scared, and witnessing DV with multiple partners.*” [FG2:94]. The effects of this were twofold. The feelings of being unsafe and afraid were felt to impact negatively upon the CYP’s levels of resilience outside of the family home, as well as causing a high level of anxiety when separating from the home.

“...at the point I came in there was a little bit of improvement at some, at one point. Looked like we were getting somewhere, and then a new partner came, mum had a new partner who moved in very quickly. And there was a question mark over his safety really. And, um, it just became total school refusal. And I think that given, what I really learnt from that was how if a young person feels unsafe, and feels like their mum is gonna be unsafe, um, and there are attachment issues that have never really been looked at. Or, um, the primary carer is in no position to kind of, is not in the right place to, to rebuild them or offer nurturing, or, or safety, there’s just no way they’ll go back. And I really remember feeling like there’s nothing that can be done here, because it was like an elastic, you know, band, back to home again. [Sarah, FG2:94]

PSNA is therefore felt to be a **red flag** or a potential marker of difficult conditions surrounding the family; a coping mechanism that appeared to be justified from the perspectives of several of the coaches, given the tough circumstances that might be in effect at home. Out of necessity, CYP were felt to be prioritising difficult conditions at home over their education, and there was a high level of consensus that any attempts to address PSNA would be *“almost impossible”* [FG2:94] unless these issues were addressed first. The initial trigger for PSNA appeared to be variable, but coaches felt that problems occurring at home were *“always an aspect”* [FG3:23]; *“interconnected”* like a *“spider web”* [FG3:24;16] and the reason why the situation often felt so *“stuck”*. [FG3:23]

“...given the scenario of that family at that time... would you be thinking, you know, if you were staring at your skeletal mother in the corner, who’s emaciated. What is your priority? (...) ...you can get used to seeing school attendance, school attendance, school attendance, and there’s a million and one reasons for that. Many of which, as a worker, you think are justified.”
[John, FG1:123]

PSNA also appeared to be **part of a spectrum of psychological problems** rather than an isolated difficulty. Coaches spoke of PSNA in association with other markers of **poor emotional wellbeing**. CYP were described variously by coaches as “*insecure*” [FG1:13], tearful, anxious and “*very low in any type of confidence*” [FG1:77]. Working closely with CYP, it became apparent that, alongside PSNA, there might also be “*low self-esteem*” [FG1:98], very few “*strategies*” or “*tools*” [FG1:27] for self-help, “*lack of aspiration*” [FG4:39], and feelings of hopelessness.

“...he had shifting anxieties – so the thing that would cause an anxiety on one day, did not cause anxiety on another day. Something else that previously hadn’t caused anxiety was now causing anxiety.” [John; FG1:19]

Accompanying features of PSNA included various features of **mental illness**. Self-harm, suicide attempts, anxiety, depression, panic attacks, separation anxiety, periods of disassociation, bipolar disorder, pathological avoidance disorder and emetophobia were all talked about as co-existing conditions or diagnoses.

“... a really dark place, ...we used to call it ‘the tunnel’. And once he got into the tunnel, he used to find it very difficult, and didn’t have any tools to get himself out of the tunnel. ...and that tunnel led to him... trying to take his own life.” [Marie, FG1:27]

CYP might also be experiencing **somatic symptoms**, such as disrupted sleep cycles or insomnia, “*stomach pains or headaches*” [FG1:49], tiredness and migraines. One coach described a young man that had “*become nocturnal (...) up most of the night...*,”

and sleeping in the day” [FG1:79]. Coaches noted that with health conditions, there could be *“a space between (...) what was real and what wasn’t real.”* [FG2:7]

Some of the CYP were also demonstrating **aggression**; *“looking for fights”* [FG2:113], being *“very, very violent”* [FG1:67] towards parents or professionals, behaving in a controlling way, *“getting in trouble with the police”* [FG1:99] or exhibiting other types of *“risky behaviour”* [FG2:9].

The phenomenon tended to be part of a *“long history of poor school attendance”* [FG1:17], with problems dating back to when CYP were *“very, very young”* [FG1:94], certainly to the beginning of primary education and *“throughout”* their *“school career”* [FG2:94]. Attendance was variously described as *“sporadic”* [FG1:13], *“super-low”* [FG2:94], and *“consistently” “very late”* [FG2:3].

Sometimes younger children had been physically forced to attend, *“being carried”* into class *“in...pyjamas”* [FG1:13], or teenagers would simply *“walk out of school”* and *“never go”* [FG2:151], *“totally refusing”* to attend [FG4:208]. PSNA, regardless of the individual circumstances, did not appear to the coaches to be a state associated with wellbeing, nor was it an isolated or disconnected event.

“And when you talk to any child over the age of 11, there’s a huge amount of history that’s gone on” [John; FG1:103]

4.3 The Causal Conditions of PSNA in coaching families: *Factors causing CYP to feel not safe enough to go to school*

In the majority of cases, this feeling of being unsafe is a product of the home environment not providing a secure base, parents having a diminished capacity and the CYP feeling that their situation is invisible to others. Additional precipitating factors, such as problematic peer relationships, adolescence, secondary transition, and having ASC exacerbate this, but are not enough to cause PSNA on their own.

4.3.1 An Insecure home base

The coaches spoke of family homes that did not provide CYP with an adequate place of safety and security. They described **chaotic or neglected home environments**, or family life where there was a **risk of physical or emotional harm** to the CYP. This included situations where there was: hoarding in the family home; a large, complex or blended family structure; family members (including siblings or grandparents) with complex mental and physical health needs or alcoholism; and child protection concerns, including **emotional abuse**. Coaches spoke of feeling shock and concern on discovering the home circumstances of some of the CYP on their caseloads.

“Um, so, we cleared the room and there was kind of pockets of rooms, constructed from cardboard and there were budgies over one end that I’d never seen before! And, and it was dense. And there was a lot of faeces, so they had dogs, there was a lot of animal faeces. But then it was obvious that, that they were also using it as a toilet, and there was a chair that we uncovered that he played video games in, and it was kind of saturated with urine.” [Viv, FG 2:15]

Coaches described homes that provided “*an unsafe environment to live in*” [FG2:29], where there could be “*massive amounts of neglect*” [FG1:61] including the presence of “*animal faeces*” [FG2:29], “*piles*” of stuff and “*lots of animals*” [FG2:31].

Homes were described as “*messy*”, “*disorganised*” and “*dirty*” [FG2:31].

There might also be exposure to “*really serious domestic violence*” [FG1:39], “*with lots of different partners*” [FG2:94] and “*lots of change*” [FG1:73]. One family had moved “*something like 18 times*” to flee domestic violence [FG1:39]. Several of the coaches also spoke about CYP feeling **fearful for a parent’s safety**, which was a strong pull for them to stay at home. **Domestic violence** in the home was a marked feature of this fear; a common feature of many of the families, both currently and as part of the family’s history.

“At one point, he talked really openly about his experiences of being scared, and witnessing DV [domestic violence] with multiple partners. And what it was like for him to see that and feel that. ...and the change, having to deal with the changes of having different men in the house, and what that was like for him as a boy. [Sarah, FG2:94]

Families appeared to be “*very, very chaotic*” [FG2:56], often characterised by parental separation and an atypical family make-up, for example siblings with different biological fathers or CYP being looked after by grandparents. Coaches observed that it was a challenge for some families simply to “*function day to day*” [FG3:182]. An unsafe home life led to many of the coaches feeling that a CYP should have been taken into care. In one case a coach spoke of the home being “*just so horrid to be in.*” [FG2:31]. Another coach spoke of a young man who had “*been told*

by his father his whole life that he was no good” [FG1:77]. One coach spoke of a girl, whose mother was an “*alcoholic sex worker*”:

“She should have been in care, without a shadow of a doubt. Home was so unsafe. ...I’d go round and mum’s face would be pouring with blood, and a client had just left, and she’d be out of it.” [Viv; FG2:111]

Poverty was a notable factor in increasing the instability of family life. Coaches spoke of families managing debt and subsequently living in “*terribly overcrowded*” [FG4:49], sub-standard or insecure housing. Houses might have “*so much damp*” [FG4:243] to be “*just...shocking*” [FG4:242], for example. The practical aspects of poverty, such as having to use food banks or proving disabled status in order to collect benefits, were marked features of many of the families’ lives. The management of these practicalities would be a high priority within the family, clearly and understandably, overriding school attendance.

“There’s a family that... I was working with some time ago, who used to have their week structured into, this is our food bank day, and that was the priority on that day, and that could be the only priority that they could manage. So, that day would definitely be a day when people wouldn’t probably go to school, because it wasn’t the priority.” [Ellen, FG4:49]

4.3.2 Diminished parental capacity

Closely linked to the concept of the insecure home base, **diminished parental capacity** was another causal condition about which the coaches spoke. It is important to note that the coaches were not motivated to ascribe blame, but rather to highlight the myriad of reasons why a parent might be unable to fulfil adequately their role as an authority-figure. The most highlighted failing in terms of the parenting role was a **lack of boundaries**. A situation that was felt to be due to parents *“just totally unable to assert themselves as having authority over the kids.”* [FG4:91]

“It was just, what this girl needed at the end of the day was a parent to say, this is what is expected of you. ...there is a requirement that you go to school. It was this idea that it was kind of presented as a choice.” [Ruth, FG1:53]

Coaches felt that this may have been the result of parents’ own poor experiences of being parented, or where they felt *“scared to challenge”* their child, one parent being *“very used to the young person telling her what to do”* [FG3:211] and another who *“would always back down”* [FG4:150]. It was felt that this might be associated with feelings of parental guilt about denying a child the few freedoms and luxuries that they were able to provide in an otherwise difficult set of life circumstances, such as unlimited access to screen time and high fat, sugary foods. Screen time, in particular, was noted to have been used early on in families *“as a kind of dummy”* which *“becomes a monster”* in that many families had *“really struggled with regaining control”* [FG4:18]. Some parents were generally felt to have **low confidence**, lacking in the skills and experience necessary to enable them to be assertive and authoritative; perhaps in association with **learning difficulties**.

“...some parents you look at, it’s almost like you’re dealing with children, because they haven’t got any of those skills. They’ve gone out there without the education, without any role models, without any sort of guidance on how to deal with what is a complex world.” [Reuben, FG4:53]

Other parents were felt to be dependent upon their children to some degree, perhaps because of the isolation of being a lone parent. One coach described a school where there seemed to be a “*big issue*” with “*single parents, wanting the children to be at home, just for that company*” [FG3:234]. Relationships between parents and children were therefore felt to exist on an equal basis, rather than hierarchically, making imposing rules and routines much more challenging. The dynamic of one parent and child was that “*they had always been friends*” [FG2:94]; a sentiment echoed by another coach who spoke of the “*blurred boundary*” between parent and child, sometimes seeming more like siblings or where a parent was reliant upon a child for “*support*”. [FG3:234]

“It was a sort of co-dependent relationship where mum would often feel not well and so she’d keep the daughter at home to look after her, and then sometimes she’d make it very sort of cosy and nice, and they’d sit in their dressing gowns all day and watch television...” [Jenny, FG1:49]

Diminished parental capacity was also felt to be the result of **poor physical or mental health**. Coaches spoke of a wide-range of “*significant health needs*” [FG4:34] in the families with whom they had worked, and cited this to be a “*very, very strong feature*” [FG4:60], frequently referring to conditions like chronic fatigue syndrome, depression, anxiety, chronic back or joint problems, agoraphobia,

fibromyalgia, or obesity-related illnesses like diabetes. Managing medical appointments, drug regimens, and the “*complications and side effects from prescribed drugs*” where parents were “*taking a whole cocktail of drugs to deal with different problems*” was felt to be an “*absolute nightmare*” [FG4:72], and would take considerable time and energy. This was also the case with obtaining diagnosis in several cases, where the condition was positioned at the boundary between a physical condition and a somatic expression of psychological pain.

Some parents were simply felt to be **overburdened** with numerous dependents; “*squashed in the middle*” [FG4:32] between looking after, sometimes “*four*” [FG2:151] or “*six*” [FG1:39; 1:156] children, and looking after their own parents who were “*struggling*” and “*rather a drain*” on resources [FG4:32]. Coaches spoke of difficulties relating to “*the practicalities*” of getting children to “*three different...schools*” [FG2:151], for example, or the logistics of managing complex family lives without any support. One coach described her experience of parents who had so many challenges to “*face day to day*”, that responding to another challenge, such as “*to get children dressed in a cold damp house in the morning*” would simply be “*too much to overcome*” [FG4:56]. Another coach described a mother trying extremely hard, but having to work very long hours to manage financially, which impacted significantly on her availability as a parent:

“...she’s a single parent, (...) so she has to work all hours... to be able to meet rent and other costs. ...she doesn’t get back from work until 8.30 at night. So, this young woman, ...between 3.30 and 8.30, she’s left to her own devices.” [Anna, FG4:113]

Short-term thinking was also felt to be a factor in diminished parental capacity, whereby managing in stressful circumstances took up all of the available thought and energy, precluding any ability to think in the medium or long term. As well as poverty being an important driver in short term thinking, parents managing drug or alcohol addiction also fell into this category, thinking only about getting through each day at a time. This made it difficult for coaches to support parents to put in unpopular boundaries on the promise of longer term gains, or to engage in thinking about the longer-term benefits of education.

“...how can you... plan? How can you be strategic? How can you think strategically? How can you think long term if you’re constantly living from one... dole check to the next? [Bill, FG4:48]

“Substance misuse, is one that I’ve come across a lot... (Parents) can set themselves up a timetable for when they do and when they don’t, and who’s gonna take the kids... ...and that can take a bit longer to impact on the education, but in my experience, it does usually impact at some point. (...) Because at some point their timetable would slip up. You know, one of them would be having their time to be out of it, and fall asleep on the bus and end up going round the loop and not getting up to pick the kids up... or mum’s time to take was usually in the morning, dad wasn’t quite ready to come down enough to get them into school...” [Naomi, FG3:54]

One coach described her discussion with a couple about paying a fine for non-attendance, within the context of being *“in a bad financial state”* where they had decided to not to continue payments and *“just...get taken to court”*. The stress and additional fines for late payment *“didn’t mean anything”* because the survival strategy was simply to delay and *“think about it later”* [FG3:313].

In relation to the concept of diminished parenting, coaches discussed that a key motivating factor for CYP with PSNA, seen in the cases they had experienced, was the, perhaps unconscious, desire to punish parents. PSNA being one of the most powerful ways to do this in a child's limited span of influence. One coach described a young man who seemed to be trying to make a point to his separated parents but returned to school once he felt they had adequately recognised that he was "*pissed off with them*" [FG4:125]. Another coach described a girl who was keen to go to court to see her mother prosecuted for her poor attendance. The coach felt that she had gone to watch because "*...there was some sense that she wanted her mum to be punished.*" [FG2:157]

"...not going to school's a fantastic way... to kick the parents in the teeth."
[Jamie, FG3:77]

4.3.3 Invisibility

Invisibility was another causal condition spoken about by the coaches. CYP were described as frequently being **missed, overlooked, or lost in the system**. This manifested in several ways. Perhaps the CYP was a member of a very large, blended family; overshadowed by the competing needs of others. Perhaps the family were experiencing profound difficulties, about which the CYP was being kept in the dark; in one case where a parent was “*very ill*” with cancer and within the family there was “*so much unspoken*” [FG1:13].

Some CYP were felt to “*slip through the net*” [FG43:370]. They might, for instance, be falling just short of the thresholds necessary to access services for mental health or safeguarding, or failing to be noticed at school because they were neither excelling, nor presenting with challenging behaviours. One girl had been described by a head of year as “*just not on our radar*” because her problems were not overtly visible [FG1:99]. Another young man, who had attempted suicide, had experienced problems accessing support from mental health services, who “*didn’t return the family’s phone calls*” so that “*it felt to him like there was nobody there*” [FG1:35].

“*...he was actually really easy to engage with because I think he was desperate to talk to somebody.*” [Viv, FG2:21]

CYP who felt more suited to a practical curriculum, might also feel *lost* in an education system that focused heavily on more academic aspects of the curriculum, or those on transition to a large secondary school, might feel less able to form

relationships with staff. Coaches described CYP who came out of school “*feeling like an idiot*” [FG3:605] because of a lack of understanding and appropriate support.

Another young man simply “*wasn’t very confident at saying to the teachers what the problem was*” which led to him being “*just lost in the system somewhere*” [FG1:7].

Communication barriers exacerbated this feeling of invisibility. CYP feeling unable to speak to adults about bullying, for example, or parents and CYP not communicating well. In extreme cases, CYP might be “*primed to hide*” [FG3:70] family dysfunction from social services. This resulted in a common feeling for the CYP of “*not being listened to*” [FG3:91], of “*nobody...listening*” [FG3:85] or “*not being noticed*” [FG3:93].

“...he’d been very badly bullied... when he was at school, and didn’t tell, the school absolutely weren’t aware of it. He didn’t tell anybody.” [Jenny, FG1:81]

Associated with this, coaches described a second motivating factor for CYP with PSNA as a **need for exposure**; to draw “*attention*” [FG3:73] to themselves or their difficult situation and to regain some degree of “*power and control*” [FG4:123].

“I was just thinking about my cases, and I think I’ve had a number of boys where there’s, it’s been, not going to school because... they’re not being noticed. They’re being, it’s almost their protest, it’s what they can do, it’s a sort of silent protest. I’m just gonna stay in bed until people realise that I’m not happy. And that, and no one’s listening to me, no one’s giving me attention... And so, I’ve had a number of cases where... they’re not... aggressive. They’re not gonna go and kick off and have fights, and... It’s just an introverted way of, I’m just staying in bed and I’m not gonna tell anyone why.” [Phil, FG3:73]

4.3.4 Precipitators

Along with the three major causal conditions outlined above, there were a number of precipitating factors identified. Coaches felt that these were not usually problematic when they existed in isolation, but could act as a trigger when the other causal conditions were present. Precipitating factors included being in the period of **adolescence**, making the **transition to secondary school**, where “...vroom, you’re in a massive new school, everything’s changed and you can’t cope” [FG3:390] and having a **health or developmental condition**. **Autism spectrum condition** was specifically noted.

“... I can’t think of a case where there’s (a) really, really supportive... parent set up, and... everyone’s really on it, but the young person’s still not going to school. (...) I think there are other reasons why children don’t go to school, anxieties, bullying, fear..., ...poor academic... abilities. I think there’s lots of reasons why, but... the problems occurring at the home is always an aspect of that.” [Phil, FG3:8]

Problematic relationships with teachers were also noted by the coaches as a factor, for example one girl feeling that a “*teacher didn’t like her*” [FG1:49], but this was rare as compared to **problematic peer relationships**. “*Getting bullied*” [FG1:3] or being “*completely rejected*” [FG1:77] by peers was the most common feature of this, with some friendship groups described as “*insecure*” and “*difficult to negotiate*” [FG4:175]. One coach noted that CYP could “*feel very visible, but for the wrong reasons*” at school, where any mistakes or differences were immediately noticed [FG4:175]. Another described a young man who struggled with “*social anxiety*” and “*didn’t want to be round other kids*” at unstructured times of the day [FG1:7].

CYP were also described as being influenced by their peer group into truanting or drug-use, and spending time out of school as part of an intimate relationship, one girl *“staying at her boyfriend’s all the time”* [FG2:151]. This related back to home not providing a secure base; coaches suggesting that the peer group or boyfriend sometimes acted as a substitute where a sense of belonging was absent at home:

“And there were a peer group saying, don’t go to school, truant with us, and the appeal of that and the sense of belonging and the structure in the peer group – also the consistency of the peer group being there every day because they were consistently off as well. That was probably the most stable part of her life, that was why she was attracted to them...” [Ruth, FG1:59]

4.4 The Context of PSNA intervention in coaching families: *Systemic resistance to change*

Intervention must overcome inflexible systems that are resistant to change. Socio-cultural-political systems, such as the class system, may be averse to the CYP feeling safe, because of inequities or limitations in the distribution of power and resources. The school system may rigidly adhere to policy or prioritise a conflicting agenda. Parents may sabotage the coaches' efforts to make changes to the family system. CYP themselves often reject support. Conflict between diverging systems must be managed for intervention to be successful.

4.4.1 Adverse socio-cultural-political conditions

Coaches spoke frequently of the wider context in which their work was embedded. They felt that they were working against powerful exosystems in their endeavours to address PSNA. Coaches described having to work with other, **ineffectual services**, in a context where there was a general **inadequacy of available resources**. The issues experienced were felt to be linked to governmental policies, for example cuts to welfare, which limited the scope of services and made it more difficult for other professionals to work effectively, or to intervene in a timely fashion where there might be lengthy waiting lists.

“...I’ve got cases at the moment where it’s an 18-month delay, I would call it, rather than a waiting list. (...) (Names a charitable organisation) for instance, there’s over 70 kids on their books, new referrals all the time, two-part time workers, no funding. The list goes on throughout all the services.”
[John, FG1:103]

Coaches described circumstances where their referrals to social services, due to safeguarding concerns, were not being “*picked up*”, the effect of which was “*legitimising what goes on*” and sending the message to parents to “*carry on*” as though the behaviours were “*ok*” [FG2:141]. In other cases, social workers had “*never got in the door*” and had subsequently “*never done anything about it*” [FG2:111]. Limited resources meant that one young man waited “*two months*” to get “*some form of intervention*” from a mental health service following hospitalisation for a suicide attempt, having been told that initial contact would be “*within three days*” [FG1:27].

Services were variously described as discharging CYP prematurely, “*fractured*” [FG3:156], not persisting when the family had been challenging, withdrawing support because of non-engagement (“*three strikes and you’re out!*” [FG1:81]), and erroneously judging that the situation was “*good enough*” [FG3:345]. CYP were felt to have been “*let down*” by services who had been unable to get “*to the root of what’s going on*”, leaving them “*really, justifiably, furiously angry and resentful with professionals*” [FG2:119]. One coach described a local mental health service as “*an embarrassment*” [FG1:29]. This context left coaches in a difficult position at times, where they felt they were trapped in an “*anxious observation*” role, watching families in difficult or unsafe situations and lacking the ability to do anything about it [FG2:135].

“I think, at the risk of sticking my neck out... having come from the social work background, we’re now reaping the ‘rewards’ of decisions that were made when these kids were younger; much younger. (...) not enough preventative work... (...) generational neglect by services, almost.” [Naomi, FG3:119]

Another inadequate resource in the context of coaches' work, was poverty of housing; currently a national problem, as well as one specific to the city in which this research takes place. Insecure housing, work and finances contribute to a family's feelings of being *unsafe* but are very difficult to address within the context of coaching work. Inability to help families in a meaningful way could be undermining in terms of coaches' efforts to build relationships. The result of one coach's impotence in finding housing for a father who "*was going to be homeless*", was that "*he completely disengaged*" [FG1:75].

Coaches also voiced their own frustration with the limits placed upon their own service in terms of time and the point at which referrals were made to them. Time limits on their involvement could prevent effective relationship-building with families. Several coaches agreed that families were referred to them "*far too late*" [FG2:200;1:69], which made the description of their service as "*early help*", "*patently not true*" [FG1:101].

Class discrimination, or the inequality of the class system, was also felt to be a contextual constraint. Families with a lower socio-economic status were felt to have an "*inherent powerlessness*" and to have less of a "*sense of entitlement*" [FG3:297] than "*affluent parents*" who were "*more vocal in challenging*", therefore ensuring that they accessed services "*a heck of lot quicker*" [FG1:151]. A lack of "*social connections*" for support or advice was also felt to be a factor, leaving those "*struggling*" alone in poverty at "*a huge disadvantage*" [FG3:321]. Coaches also noted that the fine system was not adjusted to take into consideration household

income, thus “*it penalises poorer families to a far greater degree*” [FG1:159].

Having money was noted to be “*empowering*” allowing families to buy “*influence*” [FG3:300].

“I’ve seen people with a greater education, advocate for themselves, in a better way. Put up a better argument. (...) But someone with... perhaps a lesser education, might become angry, whereas someone with a greater education might become assertive. I think that’s, that’s the let-down, they let themselves down when they become angry because services stop listening.” [Jamie, FG3:307]

Cultural values were also noted to be a powerful constraint in the context of PSNA intervention. Wider societal values were felt to scapegoat poorer families, treating them with “*mistrust*” and “*blame*” [FG4:81]. Some professionals, for example, were felt to mislabel someone out of work or on benefits as “*a shirker*”, feeling that there was a complete lack of understanding about mental illness; that they should “*snap out of it*” [FG4:80-83].

At the same time, working with a family within an “*impoverished community*” was felt to bring an additional challenge for coaches wanting to “*empower people*” because of embedded attitudes and structural barriers [FG1:112]. Some communities,

with an established history of low employment, were felt to take the resolute attitude that education had no real value to them.

“And there’s no value placed on education, because it’s never; what’s it ever done for me? And I’ve always got by. I mean, you find families like this in towns and cities across the country. ... what we’re often looking at is... generations of... unemployment and or precarious employment... That’s a new thing. Coz in the past... there’d always be work there. You know, and I think that’s... been missing for the last thirty-odd years.” [Bill, FG4:38]

4.4.2 Forcing a square peg into a round hole

Where educational provision did not match the needs of CYP appropriately, this created an additional contextual constraint to intervention. Coaches were figuratively **forcing a square peg into a round hole**. **School size, ethos and management** could all present difficulties, particularly at secondary level.

Sometimes it was simply the size of a secondary school that presented as an obstacle for an anxious CYP, with secondary schools being described as *“very scary places”* [FG4:176] and CYP described as *“just overwhelmed by the thought of going into the big secondary school”* [FG4:13].

“I sometimes feel, myself, uncomfortable when I go into a school. If I feel like that, then imagine that for ... a timid young person.” [Ellen, FG4:176]

There was also felt to be a *“huge amount of variation”* [FG1:107] in how supportive schools could be, sometimes depending upon the particular member of staff allocated as the key point of contact for a CYP with PSNA. Coaches had experiences of staff showing a very shallow understanding of, and lack of training about, the issues facing the CYP in their care, such as domestic violence or abuse. This could lead them to *“put their own personal judgements”* onto a family *“rather than understanding”*, which was felt to be *“very frustrating”* [FG2:77]. Sometimes the link person was felt to be inappropriate in terms of their position and remit within the school, which led to *“really limited”* conversations where it was *“difficult”* to *“build a plan”* [FG2:151].

School ethos could be problematic when an *“impatient”* and directive *“I’m telling you this”* approach was taken with families, conflicting with the coaching approach. [FG2:75]. One parent, for example, described a setting that she visited as *“condescending”* [FG1:81]. Schools were also felt to be *“restrained”* by their *“boundaries”* and *“responsibilities”*, which prevented them from being aware of home circumstance; unable to *“see what’s really going on”* for CYP with PSNA [FG1:95] and focused exclusively on their educational *“targets”* [FG1:98]. This could result in a limited or unsympathetic view.

Where resources were scarce, there might be a lack of presence at meetings, poor pastoral provision, and staff not following through with promises. Schools might prioritise other pressures and targets over PSNA. One school, for example, felt that they *“couldn’t manage”* to accommodate CYP with additional mental health needs [FG1:39].

School systems varied, with some considered to be overly rigid in the universal application of rules. For example, in terms of uniform, one coach described unsuccessfully *“trying to get them to... make allowances”* for a CYP with PSNA who had managed to attend school but had *“come in trainers”* and was therefore facing a sanction [FG4:179]. This **inflexibility**, or the inability to adapt to individual needs, was a specifically noted feature of the school context.

“I’m just thinking about the rigidity of the secondary school structure ...and how that really doesn’t suit some kids and young people... because of the family. Because in primary school, it seems to be, you know, you’ve got that more nurturing environment. You’ve got your one teacher, you’re one go-to person ...and I know the kids are younger but attendance seems to be more manageable. Whereas as soon as they go up to secondary, it’s a completely different set up. ...and I think... that doesn’t help, sometimes, getting kids re-engaged, and making them feel connected and safe.” [Anna, FG4:11]

Coaches felt that the *round hole* of an unwelcoming school was particularly affected by **current education policy**, which focused upon an almost exclusively academic curriculum and imposed challenging targets upon schools to achieve good results.

This was felt to constrain the actions of schools in terms of flexibility for the individual, and to limit the educational offer for those CYP who were more motivated and comfortable with a practical, *hands-on* style of learning. One coach commented that *“for these kids... our model of schooling, does not suit their model of learning and needs”* [FG4:220].

“...for those YP that have got a low self-esteem, making schools so academic and taking away creativity, is fundamentally the worst thing. And that is not helping us at all.” [Marie, FG1:98]

“...some people just don’t get that, sitting in a classroom, listening... (...) If you’re the class clown, go to clown school, you know! [laughter] Really, if you’re, I’ve got children like that. Find something that they’ll then be good at.” [Lily, FG3:602]

4.4.3 Parental Sabotage

Parental sabotage was another example, in the context of PSNA intervention, of strong resistance to change. Sometimes it was felt that parents were in such an unsafe place themselves, for example sex working or managing drug or alcohol addiction, they were simply unable to engage or accept help at all, let alone form a trusting relationship with a coach. Other parents felt comfort or safety in things remaining the same, fearful of any changes to what they had become accustomed, and were “*wary of professionals*” because of historical difficulties [FG2:94].

“Some people are really comfortable in what they’ve got. They might be asking for change, but that comfort of, of it staying the same, is really, really overriding.” [Naomi, FG3:249]

Parents might sabotage the efforts of a coach by putting up barriers to support, or actively exacerbating the issues. For example, parents might refuse to engage, miss appointments, behave abusively to professionals, encourage their children to stay off school, or exaggerate health issues. One coach, for example, spoke of a father who had “*just taken no interest, laughed, undermined everything as well*” [FG4:143]. Another spoke of “*entrenched families*” who had gained a reputation for being “*avoidant*” and “*abusive*” because they viewed professionals as “*the enemy*” [FG3:129]. Others described mothers who refused to role-model appropriate behaviour, one not even “*getting out of bed*” on a school morning [FG1:53], one turning up to meetings “*drunk out of her mind*” [FG2:113]. Coaches also spoke of “*disguised compliance*”, where a parent might only engage “*to a certain extent*”, for

example, ostensibly agreeing to something in a meeting, but having no intention of following this up [FG2:94].

“...she rings in everyday and says he’s got this, he’s got that, but can’t provide medical evidence. I mean it, that’s like so many of the cases that we’ve had. (...) I haven’t met with the family yet, but the school think that he might be getting lots of treats at home... (...) Bacon sandwiches and, you know, internet, and stuff... And it might be that mum doesn’t want him to be at school coz she likes him being around, and rewards him with films and things, so that they can do nice things together...” [Lily, FG3:36]

It was also suggested that parental sabotage might occur where a child’s PSNA was serving a purpose within a family system; parents would therefore be resistant, not always consciously, to change. One coach suggested that a mother might be “*scared*” for her son to go to school “*because of what might happen when he’s gone*” [FG3:39], suggesting either mental illness or fear of domestic abuse. The concept of **scapegoating** was discussed; where it was felt that unconsciously locating the family problems within the child served as a defence or coping mechanism, as it allowed parents to avoid seeing their own part in it. One coach said, “*they blame the young person*” because it is “*much easier*” than the parents having to come to the realisation that they “*actually may be a big part of this*” [FG3:254].

“...how can we expect a young person to change in a system that doesn’t want to change? Or continue to change, or stay changed.” [Sam, FG2:102]

4.4.4 Rejection of help by CYP

Rejection of help by the CYP themselves arose as a very common feature in the context of PSNA intervention. Perhaps because the PSNA was serving an important purpose in terms of addressing safety needs, CYP were reluctant to engage with anything that felt it might pose a threat to the status quo. Coaches found that CYP might initially agree to support but then not engage with this at all, or display disguised compliance, where they went along readily with suggestions for ways forward in conversations, but never actually carried these out in practice. Some CYP would completely refuse to engage at all; remaining mute, pretending to sleep, refusing to come out of their bedroom, refusing to give permission for referrals, or becoming verbally aggressive.

“So, we did a home visit and whilst at the home visit you could tell that the behaviour of this young man was: I don’t want you to come back. So, he got his dog to be very aggressive in front of me, which actually was quite frightening. (...) ...I have never quite met a young person that was so unreachable. Completely.” [Marie, FG1:67]

“The hardest one I ever had [laughs]; he was totally silent. (...) And, I couldn’t, there was nothing I could do with that one. He’d sit there... eyes closed, ...head like this (to one side). Just pretending to be asleep. Just a total wall!” [Jamie, FG3:200]

Coaches described this withdrawal as universal to any profession or service attempting to engage with them. CYP, for example, might also refuse medical help, miss appointments with mental health professionals, ignore e-mails from career advisors, or speak dismissively of education, seemingly suppressing any personal aspirations. The terms “*unreachable*” and “*powerful*” were used by several of the coaches to describe this level of rejecting behaviour [FG1:73; 1:69; 1:79].

“He went to two appointments at (names mental health service) and then he completely stopped going but he will not answer why or anything like that. And he’s ...quite powerful in that he closes his eyes or pretends to be asleep or faces the wall. He will never engage in discussions. (...) ...when I go there he is either asleep or pretending to be asleep, and he will not engage with me at all.” [Jenny, FG1:79]

4.4.5 Conflict

Conflict was a key constraint in the context of the coaches' work to address PSNA. This manifested in a variety of ways. Families might experience uncoordinated or **dislocated support** from services. There might be a lack of trust or **strained relationships** between professionals, schools and families. Where services felt overstretched they might engage in the practice of **passing the buck**, trying to shift the responsibility for a case onto another service. All of these aspects of conflict had the potential to sabotage success and needed to be carefully managed.

Disjointed or "*fractured*" [FG3:156] support was seen where there was "*poor communication*" [FG1:165] or even "*communication breakdown*" [FG1:53]. This occurred between professionals, who might be taking differing approaches, within schools where support was "*inconsistent*" [FG1:59] or unreliable, and between professionals and parents. Coaches had seen the detrimental effects of professionals and services working in contradictory ways; including wasted time and resources, and lost information. In particular, this was noted as an aspect of the prosecution system; cases might be "*thrown out of court*" [FG2:175] at an advanced stage in the process, because the circumstances for prosecution were felt to be inappropriate. Coaches also noted cases had "*gone backwards*" when a school did not appear to "*value*" their work, failing to attend meetings or "*respond to e-mails*" [FG2:91] or "*chopping and changing*" their approaches too quickly [FG1:53].

Where the "*bridge*" between home and school had "*broken*", this was felt to cause unnecessary distress to parents [FG2:168]. Often, this centred around the school's

decision to fine a family against the coaches' judgement because it "*torpedoes everything else constructive and... sinks it*" [FG1:147]. This would put coaches into a difficult position, having to mediate and rebuild trust where "*the relationship*" had "*completely broken down*".

Coaches described how conflict between families and schools could completely undermine the message about attendance, with parents becoming "*angry*" [FG1:81], or "*frustrated*" [FG1:21], and "*bitching about the school in front of the child*"; presenting school as "*the enemy*" [FG1:172]. Coaches also witnessed staff at schools "*treating*" a parent "*like another student...just preaching at her*" resulting in "*tears afterwards in the toilets*" [FG2:83]. Mistrust also extended to one parent's chronic back pain, which school staff were "*quite open*" that they "*thought he was faking*" [FG4:78]. Blame might be firmly allotted to the other side, thus temporarily relieving each party of the burden of responsibility, longer if a formal complaint was made. One coach spoke of a parent who had made a complaint "*to the ombudsman - she's taking it right up to the highest it can go*" [FG1:29].

"There was a big disparity between ...school saying that it was down to mum and mum saying it was down to school." [John, FG1:17]

Passing the responsibility was a commonly seen occurrence. Sometimes this was an issue of professionals “labelling” a parent and saying that “*it was down to her and her behaviours*” [FG1:23]. Other times it was schools asking coaches “*to become involved*”, then viewing it “*like it’s us to deal with it*” rather than understanding that “*they need to be working alongside us*” [FG1:88]. With overstretched services, like social care, there was seen to be reluctance to take on any case where there was a possibility that it could be under another service’s remit:

“...there was... a high level of social care need. But... children’s social care would just say ‘adult social care problem’, adult social care would say ‘children’s social care problem’. Yeah, they spent a long time doing that.”
[Sam, FG2:30]

Sometimes the coaching role led to “*incredibly conflicting*” feelings for the coaches themselves [FG2:77]. Coaches sometimes questioned the value of their role, working against systems and policies with which they disagreed, with increasingly limited resources, sometimes even doubting the value of school itself (“*people will be all right... if they don’t go to school*”) [FG1:117]. Coaches also worried that it could be “*a challenge*” not to over-empathise [FG4:194] or become subsumed into the family system. Collusion with families was something that coaches felt could arise; leading to the wrong “*messages*” “*around school attendance*” “*slowly trickling through*” to a CYP. The point about the “*importance of school*” might then “*get diluted*”, with PSNA seen as an understandable choice in difficult circumstances [FG1:135]. They noted that there was a need for regular self-reflection, to ensure that the right balance was being struck.

4.5 The Actions and Interventions in coaching families: *How coaches have successfully helped CYP to feel safe enough to go to school*

Successful intervention occurs when the CYP is helped to feel adequately safe. Family coaches have done this by parenting parents to build their capacity. They have also carefully noticed CYP and made their needs visible; including helping to make adaptations to the CYP's educational provision to create a 'square hole for a square peg'.

4.5.1 Parenting parents

As PSNA is felt to be a result of CYP feeling unsafe because of an insecure home environment and diminished parental capacity, it follows that the most successful intervention approach will involve developing and "*increasing parenting capacity*" [FG1:90]. In discussing successful casework, coaches agreed that "*building that confidence and capacity of parents*" [FG4:140] was one of the best ways of improving school attendance. The concept of being "*parental*" [FG2:56] towards parents relates to the level of careful judgement employed by coaches to gauge when parents were ready to make changes, how much support they required and what degree of challenge could be used without provoking disengagement. It suggests a nurturing approach.

"Our job is... on the basis that it's the balance between support, enforcement... and it's always reading the situation to identify what is required of us and other professionals to... help the family reach the outcomes they... want to" [Ruth, FG1:142]

Building trusting relationships with parents appeared to be the most important aspect of this, and provided a solid foundation from which to achieve “*sustained change*” [FG4:214]. This was felt to take “*a lot of time*”; ensuring that the initial period involved “*not judging... just listening*” [FG2:21]. Parents were felt to have already “*been judged so much by so many people*”, or blamed for the difficult conditions they were managing at home, that it helped to try to have an “*unconditional positive regard*” and “*not to sit and judge - at all*” [FG3:468]. There was felt to be a high risk of alienating parents, by employing an overly directive approach before a relationship had been made. To “*say it to them straight*” was felt not to work at all “*because then they will be really cross with you and disengage, and feel judged*” [FG2:37]. Instead, “*putting the hours in*”, empathising about what it might be like to “*be in their shoes*”, and being respectful and “*very diplomatic*” was felt to be much more effective [FG2:35].

“*...for me the key has been the relationship*” [Jane, FG2:56]

Coaches described coming in “*alongside*” parents [FG2:56; 3:471; 2:48], “*befriending*” and “*going with*” their “*narrative*” [FG2:21]. Within a trusting relationship, it was much more likely that parents would “*value your opinion*” as a coach, and this in turn would be “*far more impactful*” [FG2:39]. That parents felt able to trust coaches was evident in many examples of casework, where honest communication had been established and the level of engagement was high. This was a significant achievement given that many families had prior experiences that had led them to be “*really suspicious of professional approach*” [FG2:56]. Sometimes the

coach had become someone with whom a parent could share small successes, and several coaches mentioned staying in contact with a parent after the professional relationship had ended, showing how durable relationships could be.

“...she’s got no-one to say, ‘Hey, I did a good job as a parent today’ to. And... that’s been part of my role... she’ll... text me quite a lot and call me quite a lot” [Jane, FG2:56]

Building these relationships was referred to as *“the core of everything”* [FG1:101] or *“the key”* [FG2:56], with one coach describing his role as *“essentially being that loving family member”* [FG3:483]. To build trust, coaches tried to *“find some similarity”* [FG2:41] or common ground, as well as *“earning your value”* by finding *“something, in the first week or two, you can do that’s useful”*. This was described as the *“power of the quick win”* [FG3:463]. Listening was also very effective. One coach spoke of a time when he had summarised all the issues to a mother prior to a meeting, to check his understanding, at which point *“she got quite emotional and she said that’s the first time anyone’s understood”* [FG1:21]. Another coach described her approach as simply persisting in going over to the house and *“just not letting her go...”* [FG2:21].

“...with some families, to get that behaviour change, it’s like trying to give up cigarettes. It’s hard and it takes a long time (...) You can’t underestimate how important that is; to be with some of these families for that journey.”
[Reuben, FG4:214]

Once a trusting relationship had been built, parenting parents also involved **strengthening** and **empowering**. This was achieved by providing “*constant reassurance*” [FG4:155], helping parents to “*look after themselves*” [FG1:39] and “*recharge their batteries*” [FG1:29; 1:39]. Parents were encouraged to engage in activities outside of the home, for example. One coach described her work as maintaining “*hope*” to make sure “*they’re not giving up*” [FG1:118] and others felt the role was to help families to “*feel empowered*” where they were “*not feeling good enough*” [FG1:148].

“I think power is a massive part of... this kind of work. And trying to even up the power, and remove as much, for me, remove as much power of the professional as is possible to do.” [Sam, FG2:48]

Coaches also worked to raise parents’ self-esteem and build their confidence, so that they felt better able to assert their authority, “*manage conflict*” [FG4:158] and improve communication within the family. Teaching parenting skills through programmes such as ‘Triple P’ or ‘Feeling Good, Feeling Safe’ was felt to support parents to “*increase their conversations*” with their child [FG1:13], “*to listen*”, be more “*understanding and reassuring*”, “*positive and assertive*”, and, on behalf of their child, “*be that voice when they can’t use their voice*” [FG3:451].

One coach described this intervention as “*activating something*” in a parent [FG2:56] and another as “*helping them identify their inner resources*” [FG3:492]. A third coach described his role as reinforcing a mother’s discipline of her son at home by “*backing it up*” so that her son could see that “*she was serious*” [FG4:150]. From a

position of greater strength, parents were better able to commit to “*putting down boundaries*” [FG2:7] and could provide better role models; one coach spoke of a mother’s growth in confidence and how it positively “*changed the daughter’s view on life... very much*” [FG1:49]. Another coach spoke of how some parents he worked with on “*empathetic listening*”, “*developed*”, “*improved*” and subsequently “*had more time and more space*” for their son [FG3:214]

“...lots of mums are... so down in the dumps. And the pressure on their shoulders is so much that it’s difficult for them to make a change, and feel energised, and do something different and try something out, and, you know, get up in the morning, and do all those things that some people take for granted. ...I think... the coaching model’s really good at being able to be alongside and be that regular... introducing new strategies, and getting feedback from them about what went well and what was really difficult, and then working with that. And just, and it’s sort of a snowball, and I think that’s been really successful in, in some of the families I’ve worked with.”
[Anna, FG4:140]

Coaches were also engaged in **providing practical support, advocacy** on parents’ behalf, and **building a support network around the family**. Coaches described helping families to keep “*dentist’s and doctor’s appointments*” where these had been “*missed... many, many times*” [FG2:56], establishing “*morning routines*” [FG2:7], making home improvements such as “*decorating rooms*” or getting “*new bedding for all the family*” [FG1:65], as well as helping with other practicalities like “*getting them bus passes and... uniform*” [FG2:70]. Some of the support was simply about the “*logistics*” of how parents were going to manage with limited resources or support [FG2:67] or referring them to the right support services.

Coaches described “*negotiating*” with schools or services on behalf of parents [FG2:9; 1:45], or providing practical and “*emotional support*” following an incident of domestic violence [FG1:73]. One coach felt that the role helped to “*lend*” parents in tough and trying circumstances “*our power in the system*” so that “*their voice gets heard a lot more*” [FG2:90]. Other support services and charities were engaged to provide practical help to a family, and coaches helped parents to “*draw upon*” their existing “*support network*” [FG2:67] or “*brought*” other family members in to help, by “*drawing*” their “*attention*” to the fact that “*the family... needed practical input*” [FG2:67].

As well as support, **challenging** was also discussed as an important feature of parenting parents; something that had to be built up to once there was a strong foundation of trust. This involved “*getting*” a parent to “*speak very honestly*” about their situation [FG2:69], and judging “*when you can push it a bit and be a bit... firmer*” about what actions needed to be taken to move things forward [FG2:40]. Some coaches felt that it was sometimes important to be “*a bit more black and white*” with families if it felt as though no progress was being made [FG1:131]; one feeling that the threat of prosecution could be an effective “*stick*” to use to spur families into action [FG2:172] and another relating an experience where the “*enforcement*” of prosecution “*helped*” a family to turn things around [FG1:144]. Coaches also spoke of the importance of delivering the message to families that

“*school is non-negotiable*” [FG1:148] and of taking care over what language they used to describe their child’s difficulties:

*“I’ve talked to mum quite a lot about the sort of language that she uses ...
...the girl has got a slight muscle problem down one side and all it is, is that
her knee muscles aren’t very strong and so, sometimes her knee gives way.
But her mum describes it as... her ‘collapsing’ at school, ... quite a dramatic
sort of statement.... So,(I) talked to mum about... not dramatizing situations
and the type of language she’s using.”* [Jenny, FG1:49]

4.5.2 Helping CYP to be seen

The second aspect of successful intervention addresses the CYP's feelings of invisibility; helping them to be seen, and exposing and addressing the difficulties they face. Coaches spoke of doing this in a similar way to how they had supported parents; **building trusting relationships, listening and noticing, confidence-building, and advocacy.**

Coaches described that their involvement with young people helped them to feel that *“there's somebody there and they're being listened to”* [FG1:88]. Being *“listened to”* was felt to be essential in a great number of cases [FG3:94; 1:7]. This involved regular *“one to one”* sessions [FG1:39; 1:5], persisting over a long period of time, empathising, and attending closely to the *“things”* that CYP were *“interested in”* [FG1:17; 1:29]. Working in the family home over a period of time was also felt to help coaches *“to really see... what's going on for these children”* [FG1:95].

Coaches showed real fondness for some of the CYP they had worked with, and genuine pleasure at their successes. The focus was on emphasising and building upon strengths, bringing out *“all the positive things”* and using *“a lot of laughter”* [FG1:29]. Many of the coaches described *“building confidence”* and raising *“self-esteem”* [FG3:427; 3:430; 3:603; 1:3; 1:13], as well as *“building... aspiration”* [FG4:143; 4:208]. In one case, confidence was built by providing opportunities for a girl to mentor younger pupils at her school; in another, the coach helped her to find a peer who was also a young carer.

One coach described a boy who initially rejected help but then “*worked with me really well*”. The boy had felt that by helping him to research his interest in computer games, the coach “*shows he cares*”. Another young man was helped to build his confidence with the introduction of a hobby (“*skateboarding*”), which gave him a strong “*identity*” with which he could return to school with pride [FG4:328].

“Times when it’s worked really well, in my experience, it hasn’t been, I’ve got the services in place, or we’ve got a good (multi-disciplinary team) or anything... It’s just been, a child’s felt... cared about. And someone’s bothered about them.” [Phil, FG3:428]

Coaches would advocate for CYP by accompanying them to meetings or open days, negotiating with school staff on their behalf, facilitating conversations at home about difficult topics, and helping to explain their point of view to a parent, who might have “*no idea of the impact*” their actions were having [FG1:49]. Another aspect of the advocacy role was felt to be providing opportunities for school staff to hear “*other stories about the child*” when they had become “*so rigid in their perception*” [FG2:87].

“... quite often when I’ve met a young person, they’re just used to being told stuff by school. Well, you’re not doing this because of that, and you’ve got to start doing it. And told stuff by parents. And there’s been very little exploration about how they’re actually feeling about it. What are those things that do actually work for them? What are the things, who are the people they like? All of that. Just digging a bit deeper and really listening to them.” [Anna, FG4:159]

To support CYP to continue to feel visible and “*secure*” [FG1:7] in the longer term, intervention work also focused upon **identifying strategies for self-help**, and bridging and facilitating better relationships with family members, school staff and peers. Coaches talked about equipping CYP with a “*model of problem-solving*”, “*coping statements*” [FG3:458], “*strategies and ideas to cope*” with how they were feeling [FG1:39], and “*a clear plan*” [FG2:19] or “*the paths to go down*” when issues arose at school, rather than keeping things “*bottled up*” [FG1:49]. One girl was described as “*very aware of what she needs to do*” following coaching intervention [FG1:49]. CBT was a specific approach mentioned as being helpful.

Ensuring that any **safeguarding** issues were adequately addressed was an essential component of helping CYP to feel visible and safe. In several of the cases discussed a referral to social services was made, and in two cases the CYP were placed on the child protection register. In line with the causal conditions discussed in section 4.3, locating the issues within the CYP and focusing the intervention solely with them, was unhelpful. Conversely, **relieving the pressure** or taking the “*spotlight off*” the CYP [FG1:39], and looking more widely at the issues in the family and wider system, appeared to work well. Coaches described looking beyond the obvious reasons for PSNA, and not “*pointing the finger*” at the CYP as the “*problem*” [FG3:293], whilst ignoring issues in the family and beyond. Ultimately, PSNA was “*just... symptomatic of other stuff going on*” [FG1:95].

“...opening it up to a whole family approach, took the pressure of this one young person who was not attending...” [Laura, FG1:39]

4.5.3 Creating square holes for square pegs

This aspect of successful coaching intervention links closely with helping CYP to be seen, because it ultimately involves shaping and adapting the educational environment to meet the specific needs of the CYP. In order to feel safe enough to go to school, CYP needed their needs to be visible at home and at school, and to have these adequately supported. Coaches described **setting up a support network** of professionals around a CYP and their family, helping school staff to make small changes in **adapting the school environment**, having **flexibility** and taking a **strengths-based approach**.

“...I said to the school, we’re trying to put a square peg in a round hole. We need to think about something different. And the minute that was said, and school said, ‘we’ll plan it, we will do things differently’, she started going, and she was on 100% by the time.... And she did all her GCSEs and went to college!” [Naomi, FG3:92]

The support network often involved pulling together the key professionals and family members in the CYP’s life, encouraging good communication, consistency and joint problem-solving. One coach talked about a case where prior to his involvement the family and school had had *“almost no contact”*, which he had worked hard to change [FG2:64]. Another coach talked about building *“a better bridge between home and school”* [FG2:90], and a third spoke about a plan to gradually reduce the time he was spending with a child and *“handing over to other school staff to build those relationships”* [FG1:19]. Key *“information”* about a CYP was also *“passed on”* to the class teacher [FG1:21].

A good support network involved *“everybody... really communicating well”* and *“working together”* as a team, with the coach maintaining *“regular contact”* on a weekly basis with all the members *“to catch anything that went wrong”* and *“get on it really quickly”* [FG1:7]. Coaches tried to work *“alongside”* [FG1:61] other services, co-ordinating to ensure that they did not duplicate support, and linking families in with other support work or opportunities wherever it was felt to be helpful. Examples that were mentioned included social services, youth services, mental health services, the police and the post-adoption team.

Cases appeared to be most successful where the school showed *“enough willingness”* [FG2:64] and were *“happy to help”*, or where the specific school link worker was *“really good”* [FG2:67]. A long-term commitment to the process was also key. One school was described as *“amazing”* because they would *“do anything they could to keep her there”* [FG2:113]. One coach highlighted that she felt it was very important *“for the school to not remain silent”* for *“some of the teachers, to either email the YP, or send them postcards out - just to keep the connection there”* [FG1:85].

“Schools that stay with the process when there is success, and don’t say, ‘Oh thank goodness, that’s solved now’, or just go back to normal functioning. That holding ethos. If a school has that, it’s a lot more successful.” [Viv; FG2:89].

Adaptations to the school environment tended to be small but effective. Examples included: setting up a *“reduced”* [FG1:17] or *“part time timetable”* which gradually increased *“week by week”* [FG3:94]; providing a *“quiet room”* for a CYP with social

anxiety at lunch times [FG1:7]; and ensuring there was “*mapped out support*” for upcoming exams [FG1:39]. Coaches sometimes bridged between home and school, building a relationship with a child in their home environment and then initially “*accompanying*” them to school, with a graduated plan to hand over to school staff and slowly withdraw [FG1:17].

Coaches also listened to the concerns of the CYP and helped to communicate these to school so that appropriate changes could be made. This advocacy extended to coaches challenging schools where they felt they had seen inconsistency or unfair practice, such as “*changing the goal posts*” [FG1:130] or two students being “*treated completely differently*” [FG1:150]. Sometimes, where one school had proved to be “*a very bad experience*”, coaches facilitated a move to another school [FG2:98].

“...the... English group she was in she couldn't stand up and talk in front of the group. And she felt that... the teacher didn't like her. And just a very simple thing of actually moving English groups, actually meant that she wasn't developing stomach pains or headaches or whatever on days of English. And so, it was just something very simple.” [Jenny, FG1:49]

It was also felt to be very important having a “*real*” and “*named*” person at school and being “*very specific*” about the details of “*how they're going to find the person when they actually need them*” within the large and complex environment of a secondary school [FG4:164]. Specificity extended to planning for how exactly CYP were to be supported in school so that in the event of a problem they knew “*the key*

people that will help” and *“exactly what will happen”*; staff being specifically *“trained up to cope”* [FG1:39].

“...you’re on the outside listening in the family, but we need someone who’s listening in the school as well. And sometimes, people in schools, who’ve got titles like Inclusion Managers, don’t always behave in that way. So... it may not be that obvious person, it, it could be someone in a different role. So, it would have to be a lot to do with the child’s choice about who it would be.” [Ellen; FG4:167]

Coaches felt that they had greater success where they were *“solution-focused”* rather than problem-focused, *“drawing from people’s strengths and focusing on positive changes that people make, and building from that”* [FG2:84]. They worked to *“look at solutions and positives and strengths, rather than focusing on the negatives”* [FG4:31]. This was a particularly helpful way to keep moving forward despite where there might be limited resources, identifying strengths in people and *“building their capacity”* with the resources *“that you’ve actually got”* [FG1:106].

Being flexible allowed them to work around inevitable barriers, and cater for each CYP’s specific requirements. Coaches devised creative approaches to problems. One coach, for example, noticed that a young man *“had a guitar in his room”*, and *“serenaded him to get out of bed”* when it was clear that *“he wasn’t getting up”* [FG3:205]. Another coach carried out most of her assessment work *“in the hallway”* in the home of a chronic hoarder, because it was *“really difficult to get into the house”*, building up to *“actually physically clearing”* a room to move things forward

for the family [FG2:15]. This flexible approach helped CYP and their families feel visible, supported and safe enough to return to school.

4.6 The consequences of coaching intervention: *Variable success*

Due to the powerful resistance to change, coaches are not always able to sufficiently support lasting change and success is variable.

Coaches spoke of the varying success that they had had in their work with PSNA, describing the outcomes of their involvement as unpredictable and prone to relapse. CYP with PSNA had the potential to surprise the adults around them with a sudden, self-motivated determination to attend school. At the same time, they could be exasperating in their lack of improved attendance despite intensive support.

“School attendance has been... consistently the most difficult thing... that we’ve had to work with.” [Bill, FG4:204]

Coaches were all able to relate cases where CYP they had worked with were consequently *“doing really well”* [FG1:5]; where intervention had had *“a massive impact”* on attendance and academic progress, and the child’s *“attitude to learning completely changed”* [FG2:9]. In some cases, attendance had gone up above 90% and CYP were *“coping a whole lot better”* [FG1:45] and were *“much happier at school”* [FG1:13].

Although all of the coaches were able to discuss success stories, some of them described the work as *“consistently frustrating”* [FG4:204] or *“like pulling teeth”*

[FG3:401]. They spoke of how sometimes attendance had initially *“got worse when we’ve got involved”*, perhaps because they were *“there unpicking other things”* or *“poking around”* [FG3:408]. It was felt to improve *“a bit”* during the intervention, but then *“drops off”* *“quite drastically”* sometimes, after they end their involvement [FG3: 410].

Successful intervention was overshadowed by the cases in which lasting successful change could not be achieved. One coach commented that *“there’s almost too many to think of!”* when asked to speak about an unsuccessful case [FG1:61]. Coaches felt that they could put in a great deal of time and effort without effect, *“...you can do a lot, a lot, a lot of stuff and still get nowhere.”* [FG4:208]. One coach described a case where she *“tried everything I could possibly do”* to no avail. Another spoke of the inconsistency of the work, whereby one case could be successful, *“but I could have another case”* where *“the same things were put in place and the results weren’t the same at the end”* [FG1:11].

“...he started at college. He said he was really enjoying it... and then suddenly it stopped again.” [Jenny, FG1:81]

Variable success was felt to be due to the coaches’ inability to effect change where it really counted, within the family home. Focusing solely upon school was felt to be *“a bit of a waste of time”* or a *“red herring”* unless a child could also find *“that secure base and a sense of belonging... at home”* [FG1:13]. CYP were also very likely to relapse, after a change in home circumstances, or following a school holiday. One

coach described a case where progress was being made and then “*everything capitulated again... and he refused to go in*” after the Easter holidays [FG1:17].

Cases being referred at a very late stage was also felt to be unhelpful. One coach, for example, spoke of a child who had had “*every intervention... under the sun*” by the time of her involvement [FG1:13]. The context of the work, as set out in section 4.4, where there was powerful resistance to change across multiple systems, operated as a huge barrier to success.

Finally, coaches were asked a miracle question during the focus groups, about what ideal resources or support might look like in the city with no constraints. Figure 4.3 outlines these responses, which fit well with the principle of increasing safety being the primary factor in intervening in PSNA, as well as further outlining the systemic barriers that caused their intervention to have such variable success.

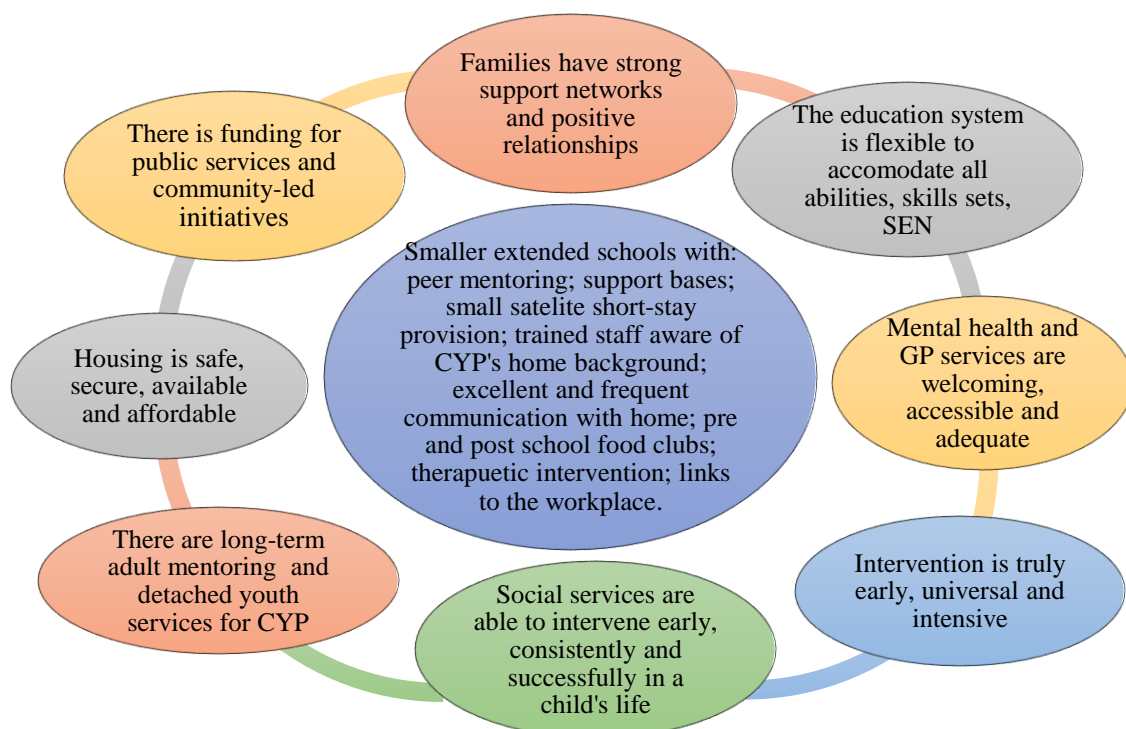


Figure 4.3: Model of the idealised scenario

5.0 Discussion

5.1 Introduction

The aim of this study was to better understand the perspectives of coaches on their work with persistent school non-attenders in coaching families; to understand what helps and what hinders successful intervention. These perspectives are comprehensively set out in chapter 4.0, and have been drawn together into a grounded theory of family coach intervention in PSNA, which describes the processes in operation. This chapter discusses the implications of this theory and, in doing so, explores the third research question set out in chapter 2.0: *How can the theory that explains the process of successful coach intervention in the local authority inform future intervention and policy development?*

The purpose of this chapter, therefore, is to comment on the significance of this theory; how it relates with other research in the field; and what the impact might be on family coaching in the local setting. The wider implications are considered, with specific thought about EP practice. The limitations of the research are also acknowledged, including reflections about the process itself. The chapter concludes with some thoughts about future directions.

5.2 Key aspects of the theory and parallels in the literature

In this section, the key aspects of the theory are reiterated, with a discussion of how each relates to other research and theory in the wider literature.

5.2.1 The central phenomenon: *Not feeling safe enough to go to school*

Key Factor 1: PSNA is felt to be ‘red flag’ and occurs when a CYP feels unsafe. It is one of many associated signs that the wellbeing and physical and mental health of the CYP is suffering.

5.2.1.1 The fundamental need to feel safe

The importance of feeling safe as a precursor to being able to attend to other, higher-order needs, such as engaging with education, immediately chimes with Abraham Maslow’s well-known concept of a hierarchy of needs in human motivation (Maslow, 1943). Maslow’s theory sets out how basic, fundamental needs of physiology and safety must first be met before a person can start to consider higher order needs, such as those of esteem or self-actualisation. Many of the CYP being supported by the coaches in this study were simply perceived to be prioritising lower order needs in the hierarchy over attending school; a typical human reaction to difficult environmental circumstances.



Figure 5.1: Maslow's hierarchy of needs

5.2.1.2 The role of secure attachments

Associations to attachment theory are also evident. The theory of attachment, as developed by John Bowlby, asserted that a main caregiver and an infant develop a close bond that is necessary for both the physical and psychic survival of the child (Bowlby, 1958). Central components of this bond are caregiver sensitivity and responsiveness, which directly affect the quality of the attachment formed and subsequently the personality development and emotional regulation of the child (Ainsworth, 1969).

Attachment relationships provide protection from fear and harm and a safe, “secure base” from which the developing child can confidently explore the world (Ainsworth, 1969; Ainsworth and Bowlby, 1991). Attachment theory sets out that a sufficiently attuned relationship leads to a healthy or secure attachment style. Insecure attachment styles result from inadequate or inconsistent caretaking, where the main caregiver has not been adequately responsive, affectionate or sensitive to the child. (Ainsworth, Blehar, Waters, & Wall, 1978).

This resonates powerfully with the theory generated from this study. CYP not feeling safe enough to leave the family home to attend school regularly is an echo of proximity-seeking behaviour, especially where the school environment appears not to be problematic. Two of the main causal factors, *an insecure home base* and *diminished parental capacity*, if they have persisted long term, may have acted to inhibit the formation of a secure attachment bond. In accordance with attachment theory, an insecure attachment style might lead to a child seeking increased proximity

to a parent, as well as increased sensitivity to anxiety about their well-being. It might therefore act to prevent CYP from feeling able to venture confidently away from the home for long enough periods necessary to maintain satisfactory attendance at school. This links fittingly with CYP described as having *separation anxiety*, one way of categorising PSNA that was outlined in chapter 2.0.

One of the coaches described the effect of home-related anxieties constantly drawing the CYP back to the home as, like “*an elastic... band*”. Ongoing and legitimate fears about the safety and well-being of a parent would act to exacerbate this; certainly, a feature of the lives of many of the CYP described in this study. Attachment theory might also help to explain why the incidence of relapse seemed to be so high, as well as why many of the CYP were so difficult to support back to full attendance. Even where the difficulties at home had been historic, the effects appeared to be much longer lasting, continuing over time to impact CYP significantly. Perhaps seeking proximity to a parent had become a default behaviour, triggered by a variety of environmental stressors.

5.2.1.3 Associated psychological conditions

If CYP were not having their fundamental needs of safety adequately met, it would follow that PSNA would not be the only sign. PSNA was indeed found, in this study, to be part of a spectrum of psychological conditions, in particular those under the category of *mental illness*. The link between PSNA and poor mental wellbeing also bears out in the wider literature. One example is a longitudinal study by Attwood and Croll (2015), which looked at the link between truancy from school in England and

mental well-being. They found that truancy, even at low levels, was associated with feelings of distress and inability to cope with everyday life. Indeed, a clear link has been drawn in the majority of the literature, between PSNA and disorders of mental health, such as anxiety, depression, separation anxiety, “emotional disturbance”, psychosomatic illness and social phobia (Chen et al., 2016; Christogiorgos & Giannakopoulos, 2014; Doobay, 2008; Ek & Eriksson, 2013; Gren-Landell et al, 2015; Honjo et al, 2001; Lingenfelter & Hartung, 2015).

Environmental exposure, for example to childhood trauma, has also been found to significantly impact upon the symptoms of mental disorders, in line with growing evidence for “the conceptualization of psychopathology as a contextually sensitive network of mutually interacting symptoms” (Guloksuz et al, 2016, p. 8). PSNA and mental illness appear from this perspective to be interrelated symptoms of environmental stressors, rather than isolated, organic conditions. Put another way, with the home circumstances of some CYP, coaches were “*not surprised*” at their PSNA, perceived not as a disorder but as a “*coping mechanism*” [FG1:123]. Given a similar context, several coaches felt that they would struggle too.

“I’d be curled up under my duvet, ignoring the world...” [John, FG1:127]

5.2.2 The Causal Conditions: *Factors causing CYP to feel not safe enough to go to school*

Key Factor 2: In the majority of cases, this feeling of being unsafe is a product of the home environment not providing a secure base, parents having a diminished capacity and the CYP feeling that their situation is invisible to others. Additional precipitating factors, such as problematic peer relationships, adolescence, secondary transition, and having ASC exacerbate this, but are not enough to cause PSNA on their own.

A key difference of this study, in contrast with much of the literature, is that, to a large extent, it removes the emphasis of PSNA being the problem of the CYP, and locates it within the wider family and environment. It suggests that any child, given the circumstances set out in section three of the findings, would be at risk of, and justified in, their PSNA. This would be at odds with a medical model, which views PSNA as a condition that might be successfully treated with medication or therapies for the individual, without also addressing adverse familial circumstances.

5.2.2.1 The impact of parental mental health problems

Parental mental health problems, for example, were found to be one of the underlying reasons that CYP were not feeling adequately safe at home. The impact of parental mental health problems on children is also highlighted by Rouf (2014). He reports evidence from the Department of Health and Ofsted that one-in-four adults in the UK is likely to experience a mental health problem in their lifetime, and that approximately 30 per cent of adults with mental health problems have dependent children. He argues that whilst many adults with mental health problems parent well, some families do require support, which may also extend to child protection involvement because of concerns about safety:

Parental mental health problems can impact on the ability to organise; to show consistent emotional warmth and manage feelings; to lay out boundaries and guidance; to keep the home safe; to supervise children appropriately; and to provide for physical needs (Rouf, 2014, p.72).

5.2.2.2 The impact of parental substance misuse and alcoholism

Parental substance misuse and alcoholism were also found to be aspects of insecure family life. Velleman and Templeton (2016), reviewed research over the past decade on the risk factors faced by children in the UK affected by parental substance misuse. They report estimates that there are approximately 3.4 million children under 16 living with at least one binge-drinking parent, and 335 000 children living with a drug-dependent user. Further, they report that more than 25% of babies under the age of 1 will have been exposed to at least one type of serious risk in their first 12 months (problem drinker, class A drug user, mental health disorder or victim of domestic violence). They summarize links made in the literature with children being at greater risk of emotional and mental health problems, including depression, anxiety disorders, obsessive-compulsive disorder and attachment-related psychological adjustment, academic underachievement, and conduct and behavioural problems.

5.2.2.3 The impact of poverty

Poverty appeared to have a significant impact upon the families in this study, as well as acting as a major obstacle to successful behavioural change. The findings draw a link between the environmental effects of poverty and the conditions within a family that might trigger an episode of PSNA, emphasising the idea that the current system

might be medicalising symptoms that are of environmental origin or *pathologizing* poverty.

The effects of poverty on children bear out in special educational needs and disability (SEND) data. A report *Special Educational Needs and their Links to Poverty*, published by the Joseph Rowntree Foundation (Shaw, Bernardes, Trethewey & Menzies, 2016), draws strong links between poverty and SEND, stating that poverty can be both a cause and effect of SEND. The report highlights that “children from low income families are more likely than their peers to have inherited SEND” and are “more likely to develop SEND in childhood.” However, they are also “less likely to receive support or effective interventions” partly because their “parents are less likely to be successful in seeking help” (p. 4).

The report cites evidence that shows links between poverty and SEND as being multi-directional. The hereditary nature of some SEND conditions and the links to low educational attainment create an element of “intergenerational disability”. At the same time, mothers living in poverty are more likely to smoke or consume alcohol whilst pregnant, and are at increased risk of relationship stress and breakdown. They are therefore more likely to have a low birth weight baby and children with some forms of SEND. Conversely, having a child with SEND can exacerbate poverty in situations where parents are unable to work due to the additional caring responsibilities. It also put additional stress on relationships which are more likely to breakdown, leading to a higher number of children with SEND living in lone parent families with more limited incomes (Shaw et al, 2016).

Allen, Balfour, Bell, and Marmot (2014) point out that there are also social determinants in mental health. They performed a meta-analysis of 115 studies, finding that risk factors for many common mental disorders and physical health conditions are heavily associated with social inequalities, whereby “the greater the inequality the higher the inequality in risk” (p. 392). Of the studies reviewed, more than 70% reported clear and positive associations between poverty and common mental disorders. Those described as poor or disadvantaged suffer disproportionately because of interacting social and environmental factors, including financial debt.

The *pathologizing* of poverty is also a concept that has been previously discussed in the literature. Hansen, Bourgois, and Drucker (2014) conducted an ethnographic study that drew upon daily observations of people using public clinics in impoverished neighbourhoods in New York City between 2005 and 2012. They found that a change to US policies on welfare support had forced those in poverty to seek monetary support increasingly through the means of a diagnosis of permanent mental disability. The authors argue that medical diagnosis has become a necessary correlate of poverty because of cultural pressure to comply to a narrow definition of being worthy of help:

Through the decades, the stigmatized labels applied to the poor have shifted: from being a symptom of racial weakness, to the culture of poverty, and now to permanent medical pathology. The neoliberal bureaucratic requirement that the poor must repeatedly prove their "disabled" status through therapy and psychotropic medication appears to be generating a national and policy-maker

discourse condemning SSI malingerers, resurrecting the 16th century spectre of the "unworthy poor" (Hansen et al, 2014, p. 76).

This resonates with the findings in this study in two ways. Firstly, that PSNA can occur where there are environmental pressures associated with poverty, but tends to be pathologized as a clinical condition. Secondly, the findings also draw a link between parents living in poverty and their propensity to seek medical diagnoses, sometimes disputed by professionals. This leads one to speculate that medical diagnosis may be one way to legitimise the circumstances in which people living in poverty find themselves; an acknowledgement of the painful condition of being reliant on welfare in a culture where such a status is highly stigmatised.

5.2.2.3.1 Short term thinking

One of the key aspects of diminished capacity described in this study was the manifestation of *short term thinking*, whereby parents appeared unable to tolerate temporary discomfort for themselves or their child, in the interests of longer term benefits. The concept of short term thinking can also be found more widely in the literature, tending to be linked with the stresses associated with poverty.

Mani, Sendhil, Eldar, and Jiaying (2013) conducted a study on the impact of poverty on cognitive performance, including reasoning and mental control. They found that Indian sugarcane farmers performed more highly on cognitive tests and demonstrated lower stress levels after harvest payments had been made. They propose that the state of being in poverty causes a preoccupation with money concerns which in turn

diminishes the ability to make reasoned and logical decisions. The average difference amounted to a 13-point drop in IQ.

Berkman (2015) reiterates this, with the idea that living in poverty forces people to live in the present, preventing the “luxury” of self-control as defined as, “choosing behaviors that favour long-term outcomes over short-term rewards” (para. 4). He describes several studies where the increased propensity to live in the present, rather than delay gratification, is significantly connected to the unreliability of the circumstances (Kidda, Palmeria, & Aslina, 2013), and to socioeconomic status, both as an adult and in childhood (Guthrie, Butler, & Ward, 2009). Berkman discusses how thinking short-term is an understandable survival strategy for those families living hand to mouth.

A famous blogpost entitled, *Why I Make Terrible Decisions, or, poverty thoughts*, (Tirado, 2013) went viral because it was felt to perfectly illustrate how being in poverty detrimentally affects a person’s decision-making skills. The following is an excerpt:

I make a lot of poor financial decisions. None of them matter, in the long term. I will never not be poor, so what does it matter if I don't pay a thing and a half this week instead of just one thing? It's not like the sacrifice will result in improved circumstances; the thing holding me back isn't that I blow five bucks at Wendy's. It's that now that I have proven that I am a Poor Person that is all that I am or ever will be. It is not worth it to me to live a bleak life devoid of small pleasures so that one day I can make a single large purchase. I

will never have large pleasures to hold on to. There's a certain pull to live what bits of life you can while there's money in your pocket, because no matter how responsible you are you will be broke in three days anyway. When you never have enough money it ceases to have meaning. I imagine having a lot of it is the same thing.

Poverty is bleak and cuts off your long-term brain. It's why you see people with four different babydaddies instead of one. You grab a bit of connection wherever you can to survive. You have no idea how strong the pull to feel worthwhile is. It's more basic than food. You go to these people who make you feel lovely for an hour that one time, and that's all you get. You're probably not compatible with them for anything long-term, but right this minute they can make you feel powerful and valuable. It does not matter what will happen in a month. Whatever happens in a month is probably going to be just about as indifferent as whatever happened today or last week. None of it matters. We don't plan long-term because if we do we'll just get our hearts broken. It's best not to hope. You just take what you can get as you spot it (Tirado, 2013, para. 11-12).

5.2.2.4 The impact of parental attitude

Parental attitude has been found to have a mediating effect on school attendance in other studies, reinforcing the findings in this study that parents could negatively influence attendance, for example by exaggerating illness. Logan, Simons, and Carpino (2012) studied how “parental pain catastrophizing” and “parental protective responses” to child pain influenced the extent of school impairment in children with

chronic pain (p. 437). They found that attendance rates were significantly mediated by the parents' approach and attitude to pain. School attendance and success in circumstances where a child had a valid reason to be absent, was heavily dependent upon the parents' responses.

5.2.2.5 The impact of feeling invisible

CYP feeling invisible was another of the causal conditions drawn out in this research. There is evidence in the literature that children's voices are not always adequately heard and that there are several negative effects for those who feel invisible.

Empowerment and the voice of the child is discussed widely in the literature. Research and legislation have increasingly emphasised the importance of giving CYP a voice and involving them in decisions surrounding their education since the United Nations Convention in 1989 on the Rights of the Child, which highlighted that children have a right to express an opinion and to have that opinion taken into account in any matters affecting them. However, there is evidence that CYP are frequently left out of decision-making procedures (Rose, 2005) and that professionals must do more still to access children's views and foster their participation (MacConville, Dedridge, Gyulai, Palmer, & Rhys-Davies, 2006; Soar, Burke, Herbst, & Gersch, 2005).

Weatherall and Duffy (2008) investigated how children's interests and their rights were safeguarded through the representation of social workers in reports prepared for

court following parental separation disputes in Northern Ireland. The findings identified several factors that reduced the accuracy of representing children's views and efficacy of promoting their rights, including competing employer and court priorities, lack of therapeutic intervention for children, variation in social work practice, and lack of training.

Openlander (2002) conducted qualitative research into the experience of being neglected. A key theme that emerged was "Feeling Invisible". Participants described feeling invisible in terms of being overlooked, being misperceived by a parent in a way that meets the parent's needs, and not having adequate consideration given to one's needs. Participants in the study described a tendency to undermine positive situations and relationships, and suffering from low self-esteem, as being two of the residual effects of this neglect.

5.2.2.6 Precipitating factors

A range of additional precipitating factors were identified in this study, which contributed to the incidence of PSNA, but only in conjunction with the other causal conditions. These included problematic peer relationships, adolescence, secondary transition, and having an ASC. A wide range of precipitating factors can be found linked to PSNA in the wider literature, inclusive of the ones that emerged in this study. The idea that there are associated, or precipitating factors does echo the wider literature in the understanding of PSNA as not the result of a single cause, but a situation that emerges as a result of a set of complex interacting factors.

Adolescence (Mabey, 2012), transition points (primary to secondary, KS3 to 4, following holidays) (Bealing, 1990; Havik et al, 2015; Mabey, 2012) and social factors, including bullying (Berkowitz & Benbenishty, 2012; Havik et al, 2014) and difficulties with peer relationships (Place et al, 2000), have all been linked to PSNA. Of course, not every child on the autistic spectrum, nor those moving to secondary school or going through adolescence, have difficulties relating to school attendance, which further delineates these features as potential triggers rather than stand-alone causes.

5.2.3 The Context of PSNA intervention: *Systemic resistance to change*

Key Factor 3: Intervention must overcome inflexible systems that are resistant to change. Socio-cultural-political systems, such as the class system, may be averse to the CYP feeling safe, because of inequities or limitations in the distribution of power and resources. The school system may rigidly adhere to policy or prioritise a conflicting agenda. Parents may sabotage the coaches' efforts to make changes to the family system. CYP themselves often reject support. Conflict between diverging systems must be managed for intervention to be successful.

5.2.3.1 Systems theory

The theory emerging from this study would imply that intervention will tend not to succeed if it seeks to work solely with the CYP; without looking at how they are part of wider, and interacting, systems. The function of PSNA for these systems around the CYP must also be addressed, as they may be resistant to, or act to sabotage, any efforts to create lasting change.

Systems theory would also view the CYP with PSNA as existing within a series of overlapping systems; each influencing and being influenced by the child's behaviour and each other (Von Bertalanffy, 2015). According to one branch of systems theory, *ecological theory*, five environmental levels influence child development and behaviour: the *microsystem*; *mesosystem*; *exosystem*; *macrosystem*; and *chronosystem* (Bronfenbrenner, 1979). The macrosystem, for example, is the cultural context in which the child resides, and the family and school systems would be thought of as interacting microsystems. Systems theory would assert that studying behaviour in

isolation will never enable an understanding of the complete picture, because behaviour is always embedded within a specific context.

This resonates highly with Nuttall and Woods' ecological model of successful reintegration (Nuttall and Woods, 2013), which was drawn out in detail in chapter 2.0. Their model shows an interaction of factors across and within systems, with many themes from other levels of the model being related to the development of the CYP's psychological factors at the core. Their research demonstrated that successful intervention "extended beyond child factors"; and highlighted the importance of "interacting contextual influences", such as family variables, on the effectiveness of intervention.

5.2.3.2 Adverse socio-cultural-political conditions

The wider socio-cultural-political *exosystem*, within which PSNA is embedded, was found to be a contextual factor in this study; cuts to welfare, the housing market and class inequality, for example, limiting the scope and effectiveness of intervention work. As discussed in section 5.2.2, these circumstances present families with much higher priority concerns than school attendance; living in poverty being associated with short term thinking, mental and physical illness and SEND.

There is no lack of evidence that poverty and insecure housing are indeed growing features of family life in the UK. According to recent United Nation estimates, more than 8 million people in Britain live in households that struggle to put enough food on

the table, and over half regularly go a whole day without eating (Taylor & Loopstra, 2016). An all-party parliamentary group on hunger has been established, which recently found up to 3 million children risk going hungry during the school holidays, leaving them vulnerable to malnutrition and undermining their education and life chances. (Forsey, 2017). The report described that there was a “deeply troubling” (p.23) impact on children who had gone hungry over the holidays and returned to class “malnourished, sluggish and dreary” (p.7).

The Institute for Fiscal Studies has described government budgetary policy over the past decade as, “the longest, deepest sustained period of cuts to public services spending at least since World War II” (Crawford, 2010). Security of housing has deteriorated within a perfect storm of rising property costs, falling wages and a net reduction in council housing stock. The homeless charity, Shelter, describes the situation as a “housing crisis”. They report on their website that homelessness is increasing, as are the number of families in private rented accommodation, one third of which currently fail to meet the “Decent Homes Standard”. Many families are described as living in “dreadful conditions” with “soaring rents, hidden fees and eviction a constant worry” (para. 5).

The housing crisis isn't about houses – it's about people. It's the family struggling to meet next month's mortgage payment. The young family renting a rundown flat, wondering if they'll ever be able to afford a home of their own. The children living in temporary accommodation, forced to change schools every time they move (Shelter, 2017, para. 1).

The impact of societal factors on PSNA is also evident in the wider literature, resonating with the theory from in this study. PSNA has been linked variously with a non-equitable public health policy (Yeung et al, 2011), lower socio-economic status (Pflug & Schneider, 2016; Place et al, 2000), poverty (Wilson, 2014), lack of wider support in the community (Coulter, 1995), authoritative governmental style (Gesinde, 2003) and marginalisation (Hoyle, 1998). These factors are echoed by the research into the work of US caseworkers discussed in chapter 2 (Sugrue et al, 2016) which found that societal issues, such as poverty and housing, as well as cultural barriers, were a factor in chronic absenteeism.

5.2.3.3 The impact of the school system

The *microsystem* of school was another contextual feature influencing success; the inflexibility of school policies and priorities sometimes acting as a barrier to progress. School factors have been drawn out in several other studies as exacerbating the problem. These have linked PSNA with the general level of disruptive or violent behaviour in class (Havik et al, 2014), student perceptions of low teacher support (Havik et al, 2015), low teacher attachment (Virtanen et al, 2014), transition from the primary to the secondary environment (Bealing, 1990), and poor communication with, and involvement of, parents (Claes et al, 2009). In a recent report entitled, *Children Missing Education*, commissioned by the National Children's Bureau, some children were found not to be receiving appropriate support from schools around bullying, SEND or mental ill health (Ryder, Edwards, & Rixe, 2017).

The broader UK education system has also been publicly criticised for being overly academic, sometimes at the expense of the mental health of CYP. Recently, a letter was written to the Prime Minister and Daily Telegraph, by a group of mental health and children's charities, calling for mental health to be an integral part of teacher training. The letter, signed by more than 2,500 teachers, 1,000 mental health professionals, 4,500 parents and 1,200 young people, urges Prime Minister Theresa May to rebalance the education system.

The letter describes a “mental health crisis in our classrooms” drawing upon estimates that “three children in every class have a mental health condition, one in four experience emotional distress, and rates of self-harm are skyrocketing”. The current education system is described as “fundamentally unbalanced, with an over-emphasis on exams and too little focus on student wellbeing” (Young Minds, 2017, para. 1-3).

5.2.3.4 The impact of the family system

In this study, some parents were described as resistant to coaching intervention, or to actively sabotage this in some cases. This might be thought about in the context of the *microsystem* of the family, resisting change because the PSNA behaviour is fulfilling a function. Perhaps providing a distraction from thinking about parental marital issues, or satisfying a need in a parent for company and support.

Systemic family therapy is a form of psychotherapy that identifies behavioural and mental symptoms within the context of the social systems people live in; focusing on

interpersonal relations and interactions with family members as the emphasis of interventions (Sydow, Beher, Schweitzer, & Retzlaff, 2010). PSNA might be viewed therefore as a symptom of disordered familial relationships being expressed by one of the family members. There appears to be a good evidence base, from meta-analysis and systematic reviews, for this approach being used effectively to intervene with a range of childhood pathologies, including delinquency, drug misuse, anxiety, depression, self-harm and anorexia (Carra, 2014; Saito, 1992), demonstrating support for the underlying theoretical principles.

A CYP's parents certainly have an impact. Virtanen et al (2014), also found an association between PSNA and low levels of parental support, describing family emotional support as being pivotal to student behavioural engagement and preventing truancy from school. McCoy, Wolf, & Godfrey (2014) present further evidence that parental perception of education as valuable is related to students' motivation for learning, and predicts higher school attendance and achievement.

5.2.3.5 The psychology of conflict

Conflict between systems was another identified contextual constraint to successful intervention in this study. Examples of this included disharmony and passing blame, sometimes between families and schools; sometimes between schools, families and professionals; and at other times between whole services or sectors (mental health services and the criminal justice system, for example). Conflict was detrimental to, and undermining of, progress.

One way of analysing conflict is through a psychodynamic lens. In *object relations theory* (Buckly, 1986), the concepts of *splitting* and *projection* are central mechanisms for dealing with disagreeable aspects of the self and of objects. Splitting of objects refers to the process of attributing qualities or intentions to others which are exclusively positive or negative. Pellegrini (2010) discusses the ways in which this is pertinent in the field of education, including where teachers are polarised as either “good” or “useless” without further nuance. Projection is defined as a defensive process in which people deflect their own repressed or anxious feelings on to others (Segal, 1989).

Splitting and *projection* might be one way to describe the high level of conflict occurring between the systems attempting to support the CYP. Where there might be significant discomfort, associated with feelings of failure or impotency in addressing PSNA, professionals and parents both showed a tendency to place the blame elsewhere; the anxiety caused by the inability to effect change, being projected outwards from parent, to school, to mental health service, to government. In the wider literature, this can be seen in studies that focus on the perspectives of PSNA from the points of view of specific groups. One study which highlighted parental perspectives, for example, found that school-based factors were the key issue (Havik, et al, 2014).

5.2.4 The Actions and Interventions: *How coaches have helped CYP to feel safe enough to go to school*

Key Factor 4: Successful intervention occurs when the CYP is helped to feel adequately safe. Family coaches have done this by parenting parents to build their capacity. They have also carefully noticed CYP and made their needs visible; including helping to make adaptations to the CYP's educational provision to create a 'square hole for a square peg'.

5.2.4.1 The impact of parenting support

Supporting parents to build their capacity was theorised to be an effective measure in coaching intervention. Other studies into PSNA have found similar. Blackmon et al (2015), concluded that it was necessary to build a committed, trusting and persistent relationship with the wider family, and that intervening by building a support network around the family was the most effective form of longer-term success.

Framing PSNA intervention as family-wide, rather than individual child focused, has also been associated with increased success. Cerio (1997) describes using a family systems approach to successfully address a case of school phobia. Success is associated with regarding the family as a network of interconnecting subsystems, and the school non-attendance as a symptom of a greater problem within the family. Cresswell and Cartwright-Hatton (2007) found evidence that using Family CBT as opposed to Child CBT increases the likelihood and longevity of successful outcomes; citing parental anxiety as a key barrier to longer-term success if this is left unaddressed.

It has been found more generally, that the effects of insecure attachment on development can be mediated as the child matures, if children subsequently experience care that is more responsive and nurturing (Belsky and Fearon, 2002). Several parenting interventions currently exist which aim to lessen the effects of insecure early attachments by attempting to strengthen bonds with caregivers and improve parental attunement and care. Several have a good evidence-base for success, for example: Video Interaction Guidance (Bakermans-Kraneburg, van IJzendoorn, & Juffer, 2008); Time Together (Butcher & Gersch, 2014); Young Children and Mothers Groups in Stockport (Warren Dodd, 2009); The Holding Hands Project (Rait, 2012); Incredible Years parenting programme (Rafferty and Trotter, 2014) and Triple P Positive Parenting Programme (Sanders, 1999). However, it should be noted that these interventions are largely directed at young children and the studies cited are not free from methodological shortcomings.

Targeting intervention at parents has also been found to be effective with older CYP. A study in Sweden (Özdemir, & Stattin, 2009) for example, worked with parents to effectively reduce underage drinking and delinquency in middle school students. Other specific studies are difficult to find, although it is well cited, throughout the literature on mental health, that effective parenting is a protective factor and therefore an aspect of a CYP's life to nurture and support (Ogden and Hagen, 2014).

5.2.4.2 The impact and importance of listening to CYP

CYP feeling that their needs were being noticed and addressed emerged as a key factor of successful intervention in this study. The child's involvement in decisions

about their education, and availability of support to make these decisions, was found to be an important part of re-engaging with education in a recent report into children missing education, commissioned by the National Children's Bureau (Ryder et al, 2017). The importance of listening to CYP is also discussed frequently in the literature surrounding child social work, education and family law; current practice being framed as both essential and inadequate (Singer, 2014; Weatherall et al, 2008).

Smith (2006) conducted a study into providing primary children with weekly, individual, half-hour listening and talking sessions with an adult, over ten weeks. The sessions were child-led and took place in a private space away from the classroom. The study showed that experiencing the focused attention of a trusted adult positively affected the children's educational progress. More importantly, it provided them with opportunities to disclose child protection issues that may otherwise have not been divulged. This is particularly pertinent given research which shows that CYP who miss education are not only at risk of under-achieving academically, but also of abuse, exploitation and neglect (Botham, 2011; Cleaver, Unell, & Aldgate, 1999; Ofsted, 2016).

In a review of research on disclosure of child sexual abuse, McElvaney (2015) highlights that significant numbers of children do not disclose experiences of sexual abuse until adulthood, if at all. She emphasises the crucial importance of having access to someone who will "listen, believe and respond appropriately".

Additionally, Tingskull et al (2015) captured data on trauma experience from 12-year-old children and their parents. They found that children tended to report higher

levels of traumatic life experience than did their parents answering on their behalf. They highlight that it is not always sufficient for practitioners to listen solely to parents; but need to find ways to listen to and hear the voice of the child.

5.2.4.3 The impact of the school environment

Although secondary to feeling safe at home, this study also theorised that making small adaptations to a CYP's educational provision could have a significant impact upon successful intervention; increasing feelings of safety and visibility outside the home. Other studies have also found links between the school environment and student attendance.

In one study students with a history of poor attendance were found to be motivated by a positive school climate (inclusive and accepting of diversity), an academic environment conducive to learning (reasonable student behaviour, a flexible curriculum and appropriately differentiated work), a fair and non-punitive approach to discipline, and good relationships with teachers (Wilkins, 2008). This is reinforced in a review of 155 research reports focusing on absence prevention and school attendance (Ekstrand, 2015); the factors that draw students to school primarily comprising, the possibility of bonding with adults, and a school climate that students deem positive. Even the condition of the school building has been found to have an impact upon academic attainment (Maxwell, 2016).

Significantly, a recent large-scale study also found that children from families with limited education have the strongest long-term response to teacher encouragement, and are more likely to progress to university as a result (Alcott, 2017). This would suggest that school factors not only have a bearing on student attendance, but that the effects of some aspects of school have the greatest influence on CYP from disadvantaged backgrounds; potentially mediating difficult family or socio-economic issues.

5.2.5 The consequences of coaching intervention: *Variable success*

Key Factor 5: Due to the powerful resistance to change, coaches are not always able to sufficiently support lasting change and success is variable.

It was the perception of the coaches that their intervention was not consistently successful and that despite significant effort, they could not always make a difference to families where PSNA was an issue. This is certainly born out in the first release of national governmental data evaluating the Troubled Families Programme (Department for Communities and Local Government, 2016). The research was unable to find consistent evidence that the programme had any significant impact upon school attendance, 12 to 18 months after families joined the programme. School attendance was slightly improved but not significantly so.

The variable success of intervention in PSNA can also be seen in the studies systematically reviewed in chapter 2, where 17 of the 31 studies reviewed achieved a rating of 0 or 1 because the evidence of any effect was either weak or non-existent. In the studies reviewed, where attendance did improve, most did not follow up for longer than 2 months, which leaves open the possibility that CYP relapsed. Several of the studies were characterised by recruitment difficulties and high dropout rates.

Rey, Marin, & Silverman, 2011, describe in detail the case study of an eight-year old boy with separation anxiety and school non-attendance, for whom CBT fails. The paper is an attempt to explain why twenty to forty percent of young people, being

treated for anxiety disorders as a whole, fail to respond to CBT. The study concludes that the severity of the boy's problems and external factors, such as parental depression and marital conflict, acted in combination to prevent success. They hesitate in recommending a longer treatment programme or pharmacological treatment, stating that "there is no evidence that more treatment means more improvement" (p. 1149). PSNA does indeed appear to be very difficult issue in which to intervene to make a significant and lasting difference.

5.3 The impact on future intervention and policy development in the local setting

Section 5.2 was concerned with reiterating the key aspects of the grounded theory emerging from this study, and how these resonated within the wider literature. This section will look at what the impact of these findings might be on family coaching, and broader practice, in the local authority. It will do this by referring back to, and answering, the original research questions posed; discussing the significance of the theory developed and how this should inform the future focus of work to address PSNA. Areas where questions remain unanswered will also be set out.

5.3.1 What are the perspectives of coaches on their work with persistent school non-attenders?

The grounded theory sets out that coaches perceived the success of their interventions to be variable, and for their role with CYP with PSNA to be frustrating and difficult. Through their collective experiences they had come to view PSNA as a ‘red flag’, signalling a CYP feeling unsafe. Generally, this lack of safety was attributed to home and family circumstances.

PSNA, in coaching families, was also felt to be symptomatic of, and perpetuated by, wider environmental conditions, which, if they remained unaddressed, undermined efforts to support a return to school. Coaches, seeing the *bigger picture* because of their work across systems, perceived PSNA to be part of a complex set of circumstances which could not be addressed with a single focus: medical; punitive; *within-child* or school-based.

The significance of this is that, in family coaching, efforts to address PSNA, where the focus is singular, are often futile. The work needs to be re-focused away from any single-track thinking, to ensure that all the causal factors are being addressed. In particular, there must be a greater emphasis on perception of safety as reported by CYP, and subsequent safeguarding work. Coaching has a unique contribution. Having one professional working intensively with a family and the multiple agencies involved, enables observation and assessment of all the contributing factors, and helps to join up the work to make it holistic. This professional is also able to see the gaps in support that exist between other services and agencies.

5.3.2 What do coaches perceive to be the factors influencing the successful reintegration of CYP to school following a period of PSNA?

The grounded theory sets out that coaches perceive that increasing parental capacity is the primary factor influencing the success of their intervention work; enabling parents to feel safe themselves, so that they are able to think longer term, and to behave as authority-figures. This is felt to be the most important way to ensure that a CYP feels *safe* and *seen*. Coaches also feel that improving the *visibility* of CYP more generally, including bespoke adaptations to their educational support, is also key.

The significance of this is, once again, to refocus work away from being school or clinic-based in isolation. Rechannelling the core of the work towards parenting approaches; focusing on security at home and what can help to improve this with a particular awareness that safeguarding concerns could be a major factor. What remains for further exploration is how best to increase parental capacity in the longer

term. This study was able to draw out some of the ways in which coaches were doing this successfully, but cannot make any substantive claims about the best methods.

5.3.3 What do coaches perceive to be the constraints operating to prevent the successful reintegration of CYP to school following a period of PSNA?

The theory sets out that coaches perceive there are systemic constraints to the success of their work. They are limited in how much they, as individuals in one agency, are able to overcome broader issues working against them. Poverty, the class system and the wider educational agenda, for example, might not be straightforward obstacles to address. Coaches perceive that even within individual families, PSNA may be fulfilling a purpose, which leads to parents and CYP rejecting their support. They often need to manage significant conflict between systems, which works against the success of their intervention.

The significance of this is the need to acknowledge these constraints within the wider organisation, so that coaches are not being set up to fail in their endeavours to intervene. Coaches need a mechanism to help them to assess and understand the particular pattern of constraints working around each case, so that they can understand the context and underlying processes. This will better enable them to plan for successful intervention. What remains for further exploration is how best to address these constraints. This study was able to elucidate what the main constraints were, but not to draw firm conclusions about how these are best overcome or addressed.

5.3.4 How can the theory that explains the process of successful coach intervention in the local authority inform future intervention and policy development?

The theory set out in chapter 4.0 of this thesis has several implications for future intervention and policy development. The tentative conclusions that can be drawn are reiterated below:

1. Coaching intervention needs to be re-focused away from single-track approaches (medical; punitive; within-child or school-based), to ensure that all the causal factors are being addressed.
2. There must be a greater emphasis on the CYP's feelings of safety, and associated safeguarding work.
3. Coaching has a unique contribution and can be a successful way to address PSNA. Having one professional working intensively with a family and the multiple agencies involved, enables observation and assessment of all the contributing factors, gives an overview of the gaps between agencies, and helps to join up the work to make it holistic.
4. Success will be greatest by rechannelling the core of the work towards approaches that increase parenting capacity; enabling parents to feel safe and secure themselves, so that they are able to think longer term, and to behave as authority-figures. Parent training approaches will not be as successful as relationship-based approaches because greater success is felt to occur when parents trust coaches. More superficial approaches may result in apparent compliance, not full engagement.

5. Improving the visibility of CYP more generally, including bespoke adaptations to their educational support, is also key. CYP respond best when they feel *listened to* and *cared about*.
6. Broader constraints such as, poverty, the class system and the wider educational agenda; rejection or sabotage by CYP and their parents; and significant conflict between systems, need to be acknowledged. Coaches need a mechanism to help them to assess and understand the particular pattern of constraints working around each case, so that they can understand the context and underlying processes. This will better enable them to plan for successful intervention.

Further research needs to be carried out in order to understand how best to increase parental capacity in the longer term as well as how best to overcome the constraints outlined. This study was able to draw out some of the ways in which coaches were doing this successfully, but cannot make any substantive claims about the best methods.

Feedback of the findings to ITF family coaches was carried out at one of their team meetings and a handout and a summary report was provided to their operational managers. Unfortunately, six months following the research study, cuts were made to several local authority services, including ITF. The number of coaches employed by the authority was halved, which has significantly reduced the scope and intensity of their work. However, the restructuring of the team also provides an opportunity for senior managers to review policy and practice. It is hoped that the findings from this study will feed into this process.

The findings were also summarised and presented to the EP service and a summary report provided to the assistant director of children's services. The team of EPs fed back that the findings resonated with their own experiences and that the findings could have wider relevance in the service work with exclusions and challenging behaviour. One EP took the findings to share with staff at the local SEMH provision, where attendance is a significant issue. Some authority-wide training has been developed for school staff and other professionals, in order to improve knowledge and practice, which will run biannually.

It has always been the intention that this research will contribute to the development of some local authority guidance and an assessment tool for use in supporting cases of PSNA. This is yet to be written, though some formulations have been made regarding the basis of an assessment tool for use with coaching families. This would incorporate a genogram and timeline, to discern any precipitating events or triggers, as well as secondary and maintaining factors. The tool would look carefully at both push and pull factors, with a specific focus on how safe the CYP was feeling at home. The emphasis of the assessment tool would be the concept of PSNA as a red flag, which should open lines of enquiry into safeguarding, and ensure that safety becomes a key focus of intervention. An initial assessment tool, which helps to measure the wider constraints operating to prevent successful intervention, might enable coaches to plan additionally for how to address these.

5.4 The wider impact and implications for Educational Psychologists

To a limited extent, this study also has transferability outside the locality where it took place. Though the research was specific to a small group of professionals working in one team, several, more general, premises about PSNA intervention have been generated as a result of the grounded theory emerging from this study:

1. Successful PSNA intervention might include measures to ensure that CYP feel adequate levels of safety and security at home;
2. Successful PSNA intervention might include measures to increase the capacity of parents to set effective boundaries and take an authority position;
3. Making changes and adaptations solely to the school system, or working therapeutically solely with the CYP, may not affect successful, lasting changes in attendance. Successful PSNA intervention might seek to identify and address all the environmental factors.
4. Intervention is more likely to be successful where all the relevant systems are cooperating, and share aims and values. Conflict between systems might be a component, and maintaining factor, of PSNA;
5. Cases of PSNA may occur more frequently among CYP with a lower socio-economic-status and those living in poverty.

These hypotheses may be helpful to any professional working with PSNA in the wider context; including those setting policies for intervention and support. At the core of this is the shift from thinking about the problem being located within the CYP or about school per se, and widening the lens to asking questions about their safety

and security at home. Additionally, once it has been developed, the assessment tool set out in section 5.3, might provide a useful starting point for other professionals and localities in obtaining an understanding of the factors involved in PSNA in their own contexts. It is hoped that the research will act to promote an additional way of thinking about the issue, and further questions to be asked about CYP behaving in this way.

The findings also have several clear implications for EPs, who are often called upon to make judgements about the best way forward in cases of PSNA. Firstly, though the individual circumstances should always be looked at on a case by case basis, EPs should remain mindful of the possibility that a CYP is being drawn out of school because they lack adequate feelings of safety and security within the family home. EPs have a clear corporate parent and safeguarding role. As PSNA might be a marker for issues that could fall into the category of child protection, at the very least, the question should be raised. Thought should also be given to what else in EP work might be a CYP *raising a red flag*. Challenging behaviour, for example, could be a different symptom marking similar underlying problems.

This safeguarding role extends to multi-agency working, where there may be ample opportunity for struggling CYP and families to *slip through the net*. The findings from child abuse inquiries (also known as Serious Case Reviews) suggest that problems with interagency working are common (Rouf, 2014). Rouf also identifies the need for agencies to work together and not ignore signs, especially where there might be *grey areas* regarding judgements about parenting. The circumstances

highlighted in this study suggest that not all CYP in abusive or unsafe homes are adequately identified or supported. EPs, who might be part of a multi-agency team or conducting visits to the family home, should always ensure that concerns are registered appropriately, erring on the side of caution and never assuming that another service will take action without following-up that this has happened. EPs might also have a role in understanding and acknowledging the unconscious processes within multi-agency working; difficult cases where professionals are most likely to pass blame or responsibility for example.

The concept of *pathologizing poverty* may also be relevant across a range of other EP work. Connections were made in section 5.2, between poverty and SEND, as well as with PSNA being part of a spectrum of psychological conditions, including mental ill-health. It would seem pertinent to explore the impact of poverty upon CYP in other areas of EP work; systematically monitoring referrals to provide further insight into this phenomenon. The knowledge that socio-economic-status has strong associations to SEND and PSNA, should also enable better planning in local authorities; early identification of those at risk of PSNA, better tracking and monitoring procedures, for example. In the local authority where this research takes place; there exists a *vulnerability index*, which is collated in order to try to identify those CYP who might struggle on transition to secondary school. Systems such as these could be extended to include risk of PSNA.

EPs would be well-placed to research the issues directly relating to families living in poverty, for example short-term thinking and prioritising food security over

education. These have been addressed in some cases through *extended schools* approaches that seek to support families more holistically, with literacy classes, free breakfast clubs, and such (Dyson, 2011). The potential impact of wider policies, such as the universal basic income (Painter, 2016), upon children living in poverty and their educational attainment, would also be useful to research.

Finally, EP practice should continue to be at the forefront of enabling CYP to have a voice in decisions regarding their life and learning, in line with current legislation, education policy, and practice. The SEND Code of Practice (DFE, 2014b) promotes pupil participation, highlighting the right of children with SEN to be included in decision-making, and the importance of determining their views. The CYP with PSNA in this study appeared to feel invisible, which exacerbated their situation. How EPs listen to and record the voice of the child has been discussed previously in the literature (Harding & Atkinson, 2009). This study reiterates the great importance of this aspect of our practice.

5.5 Limitations

This study was conducted with 19 participants over a four-month period within a single local authority team. Coaching families have multiple issues, specifically poverty-related factors, which may not be reflective of CYP affected by PSNA more generally. The overlapping ITF criteria for involvement meant that coaches mainly worked with families where PSNA was an issue alongside adult unemployment, anti-social behaviour, or both. The study cannot therefore be said to have a clear overview of how PSNA operates in general, even locally. Claims therefore cannot be generalised to other contexts or thought about more widely without first exercising great caution.

According to the criteria used to rate the *design* of qualitative studies in the systematic literature review in Appendix B, this study, in its current form, would only achieve a level 2 (moderate) rating. The aims of the study were clearly stated in chapter 2.0, and justified as relevant to current Educational Psychology practice. The methodology, research design and recruitment strategy were appropriate to the stated aims and research questions. Ethical issues were addressed, and the study was considered by the TREC (Tavistock Research Ethics Committee) to be ethically appropriate. Data was analysed rigorously using a well-known software programme and referencing is adequate. Findings are explicit, conclusions are supported by the findings, and the research is felt to make a valuable contribution to the area. However, it falls short of a 3 (strong) rating because the findings have not been triangulated, and not all the issues raised by the results have been addressed, including some anomalies. The anomalies, though few, include families where some

siblings have good school attendance alongside those with PSNA, and families where parents were felt to be middle class or academics. Additionally, the relationship between researcher and participants may not have been adequately considered and this will be discussed further in section 5.4.1.

According to the criteria used to rate the *significance of outcomes* in qualitative studies in the systematic literature review in Appendix B, this study, in its current form, would only achieve a level 1 (weak evidence) rating. The analysis is appropriate but not triangulated. However, the criteria used to critique outcomes is not fully appropriate in the case of this study, because it is not concerned with whether the coaching model is a successful intervention or not, only what factors are perceived by coaches to help or hinder. To meet the criteria for a level 2 or higher, it would have been helpful to include some statistical data about the success of the ITF team in raising attendance. This information was not made available to the researcher, despite efforts to obtain it.

Charmaz (2006) suggests that in evaluating GT studies, four criteria are used: credibility; originality; resonance; and usefulness. Evaluating this study according to these criteria leads to the following conclusions about its strengths and weaknesses:

Credibility

The research is felt to have achieved a high level of intimate familiarity with the topic from the coaches' perspectives. Systematic comparisons have been made between the

focus groups and between categories. There are logical links between the gathered data and the developed theory and it is felt that there is good enough evidence for an independent reader to agree with the claims made; reinforced by the reading of the coding system by peers and supervisors.

However, the data could be improved in terms of the range, number and depth of observations; categories would benefit from including a wider range of empirical observations in order to sufficiently merit the claims made, for example from a range of additional stakeholders (such as parents, school staff, mental health professionals and CYP themselves). Reaching *saturation* was achieved in only a partial sense. The perspectives of the coaches were mined to the point where few novel concepts were arising, and many others were being reiterated, but not to the point where *all* the possible concepts and themes were believed to have been *exhaustively* mined. The research was also curtailed by the necessity of completing within a fixed period of time and the limited number of possible volunteers.

Originality

In comparison with the wider literature, the categories are fresh and offer some new insights. There is felt to be social and theoretical significance to the work, which both challenges and refines current ideas and practices.

It might be judged that the analysis was overly descriptive and did not provide enough of a conceptual re-rendering of the data. Birks and Mills (2015) state that “a

study is not grounded theory if it does not reach a high level of conceptual abstraction that is beyond the level of description” (p.115). Chapter 4.0 is largely descriptive, and a higher level of conceptual abstraction might be considered more academically rigorous, in line with the GT methodology.

However, Charmaz (2006) talks about GT studies defining finished grounded theory in a variety of ways: “an empirical generalization, a category, a predisposition, an explanation of a process, a relationship between variables, an explanation, an abstract understanding, and a description” (p133). She cites Glaser as describing it as a “theory of resolving a main concern that can be theoretically coded in many ways” (p. 180). There is no firm agreement within the academic literature. Charmaz herself says, “when we think about identifying defining properties of grounded theory, we enter ambiguous terrain” (p. 180).

Resonance

The developed grounded theory made sense; not only to the participants themselves, who felt that it described their perspectives and experiences accurately, but also to other professionals, such as EPs and teaching staff, with whom the findings were shared. The theory was also felt to be accessible and meaningful when fed back to stakeholders in the local authority. The analysis is felt to offer some deeper insights about the processes at play, in particular about why success should be so variable in PSNA. Where the data indicated, links were drawn between individual experiences and wider systems and institutions. The fullness of the studied experience was felt to be portrayed within the theory. The analysis may not have offered all the participants’

deeper insights about their work, nor uncovered all the deeper meanings embedded in the data. It is not yet known whether the theory will resonate with CYP or parents.

Usefulness

The main objective of a practitioner researcher is to produce research that is useful to all the stakeholders; something that is clear, accessible and that can feed into future ways of working. This GT study is felt to offer interpretations that can be used in the future to frame work with PSNA and contributes to knowledge by reframing the view of PSNA as a pathology to being an environmentally-triggered indicator of difficulties at home. It is felt that future research could be sparked by this study, which pursues this idea further.

If future intervention in PSNA includes improving the safety and security of the CYP's home environment where possible, rather than simply providing medical or punitive treatment, it is felt that this study will have provided benefit to CYP more generally; even if it just inspires a checking question to be asked by professionals in each case.

5.5.1 Reflections on the process

Real world research is never straightforward. Setting up the focus groups was administratively difficult, and because the research was not a work priority for the coaches but an additional demand, last minute conflicting demands were sometimes

prioritised, leaving the number of coaches in a group a little lower than was felt to be optimal. Sickness was also an issue, with two volunteers unable to participate at all.

The focus group methodology was felt to work well, but there were inequities in terms of participant contribution. Within each group there were more and less dominant personalities, reflecting how much air time was given to each. Dominant speakers shaped the discussion; later analysis of the transcripts backing up what the researcher felt at the time to be marginalisation of less confident participants, or those newer to the role.

Factors such as the group discussion context, and politics and dynamics within the local authority, may have had a limiting effect upon how much the coaches felt they could say openly. It may also be possible that the relationship built up through previous working links with the researcher had some effect upon the nature of the data collected. The researcher and the participants existed within the same cultural local authority context, which may have led to the researcher making assumptions about shared understandings without always seeking clarification.

There is also evidence in the transcripts, of the researcher's own influence. The researcher's prior relationships with several of the coaches, through individual consultation and training, are apparent; there are references in the transcripts to past joint work or training input delivered to the team. Further, the researcher found it difficult not to be too vocal during the focus groups, putting forward her own

opinions, thus influencing the direction of discussions. The outcomes and processes may therefore have been influenced to some extent by the researcher's own position.

To mitigate the limitations associated with the focus group method and the familiarity of the researcher to the participants prior to the study, several steps were taken.

Rather than rely upon discussion questions, the format of the first two focus groups largely consisted of each coach in turn telling the *stories* of two specific cases that they had deemed *successful* and *unsuccessful*. This promoted greater equity of air space between participants and gave every participant a significant voice. This technique also allowed each participant to contribute a long, descriptive narrative about their individual experience without significant interruption. These narratives were a rich source of many of the initial codes that became the basis of the final grounded theory.

Although a prior relationship existed between the participants and the researcher, this study was presented as an attempt to find greater clarity in an area that perplexed both parties. The researcher did not present as an *expert*, but as a curious partner, drawing upon the expertise and experience of the coaches. As set out in chapter 2, the focus group technique was chosen because it was felt to moderate the influence of the interviewer. As the transcripts show, the direction of conversation was frequently influenced by the enquiries of the other participants, which led to alternative lines of enquiry and tangents being followed.

This study initially took a critical realist approach to grounded theory, assuming that it would be possible to explore the mechanisms working in the local context to impact PSNA and the efficacy of intervention; that these existed independently of the coaches' knowledge and experience. As the study proceeded it was felt that the social constructionist approach was more fitting. The focus groups provided a rich opportunity for the coaches to co-construct their own understanding of PSNA and their intervention work. As the researcher was part of the focus groups, she was also part of the process of co-construction, creating a feedback loop that flowed throughout all the groups. For example, saying that 'most coaches so far have said...' to a subsequent group, fuelled the process. It gave the greatest power and voice to the first participants, after which it became more difficult for coaches to voice divergent lines of thought. It was largely this socially constructed understanding that the research tapped into.

In terms of the process of data analysis, it was felt that generating 1400 initial codes from the first two focus groups before starting to create axial codes, was an error. This created an unwieldy amount of data that was difficult to organise. Creating the codes themselves was an attempt to be as objective as possible, grounding the codes in the data and keeping as close as possible to participant's contributions. However, it is inevitable that there was some degree of subjectivity in this process.

The researcher filters the data through a personal lens that is situated in a specific socio-political and historical moment. One cannot escape the personal interpretations brought to qualitative analysis (Creswell, 2009, p. 182).

5.6 Conclusion and future directions

This study has explored the unique experiences and perspectives of family coaches working in one UK local authority, in order to better understand what factors, they perceive, to help and hinder the reintegration of a child to school after a period of PSNA. Coaches' perspectives on the factors influencing the successful reintegration of CYP to school following a period of PSNA and the constraints operating to prevent this have been expounded. A grounded theory has been developed to describe the processes in operation, which emphasises the importance of ensuring that CYP from coaching families feel safe in their family home, as the key focus of successful intervention. A theoretical framework for successful coach intervention has been suggested, as well as implications for policy.

The key message that emerged from this study is that, in coaching families, PSNA occurs, as part of a spectrum of psychological conditions, when a CYP feels unsafe; chiefly a product of the home environment not providing a secure base, parents having diminished capacity and the CYP feeling that their situation is invisible to others. Successful intervention addresses this directly; building parental capacity, and adapting the environment to increase visibility so that the CYP is helped to feel safe enough. Coaches feel that they are working, sometimes with futility, against several powerful systems in their efforts to do this.

“You know, it’s about family relationships. It’s about having that secure base and a sense of belonging – this child at home. And I’ve had, I think quite a few of the cases I’ve worked in, (...) ...it’s not really been about school. Even though it’s presented at school. It’s always been about something that needed my focus and attention with the family at home.” [Ruth, FG1:15]

To build up a more trustworthy picture of PSNA in the local situation, it would be helpful to take this grounded theory as it stands to a number of additional stakeholders in the locality including: the home tuition service; CYP, parents; paediatricians; school staff; educational psychologists; mental health professionals and social workers. This would help to check the validity of the theory and would address the skew created by the co-occurring coaching criteria of unemployment and anti-social behaviour. A grounded theory revised and developed in this way would enhance the theoretical framework for intervention in the local area. This would further inform future intervention and policy development in the local area and potentially beyond.

Though the scale of this study has been small, it is hoped that it will help to broaden the view of PSNA; not as a psychiatric condition or a criminal activity, but sometimes as a rational response to environmental barriers to feeling safe. PSNA is one way that CYP can raise a red flag to show their distress. It is hoped that, as the adults around them, we will be able to take note and listen.

“And there’s gonna be so much rage there. And I think I feel it sometimes with older children who’ve been let down and should have been taken, accommodated really. And they have been let down by social workers who haven’t got to the root of what’s going on. And I think they are really, justifiably, furiously angry and resentful with professionals.” [Sarah, FG2:119]

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Yeung, R., Gunton, B., Kalbacher, D., Seltzer, J., & Wesolowski, H. (2011). Can health insurance reduce school absenteeism? *Education and Urban Society*, 43(6), 696-721.

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7.0 Appendices

7.1. Appendix A: Details of literature searches

Search number	Purpose of search	Search criteria applied	Exclusions applied	No. results
1	To gain an overview of the different terms used to define school non-attendance and their conceptual differences	(SU "school refus*" OR SU "School non-attend*" OR SU "school absen*" OR SU "school phob*" OR SU "school nonattend*" OR SU "school truan*") AND (SU "defin*" OR "term*")	English language Published within the last 10 years	34
2	To gain an understanding of the origins of the literature on school non-attendance.	(SU "school refus*" OR SU "School non-attend*" OR SU "school absen*" OR SU "school phob*" OR SU "school nonattend*" OR SU "school truan*")	English language Published before 1940	112
3	To gain an overview of demographic information such as: who is affected by school non-attendance; what are understood to be the key risk factors and causes; and what are the predicted outcomes for this group.	(SU "school refus*" OR SU "School non-attend*" OR SU "school absen*" OR SU "school phob*" OR SU "school nonattend*" OR SU "school truan*") AND a). (SU "risk factor*" OR "caus*") b). (SU "rate*" OR "prevalence*" OR "demographic*") c). (SU "outcome*" OR "effect*")	English language Published within the last 10 years	a). 42 b). 79 c). 80
4	To gain an overview of the key theories and models in use.	SU "school refus*" OR SU "School non-attend*" OR SU "school absen*" OR SU "school phob*" OR SU "school nonattend*" OR SU "school truan*" AND SU "theor*" OR SU "model*"	English language Published within the last 10 years	12
5	To gain an understanding of the range of intervention and treatment methods available to this group	SU "school refus*" OR SU "School non-attend*" OR SU "school absen*" OR SU "school phob*" OR SU "school nonattend*" OR SU "school truan*" AND SU "therap*" OR SU "reintegrat*" OR SU "address*" OR SU "support*" OR SU "help*" OR SU "interven*" OR SU "solution*" OR SU "approach*" OR SU "treat*" OR SU "manag*"	English language Published within the last 10 years	116

7.2. Appendix B: Systematic review of the literature on treatment and intervention of persistent school non-attendance

Systematic review of the literature on treatment and intervention of persistent school non-attendance

1.0 Flow chart showing the search methodology employed.



1.1 Table showing the search terms used

Search number	Subject terms/key words (Boolean search mode)	Search limiters applied	Number of studies identified
1	SU "school refus*" OR SU "school non-attend*" OR SU "school absen*" OR SU "school phob*" OR SU "school nonattend*" OR SU "school truan*"	English Language 2006 – 2016	PsychINFO 275 ERIC 20
2	SU "therap*" OR SU "reintegrat*" OR SU "address*" OR SU "support*" OR SU "help*" OR SU "interven*" OR SU "solution*" OR SU "approach*" OR SU "treat*" OR SU "manag*"	School-aged (6-12 years) or adolescent (13-17 years) population	PsychINFO 387,951 ERIC 60,990
3	Search 1 AND Search 2		PsychINFO 116 ERIC 12 Duplicates 5 Total unique articles 123

1.2 Table showing Inclusion Criteria and rationale

Inclusion Criteria	Rationale
Published in the English Language	Ability of the researcher to access fully
Published between October 2006 and October 2016	Earlier articles considered as having limited relevance to current practice
Research undertaken in a country belonging to the Organisation for Economic Co-ordination and Development (OECD)	Countries outside of this considered to have significant cultural differences in political, social and educational factors.
The focus of the paper is not on school-aged children	Papers which look at non-attendance in older students or pre-school children are felt to be less relevant to the review question posed about 'school' attendance as they are concerned with distinctly different populations.

1.3 Table showing Exclusion Criteria and rationale

Exclusion Criteria	Rationale
<p>Article is a book review</p> <p>The foci of the paper are the causal, co-existing or resulting factors, rather than intervention, including: psychiatric disorders, conditions and/or mental health factors (e.g. psychosomatic illness, anxiety, depression, separation anxiety disorder, ASD and post-traumatic stress); school factors (e.g. levels of disruptive or violent behaviour, methods of attendance data collection, perceptions of low teacher support, poor classroom management, levels of teacher attachment, support for SEN); CYP factors (e.g. popularity, chronic illness, asthma, hormone disorder, less healthy emotional regulation strategy, drug-use, delinquency/criminal activity, pregnancy, migraine, suicide attempt, risky sexual behaviour, exam phobia, violence, general health, level of self-control, learning difficulties/SEN, social skills, chronic pain, gender, ethnicity and sexual orientation, academic attainment); family factors (parental mental health, emotional/attachment bonds with parents, levels of parental support); societal factors (e.g. social class, poverty, inequity); social factors (e.g. bullying, peer relationships) and public health policy (e.g. expansion of public health insurance and seasonal or universal immunisation programmes).</p>	<p>Although understanding and managing the causal and co-morbid factors can be helpful in trying to address school non-attendance, these papers are not directly relevant in answering the review question. They provide useful additional information about the possible circumstances surrounding school non-attendance, but not direct evidence about how this can be specifically addressed.</p>
<p>The paper is written in general advisory terms.</p>	<p>The paper is not reporting on any specific studies, but is written to give a general overview of the subject for school-based staff or a model or guidelines for professionals. As such it cannot be said to provide 'evidence' of successful intervention.</p>

The paper is an opinion piece.	The paper does not provide evidence of intervention, instead setting out the author's personal philosophy about approaches which may be most beneficial, grounded in individual experience.
The paper is about assessment rather than intervention.	The paper is concerned with comparing methods of assessing the severity of school non-attendance, and does not provide evidence of successful intervention.
The paper explores classification, taxonomy, definition or meaning.	The paper is concerned with exploring the definition of school non-attendance and our understanding of the behaviour, rather than evidence about successful intervention.
The paper is a review of the existing literature or practice. It therefore reports secondary data. [NB/some of the systematic literature review papers will be referred to outside of this specific review]	The paper or chapter reviews the existing literature on PSNA and provides a meta-analysis, systematic literature review or general overview of several areas of the subject, rather than direct evidence about the success of an intervention. The paper may also propose a theoretical model based upon its findings, but one which is unproven. It may also be a survey or description of current professional practice or casework.
The paper describes a project which has not yet been followed-up/evaluated.	The intervention approach is described but no evaluation exists to measure its success.
The paper is an editorial	The paper is an introductory piece opening a journal edition and does not contain any information about PNSA in itself.
The paper is a retrospective of the lived experience of PSNA	The lived experiences involve several methods of intervention, none of which are measurable retrospectively.

1.4 Table showing the details of all studies identified by the search and reasons for exclusion

Reason for exclusion	Number of studies excluded
Non-OECD country	4
Book review	3
Printed correction	1
Introduction to a special edition	1
Paper explores or addresses causes or co-existing factors	35
General advisory paper	12
Opinion piece	6
Explores assessment, not treatment	2
Explores definition	2
Paper is a review of other papers or current practice	22
Paper has no follow-up or results	2
Paper is a retrospective of the lived experience of PSNA	1
Paper is an editorial	1
Total	92

1.5 List of individual excluded studies with reasons for exclusion

	Article	Reason for exclusion
1	Prevalence and correlates of truancy among adolescents in Swaziland: Findings from the Global School-Based Health Survey. Siziya, Seter; Muula, Adamson S.; Rudatsikira, Emmanuel; Child and Adolescent Psychiatry and Mental Health, Vol 1, Nov, 2007	Non-OECD country
2	Efficacy of group counselling interventions (positive reinforcement and self-control techniques) in remedying truancy among school- going adolescents in Ilorin, Nigeria. Idowu, Adeyemi I.; Durosaro, Irene; Esere, Mary O.; IFE Psychologia: An International Journal, Vol 18(1), 2010 pp. 54-65.	Non-OECD country
3	Review of Understanding school refusal: A handbook for professionals in education, health and social care. Cole, Ted; Emotional & Behavioural Difficulties, Vol 14(1), Mar, 2009 pp. 88.	Book review
4	Review of Overcoming your child's fears & worries; Understanding school refusal; Families, carers and professionals: Building constructive conversations; and Parents' anger management: The PAMP Programme. Guha, Martin; Journal of Mental Health, Vol 18(2), Apr, 2009 pp. 180-182.	Book review
5	Review of When children refuse school: A cognitive-behavioural therapy approach (2nd ed.), Therapist guide and Parent workbook. Little, Emma; Educational Psychology, Vol 28(3), May, 2008 pp. 353-354.	Book review
6	Corrections. No authorship indicated; Family Court Review, Vol 46(1), Jan, 2008 Special Issue: Including children in family law proceedings--International perspectives. pp. 10.	Printed correction
7	Introduction to special edition. Reid, Ken; Educational Studies, Vol 41(1-2), Mar, 2015 pp. 4-13.	Introduction to a special edition.
8	A Case-Control Study of Emotion Regulation and School Refusal in Children and Adolescents. Hughes, Elizabeth K.; Gullone, Eleonora; Dudley, Amanda (2010). Journal of Early Adolescence, v30 n5 p691-706.	Paper explores or addresses cause or co-existing factors

9	Why Kids Refuse to Go to School . . . and What Schools Can Do about It. Wimmer, Mary (2008). Education Digest: Essential Readings Condensed for Quick Review, v74 n3 p32-37.	General advisory paper
10	School Refusal. Wimmer, Mary (2008). Principal Leadership, v8 n8 p10-14.	General advisory paper (duplicate of the above paper)
11	In Praise of Wasting Time in Education: Some Lessons from the "Romantics". Halpin, David (2008). FORUM: for promoting 3-19 comprehensive education, v50 n3 p377-381.	Opinion piece
12	Forms and Functions of School Refusal Behavior in Youth: An Empirical Analysis of Absenteeism Severity. Kearney, Christopher A. (2007). Journal of Child Psychology and Psychiatry, v48 n1 p53-61.	Explores assessment, not treatment
13	School Refuser Child Identities. Stroobant, Emma; Jones, Alison (2006). Discourse: Studies in the Cultural Politics of Education, v27 n2 p209-223.	Explores definition
14	Impact of brief intervention services on drug-using truant youths' self-reported delinquency and arrest charges: A longitudinal study. Dembo, Richard; Schmeidler, James; Wareham, Jennifer; Briones-Robinson, Rhissa; Winters, Ken C.; Ungaro, Rocio; (2016). Journal of Child & Adolescent Substance Abuse, Vol 25(5), pp. 458-479.	Paper explores or addresses cause or co-existing factors
15	Brief intervention impact on truant youths' marijuana use: Eighteen-month follow-up. Dembo, Richard; Briones-Robinson, Rhissa; Schmeidler, James; Wareham, Jennifer; Ungaro, Rocío; Winters, Ken C.; Karas, Lora; Wothke, Werner; Belenko, Steven; (2016). Journal of Child & Adolescent Substance Abuse, Vol 25(1), pp. 18-32.	Paper explores or addresses cause or co-existing factors
16	The influence of parental mental health and family psychosocial functioning on bystander behavior of elementary school children. Jenkins, Joanna C.; Dissertation Abstracts International Section A: Humanities and Social Sciences, Vol 76	Paper explores or addresses cause or co-existing factors
17	Managing school absenteeism at multiple tiers: An evidence-based and practical guide for professionals. Kearney, Christopher A.; (2016). Publisher: Oxford University Press.	General advisory paper
18	Current status of research on school refusal. Inglés, Cándido J.; González-Maciá, Carolina; García-Fernández, José M.; Vicent, María; Martínez-Monteagudo, M. Carmen; European Journal of Education and Psychology, Vol 8(1), Jun, 2015 pp. 37-52. 15.	Review of other studies

19	School factors associated with school refusal- and truancy-related reasons for school non-attendance. Havik, Trude; Bru, Edvin; Ertesvåg, Sigrun K.; <i>Social Psychology of Education</i> , Vol 18(2), Jun, 2015 pp. 221-240.	Paper explores or addresses cause or co-existing factors
20	From waiting room to mother's lap: Parameters in testing a psychotic, school-phobic child. Kleiger, James H.; <i>Journal of Personality Assessment</i> , Vol 97(3), May, 2015 pp. 224-229.	Explores assessment, not treatment
21	Pupil absenteeism and the educational psychologist. Carroll, H. C. M. (Tim); <i>Educational Studies</i> , Vol 41(1-2), Mar, 2015 pp. 47-61.	Review of other studies
22	Coping with life by coping with school? School refusal in young people. Gulliford, Anthea; Miller, Andy; In: <i>Educational psychology</i> , 2nd ed. Cline, Tony (Ed); Gulliford, Anthea (Ed); Birch, Susan (Ed); Publisher: Routledge/Taylor & Francis Group; 2015, pp. 283-305.	Review of other studies
23	Adopting a person-centered approach to adolescent school non-attendance in Japan. Nagano, Koji; In: <i>The person-centered approach in Japan: Blending a Western approach with Japanese culture.</i> Mikuni, Makiko (Ed); Publisher: PCCS Books; 2015, pp. 15-42.	Opinion piece
24	Student behavioral engagement as a mediator between teacher, family, and peer support and school truancy. Virtanen, Tuomo E.; Lerkkanen, Marja-Kristiina; Poikkeus, Anna-Maija; Kuorelahti, Matti; <i>Learning and Individual Differences</i> , Vol 36, Dec, 2014 pp. 201-206.	Paper explores or addresses cause or co-existing factors
25	Student absences and student abscesses: Impediments to quality teaching. Wilson, Rebekah; <i>The Urban Review</i> , Vol 46(5), Dec, 2014 pp. 831-845.	Paper explores or addresses cause or co-existing factors
26	Impact of brief intervention services on drug-using, truant youth arrest charges over time. Dembo, Richard; Briones-Robinson, Rhissa; Wareham, Jennifer; Schmeidler, James; Winters, Ken C.; Barrett, Kimberly; Ungaro, Rocio; Karas, Lora M.; Belenko, Steven; <i>Journal of Child & Adolescent Substance Abuse</i> , Vol 23(6), Nov, 2014 pp. 375-388.	Paper explores or addresses cause or co-existing factors
27	Your Health, an intervention at senior vocational schools to promote adolescents' health and health behaviors. Bannink, Rienke; Broeren, Suzanne; Heydelberg, Jurriën; van 't Klooster, Els; van Baar, Cathelijjn; Raat, Hein; <i>Health Education Research</i> , Vol 29(5), Oct, 2014 pp. 773-785.	Paper explores or addresses cause or co-existing factors

28	The school situation for students with a high level of absenteeism in compulsory school: Is there a pattern in documented support? Strand, Anne-Sofie M.; Granlund, Mats; Scandinavian Journal of Educational Research, Vol 58(5), Sep, 2014 pp. 551-569.	Paper explores or addresses cause or co-existing factors
29	Pervasive refusal syndrome (PRS) 21 years on: A re-conceptualisation and a renaming. Nunn, Kenneth P.; Lask, Bryan; Owen, Isabel; European Child & Adolescent Psychiatry, Vol 23(3), Mar, 2014 pp. 163-172.	Paper explores or addresses cause or co-existing factors
30	A response to intervention model to promote school attendance and decrease school absenteeism. Kearney, Christopher A.; Graczyk, Patricia; Child & Youth Care Forum, Vol 43(1), Feb, 2014 pp. 1-25	Review of other studies
31	Problematic school absenteeism. Kearney, Christopher A.; Ross, Emma; In: Comprehensive evidence based interventions for children and adolescents. Alfano, Candice A. (Ed); Beidel, Deborah C. (Ed); Publisher: John Wiley & Sons Inc; 2014, pp. 275-286.	Paper explores or addresses cause or co-existing factors
32	School refusal behavior. Kearney, Christopher A.; Diliberto, Rachele; In: The Wiley handbook of cognitive behavioral therapy. Hofmann, Stefan G. (Ed); Dozois, David J. A. (Ed); Rief, Winfried (Ed); Smits, Jasper A. J. (Ed); Publisher: Wiley-Blackwell; 2014, pp. 875-892.	Review of other studies
33	School refusal behavior. Kearney, Christopher A.; Spear, Melissa; Mihalas, Stephanie; In: Translating psychological research into practice. Grossman, Lisa (Ed); Walfish, Steven (Ed); Publisher: Springer Publishing Co; 2014, pp. 83-88.	Review of other studies
34	Prevention and treatment of school refusal: A collaborative approach. Richardson, Diana D.; Dissertation Abstracts International Section A: Humanities and Social Sciences, Vol 74.	Review of other studies
35	The impact of separation anxiety on the social and academic functioning of young school-age males and females. Tamayo, Geraldine; Dissertation Abstracts International Section A: Humanities and Social Sciences, Vol 75.	Paper explores or addresses cause or co-existing factors
36	A meta-analysis of the effects of dropout prevention programs on school absenteeism. Tanner-Smith, Emily E.; Wilson, Sandra Jo; Prevention Science, Vol 14(5), Oct, 2013 pp. 468-478.	Review of other studies

37	Seeing red? The agency of computer software in the production and management of students' school absences. Bodén, Linnea; International Journal of Qualitative Studies in Education, Vol 26(9), Oct, 2013 pp. 1117-1131.	Paper explores or addresses cause or co-existing factors
38	Shape of change in cognitive behavioral therapy for youth anxiety: Symptom trajectory and predictors of change. Chu, Brian C.; Skriner, Laura C.; Zandberg, Laurie J.; Journal of Consulting and Clinical Psychology, Vol 81(4), Aug, 2013 pp. 573-587.	Paper explores or addresses cause or co-existing factors
39	Emotional bonds with parents, emotion regulation, and school-related behavior problems among elementary school truants. Kim, HeeYoung; Page, Timothy; Journal of Child and Family Studies, Vol 22(6), Aug, 2013 pp. 869-878.	Paper explores or addresses cause or co-existing factors
40	Psychological factors behind truancy, school phobia, and school refusal: A literature study. Ek, Hans; Eriksson, Rikard; Child & Family Behavior Therapy, Vol 35(3), Jul, 2013 pp. 228-248.	Review of other studies
41	Working in Europe to Stop Truancy Among Youth (WE-STAY) Project: Preventing truancy and promoting mental health of adolescents in different European countries. Lanzen, Christoph; Brunner, Romuald; European Child & Adolescent Psychiatry, Vol 22(3), Mar, 2013 pp. 197-198.	No follow-up
42	Management of examination phobia with brief behaviour technology. Ganesan, Rajesh; Indian Journal of Community Psychology, Vol 9(1), Mar, 2013 pp. 213-215.	Paper explores or addresses cause or co-existing factors
43	Assessment and treatment of deficits in social skills functioning and social anxiety in children engaging in school refusal behaviors. Gresham, Frank M.; Vance, Michael J.; Chenier, Jeffrey; Hunter, Katherine; In: Handbook of assessing variants and complications in anxiety disorders. McKay, Dean (Ed); Storch, Eric A. (Ed); Publisher: Springer Science + Business Media; 2013, pp. 15-28.	Paper explores or addresses cause or co-existing factors
44	Is it all worthwhile? - Effectiveness of intensive interdisciplinary pain treatment. Hechler, Tanja; Dobe, Michael; Zernikow, Boris; In: Practical treatment options for chronic pain in children and adolescents: An interdisciplinary therapy manual. Dobe, Michael (Ed); Zernikow, Boris (Ed); Publisher: Springer-Verlag Publishing; 2013, pp. 215-228.	Paper explores or addresses cause or co-existing factors

45	Indicated truancy interventions for chronic truant students: A Campbell systematic review. Maynard, Brandy R.; McCrea, Katherine Tyson; Pigott, Terri D.; Kelly, Michael S.; Research on Social Work Practice, Vol 23(1), Jan, 2013 pp. 5-21.	Review of other studies
46	'Absence makes the heart grow fonder': Students with chronic illness seeking academic continuity through interaction with their teachers at school. Wilkie, Karina J.; Australasian Journal of Special Education, Vol 36(1), Jul, 2012 pp. 1-20.	Paper explores or addresses cause or co-existing factors
47	Panic disorder and school refusal. Hella, Bryce; Bernstein, Gail A.; Child and Adolescent Psychiatric Clinics of North America, Vol 21(3), Jul, 2012 pp. 593-606.	General advisory paper
48	The strategic management of truancy and school absenteeism: Finding solutions from a national perspective. Reid, Ken; Educational Review, Vol 64(2), May, 2012 pp. 211-222.	Opinion piece
49	School avoidance and substance use among lesbian, gay, bisexual, and questioning youths: The impact of peer victimization and adult support. Darwich, Lina; Hymel, Shelley; Waterhouse, Terry; Journal of Educational Psychology, Vol 104(2), May, 2012 pp. 381-392.	Paper explores or addresses cause or co-existing factors
50	Depressive state due to isolated adrenocorticotrophic hormone deficiency underlies school refusal. Iwata, Masaaki; Hazama, Gen-i; Nakagome, Kazuyuki; Psychiatry and Clinical Neurosciences, Vol 66(3), Apr, 2012 pp. 243-244. Publisher: Wiley-Blackwell Publishing Ltd.; [Letter]	Paper explores or addresses cause or co-existing factors
51	Psychosomatic problems and countermeasures in Japanese children and adolescents. Tanaka, Hidetaka; Terashima, Shigenori; Borres, Magnus P; Thulesius, Olav; BioPsychoSocial Medicine, Vol 6, Mar 20, 2012.	Paper explores or addresses cause or co-existing factors
52	Counseling psychologists in schools. Espelage, Dorothy L.; Poteat, V. Paul; In: APA handbook of counseling psychology, Vol. 2: Practice, interventions, and applications. Fouad, Nadya A. (Ed); Carter, Jean A. (Ed); Subich, Linda M. (Ed); Publisher: American Psychological Association; 2012, pp. 541-566.	Review of other studies

53	School refusal behavior: School-based cognitive-behavioral interventions. Kearney, Christopher A.; Spear, Melissa; In: Cognitive-behavioral interventions in educational settings: A handbook for practice, 2nd ed. Mennuti, Rosemary B. (Ed); Christner, Ray W. (Ed); Freeman, Arthur (Ed); Publisher: Routledge/Taylor & Francis Group; 2012, pp. 161-185.	General advisory paper
54	School refusal. Melvin, Glenn A.; Tonge, Bruce J.; In: Handbook of evidence-based practice in clinical psychology, Vol 1: Child and adolescent disorders. Sturmey, Peter (Ed); Hersen, Michel (Ed); Publisher: John Wiley & Sons Inc; 2012, pp. 559-574.	General advisory paper
55	Popularity and school adjustment. Cillessen, Antonius H. N.; Berg, Yvonne H. M. van den; In: Peer relationships and adjustment at school. Ryan, Allison M. (Ed); Ladd, Gary W. (Ed); Publisher: IAP Information Age Publishing; 2012, pp. 135-164.	Paper explores or addresses cause or co-existing factors
56	Perceptions of teachers' support, safety, and absence from school because of fear among victims, bullies, and bully-victims. Berkowitz, Ruth; Benbenishty, Rami; American Journal of Orthopsychiatry, Vol 82(1), Jan, 2012 pp. 67-74.	Paper explores or addresses cause or co-existing factors
57	Darwin won't get outta bed: Understanding adolescent school refusal within the context of evolutionary mismatch theory. Lefevre, Dennis; Dissertation Abstracts International Section A: Humanities and Social Sciences, Vol 72(7-A) pp. 2262.	Opinion piece
58	Parental psychological symptoms and familial risk factors of children and adolescents who exhibit school refusal. Bahali, K.; Tahiroglu, A. Y.; Avci, A.; Seydaoglu, G.; East Asian Archives of Psychiatry, Vol 21(4), Dec, 2011 pp. 164-169.	Paper explores or addresses cause or co-existing factors
59	Can health insurance reduce school absenteeism? Yeung, Ryan; Gunton, Bradley; Kalbacher, Dylan; Seltzer, Jed; Wesolowski, Hannah; Education and Urban Society, Vol 43(6), Nov, 2011 pp. 696-721.	Paper explores or addresses cause or co-existing factors
60	The absence of presence: A systematic review and meta-analysis of indicated interventions to increase student attendance. Maynard, Brandy R. (2011); Dissertation Abstracts International Section A: Humanities and Social Sciences, Vol 72(2-A) pp. 741.	Review of other studies

61	Truancy Assessment and Service Centers (TASC): Engaging elementary school children and their families. Rhodes, Judith L. F.; Thomas, Johanna M.; Lemieux, Catherine M.; Cain, Daphne S.; Guin, Cecile C.; School Social Work Journal, Vol 35(1), Sep, 2010 pp. 83-100.	No results presented, descriptive only
62	A survey of school psychologists' knowledge of school refusal behavior and intervention strategies. DeAngelis, Danielle Lynn; Dissertation Abstracts International Section A: Humanities and Social Sciences, Vol 70(9-A) pp. 3339.	Review of current practice
63	From pills to programs: Lessons from medicine for developing effective lifestyle interventions. Rosen, Laura J.; Manor, Orly; Brody, David L.; Engelhard, Dan; Shtarkshall, Rony A.; Zucker, David; Preventive Medicine: An International Journal Devoted to Practice and Theory, Vol 49(1), Aug, 2009 pp. 12-18.	Opinion piece
64	On developing and evaluating lifestyle interventions. Murray, David M.; Preventive Medicine: An International Journal Devoted to Practice and Theory, Vol 49(1), Aug, 2009 pp. 19-20.	Opinion piece
65	Efficacy of LAIV-T on absentee rates in a school-based health center sample. Mears, Cynthia J.; Lawler, Elisa N.; Sanders, Lee D. III; Katz, Ben Z.; Journal of Adolescent Health, Vol 45(1), Jul, 2009 pp. 91-94.	Paper explores or addresses cause or co-existing factors
66	Psychosocial interventions for school refusal behavior in children and adolescents. Pina, Armando A.; Zerr, Argero A.; Gonzales, Nancy A.; Ortiz, Claudio D.; Child Development Perspectives, Vol 3(1), Apr, 2009 pp. 11-20.	Review of other studies
67	Quality of life in asthmatic adolescents: An overall evaluation of disease control. Alvim, Cristina Gonçalves; Picinin, Isabela Mendonça; Camargos, Paulo Moreira; Colosimo, Enrico; Lasmar, Laura Belizário; Ibiapina, Cássio Cunha; Fontes, Maria Jussara; Andrade, Cláudia Ribeiro; Journal of Asthma, Vol 46(2), Mar, 2009 pp. 186-190	Non-OECD country
68	Seasonal influenza: An overview. Li, Christina; Freedman, Marian; The Journal of School Nursing, Vol 25(Suppl 1), Feb, 2009 pp. 4S-12S.	Paper explores or addresses cause or co-existing factors
69	Functional assessment and treatment of migraine reports and school absences in an adolescent with Asperger's disorder. Arvans, Rebecca K.; LeBlanc, Linda A.; Education & Treatment of Children, Vol 32(1), Feb, 2009 pp. 151-166.	Paper explores or addresses cause or co-existing factors

70	Attendance and truancy: Assessment, prevention, and intervention strategies for school social workers. Leyba, Erin Gleason; Massat, Carol Rippey; In: School social work: Practice, policy, and research, 7th ed. Massat, Carol Rippey (Ed); Constable, Robert (Ed); McDonald, Shirley (Ed); Flynn, John P. (Ed); Publisher: Lyceum Books; 2009, pp. 692-712.	Review of other studies
71	Multi-systemic intervention for school refusal behavior: Integrating approaches across disciplines. Lyon, Aaron R.; Cotler, Sheldon; Advances in School Mental Health Promotion, Vol 2(1), Jan, 2009 pp. 20-34.	General advisory paper
72	Prospective associations between coping and health among youth with asthma. Schreier, Hannah M. C.; Chen, Edith; Journal of Consulting and Clinical Psychology, Vol 76(5), Oct, 2008 pp. 790-798.	Paper explores or addresses cause or co-existing factors
73	School refusal behavior associated with separation anxiety disorder: A cognitive-behavioral approach to treatment. Doobay, Alissa F.; Psychology in the Schools, Vol 45(4), Apr, 2008 pp. 261-272.	Paper explores or addresses cause or co-existing factors
74	Psychosocial treatments for phobic and anxiety disorders in youth. Silverman, Wendy K.; Pina, Armando A.; In: Handbook of evidence-based therapies for children and adolescents: Bridging science and practice. Steele, Ric G. (Ed); Elkin, T. David (Ed); Roberts, Michael C. (Ed); Publisher: Springer Science + Business Media; 2008, pp. 65-82.	Review of other studies
75	The school practitioner's concise companion to preventing dropout and attendance problems. Franklin, Cynthia (Ed); Harris, Mary Beth (Ed); Allen-Meares, Paula (Ed); Publisher: Oxford University Press; 2008. xi, 131 pp.	General advisory paper
76	Helping school refusing children and their parents: A guide for school-based professionals. Kearney, Christopher A.; Publisher: Oxford University Press; 2008. v, 185 pp.	General advisory paper
77	School non-attendance: Definitions, meanings, responses, interventions. Pellegrini, Dario W.; Educational Psychology in Practice, Vol 23(1), Mar, 2007 pp. 63-77.	Explores definition

78	Parent training in the treatment of school refusal behavior. Kearney, Christopher A.; LaSota, Marcus T.; Lemos-Miller, Amie; Vecchio, Jennifer; In: Handbook of parent training: Helping parents prevent and solve problem behaviors, 3rd ed. Briesmeister, James M. (Ed); Schaefer, Charles E. (Ed); Publisher: John Wiley & Sons Inc; 2007, pp. 164-193.	General advisory paper
79	Psychological characteristics and the efficacy of hospitalization treatment on delayed sleep phase syndrome patients with school refusal. Iwamitsu, Yumi; Ozeki, Yuji; Konishi, Mizuho; Murakami, Junichi; Kimura, Shin; Okawa, Masako; Sleep and Biological Rhythms, Vol 5(1), Jan, 2007 pp. 15-22.	Paper explores or addresses cause or co-existing factors
80	When children refuse school: A cognitive-behavioral therapy approach, parent workbook., 2nd ed. Kearney, Christopher A.; Albano, Anne Marie; Publisher: Oxford University Press; 2007. vii, 194 pp.	General advisory paper
81	When children refuse school: A cognitive-behavioral therapy approach, therapist guide., 2nd ed. Kearney, Christopher A.; Albano, Anne Marie; Publisher: Oxford University Press; 2007. vi, 272 pp.	General advisory paper
82	A package of interventions to reduce school dropout in public schools in a developing country: A feasibility study. Graeff-Martins, Ana Soledade; Oswald, Sylvia; Comassetto, Júlia Obst; Kieling, Christian; Gonçalves, Renata Rocha; Rohde, Luis Augusto; Taskforce on prevention of the presidential WPA program on Global Child Mental Health; European Child & Adolescent Psychiatry, Vol 15(8), Dec, 2006 pp. 442-449	Non-OECD country
83	Editorial. Ralph, Sue; Journal of Research in Special Educational Needs, Vol 6(2), May, 2006 pp. 67-68. Publisher: Blackwell Publishing.	Editorial paper
84	School phobia: Understanding a complex behavioural response. Chitiyo, Morgan; Wheeler, John J.; Journal of Research in Special Educational Needs, Vol 6(2), May, 2006 pp. 87-91.	Review of other studies
85	Recent Perspectives Concerning School Refusal Behavior. Witts, Benjamin; Houlihan, Daniel (2007). Electronic Journal of Research in Educational Psychology, v5 n2 p381-398.	Review of other studies

86	Toward Reduced Bias and Increased Utility in the Assessment of School Refusal Behavior: The Case for Diverse Samples and Evaluations of Context. Lyon, Aaron R.; Cotler, Sheldon (2007). <i>Psychology in the Schools</i> , v44 n6 p551-565.	Review of other studies
87	Out of School: A Phenomenological Exploration of Extended Non-Attendance. Baker, Matt; Bishop, Felicity L (2015). <i>Educational Psychology in Practice</i> , v31 n4 p354-368.	Retrospective of lived experience
88	Truancy: It's not about skipping school. Mallett, Christopher A.; (2016). <i>Child & Adolescent Social Work Journal</i> , Vol 33(4), pp. 337-347.	Review of other studies
89	Reading and math outcome equity of students, by language, ethnicity, and gender conditions, required to participate in an attendance court program based on excessive school absences. DeFrank, Kenneth E.; (2015). <i>Dissertation Abstracts International Section A: Humanities and Social Sciences</i> , Vol 76.	Paper explores or addresses cause or co-existing factors
90	Solution-focused family therapy for troubled and runaway youths. Thompson, Sanna J.; Sanchez, Katherine; In: <i>Solution-focused brief therapy: A handbook of evidence-based practice.</i> Franklin, Cynthia (Ed); Trepper, Terry S. (Ed); Gingerich, Wallace J. (Ed); McCollum, Eric E. (Ed); Publisher: Oxford University Press; 2012, pp. 216-230.	Paper explores or addresses cause or co-existing factors
91	The current state of truancy reduction programs and opportunities for enhancement in Los Angeles County. Gase, Lauren N.; Butler, Katherine; Kuo, Tony; Bodin, Lydia; Byrdsong, Kristen; Carter, Hellen; Cochrane, William; Cormier, Muriel; Corral, Jesus; Fitzgerald, Elizabeth; Gomeztrejo, Jennifer; Gutierrez, John; Holmes, Vincent; The Los Angeles County School Attendance Task Force Workgroup; <i>Children and Youth Services Review</i> , Vol 52, May, 2015 pp. 17-25.	Review of practice
92	School refusal. Shelton, P. G.; In: <i>Essential psychopathology casebook.</i> Kilgus, Mark D. (Ed); Rea, William S. (Ed); Publisher: W W Norton & Co; 2014, pp. 291-320.	Review of practice

1.6 List of articles that met the inclusion criteria

1	Augmenting cognitive behavior therapy for school refusal with fluoxetine: A randomized controlled trial. Melvin, Glenn A.; Dudley, Amanda L.; Gordon, Michael S.; Klimkeit, Ester; Gullone, Eleonora; Taffe, John; Tonge, Bruce J.; (2016). <i>Child Psychiatry and Human Development</i> .
2	The ecological context of chronic school absenteeism in the elementary grades. Sugrue, Erin P.; Zuel, Timothy; LaLiberte, Traci; (2016) <i>Children & Schools</i> , Vol 38(3), pp. 137-145.
3	The treatment of school avoidance in children and adolescents with psychiatric illness: A randomized controlled trial. Reissner, Volker; Jost, Diana; Krahn, Ulrike; Knollmann, Martin; Weschenfelder, Ann-Kathrin; Neumann, Anja; Wasem, Jürgen; Hebebrand, Johannes; (2015). <i>Deutsches Ärzteblatt International</i> , Vol 112(39), pp. 655-662.
4	Case manager perspectives on the effectiveness of an elementary school truancy intervention. Blackmon, Bret J.; Cain, Daphne S.; (2015). <i>School Social Work Journal</i> , Vol 40(1), pp. 1-22.
5	Dialectical behavior therapy for school refusal: Treatment development and incorporation of web-based coaching. Chu, Brian C.; Rizvi, Shireen L.; Zendegui, Elaina A.; Bonavitacola, Lauren; (2015). <i>Cognitive and Behavioral Practice</i> , Vol 22(3), pp. 317-330.
6	School refusal intervention: Cross case analysis of a multimodal, functional intervention. Dietter, Michael M.; (2015). <i>Dissertation Abstracts International Section A: Humanities and Social Sciences</i> , Vol 75.
7	Graduation outcomes for truant students: An evaluation of a school-based, court-engaged community truancy board with case management. Strand, Paul S.; Lovrich, Nicholas P.; <i>Children and Youth Services Review</i> , Vol 43, Aug, 2014 pp. 138-144.
8	Evaluation of a truancy diversion program at nine at-risk middle schools. Haight, Courtney M.; Chapman, Gillian V.; Hendron, Marisa; Loftis, Rachel; Kearney, Christopher A.; <i>Psychology in the Schools</i> , Vol 51(7), Aug, 2014 pp. 779-787.
9	Short- and long-term effects of inpatient cognitive-behavioral treatment of adolescents with anxious-depressed school absenteeism: A within-subject comparison of changes. Walter, Daniel; Hautmann, Christopher; Rizk, Saada; Lehmkuhl, Gerd; Doepfner, Manfred; <i>Child & Family Behavior Therapy</i> , Vol 36(3), Jul, 2014 pp. 171-190.
10	The inpatient treatment process for severe school refusal. Oner, Ozgur; Yurtbasi, Pinar; Er, Ayse; Basoglu, Nuray; <i>Klinik Psikofarmakoloji Bülteni / Bulletin of Clinical Psychopharmacology</i> , Vol 24(2), Jun, 2014 pp. 176-179.
11	Developmentally sensitive cognitive behavioral therapy for adolescent school refusal: Rationale and case illustration. Heyne, David; Sauter, Floor M.; Ollendick, Thomas H.; Van Widenfelt, Brigit M.; Westenberg, P. Michiel; <i>Clinical Child and Family Psychology Review</i> , Vol 17(2), Jun, 2014 pp. 191-215.

12	The effects of the stay in school truancy program on academic success in Harris county, Texas. Rosales, Carol Ann; (2014). Dissertation Abstracts International Section A: Humanities and Social Sciences, Vol 75.
13	Effective intervention for school refusal behaviour. Nuttall, Clare; Woods, Kevin; Educational Psychology in Practice, Vol 29(4), Dec, 2013 pp. 347-366.
14	Cognitive mediation of cognitive-behavioural therapy outcomes for anxiety-based school refusal. Maric, Marija; Heyne, David A.; MacKinnon, David P.; van Widenfelt, Brigit M.; Westenberg, P. Michiel; Behavioural and Cognitive Psychotherapy, Vol 41(5), Oct, 2013 pp. 549-564.
15	Predicting outcome of inpatient CBT for adolescents with anxious-depressed school absenteeism. Walter, Daniel; Hautmann, Christopher; Minkus, Johannes; Petermann, Maike; Lehmkuhl, Gerd; Goertz-Dorten, Anja; Doepfner, Manfred; Clinical Psychology & Psychotherapy, Vol 20(3), May-Jun, 2013 pp. 206-215.
16	School-based intensive exposure therapy for school refusal behavior. Maeda, Naoki; Hatada, Soichiro; Sonoda, Junichi; Takayama, Iwao; Clinical Case Studies, Vol 11(4), Aug, 2012 pp. 299-311.
17	Does contact by a family nurse practitioner decrease early school absence? Kerr, Jill; Price, Marva; Kotch, Jonathan; Willis, Stephanie; Fisher, Michael; Silva, Susan; The Journal of School Nursing, Vol 28(1), Feb, 2012 pp. 38-46
18	Educational outcomes in a system of care for children with emotional disturbance. Strompolis, Melissa; Vishnevsky, Tanya; Reeve, Charlie L.; Munsell, Eylon Palamaro; Cook, James R.; Kilmer, Ryan P.; American Journal of Orthopsychiatry, Vol 82(1), Jan, 2012 pp. 129-136.
19	If you build it, they will come: A successful truancy intervention program in a small high school. Marvul, John N.; Urban Education, Vol 47(1), Jan, 2012 pp. 144-169.
20	School refusal and anxiety in adolescence: Non-randomized trial of a developmentally sensitive cognitive behavioral therapy. Heyne, David; Sauter, Floor M.; Van Widenfelt, Brigit M.; Vermeiren, Robert; Westenberg, P. Michiel; Journal of Anxiety Disorders, Vol 25(7), Oct, 2011 pp. 870-878.
21	Short term effects of inpatient cognitive behavioral treatment of adolescents with anxious-depressed school absenteeism: An observational study. Walter, Daniel; Hautmann, Christopher; Rizk, Saada; Petermann, Maike; Minkus, Johannes; Sinzig, Judith; Lehmkuhl, Gerd; Doepfner, Manfred; European Child & Adolescent Psychiatry, Vol 19(11), Nov, 2010 pp. 835-844.
22	Evaluation of a truancy court intervention in four middle schools. Hendricks, Michelle A.; Sale, Elizabeth W.; Evans, Carol J.; McKinley, Lori; Psychology in the Schools, Vol 47(2), Feb, 2010 Special Issue: Academic intervention research. pp. 173-193.

23	Cognitive-behavioral treatment of anxious youth with comorbid school refusal: Clinical presentation and treatment response. Beidas, Rinad S.; Crawley, Sarah A.; Mychailyszyn, Matthew P.; Comer, Jonathan S.; Kendall, Philip C.; Psihologijske Teme, Vol 19(2), 2010 pp. 255-271.
24	High school students' perceptions of supports for and barriers to completion of the stay in School Truancy Prevention Program. Robinson, Linda Bell; Dissertation Abstracts International Section A: Humanities and Social Sciences, Vol 70(8-A) pp. 2904.
25	Motivational/solution-focused intervention for reducing school truancy among adolescents. Enea, Violeta; Dafinoiu, Ion; Journal of Cognitive and Behavioral Psychotherapies, Vol 9(2), Sep, 2009 pp. 185-198.
26	An adaptive approach to family-centered intervention in schools: Linking intervention engagement to academic outcomes in middle and high school. Stormshak, Elizabeth A.; Connell, Arin; Dishion, Thomas J.; Prevention Science, Vol 10(3), Sep, 2009 pp. 221-235.
27	Virtual reality exposure therapy for school phobia. Gutiérrez-Maldonado, José; Magallón-Neri, Ernesto; Rus-Calafell, Mar; Peñaloza-Salazar, Claudia; Anuario de Psicología, Vol 40(2), Sep, 2009 pp. 223-236.
28	Intensive (daily) behavior therapy for school refusal: A multiple baseline case series. Tolin, David F.; Whiting, Sara; Maltby, Nicholas; Diefenbach, Gretchen J.; Lothstein, Mary Anne; Hardcastle, Surrey; Catalano, Amy; Gray, Krista; Cognitive and Behavioral Practice, Vol 16(3), Aug, 2009 pp. 332-344
29	The truancy intervention program of the Ramsey County attorney's office: A collaborative approach to school success. Richtman, Kathryn Santelmann; Family Court Review, Vol 45(3), Jul, 2007 pp. 421-437.
30	Tele-hypnosis in the Treatment of Adolescent School Refusal. Aviv, Alex; American Journal of Clinical Hypnosis, Vol 49(1), Jul, 2006 pp. 31-40.
31	Dealing With Chronic Absenteeism and Its Related Consequences: The Process and Short-Term Effects of a Diversionary Juvenile Court Intervention. Mueller, David; Giacomazzi, Andrew; Stoddard, Cody; Journal of Education for Students Placed at Risk, Vol 11(2), 2006 pp. 199-219.

1.7 Criteria for coding of study design

These criteria are the author's own, but have drawn upon existing checklists and appraisal systems from the Critical Appraisal Skills Programme (CASP) ("CASP Tools & Checklists," 2017) in their compilation.

3	Strong	<p>Quantitative: The aims of the study were clearly stated and relevant; the methodology, research design and recruitment strategy were appropriate; the study has an active comparison group established through random allocation; the measures used have a high reliability co-efficient for the outcome being investigated; data is collected from multiple sources, using multiple methods; the statistical analyses match the stated intention and research question; all issues raised by the results are addressed, including anomalies; conclusions are supported by the results; referencing is adequate; the research makes a valuable contribution to the area.</p> <p>Qualitative: The aims of the study were clearly stated and relevant; the methodology, research design and recruitment strategy were appropriate; the relationship between researcher and participants has been adequately considered; ethical issues have been addressed; data was analysed rigorously; findings are explicit and triangulated; all issues raised by the results are addressed, including anomalies; conclusions are supported by the results; referencing is adequate; the research makes a valuable contribution to the area.</p>
2	Moderate	The above criteria are partially but not fully met.
1	Weak	Several of the above criteria are not considered to be met.
0	n/a	The above criteria are not met or the published study does not provide enough information for a judgement to be made.

1.8 Criteria of coding for significance of outcomes

3	Strong evidence	<p>Quantitative: An appropriate statistical analysis shows a significant effect-size.</p> <p>Qualitative: An appropriate qualitative analysis coupled with triangulation demonstrates a clear positive outcome.</p>
2	Promising evidence	<p>Quantitative: An appropriate statistical analysis shows a moderately significant effect-size.</p> <p>Qualitative: An appropriate qualitative analysis with triangulation demonstrates a moderate positive outcome.</p>
1	Weak evidence	<p>Quantitative: An appropriate statistical analysis shows a small effect, which is non-significant.</p> <p>Qualitative: Analysis is appropriate but not triangulated. A small positive outcome is shown.</p>
0	No evidence	<p>Quantitative: Statistical analysis is felt to be inappropriate, is lacking, or there is a non-significant effect.</p> <p>Qualitative: Analysis is felt to be inappropriate and is not triangulated. The results show outcomes to be negligible or non-existent.</p>

1.9a Study characteristics

	Study	Design	Context	Intervention	Participants	Design rating
1	Melvin et al, 2016	Quantitative. Experimental randomised, controlled, double blind design.	Australia. Psychiatry.	Augmentation of at least 12 sessions of cognitive behaviour therapy (CBT) with fluoxetine medication.	Sixty-two anxious school refusing adolescents (11–16.5 years) who met Berg’s criteria for school refusal. Participants were randomly allocated to CBT alone, CBT + fluoxetine or CBT + placebo.	3
2	Sugrue et al, 2016	Mixed methods. Thematic analysis of interviews with caseworkers.	US. Social work.	Stage 2 of a truancy intervention program for children in grades K–5, which involves allocation of a caseworker for 90 days on a voluntary basis.	Purposive sampling of 15 caseworkers and 8 supervisors working across 9 community-based agencies.	1
3	Reissner, 2015	Quantitative. Experimental randomised groups design.	Germany. Psychiatry.	Manual-based, multimodal cognitive behavioural therapy	112 school avoiders were recruited from an outpatient child and adolescent psychiatric clinic and adaptively randomized into two treatment groups. The first group received manual-based multimodal treatment (MT), the control group treatment as usual (TAU) in the child and adolescent mental health care system.	2

	Study	Design	Context	Intervention	Participants	Design rating
4	Blackmon et al, 2015	Qualitative. Grounded theory analysis of interviews.	US. Social work.	The Truancy Assessment and Service Centers (TASC) program is an evidence-based elementary school truancy intervention that utilizes specially trained case managers to rapidly assess and address the underlying causes of truancy.	Purposive sampling of 6 TASC case managers from a single site.	2
5	Chu et al, 2015	Quantitative. Non-randomised, non-controlled single group design.	US. Cognitive and behavioural psychology.	20 sessions of a psychosocial treatment program, Dialectical Behaviour Therapy for School Refusal (DBT-SR) employing mindfulness, emotion regulation, distress tolerance, interpersonal effectiveness skills, and dialectic ‘middle path’ approaches with young people and their parents. It also incorporated a web-based coaching component to provide active, real-time skills coaching to youth and parents at the times, and in the context, of greatest need (at home, during morning hours).	7 families participated in pre-assessment after responding to an open advert, all were invited to participate in the study. 4 enrolled, 2 dropped out early on, 2 attended most of the sessions.	1

	Study	Design	Context	Intervention	Participants	Design rating
6	Dietter, 2015	Mixed methods design. Interviews, focus groups, field notes, analysis of attendance data.	US. Social sciences research.	An Attendance Review Team at each school (consisting of teachers, school psychologist, area attendance officer and other professionals) convened monthly. Intervention was a graduated response involving letters home, phone calls, visits, a meeting with parents to identify obstacles and make a joint action plan.	Participants were students in three schools at the elementary and middle school grades in an urban district, identified as 'at-risk for chronic absenteeism' through attendance tracking procedures. Their parents and school professionals also participated. A total of 22 parents, 13 students, and 6 staff participated.	2
7	Strand et al, 2014	Quantitative. Non-randomised, controlled design	US. Youth work.	A truancy reduction intervention characterized by the coupling of a school-based, court-engaged community truancy board and an approach to case management known as Check and Connect.	132 students with a history of truancy. 66 exposed to the intervention and a matched comparison group of 66 not exposed to the intervention.	2

	Study	Design	Context	Intervention	Participants	Design rating
8	Haight et al, 2014	Quantitative. One group pre-post design.	US. School psychology.	Youth in a truancy diversion program in nine at-risk middle schools, attended a “mock truancy court,” where they met weekly before a “judge” until 8 weeks of consecutive perfect attendance was achieved. A weekly multi-disciplinary panel meeting recommended other services based on need, including individual academic tutoring, individual therapy, family therapy, and involvement in a municipal court Life of Crime Program designed to educate youth about the negative long-term effects of truancy.	Participants were 90 middle school students aged 11 to 15 years. There was no control group.	2
9	Walter et al, 2014	Quantitative. Within-subject control design.	Germany. Psychiatry.	Inpatient treatment, including 2-3 weekly sessions of manual-guided CBT and a weekly parent session for an average of 8 weeks. 5 participants were treated at a time.	36 adolescents (12–18 years) with chronic school absenteeism and mental health problems. 61 adolescents were offered the treatment initially.	2

	Study	Design	Context	Intervention	Participants	Design rating
10	Oner et al, 2014	Quantitative. Two case studies.	Turkey. Psychiatry.	Hospitalization due to severe symptoms which were not responsive to routine treatment. Multimodal treatment involving a three-stage cognitive behavioural intervention, family therapy, social skills training, relaxation training, contingency management, and pharmacotherapy.	2 children (a 15-year-old boy and an 8-year-old girl)	1
11	Heyne et al, 2014	Quantitative. Single case study.	Netherlands. Developmental Psychology.	The @school program, a CBT designed to promote developmental sensitivity when planning and delivering treatment for adolescent school refusal. Treatment is modularized and it incorporates progress reviews, fostering a planned yet flexible approach to CBT. Treatment comprised 16 sessions with the child (interventions addressing depression, anxiety, and school attendance) and 15 concurrent sessions with her mother (strategies to facilitate an adolescent's school attendance), including two sessions with Allison and mother together (family communication and problem solving to reduce parent-adolescent conflict). Two treatment-related consultations were also conducted with Allison's homeroom teacher.	A 16-year-old female presenting with major depressive disorder and generalized anxiety disorder.	2

	Study	Design	Context	Intervention	Participants	Design rating
12	Rosales, 2014.	Quantitative. A non-randomised, controlled design.	US. Education.	The Stay in School Truancy Prevention Program in 12 school districts. Students received assistance in the form of mental healthcare services, social services, and, in some cases, legal aid. Warning letters and sanctions such as fines were also part of the wider system.	Participants were students from 12 districts enrolled in the program from 2006 to 2011. The control group were students from 12 matched school districts that do not use any truancy prevention program	2
13	Nuttall et al, 2013	Qualitative. Explanatory case study design. Thematic analysis of interviews.	UK. Educational psychology	Multi-disciplinary intervention by professionals in the local authority including: attendance officer; parent support advisor; child and adolescent mental health services (CAMHS) using cognitive behavioural therapy (CBT) and systemic approaches.	Purposive sample. Two successful cases of involvement for school refusal behaviour in the local authority: two girls (aged 13 and 14 years); their parents and the professionals involved.	2
14	Maric et al, 2013	Quantitative. One group, pre-post design.	Netherlands. Behavioural and cognitive psychology.	Manual-based cognitive-behavioural treatment	19 adolescents (12 to 17 years). No control group.	2
15	Walter et al, 2013	Quantitative. One group, pre-post design and correlation analysis of 'predictors' of success.	Germany. Psychiatry and psychotherapy.	Inpatient treatment based on manualized CBT	147 adolescents with anxious-depressed school absenteeism.	2

	Study	Design	Context	Intervention	Participants	Design rating
16	Maeda et al, 2012	Qualitative. Single case study.	Japan. Health and welfare.	Intensive exposure therapy	One 14-year-old student with school refusal behaviour	1
17	Kerr et al, 2012	Quantitative. Non-randomized, controlled design.	US. Nursing.	A nursing intervention to decrease early school absence. The Head Start Family Nurse Practitioner (FNP) contacted families of chronically and excessively absent students by telephone, clinic visit at school, or home visit.	Children in two elementary schools K–3 (N = 449) and a Head Start program (N = 130). National statistics used as control data.	2
18	Strompolis et al, 2012	Quantitative. Single group timed comparison.	US. Orthopsychiatry	MeckCARES, a system of care designed to serve youth with severe emotional disturbances and their families. The approach is family-focused, providing comprehensive, coordinated networks of services, tailored to the needs of the child and family, while emphasizing the strengthening of natural community supports.	306 participants aged between 12 and 15-years-old.	1
19	Marvul, 2012	Quantitative. Randomised control design.	US. Education.	A 5-month program involving attendance monitoring (including daily phone calls home before school), sponsored participation in team sports, and participation in a ‘moral character’ class.	40 students out of 100 attending a small, alternative, transitional inner-city high school for students who have been severely truant in their previous school. 20 received the intervention and 20 were randomly assigned to the control group.	2

	Study	Design	Context	Intervention	Participants	Design rating
20	Heyne et al, 2011	Quantitative. Non-randomized, single group design.	Netherlands. Psychiatry/psychology.	The @school program. 10-14 hourly sessions of developmentally sensitive CBT for anxiety-based school refusal in adolescence, and 10-14 sessions with parents.	20 school-refusing adolescents (aged 10-18 years) meeting Berg criteria for school refusal, referred from an out-patient clinic.	1
21	Walter et al, 2010	Quantitative. Non-randomized, single group design.	Germany. Psychiatry and psychotherapy.	Inpatient CBT of adolescents with chronic anxious-depressive school absenteeism with or without comorbid disruptive symptoms.	147 adolescents (aged 12–18 years) with a specific phobia or other anxiety disorder or a depressive episode or a mixed disorder of conduct and emotions and who had completely ceased to attend school or showed irregular school attendance	2
22	Hendricks et al, 2010	Quantitative. Non-randomized, single group design.	US. School psychology.	A school-based truancy court intervention in four middle schools.	185 youth attending a truancy court from 2004 through 2008.	2

	Study	Design	Context	Intervention	Participants	Design rating
23	Beudas et al, 2010	Quantitative. Non-randomized, uncontrolled pre-post treatment design	US. Psychology.	Individual or family CBT for 16-20 sessions.	12 children (aged 7-16 years) with a primary anxiety disorder and comorbid school refusal, who completed treatment (of 27 who started the treatment)	1
24	Robinson, 2010	Qualitative. Phenomenological research design.	US. Education	The Stay in School Truancy Prevention Program. Personnel in the truancy program and court work together to build relationships between the students, families, and schools to reduce truancy and improve school attendance.	67 students purposefully selected and aged 18 to 21 years, from diverse ethnic backgrounds and both genders, who had participated in the program.	2
25	Enea et al, 2009	Quantitative. Non-randomised, controlled pre-post treatment design.	Romania. Psychotherapy.	A package of motivational stimulation techniques, comprising 8 group counselling sessions per week, each lasting one hour. The techniques used combined intrinsic motivational stimulation strategies, motivational interviewing and solution-focused counselling, with strategies focusing on extrinsic methods, such as successive approximation of behaviour, behaviour contracts and reinforcement techniques.	Participants were adolescents, aged 16-17 years, divided into two groups, 19 students in the experimental group, and 19 in the control group.	2

	Study	Design	Context	Intervention	Participants	Design rating
26	Stormshak et al, 2009	Quantitative. Randomised, controlled longitudinal design.	US. Counselling and school psychology.	A three-session Family Check-Up (FCU), which is designed to motivate change in parenting practices by using an assessment-driven approach and strengths-based feedback, linking families with other school and community-based interventions.	998 adolescents and their families, recruited in sixth grade from three middle schools.	2
27	Gutiérrez-Maldonado et al, 2009	Quantitative. Randomised, controlled design.	Spain. Cognitive and behavioural psychology.	8 sessions of exposure to two virtual reality environments (a school and a classroom), which individuals have to navigate through and complete activities.	36 children aged between 10-15 years, with high scores on school phobia measures, from several educational settings. 18 participants were randomly assigned to a group of treatment, 18 participants were assigned to a waiting list group.	2
28	Tolin et al, 2009	Quantitative. Single group, non-random, uncontrolled, multiple baseline case series design.	US. Psychotherapeutic counselling.	Treatment was conducted within a 15-session intensive format over a 3-week period. Treatment elements included CBT with the adolescent, parent training sessions, sleep hygiene, contingency management at home, graduated exposure, relaxation strategies and social problem-solving.	4 male adolescents, aged 13 to 16 years, sampled from 7 consecutive referrals to a school refusal program at a clinic for anxiety disorders. 2 were excluded for having co-existing conditions, 1 discontinued treatment.	2

	Study	Design	Context	Intervention	Participants	Design rating
29	Richtman, 2007	Quantitative. Single group, non-random, uncontrolled design.	US. Family courts.	The Truancy Intervention Program (TIP), a three-step graduated process consisting of: a parent meeting at school conducted by a county attorney; a hearing and written contract; and an expedited hearing at juvenile court with 6 months on probation and other sanctions.	All referrals to TIP between 1995 and 2006, from 163 schools. 24,470 students, aged 12–17, were referred to the first-step parent meeting; of these students, 6,773 were referred to the second-step hearing and 2,824 students petitioned to court.	1
30	Aviv, 2006	Quantitative. Single group, non-random, uncontrolled design.	Israel. Mental health.	Tele hypnosis: A therapeutic approach, which utilizes known hypnotic techniques, but rehearses them via the telephone, while the patient is at his/her house or on the way to school and the therapist is at the office. Participants were treated with different hypnotherapy techniques. Equipped with cellular phones and with the therapist's availability, these adolescents could benefit from hypnosis as an alternative coping strategy when the anxiety occurred.	Twelve adolescents, 8 boys and 4 girls, aged 12 to 15, referred to a clinic for treatment of school refusal, after being unsuccessfully treated with various psychotherapy and psychopharmacology techniques. Some of the referred adolescents were absent from school completely, the worst case being of absence duration of 2-1/2 years.	1

	Study	Design	Context	Intervention	Participants	Design rating
31	Mueller et al, 2006	Mixed methods. Non-clinical case study incorporating observations, interviews, surveys and student records/data.	US. Criminal justice.	A quasi-formal attendance court program, with informal court hearings, graduating to probationary periods, delinquency charges and fines.	Three young people are discussed as separate and detailed descriptive case studies. All 114 participants of the court program between 2000 and 2002 had their data analysed. 37 school administrators completed surveys.	2

1.9b Study outcomes

	Study	Measurement Tools	Outcomes	Outcome rating
1	Melvin et al, 2016	Pre, post, 6 month follow-up and 12-month follow-up, using: school attendance data; the Anxiety Disorders Interview Schedule (ADIS); the Global Assessment of Functioning (GAF); the Clinical Global Impressions Scale-Improvement (CGI-I); the Children's Depression Inventory (CDI); the Revised Children's Manifest Anxiety Scale (RCMAS); the Self-Efficacy Questionnaire for School Situations (SEQSS); the Child Behaviour Checklist (CBC); and the School Refusal Program Consumer Satisfaction Questionnaire (SRP-CSQ).	All treatments were well tolerated; with one suicide-attempt in the CBT + placebo group. All groups improved significantly on primary (school attendance) and secondary outcome measures (anxiety, depression, self-efficacy and clinician-rated global functioning); with gains largely maintained at 6-months and 1-year. Few participants were anxiety disorder free after acute treatment. During the follow-up period anxiety and depressive disorders continued to decline whilst school attendance remained stable, at around 54 %. The only significant between-group difference was greater adolescent-reported treatment satisfaction in the CBT + fluoxetine group than the CBT alone group.	2
2	Sugrue et al, 2016	Caseworker report.	The results of this study suggest that an intervention program for chronic school absenteeism that uses a time-limited case management model may not be sufficient to address the multisystem factors involved in this problem.	0

	Study	Measurement Tools	Outcomes	Outcomes rating
3	Reissner, 2015	Attendance data: Percentage of classes attended in the five days prior to the intervention, as well as 6 and 12 months afterward.	In both treatment arms, the percentage of regular school attenders rose to about 60% in 6 months, regardless of the intervention (MT 60.6%, TAU 58.3%; odds ratio [OR] for changes over baseline 6.94, 95% confidence interval [CI] 3.98–12.12, $p < 0.001$; OR for MT versus TAU 1.05, 95% CI 0.58–1.90, $p = 0.875$). The improvement persisted 12 months after inclusion. Manual-based, multi-model CBT had no significant effect above treatment as usual.	1
4	Blackmon et al, 2015	Attendance data: Percentage of referrals who improved their attendance.	TASC has a proven success rate in reducing unauthorised absence since 1999 (for example 78% of the 6,302 referrals improved attendance in 2011-12). The overarching theme indicated that the case manager was the primary agent of change. As such, intervention effectiveness was maximized if the case managers were committed to their clients' families, assisted them in building a collaborative support network, and helped them to overcome barriers that adversely affected the treatment process. Findings also suggested that unsuccessful program outcomes may be related to high caseloads and staff shortages.	1
5	Chu et al, 2015	Pre, mid, post and 4-month follow-up assessment using the: Anxiety Disorders Interview Schedule-Child and Parent (ADIS-C/P); Childen's Depression Rating Scale – Revised (CDRS-R); and youth and parent self-ratings of treatment satisfaction.	Results provide 'proof of concept' that DBT-SR is reasonably feasible and acceptable to clients and therapists and that web-based coaching provides incremental, unique benefit. 1 of the 2 participants experienced an improvement in attendance at time interval 3. Follow-up data is not included.	0

	Study	Measurement Tools	Outcomes	Outcomes rating
6	Strand et al, 2014	Evaluated school completion outcomes (i.e., graduation versus dropout)	Results revealed higher graduation and GED attainment for children exposed to the intervention. Chi-square tests showed this to be statistically significant (p=0.01)	2
7	Dietter, 2015	Researcher field notes; interviews of students, parents and staff; school data including student attendance records; and voluntary completion of School Refusal Assessment Scales.	The majority of the students in the school refusal intervention improved rates of attendance over the course of the intervention. Interviews revealed that effective communication including the use of letters, phone calls, and email among students, parents, and school was evident in all instances of improved attendance. Researcher field notes and findings from interviews showed that students, parents, and school personnel reported an overall positive perception of the school refusal intervention and improved school performance. The study concluded that attendance improvement interventions must engage students, families, school personnel, and community based service providers to be most effective. Improvements in attendance were most apparent among schools that closely followed the school refusal intervention implementation protocols, allowed for flexible decision making among members of the Attendance Review Team, and exhibited an elevated level of communication among stakeholders.	2
8	Haight et al, 2014	Revised Child Anxiety and Depression Scale (RCADS); Student Satisfaction Survey; Conners Parent Rating Scale; Parent/Guardian Satisfaction Survey	Graduates from the program demonstrated statistically significant declines in scores of separation anxiety, generalized anxiety, social phobia, depression, oppositional, hyperactive-impulsive, attention deficit hyperactivity, and cognitive-attention behaviours. Participants and their parents expressed high levels of perceived improvement in academic performance. Academic tutoring was found to differentiate program graduates from nongraduates. No statistics are given about those who dropped out of the scheme.	1

	Study	Measurement Tools	Outcomes	Outcomes rating
9	Walter et al, 2014	2-4 weeks pre, first day, on discharge, 2 and 9 months following assessments were made using: attendance data, clinical rating scales, anxiety and depression self-report measures (SCL-APD, SCL-MDD)	No changes were noted during the untreated waiting period, whereas there was a strong, statistically significant reduction in school absence rates and mental health problems from the start to the end of inpatient treatment. At discharge, 88.9% of adolescents attended school regularly or were employed (86.1 and 63.9% at 2- and 9-months follow-up, respectively). Self- and parent-reported mental health problems were significantly reduced during treatment and remained stable during follow-up. From post to follow up, there was a significant decrease in attendance.	1
10	Oner et al, 2014	Reported attendance at school.	The male participant was discharged at week 5 and symptom-free 8 months later. After three weeks of treatment, the female participant's "hallucinations" and somatic symptoms decreased. She was symptom free 6-months after discharge.	1
11	Heyne et al, 2014	Assessment pre-treatment; post-treatment, and follow-up (2-months later), using the Self-Reflection and Insight Scale for Youth (SRIS-Y); the School Fear Thermometer (SFT); the Fear Survey Schedule for Children—Revised (FSSC-R); the Multidimensional Anxiety Scale for Children (MASC/MASC-P); the CDI; the CBC; the ADIS-C/P); the GAF; and the Dutch version of the SEQSS.	The participant's school attendance improved during the course of treatment. By post-treatment, there was a decrease in internalizing behaviour, an increase in self-efficacy, and remission of depressive disorder and anxiety disorder. Clinically significant treatment gains were maintained at 2-month follow-up.	3

	Study	Measurement Tools	Outcomes	Outcomes rating
12	Rosales, 2014.	Student attendance, academic achievement, dropout data, and completion rates from the Texas Education Agency.	There were no statistically significant differences in attendance rates, academic achievement, or dropout rates. There was a statistically significant difference in completion rates.	1
13	Nuttall et al, 2013	Interviews with the young person, parent, school staff, and other professionals including the attendance officer, a family support worker and health professionals (eight interviews per case); case records (for example, attendance data).	Successful return to education was a pre-requisite. Study found a high degree of commonality in critical success factors across the two school refusal cases. Child psychological factors included: developing feelings of safety, security and belonging, confidence, self-esteem and value, and aspiration and motivation. Successful intervention extended beyond child factors to interacting contextual and family variables significant to the effectiveness of intervention. Developing positive relationships between home and school, and meeting the needs of the families, appeared to be essential in supporting the young people's success, and in both cases there was a significant role for professionals and systems.	3
14	Maric et al, 2013	School attendance; school-related fear; anxiety; depression; and internalizing problems were assessed at pre and post-treatment and 2-month follow-up using the same measures as in Heyne et al, 2014.	Post-treatment increases in school attendance and decreases in fear about attending school the next day were found to be mediated by self-efficacy. Mediating effects were not observed at 2-month follow-up.	1

	Study	Measurement Tools	Outcomes	Outcomes rating
15	Walter et al, 2013	Assessment of regular school attendance and a wide variety of mental health problems rated by adolescents and parents at discharge and at 2 months after the end of treatment.	Regression analyses indicated that neither level of school absenteeism, level of adverse psychosocial conditions and severity of mental health problems at intake could predict school attendance at discharge or follow-up in a clinically relevant way.	0
16	Maeda et al, 2012	Observations.	Through a series of treatments over 23 weeks, the student was able to return to classes on a daily basis.	1
17	Kerr et al, 2012	The aggregate percentage attendance was evaluated by grades (preschool to third grade), schools (Head Start, Elementary Schools 1 and 2), and grades and schools and compared with publicly available school district aggregate data.	There were statistically significant increases in attendance from Year 1 to Year 2 at $p < .05$ at the elementary level but not at the Head Start level.	2
18	Strompolis et al, 2012	Data collected on participants' school grades, suspensions, and absences through standardised interviews with young people and their parents using the Education Questionnaire-Revised (EQR) and the MultiSector Service Contacts-Revised (MSSC) scale.	On average, enrolment in MeckCARES is not associated with positive changes in educational variables.	0

	Study	Measurement Tools	Outcomes	Outcomes rating
19	Marvul, 2012	Pre- and post-intervention measures of educational expectations, attitude toward education, emotional, cognitive, behavioural engagement, and attendance, using the Student Engagement Survey (NSCE).	Findings indicated significant differences between intervention and control groups on all predictor variables. Absenteeism was significantly and negatively related to all predictor variables. The program successfully reduced absenteeism, increased educational expectations, attitude toward education and engagement.	3
20	Heyne et al, 2011	Pre-and post-treatment and 2-month follow-up assessments using: school attendance data; Dutch versions of the SFT; the MASC; the CDI; the CBCL and the YSR; SEQSS; and the GAF.	Treated adolescents showed significant and maintained improvements across primary outcome variables (school attendance; school-related fear; anxiety), with medium to large effect sizes. Half of the adolescents were free of any anxiety disorder at follow-up. Additional improvements were observed across secondary outcome variables (depression; overall functioning; adolescent and parent self-efficacy). No significant change was reported with regard to self-efficacy.	2

	Study	Measurement Tools	Outcomes	Outcomes rating
21	Walter et al, 2010	Assessments of school attendance and composite scores of a range of adolescent- and parent-rated mental health problems were made pre-inpatient treatment, immediately post-inpatient treatment and at 2-month follow-up. Tools used were: the German versions of the CBC and the YSR; symptom checklists assessing criteria of ICD-10 and DSM-IV for anxiety, depression, and ADHD;*	Overall, results show a considerable decline of school absenteeism and mental health problems during treatment and subsequent follow-up. Continuous school attendance was achieved by 87.1% of the sample at the end of inpatient treatment and by 82.3% at 2-month follow-up. Comorbid symptoms of anxiety, depression, disruptive and insufficient learning behaviour were significantly reduced from pre to follow-up, with effect sizes for the composite scores ranging from 0.44 to 1.15 ($p < 0.001$). *the German version of the CDI; the Learning and Achievement Behaviour Inventory (LAVI); the Anxiety Scale for Students (AFS); and the German version of the FSSCR.	3
22	Hendricks et al, 2010	A school attachment survey, administered before and after truancy court, and school records. The attachment survey was developed specifically for this intervention with items derived from the school bonding subscale of the Individual Protective Factors Index (IPFI) and the school connectedness subscale of the National Longitudinal Study of Adolescent Health (Add Health)	Results indicated a differential impact of the truancy court intervention depending on truancy severity at baseline. The intervention was most successful ($p < .05$) in increasing attendance for students with severe truancy for at least one semester, but had limited impact (non-significant) on students with moderate truancy, and no impact on mild truancy. The intervention did not result in improved school attachment or grade point averages, nor did it significantly reduce discipline offenses.	1

	Study	Measurement Tools	Outcomes	Outcomes rating
23	Beudas et al, 2010	Measures used were: the ADIS-C/P; the Children's Global Assessment Scale (CGAS); the MASC; the CDI; and the CBCL.	The dropout rate was 52%. Effects for youth who completed treatment (N = 12) ranged from $d = .61$ to 2.27. 9 of the treated participants with school refusal at pre-treatment did not meet criteria for school refusal at post-treatment.	1
24	Robinson, 2010	Retrospective focus groups, 60-minute, individual, semi-structured interviews, observational visits, statistical data from the program and use of the researcher's own Stay in School Truancy Questionnaire.	Male and female students from different ethnic groups (African American, Asian American, Caucasian, and Hispanic) identified four factors that contributed to their truancy: (1) work schedules, (2) influence of friends, (3) health issues, and (4) dislike for school. The students revealed that supports from other individuals (parents/family, friends, teachers, and other school personnel) were most important to their school completion and success. Finally, the students indicated that barriers to completion of the Stay in School Truancy Prevention Program included (a) work schedules, (b) lack of motivation to attend school, and (c) personal health issues, friends, and influence of drug use. Students shared that the Stay in School Truancy Prevention Program significantly impacted their lives. They revealed that the program gave them new direction. Students reported that it provided them reasons, excuses, and avenues to disengage from friends refusing to attend school.	2
25	Enea et al, 2009	Truancy data.	Data indicated a 61% decrease in truancy rates for the experimental group, a significant difference compared to the control group, where no drops in truancy rates were observed.	1

	Study	Measurement Tools	Outcomes	Outcomes rating
26	Stormshak et al, 2009	Yearly school-based surveys, grade point averages, attendance data and teacher report.	All services were voluntary, and approximately 25% of the families engaged in the FCU. Compared with matched controls, adolescents whose parents received the FCU maintained a satisfactory grade point average into high school, and intervention engagement was associated with improved attendance. The highest-risk families were the most likely to engage in the family-centred intervention	2
27	Gutiérrez-Maldonado et al, 2009	Spanish versions of the School Fears Inventory (SFI), the FSSC, the School Refusal Assessment Scale (SRAS) and the Strait-Trait Anxiety Inventory (STAI) for children.	Virtual reality exposure reduced the intensity of school-related fears significantly, but did not influence more general fears with any significance. Some impact was found on avoidance of negative stimuli relating to school and anxiety, as scored on questionnaires. No attendance data is provided.	1
28	Tolin et al, 2009	Assessment pre, during, post and (for some) 3-years following intervention using: the SRAS, child and parent version, the CDI, the MASC, and parent and therapist views.	Treatment was effective for 3 of 4 cases in the short term, none were able to sustain this longer term. At 3-year follow-up, all 3 of the acute treatment responders had switched to alternative educational programs, although parents rated them as significantly improved and less impaired compared to pre-treatment.	1
29	Richtman, 2007	Statistical data about the numbers of referrals at each stage, graduation rates in the county	Ten years after the creation of TIP, the graduation rates in the city of St. Paul, the largest school district in the county, have improved by over 50 percent; the number of students missing 15 days of school of more (excused as well as unexcused) has decreased by more than 50 percent; and a large majority of chronic truants and their families have been successfully connected to services to address underlying problems.	2

	Study	Measurement Tools	Outcomes	Outcomes rating
30	Aviv, 2006	Pre-screening for hypnozability using the Stanford Hypnotic Clinical Scales for Children (SHCS-C); analysis of attendance data pre-and post-treatment.	Results showed that 8 of the participants maintained full-time attendance, 3 showed partial improvement and 1 failed to improve his attendance (despite initial success) at the one-year follow-up.	2
31	Mueller et al, 2006	Attendance data for the 120 prior to, and following the first hearing. 37 school administrators completed surveys about their views of the program.	The average number of absences and lates dropped significantly after the first court hearing had taken place, though not all students improved. Survey responses indicated that school staff broadly but not wholly support the program and perceive improvements in student behaviour and academic performance.	1

CASP Tools & Checklists. (2017). Retrieved from <http://www.casp-uk.net/casp-tools-checklists>

7.3. Appendix C: Stronger Families, Stronger Communities eligibility criteria
(required to meet at least 2 of the 6 headline criteria)

Headline	Indicator	Eligibility
1. CRIME OR ANTI-SOCIAL BEHAVIOUR	YOS	Any proven offence within the last 12 months
	YCP	Referred to the Youth Crime Prevention service within the last 12 months
	ASB	Perpetrators of anti-social behaviour
	Crime EC	Crime equivalent concern (e.g. criminal behaviour/activities including child to parent DV)
2. EDUCATION CONCERN	Absence	Less than 90% attendance over a 3-term period
	FTE	3 or more fixed term exclusions over a 3-term period
	Excluded Sessions	Excluded for 10 or more sessions over a 3-term period
	Education EC	Educational equivalent concern (e.g. non-engagement, disruptive behaviour)
3. CHILDREN IN NEED OF HELP	EH Referral	A referral for early help support
	SEMH	Identified as having Social, Emotional or Mental Health (SEN Need)
	ChIN	An open Child in Need episode within the last 6 months
	CP	An open Child Protection episode within the last 12 months
	LAC	An open Local Authority Care episode within the last 12 months
	UPP	Receiving Universal Partnership Plus level of health visiting support
	CINoH EC	Child in Need of Help equivalent concern (e.g. behavioural issues, social isolation, parenting need)
4. FINANCIAL EXCLUSION	Benefits	Claiming out of work benefits
	NEET	16-18 year olds not in education, employment or training
	NEET Risk	School leavers (Y11) identified as being at risk of NEET
	Finance EC	Finance equivalent concern (e.g. debts and arrears, housing issues, unable to buy basics)
5. DOMESTIC VIOLENCE OR ABUSE	DV/DA	Perpetrators (aged 16+) and victims of domestic violence or abuse
6. HEALTH CONCERN	RUOK	Referred to RUOK
	UP	Receiving Universal Plus level of health visiting support
	UPP	Receiving Universal Partnership Plus level of health visiting support
	Health EC	Health equivalent concern (other mental or physical health needs impacting on the family)

7.4. Appendix D: Integrated Team for Families & Parenting Services

intervention offer A – 2016/17

Specific Interventions <i>(tiers of need - level 2-4)</i>	Family Coaching <i>(tiers of need - level 2-3)</i>	Parenting Interventions <i>(all tiers of need)</i>
<p>Family Coaches will be working with families with identified needs that meet the SFSC criteria that would benefit from 1:1 specific interventions or a group work programme.</p> <p>The Family Coach will not be the Lead Professional but will support the Team Around the Family to provide appropriate interventions to families engaged with the Early Help or Social Work process</p> <p>Working assertively with families, Family Coaches will provide either a specific intervention (<i>no of sessions and intensity to be negotiated, dependant on need</i>) or engage the identified family member requiring support onto an appropriate group work programme that will motivate, engage them and reinforce strategies. This will equate to around 1-2 hours of contact per week, although could increase dependant on need.</p> <p>The Family Coach will lead in monitoring progress against SCFC targets</p> <p>The anticipated engagement of the family can be between 2-9 months (<i>dependant on the level of need</i>)</p> <p>To access a Specific Intervention, an Early Help referral is required which will be discussed at the EH Weekly Allocation meeting and will be directed to the team if deemed we are the appropriate service for this family</p>	<p>Family Coaches will be working with families with multiple disadvantages that meet the SFSC criteria and fall below the social work threshold, where there are some barriers to achieving positive outcomes</p> <p>Family Coaches will take a lead in the Early Help process, completing family assessments, bringing together a Team Around the Family, making case decisions and working in partnership with other agencies, to design and deliver effective interventions to enable families or individuals to meet the goals identified in the Early Help Family Action Plan that clearly link to achieving SFSC targets.</p> <p>Working assertively with families, Family Coaches will make home visits and provide wider family work to deliver support (<i>see overleaf for examples of the type of support we offer</i>), with around 2-4 hours of contact per week.</p> <p>The Family Coach will lead in monitoring progress against SFSC targets</p> <p>The anticipated engagement of the family is between 3-9 months (<i>dependant on the level of need</i>)</p> <p>To access Family Coaching, an Early Help referral is required which will be discussed at the EH Weekly Allocation meeting and will be directed to the team if deemed we are the appropriate service for this family</p>	<p>Parenting Practitioners will offer Triple P Levels 2, 3, 4 and 5 talks/workshops and courses. Family Coaches, Early Years, will offer Level 4 & 5 courses to families where there is a child under 8 years of age.</p> <p>Level 4 courses are open to professional and self-referrals. Families who have lower level needs – as indicated at referral - will be directed to level 3 interventions. The scores on standardised questionnaires will be monitored to see that the majority of parents attending Level 4 courses start within the clinical range.</p> <p>Parenting Practitioners will offer individual Level 4 & 5 work with families of multiple disadvantage that either meet the SFSC criteria and /or are referred by social care. Early Years Family Coaches, will offer individual parenting work with families who have children under 5 years of age.</p> <p>Parenting Practitioners and Early Years Family Coaches, will work with partners to monitoring progress against SFSC targets where families meet the criteria and have given consent.</p> <p>Whilst most Triple P interventions are very brief, the anticipated engagement of the family for individual work could be between 2- 9 months.</p> <p>To access individual L4 or L5 parenting service, an Early Help referral is required which will be discussed at the EH Weekly Allocation meeting and will be directed to the team if deemed we are the appropriate service for this parent. Referrals to group courses can be made directly to the parenting service</p>

7.5. Appendix E: Integrated Team for Families and Parenting Services

Intervention Offer B – 2016/17

Group work programmes <i>(working in collaboration with other agencies)</i>	Specific interventions/Family Coaching interventions
<p>Living without Violence <i>(group for male perpetrators of domestic violence/abuse)</i></p> <p>Break4Change <i>(group for parents & their child to address child to parent violence/abuse)</i></p> <p>Triple P level 2, 3, 4 & 5 <i>(parenting groups, seminars, workshops/discussion groups)</i></p> <p>BOOST <i>(Self Esteem/confidence building group for mothers)</i></p> <p>Feeling Good Feeling Safe <i>(protective behaviour groups for parents)</i></p> <p>Emotional Regulation <i>(young people)</i></p> <p>Managing anxiety <i>(young people and parents)</i></p>	<ul style="list-style-type: none"> ➤ Fathers work <i>(supporting contact between absent fathers and their child where safe to do so) *</i> ➤ Functional Family Therapy ➤ Mindfulness techniques ➤ Solution focussed techniques ➤ Motivational interviewing ➤ Protective behaviours * ➤ Play based attachment techniques * ➤ Cognitive Behavioural techniques ➤ Practical support <i>(e.g. Morning routines, advocacy, signposting, getting to appointments, including health related etc.)</i> ➤ Managing household budget ➤ Support to adhere to tenancy agreement, housing applications, moving, joint visits with Housing Officers and access to housing services * ➤ Restorative Justice & other victim awareness interventions * ➤ Supporting improved school attendance* ➤ Supporting with return to work ➤ Promote/support access to sports, arts, other leisure and community activities * ➤ Sexual health (young people)* ➤ Emotional regulation <i>(e.g. managing stress, anxiety, anger etc.) *</i> ➤ DV work <i>(completing DASH, safety planning, consultations, link to specialist agencies)</i> ➤ Preventing (re)offending and ASB <i>(reducing risk factors, e.g. victim awareness, diversionary activities, decision making/consequences, raising aspirations etc.) *</i> <p>* <i>specific interventions</i></p>

7.6. Appendix F: Outline structure of focus groups one and two

For each family coach, individually:

- Briefly (& anonymously) tell the story of a CYP you have worked with that had poor or no school attendance, where this was successfully improved. Maybe one that has stuck in your mind or one that you feel is typical of lots of cases. What were the key features of the case? (The main factors causing the attendance problem; family circumstances; school circumstances; age etc). What support was given to this CYP (from school, ITF, family, friends and other agencies)?
- Do the same but for a CYP where the efforts to help the attendance problem were less successful.

General discussion:

- In cases where a CYP successfully reintegrated and/or improved school attendance, what do you feel were the factors that brought this about?
- In cases where school non-attendance was very difficult to change or improve, what do you feel were the factors that caused this to be the case?
- What would you like to see changed in the local context with regards to support for school non-attendance and how would this look? (Miracle question)
- What already works well?

7.7. Appendix G: Outline structure of focus group three

This focus group is going to be slightly different to the first two because I have had a chance now to look at what came out of the first groups and put together some general themes.

What I am hoping to do in this session is bring those themes to you for discussion. I've made a list, which I can give you to look at. I am hoping to go through all of these and give you the opportunity to agree, disagree, discuss, add thoughts etc. If possible, if you have a point to make, illustrating it with an example from your own work would be really helpful.

At the end, I'm going to ask a solution-focused miracle question about what your ideal resources/support would look like in the city, if there were no constraints.

Themes that came from focus groups 1 and 2

1. Not going to school is almost always a *symptom* of problems occurring within the YP's home life/family.
2. Not going to school is part of a spectrum of mental health or mental well-being problems in the YP.
3. The following factors *hinder* the process of supporting the YP with their attendance:
 - Ongoing safety or safeguarding issues at home
 - YP 'unreachable' or powerfully rejecting of support
 - Parent actively sabotaging efforts OR having diminished capacity
 - Lack of resources/long waiting lists/inadequate services
 - Becoming involved 'too late' - YP been 'overlooked' or 'missed'
 - Locating the problem solely within the YP
 - Class discrimination/discrepancies in how resources are allocated
 - Schools being inconsistent, unreliable, dismissive, unaware, quick to pass responsibility
 - Lacking clarity (causes, role, others' role/involvement, conflicted feelings about role/colluding/not being 'on message')
4. The following factors *help* the process:
 - Parent and YP helped to feel safe, secure and more confident
 - Building good relationships (regular contact, listening, understanding, getting alongside – not being directive, time...)
 - Practical help (improving support networks, signposting & referring, building bridges, mediating, building capacity/re-energising/empowering parents, 'parenting parents', establishing morning routines, making adjustments at school)
 - Advocating for YP/taking the spotlight off the YP

If a miracle happened and you could create the ideal environment/support system for maximising the likelihood of improved attendance, what would this look like?

7.8. Appendix H: Outline structure of focus group four

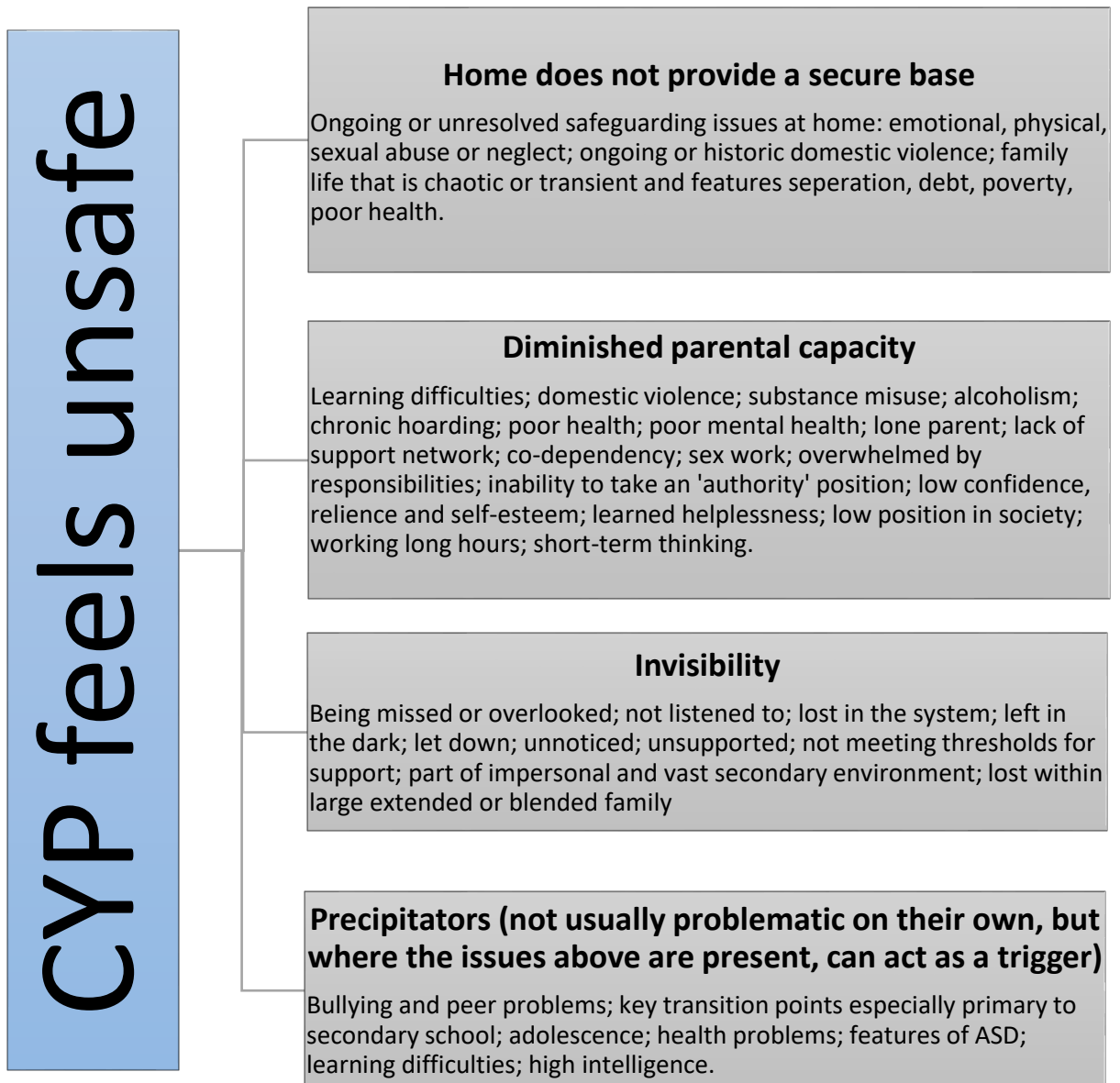
This final focus group is going to be different to the others because I have had a chance now to look at what came out of the first groups and put together a model.

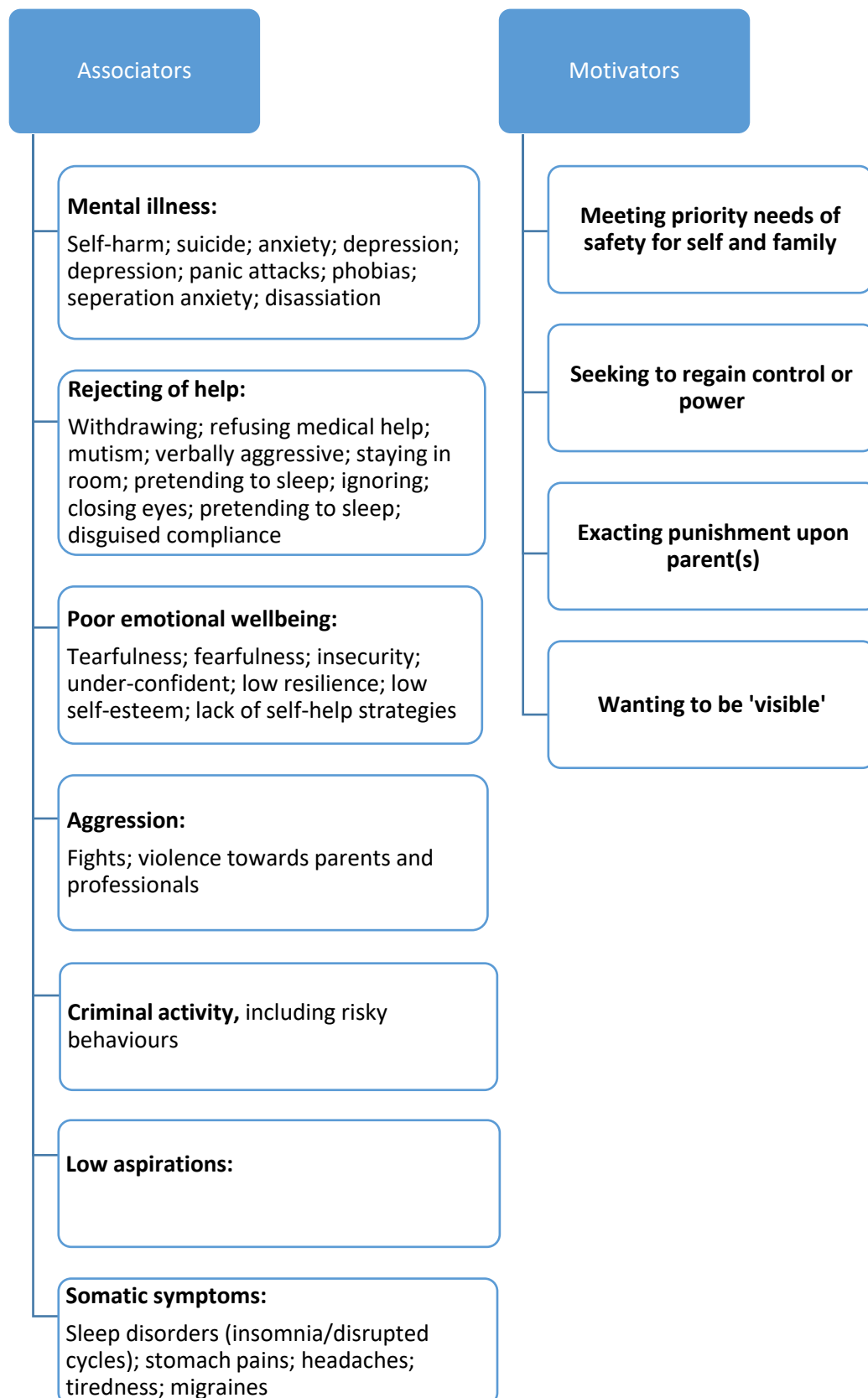
What I am hoping to do in this session is bring this model to you for discussion. I am hoping to go through it all and give you the opportunity to agree, disagree, discuss, add thoughts etc. If possible, if you have a point to make, illustrating it with an example from your own work would be really helpful.

At the end, I'm going to ask a solution-focused miracle question about what your ideal resources/support would look like in the city, if there were no constraints.

1. Look at the 3 models of PNSA, Intervention and Constraints (one at a time). Are there any questions – things that you would like me to clarify/explain?
2. Are there any points that you feel are wrong – where you disagree with the model? Why? Can you illustrate with examples from your own practice?
3. Which points do you agree with? Illustrate?
4. Miracle question. (If a miracle happened and you could create the ideal environment/support system for maximising the likelihood of improved attendance, what would this look like?)

Model 1: Persistent non-school attendance (PSNA)





Model 2: Intervention (what helps)

Help CYP to feel safe

"Parenting parents"- capacity-building

Empowering; building trusting relationships; getting alongside; helping to be safe; listening; empathising; skilling; celebrating successes; building a network of support; re-energising/activating; strengthening relationship with CYP (more empathy, better communication, better listening); laughter; Triple P; unconditional positive regard; setting up TAFs; advocacy; signposting and referring to other services; staying firm about the need to attend; facilitating access to charity/welfare/medical/legal/financial support; accompanying to appointments; acknowledging suffering; helping to process historic DV or abuse; practical support: tidying, decorating, clearing out, establishing morning routines, helping with bus passes and uniform

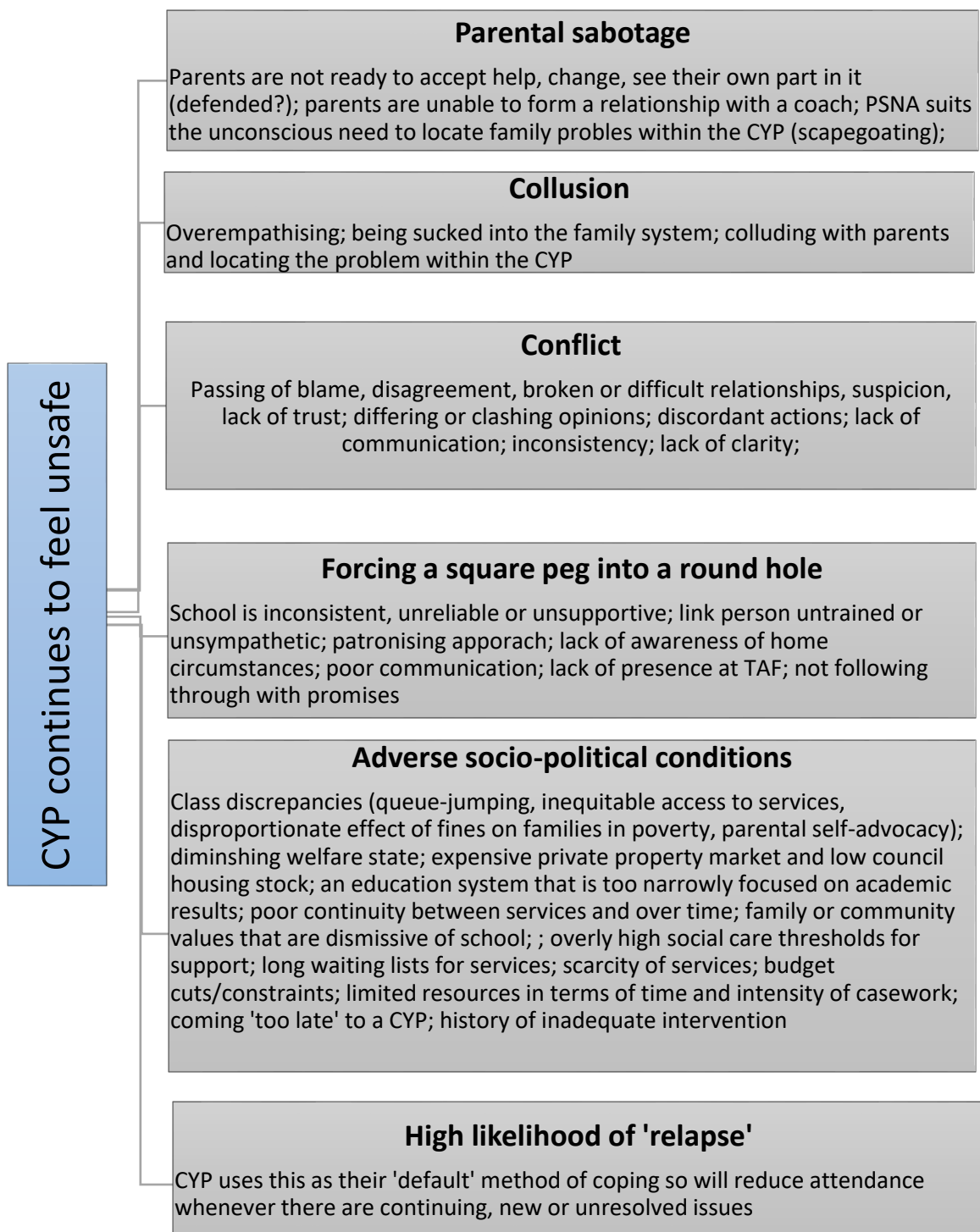
Helping CYP to become "visible"

Time; empathy; taking an interest; being present; advocating; building relationships supporting connections with others; exploring interests and strengths; seeing and sharing CYP's point of view; being flexible and persistent; looking beyond the obvious; understanding; helping them meet others in the same situation; raising aspirations; broadening the lens: taking the pressure and spotlight of the CYP as the 'problem' and looking more widely at the issues in the family and wider system; not seeking 'treatment' whilst ignoring real environmental issues; adequately addressing safeguarding issues; helping to process historic DV or abuse in the home; addressing learning needs/illiteracy

Creating a square hole for a square peg

Alternative or part time timetables; quiet spaces; social support; mentoring; staff training; additional exam/learning support; group/class changes; placement changes; staggered start times; negotiating special arrangements about uniform or not reading aloud; taking a strengths-based approach; setting up a support network; opening channels of communication

Model 3: Constraints (what hinders)



7.9. Appendix I: TREC approval letter

The Tavistock and Portman 
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2548
Fax: 020 7447 3837
www.tavi-port.org

27/07/17
Adele Tobias

By Email

Dear Adele,

Re: Research Ethics Application

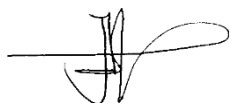
Title: *Not Going to School: Family Coach Perspectives on what helps and what hinders*

I am pleased to inform you that the Trust Research Ethics Committee formally approved your application on 27th April 2017.

If you have any further questions or require any clarification do not hesitate to contact me.

Please note that I am copying this communication to your supervisor for information.

May I take this opportunity of wishing you every success with your research.



Mrs Paru Jeram
Secretary to the Trust Research Ethics Committee

Cc. Brian Davis, Course Lead

Appendix J: Participant information sheet

PARTICIPANT INFORMATION SHEET

RESEARCH TITLE

Not Going to School: Family Coach perspectives on what helps and what hinders

INTRODUCTION

You are invited to join a research study to look at what helps and what hinders work with children and young people who are persistently absent from school in Brighton and Hove.

The decision to join, or not to join, is up to you.

WHAT IS INVOLVED IN THE STUDY?

If you decide to participate you will be asked to take part in a focus group with approximately 5-7 other family coaches. This will be facilitated by Adele Tobias and will last for about one hour and a half. The focus group will be audio-taped and transcribed so that it can be later analysed.

CONFIDENTIALITY

I will take the following steps to keep information about you confidential, and to protect it:

- All data will be kept on an encrypted laptop and audio-tapes erased once transcription has taken place.
- Following the study, the data will be kept for ten years on an encrypted memory stick and then erased in accordance with the University's Data Protection Policy.
- Your contribution will be anonymised and your name will not appear in any of the data. Once I have coded the data, there will be no way of linking statements to individual FCs.
- If you discuss any children, young people, family members or professionals during the focus group, their names will be anonymised.
- The results and any feedback will be set up as general themes and will seek to avoid including anything that might obviously identify an individual.
- All the data will be treated as confidential and will not be available to anyone except me.

RISKS?

I will be using some direct quotes in my write up which, although anonymised, could be traced to an individual, especially as the total number of participants will be less than 30. There is a small possibility that a child, young person, family member or professional could be identified as individuals in the data, despite anonymization. There may also be other risks that I cannot predict.

BENEFITS TO TAKING PART IN THE STUDY?

The research questions have been guided by what you, as a team, have expressed to me as issues when working in this area and what you would find helpful to explore. I will arrange to feedback my results at the end of the research so that your team receives some benefit for participating. I will use the results to help inform the development of policy and guidance in our local authority. I will publish my results nationally so that other professionals can draw upon them in their work. Others may therefore benefit in the future from the information I find in this study.

YOUR RIGHTS AS A RESEARCH PARTICIPANT?

Participation in this study is voluntary. You have the right not to participate at all or to leave the study at any time. If you have any concerns about the conduct of the researcher or any other aspect of this research project, contact Louis Taussig, the Trust Quality Assurance Officer ltaussig@tavi-port.nhs.uk. I confirm that this research has received formal approval from the Tavistock Research Ethics Committee (TREC).

CONTACTS FOR QUESTIONS OR PROBLEMS?

The research is being carried out by Adele Tobias. I am one of the Educational Psychologists working for the local authority in Brighton and Hove. This study forms part of a doctoral qualification at the Tavistock Clinic, overseen by the University of Essex. I am happy to discuss, in total confidence, anything relating to this research and can be contacted on: adele.tobias@brighton-hove.gcsx.gov.uk or 01273 296758.

7.10. Appendix K: Participant consent form

RESEARCH TITLE: Not Going to School: Family Coach perspectives on what helps and what hinders

I, the undersigned, confirm that (please tick box as appropriate):

1.	I have read and understood the information about this research study, as provided in the participant information sheet.	<input type="checkbox"/>
2.	I have been given the opportunity to ask questions about the study and my participation.	<input type="checkbox"/>
3.	I voluntarily agree to participate in the study. I understand that this will involve participation in one or more focus group(s) lasting approximately 1 to 1.5 hours and that these will be audio-taped. I agree to being audio-taped.	<input type="checkbox"/>
4.	I understand I can withdraw participation or unprocessed data at any time without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn.	<input type="checkbox"/>
5.	The procedures regarding confidentiality have been clearly explained to me.	<input type="checkbox"/>
6.	The use of the data in research, publications, sharing and archiving has been explained to me.	<input type="checkbox"/>
7.	I, along with the Researcher, agree to sign and date this informed consent form.	<input type="checkbox"/>

Participant:

Name of Participant

Signature

Date

Researcher:

Name of Researcher

Signature

Date