*ABC of 1 to 7 (Revised)*JUDITH WILSON
H B VALMANSERVICES FOR CHILDREN: THE
COMMUNITY**Primary and secondary care services****Integration: a new concept**Training sessions for general
practitionersGeneral practitioners in health
authority clinicsClinical medical officers in
general practitioners'
premises

Primary care services for children are provided by the community health staff of the district health authority and by general practitioners and their teams. Historically, the preventive aspects of child health (surveillance, immunisation, and health education) have been the responsibility of the health authority (and, before 1974, the local authority), but increasingly general practitioners with attached health visitors are taking on this role. Integration of these primary health services is a logical development. It can be achieved in a number of ways: by organising suitable training sessions for general practitioners (and GP vocational trainees); by employing general practitioners to work as clinical medical officers to see child patients in health authority clinics; or by clinical medical officers working in general practitioners' premises.

Initially, secondary care services were mainly hospital based, but in enlightened districts consultants or their equivalents now spend more time working in the community. Clinical medical officers, as well as general practitioners, frequently act as clinical assistants to hospital paediatricians.

Computers in community child health

Many districts are using the national child health computer system, with the option of four modules: a child register with neonatal data, immunisations, and preschool health and school health modules. Basic health data are stored and distributed to general practitioners and clinic staff and appointments are sent directly for preschool health checks and immunisations. Lists of schoolchildren due for various screening tests are produced and management advice sent to the teachers.

Child health and development

Health visitors, who are state registered nurses with additional obstetric and specific training, are based in clinics and general practitioners' surgeries. Their main role is in the home, and through health education they promote good child rearing practices. They support mothers with management problems and they are frequently responsible for some development checks. Clinical medical officers and general practitioners also carry out screening tests, but they are increasingly concerned in selective development assessment sessions.

Hearing problems

Immunisations

Is the baby unwell in any way?
Has the baby had any side effects from previous immunisations?
Did the baby behave normally during the first week of life?
Has the baby, or anyone in the immediate family, ever had fits or convulsions?
Is the baby developing normally?

Mothers can fill out a card in the waiting room at each visit for immunisation.

Screening—The schedules and contents of screening programmes vary enormously and few have been evaluated. The following programme recommended in the Court Report is frequently used:

<i>Age</i>	<i>Main objectives and assessment</i>
6–8 weeks	Discuss feeding problems and immunisation Exclude congenital abnormalities, e.g. congenital dislocation of the hips, cataracts Carry out simple neurodevelopmental check
8–9 months	Carry out distraction hearing tests Ensure sitting unsupported Assess manipulation Assess vision and test for squint
18 months	Ensure walking well Assess language and hearing Assess fine motor skills
3 years	Assess letter matching; carry out vision test using Snellen charts Carry out word discrimination hearing test Assess speech and language Assess fine motor and performance skills

Indices of growth, including head circumference, should be regularly plotted on a centile chart.

Children who fail screening tests of hearing are seen in audiology clinics staffed by an experienced community paediatrician and audiometrist. If deafness is suspected the child is referred to a consultant otologist. A child of school age, who can cooperate 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.

Immunisations should be given by a specially trained nurse who either is experienced in resuscitation techniques or has medical support nearby. The schedule recommended by the DHSS is as follows:

<i>Age</i>	<i>Immunisation</i>
13 weeks	1st diphtheria, tetanus, pertussis, polio
19–21 weeks	2nd diphtheria, tetanus, pertussis, polio
36–40 weeks	3rd diphtheria, tetanus, pertussis, polio
12–18 months	Measles
4½ years	Booster diphtheria, tetanus, polio
Newborn (of Afro-Asian origin only)	BCG
10–13 years	Rubella (girls only)
13 years	BCG
13–15 years	Polio, tetanus

School health

The school health team should consist of a doctor and nurse trained in educational medicine, a health visitor, and dental staff. Audiometric screening is carried out by the nurse or a technician, who may also do impedance tests to exclude serious otitis media. In some districts general practitioners have taken on the role of school doctor, and if the nurse has received appropriate training she may take over the main responsibility for screening. She checks the child's vision, height, and weight regularly, plotting the measurements on the centile chart. She may also screen for scoliosis and other medical conditions.

It is generally agreed that all children should be seen by the doctor and nurse around school entry. If this is delayed until the second term in school a questionnaire completed by the teacher can be of value. In the middle and high schools the doctor is more profitably employed reviewing only those children selected by nurse surveillance, together with information from teachers' and parents' questionnaires, or those with known special needs.

Secondary care: children with special needs

Child development centre—The team of professionals which assesses, treats, and supports the handicapped child and his family is ideally based in a district centre situated in the community or the hospital. The same integrated team will also support the child at home and in any group, unit, or school he attends.

Education Act 1981—This Act incorporates many of the recommendations of the Warnock Committee report (1978) on the special educational needs of children. Approximately 20% of the population have such requirements, and if they cannot be met by the resources and facilities of normal schools a statutory assessment and statement of needs must be made.

Parents can request this assessment whatever the age of the child; their consent is required only if the child is under 2 years of age. The assessment is frequently initiated by a professional. Assessment is carried out by the teacher, an educational psychologist, and a doctor, who is frequently the school doctor (although occasionally a consultant). The medical report will include all specialist opinions and the paramedical reports. A health authority has a duty to inform the education authority about a child who believes it may have special educational needs. The statement issued to the parents by the local education authority contains the parental view of proposals for placement and the professional assessment reports, and it lists the special provision to be made by the local health authority and district health authority. As a result of the 1981 Act special education is available, though not compulsory, for children from 2 years of age.

In the spirit of Warnock, the handicapped child should be integrated into a normal school whenever the necessary resources are available. The situation is reviewed annually and reassessment carried out at 13–14 years.

Special community clinics—Each district offers a variable service. There is scope for clinics in general and speciality paediatrics, psychiatry, ophthalmology, audiology, dietetics, enuresis, and the treatment of speech and language disorders. A special secondary immunisation clinic for complex problems, run by an experienced paediatrician, will increase the immunisation uptake rate.

Social paediatrics—Consultant paediatricians and senior clinical medical officers advise on child abuse, fostering and adoption, and children in day nurseries and in care. Together with the primary care team, they support families after a cot death or death from other causes.

Doctors in the child health services

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The ABC of 1 to 7 was first published in the "BMJ" in 1981 and then in book form in June 1982. Dr Bernard Valman has now substantially revised the book, and this is the last of six chapters that we are also publishing in the "BMJ." The revised edition of the book will be published in the late spring.

The medical team leader may be one of a number of doctors; a consultant community paediatrician or a senior clinical medical officer and, occasionally, a specialist in community medicine have the necessary clinical paediatric skills to fulfil this role. In other districts the district medical officer or a similar community physician is in charge. Community paediatricians and a number of senior clinical medical officers are fully accredited in paediatrics, with both hospital and community experience. Many other senior clinical medical officers and a few specialists in community medicine have many years' clinical experience, whereas community physicians and the newer specialists in community medicine have an epidemiological training.

Many clinical medical officers receive in-service training and they have some paediatric experience, but this is not obligatory. It is hoped that in the future they will have a three-year vocational training which will also be acceptable for general practice.

Medicine and the Media

The aftermath of Angie's overdose: is soap (opera) damaging to your health?

STEPHEN PLATT

Abstract

IN A STUDY designed to evaluate the behavioural impact of a fictional parasuicide—namely, Angie's overdose on the popular television soap opera *EastEnders*—information about cases of deliberate overdose treated in accident and emergency departments in 63 hospitals throughout Britain was obtained for the week after the televised overdose (experimental period) and the week before the overdose (control period). After adjusting for trends in the equivalent weeks in a control year (1985) the increase in the cases of parasuicide treated by hospitals during the experimental week was not found to be significant. A significant increase (31%) was found among people aged ≥ 45 , but this is not thought to be reliable. The increase among women alone (21%) was significant with a one tailed test. Contrary to expectations there was a positive association between trends in overdose and distance from London—that is, the further the distance of the region from London the greater the increase in cases of overdose during the experimental period—and a negative association between trends in overdose and viewing

figures—that is, the higher the viewing figure the less the impact on the incidence of overdoses.

These findings do not lend support to the claim that there was a strong imitation effect after this televised parasuicide.

Introduction

The possible role of imitation in epidemics or clusters of suicidal behaviour has long been a focus of interest and concern. Durkheim's contention that "perhaps no other phenomenon is more readily contagious"¹ is supported by more recent evidence of time-space clustering of both suicides (fatal deliberate self harm) and parasuicides (non-fatal deliberate self harm) in various institutional and community settings.²⁻¹¹ It is the alleged effect of the representation and reporting of these behaviours in the mass media (the "Werther effect"),¹² however, that has been fiercely debated over the past 20 years.¹³

The work of Phillips *et al* has consistently pointed to a strong relation between reports of non-fictional suicide in newspapers or on television and a subsequent increase in the incidence of suicide.^{12 14-16} These studies have been criticised on methodological, technical, and theoretical grounds,¹⁷⁻¹⁹ but the original findings have recently been replicated in a most convincing fashion.¹⁵ The existence of a Werther effect after the fictional portrayal of suicide on television has also been shown.^{20 21} Research evidence about the likely impact of the portrayal of parasuicide by the mass media, however, is

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