Part B: Selected issues

11. Drug-related health policies and services in prison

Although drug use is almost always mentioned in French research on prisons {Chauvenet et al. 1996}, {Observatoire international des prisons 2000; Observatoire International des prisons 2005}, {Combessie 2004}, {Chantraine et al. 2006}, it is rarely investigated as such {Bouhnik et al. 1996}, {Fernandez 2010}. Of the many studies that have examined health in prison settings ({Revue française des affaires sociales 1997}, {Haut comité de la santé publique (HCSP) 2004}), few have dealt with defining a Harm Reduction (HR) policy specifically adapted to the context of institutional confinement (prison) ({Lebeau 1997}, {Michel et al. 2008}). In 2010, a collective expert report conducted by the French National Institute of Health and Medical Research (INSERM) examined, for the first time, the idea of applying the concept of HR in France, and particularly in penal establishments. It concluded that, although various preventative tools exist in France, "there is currently no real harm reduction policy geared towards prisons" {Michel et al. 2010}. It also pointed out that the principle of equivalence of treatment with an obligation to treat incarcerated patients in the same way as outpatients, required by French law and recommended by the WHO, is not effectively applied in French prisons. The need for a policy adapted to the prison setting is nonetheless crucial: nearly one-quarter of French drug addicts go through the prison system each year {Hyest et al. 2000}.

The inequality of access to treatment for drug users in prison, when compared to outpatients, is explained by different factors that are first and foremost related to the way the prison system operates and to how treatment is organised within prisons. The objectives of the law on the one hand and the reality of prison treatment practices on the other are therefore contrasted. They need to be compared with the clinical practice guidelines and standards of quality of treatment developed in France. The purpose here is to clarify the discussion on the resources for guaranteeing equal access to treatment for both incarcerated patients and outpatients. In the last section, the weaknesses in the system of information on care provided to drug users in prison will be listed so that this problem can be better monitored in the years to come.

11.1. Prison systems and the prison population: background

11.1.1. Background information on the French prison system and prison population (Characteristics of the prison system)

French penal establishments

On 1 January 2010[167], the *administration pénitentiaire* (the Prison Service, or "PS" for the purposes of this document) had 191 penal establishments in mainland France and the French overseas departments and territories:

[167] These figures have been provided by the *administration pénitentiaire* (French Prison Service), valid as of 1 January 2010 (www.prison.justice.gouv.fr).

- 106 *maisons d'arrêt* (remand centres, or “RC”) and 35 remand wings, (“RCW”), situated in penitentiaries, for carrying out provisional detention and for prisoners with two years or less of their sentence remaining (since the November 2009 French penitentiary act)

- 37 *centres pénitentiaires* (penitentiaries, or “PI”) including at least 2 wings for prisoners of a different detention status (remand centre, detention centre and/or high security prison);

- 24 *centres de détention* (detention centres, or “DC”) and 34 detention centre wings (“DCW”) for inmates serving a sentence of one year or more and who have favourable social rehabilitation prospects;

- 6 *maisons centrales* (high security prisons, or “HSP”) and 5 high security wings (“HSW”) that house the most difficult convicted offenders, who require reinforced security and who will not be ready for social rehabilitation for a long time;

- 12 *centres de semi-liberté* (open prisons, or “OP”) and 4 open prison wings (“OPW”), which are located in the PIs. These centres house convicted offenders who have been admitted there by the judge responsible for the execution of sentences with an outside placement without monitoring or open prison regime,

- 6 penal establishments for minors ("PEM"), which are provided for in the French law of September 2002 on the orientation and programming of the justice system. The first of these was opened in mid-2008.

- 4 *quartiers centres pour peines aménagées* (resettlement prison wings or “RPW”), which are located in penitentiaries.

The management of 43 of these establishments is outsourced to private companies. Such establishments represent 4.4% of all penal establishments.

In order to manage the prison settings, the Prison Service was allocated a 2010 budget of 2.17 billion Euros (excluding pensions), or more than one-third of the Justice budget. This was up 10% compared to 2009. These budgetary credits (payment credits, excluding pensions) are broken down as follows: 54% for personnel costs, 28% for operating costs, 14% for investment costs and 4% for intervention costs (French Ministry of Justice, 2011).

According to the most recent data (1 May 2010)[168], the French Prison Service had 57,411 places in mainland France and the French overseas departments and territories[169]: 56,779 of them are "operational". In other words, they are effectively available. The others are most likely being refurbished or used temporarily for another purpose. These places are broken down according to establishment type as follows:

- 34,136 places in remand centres or remand wings (60%)

- 19,365 in detention centres or detention wings (34%)

- 1,981 in high security prisons or high security wings (3.5%)

[168] *Direction de l’administration pénitentiaire* (Prison Administrative Directorate), monthly report of the prison population and population entered on the prison register as of 1 May 2010.
[169] Within the meaning of the capacities defined in a circular dated 3 March 1988 and updated on 17 May 1998.

- 316 in resettlement prisons or wings (0.6%)
- 659 in open prisons or open prison wings, excluding “open” places in other types of establishments (1.2%)
- 322 in establishments for minors (0.6%).

The prison population

On 1 May 2010, the number of people entered on the prison register in France was 67,851 (throughout France). This population includes inmates (61,604 people) and people who are not detained but benefitting from a resettlement (6,247 people in total, with 5,611 under home detention with electronic monitoring and 636 benefitting from outside placements).

With 61,604 inmates, France had reached its highest ever prison population since the statistics began being recorded in 1852 (not taking into account the 60,000 prisoners recorded during the *Libération*, nearly one-third of whom were suspected collaborators). Of these 61,604 inmates, 15,963 were pre-trial detainees (25.9%) and 45,641 were convicted offenders (74.1%) - all occupied 56,779 operational places, representing a difference of 4,825 between the operational capacity of the penal establishments and the effective number of inmates, i.e., an overall prison density of 108 inmates per 100 prison places.

To rigorously account for the overcrowded prison conditions, we must compare the prison density with the surplus inmate indicator: 9,493 people on 1 May 2010 France-wide {Tournier 2010}. This figure better represents the overcrowded prison conditions in France because it adds the number of surplus inmates above available capacity (4,825) and the number of unoccupied operational places[170] (4,668).

Prison overcrowding varies considerably between mainland France and the overseas departments and territories, and especially between the different types of establishments: of the surplus inmates, 96% are in remand centres, since the assignment of convicted offenders to penal establishments is managed by the Prison Service according to the *numerus clausus* principle. The prisons for sentenced detainees, where the number of inmates per 100 places (85 in 2010) is decreasing, are therefore exempt from the overcrowding phenomenon. The latter pertains especially to remand centres and remand wings of penitentiaries[171], i.e., the most widely found establishments in the prison system, and which are supposed to house a majority of pre-trial detainees and convicted offenders with short sentences (with less than a year remaining of their sentence).

Developments and outlooks

Since 2008, the number of inmates has stabilised at a high level (approximately 61,000). This figure corresponds to a detention rate[172] of 96.8 prisoners per 100,000 inhabitants, (Kensey 2010), which is one of the highest in Europe (Aebi et al., 2010a). Although, for the first time this decade, the number of inmates declined significantly in 2010 (-2%), France continues to stand

[170] As Tournier mentions, this figure is especially high due to the recent opening of new establishments, such as the penitentiaries in Bourg-en-Bresse, Rennes and Le Havre (Tournier, 2010).
[171] The occupancy rate in remand centres (56% of the establishments) is 125 inmates per 100 places.
[172] The detention rate for 100,000 inhabitants reflects the ratio between the number of detainees and the number of inhabitants. It makes it possible to assess the changes in the prison population while taking into account the demographic movement of the general population.

out with its consequential prison overcrowding - the highest of the 47 countries of the Council of Europe, along with Spain, Cyprus, Bulgaria, Serbia and Croatia (Aebi, Delgrande, 2010a).

The overcrowding of French prisons can be explained by a cumulative two-phase development over time. From the mid '70s to the mid 2000s, France experienced a 30-year prison population climb {Tournier 2002}, during which the prison population increased eight times faster than the general population (+120 *vs.* +15%)[173]. This spectacular increase can be explained by the combination of three phenomena: a lengthening of the prison sentences handed down[174], the low number of resettlements until the mid 2000s (conditional discharge, suspended sentence for medical reasons, open prison regime, outside placement or home detention with electronic monitoring), the relatively low number of sentences used as alternatives to prison (e.g., community service, *jour-amende,* a fine in the form of a fixed amount to be paid per day, etc.)

Since the middle of the last decade, each of these factors has evolved, slowing down (although not reversing) the upward demographic trend. With the rise in resettlements, the number of convicted offenders receiving sentences not involving imprisonment[175] increased 15-fold between 2004 and 2010 (+ 4,200). The number of people entered on the prison register and benefitting from a resettlement increased three times faster than the prison population[176]. Moreover, alternative sentences clearly rose, especially community service and *jour-amende* penalties (day-fines), which increased by approximately 50% since 2004 {Timbart 2011}. This recent development in alternatives to prison can be interpreted as France's attempt to "catch up" {Portelli 2010}, even though France remains one of the European countries (along with Italy) where the rate of "alternative to prison" sentencing is the lowest (34.5 per 100,000 inhabitants), whereas the mean is 209 {Aebi et al. 2010b}.

Stabilisation of the inmate population, decrease in the number of surplus inmates[177], detention rate per 100,000 inhabitants and provisional detention rate (see Table 1): the French penitentiary situation seems to have evolved since the 2008 report by the Council of Europe Annual Penal Statistics {Aebi et al. 2010b}. This trend, if it is confirmed, can be explained by an increase in prison capacity that has risen four times faster than the increase in inmate numbers[178] since the 2000s[179]. Nevertheless, these transformations are insufficient to change the French situation in Europe: France remains in a median position with respect to its gross detention rate and provisional detention rate, and continues to stand out due to its elevated

[173] The ratio even reached 10 to 1 during the period from 1975 to 1995: the prison population increased by 100% vs. the 10% increase seen in the population as a whole (Tournier, 2002).

[174] Especially after the entry into force of the new 1992 French Penal Code, which increased the maximum sentence possible for a large number of offences (Kensey, Cardet, 2001). The average detention period thus increased from 4.6 months in 1980 to 7 months in 1990, then to 8.7 months in 2000 and 9.4 months in 2009.

[175] Home detention with electronic monitoring (PSE) or outside placement.

[176] +5,000 *vs.* +2,000 persons. Home detention with electronic monitoring was significant following this increase in resettlements (Kensey, 2010). It can also be related to repeated ministerial encouragement to systematically use resettlement measures during sentences: Warsmann report (Warsmann, 2003), laws aimed at fighting recidivism in December, August 2007, March 2010 and the November 2009 French Penitentiary Act (see Legal Framework).

[177] Today, the number of surplus inmates is almost one-quarter the level seen in 2004, when France had reached its highest prison overcrowding level ever (6,086 surplus inmates, and 121 inmates per 100 places).

[178] The number of prison places increased from 48,572 to 56,463 between 2004 and 2010 (+ 16.2 %), while the number of inmates rose from 58,942 to 60,978 (+3.5 %) for that same period.

[179] Since the LOPSI (the *Loi d'Orientation et de Programmation pour la Sécurité Intérieure*) French domestic security act, which authorised the state to entrust prison construction to private companies, the State launched a progressive privatisation of prison construction (with the 13 200 property programme, which was carried out as a public-private partnership) and management. The *Agence Publique pour l'Immoblier de la Justice* (APIJ, the French Public Agency for Judicial Properties) acts as project owner and private companies (like Bouygues) take care of the construction, and then the management. The Ministry foresees the creation of 13,200 new prison places by 2012.

prison density, which is much higher than that of Germany or Great Britain. In other words, the severity of France's penal policy - measured by the proportion of its inhabitants held in detention - does not distinguish it from its European neighbours. However, prison overcrowding, i.e., the ratio of the number of inmates to the number of prison places, puts France in a critical position with respect to European recommendations[180]. According to the demographic projections of the Prison Service[181], the population entrusted to the Prison Service could reach 80,000 [people entered on the prison register] by 2017 {Bérard et al. 2008}, which would assuredly oblige France to further develop alternatives to imprisonment and resettlements {Portelli 2010} to fight against overcrowded prison conditions.

Table 11-1: Increases in the prison population France-wide (2004-2010)

Year	Number of detainees on 1 January	Annual growth rate (%)	Population France-wide (in thousands)	Inmates per 100,000 inhabitants	Proportion of pre-trial detainees	Proportion of convicted offenders	Detention rate per 100,000 inhabitants
2004	58942	N.av	62251	94.7	36.9	63.1	34.9
2005	58231	-1.2	62730	92.8	34.6	65.4	32.1
2006	58344	+0.2	63186	92.3	33.8	66.2	31.2
2007	58402	+0.1	63578	91.9	31.6	68.4	29.1
2008	61076	+4.6	63937	95.5	27.5	72.5	26.3
2009	62252	+1.9	64303	96.8	25.6	74.4	24.8
2010	60978	-2.0	64700	94.2	25.2	74.8	23.8

Source: Prison Service (Ministry of Justice)

overcrowded prisons and poor detention conditions: what still ails the french prison system

Overcrowding is one of the distinctive characteristics of French prisons, as well as poor detention conditions, regularly denounced by prison unions, prison employees and French associations fighting for the fundamental rights of incarcerated people, such as *Ban public* or *the Observatoire International des Prisons* {Observatoire international des prisons 2000};{Observatoire international des prisons 2003; Observatoire International des prisons 2005}. Protests against detention conditions deemed “inhumane and degrading” reached their peak in national public debate in 2000, when the testimony of the Head Physician of one of the largest penal establishments in France was published {Vasseur 2000}. The work by Véronique Vasseur, which received wide media coverage {Décarpes 2004}, led the French Parliament to examine the issue through two Parliamentary inquiry commissions, which characterised the prison situation as “a humiliation for the French Republic” in the senatorial inquiry report ({Mermaz et al. 2000}; {Hyest et al. 2000}). The international authorities themselves stigmatised the French prison situation. On several occasions, the European Committee for the Prevention of Torture (CPT) condemned France for the state of its prisons (overcrowding, insalubrity) and the “inhuman and degrading treatment” of the inmates[182]: failure to respect privacy, promiscuity,

[180] The Council of Europe affirmed that expanding the French prison system should be an exceptional measure, since it does not offer a long-term solution to overcrowding. See recommendation No. R(99) 22, adopted by the Committee of Ministers of the Council of Europe on 30 September 1999.

[181] Established according to changes in inmate age, nationality, detention periods, provisional detention, type of sentence and resettlements (see PS executive summary presented during the establishment of the *Comité d'orientation restreint* [COR] - the committee responsible for the future Prison Act of 11 July 2007, mentioned in an article in the French daily *Le Monde* on 14 July 2007).

[182] In 2007, as during its preceding 1996 and 2003 visits, the European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment (CPT) was concerned about the high prison overcrowding rate seen in the visited remand centres in France (CPT, 2007). It also emphasised that housing pre-trial detainees and convicted offenders in remand centres for long, or even very long periods, in the same cell, went against the European Prison Rules. The CPT reiterated its recommendation

breaches in the continuity and quality of care, sublevel general hygiene, rare activities (sports, work-related, training), and numerous acts of aggression and violence among inmates.

According to the French Health Minister himself, these “unacceptable living conditions”[183] help explain the high prevalence of suicide risk among inmates - even though it has not yet been possible to establish a correlation between prison conditions and the suicide rate[184]. About a hundred suicides occur in prison each year, which is twice as many as twenty years ago. They tend to take place during the first two years of imprisonment. This represents a suicide rate that is five to six times higher than the national average. France is one of the European countries reporting the highest "excess suicide rates" in prison, {Lecerf 2009}, with 18 suicides per 10,000 inmates (2009). Hence, this problem has received particular public attention in France {Lecerf 2009}.

These repeated criticisms led to the 2008 creation of a *contrôleur général des lieux de privation de liberté* (CGLPL or "general controller of the jails")[185]. In its last annual activity report (2010), the CGLPL emphasised that the current prison situation is still often characterised by dilapidation “and at times, squalidness, in old, poorly maintained establishments” {Contrôleur général des lieux de privation de liberté 2011}.

11.1.2. Characteristics of the prison population, health and social status (Characteristics of the prison population)

Pre-trial detainees and convicted offenders

Twenty-five percent of the prison population is represented by pre-trial detainees, still awaiting trial. This is the lowest proportion ever recorded (15,395 people in provisional detention, or 25% of the prison population, as of 1 January 2010). Since 2004, the steady decrease in the proportion of pre-trial detainees has been accompanied by an increase in the number of convicted offenders {Danet 2008} and in their subsequent proportion in the prison population {Timbart 2011}. The provisional detention rate per 100,000 inhabitants decreased by 11 points over seven years, dropping from 34.9 per 100,000 inhabitants in 2004 to 23.8 in 2010 (see Table 1).

Demographic profile and living conditions

The prison population is characterised by a socio-demographic profile that is very different from the general population. The latest surveys conducted by the DREES (Directorate for research, studies, evaluation and statistics) in 1997 and 2003 revealed a population that was primarily of

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to the French authorities to develop a strategy against prison overcrowding which was aggravated, according to the CPT, by the escalating number of increasingly heavy sentences handed down. It also acknowledged the importance of the conclusions of the “*Etats généraux de la condition pénitentiaire*” (Convention on Prison Conditions) organized by the International Prisons Observatory in 2006.

[183] Memorandum of Thomas Hammarberg, Commissioner of Human Rights of the Council of Europe, following his visit to France from 21 to 23 May 2008 (20 November 2008)

[184] See the Ministry of Justice, response to written question no. 12634 by Deputy Alain Néri, OJ of 8 June 2004. This point of view goes against the words of the Ministry of Health, who claimed that "suicide prevention in the prison setting must, first and foremost, be addressed by a global approach to upgrade the prison environment and detention conditions for inmates. It is a question of promoting the continued mental health of inmates." (French Ministry of Health / Ministry of Justice, *Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues*, September 2004).

[185] The CGLPL is an independent authority created through the French act of 30 October 2007 following France’s adoption of the United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. The CGLPL effectively began operations on 13 June 2008, when Jean-Marie Delarue was appointed to supervise it.

French nationality (82%)[186], male (96.6% men vs. 3.4% women) and young (34.2 years on average): nearly half of the inmates were under the age of 30 {Mouquet et al. 2005}. However, the population is aging: while in 1978, inmates over the age of 40 represented only 15% of the prison population; today they represent nearly 30%. The ageing of the prison population namely poses problems with regard to care for very old inmates: on 1 January 2010, 3.6% of the prisoners were aged 60 or over (2,356 people, 370 of whom were over the age of 70), which is twice as many compared with 10 years ago (French Prison Service, annual figures).

The education level of the inmates is much lower than that in the general population: 68% have secondary education or higher, 23% have primary education and 2% state that they are illiterate {Mouquet et al. 2005}. The survey conducted by the INSEE (French National Institute of Statistics and Economic Studies) on the family history of the male inmates revealed their low educational level {Insee 2002}: only 39% had received secondary education or higher, 50% had no higher than a primary school education and 10% stated that they were illiterate; moreover, 64% had no diploma or certificate and 30% had reading problems. These education indicators are even lower among the youngest adult inmates, 80% of whom have no diploma or certificate and nearly 40% have trouble reading. The survey conducted among incarcerated subjects, compared to subjects seen in outside health structures, revealed that the inmates are younger and less socially integrated than the outpatients seen in health structures: 14% had secondary or higher education versus 35% for the outpatients; moreover, fewer of them had a regular income (31% vs. 48%) and a professional activity (27% vs. 40% {Pauly et al. 2010}). All of the available studies establish that this population is also characterised by a low level of professional activity: the rate of professional activity when entering prison is less than 50%, while the general rate for men aged 15-64 is approximately 75%, and even reaches 91% for 25- to 29-year-olds {social 2005}.

This population therefore presents a number of social vulnerability characteristics. Nearly one out of every five inmates stated that they did not have a stable home (17%) and 13% had no social protection ({Mouquet et al. 1999}; {Mouquet et al. 2005}). These difficult housing conditions are more rampant among women: slightly more than one out of every five women entering prison stated living in an unstable household prior to incarceration, and approximately one out of seven declared being homeless. Furthermore, 60% of detainees live below the poverty line {Marchetti 2001}.

Mental health and addictive behaviour

The prison population exhibits pathologies related to social exclusion and marginalisation. In particular, there are more mental health and addiction-related problems than outside of prison. A survey published in 2002 on mental health and psychiatric care revealed the existence of psychiatric disorders in nearly 55% of incoming inmates {Coldefy et al.}. The symptoms described by psychiatrists were varied, ranging from anxiety-depressive and addictive disorders (in 55% of these inmates) to psychoses (in nearly 20% of them). The survey further demonstrated that the mental disorders observed in this population had considerably worsened over the course of a few years. The study also revealed a high frequency of harmful alcohol and illicit drug use and addiction: 15% of incarcerations and a third of remand centre detentions were related to a drug-related offence. The general trends in psychoactive drug use revealed increased polyuse, a diversification of administration routes (increased sniffing frequency) and the increasingly frequent use of psychostimulants, cocaine and crack.

[186] The proportion of foreign inmates or inmates of unreported nationality has been steadily declining for several years (20.5% in 2005, 18% in 2009).

The first widespread epidemiological study[187] conducted in 2003-2004 on mental health in prisons objectivised the prevalence of mental disorders in the prison setting {Rouillon et al. 2007}. It indicated that 80% of male inmates and 70% of female inmates had at least one psychiatric disorder, and the large majority had several disorders. Anxiety disorders are the most frequent (more than half of the inmates in mainland France have at least one), followed by mood disorders. Of the revealed disorders, the study showed that 40% were depressive syndromes, 33% were generalised anxiety, 20% were traumatic neuroses, 17% were agoraphobia, 7% were schizophrenia and 7% were paranoia or chronic hallucinatory psychoses. More than two-thirds of the inmates had experienced various, diverse, early traumatic events, making them vulnerable to depressive and anxiety disorders. It would appear that a quarter of the inmates in metropolitan France, regardless of whether male or female, had a psychotic disorder. A suicide risk has been identified through the MINI assessment for 40% of male inmates and 62% of female inmates, and this risk is deemed to be high for nearly half of the people concerned. Moreover, nearly 40% of the inmates incarcerated for less than six months are addicted to illegal substances and 30% are alcohol-dependent. Multiple disorders are frequent in these populations, and are seen mainly as mood and anxiety disorders (3 to 4 out of every 10 inmates), anxiety disorders and drug or alcohol dependence, mood disorders and addiction, or anxiety and psychotic disorders (each of these combinations affects approximately one out of every five inmates). Depending on the population, 35% to 42% of inmates are considered by the investigators as markedly ill, severely ill, or extremely ill (on the Clinical Global Impression - Severity scale (CGI-S)). However, only two-thirds of the detainees stated having consulted a psychologist, psychiatrist or a general practitioner for a psychiatric reason before the incarceration period. This high prevalence of psychiatric disorders in prison is explained in part by the decrease in the number of cases where criminal irresponsibility is invoked[188].

The second edition of the DREES 2003 health survey of new inmates corroborates these observations. It also confirms the overrepresentation of addictions in the prison setting {Mouquet et al. 2005}. One-third of new inmates report long-term, regular use of illegal drugs before incarceration: cannabis (29.8 %), cocaine and crack (7.7 %), opioids (6.5 %), abused prescription drugs (5.4 %) and other products (LSD, ecstasy, glues, solvents, 4.0%). Nearly 11% of inmates stating that they used illegal drugs on a regular basis used multiple substances before their incarceration. This high frequency of psychoactive substance should be linked to the frequency of incarcerations resulting from drug-related offences[189] since, with the exception of cannabis, the reported use of illegal drugs is marginal in the general population.

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[187] This study, which was the first to assess the prevalence of mental disorders in the prison population, had three phases. The first was transverse on 1,000 prisoners, 800 of whom were men, selected randomly from penal establishments in mainland France (cluster sampling plan according to the type of penal establishment), 100 female and 100 male inmates in an establishment from a French overseas department; the second was a longitudinal study with a nine-month follow-up of 300 prisoners incarcerated for the first time; the third phase was a retrospective study on 100 detainees who received sentences of a long duration (Rouillon, F., Duburcq, A., Fagnani, F. and Falissard, B. (2007). Etude épidémiologique sur la santé mentale des personnes détenues en prison conduite entre 2003 et 2004. Inserm.

[188] Since the 70s, when it involved approximately 5% of crime convictions, criminal irresponsibility has stabilised at approximately 0.5% since the mid 80s, representing approximately 250 to 300 subjects declared irresponsible each year. According to Marc Bessin, "there is a strong observed trend towards declaring delinquent mentally ill people criminally responsible. Experts increasingly systematically conclude that people with significant psychiatric disorders can be criminally punished, especially if they have committed serious crimes. There is a resultant transfer of duties from the health system to the justice and prison system, which is evidenced by the increasingly high number of new inmates who were previously followed psychiatrically." Bessin, M. and Lechien, M.-H. (2000). Soignants et malades incarcérés. Conditions, pratiques et usages des soins en prison. Centre de sociologie européenne, EHESS, Paris.

[189] In fact, thanks to the French Prison Service's statistics, it is known that approximately 15% of convictions are primarily related to drug-related offences.

Viral infections

Infectious diseases also more frequently affect inmates than the general population. People who have already been incarcerated at least once have a prevalence of hepatitis C that is nearly 10 times higher than that of the general population (7.1% versus 0.8%), as is shown by the biological data of the Coquelicot survey {Institut national de veille sanitaire (InVS) et al. 2005}. Depending on the source, the prevalence of HIV in prison varies from 1.1% to 1.6%, and that of HCV (the hepatitis C virus) from 3.1% to 7.1%. While awaiting the results of the PREVACAR survey (performed by the DGS, the Directorate General for Health and the InVS, the National Health Monitoring Institute), which should be issued in the second half of 2011, the most representative survey available to date is in fact the DREES survey, which was performed among all remand centres and penitentiary remand wings in 2003: it indicates that the prevalence of HIV in the prison setting is 1.1%, or three to four times higher than what is observed outside of prison, and that the prevalence of HCV is 3.1%, or four to five times higher than outside of prison {Mouquet et al. 2005}. Moreover, 0.2% of new inmates state that they are infected by both HIV and HCV, and 0.1% state that they are seropositive for three viruses (HIV, HCV, HBV).

In addition to these figures, there were two other 2003 studies on HIV and viral hepatitis in prisons: the survey carried out "on a specific day" by the DHOS among detainees infected by HIV or hepatitis C including nearly 85% of the UCSAs and the data from the Premier observatoire en prison de l'hépatite C / First monitoring group for hepatitis C in prisons, which involved approximately 50% of the UCSAs. The DHOS study – which is not a prevalence survey since it only describes known HIV+ and HCV+ patients - revealed that 1.6% of new inmates received by the medical teams are infected with HIV, which is three to four times the rate in people not in prison (0.5%), and that 4.4% of new inmates are infected with HCV, which is four to five times the rate seen outside of prison (1%). The rates were especially high among injecting drug users (13% and 55% respectively). It underlines that 5% of the prisoners are infected either by HIV, or by HCV, or by both (DHOS, 2004). POPHEC assessed the prevalence of HCV in prisons to be 7.1% {Sanchez 2006}.

The risks of viral transmission are even higher in the prison setting since injecting drug users have a higher tendency to share their equipment {Ben Diane et al. 2001}. Hence, among the 43% of intravenous drug users who were active users before being incarcerated and who continue to inject drugs in prison, 21% state that they share their equipment {Rotily 2000}. While prison is a place where the prevalence of HIV and viral hepatitis infections is elevated, due mainly to the high percentage of intravenous drug users, it is also an environment that is conducive to risky behaviour: of incarcerated intravenous drug users, 13% to 23% started injecting in prison {Rotily 2000}. Moreover, not all of those infected with HIV or HCV are aware of this when entering prison: only 40% have already had an HIV screening test, 27% an HCV screening test and 31% an HBV screening test {Mouquet et al. 2005}.

11.2. Organisation of prison health policies and service delivery

11.2.1. Prison health (Organisation of care in prison)

Organisation of care in the prison setting

The organisation of healthcare in prison is governed by the act of 18 January 1994[190], which transfers the authority over inmate health care from the French Prison Service to the French public hospital system. By separating the health and surveillance functions, the 1994 act allowed hospitals to enter French prisons through the implementation of a system of agreements between hospitals and prisons. Today, each penal establishment is tied to a hospital establishment that is responsible for the healthcare of the inmates. This reform represents a real break with the pre-1994 situation: it helped structure the healthcare process in the prison setting by separating physical care from mental care.

The implementation of UCSAs, which are responsible for the physical care of inmates, represents the first part of the 1994 reform. Established within each prison, these units are hospital departments under the responsibility of a department head. These departments are responsible for overseeing the diagnostic testing and treatment for prisoners, and do so in the hospital environment as well, if necessary; these departments are also responsible for implementing prevention and health education actions in the penal establishments. UCSAs have therefore replaced infirmaries. In establishments with over 1,000 inmates, a pharmacist can organise and manage an internal pharmacy; in other establishments, the hospital pharmacy is used. Today, there are 178 UCSAs, or one UCSA per establishment, with the exception of open prisons.

The second part of the reform applies to the national hospitalisation scheme for detainees, which was made official by the interministerial decree of 24 August 2000. It provides for the creation of *Unités Hospitalières Sécurisées Interrégionales* (UHSI, or secure, interregional hospital units) located in eight sectors[191] in order to facilitate inmate hospitalisation. The physical healthcare provided by the UCSAs includes ambulatory care requiring technical resources in hospitals (for consultations, special testing or hospitalisation) that can only be made available to the inmates under special conditions (i.e., with a prison escort for hospital transfers and with police guards in the event of hospitalisation). Such services are costly in terms of time and personnel, and require the coordination of multiple partners and institutions. It is to limit such difficulties that UHSIs were implemented in February 2004; UHSIs can accommodate prisoners needing to undergo a scheduled hospitalisation of over 48 hours (total capacity: 170 short-stay beds). Offering medical/surgical expertise, the seven UHSIs, which have been open since 2004, are located within university hospital centres.

For mental care, treatment for inmates is provided by a Regional medico-psychological hospital service (SMPR), when there is one; some of these SMPRs have day hospital treatment available. The 26 SMPRs (one per administrative region), which were created in 1986[192], are units linked with a public health establishment and contractually affiliated with the penal

[190] French act 94-43 of 18 January 1994 regarding public health and social protection, completed by the 27 October 1994 decree and the 8 December 1994 interministerial circular.
[191] Nancy, Lille, Lyon, Bordeaux, Toulouse, Marseille, Paris Pitié Salpêtrière. The 8th UHSI will open in Rennes by the end of 2011.
[192] Décret 86-602 du 14 mars 1986 concernant la lute contre la maladie mentale et l'organisation de la sectorisation psychiatrique, et Ordonnance du 14 décembre 1986 sur la création d'unités psychiatriques dans les prisons.

establishment in which they are located. The SMPRs provide standard psychiatric care for detainees in their associated penal establishment: in addition to providing standard psychiatric care, the SMPRs are also responsible for treating alcoholism and drug abuse. They are responsible for screening for mental disorders, working towards suicide prevention, providing the quality of care that the general population receives, promoting access to health care for certain inmates who, outside of prison, generally have little or no recourse to psychiatric care, and organising continuity of care during transfers and when prisoners are released.

Since 1987, 16 penal establishments have been equipped with specialised, on-site, drug addiction treatment centres for the purpose of specifically handling drug abuse-related problems (formerly known as "*antennes toxicomanie*" or "local addiction units"). These centres are dependent on the SMPRs and complete the prison psychiatric treatment system. These Centres for Treatment, Assistance and Prevention of Addiction or "CSAPAs", which are located within the major French remand centres (covering one quarter of the incarcerated population), are officially responsible for identifying drug abusers, collecting epidemiological data on them, providing their follow-up care and preparing them for release. Since 1994, SMPRs have been replaced by the general psychiatric units that work within the UCSAs. There were 152 at the end of 2010 (versus 93 at the end of 2009).

Finally, since 2010, *Unités Hospitalières Spécialement Aménagées* (UHSA - specially equipped hospital units) have been established. Set up in hospitals[193], these UHSAs must enable psychiatric hospitalisations (with or without consent) for inmates with mental disorders when it proves to be impossible to keep such inmates in a traditional penal structure. The creation of UHSAs must, in particular, facilitate the implementation of the automatic hospitalisation provisions provided for in the 2002[194] law.

Any person who arrives in prison must meet with a physician "as soon as possible" (art. D 285 of the French Code of Criminal Procedure). This admission medical visit is mandatory. It must provide the inmate with the opportunity to report any illness requiring treatment. If the new inmate is currently undergoing treatment with drugs, the physician must be informed so that he or she can determine what should be done with the treatment (art. D 335 of the French Code of Criminal Procedure).

In light of the diverse interpretations of current legislation, in which, for example, withdrawal can be understood to be the only foreseeable method of treatment, certain laws have been drafted to specify the organisation of treatment specifically aimed at drug addicts in the prison system. The decrees of 5 December 1996 and 30 January 2002 specify the organisation for dispensing Opioid Substitution Treatments (OST). They indicate that OSTs can be initiated and followed in prison. This was the case first with High Dose Buprenorphine (HDB) which, since 5 December 1996, can be prescribed by any physician practicing in the prison setting, then methadone, able to be prescribed under the same conditions since 30 January 2002.

Equivalence of care

Inspired by the guidelines of the HCSP {Haut comité de la santé publique (HCSP) 1993}, the 1994 reform goes beyond a simple reorganisation of care: it suggests the principle of equivalence of treatment with an obligation to treat incarcerated patients in the same way as

[193] The first was opened in Lyon-Le Vinatier in May 2010. The UHSAs of Toulouse and Nancy will be completed in 2011.
[194] Article 48 of French Law 2002-1138 of 9 September 2002 on the orientation and programming of the justice system stipulated that "hospitalization with or without consent of a detainee with mental disorders takes place in a health establishment within a specially equipped unit."

outpatients by stating the objective of "ensuring prisoners a quality and continuity of treatment equivalent to what is offered to the population as a whole". The 1994 act subsequently grants prisoners social protection (article 3), which translates into a recognition of the prisoner as a citizen with the same rights as free people. The legal principle of equivalence of care (instituted by the act of 18 January 1994) according to which prisoners should be able to benefit from the same rights as the general population, was reaffirmed in the penitentiary act of 24 November 2009[195]: "the quality and continuity of care are guaranteed to prisoners under conditions that are equivalent to those of the general population" (article 46).

The general prevailing principle is therefore one of equivalence of care. Nevertheless, the State more specifically manages treatment for imprisoned people with a drug addiction by delegating said treatment to two services (general medicine and psychiatric medicine) that are dependent on the hospital service: UCSAs and SMPRs, alongside specialised, intraprison drug-addiction treatment centres operating under the responsibility of the SMPRs.

Funding for health care in the prison setting

Before 1994, health treatment and the organisation of health care for prisoners in France were the exclusive responsibility of the French Prison Service through "prison medicine"[196]. By applying a public health approach to the prison setting, the 1994 reform creates a link with the hospital environment and brings about a change of scale regarding the budget allocated to medicine in the prison setting. However, the French Prison Service continues to carry out two missions in the prison setting: that of setting out the UCSA sites according to the standards set by the French Ministry of Health and that of ensuring the safety of UCSA hospital personnel and the surveillance of detainees who come for a consultation.

The treatment of detainees is therefore the exclusive responsibility of the French Ministry of Health. Since all inmates are registered with and covered by the French Social Security, the credits for the health care of detainees (including the funding for operating the UCSAs and SMPRs) are covered by the French National Health Insurance scheme within the scope of the *Mission d'Intérêt Général* (general interest mission) budget. The funding for inmate health insurance contributions is, however, provided by the French Ministry of Justice[197].

Given the prison demographics and the prolongation of imprisonment time, the sums dedicated to health care in the prison setting are on the rise. According to the most recent figures, in 2007, the amount allocated to hospital establishments for UCSAs was 136.6 million euros, while SMPR financing was 27.7 million euros, for a population of 58,402 inmates (on 1 January 2007). Before the act of 18 January 1994, the Prison System earmarked 46 million euros in credits (300 million French Francs) for a prison population of 53,777[198]. Right after the reform, the budget for prison health care was increased to 69 million euros (393 million French Francs) in order to finance the creation of UCSAs and complement the pre-existing medical-psychological treatment system.

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[195] Acte pénitentiaire 2009-1436 du 24 novembre 2009 (NOR: JUSX0814219L)

[196] One or more temporary physicians being appointed by the regional prison service director for each establishment.

[197] Registration with the health and maternity insurance of the French general social security scheme has been mandatory for all detainees, whether French or foreign, since 1994. The state pays the corresponding social contributions through a budgetary allocation by the French Ministry of Justice to the French national health insurance fund. It also funds the portion of health care that is not covered by national health insurance: the patient's contribution for health care and the fixed hospital costs incurred during hospitalisations.

[198] As of 1 July 1993. Figures cited by Claude Huriet, professor of medicine and former French senator, in report 49 (1993-1994) written by him on the French public health and social protection bill.

The French Prison Service dedicates one million euros per year to prevention in the prison setting, which is an integral part of the overall health treatment of a detainee Since the first review of the 1994 reform, which was performed in 1996, demonstrated insufficient human resources with regard to the level of health care needed for the prison population and the constraints of the prison setting (which require significant health care human resources), measures have been taken to reinforce human resources in the psychiatric (in 1996) and physical (in 1997) sectors.

Health care personnel

The UCSA budget corresponds to approximately 470 health care personnel full time equivalents (FTEs): 306 medical personnel FTEs for physical care and 163 medical personnel FTEs for psychiatric care. In addition to these FTEs are non-medical personnel. The health personnel assigned to prison health care structures represent an estimated total of 2,400 agents (approximately 7% of the 34,000 public servants working within the French Prison Service in 2010). The number of medical full time positions assigned to prison health units increased by nearly 50% in ten years (see Table 3), whereas before 1994, health personnel were volunteers recruited by the Red Cross[199].

Nevertheless, given the concurrent increase in the number of incarcerated persons, inmate access to healthcare personnel improved less rapidly. In 2007, fewer than one medical FTE was available per 100 inmates (0.52 physical care physicians and 0.28 psychiatric care physicians). Today, there are eight physicians per 1,000 inmates, while the medical density in the general population is 3.38 physicians per 1,000 inhabitants (all specialities combined, which includes 0.22 psychiatrists per 1,000 inhabitants according to the INSEE, French National Institute of Statistics and Economic Studies). Given that the extent of the health care needs of the prisoner population is six to seven times higher than that of the general population, this difference in accessibility is deemed to be weak: regarding psychiatric disorders, the prevalence is 47% for depressive disorders in prison vs. 8% in the general population (nearly six times more) and 3.8% for schizophrenia in prison vs. 0.5% in the general population (nearly eight times more). Furthermore, the rate of inmate medical coverage is a mean rate that does not take into consideration extensive differences among establishments and geographical regions: it subsequently translates into a theoretical ease in accessing care.

[199] On 1 January 1994, there were nearly 250 physicians, 141 prison nurses and 172 nurses recruited by the Red Cross to treat inmates in application of the 17 February 1987 agreement between the French Ministry of Justice and the Red Cross.

Table 11-2: Medical personnel in the prison system (1997-2007)

	Number of inmates	Provided physical medical FTEs	Provided medical psy FTEs	Total medical FTEs	Number of medical FTEs per 1,000 prisoners
1997	54,269*	199.99	114.31	314.29	5.8
2001	47,005	257.31	146.10	403.41	8.6
2006	58,344	267.72	149.34	417.06	7.1
2007	58,402	306.00	163.09	469.09	8.0
Evolution 1997-2007	N/A	+ 53.01 %	+ 42.68 %	+ 49.25 %	+ 37.73 %

Source: Department of Hospital Care and Treatment Organisation (Dhos), French Ministry of Health
*The figure available from the French Ministry of Justice for the year 1997 corresponds to all persons entered on the prison register, whether in prison or not. The number of "actual" inmates is therefore lower.

11.2.2. Drug-related health policies targeting prisoners (Treatment policies for drug use among inmates)

Prison-related targets in national drug policies

The continuity of care for drug users upon their release has been one of the French government's strategic objectives in the fight against drugs since the first action plans drafted by the interministerial coordinating body for the fight against drugs in the 80s. It is the 1999-2001 Interministerial Mission to Fight against Drugs and Drug Addiction (MILDT) Plan that first identified incarcerated users as a priority target population for which treatment is "to be developed and reinforced"[200] {Mission interministérielle de lutte contre la drogue et la toxicomanie 2000}. This is also the first national programme document that affirms that "harm reduction in prison is a major public health issue" and supports its diagnosis with concrete proposals aimed at improving health treatment for inmates and preparing their release from prison:

- Create places for released prisoners in residential and social reintegration centres (CHRS).
- Design programmes to prepare for release with the development of Care Units for Prison Leavers (UPS) which were first tested in 1997.
- Improve the coordination and control of addictology care with the transfer of the responsibility for this coordination to UCSAs for all penal establishments[201]
- Monitor the work of the health-justice think-tank on reducing HIV and viral hepatitis transmission risks in the prison setting {Stankoff et al. 2000}.
- Reinforcement of the interministerial coordination of the prison and health services through the health-justice interministerial memorandum of 9 August 2001[202] that aimed to unite all services to reflect on the health needs of inmates and to define a way to organise services to

[200] 1999-2001 Triennial Plan, p.91.
[201] DGS/MC2/DGOS/R4/2010/390 instruction of 17 November 2010 on the organisation of addictology care in prison settings.
[202] Interministerial memorandum of 9 August 2001 on the strategies for improving the health and social care of addicted detainees who abuse legal or illegal substances.

meet these needs; the strategies presented in this interministerial memorandum[203] were integrated into several more recent administrative texts[204]

- Focus on systematically assessing the improvements provided by the measures of the Plan: the health-justice interministerial memo of 9 August 2001 was subsequently accompanied by an OFDT assessment {Obradovic 2004}, as were the UPSs ({Prudhomme et al. 2001}, {Prudhomme et al. 2003}).

Less committed to the issue of drug use in the prison setting, the 2004-2008 Plan provides for "developing a prevention programme" in the prison setting {Mission interministérielle de lutte contre la drogue et la toxicomanie 2004}. The vagueness of the objectives in this Plan lead to a low level of implementation of the recommendations from the health-justice mission {Stankoff et al. 2000} and the Delfraissy report on the treatment of HIV-infected people {Delfraissy 2002}, which was denounced by prison professionals and associations, including the AFR (French Association for Harm Reduction).

In continuity with prior plans, the 2008-2011 'Combating Drugs and Drug Addiction' Government Action Plan aims to "improve the treatment and continuity of care provided to incarcerated drug and alcohol users"[205] {Mildt 2008}. Like its predecessors, it highlights the inadequacies of treatment for drug users in the prison setting and identifies several areas for improvement. Firstly, it observes that the resources of the system for treating drug and alcohol users in the prison system are inadequate compared to the needs. Secondly, the Plan denounces the high frequency of hepatitis in incarcerated drug users and highlights the impediments to access to treatment (needing to leave the prison for hepatic consults and/or hospitalisations for hepatic biopsies, which prolong the time to treatment). Finally, it emphasises the persistence of difficulties in obtaining housing and continuity of care upon release from prison, particularly in remand centres.

Based on these observations, the Plan makes several proposals. Firstly, to improve the social rehabilitation of prison leavers, it aims to ensure that at least one housing unit is accessible per prison region to prison leavers. To this end, and through a national call for projects, the Plan created a possibility for funding 4 short and quickly accessed reception programmes for released prisoners, within existing social and medical-social structures (with housing), in relation with the hospital related to the prison. Two CSAPAs were financed in this way in 2009 (they received 300,000 euros each). Two others were similarly funded in 2010, offering a dozen places for prison leavers within units whose purpose is to offer immediate accommodation upon their release. The aim is to enable ex-prisoners to continue receiving the support they received while in prison and to establish, upon release, medical-social and social integration relays[206].

[203] The 2001 interministerial memorandum specifies the rules related to harm reduction in the prison setting: monitoring of the person throughout their imprisonment, proposal of appropriate treatment, reinforcement of risk prevention, preparation for release and the proposal of resettlements.

[204] French Ministry of Health and Social Protection, French Ministry of Justice, *Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues*, September 2004, p. 36 (http://www.sante-prison.com/les_docs/000116.pdf); interministerial circular DHOS/DGS/DSS/DGAS/DAP no. 2005-27 of 10 January 2005 on the update of the *Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues et à leur protection sociale* (http://www.sante-sports.gouv.fr/fichiers/bo/2005/05-02/a0020046.htm)

[205] 2008-2011 Plan, sheet no. 3-6, p. 67.

[206] Interministerial circular DGS/MC2/MILDT n° 2009-63 of 23 February 2009 regarding the call for projects to implement the health, social rehabilitation and harm reduction measures for the medico-social addiction aspects of the 2008-2011 government plan to combat drugs and drug addiction (http://www.sante.gouv.fr/fichiers/bo/2009/09-03/ste_20090003_0100_0154.pdf); interministerial circular DGS/MC2/DGAS/DSS/MILDT no. 2009-371 of 14 December 2009 regarding the selection of projects within the scope of the call for projects to implement the health, social rehabilitation and harm reduction measures for the medico-

Financing was also planned for five projects to implement an advanced CSAPA consultation service within the integration accommodation reception system for addicted prison leavers[207]. One single project in the *Pays de la Loire* region of France received 9,000 euros in funding through this project (additional funding for the *CSAPA Accueil Info Drogues* of the Montjoie association by the medical-social ONDAM within the framework of new full-year measures in addition to the CSAPA's overall operating budget).

The 2008-2011 Plan furthermore defined objectives for treating addicted prisoners, through provisions for the creation of 100 new alcohol addictology clinics, the establishment of hepatic clinics with Fibroscan© access[208], the training of health professionals on addictions and infectious diseases including hepatitis, the drafting and distribution of guidelines for good professional practices, particularly for opioid substitution treatments, the informing of inmates on HIV and hepatitis and, in particular, on the need for screening and re-screening when markers are negative. The Plan also suggests assessing the available HIV and HCV screening services and care, as well as the opioid substitution treatments in the prison setting, and drafting a multidisciplinary reference for preparing the social rehabilitation of addicted prisoners. For the time being, these objectives have not been assessed.

Finally, in 2010, the French Ministries of Health and Justice published the first national action plan for improving the health of detainees for 2010-2014 {Ministère de la Santé et des Sports et al. 2010}. This plan addresses all aspects of prison health policy through plans to improve the government's awareness of the state of health of detainees, to strengthen the existing health systems and develop them, to provide for reinforced measures for certain detainee categories (especially addicted prisoners), and so on. The plan emphasises the importance of continuity of care after release from prison and, in addition to creating *appartements de coordination thérapeutique* or *lits halte soins santé* (housing and health services for people in very unstable situations in France), provides for consistently organising housing for people released from prison to ensure continuity of care and the implementation of joint reference systems and training.

Policies on drug prevention, harm reduction and care for imprisoned drug users

The 2010-2014 strategic action plan on inmate health policy includes 6 main themes, including one on health prevention and promotion and one on access to care. The section dedicated to prevention, which was inspired by recommendations resulting from collective expert reports on harm reduction {Bello, P. -Y. et al. 2010}, is broken down into five measures. These measures namely aim to strengthen suicide prevention actions in prison, to assess the enforcement of the recommendations of the harm reduction policy, to act on the determinants of inmate health (practices exposing them to a risk for infection) and to make screening programmes accessible to detainees. The 2010-2014 Plan especially aims to implement HR measures that are appropriate and applicable to prisons in order to compensate for the observed weaknesses in France: distributing bleach with instructions for use, providing access to condoms, taking into consideration the infection risk of certain behaviours (e.g., sniffing, tattooing, injections), providing access to HR sterile equipment related to drug abuse, access to Fibroscan® testing in prison, improving prevention measures (inviting professional tattoo artists to prisons) and screening (developing screening during incarceration). The section of the Plan that focuses on

social addiction aspects of the 2008-2011 government plan to combat drugs and drug addiction (http://www.sante.gouv.fr/fichiers/bo/2010/10-01/ste_20100001_0100_0063.pdf)

[207] 2008-2011 Plan, sheet no. 3 -10, p.74.

[208] Blood test used to monitor patients with hepatitis C. It helps assess the degree of liver fibrosis (i.e., liver elasticity) without the need for liver biopsies, which are painful for the patients and do not provide immediate results.

treatment details six measures, especially those for reorganising available mental health care, improving the organisation, management and monitoring of inmate health care structures and organising the preparation and continuity of care upon release. Moreover, the plan defines strategies for research and surveillance by suggesting conducting repeated research on HIV and hepatitis prevalence in prisons, by implementing the Prevacar survey (sponsored by the General Health Department, and coordinated by the National Health Monitoring Institute).

The strategies of this plan are to improve care and complement the objectives of the last national plan for the fight against hepatitis (2009-2012)[209]. The latter plan defines a general framework for intervening in the prison setting, limiting itself to restating the need for hepatitis screening for new inmates and assessing the Health/Justice memorandum of 9 August 2001. The 2007-2011 government plan for the treatment and prevention of addictions[210] provides no specific actions for the prison setting.

Models of service delivery for drug users in prison

Preventing infectious diseases and harm reduction

All inmates must have an admission medical visit when they enter prison. This visit is performed by the UCSAs with a possibility to screen for infectious diseases.

To guarantee HR, which is henceforth provided for by law[211], two main tools for preventing infectious diseases have been implemented within penal establishments since 1996[212]. The 5 December 1996 circular first and foremost stipulates access to OST in prison: inmates receiving substitution treatment must not only be able to continue their treatment in prison, but also be able to initiate treatment if they wish, and especially High Dose Buprenorphine (HDB) therapy. Since 2002, OST can also be initiated for methadone[213].

In addition to substitution, penal establishments offer prevention and decontamination tools for fighting against HIV: in compliance with the recommendations of the Gentilini report {Gentilini 1996}, periodically distributing bleach in set quantities and concentrations became generalised in prison in order to clean any equipment that comes into contact with blood (such as injection, tattooing and piercing equipment). Distributing bleach chlorometrically titrated to 12° has occurred systematically since 15 December 1997, and since 2001, the Prison Service has been encouraging health personnel to inform prisoners on how to use bleach as a product to disinfect injection equipment. The legal measures implemented by the 5 December 1996 circular to fight against the spread of HIV also stipulate making condoms available free of charge (NF-compliant

[209] Strategic committee for the French national viral hepatitis plan, 2009-2012 national viral hepatitis B and C plan), January 2009, p. 17 (*http://www.sante-sports.gouv.fr/IMG/pdf/Plan_hepatites_2009_2012.pdf*)

[210] Addiction Commission, 2007-2011 government plan for the treatment and prevention of addictions, November 2006 (*http://www.sante.gouv.fr/htm/actu/plan_addictions_2007_2011/plan_addictions_2007_2011.pdf*)

[211] Loi 2004-806 du 9 août 2004 de santé publique. This law proposes an official definition of the harm reduction policy ("the policy of harm reduction for drug users aims to prevent the transmission of infection, death by overdose of intravenous drugs and the social and psychological harm related to abuse of drugs classified as narcotics", art. L. 3121-4) and places the responsibility for defining this policy with the State (art. L. 3121-3).

[212] As the main priority of the authorities since 1994 (Coppel, A. (2002). Peut-on civiliser les drogues ? De la guerre à la drogue à la réduction des risques. La Découverte, Paris.; Bergeron, H. (1999b). L'état et la toxicomanie : histoire d'une singularité française. PUF, Paris. HR is prescribed by a circular in 1996 for prisons: DGS/DH Circular no. 96-239 of 3 April 1996 related to drug addiction treatment strategies in 1996; DGS/DH/DAP Circular no. 739 of 5 December 1996 on the fight against human immunodeficiency virus (HIV) infection in prisons: prevention, screening, health care, preparation for release and personnel training.

[213] DGS/DHOS Circulaire no. 2002-57 du 30 janvier 2002 sur la prescription de méthadone par des médecins exerçant en établissements de santé.

condoms) with lubricants (theoretically obtainable through UCSAs): prisoners can keep these items on their person or in their cell. Access to prophylactic antiretroviral therapy after accidental exposure to blood is also available for health and prison personnel as well as for inmates. Subsequently, for intravenous drug users, the only current way to protect against contracting AIDS, other than post-exposure antiretroviral prophylaxis and access to condoms and lubricants in the event of sexual relations, is to disinfect syringes with bleach. These measures for cleaning injection equipment with bleach have been proven to be effective in eliminating HIV: however, it has been established that these measures are not effective enough in combating the hepatitis C virus {Crofs, 1994 #1647}. Outside of the prison setting, messages on disinfecting with bleach have furthermore been largely abandoned in favour of messages on refraining from reusing injection equipment ("À chaque injection, du matériel neuf"/"New equipment for each injection").

In contrast to the situation outside of prison, support for drug users is limited in the prison setting (counselling, peer education, primary health care) and access to sterile injection equipment (alcohol wipes, vials of sterile water, sterile cups, sterile syringes), which has been authorised in the general population since 1989, is absent from all penal establishments. There is no medicalised heroin programme in prison.

Despite the World Health Organisation's (WHO) repeated recommendations since 1993, incarcerated intravenous drug users in France subsequently do not benefit from access to sterile injection equipment. Since 1997, the refusal by the public authorities to implement syringe exchange programmes in prison has remained consistent: in 2000, the authorities deemed that implementing syringe exchange programmes was "premature" from a public opinion point of view, and mentioned the legal framework (which bans the use of illegal substances) and the counterproductive effects of introducing syringe exchange programmes in prison (risk of developing syringe exchange networks, risk of users returning to injection) {Stankoff et al. 2000}; more recently, while reviewing the penitentiary bill in 2009, the National AIDS Council reissued this proposal, recommending the immediate and progressive establishment of syringe exchange programmes in all penal establishments[214] (Conseil national du sida [CNS] 2009). These recommendations were not incorporated into the 24 November 2009 French Penitentiary Act.

Treating addiction

The UCSAs and SMPRs, which are responsible for complying with hygiene rules and implementing prevention, health education and prophylaxis actions (making post-exposure treatments available to personnel and prisoners), are also responsible for ensuring that prevention and HR tools are accessible to prisoners. All of the establishments are required to offer substitution treatment to users addicted to opioids when they enter prison: prescribing substitution medications, which is theoretically possible under the same conditions as for outpatients, to initiate or continue a treatment with methadone or high dose buprenorphine (Subutex® since 1994 and/or the generic Arrow® and Mylan®) is, however, performed dissimilarly among the establishments (see 3. Supply). In practice, access to substitution treatments depends, most often, on the UCSA physicians.

The interview with the physician during the obligatory visit upon entry into prison helps assess the drug-addicted inmates' state of health and requirements. The physician then makes the decisions that he or she feels are appropriate: withdrawal, continuing or initiating substitution treatment, referrals to specialists, detoxification, and so on. The physician can also refer

[214] National AIDS Council, opinion memorandum of 10 September 2009 on experimentation with syringe exchange programmes in penal establishments (http://www.cns.sante.fr/spip.php?article306&artpage=1-4)

prisoners to the psychiatric services (general psychiatry or SMPR, which works in partnership with the medical service, i.e., the UCSA). The 16 SMPRs that have a CSAPA (which are under the responsibility of the psychiatrist in charge of the SMPR) delegate to the CSAPAs treatment for addictions in collaboration with the UCSA. The other SMPRs (that do not have a CSAPA) work to promote the medical and psychological treatment and socio-educational follow-up of drug-addicted inmates with the integration and probation team. However, as noted by the Pradier report {Pradier 1999}, the high number of people who take part in fighting against drug addiction can sometimes be counterproductive from an access-to-care standpoint: UCSA, SMPR, CSAPA, CISIH (Centres for the Information and Care of Human Immunodeficiencies), associations... Since the DGS/MC2/DGOS/R4/2010/390 directive of 17 November 2010 regarding the organisation of care for addictions in prison, the control and coordination of addictology care have been entrusted to UCSAs; however, such care can also be contractually entrusted to a person providing psychiatric care in the establishment or in the SMPR, when there is one.

11.3. Provision of drug-related health services in prison

11.3.1. Prevention, Treatment, Rehabilitation, Harm Reduction

“Can prisoners be treated?”, ask certain health professionals who work in prisons, who answer in the affirmative to this question, but with certain reservations {Kanoui-Mebazaa et al. 2007}. In practice, access to care in prison is available, but with dual restrictions: that of sentence duration and that of a location requiring both confinement and surveillance. Although overall, emergency and basic daily care are satisfactory, the treatment of chronically ill patients proves to be insufficient, with major difficulties in access to specialist care {Contrôleur général des lieux de privation de liberté 2011}. Insufficient psychiatric care nevertheless persists and a certain number of fundamental rights still remain “ignored in prison”, such as “the right to health care” and "the protection of medical confidentiality” {Contrôleur général des lieux de privation de liberté 2011}. In other words, access to consultations within UCSAs takes place without hindrance for the most part {Kanoui-Mebazaa et al. 2007}, but not in all establishments, and for certain inmates, such as drug abusers or prisoners with serious illness, such access is more complex because their treatment is largely incompatible with imprisonment conditions.

Drug use assessment as part of the routine examination upon entry into custody

The prison population constitutes a group with a high prevalence of drug use. While the oldest survey, which was conducted in 1986 by the French Prison Service’s research department, estimated that the proportion represented by drug addicts among new inmates was 10.7% {Kensey et al. 1989}, one-third of new inmates in 2003 stated during the required admission medical visit that they had engaged in long-term, regular illegal drug use during the year preceding their incarceration {Mouquet et al. 2005}. As in the general population, cannabis is by far the most frequently used substance (29.8%), followed by cocaine and crack (7.7%), heroine and opioids (6.5%), misused medical drugs (5.4%) and other substances (4.0%), which are often amphetamines. More than one out of every ten new inmates is a polyuser of illegal drugs. Moreover, more than three out of every ten new inmates stated problem alcohol use[215] (31%)

[215] Defined, in the survey, as five or more drinks per day for men and three drinks per day for women for regular drinking, and five or more consecutive drinks at least once a month for irregular drinking.

and, although 80% of prisoners are smokers, 15% are heavy users (at least 20 cigarettes per day).

Compared to the situation observed during the prior edition of the survey, six years previously, the proportion of regular cannabis users among new inmates was on the rise in 2003, while that of opioid or cocaine users was declining ({Mouquet et al. 1999}; {Mouquet et al. 2005}). The percentage of polydrug abusers also fell, from 15% to 11%.

All products smoked, sniffed, injected or swallowed before incarceration continued to be used (albeit in reduced quantities) during incarceration {Rotily 2000}.

The prevalence of injection is high in prisons, even though the number of intravenous users seems to be declining among new inmates: 3% state having engaged in intravenous drug use in the year prior to incarceration in 2003 vs. 6% in 1997 {Mouquet et al. 2005}. The majority (61%) of drug users seen outside of prison in a specialised centre (high threshold, low threshold, general practitioners) state having been incarcerated at least once in their life: and of these, 12% injected products in prison ({Jauffret-Roustide et al. 2006}; {Jauffret-Roustide et al. 2009}). An older study established that 13% of injectors (of opioids or other substances) who were active in the year preceding incarceration injected themselves with substances during the first three months of their incarceration and half of them shared syringes, since syringe exchange programmes were prohibited {Rotily 1997}. As a result, prisons are places with a high risk of infection: they bring together a population that is often affected by drug use, instability, a high prevalence of HIV, HCV and HBV infection, and an over-representation of tattooing and piercing. This population is also frequently in and out of prison, and therefore frequently in contact with the outside world. In the 2004 French national survey on hepatitis B and C prevalence, the relative risk of contracting hepatitis B and C during incarceration was calculated: it is tenfold for HCV and fourfold for HBV {Direction de l'hospitalisation et de l'organisation des soins (DHOS) 2004}.

According to research, 60 to 80% of prisoners stop injecting during their incarceration {{Stankoff et al. 2000}: the 20 to 40% who carry on injecting seem to reduce the frequency of their injections, although they increase the quantities injected {ORS PACA 1998}. They also seem to be more often infected by HIV and/or HCV, with a very high risk of contamination from shared equipment, unprotected sex and tattooing as a result. The risks of viral contamination are even higher in prison than outside of prison, given the prevalence of HIV and HCV in prison, and the rarity of available equipment for injection: it would appear that 6 to 7% of imprisoned drug users begin injecting in prison {ORS PACA 1998}.

Furthermore, the use of more easily accessible products (such as medicines) tends to develop in prison: generally speaking, there is an observed relative transfer of use from rare and illegal drugs to medicines {Stankoff et al. 2000}. The study conducted on new inmates within the OPPIDUM programme (an annual, national pharmaco-epidemiological study) confirms that the misuse of medications is higher in the prison population than among subjects encountered outside of prison: illegal supply is twice as high and daily intake is doubled, and higher than what is authorised; nearly twice as many new inmates take substances nasally and more of them use benzodiazepines and illegal substances {Pauly et al. 2010}.

Drug prevention, information and educational activities for prisoners

In terms of information, each person entering prison receives a reception booklet from the French Prison System as well as a UCSA presentation booklet. These two documents should, in

particular, inform prisoners of the HIV/HCV/STD prevention services available in the prison setting, of access to condoms, of how to request health care, and so on. When his period of incarceration is over, a remand centre inmate has the right to access the information in his medical file; he can appoint a person of trust and define that person's role in the treatment process; inmates can consent to or refuse the care proposed to them.

In addition to the right of inmates being treated by the care system to be informed, supported by the 4 March 2002 patient rights act and the 29 April 2002 decree, the 1994 legislators wanted to make prevention and health education a major part of the penitentiary reform in addition to curative measures. The prevention and health education actions available in the prison setting fall within the scope of the UCSAs: the physician in charge of a UCSA coordinates the information and prevention actions for transmissible diseases, and does so in cooperation with the French Prison Service and in partnership with governmental services, general councils, health education committees, health insurance bodies, specialised networks and associations, and so on. In France, health education efforts can take the form of individual interviews (during consultations), group information and prevention meetings (often conducted within the penal establishment by outside workers), or initiatives to make information available (in the form of brochures and other informational documents).

In terms of prevention, inmates have access to bleach, but it is not systematically distributed and is, in most cases, not accompanied by useful harm reduction information {Michel et al. 2010}. Moreover, under illicit conditions of use, bleach is considered to be a poor HIV decontamination solution {OMS (WHO) 2005}, and a very poor HCV decontamination solution {Hagan et al. 2003}. In fact, the prevalence of infectious diseases in penal establishments remains much higher than outside the prison setting, at over 1% for HIV, approximately 3% for HBV and 7% for HCV {Bello, P. -Y. et al. 2010}. Moreover, injection practices are well-known in prisons {Michel et al. 2010}, where one to three out of every five drug users share equipment ({Rotily 2000} ; {Jauffret-Roustide et al. 2006};{Jauffret-Roustide et al. 2009}), and these populations often carry the HIV and HCV viruses. Nevertheless, imprisoned drug users do not benefit from all of the harm reduction measures that are available outside of prison, especially Syringe Exchange Programmes (SEP) ([Conseil national du sida, or CNS 2009; Conseil national du sida 2011]).

In terms of health education, efforts to support the implementation of this type of programme in a prison setting were initiated by the French Institute for Health Promotion and Health Education (INPES)[216] since the 1994 reform. Established in a dozen pilot sites and supervised by Health Education Committees, "training actions" helped group together guards, teams from the consultation and ambulatory care units, members of the Penitentiary Services for Reintegration and Probation and teachers in order to develop a shared culture for health actions. The purpose of this type of initiative is to enable professional practices to evolve by promoting coordination, the lack of which remains the main barrier to implementing prevention and education activities under the conditions and constraints of the prison setting[217]. In practice, the health education programmes are generally not implemented {Commission consultative des droits de l'homme 2006} and have only been set up in certain establishments. Theoretically, the public health establishments are responsible for working with the Penitentiary Services for Reintegration and Probation in each department, the senior management at the penal establishment and the other partners to design an annual or long-term health education programme. Nevertheless, it seems

[216] The former *Comité français d'éducation à la santé* (CFES, or the French Health Education Committee).

[217] Short speech by Philippe Lamoureaux, General Director of the INPES, "La prevention et l'education pour la sante en milieu penitentiaire: une démarche à approfondir, à interroger, au besoin à réorienter", proceedings of the symposium organised by the French ministries of health and justice and the INPES, 7 December 2004, Paris ("Dix ans apres la loi: quelle evolution dans la prise en charge des personnes detenues ?").

that generally speaking, even when such a plan exists, it becomes a dead letter. Many activity reports established by the UCSAs describe this situation. The overcrowding situation in remand centres very frequently comprises a barrier to implementing these programmes. Moreover, the medical services, when confronted with increasing numbers of new patient intakes, focus their actions on administering the care itself. In addition, the UCSAs often come up against the inadequacies in outside structures specialised in promoting health.

The section related to prevention and health education has three themes that still need to be developed[218]:

- the understanding of the mission and the role of the various health education workers
- -the legitimacy of the health education actions in the detainee rehabilitation assistance pathway
- a better adaptation of the "project methodology"[219] and the cooperative, multidisciplinary work to the prison environment[220].

Other limiting factors are often cited by professionals, such as the lack of health personnel or space, the prison conditions and the prison overcrowding, the lack of detainee motivation, their high "turnover", the lack of communication regarding projects intended for detainees and prison personnel, and finally, the search for funding.

In terms of good practice, the implementation of "health workshops" in detention centres, for example, helps disseminate information on a health issue selected by the inmates themselves within the scope of discussion groups that integrate artistic expression and entertainment that is related to the theme being discussed. With five to six sessions over a two-month period, the workshops are run jointly by a health professional and an actor with the participation of the SPIP and the UCSA.

Health education provided in prison is different from the actions taken outside of prison since the characteristics of the audience change the relationship with prevention: the inmates constitute a population with low levels of education and literacy (which can pose a problem with regard to the transmission of information messages), that is often deprived of communication (so much so that the actions can be interpreted either as being a distraction or as being an opportunity to express anger towards the legal system) and that tends to favour anything conducive to an early release. Therefore, the public is attentive, but not necessarily receptive beyond its immediate interests.

[218] Source: The "Santé en prison Dix ans après la loi: quelle evolution?" symposium organized by the French Ministers of Health and Justice and the INPES on 7 December 2004 in Paris, round table: Prevention and Health Education.

[219] Well adapted to promoting health, the methodology of the project should enable all players to create, within the establishment, conditions conducive to good health: detainees, health professionals, social and educational service professionals, guards and the Prison Service. However, in prison, organising cooperative prevention actions meets with reticence from potential partners or funding providers (the French national health insurance fund, General Councils, supplemental insurance networks). Moreover, participants do not really use the "Helath promotion and the prison setting" guide issued in 1998 by the French Ministries of Health and Justice with the CFES (*Comité Français d'Education pour la Santé*, or the French Committee for Health Education, known today as the INPES).

[220] Françoise Demichel, head of the health action unit, Regional Directorate of Lyon Prison Services, "Quelle évolution dans la prise en charge des personnes détenues ?", Proceedings of the symposium "Santé en prison" (Ministry of Health / Ministry of Justice / INPES), Paris, 7 December 2004.

Providing drug treatment and the numbers and characteristics of prisoners receiving such treatments

The treatments available in prison include opioid substitution treatments, medical support for withdrawal and counselling. There is no therapeutic community in the prison setting.

Available sources

Six main sources help (or will help) document the change in opioid substitution availability in prison, and the first two come directly from the services of the French Ministry of Health.

The first source comes from surveys conducted by the DREES, first in 1997 and then again in 2003, on a total of 134 remand centres and penitentiary remand wings. It provides the proportion of new inmates who claim that they are receiving methadone or Subutex® substitution treatment during the admission medical visit.

The second source comes from surveys on access to substitution treatments in prison. These surveys were conducted regularly by the General Health Department and the Hospital Department of the Ministry of Health *(*DGS / DHOS) among the physicians in charge of UCSAs, SMPRs or general psychiatric units on a given day between 1998 and 2004.

The third is the Common Data Collection on Treatment and Drug Addiction or “RECAP” information system implemented by the OFDT since 2005. This compendium comprises data on patients seeking assistance from drug addiction treatment centres operating in prison. It therefore only contains data from the 16 remand centres with on-site CSAPAs (Centres for Treatment, Assistance and Prevention of Addiction, formerly known as CSSTs or CCAAs, this new name coming into effect as of 2008), which were formerly known as “antennes toxicomanie” or “local addiction units”, representing one-quarter of the prison population.

The fourth source is a specific survey conducted in 2006 among UCSAs and SMPRs at the request of the DHOS, the DGS and the MILDT. These bodies commissioned the OFDT to conduct a survey to assess the impact of the 30 January 2002 decree, which provided any physician practicing in a health establishment with the ability to offer methadone substitution treatment to opioid-addicted drug abusers. This survey had a hospital section as well as a prison section.

The fifth, complementary source was the inventory of infection harm reduction measures carried out in 2010 in all French penal establishments within the scope of the ANRS-PRI2DE programme (Programme for Research and Intervention on the Prevention of Infection Risk in the Prison Setting). Through a questionnaire addressed to all USCA and SMPR department heads, this inventory explored the existence of and accessibility to infection harm reduction measures (including bleach, opioid substitution treatments, condoms, post-exposure prophylaxis, screening and information-education-communication, as well as the existence of health care for potentially risky drug use-related practices). Of the 171 penal establishments that received the questionnaire, 103 returned it completed, covering 69% of the prison population at the time of the survey.

Finally, a sixth source may be available for use in the near future: the PREVACAR survey, implemented in June 2010 by the DGS and the InVS, will help provide the first national data, in 2011, on the prevalence of HIV, HCV and STD in the prison setting thanks to the implementation of a survey plan. The survey also comprises a section on available treatments, used in 2010, which helps describe the OST services available in the penal establishments, the available HIV

and HCV care and screening, and HBV vaccine availability. The results of this second section will be presented here. Furthermore, the survey provides for an analysis of the socio-demographic characteristics of prisoners receiving OST, with a sample of 2,000 detainees from 27 penal establishments chosen at random to respond to a questionnaire.

Access to OST in the prison setting

In 2010, 9% of all inmates received substitution treatment {Michel et al. 2011a}. Furthermore, it has been established that, upon their arrival in prison, approximately 7% of inmates state being on substitution treatment, Subutex® being the declared drug used 8 times out of 10 (just like in the general population) {Mouquet et al. 2005}. This figure drops during incarceration, since treatments are not systematically continued, despite the recommendations of the 18 January 1994 act. Treatment interruption, which is an important indicator of the importance attached to continuity of care in prison, affects approximately one out of every ten inmates, even though this figure dropped between 1998 and 2004 (see Table 3).

Table 11-3: Access to substitution treatments in the prison setting

	March 1998	November 1999	December 2001	February 2004
Penal establishments	160/168 (95%)	159/168 (95%)	168 (100%)	165/168 (98%)
Prisoner pop. at the time of the survey	52 937	50 041	47 311	56 939
Number of substitution treatments	1036	1653	2548	3793
Subutex®	*879 (85%)*	*1381 (84%)*	*2182 (86%)*	*3020 (80%)*
Methadone	*157 (15%)*	*272 (16%)*	*366 (14%)*	*773 (20%)*
Total penal pop. receiving substitution	2.0%	3.3%	5.4%	6.6%
Those among new inmates receiving substitution treatment	Not collected	5.8%	12.4%	7.5%
Treatments initiated				
Subutex®	*Not collected*	*Not collected*	*88%*	*70%*
Methadone	*Not collected*	*Not collected*	*12%*	*30%*
Treatments continued				
Subutex®	*Not collected*	*86%*	*85%*	*82%*
Methadone	*Not collected*	*14%*	*15%*	*18%*
Interrupted treatments	21%	19%	5.5%	11.2%
Medical services that do not provide substitution	Not collected	34	19	6
Gen. population receiving substitution treatment (nationwide)	Not collected	70 000	92 000	100 000
Subutex®	*Not collected*	*Not collected*	*80 000 (87%)*	*85 000 (85%)*
Methadone	*Not collected*	*Not collected*	*12 000 (13%)*	*15 000 (15%)*

Source: DGS / DHOS surveys of March 1998, November 1999, December 2001 and February 2004

Although in nine out of ten cases, substitution treatment is continued upon entry in prison, the challenge of providing consistent treatment to opioid addicts consists in making accessible in prison all of the treatments that are available outside of prison. Over recent years, the total number of inmates receiving substitution treatment increased and the number of medical services refusing to prescribe OST decreased[221]. Nevertheless, accessibility to these treatments varies. In France, there is still a "pocket of resistance" with some establishments stating that they

[221] Between 1998 and 2004, the number of inmates receiving substitution treatment increased faster than the prison population. The prison population receiving substitution treatment subsequently increased from 2% in 1998 to 6.6% in 2004. Concurrently, the proportion of medical services (UCSAs, SMPRs or CSSTs) not providing substitution treatments diminished (see table 3).

have not initiated OST[222] {Morfini et al. 2001/2004}, {Obradovic et al. 2008b}, {Michel et al. 2010}), while others engage in practices that are likely to compromise the efficacy of the treatment (crushing pills or making solutions) {Michel et al. 2003}. In the 2010 PRI2DE inventory {Michel et al. 2011a}, 19% of establishments stated that they crushed or diluted high dose buprenorphine, mainly in order to limit its misuse. Moreover, methadone doses were limited in 17% of establishments, while the MA does not contain any dosing limitations. Despite repeated ministerial circulars and clinical practice guidelines, access to substitution treatment for heroin-addicted inmates remains, despite real progress, more limited than outside of prison, even though it has been demonstrated that the number of incarcerations (or re-incarcerations) is lower in people who received substitution treatment prior to or during incarceration {Rotily 2000}; {Levasseur et al. 2002}).

The PREVACAR survey helps update knowledge on available care, especially regarding OST in France. Performed in June 2010 among 145 penal establishments, this survey had an 86% participation rate, representing 56,011 detainees or 92% of the incarcerated population on 1 July 2010. Regarding available OST, the survey revealed that 100% of the UCSAs provide access to at least one of the two types of OST, either high dose buprenorphine or methadone. However, a few establishments only offer one treatment: HDB only in four establishments, and methadone only in four others. Continuity of OST care upon release is only ensured by half of the establishments (55%), and 38% of the establishments state that they do not have a formalised procedure.

Regarding harm reduction services, 18% of the UCSA teams were aware of used syringes in the establishment and 29% in the establishments with fewer than 500 detainees. The discovery of syringes mostly involves large-capacity establishments with over 150 places. These data concur with those collected during the Coquelicot survey, which revealed that 12% of drug users had injected at least once in their life ({Jauffret-Roustide et al. 2006}; {Jauffret-Roustide et al. 2009}).

The very high PREVACAR survey participation rate among establishments, thanks to the mobilisation of the treatment team personnel, helps provide epidemiological data representative of the inmate population (the missing data rate did not exceed 3%). The main limitations of the survey are seen in the declarative method of data collection and the existence of a social desirability bias on the part of the respondents, reinforced by the institutional nature of the survey. Since this survey was coordinated by the French Ministry of Health, it is possible that the participants perceived it as a monitoring of practices, thereby encouraging them to emphasise their compliance with good OST and health education practices. Furthermore, the questionnaire was filled by the physician in charge of the UCSA, who is not always the most aware of the reality of field practices, since such physicians are in less contact with the detainees. Finally, the imprecise nature of certain questions, especially those on the existence of formalised continuity of care procedures upon release, may have made certain questions difficult to understand for the respondents. The more specific information on syringes, of which the UCSAs are not always aware, comes from workers other than those of the UCSAs: they therefore represent a somewhat objective indicator of injection practices in prison.

[222] In 2004, nine prison establishments alone, representing 20% of the prison population, prescribed one-third of substitution treatments, and one of these nine establishments prescribed more than 10%. The successive editions of the survey demonstrated that there were still penal establishments where no substitution treatment was prescribed, even though this number is declining, and that certain establishments only prescribe methadone OST. Complementary qualitative studies confirmed these findings by revealing the application, in certain sites, of quotas for substitution treatment, criteria for receiving substitution treatment (estimated sentence duration, for example) or administration methods that do not correspond to the proper prescription rules: Subutex® that is crushed or diluted before administration, for example (Delfraissy, J.-F. (2002). Prise en charge des personnes infectées par le VIH. Rapport 2002. Recommandations du groupe d'experts In: DELFRAISSY, J.-F. (Ed.) Flammarion, Paris.

Although we do not know how many inmates began OST during their incarceration, we do know that the Subutex® proportion (70 %) tends to decline among treatments initiated in prison, which is explained in part by the risks associated with taking the treatment[223]. Moreover, since the governmental plan to combat illegal drugs, tobacco and alcohol (2004-2008), the authorities have been aiming to improve access to methadone OST by making it accessible in all penal establishments. This objective, which was confirmed in a circular issued by the French Ministry of Health on 30 January 2002, was assessed by the OFDT {Obradovic et al. 2008b}. The survey conducted among UCSAs and SMPRs (with a 65% response rate) revealed a remarkable progression in access to methadone. In 2006, 35% of opioid-addicted inmates were being treated within the scope of methadone OST vs. 22% in 2004 ({Obradovic et al. 2008b}, {Direction de l'hospitalisation et de l'organisation des soins (DHOS) 2004}), representing 40% of the entire opioid-dependent penal population. In 2010, this percentage remained stable (2/3 of substitute-receiving inmates received high-dose buprenorphine and 1/3 methadone) {Michel et al. 2011a}. The evolution of medical practices is evidenced in a second figure: approximately 70% of the establishments surveyed stated that they had at least one initial methadone prescription during the second half of 2006 (most often among the large remand centres, where the organisation of health care was simplified with a single prescription service). However, in 2010, 13% of the establishments that had responded to the PRI2DE inventory stated that they never initiate substitution treatment {Michel et al. 2011a}. The OFDT assessment also demonstrated that, although the rules for organising prescriptions were heterogeneous, the medical practices for dispensing and monitoring showed little variation from one establishment to another[224]. Furthermore, it appears that approximately 8% of establishments give priority to a withdrawal strategy and nearly 10% of professionals foresee the risk of overdose as a barrier to methadone prescription {Obradovic et al. 2008b}, since the known lethal risk is set at approximately 1 mg/kg/d for a non-opioid-tolerant subject (Michel, 2006). The structure of accessible OST treatment in the prison setting has therefore evolved over the past ten years: although HDB (Subutex®) is still the predominant treatment used in prison, methadone treatment is on the rise, especially since the 30 January 2002 circular allowing physicians to prescribe methadone as first-line therapy: in 2004, 30% of the treatments initiated were methadone-based (versus 12% prior to the circular).

[223] Although high dose buprenorphine is the main treatment prescribed in non-hospital practice Canarelli, T. and Coquelin, A. (2009). Données récentes relatives aux traitements de substitution aux opiacés. Premiers résultats d'une analyse de données de remboursement concernant plus de 4 500 patients en 2006 et 2007. Tendances (65) 1-6., in the prison setting, it is "relatively easy to misuse" Pradier, P. (1999). La gestion de la santé dans les établissements du programme 13 000 : évaluation et perspectives. Administration pénitentiaire, Paris. in addition to the fact that it can be "injected" or "sniffed". Since the method for dispensing methadone (as an oral solution to be taken daily in front of the treatment personnel at the dispensing medical centre) is not conducive to this kind of abuse, the French Ministry of Health authorised in 2002 initial methadone prescriptions in all health establishments, including UCSAs and SMPRs.

[224] In nearly two-thirds of cases, methadone prescriptions are shared with or delegated to a service other than the UCSA, although the latter is designated as competent in the legislation (UCSAs only carry out their mission in one-third of cases). The modalities for dispensing methadone-based treatment are, however, very homogeneous: dispensing is mainly done on a daily basis at a treatment site (dispensing is performed in cells in less than 10% of establishments) and, in general, under the supervision of a physician or nurse (except for rare cases when the treatment is handed over to the inmates themselves without monitoring of administration). The average levels of initial prescription in prisons are close to what is observed outside of prisons (in hospitals), i.e., between 23 mg/day and 76 mg/day (minimum/maximum), which translates into the proper application of the therapeutic indications, promoting caution: 60% of the treatment units state giving minimal initial doses lower than the daily initial doses indicated in the 2002 circular ("20 to 30 mg, depending on the level of physical addiction"). In contrast, one-quarter of services (generally UCSAs) state giving high initial maximal doses of at least 100 mg per day. This observation is reminiscent of the results recorded in the international literature, which reveal high, or even very high methadone doses (from over 100 mg to over 1000 mg per day), justified by a pharmacological necessity for certain patients (Maremmani, I. and et al. (2000). Methadone dose and retention during treatment of heroin addicts with axis I psychiatric comorbidity. Journal of Addictive Diseases vol. 19(2) 29-41.; Leavitt, S.B., Shinderman, M., Maxwell, S., Eap, C. and al., e. (2000). When "enough" is not enough: new perspectives on optimal methadone maintenance dose. The Mount Sinai Journal of Medicine vol. 67 (n° 5 & 6) 404-411.

Characteristics of inmates receiving OST

The characteristics of inmates receiving substitution treatment are documented by the RECAP survey (OFDT) on drug users seen in CSAPAs operating in prisons. The population of the nine CSAPAs in penal establishments that responded to the latest edition of the survey (out of a total of 16) is more homogeneous than outside of prison (see Table 4): it is comprised mainly of men (96% vs. 79%), more than half of whom are 25 to 40 years of age and often economically inactive before incarceration (approximately one-third) with a low educational level (nearly 40% state having an education level at or below middle school (the French "BEPC"). They state twice as often as CSAPA outpatients that they have alcohol and polydrug use problems. Fewer of the patients treated in prison CSAPAs for opioid problems receive OST. Furthermore, although the percentage of patients treated for an opioid problem with Subutex®-based OST in CSAPAs is comparable both inside and outside of prisons (nearly 20%), far fewer of those in prison are treated with methadone (10 % vs. 22.5 %). Finally, inmates have been on substitution treatment for longer: 44% have been on substitution treatment for more than five years vs. 31% of substitution treatment outpatients in non-prison CSAPAs.

Table 11-4: Substitution in the Nine Prison-based CSAPAs that Responded to the 2009 RECAP Survey

	CSAPAs in prisons		CSAPAs outside of prisons		2009 All CSAPAs	
	Numbers treated	%	Numbers treated	%	Numbers treated	%
Breakdown by current opioid substitution treatment						
No	**1 808**	**70.0**	37 651	56.9	39 459	57.4
Yes, Methadone	**255**	**9.9**	14 882	22.5	15 137	22.0
Yes, Subutex®	**515**	**19.9**	12 973	19.6	13 488	19.6
Yes, other	**6.0**	**0.2**	611	0.9	617	0.9
Total "usable" substitution responses	**2 584**	**100.0**	66 117	100.0	68 701	100.0
Response rate		**85.1**		76.9		77.2
Breakdown by current opioid substitution treatment duration						
Less than 6 months	**49**	**12.1**	2 958	18.0	3 007	17.9
6 months to 1 year	**39**	**9.6**	1 722	10.5	1 761	10.5
1 year to 2 years	**51**	**12.6**	2 343	14.3	2 394	14.2
2 to 5 years	**89**	**22.0**	4 221	25.7	4 310	25.6
Over 5 years	**177**	**43.7**	5 155	31.4	5 332	31.7
Total "usable" substitution duration responses	**405**	**100.0**	16 399	100.0	16 804	100.0
Response rate (in reference to the total number of patients receiving substitution treatment)		**52.2**		57.6		57.5

Source: OFDT, RECAP 2009

Preparing for release and continuity of care

Release from prison is linked to a high risk of relapse, which is sometimes fatal, for inmates receiving substitution treatment ({Harding-Pink 1990}; {Seaman et al. 1998}; {Marzo et al. 2009b}). According to a study conducted in 2001 on prisoners released from the Fresnes Remand Centre, the risk of death by overdose in former inmates was more than 120 times that of the general population [{Prudhomme et al. 2001}; {Verger et al. 2003}]. This same study established particularly high excess mortality by overdose in released prisoners under the age of 55.

The continuity of care for drug addicts released from prison is deemed a "'fundamental" issue in all the legislation organising care in prisons since the act of 18 January 1994. The 1994 act subsequently recommends preparing continuity of health care for released prisoners, in

coordination with the Penitentiary Services for Reintegration and Probation, which was reiterated in the 9 August 2001 interministerial memo and the 30 January 2002 circular, which stated that the continuity of care upon release should be "planned with the patient from the moment a prescription is indicated". More recently still, the recommendations of the Consensus conference on the follow-up of persons placed under substitution treatment[225] suggest improving "*planning for release, in cooperation with outside partners, and the generalisation of addictology consultations, aiming in particular to promote access to care, reduce harm, and prevent overdoses upon release*".

The *Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues* established by the DHOS to help professionals clearly summarises the specific conditions for providing health care to inmates at the different stages of their incarceration. It specifies that the modalities for release need to be planned sufficiently early, before the planned definitive release date. The preparation for release needs to engage the coordinated efforts of internal health and prison teams and external specialised structures. The necessary continuity of care must be in place to provide health and social support (housing, care, social protection) as well as social and professional rehabilitation support upon release. For pre-trial detainees with a bail order, information on outside health and social services for continued care must be provided upon their release. Therefore, theoretically, upon release, a prescription for methadone or Subutex® substitution treatment needs to be provided to the inmate in order to avoid any interruption in treatment while awaiting a consultation. This requires that the UCSA or the SMPR be informed beforehand of the release by the clerk of the establishment, which is not always the case. In order to receive treatment upon release, patients must know an identified, informed prescriber outside of prison to which he or she can refer for follow-up medical and/or psychiatric treatment: this can be in a specialised structure (CSAPA), a hospital structure or with a general practitioner (preferably belonging to a network that has been contacted beforehand). To promote this continuity, meetings must be organised and contacts must be made during incarceration – which often proves to be complex in practice – since admission to a CSAPA or a post-cure centre is done upon medical prescription. Prisoners who wish to benefit from such follow-up care upon release must furthermore request such care from the UCSA or SMPR physicians. The SPIP and the UCSA or SMPR personnel are responsible for informing detainees about the treatment possibilities after release.

Given the complexity of these prerequisites to be ensured in a prison setting, in practice, the recommendations are not systematically followed and the health treatment of newly-released prisoners is often insufficient. In 2003, only 30% of released prisoners who were housed in apartments of the addiction unit of the ARAPEJ 93 (an association that provides housing and follow-up care for prisoners carrying out alternative sentences to imprisonment) benefitted from the CMU Universal Health Cover scheme with complementary CMU, whereas 100% coverage of healthcare expenditures can only be guaranteed with this scheme[226]. Moreover, the OFDT's assessment of the implementation of the 2001 memorandum regarding the treatment of incarcerated people with addiction problems revealed that the "*continuity of care upon release from prison*" was among the "*treatment frameworks identified as being the most problematic*" in two-thirds of the 157 observed establishments {Obradovic 2004}. Often, drug-addicted inmates are released with a Subutex® tablet for the day and need to manage on their own, without a prescription, for the days that follow.

[225] Consensus Conference, Lyon; France, 24-25 June 2004 (http://extra.istnf.fr/portail-site/_upload/ISTNF/e-mediatheque/a_docs_ISTNF/substitution220206.pdf).
[226] Source: Observatoire International des prisons (2005). Rapport annuel. Les conditions de détention en France. 285.

Due to the difficulties involved in establishing support upon release, specific measures were implemented. In 1992, structures dependent on the SMPRs were created in order to prepare drug-addicted inmates for their release from prison: 7 Care Units for Prison Leavers (UPS), only half of which still exist today, were set up in the largest establishments, as well as a *quartier intermédiaire sortant* (an intermediary wing for released prisoners) in the Fresnes penitentiary (Val-de-Marne), which has been closed for several years. The UPS teams, which are comprised of specialised educators, social workers, psychologists and nurses, must help facilitate access for addicted inmates to housing and allow them to develop a professional project while ensuring the update of their social rights. In principal, and “to the greatest extent possible”, the people released from UPSs can, if they so desire, continue to be monitored for at least three months after release. Voluntary "interns" are recruited within the penal establishments of the region falling within the scope of the SMPR. People wishing to integrate into a UPS, but who are incarcerated in a region where there are none, should be able to request a transfer for this reason.

This specific measure targeting drug-addicted inmates was the subject of a two-tiered assessment conducted from 1999 to 2003 {Prudhomme et al. 2001}, {Prudhomme et al. 2003}). The assessment revealed difficulties in how the UPSs function: insufficient “intern” numbers, poor acceptance of the project by prison teams, poor integration of UPSs into the life of the establishments, difficulty attaining the most troubled inmate target population, difficulty recruiting interns, malfunctions related to prison constraints, and problems coordinating participants (SPIPS, the Prison Service, SMPRs, UCSAs and so on). Subsequently, improvements were planned by the MILDT, but the plan has barely evolved, other than the removal of a few UPSs (like Metz or Lyon).

More recently, the assessment of initial methadone prescriptions given by UCSAs revealed that in 2007, the UCSA professionals deemed that the continuity of care is correctly carried out for patients under methadone treatment, most often in the form of post-prison referrals to an outside CSAPA, to a general practitioner or, far less frequently, to a hospital {Obradovic et al. 2008b}. In the absence of additional data on the continuity of care upon release, it will be necessary to wait for the implementation of the new measures planned by the MILDT and the French Ministry of Health to start reflecting on the conditions for supporting opioid-addicted inmates upon release from prison. The implementation of “short and quickly accessed reception programmes for released prisoners, within existing social and medical-social structures, in relation with the hospital related to the prison"[227] will be examined closely in the years to come.

The issue of preparing the release and post-release support should be planned in relation to the future rehabilitation of the prisoner. The Prison Service carries out its rehabilitation missions through SPIPs in partnership with fifteen or so local and national associations, including, for example, Sidaction, which offers programmes for preventing HIV and hepatitis in prison, or AIDES, which performs actions within penal establishments that target HIV, hepatitis and sexually transmitted diseases (STD). In 2010, 5.4 M Euros were given to associations by the French Prison Service.

[227] These reception programmes for prison leavers were created by interministerial circular DGS/MC2/MILDT/2009/63 of 23 February 2009 regarding the call for projects to implement the health, social rehabilitation and harm reduction measures for the medico-social addiction aspects of the 2008-2011 government plan to combat drugs and drug addiction. The idea is to create group housing units, each for approximately 10 people, to provide immediate housing for prison leavers, without any time lapse between the release day and the day the prison leavers are received in these units, thereby enabling support and the continuity of medico-social and rehabilitation care.

11.3.2. Screening

Screening in prison (mandatory/optional): programme description, sampling, coverage, and evaluation

In addition to mandatory tuberculosis and syphilis screening[228], inmates are also offered optional, confidential HIV testing. All prisoners must be able to receive, if they agree to it, personalised AIDS information and counselling and, if necessary, undergo (optional) screening. The results must be given by a physician.

Likewise, hepatitis (B and C) screening is offered, but not required, even though the 8 December 1994 circular recommends offering it to high-risk people (teenagers, young adults and intravenous drug users). The hepatitis B vaccine can also be offered, but it is not mandatory.

AIDS and viral hepatitis screening is organised either directly by the UCSAs or through the free and anonymous screening centres (CDAG), which are themselves dependent on the State or the *département* (*Conseil Général,* or General Councils of each French *département*).

Depending on the practices survey, only two-thirds of the UCSAs systematically offer screening: "the HIV, AIDS and hepatitis prevention actions are not effective in all establishments" {Rotily 2000}. The consultations for giving results are more or less systematic in the event of positive results, and less frequent in the event of negative results. The Hepatitis B vaccine should be offered systematically {Bello, P. -Y. et al. 2010}.

However, the situation seems to have evolved: in the 2010 ANRS-PRI2DE inventory, 90% of all establishments (n=103) that completed the questionnaire stated that they systematically offer HIV and hepatitis screening to new inmates upon their entry in prison. The remaining 10% are prisons for sentenced detainees to which the inmates are transferred after a stay in a remand centre, where they are supposed to have already been offered screening. However, fewer than 70% state that they give the inmates negative test results {Michel et al. 2011a}. The percentage of inmates who effectively undergo HIV and hepatitis screening in prison nevertheless remains low: for example 41% of inmates were screened for HIV in eight establishments in the Paris region in 2005, 38% were screened for HCV and 37% for HBV {DRASS Ile-de-France (DRASSIF) 2007}.

11.4. Quality of Service

11.4.1. Practical guidelines and standards for drug-related health services for prisoners (Practical guidelines and standards for dispensing care)

Quality assurance for drug-related services in prison

Several documents, with varying statuses, provide guidelines for medically treating, in prison, HIV- or viral hepatitis-infected persons or drug users. First and foremost, the legislation and regulations establish governmental positions on harm reduction and the dispensing of care in prison. Hence, the 18 January 1994 act and the application circulars for the directives of the Ministries of Justice and Health (see Legal Framework), the first of which is the circular of 1994

[228] All new inmates are systematically X-rayed. Reporting tuberculosis is mandatory: the diagnosing physician reports the information to the UCSA head physician. Syphilis screening is also mandatory for the purposes of preventing STD.

authorising the prescription of methadone in prison for opioid substitution purposes, provide the main guidelines for implementing the changes introduced by the law. Moreover, in 2004, one of these circulars was accompanied by a Methodological guide on the health care of inmates, drafted by the departments of the Ministries of Justice and Social Affairs, of Health and the City. In seven chapters, it provides the modalities for organising physical care and coordinating prevention actions (ch.1), psychiatric care in a prison setting (ch.2), the coordination between the public prison service and the public hospital service (ch.3), the situation of the health personnel previously employed by the Prison Service (ch.4), the ways of providing health care to inmates (ch.5), the procedure and execution deadlines (ch.6) and the social protection of prisoners (ch.7).

In addition to these general policy strategies, various reports for guiding the organisation of health care were drafted. They also address the issue of substitution treatments in the prison setting: assessment report of the ministerial inspection corps on the organisation of inmate care {Inspection général des affaires sociales (IGAS) et al. 2001}, report of the Health-Justice mission on reducing the risk of transmitting HIV and viral hepatitis in the prison setting {Stankoff et al. 2000}, reports of the parliamentary inquiry commissions ({Mermaz et al. 2000}; {Hyest et al. 2000}). Other texts, which more specifically pertain to the policies for the fight against AIDS, also refer to care for drug-using inmates: opinion of the French National AIDS Council {sida 2011} on the risks related to drug use, the first of which dates back to 1993, expert reports on, for example, access to methadone {Caumon et al. 2002} or HIV {Delfraissy 2002}, a report by the Financial Courts {Cour des comptes 2010}, a report by the French High Authority for Health (HAS) on HIV screening {Haute autorité de santé (HAS) 2009}, and so on. Clinical practice guidelines have also been drafted on a national level for the specific aspects of prison health policy: "*Guide des bonnes pratiques de substitution en milieu carcéral*" (Good Practice Guidelines for substitution in the prison setting) in 2003[229], guidelines on the medical treatment of HIV-infected persons , the so-called "Yeni report"[230] {Yeni 2008}. These guidelines were often commissioned by the institutional authorities, even though others are the result of associative initiatives. Subsequently, the French section of the OIP published, in 2006, the first practical guide for prison leavers, with the support of the French Federation of Support and Social Rehabilitation Centres (FNARS), which brings together 750 associations working to provide support, housing, professional and social integration, and access to housing and employment for people in unstable situations. The objective of this Guide, which was completed with a supplement in 2008 to integrate the regulatory changes affecting resettlements, the preparation for release from prison and verification measures, is to provide information to prison leavers on all resources for fostering their integration upon release (OIP, 2006). This legal access tool was

[229] In 2003, the *Commission Nationale Consultative des Traitements de Substitution* (National Consultative Committee on Substitution Treatments) entrusted Laurent Michel, Head of the SMPRCSST of the Bois d'Arcy Remand Centre, and Olivier Maguet, Head of AIDES, with drafting a good practice guide to enable professionals to adapt their practices to the prison setting and to the local system. This report issued several recommendations, including an across-the-board recommendation to prescribe OST not as an end in itself, but rather as an integral part of a comprehensive, patient-focused treatment project (Michel, Maguet, 2003). The other recommendations, each of which describes the conduct to adopt in different possible situations, encourages the systematic renewal of OST upon entry in prison, the initiation of OST during incarceration to make detention serve as a springboard for treatment, the performance of urine drug testing to confirm the use of OST upon entry into prison or to resolve "therapeutic impasse" situations, and so on. See Michel, Maguet, 2003, pp. 42-51.

[230] Under the chairmanship of Professor Patrick Yéni of the CHU Bichat-Claude-Bernard, this group of mainly hospital-based experts attempted to summarise the knowledge acquired in HIV and put it into perspective to optimise patient treatment. He issued recommendations for each of the 17 policy areas identified in the document, some of which pertain to prisons: for example, he recommends systematically offering screening for HIV, hepatitis C, B/D and STDs when people enter prison, then several times during their prison stay, or in the event of antiretroviral therapeutic success, making better use of the measures allowing prisoners whose state of health is incompatible with long-term imprisonment to leave detention (*http://www.sante.gouv.fr/IMG/pdf/Rapport_2010_sur_la_prise_en_charge_medicale_des_personnes_infectees_par_le_VIH_sous_la_direction_du_Pr-_Patrick_Yeni.pdf*).

sent to all of the libraries of the 190 prisons of France for Human Rights Day on 10 December 2008.

Furthermore, the bodies specifically responsible for monitoring the health situation in prisons, like the CGLPL, make observations and recommendations in their annual report or in the guidelines for specific establishments[231].

Finally, the international[232]or national[233] consensus conferences regularly disseminate guidelines on the social care and health care of drug-using inmates. The 2004 OST conference recommended, for example, to make OST dispensing the main viral infection (HIV, HBV, HCV) harm reduction tool in the prison setting by improving training for prison treatment teams and Prison Service agents, by generalising addictology consultations for the inmates and by preparing the continuity of treatment outside of prisons and the release of inmates (prevention of overdose).

The majority of the research conducted concurs regarding six general guidelines, which sometimes correspond to existing legal obligations that are deemed to be insufficiently enforced:

1. Inform each inmate about HIV/HCV/STD prevention, access to condoms and post-exposure treatment for seropositive inmates.
2. Systematically offer HIV and viral hepatitis screening for new inmates upon their entry in prison and regularly renew the proposal during incarceration, while providing access to health information and education.
3. Train prison personnel on prevention, harm reduction and the benefits of post-exposure treatment.
4. Make condoms freely available.
5. Ensure opioid substitution strategies and syringe exchange programmes to reduce HIV, hepatitis and STD transmission.
6. In coordination with the UCSAs, involve associations that work within prisons in the prevention efforts deployed among inmates.

In addition to these national recommendations, there are, of course, international recommendations, such as the 2007 WHO/UNAIDS/UNODC report entitled, "*Effectiveness of interventions to manage HIV in prison. Needle and syringe programmes and bleach and decontaminations strategies"* {OMS (WHO) 2005}.

This review of the practical guidelines and standards for dispensing care that are in effect in France should nevertheless be examined with respect to the assessment results made available to the authorities on the efficacy of the harm reduction tools available today in the prison setting, and particularly OST and the free availability of bleach. Even though, according to the law, OSTs should be systematically offered, they still present inadequate guarantees with respect to HR, as was pointed out recently by the French National AIDS Council {Conseil national du sida 2009}. This led to several assessments of HR programmes recommending a combination of harm reduction measures, including OSTs and SEPs {Darke et al. 1998}. Likewise, the use of bleach presents difficulties. Although certain assessments demonstrate a relatively satisfactory

[231] See the "recommendations" page on the CGLPL's website (http://www.cglpl.fr/rapports-et-recommandations/dernieres-recommandations/).
[232] International consensus conference on Hepatitis C, *Gastroenterol Clin Biol*, 1999; 23: 730-5.
[233] Consensus conference. *Stratégies thérapeutiques pour les personnes dépendantes des opiacés : place des traitements de substitution*. 23 and 24 June 2004

distribution of bleach and a widespread dissemination of information on the benefits of HR {DRASS Ile-de-France (DRASSIF) 2007}, others highlight inadequacies in the access and information provided for the purposes of HR. The PRI2DE inventory of HR measures in prison and their accessibility demonstrates that in certain establishments, bleach is not provided according to the guidelines: before the recent national standardisation of the purchase of bleach by the Prison Service, the chlorometric degree (12°) was not always respected and clear information on the use of bleach for HR was only provided in 22% of the establishments that responded to the survey. The information regarding HR does not always seem to be correctly understood by the inmates or even by the prison and health personnel. It should be remembered that, although the Prison Service is responsible for distributing bleach, the information regarding its use for HR purposes should be dispensed by health personnel in compliance with the indications in the 2004 methodological guide on the health care of detainees {Michel et al. 2011a}. Moreover, the conditions of bleach disinfection efficacy are not guaranteed. Since drug use is prohibited, injection and equipment disinfection are performed in haste while, in order to ensure appropriate disinfection, significant time must be spent on the task. Finally, even when correctly used, bleach does not eliminate HCV with certainty. International organisations recommend that penal establishments distribute single-use injection equipment, since bleach distribution programmes can only be considered as a back-up strategy {OMS et al. 2007}.

Description of the existing guidelines on drug treatment (prevention, treatment, rehabilitation, harm reduction) including standards for prison OST: medications, delivery models, and control of misuse

Several initiatives that aim to set up frameworks for good practice or guidelines were carried out in France. A report on the organisation of substitution treatment in the prison setting was commissioned in 2001 by the National Consultative Committee on Substitution Treatments. It was the culmination of efforts by an observation team comprising a physician working in the Bois d'Arcy remand centre and a community activist of the AIDES association for the fight against AIDS. The report led to a “Good Practice Guide” for substitution treatment in the prison setting, which enabled professionals to adapt their practices to the prison context and to local systems {Michel et al. 2003}. After meeting inmates as well as health and prison personnel, the authors observed many difficulties in the organisation of substitution treatment. The difficulty in clarifying the “treatment” purposes in prison was highlighted in view of the security pressures related primarily to psychotropic substance trafficking, as well as the lack of resources and training for professionals. Various guidelines were formulated on access to care and treatment organisation. One of the main guidelines pertained to the need to work around an individual therapeutic project for each inmate undergoing substitution treatment and to reach a level of treatment that is equal to what is provided for outpatients. The importance of systematically renewing substitution treatments that existed before incarceration was mentioned, as was the indication to massively initiate these treatments among prisoners with opioid addiction upon entry into prison or that develops during incarceration (withdrawal related to incarceration is not, by definition, a chosen option, but it is also part of the preparation for release: integration into a healthcare process, prevention of overdose upon release and resumption of drug use with the associated consequences). The methods for delivering high dose buprenorphine, which is highly influenced by the fear of abuse and misuse that exists in prison (at levels comparable to what exists outside of prison, although more visible in prisons), should help both to trivialise delivery to “autonomous” inmates in order to avoid the useless stigmatisation and personalise delivery with dispensing in front of a care giver for the most fragile patients (i.e., the victims of racketeering or those suspected of misuse). Dispensing methadone, however, can only be performed on a daily basis in front of a care giver due to the lethal potential associated with the product in the absence of opioid tolerance or the potentiation when used with other sedative psychotropics.

Preparing for release from the moment of entry in prison is another essential recommendation, and includes organising, as soon as possible and during incarceration, contacts with future continuity of care structures. Other guidelines include training and supporting teams, the medical file, removals, urine drug testing, confidentiality of care and co-prescriptions. The report resulting from this work was distributed jointly by the French Ministry of Health and Ministry of Justice to all heads of UCSAs and SMPRs of French prisons, as well as to all Penal establishment Directors and Regional Departments of the Prison Service.

This type of measure continues today with the preparation of a good professional practice guide for opioid substitution treatments in the prison setting, in application of the 2008-2011 governmental plan. This guide, based not only on the updated guidelines of the preceding report but also supported by numerous visits with health workers in prison settings, should be available before the end of 2011.

11.4.2. Training (Personnel training)

Training prison staff in drug-related prevention, risk awareness and harm reduction

In order to implement its missions, the Prison Service (PS) relies on 34,147 agents (as of 1 January 2010) who perform various jobs: surveillance personnel, management personnel, integration and probation staff, administrative staff and technical personnel. In addition to these PS-paid personnel are health personnel affiliated with the French Ministry of Health.

The surveillance personnel represent the largest staff category (75%): this group is in constant, direct contact with the inmates. They ensure the safety inside and outside the establishment and help customise sentences and rehabilitation for people who are deprived of their freedom. They have represented 70 to 80% of the new recruits each year since September 2002, when the Ministry of Justice announced the recruitment of nearly 10,000 public servants in the prison sector over a five-year period. The management personnel represent the smallest group (approximately 1%): this group includes Prison Service Directors, who are responsible for managing establishments, and Directors of Prison Integration and Probation Services, who are in charge of the Penitentiary Services for Reintegration and Probation (SPIP). The SPIP personnel (11.5% of the PS agents) are divided into social workers (heads of reintegration and probation departments), Reintegration and Probation Counsellors and social assistants. In the prison setting, they are responsible for providing social rehabilitation assistance through individual detainee monitoring; they organise various socio-education activities within the establishment under the guidance of a department head; they prepare and monitor resettlement measures. The technical personnel (less than 2% of PS staff) have a dual role: they ensure infrastructure maintenance and help provide professional training for inmates and manage workshops. Finally, the administrative personnel (7%) provide clerk duties and accounting services. They are also responsible for the material and administrative management activities linked to the operation of the establishment and services.

In 2006, 1.6 M euros in operating funds (excluding wages and travel costs) were allocated to continuing education for agents at the *Ecole nationale d'administration pénitentiaire* (National Prison Service School); this amount represented 15,638 training days for 3,153 people (or 9% of personnel). The published figures do not specify which categories of agents received this training.

There are few specific training courses for harm reduction and prevention among all of the continuing education courses offered by the ENAP. One 12-person training class exists per year for the past few years: intended for surveillance personnel identified by the establishment, the purpose of this training course is to provide the knowledge and tools needed to become a “drug addiction specialist” and implement drug-related actions for prison personnel. These drug-addiction specialists can then follow a second training session to update their knowledge and take advantage of opportunities to exchange with their counterparts.

To complete the common law training measures, the 2008-2011 ‘Combating Drugs and Drug Addiction’ Government Action Plan provided for the implementation of interministerial training for instructors in drugs and drug addiction and basic and continuing education in each of the involved Ministries (sheet 4-1). Continuing education sessions have thus continued to be offered to civil servants on these issues (at the *Ecole nationale de la magistrature,* magistrate’s school, *Haute école de la santé publique* school of public health, and the *école nationale de l’administration pénitentiaire*, among others) although no particular initiative has been agreed upon regarding health issues.

11.4.3. Discussion, methodological limitations and missing information. Equivalence of care

Discussing the available information on drug-related health policies and services with a focus on ‘equivalence of care’

More than fifteen years after the 1994 reform entered into force, the objective of equivalence of care inside and outside of prisons is far from being attained. First and foremost, the implementation of the legal HR measure raises many issues. Regulated by the circular of 5 December 1996, the French HR measure restricts, when compared with the non-prison setting, the modalities for accessing harm reduction tools, in contradiction with the WHO’s 1993 recommendations on the equivalence of prevention and treatment for both incarcerated patients and outpatients. For example, this circular does not provide for the possibility of making sterile injection equipment available to inmates who are actively using drugs. Moreover, the various studies that have been conducted since 2001 demonstrate that HR suffers from a lack of coordination within the health care system: the reality of drug abuse is poorly understood and often negatively perceived by the administration, the coordination of those involved is limited and role-sharing between UCSAs and SMPRs remains unclear {Inspection général des affaires sociales (IGAS) et al. 2001}, {Obradovic 2004}, which limits the accessibility of inmates to care.

Furthermore, addiction treatment is not provided in the same way in all establishments ({Pradier 1999}, {Michel et al. 2003}, {Michel et al. 2005}) due in part to the differences in treatment resources. It continues to meet with opposition from certain players, particularly in establishments where there are no CSAPAs {Obradovic 2004}. Although the encouragement by the authorities to use methadone since 2002 facilitates initial prescriptions in the prison setting, it does not eliminate the refusals to prescribe observed in 2006, then again in 2010, in several establishments ({Obradovic et al. 2008b}, {Michel et al. 2008}, {Michel et al. 2011a}). Yet, the French National Consultative Committee for Ethics emphasised how the disparities in available substitution treatments is harmful to inmates (Comité consultatif national d’éthique pour les sciences de la vie et de la santé, 2006). Finally, it should be reiterated that OSTs, although they should be systematically offered, do not represent sufficient guarantees with respect to HR, and the same goes for the bleach distribution conditions.

The conditions of use for bleach do not, in fact, always comply with the guidelines (see 4. Quality of Service/Quality assurance). The PRI2DE inventory of the accessibility of HR measures in prison hence demonstrated that before the implementation of a national bleach purchasing plan by the French Prison Service, the chlorometric degree (12°) was not systematically respected; moreover, clear information on its use for HR purposes was only distributed in 22% of establishments {Michel et al. 2010}. The information on HR does not always seem to be correctly understood by the inmates or even by the prison and health personnel. It should be remembered that, although the distribution of bleach is the responsibility of the Prison Service, the information regarding its use for HR purposes should be dispensed by the health personnel in compliance with the indications in the 2004 methodological guide on the health care of detainees {Michel et al. 2011a}. Moreover, the conditions of bleach disinfection efficacy are not guaranteed, since injection and equipment disinfection are often performed in haste while, in order to ensure appropriate disinfection, significant time must be spent on the task. The benefits of an HR approach are sometimes invalidated by its very use.

Regarding access to condoms, the availability of male condoms is nearly systematic. However, in the large majority of cases, they are only available at UCSAs. Lubricants are only available in half of establishments; finally, access to female condoms in women's prisons is far more limited {Michel et al. 2011a}.

Although post-exposure prophylaxis is theoretically accessible to inmates in all penal establishments through UCSAs or the emergency centres of affiliated health establishments, 47% of the UCSA heads who responded to the PRI2DE questionnaire believe that the inmates are not informed that they can have this prophylactic treatment and 31% state that they are not in a position to answer the question. Furthermore, during the 12 months prior to this survey, only three post-exposure prophylaxis prescriptions were reported, but none of them as a result of risky drug-use behaviour. This is despite the report, in 34% of prison health care establishments, of abscesses potentially related to injection practices. Certain specify, however, that these abscesses had been acquired prior to incarceration {Michel et al. 2011a}. Sniffing among inmates was also frequently reported by treatment personnel during the survey (results not published).

Within the scope of this PRI2DE inventory, the investigation of the availability and accessibility of the various harm reduction measures in prison in France helped calculate a score to represent compliance with national guidelines (based on the December 1996 framework circular and the 2004 Methodological guide on the health care of detainees) as well as international guidelines, using as a reference the 2007 WHO/UNAIDS/UNODC report entitled "*Effectiveness of interventions to manage HIV in prison. Needle and syringe programmes and bleach and decontaminations strategies"* (see 4. Quality of Service/Quality Assurance). The objective was, within a context where access to HR measures was more limited than outside the prison setting, to assess the level of enforcement of measures recommended on a national as well as an international level, and indirectly, to assess the risk of infection in prison. The low national and, particularly, very low international score indicated to authors an overall deficiency in the application of harm reduction measures in prison in France, which reveals the absence of a public health and harm reduction policy appropriate to the needs observed {Michel et al. 2011a}.

This general assessment highlights the difficulties in enforcing the January 1994 act - difficulties that are due to four main factors.

- The difficult cohabitation of the prison and medical sectors first and foremost hinders the availability of care to inmates. For certain authors, the difference between the reform

measures “on paper” and “in practice” is explained by the insufficient preparation of professionals for the changes introduced by the law, which subsequently contributed to reinforcing the systems of opposition that structure inmate treatment: the 1994 act gives rise to conflicts between the two main categories of professionals working in the field, since it weakens the boundaries between jobs {Lechien 2001}. The medical and prison personnel, in fact, represent two opposing schools of thought: that of surveillance and security, and that of care, when, for example, the security measures imposed by the PS (handcuffs, shackles, escorts, police guards, and so on) complicate and delay, or even prevent, treatment due to a lack of material resources. The results of this antagonism is an increase in the number of internal procedures needed to resolve the health problems experienced by the inmates, such as drafting medical certificates.

- The second barrier to enforcing equivalence of care is related to the barriers encountered by the integration and probation services. The PS's rehabilitation mission, which is carried out through SPIPs, implies that inmates suffering from chronic diseases can benefit from a release medico-social plan during incarceration. This preparation for release comprises a medical component, entailing the handing over of a summary of the prisoner's file a few days prior to release, and a social component, which proves to be more difficult to organise. Often, release means returning to unstable living conditions, which disrupts the medical and therapeutic continuity planned upon release. The lack of coordination that is observed at times between the outside medical structures and the SPIPs cannot solely explain this failure: SPIPS are, in fact, confronted with insufficient social services continuity upon release, particularly in terms of housing and reception upon release from prison. Moreover, social care is usually organised within the social services of hospital departments or through patient associations. The organisation of this post-prison treatment is complicated by the fact that the reinstatement of social rights can only take place after release, and only for people whose administrative situation is in order. The contrast between the need to organise medical care for newly-released inmates and the absence of a specific social policy for prison leavers largely explains the difficulties in promoting access to care in this special population, which is already vulnerable on several levels.

- The third factor representing a barrier to the principle of equivalence of care is, specifically, related to the characteristics of the prison population, where instability, psychiatric disorders and comorbidities related to drug-addiction - objective barriers to medical care - are overrepresented. Moreover, the nature of the chronic pathologies with which patients are confronted, and their modes of treatment, which require long-term follow-up and therapeutic discipline[234] are insufficiently adjusted to the cognitive abilities of a population characterised by a low level of education.

- Finally, a fourth barrier to the application of the principle of equivalence of care is found in the special conditions of maintaining medical confidentiality in prison. Due to the lack of privacy, prisons are places where medical confidentiality is difficult to maintain: the required presence of a guard for any appointments, medical or otherwise, the closeness of quarters and the relative lack of soundproofing of treatment premises, the consultation days and the name of the physician conducting the specialised consultation, and the intake of treatments in the presence of other inmates, are all situations that contribute to breaches in confidentiality. The Prison Service regularly requests provisions for medical confidentiality to be reviewed for security reasons. Hence, the 1994 reform had paradoxical effects: it not only

[234] The treatment of HIV and chronic viral hepatitis B and C has no clinically visible translation for years. The benefits may therefore seem abstract to certain patients, which does not encourage them to undergo regular follow-up care.

made prisons a place where drug addiction could arise, it also did not even facilitate obliging prisons to become a place for giving up drugs, even temporarily ({Bouhnik et al. 1996}; {Brillet 2009}).

Although prisoner health care has made real progress since 1994, after shifting from "compassionate medicine" to hospital medicine in a prison setting, the practice contradicts the desire of lawmakers to offer prisoners care that is equal to what is received by the general population, first because the status of inmate seems to be incompatible with the principle of equivalence of care: the overcrowding of penal establishments combined with insufficient medical staff numbers (particularly psychiatric staff) and the constraints related to being in confinement automatically limit inmate access to physical and/or psychological care. Generally speaking, the health care system for detainees still has many weaknesses in terms of hygiene, waiting periods (for specialised care or hospitalisations), permanency of care (absence of permanent medical staff on nights and during weekends in the majority of penal establishments), access to specialised care (problems with escorts for outside consultations) and respect for medical confidentiality (Moreau, 2010). To ensure equality of care and long-term medico-social care after release, the necessary conditions seem to be to continue improving the medical care of prisoners within penal establishments and to develop prevention actions and harm reduction policies during incarceration.

11.4.4. Methodological limitations and missing information

The overall observation is that there is a relative lack of information on the French health care situation in prisons compared to other European countries. The data on the use of psychoactive substances among inmates in France are old {Bonnevie et al. 1996}, since the most recent data is from 2003. This relative disinterest in prison drug use as a research topic is not new. Before the 1994 reform, rare were local surveys conducted on health in prison by associations fighting against HIV or health research organisations – like ORS PACA (the regional health institute of Provence, the Alps and the Côte d'Azur in France). The first epidemiological studies dedicated specifically to the use of drugs in prison were conducted after the reform. Conducted by the National Institute of Health and Medical Research (INSERM), these surveys observed available health care limited to the treatment of drug addicts by the local addiction units, as a whole {Facy et al. 1995} or in targeted penal establishments, like the Baumettes penitentiary, where two INSERM surveys were conducted in 1996 and 1997. Even today, surveys on HIV, hepatitis and risky behaviour in prison are few and far between. The data available are often old and the way there were collected often proves to be methodologically questionable {Michel et al. 2008}.

For many years, the health of inmates was only studied, on a national level, through a general survey conducted by the Directorate for Research, Studies, Evaluation and Statistics (DREES) of the French Health and Social Ministries on the health of new inmates. The survey was conducted first in 1997 then again in 2003. The first edition of this representative survey estimated that approximately 30% of new inmates used several high-risk substances (alcohol, tobacco, drugs, psychotropic substances) and that the physicians prescribed a specialised psychiatric consultation for nearly one out of every ten new inmates (excluding addiction-related reasons) {Mouquet et al. 1999}. Psychiatric disorders in the prison setting and the special treatment provided were, however, ill-known until a specific survey was conducted in June 2001 on SMPR treatment teams responsible for prevention and psychiatric care in prisons: this survey aimed to better describe the state of health of inmates, who were questioned during the induction interview upon entry in prison or followed regularly in SMPRs {Coldefy et al.}. However, the first, large-scale epidemiological survey of the mental health of inmates, conducted

among 1,000 people and coordinated by a group of experts, was funded by the French Ministry of Health in 2003-2004, ten years after the equivalence of care act.

Since the last "new inmate health" survey conducted by the DREES in 2003, no new study on this theme has been conducted by the studies department of the French Ministry of Health: the Ministry ceased entrusting its regular surveys on substitution and on HIV/HCV prevalence to its central departments: the General Department of Health and the Department of Hospital Care and Treatment Organisation which in 2010 became the *Direction générale de l'offre de soins*. Henceforth, knowledge on the prevalence of HIV and hepatitis in prisons will be updated through the PREVACAR survey, for which the scientific coordination was entrusted to the National Health Monitoring Institute (InVS) by the General Department of Health. This decision falls within the framework of the 2010-2014 Strategic Action Plan on Health Policy for Inmates, which suggests defining a "shared corpus of data for inmate health monitoring measures that include relative indicators for monitoring chronic illnesses, mental health and infectious diseases", particularly by conducting repeated studies. The first issue of the PREVACAR survey, whose preliminary results were discussed in this paper, took place in 2010.

Moreover, the figures available on the prevalence of infectious diseases in detention sites are incomplete: they are often old, frequently declarative, aggregate data on a limited sample of inmates, and they do not help determine the proportion of drug users in prison or the established number of cases of transmission through syringe exchange. Obtaining a reliable sample is complex to the extent that certain patients cannot be questioned for disciplinary or security reasons. As a result, there is wide variability in the profile of questioned prisoners, depending on the study, since these surveys most often target populations based on legal status (provisional detention or sentencing, short sentence or long sentence) and establishment type (with variable security levels and sentence durations). The selection biases are therefore consubstantial with the practice of surveys in prison, and the existing studies need to be interpreted in accordance with the defined selection criteria. Extrapolating data proves to be tricky, especially since objective testing (such as urinary or blood testing) is rarely performed. Furthermore, traditional, standardised diagnostic instruments have not been approved for inmate populations. In addition, the fear of not respecting medical confidentiality can distort inmate reporting, likewise for the inmate psychological profile itself, which reveals a high prevalence of antisocial personalities. More generally, the surveys on drug use and high-risk practices in prison are difficult to conduct due to the reticence prisoners have in talking about illegal practices at their site of punishment and the reticence of political decision-makers. The latter are not keen to acknowledge drug use practices in a place that supposedly houses people to be tried for drug-related offences: 20% of inmates committed drug-related offences {De Bruyn et al. 2010}. Finally, the conduct of reliable studies, methodologically speaking, also encounters other obstacles in prison: Prison Service resistance, ambiguous consent in a place where freedoms are curtailed, multiple technical difficulties related to accessing establishments and inmates, and the risk of stigmatising target populations. It therefore appears necessary to impose a strong awareness of the health challenges in prison on all those involved, from politicians to people working in the field, so that the conditions needed to implement a public health policy in prison comparable to the policy implemented outside of the prison setting can exist.

Finally, in addition to their limited scope, their irregular frequency and sometimes questionable methodology, studies on the prevalence of infectious diseases, the incidence of high-risk behaviours on HIV and HCV and, more generally, the use of drugs and injection in prison, are relatively infrequent in France {Michel et al. 2008}. The 2008 report of the HIV expert group demonstrates, for example, the near absence of reliable data on HIV infection and treatment in prisons {Yeni 2008}. Other "blind spots" regarding quantitative information measures can be

mentioned: the prevalence of abuse/addiction in the general prisoner population (including prisoners with long sentences), use practices (little data on sniffing, for example), methods of drug supply in prison, the evolution of drug use prevalence during incarceration, and viral contamination during imprisonment. Although we know the prevalence of HIV and viral hepatitis, the incidence of new contaminations has never been assessed in prison, since the Prison Service opposes this type of study on the basis of principle. The little-known issue of contamination in prison would nevertheless be worthwhile to explore in order to be considered within the scope of a prison public health policy recommending, as an objective, equivalence of treatment with an obligation to treat incarcerated patients in the same way as outpatients.

11.5. Conclusion

Studies on addiction in prison are still few and irregular, which makes it impossible to follow trends. Furthermore, it is challenging to compare them with each other due to the selection bias of each survey and the methodological difficulties inherent in surveys in prison. Nevertheless, the following observations can be made: drug users are overrepresented among those in provisional detention and convicted offenders with short sentences; the substances used in prison do not seem to be prison-specific and the proportions of reported substances vary little over time; the use of injection is frequent and takes place under sanitary conditions that cannot guarantee the prevention of diseases transmissible through blood; the prison setting often fosters the initiation of illegal drug use. The non-negligible proportion of prisoners using drugs intravenously in prison, when added to the high prevalence of HIV and HCV in drug addicts, exposes inmates to a high risk of contamination since France prohibits the distribution of sterile kits.

One of the main conclusions of the collective expert report on harm reduction conducted in France in 2010 is that, although various harm reduction tools currently exist, regulated by the 1996 circular, there is no actual harm reduction policy specifically targeting prisons in France at the present time {Bello, P. -Y. et al. 2010}. In fact, despite the existence of voluntarist public health legislation addressing the health of inmates, the implementation of harm reduction tools is far from systematic: screening is still not performed; access to opioid substitution treatments (considered by the WHO as a first-line measure in prisons) remains very irregular and inappropriate practices (e.g., crushing HDB and making solutions with the substance) compromise the efficacy of these treatments; the bimonthly distribution of bleach to each inmate (considered by the WHO as second-line treatment, particularly compared to syringe exchange programmes) is infrequently observed and, in most cases, no clear instructions for use are provided; access to condoms has been generalised but the conditions of access remain unsatisfactory (information provided to inmates, confidentiality, discretion, access often only in treatment premises); finally, the prevalence of AIDS and viral hepatitis remains much higher in the prison population than outside of prison, while the treatment of these illnesses is characterised by insufficient access to specialised consultations (e.g., infectology, hepatology, psychiatrics, and addictology). Therefore, the principle of equivalence of treatment and prevention measures provided for both incarcerated patients and outpatients, recommended since 1993 by the WHO, is still not applied properly in France.

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