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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Advice to authors

We prefer short letters that relate to a recently published article and we are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.

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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

of the genital tract significantly increases the rate of transmission of HIV.⁴ Genitourinary medicine services have a pivotal role in preventing HIV infection by education, counselling, and the management of other sexually transmissible infections. It is thus of particular concern that many prisons in Scotland have no specific genitourinary medicine services, and the few existing services may be under threat.

Policies to reduce harm need to address all aspects of potential transmission of HIV and not to concentrate on injecting drug use to the exclusion of others. Furthermore, the provision of entirely confidential, high quality open access genitourinary medicine services to this group of people should be an important component of such policies.

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What about the WHO guidelines?

EDITOR,—An editorial, two papers, and news from a dozen countries: the issue of 4 February certainly brings to readers' attention the major public health problem of transmission of HIV in prison. The reporting has one or two oddities: Switzerland is apparently reduced to a province of France, being included in Alexander Dorozynski's report from Paris and excluded from the summary table.¹ Dorozynski's napoleonic view of Europe troubles me less than the failure to recognise the pioneering work from 1985 onwards of the Swiss Federal Office of Public Health and prison doctors in several Swiss cantons in promoting the equivalence of measures to prevent AIDS in prisons to those in the community: condoms, non-discrimination, bleach, methadone maintenance, and recent trials of needle exchange. These initiatives are worthy of recognition. The report from Israel is also perplexing: "every prisoner is tested on arrival . . . voluntarily," and HIV carriers are segregated while results of tests are kept confidential.⁴ How do they do it? Or is the editor just a little gullible?

My main criticism of these contributions, however, is the failure to mention the World Health Organisation's guidelines published in 1993, which provide a comprehensive, public health based approach to managing HIV infection and AIDS in prison while respecting human rights.^{2,3} This omission is all the more surprising because the *BMJ* has subjected the WHO to intense critical scrutiny recently.

Policy concerning HIV infection and AIDS in prisons is part of a wider problem of health care in prison, as the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment has repeatedly emphasised after its visits to various countries, including Britain. The committee has condemned segregation of prisoners infected with HIV and non-respect of confidentiality as unnecessary and a violation of basic human rights.⁴

Sensible policies on HIV infection and AIDS will come about only when prison health services

are independent of prison administrations and the principle of equivalence of health care including preventive measures is recognised.

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Testing in prison is uncommon

EDITOR,—We agree with O Noel Gill and colleagues that there are difficulties in measuring the incidence of HIV infection acquired in prison.¹ Reasons for this include the fact that acute HIV infection may be asymptomatic and that a pattern of repeated short prison sentences is not conducive to the detection of new infections. We appreciate the confidential nature of information about imprisonment and the problems associated with recording it accurately. We also appreciate that assessing the possible contribution of imprisonment to transmission of HIV at the national level is not easy as existing national voluntary confidential HIV and AIDS surveillance reporting systems, which safeguard confidentiality, cannot provide information about a history of periods in prison.

Our experience suggests that the frequency of diagnostic HIV testing in prison is low, although we recognise that efforts are being made to increase it. This laboratory serves one of Britain's largest prisons, catering for over 1000 prisoners, of whom nearly two thirds were serving sentences of less than four years in 1992.² A review of the source of 2562 specimens submitted for testing for antibody to HIV in 1994 showed that 50 came from the prison services. This represented an almost 100% increase on the numbers submitted in 1993. Of the 50, nine were positive for the antibody, and available information indicated that these tests were carried out to confirm a history of HIV positivity. Most of the remaining tests were carried out because of a history of injecting drug use.

We would caution against deriving any reassurance from the stable prevalence found in the unlinked anonymous studies of the prevalence of HIV among injecting drug users in England and Wales as a stable prevalence can mask an increasing incidence. We endorse the authors' sentiments and urge that every conceivable effort should be made to minimise the risk of transmission of HIV in prison, including minimising risk factors such as injecting drug use as well as sharing of potentially contaminated equipment.

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Management of ventricular fibrillation by doctors in cardiac arrest teams

Guidelines do not discount change according to clinical circumstance

EDITOR,—The audit of the management of cardiac arrest by T M Cook and J Handel agrees with many others in showing that doctors do not consistently apply guidelines on resuscitation.¹ The interpretation of this as unacceptable seems to misunderstand the nature of guidelines generally and those of the European Resuscitation Council in particular.

Guidelines suggest a course of action but do not discount change according to clinical circumstance; the European Resuscitation Council's handbook, *Guidelines for Resuscitation* (1994), states that "guidelines are not set in tablets of stone."² One of the hidden rules of medical audit is that the standard being compared with actual practice has been validated. The guidelines of 1992 represent a valuable and important consensus view, but there is no claim that they would make any difference to outcome. This is not scientific nihilism: the universal and rigid application of such guidelines does real harm to patients and their families. It follows that the fact that the guidelines are intuitively reasonable and based on the best available evidence is not sufficient to validate them for the purposes of such audit. More selective use of the arrest call makes clinical and ethical sense, and Frenchay Hospital's guidelines for "not resuscitating" as outlined in the European Resuscitation Council's handbook set a high standard. Testing such a selective approach might be a self fulfilling prophesy (and an arrest call cannot properly be designated appropriate or not after the event), but the reluctance of clinicians to make this difficult decision is clearly bad practice.

The broader issues here are the priorities of resuscitation training teams, the concept of consensus statements from expert committees, and the adoption of guidelines and protocols in general—subjects of much debate in anaesthesia. With the advent of the Cochrane Collaboration, clinicians should be able to distinguish between guidelines based on double blind placebo controlled trials, "best possible evidence," and elaborate anecdote.

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Anaesthetists are tested under examination conditions

EDITOR,—P F S Prior-Willeard and J David report their finding that skills in advanced life support are little improved since their preliminary study one year ago.¹ We agree that there is a fundamental problem of incentive and that postgraduate medical examinations must provide this incentive by including resuscitation skills as a component of practical testing. This has been firmly endorsed by the Royal College of Anaesthetists, which includes a compulsory testing station in its new objective structured clinical examination. Candidates are asked to demonstrate their skills at single rescuer basic life support for about two minutes and are subsequently examined in their ability to recognise rhythms and their theoretical knowledge of advanced life support.

Anaesthetists generally perform resuscitation to a high standard. Despite this, we believe that the inclusion of compulsory testing in the fellowship examination has provided an additional stimulus