were excluded unless specific reference was made to mental problems.

The files of 81 families involving 145 children were examined. Mental health support was needed in 40 of 82 (48%) families involving 44 parents. Services were availed from community psychiatric nurses (5%), community mental health workers (5%), counsellors (7%), general practitioners (18%), forensic psychiatrists (20%) and psychiatrists (23%).

Evidence of information sharing between social services and other health professionals was seen in 11 (61%) cases. Information was shared orally, through reports and attendance at conferences by the Child and Adolescent Mental Health Services, community psychiatric nurses and mental health workers. In one case, a psychiatrist's report was provided. Oral information sharing limited to one or two sentences occurred through second parties in three cases. In one case, the social worker contacted the designated paediatrician who obtained information from the psychiatrist.

Our audit again shows that although there are existing structures, they are not effectively integrated. This may reflect absence of protocols that work across agencies. Information sharing was not predictable, consistent or adequate. Some sharing of information occurred at the conferences. A conference may have been used to get professionals together to share information. Poor prioritisation of child protection by adult mental health services might have contributed to a lack of active seeking of information by social services. A wide range of services apart from forensic psychiatry were available locally in Coventry. Reports from forensic psychiatrists were uniformly unavailable to the conferences. Specialisation, difference in location and management structures might have contributed to this. Resource constraints may have affected decision making.

Subsequent to our audit, we nominated a liaison mental health professional between adult mental health and children's services. Through training, we encourage social workers to actively invite other agencies to share information in a variety of ways. General practitioners' invitations to conferences now provide optional ways of information sharing and include a reminder about the importance of sharing information in child protection matters. The three interagency study days were strengthened to include clear protocols for professionals.

In families in which parents with mental health problems look after children, agencies need to communicate freely and effectively. In the face of such communication, it is likely that "child in need" issues will not progress to child protection.

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Author's response

Barry Zuckerman's letter describes the "Reach Out and Read" programme as an essential part of child health promotion. As literacy is probably one of the most health-protective skills we can equip children and young people with, we would agree with him. In the UK, Bookstart was initiated in 1992, and by 2001 it had a reach of over one million children. Through the Sure Start centres in England, a scheme exists which provides every 7–9 month old living in disadvantaged circumstances, usually through the home visitor (health visitor), a pack including two board books, nursery rhymes, advice on sharing books, information on libraries and story time community events. In one area, the 9-month hearing test was organised in a local library to help capture infants at an early stage. The scheme is funded centrally by the Department of Education and Skills and the Department of Work and Pensions. Books are available in 16 languages. The scheme has been extended to 18-month olds and 3-year olds. An important point raised by Dr Zuckerman is the awareness of general practitioners and paediatricians regarding this scheme and linking parents to it.

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Re: From health surveillance to health promotion: the changing focus in preventive children's service

Blair and Hall's article¹ provides an important justification from a shift in child health surveillance to child health promotion including the important role of other disciplines and agencies. This information is relevant to the US as it is to the UK. However, I would like to bring to their attention for inclusion into their recommendations an important evidence-based activity that promotes children's development and pre-emergent literacy. Reach Out and Read (ROR) is a programme practised almost entirely in the US, in which primary care paediatricians give advice to parents about developmentally appropriate strategies to read to their child and give low-income children a book to take home at each health supervision visit from age 6 months to 6 years.² This effort is now practised in more than 3000 clinics and practices throughout the US and reaches more than three million children. The published

evidence from multiple studies shows that parents are more likely to read to their children, literacy oriented activities are increased and, most importantly, children's language development is increased by 4–8 points compared with children not exposed to ROR. Next to immunisations, ROR is the only evidence-based health promotion strategy in primary care for children. Not only is this strategy effective, but given its cost of £2.80 (€4.20; \$5.50) per child/per year it is exceptionally cost effective; children start school with at least 10 books in their home for less than £15 (€2; \$30).

I realise that paediatricians infrequently provide primary care in the UK but suggest that an effort like ROR should be part of health promotion activities, whether practised by paediatricians or general practitioners to benefit high-risk, low-income children in the UK.

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Non-adherence to tuberculosis treatment

Marais *et al*¹ reported on a prospective community-based study into adherence of mono-chemotherapy with isoniazid in preventing tuberculosis in the suburbs of Cape Town, South Africa. They studied children who were less than 5 years of age and who had household contact with an adult pulmonary tuberculosis index case. The main evaluation was the children's prescription collection at various intervals from the start of chemotherapy to the end at 6 months. They found that only 20% of the children completed ≤ 5 months of unsupervised chemotherapy. The ethical underpinning and structure of this study is questioned. It was clear that during the early stages—that is, at 1 and 2 months of the study—a number of children were not compliant with the therapy. At this stage, the guardians were not questioned regarding the reasons for non-attendance, nor educated on the importance of compliance. Furthermore, no arrangements were made for ensuring subsequent compliance. Instead, the children were simply monitored for further non-compliance, and were "allowed" to develop tuberculosis; which is what six of them did. One would assume that normal professional practice would be that whenever any non-compliers are located, a strict form of supervision or directly observed therapy be instigated—that is, before any disease progression occurred. Also, the authors