PostScript

Mothers with their babies in prison: the first Italian experience

The purpose of the study was to evaluate the health care of children living with their mothers in prison. No previous studies on this topic have been conducted in Italy.

Italian law allows female prisoners to keep their babies with them until the age of 3 years in specific nest areas. Currently, there are 15 nest areas in Italian prisons, 2804 female inmates, 64 prisoners with children aged <3 years and 64 children.¹ Our study was performed in the female detention centre of Roma-Rebibbia, Rome, Italy.

From 2003 to 2005, 150 children were admitted, with 211 accesses in all (table 1).

The low mean age and body weight on admission suggest that these children represent a vulnerable group with particular health-care needs. Inadequate housing and food, poor information about previous medical care, lack of screening at birth and of an adequate immunisation are some challenges of these families. Socioeconomic, cultural and linguistic barriers thwart these children from accessing basic healthcare services.

Children received good assistance inside the prison. Several medical examinations were conducted by paediatricians, doctors on call and other specialists. Children required medical care out of prison in case of severe diseases.

Table 1 Demographics of children and morphological parameters on admission

Age in months, mean (median)	9.79 (9.40)
Age in months, n (%)	
<1	15 (7)
2-12	110 (52)
13-24	54 (26)
25-36	29 (14)
Unknown	3 (1)
Sex, n (%)	
Male	80 (53.3)
Female	70 (46.7)
Place of birth, n (%)	
Italy	133 (88.67)
European union	8 (5.33)
East European States	5 (3.33)
South America	1 (0.67)
Unknown	3 (2)
Race or ethnicity, n (%)	
East European	101 (67.33)
Italian	6 (4)
European union	6 (4)
South American	5 (3.33)
African	2 (1.33)
Unknown	30 (20)
Mean birthweight in g, Weight in centile, n (%)	2800
<10	38 (18.01)
10-25	34 (16.11)
>25	72 (34.12)
Unknown	67 (31.75)

Table 2 Children examinations, reasons for hospitalisation and immunisation status

Admissions	
1	105 (70)
2	33 (22)
3	8 (5.33)
4	4 (2.66)
Total children	150 (100)
Total admissions	211
Examinations in prison	
Paediatrician	981 (42.85)
Doctor on call	1282 (56)
Other specialist	26 (1.15)
Total	2289 (100)
Emergency room	8
Hospitalisation	24
Immunisation status	
Adequate	21 (14)
Unknown	81 (54)
Inadequate	48 (32)
Adequate after prison	42 (28)
Vaccination in prison	
Hexavalent	
1 dose	17 (11.33)
2 doses	3 (2)
3 doses	1 (0.67)
MMR	2 (1.33)

Values are n or n (%).
Hexavalent, DTAP-IPV-Hib-HBV

Causes of hospitalisation were similar in inmates and non-inmates. After the stay in prison, 11% of children evaluated for a period >3 months showed a catch-up growth.

A small percentage of children had an adequate immunisation status before entering the prison. During their stay, the immune status of 21 (14%) children was adjusted (table 2).

There should be a balance between the possible damage of separating children from their mothers and the potential harm to children kept in prison. Parental contact is fundamental for the child and must be guaranteed inside the prison as a constitutional principle. The mother and baby relationship can promote prisoners' rehabilitation to the community. The choice to separate mothers and children is rarely justified; it often took place because of the inadequacy of the detention centre.²

However, in Roma-Rebibbia Female Detention Centre, that the general health of these children is paramount. The high number of medical examinations is probably because of the availability of medical assistance 24 h a day. Catch-up growth depends on the improved intake of more nourishing food and the continuous medical assistance. The low percentage of children whose immune status was adjusted is probably a result of the short duration of their stay in prison of most of the children.

Further data are warranted in order to understand the complex conditions of this population and improve health promotion. Our proposals are the introduction of a computerised paediatric clinical diary on a national scale; more attention to be paid to on healthcare promotion by providing healthcare educational programmes; and optimisation of

the immunisation programme in accordance with the recommended schedule for healthy infants and children.³

Prison may act as a gateway to facilitate the health and general well-being of these babies. A civil society is one that cares for its babies.

P Ferrara

Department of Pediatrics, Università Cattolica S Cuore, A Gemelli Hospital, Rome, Italy

V Emmanuele

Università Campus Bio-Medico, Rome, Italy

A Nicoletti, A Mastrangelo, G Marrone

Department of Pediatrics, Università Cattolica S Cuore, A Gemelli Hospital, Rome, Italy

G Pedote

Department Female Detention Center of Roma Rebibbia, Rome, Italy

Correspondence to: Dr P Ferrara, Department of Pediatrics, Università Cattolica S Cuore, Policlinico A Gemelli, Largo A Gemelli 8, 00168 Rome, Italy; pferrara@rm.unicatt.it

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An audit of the mental health problems of the parents of children on the Coventry Child Protection Register

Protecting children whose parents have mental health problems has long been considered to be a major child welfare issue. A survey conducted by the National Society for the Prevention of Cruelty to Children showed that 16% of parents in the community have mental health problems.¹ At the same time, the Children's Act specifies that children should be with parents wherever possible.²

The Department of Health document "Crossing bridges" is designed to enhance practice and improve services for families with a mentally ill parent.³ It suggests that the service provision could be improved by attending to seven key principles for the development of interagency and interprofessional cooperation.

We audited our services against these recommendations. The names of children were randomly selected from the Child Protection Register (September 2004). Social services records were reviewed for evidence of parental mental problems, assessments parents underwent and services provided for such families. Domestic violence, drug and alcohol misuse

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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Manjula Govindshenoy, Taruna Bindal
Coventry Primary Care Trust, Coventry, UK

Correspondence to: Dr M Govindshenoy, Coventry Primary Care Trust, Gulson Road, Coventry CV1 2HR, Contact-236, Broadway North, Walsall WS1 2PU, UK; manjula.shenoy@walsall.nhs.uk

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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.

Mitch E Blair

Correspondence to: M E Blair, River Island Academic Centre for Pediatrics and Child Public Health, Imperial College (Northwick Park Hospital Campus), Watford Road, Harrow HA1 3UJ, UK; m.blair@imperial.ac.uk

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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.

Barry Zuckerman

Boston Medical Center, Boston University School of Medicine, 771 Albany Street, Suite 3509, Boston, Massachusetts 02118, USA; barry.zuckerman@bmc.org

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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