IMPERIAL

Laidlaw Leadership in Action Programme:

Exploring international interventions for school absence

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Abstract

My Laidlaw Leadership in Action Programme offered a unique opportunity to work with international leaders in education, public health and child wellbeing from the Johns Hopkins University School of Medicine, the Bloomberg School of Public Health, Harvard University, the Rales Health Centre, Kaiser Permanente and Attendance Works, the leading US charity for advancing evidence-based school attendance solutions.

Through collaborations with multidisciplinary professionals, children and families involved in international attendance interventions, I obtained valuable insights into the multiple complex determinants of this major public health issue, the cross-sector strengths-based programmes required to address it, and the lived realities and experiences of those most affected.

This report draws together key international principles from this experience, highlighting how a public-health-informed, multi-agency, preventive approach to these determinants could improve attendance and support better long-term health, educational and socioeconomic outcomes for children.

Key Principles: School absence as a sign of child and system wellbeing, and unmet need. Cross-sector preventative, coordinated, strengths-based holistic responses

Attendance Works, Kaiser Permanente, Johns Hopkins Bloomberg School of Public Health, Harvard Department of Education and Twelve School Districts across the USA

In the US, almost one in four children are chronically absent, missing over 10% of school days (1). School absence has risen significantly since pre-pandemic levels (2), reflecting a complex interplay of individual, health, family, school, social, economic and environmental factors (3). Absence is a sign of child and system wellbeing, and a vital early warning indicator of unmet need (4). As absence is shaped by broader social determinants of health, addressing it effectively requires a preventative, cross-sector public health response rather than a school-led solution alone.

Across the US many organisations are advancing work in this field: the Bloomberg American Health Initiative and Kaiser Permanente's Thriving Schools are working nationally to improve health and wellbeing of school communities, the Johns Hopkins Centre for Social Organisation of Schools promotes equity and social justice in education, and Attendance Works, the leading national non-profit is partnering schools, districts, states, communities and US organisations to develop proactive evidence-based absence solutions (5–8). Others, including Public Health

on Call, the Healthy Schools Campaign and the Chronic Absenteeism Reduction Effort highlight the breadth of initiatives to align education and health systems for school attendance (9–11).

During my Laidlaw Leadership in Action Programme, I had the great privilege to volunteer with the All in for Attendance team and to learn more about their work (12). Their framework offers a compelling, coherent way of understanding school absence as a public health challenge, and a shared outcome of the environments, systems and relationships surrounding a child, rather than merely an educational or behavioural problem. Its three guiding principles are striking. Firstly, it argues that attendance data should be used as a vital sign of student and system wellbeing, capable of identifying need early and guiding action when linked to broader health and social data (13). Secondly, it emphasises strategic partnerships across health, education, local government, family, social and community services, coordinating care around aligned goals, with trust, shared accountability and family engagement. Thirdly, it calls for a shift from reactive, punitive responses to strengths-based policies and programmes addressing the true underlying determinants of absence with preventative, collaborative solutions and greater investment to create the conditions for all children to attend and thrive. This means funding services such as school-based healthcare, reliable transportation, universal free school meals, trauma-informed approaches, mentoring, family engagement, accessible learning, positive youth development and interventions that strengthen school climates and connectedness, co-designed around children's needs.

This experience reinforced for me the value of thinking across boundaries between health and education, between data and lived experiences, and between individual narratives of absence and the wider social, structural and environmental conditions that shape them. It highlighted how acting early to co-create supportive environments with children and families, preventing absence, is more powerful than addressing attendance difficulties once they have arisen. This model reinforced my observations in practice that attendance most often reflects whether a child feels well enough, safe enough, supported enough and included enough to participate in school life.

Key Principle: Using published absence data to drive population health and equity

Attendance Works, Kaiser Permanente, Johns Hopkins Bloomberg School of Public Health, Harvard Department of Education and Twelve School Districts across the USA

During this placement, I had the opportunity to contribute to a new project, Attendance as a Vital Sign, led by Attendance Works, Kaiser Permanente and the Johns Hopkins Bloomberg School of Public Health in twelve US school districts. Working with district leaders, charity

stakeholders, public health professionals and education experts, I gained insights into how cross-sector partnerships can address chronic absence through a population health and equity lens (14).

A particularly valuable aspect of this placement was exploring the publicly available US school attendance dashboards and state reporting cards, and observing how they facilitate population health insights, transparency, accountability and action. Enrollment, attendance, attainment and graduation data offer a population-level view of school participation, while disaggregated data reveals demographic, socioeconomic or geographical inequities (race, ethnicity, deprivation, disability, English learner status, locality), and areas of disproportionately concentrated unmet need. This can prompt investigation of underlying determinants, informing more equitable targeting of resources and responses. Public reporting of school attendance data also reframes absence as a shared community and systems concern, rather than a responsibility solely for schools or families.

Examining different data models for health and education integration, against US exemplars and appreciating how these facilitate earlier, coordinated, preventative action was fascinating.

Key Principle: Whole Child Support in School-Based Healthcare Programmes

The Rales Health Centre, KIPP Baltimore

Baltimore offers invaluable insights into chronic school absence due to its exceptionally high absence rates and dense, hyper-localised neighbourhood tracking infrastructure, facilitating cross-referencing of absence with local indicators. Through state-level At Risk for Chronic Absence (ARCA) monthly reports, neighbourhood-level data platforms such as the Baltimore Neighbourhood Indicators Alliance, and municipal databases, absence can be evaluated in relation to its wider determinants, understanding the systemic drivers and testing holistic, community-focussed interventions with leading universities (15,16).

Baltimore City Public Schools educate a large, highly diverse student population. In the 2025-2026 academic year, the district operated 150 schools, serving 76,362 pupils. Of these, 69.2% were African American, 20.2% Hispanic or Latino, 7.2% White, with fewer than 5% Asian or multi-racial, American Indian or Pacific Islander. 71.6% had low income, 55.5% received free or reduced-price lunch, 14.4% were multilingual learners and 15.1% had disabilities. 11,661 staff, including 10,591 school-based staff, cared for students, giving a student-to-teacher ratio of 15:1. 68.6% of teachers were certified and only 66 full-time school counsellors were employed. Only 28% of high school students achieved proficiency in reading and 6% in maths,

with an overall high school college readiness of 18.5%. Baltimore City Public Schools spent $18,753 per student annually with a total annual revenue of $1.89 billion (17).

Within this context, chronic absenteeism constitutes a critical crisis, with 49% of students missing 10% or more of academic sessions, and rates rising sharply after 2020 (18). Baltimore City illustrates how school absence is shaped by a convergence of social, environmental, health and educational determinants, with key factors including poverty, transport difficulties, chronic illness, violence inside and outside school, bullying, housing instability, mental health challenges, food insecurity, concerns about educational quality and a weakened student sense of connection to school. Chronic school absence is both a determinant and vital indicator of pupil wellbeing, with children who are chronically absent losing the equivalent of a full year or more of schooling across primary education, and consequences extending far beyond educational attainment to long-term health, social and economic outcomes (19).

The Ruth and Norman Rales Health Centre for the Integration of Health and Education, a Johns Hopkins Children's Centre programme, delivered in partnership with The Knowledge is Power Programme (KIPP), is an innovative comprehensive school-based model of healthcare, centred in CDC's Whole School, Whole Community, Whole Child (WSCC) framework (20). Situated in two co-located public charter schools in the Park Heights neighbourhood of Baltimore City, it provides holistic paediatric care for 1600 students, including comprehensive preventative and acute services, chronic disease management and family advocacy. Services include wellness programmes, proactive outreach, population health screens, vision, hearing, weight services, immunisations, behavioural, socioemotional, and neurodevelopmental skills support, mental health care, and family advocacy (21). The model, a national leading programme, offers continuity and individualised care for each child's needs, connecting families to community resources, housing, transport services, learning support and health insurance. Student health reviews are included in parent-teacher meetings, making each child's needs a school priority. Child-centred care is delivered by multidisciplinary health and wellness professionals, with a full health centre staffed by a paediatrician and medical director, a nurse practitioner, a medical assistant and two school nurses on the school site. A child psychiatrist visits the health centre monthly, and Rales Health Centre clinicians collaborate with mental health clinicians in managing students taking psychiatric medications. Multilevel wellness programmes for staff and students focus on physical activity, nutrition and health education, with sessions on social-emotional learning and restorative, trauma-informed approaches to school discipline and climate, led by a wellness director in conjunction with a Rales Health Centre faculty lead.

The Rales Health Centre model has achieved fantastic outcomes, with a 50% decrease in chronic absence among students with ADHD, and a 49% decrease for students with asthma.

Enrolled students had greater health and educational risk but demonstrated more educational growth than non-enrollees, with mean change from baseline for enrollees exceeding non-enrollees by 3.5 points (95% confidence interval [CI]: 2.2, 4.8) in maths and 2.1 points (95% CI: 0.9, 3.3) in reading with an adjusted rate of decrease in daily absenteeism 10.8% greater for enrollees (incident rate ratio 0.772 [95% CI: 0.623, 0.956]) compared to non-enrollees (incident rate ratio 0.865 [95% CI: 0.696, 1.076]). The Rales Health Centre generates over four dollars in net social benefit for each dollar invested, reducing missed school days and emergency room visits (22,23).

Volunteering at the Rales Health Centre, KIPP Baltimore, was a highlight of my leadership programme, revealing how children's health and education are inextricably linked (24). During my attachment, I encountered many narratives of absence: a young girl experiencing recurrent asthma exacerbations compounded by damp housing with frequent emergency department visits; disrupted absence following family moves driven by rent increases and housing insecurity; delayed vaccinations required for school enrollment due to caring responsibilities; families balancing the classroom benefits of ADHD medication against its disruptive effects on sleep at home; uncertainties around school attendance for a child with Kawasaki disease; untreated dental pain arising from barriers to accessing care; school withdrawal following persistent bullying and social isolation; recurrent minor illness masking transport insecurity; and epigastric pain linked to food scarcity. These cases illustrated how intersecting health, education, social, environmental and economic factors shape a child's ability to attend school, their sense of wellness and belonging. In almost all cases, missed school signalled broader unmet need, exclusion or inequity, rather than attendance alone. Positioning cross-sector care centrally in school-based health centres was transformative, enabling clinicians, educators and families to recognise attendance and wellbeing patterns, addressing concerns early with relational, context-sensitive, coordinated care and a full understanding of the child's lived realities, environments, relationships, and holistic needs. This approach was particularly valuable for identifying vulnerable students who might have otherwise fallen through the gaps between health, educational and social services systems. By addressing the wider structural determinants of absence alongside health needs, the model enabled whole-child support in a convenient setting, with minimal disruption to learning (25).

After this experience, I was honoured to be invited to write for CLOSLER, the journal of the Johns Hopkins Centre for Humanising Medicine, named in honour of Sir William Osler, one of the founding professors of the Johns Hopkins Hospital and a pioneer of modern medicine. My reflective piece 'School Absence as a Vital Sign' explores how school attendance should be regarded widely as a shared early sign of child and system wellbeing, inclusion and equity (26).

Key Principle: Embracing the Voices and Lived Realities of Children Absent from School

The Pull Up a Chair Initiative, UK

Volunteering with the #PullUpAChair UK creative arts initiative was one of the most formative experiences of my Laidlaw Leadership in Action Programme, transforming my understanding not only of school absence but of leadership itself (27).

Commissioned by Together for Children UK, this project uses creative arts, storytelling and participatory methods to uncover the authentic unheard voices of children and young people who are unable to participate fully in education or who are absent from school. Small group sessions led with remarkable skill, create a safe, validating environment for children to explore their experiences of school, usually surfacing hidden themes and barriers to attendance that had been difficult to articulate directly, particularly fear, trauma or distress. These had adversely impacted their social-emotional wellbeing leading to their absence.

A key strength of the programme is its relational, strengths-based approach, with thoughtful facilitation, non-judgemental adult communication and plenty of playful fun. Through simple, creative activities, children are supported to reflect on how their school environments, systems and relationships have impacted them, and to express what would help them to feel safe, included and able to return. Student voice is placed centrally to understanding. Storytelling, analogies and indirect forms of expression are powerful in enabling children to relay often-difficult experiences in safer, manageable ways. Over time, participants gain confidence to articulate their perspectives more clearly.

What was especially striking about this experience was that the children were not disruptive, unruly or wilfully defiant but socially sensitive and collaborative, with remarkable kindness, empathy, restraint and non-verbal awareness. As sessions progressed, it became clear that many children's absence had been consistently misunderstood at school. The children spoke not of their unwillingness to attend but of bullying, exclusion, relational harm, low belonging, poor system fit, ineffective adult responses or false school narratives. Several described how their talents or individuality had attracted adversity and how attempts to address this were ineffective. Others reflected on the absence of safe, trusted reporting routes, on adults who were dysregulated or defensive, and on school processes that were inflexible for their needs, leading to a gradual erosion of their emotional wellbeing and ability to attend. What was powerful was the way that their shared reflections appeared to validate their experiences, enabling them to appreciate these as wider relational and systemic dynamics, rather than personal failings. This realisation appeared relieving and liberating.

This experience profoundly shaped my understanding of school absence. It showed me that absence cannot be understood through registers, thresholds or formal categories alone, but only by engaging with the lived emotional realities that lie beneath them. It reinforced for me how easily absence can be framed as individual non-compliance or mental health issues, when it may reflect systemic, environmental or relational factors. The programme made visible how insight can be lost when adults rely only on direct questioning or administrative data, and how essential it is to create conditions in which children can speak in ways that feel safe, indirect and developmentally manageable.

I was struck by how transferable the methods felt. The tools used were simple, low-cost and readily adaptable to school or community settings, yet with expert facilitation their impact was transformative. Children left the sessions energised, connected and able to articulate their concerns clearly. Their final films and testimonials provided powerful, qualitative, personal insights into the realities behind their school absence and disengagement.

The metaphor at the heart of this programme, pulling up a chair before intervening, captures something fundamental about leadership: that meaningful action begins not with assumption or authority, but with the willingness to listen deeply before responding. This programme offered a powerful lesson in relational leadership, and the importance of creating space for voice, agency and meaning to emerge. This required trust, humility, patience and a genuine respect for the child's expertise in their own lives.

The programme reinforced for me that the most important insights into school absence reside with the children least often heard, and their lived realities. Creating the conditions in which these may be heard, is itself, a vital act of leadership, inclusion and prevention.

Key Principle: Digital Integration of Child Health and Education Records

Hamro Health School, Nepal

Working with colleagues in Nepal and the United States to shape a unified digital school health platform offered a powerful insight into the transformative potential and practical challenges of integrated digital child health and educational data systems. By connecting education and health records, attendance data, contextual information, parental communications, school nursing input and referral pathways, the platform supports earlier identification of need, improved coordination, stronger parental involvement, and greater continuity of care. It

illustrated how integrated digital infrastructure can assist a more timely, preventative and personalised response to children's health and educational needs. At the same time, the experience highlighted that the value of such digital innovation lies not only in technical design but in its ability to adapt to local context. In Nepal, implementation had to navigate a markedly different educational and health landscape from the UK and US, shaped by rural inequity, uneven digital access, workforce shortages, and often fragmented relationships between schools and health services. The experience of Hamro Health School revealed how technology can improve communication between schools, families and health professionals, supporting earlier collaborative interventions, but only when designed around the realities of local context, infrastructure, service capacity, cultural needs and resources (28).

In Tokha Municipality, Hamro Health School has digitised the health records of more than 9200 students, creating a secure system to document school-based health activity, identify issues such as vision problems, malnutrition, and chronic conditions, track population trends across schools and strengthen coordination between schools and the municipal health system (29). Hamro Health School has also linked digital tools to public health functions. Student profiles include growth charts, screening results, immunisations, allergies, chronic conditions, clinic visits, follow-up needs and referral information, as well as records of school-based health programmes such as deworming and iron supplementation (30). Parents receive regular updates and digital access to their child's information. Anonymous reporting aids planning and resource allocation at a municipal level, demonstrating the value of digital innovation and data to strengthen communication, local decision-making, and prevention.

Working with Nepalese school doctors and nurses highlighted how meaningful innovation is not simply about building advanced technology, but about developing integrated data systems that are locally relevant, adaptable and equitable, centred in the everyday realities of the communities that they serve.

Overall Learning Reflections

Across these leadership placements and attendance interventions, I have realised how school absence is rarely a simple failure to attend, but more often a vital sign that community systems are inadequately meeting children's health, developmental, or social care needs. Rather than signalling a single cause, school absence most often indicates a constellation of unmet needs, shaped by the intersection of health, relationships, poverty, socioeconomic instability, trauma, exclusion, family stress and environments in which children live and learn. Framing absence as an education-sector problem alone rather than a public health issue, limits the scope and

effectiveness of responses, compounding adverse long-term educational, socioeconomic and health outcomes for children.

The strongest responses to school absence across all these contexts were relational, strength-based, preventative and collaborative, bringing together health, education, social care, family and community support to provide individualised care centred around a child's lived reality. In England, the newly formed neighbourhood health centres (NHC) offer a unique opportunity to translate these principles into practice, treating attendance as a shared neighbourhood responsibility with tiered multi-agency support and integrated data systems. NHCs could enable child-centred care and earlier, coordinated responses to absence and its wider determinants across sectors. Effective NHC models must be psychologically safe spaces where pupil, family voice and lived experience are central to service co-design and evaluation.

Conclusion

Improving school attendance in the UK requires more than stronger enforcement or closer monitoring; it requires a shift in our perspective from single-system to cross-sector thinking and from educational to public-health-informed responses to address wider determinants. Instead of asking why children are absent from school, we must ask what is making school difficult to access, tolerate or sustain, what this reveals about their health, environments and relationships, and how cross-sector support can most effectively address these issues. Across the interventions observed, the answers differed by context yet converged on one essential truth: children are most able to attend and flourish in school when health, education, family, social and community support align around their holistic needs and lived experiences. Neighbourhood health centres in England offer the unique opportunity to build this alignment into local care and to transform attendance from a measure of failure to a shared outcome of healthier, more connected and more compassionate communities.

Leadership Reflections

Through this Laidlaw Leadership in Action Programme, I have learned that leadership is not defined by status, certainty, charisma or control, but by a deeper ethical responsibility to listen and learn, to reflect critically, confront complexity, challenge assumptions and translate insight into meaningful action, creating the conditions in which all individuals may thrive.

I have observed how leadership is often shaped in quiet moments of resolve and discernment, in kindness amid difficulty, and in the courage to remain open when understanding is partial.

I have seen how powerful leaders walk with others, listening without assumption and creating the agency, safety and trust for the quietest, most vulnerable voices to be heard with dignity, acting on their truths with integrity and accountability. Their authority lies not in their status or control, but in their moral courage to listen, serve and act.

I have come to see school absence as a public health issue and a vital sign of child wellbeing, unmet need, inequity and the capacity of systems to support and include children, demanding relational, preventative, strengths-based, cross-sector, neighbourhood responses.

Above all, I realise that the most profound insights into child wellbeing and learning in schools will only occur when the voices and lived experiences of absent children are fully heard and embraced to facilitate system growth and change, co-creating compassionate educational communities in which all children can truly flourish.

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