PUBLIC HEALTH PRACTICE & THE SCHOOL-AGE POPULATION
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Edited by

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This book is dedicated to Alice
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In early 2007, when UNICEF published its first ‘report card’ of child well-being in rich countries, there was something of a sharp intake of breath across the four countries of the UK. Using a multi-dimensional overview of the state of childhood, UNICEF was indicating UK child health and well-being as the poorest amongst 21 industrialized nations when measured on overall health factors.

How could this have happened? From 1997, the New Labour government had argued for a series of policy intentions designed to support population health improvement: a public health orientation to services; a recognition of the social and economic dimensions of health determinants; a re-orientation of service delivery designed to eradicate antiquated departmental and professional boundaries. Indeed the Chancellor’s comprehensive spending review in January 2007 reported improvement in reducing child poverty.

It would be fair to say that the shift in 1997 to a public health orientation in health and social care delivery systems set the stage for the possibility of a social model of medicine in the UK. Yet, there has been slow progress toward achievement. That slow progress has had much to do with ingrained habits of working; repetitive service re-organizations; government anxiety about the costs of redistributive approaches to the underlying causes of poverty; and an uncertainty about what is meant by a public health orientation to population health when we think about the work of clinicians and practitioners.

This profile applies to whole populations within the four countries. When we focus on child health, we find that the picture is even more alarming. In effect, we are a nation that is storing up health problems that will affect our next generation of adults. Mitch Blair and his colleagues in 2003 set an important lead by specifying a focus on child public health, a focus that had slipped off the public health agenda.

In this book, we examine the health and well-being of children of school age but we do so by re-visiting the full range of public health practice from analysis to action, in other words, from the work of epidemiology to the community interventions that seek to improve health. We do this by locating the child in the family, the school, and the community. These are the three locations that school-age children inhabit as they grow and develop from school entry to emergence into adulthood.

Within this profile of thinking, we also encounter questions about resource distribution and commissioning. Where should we invest in services to improve child health? How should we design programmes that use inter-professional skills? What is the evidence base that we need in order to make such decisions? And what are the factors that most impact on child health?

Yet services are only part of the full picture. Child health is affected by language, culture, gender, ability/disability, immigration status, housing, adult carer health, consumer behaviour, nutrition, sanitation, clean water, transport systems, and the ecology of the immediate environment. And child health issues do not emerge in single focus. It is the constellation of factors in the material and the psychosocial environments that interact to affect a child’s ability to grow and develop well or poorly.
This is the first book to open discussion of the public health practitioner’s approach to child health during the school-age years. Each chapter is the beginning of an important debate and should be read in those terms. If this book triggers widespread argument and further research, it will have achieved its purpose.

Diane DeBell
Norwich and Cambridge 2007
This book was partly prompted by Mitch Blair and his colleagues, when they published *Child Public Health* in 2003. It also benefited from an early conversation with Pat Jackson and an American ‘road conversation’ in Portland, Oregon, with Dawn Rees, particularly over a plate of oysters. A very warm thank you to Naomi Wilkinson, Clare Patterson and Penny Howes of Hodder for their expertise and calm efficiency. And thank you to the contributors to this book. It has been a genuinely collaborative venture.

I owe more than thanks to Alice, Chris, Jenny, Schnig, Jeff and Sara. Very special thanks to Alice Tomkins, who understands children and likes them, who finds them interesting, witty, and ‘usually a lot smarter’ than adults. And special thanks to Jenny DeBell, who understands both motherhood and also what it means to foster a child. For Jeff and Sara, we are all whispering a fair wind.

*Diane DeBell*

*Norwich and Cambridge*
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Section 1

THE CHILD IN 21ST CENTURY BRITAIN
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BACKGROUND AND CONTEXT

Diane DeBell

INTRODUCTION

Amy, age 14, and her brother Nathan, age 16, are adoptive children although Nathan is, in fact, his father’s birth child from a former relationship. This is a family-held secret. Nathan is currently serving a custodial sentence and Amy has been able to maintain some contact with her brother via letters delivered by her adoptive father. This young sister and brother have always been close. Since Nathan’s arrest, Amy has been distressed and angry at home and at school. Her relationships with teachers at school are poor and she frequently truants. She is currently under threat of expulsion and she has few friends. Her relationship with her mother is poor.

(DeBell, 2003, p.10)

This young girl is failing at school but no one knows why. She is the child of a complicated family profile and a judicial system that neither recognizes nor takes responsibility for its effect on the emotional lives of prisoners’ children or siblings. Amy’s teachers are not aware that she has a close family member in prison nor do they have experience of the damaging effects the stigma of imprisonment can have on a child. Amy’s attempts to keep her brother’s imprisonment a secret mean that not even the school nurse knows the nature or cause of her distress. Amy is perceived to be a problem at school and at home.
Does this compilation of circumstances describe a child health problem? And, if it does, how do we understand it in terms of child public health, in terms of preventable illness, in terms of health promotion, and in terms of public health practice?

The answers lie within our definitions of child health and well-being. For example, in contemporary Britain we now collectively agree that child emotional and mental distress is, in fact, a health problem. Indeed, child and adolescent mental health is probably the most pervasive health problem in 21st century Britain. Meltzer et al., for the Office of National Statistics, estimated in 2005 that one child in ten experiences a mental health problem at some point during their school years. The charity YoungMinds has placed that figure at double the estimate of Meltzer et al. (see Chapter 8, p.179).

Yet we often have difficulty thinking about ‘health’ in terms other than physical and endogenous descriptions. To take this one step further, social definitions of health continue to sit uneasily with medical definitions. 

*Health matters have for too long been viewed as somehow separate from the societies in which they are in fact embedded.*

*(Coburn, 2003, p.338)*

Child public health practice, in keeping with Coburn’s observation, starts from the position that each individual child’s physical and mental health is a consequence of multiple factors within the settings in which the child lives – the home; the school; the local community and neighbourhood. Furthermore, the child’s health is affected by a range of government policies arising from disparate government departments. In Amy’s case, Home Office policies on family visiting and contact affect her ability to remain in contact with her brother. Teachers and school nurses play an important part in public health practice for school-age children, but the complexities of a child’s family life as an influence on health require considerable cross-boundary thinking.

*The social environment is a public health issue because it has such a big impact on health and because public health workers can do so much to improve it. Unlike most health professionals, who are restricted to helping individuals on a case-by-case basis, public health workers can change institutions and laws that organize the social environment at a population level.*

*(Donald, 2006, p.242)*

The questions that follow are twofold:

• Is child health enabled or is it compromised by the economic, social, material and political environment of Britain today?
• Whose responsibility is child health protection and improvement?

And thus the over-riding child public health question:

• Is Britain a toxic environment for children growing up in the 21st century?

When we think about child public health, our starting point is generally the measurable and observable morbidities. This is the traditional work of epidemiology. This necessary stage of measurement means that interventions are, in turn, more likely to be focused on those facets of preventable child ill-health about which we
can hope to make a positive difference at the population level (from dental caries to sun protection; from nutrition and exercise to road safety and cycle helmets; from accidental injury to child protection).

But for public health practitioners, it is also the social and political context, not only the clinical profile, that matters when we think about how to prevent ill-health in children and young people of school age. In other words, it is the population-level information that helps practitioners in their work with individual children and families.

**A NEW CHILD PUBLIC HEALTH: WHO IS THIS BOOK FOR?**

*Child public health is emerging – or perhaps re-emerging – as a speciality of both public health and paediatrics, and as a broadly based interdisciplinary movement.*

*(Blair et al., 2003, p.3)*

In their comprehensive work of 2003, Blair et al. provide us with the grounding we need to understand causality and risk, concepts that are fundamental to the work of public health practitioners, who, in turn, seek to develop strategies and interventions to improve and protect child health. But Blair and his colleagues do not seek to conceptualize childhood nor to differentiate children by age. In this book, we focus our attention on the school-age child (from school entry at age 4 or 5 years to transition into adulthood at age 16 or 18 years). There is a range of reasons for this attention.

The developmental period from neonatal to school age has long been a focus of investment and research; the school-age years less so. Yet the school years are a long period of growth and development during which children, young people and their families often experience changing social circumstances and diverse family formations, and they experience school-led transition points as the child moves toward eventual entry into adulthood and independence.

Many diverse health and social care professionals are involved with child health during the school years. But so too are education professionals, housing and local authority officers, youth and community workers, the criminal justice system, voluntary and charitable bodies, and local community groups. This book is for these readers. It also provides a rich resource for service managers and for service commissioning bodies. Furthermore, the contributions in this book indicate many areas of need for targeted research into the issues that affect school-age child health.

This is the first book to focus attention exclusively on public health practice with the school-age population. It thereby provides a basis for debate, research and, particularly, for frontline practice. The book is organized in sections that foreground the three settings in which children grow and develop – the family; the school; and the local community/ neighbourhood. But it also opens in Section 1 with analysis of the legal issues affecting child health and the implications of difference and diversity for child health in the UK. The final section of the book specifically addresses four core health issues – child and adolescent mental health; long-term conditions; lifestyle behaviour approaches