

nothing to replace the revenue lost from cancelled paper subscriptions.

Although figure 1 shows that subscriptions account for only 12% of the *BMJ*'s total revenue, our problem is that our two other main sources of revenue are also under threat. Job advertisements, which account for 61% of our revenue, are threatened by an NHS job website for England (sites for jobs in Scotland and Wales already exist). And spending by UK pharmaceutical companies is down 8% over last year, with fewer new drugs to promote.²

Although it's unclear whether the subscription model for scientific journals will survive in the long term, it still has a few years of life left in it.³ Like any business, the *BMJ* is obliged to preserve as many different revenue streams as possible. For example, had we been solely reliant on the pharmaceutical industry for financial support—like many publications—our recent theme issue on the need to disentangle doctors from the drug industry⁴ might never have happened.

Nevertheless, the end of free access is likely to affect the sudden explosion in exposure to the *BMJ*. The number of computers accessing *bmj.com* recently reached 132 000 per week, equivalent to about 185 000 individual users per week, or nearly twice the number of people who receive the paper journal (fig 2). Nearly two thirds of these users live outside the United Kingdom, with half rarely or never seeing a copy of the paper *BMJ*—a legacy of our previous policy, strongly endorsed by BMA members,⁵ to make the full electronic journal freely available to doctors everywhere.

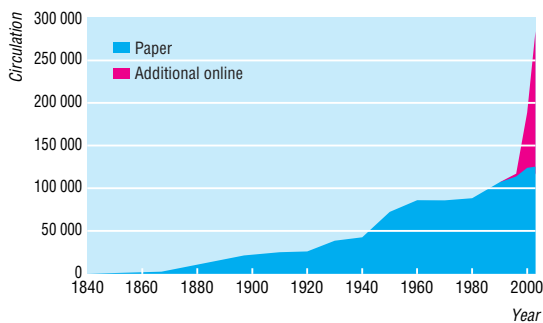


Fig 2 Weekly circulation of *BMJ*, 1840-2003

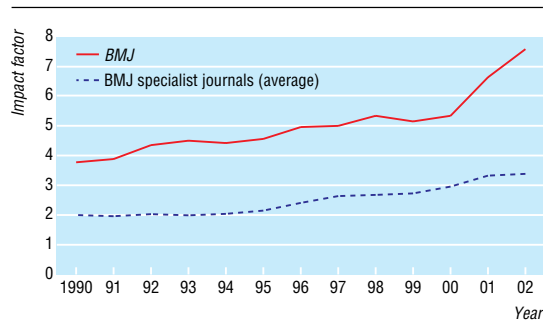


Fig 3 Impact factors, 1990-2002

While the journal's international influence has undoubtedly increased, it's much harder to quantify this than to quantify how much *bmj.com* costs (about £4.60 per BMA member last year.) One proxy for influence, at least within the academic community, is the impact factor. The *BMJ*'s impact factor has risen much faster recently than the average for the group's specialist journals, which have remained behind access controls (fig 3).

We expect to charge individuals between £10 and £20 (\$16 to \$33; €14 to €28) a year for an online subscription; charges to libraries will vary according to the number of people they serve. For users accessing the website via a library that subscribes, access will feel free. Non-BMA members whose libraries do not yet subscribe to the *BMJ* have nearly 18 months to persuade them to do so, or to save up for a personal subscription.

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Competing interests: TD and RS both work for the *BMJ* Publishing Group Ltd. Although the group's profits are likely to rise with the introduction of access controls to *bmj.com*, their salaries will not be affected.

- 1 Countries with free access. www.bmjournals.com/subscriptions/countries.shtml (accessed 26 Jul 2003).
- 2 Taylor D. Fewer new drugs from the pharmaceutical industry. *BMJ* 2003;326:408-9.
- 3 Abbasi K, Butterfield M, Connor J, Delamothe T, Dutton S, Hadridge P, et al. Four futures for scientific and medical publishing. *BMJ* 2002;325:1472-5.
- 4 Time to untangle doctors from drug industry (theme issue). *BMJ* 2003;326:1155-222.
- 5 Results of annual *bmj.com* questionnaire (Nov 2002). bmj.com/aboutsite/quest2002/#BMA (accessed 26 July 2003).

The impact of parental psychiatric disorder on children

Avoiding stigma, improving care

Four decades ago Michael Rutter in a seminal monograph highlighted risks to the development of children of parents with a psychiatric disorder.¹ Since then a good deal of research has been focused on these children and their parents. However, policy to help and support these families has lagged behind. Two recent reports by national bodies in Australia and the United Kingdom have belatedly provided some important recommendations.^{2,3} None the less, much remains

to be done both in policy terms and in the development of evidence based interventions.

Several common psychiatric disorders—including depression, anxiety, and eating disorders—affect adults of child rearing age. These disorders have been shown notably to impair social and psychological functioning, leading to difficulties in work and family life.⁴ In recent years recognition has increased of the potential impact that parental psychiatric disorder can have on a child.

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Several aspects of children's development can be affected, including their physical, cognitive, social, emotional, and behavioural development.^{5,6} Although a number of genetic and environmental mechanisms are important in linking parental psychiatric disorder to children's difficulties, there is good evidence that quality of parenting and family interaction are key mediating variables.^{5,6}

Much of the focus of health policy in this area has been on the most severe mental illnesses and particularly on those parents who need to be admitted to hospital—usually those with schizophrenia or bipolar disorder.⁷ However, little attention has been paid to other disorders that are much more common.

To help children of parents with psychiatric disorder the children need to be identified first. This can be difficult. Patients in hospital are often not asked about whether they have children, and information about children is often not recorded in medical notes.⁸ Facilities for children to visit their parents in adult psychiatric hospitals are not routinely provided.⁹ It is harder still to identify those children whose parents have a disorder but who either do not require hospitalisation or are unknown to health services. Although examples of good practice do exist in some areas,¹⁰ serious deficiencies remain. The impact of parental psychiatric disorder on children is not included routinely in medical education, and training in the sensitive discussion of parenting issues is rarely dealt with. The enduring stigma that surrounds mental illness also contributes to difficulty in discussing these issues.¹¹ Parents need to be comfortable disclosing their difficulties to their general practitioners or even to teachers when necessary. Overcoming this stigma and the other barriers is crucial. The importance of identifying and helping these children is of wider benefit than to the child alone—for example, child psychiatric problems continue into adulthood in an appreciable minority of cases,¹² and the consequent increased health expenditure means that the whole community is affected. An opportunity for prevention exists.

Steps have been identified in two recent reports from organisations on two different continents—the Australian Infant, Child and Family Mental Health Association and the UK Royal College of Psychiatrists.^{2,3} The more extensive Australian report highlights the need for improved recognition of children of parents with mental illness, the need for better identification of problems in these children, and provision of help for those problems. In addition it calls for increased support for this group of parents in their parenting roles and highlights the specific steps that could be taken to

achieve these aims. Implementing these recommendations will require changes in service provision—including closer working of primary care services and mental health services for adults and those for children, education of healthcare staff, and the challenging of stigma to enable parents to even discuss their parenting without the fear of having their children taken into care.

We believe that these service developments must be coupled with high quality health services research to monitor change and identify the most effective, efficient, and equitable way of providing treatment to this diverse group of children and families. These and other changes in the identification and treatment of children at risk will need to be introduced in a sensitive way. It would be easy to increase the stigmatisation facing parents with psychiatric problems, by seeming to adopt a language of blame. The message can and should be a positive one—parents with mental health problems and their children can be helped and deserve better.

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Tuberculin testing before BCG vaccination

May not be necessary

BCG vaccination is effective against forms of tuberculosis that occur commonly in childhood that have a high morbidity and mortality, such as tuberculous meningitis.^{1,2} Current guidelines for the United Kingdom recommend tuberculin skin testing before BCG vaccination for all children older than 3

months.³ The evidence base for this recommendation is unclear—no randomised controlled trials have been conducted to compare outcome of BCG vaccination with and without prior tuberculin skin testing, and the resulting two or three stage procedure seriously compromises uptake.