Prison: shield from threat, or threat to survival?

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The first reported HIV outbreak in a British prison, at Glenochil,¹ is an alarming but not at all unpredicted event.² Unfortunate, from the point of view of the national public health, is that prisoners do not stay in prison indefinitely—the uncontrolled spread of HIV infection between prisoners threatens the government's successful HIV control programme and presents a grave threat to the nation's health.

In this outbreak the coincident presentation of jaundice due to hepatitis B led to the recognition of HIV infection. We have no direct knowledge of conditions in Glenochil and make no comment on the prison medical service in that prison. However, as a result of our considerable experience of treating or representing hundreds of opiate dependent subjects as patients or clients we are concerned that conditions seem to be ideal for the rapid but unrecognised transmission of HIV throughout the whole of the British prison system.

We sympathise with the difficult working conditions and stressful professional relationships for doctors who work with prisoners. We also have come across individual instances of sympathetic provision of care by prison medical officers. However, more frequently described to us by former patients are feelings of injustice and antagonism towards the prison medical services. It is our view that this largely attributable to the consequences of the service enjoying the monopoly of clinical power within prisons. As it is the guardian of the prison public health and sole provider of primary care and of most secondary care, the health care service for prisoners must, in our view, assume much of the responsibility for this crisis.

Scale of the problem

Our experience is principally of West Yorkshire, but this is probably representative of the prison service nationally. There is unequivocal evidence from published and unpublished Home Office statistics^{3,5} that the philosophy and pattern of provision to opiate dependent subjects by the prison medical service diverges considerably from the consensus position adopted by drug dependency clinics in the NHS. For example, although in 1992 NHS treatment centres provided treatment with a notifiable drug (usually methadone) in 90% of renotified drug addicts,³ the corresponding figure for the prison medical service was only 29%.^{3,4} For renotified cases of addicts addicted to methadone (for which it may be reasonable to assume that many received pre-established legal prescriptions) the corresponding figures are 93% for NHS clinics and 33% for the prison medical service (unpublished data). Furthermore, it is likely that those cases where methadone was offered, the usual methadone regimen provided by the prison medical service was, at most, an accelerated seven day regimen,⁷ which does not concur with the physiological rate for the withdrawal process.⁶ It is likely, therefore, that as a consequence of not being able to choose their medical attendant, at least 60% of renotified opiate dependent prisoners, many of whom had been receiving prescribed methadone, are denied access to what is the "usual" NHS clinic

treatment in this country available to 90% of opiate dependent subjects.

The scale of this problem is immense. A recent letter in the *Guardian* from Dr Rosemary Wool, director of health care services for prisoners, quotes Professor John Gunn's estimate that 10.1% of adult men, 6.2% of young men, and 24.2% of sentenced prisoners are addicted to hard drugs.⁷ On the basis of these percentages and a total annual admission rate to prison of approximately 130 000 for England and Wales, a 30:70 ratio of young men to adults, and a 3% rate of female prisoners (Home Office, personal communication); and assuming the rate of drug dependency in those not receiving sentences to be similar to the rate in those receiving sentences, we estimate that in 1992 there were in the order of 12 550 people addicted to hard drugs, most of whom had an addiction to opiates.

This figure stands in contrast to the number of drug addicts notified to the Home Office (2586), which dramatically shows the failure of the prison medical service to identify or engage the vast majority of opiate dependent subjects in any treatment programme. An extrapolation of this problem is that the reality for an opiate dependent prisoner admitted in 1992 was that he or she had less than a 5% chance of being offered any methadone at all (and of this 5%, the vast majority would have been offered the accelerated maximum seven day course).

Dr Wool claims that those doctors who refuse to prescribe methadone do give appropriate medical attention to abolish withdrawal symptoms. The anecdotal accounts that we receive from many addicts, and the self recorded opiate withdrawal scores, psychometric assessments, and objective measurements (urinalysis and weight) recorded prospectively for our index cases, do not support this view.

In an environment where heroin is said to be very widely available at prices which, although variable, can reach as low as £5 a gram or even zero (outside prison heroin usually costs about £80 a gram) the temptation to use illegal heroin must be very great indeed.

In the past few months some accelerated methadone courses have been prescribed in Armley prison. We are concerned, however, that there seems to be very little consistency to whom the methadone regimen is offered. Furthermore, the prescribing of very short courses of methadone does not seem to form part of a coherent clinical strategy to address the individual drug misusing prisoner's clinical needs. For example, as recently as 24 December 1993 a patient who had previously been established on a reducing regimen of methadone was refused a further prescription of methadone despite a medical officer of Armley prison being advised by both the prisoner's general practitioner and his solicitor that this was the case. He was given a small reducing dose of dihydrocodeine at a level insufficient to meet his opiate requirements. His self reported opiate withdrawal score two weeks later was 66 (of a maximum 96) and he scored in the pathological range for anxiety (hospital anxiety and depression scale 18, Beck anxiety inventory 49) and depression (Beck depression inventory 36). An example of the arbitrary nature of the availability of methadone prescriptions is

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New prisons—same old ways?

that this prisoner has two brothers, both of whom are in Armley and were given methadone for a few days. All three described significant withdrawal symptoms. All were in the middle of a methadone detoxification regimen and all would therefore have required opiate substitution.

Treatment programmes and guidelines

Although we support the motivation and efforts of Gore and Bird,⁸ their recommendations for saliva testing and distribution of clean needles seem unnecessarily exotic and controversial when there is a more direct remedy. This is for the prison medical service to implement the sort of treatment programme that is standard practice in NHS drugs dependency treatment centres and certain general practices, as recommended by the Department of Health.¹⁰

Such a programme is based on a verifiable contract between patient and doctor with mutual expectations and obligations. The patient's motivation and determination to achieve abstinence is decisive to outcome and closely correlates with the degree of symptom relief obtained. Symptom relief requires both prescribed and psychological support from the doctor. The chances of success are therefore greater if withdrawal proceeds at a physiological rate. A great deal is known about the prolonged noradrenaline storm which causes the symptoms of opiate withdrawal.¹¹ The expected time course for recovery from a methadone dependent state is six to seven weeks.⁶ The Home Office has internally distributed but never published guidelines for the treatment of drug abusers in prison.⁵ These guidelines seem to be an attempt to redress what is admitted, for the reasons outlined above, to be the massive underrecognition of the problem. The guidelines seem to encourage clinical staff to change their behaviour so as to increase the proportion of opiate dependent subjects presenting to the prison authorities.

It is our view, however, that these guidelines actually breach normal standards of professional ethical care. According to recognised ethical standards in Britain, prisoners and non-prisoners are entitled to equal standards of care. Except for the lack of choice of medical practitioner, the relationship between doctor and prisoner should be no different from any other doctor-patient relationship.¹²

We consider the guidelines unethical because, although they advise a methadone withdrawal programme, their regimen is an accelerated one (seven

days) which fails to replicate the physiological rate of withdrawal. The guidelines insist that the reduction is non-negotiable despite admitting in a subsequent section that the accelerated regimen is likely to cause stress and be associated with withdrawal symptoms. This proscribes any reasonable dialogue with a doctor, which a patient would expect in an identical situation outside prison.

Two cases

Because of legal action we prospectively monitored two patients who previously had major life events and proved psychological morbidity, resulting in drug misuse. They had been successfully engaged in treatment provided by a specialist clinical psychologist (MS) and had been free of street drugs on a reducing dose of methadone. They both unexpectedly were detained in prison and had their established, necessary, and successful regimen abruptly terminated without their consent. In both patients the level of self reported subjective opiate withdrawal symptoms (including vomiting) and psychological morbidity was recorded by one of us (MR) on standard quantitative and psychometric instruments (Beck depression inventory, Beck anxiety inventory, hospital anxiety and depression scale, Penn PTSD inventory, and opiate withdrawal questionnaire). Objective measures such as weight loss and results of urine analysis were also recorded.

In March 1993, clinical concern arising from this detailed information obtained about a male patient was communicated to a medical officer at a West Yorkshire prison. Although guidelines issued two years previously state, "Without prejudice to the general principle of individual clinical judgement, it considered that the presumption should operate that a detoxification programme will be offered where there is evidence of addiction unless specifically contra-indicated," his response was that he had never offered methadone to any patient and subsequently refused to prescribe for this patient. The patient appeared to us to suffer the most severe physical and psychological symptoms. The patient's reported level of withdrawal symptoms and anxiety deteriorated to the point that he felt for the first time in his life that he was "losing control." A weight loss of 6 kg in nine days was recorded. Emergency bail was exceptionally granted for him to be transferred to an NHS psychiatric ward, where his previous regimen was immediately reinstated. He made a gradual recovery over two weeks. Four months after the incident he was still having nightmares relating to his prison experience. He now reports that the experience was connected to the onset of auditory hallucinations, from which he is still suffering.

The other case we documented in detail is of a female unconvicted patient detained in May 1993 in another West Yorkshire prison. The diagnoses made by one of us (MS) of a form of pre-existing post-traumatic stress disorder combined with pathological levels of anxiety and depression did not prevent her being denied her established reducing regimen of methadone combined with clomipramine and benzodiazepines (on which she had a dependence) in doses appropriate to her clinical need. She admitted to her solicitor to using prison heroin. She justified her actions by citing her high levels of withdrawal symptoms and pathological anxiety which, she claimed, eventually forced her against her wishes to use heroin, which is widely available in that prison. Again, detailed clinical information had been communicated to a prison medical officer, who refused to reinstate her previous regimen. After this outside intervention, however, she was prescribed a modified (but to her, subjectively ineffective) regimen and was refused any further opiate substitute. Her request for referral to an

NHS drug dependency consultant was also ignored. Her reported vomiting, depression, pathological anxiety, and exacerbation of post-traumatic stress disorder were closely monitored by us.

Ethics and outcomes

These cases illustrate an important ethical issue, the right of the prisoner to give or withhold consent. This principle is enshrined in BMA statements.¹² The unilateral suspension of a successful, necessary, and reasoned pre-existing treatment regimen in favour of one that does not conform to the mainstream pattern of treatment of drug misuse is a gross violation of this principle.

Attempts to obtain a mandamus in the High Court for these two cases were unsuccessful. The mandamus was lost on the grounds that the prison medical officers were entitled to exercise "clinical judgment." It is our view that this is an abuse of the concept of clinical judgment. Fundamental to this notion is the premise of the undivided clinical loyalty of the doctor to the patient, unhindered by disciplinary roles. A second implicit premise is the notion that, should the patient disagree with the clinical judgment of the doctor providing care, then he or she should be able to choose a different medical practitioner with a different "clinical judgment." Neither of these conditions is attached to the relationship between the prisoner and the prison medical officer. That practice in the prison medical service deviates from mainstream practice in the NHS further undermines the justification for using "clinical judgment" as a reason for failure to provide adequate substitution therapy.

The Hawthorn effect, whereby any attention to a problem leads to an improvement in performance, makes it likely that these patients were better managed than the many opiate dependent prisoners who are managed every day within the prison system. We continually receive accounts from patients and clients who have been detained in prison in an opiate dependent state of what can only be described as psychological and physical agony as a consequence of a florid withdrawal state. They describe how the standard response to a prisoner revealing his or her opiate dependent state is for inadequate treatment or, often, no effective treatment to be offered to ameliorate withdrawal symptoms.

When medication is prescribed, typically it is dihydrocodeine 30 mg, at a level quickly reducing from a maximum of 3-10 tablets per day, lasting for three to seven days. This usually represents a fraction of the patient's total opiate requirements. It is often combined with a prescription for a tranquilliser, frequently a phenothiazine, which itself produces side effects. Our patients and clients report that, as would be anticipated from our knowledge of the pathophysiology of the withdrawal process, this level of prescribing is largely ineffective in ameliorating the symptoms of the withdrawal state.⁶

The use of strip cells has recently been described and severely criticised in the *BMJ*.¹³ Such cells are often used for the patient who declares his or her opiate dependent state. Consequently, the prisoner stripped of personal clothes and social support can be left to floridly withdraw in a single cell.

An example of an "unflagged" case may be that described in a self reported, unverified account from an HIV positive man previously receiving prescribed maintenance methadone. When admitted in the summer of 1993 to a West Yorkshire prison he was given no opiate replacement treatment whatsoever, although the guidelines advise that HIV positive patients and pregnant women are to be uniquely privileged by being offered a physiologically appro-

priate methadone detoxification programme extending over weeks to months.⁷ He said, however, that he was given antiemetics in an unsuccessful attempt to control his profuse vomiting. Despite his unchecked withdrawal symptoms and, at a later stage of his withdrawal, his free association with other prisoners, he said he chose during that detention not to share syringes or even use illegal opiates to alleviate his symptoms.

We have recently received unsubstantiated but plausible reports of needle sharing between HIV positive and other prisoners in the same West Yorkshire prison. If these reports are substantiated, it would appear that we face a public health red alert.

We are also aware of a death in custody, in December 1993, at the same prison, of a known drug misuser in circumstances which in our opinion draw attention to the urgent problems which exist within the prison system.

Use of resources

It has been suggested to one of us by a prison doctor that a reason for the failure of the prison medical service to provide a service at the same level as the NHS clinic system is because of concern about resource implications. This view is not only short sighted but compromises the responsible medical officer's role as the guardian of the prison public health (Standing Order 13, Home Office). This responsibility is increased, in our view, by the unjustifiable power of the prison authorities "not to allow the Medical Officer of Environmental Health or any other local sanitary inspector to inspect the prison." (Standing Order 13, Update, 1985.)

There is considerable evidence that the treatment of drug misuse is effective—30-40% of subjects become abstinent as a result of treatment.¹⁰ The restraints of the prison environment, with the severing of previous social contacts, should present an opportunity to achieve an even more favourable outcome.

Instead of exploiting this opportunity to motivate or reinforce existing motivation of prisoners to reconsider their past lifestyle, the prison medical service's monopoly provision of care and non-standard treatment regimens, combine with what we regard as the abuse of the concept of doctor's "clinical freedom," leaves prisoners disenfranchised to the point of suffering serious avoidable morbidity. We are given to understand that the future of the prison medical service is the subject of an internal debate within the Home Office.

Long term and short term concerns

It is our view that the prison medical service has policies, practices, and attitudes which seriously diverge from both current professional standards and a wide range of key government policies. These relate to treatment of drug abuse, market forces determining quality, open government, and HIV control.

To date, the reaction of the prison medical service to our attempts to draw attention to the problem has been defensive and disquieting. The response of High Court has been a reluctance to involve itself in what it sees as professional disagreement. At present we can see no easy solution to the problem. In the long term, because patient choice is the most fundamental custodian of standards, we support those who have recommended a completely alternative model for the provision of prison medical services.

In the short term, to address the failure to control heroin misuse in prisons, the absence of coherent drug dependency treatment programmes, and the imminent threat to the public health, we are calling for inquiries

by the Home Affairs Select Committee, Her Majesty's Inspector of Prisons, the Chief Medical Officer, the Royal College of Psychiatrists, the General Medical Council, and the Public Health Laboratory Service. We also request that the concern which the BMA Ethics Committee has expressed about this issue should be translated into specific action. Finally, we advocate that past patients of the prison medical service who identify themselves as having suffered abuse in this way consult their legal representatives not only to seek legal redress but also to collate evidence for the General Medical Council.

The hitherto successful campaign by the chief medical officer and the Department of Health draws attention to the fact that the most potent factors which spread the HIV virus are denial, hypocrisy, prejudice, and neglect. To avoid an HIV epidemic this message cannot be ignored by any agency with a responsibility for the medical care of high risk patients.

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Letter from Brasília

Some primitive peoples of the tropics

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Few "primitive" peoples now exist, as Western communications, material goods, and forms of transport have swept the globe. Through studying malaria I came into contact with several primitive tribes, including the people of Wingei and Wam in the Sepik area of New Guinea and the Brazilian Indians of the Amazon. The Brazilian Indians are true environmental ecologists, wasting nothing and knowing how to conserve stocks of fish, animals, and fruits. All these primitive groups seemed to suffer from *tinea imbricata*, caused by *Trichophyton concentricum* and characterised by whirled fungal scales over the skin and often a smell of gorgonzola cheese.

"Primitive" people are rapidly disappearing as *Homo sapiens* creates a global monoculture based on such material values as television, refrigeration, and transport modes. My first contact with tribal primitive man was while driving through the Congo basin rainforest in 1963. On a straight stretch of dirt road I saw a man lying prone in the path of my Volkswagen. He seemed to be dead so I stopped and went forward on foot. Suddenly he sat up and at that signal more than a hundred pygmies emerged from the forest and surrounded my car. They were naked except for a small genital cover and carried spears and bows and arrows. There were many women and children. I spent the rest of the day negotiating my right of way (in Swahili) over this stretch of public road by payment and by treating sundry ailments. Hardly a primitive people!

New Guinea

My next contact was in 1965 while working among the people of Wingei and Wam in the Sepik area of New Guinea. Within a week I had changed my environment from New York to a guest hut in the Sepik. The first night, dogs got into the hut and broke my malaria slides. After that, on the chief's order, a fire

was lit before my hut and I had a watchman. These were indeed stone age people—no written language, no iron, no concept of the wheel, no farm animals apart from the pigs that represented wealth. Every woman had a pig value. Small money took the form of sticks of strong tobacco. Pigs were suckled at the breast by the older women—the breast remained a functional organ all their lives. In the early morning, as the swirling mountain mists dissolved in the strong sunlight and the birds of paradise took to the trees, activity could be seen in a village of huts far below. The tribe of which I was a guest did not know that village's name or speak its language. There were then 400 languages in New Guinea.

Part of the culture in the Sepik valley was based on the yam, a giant sweet potato. It grew exceptionally large—one tuber would last a man a week. A ceremony which I did not witness was the yam competition with prizes (in pigs of course) for the largest male (three roots) or female (two roots) yam. At the end of my field research on a chronic malaria syndrome I left via Lae and Port Moresby airports. At both, cargo cult personnel were in evidence, noting every "valuable" I was taking from this island, the second largest in the world.

Along the Amazon

It was malaria which also took me on Amazonian trips. During these extensive river voyages I came to know something of the Brazilian Indians, a most resourceful group. Perhaps their most impressive feature is the care with which most of them husband their environment. They waste nothing and know how many fish they should take from the river, wild animals from the banks, or fruit from the forest so as not to prejudice the resource. These genuine Brazilians are probably the first environmental ecologists. This care of nature has always been their habit, even though they burn off small patches in the forest to plant mandioca. They are skilled rivermen and woodsmen, and the environment is a friend, not an enemy.

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