2017

Prison workbook

France

2017 National report (2016 data) to the EMCDDA by the French Reitox National Focal Point

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Table of Contents

T0. Summary

Please provide an abstract of this workbook (target: 500 words) under the following headings:

- National profile
  - Summary of T.1.1: Provide core data on prison system: number of prisons and of prisoners, trends.
  - Summary of T1.2.1: please describe drug use among prisoners prior to imprisonment and drug use inside prison;
  - Summary of T1.2.2 : please describe risk behaviour and health consequences among prisoners before and in prison;
  - Summary of T.1.3: please provide a summary of the main forms of drug supply in prison;
  - Summary of T1.3.1: refer to policy or strategy document at national level deals with drug-related prison health;
  - Summary of T1.3.2: please refer to the ministry (or other structure) in charge of prison health and describe role of external (community-based) service providers (if any);
  - Summary of T1.3.3: please describe the types of drug-related health responses available in prisons in your country and if possible the scale of provision in terms of coverage and capacity.

As of 1st January 2016, France had 187 prison establishments with a total operational capacity of 58,561. With 66,678 inmates, there are 114 inmates for every 100 beds in France. Studies conducted about a dozen years ago demonstrated that one third of new inmates stated prolonged, regular use of illegal drugs in the year prior to entering prison. Nearly 11% of inmates stating that they used illegal drugs on a regular basis used multiple substances prior to their imprisonment. 10% of inmates were addicted, but the total number of problem drug users (PDU) in prison settings is not quantified in France. Injecting appears to be fairly widespread among new inmates: in the year prior to imprisonment, this concerned 2.6% in 2003. Limited studies provide data on use in prisons. The only recent surveys on the subject merely provide preliminary data. Inmates have greater rates of infectious disease than the general population: although declining, HIV infection prevalences vary, depending on the source, from 0.6% to 2.0% (three to four times the prevalence in the general population), while prevalences of HCV are from 4.2% to 6.9% (four to five times higher).

Since 1994, the Ministry of Health is responsible for health in prisons and the treatment of addiction in prison settings is based on a three-tiered system: prison-based hospital healthcare units (UCSAs - now called health units in prison setting: USMP), which are responsible for monitoring the physical health of inmates; Regional Medico-Psychological Hospital Services (SMPRs) established in each French regions handle the mental health aspects of drug addicts in establishments where no national treatment and prevention centre for addiction (CSAPA) for prison exist, and finally, CSAPAs for prison have been established in the 16 largest establishments in France (and cover approximately a quarter of the incarcerated population). Furthermore, a reference CSAPA is appointed for each prison so as to offer support for inmates with addiction problems, particularly after their release.

To guarantee the application of harm reduction measures, two main ways of preventing the spread of infectious diseases have been implemented in prison settings since 1996. First, inmates receiving OST must not only be able to continue their treatment in prison, but should also be able to initiate treatment if they wish. In addition to substitution, prison establishments offer prevention and decontamination tools for fighting against HIV and hepatitis's.

Since 2009, different laws have proposed to step up harm reduction measures in prison. The main lines of improvement concern the increased scope and role of the reference CSAPA, routine implementation of screening tests, and widespread access to all existing harm reduction measures, including needle and syringe exchange programmes. These objectives are reasserted in the 2016 health reform law. Its implementing decree is planned for late 2017, early 2018.

- New developments
  - Summary of T3: please describe the most recent developments in drug use (including NPS), and drug related interventions in prison

The report on the evaluation of interdepartmental policies on the integration of individuals placed in the hands of the prison authorities by the legal authorities, published in July 2016, issued a number of recommendations on the reintegration of inmates displaying addictive behaviour:

- the increasing number of alternative programmes to custody in the event of offences related to addictions based on the Bobigny system model.

- The development of treatment units in custody committed to fighting addictions similar to existing programmes abroad, based on the drug user rehabilitation unit (URUD) that has been implemented experimentally in one prison with the OFDT in charge of its evaluation.

- the routine implementation of a treatment and follow-up programme following custody, for all individuals suffering from addictions.

T1. National profile

T1.1 Organization

The purpose of this section is to

- describe the organisation of prisons and the prison population, in general, regardless drug use and related problems

Please structure your answers around the following question.

T1.1.1 ***Optional****. Please provide a short overview of prison services in your country: relevant topics here could include: number of prisons, capacity, & differing inmate profile (type offence, gender, age).*

Please note that SPACE statistics, which provide the statistics on the prison population in Europe (http://www3.unil.ch/wpmu/space/space-i/annual-reports/), will be used to complement this information.

Description du système pénitentiaire

As of 1st January 2016, France had 187 prison establishments (Sous-direction de la statistique et des études 2016) with a total operational capacity of 58 561. These establishments include:

- 86 remand centres and 45 remand wings (located in penitentiaries) holding pre-trial detainees (remand inmates), inmates with less than one year of their sentence left and newly convicted inmates awaiting transfer to another prison setting (detention centre or high security prison);
- 94 prisons for convicted inmates (with several wings), i.e.:
  - 50 penitentiaries including at least two wings for inmates of a different detention status (remand centre, detention centre and/or high security);
  - 27 detention centres and 39 detention centre wings holding those convicted adults with the best prospects for reintegration. Their detention programme is chiefly aimed at “re-socialising” inmates;
  - 6 high security prisons and 8 high security wings for the most difficult inmates;
  - 11 semi-custodial centres and 14 semi-custodial wings housing convicted offenders who have been referred there by a judge responsible for the execution of sentences with an outside placement without monitoring or an open prison regime, and 9 resettlement prison wings, which are located in penitentiaries;
- 6 penal establishments for minors, which are provided for in the French law of September 2002 on the orientation and programming of the justice system [Loi n°2002-1138 d'orientation et de programmation pour la justice]. And 46 wings for minors located within prison establishments.
- 1 national public health establishment located in Fresnes (thus falling within the scope of the Ministry of Health), open to inmates (defendants and convicted inmates) presenting somatic and/or psychiatric disorders.

According to data from prisons administration directorate, the prison population in France consists of nearly 80% convicted inmates, with 14.7% of them for a drug-related offence (DLO) i.e. an offense linked with drug use, drug possession and resale or drug trafficking. They are almost exclusively males (97%).

T1.2 Drug use and related problems among prisoners

The purpose of this section is to provide a commentary on the

- Prevalence and patterns of drug use and the related problems among prisoners
- Numerical data submitted in the relevant parts of ST 12, ST 9, TDI

Please structure your answers around the following questions.

T1.2.1 Please comment on any recent studies that provide information on prevalence of drug use (please specify substance covered and provide links if available). Structure your answer under the headings:
- Drug use prior to imprisonment
- Drug use inside prison

Drug use prior to imprisonment

Studies conducted about a dozen years ago by the DREES (Directorate for research, studies, assessment and statistics of the Ministry of Health) on drug use among inmates demonstrated that one third of new inmates stated prolonged, regular use of illegal drugs in the year prior to entering prison: cannabis (29.8%), cocaine and crack (7.7%), opioids (6.5%), misused medications (5.4%), other substances (LSD, ecstasy, glues, solvents: 4.0%) (Mouquet 2005). Nearly 11% of inmates stating that they used illegal drugs on a regular basis used multiple substances prior to their imprisonment. 10% of inmates were addicted [1] (Falissard *et al.* 2006) : this proportion increased to 40% of inmates who had been incarcerated for less than six months (Duburcq *et al.* 2004). However, it remains difficult to precisely quantify this phenomenon since it is difficult to interpret the conditions of admission to the prison setting.

Drug use inside prison

Imprisonment rarely means discontinuing use: all substances smoked, snorted, injected or swallowed prior to imprisonment continue to be used (albeit in reduced proportions) during imprisonment (Rotily 2000).

Detention is otherwise marked by a transfer of use from illegal drugs (which are less available) to medicines (Stankoff *et al.* 2000). Finally, an unspecified proportion of inmates begin using illegal substances or misused opioid substitution medications during their imprisonment. Misuse of medicines/prescription drugs is probably a growing phenomenon and is seen more in prisons for women than for men (Marais-Gaillard 2007).

Some recent surveys provide preliminary data quantifying substance use. A recent thesis (D'almeida *et al.* 2016) estimates that 8 out of 10 inmates smoke while in prison (tobacco and/or cannabis). According to the results of a preliminary study on the analysis of sewage outlets from three French prisons, conducted by the OFDT (Néfau *et al.* 2017), cannabis use appears to be widespread in a prison setting: apparently between 0.7 and 2.8 joints per day per inmate. The quantities used daily in prisons appear to be up to three times higher compared to the general population, even when taking into account intake by all users in prison. Conversely, heroin and cocaine use is said to be marginal (cocaine possibly representing 1 to 4 doses per 1000 inmates). Lastly, the proportions of medications (OST and benzodiazepines) observed corresponded to the doses prescribed by the healthcare units, thus validating the results obtained for other substances. These results should, however, be interpreted with caution insofar as the samples only concern a very limited number of institutions. Other samples, over longer periods and from other institutions, are currently being taken and will thus provide more robust information on use in a prison setting.

The total number of problem drug users (PDU) in prison settings is not quantified in France.

[1] According to the DSM IV criteria.

T1.2.2 Please comment on any studies that estimate drug-related problems among the prison population. If information is available please structure your answer under the following headings
- Drug related problems – on admission and within the prison population
- Risk behaviour and health consequences (please make specific reference to any available information on data on drug related infectious diseases among the prison population)

Drug related problems

Although it is known that illegal drugs are available in French prisons, it is difficult to define the magnitude of the problem. The sparse official information available on the subject goes back to the beginning of 2000s: 75% of French penal establishments were subject to drug trafficking (Jean and Inspection générale des services judiciaires 1996). In 80% of cases, the illegal substance seized was cannabis, a prescription drugs was confiscated in 6% of cases, and heroin or another drug in the rest (Senon *et al.* 2004).

Risk behaviour and health consequences

Regardless of whether initiated or continued in prison, narcotics use can seriously affect the health of the inmates by generating serious abscesses, accidents when combining medicines and other substances, severe and longer cravings, and the onset or worsening of psychological or psychiatric disorders (Obradovic *et al.* 2011). Moreover, detainees constitute a population group with numerous, cumulative risk factors considering the health and social consequences of drug use. The low levels of access to care for this population group, and more fundamentally, the unstable and marginal situations often faced before incarceration (including a lack of stable housing or social security coverage) all contribute to explaining the prevalence of “at risk” use behaviour among new inmates.

The prevalence of injection is high in prisons, even though the number of injecting drug users seems to be declining among new inmates. This concerned, in the year preceding imprisonment, 6.2% of new inmates in 1997 (Mouquet *et al.* 1999) ; this figure was only 2.6% in 2003 (Mouquet 2005). According to studies, between 60 and 80% of inmates stop injecting during their imprisonment (Stankoff *et al.* 2000). The remaining 20 to 40% who carry on injecting tend to reduce the frequency of their injections but increase the quantities injected. They also tend to be more often HIV- and/or HCV-infected, with a high risk of contamination from shared equipment, unprotected sex and tattooing (Rotily *et al.* 1998). 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 shown by the data of the Coquelicot survey in 2004.

Inmates have greater rates of infectious disease than the general population (DGS 2011; DHOS 2004; Sanchez 2006) : although declining, HIV infection prevalences vary, depending on the source, from 0.6% to 2.0% (three to four times the prevalence in the general population (InVS 2009)), while prevalences of HCV are from 4.2% to 6.9% (four to five times higher (DHOS 2004; Meffre 2006; Remy 2004; Semaille *et al.* 2013)). In people receiving opioid substitution treatment, these prevalences are even higher, both for HIV (3.6%) and HCV (26.3%), since drug use is the most frequent contamination route (70%).

The psychosocial risks related to narcotic use in prison are also high. The resulting trafficking is said to be a genuine source of violence between inmates, resulting in gangland killings, threats, and extortion (Canat and Gales 2012; Chantraine 2004; Fernandez 2010).

T.1.2.3 Please comment on any recent data or report that provide information on drug supply in prison (for example on modus operandi)

The literature on prison sociology describes bartering of psychoactive substances and medications diverted from their use as being omnipresent in French prisons. Surveys specifically focusing on the supply of drugs in a prison setting are, however, rare and out of date. Bartering is thought to be part of a wider network of transactions and is said to involve 50% of the inmate population (Jean *et al.* 1996). Cannabis is thought to be the most widely distributed substance, accounting for 80% of substances seized in French prisons, far ahead of medications (6%). Drugs are mainly thought to enter prisons via visiting rooms (47%) (Jean *et al.* 1996), reimprisonment (11.5%), return from leave (12%), packages thrown over prison walls and post. Furthermore, bartering is thought to be organised based on a "lookout" system managed by inmates, and takes place in geographical spaces not under surveillance (Jean *et al.* 1996). Walks and " yoyos[1]" are also said to be preferred spaces and methods (Chantraine 2004) for exchanging substances. The most common bartering currency is thought to be haircuts, psychoactive medicines and other goods and services (Chantraine 2004).

The strategies adopted by healthcare and prison staff in response to the influx and bartering of drugs were perceived to be partial in the early 2000s, varying according to the institutions (Jean *et al.* 1996; Obradovic 2005; Pradier 1999). Measures adopted by the prisons were mainly disciplinary in nature (disciplinary committees in 93% of cases, followed by disciplinary penalties in 95% of cases) (Jean *et al.* 1996). The public prosecutor's department made judgements in only 41% of cases. Prison healthcare units also adopted solutions to limit the misuse and bartering of psychoactive medicines (Obradovic 2005). These varied considerably, raising disagreements and profound ethical conflicts between professionals. Some freely adopted disciplinary approaches along the lines of reducing the prescribed doses, raising questions as to the equality of inmates with respect to health care compared with the general population. Others, not wishing to discriminate against the inmate population, are accused of adopting a more resigned attitude.

These studies nonetheless have undeniable limitations insofar as they are somewhat outdated. The Circé (CIRculation Consumption Exchange: drugs in the prison setting) survey is currently conducted by the OFDT with funding from the Ministry of Justice. The initial results which are expected by 2018, should enable these findings to be updated.

[1] Exchanges between inmates through windows, generally on different floors.

T1.3 Drug-related health responses in prisons

The purpose of this section is to

- Provide an overview of how drug-related health responses in prison are addressed in your national drug strategy or other relevant drug/prison policy document
- Describe the organisation and structure of drug-related health responses in prison in your country
- Comment on the provision of drug-related health services (activities/programmes currently implemented)
- Provide contextual information useful to understand the data submitted through ST24/ST10

Please structure your answers around the following questions.

T1.3.1 Is drug-related prison health explicitly mentioned in a policy or strategy document at national level? (Relevant here are any drug-specific health strategy for prisons; as well as the national drug or prison strategy documents).

The 2010-2014 “health/prison” strategic actions plan on health policy for inmates (Ministère de la santé et des sports and Ministère de la justice et des libertés 2010) stipulated acting on inmates' health determinants (practices exposing them to a risk for infection) and making screening programmes available for inmates. It provided for the establishment of suitable harm reduction measures that can be applied in prisons to remedy the shortcomings observed in France: these measures included distributing bleach with instructions for use, providing access to condoms, taking into consideration the infection risk of certain behaviours (e.g., snorting, tattooing, injections), providing access to sterile drug-use related harm reduction equipment, providing access to Fibroscan® (a non-invasive machine that can instantly detect liver fibrosis and assess its degree of advancement) testing in prison, improving prevention measures (inviting professional tattoo artists to prisons) and screening (developing screening during incarceration). Furthermore, a reference national treatment and prevention centre for addiction (CSAPA) is appointed for each prison so as to offer support for inmates with addiction problems, particularly after their release from prison. The reference CSAPAs have a half full-time equivalent worker to coordinate continuity of care. Credits are distributed according to the inmate population and density within the institutions.

The strategies of this plan are to improve treatment and bolster the objectives of the 2009-2012 national viral hepatitis strategic plan (DGS 2009) which defines a general framework for actions in prison settings, limiting itself to encouraging new inmates to undergo screening for hepatitis and assessing the Health/Justice memorandum of 9 August 2001 [Note interministérielle MILDT/DGS/DHOS/DAP n°474 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].

With a view to a future plan, an evaluation of the 2010-2014 "health/prison" plan was carried out by the departments of the Ministries of Health and Justice (Branchu *et al.* 2015). It emphasises the fact that the actions are to be conducted with a view to reducing health-related harm due to narcotic use (coordinated with the Government action plan against drugs) and that "all resources of the harm reduction measures, henceforth including syringe exchange programmes […] must be mobilised". Furthermore, besides the coverage of the reference CSAPA, currently approaching completion (75% of establishments currently present), "the challenge resides in adapting CSAPA interventions to the prison setting".

The 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours (MILDT 2013) sets forth specific health objectives for inmates:

- To strengthen the reference CSAPA by drawing up a guide and by presenting these facilities during prison health conferences;
- To develop action-research on screening activities for individuals in custody;
- To support the development of a health data collection application for new inmates;
- To organise the coordination of health workers in a prison, legal and association context, led to care for individuals referred by the justice system.

Furthermore, the health system reform law of 26 January 2016 has also reasserted the need for the diffusion of harm reduction measures in the prison setting [Loi n° 2016-41 du 26 janvier 2016 de modernisation de notre système de santé]. Article 44 reiterates the need to offer inmates a health assessment on the use of narcotic substances, psychoactive medicines, alcohol and tobacco, stating that this should be performed from the start of imprisonment. The implementing decree for this law is still pending.

T1.3.2 Please describe the structure of drug-related prison health responses in your country.
Information relevant to this answer includes: ministry in charge; coordinating and implementing bodies/organizations; relationship to the system for community-based drug service provision.

The law of 18 January 1994 [Loi n°94-43 relative à la santé publique et à la protection sociale] created the health care system as it stands today in the prison setting, based on the specialisation of services. It makes the public hospital service responsible for treatment. On the one hand, outpatient care is provided within the prison setting in specially dedicated units: prison-based hospital healthcare units (UCSA, now prison-based healthcare units: USMP) and psychiatric treatment units (regional medical/psychological services - SMPR), which offer outpatient hospital beds. The 16 prison-based CSAPA (former "drug addiction units" established since 1987) operate in connection with the USMP and SMPR. They cover approximately a quarter of the inmate population. In 2000, the interministerial legislative order of 24 August provided for the creation of secure inter-regional hospital units (UHSI) to provide somatic therapy [Arrêté relatif à la création des unités hospitalières sécurisées interrégionales destinées à l'accueil des personnes incarcérées]. Ten years later [Arrêté du 20 juillet 2010 relatif au ressort territorial des unités spécialement aménagées destinées à l'accueil des personnes incarcérées souffrant de troubles mentaux], specially equipped hospital units (UHSA), providing psychiatric care, were created. Certain inmates wishing to remain drug free can be hospitalised in these UHSA with the agreement of the medical team and after giving their consent. However, treatment of these individuals in the UHSA is not an approach prioritised by professionals, and treatment activities specifically intended for the management of addictive behaviours are practically non-existent (Protais 2015).

The methodological guide on the medical treatment of inmates (Ministère de la justice and Ministère des affaires sociales et de la santé 2012) describes a few changes which will be gradually implemented. It adopts a three-tiered approach, besides the specialist fields of the different services, based on the proposed treatments: level 1 includes appointments, and outpatient activities and services; level 2, treatment requiring part-time management (alternative to complete hospitalisation); and lastly, level 3 includes treatment requiring full-time hospitalisation. (By differentiating between outpatient management and part-time care, the current USMP are associated with level 1, like the CSAPA operating in a prison setting, whereas the SMPR belong to levels 1 and 2. The UHSA and UHSI belong to level 3).

At the same time, the legal framework of the prison harm reduction scheme also offers various possibilities for providing access to care for drug addicted inmates since the circular of 5 December 1996 [Circulaire DGS/DH/DAP n°96-739 relative à la lutte contre l'infection par le virus de l'immunodéficience humaine (VIH) en milieu pénitentiaire : prévention, dépistage, prise en charge sanitaire, préparation à la sortie et formation des personnels] :

- Screening for HIV and hepatitis is theoretically offered upon arrival (CDAG - Anonymous Free Screening Centre) but is not systematic for hepatitis C (POPHEC - First hepatitis C prison's observatory - data).
- Prophylactic measures (hygiene measures and the provision of post-exposure treatments for both staff and inmates).
- Availability of condoms with lubricant (theoretically accessible via USMPs).
- Access to OSTs and the availability of bleach to disinfect equipment in contact with blood (injection, tattooing and body piercing equipment).

This text has been updated by the 2012 Methodological Guide mentioned above. (see also section T1.4.1 below)

T1.3.3 Please comment on the types of drug-related health responses available in prisons in your country and if possible the scale of provision in terms of coverage and capacity.
Information relevant to this answer could include: health screening at prison entry, including assessment of drug use and related problems (specify rules and deadlines, approach of drug use assessment, such as use of standardise tools, medical or other staff involved; availability of treatment (psychosocial / counselling / pharmacological-assisted), OST in prison (initiation and/or continuation and requirements for continuation; treatment regimens, including dosage; collaboration with external providers; registration, coverage of drug users prisoners), harm reduction interventions (including syringe distribution), overdose prevention training and naloxone (in prison or on release), testing, vaccination and treatment of infectious diseases & referral processes to external services on release.

To prevent the health problems and the spread of drug use-related infectious disease, both of which are aggravated by the prison overpopulation problem, newly-arrived inmates are screened to determine their drug use-related health problems. Upon their arrival in prison, all inmates are offered a medical visit provided by a prison-based hospital healthcare unit. The screening includes, along with tuberculosis testing, a voluntary, free HIV test and, more recently, screening for hepatitis C as well as a hepatitis B vaccination. The PREVACAR survey conducted in 2010 (DGS 2011) showed increasingly higher rates of infectious disease screening in the last decade.
To guarantee the application of harm reduction measures, now embodied in legislation[1] [Loi n°2004-806 du 9 août 2004 relative à la politique de santé publique], and then reaffirmed in the 2016 law on health system reform [Loi n°2016-41 du 26 janvier 2016], two main ways of preventing the spread of infectious diseases have been implemented in prison settings since 1996. The 5 December 1996 circular [see T1.3.2 above] first and foremost stipulates access to OST in prison: inmates receiving OST must not only be able to continue their treatment in prison, but should also be able to initiate treatment if they wish, and especially buprenorphine therapy. Since 2002, methadone OST can also be initiated. There is no medicalised heroin programme in prison, like outside of prisons. However, in practice, not all penal establishment offer generalised access to all available treatments (Michel *et al.* 2011). In 2010, a few establishments only offered one type of treatment: buprenorphine only was offered 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 stated that they did not have a formalised procedure.

Based on the more recent PREVACAR (Chemlal *et al.* 2012; DGS 2011) and PRI^{2}DE (Michel *et al.* 2011) surveys, 8% to 9% of detainees, or 5,000 individuals, receive OST. The prevalence of OST use is highest in women and in remand centres. Buprenorphine appears to be clearly predominant (68.5% of OST prescribed in prison in 2010), although the proportion of methadone in OST is tending to increase (from 15.2% in 1998 to 31.5% in 2010). A recent survey (Carrieri *et al.* 2017) moreover showed that switching from buprenorphine to methadone could significantly reduce drug-related offences (namely the purchase and sale of narcotics), along with imprisonment levels.

In addition to substitution, prison establishments offer prevention and decontamination tools for fighting against HIV: in accordance with the recommendations of the Gentilini report (Gentilini and Tcheriatchoukine 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 the Health-Justice circular of 5 December 1996 [see T1.3.2 above] and since the Health/Justice memorandum dated 9 August 2001 [Note interministérielle n°474 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], prison administrations have been encouraging health personnel to inform inmates on how to use bleach as a product to disinfect injection equipment. The legal measures implemented by the 5 December 1996 directive to fight against the spread of HIV also stipulate making NF-compliant condoms available free of charge with lubricants (theoretically obtainable through prison-based hospital healthcare units): inmates 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 staff as well as for inmates. Subsequently, for injecting drug users, the only current way to protect themselves against AIDS, other than through 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 acceptable in eliminating HIV: however, it has been established that these measures are not sufficiently effective in combating the

hepatitis C virus (Crofts 1994). Inmates have access to bleach, but it is not systematically distributed and is, in most cases, not accompanied by useful harm reduction information (INSERM 2010). 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 ("New equipment for each injection").

In contrast to the situation outside prisons, support for drug users is limited in the prison setting (counselling, peer education, primary health care) and access to sterile injection equipment (alcohol wipes, bottles of sterile water, sterile containers "cookers", sterile syringes), which has been authorised in the general population since 1989, is absent from all prison settings.

France does not offer syringe exchange programmes in prisons. This was considered a "premature" initiative by the Health-Justice mission of 2000 before becoming the subject of new recommendations within the scope of the INSERM collective expert evaluation conducted in 2010 (INSERM 2010). As regards syringe exchange programmes, an implementing decree on the health system reform law should enable them to be introduced in a prison setting so as to achieve equivalent harm reduction measures as the non-prison environment (Branchu *et al.* 2015).

[1] 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 intravenous drug overdose 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 French government (art. L. 3121-3).

T1.3.4 Please comment any contextual information helpful to understand the estimates of opioid substitution treatment clients in prison provided in ST24.

The prevalence of individuals receiving OST is estimated based on the PREVACAR study, a cross-disciplinary study on a random sample. Hence, there may be a number of double entries for individuals having been in prison and having been followed up by a CSAPA/general practitioner for their treatment at release (and vice versa). This particularly concerns reporting data from healthcare units which have endeavoured to comply with best practices, overestimating the proportion of individuals receiving OST.

T1.3.5 ***Optional****. Please provide any additional information important for understanding the extent and nature of drug-related health responses implemented in prisons in your country.*

Two programmes aiming to prevent the psychoactive substances use in prisons and their consequences (health-related but also in terms of violence) are being launched in 2016. The first is initially intended for the inmates themselves via a programme streamed on the internal video networks in the prisons, and focusing on cannabis use. The second action concerns the misuse of psychotropic medications, thanks to information brochures intended for inmates and their associates (see T1.2.1 of the 2016 Prevention workbook).

T1.4 Quality assurance of drug-related health prison responses

The purpose of this section is to provide information on quality system and any drug-related health prison standards and guidelines.
Note: cross-reference with the Best Practice Workbook.

Please structure your answers around the following question.

T.1.4.1 ***Optional****. Please provide an overview of the main treatment quality assurance standards, guidelines and targets within your country.*

A first guide to the health care treatment of inmates was distributed in 1994 to prison system health workers. This guide was updated for the first time in 2005 (Ministère de la santé et de la protection sociale and Ministère de la justice 2004). The interministerial circular of 30 October 2012 [Circulaire interministérielle n°2012-373 relative à la publication du guide méthodologique sur la prise en charge sanitaire des personnes placées sous main de justice] updated this guide (*Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues* : Methodological guide on the health care of detainees (Ministère de la justice *et al.* 2012). In its outline, the guide reiterates the current principles of the treatment offered to inmates and persons in detention, both physical and psychiatric, in compliance with the 2010-2014 "health/prison" strategic actions plan"(Ministère de la santé et des sports *et al.* 2010). The risk of fatal overdose in former inmates was more than 120 times that of the general population (Prudhomme *et al.* 2001; Verger *et al.* 2003).

The guide specifies that the modalities for release need to be planned sufficiently early, before the definitive release date. However, in practice, the tools of the current system are often insufficient: in addition to the problems accessing care during imprisonment (especially due to overpopulation), there are difficulties finding housing and continuity of care following release, especially in remand centres.
Furthermore, the guide offers a framework agreement for field workers to ensure that inmates take advantage of their social rights. Other framework documents are also enclosed within the guide, such as useful references on treating minors.

The *Guide des traitements de substitution aux opiacés en milieu carcéral* (Guide to Opioid Substitution Treatments in prison settings) (Ministère des affaires sociales et de la santé and MILDT 2013) recommends daily supervised methadone dispensing, including on weekends and on holidays, to prevent overdose risk. But this recommendation seems difficult to systematically apply given the lack of health personnel described by professionals working in prison settings.

T2. Trends (Not applicable for this workbook.)

T3. New developments

The purpose of this section is to provide information on any notable or topical developments observed in drug-related issues in prisons in your country **since your last report.**
T1 is used to establish the baseline of the topic in your country. Please focus on any new developments here.
If information on recent notable developments have been included as part of the baseline information for your country, please make reference to that section here. It is not necessary to repeat the information.

Please structure your answers around the following question.

T.3.1 Please report on any notable new or topical developments in drug-related issues in prisons in your country since your last report examples, NPS prevalence and responses in prison.

On 6 May 2015, the Prime Minister convened the Inspectorate-General of Judicial Services, the interministerial audit and evaluation office for social and health, employment and labour policies (IGAS), and the Inspectorate-General of Finance to evaluate interministerial integration policies for individuals placed in the hands of the prison authorities.

The conclusions of this study were published in July 2016 (Delbos *et al.* 2016). Several recommendations relate to the reintegration of inmates displaying addictive behaviour, the main three being as follows:

- the increasing number of alternative programmes to custody in the event of offences related to addictions based on the Bobigny system model[2].
- the development of treatment units in custody committed to fighting addictions similar to existing programmes abroad, based on the drug user rehabilitation unit (URUD) that has been implemented experimentally in one prison with the OFDT in charge of its evaluation.
- the routine implementation of a treatment and follow-up programme following custody, for all individuals suffering from addictions.

T4. Additional information

The purpose of this section is to provide additional information important to drug use among prisoners, its correlates and drug-related health responses in prisons in your country that has not been provided elsewhere.

Please structure your answers around the following questions.

T4.1 ***Optional****. Please describe any additional important sources of information, specific studies or data on drug market and crime. Where possible, please provide references and/or links.*

Two studies, conducted a few years ago, will enter a new one-year phase, the results of which are expected in 2017-2018. This concerns the second phase of the PRI[2]DE survey (see T5.2 for the description of the first survey), which aims to study the acceptability of harm reduction measures among health workers in the prison setting, prison staff and inmates.
In addition, the Coquelicot survey will be made available in the prison setting to determine the prevalence of HIV and HCV, together with patterns of use in prisons.

Furthermore, the qualitative CIRCE (CIRculation Consumption Exchange: drugs in the prison setting) survey, jointly managed by the OFDT, aims to shed light on the way in which inmates fall into drug use, together with the trafficking mechanisms for psychoactive substances in a prison setting. The results are expected in 2018.

T4.2 ***Optional****. Please describe any other important aspect of drug market and crime that has not been covered in the specific questions above. This may be additional information or new areas of specific importance for your country.*

T5. Sources and methodology.

The purpose of this section is to collect sources and bibliography for the information provided above, including brief descriptions of studies and their methodology where appropriate.

[2] Inspired by drug addiction treatment programmes established in Quebec, the experimental programme in Bobigny has been in operation since May 2015. This is intended for persistent offenders with alcohol or narcotic addiction problems. This system proposes sentence postponement comprising stepped-up psychological and social follow-up for a period of 1 year. The court may then reassess the sentence based on how the person has changed.

T5.1 Please list notable sources for the information provided above.

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T5.2 Where studies or surveys have been used please list them and where appropriate describe the methodology.

Methodology

Analysis of samples obtained from prison wastewater

Prisons administration directorate (DAP) of the Ministry of Justice / National Center for Scientific Research (UMR 8079 - Paris Sud University) / French Monitoring Centre for Drugs and drug Addiction (OFDT)

A study on the analysis of illegal drug residues obtained from prison wastewater was conducted in 2015. This primarily involved a feasibility study to identify the difficulties in obtaining wastewater samples from closed settings such as prisons.

At the end of this study, a few samples were taken and analysed; however, unless sampling is repeated in each prison, the results obtained are not sufficient to estimate drug use. However, as feasibility has been established, new sampling campaigns will take place in 2016 and 2017. The results thus obtained will make it possible to estimate the use of drugs and certain medications in the prison settings studied. Furthermore, declaration-based surveys should be conducted within the same establishments and over the same periods, so as to narrow down and compare the results of the two approaches.

For further reading please see the OFDT memo published in March 2017: Analysis of drugs in sewage: an approach to assess substance use, applied to a prison setting.

ANRS-Coquelicot 2017: Study on use practices and the perception of harm reduction measures among drug users in a prison setting

National Institute for Health and Medical Research (Cermes3-Inserm U988) and Santé Publique France (SPF)

This study aims to determine drug use among drug users in a prison setting via a face-to-face questionnaire. The study focuses on users' perceptions of harm reduction measures, use practices (substances and routes of administration), treatment in a health setting, knowledge of transmission modes for HIV, HCV and HBV, and at-risk practices (e.g., context in which they first used drugs, sharing of equipment, use of condoms, etc.).

The survey will be carried out in different prison settings in France between September and December 2016. The results are expected in 2017.

CIRCE: CIRculation, Consumption, Exchange: drugs in the prison setting

French Monitoring Centre for Drugs and Drug Addiction (OFDT) / French National AIDS and hepatitis research agency (ANRS) / Prisons administration directorate (DAP)

This is an interview-based qualitative survey aiming to study the way in which inmates are led to use psychoactive substances (alcohol, illegal substances, psychotropic medications), the implementation of harm reduction measures, together with the trafficking phenomenon in the prison setting. This is presented in two sections: the first, mainly health-based, concerns drug use and harm reduction measures; the second concerns circulation and exchanges of psychoactive substances in the prison setting.

Health survey on new prison inmates
French Directorate for Research, Studies, Assessment and Statistics (DREES) of the Ministry of Health

This survey was conducted for the first time in 1997 in all remand centres and remand wings within prison settings. The last survey was conducted in 2003. It collects information during the admission medical visit about risk factors for the health of entrants as well as observed pathologies, which are mainly identified from ongoing treatments. Declared use of psychoactive substances included daily smoking, excessive alcohol consumption (more than 5 glasses per day) and “prolonged regular use during the 12 months before imprisonment” of illegal drugs.

PREVACAR: Survey on HIV and HCV prevalence in prison settings
National Health Directorate (DGS) / Santé Publique France (SPF)

Conducted in June 2010, this survey determined the prevalence of HIV and HCV infection and the proportion of people receiving opioid substitution treatment (OST) in prison settings. The survey also comprises a section on health care delivery in prison settings: screening organisation and practices, treatment of HIV- and hepatitis-infected individuals, access to OSTs and harm reduction.
For the "prevalence" section, data were collected through an anonymous questionnaire completed by the supervising physician. For the '"health care delivery" section, a 35-item questionnaire was sent to all 168 prison-based hospital healthcare units (UCSA): 145 of them sent them back to the National Health Directorate (DGS), (86% response rate), representing over 56,000 inmates, or 92% of the incarcerated population, on 1st July 2010.

PRI²DE: Research and intervention programme to prevent infection among inmates
French National AIDS and Hepatitis Research Agency (ANRS)

This study was designed to assess infection harm reduction measures to be established in prison settings. It is based on an inventory whose purpose is to reveal the availability and accessibility of infection harm reduction measures officially recommended in French prisons, as well as the inmates' and health care teams' awareness of these measures. To do this, a questionnaire was sent to each UCSA (prison-based hospital healthcare unit) and SMPR (regional medico-psychological hospital services) in November 2009. 66% of the 171 establishments answered the questionnaire, covering 74% of the population incarcerated at the moment of the study.
The questions pertained to, among others, opioid substitution treatments, infection harm reduction measures (e.g., bleach, condoms and lubricants, tattoo and piercing tools or protocols), screening and the transmission of information on HIV, hepatitis and other sexually transmitted diseases, as well as the treatments dispensed following suspected at-risk practices (e.g., abscesses, skin infections). A consultation with a caregiver was then conducted to specify certain, qualitative items.