



Managing diabetes in school

Children spend approximately 25% of their waking lives in school. For a child with diabetes this can create anxiety for a large number of people. Department for Education and Skills 'Managing Medicine in Schools and Early Years Settings' guidance suggests that schools should be 'making reasonable adjustments for disabled children including those with medical needs at different levels of school life; and for the individual disabled child in their practices and procedures and in their policies'. However, it also says that 'it is for Local Authorities, schools and governing bodies, settings and management groups to work out their own policies in the light of statutory responsibilities and their own assessment of local needs and resources' – which, in practice, means care is extremely variable.

The needs of children with diabetes within school hours are wide ranging. More children are being prescribed intensive insulin regimens and may need an adult carer to perform their glucose monitoring or insulin injection at school. Schools need to provide safe storage for insulin and glucose meters and ensure that private areas are available for insulin administration if required. Children need to be able to exercise safely and may need advice on insulin or carbohydrate adjustment during physical education lessons or playtimes. In cases of hypoglycaemia, all children and young people will need assistance during a severe episode involving coma or convulsions and may need help in obtaining food at times of lesser degrees of hypoglycaemia.

The school perspective

A recent Diabetes UK survey examined the provision of diabetes care in primary schools in the UK by contacting local education authorities and schools.¹ Fourteen percent of schools responded (nearly 3000 schools). In schools with children with diabetes, almost 50% had no policies to either supervise or perform blood glucose monitoring. Forty-one percent had no policy for staff to supervise giving medication, and 60% had no policy to carry out insulin injections. If children were unable to inject insulin, 70% of schools expected a parent to come and give the injection.

A separate survey of secondary schools in 2009 found that, in schools with pupils with diabetes, 79% had health care plans negotiated with the pupil, school and health care professionals and almost all had a private area for insulin administration. However, only half had provided training for staff within the previous 12 months,² which was significant as only 13% of young Diabetes UK members felt that school staff had enough training in diabetes.³

The pressure on schools can be immense: most primary schools will only have one child with diabetes attending at any one time, and some may have no such children for a long period of time. The prospect of administering subcutaneous medication rather than oral, and the concerns about blood contamination or litigation in case of an error are likely to be significant. Unfortunately, few data exist on the thoughts and concerns of teachers, although the Diabetes UK secondary school survey did suggest that teachers are keen to have more training along with standard policies and examples of good practice.

The family perspective

As part of their schools survey, Diabetes UK carried out semi-structured interviews with parents. Some parents reported being unable to go to work in order to attend school for diabetes care, some children were excluded from school activities due to a lack of support, and children as young as five were left to inject themselves. Not all school experiences are poor: parents also reported that schools with an inclusive approach and pro-active leadership did the best for their child.¹

A UK qualitative study of 43 young people (eight to 15 years) with asthma and 26 with diabetes, as well as 138 parents,⁴ found that both groups of young people experienced similar difficulties. Some young people had to administer medication in the toilets due to a lack of private space, relied on 'informed friends' rather than teachers for help, and had to ask for permission for access to stored medication. Parents were concerned about the perceived lack of knowledge of school staff and that regular snacking and monitoring of blood glucose concentrations, which were encouraged at home, were not supported in schools.

These issues are not just a UK phenomenon. Data from Spain suggest there are similar problems.⁵ A study of questionnaire data from 499 parents of children aged three to 18 years suggested that 17% of parents experienced problems when they informed the school that their child had diabetes; 8% were forced to change schools and 16% had to make treatment modifications to fit in with school. Sadly, 12% of children and young people had experienced verbal abuse from their peers.

So what can be done?

With intensification of diabetes management, it is likely that the burden on schools will increase and, unless there are robust guidelines that come with some legal weight behind them, a postcode lottery will be more evident. It is essential that changes are made with schools as opposed to imposing rules upon them. Shared working between health care and education will be essential if true improvements are to be made; this has already worked well in some areas such as Nottingham, with a programme of practical education for schools in place. There is greater scope for local authorities and primary care organisations to take a leadership role in providing training and information via the local NHS, standardised written policies and guidance, and encouragement to schools to facilitate inclusiveness at schools. Partnership working with children and their parents is likely to bring the best possible care for all children and young people with diabetes.

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References are available online at www.practicaldiabetesinternational.com.



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