Prison workbook

2021

France

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As of 1st January 2021, France had 187 prison establishments with a total operational capacity of 60 583. With 62 673 inmates, there are 103 inmates for every 100 beds in France. The situation of penitentiary establishments was strongly impacted by the health crisis of 2020 (see T3). The only recent surveys on the subject merely provide preliminary or partial data because they are not nationwide. However, 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. More recent surveys, conducted in a more localised manner, estimate the proportion of people using cannabis at between 35 and 40%. Quantification of other products leads to very different results depending on the studies. No studies provide data on NPS use in prisons. 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).

The Ministry of Health has been responsible for healthcare in prison since 1994. Health care in prison is made up of prison health units (USMP) which offer somatic and psychiatric care. Psychiatric care units (regional medico-psychological hospital services - SMPR) coordinate and support USMP. They have hospital places for during the day. To treat people presenting with addictive behaviour and the resulting somatic and/or psychiatric symptoms, these units can benefit from working with a CSAPA (specialised drug treatment centre) in a prison environment, located in eleven of the largest institutions in France (representing around a quarter of the imprisoned population) or other addiction care specialists, depending on the local organisations. A reference CSAPA is designated to each prison. Its aims are to help prepare prisoners for getting out and to promote the necessary monitoring of the inmates on their release. In 2017, 201 CSAPA reported that they had worked in a prison, with 11 CSAPA exclusively working in prisons (previously *Antennes-Toxicomanies*, created at the end of the 1980s) and 126 being reference CSAPA. These centres worked in 162 different prisons.

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. Firstly, inmates have to be able to not only continue their opioid substitution treatment (OST) that was prescribed to them before they were imprisoned but to also start such a treatment if they so desire. 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.

- New developments

Around 12 900 inmates received opioid substitution treatment in 2018, representing 7% of those who stayed in a prison setting.

In 2020 and 2021, the outbreak of COVID continued, resulting in two further lockdowns in November 2020 and April 2021. The main measures put in place during the first lockdown were maintained with a few adjustments. It should be noted that the wearing of masks by detainees has been generalised, that visiting hours and group activities have been continued in compliance with barrier measures, and that the traditional healthcare service has been resumed in the healthcare units, despite the fact that therapeutic group activities have not been resumed in most of the prison health units (USMP). However, the exceptional remissions of sentences from the March 2020 lockdown were not extended, resulting in an increase in prison overcrowding.

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

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.*

Overview of prison services in France

As of 1st January 2021, France had 187 prison establishments with a total operational capacity of 60 583 (-0.7%). These establishments include:

- 132 remand centres and 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);
- 65 detention centres and detention wings holding those convicted adults with the best prospects for reintegration or at the end of their sentence. Their detention programme is chiefly aimed at "re-socialising" inmates;
- 13 high security prisons and high security wings for the most difficult inmates;
- 31 semi-custodial centres and 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;
- 53 penal establishments and wings 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];
- 1 reception and transfer unit;
- 4 national assessment centres or similar sections where prisoners are assessed for institutional assignment;
- 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 as of the first of January 2021 consists of nearly 71% convicted inmates, with 17% 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 (96%).

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

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 Directorate for research, studies, assessment and statistics (DREES) 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 (see Table 1). 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. More recent studies were conducted in the 2010s, either in a prison setting (Liancourt) *(Sannier et al*. 2012) or on a regional scale (Picardie) (OR2S 2017). In the last study, 40% of inmates claimed to have taken at least one illegal drug in the 12 months prior to imprisonment, 22% regularly and 18.5% occasionally. Cannabis use concerned 38% of inmates, cocaine/crack use 6%, heroin, morphine or opium use 9%, and diverted psychotropic medicine use 2.7%.

The COSMOS study (Rousselet *et al.* 2019), conducted from 2015 to 2016 on all establishments in the Pays-de-la-Loire region show that the results are more or less consistent with the data collected in the establishments of Liancourt and Lyon-Corbas for cannabis use (see Table 1), but differ significantly for other products (see Table 1). It remains unclear whether these disparities are related to the survey methodologies adopted or to contrasting realities on the ground.

Table 1. Significant self-report surveys of drug use prior to entry into prison

					Consumption of drugs before incarceration							
Survey	**Scope**	**Sample size**	**Types of consultants**	**Method of questionnaire execution**	**Unit of measure-ment**	**At least one drug (excluding tobacco)**	**Cannabis**	**Alcohol**	**Cocaine/ crack**	**Opiates**	**Prescription drugs**	**At least two products**
DREES (2003)	National	6 087	1/13 new arrivals in prison	Statistical processing of files drawn up by the Health Unit for each new arrival	12 months prior to incarceration		29.80%	31.00%	7.70%	6.50%	5.40%	11%
Liancourt Health Unit (2011)	Local on the scale of an establishment	381	All inmates of the penitentiary centre	Self-administered questionnaire in the cell	Not specified: by default, entire life	60%	53%		22% cocaine only?)	18.9% (heroine only)	12.60%	24.40%
ORS Picardie (2015)	Local on the scale of the *Picardie* region	1 938	All new arrivals	Statistical processing of files drawn up by the Health Unit for each new arrival	12 months prior to incarceration	85.50%	37.90%		6.10%	9.30%	2.70%	27.20%
Lyon-Corbas Health Unit (2013)	Local on the scale of an establishment	457	All inmates of the prison	Self-administered questionnaire in the cell				na				
COSMOS (2019)	Local on the scale of the *Pays de la Loire* region	800	All new arrivals and inmates	Administration by a surveyor in a confidential location	12 months prior to incarceration		49%	73%	16.50%	8.9% (heroine only)	3.50%	

Source: compilation produced by the OFDT on the basis of the literature review.
na: data not available.

[1] According to the DSM IV criteria

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). The surveys conducted in the 2010s, at the Liancourt (Sannier *et al.* 2012) and Lyon Corbas (Sahajian *et al.* 2017) prisons, indicate cannabis use in the region of 40%, cocaine use ranging from 7% to 10% and heroin use of around 8% (see Table 2). According to the survey conducted at Liancourt, nearly 7% of inmates reportedly used morphine-based medications for non-medicinal purposes, and nearly 9% non-prescribed benzodiazepines.

The COSMOS study, already mentioned, presents consistent results for cannabis use (see Table 2), but differs significantly for other products, with alcohol, cocaine and heroin use appearing to be very low. (see Table 2).

Table 2. Significant self-report surveys of drug use during incarceration

					Consumption of drugs during incarceration							
Survey	**Scope**	**Sample size**	**Types of consultants**	**Method of questionnaire execution**	**Unit of measurement**	**At least one drug (excluding tobacco)**	**Cannabis**	**Alcohol**	**Cocaine/ crack**	**Opiates**	**Prescription drugs**	**At least two product**
DREES (2003)	National	6,087	1/13 new arrivals in prison	Statistical processing of files drawn up by the Health Unit for each new arrival				na				
Liancourt Health Unit (2011)	Local on the scale of an establishment	381	All inmates of the penitentiary centre	Self-administered questionnaire in the cell	Percentage calculated on the entire number of respondents	43.60%	38.20%		7.10%	8.1% (heroine only)	15.50 %	8.20%
ORS Picardie (2015)	Local on the scale of the *Picardie* region	1,938	All new arrivals	Statistical processing of files drawn up by the Health Unit for each new arrival				na				
Lyon-Corbas Health Unit (2013)	Local on the scale of an establishment	457	All inmates of the prison	Self-administered questionnaire in the cell	Percentage calculated on the entire number of users	83.60%	36.80%	30.40%	10.30%	7.70%	12.30%	57%
COSMOS (2019)	Local on the scale of the *Pays de la Loire* region	800	All new arrivals and inmates	Administration by a surveyor in a confidential location	Percentage calculated on the entire number of respondents		37%	2.10%	1.90%	1.1% (heroine only)	10.40%	

Source: compilation produced by the OFDT on the basis of the literature review.
na: data not available.

With regard to the methods of administration of the products, the survey carried out at the Lyon-Corbas remand prison estimates that among the users of at least one illicit product other than cannabis, the preferred method of administration was sniffing (for 60% of them) and injection (for 30%). The COSMOS survey shows that 3% of respondents report sniffing and less than 1% report injecting. A number of reports and studies have documented altered

methods of use in prison settings: the nasal route is becoming the most common, although injection is likely to persist (Michel 2018; Michel *et al.* 2011; Stankoff *et al.* 2000). Similarly, a few studies and summaries of existing surveys have shown a shift from illicit drugs to medication among some prisoners (Bouhnik *et al.* 1999; INSERM 2010, 2012; Stankoff *et al.* 2000), or even a shift from cocaine/crack and opiate use to cannabis and medications (Protais *et al.* 2019). The survey conducted in Liancourt and the COSMOS study show that between 10 and 15% of respondents use psychotropic drugs outside the prescription framework. The latter shows a clear change in use, with the use of narcotic drugs declining during incarceration while psychotropic drugs taken by prescription or bartered between prisoners are increasing.

Further to a preliminary study conducted in 3 French prisons (Néfau *et al.* 2017), the analysis of prison sewage continued in 2017, at 2 prisons in mainland France and one in an overseas department (Kinani *et al.* 2018). The findings still show the substantial presence of THC, a marker for cannabis use, in the samples. Cannabis use in prison is considerably higher than outside of prison: cannabis is taken on average between 0.5 and 4 times a day per person, which is up to 10 to 20 times the rate observed in the general population. Cocaine and MDMA use observed in custody is similar to the amount used by the general population: cocaine is taken around 10 times on average per 1,000 people and irregularly, depending on the day, as there are few people who use it. MDMA use, observed in mainland France alone, is lower than cocaine use and is also irregular, as MDMA detection in samples is not systematic. Analysis of the alcohol consumption marker has always come back negative. If alcohol is consumed, it is not consumed in sufficient quantities to be detected, amounting to less than 0.5 glasses per person. Methadone, buprenorphine and morphine use were studied at the same time in order to compare them with the dispensing data provided by the institution's pharmacy. The right amount of drugs were seen to have been collected in the two prison settings studied in mainland France. The absence of opioid substitution treatments during the overseas sampling period is consistent with the failure to detect the corresponding molecules in waste water samples.

No figures on the presence of NPS in French prisons are known, although they are found in some European countries where NPS are more widespread (United Kingdom, Germany, Sweden, Baltic countries, etc.) (EMCDDA 2018).

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

Women and minors: two groups that are not well-known

Data on the use in these two specific groups and the status of psychoactive substances in these detention facilities are scarce.

The national epidemiological surveys dating back to the 2000s (see above) are the only data on the issue. The DREES survey of 2003 (Mouquet 2005) provided data on juveniles entering prison: it showed much higher levels of alcohol and cannabis use than in the general population.

Regarding women, the same DREES survey found higher consumption than in the general population. The survey revealed that these consumptions were closer to those of incarcerated men than men in the general population, an element confirmed by the 2015 survey in Picardie, already mentioned. Among the more recent surveys, only the survey carried out in the Picardie region has a focus on women, but its results remain partial: it estimates that 17% of regular drug users, mainly cannabis, are women; the use of other products is not addressed.

On the questions regarding use during incarceration, only the 2004 Mental Health Survey of Incarcerated Persons provides data for women. In this study, 26.5% of them had abuse/dependence on at least one substance (narcotic drugs and psychotropic medicines) and 18.4% on alcohol.

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 in prison

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 figures 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). The Circé survey updates existing data on the organisation of drug trafficking in custody and the responses to it. It confirms that psychoactive substance trafficking is very widespread, particularly in men's prisons. It is reported to play a major role in drug deals, particularly for cannabis, as its use is reportedly becoming more widespread. The survey shows that currently, the two main means used by inmates to introduce banned substances are visiting rooms and by throwing them in the exercise yard. It also reveals that establishing a drug market in custody requires using specific people in specific relationships. Women (girlfriends, mothers, etc.) but also prison officers, physicians in health units, workers and other vulnerable inmates are the main individuals that facilitate drugs being introduced into custody.

The report also examines this market's organisation and the main people involved. Drug deals are part of a larger market consisting of goods, services, cash, digital currency and exchanges, and they are particularly organised based on relationships connecting the people involved in the deal. Therefore the price of substances used is not fixed in prison: it depends on the availability of the substance and the drug dealer's needs, but also on how friendly or hostile relations are between the seller and his customer. While some deals are likely to give rise to rather authentic gifts, others can establish a relationship of power and violence. The survey also shows that the social organisations where trafficking takes place are varied, ranging from organised and hierarchical networks to unorganised trafficking (like for psychoactive medicine). The report also gives credence to the idea of trafficking multiple substances in an increasingly less hierarchical way. It shows that the social organisations where trafficking takes place are varied and that this phenomenon is at the origin of specific prison pathways: from the trafficking organiser, who follows its trajectory in a linear manner in prison, to the "victim" inmate, who goes between being manipulated by networks and protected by prison authorities, as well as the inmate who makes the most of his sentence by bringing in cannabis by his own means, while forging some distant alliances with people involved in trafficking.

Finally, the survey reveals the wide variety of responses from the prison authorities. In addition to penalties, it undertakes preventative security measures (such as improving searches, setting up "anti-projection" nets to prevent inmates from throwing drugs or improving inspection teams carrying out compliance checks, etc.). Interviews also highlight a "laissez-faire" attitude and that prison officers choose how inmates are punished, allowing them to "negotiate peace" with certain inmates. In overcrowded remand centres, supervisors are faced with considerable structural contradictions and so they actually negotiate for "less fear" rather than true "social peace". The survey therefore reveals the ambivalence of an institution that is torn between security orders, which favour tighter control of drug-related acts, and the need to maintain order, which is established through negotiating with certain dominant inmates in custody. The way in which prisons operate also has an impact on the relationship between health unit professionals and inmates. Some health workers report their distress when faced with clients who are particularly prone to trafficking or misusing their prescribed drugs. This results in a general tendency to adapt prescriptions and distribution of medicine drugs, confirming previous work on this issue. Beyond this general level, however, this survey shows that, case by case, health workers become more understanding, in order to not lose contact

with usurping inmates. Few claim punitive practices, even if some report breaches in therapeutic contracts that target inmates who misuse their treatment too much. In any case, these practices in prison seem to make medical practices (at large) address "critical" situations: the dangerous increase in prescriptions due to fragmented care and the overflow of certain services; stolen or forcibly prescribed drugs; or even situations where the misused drug becomes the intermediary for a link between an inmate "in difficulty" and the care teams.

Risk behaviours and health consequences

Profiles and patterns of use of prisoners, as well as structural factors related to prison conditions such as lack of privacy, overcrowding and limited access to risk-reduction tools, etc. are just some of the specific dangers that incarcerated persons are faced with (Michel and Jauffret-Roustide 2019). While diversion of drugs exposes the risks of uncontrolled intake, the initiation of certain products is another reported element. The surveys conducted in Lyon-Corbas and Liancourt estimate the proportion of people reporting that they started using at least one psychoactive substance in prison at between 8-15%.

In addition, the routes of administration are more difficult to secure than in an open environment, due to the lack of access to risk reduction materials. The Coquelicot survey conducted in 2011-2013 showed that among those who reported injecting in prison, 2.7% reported having injected for the first time while incarcerated (Michel 2018).

Generally speaking, patterns of use have changed over the last twenty years with the development of harm reduction measures and access to substitution treatment (Cadet-Taïrou 2019). However, the Coquelicot survey (Michel *et al.* 2018) showed that among those surveyed who reported a history of incarceration and injecting, 14% reported injecting inside prison, of which 40.5% reported injecting with needle and syringe sharing[2]. Older surveys indicated that while most of the prisoners concerned stopped injecting in prison (Stankoff *et al.* 2000), others seemed to reduce the frequency, but increased the quantities injected. The survey conducted in Lyon-Corbas also shows that only 12% of injectors declared sterilising their equipment with bleach.

Prisoners are also more likely to be infected with HIV and/or HCV, so the risk of infection if they share their equipment is significant (Rotily *et al.* 1998). Overexposure to infectious diseases in prison is a more general phenomenon that goes beyond the syringes alone (DGS 2011; DHOS 2004; Sanchez 2006): although declining, the prevalence of HIV infection vary, depending on the source, between 0.6% and 2.0% (3 to 4 times higher than in the general population), while those suffering from HCV are between 4.2% and 6.9% (4 to 5 times higher) (DHOS 2004; Meffre 2006; Remy 2004; Semaille *et al.* 2013). With regard to tuberculosis, the prison environment, where a group of people with many risk factors for developing the disease live together, has a reporting rate more than 10 times higher than that of the general population in France. In 2018, TB disease was reported by 54 inmates in a population of 71 000, i.e. a reporting rate of 76/100 000. This rate was 86/100 000 in 2016 and 96/100 000 in 2017 (Guthmann *et al.* 2020). A survey of a prison population, the results of which were published in 2020, also shows that cannabis users have a greater risk of developing cardiovascular diseases than others (Mongiatti *et al.* 2020).

All in all, whether initiated or continued in prison, drug use has a major impact on the health of the persons concerned: accidents when drugs are combined with other products, severe and longer-lasting withdrawal, the appearance or reinforcement of psychological or psychiatric somatic pathologies, infectious risks, abscesses, etc. (Obradovic *et al.* 2011). Furthermore, although some risk reduction tools have been put in place in detention, the supply remains lower than in the open environment, the implementation of needle exchange programmes

[2] Sharing here may involve sharing syringes with crimped needles that have already been used, and in the case of syringes with detachable (uncrimped) needles, either sharing the body of the syringe only, sharing the needle only, or sharing both.

initially planned by law no. 2016-41 of 26 January 2016 on health system reform, for example, is proving to be a struggle in terms of its implementation (Dos Santos *et al.* 2021).

The misuse of psychotropic and substitution drugs and the trafficking it generates are also said to cause violence among prisoners, leading to settling of scores, threats and rackets (Canat 2012; Chantraine 2004; Fernandez 2010; Monod 2017; Protais and Jauffret-Roustide 2019; Tissot 2016).

In prison, prisoners identified as "weak" are likely to be subjected to physical and psychological abuse and to be used for personal gain by others. The "pointer" figure (sex criminal) (Le Caisne 2004) regularly cited in prison literature, but also the "addict" figure (Protais and Jauffret-Roustide 2019; Tissot 2016) can lead to this type of victimisation. The "addict" is seen by other prisoners as a long-term user, dependent on "hard drugs" and/or psychotropic drugs. It is, however, more the presentation of the individual that plays a role in this categorisation rather than the product consumed: the individual will be perceived as such if consumption has caused visible long-term damage, such as slowing down, drowsiness or physical degradation.

Khosrokhavar (Khosrokhavar 2004) already testified to the subjection of some incarcerated persons to trafficking networks in prison. The Circé study[3] (CIRculation, Consumption, Exchange: drugs in the prison setting) (Protais and Jauffret-Roustide 2019) shows that this type of relationship takes place over time and sometimes begins with an exchange method taking the form of a "perverted gift". Some give seemingly free products to those they have identified as "addicts" and then place them in a position of accountability and dependency. Here, the "gift" is diverted from its primary function, in order to produce a right of way situation. Some guards then witness people climbing the fences of the walking yards to fetch packages "thrown" from the outside (most often with cannabis or mobile phones), intended for certain other prisoners, in exchange for a "joint". The risks taken in carrying out this action, which is prohibited by prison regulations, are not compensated for by the meagre remuneration granted. When this situation of control is accompanied by physical abuse, these relationships are part of a long-term pattern of violence (Gandilhon 2010; INSERM 2012; Monod 2017; Protais and Jauffret-Roustide 2019)made up of pressure and abuse. For these incarcerated persons, the detention period is then part of "descending" trajectories, as described above.

The consequences of this degraded health status are important for the social development of people after incarceration. The study of the profile of clients of addiction care facilities shows a strong representation of people who have been in prison. The data from the Common Data Collection on Addictions and Treatments (RECAP scheme) aimed at monitoring the characteristics of the people cared for in the specialised drug treatment centres (CSAPA) and processed by the OFDT show that in 2018, 27% of the people cared for in these centres have already been incarcerated at some point in their life (OFDT 2019). Similarly, in the ANRS-Coquelicot survey [4]60% in 2004 and 61% in 2011 declared at least one period of detention (Jauffret-Roustide *et al.* 2009; Jauffret-Roustide *et al.* 2013). Finally, 17% of CAARUD users surveyed in the ENa-CAARUD survey reported at least one incarceration during the year.

[3] The Circé study conducted by OFDT and Cermes3 [Centre for research on medicine, science, health, mental health and society] was conducted between 2016 and 2018 and sheds light on the issue of the drug market in prisons. This sociological research draws up an inventory of psychoactive substances (narcotics, medicines diverted from their use and alcohol) present in prisons. The report examines the way in which these substances are introduced, but also the organisation of the market, the social relations that underpin it and that it generates, and the responses of the prison administration and health units.

[4] This survey was carried out in 2004 and 2011 by Cermes3 and the *Institut de Veille Sanitaire* in 5 French urban areas among a population of more than 1,500 users who had injected or snorted (regardless of the product) or smoked crack at least once in their lifetime. The people were recruited from facilities likely to receive drug users (specialised drug treatment centres-CSAPA, harm reduction facilities-CAARUD, hospital services, general practitioners (only in 2004-2006) and street teams).

The ENa-CAARUD survey also indicates that the most precarious users present a greater risk of having experienced prison than others. The survey by Pauly *et al.* published in 2010 (Pauly *et al.* 2010) which compared drug-dependent people or people on substitution treatment entering prison and seen in CSAPA shows that the factors associated with incarceration are precariousness as well as problematic use of diverted drugs.

A recent article (Jamin *et al.* 2021) comparing the views of European researchers on prison shows that the two main challenges for optimising prisoners' release remain psychosocial and medical support.

T1.2.3. Please comment on any recent data or report that provide information on drug supply in prison (for example on modus operandi)

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

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).

In 2015, the Inspectorate-General of Judicial Services, the Inspectorate-General of Social Affairs (IGAS) and the Inspectorate-General of Finance were seized in order to evaluate the interministerial integration policies for the insertion of 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 (see T.1.2.1 of the 2016 Prevention Workbook).
- the development of treatment units in custody committed to fighting addictions similar to existing programmes abroad, based on the drug user rehabilitation unit (URUD).
- the routine implementation of a treatment and follow-up programme following custody, for all individuals suffering from addictions.

The plan defining the health strategy for inmates (Ministère des Affaires sociales et de la Santé and Ministère de la Justice 2017), published in April 2017, aims to increase HIV, HCV and HBV screening resources, by proposing to develop the use of rapid diagnostic tests (RDT) and repeating screening during custody. It also encourages improving measures to identify addictive behaviours by introducing a routine health assessment “relating to the use of illicit drugs, psychoactive medicines, alcohol and tobacco” when entering prison. This assessment was already proposed by the Guide to opioid substitution treatments in prison settings, updated in 2015 in a standard format.

The 2018-2022 National Plan for Mobilisation against Addictions (MILDECA 2018) also includes several specific measures targeting prison populations, with key approaches described in section T3 of the 2018 Prison workbook.

Furthermore, the health system reform law of 26 January 2016 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]. The implementing decree has not yet been published, even though the majority of healthcare stakeholders in the prison sector and sociological surveys on the issue consider access to harm reduction measures to be “deficient” (Michel 2018) and unequal (Joël 2018) in France.

In June 2019, the Ministry of Solidarity and Health and the Ministry of Justice adopted a roadmap targeting 28 priority actions for the period 2019-2021, based on the "health/prison" strategic actions plan on health policy for inmates adopted in 2017 (Ministère de la Justice and Ministère des Solidarités et de la Santé 2019). Among these actions, 7 concern treatment for inmates with addictions: improving surveys to better understand the state of health of imprisoned people (actions 1 to 3), improving testing for infectious diseases and for identifying addictive behaviour (actions 11 and 13), ensuring continuity of care after release (action 23) and promoting community health actions for managing addictions (action 27).

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. The health of prisoners has since then been the responsibility of the general public hospital sector. A hospital establishment responsible for providing care has thus been designated for each prison.

Outpatient care is provided on the prison premises by specially dedicated units, the prison health units (USMP), which are responsible for physical and psychiatric care. Specialised units for psychiatric care (regional medico-psychological hospital services), can also intervene, coordinating and supporting the prison health units. The regional medico-psychological hospital services have day hospital places. Prison health units and regional medico-psychological services are involved in the management of addiction problems. The prison health units ensure in particular the detection of consumptions and the damages linked to them during the medical visit upon arrival in the prison carried out by a nurse for each new arrival. They then offer adapted care, in conjunction with the regional medico-psychological services if necessary, where appropriate.

The specialised drug treatment centres are also involved in the care of prisoners. Among the existing National treatment and prevention centre for addiction (CSAPA), referents, instituted in 2011, have been designated for each of the prisons (126 in 2019). These CSAPAs are responsible for intervening in detention, in conjunction with the Prison Health Units and regional medico-psychological hospital services, mainly to ensure continuity of care on release. A financial package has been set aside to allow each CSAPA designated as a referent to devote half a full-time equivalent (one full-time equivalent in large penal institutions) social worker position to work with drug users who are incarcerated or who have just been released from prison. In addition to these referral CSAPAs, other similar centres are also active within prisons. A total of 201 CSAPAs reported intervening in prisons in 2017, including 11 CSAPAs that devote their entire activity to this area (former Drug Addiction Unit created in the late 1980s). These centres have worked in 162 different prisons for 29 600 people with addictive behaviour.

Prisoners may also be hospitalised. 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 published in January 2018 (Ministère de la Justice and Ministère des Solidarités et de la santé 2017), updates the one published in 2012 (Ministère de la Justice and Ministère des Affaires sociales et de la Santé 2012). 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[5].

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 opioid substitution treatments (OST) 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 2018 Methodological Guide mentioned above.

Furthermore, since June 2017, France has been experimenting with the first therapeutic community in a prison environment, located in the Neuvic detention centre: the drug user rehabilitation unit (URUD). This adaptation of the English and Spanish drug-free unit model or the equivalent in the United States and Canada provides a community-based therapeutic framework based on a three-phase peer-helper system over a 6-month period. The programme concerns drug users who have signed up for an initiative to stop using substances. The operating assessment requested from OFDT to evaluate its implementation shows promising results: the scheme makes it possible to ease relations between inmates and prison officers (changing their practices so they are more in line with the "social" element of their tasks). The majority of beneficiaries also see positive effects on their ability to resist being offered substances and, more generally, on their social relations and where they will stand in such instances in the future. However, this assessment raises some questions, notably about the selective aspect of the programme (relatively unavailable to people who want to work in custody and sex offenders), the objectives they are aiming for (abstinence or reduced use?)

[5] 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.

and the question of the confidentiality of the personal information provided, in a context where socio-health staff and prison officers claim to be united over a "shared secret". The overall positive results identified have led to further experimentation with the aim to find answers to the operational questions raised by the assessment. Medical and economic data is also needed in order to determine whether to implement the scheme in other establishments in the country.

T1.3.3. Please fill in the table below on selected interventions, if possible; 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.

Table Drug related interventions in prison

Type of intervention	**Specific interventions**	**YES/NO** (indicated whether it is formally available or not available)	**Number of prisons in the country where interventions are actually implemented**	**Comments or specifications on the type of intervention**
Assessment of drug use and drug related problems at prison entry		Yes	Concerne toutes les prisons	All prison entrants meet a health care provider (a nurse and then a doctor) to assess their overall health state and provide them with care tailored to their needs
Counselling on drug related problems				
	Individual counselling	Yes	50% of the reference CSAPAs in 2017	
	Group counselling	Yes	44% of the reference CSAPAs in 2017	
Residential drug treatment				
	Drug free units/Drug free wings	No		
	Therapeutic community /residential drug treatment	Yes	1 establishment in an experimental setting (in Neuvic	Community care based on a peer-helper system, in 3 phases, over a 6-month period
Pharmacologically assisted treatment				
	Detoxification	No		
	OST[6] continuation from the community to prison	Yes	In all prisons	
	OST initiation in prison	Yes	In all prisons	
	OST continuation from prison to the community	Yes	In all prisons	
	Other pharmacological treatment targeting drug related problems	Nicotine replacement therapies for smoking cessation	In all prisons	

[6] OST: Opioid Substitution Treatment

Preparation for release				
	Referrals to external services on release	Yes	The 174 CSAPAs work in 161 of the 185 prison establishments.	One of their aim is to prepare inmates for their release. They monitored 29 650 people with addictive behaviour problems in 2017. In 2017, 97% of the reference CSAPAs engaged with people in an ambulatory care project on their release, 86% in a residential care project and 83% referred inmates towards other CSAPA (Fédération Addiction 2019).
	Social reintegration interventions	Yes	Data not known	In 2017, 58% of the reference CSAPAs reported to have physically supported their clients on prison leave and 48% reported to have physically supported them when they were released from prison (Fédération Addiction 2019).
	Overdose prevention interventions for prison release (e.g. training, counselling, etc.)	Yes	Data not known	CSAPA and CAARUD (low-threshold centres) specific interventions.
	Naloxone distribution	Yes	Data not known	Inmates who have just been released from prison have been the main target market for the distribution of naloxone since it became available in 2016 (cf. Note n°2016-223 of 11/07/2016). This was confirmed by the roadmap for preventing and taking action against overdose of opioids which was adopted in July 2019 by the Ministry of Health.

Infectious diseases interventions				
	HIV[7] testing	Yes	Screening test is systematically offered during the medical admission examination	
	HBV[8] testing	Yes	Screening test is systematically offered during the medical admission examination	
	HCV[9] testing	Yes	Screening test is systematically offered during the medical admission examination	
	Hepatitis B vaccination	Yes	Vaccination is systematically offered during the medical admission examination	
	Hepatitis C treatment with interferone	No		
	Hepatitis C treatment with DAA[10]	Yes	In some prisons	
	ART[11] therapy for HIV	Yes	In all prisons	
Needles and syringe exchange		No		
Condom distribution		Yes	In all prisons	
Others (specify)				

See T1.3.3 of the 2018 Prison workbook, except for the figures that have been updated in part T1.3.4 of this workbook.

In 2015, HIV and HCV screening was provided for 70% of inmates, with results routinely reported in 72% of prison health units (USMP) (Remy *et al.* 2017). Non-invasive methods for evaluating hepatic fibrosis are used in 84% of USMP, and 56% benefit from specialist on-site clinics; 66% started at least one direct-acting antiviral treatment in 2015, and 130 patients were treated.

[7] Human Immunodeficiency Virus
[8] Hepatitis B Virus
[9] Hepatitis C Virus
[10] direct-acting antivirals
[11] antiretroviral therapy

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

The number of inmates who received opioid substitution treatment (OST) in 2018 was 12 900, i.e. 7% of the people who were in prison. The proportion of inmates with opioid substitution medications in prison decreased in 2018 after a period of stability between 2013 and 2017. However, this development should be viewed with caution due to the lack of comprehensive data. Methadone continues to grow (47.4% of cases in 2018 *vs* 42.8% in 2017 and 15.2% in 1998). Buprenorphine alone is prescribed less and less (36.3% of cases in 2018 *vs* 42.1% in 2017). The share of patients treated with buprenorphine/naloxone, counted separately from buprenorphine from 2017, is slightly up on 2017 (16.3% *vs.* 15%) and is at a higher level than in the open setting. While there is the option to be treated with methadone or buprenorphine in all institutions, buprenorphine is often prescribed in only one form. Therefore, 48% of establishments only dispense the kind that only contains buprenorphine and 16% of establishments only dispense the form with buprenorphine and naloxone. The number of inmates receiving OST differs depending on the type of institution. Detention centres (facilities for inmates sentenced to more than two years) and remand prisons (facilities for remand inmates and inmates sentenced to less than two years) have the highest prevalence of opioid substitution treatment (OST), with 7% and 8% of inmates respectively receiving OST, while 4% of inmates received OST in security prison (for inmates with long sentences) in 2018 (Brisacier 2019).

In 2010, the prevalence of OST in women was more than twice that observed in males (16.5% *vs.* 7.7%, respectively) according to the Prévacar survey (Barbier *et al.* 2016). A recent survey (Carrieri *et al.* 2017) moreover showed that switching from buprenorphine to methadone in primary care could reduce misuse and thus significantly reduce drug-related offences (namely the purchase and sale of narcotics), along with imprisonment levels.

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.*

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.

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

T2. Trends

The purpose of this section is to provide a commentary on the context and possible explanations of trends.

T2.1. Please indicate notable trends in drug use and drug related problems or important developments in drug and prison policy and drug related interventions in prisons of your country over the past 5 years.

2019-2020 the French Monitoring Centre for Drugs and Drug Addiction (OFDT), with the support of the Funds for Combatting Addiction (Arrêté du 2 août 2019 fixant la liste des bénéficiaires et les montants alloués par le fonds de lutte contre les addictions liées aux substances psychoactives au titre de 2019 [Legislative order of 2 August 2019 establishing the list of beneficiaries and the amounts allocated by the Funds for combatting addiction linked to psychoactive substances for 2019]), is going to conduct a pilot survey to collect prevalence data, in accordance with the methodology for general population surveys, on the use of psychoactive substances by inmates (see also section T 1.1.3 of the Prevention 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.

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.

As in other European countries, the COVID-19 crisis continued to affect French prisons. Since March 2020, France has had 3 418 confirmed cases of COVID in prison (including 4 deaths and 3 285 cases of people who recovered from COVID-19). France has had two new lockdowns: one in November 2020 and one in April 2021. As a reminder, during the first lockdown, prisons put a number of measures in place. The main ones are: the provision of gel and masks for guards; reorganisation of the detention centre so as to ensure the application of barrier measures, the isolation of infected persons and the fourteen-day isolation period for new arrivals; the suspension of visiting rooms and group activities, but also exceptional remissions of sentences for prisoners (see T.3.1 of the 2020 “Prison” Workbook)

All of these measures were maintained throughout the year, with a few adjustments: the wearing of masks was set as a rule for all detainees, visiting hours were resumed on condition that they took place with a fixed separation device (perspex screen) or hygiaphone, and group activities, such as work in the workshops, were resumed at reduced capacity (CGLPL 2020; Montanari *et al.* forthcoming). Compliance with a sufficient safety distance was suspended in November with the second lockdown. In contrast, the exceptional remissions were only limited to the first lockdown, which led to an increase in prison overcrowding, which had fallen to 108.5% in July 2020, and then increased to 119.4% on 1st January 2021. During the lockdown period, and depending on the level of health emergency in the region where the prison is located, group activities may have been suspended.

As far as the healthcare units are concerned, while during the first lockdown, specialist consultations were drastically reduced, as was the activity of the referral CSAPAs (National treatment and prevention centres for addiction), and mainly of associations whose teams were not allowed to enter the workplace during lockdown. Healthcare services returned to normal from summer 2020. Only group activities could not be resumed in the majority of healthcare units (often due to the caution of doctors, since the prison administration did not prevent their resumption). Also of note is the development of telemedicine, electronic prescriptions and the strengthening of links to care outside of detention centres.

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.

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, have entered a new one-year phase, the results of which are expected in 2021. This concerns the second phase of the PRI^{2}DE survey (see T5.2), 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 has been conducted in prison settings to determine the prevalence of HIV and HCV, together with patterns of use in prisons. First results are expected in 2021.

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.

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 have taken place in 2017 and 2018. 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 are being conducted within the same establishments and over the same periods, so as to narrow down and compare the results of the two approaches.

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 has been carried out in different prison settings in France between September and December 2016.

Assessment of the operation of the drug user rehabilitation unit (URUD) one year after opening

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

The OFDT was appointed by the Directorate of Prison Authorities (DAP) to draw up an assessment on how the URUD operated at the time of its creation. The evaluation was presented more as an accompaniment to the scheme being implemented than as a survey to measure the impact of the treatment on people's progress. It is based on a qualitative methodology which combines observing the system for two weeks and conducting around thirty interviews with the main people involved in implementing the scheme.

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.

Survey of reference CSAPAs in prisons

Fédération Addiction

An assessment of the reference CSAPAs' professional practices was carried out through a questionnaire that was sent to all the reference CSAPAs by mail and electronically. There is now one reference CSAPA per institution (sometimes it is the same CSAPA for several institutions) and for some institutions several CSAPAs can take action (the reference CSAPA and another CSAPA). There are 126 reference CSAPAs among the 201 that work in prisons (11 of which work exclusively in prison environments). These 126 reference CSAPAs are managed by 36 inpatient centres and 49 voluntary centres. Half of the reference CSAPAs answered the questions asked, relating to their institutional characteristics, working conditions for professionals, how clear their tasks are and an outline of their role and activities carried out.

With the support of professionals and the National Health Directorate, the Fédération Addiction published a reference document that describes the best practice of reference CSAPAs and that provides an overview of this innovative scheme implemented between 2012 and 2014 (Fédération Addiction 2019).

Health survey on new prison inmates

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.

Survey on substitution treatment in prison
Directorate of Health Care Supply (DGOS)

A new information system, called "Controlling activity reports for general interest purposes" (PIRAMIG), was set up in 2017 to collect data on activity relating to health units in prison and is now handling the tasks previously performed by the Health Facility and Inmate Monitoring Centre (OSSD). The Directorate of Health Care Supply (DGOS) centralises this data. In 2017, 92% of prison settings (representing 88% of inmates in prison that year) provided data on OST. The percentage of people receiving OST is calculated by dividing the number of people that have been prescribed an OST by the number of inmates in a prison setting in a given year. The latter number is provided by the Prisons Administration Directorate (DAP).

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.