CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
- *For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the BMJ.*
- *We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.*
- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Abolishing the prison medical service

SIR,—The increasing suicide rate and level of mental illness in prisons make a parliamentary move to abolish the prison medical service and give its responsibilities to the NHS[1] fully understandable. Unfortunately, though, by itself such action would be most unlikely to improve the situation; the root cause is that prison is too often seen as a solution to society's unpleasant and difficult problems, which other agencies cannot or will not deal with, and the system is thus overburdened.

This is by no means the first time that it has been suggested that the health service should take over prison medicine, but the proposal has not been acted on seemingly because, firstly, it would cut across the borders of ministerial responsibility and, secondly, the NHS is understandably somewhat reluctant.

It is in the large, busy remand prisons that most problems occur. These establishments can receive up to 100 or more new prisoners each night; the pressure so generated gives little opportunity for each inmate to make any consistent relationship with individual members of professional or other staff. Such prisons are labour intensive and expensive to run, and so the good housekeeping necessary means that manning levels must be reasonably controlled. That in turn means that to maintain good order inmates must be locked up for considerable periods. For disruptive, unstable people this can result in outbursts of violence towards themselves or others. Given the restricted ability to manipulate the environment in the short term, psychiatric options are therefore limited. Nevertheless, prison doctors and their staff, though in short supply for many years, have learnt to work within this restraint, placing those found to be mentally ill and disturbed in the prison hospitals for closer observation; these patients are then transferred to outside hospitals whenever possible.

Greater understanding is therefore required of the difficulties inherent in running the prison system as a whole before its medical services are tampered with in isolation.

D O TOPP

Scaynes Hill,
Haywards Heath,
Sussex RH17 7NG

1 Smith R. Further call to abolish the prison medical service. *BMJ* 1991;**302**:1359. (8 June.)

Drug use and prisoners

SIR,—As a part time prison medical officer, I was interested in Dr Pierre Van Damme and colleagues' finding of increasing drug use in Belgian prisons.[1] Their findings are similar to the findings of Dr Anthony Maden and colleagues in British prisons.[2]

One of the difficulties of estimating the prevalence of drug addiction by questioning or from questionnaires such as that used by Dr Maden and colleagues is that addiction is subjective. Unless valid consent is obtained for objective testing (such as testing of urine for drug residues) then in my view the extent of intravenous drug use before reception, or within prisons, will remain a matter of speculation.

In view of the risk of transmission of HIV by illicit drug use in prisons it might be sensible to perform a pilot objective study in a local prison.

P LUSH

HM Prison,
Gloucester GL1 2JN

1 Van Damme P, Clauwers M, Van Hal G, Peeters R. Drug use and prisoners. *BMJ* 1991;**302**:1464. (15 June.)
2 Maden A, Swinton M, Gunn J. Drug dependence in prisoners. *BMJ* 1991;**302**:880. (13 April.)

Drugs, HIV, and prisons

SIR,—The editorial by Drs Michael Farrell and John Strang on drugs, HIV, and prisons is a thoughtful contribution on an important subject,[1] but I cannot let pass the statement that prisons are a "gaping hole" in the "widening net of services" for injecting drug users.

It is fair to say that provision in England and Wales—I cannot speak for Scotland—is less well developed in some prisons than others. But a void there is not, as their reference to work at Holloway prison acknowledges.

It is also true that detoxification with methadone has not been practised everywhere, but that has reflected differences of view within the profession, not lack of knowledge or care on the part of prison doctors. The recent guidelines on drug users in prison for medical officers, to which Drs Farrell and Strang refer, encourage medical officers to develop an approach whereby such a programme is always considered. The authors damn with faint praise when they say that the guidelines are a start but then add that "prison medical officers need also to liaise with local specialists and ensure that they and prison officers receive training in managing drug use." In fact, medical officers are encouraged to liaise with local specialists, and they and other health care staff are receiving training.

The charge of segregation of prisoners identified as being infected with HIV is misleading. No prisoner is segregated in the sense of having no association with other prisoners. In a recent survey of such prisoners that we commissioned, of 30 prisoners who replied to the question "With which prisoners are you currently able to associate?" 13 stated "all," 16 replied "selected prisoners only," and one replied "only those with HIV or subject to viral infectivity restrictions." The viral infectivity restrictions system is to be reviewed, and in revised guidelines about HIV which I hope to issue to the service in the next few weeks I shall be emphasising again the policy of "normal" location of prisoners who are well.

Finally, Drs Farrell and Strang comment about the prevalence of HIV infection and its relevance to policy. They mention figures suggesting that 24 HIV positive prisoners at Bristol prison identified themselves to prison officer counsellors whereas only two had been reported by the medical officer. The Prison Reform Trust deduced from these figures that the number of prisoners with HIV infection in England and Wales could be 12 times greater than the number officially recorded. That is not an inference that can be properly drawn from the Bristol figures. They are not comparable with the official figures because they are based on oral statements by prisoners unsubstantiated by results of tests. There may also have been some multiple counting because counsellors do not share information with each other.

That said, we have always acknowledged that the confirmed cases reported by medical officers may be a small proportion of actual cases. As long ago as 1987 my predecessor estimated that the actual number at that time could be between 250 and 500 in a population of 50 000. What is important is that policy and practice are based on the assumption that the prevalence of HIV infection is higher in the prison population than the general community. Our strategy for preventing HIV infection, in which education and counselling are key elements, reflects that assumption. More "client friendly" drug treatment programmes, desirable in themselves, will have an important part to play in furthering the strategy.

ROSEMARY J WOOL

Director,
Prison Medical Service,
London SW1P 4LN

1 Farrell M, Strang J. Drugs, HIV, and prisons. *BMJ* 1991;**302**:1477-8. (22 June.)

Zidovudine after occupational exposure to HIV

SIR,—Professor D J Jeffries proposes that prophylaxis with zidovudine should be available for laboratory and health care workers within one hour after they have been exposed to HIV.[1] Detailed counselling will be needed before prophylaxis is started because proof of efficacy is lacking and serious long term toxicity (particularly carcinogenicity) cannot be excluded.

For laboratory workers propagating HIV or cells that might be infected with the virus counselling before any exposure occurs will remove the pressure of time from the counselling process and facilitate