Corresponding author:
Dr Moja Kljakovic, Middlesex University, The Burroughs, London, NW4 4BT, U.K.
Email: m.kljakovic@mdx.ac.uk

Working with school refusing young people in Tower Hamlets, London.

Moja Kljakovic

Middlesex University, London, U.K.

DCP, PhD, CPsychol

Aidan Kelly

CAMHS Tower Hamlets, London, U.K.

DCP, MSc, CPsychol

Abstract

This study looks at the local context, describing quantitative data from a subset of young people seen within the inner London Tower Hamlets Pupil Referral Unit (PRU) that are extremely socially withdrawn and unable to attend mainstream education. The core aim of this research was to examine the views of professionals who work with and for these young people. Qualitative group interviews were used to gain a deeper understanding of the needs of these young people, what might contribute to their withdrawal from school and what needs to be done to help them reintegrate.

Professionals reported that these young people were highly complex in terms of their needs and presentation and that there is a lack of clarity around what causes these young people to withdraw. They agreed that a more intensive multi-layered intervention was required to meet their needs. Interventions that include gradual socialisation, parental involvement and which address the role of technology were indicated. However, more research is needed to clarify how to effectively intervene.

Key words

Introduction

School refusal is a broad term, encompassing chronic non-attendance as well as occasional truancy and the term does not necessarily indicate the cause of the behavior (Heyene, Gren-Landell, Melvin, & Gentle-Genitty, 2019). Heyene et al. (2019) discuss the definitional problems within this area at length and identify four distinct categories: school refusal, truancy, school withdrawal and school exclusion. However, previous research does not always confine to this metric and as such, other terms, which may be identified through a refusal to attend education, can also be considered when trying to understand this phenomena (Rubin & Asendorpf, 1993).

Given the difficulties with definition, research can be inconsistent regarding the causal factors of withdrawal from education. When looking at school refusal, rather than truancy, anxiety has commonly been listed as the main cause (Lauchlan, 2003). Truancy, on the other hand, was traditionally thought to be caused by conduct disorder (Berg et al., 1993). However, individuals may exhibit both truancy and school refusal and may also do so in the absence of anxiety or conduct problems (Lauchlan, 2003). Other identified correlates of school refusal include homelessness, poverty, bullying and victimization at school, sense of school connectedness as well as a lack of parental involvement (Kearney, 2008a).

Although the cause may not be clear, what is clear is that school refusal has a negative impact on a number of aspects of a young person's life. For example, school refusal has been linked to school drop out (Rumberger, 2011), violence, mental health problems and substance abuse (Kearney, 2008a). Persistent school refusal, in particular, has been identified as more problematic to treat then other forms of absenteeism and an area needing further research (Tonge & Silverman, 2019).

It is clear from the literature that it is likely to be a combination of factors that leads to withdrawal and there may be several pathways through which this can occur. As such, forming a discrete intervention plan for affected individuals may be difficult and instead interventions may need to take an individual, formulation driven approach and be multimodal (Inglés et al., 2015). Oner, Yurtbasi, Er and Basoglu (2014) provide examples of intensive multi-layered interventions for school refusal, which include individual therapy for the young person, family therapy, social skills training, relaxation training as well as contingency management and pharmacotherapy.

Local context

Research has begun to identify a subset of young people that feel unable to engage with school. International literature identified that causes of school refusal may vary by country (Inglés, Gonzálvez-Maciá, García-Fernández, Vicent & Martínez-Monteagudo, 2015) and more local-based research is needed to circumvent the associated negative repercussions.

The inner London borough of Tower Hamlets has the 4th youngest median age in the UK, at 31 years of age (Tower Hamlets Local Safeguarding Board, 2017). The

majority (32%) of the population are British Asian, Bangladeshi and 31% White British but the vast majority of the school aged population (91%) were born in the UK (Tower Hamlets Local Safeguarding Board, 2017). Tower Hamlets has the highest rate of child poverty in the UK with 49% of children and young people in Tower Hamlets living in poverty (Tower Hamlets Local Safeguarding Board, 2017).

In Tower Hamlets, the problem of school refusal has been of particular concern in recent years. Rates of reported absenteeism in secondary school students are 4% (Tower Hamlets Council, 2018). In January 2013 statutory guidance from the Department of Education made local authorities responsible for providing suitable education for children who are unable to attend a mainstream or special school because of their health needs.

The Tower Hamlets Social Inclusion Panel (SIP) has seen a significant rise in the number of cases discussed in the years following the legislative change (SIP Annual Report 2016). The SIP is responsible for coordinating care for vulnerable Tower Hamlets young people with the aim of reducing the level of offending, anti-social behaviour, school non- attendance and exclusion. The increasing numbers of cases discussed at SIP indicates that there is an unmet need in the Tower Hamlets borough for this vulnerable group of young people.

In order to learn more about school refusal and how it affects young people in Tower Hamlets a collaborative project between Tower Hamlets Child and Adolescent Mental Health Services (CAMHS) and Tower Hamlets Pupil Referral Unit (PRU) was commissioned as part of the local Transformation Plan. The project aimed to learn more about why these young people were unable to attend mainstream school and whether there were unmet mental health needs. This study forms one part of this wider project and specifically aims to understand more about the young people that withdraw from education by interviewing the professionals that work with them.

Method

Design

A mixed methods design was used to first gather quantitative data to learn more about the demographics and mental health presentation of the young people in question. Qualitative data was then gathered from professionals working with these young people. Group interviews were chosen over individual interviews to stimulate discussion and allow for generation of different ideas and richer data. It also allowed for a greater number of views to be incorporated in the time available for data collection. The professionals involved in working with these young people were interviewed to find out more about the challenges they face and insights they might have from the experience of working with this particular group. It was not within the scope of this project to interview the young people themselves due to a lack of resource and the hard to reach nature of the group.

Study setting

Initial descriptive data was gathered on young people that were enrolled on the Individual Tuition programme at the Tower Hamlets Pupil Referral Unit (PRU) in the month of June 2016. In the UK the academic year begins in September. If children are to be referred from mainstream education to the PRU it will usually take some time from the beginning of the academic year. As such, June was felt to be a time of year where the true number of young people who might ultimately end up in the PRU would be better represented. The Tower Hamlets PRU is an alternative education provision maintained by the local authority for young people that are otherwise unable to access mainstream education. The Individual Tuition programme was offered to students that could not manage in a classroom environment with other students.

Qualitative data was gathered from professionals that work at the PRU, CAMHS and those involved with the Local Authority's Social Inclusion Panel. CAMHS is a specialist mental health NHS provision for young people below the age of 18 years of age and their families. The Social Inclusion Panel is a local authority panel that consists of multi-agency youth and family professionals that meet to discuss and plan interventions for vulnerable young people in the borough that are at risk of being excluded from society.

The interviews were conducted by the second author who was a CAMHS clinician and trained clinical psychologist. He worked with a number of school refusing young people and it is likely that his experiences of doing so will have shaped his approach to this research project. For example he was struck by the high level of deprivation and poverty experienced by many of the families in the borough yet felt powerless to address this within his role as a CAMHS clinician. Although every attempt was made to remain impartial when developing the interview questions and conducting interviews, it must be recognized that their personal opinions will have impacted on the results.

Participants

Quantitative

Initial descriptive data was gathered on all 47 individuals that were enrolled on the Individual Tuition (IT) programme at the Tower Hamlets Pupil Referral Unit (PRU) in the month of June 2016. Data was gathered as a service audit and all participants consented to their data to be used in that way at point of access. For those under 16 years of age, parental consent was given. The mean age of the IT group was 16 years with 60% (n = 28) males and 40% (n = 19) females. Of the 47 individuals attending IT, 57% (n = 27) were referred by the Social Inclusion Panel (SIP), 32% (n = 15) were referred from the Pupil Referral Unit's reduced educational provision programme, and 11% (n = 5) were referred by the Special Educational Needs (SEN) panel.

Of the 35 participants open to CAMHS 11 of those participants had an anxiety disorder diagnosis, seven had a conduct disorder diagnosis, five had a depression

diagnosis, five a psychotic diagnosis, three had a learning disability diagnosis, three had an ADHD diagnosis, two had an Autism diagnosis, and one each had a diagnosis of attachment disorder and gender dysphoria. A number of participants had more than one diagnosis.

For comparison, a random sample of Tower Hamlets CAMHS users was collected. The CAMHS sample comprised 69 young people. The mean age of the IT group was 15 with 52% (n = 13) males and 48% females (n = 12). The mean age of the CAMHS group was 14 with 48% (n = 33) males and 52% females (n = 36). Due to the limited sample size and data set representing only 53% of the total IT participation group it is not possible to generalise these results.

Qualitative

Participants were invited to attend group interviews by their team managers. Managers were also invited to attend a separate group interview that we have named 'senior management group interview'. Of 15 invited, 14 participants took part. One participant, 'Adam', attended two interviews as the original Individual Tuition representative at the senior management meeting was unable to attend at late notice. The names of the participants have been changed to protect anonymity. See below for a list of pseudonyms and their professional backgrounds.

Pseudo name	Designation
Individual Tuition Group Interview	
Jane	Individual Tuition Tutor
Lucy	Individual Tuition Manager
Steph	Individual Tuition Manager
Louisa	Individual Tuition Tutor
Adam	Individual Tuition Manager
CAMHS Group Interview	
Mary	Senior CAMHS clinician
India	Senior CAMHS clinician
Lisa	Senior CAMHS clinician
Sarah	Senior CAMHS clinician

Senior Management Group Interview	
Peter	Senior CAMHS manager
Adam	Individual Tuition Manager
James	Senior CAMHS manager
Eliza	Local Authority Manager
Katherine	Local Authority Manager

Measures

Screening for Anxiety and Depression: To gain information about the mental health needs of the young people group, the Revised Children's Anxiety and Depression Scale (RCADS) self-report was administered. This is a 47-item questionnaire that measures reported frequency of a range of symptoms of anxiety and low mood. The RCADS produces 5 anxiety subscales (namely 'Separation Anxiety', 'Social Phobia', 'Generalised Anxiety', 'Panic', 'Obsessive Compulsive') and a 'Total Anxiety' score. It also gives 'Low Mood', and a combined 'Total Anxiety and Low Mood' score. Clinical thresholds are statistical cut-offs and may be indicative of a disorder but are not defining. The two used by the RCADS are 'borderline' (t score > 65, +1 SD) and 'clinical' (t score > 70, +2 SD). The t scores are calculated based upon data of a random sample of similarly aged US school children of the same sex (Law, 2013).

Of the total IT sample RCADS data were gathered for 25 individuals, this group is referred to as RCADSIT. This was compared with RCADS normative data and a random sample of Tower Hamlets CAMHS users.

Procedure

Case files were reviewed and demographic data were extracted. RCADS self-report measures are routinely given to the IT students either by their Individual Tutor or CAMHS clinician. For the IT sample at the time of this study RCADS self-report measures were available for 25 of the 47 participants (53%).

For the qualitative part of this study three group interviews were conducted. The first was held with Individual Tuition (IT) professionals (n = 5), the second with CAMHS professionals (n = 4), and the third with managers at Tower Hamlets local authority, the PRU and CAMHS (n = 5). Each interview was conducted using a semi-structured interview schedule. The schedule was developed by reviewing previous research within this area as well as speaking with staff that work with school refusing young people about what they consider important issues that need addressing. The interviewer then used their judgment to determine what questions to include. The same interview schedule was used

for each group discussion, however, there was space for participants to include other information that they felt was relevant. The interviews were recorded electronically and then transcribed verbatim.

Analysis

Descriptive statistics

IBM Statistical Package for the Social Sciences (SPSS) 23.0 was used to analyse the data. Independent samples t-tests were used to compare the RCADSIT and CAMHS groups. Where data were non-normally distributed, a Mann-Whitney U-test was used.

Qualitative

When the interviews were completed, the transcripts were analysed using Thematic analysis as outlined by Braun and Clark (2006). Thematic analysis was used to identify, analyse and report noticeable patterns within the data. Instead of organizing and dissecting the data the authors interpreted various aspects of the topic in relation to the research question (Boyatzis, 1998). The researchers made a choice to select certain themes and focus more closely on them. A rich thematic description of the entire data set was carried out as a way of understanding the most dominant themes before these themes were then considered in relation to school refusal in adolescence. Over 15 main themes were identified before the authors settled on the three themes to be further analysed, which are described below.

The aim was not to discover objective and generalisable truths, but to join together through discussion and make sense of the participant's own and shared experience (Charmaz, 2014). The themes from the group interviews were then presented to each of the research team members in turn, who reflected on the findings, fine-tuned codes, synthesised thematic patterns and compared and contrasted findings from the group interviews. Although the findings of such a small qualitative study cannot be generalized to all professionals who work with school refusing young people, the multiple perspectives provided by these collaborative meetings enhanced the trustworthiness of the findings.

Results

Descriptive statistics

For the 25 RCADSIT participants the mean RCADS t-score for the RCADS category 'total internalising' was 57.6 with 28% (n = 7) falling within the clinical range for internalising difficulties and 8% (n = 2) in the borderline clinical range. Of the RCADS sub-categories, the highest was separation anxiety disorder (SAD) with 36% (n = 25) of participants falling within the clinical range and 12% (n = 3) within the borderline clinical range. The lowest mean score was for social phobia (SP) with only

one of the 25 falling within the borderline clinical range and none of the sample in the clinical range.

In regard to how the RCADSIT group compared to the general CAMHS sample, they were significantly different in age (U = 564.0, p = .01) with the CAMHS sample being younger on average, than the RCADSIT sample.

There were no significant differences between the RCADSIT group and CAMHS group in terms of RCADS major depressive disorder (MDD) (t(92) = 0.37, p = .71) , OCD (t(92) = -.20, p = .84), SP (t(92) = 1.30, p = .20), PD (t(92) = 0.05, p = .96), GAD (t(92) = 1.13, p = .26), SAD (t(92) = - 1.00, p = .32), total anxiety (t(92) = 0.18, p = .86) or total internalising (t(92) = 0.10, p = .92) scores.

Qualitative study

Themes are presented below from the group interviews. As listed below, the three main themes that emerged from the data were 1) the varied and complex nature of the problem 2) barriers to helping these young people 3) the need to hold onto hope.

Problems are varied

Parental factors

When asked to describe what the problem is and why they thought these young people withdraw, participants identified that there are many factors involved but no one clear cause. They were able to identify some of the most recurring features of these cases such as parenting, parent-child relationships, and difficult relationships between services and parents. For example,

> Peter, a senior CAMHS manager, explained that "there are common factors, i.e. underpowered parenting, parents have a pattern of poor engagement with schools, a pattern of poor relationship with trust".

> Louisa, IT tutor, indicated that from her experience "you go to the parent's house where you go in there you want to tutor them and ...the parents are sleeping, and... you have to wake the parents up before you can even find the child so its things like that I strongly believe are the parenting issues".

> In relation to the relationships between professionals and the parents Lucy (IT manager) identified that professionals "tend to be quite hamstrung in not wanting to rock the boat or upset the family dynamic".

Psychosocial factors

Other psychosocial factors can result in young people feeling different to their peers. Participants thought that young people with diverse identities, or those outside the norm, may feel the pressure to 'fit in' with peers and that this may play an important role.

Mary, a senior CAMHS clinician, explained that "the young people that I've worked with who find school difficult, often they see themselves as different in some kind of way whether that be gender identity, might be basically fitting in with their peers and so on".

In addition to peer relationships, participants felt that bullying and victimization may play a role.

For example, Katherine, a local authority manager stated "an instance of bullying, or breakdown in relationship in school…friendships, that sort of thing, which then starts the spiral".

Technology

The use of technology to create an alternate world within which to exist was a prominent theme. It was further felt that this use of technology keeps young people somewhat connected to society and thus they may be less withdrawn than prior generations struggling with the same issues.

IT manager, Lucy, stated that for young people to "stay in their rooms is a much easier proposition these days because there are entertainments beyond the TV, there is internet and games and all sorts of means in which you can "live" in inverted commas, in your room".

Local authority manager, Eliza, further noted, "I'm not convinced that current cases are as severe as what we used to see…it's a different spectrum. There is a spectrum of people who are choosing to be in their bedrooms living in a social world that is through social media and the internet through those connections rather than the real world".

Mental health problems

There did also appear to be some associated mood and anxiety problems that were felt to contribute to young people withdrawing.

India, a senior CAMHS clinician, stated that "I suppose when I think of these young people, certainly two young girls that I am working with, in a very general sense - anxiety is there".

Another senior CAMHS clinician, Lisa, also felt mental health played a role added that "the other young person has been many years in CAHMS and her confidence and self-esteem…how she feels about herself are really, really sort of low, and so that contributes to her withdrawing".

Barriers that make it hard to reach these young people

System factors

When asked to think about some of the barriers or difficulties that might contribute towards the poor outcomes these young people have, the participants explained that services usual/standard practices don't work.

> Senior CAMHS manager, Peter, explained, "I think it is something to do with the way schools are set up and the way the education system has been set up. It has been assumed that you should all attend school on these days, be in the classroom for this many hours a day, be in the classroom depending on age group, and I think the education system could be set up in a more flexible way".

Incongruent goals

Participants described how change is particularly hard in these situations for families and professionals, due in part to the complexity of the cases, limitation on staffing resources that can make it hard to engage the young person and their family, that make it difficult to work towards a common goal.

> Local authority manager, Katherine, explained that "there are examples of parents colluding because it provides a level of security or safety for them to have their children at home; if that's a factor, which isn't in all cases, that can really make access very difficult and a lot of universal services are not equipped to do a lot of engagement".

Societal pressure

Again they also highlighted that there are social pressures that exist that lead to unrealistic expectations being placed on these young person and their families.

> Lisa, a senior CAMHS clinician, reported that in her view "education is very much about succeeding and it's pressurising kids who aren't succeeding, ultimately pressurising kids to give up and think they can't. The bar is set to much too high".

Holding on to Hope

Despite how difficult it can be to work in this area, participants reported that three general areas were important if change was to happen.

Intensive and hopeful

Firstly the type of intervention offered needed to be intensive and that the clinician/s involved needed to build a strong relationship with the young person and family and remain hopeful in order to instill hope in a system that at times is low on things to be hopeful about.

Local authority manager, Eliza reported that "what we need is intensive work in order to come overcome those barriers, intensive work with families rather than dribbling small bits of therapy and support and talk, over long periods of time, because I think there's too many gaps in between".

Senior CAMHS manager, Peter, also spoke about "I suppose remaining hopeful. I suppose as well, because there is a danger that you compare with another case where you didn't have a good outcome. Remaining positive is an important factor and it's important for the young people to feel that and we are the people with some hope".

Gradual changes

Next they spoke about gradual socialisation and opportunities for the young people to meet other young people in similar positions in a supportive and non-threatening environment.

IT tutor, Jane, explained: "A lot of kids can't make that transition from home suddenly back into school, which is a very busy environment, they need sometimes a quieter [environment], to check it out, and that step needs to be more gentle.... just trips out to the shops to have a cup of coffee, trips to the cinema and it is education and getting the kids not to think that it is not education either, it is educational, but it's also fun".

Sharing the workload

Thirdly the participants spoke about the need for a collective approach between both professionals and the family. That for the young people who got good outcomes this was a strength of their work together.

For example, local authority manager, Katherine, thought that it was important for parents to "respond to the support and strategies that are offered to them, so there is collective move to support the child in turning around".

Local authority manager, Eliza, explained that "having a family group conference actually helped, because it was about bringing them around the inadequate parenting and giving them some sort of back up, for when they needed to lay the law down, they weren't relying on the two of them to do it, but could actually fall back on other people for support".

A family group conference is a meeting with the family and professionals led by family members, which aims to empower the family to plan and make decisions for a young person who may be at risk (Lupton, 1998).

Discussion

The aim of the study was to learn more about the young people receiving Individual Tuition (IT) at Tower Hamlets Pupil Referral Unit (PRU) and how the professionals working with these young people understood their difficulties. From reviewing the literature, quantitative data on a sample of these young people and qualitative data from professionals who have worked with these young people it is clear that this problem is multifaceted and complex.

The analysis of the quantitative data gives some details on the young people that were referred to IT at Tower Hamlets PRU. The majority of these young people were known to CAMHS, on average, two years before being referred to IT. In terms of self-reported mental health symptoms they were no different to their CAMHS peers. This finding is in line with previous research (Egger, Costello & Angold, 2003) in that mental health problems are observed in the school refusing group, however, it also contrasts with previous research, summarised by Lauchlan (2003), in that although mental health problems may be related, they do not appear to be the sole cause of withdrawal.

Qualitative data was gathered from the professionals that work with these young people, many of who have decades of experience. They doubted whether these young people were a homogenous group that fit neatly into one diagnosable category. They felt that a multitude of factors might cause young people to withdraw. In particular, there may be parental factors, including the relationship between the family of the young person and mental health professionals. This is in line with findings of Heyne et al. (2019) that suggest assessment and treatment of school refusers must be multi-faceted including family, the school, and socio-cultural factors.

One factor that was highlighted by one of the local authority managers was that collusion may be occurring and some parents may prefer their child to remain at home. Although this was not a contributing factor listed by all participants, it is an interesting point to consider as much of the previous research has focused on the relationship between disengaged parents and school refusal (Kearney, 2008a) and it is conceivable that this collusion may have some positive connotations, such as a sense of support for the young person. To effectively delineate how parenting might be impacting on school refusal it is clear that professionals must work on establishing a strong supportive relationship with parents to best meet the needs of their child.

Psychosocial factors relevant to the young person such as feeling as though one does not fit in may play a role, as well as mental health difficulties of the young person. Both school connectedness and mental health difficulties have consistently been linked to school refusal in previous research (Kearney, 2008a). It was also felt that technology may play a role in allowing young people to escape. This finding is unique in that technology has not commonly been identified as a relevant factor to school refusal and differs somewhat from previous research (Fox, Henderson, Marshall, Nichols & Ghera, 2005; Rubin, Coplan & Bowker, 2009), which often cites individual level factors such as personality as the route cause. It is unclear exactly how technology could be targeted in interventions to support school refusers but this is an area for potential future research. It

may also be interesting to determine whether increased use of technology may be one factor related to the increased prevalence of school refusal observed in Tower Hamlets.

Discussion revealed that these young people are difficult to engage from a clinician point of view, often not attending appointments and denying or minimizing any emotional difficulties. It is also difficult to work with their networks; families can often be chaotic and difficult to form an alliance with, while the different agencies involved can be working towards very different and competing goals. The professionals also identified a number of barriers to working with these young people including system factors, incongruent goals, and societal pressure. These findings are helpful in regard to identifying a way forward in helping young people that withdraw from education. A multi-pronged treatment approach is indicated. For example, addressing the parents feelings of disempowerment and working to build parent's trust of mental health professionals may be effective. This is in line with previous research that suggests interventions must treat individual and external level factors (Oner et al., 2014).

Despite difficulties in identifying and working with school refusing young people, professionals were able to identify instances when services get it right and are able to make a positive impact. It was felt that interventions that were intensive and hopeful, which included gradual socialisation and were well supported, were the most effective. These factors could be held in mind when delivering a multipronged approach targeting both external and internal factors for best results. Given that parenting factors, psychosocial factors and technology were identified as relevant to the problem, interventions involving these factors may also be beneficial in reducing withdrawal.

A systematic review of randomized control trials by Maynard et al. (2018) identified that psychosocial interventions are effective at reducing school refusal behavior. The interventions included were primarily cognitive behavior therapy (CBT) based. Heyne, Sauter, Van Widenfelt, Vermeiren and Westenberg (2011) developed an effective CBT for anxiety based school refusal treatment programme that included elements of family work. The family components aimed to enhance family communication, decision-making, and problem solving. Gradual socialisation has also been a key component of effective CBT interventions such as the Back2School intervention (Thastum et a., 2019). Chu, Guarino, Rutgers, O'Connell and Coto (2019) illustrate the use of technology as a means of early identification of truancy. However, to date, combating the use of technology as a factor relevant to school refusal is yet to be examined. Although the aforementioned interventions have been shown to be effective, it is unclear whether the factors identified are essential active components.

The role of poverty by the professionals as a factor relevant to school refusal. However, previous research has identified this as a relevant factor (Kearney, 2008a) and Tower Hamlets reportedly has the highest rate of child poverty in the UK (Ashley, 2017). This is something that would be interesting to explore in future research, as it is unclear why clinicians working in one of the most deprived boroughs in London did not highlight this as a relevant factor. Zangh (2003) identified that one of the reasons for the identified link between poverty and school refusal may be that children are engaging in paid

employment, rather than school. This is unlikely to be the case in this sample as no members of the IT group were in paid employment.

Limitations

There are limitations to how we can interpret the RCADS data. The failure to find significant results when comparing the IT and CAMHS populations for everything except age may be down to the small sample size or group variance, within the CAMHS and IT sample. As previously highlighted this group of young people are extremely difficult to access and getting completed questionnaires has been a challenge.

As the RCADS does not appear to be capturing what is different about this group when compared to the rest of CAMHS, a different outcome measure might be more meaningful to try and monitor this group. More sensitive measures are needed to further extrapolate the different types of school refusal.

Three of the young people had a diagnosis of ADHD and two an ASD diagnosis. The professionals did not highlight the impact of these conditions and as such, the relevance of this was not explored in this study. Previous research has also indicated that learning difficulties may be present in a small proportion of school refusers (McShane, Walter, & Rey, 2001). There are also bigger questions as to whether the use of self-report is appropriate at all for this population; however, it was not within the scope of this study to explore. Future research may want to look at the impact of learning difficulties on school refusal and consider alternatives to self-report measures.

There are also limits to the interpretation of the qualitative data from this study. The interviews were based on clinician's accounts of their experiences in working with a subset of young people exhibiting school refusal. As such the results cannot be said to generalise to other young people who school refuse.

No particular questions were asked regarding cultural or ethnic factors in the qualitative interviews. This is a cultured area of working and as such, perhaps it should have specifically been asked what role culture or ethnicity plays in the problem of school refusal, as this factor did not arise organically through the discussions. It is interesting that this factor was not highlighted by participants through the group discussions.

The interviewer's biases must also be taken into account when interpreting these findings. For example, the interviewer had previously worked with some of the young people included in the sample. This may have influenced him in his approach to the project, although every effort was made to minimize this by an independent reviewer (the first author) acting as a second coder for the analysis and having them review the interview schedule.

Using the group interview format may also have been problematic. Some individuals may not have felt comfortable sharing their ideas in a group setting, which may have prevented more sensitive ideas from being shared. However, participants were

made fully aware of the proposed format of the study and were given the option to not take part.

A suggested area for future research is the incorporation of the young person's voice. This was beyond the scope of this project but it is suggested that future research in the area would benefit from asking young people and their families for their perspective on these issues.

Future research might also benefit from using a developed measure of school refusal such as the School Refusal Assessment Scale (SRAS-R; Kearney, 2008b) to further profile the young people of question. This might help clarify what the problem of focus is in discussion with professionals.

Conclusion

This study sought to understand school refusal in the increasing numbers of young people in Tower Hamlets being referred for individual tuition by interviewing with the professionals that work with these youth. From this study we have learnt that this group of young people are a no different to the general CAMHS population In terms of self-reported mental health symptoms. They are a heterogeneous group that all exhibit a common behaviour, school refusal. Rather than using this behaviour to define the group it is better viewed as a product of deeper underlying causes from the young person's mental, social and material world. For professionals to facilitate a high level and intensive approach to supporting vulnerable young people on the edge of society an integrated and multi-agency approach that spans health, local authority and education is called for. Interventions that are intensive and hopeful, which include gradual socialisation and parental involvement and which address the role of technology are indicated. Future studies may wish to give further exploration to the role of parents and technology in the problem of school refusal as well as gaining qualitative data from the school refusers themselves. It would also be beneficial to examine the relationships between culture or ethnicity and school refusal, as well as the impact of learning difficulties on this problem.

Declaration of conflicting interests

The Authors declare that there are no conflicts of interest.

References

Berg, I., Butler, A., Franklin, J., Hayes, H., Lucas, C. & Sims, R. (1993). DSM-III disorders, social factors and management of school attendance problems in the normal population. *Journal of Child Psychology and Psychiatry, 34,* 1187–1203.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development.* Thousand Oaks, CA, US: Sage Publications, Inc.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology, 3,*77-101.

Charmaz, K. (2014). *Constructing grounded theory.* London: Sage.

Chu, B. C., Guarino, D., Mele, C., O'Connell, J., & Coto, P. (2019). Developing an online early detection system for school attendance problems: Results from a research-community partnership. *Cognitive and Behavioral Practice, 26,* 35-45.

Coplan, R. J., Prakash, K., O'Neil, K., & Armer, M. (2004). Do you "want" to play? Distinguishing between conflicted-shyness and social disinterest in early childhood. *Developmental Psychology, 40,* 244–258.

Egger, H. L., Costello, E. J., & Angold, A. (2003). School refusal and psychiatric disorders: A community study. J*ournal of the American Academy of Child and Adolescent Psychiatry, 42,* 797−807.

Fox, N. A., Henderson, H. A., Marshall, P. J., Nichols, K. E., & Ghera, M. M. (2005). Behavioral inhibition: Linking biology and behavior within a developmental framework. *Annual Review of Psychology, 56,* 235-262.

Heyne, D., Gren-Landell, M., Melvin, G., & Gentle-Genitty, C. (2019). Differentiation between school attendance problems: Why and how? *Cognitive and Behavioral Practice*, 26, 8-34.

Heyne, D., Sauter, F. M., Van Widenfelt, B. M., Vermeiren, R., & Westenberg, P. M. (2011). School refusal and anxiety in adolescence: Non-randomized trial of a developmentally sensitive cognitive behavioral therapy. *Journal of Anxiety Disorders, 25,* 870–878.

Inglés, C. J., Gonzálvez-Maciá, C., García-Fernández, J. M., Vicent, M., & Martínez-Monteagudo, M. C. (2015). Current status of research on school refusal. *European Journal of Education and Psychology, 8,* 37-52.

Kearney, C. A. (2008a). School absenteeism and school refusal behavior in youth: A contemporary review. *Clinical Psychology Review, 28,* 451–471.

Kearney, C. A. (2008b). An interdisciplinary model of school absenteeism in youth to inform professional practice and public policy. *Educational Psychology Review, 20, 257–282.*

Lauchlan, F. (2003). Responding to chronic non-attendance: A review of intervention approaches. *Educational Psychology in Practice, 19,* 133-146.

Law, D. (2013). *Goals and goal based outcomes (GBOs).* London: CAMHS Press.

Lupton, C. (1998). User empowerment or family self reliance? The family group conference model. *British Journal of Social Work, 28,* 107-128.

Maynard, B. R., Heyne, D., Brendel, K. E., Bulanda, J. J., Thompson, A. M., Pigott, T. D. (2018). Treatment for school refusal among children and adolescents: A systematic review and meta-analysis. *Research on Social Work Practice, 28,* 56-67.

McShane, G., Walter, G., & Rey, J. M. (2001). Characteristics of adolescents with school refusal. *Australian and New Zealand Journal of Psychiatry, 35,* 822−826.

Oner, O., Yurtbasi, P., Er, A., & Basoglu, N. (2014) The inpatient treatment process for severe school refusal. *Bulletin of Clinical Psychopharmacology, 24,* 176-179.

Rubin, K. H., & Asendorpf, J. (1993). *Social Withdrawal, Inhibition, and Shyness in Childhood.* Hillsdale, NJ: Erlbaum.

Rubin, K. H., Coplan, R. J., & Bowker, J. C. (2009). Social Withdrawal in Childhood. *Annual Review of Psychology, 60,* 141–171.

Rumberger, R. W. (2011). *Dropping out: Why students drop out of high school and what can be done about it.* Cambridge: Harvard University Press.

Thastum, M., Johnsen, D. B., Silverman, W. K., Jeppesen, P., Heyne, D. A., & Lomholt, J. J. (2019). The Back2School modular cognitive behavioral intervention for youths with problematic school absenteeism: Study protocol for a randomized controlled trial. *Trials, 20 (29),* 1-12.

Tonge, B. J., & Silverman, W. K. (2019). Reflections on the field of school attendance problems: For the times they are a-changing? *Cognitive and Behavioral Practice, 26,* 119-126.

Tower Hamlets Council (2018). *Borough Profile 2018: Education.* Retrieved from: https://www.towerhamlets.gov.uk/Documents/Borough_statistics/Research-briefings/BP2018_7_Education_FINAL.pdf

Tower Hamlets Local Safeguarding Children Board (2017) *Annual Report 2016/17.* Retrieved from: https://democracy.towerhamlets.gov.uk/documents/s117300/5.2a%20Appendix%20A%20LSCB%20Annual%20Report%202016-17.pdf

Vasa, R. A., & Pine, D. S. (2006). Anxiety disorders. In: Essau C, (Ed.). *Child and Adolescent Psychopathology: Theoretical and Clinical Implications* (pp. 78–112) New York: Routledge/Taylor & Francis.

Zhang, M. (2003). Links between school absenteeism and child poverty. *Pastoral Care in Education, 21,* 10-17.