Exploring the Educational Context Surrounding the School Attendance Problems of Children Seeking Mental Health Services

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Abstract

School attendance problems experienced by children are a concern across Canadian educational systems. Higher rates of attendance issues exist among children who experience emotional and behavioural difficulties, which places them at heightened risk for poor educational outcomes. Frequently explored in educational research are variables related to school attendance problems among the general child population, however, a shortage of literature exists that explores these elements among children with emotional and behavioral difficulties. To address this void, this mixed-methods study explored child and educational elements that surrounded the school attendance problems of a sample of children receiving mental health services at a community clinic. Together, analyses of data gathered from the CANS, SDQ, and client files indicated that dynamic and reciprocal relationships existed among children's emotional, behavioural, social, and academic difficulties which contributed to their attendance and overall educational experiences. These results corroborate existing research related to school attendance problems, however, provide unique insights into the profiles of this particular population and how their needs can be better met to promote more positive school experiences.

Keywords: school attendance problems, children's mental health, emotional and behavioural difficulties, internalizing and externalizing symptoms, school refusal, school withdrawal, truancy, school exclusion

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List of Abbreviations and Acronyms

SNACK: school non-attendance checklist

OCD: obsessive-compulsive disorder

ODD: oppositional defiant disorder

ADHD: attention deficit hyperactivity disorder

IEP: individual education plan

PPCT Model: process-person-context-time model

KiTeS Framework: kids and teens at school framework

CANS: The Child and Adolescent Needs and Strengths

SDQ: The Strengths and Difficulties Questionnaire

EA: educational assistant

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For many children, school is a central context for academic, social, emotional, and behavioural development (Heyne et al., 2019b). Therefore, significant absence from school, or attendance under significant distress, is highly concerning in its ability to jeopardize this development (Kearney & Graczyk, 2014). The detrimental impact of school attendance problems on education-related outcomes is well-documented. School attendance problems are associated with academic achievement difficulties, impaired social-emotional development, significant stress, and increased high-risk behaviours (e.g., substance use) (Kearney & Albano, 2018). In addition, long-term outcomes such as school dropout and hardships entering the workforce are more likely for individuals experiencing difficulties attending school (Munkhaugen et al., 2017).

While the policies and cut-offs used to determine problematic levels of absenteeism vary across and within countries, the lack of school attendance is posited as a "universal problem," with substantial rates of nonattendance being reported by diverse nations (Melvin et al., 2019, p. 2). In the Canadian context, regular school attendance is mandatory until the age of 16 or 18 years, depending on the province or territory (Government of Canada, 2017). During this mandated period, if a child misses 10% or more of the required instructional days per year, they are deemed c*hronically* or *persistently absent* (Ontario Ministry of Education, personal communication, April 20, 2020). In the province of Ontario where the current study was conducted, 11.3% of students in publicly funded elementary schools were deemed persistently absent in the 2015-2016 school year (Ontario Ministry of Education, personal communication, April 20, 2020). This raises concern surrounding the ill-effects experienced by these students. This concern is exacerbated by findings that demonstrate children with mental health needs, including those with emotional and behavioural difficulties, are at greater risk for experiencing school attendance problems (e.g., Gase et al., 2014; Gottfried et al., 2019; Lawrence et al., 2019). With mental health remaining a pressing concern across Canadian education systems today, this compounded risk points to the necessity of providing immediate attention to this specific population, thereby providing insight into their unique profiles and informing how they can best be supported.

School Attendance Problems: Defining and Differentiating

Although school absenteeism has been identified as a widespread global issue, a lack of consensus surrounds the conceptualization and classification of school attendance problems. This poses a host of challenges for understanding and addressing attendance problems. This issue was recently discussed at the 2018 Lorentz Center Workshop on school absenteeism, whereby it was the shared vision of participating international stakeholders, including educators, practitioners, researchers and policymakers, that consensus be reached in defining and classifying school attendance problems in order to best meet the needs of students experiencing them. This workshop led to the formation of the International Network for School Attendance (INSA)—an international and interdisciplinary committee and research base that promotes school attendance and responds to school attendance problems (Heyne et al., 2019a).

In terms of conceptualization, the majority of research points to first distinguishing between problematic and nonproblematic levels of absenteeism. Problematic absenteeism is defined using a diverse array of criteria across countries and school communities (e.g., Kearney, 2008), but generally refers to more sustained absences that impose detrimental impacts onto a student. When absences become problematic, they are then typically referred to as a school attendance problem. On the contrary, nonproblematic absenteeism refers to absences that are deemed legitimate by both parents/guardians and school administration (e.g., religious holidays, illness, appointments, etcetera) and can be compensated for (e.g., through home-schooling, online education, or make-up assignments) (Heyne et al., 2019b; Kearney, 2003). These absences are typically viewed as nondetrimental to a student, although some researchers do not support this view and often contend that no safe levels of absenteeism exist. For example, Hancock and colleagues (2013) demonstrated that the average academic achievement of elementary and secondary students decreased with any level of absence, thereby highlighting that every day missed from school imposes negative impacts on a child. However, this study also demonstrated that unauthorized absences (i.e., unexplained absences or those deemed unacceptable by principal) imposed more substantial declines in academic achievement than authorized absences (i.e., legitimate reason provided for absence), which lends some support to distinguishing between nonproblematic and problematic absences (Hancock et al., 2013). Many researchers argue that such differentiation serves both scientific and practical purposes, such as

enabling for cross-study comparisons and providing insight into when action should be employed to support a child facing attendance difficulties (Henye et al., 2019b).

The umbrella term, *school attendance problem*, encompasses a collection of different types of absences which have unique characteristics. Central schools of thought exist surrounding the differentiation of school attendance problems, which fall mainly into categorical and dimensional approaches (Kearney et al., 2019a). While some researchers argue differentiation further muddies the field of problematic school absenteeism (e.g., Kearney, 2003), researchers who do assume categorical, dimensional or mixed approaches view that understanding differences between attendance problems has a plethora of benefits. For example, differentiation aids to the process of identifying risk factors associated with specific types of attendance problems, thereby informing appropriate prevention and intervention measures (Heyne, 2019).

Categorical Approaches

Categorical approaches encompass dichotomies and distinctive terms/typology that are used to differentiate between types of attendance problems. Salient dichotomies include excused-unexcused, legitimate-illegitimate, authorized-unauthorized, and acute-chronic absences (Kearney et al., 2019b). A wide range of distinctive terms are also used to describe various attendance problems, as evidenced by Heyne and colleagues' (2019b) identification of 49 different terms used in the English language literature between 1932 and 2016 to refer to various school attendance issues. Terms most often observable within the literature include: (1) *school refusal* (emotional/anxiety-based absenteeism), (2) *truancy* (unexcused absences) (3) *school refusal behaviour* (a combination of school refusal and truancy; child-motivated refusal to attend or remain in class), (4) *school phobia* (fear-based absenteeism; archaic term), (5) *school withdrawal* (parent-motivated absenteeism), and (6) *school exclusion* (school-initiated absenteeism) (Heyne et al., 2019b). The way in which these terms are used and operationalized is inconsistent, which inherently influences the ways in which attendance problems are assessed, experienced, reported, and addressed across contexts.

In an attempt to bring about consistency, Heyne and colleagues (2019b) have advised using the predominant typologies of school refusal, truancy, school withdrawal and school exclusion to differentiate between attendance problems, which differ in their etiology and presentation. This claim is backed by scientific support and grounded in the assumption that

differentiation between these main types of attendance problems, which are distinctively different although not mutually exclusive, can "benefit research in the field of absenteeism, aid efficient assessment, and promote effective intervention" (Heyne et al., 2019b, p. 10).

Heyne and colleagues (2019b) have developed the School Non-Attendance ChecKlist (SNACK)—a brief screening measure that educators, practitioners and researchers can use to differentiate between nonproblematic absenteeism and the four aforementioned types of school attendance problems (Heyne et al., 2019b). School refusal refers to a lack of attendance, which occurs with parental knowledge and despite parental efforts to secure attendance, due to a child's emotional distress in attending. On the contrary, children demonstrating truancy often try to conceal their absence from parents, which occur without the permission of the school. Truancy can occur when a child is absent from school entirely, or absent from the location they are expected to be (e.g., in the hallway or school yard versus classroom). School withdrawal constitutes absences that are attributed to either parental effort to keep a child home, or a lack of parental effort to get the child to attend. These efforts can be unintentional (e.g., inability to get a child to school, permissive parenting) or intentional (e.g., willfully trying to keep the child home). While withdrawal in the form of homeschooling is not regarded as an attendance problem among some researchers based on the assumption that children who are homeschooled are still engaged in alternative forms of education, it is considered within the current study. This is because children with emotional and behavioural difficulties are more likely to be homeschooled than children without such difficulties, often times due to perceptions that their needs are not being met within the traditional classroom (Ripperger-Suhler, 2016). Thus, homeschooling was included as a form of withdrawal to explore this link. Finally, school exclusion refers to absences that are school initiated, which can occur through discouraging a child to attend, being unable or unwilling to accommodate the child and their needs, or through inappropriate disciplinary actions (e.g., unlawful suspensions or expulsions). Some extend this criteria to include lawful disciplinary actions (Kearney et al., 2019a). In all four types of attendance problems, absences can constitute late arrivals or being absent for partial or full days, weeks, months or even years.

Dimensional Approaches

An array of dimensional approaches are also utilized to differentiate between school attendance problems, which involve defining such problems using various continua (Kearney et al., 2019b). More simplistic spectrums exist, such as categorizing attendance problems based

upon the severity of problems (i.e., *mild, moderate*, *severe* labels based upon differing criteria) (Kearney et al., 2019a). In addition, more complex continua are used such as categorizing attendance needs into multi-tiered systems of support (MTSS) for preventative and intervention strategies (Kearney et al., 2019b), as well as using Kearney and Silverman's (1990) well-known functional profiles of school attendance problems (i.e., School Refusal Assessment Scale [SRAS]).

School Attendance and Mental Health

School attendance problems have remained an enduring issue in the educational realm for decades, however, what has gained more recent attention is the link between attendance and mental health. A recent meta-analysis has estimated a worldwide prevalence rate of mental disorders in children and adolescents to be 13.4% (Polanczyk et al., 2015). In Canada, it is estimated that 14% of children aged 4 to 17 years, and 18% of children aged 4 to 16 in Ontario, experience mental health disorders that lead to significant difficulties in the home, school and community settings (Schraeder & Reid, 2015; Waddell et al., 2005). Thus, mental health issues experienced by children are a concern across Canadian health and educational systems. As mentioned previously, this concern is heightened given that children with mental health difficulties, including those with internalizing and externalizing issues, are placed at greater risk for experiencing school attendance problems (e.g., Gase et al., 2014; Gottfried et al., 2019; Lawrence et al., 2019). Thus, these children are placed at compounded risk for the adverse effects of the mental health needs they experience, as well as their experiences with school attendance problems.

Internalizing and Externalizing Difficulties

As mentioned, research demonstrates the heightened vulnerability of children with both internalizing and externalizing problems in experiencing school attendance problems. Initially developed in 1966 by Achenbach, the internalizing-externalizing dichotomy continues to be used in current research and practice to classify and describe emotional, behavioural, and social problems. This classification system is widely agreed upon and has been endorsed by The American Psychiatric Association (2013) in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). The terms *internalizing* and *externalizing* have been used in over 75,000 articles in peer-reviewed journals between 2016 and their introduction in 1966 (Achenbach et al., 2016), thereby demonstrating their widespread support.

Contemporary perspectives view this classification system less as a dichotomy with discrete categories and more like a hierarchy or spectrum, whereby the broad-band dimensions of externalizing and internalizing groupings are made up of narrow-band dimensions and co-occurring issues and behaviours (Achenbach et al., 2016). Within research literature, a range of scales with varied standardization, reliability and validity are used to assess internalizing and externalizing problems. Many of these assessments are based upon ad hoc items, scales and/or a combination of scales, which can make it difficult to compare data across different studies (Achenbach et al., 2016). Despite such differences, a general consensus exists that conceptualizes internalizing symptoms and disorders as inwardly-focused and externalizing symptoms as outwardly-focused (Nangle et al., 2016; Willner et al., 2016). Therefore, anxiety, depression, trauma- and stress- related disorders, obsessive-compulsive disorder (OCD), dissociative disorders, and eating disorders are commonly conceptualized as internalizing problems (Regier et al., 2013; Turygin et al., 2013), whereas attention-deficit hyperactive disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder (CD), antisocial personality disorder (ASPD), and substance-related disorders are commonly conceptualized as externalizing problems (Krueger et al., 2005; McMahon, 1994). While the internalizing-externalizing spectrum is often used to classify clinical diagnoses (e.g., clinical depression as an internalizing disorder), it is also used by many measures to classify general symptoms (e.g., internalizing symptoms of depression). Thus, reports of internalizing or externalizing symptoms do not always imply the presence of a diagnosed disorder. In either case, this system of classification can be helpful in the process of describing concerns and informing clinical decision-making and treatment options.

Comorbidity of Difficulties

Overlap often exists in the presentation of internalizing and externalizing symptoms (Achenbach et al., 2016). This comorbidity can remain consistent over time, thereby indicating a child is equally as vulnerable to experiencing symptoms from both domains (Willner et al., 2016). On the contrary, comorbidity can fluctuate over time. In this case, some research suggests experiencing internalizing *and* externalizing symptoms increases as a child ages, as preceding symptoms serve as risk factors for the accumulation of additional symptoms from the other domain (Willner et al., 2016). On the contrary, it is also purported that differentiation becomes

more prominent as a child ages, whereby symptoms "crystallize into more 'pure' internalizing or externalizing presentations" as development unfolds (Willner et al., 2016, p. 1033).

Research Linking Attendance and Mental Health

A large research base surrounds the link between school attendance problems and mental health concerns. In terms of internalizing symptoms, it has been demonstrated that attendance problems are closely linked with anxiety (e.g., Finning et al., 2019) and mood disorders (e.g., Gase et al., 2014) most notably, as well as other issues such as trauma- and stress-related disorders (e.g., Wherry & Marrs, 2008) and eating disorders (e.g., Carey et al., 2015; Rappaport et al., 2011). For example, a recent study conducted by El Samra and Rogers (2020) demonstrated that children seeking mental health services who were regarded as non-attenders were significantly more likely to demonstrate internalizing behaviours and emotional disorders than attenders. Behaviours commonly seen among children with internalizing issues include various forms of anxiety, including general, social and separation anxiety, depression, feelings of worry and fear, fatigue, somatic complaints, social withdrawal and sleep problems (Fornander & Kearney, 2020).

In addition to internalizing problems, research also links attendance problems and externalizing issues, and particularly those pertaining to disruptive behaviour (Kearney & Albano, 2004). Common diagnoses found to be linked with attendance problems include attention deficit hyperactivity disorder (ADHD) (e.g., Kent et al., 2011), oppositional defiant disorder (ODD) and conduct disorder (CD) (e.g., Egger et al., 2003; Wood et al., 2012). Behaviours commonly presented among these children include physical and verbal aggression, fleeing from school, temper tantrums, defiance, non-compliance, disruption, and antisocial behaviour (Fornander & Kearney, 2020; Ingul et al., 2012).

Within the literature on mental health and attendance problems, many studies focus upon specific types of attendance problems that are linked with certain internalizing and externalizing symptoms. Most prominently, discussion often surrounds the association between school refusal and internalizing symptoms, and truancy and externalizing symptoms (Dembo et al., 2016; Heyne et al., 2019b). For example, a child who is feeling anxious about a conflict with peers or about certain academic demands may be more likely to present school refusal behaviours, such as complaining of physical symptoms the morning before school or having difficulty separating from a parent at school drop-off. On the other hand, a child who leaves school without the

permission of their parents or school authorities may be more likely to present oppositional behaviours or other conduct problems. Thus, while this refusal-truancy dichotomy is helpful in capturing patterns that exist, it is important not to discount the significant overlap that exists between and within constructs (Inglés et al., 2015).

Contextual Factors Surrounding Attendance Problems

Research across fields such as education and psychology indicate that a broad range and interaction of contextual factors are associated with school attendance problems, including proximal and distal individual, parental, familial, peer, school, and environmental factors. Some research suggests that associated risk and protective factors are likely to be different depending on the type of school attendance problem being presented, leading interventions to be more effective when they are tailored to factors of particular relevance (Heyne et al., 2019b). However, the majority of research in this area does not focus upon these differing associations, but instead, either speaks to contextual factors associated with school attendance problems broadly, or examines differences in the strength of relationships between specific contextual factors and different types of school attendance problems (Melvin et al., 2019). Contextual factors most commonly associated with school attendance problems are detailed below.

In terms of *individual factors* that pertain to a student's characteristics, it has been demonstrated that age and gender are associated with school attendance problems. In general, problems tend to worsen as children get older, however, this often varies depending upon the type of attendance issue at hand (Skedgell & Kearney, 2018). For example, school refusal is often found to be more prevalent in younger aged children, whereas truancy is more often found in older-aged children (Melvin et al., 2017; Pengpid & Peltzer, 2017). Research pertaining to gender is greatly mixed, and again, frequently differs depending upon the type of attendance problem presented (Maynard et al., 2017; Skedgell & Kearney, 2018).

In terms of characteristics that relate to a child's abilities and experiences, children with physical and mental health problems are shown to be more likely to experience attendance problems (Allison & Attisha, 2019; Lim et al., 2019). As previously mentioned, school refusal is more often linked to internalizing difficulties, whereas truancy is more often linked to externalizing difficulties, however significant heterogeneity exists in children's experiences (Dembo et al., 2016; Kearney et al., 2019a). Other characteristics of this nature linked to

attendance problems include sleep (Hysing et al., 2015), intellectual or developmental disabilities (IDD) and learning disabilities (Redmond & Hosp, 2008).

Key behavioural characteristics associated with attendance problems include self-regulation (Balkis et al., 2016), attitudes towards school (Green et al., 2012), perceptions of one's academic ability (Green et al., 2012), and behaviours that stem from mental health problems (e.g., anxiety, low affect, inattention, hyperactivity) that impact one's behaviours (e.g., motivation, self-regulation) (Melvin et al., 2019).

Key *familial, community,* and *societal factors* associated with attendance problems include a lowered socioeconomic status (Balkis et al., 2016), limited family resources, (Morrissey et al., 2014), family break-up (i.e., divorced and separated parents), a lack of parental engagement and involvement (Maynard et al., 2012), parental overprotection, parental psychopathology, and unhealthy family functioning (Ingul et al., 2019). Other relevant factors include social norms and practices (e.g., Prakash et al., 2017), and neighbourhood characteristics (Deck, 2017; Gottfried, 2014).

School factors, which have social, academic and environmental components, are also highly prevalent across the literature. In regard to social elements, it has been demonstrated that poor relationships with peers, including negative peer influences, bullying and social exclusion, are correlated with attendance problems (e.g., Havik et al., 2015). In addition, problematic student-teacher relationships, including perceived poor support from teachers and a lack of attachment to teachers, are risk factors for school attendance problems (e.g., Ingul et al., 2019). In regard to academic elements, educational difficulties, including lower grades and having an individualized education program (IEP) in place for certain academic needs, are correlative (e.g., Maynard et al., 2012). Lastly, environmental elements include aspects of school climate (e.g., perceptions of safety, inclusion and support at school, connections with the broader school community, school push-out policies), the physical environment of a school, and elements of the classroom setting, school type and organizational structure (Cohen et al., 2009; Gottfried et al., 2019; Lenhoff & Pogodzinski, 2018; Spencer, 2009). For example, in terms of classroom type, it has been demonstrated students with special education needs placed in general, inclusive classrooms have lower rates of absenteeism than similar children placed in separate, specialized classrooms (Gottfried et al., 2019).

Moreover, an array of factors are implicated in the school attendance experiences of children that are grounded in the diverse contexts that surround them. In order to prevent and mitigate attendance problems, a multifaceted approach is necessary to consider these factors and the complex interplay between them.

Bioecological Models to Study Contextual Factors

Some researchers have utilized bioecological models to guide multifactorial examinations of contextual factors implicated in attendance problems (e.g., Doren et al., 2014, Gottfried & Gee, 2017; Melvin et al., 2019). These models are grounded in the bioecological systems model which posits that human development is influenced by an individual's interaction with various aspects of their environment (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006). In its most developed form, the theory encompasses the process-person-context-time (PPCT) model which includes four central concepts.

The first concept pertains to *proximal processes*, which refer to a person's reciprocal and enduring interactions with their immediate environment that influence their development (e.g., interactions with parents, peers, daily routines). Integral to these interactions are *person characteristics*, which encompass *demand characteristics* (apparent features that invite or discourage interactions; e.g., age, gender), *resource characteristics* (mental, emotional, and material resources that influence an individual's interactions; e.g., skills, experiences, resources) and *force characteristics* (behavioural dispositions that support or discourage proximal processes; e.g., variations in motivation, persistence, temperament). Next, *context* refers to the positioning of an individual and their interactions within a hierarchy of five interrelated systems, including the: (1) *microsystem* (immediate and consistent environments whereby proximal processes occur), (2) *mesosystem* (interrelations among various microsystems), (3) *exosystem* (indirect contexts), (4) *macrosystem* (social and cultural contexts), and (5) *chronosystem* (influences of time on development) (Bronfenbrenner, 1979, 1995). Finally, the concept of *time*, including *micro-time* (specific interaction/activity)*, meso-time* (degree of consistency in interactions/activities), and *macro-time* (the chronosystem) inherently influence an individual's development. Moreover, the PPCT model offers a broad lens to consider a diverse range of contextual factors implicated in children's experience with school attendance problems.

The Present Study

Studies that have explored contextual factors related to school attendance problems, including those that have utilized bioecological frameworks as a guide, are predominantly focused upon the general child and adolescent population. Thus, a paucity of research exists that explores the lived school attendance experiences of children with mental health difficulties, including emotional and behavioural problems, notwithstanding the well-established association between child psychopathology and attendance problems (Maynard et al., 2015). In response to calls for research on the attendance problems of disadvantaged populations, such as children with disabilities (e.g., Gee, 2018), Melvin and colleagues (2019) recently developed a conceptual model that facilitates research on attendance that is inclusive to *all* school-aged students, including those from minority or vulnerable populations. This model—the kids and teens at school (KiTeS) framework—applies Bronfenbrenner's bioecological systems model to organize factors associated with school attendance problems into a nested framework. This includes a complex interplay of person (demand, resource and force characteristics), parent, family and school factors at the micro- and meso-system levels, as well as broader factors at the exo-, macro- and chrono-system levels (Melvin et al., 2019). Thus, the KiTeS model aims to facilitate research towards a "multifactorial and inclusive examination" of the "development, maintenance, and alleviation of school absenteeism and SAPs [school attendance problems]" (Melvin et al., 2019, p. 4).

Looking at school attendance problems experienced by children with mental health difficulties through the lens of the KiTeS framework further highlights the dearth of literature in this area. Some research exists that examines individual and family factors relevant to this particular population, however, to our knowledge, no studies exist that explore school factors implicated in the attendance experiences of these children. In addition, the literature that does exist on contextual factors related to attendance problems is primarily quantitative and therefore does not offer richly descriptive perspectives. Thus, using data from a sample of children experiencing school attendance problems who are receiving mental health services, the aim of the present study was to build upon these lacking areas, using the bioecological systems theory (i.e., PPCT model) and the KiTeS framework as a guide. This was to provide depth of understanding surrounding the characteristics of these children, the types of attendance problems they present, as well as school-based factors implicated in their attendance problem experiences.

It was hoped that this would offer insight into the unique profiles of these children with implications for how their needs can be better met to promote school attendance and more positive educational and life outcomes.

Method

Study Design

The current study adopted an *explanatory sequential design*—a two-phased mixed-methods design that involved the initial collection and analysis of quantitative data, followed by the collection and analysis of qualitative data (Creswell & Plano Clark, 2011; Ivankova et al., 2006). A *participant selection model* was assumed whereby quantitative data were used to identify and select participants for the more in-depth qualitative portion (Ivankova et al., 2006). Emphasis was placed on the analysis of qualitative data, which was used to provide depth of understanding to the experiences of children with school attendance problems seeking mental health services (Ivankova et al., 2006).

Research Questions

As informed by relevant literature and the KiTeS framework, this study sought to explore the following research questions: (1) What are the characteristics of children receiving mental health services in a community setting who experience school attendance problems? This question sought to quantitatively and qualitatively examine the characteristics of participants by providing insight into their demographic profiles (i.e., age, sex), emotional and behavioural difficulties (i.e., internalizing and/or externalizing symptoms) and the presence and severity of their school attendance problems. (2) What types of school attendance problems do these children experience? Using qualitative data, the second question sought to distinguish between different types of attendance problems experienced by participants. (3) What are the features of the educational contexts that surround the attendance problems of these children? Finally, the third question sought to qualitatively explore educational elements, such as academic and social factors, that surround participants' experience with school attendance problems.

Participants

Participant Selection

Participants were selected from a larger database constructed through a community-university partnership which held quantitative data for 1,809 child clients who received services at a children's mental health centre in Eastern Ontario between April 1, 2017 and October 31,

2019. Children could be referred to services at the centre through a community agency, by visiting the centre's walk-in clinic with their family, or through a family's self-referral. Children were selected from this database based upon four main criteria.

First, children were selected that had no missing demographic or measure data, as this was integral to the study's design and analysis. Second, participants were selected by age, whereby children aged 5 years and younger were removed as participants. This was because they lacked school attendance data, given that school is voluntary for preschool and kindergarten. Next, participants were selected by the type of services they received, and particularly, children whose data corresponded to a general intake assessment at their first point of contact within the aforementioned 31-month period. At this point of contact, these children and their families participated in an intake assessment with one of the centre's staff members to see if their needs matched the services offered at the centre. For some children, this was their very first visit at the centre, and if their needs were suited to the offered services, they were referred on to a specific program. For other children, this was not their first point of contact, as they may have already received treatment at the centre, however, were participating in the general intake process to request services in a different program. In any case, the children who were selected based upon their general intake status went through a similar assessment process through which they provided demographic information and completed standardized measures.

Finally, criterion sampling was used to select participants who experienced problems with school attendance. This was completed using the *school attendance* subscale on a short-form version of the Child and Adolescent Needs and Strengths (CANS) tool (see Measures section), which describes the attendance levels of children using the scores of 0 (*no problems*), 1 (*mild problems*), 2 (*moderate problems*) or 3 (*severe problems*). For the purposes of this study, children who scored a level 2 or level 3 at each of their visits with the centre within the 31-month time period (ranged from 1 to 5 visits) were selected. Children who experienced no school attendance problems (level 0) or mild problems (level 1) were omitted from this study. Reasons for omitting children who scored a level 1 surrounds the nature of the absences that define this category. In particular, this score is given to children who generally attend school and have one or two excused absences per month. Thus, the scale criteria for these infrequent and excused absences indicates that only "watchful waiting" is required versus the need for clinical action. As a result, they were not considered as a defined school attendance problem within the current

study. On the contrary, selecting children with a score of 2 or 3 enabled defined attendance problems that require clinical action to be explored. Further, by selecting children who scored a level 2 or 3 at *each* of their visits with the mental health centre enabled consistency in severity of problems to be considered across time points. Taken together, this selection process yielded 20 participants, however due to extenuating circumstances related to the outbreak of the coronavirus disease (COVID-19), data for only 15 of these participants could be examined for both the quantitative and qualitative analysis.

Sample Description

The final sample of 15 participants included five female (33%) and 10 male (67%) children between the ages of six to 12 years (M=9.40 years, SD=1.92) who experienced moderate to severe problems with school attendance. All children lived at home with their parents or guardians and had English as their mother tongue. Although the original dataset used to select participants from housed quantitative data spanning from April of 2017 to October of 2019, the 15 children who were selected from the total of 1,809 received services at the mental health centre between August of 2017 and July of 2019. Thus, quantitative data relevant to the current study was collected over a 23-month period. Specifically, quantitative data collected at one time point during this 23-month period (i.e., each child's most recent visit with the centre, regardless if they had multiple visits over the 23 months) was used for the quantitative analysis. However, the analysis of qualitative data was not limited to this time frame, and all narrative data available in participants' client files was examined. Some participants only visited the mental health centre once, and thus their quantitative and qualitative data was collected at the same time. However, many participants had enduring contact with the centre over many years, and thus a plethora of longitudinal qualitative data were examined. In total, the qualitative data analyzed in the current study was collected over a nine-and-a-half-year period (January of 2010 to July of 2019). See Appendix A for a timeline of the quantitative and qualitative data collected and analyzed for each participant.

Data Collection and Measures

Quantitative Data

Quantitative data came from a de-identified database of clinical data gathered from parents and clinicians by the mental health centre as part of their client intake process. This included a) demographic information about the ages and sexes of children, b) parent-reported

data gathered with the SDQ pertaining to participants' externalizing emotional and behavioural difficulties, and c) clinician-reported data gathered from the CANS pertaining to participants' internalizing emotional and behavioural difficulties, as well as the severity of their school attendance problems. See Appendix B an overview of all quantitative variables.

The Strengths and Difficulties Questionnaire (SDQ). The SDQ is a psychometrically-sound behavioural screening measure completed by parents or teachers to assess a child's (aged 4-17 years) mental, social, emotional and behavioural functioning (Goodman, 1997; see Appendix C). Many mental health clinics, including the centre involved in the present study, use the SDQ as part of an intake assessment to gather information that informs treatment decisions about services provided to children (DiCroce et al., 2016). Additionally, it is widely used to evaluate service outcomes by examining pre- and post- scores (youthinmind, 2012). The SDQ has been translated into over 70 languages, and its reliability and validity have been demonstrated in clinic and community samples across multiple countries, including Canada (e.g., Aitken et al., 2015; Marquis & Flynn, 2009; Stone et al., 2010; Woerner et al., 2004). Additionally, the SDQ has demonstrated concurrent validity with the Rutter Questionnaire and the Achenbach Child Behavior Checklist (CBCL) (Goodman, 1997; Goodman, 1999; Stone et al., 2015), as well as demonstrating adequate internal consistency (α= .83 Total Difficulties, α= .80 Impairment scores, α= .63-.77 Subscales; Bourdon et al., 2005) and moderate test-retest reliability (r=.71 over an 8-week interval; Yao et al., 2009).

The SDQ has five scales, including *Emotional Problems*, *Conduct Problems*, *Hyperactivity-Inattention*, *Peer Problems* and *Prosocial*, with five items each. The total 25 items assess both positive and negative attributes. Parents are to rate each item using a 3-point Likert scale ranging from *not true* to *somewhat true* to *certainly true*. To score each scale (see Appendix D), items are summed, thereby generating scale scores that range from 0 to 10. These scores can be used as continuous variables or can be categorized into the three bandings of *normal*, *borderline* and *clinical.* The cut-offs for these categories have been designed so that 80% of children fall within the *normal* range, 10% in the *borderline* range and 10% in the *clinical* range (youthinmind, 2016). While a more recent 4-band categorization system has been developed, the study's centre continues to use the 3-band categorization system which categorizes their client's scores into *normal, borderline* and *clinical* groupings.

Child and Adolescent Needs and Strengths (CANS). The second measure includes a short-form version of the well-established Child and Adolescent Needs and Strengths (CANS) assessment tool, which is completed by a trained professional (i.e., clinician at centre) to assess the strengths and needs of a particular child and their family (Lyons et al., 1999; see Appendix E). It is used in community mental health settings as an information integration tool, whereby all relevant information available to the clinician-rater is used to inform the completion of the CANS (Lyons et al., 2004). For example, this information can be gathered through family consultations and the examination of any documentation provided. After accounting for such information, professional judgment is then required by the assessor to complete the various components of the CANS. Further, this tool is used to communicate the needs and strengths of a particular child among stakeholders (e.g., parents, service providers) and to inform suitable treatment options (Lyons et al., 2004).

Many versions of this measure exist, as it is deemed a communimetric tool to be modified by an agency to suit their particular needs (The John Praed Foundation, 2015). Thus, the CANS is designed to be reliable and valid at the item level (Lyons, 2009). The study's centre uses four different short-form versions of the CANS depending on the age and program of a particular child. For the current study, the *School-Aged CANS* is used which assesses children aged 6 to 12 years. This measure includes 6 scales (*Emotional/Behavioural Needs*, *Risk Behaviours*, *Educational Needs*, *Child/Youth Individual Strengths*, *Family Needs and Strengths*, and *Parents/Family/Caregiver Needs and Strengths*) with a total of 28 items. Each item, some of which assess strengths and other's needs, uses a four-level Likert scale to determine a necessary level of action. In particular, a score of 0 indicates *no evidence of a need*, a 1 indicates that *monitoring, watchful waiting, or preventive activities are required*, a 2 indicates that *action is necessary to ensure that this identified need or risk behaviour is addressed*, and a 3 indicates that *immediate or intensive action is required*. A similar mental health version of the CANS has demonstrated construct validity, in that significant differences have been found between the internalizing ($F [3, 109] = 12.77$, $p < .001$) and externalizing ($F[3, 109] = 8.27$, $p < .001$) diagnostic categories (Alamdari & Kelber, 2016). In addition, it has demonstrated concurrent validity with the Youth Outcome Questionnaire (Y-OQ; CAMH, 2009), whereby positive relationships have been demonstrated between internalizing subscales (i.e., SDQ internalization and Y-OQ intrapersonal distress [$r=.53$, $p < .05$] and Y-OQ somatic [$r=.49$, $p < .05$]), as well as a

strong correlation between both measure's externalizing subscales (i.e., SDQ externalization and Y-OQ behavioural dysfunction [r=.39, p < .05]; Alamdari & Kelber, 2016).

Study Variables. Although widely used, multi-informant approaches in the evaluation of children's mental health remains contested due to potential discrepancies that can exist among perspectives (i.e., between clinician, teacher, parent, child reports) (De Los Reyes et al., 2015; Van Roy et al., 2010). While these discrepancies can pose challenges in clinical decision-making (Renk, 2005), it is more commonly argued that these diverse viewpoints are inevitable. This is because the behaviour of a child varies across contexts and each informant understands the nature of a child's problem using a different perspective (Klein et al., 2010). Further, it is argued that these differences are valuable, as the unique insights they bring can be leveraged in the support and treatment of a child (Renk, 2005).

The current study approached this methodological issue using research that demonstrates rates of agreement among informants. Firstly, agreement among informants tends to be higher for reports of children's externalizing versus internalizing difficulties (Achenbach et al., 1987). It has been suggested that this is the result of externalizing behaviours being more directly observable, and therefore, easier to report (De Los Reyes et al., 2015). This remains consistent with parent reports (e.g., Bajeaux et al., 2018), which is also supported by the notion that parents typically maintain contact with their child's teacher, who may also provide them with key insight into a child's externalizing behaviours in the school context (De Los Reyes et al., 2015). As such, parent-reported SDQ data were used to describe the *externalizing emotional/behavioural difficulties* of participants using the variables of *conduct problems* (e.g., temper tantrums, disobedient, fights, lies/cheats, steals) and *hyperactivity-inattention* (e.g., restless, fidgets, distracted, impulsive). A score is generated for each variable ranging from 0 to 10 (see Appendix D), which can be used as a continuous variable or can be categorized into the three bandings of *normal*, *borderline* and *clinical*. For the current study, scores that fell within the *borderline* and *clinical* range were reported upon as externalizing difficulties.

In terms of internalizing difficulties, the SDQ reports upon a child's overall emotional problems, whereas the CANS includes items that pertain to specific internalizing symptoms (e.g., anxiety). Thus, clinician-reported CANS data were used to describe the *internalizing emotional/behavioural difficulties* of participants (see Appendix F) using the variables of *anxiety* (emotional disturbance such as symptoms of social anxiety, panic attacks, obsessive-compulsive

disorder, phobias, and separation anxiety) and *mood disturbance* (symptoms of depressed mood, hypomania, or mania). Scores of a 1 (*mild;* brief duration, mild impairment), 2 (*moderate;* impairment in functioning and social/school avoidance) or 3 (*severe;* prevents appropriate school/social participation) on the *anxiety* and *mood disturbance* subscales were used to constitute internalizing difficulties. Moderate and severe symptoms were reported upon more frequently than mild symptoms, as they represent difficulties that impact social and school functioning and participation, and therefore school attendance. In addition to providing more specificity into certain internalizing symptoms, the CANS also uses clinicians as informants, who calibrate their reports based upon several sources of data (e.g., family interviews, documentation, rating scales) using their professional expertise and education (Aboraya et al., 2006). In addition to this evidence-based approach, the clinical experience of such individuals provides them with knowledge surrounding normative and abnormal child behaviours and emotions, thereby enabling them to make quality judgments (Aboraya et al., 2006).

In the case of both internalizing and externalizing difficulties, it is important to note that in this context, the presence of related symptoms does not necessarily indicate the presence of a clinically diagnosed disorder. Instead, symptoms represent issues reported via scale scores based upon the perceptions of parents and clinicians surrounding child self-reports and behaviours.

Lastly, *school attendance problems* were defined using the CANS *school attendance* subscale (see Appendix F). On this subscale, score of 0 indicates no evidence of attendance problems, whereas a score of 1, 2 or 3 indicated some level of an attendance issue. Differences between these levels lie in the nature (excused or unexcused) and frequency (1-2 absences a month or weekly basis) of the absences. The current study considered a CANS score of 2 (having problems; one or two unexcused absences in a month) or 3 (excused or unexcused absences on a weekly basis or more) as a school attendance problem. As described in the literature review, this is a dimensional approach to classifying school attendance problems.

Qualitative Data

Data consisted of de-identified narrative summaries of information drawn from the client files of the 15 participants selected in the quantitative phase due to their high non-attendance scores. Each child who receives services at the mental health centre has a client file that includes a range of paper documents which serve different purposes and functions. These include an *intake form* that provides demographic information and describes the child's presenting

concern(s), among other information. However, the types and quantities of other documents that exist in a particular file vary from client to client based upon a variety of factors (e.g., number of visits to the centre types and severity of presenting concerns, contact with other services, etcetera). Thus, some files include more information than others, in addition to some providing more longitudinal information than others.

Documents most commonly found in client files that provide rich data pertaining to school attendance problems include: (a) case notes completed by a clinician that provide detailed information regarding a child and the presenting concerns, (b) treatment plans completed by a clinician alongside a child/family that describes goals and progress made, and (c) documents generated through the process of admitting/referring children to mental health services; typically includes educational records, clinical records, medical records, psychiatric/psychological records, social history, and other pertinent information. Moreover, as an example, a client file would include presenting concerns relayed by parents that may include social difficulties at school, aggressive behaviors or separation anxiety.

In order to create the de-identified summaries, all documents in participants' files were examined by a registered volunteer at the study's centre and any child or education-related information relevant to their attendance experiences were included. The use of a volunteer was necessary given the sensitive nature of client data, which was required to be kept anonymous and therefore prevented the study's researchers to access the client files themselves. Although this removed the study's researchers from the data collection process, it provided a viable means to gain access to the data which contributed richly to the qualitative portion of the study. Strategies were implemented to make this approach as rigorous as possible and to ensure the quality and trustworthiness of the data. Specifically, the volunteer was selected based upon their status as a graduate student in Education specializing in Counselling Psychology, as their foundation of knowledge pertaining to children's mental health and education, as well as their experience working in research and clinical settings, provided them with the skills to collect data of this nature in an appropriate manner. In addition, similar to the researchers of the current project, this individual was a member of a university research team that collaborates with the mental health centre involved in the present study. This provided the volunteer with direct insight into the innerworkings of the centre, its clientele, and data collection instruments/procedures, which further enhanced the trustworthiness of the data collection process. Before this process

commenced, the volunteer was trained to use a "critical eye" to establish the meaning of the documents included within client files and their contribution to the research questions being explored (Bowen, 2009, p. 33). This involved training surrounding how to remain mindful of the nature, source, authenticity, accuracy and purpose of each document (Bowen, 2009). Additionally, the primary researcher supervised the volunteer during the collection of the data to provide necessary support and guidance (e.g., to answer any clarifying questions). Moreover, specific measures were taken to ensure the validity of the study's qualitative data.

Data Analysis

The data analysis process consisted of three main phases, including the quantitative and qualitative phases (quantitative data used to shape qualitative phase), and the final integration of both phases. See Appendix G for a visual representation of the study's analysis procedures.

Quantitative Phase of Analysis

Descriptive analysis of participants' demographic data (age and sex) and measure data (emotional/behavioural and school attendance variables) was conducted to provide insight into the profiles of children receiving mental health services who were experiencing school attendance problems. Data collected at each participant's most recent visit with the mental health centre was used for analysis. For some children, this was their very first visit with the centre. However, the majority of participants had received treatment at the centre many times before this. Thus, the quantitative data represents a single time point (or "endpoint," per say) at which the most recent demographic information and measure data was collected for these 15 children.

Qualitative Phase of Analysis

The qualitative analysis provided the opportunity to examine longitudinal perspectives gathered from data collected months or years prior to the quantitative endpoint data. The qualitative analysis consisted of two main processes. First, the de-identified summaries were read and re-read in order to become familiarized with the dataset. Key words and phrases that related to participants' experiences with attendance problems were coded, including child and educational elements (Braun & Clarke, 2006). This involved a continual process of refining to ensure that all important codes were accounted for. Henye and colleagues' (2019b) four typologies used to differentiate between attendance problems were then applied onto the data. Specifically, the researchers' definitions of each type and their School Non-Attendance Checklist (SNACK) were both used as a guide to categorize and describe the types of attendance problems

presented by participants. This involved re-reading the narrative summaries multiple times to ensure the typologies assigned reflected the experiences of the children. Once the attendance experiences of all participants were classified, participants were then grouped based upon their typology (e.g., one child demonstrating school withdrawal and truancy, five children demonstrating solely school refusal, etcetera). Key contextual elements were described across the groupings of children, which enabled key similarities and differences to be explored.

Finally, thematic analyses were conducted, which involved describing the themes and subthemes that emerged across the experiences of all participants, thereby epitomizing an inductive approach rooted in grounded theory (Bryman, 2016). Various examples of participants' experiences were used to illuminate the themes. Throughout the entirety of the analysis process, dialogue was held between researchers on the current project to discuss issues of reflexivity and to review the credibility of the patterns and themes observed (Dodgson, 2019). For example, the primary researcher (i.e., graduate student completing the current thesis project) often conferred with their thesis supervisor (i.e., professor at the University of Ottawa and co-researcher on the current project) for support, both of whom are members of a research team who collaborates with the study's children's mental health centre. In addition, the primary researcher often consulted with the volunteer who collected qualitative data for the study to gain clarity into any aspects of the narrative summaries that were unclear to them. In addition, the volunteer reviewed the themes observed from the narrative summaries to ensure they accurately represented what was included in the raw client files.

Interpretation Phase: Bringing the Qualitative and Quantitative Data Together

Once the quantitative and qualitative data were analyzed and presented separately, results from both analyses were then discussed together to develop a deep and varied understanding of the phenomena of school attendance problems among this sample of children receiving mental health services. The qualitative results, which were more heavily focused upon, were used to explain and elaborate upon the quantitative results (Ivankova et al., 2006). For example, while the quantitative results were able to indicate the presence and severity levels of emotional and behavioural symptoms at one time point, the qualitative results were able to provide further detail into the nature and experience of those difficulties within the educational setting, often longitudinally. Additionally, the qualitative analysis offered unique insight into aspects of participants' educational experiences that extended beyond the capacities of the quantitative

analysis, including social and academic elements. Taken together, the quantitative and qualitive results addressed the research questions surrounding the characteristics of the participants, the types of attendance problems they experienced, and any other educational elements that surrounded their school attendance experiences.

Results

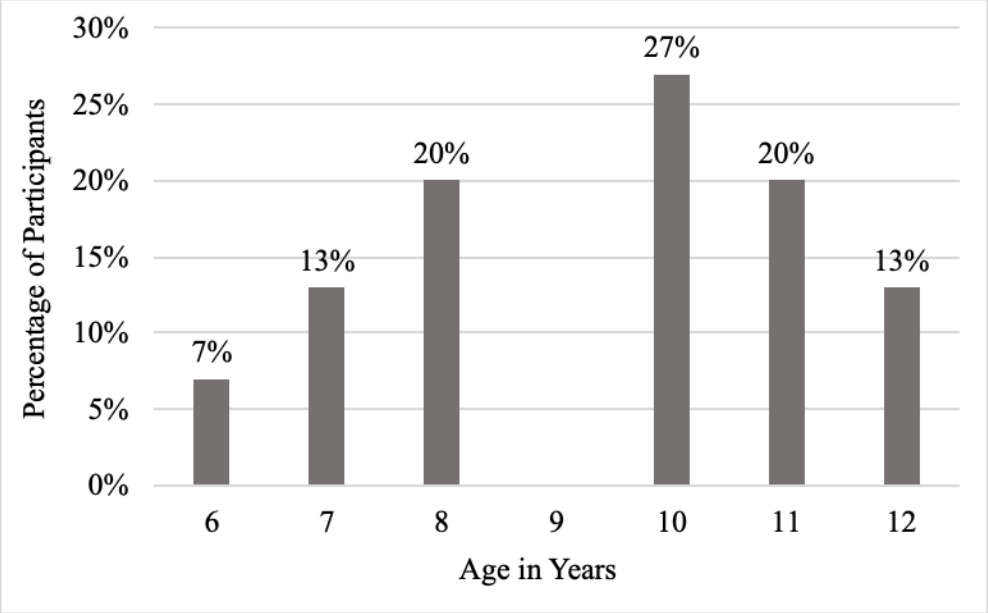
Quantitative Results from CANS and SDQ

Demographic Characteristics and Attendance Levels

At their most recent point of contact with the mental health centre, participants ($N = 15$) ranged from six to 12 years old, with a mean age of 9.40 years ($SD = 1.92$; see Figure 1). The most common age was 10 years old. In terms of sex, which remained consistent with the gender identities reported for each participant, the sample included twice as many male ($n = 10$; 67%) than female ($n = 5$; 33%) children. As part of the aforementioned selection criteria, participants were chosen who had moderate or severe attendance problems. The majority of children (60%) presented severe attendance issues, and therefore were missing school on a weekly basis or more. This is compared to the 40% of children who experienced moderate attendance issues, thereby missing school on a monthly basis. More male children experienced severe attendance issues.

Figure 1

Percentage of Participants by Age, in Years



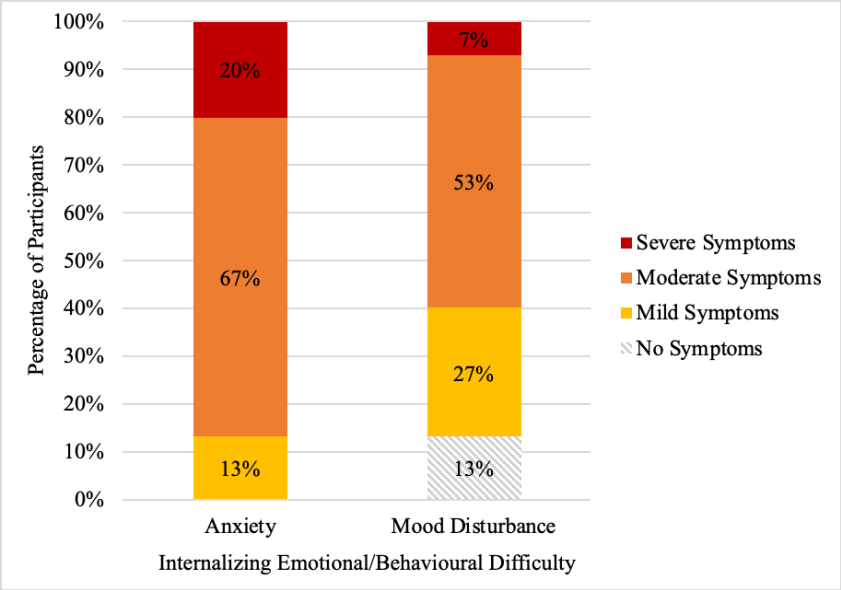
Internalizing Emotional/Behavioural Symptoms

The quantitative data indicated that all 15 children experienced internalizing symptoms, either in the form of anxiety (e.g., social anxiety, separation anxiety), mood disturbance (i.e., depression, mania, hypomania) or both. As shown in Figure 2, all participants experienced anxiety in some form and 87% (n = 13) of children experienced some level of mood disturbance. Male and female children experienced similar levels of anxiety (M = 2.1, SD = .57 versus M = 2.0, SD = .71) and mood disturbance (M = 1.60, SD = .55 versus M = 1.50, SD = .97). Given the small sample size, statistical evaluations of differences between groups were not appropriate. Looking at all children, internalizing symptoms were highly prevalent among the sample, with anxiety being presented more frequently and severely than mood disturbance.

The majority of all participants experienced moderate levels of both anxiety (67%; n = 10) and mood disturbance (53%; n = 8), as shown in Figure 2. The criteria for moderate symptoms of anxiety on the CANS include the presence of school/social avoidance and impaired functioning. In terms of severe symptoms, 20% (n = 3) of participants experienced anxiety that according to the criteria, prevents all participation in school, friendship groups, or family life. This is compared to one participant (7%) who experienced similar impacts as a result of mood disturbance. Looking at the combined percentages of moderate and severe symptoms, 87% (n = 13) of children experienced levels of anxiety and 60% (n = 9) experienced levels of mood disturbance that impaired or prevented participation in school, friendship groups, or family life. Moreover, anxiety was experienced more frequently and severely than mood disturbance, however symptoms in both domains prevented participants from attending or functioning appropriately at school according to the CANS criteria.

Figure 2

Severity of Internalizing Symptoms Experienced by Participants



The quantitative data also indicated that the majority of participants (87%; $n = 13$) experienced both anxiety *and* mood disturbance. When presented together, it was most common for participants (60%; $n = 9$) to experience anxiety and mood disturbance of similar severities, while the remaining participants (27%; $n = 4$) experienced more severe levels of anxiety than mood disturbance. When presenting symptoms of both anxiety and mood disturbance, no participants experienced more severe levels of mood disturbance than anxiety. In terms of the impact on participants' educational experiences, 60% ($n = 9$) of the children experienced levels of both anxiety *and* mood disturbance that interfered with attendance and functioning at school. Moreover, the schooling experiences of participants were frequently disrupted by their experiences with anxiety and mood disturbance.

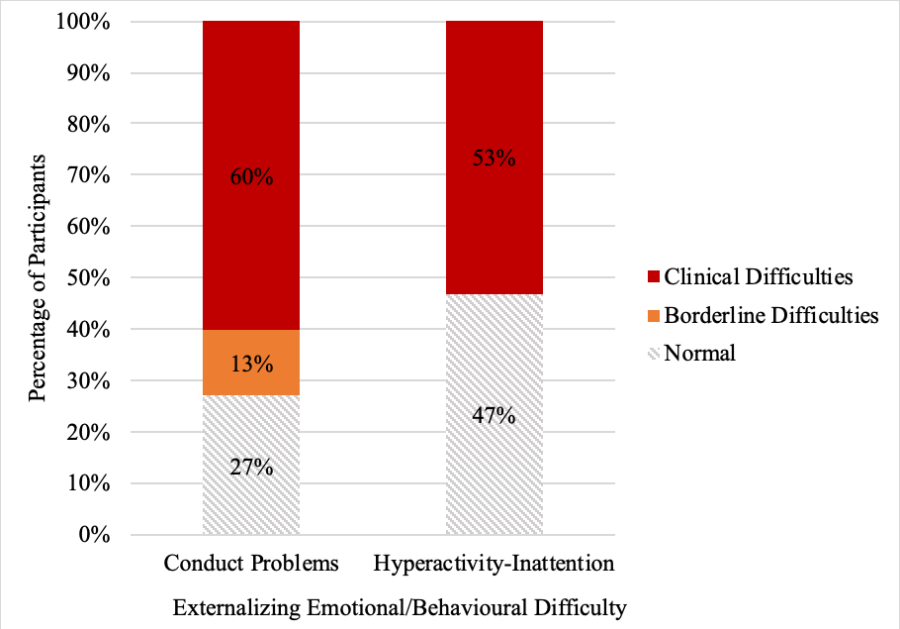
Externalizing Emotional/Behavioural Symptoms

Although experienced less frequently than internalizing symptoms, externalizing symptoms in the form of conduct problems (e.g., temper tantrums, disobedient, fights) and/or hyperactivity-inattention (e.g., fidgets, distractible, impulsive) were still highly prevalent among the sample and were experienced more severely than internalizing symptoms. As shown in Figure 3, 73% ($n = 11$) of children experienced conduct problems and 53% ($n = 8$) experienced hyperactivity-inattention. Thus, conduct problems were experienced more frequently and also more severely than hyperactivity-inattention. Taken together, 85% of participants presented

clinical externalizing symptoms that indicated significant difficulties in regulating their behaviours, attention and impulses. In terms of sex differences, male children experienced greater levels of symptoms from both externalizing areas than their female counterparts (conduct problems: $M = 4.40$, $SD = 2.22$ versus $M = 2.60$, $SD = 1.67$; hyperactivity-inattention: $M = 6.80$, $SD = 3.36$ versus $M = 3.60$, $SD = 3.36$). Again, statistical evaluations of differences between groups were not appropriate here. Among all children, externalizing symptoms were experienced by the majority of participants, with conduct problems being experienced more frequently and severely than hyperactivity-inattention.

Figure 3

Severity of Externalizing Symptoms Experienced by Participants



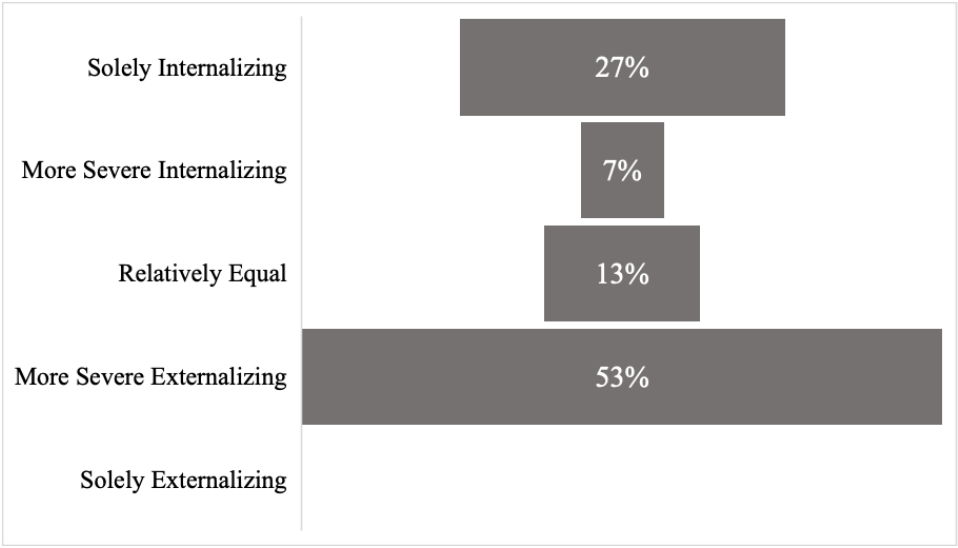
Similar to the overlap in internalizing symptom areas, the quantitative data also showed that participants often experienced conduct problems *and* hyperactivity-inattention. Of the 53% ($n = 8$) of children who presented symptoms from both domains, the majority (47%; $n = 7$) experienced them at similar severity levels, with the remaining demonstrating more severe conduct problems (20%; $n = 3$) or more severe hyperactivity-inattention (7%; $n = 1$). Evidently, most participants experienced difficulties regulating their behaviours and their attention and impulses.

Concurrent Internalizing and Externalizing Symptoms

In addition to overlap within the internalizing and externalizing domains, the quantitative data also indicated that experiencing symptoms from both domains was common among the sample, as shown in Figure 4. While 27% (n = 4) of participants experienced symptoms from only one domain (i.e., internalizing), 73% (n = 11) experienced symptoms from both domains. In terms of the former, the majority of children (53%; n = 8) presented with more severe externalizing than internalizing symptoms. Thus, when a child presented with anxiety, mood disturbance, conduct problems and hyperactivity-inattention, it was more common for them to present more severe symptoms in regulating their behaviours, attention, and impulses.

Figure 4

The Presentation of Internalizing and/or Externalizing Symptoms Experienced by Participants



Quantitative Summary

Overall, the quantitative data points to several main findings. Specifically, the data indicated that internalizing and externalizing symptoms were both highly prevalent among the sample of students with attendance problems, although internalizing symptoms were experienced more frequently than externalizing symptoms. In particular, anxiety was experienced by all participants, thereby making it the most common concern. The severity of symptoms from both domains were most often rated as clinical, which therefore largely interfered with the educational experiences of participants, including their attendance and ability to function at school. Externalizing symptoms were more prevalent among boys, whereas anxiety and mood disturbance were experienced similarly by children of both sexes.

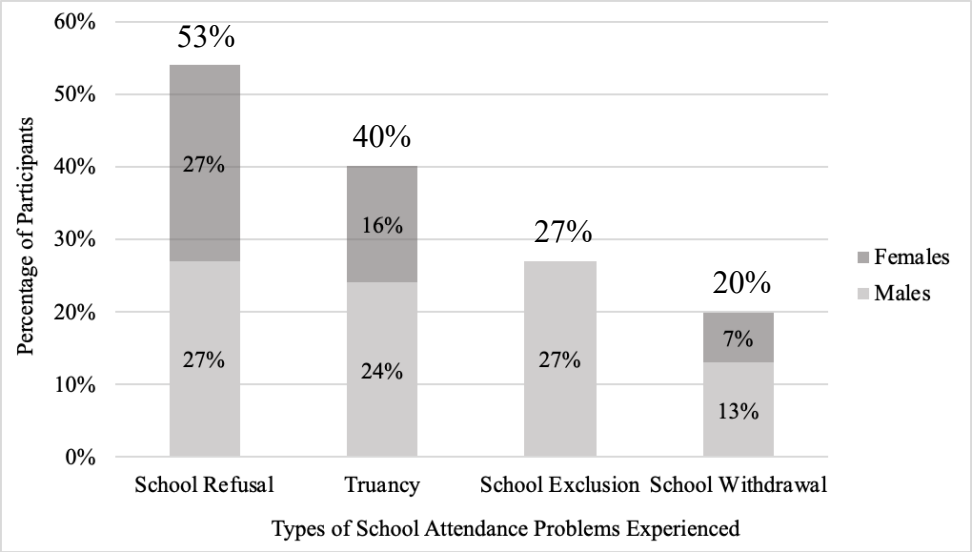
Analyses also indicated that experiencing overlap within and between the internalizing and externalizing domains was common among the children. Moreover, this sample of children, who have defined attendance problems, experience significant emotional and behavioural difficulties that interfere with their educational experiences. While this dataset was able to provide us with brief insight into the nature and severity of these difficulties, the following qualitative data provides deeper insight into the context surrounding the experience of these difficulties.

Qualitative Results: School Attendance Problem Profiles

School attendance problems were experienced in various ways by participants. Some children were persistently late to school or only attended for parts of the day. Others missed entire days, weeks, months and even years of school on an intermittent or consistent basis. Many presented a combination of these problems which remained stable or fluctuated over time. Despite individual differences in the school attendance experiences of children, key patterns emerged in their presentation that enabled Heyne and colleagues' (2019b) four main typologies to be mapped onto the data. In this regard, Figure 5 reflects the frequency of participants demonstrating each of these types of problems. As illustrated, school refusal was the most common type of problem and school withdrawal was the least common. School refusal was experienced equally by male and female participants; however, truancy, school exclusion, and school withdrawal were experienced more frequently by male children.

Figure 5

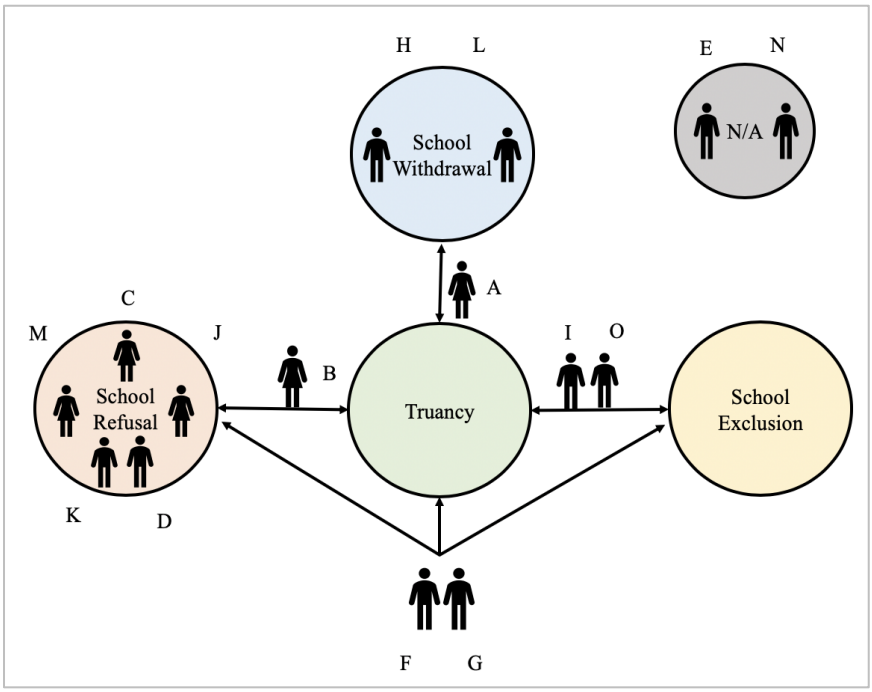
The Percentage of Attendance Problem Typologies Experienced by Male and Female Children



Similar to the internalizing-externalizing classification system, school attendance problems are complex, and children can present characteristics of multiple types of problems at one point in time or across time and contexts. Thus, while the four main typologies are distinct, they are not mutually exclusive (Egger et al., 2003; Heyne et al, 2019b). This is reflected in the current analyses; wherein significant overlap exists in participants' presentation of attendance problem typologies. As represented in Figure 6, which illustrates the school attendance problem profiles of all 15 participants, the experiences of six children (40%) reflected multiple typologies. Specifically, the experiences of four children (27%) reflected two types and the experiences of two children (13%) reflected three types. On the contrary, the experiences of seven children (47%) reflected only one type of school attendance problem, including those who experienced solely school refusal or solely school withdrawal. No child presented the sole experience of truancy or school exclusion but instead, experienced these typologies in combination with others. Not enough information was provided to describe a typology for the experiences of the remaining two children (13%). The following details the experiences of these children based upon their presentation of problems.

Figure 6

The School Attendance Problem Profiles of Participants



Note. This illustrates the types of school attendance problems that were experienced by participants. As shown, some participants experienced one type (M, C, J, K, D, H and L), whereas others (A, B, F, G, I, and O) experienced multiple types. Not enough detail was provided for participants E and N to categorize their experiences into a typology.

Solely School Refusal (the inextricable link between anxiety and refusal)

School refusal was experienced by five children, including three female and two male children between the ages of six and eleven, who demonstrated strong emotional reactions about going to school. While most of these children presented enduring issues with refusal behaviours over several months and years, the absences of one child reflected a transition from nonproblematic to problematic absenteeism over a short duration of time. In this case, the child was initially absent due to illness, however due to the difficulty in breaking the routine of staying home, began to demonstrate refusal behaviours that resulted in a significant number of school absences. This child, a 10-year-old girl, was described as enjoying school and learning otherwise. Moreover, while school refusal was spurred on incidentally and abruptly in this unique case, the analysis indicated that it was more likely for children to present enduring refusal behaviours, often beginning in a child's early school years and persisting for many years.

For this group of five children, the act of leaving home and entering the school building was noted as particularly difficult. This transition was often characterized by somatic complaints, difficulties getting out of bed, temper tantrums, and physical aggression towards the parent who was encouraging their child's attendance. All of these children experienced symptoms of anxiety, including two with specific mention of separation anxiety, which further complicated the transition from home to school. As noted frequently throughout the files of these children by multiple stakeholders, such as clinicians, teachers and parents, anxiety served as a significant barrier to school attendance for these children.

Once in the school environment, anxiety continued to present challenges for these five children, oftentimes making it very difficult to participate in classroom activities. For example, it was described in the file of an eight-year-old girl that her severe anxieties about weather conditions, such as flooding and tornadoes, would often interfere with her ability to function at school. As another example, a 12-year-old girl was described as experiencing frequent panic attacks and returning home from school crying due to her anxieties surrounding academic achievement and peer conflict. In particular, this child was described as being very fearful of academic failure and would become very anxious about the incidences of peer victimization she faced, including cyber-bullying and face-to-face bullying. Moreover, anxiety was described as significantly interfering with the attendance and functioning of these children at school.

In terms of other emotional and behavioural symptoms experienced, suicidal ideation and self-harming behaviours were pertinent in over half of these children's files, including one child who also presented with clinical levels of sadness and enduring sleep problems. The teacher and psychologist of this particular boy reported the presence of dark circles under his eyes on multiple occasions, as well as increased social isolation from peers and a disengagement from activities he previously enjoyed. Similar to other children, comments and gestures related to suicide and self-harm were frequently spoken of by this child within the school setting, which often surrounded statements of not wanting to be alive in this world.

While the majority of these participants presented physical aggression towards a parent when being dropped off at school, it was uncommon for this group of children to present externalizing behaviours within the school environment. Only one male child was described as presenting behaviours of this nature. This child was diagnosed with ADHD when he was five years old and continued to present externalizing behaviours until grade three at his most recent

visit to the study's mental health centre. For example, this child was defiant and disruptive during instructional time, and would often have aggressive outbursts that jeopardized the safety of his classmates. In relation to school refusal, this child most often presented behavioural concerns when first arriving at school and being anxious of having to separate from his mother. Once he transitioned into the school day, he was described as making positive connections with peers and teachers and managing academic expectations. Moreover, internalizing concerns were highly prevalent among this group.

In terms of interpersonal relations, the majority of these children were described as developing positive relationships with their peers, which often consisted of maintaining a small group of close friends. In the minority of cases where problematic peer relations were described, such as in the case of the young girl who endured incidences of peer victimization, these children were also described as having good friends. Thus, in general, peer relations tended to be positive among this group of children. On the contrary, the academic experiences of these children tended to be less positive, with the majority of participants experiencing difficulties in learning. In particular, many children faced difficulties in reading, writing, and math, and one had a formally diagnosed learning disability in these areas. Children with such difficulties often had an individualized education plan (IEP) put in place to meet their academic needs, as in the case of five children (33% of the sample). In addition, four (27%) children attended specialized education programs due to the culmination of their academic, emotional, and behavioural difficulties that necessitated additional support outside of the traditional classroom.

Taken together, the experiences of this group of children demonstrate a strong association between anxiety and the refusal of school.

School Refusal and Truancy (where internalizing and externalizing difficulties meet)

In terms of school refusal and truancy combined, one girl was described as presenting intermittent periods of nonattendance over a five-year period. The child first received treatment at the mental health centre for school refusal at the age of eight years old. Within that school year, the child missed 40 days of school. Significant periods of absences were reported in following school years, despite the reported collaborative efforts of the child's family and school to incentivize her attendance. As reported by the young girl's father, she refused school "no matter what we do or try." In terms of the presentation of these refusal behaviours, this child would often become very distressed when having to get on the school bus or when entering the

school building. If she arrived into the school, she would become defiant with her teachers and refuse to complete tasks. Once she settled into her school routine however, it was described that the child admired her teacher and enjoyed learning. However, these positive feelings did not seem to foster more sustained attendance, and the child continued to present refusal behaviours until her most recent visit at the centre at the age of 12 years. In addition, truant behaviours were also demonstrated by the child across these years, which consisted of fleeing from the classroom and school property.

In terms of emotional difficulties, this child was described as experiencing symptoms of anxiety and depression. The young girl's clinician reported that the child lacked the skills to manage these feelings in an age appropriate manner, and instead, often presented with non-compliance and defiance as a means of coping. This was also reflected in the child's report cards, in which teachers noted lagging social skills, along with difficulties in reading. However, she excelled in many other academic areas

In considering influences on her anxiety, it was mentioned by multiple stakeholders that social settings and relations often served as a trigger for her mood changes. For example, the child voiced to her clinician that she worried about upsetting her friends about not going to school. Peer conflict was also mentioned on multiple occasions, which often contributed to her anxious feelings. For example, the child was described as perpetrating, as well as being the victim of peer aggression. Brief mention of the child's physical health problems was mentioned, as they also contributed to her mood disturbances.

In general, the internalizing concerns of this young girl led her down a long path of refusing school. As part of the complexity of her experiences, the child also presented externalizing behaviours and truancy as a means to cope with her feelings, thereby acting as a sort of "diamond" in the "school refusal rough."

Solely School Withdrawal (homeschooling: a first choice or last resort?)

The experiences of two male children reflected school withdrawal, although for diverse reasons. One child was described as being homeschooled for a full school year at the age of seven due to the significant behavioural issues he presented during the previous school year. For example, difficulty with task switching, managing irritability, and self-regulation were discussed in the child's file, along with the presentation of physical and verbal aggression towards staff and other students. After spending a full year at home, the child entered a new school at eight years

old for "a fresh start." In contrast, the other 11-year-old boy was described as being homeschooled due to his experience with anxiety, however no further details were provided in his files. These two male children both were intentionally withdrawn from school, however for opposing reasons. One was homeschooled to support the child's externalizing concerns, whereas the other for internalizing concerns.

School Withdrawal and Truancy (the parent, the child, and the school day)

School withdrawal and truancy were reflected in the experiences of one girl from the ages of six to ten years. In terms of withdrawal, it was described that the child's mother would not wake up in the mornings to take her daughter to school, leading to "chronic lateness." This reflected unintentional withdrawal, as there was no mention of the mother deliberately trying to keep her child at home, as was the case in the homeschooling situations above. In terms of truancy, this child was described as consistently leaving the classroom without the permission of her teacher. Mention of a host of externalizing behaviours also filled the file of this particular child, who was diagnosed with ADHD and ODD at 8 years old. Behaviours included defiance, disruption, and physical aggression. No mention of learning difficulties was presented; however, this child was described as experiencing social skill challenges. For example, the young girl was described as both the perpetrator and victim of peer aggression. In terms of victimization, the child frequently brought concerns to counselling sessions with her clinician, often claiming that she does not have many friends and that other children are unkind to her and laugh at her. Moreover, an interaction of factors relating to the child, her parent, and her peers played a role influencing the attendance and functioning of this girl at school.

Truancy and School Exclusion (difficulty supporting student behavioural needs at school)

Many similarities can be drawn from the experiences of two male children in terms of their attendance profiles and emotional and behavioural difficulties. In particular, both boys demonstrated extensive histories of attendance problems in the form of truancy and school exclusion, and also presented significant behavioural difficulties from a young age that persisted for many years. For example, both boys experienced suicidal ideation and were diagnosed with ADHD. Most saliently, however, both children exhibited enduring aggression which largely interfered with their educational experiences. This behaviour included both verbal and physical aggression (e.g., violence, threatening with words and weapons, destruction of property) that was often directed at staff and students. For example, one child voiced to his clinician that he did not

trust school staff to keep him safe, and thus, felt compelled to use "physical force" as a means to do so. The other child often presented aggression when situated in large groups and when expected to engage in activities perceived to be undesirable. As a result of their aggressive behaviour, both children experienced school-initiated exclusionary practices throughout their educational journeys. Specifically, one child was expelled from preschool and the other was suspended in his early elementary years.

In regard to truant behaviours, both children were described as frequently fleeing from the classroom and school property and refusing to return. One child was described as engaging in these behaviours to avoid schoolwork and school all together. It was explained by this child's teacher that they would spend most of the day sitting under his desk or in the hallway and was "triggered" by just being at school. These behaviours persisted despite the multiple interventions that were put in place in an attempt to support this child, such as a behaviour management plan, a half-day school schedule, working with an educational assistant (EA), and attending multiple specialized education programs and classrooms. The difficulties experienced by this child were also complexly intertwined with their diagnoses of anxiety, depression, and ODD, as well as the experience of sleep difficulties.

In addition to the significant behavioural difficulties experienced by these two children, other key areas of concern surrounded social and academic elements. Both children had mention of interpersonal difficulties with peers. For example, it was mentioned that one child had not been invited to a single peer's birthday party in over three years due to their difficulties in relating to other children and maintaining friendships. In terms of academic elements, one child was described as experiencing learning difficulties, achieving below academic expectations, and having an IEP in place for individualized educational support. It was described that the limited attendance of this child, as well their severe behavioural difficulties (e.g., aggression, hyperactivity, inattention, refusal of schoolwork), contributed to these academic outcomes.

Taken together, the two boys who experienced truancy and school exclusion presented significant externalizing behaviors that hindered their educational experiences. Specifically, physical aggression was heavily portrayed as a barrier to their attendance and engagement.

Refusal, Truancy, and Exclusion (a profusion of presentations and predecessors)

The final grouping includes two male children who demonstrated a myriad of attendance problems over the course of their educational journeys thus far, including school refusal, truancy,

and school exclusion. One of the boys was described as putting forth "uncontrollable anger," aggression, and "meltdowns" that could last up to two hours, all of which prevented attendance on a regular basis. Refusal and truant behaviours were often preceded by academic expectations that were perceived to be difficult by the child, as well as being told "no" by teachers. This child also received multiple suspensions for the unsafe behaviour they presented on school grounds, including several suspensions within a three-month period.

Similarly, the verbally and physically aggressive behaviours demonstrated by the second child also resulted in multiple suspensions, and also necessitated support from a school social worker, one-to-one attention from an educational assistant, a significantly shortened school day (ranging from one to three hours a day over multiple school years), and the attendance of multiple specialized education programs. Academic tasks were described as an area that brought about significant frustration, defiance, disruption, and truant behaviour among the child, as well as suicidal ideation. One of his teachers claimed that this young boy was indeed academically capable, despite his learning difficulties in reading, writing, and math for which he had an IEP in place for, however that he "gives up too easily." From the child's perspective, as voiced to his teachers, parents and clinician, school was simply "too hard." A plethora of elements contributed to the difficulties of this child, including their symptoms of ADHD, formal diagnosis of anxiety, and problematic relations with peers (i.e., getting "picked on" by peers, as reported by teacher and parents). Particular significance surrounds the anxiety experienced by this child in regard to failure, to which all clinicians and assessments indicate underlies his behavioural challenges. As spoken by one clinician, the child experiences "school phobia" that contributes to his host of difficulties and lack of school attendance.

Collectively, the experiences of these two children highlight the complexity of school attendance problems and the contextual elements that surround them. These children experienced an intersection of attendance typologies due to the host of emotional, behavioural, social, and academic difficulties they faced.

The Two Participants Without a Defined Typology

Although the files of two male participants did not provide enough detail to classify the specific types of attendance problems they experienced, a host of contextual factors surrounded their significant absences that provide insight into their experiences. In particular, anxiety, sleep problems, aggression, emotion regulation difficulties, and problematic peer and teacher relations

were mentioned. Again, this points to the necessity of examining the host of contextual factors that surround a child in order to gain insight into their educational experiences.

Qualitative Results: Themes and Subthemes

Looking collectively across the experiences of the participants, three major themes emerged which surround their emotional and behavioural difficulties, social difficulties, and academic difficulties. All three themes reflect child- and school- related elements that surround the school attendances experiences of participants. Within the main themes, eight subthemes were also named, including three within the emotional/behavioural difficulties theme (internalizing symptoms, externalizing symptoms, and other difficulties), two within social difficulties (interpersonal relations with peers and teachers), and three within academic difficulties (learning, academic achievement and school supports). See Figure 7 for a visual representation of the themes and subthemes captured. As represented by the size of the circles surrounding the themes, emotional and behavioural difficulties encompassed the most apparent theme, followed by social difficulties and then academic difficulties.

Figure 7

Visual Representation of Themes and Subthemes

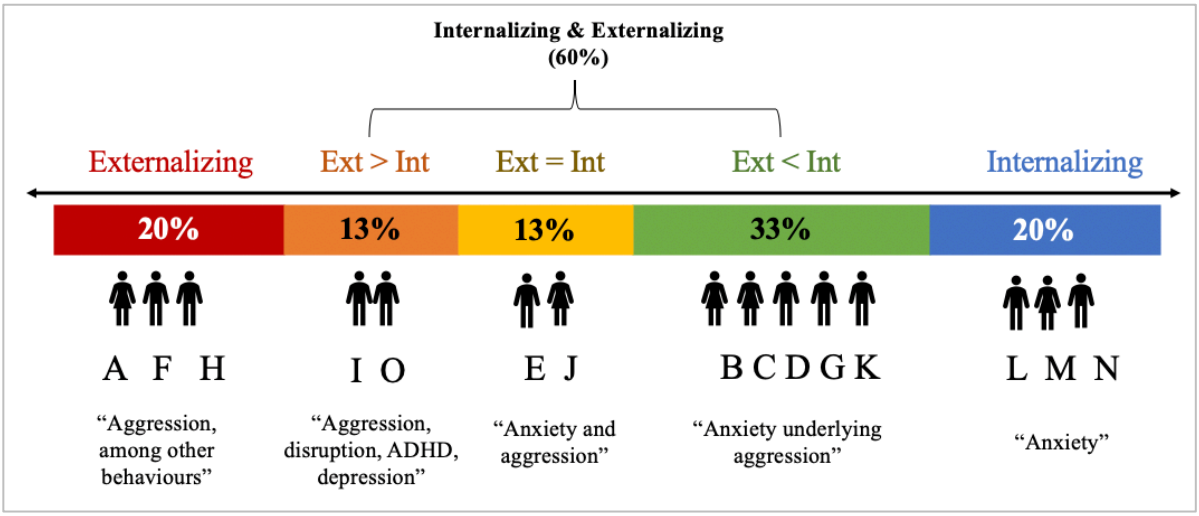
Emotional and Behavioural Difficulties and School Attendance Problems

The most common theme, identified in all client files, encompasses the strain placed upon participants' attendance and functioning at school alongside their emotional and behavioural difficulties. Such difficulties included both internalizing and externalizing concerns such as anxiety and aggression, as well as other needs, including emotion regulation difficulties, suicidal ideation/self-harm, and sleep difficulties. Most commonly, the language used in client files positioned these difficulties as causal influences on hindered attendance and functioning, particularly in terms of anxiety and aggression directly preventing attendance. Reciprocally, mention of absenteeism creating or exacerbating emotional and behavioural difficulties were only described in one child's file, whereby her prolonged absences due to illness induced anxiety about returning to school. However, drawing on the theoretical framework of the study (i.e., bioecological systems model) which emphasizes the reciprocal interactions between a person and their environments, it is likely that emotional and behavioural difficulties were reciprocally related with attendance problems more often than what was described in client files.

Most commonly, participants were described as experiencing many different types of emotional and behavioural difficulties, which often worked together to make attending and functioning at school challenging for them. This is illustrated in Figure 8 below, which provides a visual representation of the spectrum of difficulties presented by participants, including those from both internalizing and externalizing domains. As shown, some participants demonstrated primarily internalizing or externalizing symptoms, however the majority (60%) experienced an overlap of difficulties. Most prominently, a grouping of five children emerged whose underlying anxiety was described as manifesting into aggressive behaviour. The following section details how and why the various emotional and behavioural difficulties were experienced by the children.

Figure 8

The Spectrum of Internalizing and Externalizing Difficulties Experienced by Participants



Note. The figure illustrates the percentage of participants who demonstrated primarily internalizing or externalizing difficulties, as well as those who presented difficulties in both domains, including predominantly internalizing, predominantly externalizing, and a relatively equal representation of both.

Internalizing Symptoms, and Particularly Anxiety. The presence of internalizing symptoms was represented in the client files of 80% of children. These symptoms were captured as symptoms and formal diagnoses of anxiety and depression. Anxiety was most commonly described in the client files, and slightly more frequently by female participants. In some cases, it was discussed as a formal diagnosis, however it was more common for general symptoms of anxiety to be described. These symptoms were discussed in a variety of ways, thereby illuminating the diversity in ways anxiety could be experienced and presented among children. In terms of *how* it was experienced, anxiety manifested as panic attacks, somatic complaints, temper tantrums, and simply "appearing anxious" as reported by teachers, parents and clinicians. In regard to *why* it was being experienced, anxiety was described as stemming from a host of sources, some more common than others. For example, it was mentioned that one child's experience of anxiety surrounding weather conditions caused significant problems attending and being engaged at school. More common examples included symptoms of separation anxiety (i.e., separating from significant parental figures to attend school) and social anxiety (e.g., public speaking, being the center of attention, conflict with peers, peers looking at/talking about a

child). Additionally, anxiety surrounding academics (e.g., "school is too hard", unclear or perceived heightened academic expectations) and transitions/changes in routine was mentioned on multiple occasions. Taken together, it was frequently noted that these varying facets of anxiety interfered with participants' functioning at school and attendance all together. On multiple occasions were statements such as "anxiety is keeping the child from attending school" and "anxiety is the underlying problem" observable within client files, as often spoken by clinicians and other professionals.

Depression was also captured in the files, although to a significantly lesser extent than anxiety in terms of frequency and detail. In total, three male children had mention of depression in their files, two of which also experienced anxiety. One child was described as having a formal diagnosis of depression, whereas general depressive symptoms were discussed in the files of two participants. Examples of symptoms include heightened levels of sadness in the classroom, social isolation, and a withdrawal from activities previously enjoyed. No explicit connection was referenced between these symptoms and school attendance. Moreover, the experiences of the participants position internalizing symptoms, and especially anxiety, as a significant barrier to attendance and engagement in school.

Aggression and Other Externalizing Symptoms. Equal to internalizing symptoms, externalizing symptoms were described in the files of 80% of participants, more of which were boys. These symptoms were captured in four main ways, including the presentation of disruption, aggression, symptoms and/or diagnoses of attention-deficit hyperactivity disorder (ADHD), and oppositional defiant disorder (ODD) or general defiance. Again, the majority of participants presented a multitude of these behaviours, as well as symptoms in other domains.

Verbal and physical aggression were the most salient externalizing behaviour presented by the participants. While some children were aggressive with siblings and parental figures when being dropped off at school, aggression was most often described as manifesting within the school setting. In particular, it was frequently discussed in the context of "aggressive meltdowns" that involved the presentation of violence towards staff and students (e.g., kicking, punching, biting, pushing, using weapons), property destruction (e.g., throwing items), hostile/threatening comments, screaming and swearing. In the case of one participant, the duration of aggressive "temper tantrums" lasted up to two hours, which thereby preventing school attendance. In other cases, the aggressive behaviour presented by participants was of such

violent nature that classrooms had to be evacuated to protect the safety of other students, behaviour management plans were established, and in some cases, students were suspended and even expelled for their behaviour. Reasons varied for why aggressive behaviour was presented by participants. Examples of triggers include being in large groups, being told "no" by a teacher, being overwhelmed, and having to engage in activities perceived as undesirable (e.g., being in class/school). In a unique case, one participant voiced to their clinician that they do not trust school staff to keep them safe, and thus, felt compelled to use "physical force" as a means to do so. Many of these factors are linked with feelings of anxiety, which again, demonstrates the commonality of experiencing concurrent symptoms. Moreover, aggression was heavily portrayed as a barrier to the attendance and engagement of the children at school.

Disruptive and defiant behaviours, as well as those relating to ADHD, were also described in the files of many participants. Disruption was portrayed as behaviours that interfered with instructional time and the learning of peers. Examples of behaviours included being "silly" or "rude," speaking out loudly when not interested, fidgeting, leaving the classroom, and talking to classmates at inappropriate times. In terms of defiance and ODD, some children were described as being non-compliant to the expectations of teachers, and most commonly, the request to complete schoolwork. Lastly, ADHD and related symptoms of inattention, hyperactivity, and impulsivity were pertinent in the files of approximately one third of participants. Difficulties in all three of these externalizing areas were often experienced in tandem, as well as alongside aggression, self-regulation/emotion-regulation challenges, and anxiety. Taken together, externalizing behaviours were described as interfering with the functioning and educational experiences of participants.

Other Pertinent Difficulties. Three other areas of emotional and behavioural difficulties experienced by participants include emotion regulation difficulties, suicidal ideation/self-harming behaviours, and sleep problems. These were experienced concurrently with other internalizing and externalizing symptoms. Difficulties with self- and emotional- regulation were discussed in the files of over half of participants. Regulating anger was frequently mentioned. In terms of the second area of difficulty, almost half of children were claimed to be a risk for suicidal ideation and/or self-harming behaviours. While some children put forth solely suicidal comments (e.g., "I don't want to be part of this world," "I shouldn't be alive"), more children exhibited comments and self-harming behaviours. A last key difficulty pertains to the sleep

problems demonstrated by a few participants, a couple of which had brief mention of difficulties sleeping, however one of which had mention of enduring issues lasting over two years. All three of these difficulties were described as impacting the educational experiences and overall functioning of the children.

Social Difficulties and School Attendance Problems

This theme encompasses narratives captured in 80% of the children's files which pertain to peer and teacher relationships, of which influenced and were influenced by, school attendance problems.

Child-Peer Relations. Peer difficulties were reported in the files of 80% of children. More female children were described as experiencing such difficulties, which were discussed in two main ways. Firstly, they were described as general peer problems, which were often centred around difficulties making friends and "fitting in" among peers. Difficulties in daily interactions and communications with peers were also described, such when having to share or take turns with classmates. In most of these cases, lagging social skills were mentioned as a contributor to these difficulties. For example, as mentioned previously, one child had not been invited to a peer's birthday party in over three years due to their difficulties in relating to other children and maintaining friendships.

Another way in which peer difficulties were described centres around peer aggression, including aspects of victimization and/or perpetration. Many children were described as perpetrating incidences of peer aggression within the classroom and larger school setting. For example, one child was reported as instigating roughness on the school yard and in the classroom due to the feelings of enjoyment he received from fighting, as well as his feelings of not wanting to be at school. In addition to perpetration, several children were described as being victimized by peers, some of which also instigated incidences of peer aggression. This victimization was exemplified through statements such as being "picked on" or "bullied" at school and such experiences often induced heightened feelings of anxiety and worry among children. For example, a six-year-old child voiced concern to their clinician that other children would laugh at her and were "mean." In addition, elevated levels of anxiety were reported in the file of a 12-year-old child who experienced repeated incidents of cyber-bullying and face-to-face victimization, which often resulted in this child returning home from school significantly distressed.

Problematic peer relationships were described as both influencing school attendance problems and being influenced by attendance, wherein negative outcomes resulted in both cases. For example, bullying was often described as preventing attendance and conversely, absences from school often prevented friend-making. Some children with persistent school attendance problems were also described as being capable of developing positive relationships with peers. For example, it was described many times that participants interacted well with other children when they attended, and even made close friends. However, it was also described that these relationships were hindered due to their significant absences. Moreover, narratives surrounding social relations with peers were closely linked with the lack of school attendance.

Child-Teacher Relations. Although described in significantly less detail, relations maintained with teachers were described in just over half of the children's files. In a minority of cases, positive child-teacher connections were mentioned, such as the case of a male child who was described as doing well at school when working with the male math teacher. However, more commonly, problematic child-teacher relationships were discussed (40% of children), which often resembled a child presenting aggressive and defiant behaviours toward their teacher. Most of these instances were described as being carried out by male participants. For example, one child often used classroom objects to threaten their teacher with, such as pointing scissors at them during an angry outburst. Thus, negative relationships with teachers were not talked about as specifically hindering school attendance or functioning at school, but instead, as a sort of side effect of not wanting to be at school. Moreover, problematic relations with teachers were often positioned alongside a child's discontent about having to attend school.

Academic Difficulties and School Attendance Problems

Academic difficulties related to learning, academic achievement, and/or school supports (i.e., specialized education programs, IEP, support staff) were described in the files of seven participants (47%). While learning difficulties were discussed in the cases of both male and female participants, difficulties related to achievement and school supports were only spoken about in the cases of male participants.

Significant overlap was demonstrated among academic difficulties, whereby the presence of one difficulty majorly indicated the presence of difficulties in other areas. Similar to social difficulties, academic difficulties were discussed in a reciprocal manner such that attendance problems were described as both promoting and being promoted by academic difficulties. For

example, lowered achievement often resulted from significant absences from school, whereas the refusal of school often resulted from a fear of academic failure or learning difficulties.

Learning and Academic Achievement. Learning difficulties were mentioned in approximately half of client files. Only one child was described as having a diagnosed learning disability in writing and math, whereas more children presented general learning difficulties. Children with these difficulties were more likely to have lowered academic achievement. However, competing narratives also existed that suggested achievement and learning difficulties more so resulted from a lack of school attendance. In this case, even children with pronounced learning difficulties were described as being "academically capable," however that the range of contextual elements that prevented their attendance and engagement resulted in academic challenges. For example, one child's teacher claimed that they could manage academic expectations when they attended, but that they have only come to school for two days since the start of school year two months ago. In another case, it was described that one child had the ability to be successful academically, however that their fear of failure impedes their ability to do so. Moreover, these narratives suggest that learning and achievement difficulties are reciprocally related to attendance problems, whereby a child's academic success is highly dependent on their surrounding circumstances.

School Supports. The need for additional school supports were captured one third of the children's files, all of which were male. In these five cases, the boys were described as having an Individual Education Plan (IEP) in place. This enabled them to receive accommodations, modifications and/or alternative programs in certain areas of difficulty (Ontario Ministry of Education, 2017). Most often, this programming surrounded the academic areas of reading, writing and math, however, since these children also experienced a host of other internalizing and externalizing difficulties, programming also targeted certain emotional and behavioural areas as well. For example, alternative planning to address the self-regulatory skills of children was mentioned on multiple occasions.

In the case of two male children with the most severe behavioural difficulties of the sample, school support workers were positioned as essential staff to assist them in functioning at school. Both of these children received support from education assistants (EAs), and one also received additional support from a school social worker. These children attended on a significantly shortened school day schedule, and during this time, were provided with one-to-one

support by EAs. Despite this support, the behavioural needs of both children were described as exceeding the capacity of their schools, and as a result, were transitioned to intensive care/treatment classrooms (called Section 23 classrooms in Ontario). Two additional children from the sample were also described as entering into such specialized education settings for the emotional and behavioural difficulties they experienced. Thus, four children in total attended specialized classrooms. Within these settings, which are designed to support children whose circumstances or needs prevent them from being successful in a typical classroom, programs and services are provided that combine educational programming with the provision of mental health treatment. In addition to a Section 23 classroom, one of these children also attended a private educational program in hopes that it would better suit their needs. In all children's experiences, attendance in these specialized settings was described as temporary, as they all transitioned back to their neighbourhood schools once being discharged from their programs. Moreover, many children required the provision of additional supports, both inside and outside the realm of their neighbourhood schools.

Taken together, academic difficulties were prevalent in the files of approximately half of participants, whereby they were posited as being highly interconnected to the children's school attendance experiences. They were often prevalent in conjunction with other emotional and behavioural difficulties, particularly anxiety and aggression.

Qualitative Summary: Considering Intersectionality from All Angles

The qualitative analysis indicated that children experienced various types of attendance problems, and most commonly, school refusal. Some participants experienced one typology, whereas others demonstrated multiple different types at both singular and diverse time points. Key patterns emerged when examining the experiences of children based upon the type(s) they presented. First, it was indicated that anxiety was highly associated with school refusal whereas externalizing difficulties were more commonly experienced by children who presented truancy and school exclusion. These conclusions seem logistically consistent, as children who are anxious are more likely to become emotionally distressed about attending school, just like children who present defiance, hyperactivity, and aggression may be more likely to flee from the classroom and be suspended. However, taking a deeper look at the profiles of children also revealed that an overlapping of internalizing and externalizing difficulties, as well as other social and academic difficulties, were experienced by children from all groupings of attendance

typologies. For example, many school refusers also presented aggression, and many truant children experienced anxiety and depression. Moreover, the qualitative analysis indicated that children's difficulties and experiences are complex.

This overlap remains consistent with the key themes that emerged from the analysis, which also pointed to the complexity of contextual factors implicated in the attendance problems of the children. More specifically, the thematic analysis indicated that the significant emotional, behavioural, social, and academic difficulties experienced by participants were intricately intertwined and reciprocally related to their attendance problems. All in all, light was shed onto child- and school- related elements that surrounded the diverse school attendance problems experienced by children seeking mental health services.

Discussion

While it is well-supported in research literature that children with mental health difficulties are placed at heightened risk for attendance problems, little is actually known about their attendance experiences and the broader context surrounding these. Thus, the goal of the current study was to further understanding of the profiles and educational experiences of children seeking mental health services who face difficulties with attendance. Emotional, behavioural, social, and academic elements implicated in the educational experiences of these children were explored, thereby building upon existing areas of research and providing unique insight of particular relevance to this population.

Prior studies, which are largely quantitative, have typically examined factors correlative with specific types of school attendance problems among the broader child and adolescent population. Conversely, the present study explored contextual elements surrounding multiple types of non-attendance experienced specifically by children receiving mental health treatment. An inclusive framework (Melvin et al., 2019) grounded in bioecological theory (Bronfenbrenner and Morris, 2006) was assumed to guide the multifaceted exploration of child and school factors implicated in the attendance experiences of these children. Using a mixed-methods approach, the analysis of quantitative and qualitative data revealed the following main findings, many of which are supported by research literature.

The Context Surrounding Attendance Problem Typologies

The current study indicated that an array and interaction of contextual factors contributed to the attendance problems experience by children, which were embedded within various

interrelated systems. The types of attendance problems experienced by children were varied. While the experiences of some participants reflected only one type of attendance problem, other children experienced multiple typologies at concurrent or consecutive time points. This finding aligns with Heyne and colleagues' (2019b) claim that while the four main types of attendance problems are distinctively different, they are not mutually exclusive.

In terms of age differences, most children were 10 years old at the cross-sectional quantitative time point. However, the qualitative data provided us with broader, more longitudinal perspectives at the chronosystem level that indicated that the majority of participants experienced difficulties that endured over months and years, often beginning in their very early school days. These findings suggest that school attendance problems are experienced by children of a range of ages but that further research is needed to explore specific age-related patterns among children seeking mental health treatment who have attendance problems (Melvin et al., 2019; Skedgell & Kearney, 2018).

School Refusal and Anxiety

School refusal was the most common typology experienced by children, as comparable to a plethora of other studies (e.g., Munkhaugen et al., 2017). Research literature points to the close association between school refusal and internalizing mental health concerns, which was indeed echoed by findings in the current study (Kearney et al., 2019a). In particular, refusal and anxiety were found to be closely intertwined (Kearney, 2008). This link is expected given that school refusal is defined by emotional distress about attending school, as was reflected in both of the study's measures (CANS and SNACK) used to define this typology. Additionally, school avoidance behaviours were even included in the CANS anxiety criteria, which further supports the inherent association between school refusal and anxiety.

Refusal behaviours often stemmed from anxieties surrounding separating from a parental figure, social concerns (e.g., peer conflict), and/or academic difficulties (e.g., fear of academic failure), which significantly interfered with the capacity of children to function at school or attend all together. This highlights how child, family, and school factors interact to shape a child's educational experiences. In terms of sex differences, children presenting solely school refusal were predominantly female, whereas children presenting school refusal and other typologies were more commonly male. Further studies are needed to explore links between sex,

internalizing/externalizing symptoms, and attendance typologies among children receiving mental health treatment.

Truancy, Exclusion, and Externalizing Behaviours

The next most common typologies were truancy and school exclusion, which were experienced more frequently by children demonstrating predominantly externalizing behaviours. As consistent with many studies, this was more commonly male participants, however, again, the small sample size of the current study necessitates further research to explore sex differences (Daniels, 2011; Dembo et al., 2016). Similar to school refusal and anxiety, the nature of truancy and school exclusion provides an explanation for their close association with externalizing behaviours. Truancy, defined as the act of leaving school or classroom property without permission, more closely resembles conduct problems and is even included in the criteria for conduct disorder within the DSM-5 (American Psychiatric Association, 2013).

In terms of school-initiated exclusionary practices, previous research suggests that suspensions or expulsions are measures used for students who present behaviour deemed as threatening and dangerous by school officials, with the externalizing behaviours of aggression and defiance being lead causes (Burke & Nishioka, 2014). This was the case in the current study. Evidence suggests a disproportionate impact of suspensions and expulsions on students of certain populations, including children who are Black, and/or who have disabilities and emotional/behavioural problems (James & Turner, 2017; Morgan et al., 2019; Quin, 2019). Current regulations in the province of Ontario require principals to consider mitigating factors such as special education needs, the presence of an IEP, and a student's ability to control their behaviour in their decision to suspend a student (Ontario Ministry of Education, 2020). Narratives within the educational realm position school staff as ill-equipped to manage the "current classroom climate" comprised of students with increasingly complex needs (i.e., violence, mental health difficulties), which also result in increased push-out practices (Whitley et al., in press, p. 19). In recognition of the race-related disproportionality in particular, the Ontario Ministry of Education announced in July of 2020 that suspensions would no longer be allowed in elementary schools from Kindergarten to grade three (CBC News, 2020). How this policy shift affects the school attendance and broader educational experiences of children with mental health difficulties has yet to be seen.

School Withdrawal to Support Internalizing/Externalizing Difficulties

Finally, school withdrawal was experienced by three participants, two of which were boys. Parent-initiated absences are less researched than other types of attendance problems. In our study, one girl experienced withdrawal as a result of her parent having difficulty getting her to school on time. On the contrary, two other male participants experienced withdrawal in the form of homeschooling, one due to his behavioural concerns and the other due to his difficulties with anxiety. Thus, withdrawal was chosen as a means to address the needs presented by these children, which fell along opposite sides of the internalizing-externalizing spectrum. A parent's decision to homeschool their child can be influenced by a host of factors, such as parenting styles, parental attitudes toward school, a parent's mental and physical health, and parental involvement in their child's schooling (Melvin et al., 2019). Pertaining to children with emotional/behavioural concerns and special education needs, narratives often surround parental perceptions that their child's needs cannot be met within the traditional school setting (Kendal & Taylor, 2016). Similar to the experiences of students who are placed in special education settings, including several within the present study's sample, alternative education settings serve as a "safe havens" for many children and their families (Whitley et al., in press, p. 19). While not a particular focus of the current study, these elements surround parental factors at the micro- and meso- levels that have demonstrated to be linked to a child's attendance and school engagement.

Taken together, various types of attendance problems were experienced by participants and were shaped by diverse contextual factors. The demand, resource, and force characteristics of children were shown to influence their capacity to engage in proximal processes. Particularly, interactions were demonstrated between participants' sex (demand), their internalizing and externalizing mental health difficulties (resource), and the related emotions and behaviours they put forth (force; e.g., ability to regulate anger), all of which shaped their attendance experiences. The next section provides more detail into child and school elements, of which were greatly intertwined, that related to the experiences of the sample as a whole.

Child Characteristics: Emotional and Behavioural Difficulties

As expected, the present findings indicated that children with defined attendance problems who were receiving mental health treatment experienced significant emotional and behavioural difficulties. As supported by research literature, attendance problems were linked with symptoms from both internalizing (i.e., anxiety and depression) and externalizing (i.e.,

behavioural difficulties) domains (Allison & Attisha, 2019; Lim, et al., 2018). In addition, sleep difficulties, emotional/self-regulation difficulties, and suicidal ideation were prevalent among the sample, and were associated with attendance problems (Balkis et al., 2016; Hysing et al., 2015; Evans et al., 2004). Again, we see interactions between a child's attendance experiences and their resource and force characteristics.

Results were somewhat mixed pertaining to sex differences in internalizing symptoms experienced, however we found that boys were more likely to present externalizing behaviours than girls, which is in line with ample existing evidence (e.g., Rosenfield, 2000). This may explain why the sample was comprised of more male children. In other words, externalizing behaviours are more often recognized and regarded as disruptive by school staff, and thus, the children who present them are more likely to be referred to school and community services as compared to children who present primarily emotional difficulties (Sheaffer et al., 2020; Splett et al., 2019). Bradshaw and colleagues (2008) refer to this as the "squeaky wheel phenomenon," whereby more overt difficulties are attended to more frequently (p. 171). Thus, it follows that the sample of children receiving mental health services would be comprised of more boys given the heightened likelihood of them presenting overt needs. This is not to say, however, that girls presented solely internalizing behaviours, as they did experience a range of symptoms from both domains. Moreover, while this study positions school attendance problems as more prevalent and severe among male children, as supported by several studies (e.g., Chu et al., 2019; Pengpid & Peltzer, 2017; Uppal et al., 2010; Egger et al., 2003), the present sample size is very small and further studies with a greater number of participants are needed to investigate this link and the relationship between school attendance problems, sex and/or gender, and mental health needs.

Looking at the sample as a whole, emotional and behavioural difficulties contributed largely to difficulties attending school and having positive educational experiences. Most commonly, children presented concurrent difficulties which collectively contributed to their difficulties. For example, many participants experienced aggressive behaviour as a result of their underlying anxiety, which echoes research that posits internalizing and externalizing categories as not discrete (Achenbach et al., 2016). A small body of previous research reviewed by Andrews and colleagues (2019) supports the significant correlation between social anxiety and reactive and relational forms of aggression among children and youth; associations with physical aggression are less commonly noted. An explanation for the more surprising link with relational

aggression pertains to its more covert and subtle nature, which therefore makes it less risky and minimizes the risk of negative evaluations by peers (Andrews et al., 2019). Reciprocally, it may be likely that children who participate in relational aggression become more socially anxious as a consequence of such social difficulties. The authors concluded that there is evidence for both a flight and fight response on the part of children and youth experiencing anxiety, as was noted in our small sample. The intertwined nature of anxiety and aggression highlights the importance of educators getting to know their students and developing understanding of the complexity of their needs and the root causes of their behaviours. It also suggests a need to adopt a multi-faceted view and approach to behaviours in school such as that adopted within multi-tiered positive behavioural intervention and support models (McIntosh, 2014). This kind of model reflects a recent shift away from an individual, deficit-centred approach towards one that is more ecological and that considers the dynamic and reciprocal interactions surrounding a chid (Whitley, in press).

School Elements

Study findings also indicated that many children faced difficulties socially and academically at school, which were reciprocally intertwined with their school attendance problems. Several participants voiced concerns to trusted adults pertaining to these difficulties (e.g., “school is too hard” or “kids laugh at me” or “do not trust school staff”), which speaks to the necessity of supporting students in these areas.

Social Difficulties: Peer and Teacher Relations

Half of the participants were described as experiencing difficulties with peer relations and 40% were described as experiencing difficulties with teacher relations. Looking more closely, girls experienced more problematic relations with peers (80% of girls versus 40% of boys), whereas boys had more problematic relations with teachers (20% of girls versus 50% of boys). Some research suggests that male children are more likely to experience attendance problems as a result of difficulties with school staff given that they tend to present higher rates of oppositional and other externalizing behaviours, which often invites reactive behaviour from teachers (Davies & Lee, 2006; Hendron & Kearney, 2016).

In terms of relationships with peers, a plethora of research suggests that poor peer relations, including peer aggression, is associated with attendance problems among both male and female children (Cohen et al., 2009; Havik et al., 2015). Students who are victims of peer

aggression have especially shown to miss more school (Acosta et al., 2019). Interestingly, more children were described as perpetrators of peer aggression, especially those who demonstrated externalizing behaviours. It is plausible their behavioural difficulties play more of a significant role in fostering nonattendance than their peer relations in this regard, although again, these experiences and difficulties are likely dynamically and reciprocally related.

Research also demonstrates that problematic student-teacher relations are associated with attendance issues (Ingul et al., 2019). In addition, there is research that suggests close student-teacher relationships are especially protective for children with high levels of need, particularly in regard to emotional, social, and behavioural difficulties (Zolkoski, 2019). Although described in less detail than other concerns, the mere mention of poor relations with school staff experienced by children highlights the importance of a teacher's role in building positive, supportive relationships with their students and the challenges in doing so with students struggling with emotional or behavioural concerns. A host of research demonstrates that such relationships are necessary for student engagement and other educational and wellness outcomes at school (Buttner et al., 2016; Mihalas et al., 2009) but are often negative and problematic for students with internalizing and externalizing disorders (McGrath & Van Bergen, 2015; Murray & Zvoch, 2011; Zee & Roorda, 2018). A review conducted by McGrath and Van Bergen in 2015 found that students with externalizing disorders were more likely to report conflict and lower trust with their teachers; authors concluded that the relationship between student-teacher conflict and student aggression is likely bi-directional. Recent longitudinal evidence supports the unique contribution of student-teacher conflict and closeness to student aggression (Behrhorst et al., 2020; Lee & Bierman, 2018). Findings point to direct links between a child's demand, resource, and force characteristics and peer/teacher interactions at the mesosystem level.

Academic Difficulties: Learning, Achievement, & School Supports

Similarly, associations between academic difficulties and child factors were identified, which also influenced participants' ability to attend and engage at school. Approximately half of the children in the current sample were described as experiencing academic difficulties. Consistent with findings from previous absenteeism-related literature, many children experienced learning and achievement difficulties, particularly in the areas of math, reading, and writing (Ginsburg et al., 2014; Maynard et al., 2012). These difficulties were reciprocally related to their attendance problems such that being away from school fostered academic challenges, and

academic challenges often fostered the will to be away from school (Gest & Gest, 2005). Related to this, an interesting narrative emerged that positioned several of these children as academically capable, while navigating a range of contextual elements (e.g., anxiety, conduct problems, significant absences) which prevented them from being academically successful. Attitudes toward school and perceptions of academic ability, which serve as force characteristics in their influence on a student's behaviour, also played a role in the success of these children, which have been linked to absenteeism (Balkis et al., 2016). Again, this emphasizes the interplay between contextual factors that contribute to one's educational experiences. This finding also points to the importance of school-based interventions being multifaceted in their aim to improve student outcomes (Hunter et al., 2018; Sutherland et al., 2008). Approaches that have combined academic, emotional, and behavioural elements have demonstrated to be fruitful in their efforts (e.g., Chaparro et al., 2012).

In addition to learning and achievement, several other children required the implementation of additional school supports to meet their needs. These supports included the implementation of an individualized educational plan (IEP), receiving assistance from an educational assistant (EA), and transitioning to specialized education classrooms, all of which have shown to correlate with attendance problems (Skedgell & Kearney, 2018). The provision of these supports depended upon the particular needs of the children (e.g., IEP for force characteristic of self-regulation), as well as the resources of their school (exosystem factors of classroom setting, school type, and school organizational factors; Melvin et al., 2019). Externalizing behaviours such as aggression and noncompliance often served as a predecessor to the implementation of these supports. Again, a link can be drawn between externalizing behaviours, academic difficulties, and male children, as all of the children who received these special education supports were boys. Moreover, whether provided within or outside of the traditional classroom setting, many children required additional supports to meet their academic needs, which were complexly intertwined with emotional and behavioural needs. Taking a holistic glace, a range of child and school factors at various levels were identified that were reciprocally related to the attendance problems experienced by children.

To conclude the discussion and illustrate the interplay of contextual factors on school attendance, the experiences of a young girl (Kara) who presents with school refusal can be considered. When getting ready for school in the morning, Kara engages with the family

members she lives with, and these interactions are reciprocally influenced by her characteristics and those of her family. For example, Kara's mother experiences severe depression which often limits her ability to support her daughter in getting to school on time, or at all some days. These absences and late arrivals are multiplied when Kara experiences emotional outbursts as a result of the anxiety she experiences when separating from her mother. This also relates to the peer rejection and resulting isolation she experiences as a result of her anxiety, especially during recess time. In addition, Kara has not had many experiences away from her mother, partly due to her young age of six years old as well as her shy disposition. Since she works from home, Kara's mother allows her to stay at home some days to avoid feeling anxious, which also alleviates her own stress of getting Kara to school. In addition, the family cannot afford a car and thus, keeping Kara at home also prevents the hassle of having to take public transportation to get her to school. More recently, however, Kara's teacher has made efforts to work with her and her mother to develop strategies that will support increased attendance. For example, a transportation arrangement has been made so that Kara gets picked up most mornings by a classmate's family, who live in the same neighbourhood. Since the development of this arrangement, Kara has made it to school on time much more frequently.

The above anecdote reveals how a host of child, parent, family, and school factors at multiple levels can have an influence on the attendance or attendance problems of a child. This aligns with Bronfenbrenner and Morris' (2006) bioecological systems theory (i.e., PPCT model) which positions development as unfolding within nested social systems that are reciprocally influenced by a child's developmental processes. Similarly, the current study findings support Sameroff's (1990, 2004) multiple risks model, which theorises that a full range of risk factors implicated within the various ecological subsystems that surround a child must be considered to gain insight into their development and wellbeing outcomes. This model posits that risk factors tend to cluster, which has cumulatively adverse effects on a child's developmental outcomes, including their educational outcomes. This was demonstrated within the current study, whereby the attendance experiences of participants were often hindered by a range of contextual factors versus any single factor. For example, participants often faced a host of emotional, behavioural, academic, and social difficulties, which collectively and reciprocally impeded their ability to attend and function at school. This was especially the case given that participants often came from multiple-risk families who faced difficulties and experienced risks in many domains.

Moreover, both the bioecological systems theory and the multiple risks model highlight the importance of broadening one's lens to consider multiple influences on child development. As an application of the bioecological systems theory, the current study utilized the KiTeS framework (Melvin et al., 2019) to guide a multifaceted analysis that was of particular relevance to school attendance problems (i.e., incorporated candidate factors applicable to absenteeism) and was inclusive of all children. This analysis confirmed existing research that demonstrates a complex interaction of contextual factors shapes the attendance experiences of a child, however it also provided unique insight into the specific experiences of a sample of children who received mental health treatment. Results revealed that these children often faced multiple risk factors which placed them at heightened risk for attendance problems and the adverse effects that accompany such difficulties. The emotional and behavioural difficulties experienced by these children were of particular salience in contributing to their challenging school experiences, which often impacted many other areas, such as their social relations with peers and teachers, and their academic outcomes. Moreover, drawing on a complex lens as informed through the aforementioned theoretical models, this study contributes to our understanding of attendance difficulties and the complex interaction of contextual factors that surround them.

Limitations

Despite the contributions of the current study, several limitations should be noted. The first surrounds the methodological constraint of having to use a volunteer to collect qualitative data from the client files. Due to confidentiality purposes, only the de-identified narrative summaries created *from* the files that could be accessed by the researchers. Thus, we were required to analyze data that had already been interpreted by another individual, who brought with them their own biases and judgements. This was an inherent limitation of this approach, despite measures taken to ensure the quality and trustworthiness of the data collected (e.g., volunteer selection, training and supervision of volunteer). The use of a volunteer also prevented us from gaining further insight into particular areas of interest after the narrative summaries had been created. We did maintain communication with the volunteer throughout the analysis process to explain any components we found unclear and/or confusing, which was very helpful. However, the volunteer was not always able to answer questions that required her to go through the files again to gather further details (e.g., is there further information pertaining to the role of child-teacher relationships in relation to a child's attendance experience?). This was because the

outbreak of the coronavirus (COVID-19) pandemic prohibited access to the file room during the study's data collection period. Sometimes however, the inability to expand on certain areas was a result of the nature of the files, not the restricted access to the file room. The volunteer reported that some files were very sparse, especially for children who only visited the centre one time. Most notably, this prevented us from classifying the types of attendance problems experienced by two participants due to the sparse narrative data that was included in their files.

The outbreak of COVID-19 also prevented the volunteer from collecting data from the files of five children that were originally identified in the participant selection process. However, due to the qualitative focus of the study, sample size did not pose as a detriment, and having 15 participants versus 20 did not detract from the insights gleaned from the data.

Another key limitation surrounds the nature of the quantitative data used in the current study. This pertains to the use of multiple informants to report upon the internalizing and externalizing symptoms of participants. Parent-reported SDQ data were used to describe the externalizing emotional and behavioural needs, whereas clinician-reported CANS data were used to describe internalizing emotional and behavioural needs. Research pertaining to rates of agreement among informants in the evaluation of children's mental health was drawn upon to make this methodological decision. As well, the CANS provided more specific insight into participants' internalizing mental health difficulties (i.e., anxiety and depression versus SDQ general "emotional problems" scale). However, this decision is still grounded in the assumption that parents are more equipped to report upon their child's externalizing symptoms, and clinicians upon internalizing symptoms. This should be kept in mind when interpreting the findings of the study, as it may have had an influence on the prevalence and severities of emotional and behavioural difficulties reported. A comparison between informant reports of emotional and behavioural difficulties, potentially through the use of composite scores using both measures, may have been a more rigorous approach to address this methodological issue.

A last key limitation pertains to the widely variable time intervals over which quantitative and qualitative data were analyzed. The current sample comprised of participants who visited the mental health centre only once, as well as participants who visited the centre multiple times over several months or years. This influenced the quantity of data that was available to analyze for each participant, whereby children who had multiple contact points with the centre had more data to analyze. This inherently influenced what findings emerged from the analyses, which may

have different if all participants received the same extent of services. Perhaps unique themes would emerge, or themes that did emerge would become less or more apparent given the increased analysis of data.

In addition to differences in the quantity of data available to analyze, this data was gathered across variable time points depending on when each participant received services. For example, some participants had data collected as early as the year 2010, whereas others only had data collected in 2019. Thus, the data was not uniform across the sample, which is inherently influenced by a range of historical factors. For example, differences in clinical practices, diagnostic criteria, and data collection procedures across time could influence the nature of data collected. In addition, differences across days (e.g., clinician providing services or mood of child on particular day), months (e.g., seasonal weather patterns, school schedules), and years (e.g., current world events) could foster variability in the nature of data collected, both across and within participants' experiences. Moreover, while some insight was provided into longitudinal patterns across certain participants' experiences, which reflect a strength of the study, further insight of this nature would have been provided if the data collection time points were uniform across children. Moreover, if all children were sampled the same amount of times at the same time points, the conclusions drawn from the current study may have been different.

Future Research

Due to the education focus of the current study, discussion of family elements related to the attendance experiences of children were largely absent. It is recommended that future complexity models explore such family factors (e.g., child-parent relations and attachment), which have been demonstrated to contribute largely to the educational experiences of children, possibly in combination with education-related variables. The KiTeS framework developed by Melvin and colleagues (2019) provides a useful platform to begin investigations of the plethora of contextual factors that are implicated in nonattendance. Research demonstrates that effective interventions for attendance problems take a multifaceted approach in considering an array of factors that foster and maintain such problems.

The social experiences of children with attendance problems who are receiving mental health services is another key area that would be advantageous for future research to investigate further. The current study emphasized that a sample of children from this population faced significant social difficulties, of which were reciprocally related to their attendance experiences.

In terms of child-peer relations in particular, brief insight was provided into the profiles of participants as bullies and/or victims of peer aggression. It was demonstrated that both profiles fostered negative feelings towards school, which often related to school absences or attendance under significant distress. The majority of participants who experienced problematic peer relations were portrayed as being perpetrators of verbal and physical aggression, especially those who demonstrated externalizing behaviours. This is interesting given that research more often highlights the association between victimization and absenteeism. These findings necessitate future research on the relationship between a child's involvement in peer aggression and their attendance experiences. For example, exploring relationships between bully and victim profiles in relation to specific types of attendance problems, especially as experienced by children with mental health difficulties, would provide a fuller understanding into the characteristics and experiences of these children. This may offer a more comprehensive understanding of how to support children in such social areas in order to foster attendance and more positive school experiences. Exploring specific age- and sex- related patterns could also further illuminate these elements in order to provide more tailored support. Taken together, further exploring contextual elements that are implicated in the school attendance experiences of these children, including family and school elements, may yield data that directly supports prevention and intervention measures. In turn, this will foster improved school attendance, as well as children's educational and overall life outcomes.

Conclusion

Taken together, the current study highlighted the dynamic, reciprocal relationships that existed between contextual factors which surrounded the school attendance problems of children seeking mental health services. The various types of attendance problems experienced by children were situated within a complex interaction of child and school elements. Age, sex, emotional and behavioural difficulties, relations with peers and teachers, and a multitude of academic difficulties influenced, and were influenced by, the significant difficulties these children faced in attending school. A concatenation of difficulties was often experienced by students, which points to the importance of getting to know the "whole child" in order to provide supports that are effective in fostering attendance and positive school experiences. As stated by Kimberlé Crenshaw (2019), if we are not intersectional in our approach, "the most vulnerable, are going to fall through the cracks" (p. 57).

Implications for Practice

Many children within the current study were indeed described as experiencing difficulties that impeded their ability to attend and engage at school. Missing school matters, and thus these children require our attention and support in order to improve not only their attendance, but their educational outcomes and overall wellbeing. This means seeing beyond the overtly defiant and truant student to recognize one who is terrified of failing academically, one who feels as though fleeing the classroom and resisting schoolwork is the only way to cope with these anxious feelings. In many cases, the child's defiant and truant behaviour would be the focus of school-based interventions. However, knowledge of complex interactions between factors highlights the importance of also seeing beyond the "squeaky wheel" to address the child's anxiety which is leading to significant strain in their life.

Many researchers and educators advocate for the use of multi-tiered systems of support (MTSS) to prevent and address school attendance problems (Kearney et al., 2019a; Lyon & Cotler, 2009). These models provide leveled interventions that account for complex contextual factors (Whitley et al., in press; Weist et al., 2018). Evidence surrounds the effectiveness of these models, such that schools who implement such approaches have less reported rates of school absenteeism (Freeman et al., 2016). MTSS models in relation to addressing attendance problems among children with emotional and behavioural difficulties should be further explored.

A final note surrounds the important role of educators as partners in the prevention, identification, and intervention of mental health challenges among students, which are greatly intertwined with school attendance problems (Whitley et al., 2013). This includes being aware of risk and contextual factors surrounding nonattendance, as well as related signs and symptoms, to provide appropriate school-based prevention and intervention supports. This awareness is also essential for knowing when a child should be referred to outside clinical and community-based services. This highlights the necessity of mental health literacy among educators and related training so as not to overlook difficulties that require attention and support. In addition, research points to the positive impact a caring adult can make on the educational and attendance experiences of children, which again, speaks to the important role of teacher in a student's lives (David-Ferdon et al., 2016). Moreover, using an intersectional and multifaceted approach as reflected within the bioecological theory (Bronfenbrenner & Morris, 2006), educators hold the power to make a positive difference in the lives of children facing school attendance problems

who experience mental health difficulties. It is a priority to support these children, and thus a priority to understand the complexity of their experiences.

References

Aboraya, A., Rankin, E., France, C., El-Missiry, A., & John, C. (2006). The reliability of psychiatric diagnosis revisited: The clinician's guide to improve the reliability of psychiatric diagnosis. *Psychiatry (Edgmont)*, *3*(1), 41-50.

Achenbach, T. M. (1966). The classification of children's psychiatric symptoms: A factor-analytic study. *Psychological Monographs: General and Applied, 80*(7), 1-37. http://dx.doi.org/10.1037/h0093906

Achenbach, T. M., Ivanova, M. Y., Rescorla, L. A., Turner, L. V., & Althoff, R. R. (2016). Internalizing/externalizing problems: Review and recommendations for clinical and research applications. *Journal of the American Academy of Child & Adolescent Psychiatry*, *55*(8), 647-656. http://dx.doi.org/ 10.1016/j.jaac.2016.05.012.

Acosta, J., Chinman, M., Ebener, P., Malone, P. S., Phillips, A., & Wilks, A. (2019). Understanding the relationship between perceived school climate and bullying: A mediator analysis. *Journal of school violence*, *18*(2), 200-215. https://doi.org/10.1080/15388220.2018.1453820

Aitken, M., Martinussen, R., Wolfe, R. G., & Tannock, R. (2015). Factor structure of the strengths and difficulties questionnaire in a Canadian elementary school sample. *Assessment for effective intervention*, *40*(3), 155-165. https://doi.org/10.1177/1534508414560347

Alamdari, G., & Kelber, M. S. (2016). The child and adolescent needs and strengths as an outcome measure in community mental health: Factor analysis and a validation of the short form. *Community mental health journal*, *52*(8), 1118-1122. https://doi.org/10.1007/s10597-016-9996-3

Allison, M. A., & Attisha, E. (2019). The link between school attendance and good health. *Pediatrics*, *143*(2), 1-13. https://doi.org/10.1542/peds.2018-3648

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. Washington, DC: American Psychiatric Publishing.

American Psychological Association (2013*). Conduct disorder.* https://dictionary.apa.org/conduct-disorder

Andrews, L. A., Brothers, S. L., Sauve, J. S., Nangle, D. W., Erdley, C. A., & Hord, M. K.

(2019). Fight and flight: Examining putative links between social anxiety and youth aggression. *Aggression and violent behavior*, *48*, 94-103. https://doi.org/10.1016/j.avb.2019.08.005

Bajeux, E., Klemanski, D. H., Husky, M., Leray, E., Chee, C. C., Shojaei, T., ... & Kovess-Masfety, V. (2018). Factors associated with parent–child discrepancies in reports of mental health disorders in young children. *Child Psychiatry & Human Development*, *49*(6), 1003-1010. https://doi.org/10.1007/s10578-018-0815-7

Balkıs, M., Arslan, G., & Duru, E. (2016). The school absenteeism among high school students: Contributing factors. *Educational Sciences: Theory & Practice*, *16*(6), 1819-1831. https://doi.org/10.12738/estp.2016.6.0125

Behrhorst, K. L., Sullivan, T. N., & Sutherland, K. S. (2020). The impact of classroom climate on aggression and victimization in early adolescence. *The Journal of Early Adolescence*, *40*(5), 689-711. https://doi.org/10.1177/0272431619870616

Bourdon, K., Goodman, R., Rae, D., Simpson, G., & Koretz, D. (2005). The strengths and difficulties questionnaire: U.S. normative data and psychometric properties. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(6), 557-564. https://doi.org/10.1097/01.chi.0000159157.57075.c8

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal, 9*(2), 27-40.

Bradshaw, C. P., Buckley, J. A., & Ialongo, N. S. (2008). School-based service utilization among urban children with early onset educational and mental health problems: The squeaky wheel phenomenon. *School Psychology Quarterly*, *23*(2), 169. https://doi.org/10.1037/1045-3830.23.2.169

Braun, V. and Clarke, V. (2006) Using thematic analysis in psychology. Qualitative Research in Psychology, 3 (2). pp. 77-101.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments in nature and design*. Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. (1995). Developmental ecology through space and time: A future perspective. In P. Moen & G. H. Elder, Jr., (Eds.), *Examining lives in context: Perspectives on the ecology of human development* (pp. 619-647). Washington, DC: American Psychological Association.

Bronfenbrenner, U., & Morris, P.A. (2006). The bioecological model of human development. In W. Damon & R. M. Lerner (Eds.), Handbook of child psychology: Theoretical Models of Human Development, Vol. 1 (pp. 793-828). Hoboken, NJ: John Wiley and Sons.

Bryman, A. (2016). *Social research methods*. Oxford: Oxford University Press.

Burke, A., & Nishioka, V. (2014). *Suspension and expulsion patterns in six Oregon school districts* (REL 2014-028). Washington, DC: U.S. Department of Education, Institute of Education Sciences, National Center for Education Evaluation and Regional Assistance, Regional Educational Laboratory Northwest.

Buttner, S., Pijl, S. J., Bijstra, J., & Van den Bosch, E. (2016). Personality traits of expert teachers of students with EBD: Clarifying a teacher's X-factor. *International Journal of Inclusive Education*, *20*(6), 569-587. https://doi.org/10.1080/13603116.2015.1100222

CAMH. (2009). Youth Outcome Questionnaire. Retrieved from https://www.porticonetwork.ca/web/knowledgex-archive/amh-specialists/screening-for-cd-in-youth/mental-health-disorders/yoq12

Carey, F. R., Singh, G. K., Brown III, H. S., & Wilkinson, A. V. (2015). Educational outcomes associated with childhood obesity in the United States: Cross-sectional results from the 2011–2012 national survey of children's health. *International Journal of Behavioral Nutrition and Physical Activity*, *12*(1), S1-S3. https://doi.org/10.1186/1479-5868-12-S1-S3.

CBC News. (2020, July 6). Ontario to end 'discriminatory' practice of academic streaming in grade 9. CBC News. https://www.cbc.ca/news/canada/toronto/ontario-streaming-high-school-racism-lecce-1.5638700

Chaparro, E. A., Smolkowski, K., Baker, S. K., Hanson, N., & Ryan-Jackson, K. (2012). A model for system-wide collaboration to support integrated social behavior and literacy evidence-based practices. *Psychology in the Schools, 49*(5), 465-482. https://doi.org/10.1002/pits.21607

Chu, B., Guarino, D., Mele, C., O'Connell, J., and Coto, P. (2019). Developing an online early detection system for school attendance problems: results from a research-community partnership. *Cogn. Behav. Pract.* 26, 35–45. https://doi.org/10.1016/j.cbpra.2018.09.001

Cohen, J., McCabe, L., Michelli, N. M., and Pickeral, T. (2009). School climate: research, policy, practice, and teacher education. *Teachers College Record* 111, 180–213.

Crenshaw, K. (2016*). "Reach everyone on the planet…": Kimberle Crenshaw and intersectionality*. Gunda Werner Institute in the Heinrich Boll Foundation and the Centre for Intersectional Justice. https://www.boell.de/sites/default/files/crenshaw_-_reach_everyone_on_the_planet_en.pdf

Creswell, J. W., & Plano Clark, V. L. (2011). Designing and conducting mixed method research. 2nd Sage. *Thousand Oaks, CA*, *201*.

Daniels, H. (2011). Exclusion from school: A study of practice in England. *Sinéctica*, (37), 1-16.

David-Ferdon, C., Vivolo-Kantor, A. M., Dahlberg, L. L., Marshall., K. J., & Hall., J. E. (2016). *A comprehensive technical package for the prevention of youth violence and associated risk behaviors.* US Department of Health and Human Services, CDC, National Center for Injury Prevention and Control.

Davies, J. D. & Lee, J. (2006). *Factors controlling attendance in United Kingdom*. Teacher College Colombia University Press.

Deck, S. M. (2017). School outcomes for homeless children: Differences among sheltered, doubled-up, and poor, housed children. *J. Children Poverty* 23, 57–77. http://doi.org/10.1080/10796126.2016.1247347

De Los Reyes, A., Augenstein, T. M., Wang, M., Thomas, S. A., Drabick, D. A., Burgers, D. E., & Rabinowitz, J. (2015). The validity of the multi-informant approach to assessing child and adolescent mental health. *Psychological bulletin*, *141*(4), 858-900. https://doi.org/10.1037/a0038498

Dembo, R., Wareham, J., Schmeidler, J., & Winters, K. C. (2016). Exploratory two-level analysis of individual-and school-level factors on truant youth emotional/psychological functioning. *The Journal of educational research*, *109*(6), 596-607. https://doi.org/10.1080/00220671.2014.1002881

DiCroce, M., Preyde, M., Flaherty, S., Waverly, K., Karki-Niejadlik, N., & Kuczynski, L. (2016). Therapeutic engagement of adolescents with emotional and behavioural disorders*. Child and Adolescent Social Work Journal, 33*(3), 259-271. https://doi-org/10.1007/s10560-015-0419-z

Dodgson, J. E. (2019). Reflexivity in qualitative research. *Journal of Human Lactation*, *35*(2), 220-222.

Doren, B., Murray, C., & Gau, J. M. (2014). Salient predictors of school dropout among

secondary students with learning disabilities. *Learning Disabilities Research & Practice*, *29*(4), 150-159. https://doi.org/10.1111/ldrp.12044

Egger, H. L., Costello, J. E., & Angold, A. (2003). School refusal and psychiatric disorders: A community study. *Journal of the American Academy of Child & Adolescent Psychiatry*, *42*(7), 797-807. https://doi.org/10.1097/01.CHI.0000046865.56865.79

El Samra, C., & Rogers, M. (July 2020). *Patterns of school absenteeism: Comparing attenders and non-attenders seeking mental health services.* [Gimme-5 Presentation]. 81st Canadian Psychological Association Annual National Convention, Montreal, Quebec, Canada.

Evans, E., Hawton, K., & Rodham, K. (2004). Factors associated with suicidal phenomena in adolescents: a systematic review of population-based studies. *Clinical psychology review*, *24*(8), 957-979. https://doi.org/10.1016/j.cpr.2004.04.005

Finning, K., Ukoumunne, O. C., Ford, T., Danielson-Waters, E., Shaw, L., Romero De Jager, I., Stentiford, L., & Moore, D. A. (2019). The association between anxiety and poor attendance at school–a systematic review. *Child and Adolescent Mental Health*, *24*(3), 205-216. https://doi.org/10.1111/camh.12322

Fornander, M. J., & Kearney, C. A. (2020). Internalizing symptoms as predictors of school absenteeism severity at multiple levels: Ensemble and classification and regression tree analysis. *Frontiers in Psychology*, *10*, 3079. https://doi.org/10.3389/fpsyg.2019.03079

Freeman, J., Simonsen, B., McCoach, D. B., Sugai, G., Lombardi, A., & Horner, R. (2016). Relationship between school-wide positive behavior interventions and supports and academic, attendance, and behavior outcomes in high schools. *Journal of Positive Behavior Interventions*, *18*(1), 41-51. https://doi.org/10.1177/1098300715580992

Gase, L. N., Kuo, T., Coller, K., Guerrero, L. R., & Wong, M. D. (2014). Assessing the connection between health and education: Identifying potential leverage points for public health to improve school attendance. *American journal of public health*, *104*(9), e47-e54. https://doi.org/10.2105/AJPH.2014.301977

Gee, K. A. (2018). Minding the gaps in absenteeism: Disparities in absenteeism by race/ethnicity, poverty and disability. *Journal of Education for Students Placed at Risk (JESPAR)*, *23*(1-2), 204-208. https://doi.org/10.1080/10824669.2018.1428610

Gest, S. D., & Gest, J. M. (2005). Reading tutoring for students at academic and behavioural

risk: Effects on time-on-task in the classroom. *Education and Treatment of Children, 28*(1), 25-47. www.jstor.org/stable/42899826

Ginsburg, A., Jordan, P., & Chang, H. (2014). *Absences add up: How school attendance influences student success.* Attendance Works. https://www.attendanceworks.org/absences-add-up/

Goodman, R. (1997). The strengths and difficulties questionnaire: A research note. *Journal of child psychology and psychiatry, 38*(5), 581-586. https://doi.org/10.1111/j.1469-7610.1997.tb01545.x

Goodman, R. (1999). The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. *The Journal of Child Psychology and Psychiatry and Allied Disciplines*, *40*(5), 791-799. https://doi.org/10.1111/1469-7610.00494

Gottfried, M. A. (2014). Chronic absenteeism and its effects on students' academic and socioemotional outcomes. *Journal of Education for Students Placed at Risk (JESPAR)*, *19*(2), 53-75. https://doi.org/10.1080/10824669.2014.962696

Gottfried, M. A., & Gee, K. A. (2017). Identifying the determinants of chronic absenteeism: A bioecological systems approach. *Teachers College Record*, *119*(7), n7. https://www.tcrecord.org/Content.asp?ContentId=21802

Gottfried, M., Stiefel, L., Schwartz, A., & Hopkins, B. (2019). Showing up: Disparities in chronic absenteeism between students with and without disabilities in traditional public schools. *Teachers College Record*, *121*(8), 1-34.

Government of Canada. (2017). *Elementary and secondary education*. https://www.canada.ca/en/immigration-refugees-citizenship/services/new-immigrants/new-life-canada/enrol-school/elementary-secondary.html

Green, J., Liem, G. A. D., Martin, A. J., Colmar, S., Marsh, H. W., & McInerney, D. (2012). Academic motivation, self-concept, engagement, and performance in high school: Key processes from a longitudinal perspective. *Journal of adolescence*, *35*(5), 1111-1122. https://doi.org/10.1016/j.adolescence.2012.02.016

Hancock, K. J., Shepherd, C. C., Lawrence, D., and Zubrick, S. R. (2013). *Student Attendance and Educational Outcomes: Every Day Counts*. Report for the Department of Education, Employment and Workplace Relations, Canberra.

Havik, T., Bru, E., & Ertesvåg, S. K. (2015). School factors associated with school refusal-and truancy-related reasons for school non-attendance. *Social Psychology of Education*, *18*(2), 221-240. https://doi.org/10.1007/s11218-015-9293-y

Hendron, M., & Kearney, C. A. (2016). School climate and student absenteeism and internalizing and externalizing behavioral problems. *Children & Schools*, 38(2), 109–116. https://doi.org/10.1093/cs/cdw009

Heyne, D. (2019). Developments in classification, identification, and intervention for school refusal and other attendance problems: Introduction to the special series. *Cognitive and Behavioral Practice*, *26*(1), 1-7. https://doi.org/10.1016/j.cbpra.2018.12.003

Heyne, D., Gentle-Genitty, C., Landell, M. G., Melvin, G., Chu, B., Gallé-Tessonneau, M., Askeland, K. G., Gonzalvez, C., Havik, T., Ingul, J. M., Johnsen, D. B., Keppens, G., Knollmann, M., Lyon, A. R., Maeda, N., Reissner, V., Sauter, F., Silverman, W. K., Thastum…& Kearney, C. A. (2019a). Improving school attendance by enhancing communication among stakeholders: Establishment of the International Network for School Attendance (INSA). *European child & adolescent psychiatry*, *29*, 1023-1030. https://doi.org/10.1007/s00787-019-01380-y

Heyne, D., Gren-Landell, M., Melvin, G., & Gentle-Genitty, C. (2019b). Differentiation between school attendance problems: Why and how*?. Cognitive and Behavioural Practice, 26*(1), 8-34. https://doi.org/10.1016/j.cbpra.2018.03.006

Hunter, W. C., Elswick, S. E., & Casey, L. B. (2018). Efficient wraparound service model for students with emotional and behavioral disorders: A collaborative model for school social workers and teachers. *Children & Schools, 40*(1), 59-61. https://doi.org/10.1093/cs/cdx030

Hysing, M., Haugland, S., Stormark, K. M., Bøe, T., & Sivertsen, B. (2015). Sleep and school attendance in adolescence: results from a large population-based study. *Scandinavian journal of public health*, *43*(1), 2-9. https://doi.org/10.1177/1403494814556647

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*(1), 37-52. https://doi.org/10.1016/j.ejeps.2015.10.005

Ingul, J. M., Klöckner, C. A., Silverman, W. K., and Nordahl, H. M. (2012). Adolescent school

absenteeism: modelling social and individual risk factors. *Child Adolescent Mental Health 17,* 93–100. http://doi/org10.1111/j.1475-3588.2011.00615.

Ingul, J. M., Havik, T., & Heyne, D. (2019). Emerging school refusal: A school-based framework for identifying early signs and risk factors. *Cognitive and Behavioral Practice*, *26*(1), 46-62. https://doi.org/10.1016/j.cbpra.2018.03.005

Ivankova, N. V., Creswell, J. W., & Stick, S. L. (2006). Using mixed-methods sequential explanatory design: From theory to practice. *Field methods*, *18*(1), 3-20. https://doi.org/10.1177/1525822X05282260

James, C.E. & Turner, T. (2017). *Towards race equity in education: The schooling of black students in the Greater Toronto Area.* York University. https://edu.yorku.ca/files/2017/04/Towards-Race-Equity-in-Education-April-2017.pdf

Kearney, C. A., and Silverman, W. K. (1990). A preliminary analysis of a functional model of assessment and treatment for school refusal behavior. *Behav. Modif. 14*, 340–366. http://doi/org10.1177/01454455900143007

Kearney, C. A. (2003). Bridging the gap among professionals who address youths with school absenteeism: Overview and suggestions for consensus. *Professional Psychology: Research and Practice, 34*(1), 57-65. https://doi.org/10.1037/0735-7028.34.1.57

Kearney, C. A. (2008). School absenteeism and school refusal behavior in youth: A contemporary review. *Clinical psychology review*, *28*(3), 451-471. https://doi.org/10.1016/j.cpr.2007.07.012

Kearney, C. A., & Albano, A. M. (2004). The functional profiles of school refusal behavior: Diagnostic aspects. *Behavior Modification*, *28*(1), 147-161. https://doi.org/10.1177/0145445503259263

Kearney, C. A., & Albano, A. M. (2018). *When children refuse school: A cognitive-behavioural therapy approach: Therapist guide*. New York: Oxford University Press.

Kearney, C.A., Gonzalvez, C., Graczyk, P.A., & Fornander, M. J. (2019a, October 15). Reconciling contemporary approaches to school attendance and school absenteeism: Toward promotion and nimble response, global policy review and implementation, and future adaptability (part 1). *Frontiers in Psychology, 10*, 2222. https://doi.org/10.3389/fpsyg.2019.02222

Kearney, C.A., Gonzalvez, C., Graczyk, P.A., & Fornander, M. J. (2019b, November 29).

Reconciling contemporary approaches to school attendance and school absenteeism: Toward promotion and nimble response, global policy review and implementation, and future adaptability (part 2). *Frontiers in Psychology, 10*, 2222. https://doi.org/10.3389/fpsyg.2019.02605

Kearney, C.A., & Graczyk, P. (2014). A response to intervention model to promote school attendance and decrease school absenteeism. *Child Youth Care Forum, 43,* 1-25. https://doi.org/10.1007/s10566-013-9222-1

Kendall, L., & Taylor, E. (2016). 'We can't make him fit into the system': parental reflections on the reasons why home education is the only option for their child who has special educational needs. *Education 3-13*, *44*(3), 297-310. https://doi.org/10.1080/03004279.2014.974647

Kent, K. M., Pelham, W. E., Molina, B. S., Sibley, M. H., Waschbusch, D. A., Yu, J., Gnagy, E. M., Biswas, A., Babinski, D. E., & Karch, K. M. (2011). The academic experience of male high school students with ADHD. *Journal of abnormal child psychology*, *39*(3), 451-462. https://doi.org/10.1007/s10802-010-9472-4

Klein, J. B., Lavigne, J. V., & Seshadri, R. (2010). Clinician-assigned and parent-report questionnaire-derived child psychiatric diagnoses: Correlates and consequences of disagreement. *American Journal of Orthopsychiatry*, *80*(3), 375-385. https://doi.org/10.1111/j.1939-0025.2010.01041.x

Koçak, P. (2020). *Public classroom to homeschool: Finding a place for AD(H)D children in Alberta in 2010* [Doctoral dissertation, University of Lethbridge]. University of Lethbridge Research Repository (OPUS).

Krueger, R. F., Markon, K. E., Patrick, C. J., & Iacono, W. G. (2005). Externalizing psychopathology in adulthood: A dimensional-spectrum conceptualization and its implications for DSM-V. *Journal of abnormal psychology*, *114*(4), 537-550. https://doi.org/10.1037/0021-843X.114.4.537

Lawrence, D., Dawson, V., Houghton, S., Goodsell, B., & Sawyer, M. G. (2019). Impact of mental disorders on attendance at school. *Australian Journal of Education*, 63(1), 5-21. http://doi.org/10.1177/0004944118823576.

Lee, P., & Bierman, K. L. (2018). Longitudinal trends and year-to-year fluctuations in student–

teacher conflict and closeness: Associations with aggressive behavior problems. *Journal of school psychology*, *70*, 1-15. https://doi.org/10.1016/j.jsp.2018.06.002

Lenhoff, S. W., & Pogodzinski, B. (2018). School organizational effectiveness and chronic absenteeism: Implications for accountability. *Journal of Education for Students Placed at Risk (JESPAR)*, *23*(1-2), 153-169. https://doi.org/10.1080/10824669.2018.1434656

Lim, E., Davis, J., Choi, S. Y., & Chen, J. J. (2019). Effect of sociodemographics, health-related problems, and family structure on chronic absenteeism among children. *Journal of school health*, *89*(4), 308-318. https://doi.org/10.1111/josh.12736

Lorentz Center. (2018). *School absenteeism: Universal problem seeks gold standard solutions.* https://www.lorentzcenter.nl/lc/web/2018/947/description.php3?wsid=947&venue=Snellius

Lyon, A. R., & Cotler, S. (2009). Multi-systemic intervention for school refusal behavior: Integrating approaches across disciplines. *Advances in School Mental Health Promotion*, *2*(1), 20-34. https://doi.org/10.1080/1754730X.2009.9715695

Lyons J.S. (2009). The child and adolescent needs and strengths. In: *Communimetrics* (pp. 93-133). Springer, New York, NY.

Lyons J.S., Griffin E., Fazio M., & Lyons M.B. (1999). *Child and adolescent needs and strengths: An information integration tool for children and adolescents with mental health challenges (CANS-MH), manual*. Chicago: Buddin Praed Foundation.

Lyons, J. S., Weiner, D. A., & Lyons, M. B. (2004). Measurement as communication in outcomes management: The child and adolescent needs and strengths (CANS). In M. E. Maruish (Ed.), *The use of psychological testing for treatment planning and outcomes assessment* (3rd ed., Vol. 2, pp. 461–476). New York, NY: Routledge.

Marquis, R. A., & Flynn, R. J. (2009). The SDQ as a mental health measurement tool in a Canadian sample of looked-after young people. *Vulnerable Children and Youth Studies*, *4*(2), 114-121. https://doi.org/10.1080/17450120902887392

Maynard, B. R., Brendel, K., Bulanda, J. J., Heyne, D., Thompson, A., & Pigott, T. (2015). Psychosocial interventions for school refusal with primary and secondary school students: A systematic review. *Campbell Systematic Reviews*, *11*(12). https://doi.org/10.4073/csr.2015.12

Maynard, B. R., Salas-Wright, C. P., Vaughn, M. G., & Peters, K. E. (2012). Who are truant

youth? Examining distinctive profiles of truant youth using latent profile analysis. *Journal of Youth and Adolescence*, *41*(12), 1671-1684. https://doi.org/10.1007/s10964-012-9788-1

Maynard, B. R., Vaughn, M. G., Nelson, E. J., Salas-Wright, C. P., Heyne, D. A., & Kremer, K. P. (2017). Truancy in the United States: Examining temporal trends and correlates by race, age, and gender. *Children and youth services review*, *81*, 188-196. https://doi.org/10.1016/j.childyouth.2017.08.008

McGrath, K. F., & Van Bergen, P. (2015). Who, when, why and to what end? Students at risk of negative student–teacher relationships and their outcomes. *Educational Research Review*, *14*, 1-17. https://doi.org/10.1016/j.edurev.2014.12.001

McIntosh, K. (2014). Positive behavioral interventions and supports—Soutien au comportement positif (PBIS-SCP) in Canada: Deep history, promising future. *Canadian Journal of School Psychology, 29*(3), 155-160. https://doi.org/10.1177/0829573514545957

McMahon, R. J. (1994). Diagnosis, assessment, and treatment of externalizing problems in children: The role of longitudinal data. *Journal of Consulting and Clinical Psychology*, *62*(5), 901-917. https://doi.org/10.1037/0022-006X.62.5.901

Melvin, G. A., Dudley, A. L., Gordon, M. S., Klimkeit, E., Gullone, E., Taffe, J., & Tonge, B. J. (2017). Augmenting cognitive behavior therapy for school refusal with fluoxetine: A randomized controlled trial. *Child Psychiatry Hum. Dev.* 48, 485–497. http://doi.org/10.1007/s10578-016-0675-y

Melvin, G. A., Heyne, D., Gray, K. M., Hastings, R., Totsika, V., Tonge, B., & Freeman, M. (2019). The kids and teens at school (KiTeS) framework: An inclusive nested framework for understanding school absenteeism and school attendance problems. In *Frontiers in Education*, *4*, 61. https://doi.org/10.3389/feduc.2019.00061

Mihalas, S., Morse, W., Allsopp, D., & Alvarez Mchatton, P. (2009). Cultivating caring relationships between teachers and secondary students with emotional and behavioral disorders: Implications for research and practice. *Remedial and Special Education*, *30*(2), 108–125. https://doi.org/10.1177/0741932508315950

Morgan, P. L., Farkas, G., Hillemeier, M. M., Wang, Y., Mandel, Z., DeJarnett, C., & Maczuga,

S. (2019). Are students with disabilities suspended more frequently than otherwise similar students without disabilities?. *Journal of school psychology*, *72*, 1-13. https://doi.org/10.1016/j.jsp.2018.11.001

Morrissey, T. W., Hutchison, L., & Winsler, A. (2014). Family income, school attendance, and academic achievement in elementary school. *Developmental psychology*, *50*(3), 741-753. https://doi.org/10.1037/a0033848

Munkhaugen, E. K., Gjevik, E., Pripp, A. H., Sponheim, E., & Diseth, T. H. (2017). School refusal behaviour: Are children and adolescents with autism spectrum disorder at a higher risk?. *Research in Autism Spectrum Disorders*, *41*, 31-38. https://doi.org/10.1016/j.rasd.2017.07.001

Nangle, D., Hansen, D. J., Grover, R. L., Kingery, J. N., & Suveg, C. (2016). *Treating internalizing disorders in children and adolescents: Core techniques and strategies.* New York, London: Guilford Publications.

Ontario Ministry of Education. (2017, March 8). *An Introduction to Special Education in Ontario*. http://www.edu.gov.on.ca/eng/general/elemsec/speced/ontario.html#:~:text=An%20IEP%20is%20a%20written,to%20learn%20and%20demonstrate%20learning.

Ontario Ministry of Education. (2020, April 14). *Suspension and expulsion: What parents and students need to know*. http://www.edu.gov.on.ca/eng/safeschools/suspexp.html

Pengpid, S., and Peltzer, K. (2017). Associations between behavioural risk factors and overweight and obesity among adults in population-based samples from 31 countries. *Obes. Res. Clin. Pract.* 11, 158–166. http://doi.org/10.1016/j.orcp.2016.08.001

Polanczyk, G. V., Salum, G. A., Sugaya, L. S., Caye, A., & Rohde, L. A. (2015). Annual research review: A meta-analysis of the worldwide prevalence of mental disorders in children and adolescents. *Journal of Child Psychology and Psychiatry*, *56*(3), 345-365. https://doi.org/10.1111/jcpp.12381

Prakash, R., Beattie, T., Javalkar, P., Bhattacharjee, P., Ramanaik, S., Thalinja, R., Murthy, S., Davey, C., Blanchard, J., Watts, C., Collumbien, M., Moses, S., Heise, L., & Isac, S. (2017). Correlates of school dropout and absenteeism among adolescent girls from marginalized community in North Karnataka, South India. *Journal of adolescence*, *61*, 64-76. https://doi.org/10.1016/j.adolescence.2017.09.007

Quin, D. (2019). Levels of problem behaviours and risk and protective factors in suspended and non-suspended students. *The Educational and Developmental Psychologist*, *36*(1), 8-15. https://doi.org/10.1017/edp.2019.4

Rappaport, E. B., Daskalakis, C., & Andrel, J. (2011). Obesity and other predictors of absenteeism in Philadelphia school children. *Journal of School Health*, *81*(6), 341-344. https://doi.org/10.1111/j.1746-1561.2011.00599.x

Redmond, S. M., & Hosp, J. L. (2008). Absenteeism rates in students receiving services for CDs, LDs, and EDs: A macroscopic view of the consequences of disability. *Language, Speech, and Hearing Services in Schools*, *39*(1), 97-103. https://doi.org/10.1044/0161-1461(2008/010)

Regier, D. A., Kuhl, E. A., & Kupfer, D. J. (2013). The DSM-5: Classification and criteria changes. *World Psychiatry*, *12*(2), 92-98. https://doi.org/10.1002/wps.20050

Renk, K. (2005). Cross-informant ratings of the behavior of children and adolescents: The "gold standard". *Journal of Child and Family Studies*, *14*(4), 457-468. https://doi.org/10.1007/s10826-005-7182-2

Ripperger-Suhler, J. (2016). Homeschooling: An alternative to traditional school. *The Brown University Child and Adolescent Behavior Letter*, *32*(4), 1-5. https://doi.org/10.1002/cbl.30113

Rosenfield, S. (2000). *Gender and dimensions of the self: Implications for internalizing and externalizing behavior.* In E. Frank (Ed.), *American Psychopathological Association series. Gender and its effects on psychopathology* (p. 23–36). American Psychiatric Publishing, Inc.

Van Roy, B., Groholt, B., Heyerdahl, S., & Clench-Aas, J. (2010). Understanding discrepancies in parent-child reporting of emotional and behavioural problems: Effects of relational and socio-demographic factors. *BMC psychiatry*, *10*(1), 1-12. https://doi.org/10.1186/1471-244X-10-56

Schraeder, K. E., & Reid, G. J. (2015). Why wait? The effect of wait-times on subsequent help-seeking among families looking for children's mental health services. *Journal of abnormal child psychology*, *43*(3), 553-565. https://doi.org/10.1016/j.ejeps.2015.10.005

Sheaffer, A. W., Majeika, C. E., Gilmour, A. F., & Wehby, J. H. (2020). Classroom behavior of

students with or at risk of EBD: Student gender affects teacher ratings but not direct observations. *Behavioral Disorders*. https://doi.org/10.1177/0198742920911651

Skedgell, K., & Kearney, C. A. (2018). Predictors of school absenteeism severity at multiple levels: A classification and regression tree analysis. *Children and Youth Services Review*, *86*, 236-245. https://doi.org/10.1016/j.childyouth.2018.01.043

Spencer, A. M. (2009). School attendance patterns, unmet educational needs, and truancy: A chronological perspective. *Remedial and Special Education*, *30*(5), 309-319. https://doi.org/10.1177/0741932508321017

Splett, J.W., Garzona, M., Gibson, N., Wojtalewicz, D., Raborn, A., & Reinke, W. M. (2019). Teacher recognition, concern, and referral of children's internalizing and externalizing behavior problems. *School Mental Health*, *11***,** 228–239. https://doi.org/10.1007/s12310-018-09303-z

Stone, L. L., Otten, R., Engels, R. C., Vermulst, A. A., & Janssens, J. M. (2010). Psychometric properties of the parent and teacher versions of the strengths and difficulties questionnaire for 4-to 12-year-olds: A review. *Clinical child and family psychology review*, *13*(3), 254-274. https://doi.org/10.1007/s10567-010-0071-2

Stone, L. L., Janssens, J. M., Vermulst, A. A., Van Der Maten, M., Engels, R. C., & Otten, R. (2015). The strengths and difficulties questionnaire: Psychometric properties of the parent and teacher version in children aged 4–7. *BMC psychology*, *3*(1), 4. http://doi.org/10.1186/s40359-015-0061-8

Sutherland, K. S., Conroy, M. A., McLeod, B.D., Kunemund, R., & McKnight, L. (2018). Common practice elements for improving social, emotional, and behavioral outcomes of young elementary school students. *Journal of Emotional and Behavioural Disorders, 27*(2), 76-85. https://doi.org/10.1177/1063426618784009

The John Praed Foundation. (2015). *Communimetrics.* https://praedfoundation.org/tools/eating-disorder-symptom-severity-scale-eds3/

Turygin, N. C., Matson, J. L., Adams, H., & Belva, B. (2013). The effect of DSM-5 criteria on externalizing, internalizing, behavioral and adaptive symptoms in children diagnosed with autism. *Developmental neurorehabilitation*, *16*(4), 277-282. https://doi.org/10.3109/17518423.2013.769281

Uppal, P., Paul, P., & Sreenivas. (2010). School absenteeism among children and its correlates:

A predictive model for identifying absentees. *Indian Pediatrics*, *47*(11), 925–929. https://doi.org/10.1007/s13312-010-0156-5

Waddell, C., McEwan, K., Shepherd, C. A., Offord, D. R., & Hua, J. M. (2005). A public health strategy to improve the mental health of Canadian children. *The Canadian Journal of Psychiatry*, *50*(4), 226-233. https://doi.org/10.1177/070674370505000406

Weist, M. D., Eber, L., Horner, R., Splett, J., Putnam, R., Barrett, S., Perales, K., Fairchild, A. J., & Hoover, S. (2018). Improving multitiered systems of support for students with "internalizing" emotional/behavioral problems. *Journal of Positive Behavior Interventions*, *20*(3), 172-184. http://doi.org/10.1177/1098300717753832

Wherry, J. N., & Marrs, A. S. (2008). Anxious school refusers and symptoms of PTSD in abused children. *Journal of Child & Adolescent Trauma*, *1*(2), 109-117. https://doi.org/10.1080/19361520802084061

Whitley, J., Lupart, J. L., & Beran, T. (2009). The characteristics and experiences of Canadian students receiving special education services for emotional/behavioural difficulties. *Exceptionality Education International*, *19*(1), 14-31. https://ir.lib.uwo.ca/eei/vol19/iss1/3

Whitley, J., Smith, J. D., & Vaillancourt, T. (2013). Promoting mental health literacy among educators: Critical in school-based prevention and intervention. *Canadian Journal of School Psychology*, *28*(1), 56-70. https://doi.org/10.1177/0829573512468852

Whitley, J., Klan, A., & D'Agostino, B. (in press). Narratives of funding related to Inclusive Education: Canadian news media from 2014-2019. International Journal of Inclusive Education (IJIE).

Whitley, J. (In Press). Evidence-based practices for teaching learners with emotional and behavioral disorders. In U. Sharma & S. Salend (Eds.). *Encyclopedia of Inclusive and Special Education*. New York, NY: Oxford University Press.

Willner, C. J., Gatzke-Kopp, L. M., & Bray, B. C. (2016). The dynamics of internalizing and externalizing comorbidity across the early school years. *Development and psychopathology*, *28*(4 Pt 1), 1033-1052. https://doi.org/10.1017/S0954579416000687

Woerner, W., Fleitlich-Bilyk, B., Martinussen, R., Fletcher, J., Cucchiaro, G., Dalgalarrondo, P.,

Lui, M., & Tannock, R. (2004). The strengths and difficulties questionnaire overseas: Evaluations and applications of the SDQ beyond Europe. *European child & adolescent psychiatry*, *13*(2), ii47-ii54. https://doi.org/10.1007/s00787-004-2008-0

Wood, J. J., Lynne-Landsman, S. D., Langer, D. A., Wood, P. A., Clark, S. L., Mark Eddy, J., & Ialongo, N. (2012). School attendance problems and youth psychopathology: Structural cross-lagged regression models in three longitudinal data sets. *Child Development*, *83*(1), 351-366. https://doi.org/10.1111/j.1467-8624.2011.01677.x

Yao, S., Zhang, C., Zhu, X., Jing, X., McWhinnie, C. M., & Abela, J. R. (2009). Measuring adolescent psychopathology: Psychometric properties of the self-report strengths and difficulties questionnaire in a sample of Chinese adolescents. *Journal of Adolescent Health*, *45*(1), 55-62. https://doi.org/10.1016/j.jadohealth.2008.11.006

youthinmind. (2012, January 1). *Uses of the SDQ*. https://sdqinfo.org/d0.html

youthinmind. (2016, November 11). *Scoring the SDQ*. https://sdqinfo.org/py/sdqinfo/c0.py

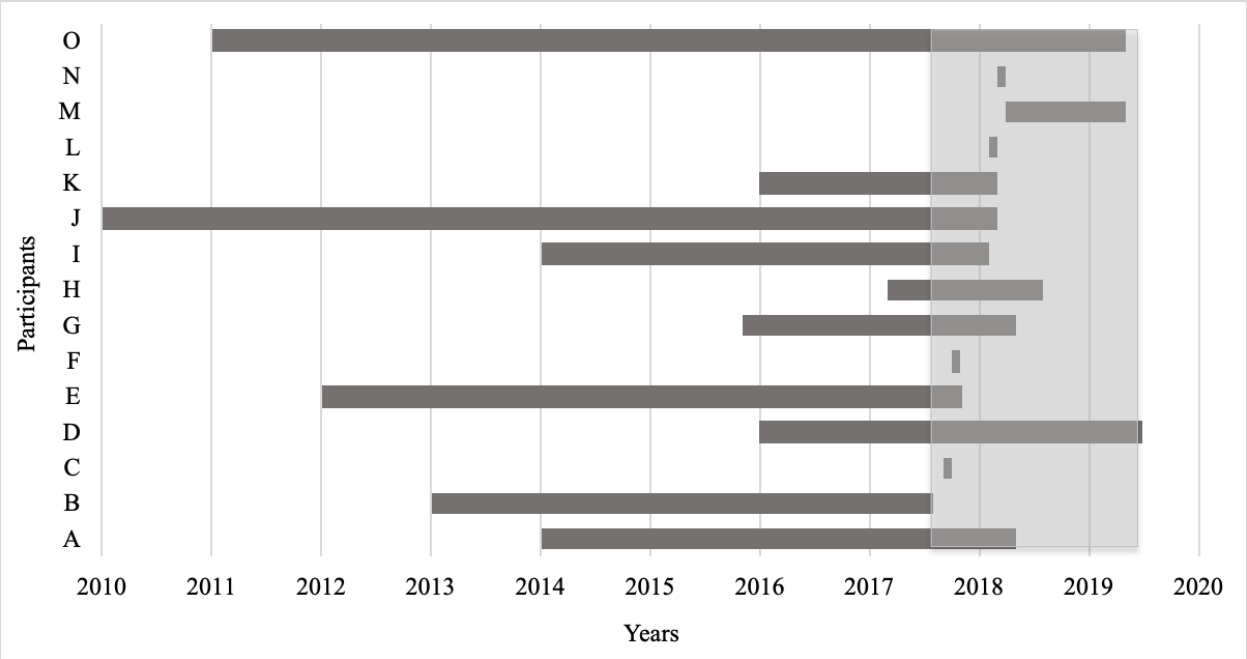
youthinmind. (2020, January 26). *English (USA).* https://sdqinfo.org/py/sdqinfo/b3.py?language=Englishqz(USA)

Zee, M., & Roorda, D. L. (2018). Student–teacher relationships in elementary school: The unique role of shyness, anxiety, and emotional problems. *Learning and Individual Differences*, *67*, 156-166. https://doi.org/10.1016/j.lindif.2018.08.006

Zolkoski, S. M. (2019). The importance of teacher-student relationships for students with emotional and behavioral disorders. *Preventing School Failure: Alternative Education for Children and Youth*, *63*(3), 236-241. https://doi.org/10.1080/1045988X.2019.1579165

Appendix A

Timeline of Participants' Quantitative and Qualitative Data



Note. This visual represents a timeline of participants' contact with the mental health centre. The dark grey bars represent the total time each participant was in contact with the centre. Qualitative data were examined over the entirety of this contact, whereas quantitative data were collected at each child's most recent visit with the centre. The light grey box encompasses the period of quantitative analysis, which spanned 23 months (August 2017 to July 2019). In total, data were examined over a nine-and-a-half-year period (January 2010 to July 2019).

Appendix B

Study Variables from the CANS and SDQ

Variable	Measure	Scale	Subscale	Item Description	Scores Selected
School Attendance Problems	CANS 6 scales 28 total items 4-point Likert scale	Educational Needs	School Attendance	-Item describes the child's attendance at school	2 (moderate) 3 (severe)
Internalizing Emotional/ Behavioural Difficulties	CANS 6 scales 28 total items 4-level Likert scale	Emotional/ Behavioural Needs	Anxiety	Symptoms of social anxiety, panic attacks, obsessive-compulsive disorder, phobias and separation anxiety	1 (mild) 2 (moderate) 3 (severe) *2 and 3 reported upon more given they interfere with school/social functioning
			Mood Disturbance	Symptoms of depressed mood, hypomania, or mania	1 (mild) 2 (moderate) 3 (severe) *2 and 3 reported upon more given they interfere with school/social functioning
Externalizing Emotional /Behavioural Difficulties	SDQ 5 scales 25 total items 3-point Likert scale	Conduct Problems	N/A	-Often has temper tantrums or hot tempers -Generally obedient -Often fights with other children -Often lies or cheats -Steals from home, school or elsewhere	Borderline Clinical
		Hyperactivity -Inattention	N/A	-Restless, overactive -Constantly fidgeting -Easily distracted, concentration wanders -Thinks things out -Sees tasks through to the end	

Appendix C

The Strengths and Difficulties Questionnaire (SDQ)

(versions for 4 to 10-year-old and 11 to 17-year-old youth; youthinmind, 2020)

Strengths and Difficulties Questionnaire

P or T 4-10

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of the child's behavior over the last six months or this school year.

Child's name ..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children, for example toys, treats, pencils	☐	☐	☐
Often loses temper	☐	☐	☐
Rather solitary, prefers to play alone	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often offers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees work through to the end	☐	☐	☐

Signature ..... Date .....

Parent / Teacher / Other (Please specify):

Strengths and Difficulties Questionnaire

P or T [11-17]

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of this young person's behavior over the last six months or this school year.

Young person's name ..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other youth, for example books, games, food	☐	☐	☐
Often loses temper	☐	☐	☐
Would rather be alone than with other youth	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other youth or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other youth	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other youth	☐	☐	☐
Often offers to help others (parents, teachers, children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets along better with adults than with other youth	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees work through to the end	☐	☐	☐

Signature ..... Date .....

Parent / Teacher / Other (Please specify):

Thank you very much for your help

Appendix D

The SDQ Scoring Guide

Conduct problems and hyperactivity scales used in current study (youthinmind, 2016)

Scoring the Strengths & Difficulties Questionnaire for age 4-17 or 18+

The 25 items in the SDQ comprise 5 scales of 5 items each. It is usually easiest to score all 5 scales first before working out the total difficulties score. 'Somewhat True' is always scored as 1, but the scoring of 'Not True' and 'Certainly True' varies with the item, as shown below scale by scale. For each of the 5 scales the score can range from 0 to 10 if all items were completed. These scores can be scaled up pro-rata if at least 3 items were completed, e.g. a score of 4 based on 3 completed items can be scaled up to a score of 7 (6.67 rounded up) for 5 items.

Note that the items listed below are for 4-17-year-olds, but the scoring instructions are identical for the similarly-worded '18+' SDQ

Table 1: Scoring symptom scores on the SDQ for 4-17 year olds

	Not True	Somewhat True	Certainly True
Emotional problems scale			
ITEM 3: Often complains of headaches… *(I get a lot of headaches…)*	0	1	**2**
ITEM 8: Many worries… *(I worry a lot)*	0	1	**2**
ITEM 13: Often unhappy, downhearted… *(I am often unhappy….)*	0	1	**2**
ITEM 16: Nervous or clingy in new situations… *(I am nervous in new situations…)*	0	1	**2**
ITEM 24: Many fears, easily scared *(I have many fears…)*	0	1	**2**
Conduct problems Scale			
ITEM 5: Often has temper tantrums or hot tempers *(I get very angry)*	0	1	**2**
ITEM 7: Generally obedient… *(I usually do as I am told)*	**2**	1	0
ITEM 12: Often fights with other children… *(I fight a lot)*	0	1	**2**
ITEM 18: Often lies or cheats *(I am often accused of lying or cheating)*	0	1	**2**
ITEM 22: Steals from home, school or elsewhere *(I take things that are not mine)*	0	1	**2**
Hyperactivity scale			
ITEM 2: Restless, overactive… *(I am restless…)*	0	1	**2**
ITEM 10: Constantly fidgeting or squirming *(I am constantly fidgeting….)*	0	1	**2**
ITEM 15: Easily distracted, concentration wanders *(I am easily distracted)*	0	1	**2**
ITEM 21: Thinks things out before acting *(I think before I do things)*	**2**	1	0
ITEM 25: Sees tasks through to the end… *(I finish the work I am doing)*	**2**	1	0
Peer problems scale			
ITEM 6: Rather solitary, tends to play alone *(I am usually on my own)*	0	1	**2**
ITEM 11: Has at least one good friend *(I have one goof friend or more)*	**2**	1	0
ITEM 14: Generally liked by other children *(Other people my age generally like me)*	**2**	1	0
ITEM 19: Picked on or bullied by other children… *(Other children or young people pick on me)*	0	1	**2**
ITEM 23: Gets on better with adults than with other children *(I get on better with adults than with people my age)*	0	1	**2**
Prosocial scale			
ITEM 1: Considerate of other people's feelings *(I try to be nice to other people)*	0	1	**2**
ITEM 4: Shares readily with other children… *(I usually share with others)*	0	1	**2**
ITEM 9: Helpful if someone is hurt… *(I am helpful is someone is hurt…)*	0	1	**2**
ITEM 17: Kind to younger children *(I am kind to younger children)*	0	1	**2**
ITEM 20: Often volunteers to help others… *(I often volunteer to help others)*	0	1	**2**

Total difficulties score: This is generated by summing scores from all the scales except the prosocial scale. The resultant score ranges from 0 to 40, and is counted as missing of one of the 4 component scores is missing.

'Externalising' and 'internalising' scores: The externalising score ranges from 0 to 20 and is the sum of the conduct and hyperactivity scales. The internalising score ranges from 0 to 20 and is the sum of the emotional and peer problems scales. Using these two amalgamated scales may be preferable to using the four separate scales in community samples, whereas using the four separate scales may add more value in high-risk samples *(see Goodman & Goodman. 2009 Strengths and difficulties questionnaire as a dimensional measure of child mental health. J Am Acad Child Adolesc Psychiatry 48(4), 400-403).*

Generating impact scores

When using a version of the SDQ that includes an 'impact supplement', the items on overall distress and impairment can be summed to generate an impact score that ranges from 0 to 10 for parent- and self-report, and from 0 to 6 for teacher-report.

Table 2: Scoring the SDQ impact supplement

	Not at all	Only a little	A medium amount	A great deal
Parent report:				
Difficulties upset or distress child	0	0	1	2
Interfere with HOME LIFE	0	0	1	2
Interfere with FRIENDSHIPS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2
Interfere with LEISURE ACTIVITIES	0	0	1	2
Teacher report:				
Difficulties upset or distress child	0	0	1	2
Interfere with PEER RELATIONS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2
Self-report report:				
Difficulties upset or distress child	0	0	1	2
Interfere with HOME LIFE	0	0	1	2
Interfere with FRIENDSHIPS	0	0	1	2
Interfere with CLASSROOM LEARNING	0	0	1	2
Interfere with LEISURE ACTIVITIES	0	0	1	2

Responses to the questions on chronicity and burden to others are not included in the impact score. When respondents have answered 'no' to the first question on the impact supplement (i.e. when they do not perceive themselves as having any emotional or behavioural difficulties), they are not asked to complete the questions on resultant distress or impairment; the impact score is automatically scored zero in these circumstances.

Cut-points for SDQ scores for age 4-17: original 3-band solution & newer 4-band solution

Although SDQ scores can be used as continuous variables, it is sometimes convenient to categorise scores. The initial bandings presented for the SDQ scores were 'normal', 'borderline' and 'abnormal'. These bandings were defined based on a population-based UK survey, attempting to choose cutpoints such that 80% of children scored 'normal', 10% 'borderline' and 10% 'abnormal'.

More recently a four-fold classification has been created based on an even larger UK community sample. This four-fold classification differs from the original in that it (1) divided the top 'abnormal' category into two groups, each containing around 5% of the population, (2) renamed the four categories (80% 'close to average', 10% 'slightly raised, 5% 'high' and 5% 'very high' for all scales except prosocial, which is 80% 'close to average', 10% 'slightly lowered', 5% 'low' and 5% 'very low'), and (3) changed the cut-points for some scales, to better reflect the proportion of children in each category in the larger dataset.

Note that these cut points have not been validated for use with the 18+ SDQ, so we suggest that it is safest to use continuous scores rather than categories for this measure

Table 3: Categorising SDQ scores for 4-17 year olds (not validated for 18+)

	Original 3-band categorisation			Newer 4-band categorisation			
	Normal	Borderline	Abnormal	Close to average	Slightly raised (/slightly lowered)	High (/Low)	Very high (very low)
Parent completed SDQ							
Total difficulties score	0-13	14-16	17-40	0-13	14-16	17-19	20-40
Emotional problems score	0-3	4	5-10	0-3	4	5-6	7-10
Conduct problems score	0-2	3	4-10	0-2	3	4-5	6-10
Hyperactivity score	0-5	6	7-10	0-5	6-7	8	9-10
Peer problems score	0-2	3	4-10	0-2	3	4	5-10
Prosocial score	6-10	5	0-4	8-10	7	6	0-5
Impact score	0	1	2-10	0	1	2	3-10
Teacher completed SDQ							
Total difficulties score	0-11	12-15	16-40	0-11	12-15	16-18	19-40
Emotional problems score	0-4	5	6-10	0-3	4	5	6-10
Conduct problems score	0-2	3	4-10	0-2	3	4	5-10
Hyperactivity score	0-5	6	7-10	0-5	6-7	8	9-10
Peer problems score	0-3	4	5-10	0-2	3-4	5	6-10
Prosocial score	6-10	5	0-4	6-10	5	4	0-3
Impact score	0	1	2-6	0	1	2	3-6
Self-completed SDQ							
Total difficulties score	0-15	16-19	20-40	0-14	15-17	18-19	20-40
Emotional problems score	0-5	6	7-10	0-4	5	6	7-10
Conduct problems score	0-3	4	5-10	0-3	4	5	6-10
Hyperactivity score	0-5	6	7-10	0-5	6	7	8-10
Peer problems score	0-3	4-5	6-10	0-2	3	4	5-10
Prosocial score	6-10	5	0-4	7-10	6	5	0-4
Impact score	0	1	2-10	0	1	2	3-10

Note that both these systems only provide a rough-and-ready way of screening for disorders; combining information from SDQ symptom and impact scores from multiple informants is better, but still far from perfect.

Appendix E

The School-Aged CANS

(Lyons et al., 1999)

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)© CCC MINI - CANS SCHOOL AGE

Please √ appropriate use: ☐ Intake ☐ Admission/Reassessment ☐ Discharge Date: M M D D Y Y

Youth's Name | DOB m m d d y y | Gender ☐ M ☐ F | Mother Tongue

Mental Health Needs

	0= No Evidence	1=watch/prevent	2=causing problems	3=causing severe or dangerous problems
1. Anxiety	○	○	○	○
2. Mood disturbance	○	○	○	○
3. Attention/Hyperactivity	○	○	○	○
4. Impulse Control	○	○	○	○
5. Oppositional Behaviour	○	○	○	○
6. Conduct Behaviour	○	○	○	○
7. Adjustment to Trauma	○	○	○	○
8. Attachment Difficulties	○	○	○	○
9. Parent-Child Relations	○	○	○	○

Risk Behaviours

0 = no evidence 1 = history, watch/prevent 2=Recent, Act 3=Acute, Act Immediately

	0	1	2	3		0	1	2	3
10. Suicide Risk	○	○	○	○	13. Aggression – Objects	○	○	○	○
11. Self Injuring Behaviours	○	○	○	○	14. Cruelty to Animals	○	○	○	○
12. Other Self Harm	○	○	○	○	15. Danger to Others	○	○	○	○

Educational Needs

0 = no evidence 1 = watch/prevent 2=Act 3=Act Now/Intensive

	0	1	2	3					
16. School attendance	○	○	○	○	17. School discipline	○	○	○	○

Child/Youth Individual Strengths

0 = centerpiece 1 = useful 2=Identified 3=Not Yet Identified

	0	1	2	3		0	1	2	3
18. Peer Relations	○	○	○	○	20. Adaptability to Change	○	○	○	○
19. Self expression	○	○	○	○	21. Family	○	○	○	○

Parents/Family/Caregiver Needs and Strengths

0 = no evidence 1 = watch/prevent 2=Recent/Act 3=Act Now/Intensive

22. Discipline/Parenting skills	○	○	○	○
23. Problem-solving	○	○	○	○
24. Knowledge of child	○	○	○	○
25. Parental responsiveness	○	○	○	○
26. Ability to communicate	○	○	○	○
27. Understanding impact of own behaviour on children	○	○	○	○

Family Needs and Strengths

0 = no evidence 1 = watch/prevent 2=Recent/Act 3=Act Now/Intensive

	0	1	2	3
28. Family stress	○	○	○	○

Appendix F

Study Variables from the School-Aged CANS

ANXIETY

Symptoms included in this dimension are those of social anxiety, panic attacks, obsessive-compulsive disorder, phobias, and separation anxiety.

0 This rating is given to a child/youth with no emotional problems. No evidence of anxiety.

1 This rating is given to a child/youth with mild emotional problems. Brief duration of anxiety causing mild impairment of peer, family, or academic function that does not lead to gross avoidance behaviour.

2 This rating is given to a child/youth with a moderate level of emotional disturbance. This could include frequent anxiety attacks, obsessions, rituals, hypervigilance, leading to impairment in functioning and social/school avoidance.

3 This rating is given to a child/youth with a severe level of emotional disturbance. This would include a child/youth who stays at home all day due to anxiety or one whose emotional symptoms prevent any participation in school, friendship groups, or family life.

MOOD DISTURBANCE

Symptoms included in this dimension are symptoms of depressed mood, hypomania, or mania.

0 This rating is given to a child/youth with no mood problems. No evidence of depression, hypomania or mania.

1 This rating is given to a child/youth with mild mood problems. Brief duration of depression, irritability, or impairment of peer, family, or academic function that does not lead to gross avoidance or inappropriate behaviour. Mild mood swings with some evidence of hypomania.

2 This rating is given to a child/youth with a moderate level of mood disturbance. This would include anhedonia, episodes of mania, depression, social withdrawal or school avoidance.

3 This rating is given to a child/youth with a severe level of mood disturbance. This would include a child/youth whose emotional symptoms prevent appropriate participation in school, friendship groups, or family life.

SCHOOL ATTENDANCE

This item describes the child/youth's attendance at school.

0 No evidence of attendance problems. The child/youth attends regularly.

1 The child/youth has some problems attending school, although he/she generally goes to school. He/she may have one or two excused absences per month.

2 The child/youth is currently having problems with school attendance. He/she may have one or two unexcused absences in a month.

3 The child/youth is missing school on a weekly basis or more, whether excused or unexcused.

Appendix H

Visual Model of Study's Mixed Methods Sequential Explanatory Design

Phase	Procedure	Product
Quantitative Data Selection	Criteria was used to select participants from a database that holds quantitative data for 1,809 child clients who received services at the mental health centre between April 1, 2017 and October 31, 2019.	Numeric data acquired for 15 participants (5 females, 10 males) aged 6-12 years who experienced moderate to severe school attendance problems. These children received services between August 31, 2017 and July 24, 2019.
Quantitative Data Analysis	Perform descriptive analysis of demographic information (age and sex) and measure data (parent-reported SDQ data and clinician-reported CANS data).	Descriptive statistics pertaining to participants' age, sex, internalizing and externalizing emotional/behavioural needs, and school attendance problems.
Using Quantitative Phase to Inform Qualitative Phase	Client files located for 15 participants identified in quantitative phase. De-identified narrative summaries created by a register volunteer at the study's centre.	Narrative summaries for 15 participants that include child and education-related information relevant to participants' attendance experiences.
Qualitative Data Analysis	Narrative summaries read and coded for contextual elements surrounding the school attendance experiences of participants. Heyne and colleagues' (2019b) four typologies used to differentiate attendance problems applied onto data, and contextual elements	Key child and educational elements relevant to participants' experiences with school attendance problems identified. Types of attendance problems experienced by children identified. Contextual factors relevant to the particular types noted.

	examined and described across groupings of children. Thematic analysis conducted to describe themes and subthemes that emerged from the data	Key themes and subthemes relating to the context surrounding the attendance problems of children seeking mental health treatment identified.
Integration of Quantitative and Qualitative Results	Quantitative and qualitative data discussed together in the final discussion section.	A deep and varied understanding of the phenomena of school attendance problems among the sample of children receiving mental health services. Research questions addressed surrounding the characteristics of participants, the types of attendance problems they experienced, and other relevant education elements that surrounded their attendance experiences.