HIV infection in prisons

Most drug injectors stop injecting on entry to prison

EDITOR,—To assess the wider implications of the recent outbreak of HIV infection in Glenochil prison^{1,2} it is important to refer to the situation in other prisons. Previous research in Scottish prisons indicates the following basic principles: the extent and pattern of injecting and needle sharing vary among prisons; that most people who inject before imprisonment stop injecting when they enter prison; and that the minority who inject in prison are much more likely to share injecting equipment than are drug injectors in the community.^{3,4}

Drug services provided in prisons should take account of the finding that while there is a high level of sharing among those who inject in prison, most users stop injecting on entry to prison. It seems circumspect, therefore, initially to introduce options such as cleaning fluids, advice on reducing harm, and counselling in parallel with programmes offering reduction prescribing of opiates and benzodiazepines.

Monitoring and evaluation of such initiatives would determine whether further measures—such as needle exchange—should be introduced to minimise the risk of transmission of HIV. While the Scottish Prison Service, for example, has become increasingly accepting of harm reduction goals, needle exchange is unlikely to be acceptable as a first level option to the service's management, or to staff in Scottish prisons. Furthermore, previous research has indicated that not all prisoners—including those currently injecting in prison—would be in favour of needle exchange in prison.⁵

While prison and public health authorities should always be alert to the potential for transmission of HIV, implementation of the appropriate preventive measures in a particular prison should take account of the characteristics of drug using behaviour within that prison and within the prison catchment area.

It is important that prisons and public health authorities work collectively to address transmission of HIV in prisons and avoid polarisation and conflict of interest that could be identified as detrimental to the successful implementation of drug services in prison.

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- 4 Shewan D, Gemmell M, Davies JB. Prison as a modifier of drug using behaviour. *Addiction Research* 1994;2:203-15.
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High risk behaviour is common in prisons in Berlin

EDITOR,—The issue of 4 February provides important further evidence that injecting drug users in prisons are at high risk of acquiring parenterally transmitted diseases. In a recent study among 612 injecting drug users in Berlin 418 reported a history of imprisonment.¹ Of these, 202 continued to inject while in prison and 152 of these started sharing needles during their imprisonment. Needle sharing in prison proved to be the most important risk factor for HIV infection as well as a major risk factor for infection with hepatitis B and C viruses (adjusted odds ratio 10.0, 1.7, and 9.8 respectively). On the other hand, injecting drug users proved to have substantially reduced their risk behaviour outside prison. Of the study's participants, 352 (58%) stated that they had not shared needles at all or had shared only with a regular partner during their injecting career. This proportion had been about 20% in a previous study.²

Thus information campaigns and other preventive measures such as needle exchange programmes seem to have successfully generated awareness of risk and changes in behaviour among injecting drug users. High risk behaviour is still common¹ only where injecting drug users are not able to protect themselves according to their new awareness of risk—that is, inside prisons. Thus successes in prevention outside prisons are in severe danger of being damaged by the unacceptable situation inside prisons.

O Noel Gill and colleagues raise the question of why the seroprevalence of HIV among injecting drug users in the community has not been rising if HIV is being transmitted frequently in prison.³ If the above information is taken into account, one possible answer is a shift in the risk of infection from outside prison to inside: a reduction in risk and incidence outside prison seems to be counteracted by high risk behaviour inside. The result could be as stable prevalence in community based samples while populations in prison face a high incidence; this is corroborated by other studies.^{4,5}

In Berlin, as a consequence of the study results mentioned above, a political debate has started about how to reduce risks of transmission in prison

settings. As a first step, a medical kit containing health information leaflets and a bleach-like disinfectant was made available for injecting drug users entering prison. This measure, however, is unlikely to be effective: on the one hand, injecting drug users in prison settings usually do not have the time to clean used injection equipment thoroughly; on the other hand, even thorough cleaning does not result in real safety.⁶ A better approach would be the controlled provision of sterile injecting equipment (as has just started in Hindelbank prison in Switzerland) or methadone maintenance for imprisoned injecting drug users, which has recently been made available for those who were already in such a programme outside prison.

This risk of HIV infection in injecting drug users during imprisonment should be addressed immediately. The situation in prisons counteracts any preventive successes outside prisons.

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Genitourinary medicine services are important

EDITOR,—Two articles report the alarming spread of HIV in a Scottish prison.^{1,2} While intravenous drug use in prisons is clearly a major risk factor in the spread of HIV among inmates, we believe that the role of sexual intercourse also needs to be more thoroughly examined.

Sexual intercourse occurs between incarcerated men,^{3,4} yet condoms are not freely available in Scottish prisons. Inmates often express concern regarding confidentiality, and this is particularly so with regard to sexual intercourse between men, which is subject to strong institutional disapproval. Thus the 1% of prisoners at Glenochil who admitted to anal intercourse while in prison² may represent a considerable underestimate. Furthermore, no attempt seems to have been made to estimate the incidence of other sexual practices that may be associated with the transmission of HIV.

It is well recognised that people in prison often have lifestyles that put them at risk of acquiring sexually transmitted infections⁵ and that infection