this threshold, a major aim of our article. This identification of an apparent "threshold" is new and needs to be replicated, since other research has suggested a more continuous relation between income and morbidity.[2] The article did not examine the costs to society incurred by children and families living below this threshold, which, as Sim indicates, are influenced by proper and improper use of social-assistance benefits and go beyond the costs of social services to include the health care, educational and possibly legal costs.

Second, Sim suggests that the psychiatric label may not mean morbidity (i.e., a disability that requires or will respond to treatment). He further suggests that "psychiatric disorder" is inadequately defined. The outcome variable "psychiatric disorder" was defined in Appendix 1 of our article, and a reference was provided should a reader wish to understand the definition in more detail.[3] The definition of "disorder" is based on well-established standards in child psychiatry.[4,5] Although in each child with a given disorder impairment and amenability to treatment vary (on the basis of child and family circumstances, the particular disorder, the availability of treatment resources and other factors), the use of standardized measures to define "disorder" reflects the consensus of experts and is accepted as meaningful by many working in the field. The causes of the child's disorder, such as parental or domestic issues, were beyond the scope of our article and of the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed, 1980 (DSM-III); determination of such causes requires a careful clinical workup for each case.

The main issue in Sim's comments seems to be what proper research methods add to our understanding of this or any field of study. First, clear definitions of economic disadvantage and child morbidity are a starting point. They may not be the preferred definitions of every one with an interest in the field, but they are at least clear about what is meant. Furthermore, and more important, our definitions allow other researchers to repeat this study, to agree or disagree with our ideas on the basis of their results and to offer more finely tuned or alternative hypotheses for the results obtained. There is also a need for field studies that compare and contrast different strategies to improve the quality of life for children living in poor families (e.g., income strategies v. strategies aimed at parents v. child-focused strategies v. combination strategies).

This critical exchange among researchers helps push ahead our understanding of the mechanisms of morbidity in poor children and advances our effort to help these children and families appropriately. Although rigorous methods may appear to Sim to be a "practice of ensuring publication through a sufficiency of elegant although irrelevant algebra," we heartily disagree. The real tragedy is that the thinking about the mechanisms that place disadvantaged children at risk has been driven by ideologic differences and not by evidence.

Ellen L. Lipman, MD, FRCPC
Assistant professor
Department of Psychiatry
McMaster University
David R. Offord, MD, FRCPC
Director
Centre for Studies
of Children at Risk
Chedoke–McMaster Hospitals
Head
Division of Child Psychiatry
McMaster University
Research director
Chedoke Child and Family Centre
Michael H. Boyle, PhD
Associate professor
Department of Psychiatry
McMaster University
Hamilton, Ont.

References

1. Scott JA: Problem families: a London survey. *Lancet* 1958; 1: 204–208
2. Duncan GJ: *Income dynamics and health*. Presented at the conference Measuring Social Inequalities in Health, Annapolis, Md, Sept 1994
3. Boyle MH, Offord DR, Hofmann HG et al: Ontario Child Health Study: I. Methodology. *Arch Gen Psychiatry* 1987; 44: 826–831
4. Achenbach TM, Edelbrock CS: Behavioral problems and competencies reported by parents of normal and disturbed children aged 4 through 16. *Monogr Soc Res Child Dev* 1981; 46: 1–78
5. Spitzer RL, Andreasen N, Arnstein RL et al (eds): *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed, American Psychiatric Association, Washington, 1980

HIV INFECTION IN PRISONS

The article "Prevalence of HIV infection in provincial prisons in British Columbia" (*Can Med Assoc J* 1994; 151: 781–787), by Drs. Diane A. Rothon, Richard G. Mathias and Martin T. Schechter, and the editorial "Confronting HIV infection in prisons" (*Can Med Assoc J* 1994; 151: 743–745), by Dr. Catherine Hankins, are worthy of comment.

The estimated prevalence rates of HIV infection of 3.3% among female inmates and 1% among male inmates, with an overall prevalence of 1.1%, reflect the philosophy of those who dictate AIDS policy in British Columbia. The authors note that 8.7% of the study population refused to be tested and that the refusal rate was significantly higher among those who reported a history of injection drug use than among those who did not report such a history ($p < 0.001$). Therefore, the calculated prevalence of 1.1% is a minimum. The true rate could be as high as 9.8%.

The solution proposed in the editorial is free condoms, clean injec-

tion equipment and education. "Upon their release, rather than being multipliers of viral transmission, former inmates could become effective multipliers of the message about preventing HIV infection and thus help create new social norms in the milieu to which they return."

The operative word here is "could." Survival, not concern for the welfare of society, is the prime consideration of those detained at her Majesty's pleasure. Abrogation of societal responsibility played a major role in the whereabouts of these inmates in the first place. To entrust public safety to such people, as Hankins suggests, is not without some danger.

There is another option. Since wards of the state deserve protection, after conviction all new arrivals to custody should be routinely screened for HIV and appropriately segregated when indicated. Now that routine screening of pregnant women for HIV, for the benefit of the infants, has been endorsed in BC,[1] there is a precedent for the protection of those unable to control their own situation.

James E. Parker, MB, FRCPC
Abbotsford, BC

Reference

1. Patrick DM, Rekart ML: AIDS update: routine screening and zidovudine therapy to prevent HIV transmission. *BC Med J* 1994; 36: 613–617

It is certainly true, as Dr. Rothon and associates and Dr. Hankins show in their articles, that aspects of prison life pose a public health problem. Overcrowding, which is common in jails, was recently associated with an epidemic of pneumococcal disease in a US prison.[1] Valuable as they are, these articles fail to address the much larger issues. Prisons socialize people to maladaptive behaviour, and they breed violence, despair, cynicism and crime. Physicians and public health experts should focus their efforts not only on controlling AIDS and other diseases but also on closing prisons and diverting inmates to healthier, community-based programs. If controlling criminals and meting out "just desserts" are issues, community programs can be made as controlling or as punitive as prisons[2] without having the same detrimental consequences for public health.

Bruce Williams, MD, CCFP, FRCPC
Willowdale, Ont.

References

1. Hoge CW, Reichler MR, Dominguez EA et al: An epidemic of pneumococcal disease in an overcrowded, inadequately ventilated jail. *N Engl J Med* 1994; 331: 643–648
2. Petersilia J, Deschenes EP: Perceptions of punishment: inmates and staff rank the severity of prison versus intermediate sanctions. *Prison J* 1994; 74: 306–328

BASIC STATISTICS FOR CLINICIANS: 3. ASSESSING THE EFFECTS OF TREATMENT: MEASURES OF ASSOCIATION [CORRECTION]

In this article by Dr. Roman Jaeschke and associates (*Can Med Assoc J* 1995; 152: 351–357) a formula was given incorrectly owing to a typographic error. In the section on relative risk reduction, the formula for calculating this measure should have been {[C/(C + D)] – [A/(A + B)]}/[C/(C + D)]. We regret any confusion this error may have caused. — Ed.