*ABC of 1 to 7*JUDITH WILSON
H B VALMANSERVICES FOR CHILDREN:
THE COMMUNITY

The fieldworkers of the district child health services are based in local clinics. The emphasis of their work is preventive and concerns identifying and treating abnormal developmental patterns in the home, clinic, school, or nursery. The services may be divided into two groups: those provided for all children, comprising mainly screening, immunisation, and health education; and those specific services provided for children with special problems.

Child development

When they are born, children in Harrow district are entered into the child health computer, which automatically sends appointments for immunisations. Developmental checks are performed at 6 weeks, 8 months, 18 months, 3 years, and 4 years (if necessary). A child whose growth and development are normal at 6 weeks and 8 months should not be assessed again until 18 months. The computer programme can also be adapted to include invitations for developmental checks as well as immunisations, and GPs who do their own developmental clinics could also use the computer to issue their own appointments. At 18 months particular attention is paid to the child's motor agility and comprehension of language. At the next review, at 36 months, most children will co-operate with the Sheridan-Gardiner vision test and the Reed hearing test. Their expressive language and general abilities may also be assessed. They are seen again at 4 years only if a doctor, nurse, teacher, or parent considers there is cause for concern. With the agreement of local general practitioners in Harrow some simple medicaments (such as emulsifying ointment, dicyclomine hydrochloride, silicone cream, and treatment for head lice) are available in clinics.

The clinics are run by clinical medical officers and health visitors, often helped by a trained nursing auxiliary or volunteer, who performs simple tasks such as weighing babies.

Immunisations

3 months.....	Diphtheria-tetanus-pertussis, oral poliovaccine
5 months.....	Diphtheria-tetanus-pertussis, oral poliovaccine
9 months.....	Diphtheria-tetanus-pertussis, oral poliovaccine
18 months.....	Measles
4 years.....	Diphtheria-tetanus, oral poliovaccine
11 years.....	Rubella
13 years.....	BCG
15 years.....	Tetanus optional oral poliovaccine

A separate immunisation clinic, with a specially trained nurse, runs simultaneously with a child development clinic. This ensures more effective use of professional time. Triple and polio immunisation is given at 3 months, 5 months, and 9 months; measles immunisation at 18 months, after the developmental check; and the "preschool booster" (diphtheria, tetanus, and polio immunisation) at 4 years.

Domiciliary care

Health visitors attached to general practices continue to observe children at home after they have reached 12 months but at less frequent intervals than with younger infants, depending on the family's needs. Families who cannot or will not attend clinics can receive their immunisation and developmental examinations at home from the clinical medical officer.

One health visitor in our district has set up an extremely successful system of self-help support groups for mothers with babies or young children. All health visitors advise the leaders of mother and toddler groups and playgroups.

School health

The school health team consists of a clinical medical officer, school nurse, health visitor, audiometrician, and dentist. Children attending nursery classes run by the education authority, many of whom have social and developmental problems, are seen when required. Otherwise all children are assessed during their second term at school (at 5 years) after their parents and teachers have completed a detailed questionnaire. They are weighed and measured by the nurse, who also tests visual acuity and colour vision, using the Sheridan-Gardiner tests. The doctor tests the developmental skills vital for satisfactory learning—hearing, speech, language, memory, and manipulative and locomotor skills. A physical examination is of secondary importance for a child who has been seen before. Problems identified at this initial assessment are reviewed in a school clinic or the child is referred to his GP or appropriate agency. All children have audiograms shortly after entering school.

The school nurse sees children yearly, particularly to exclude head lice and verrucae. The clinic dentists also carry out annual screening. The health visitor liaises among the school, the family, and the GP; she is also concerned in health education. The whole team advises teachers about the management of a child's medical problems in school.

Children with speech and language disorders

Speech therapists work in many of the clinics and they will assess a child with language problems as early as 18-24 months of age, provided a hearing loss has been excluded. Treatment usually comprises guidance for the parent until the child is about 3 years old and can co-operate with individual treatment.

Young children with severe communication disorders are placed in a special pre-school group organised by a speech therapist. If the problems persist at school entry the children transfer to a language unit attached to a normal school, which a therapist attends. A community paediatrician (senior clinical medical officer) visits both units regularly.

Children with hearing problems

Children who fail screening tests of hearing are seen in audiology clinics, staffed by an experienced community paediatrician and audiometrician. If deafness is suspected the child is referred to a consultant otologist. A child of school age, who can co-operate with audiometry, may be referred to a local clinic solely for an audiogram.

A child with severe hearing impairment requiring education at a partially hearing unit is monitored in school by the team and by a teacher of the deaf.

Children with other problems

Visual problems—Vision clinics, staffed by an ophthalmologist, nurse, and orthoptist, assess children who fail the initial screening tests. The orthoptist treats amblopia and squints if an ophthalmologist considers that the child does not need surgery.

Enuresis—A community paediatrician and children's nurse run an enuresis clinic for children aged 5 years and over. They exclude physical and psychiatric disease and use alarms and star charts. Progress is carefully monitored and these methods have proved very effective.

Dietary problems—A dietitian holds a community clinic, primarily for obese children, but also for others with dietary problems, such as milk allergy. Diabetic children may also be referred for advice.

Verrucae—Children with verrucae can be treated by chiropodists using cryotherapy in some local clinics.

Children with severe mental and physical handicap

The pattern of care for children with severe handicaps depends mainly on their age. Up to 2 years most of the care is hospital based, but in a group setting. The community services do, however, provide some therapists, a health visitor, and some medical services. Between the ages of 2 and 5 years handicapped children are entitled to special education in opportunity playgroups, day nurseries, and special nursery classes. Whenever possible the handicap team assesses the child and treats him in the community. From 5 to 7 years the children are placed in normal schools whenever possible and the therapists visit them at school. A child requiring special education receives all his assessment, treatment, and paediatric care in the special school.

A senior dental officer skilled in the dental care of the handicapped works in a clinic next to a special school. She refers the children who need general anaesthesia to the day care unit at the local district general hospital.

Handicapped children over the age of 2 years who are incontinent are provided with disposable pads, pants, and sheets.

The doctors and their training

Doctors working in community health are clinical medical officers and senior clinical medical officers, and like general practitioners they are clinically autonomous. They are accountable for the organisation of their work to the district medical officer, who may delegate this responsibility to a specialist in community medicine responsible for planning and co-ordinating child health services. The senior clinical medical officers provide secondary care and are often called community paediatricians. The clinical medical officers provide primary care. In Harrow the general practitioner vocational trainees also spend some of their time working in the community child health services while on the paediatric rotation.

There is no training or career structure for doctors in the community health services. A working party of the Royal College of General Practitioners and the joint committee of the British Paediatric Association and the Royal Colleges of Physicians has proposed a three-year training programme for clinical medical officers which is acceptable for general practice and includes 18 months' hospital and community paediatric experience. Meanwhile, in Harrow all clinical medical officers are given in-service training and attend courses on child development and educational medicine. Many have paediatric experience and possess the diploma in child health.

The senior clinical medical officers are experienced clinicians and have attended specialised courses on assessment and treatment of the handicapped child and on educational and social paediatrics. Several possess the MRCP and are accredited hospital paediatricians. It has been suggested that their future training will be similar to that of the hospital paediatrician, with additional community experience.

Dr Judith Wilson, DCH, MRCP, is principal physician, child health, Harrow Health District, and Dr H B Valman, MD, FRCP, consultant paediatrician, Northwick Park Hospital and Clinical Research Centre, Harrow.