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Addictions in Prison

A Survey on Socio-Sanitary Care for Addicted Prisoners

Using or Overusing Licit or Illicit Substances

This summary highlights the results from a survey carried out in 2003 through a questionnaire set up by the OFDT (French Monitoring Centre for Drugs and Drugs Addiction), and covering 157 prisons. The full report is available in French on the monitoring centre website[1].

At the request of authorities (Interministerial Mission for the Fight Against Drugs and Drug Addiction, Ministry of Employment and Solidarity, Ministry of Justice), the 2003 survey on socio-sanitary care in prison [1] enabled a first assessment of the enforcement of the August 9th, 2001 Interministerial Note. The latter asked the penal and sanitary departments involved to investigate the availability of care services for drug users inside prison (by outlining a common inventory) in order to reconfigure prison health care by introducing more collaboration between services and developing a public health approach to the organisation of prisons. Such an organizational scheme whose procedure applies to "the care of prisoners having an overuse or an addiction problem" was supposed to fully identify the role of each service involved (see below: a reminder of the legal context for coordinating care) in order to meet up five purposes:

- methodically detecting every overuse and/or addiction situation, no matter what psychoactive substance may be involved, through a diagnosis device supplied by prisons (called the "mini-grade grid" in reference to the Mini International Neuropsychiatric Interview, adapted so as to be used for pinpointing disorders as regards the use of psychoactive substances);
- advising a particular care matching the needs of each prisoner;
- developing prevention, notably for the risks caused by the use of specific substances;
- giving preference to an adjustment of prison sentences in order to develop measures that enhance opportunities for rehabilitation including medical and social arrangements;
- anticipating the release of prisoners subjected to an overuse or an addiction.

[1] http://www.ofdt.fr/ofdt/epp3.htm

Reminder of the legal framework organizing care in prisons

The 94-43 Act of January 18th, 1994 relating to public health and social protection induced an evolution in the care of prisoners. Its main purpose was to provide the inmates with a quality care and make the availability of care inside prison equal to that outside. In order to make these targets possible, additional measures were set up:

- the transfer of the planning and arrangement of the prisoners' sanitary care to public hospital service: up till now every prison had been provided with a UCSA (*Unité de consultations et de soins ambulatoires*; Consultation and Ambulatory Care Unit) attached to the nearest hospital;
- the affiliation of each imprisoned individual to the general welfare system, from their first day in prison onwards, and the possibility to benefit from the French universal Social Security cover since January, 2000.

The care of detained individuals with an addiction to licit or illicit substances depends both on the UCSA, under the responsibility of a hospital practitioner, and psychiatric departments: the SMPR (*Service médico-psychologique régional*; Regional Medico-Psychological Regional Service) or general psychiatry department. Specialized care centres for drug-addicts (CSST: *Centres de soins specialisés aux toxicomanes*) are settled within 16 penal complexes, the ex-"drug addiction" units ("antennes toxicomanie"), provided with the 1992 status of "CSST taking place in a prison context" and belonging to the SMPR. In other penal complexes, the care of detained individuals with an addiction is performed by outside CSST and CCAA (*Centres de cure ambulatoire en alcoologie*; Alcohol Ambulatory Treatment Centres) entitled to contribute in prisons.

The SPIP (*Service pénitentiaire d'insertion et de probation*; Integration and Probation Penal Service) is responsible for the incarcerated individual's social attendance, which vouches for a consistent care and follow-up.

When the August 9th, 2001 Note was issued, most recent estimates (1997) suggested that 60% of those entering prison had a drug-related problem; e.g. a problem in connection with the use of alcohol and/or other substances which needed a personalized care [3]. Addressing the needs of prisoners who experience an extensive range of health problems is therefore a critical challenge for both public health and crime reduction policy. These prisoners did not always reveal their addiction to sanitary, socio-educative and supervising services, which did

not perform regular investigations themselves: therefore addiction troubles were not always identified. As a majority of inmates infected by HIV and hepatitis are drug users who also tend to adopt risky behaviours during detention (notably those resorting to an intravenous mode), it can be easily assessed how crucial the needs were to improve the spotting of problems and to adapt the treatment of addictions in prison [4].

The purpose of the survey was to evaluate the progress of thoughts in each department and also to pinpoint deficiencies and disparities in the sanitary and social care supplied to prisoners all through their incarceration and when being discharged. It was carried out through a questionnaire set up by the OFDT in Spring 2003, in connection with the MILDT, the DGS, the DHOS and the DAP[2], addressing all DDASS (*Direction départementale des affaires sanitaires et sociales*; Departmental Management for Health and Social Action) within Metropolitan France and in the overseas departments, which vouched for the required procedures and answered for the penal institutions.

Forty-Two Percent of Prisons Signing an Agreement

While a great majority of institutions has begun to give thoughts to the subject, all agreements for care were not signed by the end of summer 2003. In 66 prisons (42%) an agreement is whether signed or ongoing, binding together an average of 5 to 6 stakeholders inside the institution or outsiders (associations, CHRS, etc.). The procedure has been subjected to various levels of involvement according to the sites: some of them have not gone further than the launching step or the formal nomination of a person in charge of an "addictions" project, while others have reached the inventory step (109 out of 157 institutions surveyed) and/or an agreement.

Characteristics of the sampling

92 DDASS out of 100 have sent a valid answer, as far as the institutions located on their territories are concerned, and that proves a most satisfactory turnout[3]. The self-governed CSL (*Centres de semi-liberté*; Partial release centres), where care comes under common law — as opposed to the CSL attached to a penal complex or a prison — have been discarded from the

[2] *Direction générale de la Santé* (General Health Department), *Direction de l'hospitalisation et de l'organisation des soins du ministère des Solidarités, de la Santé et de la Famille* (Management for Hospitalisation and Care Planning in the Ministry of Solidarities, Health and Family); *Direction de l'administration pénitentiaire au ministère de la Justice* (Prison Service in the Ministry of Justice).
[3] This turnout is a global ratio for returned questionnaires. The no-answer ratio varies according to questions.

sphere of the survey, as the offenders accommodated in CSL structures can be considered as "part-time inmates".

The sampling achieved includes 157 penal institutions out of 168 being targeted by the survey (that is 93% of the whole). They break down as follows:

- 108 prisons (usually accommodating offenders remanded in custody before trial, and convicted prisoners whose time remains under or equals one year);
- 23 detention centres (accommodating individuals with medium to long-term sentences to serve);
- 22 penal complexes (mixed institutions accommodating offenders and those having short and long-term sentences to serve, which include both a "prison" section, and/or a "central prison" section, and/or a "detention centre" section);
- 4 central prisons accommodating prisoners with long-term sentences to serve under disciplinary regime.

As a reminder, when the survey was carried out, the national prison overpopulation rate was nearing 125% (60 963 prisoners for 48 603 cells). It is around 120% in the surveyed sampling.

The impulse given by the "addictions" project supervisor seems indisputable in the 108 institutions where one is nominated. Responsible for the procedure and managing the group whose mission is to establish a local diagnosis, he/she is to be designated during the first meeting, primarily among psychiatry contributors. Apart from three "departements", each time an agreement has been signed or in progress, such a supervisor has been nominated beforehand. He/she may be a practitioner or a hospital doctor (42%), a psychiatrist (30%), a psychologist (11%), a nurse (8%) or may belong to another job (9%). In most of the cases he/she comes under the UCSA or a hospital centre. Otherwise the attached service is a psychiatric department (30%), a CSST (10%) or, infrequently, the SPIP, the institution management or an association.

Problems being spotted by the inventory achieved or in progress, when the survey is carried out, are for more than two-thirds: a coordination difficulty between services (63%), a lack of medical and paramedical staff (40%) or, for about 1 institution out of 5, a problem relating to the acceptance of substitution (see below). The care context acknowledged as the more challenging ranks in decreasing order as follows: discharge (in most of the institutions);

care supply for alcohol and tobacco addiction, both identified in one third of the penal establishments); problems connected with care in a sentence adjustment context or at the admission to prison (in 20% of institutions).

Detecting Addiction at Admission to Prison is Not Systematic Yet

Contrary to the directions stipulated in the note, detecting abuse or addiction conditions, whatever psychoactive substance is at stake, is not systematically performed for each substance : less than 60% of the institutions having responded (70 structures) use specific devices to locate abuse or addiction conditions, including the mini-grade grid.

The no-answer ratio close to 30% shows a comparative lack of information among the DDASS when it comes to organizing care for those entering prison. In more than 8 prisons out of 10 (84%), the UCSA is the service responsible for spotting at the entrance. The SMPR plays this part in 2 establishments out of 10 (17%). In some prisons, the CSST and/or the SPIP are in charge of detection.

The mini-grade diagnosis tool, adapted by central services to be distributed in all French institutions, is used in some of them but its relevance is questioned, even subjected to controversy, by sanitary services. While most of them acknowledge its arrangement and precision, its manageability for the medical examination when the prisoner enters prison is often questioned, so that other devices are often given preference (CAGE-DETA test which enables screening a problematic alcohol use through four questions; “informal” detection during the admission interview; investigation of toxic addictions, as well as questioning about his/her medical and psychiatric background, etc.)

Mode of Detecting Addictions at the Entrance to Prison

In 157 institutions	**Service responsible for entrance spotting**				**Use of spotting tools** (including mini-grade)
	UCSA	SMPR	CSST	SPIP	
Number of Institutions involved	93	19	5	5	70
Among 157 institutions (in %)	83.8	17.0	4.5	4.5	58.3

No-answer	46	45	45	45	37

Sources: OFDT – Addictions in prison

An Ill-Assorted Care Supply

The ambition of the Interministerial Note, that consisted in recommending a health care system meeting the inmates' needs, seems to be partly achieved.

The availability of substitute treatments for opiates is not guaranteed in all institutions: it is in that respect that the principle of equality of care with outside prison drug users, as claimed in the January 18th, 2004 Act, is the most upset. For 22 institutions out of 109 which reported an answer (20%), the DDASS has pointed out an acceptance of substitution issue, whereas the note encouraged medical staff to carry on the treatments previous to incarceration: these "reluctant" institutions are important structures, accommodating an average of 316 individuals, and mostly detention centres.

There is an obvious heterogeneity of practices among institutions: some practitioners, who systematically stop every treatment, refuse substitution by principle because of personal standpoints or disagreements between prescribing services (UCSA, SMPR or general psychiatry departments). Other medical teams endeavour to keep on the treatments set off outside yet do not prescribe new ones. Eventually, in others, substitution treatments are carried on and sometimes started out: such a deduction is confirmed by the survey of the Ministry of Solidarities, Health and Family, carried out during a fixed week in February 2004, showing that 7 institutions (in particular detention centres or central prisons) initiate rather than carry on treatments [5].

Requirements due to the prison system make access to treatment as difficult as medical follow-up. Treatments are granted when sanitary services are on duty, yet there are not enough practitioners and nurses to control the intake beyond treatment supply, hence two types of risks: an indirect use of the substance with the intention of trafficking (particularly Subutex®), and a self-dosage, which may be fatal to the prisoner, notably when combining methadone with another psychoactive substance. To prevent such misuses, institutions have developed separate strategies, including for instance the "8 mg rule", which consists in distributing only Subutex® pill boxes containing less than 8 mg (Béthune prison) in order to avoid trafficking and one single major intake.

The care of alcohol overuse and harmful use has remarkably progressed: 102 institutions were giving to a specialized consultation in 2003 vs. 2 institutions only in 1997. Nowadays alcohol specialized consultations are therefore available in 80% of institutions for which an answer has been reported. However the care supply does not match what is at stake: in some institutions among the responding ones, 1 prisoner out of 2 claims a challenging alcohol use, and almost 3 out of 4 meet alcohol addiction standards; yet in most prisons, outside consultations for alcohology still remain restricted and depend on forbidding waiting time, sometimes even beyond the sentence duration. Such lack of care supply is all the more prejudicial as alcohol-addicts tend to overshadow their pathology: so they rarely ask for care and even reject it. Therefore the needs actually expressed remain below the actual ones. The lack of request being often misleading, penal institutions have to settle a "care supply revealing request", as a DDASS "médecin-inspecteur" has claimed. The concern for a better care is all the more crucial as alcohol abuse or addiction is attested as an issue favouring various offences (assault on people, offences against the Highway Code, etc.) which are real sources of penal reoffending.

In a penal context where nearly 80% of inmates are smokers, the care for tobacco addiction is comparatively uncommon and comes under local projects [3]. In almost 2 institutions out of 3, nicotine substitutes are available through the UCSA, and most of the time to be paid, under patch or gum forms. Financing enabling a free supply hardly lasts.

Care Supply for Tobacco Addiction

In 157 institutions	**Nicotine substitutes availability**	**Non-smoking cells**
Number of institutions concerned	67	26
Among 157 institutions (%)	59.3	24.3
No-answer	44	50

Source: OFDT – Addictions in Prison

The free access to tobacco severing for impoverished prisoners seems to take place in a restricted number of institutions, while the high cost of nicotine substitutes tends to dissuade

inmates. Therefore the care supply varies according to sites, with sometimes significant initiatives (opening of tobaccology consultations in penal centres) even though they often target specific communities (impoverished individuals, pregnant women). Furthermore in 26 institutions (almost 1 out of 4 in the sampling) non-smoking cells can be found. The expansion of those seems hardly possible because of the penal overpopulation. Thus structural factors also work against developing sound prison healthcare services. These include the standards of accommodation and facilities, the custody and control ethos of prisons and factors relating to staff and inmates.

Conclusion

This survey acknowledges the benefit of the agreement process and shows the outstanding deficiencies in the health care system. Its purpose was neither to deliver a quantitative evaluation of the needs of the inmates with an addictive condition, nor an assessment of the necessary measures to meet those requirements satisfactorily. Such an assessment would nevertheless be essential to adjust the authorities' accomplishments. Its purpose was not either to collect prisoners' opinions, as they are those who use the health care system, although many lessons could also be drawn from such an approach.

The main benefit of the agreements was to strengthen cooperation and formalize existing partnerships in order to carry on the current organizational structures. The DDASS general approval shows they have considered the agreement process significant, as far as sharing information for addiction care and improving partnership are concerned. Half of them even claim agreements have given them the opportunity to set up new dialogues.

Despite central administrations and local services joining their forces, the continuity and similarity principle between care inside prison and that outside has not been acknowledged yet in a significant number of institutions. In many prisons the availability of services for drug users is extremely limited, although examples of good practice do exist. The official note has encouraged services to give a better description of the needs and to formalize a care process in unison, but it has not met the requirements for a radical change, when collaboration was challenging. Obviously the best interests of prisoners and the public are likely be served through stronger and more robust partnerships with agencies and interest groups outside prison. Given that most imprisoned offenders are released after relatively short periods of confinement, custody would best serve the public by being more supportive and empowering, thereby embracing public health principles and practices. However, this implies far reaching

changes in the management of offenders. These persisting structural difficulties (relating to both collaboration between services and management) must be related to the operational restrictions of the care system, which is supported by sanitary teams shortened by psychiatric staff deficiency, in a comparable way to what can be observed outside prisons.

The survey also echoes expectations expressed by contributors in penal context, when it comes to unambiguous directions from central authorities, which could restate governmental orientations as stipulated in the August 9th, 2001 Note. Personnels appeal to be provided with a common training among sanitary, penal and social contributors. Eventually a strong request for additional means is becoming clear, for the UCSA and in psychiatry, where staff deficiency crisis may increasingly affect the delivery of health care.

The results of this survey allow reasserting the role of central authorities as far as communication, activities and training are concerned, to carry on joining together teams around a public reasoning brought up to date, legible and focused upon desirable steps forward. For instance, it seems crucial to keep on encouraging the good practices of substitution, by attempting to bridge the gaps observed in professional habits. The ongoing evaluation of the Governmental Plan for the Fight Against Illicit Drugs, Tobacco and Alcohol (2004-2008) should give the opportunity to achieve a new inventory in line with all these targets.

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For more information

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[2] Note interministérielle DGS/DHOS/DAP/MILDT du 9 août 2001 relative à l'amélioration de la prise en charge sanitaire et sociale des personnes détenues présentant une dépendance aux produits licites ou illicites ou ayant une consommation abusive.

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