HEALTH NEEDS OF SCHOOL AGE CHILDREN

The views of children, parents and teachers linked to local and national information

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EXECUTIVE SUMMARY

Background

It is well recognised that the pattern of disease in children has changed markedly over the past 50 years, since the NHS came into being. Mortality has fallen, but a significant proportion of children are now growing up with longstanding medical conditions and disabilities; emotional and behavioural problems have become a significant feature in many children’s lives. There has also been remarkable growth in knowledge of the mechanisms that lead to ill health in children and that promote their optimal development – as well as in treatment approaches and technologies. But the complex inter-relationships of the many influences that can make an impact on children’s health are still incompletely understood, as is the effectiveness of many of the traditional ways of providing treatment and care services. If “health” is taken to mean physical, mental and social well-being, and “health needs” are taken as the ability to benefit from service provision, there is at present no up-to-date and comprehensive picture of the health needs of children in this country, over their vitally important school years.

The study

The health needs of primary and secondary school-age children were studied in four parts of England: a rural locality in the South West; a suburban city locality in the North East; an inner city locality in the Midlands; and a mixed country town/rural locality on the South coast.

The core data for the study were obtained by means of separate focus groups with primary- and secondary-school pupils in each of the local areas, and with parents, teachers and school staff at the same primary and secondary schools. We also gathered information about children’s health needs from other school staff (particularly the head teacher) and the local education authority, and from many others working in children’s services in each of the four local areas: primary health care, acute and community child health, child and adolescent mental health, health promotion, social services, education welfare, educational psychology, special needs, the voluntary sector, the youth service, and youth justice services. Further information was obtained from a number of sources of local data such as Children’s Services Plans.

Findings

The published literature on the health needs of children

This was not an epidemiological study. However, reasonable estimates of children’s needs in terms of disease conditions and the presence of risk factors can be made from a review of the literature. The pattern of health needs is summarised below.

Although children are much less likely to die in infancy and childhood than in previous times, and the incidence of many diseases (notably infectious diseases) has fallen - often dramatically - a significant proportion of children in England today live
with increasingly complex and often new health disorders and/or major risk situations for their health and future functioning and wellbeing.

There is evidence that a significant proportion of children have health needs at the time when they first enter school in England - at 4 or 5 years old - which may or may not have been identified and managed by preschool services. These problems will include hearing impairment; communication problems, speech problems and language delay; problems with vision; problems with growth; conditions such as clumsiness and cerebral palsy, allergies, respiratory conditions and asthma; longstanding and severe disorders such as cystic fibrosis and sickle cell disorders; a range of conditions that are disabling; and emotional and behaviour problems.

Further health problems may arise during the school years: such as accidental injury, new onset of conditions such as asthma, varying degrees of complications of longstanding conditions, especially emotional and behavioural disorders, acute episodes of varying degrees of nuisance and seriousness (from head lice infestation to meningitis), and the emergence of eating disorders and obesity and health risk behaviours such as smoking and substance misuse.

Certain children and those living in certain situations and localities have particular risks and particular needs. Clear examples are given by children who have chronic illnesses and disabilities and by children from families living in conditions of socio-economical disadvantage, and who are poor (identified as eligible for free school meals). Children who are looked after by the local authority have multiple risks, with telling findings reported that in the Oxfordfordshire care system, 67% of adolescents had psychiatric disorder compared with a 15% prevalence among those living with their own families; for adolescents in residential care, a rate of 96% was found (McCann et al 1996). In addition, children who are carers, children who have parents with mental illness, and children from refugee and newly immigrant families are likely to have particular health needs.

There is good evidence that children excluded from school are a particularly vulnerable group, with multiple risks for mental health problems, many living in disadvantaged communities, and in families facing poverty, social isolation and lone parenthood (OFSTED 1996); 21% of the children excluded from the 39 schools studied by OFSTED were in the care of the local authority at the time of exclusion. School exclusions are rising, with 13,500 permanent exclusions in 1997, a rise of 10,000 since 1990.

The findings of our study focus on the extent to which different types of needs are met and in what way, in order to identify unmet needs and how services might develop, in line with evidence of effectiveness and local and national priorities.

**Health promotion**

All children need accurate information, advice and skills in order to promote healthy behaviours, for example, with regard to healthy eating and drinking alcohol. Some groups have particular needs; examples are given by:
(i) school populations that have a high proportion of children with emotional and behavioural problems, where whole school approaches to raising self-esteem may be indicated;

(ii) children from traveller families who frequently miss out on routine primary care and preventive services – and schooling - where targeted outreach services may be indicated. Targeted approaches have also been shown to be effective in risk populations of children within schools, such as those using alcohol.

We found that, together, local Health Promotion services and the PSHE curriculum were doing well in providing information; the children, in general, were well informed on a full range of health matters, but with regard to both sex education and drugs education, it was felt that programmes should start with younger children than at present. However, what older children told us showed that they did not have robust positive attitudes, nor the necessary skills to deal with the pressures (from family, peers, the community environment, and the media) that encourage risky behaviours. The development of attitudes and skills that enable healthy choices to be made, depends on children having opportunities for frank discussion and safe exploration of their views and attitudes (teachers are often not the best people for this, nor is the school nurse unless specially trained and skilled), and access to accessible local sources of continuing, credible, confidential sources of advice. These opportunities can be provided by or in the school. In rural communities, services on the school site and linked to the school day may be very important. In cities and towns, walk-in facilities are useful. Easily visible information needs to be available wherever a young person may see it - posters in the GP surgery, the library, the youth club, the chemist etc., backed up by an appropriate range of local services. Young people need a range of people who have the time and capability to talk to them, and to be assured of confidentiality, the credibility of the adult in that role, information and advice that is relevant to them as an individual, and continuity in their access to a helping adult. The value of informal situations as is presented in drama, gym and dance clubs, and sports cannot be overestimated. Again, particular approaches may be needed to ensure access for hard-to-reach children, such as habitual truants and children excluded from school.

We found that children frequently felt that they had little or no control over the basic day-to-day decisions affecting their lives and lifestyles, so that their own knowledge and capabilities could not be exercised. Even where children were members of the school council, their perception was that they were not properly listened to nor their concerns adequately responded to. Peer-led approaches show evidence of effectiveness in research studies, and were reported with satisfaction by children in our study.

Parents are of the utmost importance in promoting their children’s health. All approaches based in schools will have greater effect if they involve parents, and parents expressed many needs of their own (eg. up-to-date knowledge about drugs) which the school can help to address. We found much less involvement of parents once a child has left primary school, especially in rural communities. Parents often felt uninformed and powerless to influence their children’s eating habits and TV watching, for example.
With regard to health promoting activities and to a range of health care concerns, the respective roles of school and parents are exceedingly unclear and tend to differ in different places as well as over different issues. The respective roles of parents, the school, and the school health service – principally the school nurse – also differ. The school may be regarded as an integral part of the local community - as a resource as well as a beneficiary – or not. The extent to which parents, the health service, and the school share with each other, relevant information about the child forms the basis for meeting each child’s needs. A great deal of unmet need reflects lack of local community commitment to children and families (and thus also to local schools) in matters such as play and sports facilities, transport, libraries, and more general Family Support. Because of poor transport, limited facilities, and the cost, we found widespread inequity in the opportunities for children and families to avail themselves of healthy lifestyle facilities, whether in cities, towns or rural neighbourhoods.

Contemporary life gives emphasis to certain needs for children’s health, such as safe arrival at school when parents do not accompany them. At present no statutory service has the capacity fully to meet such needs. Elements of current service “systems” such as school catering arrangements, and the length and timing of the school day are often at odds with what is known to be best for children’s health. There is often a mismatch in assumptions about the capabilities of parents, of schools, and of the health and other services, so that they work at odds whereas they could reinforce each other’s efforts. For example, teachers may see the need for a child to have more nutritious meals, to get more sleep, or to watch less television, but in spite of the parents agreeing with this, no changes seem to be made. And parents who genuinely want the best for their children seem often to feel the need for the school’s support, for example in “requiring” that children get to bed earlier.

The management of illness
The arrangements in school for the management of illness such as asthma attacks, varied in such matters as which person had charge of inhalers, and whether teaching staff had received training (or remembered it). Arrangements for the administration of medication, Ritalin and the general management of children with ADHD in particular, differed widely and caused much concern. This is mirrored by the differing relationships that we found between schools and different elements of the local child health services: the school nurse, the school doctor, paediatricians, GPs, and specialist services such as the child and adolescent mental health service. Between these services themselves, the relationships and how responsibility is shared for managing particular types and severity of problem also differed widely. School staff largely felt inadequately informed and prepared to support children with rarer and stigmatising conditions, such as epilepsy, sickle cell anaemia, and mental health disorders – although crisis arrangements were usually in place. With regard to these children, there was a feeling that neither parents nor the child’s specialist fully appreciated (for the child’s sake) the need for the school to be informed and supported, nor the value of the support that the education system could provide. There is an issue as to how to achieve increased availability of the resources to meet even well recognised children’s health needs within the education system, via local commissioning and service agreements.
**Special Needs and Disability**

In all locations, concern was voiced about a lack of adequate training and resources within mainstream schools to support learning for pupils with statements of SEN. Particular difficulties were reported in relation to those pupils with identified needs but whose provision was considered capable of being met within the school’s resources and not the subject of a statement. Where local policies had led to inclusion of nearly all pupils with SEN in mainstream, it was suggested that those pupils were often unable to take full advantage of school opportunities. Learning support for pupils not attending school, for whatever reason, also tends to be severely limited, although in some places, children were receiving tuition and supervised activities for a greater part of the school day, with the hope of increasing the hours by means of internet connections that were being developed to the children’s schools. Concern was expressed that the development of behaviour support services might squeeze learning support resources.

Real problems were described in coordinating the provision in school of various types of support and therapy, and in fitting this in with an individual child’s school timetable. The enormous range and heterogeneity of special needs that might be present in any one school caused a great deal of anxiety among staff, and concern about the availability of the range of special skills needed to meet these. Schools frequently had no suitable room or facilities for therapy or for confidential counselling.

All mentioned a lack of preventive and early intervention services for reading and speech delay, and in developing social skills and play etc. For primary school children in particular, this meant that low self-esteem and emotional literacy were not addressed and that vulnerable children remained at risk of developing behavioural problems that would in turn, interfere with learning.

The management of mental health and behaviour problems was a major concern among all the individuals and groups with whom we worked, with the expected exception of the children themselves who confined this discussion to matters of “stress”. However, secondary school children reported a lack of accessible, sympathetic and trustworthy sources of advice and help over stress-related, relationship, and emotional health concerns. Parents did not know where to turn for informal informed advice, if they could not find someone at or through the school. School staff in general reported their own lack of time, knowledge and skills to manage and help children who were at a disadvantage in the classroom and playground because of emotional and/or social development delay or disturbance. School staff were acutely aware of the needs of these children, and all the more frustrated because of the limitations of their capabilities and those of the relevant specialist and multiagency services to work with schools to help with a whole range of approaches.

**How health needs are assessed**

Knowledge at school entry about the health needs of individual children now depends, in almost all places, upon an interview carried out with the child and parents by the school nurse with added information passed on from the preschool services. In some
schools, the school nurse also compiles a health profile of the school population. However, information tends to be lacking for the most vulnerable children who may have missed out on preschool services, or whose parents do not pass on useful information to the school. The extent to which schools act on information and advice about individual children’s health needs varies from place to place. We also found great variation in the extent to which schools and the local child health services responded to school health profiles.

The prevalence of certain problems and risk situations among children will differ in different schools. For example, it has been shown in research studies, that the prevalence of emotional and behavioural problems can differ widely between different schools within one city and certainly across one local education authority. Children’s needs will be met depending on the interplay between the capacities of parents, carers, the school, and local primary care and specialist services. But school health profiles do not, as yet, provide sufficiently in-depth assessment of health needs to direct the appropriate provision of services. Again, there is considerable variation in the extent to which local computerized information systems can provide accurate comprehensive information even about children with significant illness conditions. Throughout the country, there is a major shortfall in the translation of information about the disease and risk conditions of children into their needs for particular types of services to effect improvement.

In some places, special efforts have been made to consult with children and young people themselves regarding their health needs. So far, we have not heard of systems that allow continuing consultation with young people that would indicate how effectively service changes meet needs, and thus the direction for further improvements.

**What the study has shown to be the elements of a good service**

1. School entry is a prime opportunity for taking stock of the health needs of all children individually, and linking this to their educational needs and the opportunities provided by the school as a setting for the universal education service. Parents need to be given information at this stage about their children’s health needs, and about informal and formal access to local services.

2. This task should be undertaken by the local child health service, working with the local education authority and with schools as one (supremely important) setting for the promotion of children’s health and the delivery of health services where this best meets the needs of individual children. In this model, a school health service, as such, does not exist but the school becomes an important part of the service system for children’s health and well-being, as it is above all, for their education and social development.

3. A health interview with each individual child at the time of entry to primary school will also form the basis of individual school health profiles which are needed to plan and monitor whole school approaches in health promotion, support to teachers, and targeted programmes, on a continuing basis.

4. Local child health services should take the lead in work with schools, the local health promotion service, and other relevant local services to develop comprehensive health promotion programmes that are tailored to meet
children’s needs in different circumstances according to age and specific local circumstances. Implementation of these programmes in schools should be based on the best available evidence of effectiveness, and pupil participation should, in any case, be an important component.

5. A designated member of the child health services should have sufficient time, the requisite seniority, knowledge, and skills, and designated responsibility to work with each school and its pupils to coordinate and obtain services to meet the health needs of individual children and of the school as an organisation, across all the relevant agencies and services. “School” nurses could play this role – many do already. But if they are to do this, significant changes need to be made to their overall numbers, their training, and to the structure of many local child health services.

6. Effective coordination of services for individual children and for schools will make a significant and positive difference in meeting children’s health needs. Crucially, the child health services also need to enhance the knowledge and skills resource within services that are currently available and also seek to augment these, in the light of contemporary children’s needs and of what is known to be effective in meeting needs. At present, mental health and emotional needs are paramount, and their pervasive influence on learning and in multiple risks to health are a major concern to all.

7. The school nurse cannot do all the things that different individual nurses currently do. The local child health service, with the schools – with the health and the local education authority - needs to shape local services so that the health needs of all children are adequately assessed and acted upon, with agreed priority given to local development of certain types of provision for individuals and schools, as indicated.

8. The current indications are for three key general developments:

   a. the appointment of coordinators who can lead the development and management of services across all the relevant agencies and disciplines in and with each school on a day-to-day basis and contribute to strategic planning and monitoring;
   b. the training and deployment of sufficient clinical staff with new knowledge and skills, particularly in the field of emotional and behavioural health and also in complex physical conditions, to provide an accessible and acceptable service for children – and to support staff - in schools and local community settings;
   c. improved availability of specialist input, especially speech and language and communication therapy, physiotherapy, occupational therapy, and mental health expertise.

9. Many services promote both children’s health (particularly mental health) and learning. Local commissioners of both health and education services need to agree on the local needs for provision of these services and jointly to agree on how this will be resourced and evaluated. Apart from some programmes which should be developed universally, such as knowledge and skills regarding food and nutrition, and good facilities for exercise, priorities for others such as substance abuse prevention should be decided on the basis of school health and community profiles, and their impact carefully evaluated. Credit for positive outcomes needs to be shared. The achievement of schools
as well as that of the health and social services should be measured by their progress towards targets relative to baseline levels of children’s needs.

10. An interagency strategic approach is required to meet the health, social care and educational needs of all children, linked to those of their families. This is particularly the case for children who, for one reason or another, are not attending school. Development in the appropriate resources and service organisation that will cost effectively match provision to children’s needs demands rethinking of traditional professional roles, training, skills, and relationships within and between health, social care, and education agencies and this should begin to be incorporated into local Health Improvement Plans and other joint strategies.
INTRODUCTION

There is now a good deal of published literature on the health of school age children, covering risky behaviours, mild, self-limiting and acute problems, and chronic, complex, severe and life-threatening disorders. Health is crucially important for optimum development in children and for them to be able to take full advantage of education and of being at school (Court Report, DHSS et al 1976). In addition, many kinds of learning that take place in the school setting are recognised as important for present and future health.

There are well-documented changes over time in the prevalence and manifestation of health problems in children (Alberman and Peckham 1986; Forfar 1988; Botting; Dale; and Mayall, In Botting (ed) 1995). Thus the needs of a population of school children in the new millennium are likely to be different from those of even 25 years before. At any one time, the levels and types of problem will differ according to population and environmental characteristics. Health care needs will be influenced by the currently available approaches in prevention, treatment and management, and the extent to which these are actually applied. There is growing evidence about how different types of needs can be met appropriately and most effectively.

The implication underlying determination of health needs is that, in order to be defined as such, the needs can be met or ameliorated by the provision of services or other known interventions (NHSME 1991; Wright et al 1998). But a somewhat limited picture of the health needs of children has, up to now, been given in the literature, especially when what is meant by “health” is as given in the World Health Organisation (WHO) definition: “a state of complete physical, mental and social wellbeing” (WHO 1947). In addition, the picture or profile of health needs has, until very recently, largely been based on counts of disease incidence and prevalence and has not included factors such as the accessibility and effectiveness of services, that are important in addressing unmet need.

It is increasingly recognised that what children themselves perceive as their health needs is highly significant and must be taken into account in the provision of services, as well as parents’ views on their behalf. The opinions of those with experience, knowledge and expertise in working with children also make a key contribution to understanding what is required of services. Up to now, the views of children and parents have received little systematic attention, and gathering the opinions of professionals has been limited in general or included only certain groups of professionals, notably paediatricians. The knowledge and experience that resides in the voluntary sector, in particular, has been neglected, although recognition of its importance has grown.

Following publication of the Green Paper on public health, Our Healthier Nation, the government set up a Healthy Schools Programme in 1998. Funded by the Department of Health (DH) and the Department for Education and Employment (DfEE), the aim was to build on the concept of the healthy school. The objectives were to promote educational achievement, and health and emotional wellbeing, thereby to support pupils in improving the quality of their lives lifelong (DH 1999). Eight pilot sites were established in different parts of England, to investigate issues such as: school
ethos and learning environment; planning, teaching and resourcing of personal, social and health education (PSHE); pupil motivation and attitudes to learning; focus on self esteem; planned opportunities for addressing specific health issues; working alongside other specialist agencies; support for pupil welfare and guidance; and provision for spiritual, moral, social and cultural development.

Linked to this initiative, the DfEE and the DH jointly sponsored a project on the health needs of children of school age. This project is reported here. Its main objective was to gather views about their health needs, from children and parents, alongside those of a full range of professionals and others who work with children. These are examined in relation to the published literature on health needs and on the effectiveness of services. This includes the contribution made by all services that may have an impact on the health of school age children, on the underlying premise – now well established – that multifaceted flexible approaches are required to meet the health needs of children. The aim of the project is to provide a more fully informed basis than has been available up to the present, for policy and strategic development of services for school age children in England.

1 In this report, school age is taken as 4 - 5 years of age up to a child’s 18th birthday, so as to harmonise with the definition of a child in the Children Act 1989, under which local authority responsibilities to children are defined. The words “child” and “children” will be used to cover this age range except where a distinction is made between younger children and older children/adolescents.
BACKGROUND

Children’s health in England

Children of school age are widely regarded as being the healthiest sector of the population. This is largely because mortality figures show that, after relatively high death rates in infancy, the rates in childhood are the lowest for any age group. In addition, very little information about the health of children in general has been collected and published routinely. However, in the past five or six years, a number of publications have brought together data and information from many different sources to present a comprehensive picture of the health status of children in England, and of the circumstances in which they live that present significant risks to their health. The following section sets out the key health issues for children of school age. Much of the material comes from the recent publications listed below, and subsequently. These are not referenced separately; references in this section are given only for sources of material not found in the following key reports:


Mortality

International comparisons show that the death rate for children aged under 5 years in the United Kingdom is higher than almost anywhere else in Europe.

The most common cause of death in school age children is accidents; the overall rates have been falling but accidents leading to long term disability and handicap are rising. Children in Social Class V are four times more likely to die in an accident than those in Social Class I. In 1997 the number of road traffic accidents involving young people under the age of 19 years totalled 72,154. Fatalities and serious injuries accounted for almost 16% of these, with most suffering physical injuries of mild to moderate severity (DETR 1997). Head injuries account for 15% of deaths of children aged 1-15 years, although the rate is falling because of fewer road accident deaths (Jennet 1998). However, among children attending accident and emergency departments after head injury – fewer than 10% of whom have any evidence of brain damage - road accidents (many as pedestrians) account for 70% of severe and fatal injuries. New research shows that post-traumatic stress disorder (PTSD) is found in 34.5% of children...
involved in road traffic accidents, but in only 3% of a control group of children who sustained sports injuries (Stallard et al. 1998).

Following a rise in suicide rates for young men during the early 1990s, there has to some extent been a fall since, although this applies much less to 15-24 year-olds than to older men (analysis of suicide data from the Office for National Statistics). Rates in young women are lower and have remained steady. Considerable regional variations are seen, with Scotland and the Republic of Ireland having significantly higher rates than England and Wales, not having shown the recent fall to the same extent. Suicide rates are the main available indicator of mental health problems in young people, but their use is limited. Given that there are strong pressures on coroners to avoid a verdict of suicide, a better indication of the real extent of the problem may be given by the higher figures for non-accidental deaths (Madge and Harvey 1999). Accurate information on the rates of attempted suicide are even more difficult to obtain, but a recent review states that attempted suicide is very much more common in girls than boys, with a ratio of about 4:1 (Kerfoot 1996). It has been calculated that there are nearly 20,000 suicide attempts by teenagers in the UK per year which result in hospital referral; and this is the most common reason for acute medical admission of young people (Hawton and Fagg 1992).

Preventable deaths still occur in children from a number of causes, including infectious diseases such as meningitis and HIV-related infection (McCormick and Hall 1995), and from substance misuse. The marked rise over time in the UK, in solvent-related deaths (most of which follow rapidly on use that affects liver function) almost certainly reflects a real rise in solvent use. From 1983 to 1990, the number of deaths – predominantly among 12 to 16 year-old children - rose from 82 to 149 (Taylor et al 1993; Institute for the Study of Drug Dependence 1993).

**Morbidity**

The pattern of ill health in children has changed significantly over the past 50 years, and rapidly over the past 25. Incidents of acute illness from which children recover or die are no longer the predominant feature, and there is very great heterogeneity in the conditions from which children may now suffer, increasingly over extended time periods, and often into adult life. These conditions tend increasingly to be complex in nature and to have a profound impact on many aspects of children’s lives.

There are no data from which to estimate the total burden of prevalence of ill health in children, to compare with, for example, the estimate made nearly 25 years ago in the Warnock report of up to 20%, with 2% of children with a continuing need for special educational provision because of severe difficulties with learning (DES and Welsh Office 1978). It is of note that a higher national prevalence figure of children with a disability sufficiently serious to interfere with the carrying out of normal daily activities was reported in a national survey of disability in Great Britain (Bone and Meltzer 1989). Over 3.8% of 5 to 9 year-olds and 3.5% of 10 to 15 year-olds reported such a disability. Nearly two thirds of these children reported more than one disabling condition. And there was an average of 2.7 conditions (out of 11 categories studied) among all the children identified as disabled. Behavioural disability was the most common disability overall, found in 2.1% of children.
Chronic illness

Three measures of morbidity are available from the General Household Survey, which has been carried out by OPCS continuously since 1971 and in which parents are asked about their children’s health: long-standing illness, limitation of activity arising from long-standing illness, and restricted activity arising from illness in the two weeks before the interview. There is no evidence that the health of children, as perceived by their parents, has improved. The figures are based on parent report in children between the ages of 2 and 13, and on self-report at older ages. In 1997, the Health Survey for England gave the following figures:

- Long-standing illness, disability or infirmity that had troubled them or was likely to affect them over a period of time: 26% boys (ages 2-15); 22% girls; 27% young women (YW, ages 16-24); 23% young men (YM).
- Long-standing illness that limited their activities in some way: 10% boys; 9% girls; 11% YM; 13% YW. Respiratory conditions were the most commonly reported overall, followed by conditions of the skin for boys and girls and conditions of the musculoskeletal system for YM and YW.

Having a parent with a longstanding illness or who smoked increased the likelihood of reported longstanding illness among children aged 2-15.

- 13% of both boys and girls reported acute sickness in the previous two weeks.

However, overall, their own health was rated as good or very good in 91% of boys and girls, but this declined to 87% in YM and 84% in YW. The proportion of those reporting good or very good health was relatively low in manual social classes and, for boys and girls, in households with lower incomes.

Specific epidemiological studies give figures for the prevalence of a number of individual disease conditions. These show increases in incidence, most notably for asthma and juvenile onset diabetes. Asthma is the single most prevalent medical condition in childhood, and according to the 1997 Health Survey for England, doctor-diagnosed asthma was found in 23% and 19% respectively of boys and YM; and in 18% of both girls and YW.

In many other conditions such as cerebral palsy, epilepsy, cystic fibrosis, congenital heart disease, sickle cell disorders, and childhood cancers there have been marked increases in survival into adult life, of children who would often previously have died in infancy. Children living with conditions such as these may face increasingly complex secondary complications, and side effects of long term treatment regimes. For example, Morris-Jones and Craft (1990) have documented how, following successful treatment for acute lymphocytic leukaemia, children may face significant problems including renal and cardiovascular dysfunction, problems with fertility, secondary tumours, neuropsychological sequelae and social problems.

Low birthweight is a well-established indicator of risk of ill health in childhood and later life. More than one in 14 babies born in Britain weighs less than 2.5kg, a rate matched in Europe only by Albania (BMA 1999). There has been increased survival of very low birthweight babies since the early 1970s, and the rate of handicap in
surviving infants has also decreased (Kitchen et al. 1992). But when school performance in children with very low birthweight was compared with that of normal birthweight children, lower attention scores, language skills, scholastic competence and higher daydreaming and hyperactivity scores were found in the low birthweight group (Klebibanov et al. 1994). And follow-up studies into late teenage show a significant amount of impairment (Anders and Kallen 1998), although the cohort studied was born in 1973-5, and many advances in neonatal care have occurred since then, which may have resulted not only in greater survival but also better long term development of such infants.

**Emotional and behavioural difficulties**

Scientific evidence points to the increased vulnerability, in terms of emotional and behavioural development, of children with a chronic disease (summarised in Wallace et al. 1997). The risk of mental health problems in children with brain damage and neurological conditions is particularly high, as it is where there are specific and general learning difficulties, and language and communication problems (Graham 1986).

Overall, in children between the ages of 4 and 20, the prevalence of mental ill health, manifest in a wide range of emotional and behavioural difficulties, is in the range of 10% to 33% (Target and Fonagy 1996). Severe and pervasive disorders affect between 7% and 15%. Worrying levels of depression in young children are becoming recognised: 0.5-2.5% among children and 2-8% among adolescents (Harrington 1995). And the current levels of disruptive behaviours and conduct disorders are of major concern to all who work with children. Studies carried out in an Outer London Borough found that 7% of 3 year olds had moderate to severe behaviour problems, with a further 15% having mild problems (Richman et al. 1982). When followed up at the age of 8, 73% of boys and 48% girls still had problems. A review of recent research on behaviour problems in preschool children also confirms that serious externalizing problems that are identified early often persist (Campbell 1995). And in school, the following remark from a headteacher quoted in an article in the Independent Education Supplement (Welford H. A better class of behaviour. 11th March 1999) is heard over and over again: “Behaviour problems are a far greater challenge to the other children, the school as a whole and the staff than reading difficulties, or any other learning problem”. The impact of mental health problems in childhood is considerable, in terms of distress to the child and family, of interference with education and social relationships, and of mental illness in adulthood (summarised in Target and Fonagy 1996; Caspi et al 1996; Rutter 1996).

There has been a real rise in psychosocial disorders in industrialised countries across the world since the Second World War (Rutter and Smith 1997). The psychosocial disorders considered in this major analysis of studies from many countries, are ones that are common but involve a serious malfunctioning of individuals in their social setting. These disorders tend to rise or peak in frequency during the teenage years: namely, crime, suicide and suicidal behaviours, depression, eating disorders (anorexia and bulimia), and abuse of alcohol and psychoactive drugs. Not included were less common conditions that also increase in frequency during adolescence, but which seem to represent qualitatively distinct disorders apparently less open to broader social influences, namely, major mental illnesses such as schizophrenia and organic brain
disorders. Rutter and Smith report that, for some disorders in young people, the rise seems to apply about equally to both sexes; but for suicide and possibly depression, it has affected males more than females; for crime, females have been affected more than males. As suggested by the findings from the 1997 Health Survey for England (quoted below) there is growing evidence, following the natural history of mental health disorders in young people through puberty and beyond, that girls and boys may well show differential risks of mental ill health in response to specific risk factors and situations, indicating that different types of preventive approach may be useful for girls and for boys (Fonagy et al. 2000).

In the 1997 Health Survey, psychological wellbeing was assessed for children aged 4 to 15 using the Strengths and Difficulties Questionnaire (SDQ) (Goodman 1997) by means of a self completion booklet given to parents. Boys were more likely than girls to have high scores, except on Emotional Symptoms where girls were more likely to score higher. Children aged 7 to 9 were more likely to score high on the Conduct Problems and Hyperactivity scales than were children aged 10 to 15. The SDQ Total Deviance score was significantly related to self-reported general health and longstanding illness and (for boys only) to acute sickness in the past two weeks. The Total Deviance score increased from Social Class I to Social Class V and from higher to lower income households. It was higher in lone parent households than in two parent families. There was a significant inverse relationship between SDQ score and the mother’s educational attainment, but not with the father’s educational attainment. The SDQ score was also related to both mother’s and father’s GHQ12 score (see next paragraph). This relationship was stronger for daughters than sons and for mothers than fathers. The Total Deviance score increased markedly from ACORN Category A to Category F (ACORN is a geo-demographic classifier based on categorisation of 1991 Census Enumeration Districts. ACORN does not seek to rank or score areas monotonically on a single dimension, but there is a broad tendency for levels of prosperity to decrease across the six Categories A to F).

In young people aged 13 to 24, using a self-completion questionnaire, the 1997 Health Survey used a set of questions that comprise the well-established General Health Questionnaire (GHQ12), designed to detect possible mental illness in the general population. Scores above the threshold were found more often in females than in males, and prevalence increased with age. GHQ12 was found to be significantly related to general health measures, but did not differ significantly by social class or household income. The prevalence of high GHQ12 scores was higher among lone parent families than among two parent families. Females’ scores were significantly associated with their mothers’ GHQ12 score, but not their fathers’. The GHQ12 scores of males were not associated with either parent’s GHQ12 scores.

Preliminary findings have just been published from a national study of psychiatric morbidity in children (aged 5-15 years) in Great Britain (Government Statistical Service, 1999). Random sampling of child benefit records (which include nearly all children in the UK) was used to recruit children. Specially trained interviewers interviewed the parents of 10,438 children (83% response) and 4500 of the older children (aged 11-15) themselves. A postal questionnaire was sent to the teachers of all children who had participated in the survey. A diagnosis of mental disorder was based not just on symptoms but on evidence of distress or interference with personal
function. A number of standardized instruments were used including the SDQ, which assesses children’s competencies as well as deficits (Goodman, 1997), and prompted questions from the interviewers about the impact of symptoms on children’s lives. Some 10% of children in England, Scotland and Wales were found to have some type of mental disorder, with no differences between the three countries in the prevalence rates. In three broad groupings, 5% of children were found to have conduct disorders, 4% emotional disorders, and 1% were classed as being hyperkinetic. As yet, figures for co-morbidity have not been published. The proportion with any mental disorder, across the age range, was greater among boys than girls. A strong association was found separately between social class and family income, and the mental health of the child. Children from families in social class V (unskilled occupations) were three times more likely to have a mental health problem than those from social class I (professionals). The association was found for all three groups of disorders. The prevalence of any mental disorder ranged from 16% among children living in families with a gross weekly household income of under £100 to 9% among children of families in the £300-399 weekly income bracket, and to around 6% in those families earning £500 per week or more. This trend was evident for all three groups of disorders: emotional, conduct, and hyperkinetic.

The SDQ was also used in a study carried out in 15 primary schools, two secondary schools and one special school, from a range of rural to urban environments in York. Preliminary findings show a total “case” rate of 13% (Kind et al 1999). “Caseness” was based on a total difficulty score computed for each child using 20 items defined by the major SDQ sub-scales, and indicated by severe problems in at least 8 of these. Overall, “caseness” was found in a ratio of boys to girls of 1.7 to 2:1, depending on age and school. But case rates differed widely between schools: with a range of 3.8% to 18.1% in the primary schools and 10.7% to 41% in the two secondary schools.

**Oral health, obesity, and nutrition**

There is now also more information and understanding of the consequences of problems that have a lower profile, such as poor oral health and tooth decay, obesity (linked to raised blood pressure and coronary heart disease risk), posture and spinal problems. The Health Education Authority (June 1999) report that in some parts of the country, more than a fifth of three year-olds have “rampant” tooth decay. Sugary foods and drinks are blamed for this. In a recent editorial in the British Medical Journal, Professor Elizabeth Kay points out that although dental decay most often gives rise to acute symptoms, other almost ubiquitous oral problems - mostly due to plaque - can have serious consequences (Kay 1999).

The 1993 United Kingdom Child Dental Survey showed that children who only attended dentists when having problems had more decayed and filled teeth than children who attended when asymptomatic (O’Brien 1994). The so-called “regular attenders” tended to have fewer teeth extracted. And a recent systematic review showed that one of the most effective ways of ensuring that the habit of thorough tooth cleaning with a toothbrush was established was for people to receive simple but individualised advice from dental staff on a regular and repetitive basis (Kay and Locker 1997). Thus regular attendance appears to be important for the delivery of health messages.
The 1997 Health Survey showed that according to measured body mass index (BMI), 23% of young men (aged 16-24; YM) and 19% of young women (aged 16-24; YW) were overweight, and a further 6% of YM and 8% of YW were obese. Interestingly, 2% of YM and 20% of YW who had desirable body mass index (BMI) said they regarded themselves as too heavy. 18% of YM and 49% of YW were trying to lose weight; even among underweight women, 10% were trying to lose weight, and 45% of YW with desirable weight were trying to lose weight. Children with overweight parents or who were in the top weight quintile at birth were more likely to be in the top BMI quintile. A recent analysis has shown that even between the ages of 2 and 5 years old, British children are significantly overweight and obese - equally in boys and girls – at levels that have a strong likelihood of persisting into adulthood and that are associated with several adverse health outcomes (Reilly et al 1999). Other studies are beginning to show how important it is to prevent too rapid weight increase over these early years or even younger (De Spiegelaere et al 1998).

The implications of these findings are highlighted by an Australian study in which 2,000 male and female students aged 14 and 15 years were followed over 3 years (Patton et al 1999). Of these, 8% of the girls had followed strict diets and a further 60% had dieted at a moderate level. Those who dieted strictly were 18 times more likely to develop an eating disorder than those who ate whatever they liked. Even those who dieted moderately were at five times the risk. However, although dieting and preoccupation with body weight and image are common, dieting in the majority of girls has previously been shown by the same authors to be a benign practice, without progression to clinical status (Patton 1990). The prevalence in European countries, varies around a mean of about 1 per 1,000 in young women below the age of 20 years. There is no convincing evidence to suggest that rates have been increasing over the past 50 years (Fombonne 1995). But in certain societies, such as in Spain, eating disorders have become a complex emerging health problem, with 0.5% to 2% of young people aged between 14 and 24 years having either anorexia or bulimia or being at risk of developing these disorders (Bosch 1999).

There is reasonable evidence both for (Franko and Omori 1999) and against (Patton 1990) the hypothesis that abnormal attitudes to eating, dieting, and frank eating disorder are part of a continuum. Studies consistently show that young people – mainly girls - with anorexia nervosa and bulimia nervosa (which has an age of onset in late adolescence) frequently also have depression, and this may precede the onset of eating disorder and/or remain after the main symptoms and signs of the eating disorder remit. A prospective study of 400 school girls, followed up from age 11-12 to age 15-16, also found that girls with low self esteem at the younger age were at significantly greater risk of developing the more severe signs of eating disorders as well as other psychological problems by the older (school leaving) age (Button et al 1996).

Young women, particularly those aged 20-24, were less likely to be frequent consumers of sweet foods, soft drinks, crisps and chips than YM and children (aged 2-15). Less than a fifth of children and young adults reported eating fruit or vegetables more than once every day, compared with the recommendation of five portions a day. Eating habits appeared to be related to social class and household income in children but not in young adults of either sex. The proportion of children frequently
consuming fruit and vegetables decreased from Social Classes I/II to IV/V and from higher to lower income households, while the proportion consuming sweet foods, soft drinks and crisps increased.

Mean systolic blood pressure (SBP) was significantly associated with Body Mass Index (BMI). Children’s mean SBP was higher where the parents were hypertensive; however, this relationship was greatly diminished when BMI was taken into account. There was no clear relationship between mean SBP and social class of head of household, region, ACORN Category or household income.

There are other significant matters relating to poor nutrition. As an example, a national diet and nutrition survey of pre-school children showed significantly low iron levels in 2 year old children of Asian parents living in England, and a prevalence of anaemia of 20-29%. And there is considerable evidence of an association between iron deficiency and impaired mental and motor function in childhood in various ethnic groups. From the large national study, the findings of previous smaller scale studies have been confirmed, in that 12% overall, but up to one third, of children from three different Asian groups in the UK have haemoglobin concentrations that may be associated with delayed development (Lawson et al 1998).

**Risk behaviours**

Besides eating habits, there are a number of behaviours which are associated with significant risks to health in children. These include lack of exercise, smoking, drinking, drug taking, bullying, and early and frequent sexual activity.

There is now good evidence that physical activity and exercise in children has been reducing over recent years. In the mid 1970s, 72% of children aged 5-10 years old walked to school; now just 59% do. Children aged 11 to 15 years were found to have reduced their number of walks during the ten year period between 1986 and 1996 by 29% (DETR June 1999). The Royal Automobile Club (RAC) carried out a Motoring Services Survey in 1996. They found that the number of secondary school pupils who walked to school had dropped from 61% in 1975 to 53% in 1995. Cycling to and from school had declined from 6% in 1985 to 2% today. The survey also found that 81% of journeys to school took only 10 minutes to walk.

A reduced level of activity of all sorts is backed up by self-report surveys of many thousands of young people (Biddle et al 1998). At ages 14-15, 38% of girls were doing no physical activity, although boys were doing more. At age 11 and 12, however, there was no difference in the proportions of girls and boys doing any physical activity. Trew (1997) compared the amounts of time spent by teenagers on various activities. She showed that sport took up an average of 3.74 hours a week; which is more than homework or computing, but significantly less than television (average, 5.52 hours).

Sonia Livingstone, an author of a London School of Economics study, *Children, Young People and the Changing Media Environment*, reports that a third of parents questioned said that their children spent “very little” or “none” of their time outside the home or garden without adults around. This was largely because of fears that their children could be the victims of crime or become involved with illegal drugs.
Nowhere else in Europe are young people so dissatisfied with what is available locally to do outside their homes. They cannot find affordable or accessible meeting places. They complain about a lack of cafes, parks, swimming pools, cinemas, skating rinks and youth clubs. Six to 17 year-olds spend on average two and a half hours almost every day in front of the television screen filling in time. Some 63% of 9 year-olds have their own television and 21% have a video recorder; two thirds play computer games and 68% have a personal stereo.

A survey of 2,126 primary and secondary schools carried out by the National Association of Head Teachers found that 94% of primary schools had no gym and more than half have to share a playing field. More than 100 primary schools and 55 secondaries had no access to a playground. Although virtually every school had a hall, it was used for assemblies, drama, teaching, meals and tests as well as PE. After school sports were in competition with homework clubs.

The prevalence of self-reported smoking was higher in 1995-7 than in 1993-4 among young men and young women. At age 15, 13% of boys and 14% of girls reported regular smoking (at least one cigarette a week). The proportion of YM claiming to be current smokers increased from 20% at age 16 to 40% at age 18, very little below the average prevalence level for age 20-24 (41%). Among YW, 25% smoked at age 6, and 41% at age 20-24. The evidence from analysis of cotinine levels, is that smoking hardly starts before the age of about 11 or 12, when it starts to rise steeply. Both self-report and cotinine show relatively low levels of smoking among young people in households in SC I and high levels among those in households in SC V. The prevalence was highest among young people in social housing and lowest among those in owner-occupied accommodation. Levels of smoking among children aged 13-15 were higher in households where at least one adult smoked (24%) than in households where no adult smoked (7%).

Children’s alcohol consumption may be under reported, like their cigarette smoking, when parents are present when the data are collected. But the proportion who claimed to have had a whole alcoholic drink increases from 5% of boys and 4% of girls at age 8 to 71% and 72% respectively at age 15. The proportion of boys aged 13-15 who report drinking alcohol in the past week increases from 20% at age 13, to 29% at age 14 and 44% at age 15; in girls, the figures at all ages are 15%. Comparisons between rates in 1993 and 1997, show a startling increase in the amount of alcohol consumed by young men aged 16 to 19 years, with a much smaller rise in young women.

The impact of alcohol consumption in children and adolescents is considerable. Alcohol use is associated with increased sexual activity and with unsafe sex (RCP 1997). A number of studies have shown that alcohol consumption by adult or adolescent drivers is responsible for a majority of road traffic accidents in the young (RCP 1997). Alcohol abuse is a major risk factor in male teenage suicides. It has been shown in the United States, that one in three adolescents who commit suicide is intoxicated at the time of death.

Although Home Office statistics show that the number of notified drug addicts under the age of 21 increased from 1,501 in 1990 to 2,231 three years later, a survey by researchers at Exeter University, of 35,000 children aged 12 to 15, showed that the
number who claim to have taken drugs has dropped by 5% since 1996, when one third of 14-15 year-old boys said they had experimented with drugs. In 1997, the figure was 27%. But all studies show an increase in drug use with age. And there is major concern over the small but growing number of children of primary school age who now use drugs (NHS HAS 1999). In some parts of the country, there is also alarm over how cheaply heroin may now be bought, and over the accompanying rise in heroin use even among young children (Middlesbrough Children and Families Service, personal communication). A three-year Home Office project among school children in two areas of the North of England has shown that 2% of children aged 13 and 14 in Northumbria and 3% of those aged 15 and 16 in West Yorkshire had tried heroin (Paul Wiles, director of research, development and statistics at the Home Office, reported in The Independent, 4th September 1999). By the age of 16, 14% of youngsters had been in situations where heroin was available or was offered to them. The European Monitoring Centre for Drugs and Drug Addiction has recently reported (The Independent 23rd November 1999) that British teenagers are more likely to have used all categories of illicit drugs than their counterparts in any other European Union country.

Miller and Plant (1996) found that both smoking and illicit drug use were significantly heavier among those (of over 7,000) UK secondary school pupils who reported below average school performance, and much less among those indicating that their performance was above average. There was a strong relationship between cigarette smoking and cannabis use; only 6.9% of non-smokers had ever tried cannabis, and the percentage rose with the level of smoking. Drug use in adolescents is closely associated with psychiatric disorder, and with criminality (Fonagy et al 2000). The role of tobacco and alcohol as “gateway” drugs has been confirmed in a 20-year follow-up cohort of adolescents (Kandel 1992); with tobacco being particularly influential for women and alcohol for men. The majority of drug use among teenagers is experimental and short term. Use of cigarettes and alcohol, and to a lesser extent, cannabis, tends to be more protracted. Prospective research suggests that most people will not sustain measurable long-term harm from transient or short-term use. But the earlier adolescents start drug or alcohol use, the more likely they are to have a persisting problem.

Bullying remains prevalent in many schools and neighbourhoods. Turtle et al (1997) report that 19% of boys and 17% of girls were bullied during the current school term, and that only 49% said they had never been bullied. Among all children of year 4 (mean age 9 years) in primary schools in Newham, East London, in 1992-3, 22.4% reported that they had been bullied at some time at school or at home (Williams et al 1996). There was an association between being bullied (“sometimes or more often”) and not sleeping well, bed wetting, and experiencing more than occasional headaches and tummy aches. A significant trend for increasing risk of symptoms with increased frequency of bullying was shown for all reported health symptoms. Other studies in the UK have shown considerable variation in rates of having been bullied and bullying others (Forero et al 1999), and that involvement in bullying is greater in boys than girls and decreases with age. Children have been shown to be more likely to be bullied in small village primary schools than in large inner city schools because they have less chance of making alternative friends (Wolke 1999). The rate in English primary schools is greater than in secondary schools and in other European countries.
Salmon et al (1998) and Leff (1999) in West Sussex report a high degree of vulnerability among children who are bullied, from a number of causes such as physical and learning disability, neglect, and family adversity. And a study of nearly 16,410 adolescents aged 14-16 in secondary schools in two regions of Finland found that about 10% reported being bullied at least weekly at school. Adolescents who were bullied were found to have an increased risk of depression and suicidal ideation, with bullies often as depressed as those who were bullied; suicidal ideation was even more common among bullies Kaltiala-Heino et al (1999).

Britain has the highest teenage birth rate in Western Europe, and the highest rate (in 1997) of legal terminations: 22 per 1000 women aged under 20 (Wellings and Kane 1999). In 1996 in Britain, teenage females accounted for 20% of all terminations and 9% of all births. Rates of terminations rose by 14.5% in the under 16s and by 12.5% in 16-19 year-olds between 1995 and 1996. Maternity rates also rose in these two age groups, by 6.7% and 4.6% respectively. The rises took place in all health regions but termination rates varied from 2.2 to 10.5 per 1000 and live births from 1.1 to 9.9 per 1000 between health districts, the highest rates being in urban districts. “Teenage parents tend to have poor antenatal health, lower birth weight babies and higher infant mortality rates. Their own health and their children’s is worse than average. Teenage parents tend to remain poor and are disproportionately likely to suffer relationship breakdown. Their daughters are more likely to become teenage mothers themselves. Teenage mothers’ usually disadvantaged backgrounds contribute to these effects. But having a young baby makes it worse” (p. 23 In: Social Exclusion Unit 1999)

Recently there has also been a rise in teenagers in the incidence of sexually transmitted infections (STI). Gonorrhoea, the STI most indicative of trends in risky sexual behaviours, rose by over 30% for both male and female teenagers between 1995 and 1997 (Nicoll et al. 1999).

There has been a dramatic fall in the age at first intercourse, seen particularly among young women who were in their teens in the 1960s. Wellings et al. (1994) found that nearly 90% of young women born in 1971 had sexual intercourse before the age of 20, compared with fewer than 30% of those born in 1931. Other European countries may have similar rates of adolescent sexual activity but contraceptive use is much more common.

Risk factors
Many of the risk behaviours described above show associations with each other. Many are more likely to be found among children growing up in families living in adverse circumstances. And more health problems and lower self esteem were found among young people who reported more conflict with parents (regardless of family structure), in a study in the West of Scotland (Sweeting and West 1996). The most consistent associations were found in respect to the amount of time that young people had spent with the rest of their families before the age of 16. Those who had spent more time were less likely to smoke or to have tried illicit drugs before the age of 18, with young women less likely to have become pregnant. They were more likely to have left school at an older age, to have some qualifications, and to be students. Strong attachment or bond between an adolescent and their parent(s) has now been
shown repeatedly to be a potent protective factor for a range of risk behaviours in children and young people (Fonagy et al. 2000).

When most children start school it is assumed that they do not have to be taught how to speak and how to listen. There is increasing anecdotal evidence from teachers that children arrive at school with very limited communication skills because their parents or carers have not spent time talking to them. The ability to speak and listen effectively develops only slowly after starting school and is a problem for many children throughout the primary school years. Children from less advantaged social backgrounds were significantly poorer as both speakers and listeners. Children with only partial competency in speaking and listening are likely to have difficulty in comprehending verbal information presented at the level and pace of much classroom discourse. (Lloyd and Peers 1999). From the mid-1960s the studies carried out by Rutter and colleagues on the Isle of Wight - and further studies since - have shown the significant risks associated with speech and language delay, of poor school attainment, poor peer relationships, poor self esteem and emotional and behavioural problems (Rutter 1984 & 1985; Rutter et al. 1979).

An assessment of mental health needs was carried out in one of the most socially deprived areas of the UK (Davis et al. 1999). This study maps, in graphic detail, the many inter-related risks to health that may be found among young families living in poverty, deprivation and disadvantage in similar communities. Children between 0 and 16 years of age were randomly selected from the lists of three large GP practices in south-east London. The study involved preliminary exploration of first the nature, severity and frequency of specific but persistent psychological and social problems in children/young people; and second the psychosocial context of these problems in terms of a set of factors considered to put children at risk. High levels of both problems and risk factors were found. Nearly 72% of the children had at least one moderate to severe problem, and nearly 37% had three or more. The most frequent difficulties were: disruptive behaviour, tantrums and eating problems in the 0-4 year-olds; anxiety, persistent lying, depressed mood, temper control, and defiance in the 5-10s; temper control, depressed mood, defiance, food faddiness/eating problems, and father relationship problems in the 11-13s; and crime, school discipline problems, multiple sexual relationships, lying, high smoking/alcohol use, truancy, somatic anxiety, sleep problems, mood swings, temper control, and drug use in the 14-16s.

Over 85% of the sample had at least one risk factor for child mental health problems, and over 51% had three or more. The most common included: maternal and paternal mental health problems; environmental problems in relation to housing and neighbours; social isolation; chronic physical health problems in the parents; and troubles with the police. Many of the parents had themselves experienced adversity in childhood with more than 10% separated because of problems in the family. Many of the children had experienced bereavements, and other adverse life events, problems with school work, and difficulties relating to neurological or locomotor functioning.

The number of problems per child was significantly correlated with the number of risk factors, with concerns about the mother’s parenting, adverse life events, sexual abuse of the child, police trouble in the father/partner, problems with neighbours, and maternal mental health problems accounting for 37% of the variance.
The authors point out that caution must be exercised with these findings because the sample size was relatively small, a number of children were known not to be registered with a GP, there was a high rate of refusal to participate, and there were methodological problems. However, the sample characteristics and the results are congruent with previous studies. Furthermore, 25% of the sample considered they needed help and 22% had already sought it. And although 28.1% of the children had no severe problems at all, only 24 children (9.5%) were without risk factors.

Among the associations between ill health in children and families and indicators of socio-economic disadvantage, poverty is now established as a major determinant of health. One in three children in Britain lives in poverty (defined as an income of less than half the mean equivalised income after housing costs): that means more than four million children, up from about 1.3 million in 1979. In the 18 years between publication of the Black and Acheson reports (DHSS 1980 and 1998), there has been an increase in income inequality in the UK; 24% of the population had an income below half the average after housing costs in 1995-96 compared with 7% in 1977. Families with children have been hardest hit: 31% of children live in households with less than half the average income after housing costs, and more than one million children live in families without a wage earner (DSS 1998). Research published by the Institute of Fiscal Studies (Gregg et al. 1999) shows that 89% of children of single parents are living in poverty, and the number of children living in lone parent families trebled between 1968 and 1995/6. Half of today’s poor children live in households where nobody works and, on international comparison, the UK has the highest level of joblessness among families with children. A report produced by the Family Budget Unit at King’s College London (1998), concluded that the income needed to sustain good health and child development is substantially above that provided in the UK by income support or the proposed minimum wage.

A UK Treasury report, *Tackling Poverty and Extending Opportunity*, shows that children born in the top social classes perform 14% better in educational and developmental tests at 22 months of age than those in the manual and semi-manual classes. This study showed that the gap between rich and poor in the United Kingdom has widened sharply in the past 20 years, a trend that is unique in Europe. An analysis carried out for the Smith Institute by Professor John Bynner and Professor Heather Joshi has also shown that contemporary young people (who were born in 1970) have faced persistent inequality of opportunity throughout their lives (reported in The Independent 21st May 1999). Although more people now go to higher education, the researchers found that the daughter of an educated professional father achieved, on average, three educational levels higher – a degree rather than GCSEs - than a daughter of an unskilled man who had left school before 16. But the gender gap has narrowed in comparison with young people born in 1958; women born in 1970 obtained similar levels of educational qualifications as men compared with previously, when women achieved much lower educational qualifications than men. But both men and women, born in 1970, got better jobs if they came from a more advantaged parental background. Professor Bynner is quoted as saying: “Although people have moved up classes, and the unskilled classes have shrunk, those who have stayed at the bottom end are worse off. Children born in the lower classes are 20 per cent more likely to be unemployed than those from higher up the social
scale…..

Education is vital for success in the labour market but it is also the major vehicle for the transmission of inequality - or otherwise - from one generation to the next.”

In a population-based study in south-east Netherlands, Bosma et al (1999) studied the increasing evidence that differences in adult health were partly caused by socio-economic factors during early life and upbringing. They showed that part of this association could be explained by a higher prevalence of unhealthy psychological attributes (personality factors and coping styles) in subjects who grew up in lower social classes. Self-rated poor health was associated with external locus of control, neuroticism, and the absence of active problem-focused coping; the findings were independent of adult social class and height.

The relationship between poverty and risk taking behaviour undoubtedly exists although its exact nature is complex (Harker and Harker 1998). One example is that being below the poverty threshold has been shown to have an independent effect on both smoking and ability to quit (Flint and Novotny 1997). It is of note that poverty is a major causal factor in the rise in incidence of tuberculosis in both developing and the developed countries (Bhatti et al. 1995).

Groups of children at risk
Certain children and those living in certain situations and localities have particular risks and particular needs. Clear examples are given by children who have chronic illnesses and disabilities and by children who are poor (identified as eligible for free school meals). Mention should be made of children who are looked after by the local authority, in whom studies of health risk are now becoming available (Mason NCB). These young people suffer multiple risks, particularly with regard to their mental health. A recent study of adolescents in the Oxfordshire care system, found a 67% prevalence of psychiatric disorder, compared with a 15% prevalence among adolescents living with their own families; a rate of 96% was found among adolescents in care in residential settings (McCann et al. 1996). A significant feature was the high rate of depression (23%) among this group; again, because a number of studies have established that these kinds of “internalizing” disorders are much less likely to come to the attention of specialist services (Cohen et al. 1991). A study in Glasgow found that depression was significantly more common among children (aged 5 to 16 years) – at the time of entering local authority care – entering residential establishments than among those in foster care (Dimigen et al. 1999). And in this study of 70 children, conduct disorder was found in over a third.

Children excluded from school are another vulnerable group (Barnes 1998). Although no-one knows precisely how many children are out of school at any one time because of truancy or exclusion, but each year, at least one million children truant and over 100,000 children are excluded temporarily (Social Exclusion Unit, 1998). Permanent school exclusions are rising, with a prediction based on sharply rising trends from 1990 onwards that more than 14,000 pupils would be permanently excluded from schools in England in the 1995/6 school year (Parsons 1996). In 1997 there were 13,500 exclusions, a rise of 10,000 since 1990. There is good evidence that these youngsters have multiple risks for mental health problems, many living in disadvantaged communities, in families facing poverty, social isolation and lone
parenthood (OFSTED 1996). Further evidence is given in that 21% of the children excluded from 39 schools studied by OFSTED were in the care of the local authority at the time of exclusion.

In addition, other groups of children are known to have both particular health risks and particular needs for service provision, often relating to access. These groups include children who have parents with mental illness, children who are carers, and children from refugee and newly immigrant families.

**Current Service Provision**

In this project, we have taken into consideration the full range of services for children from many agencies as well as the NHS – wider than has traditionally been known as the school health service. In view of the crucial importance of the family and home background in children’s health, a number of services that are not designated specifically as children’s services should also be included in this framework.

However, services for children (as distinct from infants) were originally developed as The School Health Service. And in a recent short review of school nursing, the main elements of the school health service are defined as: routine screening and surveillance; safeguarding the health and welfare of children; a confidential advice service for children; family support; and health promotion (Hall 1999). Hall discusses the extent to which these elements meet needs and have been shown in scientific studies and from other evidence to be effective in doing so.
METHODS

Research design

The study was carried out at four of the Healthy Schools Programme sites in England. The sites were selected to include populations and environments with different characteristics, in order to maximise what could be learnt and the possibility of generalisation from the findings. Particular care was taken to work in different parts of England: in the inner city, a medium-sized town, and rural areas; in a community with a high proportion of minority ethnic groups; and in areas demonstrating high levels of socio-economic deprivation and middle range socio-economic characteristics.

A rapid appraisal approach was used to gain a perspective of the health needs of children of school age in each of the four sites (Annett and Rifkin 1995; Murray 1999). Information was collected from several sources:

- Separate focus groups with children, parents and school staff in a primary and a secondary school at each site.
- Interviews with selected professionals providing services to children in health, education, social services, and other relevant services, including the voluntary sector in each of the four sites.
- Existing written material about each school, its neighbourhood, and the local population.
- Relevant local statistics collected or reinterpreted as part of this appraisal.

At each site, the Healthy Schools Programme team identified schools that were interested in the project and were willing to take part. We (ZK and RT) then liaised with the headteacher and a named teacher at each of the schools, to plan our visits.

All the focus groups were held on school premises. Detailed notes were taken throughout the focus groups by one of us. Participants were told that the issues raised would be described in a national report for the Government, but were assured that they would not be named personally, even if what they said was quoted. In the case of the children’s focus groups, the schools were given freedom to choose the participants, from any age group. The only request was that they should choose purposefully, so that each group comprised children who were willing to put forward their views. This is in line with rapid appraisal methodology. The focus groups were not overtly structured in terms of the subject matter, since the aim was to hear what the participants themselves perceived as health needs. More information on the practical aspects of the structure of the focus groups is detailed below in the section on the collection of data. Permission for their children to take part in the focus groups was obtained from parents, by the school, using a letter that we designed for this purpose in discussion with each school.

Teachers’ groups were planned for immediately after school or during the school day when a number of interested teachers were free. Parents’ groups were planned at times that were most convenient for each school, sometimes at the beginning of the
school day, sometimes at the end of the afternoon session and occasionally later in the evening.

We have compared our findings from the focus groups with national epidemiological and other research-based information on the health and attitudes to health of children aged 4 to 18 years. Currently available evidence regarding effective approaches to prevention, treatment and longer term care, have also been reviewed. Our focus has been on health problems that have particular impact on children’s capacity to benefit from education and from attending school, and on the role of education and the school in promoting children’s health and in supporting those with health problems.

Collection of data
The fieldwork was carried out between March and early June, 1999. We worked in one secondary school and one feeder primary school in each of our four localities.

The focus groups were run in a semi-structured manner. However, we were anxious not to run them too strictly, but to encourage the participants to talk about what were their major concerns. Above all, we avoided “putting words into their mouths”. In the case of the children’s groups, the participants were given an opportunity early in the session to discuss the meaning of health with a partner. This alerted us to major interests and gaps, so that we could ensure that all aspects of health needs would be considered later in the session. Generally a minimum of guidance was needed and issues were raised spontaneously. Our informal “headings” included: what is health; how is health maintained and promoted; what are the causes of unhealthiness and how can it interfere with daily life; and where to go for help and advice. During the discussion we also ensured that chronic conditions, disability, emotional health, behavioural issues and risk-taking behaviour were included.

Focus groups with children
Nine groups were held, with a maximum of 16 participants and a minimum of five, comprising fairly even numbers of boys and girls. Most groups were drawn from one year group: years 1 (aged 5-6), 6 (aged 10-11), 9 (aged 13-14) and 11 (aged 15-16) were included. A mixed group of years 7 and 8 (aged 11-13) was very successful, but in another mixed year group, with children of widely differing ages, the younger children seemed to be deterred from expressing their views fully. More than 100 children and young people took part in all; the sessions were very lively and in some instances, it was difficult to bring the discussion to an end.

Focus groups with parents
Groups of parents were seen at the beginning of the school day in primary schools, once their children were safely installed in their classrooms. Others chose to meet in the evening. Wherever possible, parent governors were included. The parents were all self-selected and did not necessarily represent the school population. The turn-out was higher when a PTA or Parents’ Association was involved. In two secondary schools, no parents responded to the invitation. In both these schools, the headteachers reported that it often proved difficult to get a group of parents together, for various reasons, including distance and poor transport between home to school.
Focus groups with teachers and other school staff

Some governors were also included with the teachers, as were canteen staff, lunch-time supervisors, ground staff, school secretaries, welfare assistants and special needs assistants. In primary schools, usually all the teaching staff participated. In secondary schools, there was generally a mixture of subject teachers, some of whom were year heads. Nearly always included in the focus groups were teachers with a special role in this field, such as special educational needs co-ordinators, tutors for the pastoral curriculum, PE staff, teachers with a counselling qualification, school-home liaison staff and teachers of personal, social and health education. A good deal of time was also spent in individual discussion with the headteachers and often the teacher responsible for PSHE.

Discussions with health service professionals

We met with professionals who provided health services in the local community, and especially in schools. Discussions were held individually and in groups, depending on what seemed most appropriate in each instance. The following professions were consulted: paediatricians, including both consultants and staff grade doctors; child and adolescent psychiatrists; clinical child psychologists; school nurses, including those working in special schools; other nurses working in a variety of specialist areas, such as health visiting, sexual health, child protection, diabetes, special needs and home nursing; community dentists; physiotherapists, speech and language therapists, occupational therapists, dieticians and staff working in health promotion. General practitioners serving the schools’ catchments were also interviewed.

The discussions with health professionals had three aims. The first was to seek out any recent information about health needs that was available locally. We had in mind documents such as Local Authority Children’s Services Plans, needs assessment prepared for the Child Health Services or Child and Adolescent Mental Health Services, data from the Child Health Information System, other relevant surveys, health visitor profiles, individual school profile data from the school nursing service, school entry medical data, and health behaviour surveys. The second aim was to discover if there were any special or innovative services or models of provision for this age group. Thirdly, we wanted to elicit the perceptions and experiences of each person consulted with regard to the health needs of school-aged children locally. We asked how well they considered that local services were meeting these needs and if they could identify unmet needs. We aimed to get a perspective specific to each professional group, to specific groups of children, as well as from each individual person.

Discussions with headteachers and Education Department staff

Considerable time was spent in discussion with the headteachers from all eight schools. In addition, educational welfare officers (EWOs), educational psychologists (EPs), advisers in drug education and those developing behaviour support plans were interviewed. The aims of these interviews were similar to those for health service professionals, as described above, except that the slant was on school-based statistics, such as school exclusions, statemented pupils, pupils with special needs, number of teenage pregnancies, school absences for health reasons and non-health reasons, data
on bullying and policies on anti-bullying measures, and any relevant surveys of the school population.

**Discussions with others**

We also sought information from documentation and sometimes through face-to-face or telephone discussions, with the police, local voluntary sector organisations and social services departments. Other County Council departments, such as the Surveyor’s Department, were found, for example, to have an interest in children’s health and fitness through travel awareness campaigns.
RESULTS

Locality A

Needs profile

- This is a rural county and the most sparsely populated in England. The schools we worked in served areas with less than 2 persons per hectare; the county average is 1.3, and the figure for England is 3.6.
- The population is older than for the country as a whole, with smaller percentages in each age group up to age 44 than the national average, and higher percentages of ages 45 and over. Since the 1950s, the population has steadily risen due to immigration.
- There is a small minority ethnic population spread across the county. In addition, approximately 600 gypsies and travellers are in the county at any one time.
- The infant mortality rate in 1998 was very low at 2.8%, compared with a national average of 5.7%.
- The proportion of low birthweight babies was 7.1% in 1998, slightly above the national average.
- 2.5% of the population under 18 years reported a limiting long-term illness or disability in the 1991 census.
- In 1997, the pregnancy rate per 1000 females aged 16-19 was 54.7 (national average 66.3) and for females aged 11-15 it was 2.3 (national average 3.4).
- 20% of the school population are on the Special Educational Needs register, and 4.5% have a statement of special educational needs. This figure is considerably above the national average.

The local school environment

Twenty schools in this county are taking part in the Healthy Schools pilot; 11 of these have chosen emotional health as their priority out of 6 possible topics. It is of note that of 40 schools that applied to be considered for the Healthy Schools pilots, 24 wanted to focus on emotional and mental health.

Due to a policy of integration, only 1% of children are placed in special schools; the vast majority of children with special needs are in mainstream schools.

It was felt in the secondary school, that more curriculum time was needed for PSHE (currently 5%), and more teacher training in general. This was partly in order to have more time for spiritual and moral aspects in education. There was under-use of Drama and Art as valuable and fun ways in which children could express themselves and achieve in less formal areas (especially if they were not good in academic subjects). Teachers were in the classroom for nearly the whole of the school day and had very little opportunity for any informal activity or conversation with pupils. Both the primary and secondary school head teachers were in class for 60% of their time; each ran their school on between half and one day a week.

Both schools pay for a psychologically trained social worker to come in once a week as a resource for children and staff. Access to the specialist child and adolescent
psychiatric service is very poor, largely because of the lack of professional staff in the service. The educational psychology service is good. Because of the scattered nature of the school population, the secondary school’s relationship with the children’s GPs was variable and from the children’s point of view, not very helpful, as each doctor was remote from the school. There is potential to involve the Youth Service more, but the Youth Service can operate more effectively in towns and many children live in small villages. There is an issue for children under the age of 10 years who are not served by the Youth Service or Youth Clubs.

There were difficulties for children to go to their GP (especially for emergency contraception, for example) because it was so obvious in a small village where the child was likely to be known by everyone. There are also difficulties in going for health care advice away from the home village because there is virtually no public transport. In order to meet the needs of children for accessible confidential advice, care and support, one GP practice has set up a “surgery” that operates for half the school day every working day on the premises of a large secondary school, but quite separately. A nurse (not the school nurse) and one other member of the practice team - often the doctor - are available at all times to the children at the school. Children are known to visit a number of times before they summon up the courage or the trust to ask to see the nurse or the doctor. They may bring their lunch to eat in the waiting room with a friend. The waiting room is designed to be as much like an ordinary sitting room as possible. This project is known as Tic Tac and was originally set up as a confidential young person-friendly sex education and contraceptive service. It has developed into a full primary care service for the young people, with a broad emphasis on meeting mental health needs. Local evaluation has shown it to be very well used and well thought of. The project is now forming the basis of the development of county-wide designated health services for young people, with support from all the relevant statutory agencies and many of the voluntary organisations.

Some of the communities in this county are very isolated. A lot of families come to this part of the country thinking that they would be able to have a reasonable quality of life in its pleasant surroundings but they become isolated and poorer because there is so little employment. The teachers said that drug taking and alcohol abuse were common among parents and that young children were sometimes inadequately fed and left very much to themselves. Some local schools were very small and therefore service providers, like the school nurse, had a great number of different establishments and distance to cover.

Transport is a major issue in making it possible for children to go on expeditions (payment for transport has to be raised for each separate trip), let alone to go to activities on a day-to-day basis (the entrance money for the nearest Sports Centre is expensive for many families and the transport to get there is a problem).

The secondary school runs to a short school day so as to accommodate the long travel time of many of the pupils. Most children arrive and go home in special buses. It is difficult for them to stay for after school activities unless transport is laid on for them. Many do not have any breakfast before they leave home. There is food available on their arrival at school, but they often don’t eat it or buy something unhealthy at break time. Break and lunch times are very short. There is no sit-down meal, just snacking
really. A commercial firm provides the school lunches. The healthy choice foods are limited and either run out early or are more expensive and so are not bought. If these are not taken, the firm tends not to provide them in future as they are not profitable.

Focus groups

Children

Primary

(12 children aged 10-11 from Class 6)

Six felt that they were healthy and six not very healthy. Reasons for being healthy included: “I play football... netball... tennis”; “I like sport”; “My Mum’s a health freak”; “I’m vegetarian and don’t eat chocolate”; “I play outside”; “Mum knows about what’s healthy”; “My parents run and I run with them”; “I go to Fitness Club”; “I go to the beach”; “Neither of my parents smoke”; “I don’t eat sweets or have sweet fizzy drinks.” Reasons for being unhealthy included: “I eat chocolates and sweets and drink too much coke”; “I spend too much time sitting and watching TV and playing on my computer”; “I don’t get enough exercise”; “I don’t run around as much as my brothers and sisters”; “I don’t get out enough.” Some felt that eating lots of sweets was balanced by doing exercise.

From the quotations above, it can be seen that the children had a keen interest in food. Only two of the 12 had school lunch, the rest bringing packed lunch. They brought snacks for playtime, but chocolate was not allowed.

Smoking was the next subject raised and they all knew of the dangers and problems of addiction: “It’s really hard to stop”; “It’s very bad if you have asthma”; “My granddad died early because he smoked”; “My dad’s a boat builder and he works with varnishes - he smokes too, and he shouldn’t”; “It can affect your chest”; “It’s expensive”; “You shouldn’t smoke in front of your child, my dad goes in the garden to smoke”; “My sister was trying to get pregnant and she couldn’t because she smoked.” One boy said he might smoke to impress his friends: “It’s tempting when other people do it.” They told us that it was easy to get cigarettes if you were underage: “You get older friends to buy the cigarettes for you.”

On drugs, one child suggested that you take drugs to try to make yourself feel happy, but it’s better to go to a counsellor or sort yourself out. The children agreed that you could get depressed if something happened to your family. Boys were frightened to feel like losers in front of the girls. There was wide agreement in the group that it would become more difficult at the secondary school: “As a teenager you get fat and have other problems and that’s when you need help most.” “If you feel unhappy, you should find out what it is that’s making you unhappy, and you need to find someone to talk to: relatives, close friends; family - someone you trust.” Another suggestion was to ring Childline or it might be possible to look up some advice in a book. The discussion went on to consider how best to keep yourself happy. Suggestions included talking to friends, doing some exercise like going to the gym or swimming and making yourself feel good.
The children also talked about bullying. “If you’re bullied, it’s important to talk it through. It would be difficult to talk to the head or deputy head because people would say you’re snitching.”

Secondary

(10 children of mixed age from Years 7 to 13)

Only one out of the ten thought that they were not very healthy. Reasons for being healthy included: doing plenty of exercise and sports; being able to do sports without getting puffed out; eating salads and not eating chips; having a good diet; and “You feel healthy if you feel good about yourself” (girl). Reasons for being unhealthy included: not liking a balance of foods; not sleeping well; not getting enough exercise; drinking too much beer.

On food, the children were critical of the school lunch and said that the older children go out at lunch time to buy things at the shop. “The food in school is poor; the school council nags them and then they do something about it. It is expensive for the healthier options.” and “By the end of the session, the food is cold and the healthier options are gone. It’s unappetising”. Most had breakfast but two said they did not have time because they had to start so early to catch the school bus. The canteen is open before school in the morning but these two did not use it. The children were also critical of having to eat quickly because the lunch break was only 30 minutes long.

One of the older girls made a general statement in relation to risky behaviour: “There’s too much being told what not to do but not enough about what you can do. If you smoke, it depends on your friends, if you want to do it, you will and no-one will stop you.” On drinking: “It’s a sociable thing to do with your mates; there’s little else to do around here.” On drug taking, they welcomed the initiative of the police coming in as part of their PSHE: “You don’t think of the later effects when you are young; you think you can get away with it.” They went on to talk about Leah Betts, saying that her death really made young people think. They suggested that advertisements on British TV and items included in soaps like “East Enders” were really not effective: “We know it’s not real life.” It needs real life accidents and the impact of shock tactics like the Australian ant-smoking advertisements to have an effect. The Australian advertisements had been shown to some pupils as part of a discussion group, and they described them to us in graphic detail (Chapman 1999), and said that they definitely made them want to stop smoking or not to start. This type of approach tends to be studiously avoided in schools, with little impact as a result.

Sex education started in primary school and was repeated and got rather boring. Some of the pupils had some of the information twice; everybody needs information at some point but the timing was not always right; it depended on your maturity. They would have liked to have a specialist come in, because the teachers were not good at it; they were embarrassed, and did not know enough about the subject. They said that boys and girls were separated for some of the sex education, and they did not see the need. They also felt that the school governors limited the extent of the discussion; children were told to go and ask their parents for further information, but they did not always want to do this.
It was clear that posters about where to get information about contraception etc were not allowed in school, and that the youngsters did not see these anywhere else they went such as a library, chemist shop, GP surgery. Telephone helplines were not felt to be very useful because they tended to be nationally run and did not give locally relevant information or continuing help. There was also advice in magazines but again it was not locally relevant. The older pupils felt that the poster ban was due to the governors, whom they felt might be out of touch and should not have the last say. They felt that teachers had a better knowledge of their needs. Although pupils were on the school council, this was felt to be ineffective and they did not feel that anyone took any notice of their views.

It seemed that young people had a lot of difficulty in obtaining information. They may already have some knowledge, but it was very difficult to know where to go for help. Some said they really only wanted to talk to someone whom they felt they knew well enough and who would be around locally to go back to if necessary. They discussed the benefits of going to their GP, but felt that everybody in the village would know that you had been. The younger children said that they would talk to friends; the older children said friends were not suitable if they were really worried about something, because they would joke. The problem of going to someone totally independent was that the person would not really know about them; it was better to go to someone that you knew and trusted. Teachers were not really the right people because they were there primarily for a different purpose. Children did not want to expose their weaknesses to their teachers. Also the children felt that teachers were not allowed to keep things confidential but had to report to the ETHOS team (see report on focus group with teachers on page 28). They also felt that teachers did not necessarily know enough about the sorts of things that worry young people.

Lastly the children told us about their anti-bullying council, set up by the sixth formers themselves. The idea was that it was easier for children to talk to someone nearer their age group. Those responsible for the scheme had been on a course for training, and they felt that it was doing something useful.

Parents

Primary

The parents thought that dealing with headlice was an important health issue, and felt that the school nurse was not doing the job that they wanted from her. Because dealing effectively with head lice depended upon every parent doing their bit – and some did not – the feeling was that the school nurse should take over, and do it for everybody. They discussed other possibilities, such as using the practice nurse at the GP surgery. Most had no idea of the school nurse’s role and what the school health service had to offer. There was considerable confusion within the group over the timing of the school entry interview, and some said that they had never been invited to attend a health interview with their child. They said that the school doctor did a school medical but parents did not necessarily feel that this was a good thing, as it was felt that it might be intimidating for a child to get undressed in front of a strange doctor. The community dentist came regularly to the school but the parents said they got no feedback - perhaps this only happened when a problem was uncovered. There were also complaints about access to NHS dentists in the nearby town. It was a
difficult journey by bus, and mothers were told that they had also to register if they wanted their child to be seen; this often meant that the mother had to pay privately because they were told that the NHS list was full. All in all, the parents felt that they had inadequate information: “Preventive information is so important especially in rural areas where transport is so poor.” and “No-one knows what services families are entitled to.”

The parents wanted school milk reintroduced because they felt that children needed something to drink, especially something nourishing that was not sweet. They felt that orange squash was not adequate. They had campaigned hard to raise money for a fridge in the school in which to keep the milk, but there still seemed to be difficulties in the way of making milk available; this was not because children did not want to drink it as most said they liked milk.

In year 6 the children had good lessons in smoking, drugs and drinking and the parents were all in favour. They said there was a drug problem but only related to the “surfers” (who came into the district in the summer months), although others felt that local families were also involved. They went on to talk about the secondary school, “You lose control of the situation; I can’t even envisage the school and what he’s doing.” It was a long journey: the children got on the bus at 7.30am and returned at 3.30pm. There were problems if the bus did not turn up, because children might get stranded with nowhere to go, since parents might have gone off to work. Also they felt that the school might find it very difficult to contact parents if children did not arrive at school, but they felt that this should happen. The school had to make a judgement about whether a parent needed to be told when a child had an accident or felt ill in school, and whatever was done, parents might disagree with the school’s decision.

The parents felt that the classes were small, teachers had time to talk to the children; and that their children’s emotional needs were well cared for. They felt that the teachers were caring and observant, and that learning difficulties were picked up at an early stage at the school.

The parents said that there were good sports facilities in the local town, but getting a place at the facilities and getting children there and back was difficult because of the timing of buses and the cost. It was difficult for children to do things in the village: lanes were very narrow for cycling, and there was a lot of traffic in the summer period. Although it seemed an attractive little village, there were quite a lot of dangers.

They also felt that the children needed more from the school to counteract media messages; the school did not provide enough to encourage children to lead a healthy life. The most powerful messages came from television. Parents felt powerless in dealing positively with what children saw on TV; they wanted the school to back them up.

Secondary
No secondary school parents were seen. This school serves a very scattered rural community with very poor public transport. Many parents do not have cars. We were told that parents tend to come to the school only if they really need to.
Teachers
Primary
The integration of children with disabilities has worked well so far and they would like to see more, especially of children with, for example, Down’s syndrome. But it does not work everywhere, because inadequate support is provided. Inter-agency provision can be a problem, especially occupational therapy, speech and language therapy. There has been poor liaison with the school, for example from speech therapists; the teachers never hear back when they refer children with a speech difficulty. Problems with motor skills seem to be better managed, perhaps because these are more obvious. If all schools are not adapted, children have to be bussed in to the ones that are. This is a pity because they lose out in belonging to their home community.

There was concern over the need for a statement in order to get help for young children with reading delay, because a child has to have a reading age three years below their chronological age in order even to start the process. Hence it is not possible for the school to obtain a statement and thereby, extra resources to tackle serious reading delay in a child before the age of 7. It seems counter-productive, with no element of trust in the teachers and their judgement. We were told that some children are virtually mute when they come into school and the reception and/or nursery class teachers are experienced in making a diagnosis. Statements for behavioural problems, however, can be arranged at an earlier age.

They believe that behaviour problems are at the core of other health issues and that is why this school chose the emotional health option in the Healthy Schools initiative. They felt that teachers could make most progress in this area. In teaching/learning terms, this is about ‘thinking skills’, ‘how to motivate oneself early on’ and ‘self talk’. These are all issues that need to be tackled in the curriculum in the early years. To a certain extent, teachers have always taught these skills, but there is always a problem of combating what goes on at home. Teachers feel that a consistent approach is necessary. Sometimes the child is behaving well by Friday afternoon, and then on Monday morning they have to start again. Everything can fall apart in secondary schools too, because a child will have many teachers and rarely one that he or she can build a relationship of trust with.

There was felt not to be enough guidance for teachers to deal with withdrawn, distressed children. It also needs time – half an hour spent could be time well-invested. How should they train? They use the TAC AID courses, but these are quite expensive – they cost £200 and then a further £100 to replace the teacher with a supply teacher for the day. The teachers queried whether ancillaries and support staff could be trained up to help, because they have more time than the teachers. Some children, and families too, become too dependent. A village school, like this, knows quite a lot about the community it serves. Their main source of outside help is a Psychiatric Social Worker, who is based in Social Services, but is paid for by Education. They refer children to her via their families. She liaises with the school through reports. She is enormously useful, taking the pressure off teachers, but unfortunately she has a long waiting list.
School staff felt that there was too much pressure on children to achieve targets in reading and maths and parents also add to these pressures. It seemed wrong to be talking to 10 year-olds about failing in these terms. There seems more stress amongst children at an earlier age, perhaps related to SATS and the requirement for early achievement. There is also individual targeting for children not quite reaching level 4. And the government is now pushing for more competition in sports.

Liaison with the GP is generally poor. For example, a child with a burst ear drum was picked up in school through regular hearing tests. It was suggested that the parent should take the child to the GP, but it took three days to get an appointment.

The school nurse does the usual examinations and screening. She also helps with asthma and supports teachers in PSHE, starting with hygiene “Keeping ourselves clean”. She also deals with parents over head lice. The school works with her to get help for particular children e.g. they recently had to deal with a child with an unpleasant smell, whom the other children were rejecting. She suspected neglect and brought in the social services and the problem seems to have been solved.

In a village of this size, most children walk to school and this is good exercise. They agreed with the parents that the Sports Centre in the local town was quite good, for example in running special summer activities. But the poor families cannot get there.

Drugs are a big issue in this community, because they are widely available. Their sale is very obvious – it is not anonymous like in a large centre. A special meeting held in the village turned out to be very negative, since the villagers were very defensive. The parents bury their heads in the sand, but children are as much at risk as in large cities.

Secondary
A wide selection of subject teachers and governors attended the meeting, including the SENCO and the head of the ETHOS team. The school secretary and caretaker also participated. Two of those present were also parents.

The ETHOS team was set up eight years ago. It has four members who have both academic and pastoral duties. Each has a caseload of students whom they monitor throughout their school career. They look at pressures on the children and deal with parents. They work in support of the tutors, who would be the first person for a child to approach if they wanted help or advice. The tutors stay with the same class for five years.

A lot of children seem to have problems with bereavement. Two members of staff have done courses on bereavement counselling. All staff are involved in the first instance and then, if there is greater need, the children are funnelled through to the counsellors. If one child has a “loss”, their fellow students tend to be very helpful.

There is a lot of depression amongst children, which is often revealed in body language. There is also much post-viral syndrome and glandular fever and a clear increase in anorexia (1 or 2 girls at any one time). There is a feeling amongst the staff that children are put under great pressure by the constant testing in school, and they
suspect a link between stress and physical illness. They have the services of a psychiatric social worker once a week and the school also pays for a counsellor.

The physical fitness of the children is not good, but the school allocates as much time as possible to PE. They feel that exercise also leads to greater alertness.

Each year they have at least 1 teenage pregnancy. The teachers felt that the sex education lessons were adequate and in addition, a local GP comes into the school to talk to Year 11 about AIDS and other sexually related issues.

The school doctor is well liked but does not come in at all often. The receptionist is the person that children turn to for advice on any matter. She has first aid training and keeps the asthma inhalers. A helicopter lands on the playing field when it is necessary to take a child with an asthma attack to hospital. The practice regarding prescription of Ritalin is totally variable and schools get caught in the middle of what parents, children and different GPs seem to want. There are local efforts now to try to develop an agreed consistent local policy.

The teachers feel that the school is an important part of the social scene, as it is the only place where many of the children meet, due to the very large rural catchment. They believe that activities such as drama are very important in allowing the expression of feelings, and, through exploring ways of dealing with feelings, play an important caring role. The region is economically deprived, with 16% unemployment and an elderly population. Wages are low and the children have low expectations. There is no back-up Youth Service as is available in the larger towns in the county. In fact there appears to be little structure to life, for example provided by the Police or Church. Parents appear to live unstructured lives and children make up their own rules. Children are exposed to a pub culture very early. In fact one pub is open for teenagers to play games. Alcohol is the biggest problem and plays a major part in the lives of the children, girls as well as boys.

Twenty percent of children are eligible for free school meals, and there is no stigma attached to this. But the quality is not good. However, parents often regard this as is the main meal of the day for their children.

Lack of sleep is a problem for many children. They often have their own TV and video recorder and frequently stay up until midnight. Then they have to get up at 6.30 am to be ready for the school bus. This puts them under pressure and tiredness leads to a lack of interest and commitment in their lessons. Parents do not seem to be able to deal with this in their children. In fact some condone it and make excuses for the tiredness. If teachers complain, the parents think that the teachers are trying to take over parenting and they become unhelpful. Parents often seem to feel inadequate and shun any chance that they might be confronted by “experts”. There is a strong feeling in the community of being anti-establishment.

School phobia is not uncommon. In year 7 it can be due to poor adaptation to secondary school. This affects at least one child a year at this stage, and currently there are three children aged 15/16. Often these children seem calm in school, but their parents have terrible problems in the morning actually getting them to school.
There are several centres for education out of school and the staff also work with children at home. Their experience is that many children end up there due to alienation in their mainstream school, where somehow they have missed out on the support they need. It may be that they have failed to find someone to talk to – it is often only small things. They are usually very fearful of coming back and need a lot of support.

**Locality B**

**Needs profile**

- Three quarters of the area of the county is rural, with residents living in small towns and villages.
- The level of social deprivation is high. Previous reliance on heavy industry has left a legacy of high unemployment and a social infrastructure and community identity without a focus.
- This is the poorest county in England in terms of average disposable income.
- The infant mortality rate of the county in 1994 was 5.9%, compared with a national average of 6.1% (County Public Health Statistics).
- The unemployement rate in the wards around the schools in 1996 was 15% (compared with 7.6% nationally) of whom 65% are long term unemployed (55% nationally). There are high levels of casual employment and part-time female employment.
- Youth employment is a significant problem. It is estimated that 1/3 of all unemployed are under 25.
- In 1996, 56% of school leavers continued in education, compared with a national rate of 60%.
- The secondary school’s own files show that 25% of the pupils live in single parent families, compared with a national figure of 13%.
- 4.4% of the student population have statements of Special Educational Need (2.9% nationally).
- The percentage of the school population permanently excluded in 1995/6 was 0.13 (nationally it was 0.17).
- At secondary school, unauthorised absences from school stand at 1.3% , compared with 1.0% nationally. At primary level they are lower than the national average.

**The local school environment**

The study schools are located in a medium-sized town. The secondary school also admits children from several semi-rural dormitory villages within a four mile radius of the town. The headteacher of the secondary school described the catchment of the school as deprived. Most pupils come from large council estates and close to 40% are entitled to free school meals. He suggested that poor nutrition and over-reliance on alcohol, together with smoking, were the chief health problems of the community. He felt that the life style of the families was very poor, with narrow horizons, and that there is little parental support for the education process – “It is something that is ‘done’ to their children.” Nationally, there is a correlation between the educational
level of parents and the academic success rate of their children; here the percentage of parents with post-school qualifications in the six wards (the school catchment) is 8%, compared with a national figure of 13.4%. There is not a culture of learning and success and the families and the children have low aspirations. In particular there is a situation in this town that reverses the national trend for girls to do better at school than the boys. The expectation for girls is very low and they do not do well, with depressed horizons and poor self image. Many are secondary carers, with family responsibilities, and the proportion of those who get pregnant while still at school is above the national average.

In the primary school, 35% have free school dinners and 27% are at stages 2 or 3 of the code of practice for special educational needs. Most of the children come from two large council estates, though some in each school class live in privately owned homes on the new estates. The area is overwhelmingly white, with families living here for generations. Only 4 of the 170 children do not speak English as their first language. There is still a strong reliance on family; grandparents are often actively involved with the day to day care of their grandchildren. Grandparents often come into the school to help, instead of the parents, especially at Key Stage 1 (up to age 7). The “dinner nannies”, too, are a most helpful group of women, excellent at ensuring that the children eat sensibly and behave well at dinner time, as well as being good at dealing with minor accidents. The meals are still cooked on the premises and cost £1.20.

The school has a policy of taking children from the Women’s Refuge. Because of this, all members of staff carry personal alarms. Other parents, too, have been violent in the recent past.

A special element of the population comprises settled travellers, who tend still to move away for a period during the summer. Their culture differs greatly from the ‘native’ population. They place less value on formal education and it is quite difficult to get their children to attend school. The primary school finds that traveller children are often 18 months behind their chronological age.

The Educational Welfare Officer for the study schools spends a lot of time on home visits, up to 25 in a normal week. On the largest council estate she reported very low self esteem in families, with parents demoralised and defensive and low in parenting skills. Their main priority in life is to make do on low wages or benefits. At the secondary level she has found a high level of mental health problems amongst the parents, so that the children have to be the carers. She finds that most of her referrals are to social services or the mental health team.

This county has made positive steps to encourage children to participate in decisions that affect them, creating opportunities for them to comment on issues. A Children and Young People’s Council has been established. Work has been commissioned using children as researchers. This is reported in the Children’s Services Plan 1998-1999.

Professionals from several fields identified a gap in services for children with emotional problems, not severe pathology which is covered by the Child and
Adolescent Mental Health Service, but lesser problems that might show first as changes in behaviour in school. In connection with this, there is felt to be a great need for parents to improve their skills in managing their children’s behaviour, in the case of both young children and teenagers.

The school nurses were also concerned about depression amongst teenagers. On the whole they found GPs unresponsive with little understanding of this age group. The educational psychologists also felt that depression was an area that needed more attention, since from the age of 14 it might mark the early stages of a serious mental health disorder. Teaching staff are not skilled at picking this up and there is a tendency for other professionals to ignore the problem since the young person would soon be moving on to the adult services.

Four disorders were reported as being of particular concern to parents: attention deficit disorder, dyspraxia, dyslexia and conditions on the autism spectrum. The parents often request medication, which is not monitored well. The paediatricians feel that children on the autistic spectrum are not well managed. Such boisterous children are often difficult to handle and parents often do not cope well, especially when there are not two parents to share the load. Much more speech and language therapy is needed.

Another large gap in children’s health services is a named doctor to take responsibility for children looked after by the local authority, who form a high risk group.

Children with chronic disorders are, on the whole, able to attend school with few problems. There remain some problems of the provision of a safe, comfortable and private environment for medical procedures, such as self catheterisation or insulin injection. In the case of diabetes, the most difficult situation arises when a child is diagnosed when already at secondary school. Frequently no-one in the school gets a handle on the dangers and the speed with which a child can deteriorate.

Although there is already a constipation service, this remains a problem right across the age groups. There is a need for support in the school environment and help with practical care.

Sexually transmitted infections can also be problematic and there can be referral problems especially for younger teenagers in danger. An example was given of an under-age girl in a sexual relationship with an older person known to have syphilis.

Another group of children whose needs are not fully addressed are those with disabilities now attending main-stream schools. It is often difficult for these children to join in extra-curricular activities, especially those that are exercise-based. It is also time-consuming for therapists to visit a number of schools. For children with special needs, especially those with medical needs, respite care is a huge problem, which gets worse as the children get older.
Focus groups

Children

Primary

(12 children from Year 6, aged 10-11)
Diet and exercise were the issues first raised. The children were aware of the need for a balanced diet, the value of fibre in the diet and the advice on eating five portions of fruit and vegetables each day. However, several found a balanced diet difficult to deal with, since they did not like vegetables and were constantly tempted by chocolates and crisps. Ten out of the 12 brought a packed lunch to school, which enabled parents to share in the decision on what was suitable. One child took vitamin tablets since his mother felt that what he chose to eat was not adequate.

During term time, most exercise was related to activities organised by the school, such as netball and football. During the holidays, walking and swimming were mentioned as family activities, though children living with only one parent felt these had been reduced.

They were interested in sleep. Ten of the 12 had a TV or play station in their bedrooms and watched late programmes. One girl suggested “I have on the TV to make me go to sleep.”

If the children had a health problem or something that was upsetting them, most said they would talk to a family member or someone close to the family. At school they would go to their class teacher, the school secretary or the caretaker. The school nurse was well known to them and was a possible choice, though the general feeling was that she was there for a different purpose.

The children had a firm awareness of the dangers of smoking. They also felt that it was a smelly habit and was dangerous for other people nearby who might inhale the smoke. However, they were unsure how they would react to peer pressure to try cigarettes, which they felt sure would come in secondary school: “They call you chicken, if you don’t agree” and “They think it’s cool to smoke.”

The dangers of alcohol were seen in terms of controlling intake and the possibility of accidents if driving while drunk. Solvent abuse was also mentioned.

Secondary

(Mixed group of 16 children from Years 7 and 8, aged 11-13)
All said that they were basically healthy, though for four there were a few question marks over tempting but unhealthy foods and too little exercise. Only two of the group seemed to be really keen on sport, one playing football and another belonging to an athletics club. They were concerned about obesity and how it might affect their life style: “You puff and pant” and “You can’t get around so well.” And “You get tired quickly.” They also mentioned that being fat might increase the likelihood of heart disease. However, they were mostly very happy to get lifts in a car, wherever they were going. Eleven out of the 16 usually came to school by car.
A quarter admitted that they had tried cigarettes and they had several suggestions as to why they might succumb to the habit: “Your friends might smoke.” and “To join in the trend.” And “Curiosity” and “You might want to copy older people.” One boy felt you might start because others bullied you. All had tried alcohol and described its dangers largely in terms of violent behaviour: “When you’re drunk you might get into fights, or vomit or end up hurting someone.”

Fourteen of the 16 had a TV in their bedroom. The hours they spent watching per day varied from 1 to 6. Ten said they went to bed with the TV on.

Following a discussion on where to go for help and advice on a health-related problem or a worry that was upsetting them, one child summarised for the group “You’d go to someone sympathetic who knows you quite well.” For half this would be a family member. For this group, it was rarely a parent; more usually they mentioned a grandparent, an aunt or a cousin. For a quarter it would be a close friend. The rest would keep it to themselves: “I’d boot a ball about….” One mentioned Childline. None felt that anyone at school could be trusted sufficiently. They discussed whether the Head of Year was approachable and decided not. They did not feel they could trust the bullying counsellors (other children, with training), because they would want to know more than was necessary. None of them thought of the school nurse. They thought that a school counsellor would be useful.

**Parents**

**Primary**

In terms of exercise and encouraging their children to go out to play, the parents felt that there was a lack of public play facilities, especially parks where children could practice their cycling skills in safety. However, they felt that it was still possible for children to play out on the street close to their homes: “The neighbours look out for them.”

They felt that most parents were aware of what constituted an adequate diet, but felt that gimmicky marketing techniques used by the large supermarkets did not help, since it encouraged children to demand fashionable and probably more expensive alternatives. Television, in general, led to unreasonable expectations.

Drugs were a major worry. The older children had great street knowledge and the parents did not have adequate information and skills to maintain awareness and to offer sound advice.

Symptoms that might indicate a mental health problem were also discussed. It was felt that most would be obvious in the school setting and that, at the primary stage, the class teacher would pick them up. Some, such as a child being withdrawn, might well be school-based, as in bullying, and the school generally dealt well with such problems. In other cases, such as nervousness or worrying, the school might be instrumental in acquiring a referral to a specialist source of help.

**Secondary**

No parents accepted our invitation to take part in a focus group.
Teachers
Primary
The teachers were fully taken up with statutory testing and were unable to talk to us.

Secondary
The teachers welcomed help from other agencies in the PSHE programme, particularly for drugs and sexual health. For drugs, the RIDE programme is used throughout comprehensives in the county and in year 6 of primary schools. It involves police officers and is supplemented by education through drama, a successful peer education effort. Sex education is extensive and the input of school nurses is valued, since they answer questions about the body with less embarrassment and greater knowledge. Some teachers felt that there was a gap related to the opportunity to ask personal and intimate questions and that some single sex lessons should be re-introduced. It was felt that young people needed more information on sexually transmitted infections.

Nutrition had become an important issue and the staff had conducted a survey of eating habits throughout the school. The concern was originally raised by a special needs support assistant who was watching the lunch-time purchases and behaviour of a particular pupil. The staff became convinced that many pupils were not eating properly and that this affected the afternoon’s lessons. They cited lack of concentration, over-excitability and poor behaviour as possible results. In the survey it was discovered that some pupils did not have an adequate breakfast. Some did not even have a drink and bought food on their way to school. The school lunch is priced at £1.25 and the staff felt that a wholesome meal could not be provided for this amount. The same menu was used week after week and the children became bored.

The teachers felt that many of their pupils came from deprived homes with narrow horizons. They felt that this showed not only in the quality of meals provided at home, but also in poor levels of support for the children in school activities and in parent’s reactions to poor behaviour in their children. Positive parenting schemes have been tried with mixed success, and failures are being analysed to inform new schemes. Positive parenting is included in the syllabus at the multi-agency unit for pregnant schoolgirls. A course on childcare is also being introduced as part of the syllabus for low achievers.

The teachers felt that poor levels of fitness were also due to lack of exercise. Although the school had good field facilities, they were under-used and little swimming was now provided. It was felt that a new initiative was needed to encourage participation. It was not fashionable to go to the youth club, though the youth leaders were working hard to provide attractive facilities.

The secondary school is resourced for children with physical handicaps, but they have experienced enormous problems in co-operation with the health authority, despite strong encouragement from the consultant community paediatrician and the manager of the child health services.
For problems affecting the behaviour of pupils, services provided by the Education Authority are very supportive. The Behaviour Support Service, the Educational Welfare Service and Educational Psychology Service are all excellent. When a mental health problem is suspected, the school can only suggest that the parents approach their GP to discuss referral to the NHS Child Clinical Psychology and Psychiatric Services.

Locality C

Needs profile

- Children aged 0 to 16 make up 25% of the population of the city. There has been an increase since 1991 in the numbers aged 5 to 14 and a decrease in the numbers aged between 0 and 4.
- 23% of households with children had 3 or more children in 1991; this compares with 18% in the city as a whole.
- Infant mortality was above the average for England and Wales between 1994 and 1996, at 7.7 per 100,000 compared to 6.1.
- Low birthweight was above the rate for England and Wales in 1996, at 9.6% of all live and stillborn infants compared to 7.6%.
- 17.3% of the city’s residents had a limiting long-term illness or disability in 1991, nearly a third higher than the average for England and Wales (13.1%). The city had the sixth highest standardised level of long-term illness out of 366 local authority areas in England.
- The annual years of life lost per 10,000 resident population aged under 75 from suicide and self-inflicted injury in males is 59.1 compared to 37 in the NW Region and 34.35 in England and Wales.
- The City Council’s Planning Studies Group found significantly higher levels of long-term illness in 1991 in the “Black other” category (which included those who defined themselves as “Black British”), the Black Caribbean category, the Pakistani community and the Bangladeshi community.
- This is the second most socially deprived authority in England and Wales. The ward where the project schools are located is among the most deprived wards.
- According to the 1991 census, between 25 and 59% of children in wards in the central city wards come from minority ethnic backgrounds. The national average is c.12%.
- In the autumn of 1996, 17.1% of the city work force was unemployed, which was almost double the national average, and in the six inner city wards the percentage unemployed rose to 25.1%. 44% of households with dependent children had no adult in employment. Nationally, from September 1993 to February 1997, 19% of the outflow from the unemployment register were leaving the employment market; But in this city, 64% were not leaving the unemployment register for a job.
- Proportion with statements of special educational needs is 32%, higher than the national average.
- 40% of under-16 year olds are growing up in lone parent households, compared with 20% in Great Britain as a whole.
• At any one time, almost 1 in 100 children in the city are in the care of the local authority. Two-thirds of children coming into care are between 0 and 2 years old or between 13 and 15.
• Between April and June 1995, the City Housing Department provided temporary accommodation for families, which included 451 children. The Traveller Education Service estimates that any one time up to 400 children from traveller families face eviction from temporary sites in the city.
• The northern part of the city has the highest rate of under-age conceptions in the country at 20 per 1000 girls aged under-16. Rates in the rest of the city also exceed the national average. Rates of abortion in teenagers are low but attendance at Family Planning Clinics is high.
• 69% of registered drugs users were aged under 30. Many of those in their 20s started to use drugs at a younger age.
• Seven of the ten wards with the lowest “income to child” ratios are among the eight wards with the highest mortality rates.

The local school environment
The city has a Young People’s Council, made up of two elected representatives from each high school and from youth groups. Consultation on health issues was carried out in December 1998 with 53 of these young people as part of developing the city’s Healthy City Plan. The young people rated their own health at present at 7 out of 10, and thought that when they were 30 years old it would be 7.8 out of 10, but by the time they were 60, it would be 4.4 out of 10. Their priorities for action on health improvement are: drugs (by a large majority); housing; pollution; teenage pregnancy and sexual health; anti-stress and anti-bullying measures; exercise and healthier eating.

Our discussions with Child Health and Education staff highlighted that in the centre of the city, and in particular in the localities where our study schools are located, safe play space is very limited and little used. It is very difficult for parents to supervise from the top of a tower block. There is a culture of taking taxis. Parents do not walk anywhere and also have poor physical activity. Children with moderate learning disability probably tend to be over-protected, and quite often do not attend appointments. There may be child protection issues where children have not been given medication but a study has shown that children with chronic illnesses are not worse school attenders. The children have poor diets with an excess of fat and sugar, and very poor physical activity. Many parents have poor literacy skills and cannot understand letters etc. Also, now for a second generation, they do not play with their children. All they may do together is watch television.

The level of need is going up in mainstream as well as in special schools. There are many more different diagnoses e.g. autistic spectrum. All need multidisciplinary working. Professionals have to prioritise more and more, and therefore neglect many areas completely. For example, dieticians have to do more gastrostomy feeding and this takes a lot of time. The threshold for being taken on by the Social Services Disability team is high; essentially children will only be seen if there is a child protection issue. Occupational therapy is over-stretched.
The prevalence of speech and language difficulties in children at the time of school entry is considerable. These children tend to be regarded as children with learning disabilities, and dealt with under that umbrella, or not at all, whereas they have very specific problems needing special skills. An example was given of a child in reception class. “No wonder he is not speaking, as he still comes to school with a bottle. But why does he come with a bottle? Is that the only food he’s getting or is it because he needs the comfort? Is he also not being talked to and listened to?” One member of the primary school staff said to the speech and language therapist: Now you’ve taught the kid to speak, he’s pester ing me! This last remark was given as an example of how the therapists often feel that staff in schools need to have a better understanding of their work and then could help to promote it. But as in so many other instances, these therapists fully appreciated how immensely difficult this was and how much the school staff valued the specialist input. Occupational therapists are concerned about children with dyspraxia and the physiotherapists about those with motor problems.

The primary school in which we carried out focus groups, interviews and discussion is situated in the centre of the city. The percentage of children in households (excluding owner-occupiers) dependent on Housing Benefit is 70% or above. Young people unemployed and claiming job seekers allowance is 20% (25% of young men) in this ward. The school mainly serves two estates, which have very many problems and a large transient population. Of the 46 children who enter the school at age 5, by Year 6 (11 year-olds), only 33% of children will be the same. The 46 children in Year 6 last year went on to 18 different schools. There is a lot of closure and reopening of schools.

The other area served by the school has been an Asian community for at least the past 30 years. The houses are quite grand because it was a wealthy area during the Industrial Revolution. In the recent past, 80% of the population of the school was Asian; now it is 60%. Because they are upwardly mobile and see this area as less good now, these families are moving to the south of the city. As a result, since September 1998, the school has lost 20% of its top-scoring children. Two groups are moving in to the area: Afro-Caribbean families from a nearby ward (where there is an enormous building and regeneration programme going on and a net loss of houses in order to create a more spacious environment; also trying to “de-ghettoise”). This has brought a lot of disaffected young black lads in, whose parents are very poor (the houses in the area can hardly be given away because it is regarded as such an undesirable area), with a strong drug culture. The other group is of poor and very mobile families; there are some 4 year-olds, for whom this is their fourth school. A new group that has come into the area, are Somalis; the boys are very aggressive and their mothers admit this. These mothers are very interested in and supportive of the school but often do not speak English well or know how to get things done in this society.

The most significant aspect of children’s needs is that the social and emotional demands on them (and that they therefore make on the school) are great and getting worse. Out of 320 children, 100 are going through statementing procedures at present. All those who are statemented as having special educational needs, should
then have individual education plans that are reviewed every half term. There are quite inadequate resources to implement this requirement. School nurse resources are also very thin on the ground. The school used to have the school nurse in for half a day a week, but this no longer happens. The school nurse picks up on referrals to the Accident & Emergency Department; GPs should also get this information directly. But the health visitor and the community child health services are not routinely informed about children who are not in school. The police will also send information through to the school nurse about domestic violence etc.

The school is having to deal with many more children with special needs - as in all mainstream schools - because of the closing down of special schools all over the city in line with Education Authority policy. The allocation of resources is felt to be inadequate and inequitable. The same amount of money is given to each school each year, with no match to the specific levels and types of need of the SEN pupils in the school. The school is a pilot for the trial learning support service in mainstream schools, which consists of a classroom assistant for half the week for each statemented child, with a special visiting teacher once a fortnight. This special teacher acts as a gatekeeper for Stage 3 children. This means that educational psychologists are one stage further away and only see children at the edge and this leads to problems. The special teachers are far too thinly spread. Also they are newcomers, not part of the team and the system is not functioning well. It would be better if the fund could be used for more time from the school SENCO. Here it is the Deputy Head, and she would do the job better. If each school were given the cash to spend as it wished, it might be able to develop resources to meet its children’s needs better.

The local EBD school has been running at 60% of its previous capacity which means that more children with emotional and behavioural difficulties must be managed within mainstream provision. Currently there are 3 statemented children in this primary school in this category; each has a support worker twice a week for an hour. There are three centres for EBD across the city, but it is very difficult to refer to one of these. Children are sometimes accepted for part of the week and it is difficult to see how this benefits the child. An example is a nursery-aged child, not yet statemented, but with many needs. He has been placed in an EBD Centre for three days and is back at the primary school for the other two. Many services are provided at the EBD Centre and the school feels he would benefit greatly from full-time attendance there.

The school would like to do more preventive work in the nursery class but the pupil/teacher ratio is 1 to 14, which allows for very little spare capacity. The Deputy Head is also the SENCO. Resources for special needs are linked to the number of children at stage 3 of the SEN Code of Practice; therefore, there are no resources to do preventive work and little incentive. The only member of staff in the whole school who has any spare capacity at all to deal with extras or emergencies, is the head teacher. He would like to take the most difficult child out of each class, and be able to do intensive work with the resulting small class of 11. He thinks he could make a lot of difference with them and, in addition, the teachers in each of the 11 classes would then be able to do better work, with their most difficult pupil removed. It is difficult for a school to plan strategically to improve things because all the pots of money are tied to specific, often short-term targets, which may or may not fit with priority needs or the local strengths of the children in a particular school.
General practitioner views
A general practitioner working in the locality in which the study schools were situated reported four main areas of concern:

1. Children have difficult relationships with the adults who mean most to them. This includes service providers. And after family break-up, children cope in a variety of worrying ways.

2. There is a problem with the recognition of mental illness in children; parents may fail to alert services because they are afraid that the child might be taken away from them. Difficult behaviour tends to be seen by parents not as a health problem but as their fault at not being able to control their child. The Somalis in particular seem to be strangely hostile to services.

3. A significant number of children act as carers. There are particular issues for some minority ethnic families because children may be left to act as carers because of the language and other poor access barriers to services for members of the family. But there may be taboos about the caring role, with a good deal of conflict surrounding it.

4. Asthma and skin disorders such as eczema are prevalent among the under-fives. There is also a significant amount of rickets and nutritional problems generally. The practice is doing some work with Muslim schools.

Focus groups
Children

Primary

(*10 children from Year 1, aged 6*)
They had recently completed a health project called PRIDE 1. It was based on the principle of keeping themselves safe, and dealt with healthy/unhealthy, safe/unsafe activities. All had received certificates in a special assembly, including their parents who had been involved in the project too. Each child took home a bag with materials, a Pritt stick and scissors and, with a parent’s help, had constructed a snakes and ladders game, a puppet and a house game. They seemed to have a healthy memory of what they had learned. However, some said that their parents were not interested, did not learn anything and watched TV while they did the project!

There were “house rules” which included: don’t touch the cooker; don’t play with matches or a lighter; don’t push anything into the electric socket (especially with wet hands); don’t play on the stairs; don’t open the door to strangers. They also said: don’t pick up glass; don’t pick up syringes (one boy said “There are a lot round my house.”)

All but two had a television in their bedroom and they listed a lot of programmes they watched, most of which were designed for children. One child said that he never put off his TV. Five said that they were often tired.

About half walked to school, a couple came by car, the rest by bus. They knew road safety rules. All said they had bikes, had learned to ride and rode in the park, in their gardens or on the pavement. All but one said they could swim.
Drug use was the first topic they raised. They could name the “bad ones”. All said that they did not know anyone who took drugs. For “good drugs”, they named aspirin, painkillers, inhalers for asthma, injections for diabetes. They knew of acute infections, such as meningitis, since one child’s sister had contracted it and the whole family had been immunised. There had also been a lot on television recently and pamphlets were available. They knew the symptoms.

More than half had tasted alcohol. “It's legal” they told us. They knew it caused dehydration, hallucinations, hangovers and that it was dangerous to drive. Smoking was disliked, because it makes asthma worse and could lead to heart disease and cancer.

They were eager to tell us about exercise and other pastimes. Seven of the 10 rode bikes, on the pavement, in the park and in the back garden. But they were not allowed to ride on the streets because their parents felt it was not safe. No safety training was available for cyclists. Most were able to swim and several went regularly to the swimming baths. Many after-school activities were provided and the children in the group went to gym, football, athletics and netball. Individual children also told us about karate, self defence, dancing, modelling club (war games) and French club. Other important non-school activities included visiting a separated parent in another town. Asian children often went to visit relatives. Most did not seem too bothered about watching much TV.

They knew a lot about fire. They had been on a course organised by the fire brigade, where they learned about smoke inhalation and how to escape from a smoke-filled building. The practical exercises undertaken as part of this visit had made a big impact.

They seemed interested in diet and cooking. They knew all the healthy foods and about the need for drinks during the day. This was the only school where the children told us that they liked school lunch. They practised their skills, by making tea and/or snacks for their parents.

The children were interested in bullying and emotional health: “My sister was bullied – they called her names. She was crying. My big brother came home and said that some people commit suicide because of bullying. And then she laughed.” Most of them put forward reasons why they might be sad or worried, such as the death of a grandparent or a pet. About half of the group said they would go to a family member or a close friend for advice. The headteacher, deputy head, school caretaker and school nurse were all mentioned. Two of them knew and liked their GPs. All said that they knew the school nurse. One family (with 5 children and one Italian parent) held regular family meetings on Wednesdays and Saturdays, to talk over problems and plans.
The children said they had had no formal sex education lessons as yet, but they had already learned a lot at home from mother or parents and also from brothers and sisters and from friends.

Secondary
5 boys aged 13 and 14, from Year 9
The girls from this class had declined the invitation to attend, saying “It would be boring.” The boys represented a good ethnic mix and were lively and articulate.

All had a clear picture of their own health or lack of it. Their main comments were to do with obesity, lack of fitness (couch potato), and minor ailments (colds, sinusitis, catarrh). They felt healthy - and looked it! They knew what they needed to do to stay healthy, but occasionally they succumbed to temptations, e.g. chips with gravy at lunch time, buying chocolate or sitting for hours in front of the TV. Most felt that it was their own job to look after their health, but one child who was overweight, was working in partnership with his mother. They were also quite willing to give advice to each other. They decided that one boy was unhealthy (he had colds all winter) because he did not get out and walk in the fresh air. His father brought him the 3.5 miles to school. The rest felt he was over-protected, and that he should walk to the main road and take the bus.

Most could think of the effect of ill health on daily living, largely from the experiences of their families. All had examples of relatives and friends with health problems: an uncle with leukaemia who had to go to hospital, had to avoid catching infections, was unable to work, in fact unable to do much at all. Another boy’s father had diabetes and had to give himself injections and be on a special diet. A grandmother was overweight with bronchitis and could not get to the shops. Another’s mother smoked. They also discussed physical disability. One of the boys knew someone who had had a leg amputated and was in a wheel-chair. They decided that this person was not ill but that it was more difficult for him to maintain good health. One boy also described a wheel-chair-bound child with learning disability who needed a lot of care and attention.

We then talked about the major causes of ill health. They had knowledge or experience of chronic illness, especially asthma and diabetes, and described the need to carry medication and snacks, and if young, the need for help with injections. They also gave AIDS as an example. Recent television programmes meant that they all knew about meningitis and e-coli. TB was uppermost in their minds, since they had all had Heaf tests and were comparing reactions and discussing if they would need to be given BCG. They brought up the need for personal hygiene, and the cleanliness of wash basins, toilets, drinking water, and the canteen.

In relation to emotional health, they mentioned stress, anger, anxiety and sadness. One had suffered panic attacks and was seeing a psychiatrist on a long-term basis. Another had had sessions with a psychologist because of headaches, and had learned relaxation techniques to reduce tension. When questioned where they would go for help if they felt depressed, two thought their friends, but another thought friends would not be a good idea, since they would not take it seriously. He favoured his mother or grandmother. Another said his uncle, as someone he trusted (no mother
here, short-tempered father and father’s girl friend living just up the road). No one mentioned any one in school, except for friends. They said that they could not trust the teachers and they thought of the school nurse in terms of immunisations and dealing with minor accidents.

The discussion then turned to unhealthy behaviours. Lack of exercise, poor diet, and poor personal hygiene were all mentioned. They know what are the healthy foods and the school salad bar got a particular mention. They took some time to come round to smoking, alcohol and drugs. They all knew the possible outcomes. They thought that their PSHE lessons had been good, but felt that they should have learnt something about drugs earlier, in primary school. We also talked individually to an Afro-Caribbean girl who thought that exercise was important in keeping fit. She went swimming because it was also fun.

**Parents**

**Primary**

The first topic raised was food. Lunch is still cooked on the school premises and most children like it. They have some choice, but it is monitored through the “traffic light “ system – children have to choose 1 red item and so many green items. Milk is no longer available at playtime and discussions are being held with regard to its possible reintroduction. The school is prepared to pay, but do not want to waste money. Some parents say their children don’t like milk; others are in favour. Only a small percentage of children come to school without breakfast. Everyone is now aware of need for drinks during the day, but there is no water fountain in the school. The children bring in drinks, but some are unsuitable. The staff say it causes a hassle.

The parents seem satisfied with the PE provided in school time. There are also a lot of after-school activities: football, tennis, netball, gymnastics, cricket. They were unhappy that swimming has been cut; it is now available to just two classes at a time, for one term each. Apparently, there is a financial problem and the number taken to the pool has been reduced gradually over the past 5 years. Now it is difficult to find pool time. Out of school, swimming pools are not accessible for parents around here. Sports centres are also far away and expensive. It is not safe for bikes. Cycling is not allowed in the parks and the police do not do cycling proficiency tests.

Other after-school and holiday activities were described. The school is quite good at arranging trips which, on the whole are reasonably priced, though some families have problems paying. There are not many local facilities and children get bored. Summer play schemes are arranged, but of course numbers are limited.

We had a discussion on where to go for advice. Most thought of asking their own GP but few thought of the school nurse, whom they saw in terms of eye tests at nursery age. One mother did not know where to turn with a possible eating disorder in an eight year-old who was very thin and would not eat a balanced diet. Another described a problem with soiling; the child had seen a psychologist at the Child Mental Health Centre (NHS facility), but had found the experience stressful, and the mother felt they were back where they had started. There was general agreement that referrals to this
Centre were difficult and also that travelling to the LEA Behavioural Centre was difficult. The level and type of expertise did not seem to be what was required.

We discussed the importance of getting involved in the school (these parents belonged to a new parent’s organisation). The parents decided that it was well worthwhile since you get to know what is going on.

On health education, the parents decided that PRIDE was a good programme. All were in favour of its coverage of drugs, alcohol and smoking. Sex education was more controversial. We discussed TIC TAC, since it had been described on a recent TV programme. Not all were in favour, especially the Asian parents, but all were agreed on the importance of tackling sex education in the home.

Lastly the issues of racism and promotion of self esteem were raised. The curriculum is designed to exclude ethnicity and this was felt to add to the problems of black children in developing a positive identity.

Secondary
This group included a parent who worked in the school catering department. They were pleased at the recent introduction of a salad bar which was being used, although it was in competition with the pasta shop and the “chippie”. They felt it was a pity that there was no cookery room at the school.

The parents said they would like to see a school based health centre.

A lot more use could be made of school nurses and counsellors, particularly with regard to sexuality and sexual health. It was felt that the school did not deal with these matters openly - perhaps they could not. Sex education programmes should include skills in “speaking up for yourself”. Some girls acted in a sexually provocative way and they needed to learn that this was not acceptable behaviour. Special skills were needed to do work of this kind with young people, and it was recognised that school nurse caseloads were already overloaded.

Opportunities for exercise were seen as important, as physical exercise could give one a sense of achievement. There seemed to be quite a lot of different kinds of activities on offer. It was important to make sure that “acceptable” forms of exercise were available, that fitted in with young people’s desired image.

Teachers
Primary
The teachers initiated the discussion with the question of exercise. It is difficult for children to keep fit. There are poor facilities in the locality and so the school tries to help by getting children onto courses and also arranges for experts to come into the school to help, running several after-school clubs (see above, listed in parents’ section). Few children do additional active after-school leisure pursuits – the parents have to be committed and few are. Also the environment is unhealthy and unsafe, with broken bottles and syringes in play places. The situation is improving slightly, but is still poor. As a result, children have no concept of the effort required and they
easily get puffed. The school is trying to improve matters by organising the lunch
time more; they have 50 minutes and feel this is a valuable time for exercise. So they
take out equipment and have trained organisers.

Diet and teeth are also a worry. Many children’s teeth are in poor condition. Parents
are not healthy themselves, and most do not know what is a balanced diet. Food at
home is often unhealthy, though sometimes this is a necessity, because of large
families and low incomes. The school has had a problem with sweet fizzy drinks at
playtime, but you cannot demand sugarless fruit drinks, because they are more
expensive. Playtime milk is also a problem. The school will pay, but they ballot ed all
parents and the majority did not want it reintroduced. School meals also are not as
good and wholesome as previously, with reconstituted chicken and potatoes.

The teachers were also concerned about the effect of too little sleep and too much TV.
Many young children watch TV until late. Their attention span at school is very poor
and they don’t listen properly, with an understanding that a response will be required.
They are used to a high level of background noise. Parents seem to have little control.
In fact, parenting skills are very poor. They sometimes ask the teachers for help “I
can’t get him to eat breakfast. Will you tell him? He’ll listen to you.” Pastoral care
in this school is very good. Teachers are very caring (and parents say they are
approachable). In secondary school, it is very poor and the children don’t get the
same nurturing.

Primary children need knowledge of drugs. The city has a programme called “Kick
it”. Experts make an annual visit to schools, with the message “You need to be
healthy; you can’t be healthy if you take drugs, drink alcohol or smoke.” It is useful to
have someone from outside coming in, because the children listen more. Shock
treatment may work, especially in combination with other methods, but reinforcement
from home is also needed.

Challenging behaviour is perhaps the most difficult and stressful situation for teachers
to deal with. The school nurse cannot be effective at this stage, since the referral
system is very slow. In the meantime the teachers have to try to contain the child.
This often affects the other children in the class. Sometimes exclusion seems the only
option. The LEA runs a “behavioural” school, which has an outreach service, but it is
quite inadequate. They employ a range of teachers and classroom assistants who have
had job training - you would therefore expect them to have skills in this area, but
these were not felt to be obvious. The service has to be accessed through the
educational psychology (EP) service.

Depressed and withdrawn children are also a problem for teachers. Parents apparently
find the NHS Child Mental Health Centre very stressful, perhaps because it requires a
lot of role play and they have to open up about issues. If the teachers think that a child
is withdrawn, they could involve the school doctor, by putting the child in for a school
medical. Emotional problems affect a child’s learning ability. They gave us an
example of a boy who does not have severe behavioural problems, but a poor self
image. His parents find him impossible to handle and they are almost saying “We
want you to parent him.” What can teachers do? SERIS (Supporting children with
Special Needs) is available, but who should be talking to them? It is not a teacher’s
role. Sometimes the teachers feel that a self-help group for teachers is needed and this focus group has been useful in this respect!

Secondary

The major preoccupation of the secondary teachers was with mental health needs, which they felt were unmet in terms of counselling as well as psychiatric interventions. There is a high rate of bereavement among children in the school, and many have suicidal tendencies. The school can see problems coming but have nowhere to go for help at an early stage. The school nurse can assist sometimes and the other source of specialist help from the NHS is the Child Mental Health Centre. The Educational Psychology service is extremely limited; the school sees the EP for perhaps three days a year and there is a huge waiting list for statementing. There is a lack of cultural awareness and no-one is good with the needs of black children. There is nothing for refugee children (many of whom are traumatised from war experience) and the school has 8% Somalis. Because there is a high rate of movement of families in and out of the area, the school has many new arrivals. A number of these children are already severely damaged and there is little or no information, let alone outreach support for them from their previous home services. Some families move in order to avoid their previous home Social Services, and so do not want to be linked in to new services.

We were told that, on arrival at age 11, 70% of children were not able to sit still for lessons, that some were very damaged, and that also in Year 8, 70% of the children needed some sort of counselling. The average reading age on entry to the school was 6 years old. In fact, the school functioned as a school for moderate emotional and behavioural difficulties. The class sizes were too big to manage satisfactorily this number of children with such serious problems, let alone being able to offer positive help. If children were known to Social Services, mental health expertise was often not sought when the school felt it was needed, because Social Services were extremely reluctant to “label” a child as having a mental health problem. The school felt that many of these children needed some sort of sanctuary, and the school might be the only place where they felt they got it. The teachers thought that they needed a qualified counsellor experienced with children, on site. Parents were not fulfilling a supportive role with their children (95% of children were felt to have significant family problems) and by default, the teachers took this on.

The feeling was that Education was used as a whipping boy to sort out all ills, using the evidence of school attainment to monitor its performance. But this school was dealing with children from a burgeoning underclass living in extreme poverty. There was a great deal of extra work in the school to deal with child protection matters alone. Teachers may well have to talk to the abusing parent. Apart from the social and health issues, the educational issues were enormous, and no money was attached for help with these extra needs; only allocated according to pupil numbers. If one got the class sizes down so as to work better with very needy children, one was penalised in that fewer numbers meant less funding. In addition, school achievement is not assessed on the basis of differing base-lines between schools. The progress made by children at this school was often remarkably good but the Year level is still likely to be below national targets, because these children start so far behind. It is difficult to
create a legitimate sense of achievement, pride and further motivation in pupils and teachers when the “mark” will inevitably be “failed”.

The Home-School Liaison Service was doing a particular project with Afro-Caribbean children, mainly 16 year-old young men, whose families have lived in this country for three or four generations. They no longer have a feeling for a specific Caribbean community. They come from backgrounds of very great economic and social deprivation, with extremely limited opportunities to move away from totally dismal expectations; they do not see black people succeeding. A high proportion of those on the project will have spent some time in prison. The project works to increase a sense of self worth, purpose and goals for the young people. Young men are referred to the project by the year head, the head-teacher, or by a parent or carer. School based group work and one-to-one advice and guidance are offered, including work with parents where possible. The school also supports transport and administration costs for expeditions to see other places, such as mountains or foreign cities. The hope is that this will relieve the bleak sense of the world. The project was originally funded by the Home Office, but now the school has to raise the money. The counselling is geared to the needs of Afro-Caribbean children, by people who know the community and are specifically trained. Otherwise these children will not trust just anyone nor allow just anyone to help them. Many of their problems are highly sensitive such as having a father in prison or a brother recently shot. Many of the opportunities for counselling arise when out on expedition - up a mountain or rock climbing.

Food and diet were further issues raised by the teachers. The school catering was contracted out and did not provide a nutritious choice at a reasonable cost. The children have easy access to a machine that dispenses Coca Cola, chocolate and other snack foods.

**Locality D**

**Needs profile**

- The infant mortality rate in 1991 was 4.6% compared with a national average of 7.3% (OPCS VS1 Statistics).
- The proportion of low birth weight babies is 6.10%, slightly below the national average of 6.80% (OPCS VS1 Statistics).
- The yearly average (1988-1993) of live births to teenagers aged 15-17 is 10.42 (per 1000) in the neighbourhood of the school, compared with 6.85 for the county (County Health Reference Atlas 1994/95).
- The percentage of single parents across the county varies from 0.8 to 1.8, lower than the national average which stands at 2.1% (1991 Census).
- The unemployment rate across the county is 6.19%, but it is higher in the neighbourhood of the school (7.17%).
- In the southern coastal part of the county, 1.9% of the child population (aged 0-15 years) had a non-white ethnic origin (1991 Census).
- In September 1996, 713 children (0.46%) were being looked after by the Social Services Committee (County Children’s Services Plan 1997/98).
The local school environment

Our schools are located in a coastal village, half an hour by road from the county town. For the south of England, it is quite isolated, since there is no road running along the coast and there is only one road into the village. Public transport is limited to buses, which are not very frequent. It was formerly a busy tourist area, but tourism has declined along with other UK locations, so much so that the area is in receipt of money from the EU Single Regeneration Budget. Most people are employed in farming or farming-related industries or in tourism. Fifteen percent of primary children and 12% of secondary children are entitled to free school meals.

The population pyramid shows a distortion to the 60+ age group, since this is a popular retirement area. Services are also skewed to the elderly. A new estate is being built in an attempt to attract younger families and even out the population profile.

The indigenous population is very stable, with very few families moving away from the area. At the same time, there is evidence of an inward movement of families who are often under stress, often linked to family break-up or unemployment. Thirty ‘incoming’ children were enrolled at the secondary school during the course of the previous academic year (the total on the school roll is 500). More than half were already on the special needs register or were added to it within three months. They included some already statemented, some with emotional difficulties and some expelled from other schools.

The primary school has a reputation for dealing well with children with special educational needs and hence they get more than their fair share. Five percent of the children have a statement and 29% are at Code of Practice stages 2/3. The school has built up a fair amount of expertise in this area, but they find it very time consuming, especially attending conferences and preparing follow-up. It is not always easy to deal with Social Services. They should be pulling together all the work done in the various agencies, but frequently they do not communicate back to the school. An example was of a mother who often appeared drunk, so that the school had concerns about care and nurturing. The school involved social services, but they have had no feedback.

The primary school also has problems with children who are enrolled just for the summer term. Since they come in after Easter, they are not funded and there is no support from the LEA. The children often have behaviour problems. We heard of one child whose mother left him with her sister and then returned to London. The child shows signs of great disturbance, fighting and spitting in people’s faces and is generally very difficult to handle.

The school is very interested in behaviour and recently sent out a questionnaire to parents, covering possible behaviour problems, signs of happiness and unhappiness, changes in habits and bullying.

Most professionals, from health and other agencies say that their chief concern is about emotional health. Teachers have less time than previously for the pastoral care
of their pupils and they have moved away from looking after their well-being. There is a great emphasis on the national curriculum, and the time with the form tutor is taken up with a multitude of tasks. The educational psychologists no longer have time for consultation and teachers’ training does not contain much on physical and emotional development. At the same time, the number of young people who self harm or attempt suicide continues to remain high and there seems to be a high level of stress and worry and minor mental health symptoms. For the latter there seems to be a gap in the services and young people seem unsure where to go for advice or even for a chat. School nurses report that at ‘drop-ins’ they are asked questions on sexual issues, drugs, alcohol, smoking, eating disorders, body development, family problems and relationships. They also report that for serious mental health problems such as borderline personality disorders, severe conduct disorders and drug addiction linked with underlying psychological problems, that are found especially in adolescents, there is a marked gap in services. The Child and Adolescent Mental Health Service also reported a gap in all services (Health, Education and Social Services) for children excluded and school refusers.

Sexual health advice for teenagers is widely available in the county, though more difficult to provide in the rural areas. A sexual health nurse runs the Youth Drop-in in the town on most days, including Monday morning (mainly for the morning-after pill), and at times in the mid- to late- afternoon when pupils can get there after school. She has tried similar clinics in small towns, but no-one came. The school nurses discussed whether such clinics should be based in schools, as is increasingly happening in the USA, where schools are seen much more as a community resource. Most of the school nurses have also done family planning training and are available for advice at drop-ins at the secondary schools. However, they say that girls often ignore their advice and then arrive back for pregnancy testing.

There is evidence that many young people who smoke would like to give up. There is a gap in advice, support and education in this area.

Children with chronic illness have both medical and emotional needs in school. On the whole the administration of medication has been sorted out, though there are still fears about the use of emergency adrenalin administration in the case of peanut allergy. There was some concern about the monitoring of children on stimulants and anti-depressants. Dealing with emotional problems for children with chronic disorders is less-well organised. There is also a great need to deal with constipation and soiling in secondary as well as primary schools. With the current screening programme, children with co-ordination problems can be missed and it is difficult for teachers to judge whether a referral is appropriate, though early referrals have the most successful outcomes.

A special conditions register (SCR) linked to the child health computer system’s register of all children has been in use in the county since 1977 (Woodroffe and Abra 1991). Of the 155,000 children aged 0-17 resident in the county in 1990, 4.3% were included on the SCR. Altogether 45.7% of children on the SCR had physical conditions with mild or no disability and 17.2% had moderate educational problems. The prevalence of severe hearing loss as defined, was 1.7 per 1000 aged 5-17. A
The well-validated prevalence of diabetes mellitus was recorded for 1.2 per 1000 children aged 0-17.

The County Community Dental Service believes that oral health is marginalised and so they are attempting to integrate it into general health. In addition to regular screening and specialist care for vulnerable children, they also promote healthy eating and provide resources for teachers as part of the school curriculum. They have recently completed a primary school snack survey and as a result have made recommendations on availability of drinks, free access to cold fresh water, snacking policies and provision of school milk.

Staff in the School Health Service feel that they have recently lost opportunities for health promotion with parents. Many professionals are concerned that parents appear to be having great problems with parenting and in particular with dealing with poor behaviour.

Accidents are the main cause of mortality and an important source of morbidity for children of school age. Statistics show that 12 year-olds are particularly vulnerable and it is surmised that, at the change to secondary school, they attempt to be more independent but, by this time, they have forgotten their earlier traffic safety education. There appears to be a resigned acceptance that children are playing indoors more and have fewer opportunities for communal play in the fresh air. They are also taken to school by car, rather than walking or cycling. There seems to be a need for a new awareness campaign for parents and children, dealing with safety and dangers, the social and health benefits of playing outside and travel awareness linked with pollution and fitness.

**Focus groups**

**Children**

**Primary**

*(12 children from Year 6, aged 10-11)*

All the children stated that they were healthy. Their reasons were mainly to do with healthy behaviour, especially exercise. All participated in school-based sports activities. Out of school they cycled, ran or walked, played outside in the garden, had golf lessons, went to hockey or gym club, did kick-boxing or played tennis and football. Other reasons were to do with eating fruit and vegetables.

They described unhealthiness largely in terms of older relatives: “My mum smokes.”; “My dad started a new job and has put on a lot of weight.”; “My granddad has asthma and still smokes.”; “My grandma has arthritis and needs a walking stick.”; “My aunt and uncle are overweight.”

As can be seen from the above quotations, the children were very aware of the dangers of smoking and also of the problems of addiction: “My dad is trying to give up and gets very bad tempered.”
When asked where they would go for help if they had a health problem or felt upset or anxious, two children chose their GP, but most said a parent or grandparent or a friend. One said he would go to his class teacher.

**Secondary**
*(12 children from Years 8 and 9, aged 12-14)*

Most of the group felt that they were healthy enough. Their perceptions of healthiness were based on exercise and diet.

When describing their leisure activities, the older pupils talked about meeting in groups and standing about on the pavement and drinking. They stated that there was little else to do in the village and it was expensive and difficult to go elsewhere, since the buses were infrequent. The shop-keepers were aware of the problem and tried to stop underage drinking, but it was always possible for young teenagers to obtain alcohol through older friends. In the summer months, the influx of tourists also affects the behaviour of local children. When pressed, they listed the dangers of excessive drinking, but clearly such dangers seemed a long way away.

Several of the children smoked. One 14 year-old girl stated that she was trying to give up, because of the expense.

**Parents**

**Primary**

As elsewhere, the first subject raised was headlice. The parents felt that the school health service was not doing as much as previously, and headlice remained a problem. Other medical problems were dealt with well by the school. For instance, a lot of children have asthma, but the teachers are trained to deal with difficult situations and the medication is kept in the school office from where it is quickly available. The class teachers are very approachable and the headteacher supportive.

The parents were strongly agreed that, by Year 6, the children need both basic sex and drugs education. They were quite worried about the lack of amenities for teenagers. Young children see teenage girls smoking and gangs drinking on the streets. In the summers, too, holiday-makers are sometimes very relaxed in their behaviour. There is really very little to do in the village for adults, except to go to the pub. Horizons are quite limited and young girls often settle down near their mothers, with a baby.

The school used to do its own school dinners and they were very much liked. Now 80% of the children have packed lunches.

The parents felt that their children kept quite fit. They did PE three times a week and there are gym, football and netball clubs after school. Bikes were very popular, especially with the boys. In the summer children walk and go on the beach, but it is a little worrying because of the number of outsiders on the campsites. The nearest swimming club for children is a long drive or bus ride.
Most families are pressing for a “paramedic” centre in the village, because of the distance to the district hospital. There is only one road into the village. It is narrow and congested in the summer. There is an estate of new houses in the village and the school rolls are rising, but there are no new amenities, except for the new health centre which is being built.

Secondary

Children are felt to be under greater pressure than the last generation. They receive very little praise in the media and what they do achieve tends to be demeaned, as for example GCSE results. Their stress may be linked to the need to get a job and earn well. In general, the media picture of young people is that they are troublesome and difficult. Building a positive self image seems to be more difficult for girls than boys – there are poor role models and the parents are always afraid of eating disorders. Boys seem to do better, but the high and recent rise in suicide rates amongst teenage boys seems to belie this. A GP who had had children at the study secondary school nearby, felt, however, that the school did not expect enough of pupils, and that they were demotivated because of expectations that are low.

There is a good programme for drug education in the county. It certainly makes the children aware. It is necessary because drugs are widely available and most children know where to go to get them. The more it is talked about and the dangers pointed out the better. There is a lot of peer pressure.

As far as drinking is concerned, the great difficulty is that alcohol is socially acceptable and is linked to the major forms of recreation and leisure activity for adults. It makes education very difficult, when it is not reinforced at home. But there are dangers and young people gather and drink too much. There is a town-wide scheme, including the village, for warning other retailers to be on the look-out for particular young people. This is for the sale of both alcohol and cigarettes. So many young people are smoking and the parents are very concerned.

When behavioural problems arise, children can really suffer, because it takes a long time to get an assessment done and sometimes it is done too late after a lot of harm has occurred. It is not the school’s fault – it is just that the system is stretched very thin. Also the Educational Psychology system is very busy; schools are allocated so many hours per term and therefore, the schools have to prioritise and choose only the most serious cases to be seen. More parental education is needed, too, and they need to take greater responsibility for their children’s behaviour. Perhaps more attention should be given to parenting in the school curriculum? Will it be included in the new Citizenship syllabus?

Games and sports are important, since it is an area where some children can succeed. It also teaches children to control aggression. Not so much time is allotted to PE as in the past and it is even being cut in the primary schools. Children do not get as much exercise as they should; they do not even walk to school. Considerable effort were being made to introduce dancing and other forms of exercise into after-school activities, but there was no guarantee that they would be well attended.
**Teachers**

**Primary**

The emotional needs of the children are the main problem, even at this age. Many seem to be under great pressure because of problems at home. One teacher gave an example of a child who was not eating and she was worried about a possible eating disorder. In this case, the class teacher would first try to talk to the parents; if they did not respond and the worry remained, she would go to the headteacher. An alternative would be to use the school nurse, who came in every week, though perhaps not for what they considered a social problem. In one case recently the nurse had been involved in a behaviour problem of a child in the reception class.

Health related issues are taught as part of the science curriculum and the school nurse is used as a resource. In years 1 and 2, they deal with healthy eating. In years 3 and 4, personal health is covered. In year 6, drug education is started. The children are taught to have an awareness. The teachers are fearful of using scare tactics, in case a family member is involved. They could do with support from outside.

Nutrition is another problem. On the whole the parents do not give balanced meals, perhaps because of the expense of fruit and vegetables, perhaps because of the time involved in preparation. Most no longer eat meals properly at a table; from one class, 10 sat down for a meal, the other 20 had it off their laps.

The teachers are concerned that they have to spend so much time on teaching concentration and listening skills. They believe it is the effect of TV; it is always on, as background noise; the children just have to watch - there is no need to respond. Many children have TVs in their rooms and they watch until late. They find that peer pressure encourages this: "What did you see?"; "Did you see.....?" Children are often tired and cannot cope with the school day.

The school is equipped for children with physical disabilities and feels it manages them well. There have been negotiations in the past for the provision of equipment and aids for the disabled e.g. a splint and a hard hat. The staff never expect anything to go smoothly. There is poor contact between health workers. Two turn up at once for the same child, or none come at all. They need a key person to co-ordinate the care. The speech and language therapist also comes into the school, but she is very stretched for time.

**Secondary**

In year 11 (age 16) in particular, long term absence is on the increase. Currently there are two pupils with clinical depression. The level of distress amongst the pupils is on the increase. There is great anxiety, because of pressure to get work in. There is a general lack of confidence, a lack of self esteem. “I can’t” or “I won’t” descends into an inability to do. Under-achievement is often linked with surface bravado. Our culture suggests that things are easy (as shown on TV), but they are not. We have lost the culture that says that children need to learn difficult things. Younger children, too, arrive at secondary school with an expectation of achievement that is difficult to sustain.
At this age young people often do not want to relate to other service agencies. Sometimes their problems go back to things that happened a long time back, but when they feel under pressure things build up into a crisis point. More than 20 per cent come from dysfunctional families. Some have under-supportive families, some are over-protected.

Even the more able students suffer from stress to reach self-imposed targets. We need to take care about what is said publicly, because young people take it personally. The media is especially at fault, e.g. you hear on the news: “The standard of GCSE results is not so good this year.” The current culture that over-values exam results is also to blame. The Education System is also to blame – humanity is squeezed out of what it can offer. There is a business, mechanistic attitude towards individual children.

There are other health hazards due to “normal” living. These include lack of sleep and lack of food. Not infrequently you get children saying “I feel dizzy” or “I don’t feel well.” and you find that they have not eaten since the previous day or had hardly any sleep. There is little nurturing and a lack of structured parenting. Many teenagers operate entirely within the peer group. The compressed school day is also a health hazard, with only 30 minutes at lunch time. A quarter come in by bus and the length of day is constrained by transport.

Five percent of pupils are statemented, but these are not the problem. The difficulty lies with the 25% who present with behavioural problems. It is particularly high in this school, because the school has a reputation for dealing well with them and the County encourages them to come here. Teachers are sometimes out of their depth and have little assistance. There is even lack of time to find an opportunity to talk to the child. Teachers feel they are doing their best, but lack of success is very destructive of morale. There has been more stress-related illness amongst staff in recent years. The staff feel that a regular counselling service is needed for pupils, on a permanent basis.

Summary of findings

Perceptions of health and health concerns
The majority of children felt they were healthy, their perception of their own health being based largely on healthy behaviour, especially diet and exercise. There was little difference between primary and secondary school children, nor between the different localities, though possibly the primary school children in Locality A were more aware of being less than healthy. The children’s general knowledge of food and diet and the need for exercise was impressive. When asked about unhealthiness, the children answered in terms of older relatives. Unhealthy behaviour again featured large, but also illnesses such as diabetes and arthritis. They also had concern about the effects of unhealthiness on life style. In both primary and secondary schools the children raised concerns about being overweight. They also knew a great deal about smoking and alcohol. However the issues of drugs and sexual behaviour in relation to health were rarely raised without encouragement. A marked exception were 10-year olds in Location C who had completed a PRIDE 2 programme and could name “good” drugs and “bad” drugs.
The main concerns of the parents of primary children were head lice, dental care and healthy eating. They felt it important that good amounts of PE were maintained at school, since it was often difficult and expensive to access municipal and private sports facilities. They were also anxious as to what lay ahead for their children in the larger and more complex environment of secondary school, where their behaviour would almost certainly be more influenced by their school friends. There was a widespread feeling that parenting for this older age group would be difficult. At secondary level the main concerns were with increased levels of stress and anxiety in their children and also their obsession with body image. Parents across the board raised the issues of alcohol consumption amongst under-age children. They all also expressed worry about the widespread availability of illegal drugs and their own lack of knowledge.

The teachers in primary schools expressed concerns about the number of children who had insufficient sleep and did not eat breakfast. They felt that many young children watched many hours of TV and this, together with lack of traditional play, affected their social skills (talking, listening and responding) and led to an inability to benefit from classroom and group activities and to behaviour problems. In secondary schools, the teachers’ main concern was the high levels of stress, anxiety and depression, which they felt was often linked to the frequent achievement testing. Poor levels of exercise were also a worry; children could not manage any sustained effort without getting breathless. There were also concerns about poor nutrition and the possible effect on children’s behaviour. In connection with healthy eating, the teachers and older pupils felt that the catering for school lunches (now usually contracted out) was inadequate and unimaginative, and the system allowed children to choose badly and end up with a less than healthy combination.

At both primary and secondary levels, teachers expressed concern about the quality of caring and nurturing provided by parents and this was echoed by staff from the child health services. In particular, parents seemed to have problems in controlling their children’s behaviour. There was felt to be a need to provide parenting programmes for parents of pre-school and teenage children. In every school, teachers expressed their worry about the growing numbers of children from disaffected families, with limited horizons and low expectations. In Location C, a large number of pupils come from an under-class with a strong drug culture. In Location B there is high unemployment and dependence on alcohol. But even in rural areas, examples were cited and in Location A we were told: “People appear to live unstructured lives and children make up their own rules.”

Experience of ill-health and attitudes to it

Amongst the children in the focus groups were a number who suffered from asthma or diabetes and they were well briefed in how to manage it. Nearly all had experience of a relative or another pupil with a chronic illness or disability and were very accepting of such disabilities. A high proportion had experience of hospital, especially through the accident unit or outpatients. However, most connected ill-health with age and older children disregarded the possible results of risk behaviours. However, many young children were critical of parents and other family members leading an unhealthy lifestyle, particularly smoking.
Many primary children seemed apprehensive about their transfer to secondary school and were fearful about the temptations to smoke and drink. They knew that smoking was unhealthy and expressed disgust with it as a habit and yet many felt they would try it. By the age of 13-15, about one third admitted to smoking, using older friends and siblings to buy cigarettes for them. Several wanted to give up, not because of fears of ill-health, but because of the expense. The school nurses felt that programmes should be introduced into schools to help teenagers to stop smoking.

Similarly young children felt it was inevitable that they would end up drinking, since it was what everyone did. Secondary pupils felt that young people would try things if they wanted and there was little that would deter them. The only messages that really hit were accounts of real-life experiences of death after taking drugs (Leah Betts), or a serious accident after drinking. It was suggested that hard-hitting advertisements, like the Australian ones that use shock tactics (Chapman 1999), should be available here.

Where and how children learn about healthiness
The PSHE curriculum, throughout our four localities, resulted in pupils with a detailed knowledge of health issues. In primary schools the children appeared to know more about food and balanced eating than their parents, who tended to get their information from the TV and especially advertisements. Some of the secondary children had criticisms of the lessons, stating that they needed information on drugs earlier and that it was necessary to bring in experts (such as the police in the case of drugs) to teach it. For sexual health, too, outside experts, such as nurses, were able to answer questions more readily. There was also a need for more time, to ask questions.

Children, especially in primary school, seemed to have lively ongoing discussions with their parents about health matters, and to be proud of parents who were clearly living a healthy lifestyle. This confidence contrasted with the lack of confidence among parents themselves in their knowledge about what are the healthy options and in implementing them for themselves and their families.

Teachers, too, welcomed outside experts, especially in lessons on risk behaviours. In this case, they felt their pupils could explore issues and feelings more fully. There was a feeling that some sex education sessions should be single sex to offer an opportunity for questions unlikely to arise in a mixed class. School nurses holding drop-ins reported that girls in particular bring sexual health questions to them.

Where to turn to for help
Primary school children usually went to mothers, close family members or family friends for help. This was particularly the case amongst children of all ages from Asian families in Location C and the extended family still seemed very influential in Location B. Secondary school-age children were often unsure where to go for help. They needed someone they could trust, who knew them quite well and who would not break their confidence. They were not happy using what appeared to be a well-designed pastoral care system (ETHOS), since they did not feel safe talking to teachers on confidential issues. If they needed to find expert help, there was a lack of accessible information about services and people to go to. In rural areas there was
inadequate transport to get them to a nearby town to seek advice. In urban areas, there seemed little community cohesion, with clear leaders for children to approach.

Parents also often felt lost and were uninformed about whom to approach about a health matter that was affecting their child at school. There was generally a lack of knowledge of what should be available through the school health service. Most did not know the school nurse and were not aware of the scope of her work. At primary school most knew the class teacher and felt this was a starting point. At secondary level, parents sometimes felt intimidated by the school and the type of problems their children were coping with, especially emotional problems of which they had little experience.

Increasingly teachers were encountering children with behavioural and emotional problems, at a point when they had less time and fewer resources to deal with them. They wanted to play a greater part in supporting children and enabling them to make healthy choices in the way they led their lives but to do this required time and resources that were largely not available to them. They often felt at a loss to know which way to turn for help when faced with particular problems, and were experiencing grave difficulty in identifying and securing referrals to specialist services for health related matters. Education Authority services were often over-stretched and the specialist Health Authority services (especially the CAMHS) had long waiting lists, and services were not able to respond except when matters had become serious or in crisis. There was the feeling that schools, where children spend so much of their time and which know the children well and care about them, were often at the mercy of a “lottery” regarding advice and support from their colleagues in local services; there is a particular instance of the management of ADHD. The school nurses did not have sufficient time at any one school. As a result, teachers frequently had to manage as best they could with children with complex needs. As well as the concerns of school staff, the local child health services often felt also that they had too little time and opportunity to work in and with schools to help with the whole range of children’s health matters.

Teachers reported an apparent lack of communication between the health service personnel visiting the school for particular pupils with special needs, so that there might be a gap when no-one came and then two people would turn up on the same day. They also suggested that more speech and language therapy and occupational therapy was needed and that it would be helpful to receive greater feedback on progress and outcomes.

**Concerns of health professionals**

The most frequently raised topic was emotional health, which might become apparent first in changes in a child’s behaviour. Teachers needed help in recognising the problem, containing it and identifying sources of help. Depression, in particular, needed more attention. Parents also needed help with parenting issues. There was specific concern about children with attention deficit disorder, dyspraxia and conditions on the autism spectrum. Additional resources were needed in clinical psychology, speech and language therapy and occupational therapy. It was reported that it is generally more difficult and time-consuming to provide an adequate service
for children with disabilities now attending main-stream schools. The problems of support and practical care for children with long term constipation were also raised.
DISCUSSION

“The truth is rarely pure, and never simple”  Oscar Wilde

This study confirms the evidence, over a wide range of issues, from other sources on the health needs of children of school age. However, it adds considerable insight on certain aspects of needs, particularly relevant to the level, type and style of service provision that is needed to make effective improvements. The relevance and validity of the study conforms well to current ideas on quality in qualitative research (Mays and Pope 1999). The collection of detailed information from statistical sources and from many local service providers has enabled us to cross check the information and views expressed by the children, parents and school staff, and to put them in context. We feel that we have developed a rounded view of unmet needs, not limited to the opinion of a single group. Many of the findings are generalisable, although a chief finding is that the needs of children in primary and secondary schools are different, as are the needs in different schools. But how needs are met and the manifestation of unmet needs is further dependent on local circumstances, which have also given rise to innovative and promising service repsonses.

There is now a good deal of published evidence that although children are much less likely to die in infancy and childhood than in previous times, and the incidence of many diseases (notably infectious diseases) has fallen - often dramatically - a significant proportion of children in England today live with increasingly complex and often new health disorders and/or major risk situations for their health and future functioning and wellbeing.

A significant proportion of children have health needs at the time when they first enter school in England - at 4 or 5 years old - which may or may not have been identified and managed by pre-school services. These problems include hearing impairment; communication problems, speech problems and language delay; problems with vision; problems with growth; conditions such as clumsiness and cerebral palsy, respiratory conditions, allergies, and asthma; longstanding and severe disorders such as cystic fibrosis and sickle cell disorders; a range of conditions that are disabling; and behaviour problems.

Further health problems may arise during the school years: such as accidents, new onset of conditions such as asthma, varying degrees of complications of longstanding conditions, especially emotional and behavioural disorders, acute episodes of varying degrees of nuisance and seriousness (from head lice infestation to meningitis), and the emergence of health risk behaviours.

The great majority of children we talked to felt they were healthy. This finding is in line with most other studies, although the questionnaire study by Sweeting and West (1998) challenges this, in that only 47% of 11 year-olds described their health as “good” in the previous year. This was a representative sample of a predominantly urban area in and around Glasgow city. Our focus groups were with children selected by their teachers because they were thought likely to have a lot to say for themselves, i.e. were among the brightest and most forthcoming, including a child with a major
physical disability who took part in one group, and a number who said that they had significant medical conditions (asthma and diabetes). There is also the issue as to what children will admit to when talking openly in a group - especially to people whom they are meeting for the first time - as opposed to completing a questionnaire in private.

Sweeting and West note that their self-report figures are in line with another recent study that found poor levels of physical and mental health in an older group of adolescents followed up between the ages of 15 and 21 (West and Sweeting 1996). We did not find a marked difference between the perceived healthiness of primary and secondary school pupils. It is likely that the particular urban environment is important in the high rates found in Glasgow. However, we found close agreement between children, parents, and teachers in secondary schools, about emotional problems and the high degree of stress. Studies show that health problems are more likely to represent serious and significant disorders if they are reported from more than one source (Brandenburg et al 1989). And there are unresolved questions regarding the clinical significance of, for example, the relatively high levels of anxiety and depressive symptoms that are reported by teenagers themselves (Rutter 1989).

With regard to illness conditions, results from Sweeting and West give 20% reporting migraine or headaches and 13% reporting asthma. Recent stomach aches or sickness, colds or flu, and headaches were each reported by around 60%. ‘Malaise’ (emotional) symptoms were common. Parent-child agreement was greatest for the presence of longstanding illness and the conditions of asthma, diabetes and skin problems. It was lower for recent symptoms, particularly those categorised as reflecting malaise. In our study, a number of children clearly had or knew others who had asthma but we hardly had any report of stomach aches, headaches or migraine. We were struck by the interest and graphic detail children showed in the health of their parents. But the limited impact that this may have on their own decisions about healthy behaviour may be explained by studies that are now showing that while adolescents show an awareness of an accumulation over the life span of social and health-related problems, they tend to rate their own future as different from the normative life span and as better than the future of others (Malmberg and Norrgard 1999), findings consistent with those of the Young People’s consultation in locality C.

In our study, we were not able to give particular attention to a number of groups of children who have, or are likely to have, particular health needs. However, a number of other targeted studies have been carried out recently. Previously, studies of young people with chronic medical conditions have shown that they rarely rate their general health as anything but good (Fogelman NCDS cohort at 16). But Lightfoot et al (1998; 1999) talked to pupils with a chronic physical condition, their parents and teachers, and have explored in depth their support needs in relation to the children’s lives in school. Their findings mirror what was reported to us, and show a situation where the amount of help for the increasing number of children with special needs is severely limited. We found that mainstream schools are frequently left for much of the week without extra help, to deal with major needs for support in the classroom, playground, lunch time etc. for pupils who have an increasing range of needs. This increasing range and the increasing severity and complexity of problems now presented by children with special needs who are educated in mainstream school
means that the limited extra support available in schools is keenly felt. Recent research has even shown that children with life threatening illnesses are sometimes excluded from school because of their health needs (Nash, 1999). This goes alongside the need to support an increasing number of children with moderate difficulties who are not officially eligible for any extra support. The other issue that was raised in our study was that not only the amount but also the experience and expertise of the support available was patchy, and sometimes did not appear to the school staff to be sufficiently skilled to deal with the problems of individual children. In addition, the experience of individual children and families was of services that were organised so as to fit in with service organisation timetables and constraints and that often were not able to work effectively because no account had been taken of the actual requirements of the child in school or of other aspects of his or her life. Schools often had no suitable free space where a child could be given therapy, nor a private room when this might be necessary.

For another group at risk - refugee children - preliminary findings from one of the 22 research projects in the ESRC’s Children 5-16: Growing in to the Twenty First Century Research programme - Extraordinary Childhoods: social roles and social networks of refugee children, show that for most refugee children the education system seems to be the only statutory agency from which they derive support in settling in to their new lives. This study is based on in-depth conversational interviews, carried out between July and September 1997, with 35 refugee children - Bosnians, Somalis, Sri Lankan Tamils, and Turkish Kurds who arrived in Britain around 1994 (Candappa 1999).

Although parents, teachers, and local child health staff all regarded the mental health needs of children as highly significant, there was relatively little overt discussion of these in the children’s focus groups, except regarding the kind of help that would be really useful when in difficulties – that applied to all sorts of difficulties. This finding is not unexpected as mental health is a difficult, sensitive and complex matter. Specific studies have now begun to explore young people’s needs with regard to mental health which add considerably to our understanding of how more effective services should be developing (Leon 1999). Our findings are in line with the findings of these studies that when experiencing difficulties, a young person is not always aware of what is happening or may be confused or frightened about what they are feeling, and tend to hide their worries. Also, that it took a long time for parents, family, or teachers to notice signs of mental ill health.

Butler and Williamson (1994) found that many children were reluctant and even fearful to discuss problematic issues with people who might potentially be able to help. The children’s dilemma was that once they conveyed something to adults, the power to determine what should then be done was taken out of their hands... Listening to children is likely to reveal important things about their problems and their own resources. But adults must be willing, not only to listen, but also to refrain from disempowering children by taking action on their behalf without involving them in the decision making process (Lansdown 1994; 1995). Here, the disempowering experience of secondary school pupils on the school council in Location A should be remembered. Children’s confidence in the services depends upon personal relationships (Sandbaek 1999). Sandbaek interviewed children aged between 11 and
14 who had received services from child welfare and protection, school counselling or
the child psychiatric clinic in a suburban community in Norway. She found that
children often see possibilities in their lives that adults that adults are not aware of or
do not pay attention to. Connecting the helping process to children’s interests or
social achievements and people they have confidence in may strengthen the positive
elements in children’s lives. Such an approach is also likely to raise the children’s
self esteem.

We found everywhere - as in Aggleton et al’s study (1996) - that children’s
knowledge about health matters was good. From a young age in primary school, they
have accurate information about the importance of healthy eating, taking exercise, and
not smoking in reducing their risk of developing short- (obesity, aggravating asthma)
and long- (cancer, heart disease) term health problems. They almost always know
more than their parents, and about some matters such as drugs, they know more than
their teachers, with the exception perhaps of some PSHE teachers. The adults
admitted this. From what we learnt in the focus groups, it is not surprising that
research still shows that knowledge and understanding about sex may be the
exception. The West Midlands Young People’s Lifestyle Survey, for example,
reported that 26% of year 9 pupils (aged 13-14) did not know that they could become
pregnant the first time they had sex (NHS Executive West Midlands, 1997). Children
had confidence only in adults who they recognised as having specialist expertise in a
particular area - and these adults will be different for different concerns, e.g. the police
with regard to drugs, the Family Planning clinic or the GP for contraceptive and
emergency contraceptive advice. In particular, children wanted to get information
about health risk behaviours from people who they sensed as being comfortable
talking about these matters, and with whom young people could discuss things openly
and explore their feelings and ideas. It is an over-riding concern for children that they
can talk to someone in complete confidence when they feel they need to. Children
said they would like to know more about drugs from an earlier age because these now
become part of their world before they are offered accurate information.

The children obtain a good deal of factual information from lessons but their parents
get it mainly from television. Many parents would like more information about a
number of health matters, and for example, would value even a yearly workshop on a
particular topic from the school nurse. And this might ensure that parents met and had
a chance to speak with the school nurse. It is interesting that the penetration of
healthy messages into the home via children and in children’s interests is not
necessarily as good as might be assumed - as evidenced by some parents’ lack of
involvement in the PRIDE projects. A study showing the very limited extent to which
parents of children with asthma were able to give up smoking supports these findings
(Irvine et al 1999).

But from the children’s point of view, the important role of friends and relatives, and
the centrality of mothers is confirmed by Aggleton et al (1996). Together with
teachers and school nurses they probably come closest to providing for the various
health and health education needs which arise in the day-to-day context of young
people’s lives. Aggleton et al (1996) conducted one-to-one and group interviews with
990 young people aged 8-10, 11-14 and 15-17 in two locations, one in the north of
England and the other in London, and their most striking finding was the effect of the
young people’s relationships with friends and family on their sense of well being. But these researchers found that those with a more generic role such as teachers, school nurses and youth workers who have regular contact with a range of young people, are well aware of the true concerns of children. However, it must be acknowledged that they are often poorly organised, resourced and trained to meet the needs they recognise satisfactorily. More often than not real help is not feasible if these workers are not able to work jointly with colleagues in social services, behaviour support, other parts of the health service such as a community paediatrician or the family planning service, and the voluntary sector. When it comes to bringing in help from a more specialist service, eligibility criteria – which may differ for different services and may determine which service foots the bill - may seriously undermine the availability of co-ordinated, efficient and timely service provision for children and families with complex needs. This concern has recently been highlighted in a ruling that physiotherapy, occupational therapy and speech therapy were measures directly related to the learning difficulties of a child “S”, and therefore amounted to special educational provision as opposed to health provision (London Borough of Bromley v Special Educational Needs Tribunal and others, 17th June 1999). This makes it clear that schools are required to have the resources available to fulfil their duties in meeting these needs. All the evidence indicates that there is a widespread shortfall in this capacity.

In primary school, not only are the welfare responsibilities of the school greater but often parents can be more involved. Just one of the reasons is that the percentage of women working full-time when the youngest dependent child is aged 0-4 is 18% (33% working part time), while for women with the youngest dependent child aged 11 -15, the rate is 34% (40% part time) (ONS 1998). But the capacity of parents to be involved varies, and if they are themselves needy, they may be very difficult to reach. Support may best be offered through the voluntary sector. An example is a National Children’s Bureau project in Location C, whereby the needs for family support and the resulting services are offered through schools (NCB 1997). Previous attempts by the local social services had been unable to reach or to engage many needy families.

Failure to consider the transport needs of families with young children is another example of the importance of structural support for families. Emphasis in transport planning has been on long journeys and journeys to work, rather than on journeys to shops, for child minding or travel to school (Public Health Alliance 1991). As traffic volume has increased, parents have become increasingly anxious about children’s safety when playing outside, an important factor in the decline in levels of children’s physical activity (DH 1995). In a survey commissioned by Barnardo’s, 60% of parents said that they were very worried about their children playing outside (McNeish and Roberts 1995).

Preschool services depend crucially on partnership with parents. But school entry is a critical time when a child may first manifest problems, and also when parents become focused on the child, giving an opportunity to explore and address what is going on. Our study showed that many parents of primary school children were closely involved with the school, and well acquainted with the details of what their child did there, what they ate and what they felt. In one school, parents were actively campaigning for the reintroduction of milk in school. However, these thoughtful and energetic parents
largely mothers) did not feel they had much influence over this or over other matters of concern with regard to their children’s health and wellbeing. Although some, but by no means all, remembered meeting the school nurse or having attended with their child an interview to discuss their health, they had no idea what they could expect to happen during their child’s school career, regarding health checks and screening, immunisations, or visits to the dentist; nor on what they themselves should be responsible for, and what was offered by the child health services or the school as a matter of course.

We found very little organisation into more formal parent groups, and very little link to local services or groups outside the school. There was no thought of parents lobbying their local councillors, for example, for better access to playing field during the school holidays, or improving the safety of access to play spaces. Along with this came almost a demand that the school nurse should deal with head lice for them (along the lines of a regular communal hair washing session; their complaint was that some parents did not pull their weight, so all would get infected again). There is no question that, in some ways, many parents would like the school, including the school health service, to take on more of a parenting role than the service providers feel is appropriate or that they are adequately resourced to fulfil. A further example is shown in a recent survey commissioned by the Local Authority Caterers’ Association (Gallup survey reported in School Meals Week in the Independent, April 26th, 1999) in which nearly four in ten parents of 8-16 year-old children said would like the option of breakfast at school (44% of children would like it too) and one in five would like children to remain there for an evening meal. In the matter of whose responsibility it is to check that each child has arrived at school safely each morning there is a clear dilemma over who practically can make the necessary checks……

Children have clearly taken control in certain areas – even in primary school - most notably in watching television. Even though 81% of parents say they think that it is desirable that children stop watching television at 9pm, 63% of 9 year-olds have TV in their own rooms and many admit to watching after this hour. Usually their parents turn the TV off when they come to bed at 11-11.30pm. Teachers notice how tired children are during the school day but seem unable to influence children’s late night viewing at home. A study of 1,300 students in the US, showed that a school based programme which aimed to cut down television viewing to less than two hours a day increased activity among the students and reduced their exposure to commercials for sweets and junk food (Gortmaker et al 1999). Over two years, obesity fell among the girls who went to schools involved in the programme (from 23.6% to 20.3%) and rose among those at control schools where it did not run (from 21.5% to 23.7%). Among boys there was little change.

There is a different scenario at secondary school, and many parents said that they had no idea what happened at school and what sort of lives their children were now leading. There may be a certain inevitability of deterioration in health during the secondary school years. All studies show an increase in the taking up of unhealthy behaviours, and what children know about the health risks does not appear to have much influence on these behaviours in relation to what they know about their own lives - about what matters most to them: a job, fun things to do, friendships. Children’s own anticipation that entry into secondary school means that will certainly
become more complicated and stressful may be linked with their worries about the changes accompanying puberty (Kmietowicz, 1998). Their relationship with their parents remain of enormous importance but following a trend that starts in primary school, for many young people these relationships seem to be characterised by increasing distance. According to one study of 200 school pupils and their parents in the United States, parents are clueless about the extent of their children’s bad habits (Young and Zimmerman 1998). The questionnaire survey found that parents substantially underestimated their children’s smoking, drinking, drug taking, and sexual activity. Many were also unaware that their children carried weapons to school. The distance between children and the adult world is also understandable in that the knowledge that children learn at school about healthy eating, for example, seems to be undermined by the food and meals available at school, and the experience of meal-times. The school council represents a vital opportunity for children and parent governors to meet and to discuss the realities of the full range of concerns of both. But clearly further efforts are needed in order to ease the emerging independence and competence of children by actually listening to them and enabling them to influence decisions and to help in assessing the outcomes (Osler and Starkey 1998). We should not ignore the importance of perceived control and self efficacy in influencing health risk, and make increasing opportunities for children to gain these capabilities (Bosma et al 1999; Stewart-Brown 1998).

A number of teachers in primary schools told us of their concerns about the great divide in culture as well as the practicalities of daily school life between the top class in primary school and the lowest class in secondary school, and a number of attempts to prepare pupils for entry to secondary school were made, including visits of children from one to the other, and an exchange of teachers between the two classes for a week at a time. There are clearly major difficulties in carrying out these arrangements and limited usefulness when a single secondary school draws from a number of feeder primaries, or when children from one primary school regularly move on to a number of secondaries. However, a promising pilot project in Bristol is currently evaluating (using a case control methodology) a structured preparation programme for children in primary schools who have been identified as at risk of problems, including truancy and exclusion when they enter secondary school.

Secondary schools are entirely different places to primary schools, and the evidence is that children really are beginning to move away from adults and create their own peer group and their own all-important worlds. To the extent that parents and teachers can be their friends, they are still immensely influential. At present, the capacity of teachers to play this role is severely limited. A child will be taught by a number of different teachers during the school day and over the years. There may be no one teacher that a child spends much time with. And in any case, teachers have almost no spare time to talk to individual children or to have informal discussions, or to play sports etc. Even in the secondary school with the well worked out ETHOS programme aiming to provide child-friendly clear and ready informal confidential access to advice and help from specially trained teachers in the school, this was regarded by the children with suspicion and as not really helpful. A number of secondary school teachers, in particular, clearly felt frustrated at how little time they had to get to know pupils while doing drama and art, and playing sports etc with pupils; and felt that this was squeezed out because of the current emphasis in schools.
on academic achievement, which in turn created a greater need for more opportunities for the informal activities. We found opposing attitudes towards the pressure on schools and pupils for academic achievement (some parents feel that children are not under enough pressure), and this has been reported elsewhere (Gallup survey for The Daily Telegraph, reported in YoungMinds Magazine, 1999; 42 (Sept/Oct): 6).

Studies of the effectiveness of health promotion and prevention programmes have highlighted the importance of pupils perceptions of the “fidelity” of the staff who are carrying out the programme. A key example is given by a cognitive-behavioural substance abuse prevention approach in which interventions were led by teachers and by peers were compared (Botvin et al 1990). The most effective approach was peer-led; but for girls, this prevention programme was also effective if implemented with fidelity by classroom teachers. It was found that many teachers did not implement the skills training portion part of the programme. The authors suggest the following possible reasons why the intervention was inadequately implemented by participating teachers: they may not have been convinced that the approach being tested was as effective as teaching factual information about drugs and the adverse consequences of use, or they may simply have felt comfortable using such an approach since few teachers have any training or experience in teaching cognitive-behavioural skills; and participating teachers were not selected according to consistent and well worked-out criteria. The authors conclude, as have others, that it is obviously necessary to have enthusiastic, confident and adequately trained providers of these types of programme. The efficacy of peer-led health promotion is also showing considerable promise (Cowie 1999). Apart from the delivery of whole school or risk-focused health promotion programmes, in work with individual children it is also increasingly being demonstrated that: “the essential ingredient of effectiveness...is not the range of service options, but the human qualities of the individuals who provide these options. If they are not respectful, empathic and genuine, then little they do will be of value to families” (Davis et al 1999).

The complexity of the emerging knowledge about children’s health needs and the effectiveness of approaches to meet them unequivocally indicates the need for closely integrated multidisciplinary and interagency responses (Chesson 1999). Current Government policies fully acknowledge this also, and the same messages apply to the key inter-related concerns for the well-being of children, as the editor of the British Medical Journal, Richard Smith (1999) has summarised as a four pronged strategy to eradicating child poverty in Britain, which it recognises will take at least 20 years. The first prong is to promote work; many children live in families that have been without work for years. Getting children in these families out of poverty will be especially difficult. It may take both parents to work to pull a family out of poverty, and there are questions about the effect on children of both their parents having to work. The education system has the task of better preparing young people for the sort of paid work that is required in today’s society and for occupation in adult life that is fulfilling if there is no paid work.

The second prong of the government’s strategy is to direct money towards children in greatest need, largely by means of increased benefits and tax credits. Here again, Smith points out that means tested benefits are often felt to be stigmatising and may encourage social exclusion; half of very poor people do not take up benefits to which
they are entitled. Education is a universal service, and perhaps in many parts of the country today, may be the chief or only local community resource. It can serve to ensure that all children have access to a sufficient and healthy diet, adequate exercise and the habit of exercise, and as the conduit for a great deal of family support in a non-stigmatising manner (NCB project in Location C. This does require schools to have the capacity to work with an extensive range of other local services and community groups.

The third prong is to improve services, particularly education, for all children. At preschool, the Sure Start programme should provide support and education based on the Head Start programme in the United States, showing significant long term benefits. The final prong of the strategy is to mobilise voluntary help and community action. This is not only an “extra pair of hands” to supplement what statutory services can, the voluntary sector has developed expertise that often spans boundaries and eligibility criteria for the more traditional services; and can also build local networks that enable access and acceptability for the most in need. All the points made apply equally in meeting children’s health needs, as is the centrality of the education system in this, with the health care system; both should be working as a single system.
CONCLUSIONS

Of key importance for the health of children of school age, is the way in which they have been nurtured and their health promoted from infancy and in the pre-school years. Many of the problems that are evident when children arrive at school for the first time relate to conditions that have developed in the first months or years of life or that have been present since birth. Children growing up in families facing adversities of many kinds are also likely to start school showing signs of disadvantage and even neglect. The concerns reported to us by teachers in the primary schools and by local professional and other staff bear this out: speech and language problems, poor ability to play, poor concentration, poor social skills, inadequate family meals, and behaviour problems. Maternity, primary health care and child health services, linked to local Early Years services offer help and interventions aimed at supporting families and the identification, assessment and management of problems at the earliest opportunity. A number of voluntary sector projects and the government’s major national Sure Start initiative aim to provide targeted approaches based on evidence of effectiveness. When children enter primary school, services need to continue the models of good practice that have been developed for work with families in the early years, with the added imperative of incorporating the school as a central part of children’s lives, and as an added resource in any work that is done to improve the health and lives of children in any community.

We have increasing evidence of what is needed in this task, and of effective approaches. The important family and school influences on behavioural development were first analysed by Rutter in this country decades ago, and he has clearly stated that: “The effects are sizeable but vary markedly across individuals and according to ecological context; moreover, they are transactional rather than unidirectional in nature (1984). Long-term effects are far from independent from intervening circumstances. Rather, the continuities stem from a multitude of links over time. Because each link is incomplete, subject to marked individual variation and open to modification, recurrent opportunities to break the chain continue right into adult life.” The evidence shows that family background has its main effect in the qualities that children bring with them at school entry but that gains during the years that follow are at least as much a function of the school attended (Rutter 1989). Rutter concludes that “it is probable that some of the school effects on pupils’ attainments and behaviour stem from influences on habits, attitudes and self-concepts, as well as from more direct effects on learning”.

Most of the relevant research has so far come from outside the UK, with examples such as the Head Start program (summarised in Barnes McGuire et al 1997), the New Haven Primary Prevention study (Comer 1985), the work of Olweus (1993) in Norway, and that of Kolvin (1981) in the UK, all having shown that long-term and system wide effects are possible from school-based initiatives. The effectiveness of specific features have now been identified in school-based programmes for particular need such as in tackling bullying (Smith and Thompson 1991) and alcohol and drug misuse (Fonagy et al 2000). All the research, however, indicates that the greatest positive impact results from multifaceted approaches and multisystem interventions, with work in schools linked with appropriate and coordinated provision in other
settings, including the home. The evidence also shows that preventive programmes for high risk populations of young people require intensive interventions and specific skills.

The health needs of children cannot adequately be met by a traditional style school health service. However, schools are crucially important in that they afford access to all children, and are regarded as a non-stigmatising source of advice and help over mental health, drugs, sexual health and family support. Services for children’s health need to be able to work in school and with schools. Schools themselves, as integral to their core task of education, can be a crucial influence on children’s health, with important knock-on effects on the health of families as a whole. The emphasis will be different at primary school age and at secondary school age. It should not be forgotten that schools are a prime socialising environment, and in current times, when it is recognised that parents, extended families and neighbours are less available to play a role in this, the school becomes vitally important. In spite of clear research evidence of this and the romanticised reminiscences that have been capitalised upon in the recent teachers’ recruitment advertising campaign, there are many barriers for schools to overcome in playing this role, and it can be extremely difficult to do it well and to sustain it. Comer (1980) showed how a broad model of school change could ensure that child mental health becomes a concern for the whole school as well as the surrounding community. And the government’s Healthy Schools Programme has been developed along these lines as a major step forward in developing services for the promotion of children’s health (including mental health), working with the school population and with the school as an organisation. Both these approaches must become embedded in future approaches to meet the health needs of school aged children, alongside interventions with individual children.

The availability and quality of research on effectiveness in the prevention and management of child health problems is patchy, although much is known for a number of specific conditions, such as epilepsy (Smith 1998) and cystic fibrosis (CSAG 1993), and in the directions for effective development of speech and language therapy, for example (Enderby and Emerson 1996). The development of a system that is effective in meeting children’s needs depends upon increasingly specialised resources because of the increase in knowledge about what works. Specialists from a range of disciplines are needed to offer timely and often intensive interventions and to train parents and others, such as school staff, in recognising when things may be going wrong and in how to support the child so that the need for more specialist attention may be avoided. However, it is no good if services can only become available at a certain level of severity when effectiveness is likely to depend upon intensive, multifaceted and lengthy intervention - and the resources for such provision do not exist or cannot be made adequately accessible to the child. On all counts, effectiveness will be greater if intervention can act more preventatively. In the field of child and adolescent mental health, there are welcome developments in making specialist skills more readily available, notably in the appointment of primary mental health care workers in many parts of the country (Hayden 1997), and in projects such as that reported in locality D where a dual trained child clinical and educational psychologist is working in schools.
The effectiveness of much of the traditional school health services is not proven by the available studies. And in view of the findings of the study reported here and other studies, radical solutions are indicated for the development of child health services, in and with schools. Recent reviews of the role of the school nurse are a welcome recognition that where there is an inevitable shortage in resources for child health, there needs to be major reconsideration regarding what skills can best meet the health needs of children and how they can be applied to best effect (Bagnall and Dilloway 1996; Lightfoot and Bines 1996).

Careful reviews of the value of the school entry health check leave many questions unanswered regarding the identification of new or ongoing health problems and the effectiveness in otherwise improving children’s health, for example as an opportunity for health education (Barlow 1998). However, given parents’ reported lack of information and misguided expectations about the child health services and the provision in school, including the role of the school nurse, it would seem to be a prime requirement at the time of entry to primary school, that every child and parent has an interview with a child health nurse and with the head teacher. This is the practice in a number of schools already, and enables the acknowledged sharing of information about any child and family problems between the parents, the school and the local child health services. It should guide the parents as to whom they should make contact with if they want to discuss any matter about their child, and how, and offer encouragement for them to become involved in school and out-of-school activities. This interview - more a meeting - is necessary to begin to establish an informed and trusting relationship between parents, the child health services, and the school, while also encouraging parents in their responsibility for promoting the health of the child and the family, but making it clear that there are readily available sources of more expert and friendly advice and help when required. Matters discussed at this interview should be entered on the parent-held child health record. It would seem desirable that the interview is held with both the head teacher or a senior (possibly the PSHE) teacher and the child health nurse, with the parent(s) – again, preferably with both parents – so that issues of confidentiality over matters regarding the child’s welfare can be discussed. This meeting is particularly important for children who, for one reason or another, have missed out on preschool services. This interview will inevitably promote a positive basis for the home-school agreement (required of every school from September 1999, by the 1998 School Standards and Framework Act).

The school entry interview also forms the basis for a school health profile, which is an essential planning tool for the school and the child health and other services. Services for the health needs of individual children and for school population should be planned jointly on the basis of the most comprehensive information possible, by the school and the child health service coordinator. It is recognised that there are barriers to making use of the information from the health interviews. A school profile, even where health and family background characteristics of individual children are anonymised and collated, is often still regarded as being highly confidential. We were told by one headmaster that he felt unable to broadcast the level and types of needs of his school population that were revealed from the school nurse profile because this would put off parents sending children to the school. The inability to make full use of the information, also means that there is an inadequate baseline from which to judge the progress of pupils and the real achievements of a school. In addition, it may be an
embarrassment to face the fact of inadequate resources in the local child health services to meet the health needs that are identified in the school health profile.

However, by “joining up” a number of the ideas and opportunities offered in a number of the government’s new policies, it is possible to draw up a workable vision for services to improve the health of school aged children. This must be based on child health services that serve defined communities. Primary care groups and primary care trusts will be key in this development. It is proposed that the local child health services form the hub in a hub and spoke model, as proposed for the development of cancer services in the Calman-Hine Report (NHSE 1995). This model aims to maximise scarce specialist resources. The evidence on how to meet the health needs of children increasingly highlights the effectiveness of approaches from professionals who are up-to-date and maintain their experience and expertise. In order to ensure equitable coverage and quality control of services, locality based teams (the spokes) need to be trained and supported on a continuing basis as part of the larger “district” child health services. Each locality team will provide locally sensitive flexible services that maximise access for all children and families. A member of the locality team will be responsible for planning and coordinating with each school in the “patch”, the health promotion programmes and the interventions for individual children identified by the school health interviews and the school health profile. It is uncertain whether the child health coordinator needs to be a school nurse or not.

The child health services should take a lead role in coordinating will make an improvement in effectiveness within current resources. The development of local protocols eg. for ADHD will make difference to the way schools can work alongside, and coordination of therapy, care tasks, learning and behaviour support will make fundamental difference to the child and to class teachers. Schools need direct access to specialists within the district child health and other services over certain matters such as an outbreak of meningitis. These specialists should work with groups of schools, through the child health locality teams, to develop commonly agreed protocols for the management of infectious disease control, the delivery of medications in school etc. Locality child health teams will work closely with schools and should be adequately resourced to spend sufficient time in every school to perform screening and day-to-day advice to teachers, parents and children on a range of matters. Nurses will be key members of these teams but some may also specialise in managing emotional and behavioural difficulties, others in advising on sexual health and contraception, others in managing special physical needs etc. A number of the health needs of school populations will best be met by staff in non-health agencies such as the police. An important role for the locality teams will be their networking with all the relevant local services and agencies, including primary care and the voluntary sector. A member in each of these teams should take responsibility for planning the provision across all needs (health promotion, meeting individual and group needs, training, and maintaining the school as a safe and healthy environment) with each school, and co-ordinating the various inputs so that they reinforce each other. The child health coordinator will also have an important role in acting as a bridge between the school and the local community so that they can work together to improve local facilities for healthy eating, play, and exercise.
Finally, in order to meet the health needs of school age children, schools need to be able to act as advocates within their local communities for resources and opportunities that will enhance the lives of children. Parents and governors have an important role to play in acting as a bridge between children in school - the growing generation - and the wider community. This is not only better to meet the children’s needs but also to strengthen the role of the school as a community resource. It is important that the young in their turn, are given real and increasing opportunities to learn how to play their part and to be effective in community action.

**What the study has shown to be the elements of a good service**

1. School entry is a prime opportunity for taking stock of the health needs of all children individually, and linking this to their educational needs and the opportunities provided by the school as a setting for the universal education service. Parents need to be given information at this stage about their children’s health needs, and about informal and formal access to local services.

2. This task should be undertaken by the local child health service, working with the local education authority and with schools as one (supremely important) setting for the promotion of children’s health and the delivery of health services where this best meets the needs of individual children. In this model, a school health service, as such, does not exist but the school becomes an important part of the service system for children’s health and well-being, as it is above all, for their education and social development.

3. A health interview with each individual child at the time of entry to primary school will also form the basis of individual school health profiles which are needed to plan and monitor whole school approaches in health promotion, support to teachers, and targeted programmes, on a continuing basis.

4. Local child health services should take the lead in work with schools, the local health promotion service, and other relevant local services to develop comprehensive health promotion programmes that are tailored to meet children’s needs in different circumstances according to age and specific local circumstances. Implementation of these programmes in schools should be based on the best available evidence of effectiveness, and pupil participation should, in any case, be an important component.

5. A designated member of the child health services should have sufficient time, the requisite seniority, knowledge, and skills, and designated responsibility to work with each school and its pupils to coordinate and obtain services to meet the health needs of individual children and of the school as an organisation, across all the relevant agencies and services. “School” nurses could play this role – many do already. But if they are to do this, significant changes need to be made to their overall numbers, their training, and to the structure of many local child health services.
6. Effective coordination of services for individual children and for schools will make a significant and positive difference in meeting children’s health needs. Crucially, the child health services also need to enhance the knowledge and skills resource within services that are currently available and also seek to augment these, in the light of contemporary children’s needs and of what is known to be effective in meeting needs. At present, mental health and emotional needs are paramount, and their pervasive influence on learning and in multiple risks to health are a major concern to all.

7. The school nurse cannot do all the things that different individual nurses currently do. The local child health service, with the schools – with the health and the local education authority - needs to shape local services so that the health needs of all children are adequately assessed and acted upon, with agreed priority given to local development of certain types of provision for individuals and schools, as indicated.

8. The current indications are for three key general developments:

   a. the appointment of coordinators who can lead the development and management of services across all the relevant agencies and disciplines in and with each school on a day-to-day basis and contribute to strategic planning and monitoring;

   b. the training and deployment of sufficient clinical staff with new knowledge and skills, particularly in the field of emotional and behavioural health and also in complex physical conditions, to provide an accessible and acceptable service for children – and to support staff - in schools and local community settings;

   c. improved availability of specialist input, especially speech and language and communication therapy, physiotherapy, occupational therapy, and mental health expertise.

9. Many services promote both children’s health (particularly mental health) and learning. Local commissioners of both health and education services need to agree on the local needs for provision of these services and jointly to agree on how this will be resourced and evaluated. Apart from some programmes which should be developed universally, such as knowledge and skills regarding food and nutrition, and good facilities for exercise, priorities for others such as substance abuse prevention should be decided on the basis of school health and community profiles, and their impact carefully evaluated. Credit for positive outcomes needs to be shared. The achievement of schools as well as that of the health and social services should be measured by their progress towards targets relative to baseline levels of children’s needs.

10. An interagency strategic approach is required to meet the health, social care and educational needs of all children, linked to those of their families. This is particularly the case for children who, for one reason or another, are not attending school. Development in the appropriate resources and service
organisation that will cost effectively match provision to children’s needs demands rethinking of traditional professional roles, training, skills, and relationships within and between health, social care, and education agencies and this should begin to be incorporated into local Health Improvement Plans and other joint strategies.
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APPENDIX – Local sources of information and People interviewed

Locality A

Local information obtained
- Children’s Services Plan 1997-2000
- Annual Report of the Director of Public Health
- Current prevalence figures for significant medical condition among 3-16 year-olds from the Child Health System
- Healthy Cambourne Project. End of Year Report 1994/5
- “Hear Our Voice” Young People’s Mental Health Project report

People interviewed
- Steve Colwill, Child and Family Services, The county County Council
- Jenny Doble, Clinical Psychologist and Clinical Director, Child and Family Services
- Jim Gould, Deputy Director of Social Services and Head of Children’s Services, The county County Council; Chair of the HAZ Children’s Services Group
- Sarah Griffiths, Senior Education Welfare Officer
- Janet Harris, Consultant Community Paediatrician (school doctors)
- Jonathan Harris, Secretary for Education
- Bill Henthorn, Manager, Out of School Education Services
- Roger Kitching, Headteacher, Sir James Smith Community School
- Jane Lee, Deputy Headteacher, Port Isaac County Primary School
- Chris Nash, Community Nurse Manager (health visitors and school nurses)
- Kate Pitt, Headteacher, Port Isaac County Primary School
- Michael Rutter, LEA Officer
- Larry Thompson, PHSE lead teacher, Sir James Smith Community School
- John Tilbury, General Practitioner
- Cynthia Watmore, Chair of The county Voluntary Sector Groups
- Richard Williams, Educational Psychologist and Director, Child and Family Services, The county County Council
- group of EWOs
- PHSE teacher at Sir James Smith

Locality B

Local information obtained
- A Strategy for Children’s Health in County Durham.
- Durham Anti-Bullying Service, Education Service, Durham County Council.
- Socio-Economic Data. Using data analysis to raise achievement at King James I.
  King James I Community College.
- Service specification for a combined health service in County Durham.

People interviewed
- Barbara Bennett, Special Needs Support Assistant
- Janice Bosher, Head of Children’s Community Physiotherapy
- Paddy Burleton, Specialist Health Visitor, Child Protection
- Liam Cairns, Co-Ordinator, Investing in Children
- Gill Cartwright, Senior Nurse, Community Children’s Services
- Nneena Cookey, Consultant Community Paediatrician
- Paula Davison, Paediatric Home Care Team
- Susan Dent, Head of Pastoral Curriculum
- Vickie Dillon, Paediatric Home Care Team
- Carole Dixon, Specialist Health Visitor, Special Needs
- Margaret Dobinson, Team Leader, School Health Service
- Dawn Dodds, Specialist Health Visitor, Special Needs
- Mr Hutchinson, Headteacher, Henknowle Primary School
- Kim Lawther, Paediatric Home Care Team
- Ed Lott, Headteacher, King James I Community College
- Estelle Louw, Consultant Child Psychologist
- Jean McCalman, Pupil Casework Officer (health issues), Education Authority
- Trudy Osman, Educational Welfare Officer, Education Authority
- Chris Parry, Manager, Family Services Directorate
- Mary Ridley, Paediatric Diabetes Specialist
- Margaret Robson and 7 colleagues, School Nurses
- Wendy Stafeckis, SENCO
- Marianne Taylor, Senior Educational Psychologist, Education Authority
- K. Vasey, General Manager, Child Health.

Locality C

Local information obtained
- Core Programme of Health Care for School Age Children in Manchester.
- Manchester Health Plan Consultation at Manchester Town Hall on 7.12.1998 - notes from Manchester Young Peoples Council.
- Special Needs and Health Promotion: A Primary Care Team Approach (Vanessa Brown’s dissertation for the Diploma in Management Studies at the Manchester Metropolitan University). This includes a consultation with young people with moderate learning disabilities and their parents, about health and access to health services.
- A profile of Poverty and Health in Manchester by Steve Griffiths for Manchester Health Authority and Manchester City Council
- The School Nurse Role in Healthy School Schemes. Report from School Nurse meeting, January 1999 by Donna Webster for Mancunian Community Health NHS Trust and Mancunian Health Promotion. Also a Case Study of Good Practice in the involvement of the school nurse in the healthy school scheme
- A Special Educational Needs Strategy for Manchester, Manchester City Council March 1999
- School Health Profile 1997/8; and Primary and Secondary School Health Profiles 1998-9, Mancunian Community Health NHS Trust
- Child and Adolescent Mental Health Services in the Manchester Health Authority: the commissioning agenda and options for service development, Kurtz Z, Wilson P, Trowell J. for Young Minds April 1997
- Championing Children, National Children’s Bureau Report on Manchester City Council’s Services for Children, 1996
- Audit of Selective School Entry Assessment, 1998
- Report of a pilot study of Health Service Needs of Children not in School (one high school in Manchester) by Anne Ferguson, community paediatrician and Rosanna Hodgson, school nurse.

People interviewed
- Anna Addison, Director, Children and Young People’s Directorate, Mancunian Community Health NHS Trust
- Marie Ash, School Nurse
- Alison Balkas, Head of Physiotherapy
- Devon Brown, Home-School liaison
- Vanessa Brown, Mancunian Health Promotion Specialist Service
- Andrew Cant, Head of Pupils Division, LEA
- Pat Cantillon, Headteacher, Plymouth Grove Primary School
- Denise Ditchfield, Speech and Language Therapy
- Ben Douglas, teacher, head of Year 8
- Marilyn Eccles, Deputy Chief Education Officer
- Anne Ferguson, Consultant Paediatrician Community Child Health
- Liz Grant, SEN teacher and Child Protection co-ordinator, Ducie High School
- Ann Hoskins, Director of Public Health, Manchester HA
- Ian Jackson, teacher, head of Year 9
- Helen Jones, Headteacher, Manchester Hospital Schools and Home Teaching Service
- Elizabeth Law, Chief Executive, Mancunian Community Health NHS Trust
- Gail Nicholson, Deputy Headteacher, Ducie High School
- Dawn Peters, Headteacher, Ducie High School
- Donna Webster, Healthy School Award - School Nurse Secondment
- Jeanette Wilkes, General Practitioner
Locality D

Local information obtained
- Investors in Health, West Sussex Health and Education Partnership. Report of a conference held 3rd December 1998 at the Jarvis Hotel, Chichester, West Sussex Health Authority, and West Sussex County Council.
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- Walking to School. Parent Information, TravelWise, West Sussex County Council and West Sussex Health Authority.
- Road User Education, Training and Publicity in West Sussex. TravelWise. West Sussex County Council.
- Introducing the School Health Service, West Sussex Health Authority.
- West Sussex County Council, Social Services Department. Quality protects – transforming children’s services, 1999.
- West Sussex Health Authority. Having well-being in mind. (To assist schools as organisations to critically review mechanisms for addressing the mental well-being of their communities).

People interviewed
- George Bell, Headteacher, the Medmerry Primary School
- Gill Blunden-Codd, Health Visitor (Hospital Liaison)
- Melissa Bracewell, Paediatrician
- Paulette Cassidy, Community School Nurse
- Maggie Collins, Community School Nurse (Special Schools)
- Carole Druce, Community School Nursing Sister
- Thelma Edwards, Oral Health Promotion Co-ordinator
- Fiona Feehan, Adviser in PHSE, Education Authority
- Richard Flaxbeard, Clinical and Educational Psychologist
- Dr Harris, General Practitioner
- Chris Harrison, Child Protection Supervisor
- Roger Hayle, Manhood Community College
- Richard Kemp, Headteacher, Manhood Community College
- Ann Kimber, Clinical Child Psychologist
- Occupational Therapist (on behalf of Eli Kumar)
- Ian Patrick, Road Safety Officer, Surveyor’s Department
- Sue Pead, Sexual Health / Family Planning Nurse
- Quentin Spender, Consultant Child Psychiatrist
- Ann Wallace, Consultant Community Paediatrician
- Phillipa Whittle, Community School Nurse
- Dr Willcox, General Practitioner


