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Title page

Editorial: The role of community paediatrics in supporting schools to avoid exclusions that have a basis in health

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Introduction

School exclusion is not just an education issue, but is increasingly recognised as pertinent to child health (Parker and Ford 2013), with implications for how education, health, social care and voluntary sector services should interact to support children at risk in a holistic, integrated manner. Children who are excluded from school due to behavioural difficulties may have an underlying mental health or developmental condition which is unrecognised or inadequately supported, and the consequences of exclusion go further than a few days missed from school. This editorial aims to outline the risk factors for school exclusion, to explore the role of community child health services in supporting schools to avoid exclusions that have a basis in health, and suggests a potential care pathway by which this may occur. Although exclusion is clearly a cross-disciplinary issue, we want to clarify the role of the Paediatrician for those in other sectors who may have less experience of what medical services can offer in such situations.

The big picture

Schools can be an effective setting for promoting child health, yet it is argued that some are doing more to harm than to help pupil wellbeing (Bonnell et al. 2014). School exclusion is a disciplinary tool used to remove a child or young person from the school environment, and with the advent of 'zero-tolerance' behaviour policies, it is a practice on the increase internationally (Brownstein 2010). This is despite evidence that such disciplinary approaches seldom deter inappropriate behaviour and do not increase school safety (Skiba and Peterson 2000). The fact that children often experience recurrent exclusions (Parsons et al 2001, Theriot, Craun and Dupper 2010, Bowman-Perrot et al 2013) is testament that it is a practice that punishes rather than seeks to address underlying difficulties.

Although both permanent and fixed-term school exclusions in England are reported to be declining (DfE 2014a), there is concern that these data hide a much wider burden of hidden exclusion practices. The decrease in formal exclusion rates may not reflect improvement in the inclusion of children with behavioural difficulties; rather it may signify an increase in internal and unofficial exclusions, managed moves and parents being pressured to withdraw their child from school (experiences potentially as detrimental as official exclusions) (Munn, Lloyd and Cullen 2000). These practices particularly affect children with special educational needs and disability (SEND), as highlighted by the office of the Children's Commissioner (Children's Commissioner 2013), the Local Government Ombudsman (LGO 2014) and a number of charitable organisations (Ambitious about Autism 2014, Contact a Family 2013, Butler 2011, Evans 2010).

The most common reason for exclusion is persistent disruptive behaviour (DfE 2014). However, wide variation exists in the ethos of different schools with regards to children with behavioural difficulties; with one school's severely disruptive behaviour equivalent to another's minor disruption (Parker and Ford 2013), evident in observable differences between 'high' and 'low' excluding schools (Hatton 2013). Such variation in exclusion rates occurs despite Department for Education (DfE) legislation that exclusion should be a last resort in response to a serious breach of school policy, or where the education or welfare of the pupil or others is at risk of serious harm (DfE 2012).

Risk factors for school exclusion

School exclusion is a practice biased towards vulnerable children. National education data in England demonstrate that school exclusions are applied disproportionately to certain groups; including boys, some ethnic minorities (Black Caribbean, Gypsy/Roma and Traveller of Irish Heritage), children eligible for free school meals, looked-after children, and children with SEND (who account for 7 in 10 of all permanent exclusions). In the US, the disproportionality of exclusion rates amongst such groups (particularly African-American boys living in poverty) is also strongly evident (Bowman-Perrot et al 2013, Kreizman, Leone and Achilles 2006, Skiba et al 2002, Zhang, Katsiyannis and Herbst 2004).

A body of qualitative work suggests that children and young people excluded from school face a wide range of difficulties in different areas of life and throughout their life-course (Daniels et al 2003, Hayden 1997, Munn and Lloyd 2005, Parker et al 2015, Parsons et al 1994). Taking a broad perspective, exclusion may result from a complex interaction between child factors, family and home characteristics and school-level variables, which all occur within, and interact with, the wider community and societal context. Thus the problem does not reside solely within the child, as is often the perception, but results from a constellation of contributing factors.

Quantitative research on the wider characteristics and circumstances of excluded children is relatively sparse, particularly using population-level data. Although it is plausible that school exclusion occurs more frequently in those who have a neurodevelopmental disorder or mental health condition, there are surprisingly few studies testing this relationship (Parker et al 2014, Whear et al 2013). Beyond the demographic variables previously described, other factors associated with exclusion are shown in Table 1.

Table 1: Risk factors for school exclusion

Risk factors for school exclusion	
Socio-demographic variables	Male, Certain ethnic minorities, Children living in poverty, Looked after children and Children with SEND (DfE. 2014)
Additional pupil factors	Academic failure, previous suspensions and high severity of the last exclusion episode (Theriot, Craun and Dupper 2010) Rebelliousness, antisocial and violent behaviour (Hemphill et al 2013) Low social skills, and Emotional and behavioural difficulties (Achilles, Mclaughlin and Croninger 2007, Bowman-Perrott et al 2013)
Family and home risk factors	Single parent households, younger maternal age, low maternal education levels, low family income. Low parental expectations, involvement and satisfaction with the school (Achilles, Mclaughlin and Croninger 2007, Bowman-Perrott et al 2011, McElderry and Cheng 2014)
School factors	School mobility and urban schools (Achilles, Mclaughlin and Croninger 2007, Bowman-Perrott et al 2013) Low school commitment (reflective of school climate) and low school socio-economic status (Hemphill et al 2013) High suspension rate (Theriot, Craun and Dupper 2010) Smaller school size and lower attendance rates (Bruns et al 2005) High percentage of Black students and high percentage of students receiving free/reduced price lunch (Raffaele-Mendez 2003)

UK birth cohorts such as the Avon Longitudinal Study of Parents and Children (ALSPAC) offer an excellent opportunity to examine a broad range of risk factors for school exclusion across multiple time points in childhood. Analyses of ALSPAC data suggest that excluded pupils face multiple and wide-ranging difficulties compared to non-excluded children. Family and home factors showing strong associations with exclusion include low family income, family adversity and maternal psychopathology. Child factors include male sex, lower intelligence quotient, mental health difficulties, psychiatric disorder, social communication difficulties, antisocial activities, bullying or being bullied, low educational attainment, and special educational needs. School factors include lower school engagement and worse relationship with the teacher. Many of these difficulties are identifiable at or prior to primary school entry, giving opportunities for early intervention. There are particularly strong relationships between exclusion and mental health and social communication difficulties. Of children excluded by 8 years, 1 in 3 had scores exceeding clinically significant thresholds on the Social Communication Difficulties Checklist at 7 years and 40% had evidence of significant mental health difficulties on the Strengths and Difficulties Questionnaire prior to school entry. For those excluded at 16 years, the proportions were 15% and 20% respectively. These associations hold true after adjusting for appropriate confounding factors, and remain evident throughout childhood and adolescence (Paget et al 2015, Parker 2014).

Why does it matter? Consequences of school exclusion

School exclusion may compound the difficulties of children already vulnerable to poor health, educational and social outcomes. In the shorter term, exclusion may be ineffective in altering behaviour. It increases the likelihood of further exclusions and worsening psychological distress for the child, as well having significant impacts on families and others in the school (Parker et al 2015). Discontinuity in education is an important concern, not least because education and health are so strongly synergistic. Vicious cycles are generated because of the lack of professional support and adult supervision that may be associated with exclusion (AAP 2003), and such pupils risk becoming part of a lost group of children missing from education (NCB 2014).

In the longer term, excluded children have been shown to be at risk of a range of adverse outcomes including poor mental and physical health, substance abuse, low educational achievement, unemployment, homelessness, antisocial behaviour and involvement in crime (Arcia 2006, Berridge et al 2001, Daniels and Cole 2010, Hemphill et al 2006, Hemphill et al 2012, Parsons et al 2001, Pirrie et al 2011, Skiba et al 2003). School exclusion can be an important pathway towards educational failure and social exclusion, with huge potential costs to the individual, their family, the education sector, health services, criminal justice system, and welfare state (Commission for Racial Equality 1996, Scott et al 2001).

The Paediatrician's role

In 2003 the American Academy of Paediatrics (AAP) committee on school health highlighted that school exclusion is an issue that requires more attention from health care professionals, with recommendations targeted at paediatricians who can help schools understand and address the root causes of disruptive behaviour, and advocate for alternative disciplinary policies (AAP, 2003). In the UK, the response of the Royal College of Paediatrics and Child Health (RCPCH) and National Children's Bureau to the recent report 'Why children die' also called for a much stronger focus on

child mental health, particularly for children most at risk, such as those excluded from school (Wolfe et al 2014).

Paediatricians have an important role in advocating *for* all children's rights around health and wellbeing, and advocating *against* punitive practices that further disadvantage children with additional or complex needs. They can support educational services in providing, both through their own systems and through integrated services and partnerships, an environment and a range of resources that support pupil health and wellbeing and decrease the likelihood that pupils will engage in behaviours requiring disciplinary action (AAP 2003). Child health professionals also have an advocacy role specifically for children with long term health conditions and/or SEND who are being illegally excluded from school.

Paediatricians in England can refer to recent legislation on 'Supporting pupils at school with medical conditions' (DfE 2014b) in advocating that all children with medical conditions, affecting both physical and mental health, are properly supported so that they can play a full and active role in school life, remain healthy and achieve their academic potential. This legislation states that schools do not have to wait until a formal diagnosis is made before providing support to pupils. In cases where a pupil's medical condition is unclear, paediatricians may be involved to give medical advice on what support is required, based on available evidence. Paediatricians should co-operate with schools that are supporting children with a medical condition by providing appropriate information and advice about the condition, liaising with school nurses and other healthcare professionals such as specialist and children's community nurses and paediatric therapists, as well as participating in locally developed outreach and training (DfE 2014b).

There are a number of potentially harmful and discriminatory practices that children with medical conditions or SEND may be subject to in school, described in qualitative investigations into the experiences of excluded children (Ambitious about Autism 2014, Children's Commissioner 2013, LGO 2014, Parker et al 2015). Paediatricians can strongly advocate against these by referring to this legislation and DfE guidance, which clearly states that it is not acceptable practice to:

- Send children with medical conditions home frequently or prevent them from staying for normal school activities, including lunch, unless this is specified in their individual healthcare plans.
- Require parents, or otherwise make them feel obliged, to attend school to administer medication or provide medical support to their child, including with toileting issues. No parent should have to give up working because the school is failing to support their child's medical needs.
- Prevent children from participating, or create unnecessary barriers to children participating in any aspect of school life, including school trips, (e.g. by requiring parents to accompany the child).

Reference can also be made to the Equality Act (2010), which states that disabled children and young people must not be discriminated against, harassed or victimised, and that *reasonable adjustments* must be made to ensure that disabled children and young people are not at a substantial disadvantage compared with their peers. This duty is anticipatory: adjustments must be planned and put in place in advance, to prevent that disadvantage.

Finally, community child health services can help directly with the diagnosis of any underlying developmental or health conditions in children affected by exclusion. Community paediatricians

traditionally lead the multi-disciplinary 'team around the child' in such cases, and have expertise in co-ordinating a holistic and integrated approach to the investigation and management of children with additional or complex needs. Although we use the term Community Paediatricians, both General and Developmental Paediatricians, as well as those working in Neurodisability may have similar children in their caseload.

Current challenges

In reality, care pathways to assess and manage children presenting with disruptive behaviour may be ad-hoc or non-existent. Families may be pushed between education and health services, and between primary and secondary care, experiencing huge difficulty accessing appropriate assessment and support (LGO 2014, Parker et al 2015). Anecdotally it is reported that some schools even use the exclusion of a child as a gatekeeper to services, due to the high threshold of need that children are required to demonstrate (Parker and Ford 2013). Many such thresholds are arbitrary and do not reflect the spectrum of difficulties facing children and families, rather reflecting funding constraints and a binary distinction between those that meet criteria for a diagnosis and those that don't. In particular, the reluctance of service involvement in cases of children with 'only behaviour' may ultimately be counter-productive given that behavioural difficulties in children are strongly predictive of adult mental health problems (Kim-Cohen *et al.* 2003), and unaddressed may lead to escalating difficulties educationally, socially and with the health of the child and family. However it is difficult to prescribe which service is best placed to support such families, given all public sector services are currently stretched and struggling to see those children that do meet their referral criteria. Early intervention with good access to parenting courses and behaviour management training for school staff is key, as well as intensive support for those families at high risk (e.g. the Family Nurse Partnership scheme).

Another challenge is the significant disconnect that often occurs between services, with silo-working and failures in communication which further disadvantage the child and lead to delays in provision of appropriate support. The recent reforms under the Health and Social Care Act in England have increased fragmentation in the NHS, and may add further to unwarranted variation in accessibility and availability of services for children with complex needs. The move towards Education, Health and Care (EHC) plans may be desirable if it ensures that services are organised and integrated with the needs and preferences of the child and their family firmly at the centre; however this change also involves huge organisational challenges that services are currently struggling to overcome.

One speciality which is particularly struggling is Child and Adolescent Mental Health (CAMHS), and consideration of a care pathway involving CAMHS must acknowledge that demand for services is already far exceeding supply. Unfortunately this is the service within child health to which schools often aim to refer excluded children. The UK Government Health Select Committee (2014) recently concluded that there are 'serious and deeply ingrained problems with the commissioning and provision of children's and adolescents' mental health services, which run through the whole system from prevention and early intervention through to inpatient services for the most vulnerable young people'. Both CAMHS service providers and users report increased waiting times, rising referral thresholds, and inadequate service quality as a result of rising demand in the context of cuts to funding, all with potentially devastating impacts (House of Commons Health Committee, 2014). Meanwhile, a recent national survey of head teachers found that whilst training opportunities, the

use of screening tools and internal referral pathways are in place in some schools, staff have a tendency to underestimate behavioural and emotional problems amongst their pupils, and report an increased workload that has impacted on their ability to identify mental health problems. Over half of head teachers report local CAMHS to be ineffective in supporting their pupils (Taggart, Lee and McDonald, 2014). The lack of equity with physical health services for children and young people is inexcusable, and in response to the report of the work of the Children and Young People's Mental Health Taskforce in March 2015, the UK government has committed £1.25bn of extra investment in mental health services for children and young people over the next five years (available at <https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people>).

Moderate to severe disruptive, antisocial or aggressive behaviour is present in over 60% of cases referred to CAMHS (Audit commission 1999). From our own experience, similar children form a significant proportion of the caseload in community paediatrics, with problems manifest at school a common presenting issue. The complexity of clinical work undertaken in community paediatric services, and the role paediatricians play in the management of children with emotional and behavioural difficulties not meeting thresholds for CAMHS, should be recognised by commissioners of health services. Likewise, children with mental health issues are more likely to have sought help from teachers or from primary care professionals than either mental health or paediatric services (Ford et al 2007), illustrating that mental health really is 'everybody's business' and wider public sector services should be better acknowledged and supported in the part that they play.

An integrated care pathway for children who are excluded or at risk of exclusion

Guidance on exclusion from the DfE states that: 'Disruptive behaviour can be an indication of unmet needs. Where a school has concerns about a pupil's behaviour it should try to identify whether there are any causal factors and intervene early in order to reduce the need for a subsequent exclusion. In this situation schools should give consideration to a multi-agency assessment that goes beyond the pupil's educational needs.' For those children with identified SEND, the guidance states that school exclusion should trigger a review, including an evaluation of the adequacy of existing support (DfE 2012).

There is a need to expand upon the DfE's guidance and define integrated care pathways for the multi-agency assessment and support of children affected by exclusion. Helping schools avoid exclusions requires working through a pathway of identification, assessment, intervention and review of children and young people at risk. In Figure 1 we suggest a possible care pathway by which this may occur, with the purpose of stimulating discussion and challenging existing ways of working. However we are realistic in acknowledging the huge challenges (both organisational and financial) to operationalise such a care pathway, and recognise the need for such processes to be subject to detailed planning and economic modelling.

The care pathway aims to promote early intervention for children recognised as at risk of school exclusion, in order to help redirect them onto a more positive trajectory. Ideally such a care pathway would identify children before a permanent exclusion occurs to help prevent such damaging experiences; however we recognise the significant initial investment and workload this would require. It may be unrealistic to convene such assessments for all short term exclusions, but given

there is good evidence that such exclusions often precede permanent exclusion, repeated temporary exclusions should be used as a marker of children at risk.

To make such a care pathway work, professionals working in health, education, social care and the voluntary sector, need to understand each other's roles, establish clear lines of communication, and develop a shared understanding of the services and referral systems available in each area. Integrated working is facilitated by co-location of school health teams with community child health, CAMHS, social care and education services, with single point of entry referral systems. Close relationships with local schools is important, and some community child health clinics may effectively occur within school settings.

For early identification to occur, it is essential that all professionals working with children, particularly school staff (who are effectively front-line professionals in child health), have basic skills in the identification and management of mental health and developmental difficulties. This should enable them to identify children and young people who are vulnerable, and ensure that they know how to access more specialised services for those they cannot manage themselves.

As a starting point, there are some excellent resources available which services can use and signpost others to. DfE have published guidance on mental health and behaviour to help schools identify and support pupils who are having difficulties, and make appropriate referrals to specialist agencies where necessary (DfE 2014c). Two recent framework documents on mental health and emotional wellbeing in schools add further evidence-based, straightforward and practical guidance for schools and services (PHE 2015, Weare 2015). MindEd, a free online training tool, is also available to enable anyone working with children and young people to learn more about specific mental health problems (www.minded.org.uk), and guidance produced by the Royal College of Psychiatrists clarifies which children need referral to CAMHS (<http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr195.aspx>). The Council for Disabled Children have produced a set of information resources (available at www.councilfordisabledchildren.org.uk), with the 'Information about behaviour' resource particularly useful for families and professionals alike. Other useful resources include the NICE guidelines on antisocial behaviour and conduct disorder, ADHD, autism, social anxiety disorder, and social and emotional wellbeing in children and young people (available at www.nice.org.uk). These guidelines commonly emphasise the need for education, social care, paediatric services and CAMHS to work together to develop effective local care pathways.

If school staff and/or parents have concerns about a child or young person, these should be acted on and not left until the crisis point of exclusion. Once a child is identified with significant behavioural difficulties, the integrated care pathway recommends that the school should convene an initial multi-agency information sharing and planning meeting, with input from parents, teaching staff, and others such as the Special Needs Co-ordinator (SENCo), school counsellor, school nurse, primary mental health worker, or educational psychologist as appropriate. It is of vital importance that the child is kept at the centre of this process and their views and experiences actively sought. Taking a holistic approach whereby protective and exacerbating factors at school, at home and within the child, are explored, should prevent the blame being solely squared at one target, as disruptive behaviour is likely to be multifactorial. An ethos of shared responsibility and a consistent joined up

approach between school, home and any services involved should be encouraged, with tools such as the Single/Common Assessment Framework (SAF or CAF) a useful aid to this.

Some schools employ a specific family liaison worker as part of their pastoral care system, who can aid partnership and communication between school and home. They may also act as the school counsellor and/or SENCo, and schools that prioritise this as a full time position (rather than as additional duties on top of a teaching position) have found this to be a worthwhile use of resources. Some schools have a regular meeting with a member of the community child health and/or CAMHS team where they can discuss specific cases and get advice and support about starting baseline assessments, early intervention strategies, whether a referral is appropriate and to whom. Such meetings may help schools decide in difficult cases which children require which services, given service limitations and that not all children may need to be seen by all services. Screening tools such as the Strengths and Difficulties Questionnaire (www.sdqinfo.com) can help to identify children and young people with more severe behavioural difficulties requiring a higher level of assessment and support.

Intervention should be offered in a tiered approach, with initial support from school nurses, primary mental health workers, school counsellors and school pastoral care staff utilised effectively and in good time. Active treatment of behavioural difficulties requires easy access to parenting training courses, as well as training for teachers and teaching assistants on behaviour management in the classroom, as this is most common reason given for exclusion (Parker 2014). Voluntary sector services clearly have an important role to play, for example, the excellent charity 'Place2Be' which provides in-school counselling services, support and expert training to improve the emotional wellbeing of pupils, families, teachers and school staff (www.place2be.org.uk). The role of social care is also essential, for example through contributing to assessments (e.g. SAF or CAF) and providing parenting and family support.

For young people experiencing mild to moderate mental health problems, there should be increased access to psychological as well as other therapies in schools or in the community. The current expansion of the Improving Access to Psychological Therapies (IAPT) programme for children and young people should help enable this (www.iapt.nhs.uk/cyp-iapt). Children who are displaying more severe difficulties can then be prioritised for referral to specialised services. Ideally all secondary schools should have routine access to a named primary mental health worker, either on site or through an effective referral pathway to CAMHS, to enable access for more complex conditions (e.g. where there are also parental mental health issues).

However the majority of children with moderately severe behavioural problems will need to be referred by school nurses for a more general paediatric and developmental assessment. This assessment by the community or developmental paediatrician should result in a formulation of the child's presentation, specifically seeking evidence of developmental disorders or traits commonly associated with behavioural difficulties, such as ADHD, ASD, or conduct disorder. Although such diagnoses are not usually made in a one off clinic appointment, the paediatrician can direct the child onto the correct pathway as appropriate e.g. an Autism Spectrum Condition assessment. Other potential associated problems may be considered, such as learning difficulties, hearing, vision or physical impairments, speech and language disorder, developmental co-ordination disorder, emotional disorders, sensory issues, genetic conditions, pain or discomfort or dental problems, to

name but a few. Paediatricians should also assess whether the behaviour is occurring in response to any particular stressors in the child's life, such as bullying or abuse, and should also consider the parents' or carers' mental health.

Depending on the outcome of the assessment, the paediatrician can then make referrals to CAMHS or other child health professionals for further assessment and management as required (e.g. Speech and Language Therapy, Occupational Therapy, Physiotherapy, Audiology, Ophthalmology, other Paediatric specialities), and advise on potential interventions or support needed in the shorter term. If long term management of a health or developmental condition is needed, the paediatrician can be involved in regular review of the child's condition, service provision and effect of interventions, ensuring that the situation is reviewed at least annually or if the child's condition changes. If the child requires an Education, Health and Care plan, the paediatrician should contribute to this, clearly describing the child's strengths and difficulties, the required support and desired child-orientated outcomes. The paediatrician may also be involved in delivering, commissioning and/or advising on any appropriate training needs for school staff in relation to the child's condition. A structured annual review will ensure that interventions are appropriate and effective, and plan for transitions such as moving to secondary school.

Overall, the assessment and management of children excluded from school should occur in a holistic, multi-disciplinary manner, ideally when the child is identified at risk, allowing opportunity to intervene and reduce the risk of the school placement breaking down. Intervention should address the child's needs directly as well as identifying contributing factors in the family, home and school environment, and progress should be reviewed regularly.

Economic context and commissioning

There are huge financial considerations in providing such services in a time of austerity, but such early intervention makes sense from an economic and public health perspective, as well as potentially improving the life chances of individual children. Although a full economic model of the suggested care pathway is beyond the scope of this paper, we envisage a model would work out as cost-effective, given the potential long term cost-saving implications to Local Authorities. Up to date accurate figures are unavailable, but a conservative estimate from almost a decade ago puts the cost of each excluded child to society at £63,851, given the costs to the education system, health and social services, as well as the impact of lower earnings and higher crime (NPC. 2007). Other estimates have been significantly higher than this, including an estimate of £300,000 per excluded child (Reid 2007), and given the huge annual costs of a place at a Pupil Referral Unit alone, such estimates are likely to be more realistic. Now that the UK government seem to be accepting that child mental health in particular needs more resources, we must keep making the argument that investment into secondary prevention in the early years can be cost effective, as it saves specialist healthcare costs (e.g. CAMHS) later and results in better educational attainment (leading to higher earnings and taxes) and reduction in criminal justice costs.

We of course acknowledge the difficulties in funding in NHS, educational support and social care, and the added complexity of the new funding landscape with a plethora of commissioners. The movement of commissioning of school health to local authorities, and of secondary locality-based paediatrics to Clinical Commissioning Groups (CCGs), could have the advantage of achieving more joined-up understanding to support an exclusion care pathway (which will be the only way that such

complex issues will be funded in the future). Commissioning of services to support child health in schools must have input from all parties involved, via the local Health and Wellbeing Board, to ensure it is as responsive to the needs of the local population as possible. However it is interesting to note that a paediatrician's role in advocacy and public health may sometimes conflict with their involvement in the commissioning of child health services within tight funding constraints.

Take home message

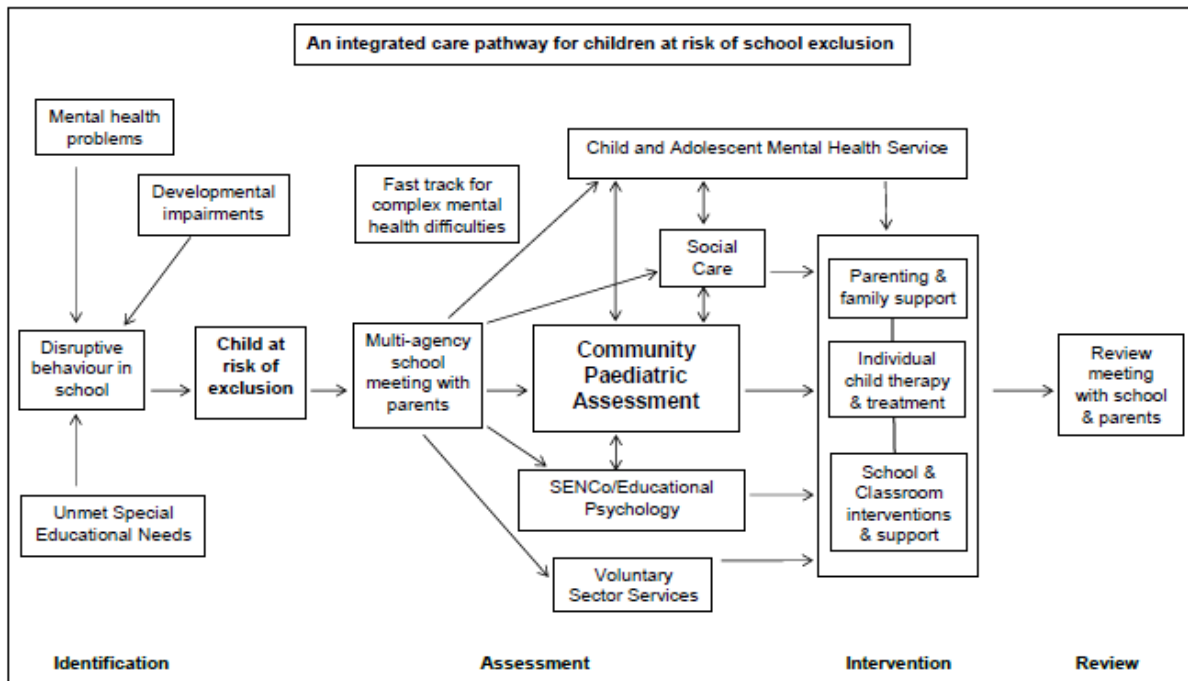
School exclusion is associated with a range of child, family and school-based risk factors. Many of these risk factors are present early in childhood, and potentially open to early identification and intervention. Children who are excluded, or highlighted as at significant risk of exclusion, warrant a multi-disciplinary assessment to identify any unrecognised or inadequately supported difficulties underlying the disruptive behaviour, particularly mental health or developmental conditions. School exclusion is not simply an education issue and community paediatricians have an important role to play in assessing, supporting and advocating for children at risk. A proposed integrated care pathway aims to promote inter-agency co-operation to improve early identification and intervention.

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Appendix

Figure 1: A care pathway for children at risk of school exclusion



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