Table 1—Numbers of subjects (n = 89) attending psychiatric liaison service who were known to local psychiatric services

	At time of court appearance	Before court appearance
Not known to psychiatrist	19	—
In touch with psychiatrist	18	61
With named probation officer	12	36
With named social worker	10	35
In touch with community psychiatric nurse	0	0
Known to key worker	0	0

year of discharge through the court diversion scheme can be expressed as 11.5 per 1000 discharges per year. The total of 54 admissions yields a rate of 16.4 per 1000 discharges per year.

Comment

Subjects presenting to the court diversion scheme were local residents committing offences locally.

Although we expected that most would be homeless, temporary residents, or suffering from mental illness of recent onset, few were homeless and most who required hospital admission were previously known to local services. Despite their vulnerability, none of those previously known to the local services was receiving ongoing care and few were receiving intermittent care. Better formalisation of multidisciplinary care plans² and supervision registers and close monitoring by community supervision³ may result in a substantial improvement in the health and social functioning of this group.

Funding: The court diversion scheme was established with funding from the Home Office and subsequently in contract with Enfield and Haringey Health Agency.

Conflict of interest: None.

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Descriptive survey of antenatal HIV testing in London: policy, uptake, and detection

Sandra E MacDonagh, Janet Masters, Barbara A Helps, Pat A Tookey, A E Ades, Diana M Gibb

Avoidance of breastfeeding¹ and use of antiretroviral therapy² can substantially reduce the risk of a mother transmitting HIV to her child. The Department of Health has recommended that antenatal HIV testing should be offered to all women in areas of high prevalence such as London.³ We examined HIV testing policy and practice in London maternity units and related policy to uptake of testing and detection of previously undiagnosed HIV infection.

Methods and results

In spring 1995 one interviewer conducted a telephone interview with a professional involved with

HIV issues at each of London's 33 maternity units. Information on women booking for antenatal care over the previous 12 months and the number who elected to have an HIV test were collected by postal questionnaire from 32 units. Copies of written information available for staff and women were also collected.

The total number of HIV infected women delivering in 1993 and 1994 in each unit was estimated from unlinked anonymous antenatal and neonatal seroprevalence studies (unlinked anonymous HIV seroprevalence monitoring programmes in England and Wales, data to the end of 1994, Public Health Laboratory service, Institute of Child Health). Confidential reports of pregnant HIV infected women⁴ over the same period were examined to determine how many women had been diagnosed before or during the reported pregnancy. The ratio of the number of women first diagnosed during the reported pregnancy to the total number of infected women minus those previously diagnosed was calculated to assess the efficiency of the screening policy.⁵

In 13 units all women were offered an HIV test (universal policy), in 14 only those perceived to be at high

Table 1—Antenatal HIV testing and seroprevalence by policy type in London maternity units

	Universal (n = 13)	Selective (n = 14)	Request (n = 6)	Total (n = 33)
Seroprevalence/1000 deliveries				
Median seroprevalence	2.9	0.8	0.7	1.2
Range	0.7-4.4	0-2.8	0-4.5	0-4.5
Staff				
Designated staff*	10	5	0	15
Staff training	10	2	0	12
Written information				
Available	13	8	2	23
Outlines modes of transmission of HIV including mother to child transmission	10	3	0	13
Explains that mother to child transmission can be reduced by avoiding breast feeding	7	0	0	7
Mentions the availability of medical interventions to reduce transmission	3	0	0	3
Translations available	6	2	1	9
Uptake and detection				
Median % uptake (range)†	4 (0-43.5)‡	0.1 (0-0.8)	0 (0-1.5)	0.8 (0-43.5)
Median % detected (range)‡	3.8 (0-100)	0 (0-50)	0	0 (0-100)

*Minimum 1 day per week; 9 were full time.

†Only 24 units (11 universal, 8 selective, and 5 request) supplied data on uptake of HIV testing.

‡Four units < 1% uptake, 3 units 1-10%, 2 units 11-20%, 2 units > 20% uptake.

Epidemiology and Biostatistics Unit, Institute of Child Health, London WC1N 1EH
 Sandra E MacDonagh, research midwife
 Janet Masters, research assistant
 Barbara A Helps, research fellow
 Pat A Tookey, research fellow
 A E Ades, reader in epidemiology and biostatistics
 Diana M Gibb, senior lecturer in paediatric epidemiology

Correspondence to: Ms MacDonagh.

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risk of infection were offered testing (selective policy), and in 6 only those who asked were tested (request policy). In 15 units at least one staff member had specific responsibility for HIV issues. Training on HIV in pregnancy was provided for staff, mainly midwives, in 12 units, but only 9 units had written protocols that included guidelines on the procedure for offering HIV testing. Written information about HIV infection in pregnancy was available for women attending 23 units and is summarised in table 1.

Overall only 22 of an estimated 322 previously undiagnosed HIV infected women booked in these units during 1993 and 1994 were identified, 2/126 in units with selective or request policies and 20/196 in units with a universal policy. These women were identified in 9 of the 13 units with a universal policy compared with only 1 of the 20 units with other policies ($P = 0.0002$, two tailed Fisher's exact test).

Information on uptake of HIV testing over the previous year could be supplied by only 24 units. In most the uptake was low, being under 10% in 7/11 units with universal policies and never exceeding 1.5% in the units with other policies (table 1). Detection of previously undiagnosed infected women in units with a universal policy was significantly increased with higher uptake of testing. This finding was largely attributable to those two units where uptake of testing was over 40% and detection of previously undiagnosed women exceeded 20%.

Comment

In view of the high prevalence of HIV infection among pregnant women in London (1 in 580) and the real potential to reduce mother to child transmission the

failure of maternity services to identify infected women is of concern. In many units no written information on HIV and pregnancy was available for women and, where it was, information on the potential to reduce transmission was often omitted. In addition in most units midwives had received no training to enable them to discuss these issues with women. The inability of nine units to supply data on the number of women tested is also worrying. Only after both the uptake and process of offering antenatal HIV testing is routinely audited can more detailed study of the cost effectiveness of different approaches be undertaken.

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Conflict of interest: None.

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Incidence of adverse reactions after administration of high dose diphtheria with tetanus vaccine to school leavers: retrospective questionnaire study

In October 1994, after an increased incidence of diphtheria in eastern Europe, the Department of Health recommended that all children aged 15-18 years should receive a combined tetanus and low dose diphtheria vaccine in place of tetanus vaccine alone.¹ Low dose vaccine is recommended for adults and older children because of the possibility of serious reactions in those who are immune. In March 1995, 220 children aged between 14 years 4 months and 16 years 1 month were inadvertently given high dose diphtheria with tetanus vaccine. When this error was discovered the immunisa-

tion sessions were halted and stocks of the high dose vaccine were withdrawn from schools.

Subjects, methods, and results

Following an official inquiry into the incident, the parents of all children involved were sent a questionnaire about the incidence, severity, and duration of side effects experienced by the children after being given the high dose vaccine. Three possible local reactions and five systemic reactions were listed, together with an indication of severity (see appendix).

A total of 153 (70%) questionnaires were returned. One child had received only polio vaccine, and two forms were returned not completed. These three were therefore excluded.

Twenty six children (17%) reported consulting a doctor after the vaccination. Forty eight children (32%) missed 1-15 (mean 3.5) days of school. The commonest reasons given were flu-like symptoms (15 children), fever (10), and headache (10).

School of Medicine,
University of
Southampton,
Southampton SO16 6YD
Peter D Sidebotham, lecturer,
community child health

Department of Child
Health, Bath and West
Community NHS Trust,
Bath BA1 3QE
Simon W Lenton, consultant
paediatrician

Correspondence to:
Dr Lenton.

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Table 1—Numbers of reported reactions to high dose diphtheria with tetanus vaccine in 141 children aged 14-16 years

Reaction	Mild (n = 380)	Moderate (n = 311)	Severe (n = 87)	Total (%) (n = 778)
Redness at injection site	45	64	15	124 (83)
Swelling at injection site	30	82	8	120 (80)
Itching or pain	52	65	1	118 (79)
Fever	68	8	12	88 (59)
Tiredness; feeling generally unwell	67	24	22	113 (75)
Headache	34	50	8	92 (60)
Joint or muscle aches	56	18	4	78 (52)
Rash	21	—	13	34 (23)
Wheeze	7	—	4	11 (7)