ABSENCE FOR MEDICAL REASONS: A NEGLECTED ISSUE IN SCOTTISH EDUCATIONAL POLICY

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SYNOPSIS

Improving school attendance is a target for countries world-wide as part of their drive towards more effective, inclusive schools and higher pupil achievement. This article first seeks an educationally substantive, rational basis for improving school attendance among the reasons normally put forward. It then looks at how school attendance/absence in general is perceived in Scotland, as reflected in educational research, policy and practices. It concludes that 'unauthorised' absence has attracted more official attention than 'authorised', despite higher absence levels of the latter. The article then focuses on the largest single given cause of absence—medical reasons—and suggests that this issue should be disaggregated and addressed for the dual purposes both of supporting better the education of those children whose absence is inevitable, and of enabling the improved school attendance of those children who could, in terms of their health, actually attend school. Ways ahead are proposed.

INTRODUCTION

There is widespread concern in Scotland about school attendance, evidenced in the publication by the Scottish Executive of attendance/absence 'league tables' (HMIs Audit Unit 1999) and the funding of national and local research and development projects focusing on, among other things, improving attendance (cited later). In Scotland the broad sweep also includes improving school ethos (HMIs Audit Unit SOEID 1996) and the setting of school attainment and management targets (HMIs Audit Unit SOEID 1993, SOEID 1998a, Scottish Parliamentary Corporate Body 2000).

Recent research established a link between absence and lowered examination performance (Malcolm, Thorpe and Lowden 1996). It is important to recognise that there is a widespread belief at all levels in Scotland that improved attendance *will* bring about better results, and that doing well in the attendance league tables *is* vitally important to schools' standing with parents and in their authority and to their authority's standing nationally with the Scottish Executive. In an article purporting to address the issue of absence/attendance at school, it is surely wise to question the common sense belief that school attendance is indeed 'good for children's education', especially when there are significant numbers of children absent from school for a wide variety of reasons which are, presumably, valid to them.

WHY IMPROVE SCHOOL ATTENDANCE?

Malcolm *et al* (1996) established, in SOEID funded research, a low but statistically significant correlation between absence and lowered performance in English and Mathematics Standard Grade assessments. The researchers stressed that the link between absence and lowered attainment was not necessarily causative. Indeed they surmised that, 'While missing school in itself might well bring about a drop in attainment, consistently getting poor marks could equally cause a pupil to lose heart and think that there was little point in attending' (Malcolm and Thorpe 1996:3). They also highlighted substantial attendance variation between schools and among pupils, noting that some pupils with extensive absences still achieved very well. They suggested that a number of inter-related influences impacted on attainment,

not least the general ability of children and aspects of individual schools. Despite these provisos, they asserted, 'The fact that explained absence is comparable in its effects to unexplained absence underlines the importance (with respect to pupils' performance in examinations) of reducing the extent of absence from school of either kind' (Malcolm *et al* 1996: 44).

Research in the US (Fowler, Johnson and Atkinson 1985) found that lowered national achievement tests results had no statistically significant link to absence alone in children with chronic health conditions. It found, not surprisingly, strong links between lower results and certain medical conditions in which impaired cognition might be a feature such as epilepsy and spina bifida. However, it also found a link between lowered achievement and those conditions associated more frequently with the black population than the white but not linked to possible cognitive impairment, such as some forms of anaemia. The link with the black population ties in to the strongest correlation found in this study which was with socio-economic disadvantage as defined by low parental socioeconomic status (being unemployed, living on social benefits, living in poor housing conditions etc.).

Pless, Cripps, Davies and Wadsworth's findings (1989: 73) in a similar study supported those of Fowler *et al,* reporting,

> ...significantly lower combined mean scores were achieved by both boys and girls who had been chronically ill, but these lower scores were achieved only by manual social group children of both sexes. Score differences were unlikely to be the result of absence from school, since scores did not vary significantly with length of absence…

Seeking links between socio-economic status and achievement was not part of Malcolm *et al's* remit from the SOEID. Their achievement data in the correlation with absences were the 1994-5 Standard Grade English and Mathematics results, excluding 'no award' results. Standard Grade, despite its original intention to provide 'assessment for all', does not fulfil this aim. 10-20% of pupils either fail to achieve any grade, take alternative courses, or absent themselves from assessment (Higher Still Development Unit 1997). Malcolm *et al's* pupil sample was therefore not complete across all pupils, even at this particular stage, nor, arguably, was it free from socioeconomic bias.

While Closs and Norris (1997), in their study of the education of children with chronic and/or deteriorating medical conditions, investigated academic achievement in detail only at the level of the small number of profiled individual pupils from whom no generalisable conclusion may be drawn, they did have other substantial anecdotal evidence on these and other absent pupils trying to 'keep up' with peers attending school. It appeared from Scottish Local Authority (LA) questionnaire returns, and from LA and school staff interviews, again not surprisingly, that parents' capacity to support their child, and their assertiveness in maintaining links with, and extracting homework from, their child's school were thought to be critical factors, along with the child's own ability and motivation. Such characteristics are not exclusive to families with higher socioeconomic status, but may be more strongly associated with them.

It might therefore be tentatively hypothesised that, just as pupils at socio-economic disadvantage have been shown over the years to be educationally disadvantaged *in* school (Wedge and Essen 1982, Dyson 1997), so they may be disproportionately even further disadvantaged *in absence* from school, whether on medical or other grounds. Improved attendance might, then, play a larger part in raising achievement in pupils whose learning is already at risk, who may have difficulties in learning, or lack parental support or are at socio-economic disadvantage. While recent Scottish Executive initiatives in Early Intervention and Community Schools are

steps towards reducing educational disadvantage and social exclusion, pupils who are frequently absent will benefit less than those present from in-school strategies to support learning.

If the directly causative link between attendance and educational performance is not established, and the more complex links only hypothesised, what other reasons are there for attending school? *Close to the Mark* (Quality in Education Centre 1997) lists a range of other reasons, including:

- making it easier to establish effective learning
- enabling the establishment of good patterns of behaviour and attitudes to learning which lead on to employment, continuing education and effective use of leisure
- establishing young people as part of a positive social structure
- enabling parent-teacher-pupil partnerships
- reducing the likelihood of young people being involved in dangerous or delinquent activity
- allowing better use of staff time and other resources.

While these might be viewed as common but unproven beliefs, their impact on teachers' and administrators' attitudes and practices and the irritant effect of absence are part of the reality of schools and cannot be ignored.

School, for most children, is the place where peer relationships, including friendships, are established. James, Jenks and Prout (1998) discuss how the recent development of the concept of children's agency allows the peer group to be seen now as an important constructive - rather than dangerous/negative - influence on children. 'It is becoming clear how children's friendship networks help facilitate processes of cultural reproduction, for it is largely with their peers that children play, tell jokes and swop ideas' (James *et al* 1998:95). Ramsey (1991:2) writes,

> Both observations and self-reports attest to the importance of friendships, not only to children's immediate enjoyment of school and recreational activities, but also to many aspects of their physical, cognitive, emotional, and social development. For both children and adults, friends enhance our pleasure, mitigate our anxieties, and broaden our realm of experience.

Asher (1990:2) suggests that positive peer relationships may be even more important now because children spend more time together - in schools, after-school clubs and leisure activities - than before. In this informal but vital developmental aspect of attending school the losses to absent children are incalculable.

The Truancy File (Quality in Education Centre 1995) lists the reasons given by young people for attending school:

- meeting friends
- learning new things
- achieving success
- pleasing parents.

Again, these are persuasive reasons, although school need not be the only locus in which young people could achieve them. Young people listed bullying, difficulties with lessons, feeling a failure and home problems as reasons for *not* going to school.

In recent research findings (Bolton 1997, Closs and Norris 1997) the main reasons given by absent, ill children and young people for wanting to attend school were,

first, to make or be with friends and, second, to be like everyone else. Learning losses were regretted by relatively few children, their work-related concerns being more about the effort required later to 'catch up'.

It therefore seems that, providing in-school circumstances are positive, most young people themselves *do* want to be there, even if their reasons differ from those of 'the powers that be'. There are also sufficient educational and human developmental reasons for ensuring both that school is perceived as a positive environment by young people and that their attendance is improved.

PERCEPTIONS OF ABSENCE/ATTENDANCE IN SCOTLAND AS REFLECTED THROUGH POLICIES, PRACTICES AND RESEARCH

The stimulus for funded educational research and for policy and practice developments may lie in Government perceptions, in HM Inspectorate perspectives and in public pressure from media and parents (Munn 1998). This can result in competition between the needs of different groups of pupils and in the emergence of dominant issues which capture attention and resources. The writer would suggest that, during the early and mid 1990s, indiscipline, exclusions and truancy/absence conglomerated to be just such a dominant issue.

While changes in the socio-political climate during the later 1990s may have converted the terminology to positive discipline, inclusion and attendance, the underlying theme was constant. Disaffected youngsters were perceived as dangerous to others and destructive to themselves, a drain on society rather than active contributors, part of an excluded sub-stratum of society. It was hoped that education held the key. Relevant research and development was therefore required to identify problems and find ways forward.

The dramatic increase in school exclusions in England and Wales (Parsons 1999) was a solemn warning to Scotland. The Scottish Office funded both extensive research into the behaviour-related exclusion of children and young people from their schools and pilot projects to find alternatives to exclusion (Cullen, Johnstone, Lloyd and Munn 1996). This research culminated in national guidance for authorities and schools (SOEID 1998b) aimed at ensuring that the management of exclusion was regulated and its incidence carefully recorded. Schools were expected to 'contain' pupils, using exclusion only as a final resort in the most extreme cases.

The policy focus on truancy and indiscipline is of long-standing, from the Pack Report (SED 1977) to more recent research by Munn and Johnstone (1992). Government concern is evidenced in the publication of local authority 'attendance league tables', the setting of school attendance targets, and funding of research projects (Malcolm *et al* 1996, Quality in Education Centre 1995 and 1997) focusing on improving attendance and preventing truancy. In Malcolm *et al's* research, as already discussed, links were sought between attendance/absence and attainments.

In addition to concerns about educational attainment and international comparisons, there was also genuine concern in some quarters for the well-being of young people themselves. Thus, while *Close to the Mark* (Quality in Education Centre 1997) looked at means of monitoring and confronting truancy and absence through 'direct attendance pathways', it also emphasised positive support and encouragement for attendance, 'ethos pathways'. It held out the carrot of improved performance, 'Recent research in Scotland demonstrates a strong link between attendance and attainment' (Quality in Education Centre 1997:4 in a reference to Malcolm *et al* 1996), an overstatement of the researchers' own claims. While *Close to the Mark* explicitly addresses unauthorised absence it may also implicitly address authorised absence, concepts which will be examined in the next section.

During this same period of time, however, through almost all of the 1990s, children absent on medical grounds had almost no public profile. Is this important

in the context of a discussion on school attendance/absence and possible related educational gains/losses?

DIFFERENT KINDS OF ABSENCE, DIFFERENT OFFICIAL RESPONSES

The Scottish Executive Education Department requires schools and education authorities to differentiate in their statistical returns between 'unauthorised' and 'authorised' absence - the latter including absence on medical grounds. The author will argue that the lack of focus on authorised absence and the lack of differentiation between its constituent elements are important defects in a system overtly committed to social and educational inclusion.

In schools' registration systems pupils reported off school ill, or attending medical/dental facilities for consultation or treatment are marked 'M', for medical. This comes into the wider Scottish Office classification of 'Authorised Absence' along with bereavement, study leave, religious observance, family holidays when attendance is otherwise satisfactory, attendance at Court, Care Reviews or Children's Hearings, weddings of immediate family member and extended visits overseas to relatives. 'Unauthorised Absence' includes truancy as a result of premeditated or spontaneous action on the part of the pupil, parent or both, family holidays when attendance otherwise is unsatisfactory and unexplained absence. Malcolm *et al's* research(1996) used the terms 'explained' and 'unexplained' to refine the analysis of their absence/attendance data, reallocating or eliminating some classification anomalies.

The SEED HMI Audit Unit statistics (1999) for 1996/97, 1997/98 and 1998/99 gave the national average attendance and absence in primary schools as 94-95 per cent attendance, *5* per cent authorised absence and zero per cent unauthorised absence. Examination of the 1998/99 statistics for the primary stage of individual authorities showed that the highest levels of authorised absence were (in two authorities) 6 and 7.4 per cent, while for unauthorised absence the figures were (in five authorities) between 0.5 and 0.9 per cent. The equivalent figures over the same three year period at the secondary stage showed the national average attendance at 88-89 per cent, authorised absence at 10-11 per cent and unauthorised absence at 1 per cent. In the 1998/99 session the highest figures for authorised absence at the secondary stage were (in eight authorities) between 10.1 and 16.5 percent, while eight authorities registered between 2 and 4.1 per cent unauthorised absence.

Even allowing then for substantial variation between schools (and between different years in secondary schools), *very significantly larger numbers of pupils are involved in authorised absence than unauthorised.* Malcolm *et al's* data, gathered over two terms, allows comparison between the fourth year national average figures of 12 per cent and 2 per cent respectively of authorised and unauthorised absence with their own findings of 8.3 per cent and 4.7 per cent respectively of explained and unexplained absence (Malcolm *et al* 1996:7). Again, 'explained absence', heavily outweighed 'unexplained', although the differential was smaller than in Audit Unit statistics.

While the proportion of authorised/explained absence registered as absence on medical grounds can be relatively easily calculated at individual school level from registration printouts, national statistical data is not available. The Scottish Office does not request it from schools, a point salient to this discussion. School experience is that pupils registered as absent on medical grounds comprise the largest proportion overall of absences. The neglect of absence on medical grounds as an issue for debate and possible development is, therefore, surprising, especially in contrast to the substantial resources spent on the much smaller numbers of pupils presenting discipline and/or truancy problems.

Are there practical, ethical or attitudinal barriers to confronting this issue? There are, of course, many competing heavy demands on education staffs' time and thought. A quiet, intermittently absent and debatably poorly population, probably assumed to be safe in bed rather than involved in crime when absent, are not in an obviously strongly competitive situation for attention.

The already mentioned dominance of truancy/absence, discipline and exclusion in Scottish educational thinking obscured to some extent other important issues. There may also be a perception that some types of 'explained/authorised' absence may be too personal and sensitive to challenge, touching as some of them do on family beliefs and culture. There could be concerns about civil liberties and state intervention in personal matters. Family funerals and weddings, religious observance, court appearances and visits to overseas relatives ('heritage visits') can hardly be denied, although schools are now challenging the last along with holidays in term time for any pupils.

The Scottish Executive requirement for only aggregated authorised absence figures suggests to schools and authorities not only that sub-categories such as 'medical' may be unimportant in themselves but also that they may be less amenable to improvement than unauthorised absence. However, although concepts of health and illness are highly personal (Bury 1997:32) and often deeply rooted in family cultures and histories, they are constructs which may be amenable to beneficial change, particularly if the environment in which they are experienced also changes. A bored and lonely pupil may go off school with 'flu' while the same symptoms may be identified as an inconvenient 'sniffle' by a socially and academically engaged pupil continuing to attend school.

A cynical view might be that absence is not invariably unwelcome to teachers, especially absence of children perceived as problematic in behaviour or learning. The writer will suggest later that some children absent on medical grounds come to be seen as 'bad pupils', along with other more obvious candidates for such labelling. Teachers may not then press for their improved attendance.

Much change in educational policy has been stimulated by parental action (Munn 1998). However, parents of ill children are often preoccupied emotionally and physically with their child's condition and have little time or energy to spare for campaigning in relation to education. The links of poor health with lower socio-economic status (Acheson Report 1998) may mean that some parents already feel disempowered. Parents of children reported as 'ill' as a cover for truancy may collude willingly or unwillingly with their absent children and are also likely to 'lie low'.

The incidence of significant ill health and medical conditions in children has been shown to be underestimated by education staff who suggested, in a national survey of education authorities, figures as low as one per cent (Closs and Norris 1997). The British Paediatric Association *(1995),* however, estimated on the basis of research and available medical statistics that around ten per cent of the child population have a chronic health condition which affects their everyday functioning. Since this figure does not include children with acute or routine 'one-off' illnesses, the underestimate of education personnel is very substantial indeed. This assumption of low numbers makes the lack of focused educational thought more understandable, if not excusable.

Low levels of knowledge, understanding and personal experience in education staff, teachers and policy makers about medical matters and their implications for educational practice is widespread (Eiser 1993, Larcombe 1995, Closs 2000). Lack of empathy and interest results from this and the motivation to include children with medical conditions may be low as a result (Ward, Center and Bochuer 1994). A particular issue in relation to attendance is the need to accept that, for many

children, their state of health is not dichotomously either 'fine' or 'ill' - it is someplace in between, a state which teachers found hard to understand and even harder to address with pupils in school (Closs and Norris 1997).

Linked to this conceptual difficulty is a practical one. Many schools also lack what they feel is adequate medical and paramedical support. In some areas there are no school nurses, and auxiliaries may not provide support that would enable a child with a health difficulty to attend school rather than be absent. School doctors under time pressures may not be able to contribute to staff development. National guidance on issues such as medication and medical treatment in school is long awaited in Scotland and teachers' Unions are resistant to teachers being involved in such practices without training and legal indemnification.

Research has shown that most LAs in Scotland do not believe that it is the responsibility of schools to stay in touch socially or educationally with pupils absent on the grounds of health, although some do so voluntarily (Closs and Norris 1997). There was little realisation on the part of schools that absent children who had 'lost touch' were fearful of returning. Enabling learning, by sending and marking homework or collaborating with outreach teachers, was seen as an aspect of benevolence, not a school duty. It is interesting that in *The Truancy File* (Quality in Education Centre 1995) 'Andrea absent through illness' is depicted as being accepted and nurtured by her school, in contrast with 'Fiona truanting' who is neglected and rejected. The probability, as reported not only by many children and parents but also by schools and LAs, is that *both* Fiona and Andrea would be neglected.

Finally, could there be a particular resistance to addressing health issues and their implications in Scotland? Even in the days of 'categories' of special educational needs and disabilities, Scotland lacked one category used elsewhere in the UK and Europe, that of 'delicate' children. Are we too macho or squeamish to face that particular reality?

A CLOSER LOOK AT PUPILS ABSENT ON MEDICAL GROUNDS

Is it possible to group pupils absent on medical grounds in a way that would facilitate discussion of the nature of their absence, their educational and pastoral/guidance needs and the implications for policy and practice? During the writers' recent research (Closs and Norris 1997) discussions and interviews with LA and school personnel about pupils experiencing the full spectrum of medical conditions from routine, mild and transient to life-threatening, identified absence as a major issue. Discussion of absence inevitably led also to recognition of the wider population of absentees registered as 'medical' whose ill-health credentials were less sure.

A model of four sub-groups of pupils is proposed. The least troubling group, to themselves and to education staff, were those pupils who had average to good attendance normally but who had a straightforward one-off medical condition necessitating relatively short absence. This would have been credibly explained by parental communication and/or medical certification. These pupils would generally return when expected. Their conditions might be anything from a common cold to chickenpox, appendicitis or a broken limb. The key educational issue for these pupils was ensuring that they caught up with lost work on their return.

The second group were also clearly perceived as having 'justified' medical absence. They had more serious, longer term or chronic or recurrent conditions. Fluctuation or deterioration in such conditions could also be a factor. Acute eczema, childhood cancers, serious burns, orthopaedic surgery, or genetically determined conditions such as cystic fibrosis or muscular dystrophy exemplify the range. Education staff overtly accepted these children and their conditions and were sympathetic, especially initially. However, it was plain that many staff found the unpredictability of onset and duration of symptoms and absence, especially

where there was a negative prognosis, deeply troubling at a personal level. It was also problematic professionally in terms of planning and delivering education and ensuring progress. In interview some staff spoke of frustration, rejection or over-identification and distress (Leaman 1995). School-home contacts were sometimes strained or lapsed.

A third group were more nebulous and heterogeneous. Some of them may have had substantive medical problems at some point, as in the second group above, but were absent more often or longer than seemed justified. Such absence could be a preemptive measure by over-anxious parents or children who have been sensitised by previous episodes of illness, by children who feel they are no longer part of their school community after prolonged or repeated absence, or by parents who may have justified concerns about schools' capacities to respond to their children's needs (Eiser 1993, Larcombe 1995). Children who were perceived as 'different' or 'unattractive' by their peers, as a result of symptoms or treatment of a condition, may be bullied by pupils and even by staff. (La Greca 1990, Eiser 1993, Closs 1998). In other children there might be a question of mental health difficulties such as depression or of being part of a family whose difficulties found expression through real or presented ill-health. Other significant reasons could also underpin such absence; from unreported bullying, family problems and broken friendships - all recognised as of great importance to children and young people - to boredom and disaffection from school and poor relationships with staff. Children whose own, or whose family, value systems did not allow them to express disaffection from school more overtly could be prone to 'medical absence'. Education staff responses to this group of pupils were very varied and included empathy and support but commonly also perplexity, frustration and irritation. This group of children will need learning and 're-entry' support, a few may need professional individual or family counselling, and some will also need emotional and friendship 'scaffolding' with their peers, a task for skilled and empathic teachers.

Finally there are the pupils for whom medical reasons are one of a range of fronts for truancy, with or without parental collusion, a factor referred to by Malcolm *et al* (1996) and earlier by Munn and Johnstone (1992) and the Pack Report of 1977. The general school response to all but the most blatant cases, for which formal procedures of investigation would be set in motion, is of impotent frustration and anger, occasionally tinged with relief. This writer would also suggest that, with the publication of league tables and attendance targets, some schools may now fall in more readily than before with a medical 'excuse' rather than record an 'unauthorised' absence. Some of the approaches mentioned in relation to the third group may also be necessary also for this fourth group. A climate in which schools could report and reflect with honesty on their practices and statistics without fear of censure would also be a significant contribution to positive action.

While pupils in the first group were broadly perceived as unfortunate but 'good', deserving of sympathy and support, those in the fourth group were perceived as generally undeserving and 'bad'. Pupils in the third group and even some in the second group, were often perceived initially as 'good' pupils but moved at varying speeds towards being perceived as 'bad' pupils. Whether this change in staff perception occurred or not seemed to depend on a number of variables such as staffs level of understanding of, and belief in, the reality of the medical condition, the length and frequency of absence, parents and children's responses to schools' expectations and efforts.

> It's a shame for him and us, we just start him on something and he seems to get hold of it, then off he goes again for another 2 days or 3 weeks, so it's one step forward and two steps back, again and again. It's all very tiresome

and after a bit you lose heart and, shamefully really, stop trying. If only he could just go off. really get better, then come back and stay back (Year Head, of pupil with recurrent kidney condition) (Closs and Norris 1999).

The writer suggests that, with the exception of the first group who are not at any serious risk, many of the pupils identified in the three other groups above could be supported towards better attendance and greater general well-being, provided policy managers and practitioners were prepared to address the relevant issues. As matters currently stand, only the absence-related issues of the fourth group are being actively addressed by the great majority of LAs and schools.

CONCLUSION: WAYS AHEAD FOR PUPILS ABSENT FOR GIVEN MEDICAL REASONS

Ways ahead can be summarised under the heading of legislation and guidance, staff development, and developments in school provision and practices.

Legislation and guidance

- The law in Scotland requires to be changed in line with the recommendations of the *Riddell Report'* (Scottish Executive 1999) and the proposed *Standards in Scotland's Schools etc. Bill* (Scottish Parliamentary Corporate Body 2000), Section 37, to give children a statutory entitlement to education when they have substantial unavoidable medical absence. This alone will certainly sharpen the focus on the whole issue of absence on medical grounds. Guidance on standards of provision, the locus of responsibility for making provision, the maintenance of home-school contact and procedures and support for returning to school will all be needed.
- Inter-agency and inter-service co-operation must be guaranteed in line with the *Children (Scotland) Act 1995* to cover the practical support of children with overt medical needs and those whose real needs may be more for guidance, counselling and pastoral support. Guidance should be issued to schools urgently.
- Children with health conditions which impact on their education, through debilitation while at school or through absence, should be perceived as having special educational needs and should be eligible for inclusion in special educational provision and arrangements including support for learning, flexible attendance, the setting up of Individualised Education Plans (IEPs) and, when appropriate, the opening of a Record of Needs.

Staff development

- The development of generic interpersonal skills is necessary for staff to listen actively to pupils and parents, to work with them sensitively and honestly, to acknowledge the reality of their feelings and experiences, to grasp the educational implications of these and to work co-operatively towards their resolution. This will be as important in working with absent or present pupils who have overt medical conditions (groups one and two in the earlier analysis) as it will be in working with those absentees whose medical absence credentials are more complex or dubious (group three) or probably fallacious (group four).
- Pupils in groups two, three and four might benefit from peer support and group counselling approaches. It would be important however that staff, as part of this process, also looked specifically at their own responses to illness,

death, psychosomatic and neurotic distress and attempt to resolve, or at least acknowledge, any personal barriers to working constructively with affected pupils.

- There is a very real need for education staff to understand more about medical and psychosomatic conditions and about family dynamics in relation to health, their implications for education and their psychological and practical impact on the lives of pupils and their families. The writer would suggest that greater understanding is a prerequisite to encouraging attendance and being able to deliver an appropriate curriculum within an appropriate affective climate.

Developments in provision and practices

- Many of the 'Ethos Pathways' of *Close to the Mark* (Quality in Education Centre 1997) such as the development of multipurpose support bases to offer individually tailored 're-entry' programmes after absence (or indeed to pre-empt it) would be invaluable to pupils with actual or apparent health needs.
- Although the 'Direct Attendance' Pathways suggested in *Close to the Mark* have overtones of policing wrong-doers, some - such as phoning the family at home when absence is first noted and regularly thereafter - also have much to offer children who are absent on medical grounds provided the approach is supportive and blame-free. Phonecalls, letters and mutually agreed home visits could also offer social contact and continuity with staff and peers to reduce detachment and disaffection from school and school phobic symptoms that may arise from prolonged absence of any kind.
- Local developments arising from national initiatives such Early Intervention and Community Schools should work in ways which enable children with health difficulties, present in school *or* absent, to be included.

These changes in legislation, policy and practice would reduce unnecessary 'medical' absence and enable the education of longer-term or recurrent absentees with substantive medical reasons for absence. They would ensure greater equity in provision of education and, in many cases, enhance social inclusion with peers and in the larger school community. Finally they would also enable children with significant problems in their lives to be happier in school, surely a valid aim in itself. Fortunately, although the precise nature and causality of the links between attendance, happiness and improved attainment may be open to debate, the three are certainly not incompatible.

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