

Absence and disengagement in children and young people

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Absence and disengagement in children and youth is multifaceted and complex in nature. Characteristics and risk factors reported in the literature and listed in the sections below are intended to inform and guide your practice. Young people engaged with your service may or may not present with similar characteristics and risk factors, or present with unique characteristics or additional risk factors.

Definitions of absenteeism from school

Truancy is unexcused, illegal absences, not based on anxiety about attending school. Parents are unaware of the absence. Frequently associated with antisocial behaviour, including delinquent and disruptive acts, the child does not stay home and is not interested in schoolwork or conforming to academic and behaviour expectations (Fremont, 2003).

School refusal generally refers to anxiety-based absenteeism, often from separation, generalized, or social anxiety. Parents are aware of the absence. The child usually stays home and is willing to do schoolwork at home (Fremont, 2003).

School withdrawal refers to inexcusable absences where parents intentionally keep a child home from school for economic purposes, to conceal maltreatment, to protect a child from a school-based threat, or to assist a parent (Kearney, 2004).

Young people who engage in truancy or school refusal are not a homogeneous group, but instead have different risk issues and a variety of factors relating to school absenteeism (Maynard, Salas-Wright, Vaughn, & Peters, 2012). Most research to date has focused on truancy, however, the literature on school refusal is also reviewed below.

Predictors and correlates of truancy and school refusal

Predictors and correlates of truancy and school refusal can be categorised according to the

following: individual, family, school and community characteristics and their associated risk factors (Maynard et al., 2012).

Individual characteristics and risk factors for truancy and school refusal

Individual characteristics and risk factors include:

- older (high school) age (Attwood & Croll, 2006; Ek & Eriksson, 2013)
- lower socioeconomic status (Attwood & Croll, 2006, 2015; Marks, McMillan, & Ainley, 2004)
- lower educational aspirations (Attwood & Croll, 2015; Henry, 2007)
- poor school performance (Henry & Huizinga, 2007; Hunt & Hopko, 2009; Vaughn, Maynard, Salas-Wright, Perron, & Abdon, 2013)
- substance use (Best, Manning, Gossop, Gross, & Strang, 2006; Henry, 2007; Muula, Rudatsikira, Babaniyi, Songolo, & Siziya, 2012)
- mental health and learning disabilities (Attwood & Croll, 2015; Southwell, 2006)
- externalizing behaviours (Vaughn et al., 2013)
- depression, anxiety (particularly separation anxiety) disorder or oppositional defiant disorder (Egger, Costello, & Angold, 2003; Kearney & Albano, 2004; McShane, Walter, & Rey, 2001).

The following studies provide estimates of prevalence rates of the disorders listed above within community and clinical samples. A community study in the USA assessed 165 young people with anxiety-based school refusal and 517 with truancy for mental health problems (Egger et al., 2003). Overall, 25% of the anxiety-based *school refusal* group received a diagnosis. Specific diagnoses included depression (13.9%), separation anxiety disorder (10.8%), oppositional defiant disorder (5.6%), and conduct disorder (5.0%) (Egger et al., 2003). The most common

diagnoses for young people in the *truancy* group included conduct disorder (14.8%), oppositional defiant disorder (9.7%), depression (7.5%), and substance abuse (4.9%). Overall, 25.4% of this group received a diagnosis (Egger et al., 2003).

Kearney and Albano (2004) examined 143 5- to 17-year-olds with school refusal behaviour in the USA who had been referred to an outpatient therapy clinic for problematic school absenteeism. The most common primary diagnoses included separation anxiety disorder (22.4%), generalized anxiety disorder (10.5%), oppositional defiant disorder (8.4%), and depression (4.9%) (Kearney & Albano, 2004). A similar Australian study assessed 93 inpatients and 58 outpatients aged 10–17 years with problematic school absenteeism. The most common disorders were major depression (31.8%), dysthymia (25.2%), oppositional defiant disorder (23.8%), and separation anxiety disorder (22.5%) (McShane et al., 2001).

Family characteristics and risk factors for truancy and school refusal

Family characteristics and risk factors for truancy and school refusal include:

- lower levels of parental education (Henry, 2007; Uppal, Paul, & Sreenivas, 2010)
- parental mental health problems (Egger et al., 2003; McShane et al., 2001)
- low levels of parental supervision (Cullingford, 1999; Egger et al., 2003; Henry, 2007; Muula et al., 2012)
- lack of involvement in the child's educational progress (Attwood & Croll, 2006; Epstein & Sheldon, 2002; Kearney, 2008; Muula et al., 2012; Vaughn et al., 2013)
- low levels of family cohesion (Corville-Smith, Ryan, Adams, & Dalicandro, 1998; Lagana, 2004; Uppal et al., 2010)
- maltreated young people are more likely than non-maltreated peers to be absent from school. This may be due to parents who attempt to hide abuse, child hospital stays or mental and/or physical recovery time from abuse (Kearney, 2001).

Please note: Some maltreated children attend school consistently or stay longer after school to avoid going home (Kearney, 2001).

School characteristics and risk factors for truancy and school refusal

School characteristics and risk factors for truancy and school refusal include:

- poor relationship with teachers (Attwood & Croll, 2015; Corville-Smith et al., 1998)
- lower levels of teacher and school support (Lamb, Walstab, Teese, Vickers, & Rumberger, 2004; Rosenfeld, Richman, Bowen, & Journal, 2000)
- being a victim of bullying (Muula et al., 2012)
- school quality (Lamb et al., 2004).

Community characteristics and risk factors for truancy and school refusal

Community characteristics and risk factors for truancy and school refusal include:

- delinquent peer affiliations (Henry & Huizinga, 2007)
- poor adult supervision (Henry, 2007)
- living in disorganized, unsafe, or unsupportive neighbourhoods (Bowen, Bowen, & Ware, 2002; Chapman, 2003; Crowder & South, 2003; Reid, 2005)
- being placed in foster care (Taussig, 2002).

Truancy and later life outcomes

Understanding truancy is important because of its negative association with school drop-out/early leaving, delinquency, anti-social behaviour, problem drinking, later unemployment, and crime (Attwood & Croll, 2015; H. Kim & Page, 2013; Rocque, Jennings, Piquero, Ozkan, & Farrington, 2017).

Absence from home

Characteristics and risk factors for running away from home

Characteristics and risk factors for young people running away from home include:

- past runaway behaviour (Brooks Holliday, Edelen, & Tucker, 2017)
- lack of parental support (Tucker, Edelen, Ellickson, Klein, & Adolescence, 2011)

- low parental monitoring (Tyler & Bersani, 2008)
- poorer relationships with parents and poor family functioning (Brooks Holliday et al., 2017; Moon, Kim, & Kim, in press; Sanna J. Thompson, Maccio, Desselle, & Zittel-Palamara, 2007; Sanna J. Thompson, Zittel-Palamara, Maccio, & Forum, 2004)
- experiencing physical or sexual abuse at home (M. J. Kim, Tajima, Herrenkohl, & Huang, 2009; Meltzer, Ford, Bebbington, & Vostanis, 2012; Moon et al., in press; Sanna J. Thompson & Pollio, 2006)
- substance use by the young person (Brooks Holliday et al., 2017)
- behaviour problems and delinquency (Brooks Holliday et al., 2017; Meltzer et al., 2012).

Evidence indicates that running away is related to negative outcomes during youth and later in adulthood. Running away as a young person increased the risk of:

- becoming victims of physical violence during youth (Crawford, Whitbeck, & Hoyt, 2011)
- drug and alcohol use during youth (Crawford et al., 2011; Johnson, Whitbeck, & Hoyt, 2005)
- suffering from mental health issues including depression and self-harm during youth (S. J. Thompson, Cochran, & Barczyk, 2012)
- suicidal ideation and attempts as an adult (Benoit-Bryan, 2011; Meltzer et al., 2012)
- drug use as an adult (Benoit-Bryan, 2011)
- contracting a sexually transmitted disease as an adult (Benoit-Bryan, 2011)
- lower personal income as an adult (Benoit-Bryan, 2011)
- lower educational levels as an adult (Benoit-Bryan, 2011)
- higher dependence on public assistance as an adult (Benoit-Bryan, 2011).

Absent without approval/ disengagement from treatment

An estimated 7% of young people in Western societies are limited in functioning to the

degree that psychiatric treatment is warranted (Rutter & Stevenson, 2008). Of those, between 28-75% in treatment disengage before treatment is complete (de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013).

Children with behaviour problems who do not receive treatment are more likely to do poorly at school, engage in delinquent activities, misuse drugs and alcohol and be unemployed, as compared with those who receive treatment (Lochman & Salekin, 2003; Moffitt, Caspi, Harrington, & Milne, 2002).

A large meta-analytic review of 48 studies undertaken by de Haan et al. (2013) identified several factors associated with treatment disengagement in young people (studies were predominantly conducted in the US and England).

Predictors of disengagement from treatment include:

- the child having more contact with peers who engage in delinquent behaviour
- being from an ethnic minority
- being diagnosed with an externalizing disorder
- lower socioeconomic status
- having a younger mother
- living in a single parent household with no father
- the parent having psychiatric problems
- poor parenting
- being homeless
- the mother not knowing the child's diagnosis
- the parent having low confidence of the child doing well in treatment
- having a lower quality of therapeutic alliance
- having more cancellations or no-shows
- a lower perceived relevance of treatment (de Haan et al., 2013).

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