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OPINION PREVENTION EN

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OPINION ON SYRINGE EXCHANGE PROGRAMS IN CORRECTIONAL FACILITIES

The French Public Health Code, as modified by law # 2004-806 of August 9, 2004, mandates the principle of risk reduction measures in order to "prevent transmission of infections, mortality through overdose of injections of injectable narcotics, and the social and psychological damage linked to addiction to classified substances". To further this goal a number of tools may be provided to users of injectable drugs: access to sterile annex material to injection (alcohol pads; vials of water; filters; containers or "cookers"; syringes) within the framework of syringe exchange programs; access to substitute opiate treatments (since 1994, high-dosage Subutex® buprenorphine and/or, following that date, generic Arrow® et Mylan®; methadone); and psychological accompaniment (counselling, peer education, outreach[1], primary health-care).

This palette of risk reduction measures should be available to the whole population, including persons in correctional facilities. In this regard, the proposed penal law adopted by the French Senate on March 6, 2009 observes that "quality, permanence and continuity of health care are guaranteed to prisoners, in conditions equivalent to those dispensed to persons receiving care in public or private health institutions (...) the penal authorities encourage coordination of the various actors working in sanitary prevention and education"[2] . Similar principles were mandated by Parliament when it promulgated law # 94-43 on January 18, 1994: to wit, the public hospital service ensures that care is dispensed to persons detained in correctional facilities, and contributes to prevention and health education of detainees; detainees benefit from access to care and to prevention identical to that offered to the general population. Nonetheless, despite this major reform -- which removes the penal authorities' responsibility for organizing health-care -- significant disparities continue to exist in access to care and to prevention between the general population and detainees in correctional establishments.

In particular, French correctional facilities, which house significant populations of intravenous drug users, do propose risk-reduction techniques to detainees, including access to opiate substitution treatment and/or tools for prevention and decontamination of material destined for intravenous injection (bleach). But they refuse access to sterile injection material in the framework of syringe exchange programs. Although such programs have been authorized in the general population since 1989, and have been set up in other national contexts, they are absent from penal establishments for men and women. Nonetheless, there is access to psychoactive injectable substances (psychotropic et psychostimulant products) in correctional facilities. Intravenous use of these products remains a dangerous practise, notably in regard of the risk of transmission of infectious diseases within a prison population whose HIV prevalence is two to four times higher than that of the general population, and whose Hepatitis C prevalence is five to eight times higher. Although personal usage of syringes does seem to have been largely adopted by intravenous drug users, sharing of annex material to injection (cotton wool, spoons, water), and re-use of personal syringes, constitute relatively common risk practices.

Access to sterile injection material should be guaranteed to intravenous drug users, regardless of their penal situation. National standards of risk reduction, defined by decree #2005-347 of April 14, 2005 (and particularly its chapter III, on distribution of prevention material) apply to the entire population, including detainees. Use of narcotics is forbidden by law in the general population[3], and regulations forbid narcotics within correctional facilities[4]. However, the law does not forbid distribution of prevention material, and the regulations currently in force mandate risk reduction in its widest sense.

[1] Programs to provide services to communities difficult to reach through conventional means

[2] Article 20 of the proposed penal law, adopted following a declaration of vital urgency by the Senate, March 6, 2009.

[3] Law No.70-1320, December 31, 1970.

[4] Article D249-1 of the Code of Penal Procedure.

For the past fifteen years, the National AIDS Council has called for reform of the risk reduction measures in correctional facilities[5] and has recommended that syringe exchange programs be established within places of detention,[6] bearing in mind the experience of other countries[7]. The risk reduction measures set up in French correctional facilities remain insufficient. They group tools that have been judged to be ineffective by international organizations (use of bleach), or which are put into practice in diverging ways within different facilities (opiate substitution programs). The epidemiological data available is dated and incomplete. Finally, experimentation of one of the most satisfactory measures (syringe exchange programs) is not envisaged by the authorities, despite international recommendations and the positive evaluations of experience in foreign countries. Contrary to the popular belief, all studies show that syringe exchange programs do not encourage either an increase in consumption of injectable narcotics, or an increase in crime within correctional facilities. They are an effective way to prevent transmission of infectious diseases, and also provide oversight of injection practices, thus contributing to a decrease in overdoses and abscesses.

The Council hopes that when the penal law is promulgated syringe exchange programs can be set up, in a gradual manner but without delay, prior to the publication of the upcoming study on prevalence of HIV and Hepatitis C infection in detainees (PREVACAR). The results of this study will not be known before 2011, and its data will not be comprehensive; it will not provide definitive data regarding the proportion of intravenous drug users in prison, or known cases of transmission due to sharing of syringes. Regarding this point, the Council favours launching a pilot phase of syringe exchange programs prior to their generalisation.

Legitimate concerns about crime within correctional facilities and the penalisation of narcotics use should not be obstacles to experimenting the most effective tools of risk reduction. Imprisonment is a sentence that deprives a criminal of freedom, not health care or prevention. Risk reduction measures should be fully set up in correctional facilities, in accordance with the Public Health Code. Thus, in the coming months, the Council plans to produce more in-depth work on risk reduction for imprisoned intravenous drug users.

PREVALENCE OF RISK PRACTICES AND INFECTIOUS DISEASES IS DISTURBING AND INSUFFICIENTLY STUDIED

There is a relative dearth of data in France regarding the prevalence of infectious diseases, the impact of risk practises on HIV and Hepatitis C serology, and, more generally, use of narcotics and recourse to injection within correctional facilities. In its chapter on the epidemiology of HIV infection, the 2008 report of the HIV expert groups notes a near-absence of solid data on HIV infection and its treatment in prisons[8]. However, the data from other countries are alarming[9].

The number of intravenous drug users currently in French correctional facilities is not known. However, cross-analysis of several studies and data series yields some indications. The RECAP study, which looks at drug-users undergoing professional treatment[10], groups 33,552 patients in its "opiates/cocaine and other substances" category; 39.4% of them have experienced detention in correctional facilities[11]. The so-called Coquelicot study effected by the ANRS in 2006[12] followed up a sample of 1,462 drug-users, including 61% who declared that they had experienced a

[5] National AIDS Council, ***Opinion and report on medical situations in the prison environment for which confidentiality cannot be absolutely guaranteed***, January 12, 1993 http://www.cns.sante.fr/IMG/pdf/1993-01-12_avi_fr_politique_publique.pdf

[6] National AIDS Council, *Les risques liés aux usages de drogues comme enjeu de santé publique. Propositions pour une reformulation du cadre législatif (*Risks linked to use of narcotics as a public health issue: proposals for a reform of legislation), June 21, 2001, p. 99 sq. http://www.cns.sante.fr/IMG/pdf/2001-06-21_rap_fr_politique_publique.pdf

[7] National AIDS Council, *Rapport sur la politique publique de prévention de l'infection à VIH en France métropolitaine suivi de Recommandations pour une meilleure application de la politique publique de prévention de l'infection à VIH* (Report on public policy regarding prevention of HIV infection in continental France, followed by recommendations for better application of public policy for prevention of HIV infection), November 17 2005, p. 18 http://www.cns.sante.fr/IMG/pdf/2005-11-17_rap_fr_prevention.pdf

[8] Yeni P (dir.), *Prise en charge médicale des personnes infectées par le VIH. Recommandations du groupe d'experts*, Paris, Flammarion, 2008, p. 4.

[9] Jürgens R, "VIH/sida en prison : développements récents", *Revue canadienne VIH/sida et droit*, 2002, 7(2/3) :14-21 http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1181

[10] This care is effected under the aegis of specialized for narcotics users (CSST), alcohol treatment centres (CCAA), and in clinics for the treatment, accompaniment and prevention of addiction (CSAPA).

[11] French Monitoring Centre for Drugs and Drug Addictions (Observatoire français des drogues et des toxicomanies), *Recueil commun sur les addictions et les prises en charge (RECAP)*, OFDT, 2007, p. 13. http://www.ofdt.fr/BDD/publications/docs/recap2007.pdf

[12] BEH No.33, September 5, 2006 http://www.invs.sante.fr/beh/2006/33/index.htm.

period of incarceration[13]. According to the 1997 declarative study of the Directorate of Research, Studies, Evaluations and Statistics[14] which was renewed in 2003[15], 6.5% of people entering prison admitted using injectable drugs on at least one occasion, 2.6% of them during the twelve months preceding entry into the correctional facility[16].

Data furnished by the Ministry of the Interior and the Ministry of Justice note a significant increase in arrests, convictions and sentences of imprisonment for infractions to narcotics legislation in recent years. Arrests for narcotics use have constantly increased since 2002-2003, and reached a new record of 176,000 arrests in 2008, a rise of 31% compared to the preceding year[17]. Specifically, arrests of heroin users increased by 140% between 2003 and 2008. Data extracted from the statistics of the legal authorities also confirm an increase in convictions for narcotics infractions since 2002 (up 62% between 2002 and 2006), and an increase in prison sentences (up 53% in the same period). The number of convictions for repeat offences in narcotics has also massively increased (up 273% between 2002 and 2006[18]), and modification of sentences to allow day release, release on parole or on probation have fallen (down 74% between 2003 et 2005).

The available data also indicate a possible increase of the number of drug-users in correctional facilities. However, they do not elucidate on the use of narcotics in prison. The Coquelicot study does note that 12% of persons with past experience of incarceration declare that they continued their practice of injection in prison, involving shared syringes in 30% of cases[19]. Risk practices linked to injection are thus far from marginal among injectable drug users. The most frequently injected products are morphine sulphates (64%), cocaine (37%) and heroin (29%)[20]. The specific conditions in which the injection is performed[21] (practices of group injection, in unsanitary locales, involving shared annex material to injection), and the eventual alteration of consciousness of users of injectable drugs at the time of injection, mean that strict respect of the rules of hygiene that are imperative -- including within correctional facilities -- is probably not observed. Poor observation of these rules is disturbing, particularly since prevalence of infectious diseases remains widespread among users of injectable drugs.

The DREES study, which provides statistics on the prevalence of infectious diseases among persons entering prisons, is based solely on declarative data, and given the particular situation of the individuals concerned at the time of interview, these data may be judged relatively weak. According to the DREES, the prevalence of HIV is 1.1%, that of Hepatitis B virus is 0.8%, and of Hepatitis C virus is 3.1%. The proportion of entering detainees who declare positive serology to HIV and/or the Hepatitis B and Hepatitis C viruses was 4.2% in 2003, compared to 6.5% in 1997. The Coquelicot study, which is based on biological data, shows different results. Looking at a sample of drug-users, of whom 61% say they have spent time in correctional facilities, overall seroprevalence of HIV is 10.8%, seroprevalence of the Hepatitis C virus is 59.8% and co-infection with both HIV and Hepatitis C is 10.2%. Almost all drug-users who are seropositive for HIV are also infected with the Hepatitis C virus.

ACCESS TO RISK REDUCTION IS PARTIAL, VARIES WIDELY, AND IS OFTEN NOT ADEQUATELY EVALUATED

The January 18 1994 law on public health and social insurance includes detainees within the common-law regime of social welfare programs, and guarantees them health care that is of equivalent quality and continuity as that which benefits the general population. Notably, France applies the International Covenant on Economic, Social and Cultural Rights (ICESCR), which expressly recognizes that the right to the highest possible health norms should be

[13] The subjects included are volunteer drug-users who have injected and/or sniffed narcotics "at least once in their lifetimes". The study is multi-city; recruitment of drug-users was effected between September and December 2004 throughout the therapeutic chain specific to drug-users, and in the offices of general physicians prescribing opiate substitution treatments.

[14] *Etudes et résultats*, "La santé des entrants en prison en 1997", issue No.4 May 1999.

[15] *Etudes et résultats,* "La santé des personnes entrées en prison en 2003", issue No.386, March 2005, p. 3 http://www.sante.gouv.fr/drees/etude-resultat/er-pdf/er386.pdf

[16] This study gathers information on risk factors for the health of entering detainees during the medical visit on entry into prison. In 2003, 6,087 persons were interviewed, or one in thirteen entering detainees; according to the DREES, they were representative of all detainees entering correctional facilities that year.

[17] Office central pour la répression du trafic illicite de stupéfiants (Central Office for the Repression of Illegal Narcotics Trafficking), *Les grandes tendances de l'usage et du trafic illicite de produits stupéfiants en France*, Nanterre, OCRTIS, 2009, 23 p.

[18] Note a 110% increase in all convictions mentioning repeat offenses in this period.

[19] BEH No.33, *op. cit.*, p. 246.

[20] Note that the use of high-dose buprenorphine for non-substitutive purposes is practiced by detainees in correctional facilities: Escots S, Fahet G, *Usages non substitutifs de la buprénorphine haut dosage, Investigation menée en France en 2002-2003*, OFDT-Trend, 2004 http://www.ofdt.fr/BDD/publications/docs/epfxsek6.pdf

[21] Bonnet N et al., *L'injection à moindre risque*, Paris, édition CILDT / Apothicom, 2008 ; OFDT / ORS, *Tendances récentes sur la toxicomanie et les usages de drogues à Paris : état des lieux en 2008*, June 2009.

maintained for persons in detention[22]. This guarantee has been accompanied by reform of the health system in place in correctional facilities. Organization of health care has been unified, and within prisons, units for outpatient care and consultation (UCSA) have been generalized in order to insure prevention and the organization of physical and psychiatric care, as well as the organization of care within hospitals.[23] Several institutions house regional medical-psychological units (SMPR).

Health-care institutions are notably responsible for respecting rules of hygiene, leading actions for prevention, health education, and prophylaxis, and for ensuring that prevention and risk reduction tools are at the disposal of detainees. An interministerial note by the Health and Justice authorities, on August 8, 2001, recalls the following rules regarding risk reduction in correctional facilities: follow-up of the patients concerned throughout their incarceration, proposal of suitable care, reinforcement of risk prevention, preparation for release and proposals for modification of sentences[24]. This note has been repeated in several recent administrative texts[25,26]. Risk reduction, which has been a high priority of the authorities since 1994[27], was mandated through an official circular in 1995 for the general population[28], and in 1996 for detainees of correctional facilities[29]. It gave rise to the August 9, 2004 law.

Two principal tools of risk reduction are in place within prisons. Firstly, the circular of December 5, 1996[30] mandates, within the framework of fighting HIV infection, the use of opiate substitute treatments, particularly high-dose buprenorphine, which is the treatment most often prescribed in France[31]. The available data from abroad, which deal most often with methadone[32], demonstrate several beneficial aspects of deploying opiate substitution treatments in prison, whether such treatment was initiated prior to entry in the correctional facility (and continued during incarceration), or initiated while in detention. Opiate substitution treatments contribute to deferring the injection of heroin, sharing of syringes and risk of transmission of HIV[33]. They diminish risks of seroconversion to Hepatitis C, repeat imprisonment, and mortality (which falls to zero)[34], and they facilitate continued medical follow-up for patients[35] and screening for infectious diseases, since detainees receiving opiate substitution treatments are more likely to know their HIV and Hepatitis C status[36]. They reduce the risk of overdose and mean that users are less likely to spend much of their time seeking out narcotics[37]. In addition to opiate substitution, the authorities have

[22] See article 2(2) of the *International Covenant on economic, social and cultural rights*, UN Doc. A/6316 (1966).

[23] Decree No.94-929 of October 27, 1994 regarding health care dispensed to detainees by health establishments assuring the public hospital service, the health insurance of detainees, and the situation of nursing staff of decentralized units of prison administrations; Circular No.45 DH/DGS/DSS/DAP of December 8,1994 regarding the organization of physical and psychiatric care in correctional facilities and its methodological guide.

[24] Interministerial note of August 9, 2001, *Orientations relatives à l'amélioration de la prise en charge sanitaire et sociale des personnes détenues présentant une dépendance aux produits licites ou illicites ayant une consommation abusive*.

[25] Ministry of Health and Social Protection, 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

[26] Interministerial Circular DHOS/DGS/DSS/DGAS/DAP No.2005-27 of January 10, 2005 updating the methodological guide regarding health care and health insurance of detainees cited above, http://www.sante-sports.gouv.fr/fichiers/bo/2005/05-02/a0020046.htm

[27] Regarding the history of risk reduction programs, see Coppel A, *Peut-on civiliser les drogues? De la guerre à la drogue à la réduction des risques*, Paris, La Découverte, 2002 ; Bergeron H, *L'Etat et la toxicomanie, Histoire d'une singularité française*, Paris, PUF, 1999.

[28] Circular No.37 of April 12, 1995 regarding the prevention of infectious risks among intravenous drug users and accessibility of sterile injection material.

[29] Circular DGS/DH No.96-239 of April 3, 1996 regarding guidance in care for drug addicts in 1996; Circular DGS/DH/DAP No.739 of December 5, 1996 regarding the fight against HIV virus in correctional facilities: prevention, screening, health-care, preparation for release and training of personnel.

[30] Circular DGS/DH/DAP No.96-739 of December 5, 1996 regarding the fight against HIV in correctional facilities.

[31] Canarelli T, Coquellin A, "Données récentes relatives aux traitements de substitution aux opiacés", *Tendances*, No.65, May 2009, p. 4. Other opiate substitution treatments are possible; they include levomethadone, dilydrocodeine and codeine http://www.ofdt.fr/BDD/publications/docs/eftxtcp5.pdf

[32] Stallwitz A, Stöver H, "The impact of substitution treatment in prisons–A literature review", *International Journal of Drug Policy*, 18, 2007, 464–474, p. 465.

[33] Dolan K, Wodak A, Hall W, "Methadone maintenance treatment reduces heroin injection in NSW prisons", Drug & Alcohol Review, 17, 1998, 153–158; Dolan K, Hall W, Wodak A, "Methadone maintenance reduces injecting in prison", British Medical Journal, 312 (7039), 1996, 1162

[34] Dolan K, Shearer J, White B, Zhou J., Kaldor J, Wodak A, "Four-year follow-up of imprisoned male heroin users and methadone treatment: Mortality, re-incarceration and hepatitis C infection", *Addiction*, 100 (6), 2005, 820–828.

[35] Levasseur L, Marzo J-N, Ross N, Blatier C, Lowenstein W, "Fréquence des réincarcérations dans une même maison d'arrêt: rôle des traitements de substitution", *Annales de Médecine Interne*, 2002, 153(3), 14-19.

[36] Obradovic I, Marzo J-N, Rotily M, Meroueh F, Robert P-Y, Vanrenterghem B, Seltz F, Vogt P, RECAMS group, "Substitution et réincarcération. Eléments d'analyse d'une relation complexe", *Tendances* issue No.57, December 2009.

[37] For documentation of the benefits of opiate substitution, see Heimer R, Zambrano J, Brunet A, Marti Ortiz A, Catiana H, Newman R, "Methadone Maintenance in a Men's Prison in Puerto Rico: A Pilot Program ", Journal of Correctional Health Care, vol. 11, No. 3, 295-305 (2005).

endorsed the conclusions of the Gentilini report[38], including generalization of periodic distribution of bleach, in specified quantities and concentrations, in order to clean the injection material of drug users. Prison authorities distribute bleach titrating 12 chlorometric degrees per litre of water, and since 2001 have recommended widespread diffusion by health personnel of information regarding the use of bleach to disinfect injection materials.

This system for risk reduction has never been questioned, but it does present a number of difficulties. Firstly, it suffers from the poor coordination in place within the health system. Various evaluations that have taken place within correctional facilities since 2001 point to a number of gaps in care for drug users. The reality of drug addiction is poorly perceived by the authorities; coordination of the various actors is limited; and in particular, the division of tasks between the UCSA and SMPR units remains unclear[39,40]. Partly as a consequence of uneven care, the treatment of addiction remains erratic[41] and continues to face opposition from several actors, particularly in facilities where no centre specialized in drug addiction (CSST) has a role[42]. Although the government's encouragement of recourse to methadone has since 2002[43] facilitated primo-prescription within French correctional facilities, it has not eliminated the refusals of prescription which were noted in several facilities in 2006[44]. The *Comité consultatif national d'éthique*, a government advisory agency on bioethics issues, has emphasized that the disparity of substitution treatments offered to detainees may be extremely damaging to their well-being[45]. It should also be noted that although opiate substitution treatments should be systematically proposed, they do not guarantee risk reduction. Several evaluations of risk reduction programs propose a combination of risk reduction measures ranging from opiate substitution treatments to syringe exchange programs[46].

The use of bleach is also problematic. Studies have found that the distribution of bleach is relatively satisfactory, and that information about the reasons for risk reduction is widely available[47]. However, information about risk reduction does not appear to be well integrated by many detainees, or by the personnel of correctional facilities. In addition, domestic bleach, titrating 9°, is sometimes distributed in place of bleach titrating 12°, and the probability of effective disinfection is not guaranteed. Effective disinfection requires a significant period of time, but because consumption of narcotics is prohibited, injection (and thus disinfection of injection material) is often effected very rapidly. Moreover, even when it is correctly employed, bleach does not guarantee elimination of the Hepatitis C virus. International organizations recommend that correctional facilities distribute single-use injection material, and consider bleach distribution programs only as a second-stage back-up strategy[48].

Despite this, the French authorities do not envisage any alternative to distribution of bleach. The latest 2009-2012 national plan[49] for fighting hepatitis defines a framework for intervention in correctional facilities that is limited to reinforcing incentives for screening of hepatitis in detainees entering prisons, and an evaluation of the Interministerial Health/Justice note of 2001. The 2007-2011 Plan for Care and Prevention of Addictions (*Plan de*

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[38] Gentilini M, *Infection à VIH, hépatites, toxicomanies dans les établissements pénitentiaires et état d'avancement de l'application de la loi du 18 janvier 1994, Rapport au Garde des Sceaux et au Secrétaire d'Etat à la Santé*, Tome 1, p. 79, 1996 http://lesrapports.ladocumentationfrancaise.fr/BRP/974008900/0000.pdf

[39] Inspection générale des services judiciaires, Inspection générale des affaires sociales, *L'organisation des soins aux détenus. Rapport d'évaluation*, juin 2001, p. 5. http://lesrapports.ladocumentationfrancaise.fr/BRP/024000176/0000.pdf

[40] See also a study of 157 locations, Obradovic I, *Addictions en milieu carcéral. Enquête sur la prise en charge sanitaire et sociale des personnes détenues présentant une dépendance aux produits licites ou illicites ou ayant une consommation abusive*, OFDT, 2004, p. 45 http://www.psy-desir.com/leg/IMG/pdf/drogue-prison.pdf

[41] *La France face à ses prisons*. Report made on behalf of the Parliamentary mission of inquiry into French prisons, *op. cit.*; Pradier P, *La gestion de la santé dans les établissements du programme 13 000. Evaluation et perspectives*, 1999.

[42] Obradovic I, *Addictions en milieu carcéral. Enquête sur la prise en charge sanitaire et sociale des personnes détenues présentant une dépendance aux produits licites ou illicites ou ayant une consommation abusive, op.cit.*

[43] Circular DGS/DHOS No.2002/57 of January 30, 2002.

[44] Eleven facilities evaluated do not provide opiate substitution treatments. Obradovic I, Canarelli T, *Initialisation de traitements par méthadone en milieu hospitalier et en milieu pénitentiaire. Analyse des pratiques médicales depuis la mise en place de la circulaire du 30 janvier 2002 relative à la primo-prescription de méthadone par les médecins exerçant en établissements de santé*, OFDT, février 2008. http://www.ofdt.fr/BDD/publications/docs/eftxioo4.pdf

[45] Comité consultatif national d'éthique pour les sciences de la vie et de la santé, *La santé et la médecine en prison*, Opinion No.94, November 2006, p. 32 http://www.ccne-ethique.fr/docs/fr/avis094.pdf

[46] Darke S, Kaye S, Finlay-Jones R, "Drug use and injection risktaking among prison methadone maintenance patients", *Addiction*, 93 (8), 1998,1169 - 1175.

[47] See, for example, DRASS Ile-de-France, *VIH/IST/hépatites en milieu carcéral en Ile-de-France. Etat des lieux et propositions*, September 2007 http://ile-de-france.sante.gouv.fr/img/pdf/Etat_des_lieux_carceral_definitifseptembre2007_-_Version_compressee_.pdf

[48] WHO, UNODC and UNAIDS, *Interventions to Address HIV/AIDS in Prisons: Needle and Syringe Programmes and Decontamination Strategies*, 2007 http://www.who.int/hiv/idu/oms_%20ea_nsp_df.pdf

[49] Comité stratégique du plan national hépatites virales, National Plan for fighting Hepatitis B and C, 2009-2012 (Plan national de lutte contre les hépatites B et C, 2009-2012), January 2009, p. 17. http://www.sante-sports.gouv.fr/IMG/pdf/Plan_hepatites_2009_2012.pdf

prise en charge et prévention des addictions)[50] does not envisage specific measures in correctional facilities. Refusal to institute syringe exchange programs in prisons has been constant since 1997. In 2000 the authorities, who wish to wait until existing risk reduction programs receive full public acceptance, cited the legal framework that prohibits usage of narcotics and the risks of establishing networks for syringe exchange and encouraging the resumption of injection[51]. The position of the French authorities, which has not received systematic re-examination since that date[52], is not based on available international data; indeed, they contradict its basis.

THE BENEFITS OF SYRINGE EXCHANGE PROGRAMS ARE WIDELY RECOGNIZED

Correctional facilities in a dozen European and Central Asian countries, including Switzerland, Spain and Germany[53], have experience of syringe exchange programs. In 2006, about fifty correctional facilities offered programs whose exact modalities differed, but whose objective -- the reduction of the risk of transmitting infectious diseases -- was the same. As in the non-prison environment, the delivery of sterile syringes is guaranteed in exchange for return of used syringes. Nonetheless, officially, usage of and traffic in drugs classed as narcotics remain prohibited. Thus the prison personnel are mandated to confiscate all prohibited products, including injection material, unless they have been issued within the framework of the syringe exchange program. Syringe exchange programs thus do not aim to encourage use of narcotics within detention facilities; their goal is to protect the health of detainees, who are under the responsibility of the penal administration. The establishment of syringe exchange programs results from the observation that narcotics do circulate in correctional facilities despite the prohibition of their traffic and, in some cases, of their use.

Such programs for syringe exchange have been established in countries with varying correctional systems, such as Switzerland, Germany, Spain, Moldova, Kyrgyzstan, Belarus, Armenia, Luxemburg and Iran. The earliest programs were set up, in 1992 and 1994, in two Swiss correctional facilities, on the initiative of the medical staff and in close coordination with the local authorities[54]. Following this Swiss initiative, syringe exchange programs developed in Germany (1996) and Spain (1997). Syringes are distributed either by automatic distribution machines, or by health-care personnel with the assistance of non-governmental organizations. Given their success, these experiments were extended to more prisons in each country, particularly in Spain, where in 2001 syringe exchange programs were generalized throughout the country[55]. The practice of sharing injection material is traditionally very widespread in Spain[56], and the country's early establishment of risk reduction programs, notably its introduction of a methadone maintenance program in prisons in 1992[57], may largely explain the generalization of syringe exchange programs in correctional facilities.

Studies confirm that such programs in correctional facilities do contribute to reducing the risk of transmission of infectious diseases. Firstly, they observe that syringe exchange programs contribute to limiting the use of shared syringes[58], and to the containment of transmission of HIV and Hepatitis C. An examination of the results of an evaluation of syringe exchange programs in eleven correctional facilities in Switzerland, Spain and Germany shows

[50] Commission Addictions, *Plan for care and prevention of addictions 2007-2011 (Plan de prise en charge et de prévention des addictions 2007-2011)*, November 2006. http://www.sante.gouv.fr/htm/actu/plan_addictions_2007_2011/plan_addictions_2007_2011.pdf

[51] Health-Justice Mission, *op.cit.*

[52] Response by the Ministry for Health, Youth, Sports and Civic Associations, published in JO Sénat, August 28, 2008, p. 1738.

[53] WHO, UNODC and UNAIDS, *Interventions to Address HIV/AIDS in Prisons: Needle and Syringe Programmes and Decontamination Strategies*, *op.cit.*, p. 12.

[54] Harding N, "Preventing HIV transmission in prison: a tale of medical disobedience and Swiss pragmatism", *Lancet*, 1995, 346:1507; Nelles J, Dobler-Mikola K, Kaufmann B, "Provision of syringes and prescription of heroin in prison: The Swiss experience in the prisons of Hindelbank and Oberschöngrün", in Nelles J Fuhrer A (eds), *Harm Reduction in Prison*, Berne, Peter Lang, 1997, p. 239-262.

[55] 38 correctional facilities out of the 69 country-wide established syringe exchange programs in 2006; WHO, UNODC et UNAIDS, *Interventions to Address HIV/AIDS in Prisons: Needle and Syringe Programmes and Decontamination Strategies*, *op.cit.*, p. 25.

[56] Regarding the Spanish experience, see Ramirez-Jonville A, "La politique de Réduction des risques en France et en Espagne", *Le Courrier des addictions* (7), No.2, April-June 2005.

[57] Delegación del Gobierno para el Plan Nacional sobre Drogas, Ministerio Del Interior, Plan Nacional Sobre Drogas: Memoria 2000, Madrid, Ministerio Del Interior, 2001, p.58.

[58] In Hindelbank (Switzerland), evaluation of the program noted that the practice of sharing syringes had disappeared since the program was established. At onset, 8 out of the 19 women who injected narcotics admitted having shared syringes in prison during the month preceding the program. After the 12-month pilot phase, only one detainee (who had entered prison a short time priori to the interview) admitted having shared syringes. Nelles J, Fuhrer A, Hirsbrunner HP,Harding TW, "Provision of syringes: the cutting edge of harm reduction in prison?", British Medical Journal, 1998.

that such programs, alongside other risk reduction measures (opiate substitution treatments, counselling)[59] strongly reduced syringe sharing in seven out of the eleven facilities[60], and contributed to lower prevalence of HIV and Hepatitis C in two of the five facilities that performed blood tests[61]. In the three other facilities in which prevalence was established the level of infection remained stable. For example, in Germany, the number of detainees who admitted sharing syringes fell from 54 before the program to 4 during the first four months of the program[62]; there were no new cases of HIV infection, and only four new cases of Hepatitis C infection were observed. It was established with certitude that one of the seroconversions stemmed from sharing annex material to injection[63], and this phenomenon, noted also in Spain[64], remains a constant problem on which syringe exchange programs have little impact. In addition, syringe exchange programs do not contribute to increased use of narcotics or injectable psychoactive substances. The study cited above demonstrated that the availability of sterile syringes did not increase injection practices among detainees[65]. Moreover, syringe exchange programs encourage use of opiate substitution treatments, as noted in Spain. In addition to reduction of HIV transmission, the benefits to the health of detainees have also been clearly established. Establishment of syringe exchange programs in the first two pilot prisons in Switzerland eliminated the appearance of abscesses and decreased overdoses of heroin[66]. In addition, syringe exchange programs also benefit society in that their cost, extended to all injectable drug users in a country, is significantly lower than the estimated cost of health-care for HIV seropositive persons contaminated by shared injection material[67].

Secondly, syringe exchange programs may ensure increased security in correctional facilities, including the safety of prison personnel. In all the fifty or so prisons that have established such programs there has been no case of usage of a syringe as a weapon. Moreover, the risk of injury from syringes issued in correctional facilities appears to be very low[68]. These syringes are either returned, as part of the exchange program[69], or kept in a specific place (most often the pouch issued by the syringe exchange program), thus avoiding the accidental injuries that sometimes occur when guards or wardens search prisoners' cells[70]. The prison personnel can supervise the delivery, stockage and exchange of the syringes; they know how many syringes are in circulation, and which detainees have access to them. Syringe exchange programs are thus strongly accepted, not only by detainees (who demonstrate a high level of respect for their regulations, particularly in Germany[71]), but also by the prison personnel. Despite their initial

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[59] Stöver H, "Evaluations positives de projets pilotes d'échange de seringues en prison", *Revue canadienne VIH/sida et droit*, 2000 5(2/3) p.68 http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=826

[60] Stöver H, Nelles J, "Ten years of experience with needle and syringe exchange programmes in European prisons", *International Journal of Drug Policy*, 2003, 14(5/6), p. 442.

[61] Lines R, Jürgens R, Betteridge G, Stöver H, Laticevschi D, Nelles J, L'échange de seringues en prison: leçons d'un examen complet des données et expériences internationales, Canadian HIV/AIDS Legal Network, 2006, p.54.
http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1171

[62] Dolan K, Rutter S, Wodak AD. "Prison-based syringe exchange programmes: A review of international research and development". Addiction. 2003, p. 27. http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/TR_19/$file/TR.112.PDF

[63] Stark K et al. (2005). "A syringe exchange programme in prison as prevention strategy against HIV infection and hepatitis B and C in Berlin, Germany", Epidemiol Infect, Dec 22; 1-6.

[64] Miguel Garcia Villanueva, responsible for the medical service of the Pamplona correctional facility, P*révention du sida, des hépatites et des IST en prison: état des lieux et perspectives*, 46th CRIPS meeting, September 2002. Regardingthe Spanish government's instructions to discourage sharing annex injection material, Ministerio Del Interior/Ministerio De Sanidad y Consumo, Needle Exchange in Prison Framework Program, Madrid, Ministerio Del Interior/Ministerio De Sanidad y Consumo, 2002, p.10.
http://www.ahrn.net/library_upload/uploadfile/file3315.pdf

[65] *Id.*

[66] There are two explanations for the decrease in overdoses. Firstly, drug users inject a smaller quantity of narcotic; where syringe exchange programs are not in place, limited access to syringes means that the dose injected is larger. Secondly, the establishment of a syringe exchange program changes the nature of the counselling provided, and facilitates dialogue between health-care personnel and the injectable drug user: prevention messages regarding risk practices and overdose thus have more impact. Canadian HIV/AIDS legal network, *L'échange de seringues en prison: leçon d'un examen complet des données et expériences internationales*, *op. cit.*, p. 55.

[67] Holtgrave D, Pinkerton S, Jones T, Lurie P, Vlahov D, "Cost and cost-effectiveness of increasing access to sterile syringes and needles as an HIV prevention intervention in the United States", *Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology*, 1998, 18(Suppl 1): S133-138.

[68] *Ibidem,* p. 50.

[69] In the two Swiss pilot prisons, the rate of return is close to 99%: Stöver H, Nelles J, "Ten years of experience with needle and syringe exchange programmes in European prisons", *op. cit.*

[70] Personal interview with P. Fäh, director of the Oberschöngrün prison, March 1 1996, cited in R. Jürgens, "Échange de seringues en prison: un survol", Bulletin canadien VIH/sida et droit, 1996, 2(4): 1, 38-40.

[71] Stöver H, "Evaluations positives de projets pilotes d'échange de seringues en prison", *Revue canadienne VIH/sida et droit*, 2000 5(2/3):65-69.

suspicion at the onset of such programs, prison personnel fully approved them in following years[72], even becoming activists for reinstatement when a program was closed[73].

Overall, international organizations expressly recommend that "sterile needles and syringes, and sterile tattoo equipment" should be accessible to detainees "in a manner that is confidential and non-discriminatory"[74,75], and they indicate that "provision of sterile syringes and needles" is among the services that must be provided to persons in prisons and other detention facilities[76]. These recommendations have been poorly followed, despite the satisfying results of the first pilot syringe exchange programs in prisons. In Europe, the Council of Ministers issued recommendation R (93) 6 in 1993, encouraging states to "set up and develop health education programs in order to minimize risks, and particularly to include information regarding the necessary disinfection of injection material or use of single-usage material"[77] .

Having given consideration to these elements, the National AIDS Council recommends that syringe exchange programs should be set up in correctional facilities.

[72] Nelles J, Fuhrer A, Vincenz I, Prevention of drug use and infectious diseases in the Realta Cantonal Men's Prison: Summary of the evaluation, Berne, University Psychiatric Services, 1999.

[73] L'échange de seringues en prison: leçons d'un examen complet des données et expériences internationales, cf. *supra* p.33.

[74] United Nations High Commissioner for Human Rights and UNAIDS, *International Guidelines on HIV/AIDS and Human Rights, consolidated version*, UN Doc. HR/PUB/06/9, 2006, Guideline, par. 21(e).

[75] UNODC, WHO and UNAIDS, HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for an Effective National Response, 2006, p. 10.

[76] WHO, *Priority Interventions: HIV/AIDS prevention, treatment and care in the health sector*, August 2008, p. 25. www.who.int/hiv/pub/priority_interventions_web.pdf .

[77]Recommendation No. R (93) 6 of the Committee of Ministers to Member States concerning prison and criminological aspects of the control of transmissible diseases including AIDS and related health problems in prison (adopted October 18 1993) I-B (18).