

DNA profiling of detained patients

Sir—DNA profiling has had a substantial effect on criminal investigations and could also have serious implications for some individuals with psychiatric illness because of new UK legislation. The Criminal Evidence (Amendment) Act 1997¹ enables the police to obtain non-intimate body samples of hair or saliva for testing from individuals convicted of particular offences, including sexual or violent crime and some forms of burglary. The Act also includes patients detained under the Mental Health Act 1983² on a hospital order after conviction for similar offences or found unfit to plead or acquitted of like charges on the grounds of insanity. In these circumstances, the responsible medical officer can defer sampling if judged to be counter therapeutic. Otherwise, the procedure can proceed without the patient's consent and, if necessary, by the use of force. When a patient does refuse, there should be discussion between those concerned about whether the sample should be taken with or without the presence of members of the clinical team.

This legislation runs contrary to the idea that when mental illness leads to conflict with the law, psychiatric rather than custodial care is required. A small proportion of the 2000 or more patients to whom the Act applies may actually have been acquitted due to their disturbed mental state. This legislation implies that certain offenders with psychiatric illness should be singled out because of their offence and treated in the same way as their mentally well counterparts in prison.

The ethical difficulties associated with this issue are alarming. Should mental-health professionals assist in obtaining samples for non-clinical reasons? If patients do not give their consent, should managers provide access and facilities for the police to undertake these procedures? Should members of the clinical team restrain patients in such circumstances? Alternatively, should they withdraw and leave their patients unsupported? Where does legal responsibility lie for the safety of those concerned? Will Health Trusts insist on the involvement of clinical staff trained in control techniques to keep to a minimum the possibility of physical harm and reduce potential litigation? Should psychiatrists resist approaches from the police and delay until the patient is discharged, at which point the power lapses?

Psychiatry has advanced from the custodial role associated with locked doors and straitjackets. Treatment depends upon a trusting relationship with the patient. Establishing such a relationship can be a lengthy process with offenders. That relationship is central to good care; for many it prevents relapse and for a few, serious reoffending.

DNA profiling may be an important investigative tool but involving offenders who are psychiatric inpatients is not the way to proceed. Perhaps the law should authorise the collection of samples on arrest or conviction and in a custodial setting.

**Martin Humphreys, Bea Brockman*

*Department of Forensic Psychiatry, University of Birmingham, Reaside Clinic, Birmingham Great Park, Rubery, Birmingham B45 9BE, UK

- 1 Criminal Evidence (Amendment Act) 1997. London: HM Stationery Office, 1997
- 2 Mental Health Act 1983. London: HM Stationery Office, 1983.

Safe disposal of sharps

Sir—H V Wyatt's (Jan 3, p 70)¹ suggestion for the use of ring-pull cans recycled to serve as sin-bins (*sic*) does not address the key issues central to the safe disposal of sharps and related wastes in poorly resourced regions of the world. Cin-bins, and other proprietary sharps containers, are generally unavailable in developing countries. Despite this, every attempt must be made to remove used sharps from circulation. Used drink cans, as recommended by Wyatt, can be more effective than open boxes, or other impromptu containers that are pressed into service; used paint or food tins may also be used. Labelling is particularly important and all containers should be clearly marked to identify their new contents. Internationally recognised biohazard warning signs may not be properly understood and, particularly in regions where literacy levels are low, a more basic skull and crossbones stencil affords a more recognisable supplementary warning.

Removal of filled sharps and other clinical waste containers presents further difficulties. In parts of Africa, South America, and elsewhere, there is substantial evidence that hypodermic needles and other disposal items are salvaged from hospital wastes to be reused. In several South American countries, dwellers who live in garbage dumps (*los*

Minadores) gather used syringes, needles, and sheaths for resale; in some places the illicit resale of discarded items is more organised with collection of used syringes and needles directly from hospitals.

Locally trained staff often fail to recognise a substantial risk of infection associated with clinical wastes and continuous education and instruction are essential to ensure disposal is properly and safely undertaken. Further difficulties occur when wastes, including filled sharps containers, are removed for disposal. Adequate destruction by high-temperature incineration or deep burial is unlikely to be available. Where geological and hydrological conditions permit burial of wastes may suffice, although great care should be taken to maintain security at all times.

For sharps, effective low-cost destruction can be achieved before terminal disposal with encapsulation in effervescent plaster-of-Paris formulations, or by crushing of filled containers; the risk of limited aerosol generation during such procedures is outweighed by the benefits associated with effective prevention of reuse of sharps. An inequality in the global provision of health-care services and, consequently, in the safe disposal of health-care wastes is the real sin.

J Ian Blenkarn

Department of Infectious Diseases, Imperial College School of Medicine, Hammersmith Hospital, London W12 0NN, UK

- 1 Wyatt HV. Drinks cans recycled as sin-bins. *Lancet* 1998; 351: 70.

DEPARTMENT OF ERROR

Trial to reduce transmission of HIV-1 on schedule in Uganda (Dec 6, p 1683)—In this News piece by Anderson Wachira Kigotho, a trial organised by Makerere University was reported to be investigating the prevention of mother-to-child HIV-1 transmission in Uganda by use of short-course zidovudine treatment. The piece also stated that no participants would receive placebo. No such trial is underway or planned at this time, and the current Ugandan perinatal HIV-1-transmission trials continue with placebo control.

Analysis of the α -synuclein G209A mutation in familial Parkinson's disease—In this Research Letter by Sepideh Zarepari and colleagues (Jan 3, p 37), the second author's name should read Jeffrey Kaye.

Maintaining abstinence from alcohol with γ -hydroxybutyric acid (Jan 3, p 38)—In this letter by G Addolorato and colleagues, the third author's name should be Capristo, not Caprista.

A woman with nodules in her lungs—In this Case report by H Järveläinen et al (Feb 14, 1998, p 494) the chest radiographs were transposed: that on the top should have been on the bottom.