WB 5.1 Prison

France

2015 National report (2014 data) to the EMCDDA by the French Reitox National Focal Point

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The EMCDDA is investigating how the submission of the workbooks could be made easier through the use of technology. In the first instance, a pilot using templates in Word with defined fields to distinguish the answers to questions is being tried. The outcome of the pilot will be to evaluate the usefulness of this tool and establish the parameters of any future IT project.

Templates have been constructed for the workbooks being completed this year. The templates for the pre-filled workbooks were piloted in the EMCDDA.

1. The principle is that a template is produced for each workbook, and one version of this is provided to each country, in some instances pre-filled.
2. Answers to the questions should be entered into the “fields” in the template. The fields have been named with the question number (e.g. T.2.1). It will be possible to extract the contents of the fields using the field names.
3. Fields are usually displayed within a border, and indicated by “Click here to enter text”. Fields have been set up so that they cannot be deleted (their contents can be deleted). They grow in size automatically.
4. The completed template/workbook represents the working document between the NFP and the EMCDDA. Comments can be used to enhance the dialogue between the EMCDDA and the NFP. Track changes are implemented to develop a commonly understood text and to avoid duplication of work.

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T0. Summary

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

- National profile

As of 1st January 2014, France had 191 prison establishments with a total operational capacity of 57,516. With 67,075 inmates, there are 117 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. The prevalence of injection is high in prisons: in the year preceding imprisonment, 2.6% of new inmates were concerned in 2003. 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), which are responsible for monitoring the physical health of inmates, Regional Medico-Psychological Hospital Services (SMPRs) established in each of the 26 French regions handle the mental health aspects of drug addicts in establishments where no local units exist, and finally, “local addiction units” have been established in the 16 largest establishments in France (and cover approximately a quarter of the incarcerated population). 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. Drug-related prison health is mentioned in the 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours, which sets forth specific prevention objectives for inmates, and in the 2010-2014 “health/prison” strategic actions plan on health policy for inmates. 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.

- New developments

The 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours (MILDT 2013) comprises several measures specific to inmate populations currently being implemented. Among other measures, this includes the diffusion of messages on prevention by video and the development (with a view to prevention) of support groups on addictive behaviours, the improvement in the management of individuals presenting addictive behaviours, and increased regular monitoring of inmate health data.

Furthermore, the bill on the reform of the health system (known as the health act, which has yet to be adopted by the Senate) provides for the application of harm reduction measures to inmates and the reinforcement of reference CSAPAs in the largest prisons.

T1. National profile

T1.1 Organization

The purpose of this section is to:

- Describe the organisation of prisons and the prison population.

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.

As of 1st January 2014, France had 191 prison establishments (Sous-direction de la statistique et des études 2014) with a total operational capacity of 57,516. These establishments include:

- 99 remand centres and 41 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);
- 85 prisons for convicted inmates (with several wings), i.e.:
  - 43 penitentiaries including at least two wings for inmates of a different detention status (remand centre, detention centre and/or high security);
  - 25 detention centres and 37 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 5 high security wings;
  - 11 semi-custodial centres and 10 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 7 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]. The first of these was opened in mid-2008.
- 1 national public health establishment (thus falling within the scope of the Ministry of Health), open to inmates (defendants and convicted inmates) presenting somatic and/or psychiatric disorders.

The prison population in France consists of nearly 80% convicted inmates, with 14% present due to a drug-related offence (DLO); the mean age is approximately 34.5 years, and almost exclusively concerns males (96%) (Direction de l'administration pénitentiaire (DAP) 2014).
With 67,075 inmates as of 1st January 2014 for 57,516 operational beds, there are 117 inmates for every 100 beds in France.

T1.2 Drug use and related problems among prisoners

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

- Prevalence 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: this proportion increased to 40% of inmates who had been incarcerated for less than six months (Falissard *et al.* 2006). 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). Furthermore, there is an observed 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.

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

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 1996: 75% of French penal establishments were subject to drug trafficking. 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). Nearly twenty years later, some elements indicate that the situation has not changed much. Cannabis remains the most

widely trafficked illicit substance within French prisons, and trafficking of buprenorphine, sedatives and cocaine hydrochloride is also increasing.

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 (2004).

As a result, 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%).

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) stipulates acting on inmates' health determinants (practices exposing them to a risk for infection) and making screening programmes available for inmates. It provides for the establishment of suitable harm reduction measures that can be applied in prisons to remedy the shortcomings observed in France: these measures include 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®[1] 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. 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.
The 2013-2017 Government Plan for Combating Drugs and Addictive Behaviours (MILDT 2013) sets forth specific health objectives for inmates (see T3.1).

[1] A non-invasive machine that can instantly detect liver fibrosis and assess its degree of advancement.

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.

Since the law of 18 January 1994 [Loi n°94-43 relative à la santé publique et à la protection sociale], which transferred the responsibility for health in prisons from the Ministry of Justice to the Ministry of Health, the treatment of addiction in prison settings is based on a three-tiered system: prison-based hospital healthcare units (UCSAs), which are responsible for monitoring the physical health of inmates, Regional Medico-Psychological Hospital Services (SMPRs) established in each of the 26 French regions handle the mental health aspects of drug addicts in establishments where no local units exist, and finally, since 1987, “local addiction units” have been established in the 16 largest establishments in France (and cover approximately a quarter of the incarcerated population). This general scheme is also accompanied by another, set up on an experimental basis: UPSs, or care units for prison leavers, exist in 7 establishments.

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 UCSAs)
- Access to OSTs and the availability of bleach to disinfect equipment in contact with blood (injection, tattooing and body piercing equipment).

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: assessment of drug use and related problems at admission; availability of treatment (psychosocial / counselling / pharmacological-assisted), 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 [Loi n°2004-806 du 9 août 2004 relative à la politique de santé publique][1], two main ways of preventing the spread of infectious diseases have been implemented in prison settings since 1996. The 5 December 1996 circular [see 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 HDB therapy. Since 2002, methadone OST can also be initiated. There is no medicalised heroin programme in prison, unlike 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: HDB 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. The predominance of buprenorphine seems marked, even though the proportion of methadone among OSTs tends to rise.

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 above] and since the Health/Justice memorandum dated 9 August

2001 [Note interministérielle MILDT/DGS/DHOS/DAP 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 circular 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 ("À chaque injection, du matériel neuf"/“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). There was also no specific programme in prisons to provide information on how contamination occurs through injection practices.

[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 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.*

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.

T1.4.1 ***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 DGOS/DSR/DGS/DGCS/DSS/DAP/DPJJ 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 and Ministère des affaires sociales et de la santé 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.

T3.1 Please report on any notable new or topical developments in drug-related issues in prisons in your country since your last report.

Several measures specific to inmate populations in the 2013-2017 governmental plan (MILDT 2013) are currently being implemented, notably:

- The use of videos to diffuse messages on prevention in a prison setting.
- The development of support groups on addictive behaviours with a view to prevention.
- Improvement in the organisation of the management of individuals presenting addictive behaviours in a prison setting, by reinforcing intervention by hospital liaison teams specialising in addiction medicine (ELSA). This involves offering management in a prison setting in which addiction clinics are not available, and where specialist follow-on management cannot be provided by a CSAPA.
- The promotion of practices recommended in the Guide to Opioid Substitution Treatments in prison settings.
- Reinforcement of regular monitoring of inmate health data in the context of a health-justice partnership working group, coordinated by MILDECA.
- Installation of anti-projectile systems (nets, videosurveillance), millimetre wave scanners and training of personnel in the use of these systems.

Furthermore, from a legislative perspective, Article 8 of the bill on health system reform (known as the health act) provides for the application of harm reduction measures to inmates (including the possibility of trialling needle and syringe exchange programmes in prisons), according to conditions adapted to the prison setting. There are also plans to reinforce the reference CSAPAs (each prison has a reference CSAPA which liaises between the prison and the external environment) in the largest prisons. This bill was adopted by the Assemblée Nationale in April 2015, and has yet to be debated by the Senate before being definitively adopted. Once the law has been promulgated, a decree is expected to be drafted in the Council of State, stipulating the conditions for application of these measures.

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, studies or data on drug use or drug problems among prisoners' particular interest studies on psychiatric comorbidity and post-release mortality. Where possible, please provide references and/or links.*

The Toulouse University (Université de Toulouse-Jean Jaurès) is currently conducting the study "Backgrounds and addictive paths of incarcerated individuals and inmates" (*Parcours de vie et trajectoire addictive chez les personnes incarcérées et placées sous main de justice)*, with funding from MILDECA.

*T4.2 **Optional**. Please comment on any other important aspect of this topic that has not been covered in the questions above but is important for your country.*

T5. Notes and queries

The purpose of this section is to highlight areas of specific interest for possible future elaboration. Detailed answers are not required.

Please structure your answers around the following questions.

No current question

T6. Sources and methodology

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

Please structure your answers around the following questions.

T6.1 Please list notable sources for the information provided above.

- Series of inmate statistics (1980-2014). Ministry of Justice. (see bibliography)
- Collective expert report on infectious harm reduction measures (2010). INSERM (see bibliography)
- Health survey on new prison inmates (1997, 1999, 2003). DREES.
- PREVACAR survey (2010). DGS.
- ANRS-PRI²DE inventory (2009). ANRS

T6.2 Where studies or surveys have been used, please list them and where appropriate describe the methodology.

Methodology

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) / French Institute for Public Health Surveillance (InVS)

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 (UCSAs): 145 of them sent them back to the 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.

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