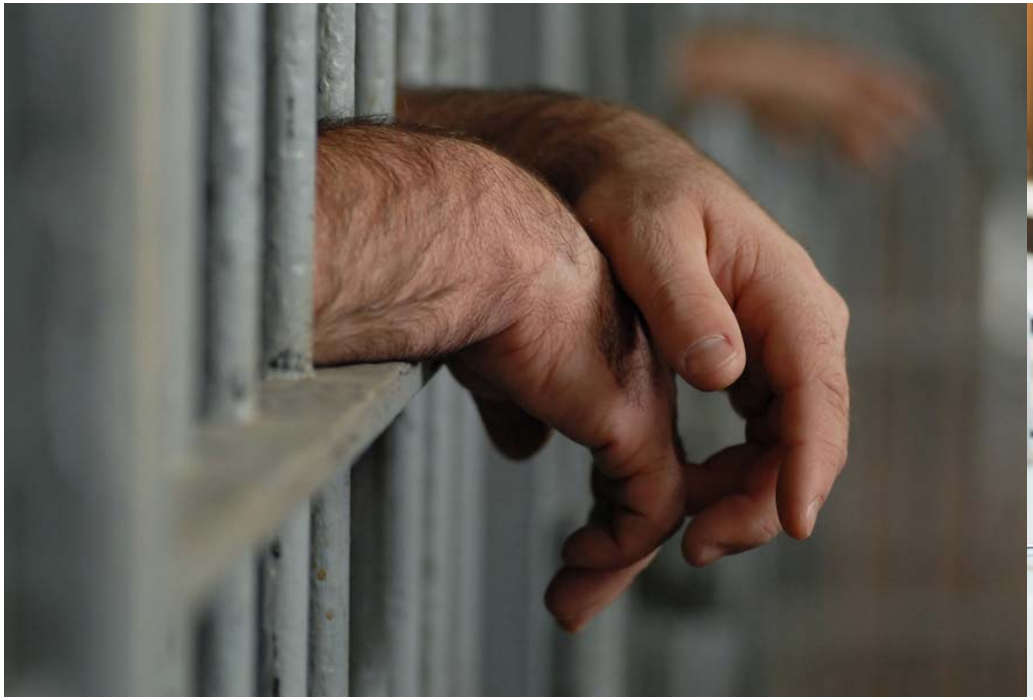
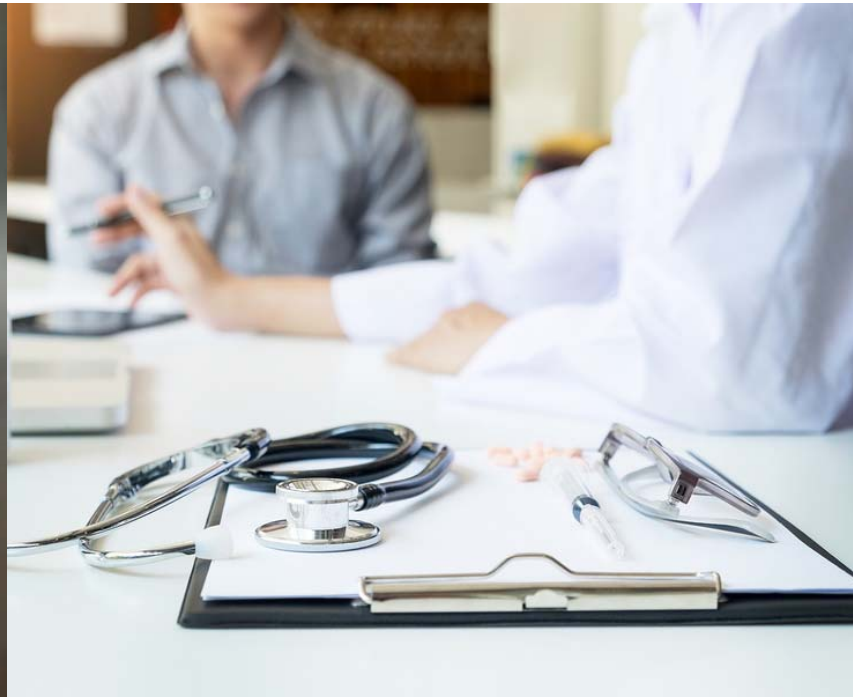
KCE REPORT 293

Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

ORGANISATION OF HEALTH CARE IN BELGIAN PRISONS





KCE REPORT 293
HEALTH SERVICES RESEARCH

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Disclaimer:	• **The external experts were consulted about a (preliminary) version of the scientific report. Their comments were discussed during meetings. They did not co-author the scientific report and did not necessarily agree with its content.** • **Subsequently, a (final) version was submitted to the validators. The validation of the report results from a consensus or a voting process between the validators. The validators did not co-author the scientific report and did not necessarily all three agree with its content.** • **Finally, this report has been approved by common assent by the Executive Board.** • **Only the KCE is responsible for errors or omissions that could persist. The policy recommendations are also under the full responsibility of the KCE.**
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LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
CAP	Centraal Aanmeldingspunt drugs
CGG	Centrum voor Geestelijke Gezondheidszorg
CMC	Centre Médical /Medisch Centrum
ECG	Electrocardiogram
FOD	Federale overheidsdienst
FPS	Federal Public Service
FTE	Fulltime-equivalent
GP	General Practitioner
HCS	Health Care Service
HIS	Health Insurance System
INAMI	Institut National d'Assurance Maladie-Invalidité
MHC	Mental Health Care
PHC	Prison Health care
PSS	Psychosocial Service
PrimHC	Primary Health Care
RIZIV	Rijksinstituut voor Ziekte- en Invaliditeitsverzekering
SPF	Service Public Fédéral
WHO	World Health Organisation
UN	United Nations

SCIENTIFIC REPORT

1 BACKGROUND

Prison health care is a subject of increasing international concern. Not only legal elements (e.g. the access to health care for prisoners, as guaranteed by the UN Basic Principles for the Treatment of Prisoners) play a role in this surge, there are also considerations of public health and social justice. The first refers to the fact that deficient (or absent) prison health care represents a public health risk. Both released inmates and members of staff can transfer diseases and conditions from within the prison walls into society. The second poses that the fight against health inequalities (the unjust and systematic differences in health between people from different socio-economic classes or demographic groups) contributes to a better health for all. Prisoners mainly originate from the lower and most vulnerable layers of society, and prison health care might contribute to the reduction of health inequity if organised in an equitable way [1, 2].

The WHO clearly states that in order to achieve quality prison health care, its provision cannot be isolated from health care in society at large. Its Moscow Declaration on Prison Health [3] clearly urges member governments in the European Region of WHO to integrate their prison health services into public health services, or to make them work closely together. Several member governments in the WHO European Region already transferred the responsibility for prison health to their health ministries: Norway, France, UK, Italy, Ireland, some Swiss cantons and two autonomous regions of Spain [2, 4, 5].

Belgium also considers implementing such a reorganisation in the future [6-10] and hereto the Ministry of Justice and the Ministry of Social Affairs and Public Health installed a steering committee penitentiary health care to prepare this transfer[a]. This reorganisation is necessary, since Belgian prison health care is severely criticised, nationally and internationally, see for example [11, 12-21].

[a] https://www.dekamer.be/kvvcr/showpage.cfm?section=qrva&language=nl&cfm=qrvaXml.cfm?legislat=54&dossierID=54-b052-867-0525-2015201605775.xml

This lead the RIZIV – INAMI, FOD Justitie – SPF Justice[b], and the Ministry of Justice and the Ministry of Social Affairs and Public Health to ask KCE to revise the Belgian health care services in prisons with the view of conforming with international and national laws, in particular the 2002 Act on the patient rights and the 2005 Act on principles of prison administration and prisoner status (further referred to as the Dupont Act). The expected output is a proposal for an actionable reform of the organisation of health care services in prisons so as the principle of health care equity for incarcerated and free citizens is guaranteed while accounted for the specificities of the prison setting. To perform this health care needs assessment, a series of studies is initiated by KCE of which this is the first. The specific aim of this study is "to explore the current organisation of health care services in Belgian prisons in terms of availability, comprehensibility, reachability, continuity, quality and legality."

The health services under study in this project include the services provided in Belgian prisons (not the care provided e.g. in Centres for Social Defence or services provided to inmates who live extra-muros e.g. with an ankle bracelet) aiming at the diagnosis and treatment of disease, or at the promotion, maintenance and restoration of health. Both personal and non-personal health services are included. The health related programs or interventions in the prisons organised by other governments then the FPS Justice (e.g. health promotion programs of the Communities or services provided by local welfare organisations) are not studied here, but a look at it is given in another chapter.

This study focuses on the availability, comprehensibility, reachability, continuity, quality and legality of prison health care:

1. Availability:
   available types of health services; human resources available in and outside regular hours; organisation of human resources.
2. Comprehensibility[c]:
   availability of programs for specific groups or specific conditions (e.g. mental health, health promotion).
3. Reachability[d]:
   procedure to consult a health care provider; triage; waiting lists.
4. Continuity of care:
   organisation of the process of care in the prison; collaboration between disciplines intra- and extra-muros; follow-up care; dispatching of medical treatments.
5. Quality of care:
   quality control; guidelines; restrictions in care because of budgetary or HR reasons; medical file keeping; complain procedures.
6. Legality:
   patients' rights; relation health provider/administrative direction; medical secret; competencies and responsibilities of the different governmental levels.

[b] Further referred to in this report with the term in English: Federal Public Service Justice (FPS Justice).

[c] In this report further referred to as "comprehensiveness".

[d] In this report further referred to as "accessibility".

2 SITUATION ANALYSIS

2.1 Methods

A mixed-method approach was used to enable a complete insight into the current situation.

2.1.1 Setting up of an expert and stakeholder group

In order to guide the process, identify information sources, discuss intermediate results, and provide the research team with insights, a group of experts and stakeholders was set up. KCE published a call for participation at the start of the project. The list of participants, which includes a wide panel of expertise and institutional affiliation, is available in the colophon of this report.

2.1.2 Review of available data

Scientific, legal, and grey literature was screened for relevant and recent information regarding the organization of the health care in Belgian prisons. This was done by identifying key publications, as indicated by experts and stakeholders.

Data related to the organisation of health care in Belgian prisons was collected from the Federal authorities involved in the organisation and financing of health care for prisoners being the FPS Justice and RIZIV – INAMI (Table 1). Data were extracted and captured in a common spreadsheet from which descriptions are provided, and estimations were derived. Data was analysed using SPSS 21.0 [22].

In general, all data used refer to the year 2015. When 2015 data was unavailable, data from previous years was used. Table 1 – Data used for estimations presented in this chapter

Composed indicator on the organisation of health care in Belgian prisons	Variable in the original source	Year	Source
Number of physicians working in prison, per discipline	Number of physicians writing an invoice to FPS Justice for provided care in prisons, including details on their discipline	2015	Invoices from the Services of Health in Penitentiary Institutions from November 2015
Number of FTE nurses/100 prisoners/prison	Mean population of prisoners, per prison	2015	Annual report of the Directorate General for Penitentiary Institutions
	Number of FTE nurses working for FPS Justice	Retrieved 23th of November, 2015	Internal staff document from the Services of Health in Penitentiary Institutions (2015)
Hours of care per prison (general practitioner, dentist, psychiatrist and physiotherapy)/100 prisoners/prison	Mean population of prisoners, per prison	2014	Annual report of the Directorate General for Penitentiary Institutions
	Hours of care per prison (general practitioner, dentist, psychiatrist and physiotherapy)	2014	Gezondheidszorg voor gedetineerden kost een veelvoud (Francis Desmet)

2.1.3 Interviews of key informants

Key informants with different professional backgrounds were identified, including staff members of the Health Care Services in prisons, health/welfare professionals working in prison and staff from the prison management and security team, as well as civil servants, social workers and health professionals who are not directly employed in prisons, but have a specific expertise on health care provision in prisons. Maximum variation in participants with regard to the level at which they work (organisational (i.e. the prison) or institutional (e.g. FPS Justice)), their domain of expertise (e.g. general medical care, mental health care, forensic welfare, management, security) and the prison's regime (e.g. closed versus open) and population (internees, accused, sentenced -long and short term) was striven for to ensure a maximum variation in experiences and knowledge. In order to select and recruit respondent, different strategies were used[e].

An interview guide for semi-structured interviews was used[f]. The interview guide was drafted based on the results from the general overview of the literature and inputs from experts. The resulting interview guide is added to this report as Appendix 01.

The data were collected between late December 2015 and early February 2016, in the mother tongue of the respondent and by a native speaking researcher, at the location chosen by the respondents (prison, home, public administrative centre…). The interviews were audio-recorded. In order to be time-efficient, verbatim transcriptions of the interviews were not made, but analyses were based on the audio-recordings and performed in Excel files. Hereto, the researchers first identified important themes or concepts in the interviews (i.e. free coding) and linked these codes to specific time positions in order to browse more easily through the interviews. The results of this free coding were compiled in an Excel file, which contains a general overview of all codes and a casewise overview (codes for each individual interview separately). In a next step, the researchers used axial coding (i.e. grouping codes under general themes (e.g. strength) and subthemes (e.g. care)) to structure the identified codes and to integrate them in one general coding tree. The internationally recognised model of a SWOT[g] analysis was used to structure the codes in this process of axial coding. Additionally to the four broad categories of this model, possible solutions suggested by the respondents were coded as improvement. Although one must be very careful to quantify qualitative data, we give the reader some notion of the importance of the identified codes: topics that were mentioned by at least six respondents are considered to be 'redundant', referring to the reiteration of the same topic throughout the interviews. These codes are described in detail below. Other, less redundant topics are also mentioned in this report, but are described in less detail. To safeguard the anonymity of the respondents, all quotes included in this report are translated to English by the research team.

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[e] These strategies were:

- The members of the expert group were asked to make suggestions.
- Persons that were already known by the research team (due to their collaboration to previous research) were asked to participate.
- The team sought to recruit persons who had published on the subject, and/or have taken a public stance on the topic.
- Finally, some respondents who agreed to participate brought the research team in contact with additional possible respondents.

[f] The advantage of using semi-structured interviews is flexibility, which allows for a more in-depth and open data collection. The use of open-ended questions gives the respondent the possibility to freely share his/her view without being restricted by pre-defined answer categories. The method of interviewing gives the researcher the possibility to react immediately to what has been said and to ask for clarification or elaboration. It also allows the researcher to adapt the way of questioning (wording, additional framing, sequence…) according to the type of respondent or context.

[g] A SWOT analysis describes a system or organisation by placing key information into two main categories: internal factors (i.e. the strengths and weaknesses internal to the organisation), and external factors (i.e. the opportunities and threats presented by the organisation's environment). In this case, the local prisons and their staff is considered as being part of the internal level, and the broader environment of the prisons (legal framework, etc.) as the external level.

2.1.4 Questionnaire survey of head MD in prisons

In order to complete our situation analysis for each prison, a structured questionnaire was distributed among the responsible physicians of the Health Care Services in Belgian prisons. More specifically information on the following dimensions was collected[h]:

- availability: available human resources and material resources such as medical equipment and medication
- accessibility: the process of requesting care, waiting times, triage and transfers for medical reasons
- comprehensiveness: the type of care provided within the prison walls, the presence of screening for specific diseases and the presence of general and specific health promotion programs
- continuity: the organisation of out-of-hour care (at night and during the weekend), the permanence of the nursing staff, the handling of chronic diseases, the flow of medical information during the different stages of a person's imprisonment (i.e. the entry, the actual stay, and the release)
- quality: the use of guidelines and protocols, the nurses' permanent education, multidisciplinary patient meetings, the evaluation of care processes, the handling of critical incidents, the ways inmates can evaluate the provided care

The survey used a mix of open and closed ended questions that were specifically developed for this study. Since the specific aim of this study the use of existing validated questionnaires or questions was not possible. However, several actions were undertaken to maximize the validity of the instrument. Firstly, the development of the questions was done based on the input of experts in the field being the members of the expert panel, the research team at KCE and external experts for specific topics (e.g. for the questions regarding the quality of care the president of the European Society for Quality and Safety in Family Practice, EQUIP, was consulted). Secondly, a first draft of the questionnaire was pre-tested by two physicians with former experience in prison health care. Based on this exercise some questions were modified and adaptations to the lay-out were made to make the questionnaire more structured and transparent.
The survey was sent electronically in a Word-format to all responsible physicians of the Health Care Services in the Belgian prisons. Hereto their official FPS email address was used. Data were collected between the end of March and the end of April 2016.

Several strategies were used to maximise the response rate[i]. Data were analysed using descriptive statistics. Considering the low numbers, more sophisticated analysis was not possible.

An ethical approval was obtained from the Ethics Committee of Ghent University Hospital (project number EC/2015/1375, registration number B670201526571).

h Since the large number of questions, we do not present all questions and their answer categories here. Hereto we refer the reader to the questionnaire in appendix nr 02.

i The FPS Justice was asked to send a message to all responsible physicians not only to announce the survey, but also to stimulate them to fill in the survey as soon as possible. A reminder was sent in the third week of data collection to those who had not answered to the first call. The researchers also contacted all physicians and/or the nursing staff of the prisons by telephone a few days after the survey was sent out. The goal of this contact was to check whether the respondents received the survey well (not all physicians consult their official FPS mail address regularly) and to provide clarification if needed. These calls were repeated a second time during the first week, and also the second and third week of the data collection. In case the physicians requested to also send the survey to the nurse of the Medical Health Service, a colleague physician or another colleague, this was done. Thirdly, in the invitation it was clearly indicated that the respondent's anonymity would be guaranteed. Reporting the data would only be done on the level of the prison and not on the person who filled in the survey (nurse, physician responsible for the Medical Health Service, colleague physician or other collaborator)i

2.2 Target population

2.2.1 How many prisons are there?

There are 35[j] prisons in Belgium (17 in the Flemish region, 16 in the Walloon region, and 2 in the Brussels region) [23]. Part of the prisoners registered in Wortel prison are in reality jailed in Tilburg, in the Netherlands. Some prisons welcome primarily condemned prisoners, and others have a majority of accused individuals (House of Arrest or Remand Prison), or combined both condemned and accused individuals (see table 2). Paifve which is an establishment for social defence welcome only mentally ill offenders (further named 'internees')[k]. Twelve (34%) have a specialised annex or section for mentally ill offenders. Overall, their average capacity is 279, ranging from 25 to 847 prisoners. The average number of prisoners is 307, but variation is high (range 21-908), leading to an average overpopulation rate of 10,1% in 2015 (16.6% in 2014).

2.2.2 How many prisoners are there?

Over the year 2015, the mean daily number of prisoners was 11.040, among whom 31.7% were accused, 58.5% were condemned and 8.2% were mentally ill offenders[l] [23]. The latter number is decreasing in recent years (1 088 or 9.4% in 2014, 904 or 8.2% in 2015 and 750 in September 2016[m]), a reflection of the public policy to welcome mentally ill offenders in a setting where they can receive the care they need; it is expected to further decrease when new Forensic Psychiatric Care Centers (FPC) will open in coming years. The mean length of detention increased since the late 20th century and almost doubled from 3.5 months in 1980 to 6.9 months in 2007 [24] and 7.5 months in 2012 [25]. In 2014 the mean length of detention was 7.3 months [26].

Besides the yearly average number of prisoners, two important dimensions will impact the organization and cost of health care. First, the turnover of prisoners is very high, with a significant proportion of individuals being jailed for a short period. According to Sidis suite, in the one year period 4/04/15-4/04/16 , a total 26 511 prisoners spent at least one day in jail; during that period, 14 435 new prisoners entered for at least one night stay and 13 458 left prison. This is of importance, as a medical consultation is mandatory for every new entry. Second, although the vast majority of prisoners have an ordinary regime, i.e. they stay permanently in prison, it is noteworthy that a yearly average of 1 040 additional individuals are under electronic surveillance outside prison walls (Sidis Suite 2015).

The presence of mentally ill offenders in prison is a particularity of the Belgium prison system at odds with all international recommendations. This particularity has regularly been criticized by several organizations, including the Committee for Prevention of Torture [27-29]. Jamoulle [30], and also Salize and Dressing [31] stated that mentally ill offenders confront a double stigmatisation, both as offenders and as mentally ill. Fear and distance characterising the public's attitude towards people with mental health problems [32-34] are also present within the prisons [14], including some health care providers [35].

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j There is some inconsistency in the way the number of prisons is reported. The figure most often reported (35) counts in most cases the prisons of Forest and Berkendael as 1 prison. However, when individual prison statistics are reported, these prisons are separated, resulting in an overall number of prisons of 36.

k Under Belgian Law, people with mental disorder charged with offences but who are deemed lacking criminal responsibility are labelled as internees. They are considered psychiatric patients. But a proportion of them are jailed.

l 1.7% were classified under "other legal status"

m De Belgische Kamer van Volksvertegenwoordigers, 2016, Schriftelijke vraag en antwoord nr : 1494 - Zittingsperiode : 54

Table 2 – Prisons characteristics and population in 2015

		Mean population 2015	Mean overpopulation (%)	Men (%)	Convicted (%)	Internees (%)	Psychiatric Section	Polyclinic (CMC)	Special Care Section *
1	Andenne	409,4	3,4	100,0%	94,6%	0,0%	No	No	No
2	Antwerpen	564,5	28,6	89,8%	11,1%	8,1%	Yes	No	No
3	Arlon	117,2	5,6	100,0%	56,3%	0,0%	No	No	No
4	Berkendael	86,4	35	0,00%	38,6%	12,6%	No	No	No
5	Beveren	289,9	-7,1	100,0%	87,7%	0,0%	No	No	No
6	Brugge	718,0	19,3	83,8%	50,8%	5,6%	Yes	Yes	No
7	Dendermonde	186,3	10,9	100,0%	26,7%	0,1%	No	No	No
8	Dinant	43,7	36,7	100,0%	25,8%	0,0%	No	No	No
9	Gent	355,8	19	83,2%	28,5%	15,8%	Yes	No	No
10	Hasselt	539,4	19,9	93,6%	61,1%	0,0%	No	No	No
11	Hoogstraten	163,5	-3,8	100,0%	97,9%	0,0%	No	No	No
12	Huy	81,7	27,7	100,0%	56,7%	0,0%	No	No	No
13	Ieper	75,4	12,6	100,0%	20,4%	0,1%	No	No	No
14	Ittre	412,3	-1,8	100,0%	98,9%	0,0%	No	No	No
15	Jamioulx	314,8	35,7	100,0%	39,5%	7,6%	Yes	No	No
16	Lantin	907,6	30,8	92,4%	53,4%	4,0%	Yes	Yes	No
17	Leuven Centraal	342,1	-2,3	100,0%	92,0%	0,1%	No	No	No
18	Leuven Hulp	176,4	18,4	100,0%	37,1%	13,5%	Yes	No	No
19	Leuze-en-Hainaut	206,6	-33,8	100,0%	97,7%	0,0%	No	No	No

20	Marche-en-Famenne	304,6	-2,4	96,2%	84,4%	0,0%	No	No	No
21	Marneffe	132,0	0,8	100,0%	98,1%	0,0%	No	No	No
22	Mechelen	114,8	36,7	100,0%	22,0%	0,4%	No	No	No
23	Merksplas	541,4	-17,2	100,0%	50,7%	43,5%	Yes	No	Yes
24	Mons	400,7	30,5	88,1%	62,2%	5,8%	Yes	No	No
25	Namur	188,0	34,3	100,0%	39,9%	11,1%	Yes	No	No
26	Nivelles	243,0	26,6	100,0%	72,9%	0,0%	No	No	No
27	Oudenaarde	145,7	10,4	100,0%	63,4%	0,1%	No	No	No
28	Paifve	200,3	-2,3	100%	1,0%	98,5%	Yes	No	No
29	Ruiselede	56,7	9,1	100,0%	97,7%	0,0%	No	No	No
30	Saint-Hubert	215,4	-1	100,0%	98,6%	0,0%	No	No	Yes
31	Saint-Gilles/Sint-Gillis	751,5	28	100,0%	46,9%	0,4%	No	Yes	No
32	Tongeren	20,9	-16,5	100,0%	100,0%	0,0%	No	No	No
33	Tournai	195,6	6,9	100,0%	70,5%	0,0%	No	No	No
34	Turnhout	258,9	-3,8	100,0%	20,6%	36,2%	Yes	No	No
35	Vorst/Forest	495,1	37,4	100,0%	17,8%	18,4%	Yes	No	No
36	Wortel (&Tilburg)	785,1	-7,3	100,0%	97,9%	0,0%	No	No	No
	Mean	11040,7	10,1	95,6%	58,9%	8,2%	-	-	-

Source: Rapport Annuel DG EPI 2015 and informal info from DG-EPI
**Geriatric section or special care section for disable prisoners*

2.2.3 What is the demographic and social profile of prisoners?

The vast majority of the persons incarcerated in Belgium are men[n] (95.6%).

The jailed population is mostly composed of adults being 40 years or younger (more than 60% of incarcerated individuals) 25, 38. However, a slight increase in the proportion of elderly can be observed (Table 3).

Table 3 – Age structure of the jailed population in Belgium (September 1st 2008, 2010 & 2013)

Year	Total	<18	18 - 21	21 - 25	25 - 30	30 - 40	40 - 50	50 - 60	60 - 70	70 - 80	>80	Unknown
2008	10.234	0,3	4,6	12,3	19,1	33,5	19,1	8,3	2,1	0,6	0,1	0,1
2010	11.382	0,8	4,1	12,3	18,3	33,3	20,3	7,9	2,5	0,6	0,1	0,0
2013	12.697	0,6	3,7	11,3	18,3	32,6	20,9	8,9	3,2	0,6	0,1	0,0

Source: [25]

Some authors have stated that the increasing numbers of long term sentences brings forth the question of ageing of the penitentiary population, and the increasing necessity to set up specialised care (e.g. end-of-life care) for the elderly inmates [5, 37, 39-42] or internees [43].

Nearly half of all prisoners (45%) are of foreign nationality. In 2015, there were prisoners from over 130 countries incarcerated in Belgium [23]. The presence of foreigners has become more and more prominent in Belgian prisons [24], from 21,3% in 1980 to 44% in 2013 [44] and between 2003 and 2013 the number of jailed foreigners without residence permit rose from 1.657 to 3.174. This implies that in 2013, 59% of all foreigners incarcerated had no residence permit, a group which represented 26.1% of the entire jailed population [44].

Prisoners are often characterised by a low education level, low activity level and high unemployment – before incarceration. Half of them had already been in touch with justice while being underage. They also often have limited social ties. Most inmates come from broken families, characterised by exclusion, neglect and poverty. 40% of them were living alone before being jailed, and only 20% of the jailed men were married before their incarceration [45, 46]. In summary, inmates already experienced processes of marginalisation before being incarcerated [30].

[n] The fact that the majority of incarcerated people are male does not imply that the question of health care for jailed women (and their children) is absent from the literature and debate [5, 36, 37]

These demographic and social elements impact health care. Apart from language, elements such as culture and ethnic origins [47, 48], social class [49-51], gender [52] and age [53] impact the way people conceive notions as health and illness. Further, the difference between physicians and their patients with regard to social class may have a significant negative impact on the communication between both parties [54].

Further, inmates often belong to society's less powerful social groups. A low degree of (social) power relates to fatalistic conceptions of health and illness [55]. This is also referred to as an 'external locus of control'. People with an external locus of control perceive health and illness as something happening to them and on which they have no grip. Apart from the impact of the social background of incarcerated persons on their capacity to take an active role in their health, the specific context of the prison might increase their perception of having little grip on their health.

2.2.4 What are the health needs?

Health needs of prisoners differ from the main population's ones [15, 38, 56]. De Maere et al. [57] state that the inmate's social origins explain the higher prevalence of 'social diseases' such as for example tuberculosis, the latter being estimated 5 to 10 times higher than in the main population. Many prisoners (5-10%) have psychiatric disorders. Van Mol [5] states that psychoses appear 5 times more in the penitentiary population than in the general one. Substance abuse is an important health problem: one in three detainees uses drugs during detention [58, 59]. A recent study assessed the health needs using a structured questionnaire in a representative sample of 817 inmates in 12 purposively selected prisons in Brussels and Flanders [60]. It shows that inmates are in significantly worse health than the general population. This is obvious for outcomes relating to physical health (e.g. being in pain, having a chronic condition,..), health behaviour (e.g. smoking, healthy eating,..) and social health (e.g. trust, loneliness,…). Especially the generalized presence of mental health problems within the prison is remarkable. Although a detailed exploration of the reason of this extensive health burden was not possible, the study suggests that both the composition of the prison population and the specific living-and working conditions inmates are exposed to endanger their health. In 2015, 44 deaths were reported in Belgian prisons (approximately 4 per 1000 prisoners), of which 16 suicides (around 1 in 3 deaths).

More extensive information about health problems and health care needs of prisoners can be found in another chapter.

2.3 Health care organization and provision

It is important to note that some health care providers work for the Psychosocial sector in prisons, i.e. they fulfil a role of medical experts for the Justice Department and are not committed to provide clinical care. A given provider is necessarily affected either to the health care sector or the psychosocial sector, never to both sectors. The current section concerns only the health care sector.

2.3.1 What health care services are available?

2.3.1.1 Curative care

According to the aforementioned Dupont Act, the Health Care Service is in each prison responsible for providing primary health care. This includes general medicine, dental health care and psychiatry. Nursing and paramedic (physiotherapy) personnel also needs to be present, just like a pharmacy. Within bigger prisons, the service also provides specialist medicine (e.g. gynaecology, dermatology, radiology…), but the inmate can only get access to specialist and hospital care through a referral by a general practitioner [38]. In order to guarantee the continuity of care during the night and weekend, or during strikes of the prison's staff, an appeal to external care providers is made. The concrete modalities for the organisation of out-of-hours care are agreed upon by the prison's manager and the local medical organisations[37].

Hospitalisation can be made in the prisons of St-Gillis/St-Gilles and Brugge (which both have a Medical Centre (CMC) where other prisons can send their inmates for diagnosis and treatment by medical specialists; according to Van Mol there are 24 hospital beds in CMC Brugge and 13 in CMC St-Gilles [5]. Moreover, the prison of Lantin hires 4 beds in a secured room at the Hospital La Citadelle in Liège [61]. The inmates are, in case of emergency,

sent to local hospitals. In 2009 there were 1018 hospitalizations, either in the CMCs or in a local hospitals[o].

Some prisons are furthermore equipped with special psychiatric sections for internees and detainees with psychiatric disease. Finally, in the prisons of Merksplas and St-Hubert, there is a care ward for elderly inmates and disabled persons in (see Table 1) [37] [5].

HIV and Hepatitis B and/or C testing on admission and HIV testing on release are offered, if requested by the inmates. These services are however only available to less than 50% of all inmates. Condoms and vaccinations against hepatitis are provided. The latter is provided free of charge and on request, and offered to risk groups in a minority of prisons [62].

According to data from 2012/2013, there are four Centres for Social Defence specialised in the treatment of internees in Belgium, 3 of which are situated in Wallonia. Two of these are under the supervision of the Walloon Region (Tournai and Mons) and one depends directly from the FPS Justice (Paifve). If there are no places available in these centres, the internees are put in the psychiatric section[p] of Forest/Vorst (n=52), Jamioulx (n=16), Lantin (n=40), Mons (n=23), Namur (n=22), Antwerpen (n=51) and Leuven-Hulp (n=40) (overall n=244) [63]. Until 2014, no Centres for Social Defence were set up in the Flemish Region, where the emphasis is put on classical psychiatric hospitals, psychiatric sections of the prisons and the development of "external care circuits" [14]. However, in 2014 the first Forensic Psychiatric Centre[q] in Gent[r] (n=264) was opened [64].

The mental health care is provided in the prisons' psychiatric sections by a psycho-medical care-team, which has to be composed of psychiatrists, psychologists, nurses, occupational therapists, educators and psychomotor therapists [5]. While psychiatrists also provide mental health care to all prisoners, they spend a lot of their time treating the internees [63].

In order to support these health care providers, and to achieve a similar health care provision in every prison, the Service Health Care Prisons (SPF Justice) issued guidelines regarding substitution treatment and infectious diseases, and procedures for dentists, physiotherapists, and psychiatrists [5]. Also the Penitentiary Health Council issued advices [7, 36, 41, 65-71], as did Raadgevend Comité voor Bio-ethiek[72].

2.3.1.2 Health promotion

Health promotion is under the political responsibility of regions. In Wallonia and Brussels there were, during the period 2013-2014, programmes focusing on health promotion and prevention (14 prisons), drug uses (9 prisons), alcoholism (9 prisons) and mental health (4 prisons) [73]. Bertrand and Clinaz[73] report that there are however not enough means devoted to these programmes. Moreover, the offer is insufficient compared to the large number of inmates, and the offer is rather unequally distributed (i.e. some services are absent in some prisons).The individual annual reports of the prisons in Flanders learn us that in each of them one can find programs for drug users and problems, and mental health issues [74, 75].

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[o] https://www.senate.be/www/?MIval=/Vragen/SVPrint&LEG=5&NR=5547&LANG=nl

[p] The psychiatric hospitals and institutions, and the Centres for Social Defence are not included. The presented figures also do not include the cells for Social Defence situated in the Belgian prisons. Concretely, the prisons of Brugge, Merksplas and Turnhout are not presented here.

[q] A second FPC (182) is under construction in Antwerpen [64] and the university psychiatric centrum Sint-Kamillus in Bierbeek will welcome soon 30 internees (http://www.deblock.belgium.be/nl/maggie-de-block-en-koen-geens-zorgen-samen-voor-langdurige-forensische-opvang-ge%C3%AFnterneerden)

[r] The FPC Ghent is funded partially by the FPS Justice (accommodation and security) and partially by the HIS (care, medical drug, and medical honoraria).

- Regarding the drug users programs, there are several projects [37, 76, 77]:
  - The drug-free department of the prison of Brugge
  - The central Registration Point Drug Use: in Flanders known as Centraal aanmeldpunt voor druggebruikers (CAP), in Wallonia as 'Step-by-Step', and as 'Le Prisme' in Brussels
  - The B.leave project in Ruiselede
  - The project Boule-de-neige in Wallonia and Brussels

Since 2006, each prison is obliged to set up a 'local steering group drugs', in collaboration with extra-muros aid workers, and under the supervision of the prison's manager and chief physician. Moreover, two coordinators, appointed by the SPF Justice, connect the local prisons and the central administration and uphold the collaboration with the extra-muros drug welfare work. However, the functioning of these local steering groups is reportedly low (see below).

2.3.1.3 Health protection

The members of the Health Care Service further contribute to the protection of the staff's and inmates' health. Health protection includes, among other things, hygiene, food, wellbeing at work, the distribution of medication and the removal of medical waste [37]. But this is seldom applied (cfr. le guide du prisonnier en Belgique)

2.3.1.4 Legal obligations

The Dupont Act prescribes that every incoming inmate has to be evaluated by a physician within 24 hours after admission to the prison [5]. It is also during this first encounter that the general practitioners screen the inmate's mental state [78]. This first consultation is also done for any transfer from a prison to another. Further, within four days after his/her arrival, the inmate is received by a member of the Psychosocial Service.

Additionally, the Health Care Service also provides support to drug use programmes, and to departments where inmates are subjected to individual and special security measures.

2.3.2 How many health care providers are involved?

Nurses and physicians clearly represent the bulk of the penitentiary care workforce. Both groups comprise almost 8 out of 10 intra-muros care providers. The nurses and physicians are followed by the physiotherapists, dental care professionals (dentists and their assistants), and the psychologists. These groups represent respectively 6%, 5% and 2% of the total care work force Finally, a last category regroups different providers such as for example pedicures, social workers, therapists, speech therapists… These 'Others' represent about 10% of the total workforce.

Within the health care workforce, a difference can be made between self-employed (52 %), employed care providers (30 %), and interim workers (18 %). Physiotherapists and dentists are all self-employed, while their assistants and the psychologists all work as employees.

Nurses constitute the most important group of care providers. They represent 45% of the total available human resources. Almost 85% of the nurses are employees, either as interim workers (45% of the employee-nurses) or as direct employees of the FPS Justice (55% of the employee-nurses). Nurses constitute 70% of the care staff which is directly employed by the FPS Justice in prison.

Physicians are the second most important group (N=248, 32%), and consist of both general practitioners (50% of all physicians) and medical specialists (50% of all physicians). Contrary to the nurses, physicians are almost exclusively self-employed (99% of all physicians). Table 3 provides an overview of the number of physicians providing medical care in Belgian prisons, according to their discipline. Psychiatrists represent the greatest group (33%) of medical specialists, followed by the dermatologists (13%), radiologists (9%) and gynaecologists (6%).

Table 4 – Number of physicians according to discipline (at national level)

Discipline	Number
General practitioners	124
Psychiatry	41
Dermatology	16
Radiology	11
Gynaecology	7
Orthopaedics	6
Otorhinolaryngology	5
Cardiology	4
Surgery	4
Urology	4
Ophthalmology	4
Physiology	3
Gastroenterology	3
Infectiology	3
Internal medicine	3
Anaesthesiology	2
Neurology	2
Paediatrics	2
Pneumonology	2
Plastic Surgery	1
Stomatology	1
Total	248

Source: Invoices from the Services of Health in Penitentiary Institutions from November 2015

In January 2015, the FPS Justice employed 288 persons (i.e. 244,45 FTE) directly within the prisons' health care departments [64], mostly nurses and paramedics.

The aforementioned 288 statutory and contractual health care providers are complemented by 500 self-employed workers (general practitioners, medical specialists, dentists, pharmacists, nurses…), interim-nurses, and health care providers and collaborators with an external employer (e.g. assistance in case of drug abuse) [5].

Various failures have been reported by the International Observatory of Prisons [18]:

1. Failure to provide independent health care. Budgetary considerations can influence therapeutic decisions,
2. Failure to offer access to a general practitioner or to specialised care at the right time. Understaffing of medical personnel results in very short consultation times, discontinuous care outside duty hours, and long waiting lists for some health care disciplines (e.g. dental care). Screening by duty prison staff of prisoners' requests for access to the medical staff has also been reported, as well as the performance by non-medical staff in custodial functions, of work for which they are not qualified, such as distributing prescribed medicines,
3. Failure to offer and carry out any medical entry examinations or unreasonable delays in doing so have also been mentioned,
4. Failure to effectively enable and organise continuity of care for prisoners on transfer. Understaffing of prison personnel and/or police departments makes the transfer of prisoners to regular health facilities for complementary exams difficult. This results in exams being postponed,

5. Failure to develop programs of health prevention and promotion[s], the prisons' medical departments focus almost exclusively on curative medicine. Physicians have no time to spread prevention messages, and educational brochures are scarce (and come mainly from the civil society). Moreover, screening for transmittable diseases is not offered to all prisoners, but only to those persons belonging to a group deemed hazardous,
6. Failure to provide and carry out a comprehensive drug policy for prisoners that combines medical detoxification, psychological support, life skills, rehabilitation, substitution programmes and prevention[t].

The care for internees is often pointed out as major problem in terms of health care and ethics. Although the governmental masterplan for prisons[u] foresees the opening of 860 psychiatric beds for mentally ill offenders, in 2015, 8% of the prisoners in Belgium are internees [23]. In principle, they should be interned in institutions for social defence which are intermediates between prisons and psychiatric hospitals (in 2015, around 200 were indeed kept in the Paifve centre for social defence). However a proportion of mentally ill offenders are also incarcerated and placed in the psychiatric sections of prisons, which are overcrowded and where the psychiatric follow-up is sub-optimal or even non-existent [11, 14, 16, 17, 19, 37, 82].

Another issue regularly pointed out is the overcrowding of prisons. On average, the number of prisoners is higher by 10% to number of beds (see Table 1). This average figure hides the fact that in some prisons the rate of overcrowding is much higher (more than 30% in Berkendael, Dinant, Forest, Jamioulx, Lantin, Mechelen, Mons, Namur) [23]. Moreover, temporal variations in prison population through the year may result in peak of overcrowding. The governmental masterplan for prisons[v] foresees the building or renovation of 1 432 beds.

Prisoners themselves can express their complaints during the regular visit of the local surveillance commissions[w]. About 10% of the complaints that are filed by prisoners refer to the health care provided in prisons. Most of these complains focus on the organisation of care (49%) and the consultations/examinations during detention (25%). Prisoners denounce the long waiting lists for specialised care (mainly psychiatric and dental care), the lack of continuity of care, and a sub-optimal quality of care [12].

Regarding (illegal) drug use help, it is stated that this is insufficient and that the deployment of an integrated penitentiary drug policy stagnates (or even declines). Moreover, the local steering groups only gather sporadically and the national coordinators' job time has since 2013 been radically reduced [37, 73, 76, 83-85].

The Dupont Act's implementation is selective and delayed. The inmates' rights regarding health care are still not legally enforceable [5, 37]. The limitations imposed by the Dupont Act are deemed as being in contradiction with the Patients' Rights Act. The principle of equivalence indeed also implies equivalence between the prisoners' rights and those of every citizen [37]. Put briefly, as one author states, it seems that the Dupont Act has not changed the prison, rather the opposite occurred [86]. The Dupont Act was adapted to the existing logic of the prison social context [86], i.e. one based

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[s] The Observatoire International des Prisons observes here that the question of sex within the prison's walls remains a taboo subject. [18,] See also [79]. It is noteworthy that in Belgium the theme of sexuality within prison walls is underinvestigated. The sole exception being the doctoral dissertation of Axelle François [80].

[t] Michel and colleagues observe that, based on an analysis of 50% of all Belgian prisons, there is a low level of adherence to international recommendations for preventive interventions regarding HIV and Hepatitis C. [81]

[u] Approved in May 2016 http://www.deblock.belgium.be/nl/terugdringen-overbevolking-gevangenissen-en-aangepaste-opvang-en-zorg-voor-ge%C3%AFnterneerden

[v] Approved in May 2016 http://www.deblock.belgium.be/nl/terugdringen-overbevolking-gevangenissen-en-aangepaste-opvang-en-zorg-voor-ge%C3%AFnterneerden

[w] The Central Supervision Council for the prison system and the related local commissions supervise the way inmates are treated and all relevant instructions. http://www.ctrg-ccsp.be/nl

on a security and disciplinary rationality. This issue is discussed more in depth in another chapter.

2.4 SWOT analysis based on key informants' view

The research team interviewed 18 key-informants, in 15 interviews (some respondents asked the presence of a colleague in order to be able to provide more detailed information): a general practitioner working within the prison, a general practitioner working outside the prison, a former civil servant, a surgeon formerly working in one of the medical centres, two security officers, two psychiatric nurses, two nurses, two welfare workers, two drug welfare workers, a psychiatrist, a psychologist, and two prison managers.

2.4.1 Strengths

With regard to the strengths of the health care in Belgian prisons, the following broad topics are redundantly mentioned by the respondents: organisation of care, access to care and health care staff.
Organisation of care

Some aspects of the organisation of care within prison walls are identified as strengths by more than 6 respondents. With regard to the provided care, most respondents state that the somatic care within prison walls is functioning. Furthermore, they mention that the inmates have an easy access to medication, although they recognise that this easy access is not advantageous per se (the important pitfall is that it is associated with a reduction of psychological care and an increase of the use of psychotropic medication– see also the part on weaknesses). Next to this, the respondents stress that the Belgian prison health care has a good functioning screening and that the basic medical equipment is sufficiently present.

2.4.1.1 Access to care

Most respondents further stress that access to care (including the in general positively evaluated medical centres) is an important strength of the current health care system in prisons. The population in prisons is predominantly made up of people from marginalised or weakened social groups, who have difficulty getting access to health care outside the prison walls. Prison health care is seen by the respondents as a way to offer health care to individuals or group who normally do not find their way to professional health care. This is described by one of the interviewed general practitioners as follows:

> *"The opportunities that it offers, which I see, is that you can reach people there [the prison] which you normally would not reach… when I look at the population [the inmates], there are a lot of persons who… fall short in health care or that you cannot reach with the health care, for whatever reason. And when they are with us… okay they do not have much of a choice. Relatively they do. But at least they get seen once when they enter my office, and if we detect something, yes, then we often start a follow up." (General Practitioner).*

2.4.1.2 Health care staff

Finally, the last strength of prison health care advanced by the respondents is the staff working in the prisons. The respondents describe the staff members as motivated and involved people, who display idealism and care ethics. This is illustrated by the fact that they are resourceful, and seek practical solutions when confronting problems in their daily work. It is important to stress that the respondents agree that the nursing personnel is an important group of the staff. The identified strengths in the position of the nursing personnel is that they have a good knowledge of the inmates and the prison guards, are easily accessible and are constantly present.

2.4.1.3 Other

Other strengths of the current health care provision, which are however mentioned by less respondents, are organisation of work, the labour status of the staff, the infrastructure and the relations between inmates and care providers. Regarding the first, some respondents value the collective aspect of prison health care. As the following citation illustrates, this mainly refers to the easy (in)formal collaborations between different care providers:

> *"Yes, the way…of organising things… you're really surrounded. That's different in the private practice, (…) there you have to organise much more by yourself. There… a part of the tasks is taken over by the nurses. (…) And also (…) you work very closely with these nurses. That's something different (…)" (General Practitioner).*

The second item, employment status, refers to the good wages for statutory care providers, and the physicians' voluntary commitment. Respondents claim that it requires a certain personal commitment to provide care within the prison's walls. This view is expressed as follows:

> *"If it is not your thing, you won't survive in here. (…) I talked a lot with people who said 'yeah, you will never get me inside" (General Practitioner).*

Regarding the available infrastructure, some respondents referred to the improvements regarding hygiene and the adaptations made for disabled inmates in recently build prisons.

Finally, during one interview, respondents stated that their independence from FPS Justice as welfare workers facilitated forming a trusting relationship with the inmates.

2.4.1.4 Summary

To summarize, the respondents emphasize the easy access for inmates to somatic health care (with good access to medication and which is properly equipped on a basic level), provided by a dedicated and resourceful staff as the most important strength of the health care in Belgian prisons. In this context, the nursing staff is referred to as a key role player.

2.4.2 Weakness

In general, seven weaknesses of the current health care system in prisons are mentioned be nearly all respondents : the workload, the relations between care providers and other staff members, the organisation of care, the relations between care providers and inmates, the employment status, the training, and the relations between care providers.

2.4.2.1 Workload

Regarding the workload, respondents indicate that in their opinion their workload is extremely high: the relation between the (high) demand for health care by the inmates on the one hand, and the provided health care on the other hand is said to be out of balance. The respondents attribute the high demands for health care by prisoners to the 'wrong' use by some inmates of the health care services. They mention that some of them use the health care services for demands not directly related to health issues. For instance, it is mentioned that inmates sometimes go to health care services in order to get out of their cell or to meet other inmates. Further, respondents indicate that some of the inmates consider the physicians as their "candy shop" (quote by Security Officers), i.e. the place where they only seek to get medical drugs. Almost all of the respondents mentions the understaffing of the health care services. The imbalance between demand and provision is worsened due to the absence of a system of triage.

2.4.2.2 Relation between care providers and other staff members

In contrast to the collaboration between care providers, respondents describe the relations between care providers and other members of staff (especially the security staff and the management) as being essentially difficult and characterized by tension and suspicion.

A first aspect of the difficult relation between care providers and security staff, is the mutual interdependence between their respective tasks, meaning that one group's actions impact the other group's work. For example, the decision by health care providers to transfer an inmate to the prison's medical service or to an external hospital has a profound impact on the (already high) workload of security officers, as illustrated by the following citation:

"Say that you refer someone to the hospital, then the consequence is that they [the Security officers] need to send someone (…) but it is not that they let these come from somewhere else, they come from the normal pool. So, the consequence is that there is indeed less staff left on the floor, or that people have to interrupt their day off. So, this impedes the relation sometimes." (General Practitioner)

In turn, care providers experience to be '"dependent on the security officer's good will" (quote by Surgeon) for the successful performance of their work, e.g. to get access to the inmates:

"While they [security officers] can have the feeling 'you provide us with extra work', and that we can have the feeling 'you thwart us, you do not call this inmate fast enough…" (Welfare workers)

Secondly, care providers complain about the breaches in their diagnostic and therapeutic freedom (closure of care provision) which is essential to care provision. While care provision is in theory exclusively in the hand of professional care givers (i.e. the closure), respondents testify of the existence of security officers and managers' interference in the exercise of their work. While it is admitted that in some cases this interference can be driven by good intentions, care providers still highly resent such interferences.

Thirdly, the communication problems between care givers and other staff members are emphasized. Essential in this situation are the conflicts and tensions that are caused by (1) on the one hand the wish and obligation for care givers to safeguard their professional secrecy, and (2) on the other hand the wish of the security officers and managers to know what is going on within the prison. The fear of being contaminated by communicable diseases– and of consequently contaminating the officers' relatives, e.g. by TBC – helps explain the security officers' stance on this issue. As the Security officers stated, *"medical secrecy only goes to the point…that our security is not compromised."*

Fourthly, the interviews show the impact of the discrepancies between both groups regarding the understanding of the domains 'care' and 'health'. Respondents mention the security officers' lack of 'health knowledge' to be very influential, as is illustrated by the following quote.

"TBC, Hep C, HIV came in. (…) And they wanted at some point to have a sign on the cell's door on with the Name and 'HIV'. … We [the physicians] had to explain. There were also afraid that this was contagious…hallucinating, their representations of the contamination by HIV." (Surgeon).

This lack of "health knowledge" also causes security officers to possibly misinterpret symptoms associated to a specific health issue (e.g. aggressive behavior, scolding), and thus react in a wrong way from a care point of view (e.g. isolation instead of treatment). Further, the absence of this health knowledge facilitates feelings of fear to thrive (as is illustrated by the quote above):

"You sometimes see a lot of concern about cases … When an inmate gets screened for TBC (…) and it appears that further examination is necessary, then they [the inmate] need to be isolated. And… these security officers, these people freak out. I understand that, they do not know anything about that." (General Practitioner).

Moreover, the care providers complain about the security officers' lack of understanding when it comes to the health care. The security officers do not understand the precise role of care providers and the meaning of their work.

"Managers and security officers do not always understand the sense of our presence, and of our action" (Psychiatrist)

"[difficult relations with security officers] sometimes due to ignorance, or not really knowing what this [the care activity] really is about." (Welfare workers).

The above described 'conflicts' between care providers and security officers are essentially presented in the interviews as a contradiction between two logics, the logic of care and the logic of security. The analysis of the respondents' answers reveals however that the conflict rather seems to be based on the different meanings people give to the notions of care and security. Concretely, out of the interviews emerges a contradiction between those who use a narrow definition of the notions of care and security, and those with a broad definition. This implies that on the one hand, some see care as those actions aiming at the absence of disease (narrow definition of health), and security as aiming at the absence of violence (narrow definition

of security). On the other hand, there are those who conceive care as those actions contributing to the social, physical and psychological wellbeing of people (broad definition of health), and security as those actions favouring the well-being within society (broad definition of security). Caregivers mention that the narrow definition of care is omnipresent in other disciplines working in prison, which could explain the above mentioned tensions.

According to the interviewees, however, this situation is different for the various disciplines providing care in Belgian prisons. For instance, the relationship between nurses and the security officers is considered less problematic than the relation between security officers and the physicians. A possible explanation could be the constant presence of the nurse, allowing for a better relationship with the security staff. For the security staff, the physician appears to be a figure who simply "comes and goes" (quote by Manager), and is never seen by the majority of the staff members.

> *"In fact, we [the Security Officers] never speak with that man [the physician] (…) or it is by chance in the hall (…) there is no relation." (Security Officers)*

> *"He [the physician] has his own patients and practice outside…If I am allowed to put it a little bit in a disrespectful way, it is a small complementary job here in the prison, he comes quickly, sees his persons, and he is gone" (Security officers).*

Furthermore, the issue of perceived differences in status between the doctor and the security officers is mentioned by some respondents as a potential explanation for this situation.

> *"The security officer always has the feeling of being the inferior…they still have the feeling of being abandoned…they have the feeling, when they call the physician that the physician leaves them alone with the problem." (Manager).*

> *"I always said, address them [the security officers] as human beings, not in an elitist manner as a physician because you think that you are superior to them." (Surgeon).*

2.4.2.3 Organisation of care

The respondents also attracted the attention to different problems regarding the general organisation of care as weaknesses in the current health system.

Type of care provided

A first aspect evaluated as a weakness concerning the organisation of care refers to the type of care provided. The respondents admit that they can only but offer the basic somatic care or basic welfare services, due to the lack of means and the high workload. As was said during an interview with nurses working in prison, the high workload fosters a feeling of being in an "assembly line work". Most respondents mention important weaknesses in the provision of mental health care, which is mainly reduced to the drugging of inmates and is perceived as inadequate with regard to offering psychotherapeutic care. Further, respondents also point to the insufficient attention for preventive care (e.g. smoking, sexual health), the limited spread and use of clinical guidelines and care protocols by care givers and the rather organisational character of these protocols, i.e. focused on procedures and not on treatments.

Continuity of care

A second aspect of the organisation of care which is considered as a weakness is the continuity of the provided care.

The respondents firstly point to the long waiting lists for specialised care such as the medical centres[x], dentists, and psychiatrist. Secondly, the impact of the security staff's strikes in this matter is cited by diverse respondents. While they recognise the right to strike and the legitimacy of the strike's reasons, the respondents however state that strikes have a negative impact on their work; the provided care gets limited to the strict necessary care and the extremely urgent cases. Thirdly, the continuity of care is hampered by the electronic medical file, which was during an interview described as being "catastrophic" (quote by Psychiatrist). Respondents not only refer to its non-user-friendly character. They also emphasise that necessary information is often missing in the medical files (incomplete registration) or that the included information is not well registered (lack of quality). They explain the problematic registration by (1) the physicians' reluctance regarding paperwork, and (2) the experienced time pressure care givers face – leaving them with little time to fill in all necessary information. Fourthly, some respondents also stated that the continuity of care in the different psychiatric annexes is jeopardized by absence of care givers during the night and weekends, mainly in different psychiatric annexes, and the irregular presence of physicians within the prison. Fifthly, the continuity of care when an inmate gets transferred is also judged problematic by some respondents. The lack of continuity at the moment of transfer is not only attributed by the respondents to the aforementioned weaknesses of the medical file, but also to disparities between prisons regarding the locally provided psychological treatments and welfare programs. It is thus possible that a transfer hinders the follow-up of a therapeutic program started up in a specific prison, because it is not available in the new prison. Caregivers further complain about the fact that they get informed very late – or not at all – of either an inmate's transfer to another prison or his/her release. This brings forth the final problem regarding the continuity of care. There is little guarantee that the provided care is continued outside the prison walls; there is a lack of information about the moment of release (see above), care givers do not systematically provide a referral letter to the inmates, foreign inmates do not necessarily have a general practitioner in Belgium, and isolated and marginalised persons experience important difficulties to find access to health care in the "parallel circuit" of regular health care, often due to lack of resources (documents, network of friends and kin, money…). Even if former-inmates have access to care outside the prison walls, the exchange of medical information (medical files) between caregivers within and outside prison walls is described to be very difficult.

The prison as an environment for care

The context in which health care takes place is also perceived as a weakness of the current health care organisation in Belgian prisons.

This aspect covers different dimensions. First of all, respondents stress the harmful character of the imprisonment itself, i.e. the so-called detention harm. As the following citations show, some respondents describe the prison as a pathogenic and criminogenic environment:

> *"When you put someone in a cell for most part of the day, then this does not only have a mental but also physical…you get complications. Even if you are well (…) if you do this to a human being, it will have an influence on his mind and body" (Psychologist).*

> *"You criminalise in prison." (General Practitioner).*

Secondly, the prison is also the physical context in which care givers act; respondents complain about the dilapidated state of some prisons and IT infrastructure. They denounce that most of the prisons are not adapted to the needs of disabled inmates and the provision of care in general. Put briefly, the respondents complain that the prisons' design does not take the provision of care into account.

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[x] During an interview it was stated that inmates are reluctant to go to these medical centres, because they 'lose' their cell when they are transferred. Consequently, they favour treatment within mainstream hospitals.

Thirdly, respondents problematize the uneven relation between care and security within the prison's walls. The respondents acknowledge the specific nature of the prison, with its focus on security. However, they criticise the prioritisation of the second over the first, and see the prison's internal regulations – or a plethora of rules – as obstacles to care:

> *"You work within the contours and rules of the house. I think that we sometimes have wild plans and ideas, and that then you need to readjust these because some material is not allowed, or that you cannot bring together that much people without surveillance. (…) Yeah, there are a lot of rules to respect (…) but yeah, we know that, and we take it into account (…) but sometimes you think 'if it could be possible then it could all happen more fluently (…) Some of these rules are there because they need to be there, because of the security aspect (…) These rules are obstacles, but they will always be there in the context of the prison." (Welfare workers).*

This brings respondents to speak of the prison as a 'care-killing' environment, or to express the feeling that care is not a priority – when compared to the overall functioning of the prison, as is stated in the following citations:

> *"These are moments of crisis [an inmate being catatonic during three weeks]. And Justice is a little bit afraid of this, the security is afraid of this. Because it is unpredictable. You cannot, or with more difficulty, predict what that kind of people will do. And the reaction is often…'we will put him preventively for aggression during a night in an isolation cell (…) The idea that during a crisis you need to provide the most care, that's foreign to Justice." (Psychologist).*

> *"In a hospital, they have a care culture. Here it is not a priority. The priority here is: food distribution, visits (…) Then, we need to wait to provide an injection, which is important, and we need to wait because it's soup time … and then everything comes to a standstill." (Psychiatric nurses).*

2.4.2.4 Relations between care providers and inmates

The relation between care providers and inmates appears as a difficult one. A first difficulty is the distrust between both parties, which hinders the constructing of a therapeutic relationship. Inmates are distrusting towards care providers because they perceive the care giver as being a part of the judicial system, and thus have doubts regarding the care giver's professional secrecy. As was said during an interview:

> *"The main issue, and which we have to fight every day, is the impression of our affiliation to the judicial system. This is, and especially for the new patients, a major difficulty during our initial encounter that they come to see us not as a pawn of justice, that it [justice] does not own us, and that we do not have to account to it. That's complicated." (Psychiatrist).*

Inmates, further, can lack privacy when interacting with the care giver because of the presence of security officers and/or other inmates, for example acting as translators, and they cannot freely choose their caregiver. The caregiver, in turn, is afraid of being manipulated by inmates seeking to get medical drugs or other advantages (e.g. an official attest for the Sentence Enforcement Court), or sees only a prisoner – and not a patient. Such view is clearly expressed by the following quote:

> *"The shadow of the 'inmate' crushes everything [person as a patient with rights]" (Psychiatrist)*

Secondly, both parties are mismatched. Put differently, they do not know each other. This means that, on the one hand, inmates are not (fully) aware of the precise role and relevance of the care providers, and thus get confused or have wrong expectations when consulting care givers. On the other hand, the respondents attract attention to the difficulties they have to interact with the inmates due to language barriers. It is also important to stress here that different respondents considered the written aspect of health care in prisons (written demand for a consultation, brochures…) as an obstacle for the (illiterate, mentally feeble, foreign) inmates access to care.

2.4.2.5 Training

In general, different respondents identify the lack of specific training as a weakness in the current health care system. Three big issues concerning training are stressed in the interviews. Firstly, the respondents state that it is very difficult for them to attend the training sessions organised by the FPS Justice, even if they express the desire to do so. The main reason for this is their lack of time. Respondents state that the distances – sessions are organised in Brussels – and their high workload, makes it impossible for them to attend these trainings. Further, according to the respondents, there are no training sessions for the interim workers. Finally, they criticise the rather scant amount of time devoted to the aspect care within the security officers' training.

2.4.2.6 Employment status

The labour status was also presented as a current weakness in the system. The main issues here were the health care providers' remuneration, the precarious character of the interim workers' statute, the absence of a formal contract between the administration and the physicians, and the absence of promotion possibilities for the care providers.

2.4.2.7 Inter- and intradisciplinary collaboration

Respondents complain about the non-integrated character of care in prison, and some respondents refer to the lack of collaboration between different caregivers by referring to the disciplines as being fragmented. As such, they refer to the lack of sustained relations between the different care providers. Due to a lack of time, care givers do not meet and do not know each other, and the necessary information and knowledge does not circulate between them.

> *"If I look at my colleagues…the general practitioners, we do not see each other enough (…) from time to time I see them pass. But that is very exceptional, when I have to be there during the evening then I see my colleagues… and then once in a month on the staff meeting. That is really limited. That's too little." (General Practitioner)*

> *"We don't know who… Who is the psychologist in charge of the inmates?...Who is the social worker?...Who do we need to address regarding the organisation of courses?" (Surgeon).*

2.4.2.8 Staff

Finally, respondents attracted the attention to the staff's high turnover and the rather inexperienced welfare workers (due to their young age).

2.4.2.9 Summary

To summarise, the most redundant weaknesses are the following: health care gets limited (in its impact, content and continuity) by the prison environment, a fragmented care provision, a lack of means and opportunities (e.g. staff, time, training), and distrust and tensions between the different actors.

2.4.3 Opportunities

The following broad teams were mentioned as opportunities for the current health care system in Belgian prisons; the experience and expertise of external care providers, alternative forms of detention, HIS intervention, and legislation.

2.4.3.1 External care providers' experience and expertise

The first element, and the only redundant code in the broad theme of 'opportunities', refers to the experience and expertise of external care providers regarding the provision of care to socially fragile groups (e.g. social work), and the collective organisation of this provision (e.g. in hospitals or Community Health Centres).

2.4.3.2 *Alternative forms of detention*

Secondly, some respondents spoke of the alternative forms of detention such as the Scandinavian model, or the Huizen projecty, which emphasise the inmates' re-integration.

2.4.3.3 *Other*

Finally, some respondents attracted the attention to the already existing HIS' intervention into the costs of prison health care, the existing Patient Rights Act – which should apply without limitations within the prisons.

2.4.3.4 *Summary*

To summarise, the most redundant view regarding the opportunities is the following: the external care providers possess the expertise and experience regarding the provision of care to marginalised groups and the collective organisation of this provision.

2.4.3.5 *Threats*

The following environmental elements were redundantly mentioned to hamper the realisation of health care provision in Belgian prisons: budgetary restrictions/cuts, relations with external care providers, and the social representations. Less frequently cited threats to health care provision in this context are the legal frame, the production and transmission of knowledge, and the inmate's past.

2.4.3.6 *Budgetary caps*

One of the most cited threats by the respondents are the budgetary caps. The respondents state that these hamper the possibilities for (1) training of the staff , (2) health prevention and re-integration of inmates; (3) the relations between intra-muros care providers, "which dilute because people get overcharged" (quote by Surgeon), (4) the offer and quality of prison health care, (5) the number of security personnel; and the regime applied to prisoners.

> *"…the budgetary caps within Justice, this will have an impact on the detention regime. As a consequence, they (the inmates) will stay even more in their cell. And this will automatically impact certain aspects on which we work, like health. Staying longer in the cell, feelings of depression and fear, the fact that they will be more alone (…) yeah, isolation, no more human contact, not even with the security officers because they do not have any time because they need to fill in the gaps and run from one place to another". (Welfare workers).*

2.4.3.7 *Relations with external care providers*

The existing relations with external care providers are described as (extremely) difficult, whereby there is little to no interaction between internal and external care providers. Firstly, respondents speak of the difficulties external care providers face when they seek to enter the prison. Secondly, respondents state that external care providers refuse to collaborate with their intra-muros counterparts, or are reluctant to treat inmates – even former inmates. This reluctance is based on specific challenges the extra-muros care provision faces on the one hand, and on specific social representations (see here after), on the other hand.

Regarding these challenges, firstly, the de-institutionalisation of mental health care leads to the disappearance of beds for heavy mental pathologies. As a consequence, the prison (and its annexes) becomes the sole "asylum" for these problematic cases (Psychiatrist). According to one respondent: "the external world did not offer anything, and did not want to"

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[y] The Huizen project pleads in favour of replacing the existing prisons by more or less hundred small scaled 'houses of detention', which are integrated into the fabric of the 'free' society as much as possible. Within these small scaled houses prisoners would benefit from a personalized approach.

(quote by Surgeon). This leads to the impression that the external psychiatry uses the prison as a way to get rid of its (most) problematic cases.

Secondly, respondents point to the fact that external care providers consider the provision of care to (former) inmates as an extra burden on their already tight resources and time schedules. Regarding the latter, respondents clearly state that some local medical associations refuse to send their members to provide care within prisons during the night because of the feared loss of time at the (difficult) entry of the prison – due to the prison's security measures.
Social representations

According to the interviewees, social representations of prison and prisoners hamper not only the relationship between external care providers and (ex)inmates, but also the relations between intra- and extra-muros care providers.

The social representations of prisons and prisoners impact the way people outside the prison both analyse and evaluate a subject (e.g. prison). Respondents state that a weighty view in contemporary society is this of the imprisonment as an act of retaliation by society. They spoke here of the repressive thinking present in society, i.e. the "contemporary discourses of vengeance" (quote by Psychiatrist). As the respondents stated, policy makers take the public opinion into account when designing the public policies. The implication of such a view is the limited public support for programs seeking to foster the inmates' re-integration in society. As stated during one of the interviews, "investing in inmates is not popular. It is more popular to invest in children than to invest in a child murderer" (quote by Welfare Workers). Respondents clearly state that the prison is perceived as being a "luxury hotel" (quote by General Practitioner) in which inmates have an easy life spending their days gaming , as "dependents" (quote by Psychiatrists) living on the tax payers' back. The prison is also perceived as a place of danger. External care givers' view of inmates as "sources of potential harm" hinders their interaction with the inmates. Respondents mention that this prevailing negative attitude impedes former inmates to seek care after their release due to the stigma associated to prison. Further, the prison is seen as a 'dumpster', and not just for inmates. Indeed, not only the latter are being perceived as being people of low quality, the respondents also feel they are perceived as such by their external colleagues.

2.4.3.8 Other

Less redundant threats to the current health care system were the legal frame, the inmate's past experiences with care, and finally, the production and transmission of knowledge. The first refers to the absence of the execution decrees for these articles of the Dupont Act pertaining to health care. Secondly, respondents mention the absence of specific programs or centres within the Medical Faculties dedicated to the production and dissemination of knowledge regarding the forensic field, especially forensic psychiatry. Finally, previous negative experiences of inmates with welfare work outside the prison walls is mentioned in one interview as a possible threshold for the work of care providers within the prison's walls.

2.4.3.9 Summary

To summarise, the respondents' most redundant view on the posed threats is the following: prison health care is at risk of being cut off from the rest of society, and its resources.

2.4.4 Possibilities for improvement

Talking about the strengths, weaknesses, opportunities and threats for health care organisation in Belgian prisons, respondents also suggested some possible improvements. The following views were expressed (from the most to the least redundant): the organisation of care, the relations between care providers and security staff, the possibilities and means, the employment status, the training, and the relations with the inmates.

2.4.4.1 Organisation of care

Regarding the organisation of care, the respondents expressed the wish to see, firstly, improvements with regard to the access to care. More precisely, the suggestion is made to organise a system of triage, both internally (by the nurses) and externally (for example, to refer inmates with heavy psychiatric burdens to appropriate forensic care instead of entering in prisons who are not adjusted to treat them). Also, respondents suggest to provide the general practitioner with the role of gatekeeper, for instance to gain access to specialise psychiatric care. Secondly, the aspect of continuity of care is addressed. Possible opportunities to improve continuity of care mentioned by the interviewees are (1) increased medical presence during the night (for the care teams), (2) better communication, (3) improving the exchange of medical information (e.g. systematic letter of dismissal, improving the electronic medical file), and (4) the standardisation of medical care through the use of protocols. Closely related to the aspect of continuity, is the cooperation between care providers. The respondents desire to see an increased cooperation both between the intra-muros care providers, and between the latter and their external counterparts. They claim that such amelioration could happen through, for example, the creation of intermediary structures (i.e. on the border between intra- and extra-muros), through a system of accreditations for external care providers (allowing them an easy access to the prison), or through a medical file accessible for internal and external care providers. It is also in this regard that some respondents expressed to be in favour of integrating the inmates into the Health Insurance System, and even the Social Security.

2.4.4.2 Relations between care providers and security staff

The second most redundant view is this of the relations between care providers and the security staff. Besides the statement that more staff is needed (see hereafter), communicating and informing the other disciplines on the meaning of one's work, and consulting each other, are considered as the most important ways to improve the relation between different disciplines working within the prison walls. An important condition to enabling this communication in a positive way, according to the interviewees, is that the care provider should be able to decide which information can be shared with colleagues (respecting medical secrecy). Further, respondents claim that both groups need to learn to know and respect each other's specificities, and to display basic human respect. Finally, it was also said that forensic care givers need specific Ethical Comities, acting as a (peer) support for care providers confronting non-medical actors' interferences.

2.4.4.3 Possibilities and means

The possibilities and means are the third area of improvements. Here the respondents expressed the wish to see not only more material means, money and staff being devoted to the prison health care (and the security). They also pleaded to have more time.

2.4.4.4 Employment status

Fourthly, the employment status refers to the respondents' wish to make the job attractive (remuneration, maintain seniority when coming over from other organisation) in order to attract new personnel, and more stable for the interim and self-employed (trough nominations and contract).

2.4.4.5 Training

Fifthly, with regard to training, respondents would wish to see a greater focus on care in the security officers' training and more retraining possibilities for the physicians.

2.4.4.6 Other

A final possibility of improvement, which was mentioned by a minority of the respondents, was a plea in favour of a more human contact with the inmates by the care providers, to address some of the mentioned weaknesses and threats in the system.

2.4.4.7 Summary

To summarise, the most redundant view on the improvement possibilities is the following: providing more means and possibilities to a prison health care based on an integrated care, in which the providers of care enjoy an attractive employment status and improved training opportunities. Hereby, integrated care is understood as the multidisciplinary collaboration between all care givers (extra- and intra-muros) in order to provide the inmates with integral care (i.e. care focusing on the somatic, mental and social dimensions of health).

2.4.5 Conclusion

The present chapter's aim is to describe the current general organisation of health care services in prison in terms of strengths, weaknesses, opportunities and treats, based on 15 semi-structured interviews with experts on this topic. It is important to acknowledge that, due to the relative low number of participants, caution must be paid to the generalizability of the findings. Also, it is possible that given the sensitive topic the respondents gave socially desirable answers. Keeping this in mind, 6 summarizes the main results of the interviews and integrates the most redundantly identified strengths, weaknesses, opportunities, strengths and improvements:

Table 5 – Final SWOT-analysis based on 15 semi-structured interviews

Strength	Weakness
Access for inmates to somatic health care (with good access to medications and basic equipment), provided by a dedicated and resourceful staff – with a special mention for the nursing.	Prison health care gets limited (in its impact, content and continuity) by a (pathogenic and criminogenic) environment, a fragmented provision of care, a lack of means and opportunities (e.g. staff, time, training, statute), and the distrust and tensions between the different actors.
Opportunity	**Threat**
The external care providers possess the expertise and experience regarding the provision of care to marginalised groups, and the collective organisation of this provision.	Prison health care is at risk of being cut off from the rest of society and its resources.
Improvements	
Providing more means and possibilities to a prison health care based on an integrated care, in which the providers of care enjoy an attractive employment status and improved training opportunities.	

2.5 Survey among medical doctors

Staff of 26 out of 35 prisons[z] in Belgium returned the filled-in survey (response rate of 74%). The questionnaire was filled in either exclusively by a physician[aa] (N= 13), exclusively by a nurse (N= 2), or jointly by a physician and a nurse (N= 9). The retrieved data come from prisons that cover more than 80% of the incarcerated population in Belgium and includes prisons which vary in size and in their population's composition. The participating prisons are characterised by a fairly diverse distribution with regard to the legal status of the inmates (proportion of convicted inmates ranging from 11,8% to 98,6%; proportion of internees ranging from 0% to 48,4%). Women and convicted inmates and internees are overrepresented in the participating prisons in comparison with the non-participating prisons. In comparison to non-participating prisons, participating prisons are more equipped with specialised medical units; they entail all a psychiatric annex, a polyclinic, and one (out of the two available) care section.

A detailed analysis of the non-response per question shows that only 5 questions were left blank by more than 20% of the respondents:

- 3.11b Additional information regarding the presence of condoms
- 1.14b Which medical drugs and products can an inmate buy freely?
- 1.17 Which measures are taken in order to reduce the risk of incidents with the medications?
- 3.12b Additional information regarding the associations or NGO's working in prison
- 3.7b If there is drug addiction program, please provide more details?

2.5.1 Availability

The respondents state that on average these general practitioners are active within the prisons' walls during 24 hours per week (ranging from 4 to 70 hours per week). When asked for their opinion regarding the current GP workforce in prisons, 72% of the respondents report that the number of GPs is satisfactory. However, a quarter (24%) of the respondents state that the current GP workforce is insufficient. Even though the satisfaction with the number of available GPs seems present, most of the respondents (64%) indicate that it is difficult to recruit general practitioners to work in prison. Six respondents report not to be able to answer this question.

2.5.1.1 Medical equipment

Electrocardiography (especially) is part of the basic offer of care in Belgian prisons (present in over 70 % of the investigated prisons). The presence of radiography is confirmed by 36% of the respondents. In the prisons of Mechelen, Hoogstraten, Forest/Vorst, Nivelles and Dinant nor ECG, nor radiography is available.

2.5.1.2 Pharmacology treatment

Medical drugs are delivered to Belgian prisons by an external pharmacist. This external pharmacist is exclusively responsible of preparing the doses of medication for the inmates in more than half (68%) of the investigated prisons. In about a quarter (28%) of the studied prisons, this external pharmacist is assisted in this task by a member of the nursing staff. Finally, one prison also mobilises its own pharmacist for this task. Qualitative data provided by some respondents learn us that the nurses and/or internal pharmacist are mainly consulted to take up the dosing of medical drugs

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z The questionnaire was not sent to the Centre of Social Defence of Paifve

aa To protect the anonymity of the respondent we do not mention here whether this was the physician responsible for the Medical Health Service or a colleague.

during the weekends and nights, when a treatment starts, in case of urgencies, and for newly arrived inmates.

The collected data show that the distribution of medical drugs to the inmates is in all prisons in hands of the Security Officers and /or the nursing staff. In almost half (48%) of the investigated prisons, we see that the Security Officers are exclusively in charge of the distribution of medical drugs. Only in about a quarter (28%) of the prisons, the nursing staff are in charge of this distribution. In 24% of the investigated cases the distribution of medical drugs is a joint task of Security Officers and Nursing staff

There are three ways Belgian prisoners have access to medical drugs. The first way is via a prescription by a physician. A second method is directly through the nursing staff. The survey shows that the nursing staff provides inmates with medication without prescription, but that this refers generally to over the counter medication (analgesics, disinfectants, anti-emetics, antidiarrheal medication, and anti-allergics). Thirdly, in about three quarters of the participating prisons, inmates can acquire medical drugs and medical products without a prescription of the GP or interference of the nursing staff: Brugge, Hoogstraten, Ieper, Leuven-Centraal, Ruiselede, Turnhout and Dinant. In these prisons, inmates can directly buy medical products and medications through the so-called 'medical cantine'[bb], which will then order the desired medication and products at an external pharmacist. The possibility to access medication via the 'medical cantine' is restricted by (1) the content of the 'medical cantine', and 2) the final decision of the prisons' management, who bear the final decision over whether or not the requested product will be ordered. The costs for the ordering of medical products through the cantine are taken up by the inmate, which affects the availability of this procedure for some inmates (financial barriers).

Finally, 57% of the prisons participating in this survey (Antwerpen, Brugge, Hoogstraten, Ieper, Leuven-Centraal, Merksplas, St-Gillis/St-Gilles, Wortel, Dinant, Vorst/Forest, Jamioulx, Mechelen and Marche) report incidents regarding medical drugs during the last three months. The most cited problems are: the wrong delivery by the external pharmacist or no delivery at all, the wrong dose or patient takes daily dose in once, the wrong moment of intake, and mixing up patients. Asked which steps were undertaken to prevent these incidents, the respondents pointed to three main solutions: reporting the incident to the pharmacist, a control of the medication by nursing staff and/or physician, and the intake of medical drugs under surveillance.

The intake of medical drugs under surveillance is, according to the collected data, a widespread practice. It is done in almost all (96%) prisons under study. The decision to impose an intake under surveillance is based on the type of medical drug (i.e. substitution treatment, psychotropic drugs, TBC medication, and morphine patches and – derivatives) and/or the type of patient (mental issues, elderly, known problems with compliance, suicidal, and not being capable of taking drugs by himself). The data show that the nursing room and the cell are the two most common places where this intake under surveillance takes place.

Finally, all participating prisons stated to have access to retro-viral medication, hepatitis B and hepatitis C. Two respondents reported that they do not know whether or not medication for hepatitis is available.

[bb] The French sociologist Monique Seyler describes the Cantine system in prisons, as the 'surplus' that inmates are allowed to acquire, at their own costs, through the prison's administration in order to improve their daily life in prison. [87]

2.5.2 Accessibility

2.5.2.1 Request for care

When an inmate wishes to see a physician, the survey shows that in most of the studied prisons they can express this wish either orally or through a written demand on paper. Only two prisons enable such a request to be communicated through an electronic medium. In the majority of the investigated prisons (76%), the inmates are not obliged to indicate the reason of their request of care. In six prisons (Gent, Oudenaarde, Dinant, Ittre, Jamioulx and Beveren) such motivation is however obligatory.

Mostly, the inmate's request for care reaches the physician through a personal handing over of the demand by the inmate to the MD, either by the Security Officers and/or a member of the nursing staff. This procedure is sometimes complemented by the possibility to post requests for care into a closed mailbox. Only in four prisons, this is the exclusive way in which a request for care is communicated to the MD.

The collected data furthermore illustrate that inmates who are not capable of filling in a written request of care (illiterate, foreign language…) are mainly assisted in communicating their request by (1) the security officers (in 24 prisons), (2) a member of the nursing staff (in 20 prisons) and/or (3) a fellow inmate (in 23 prisons). To a lesser extent, respondents also mention other actors in this context, such as the prison management, the psychiatrist, PSD, etc.

2.5.2.2 Waiting times

Respondents were also asked to indicate the estimated time frame between the request of care of the inmate and the medical consultation, and those factors that influence this time frame. The vast majority of the respondents indicate that the medical consultation follows the inmates' request for care in maximum 24 hours. Only one respondent states that inmates have to wait up to 48 to 72 hours. The five most cited factors that influence the time lag between the request of care and the following medical consultation with the MD are the number of requests for care that are filed (17 respondents), the inmate's activities (e.g. work, ..) (16 respondents), the prison's activities (14 respondents), an assessment of the urgency of the demand made by the nurse (triage, see further) (12 respondents), and the lack of medical personnel (12 respondents).

2.5.2.3 Triage system

The survey also shows that in 71% of the investigated prisons there is no system of triage. Those respondents who indicate the presence of a triage system (Antwerpen, Oudenaarde, Dinant, Vorst/Forest, Jamioulx, Namur and Mechelen) declare that it is either in hands of the nursing staff or physician, and takes place when there are too much requests for care, in case of medical emergencies, for inmate with and 'above average' consultation behaviour, during weekends, or for newly arrived inmates.

2.5.2.4 Transfers for medical reasons

If specialised care is needed, inmates can either be transferred to the CMC or extra-muros care facilities.

Results of the survey illustrate that transfers to the CMC often encounter long waiting times (explicitly mentioned by five respondents). Transfers to extra-muros care facilities take place in cases of medical emergency or for specific treatments which the local prisons or CMC cannot offer (e.g. specialised medical examinations and/or treatments, medical imaging, etc.).

All prisons mention delays in the transfers to extra-muros care. The most cited reasons for such delay are the patient's refusal for transfer (16 respondents), unavailability of the security staff needed for the transfer to or stay in extra-muros care (13 refer to the unavailability of internal security staff and 8 refer to the unavailability of external security staff) and the patient's estimated dangerousness (9 respondents). Finally, more than half of the prisons state to register the transfers for medical reasons, including the reason. Four respondents report not to know the answer to this question.

2.5.3 Comprehensiveness

To evaluate the comprehensiveness of penitentiary health care, the scope of the care provided within the prisons' walls is scrutinized, with regard to the screening of diseases and health promotion/preventive health care.

All examined prisons offer TBC screening at entry. In 75% of the studied prisons, TBC screening is the only type of screening being systematically offered when inmates enter the prison. Only six respondents indicate that next to TBC screening, inmates also get proposed to be screened for Hepatitis and HIV at entry. During the inmates' stay in prison, TBC screening is again systematically proposed in all interrogated prisons. Additionally, 50% of the investigated prisons offer screening for hepatitis and HIV. Finally, screening for diseases at departure is quasi inexistent. Only three prisons offer a screening for diseases when inmates leave the prison. More specifically, two prisons offer TBC screening at liberation, and only one prison proposes HIV screening at liberation.

Only 39 % of the prisons state that a general program aimed at health promotion is present within the prison's walls. In general, the respondents refer to the activities and programs of associations and non-governmental organisations which are funded by the local governments in with regard to health promotion. Twelve of the investigated prisons state that such associations and NGO's are present in their prison, and are active in the fields of mental wellbeing, drug addiction, integration, and health education. Third, respondents were asked whether specific interventions tailored to important health issues in prisons were provided. Regarding mental health, the respondents were asked if there was a program specifically aimed at improving the mental wellbeing of the inmates. The presence of such programs is reported by 29% of the respondents, four do not know the answer. The respondents refer to either the offer organised by the Federated States, in which external organisations (e.g. CGG, CAP or the Forensic Welfare Service) offer psychotherapeutic activities, or interventions by intra-muros care providers such as individual consultations with a member of the PSD, the physician, nurse, and the representative of the inmate's religion. 67% of the respondents indicate that inmates with anxieties or depressions get offered psychological consultations. Three respondents do not know the answer to this question. Respondents refer here to consultations offered by the internal services of the prison (i.e. the PSD, social worker, psychiatrist, psychologist, GP, psychiatric nurse), and organisations funded by the Federated States (i.e. Centres for Mental health (CGG), Forensic Welfare Service).

Concerning drug abuse, 71% of the respondents indicate that a substance abuse treatment program is present in their prisons. They state that both substance abuse of illegal (e.g. heroin) and legal (i.e. alcohol and tobacco) products is being treated. This treatment is taken up by different actors such the prison's health care providers, the CAP, the Centres for Mental Health (CGG), De Rode Antraciet, and the AA. A needle exchange program is not offered in any of the participating prison.

Regarding tattooing and piercing, all respondents – except for two – state that there are no initiatives to limit the sharing and the reutilisation of equipment for tattooing, piercing and other forms of skin lesions.

Regarding sexual health, only five respondents indicated that programs aimed at sexual health exist within their prison. These programs mainly consist in the distribution of information leaflets and condoms, and is generally in hands of the PSD and the NGO's funded by the Federated States. Condoms are made available to inmates in almost all investigated prison. Only one respondent provided a negative answer to this question. These condoms can be obtained at the nursing office, through the pharmacy's cantine, in the room for intimate visit, or on demand of the inmate.

2.5.4 Continuity

The dimension of continuity seeks to investigate how uninterrupted care is being assured for inmates in Belgian prisons.

2.5.4.1 Out-of-hours care

When asked for the way the continuity of care is guaranteed during the night, half of the respondents state that the general practitioners working in prison (exclusively)[cc] take care of this out-of-hours care. This is followed by a small group of prisons who rely on the local doctors-on-call (4 respondents), and a group of prisons in which there is a combination between the prison's doctors and the local doctors-on-call (4 respondents). Two respondents indicate that their prison relies on the emergency service (i.e. the 100) for out-or-hours care and three respondents indicate that there is no out-of-hours care during the night. A similar procedure is described for out-of-hours care during the weekend, with the majority of the investigated prisons again exclusively relying on their own general practitioners. To a lesser extent, out-of-hours care during the weekend is organised by a combination of local doctors-on-call and the prison's doctors (6 respondents), these two actors and a member of the nursing staff (1 respondent), the exclusive use of the local doctors-on-call (2 respondents), and the combination of the prison's general practitioners and the emergency service (2 respondents).

Regarding the permanence of the nursing staff, the vast majority (88%) of the respondents indicate that there is no permanent presence of the nursing staff in their prison. In none of the prisons there is a permanent presence of physicians.

In case the physicians is not in the prison and a request of care is filed by one of the inmates, the following procedure is rather standard amongst the participating prisons. While two respondents indicate that handling the request of care is at that moment not possible, in most cases the nurse and/or security officer function as a 'triage' for the request of care when the GP is not present; they need to decide whether or not to contact the physician or the emergency services. If the inmates demand is deemed 'not serious' or not urgent by them, then the inmate will get registered for the first following consultation when the MD is present in the prison.

Regarding the follow-up of care and medical examinations of chronic diseases, the collected data show that the electronic medical file, is the most widely used instrument (reported by 79 % of the investigated prisons) to guarantee continuity of care.

2.5.4.2 Flow of information

In a next set of questions the research team sought to get a view on how the medical information on inmates circulates 1) between the prison and the 'outside world', 2) between the different prisons, and 3) between the different care providers within the prison.

The collected data show that in the vast majority (88%) of the cases when a person enters their prison, the extra-muros treating physician is only contacted sporadically (21 respondents). Only one respondent states that the extra-muros treating physician is always contacted. Two main reasons to contacts extra-muros colleague(s) are given. Firstly, such contacts are related to the nature of the pathology or treatment (e.g. heavy chronic diseases, substitution treatments, and patients with mental issues and treatments). Secondly, contacts are made in order to obtain additional information. This occurs when the information provided by the patient is deemed unclear (or not provided at all by the patient), to obtain specialists reports and medical imagery, and finally to corroborate externally initiated treatments and/or pharmacotherapy in case of doubt.

[cc] One respondent added that even they call the local doctors-on-call, these refuse to come to the prison. This echoes one of the findings of the interviews (see chapter 2).

The data show that the circulation of medical information between different prisons, when a person gets transferred to another prison, occurs mainly through the electronic file EPICURE (cited by all respondents), sometimes in combination with other channels such as the telephone, fax, post and/or email.

Regarding the circulation of medical information between the different disciplines working in one prison, 25% of the respondents state that there is no meeting between the different involved care providers regarding the inmate(s). If such meetings are organised, they are in the majority of the cases not organised on a regular basis, but rather have an ad-hoc nature meaning that the concerned providers of care only meet (or get in touch) when deemed 'necessary'.

Regarding the exchange of medical information at the moment of release, results of the survey show that such exchange is absent in four prisons. All other respondents indicate that medical information is exchanged by either handing over a copy of the medical file to the inmate or a contact with the extra-muros GP (either at the moment of release or afterwards). It is important to notice that this exchange of medical information is considered conditional; the exchange of medical information at release only takes place upon request by the inmate and/or by his treating GP, in case of a severe pathology, or if the GP deems it necessary to maintain a strict medical follow-up. Finally, we asked whether or not inmates are given a follow-up dose of medical drugs at their liberation, and for how many days. The collected answers learn that vast majority (83%) of the prisons do allow released inmates to get a dose of medical drugs at liberation. In mean, they receive a dose of three days medication (the lowest being 1 day, and the highest 5 days). Some respondents also stated that the decision concerning a final dose of medication depends upon the patient's medical status, and the nature of the medication itself.

2.5.5 Quality

Finally, we sought to gather information on how the equivalence of care within penitentiary health care, which is provided by different involved services and persons, is being guaranteed.

Guidelines for good practice are essential within the framework of providing evidence based medicine. Most prisons (67 %) stated that general guidelines for good practice are present in their prison and that they are mainly related to the treatment of scabies and TBC. Most prisons (79 %) furthermore indicate that specific care protocols for the nursing personnel (also mostly on TBC and scabies) are present. Three respondents do not know the answer to this question. The evaluation of the application of protocols and good practice recommendations is less widespread. Only 50% of the respondents state that such evaluations occur within their prison. Three respondents do not know the answer to this question.

The evaluation of the general care processes seems less present than the evaluation of the application of protocols, and is only taken up in 30% of the investigated prisons.

A next way of investing in quality of care is the training of staff. A majority of the respondents indicate that there are continuous formation courses for the nursing staff. One respondent indicated however, that while these courses exist, time constraints limit the staffs' ability to participate in them. Furthermore, this training offer is not open for interim-nurses – who make up an important proportion of the nursing staff.

In line with the situation described concerning the exchange of medical information between different disciplines within prisons, data suggest that patient meetings between care providers are mainly organised ad-hoc (only take place when problems arise). The systematic organisation of patient meetings is only reported in about one-third of the investigated prisons. If patient meetings are organised, GP's and the nursing staff are always involved. The presence of other disciplines (such as for example the psychiatrist, and the dentist) depends on local customs in the specific prison and the specificities of the debated patient and his/her pathology.

As a following indicator of quality of care, the handling of critical incidents within the prison's walls was investigated. 79% of the respondents indicate

that critical incidents are reported and registered. Moreover, when asked what happens with critical incidents, 65% of the respondents indicate that these critical incidents get analysed and subjected to a follow-up. Only in four prisons the analysis and follow-up of critical incidents was not organised. Four respondents indicated that they did not know the answer to this question.

Finally, the survey sought to map the different ways inmates can express their opinion on the quality of the care they receive. Three respondents indicate that a system for inmates to express their opinion on quality of care is not available in their prison. In the other investigated prisons, three main methods exist for the prisoners to express their opinion on this matter; inmates can provide their evaluation either (1) directly to the care staff (physician and nursing staff),(2) to the prison's manager or (3) to the Central Surveillance Committee.

Less reported methods to evaluate the quality of care for inmates are via the inmate's lawyer (or any other representative), his/her extra-muros general practitioner, and the National Order of Physicians.

2.5.6 *Problems & Solutions*

Finally, the survey asked which were the most important problems for the medical staff working in prisons, and which solutions could be offered. According to the physicians, the lack of financial means is clearly the most important issue. The other most important problems they mention are the lack of information regarding the release date of inmates, which hinders continuity of care, the lack of education of the medical staff, the problem of double loyalty (i.e. the tension between providing good health care and maintaining order and safety), and finally the difficult access to secondary care. The entire list of the problems identified by the respondents can be found in appendix 03. The most important problems experience by nurses are very similar to the concerns expressed by the general physicians. Nurses consider the lack of financial means, the lack of information regarding the inmate's release date, problems in the collaboration with the penitentiary staff due to their understaffing, and the difficult balance between care and security as their main problems. A more detailed overview of the problems mentioned by the nurses can be found in the appendix 04.

Finally, the respondents were asked to propose the solutions they envisioned to solve the problems they identified. Both physicians and nurses focus on making available more means (both with respect to time and finances) and investing in equipment (e.g. replacing the electronic medical file with a more user-friendly interface, and updating the old medical equipment). Furthermore, they suggested investing in the education of staff, both before and during their professional career in prisons (e.g. learning the specificities of the penitentiary context in the general training for medical staff, attention for the specificities of each other's role in the provision of care, enabling continuous formation while working in the prisons, …), the organisation of the CMC (e.g. shorter waiting lists), the communication within the prison (e.g. getting informed timely of the inmate's release date). Finally, some doctors favour a transfer from the FPS Justice to the FPS Public Health, amongst others as a solution for trust problems experienced by inmates who question the objective role of physicians paid by FPS Justice.

2.6 Discussion of the main results

2.6.1 *Availability*

On average, 11.040 prisoners resided in the 35 Belgian prisons in the year 2015. In each of these prisons, penitentiary health care is provided through the local Health Care Service. This service is in charge of providing general medicine, dental health care, and psychiatry. In almost all prisons this offer is further supplemented with specialist care by visiting specialists (4 of the prisons participating in the survey mentioned that this was not available in their prison). Furthermore, some prisons offer specialist care in specific organisational units. These units are the psychiatric sections which provide care to internees and inmates suffering (available in 12 Belgian prisons), the medical centres (CMCs) which focus on hospitalisation and possess an operation room (available in 3 Belgian prisons), and the care section devoted to the provision of care to elderly and disabled incarcerated persons (available in 2 Belgian prisons).

Based on data from the FPS Justice, 774 caregivers provided penitentiary health care in the fall of 2015 (based on data from October-November 2015). Central in this workforce are the nurses (45 %, mainly working as employees

of FPS Justice or as interim-workers) and physicians (32%, working as self-employed). The penitentiary care work force is characterized by an immense diversity with regard to both the function and employment status of care providers. Although the interdisciplinary composition of the team and its motivation and involvement are during the face-to-face interviews mentioned as strengths of the current system, underlying challenges hinder the interdisciplinary team to thrive. For instance the lack of knowledge on the task and expertise of the different colleagues, the different employment status and schedules are mentioned as a source of frustration and stress and might explain why the interdisciplinary nature of the team is largely restricted to an 'on paper' situation (no structural interdisciplinary team meetings, etc.). Further, the position of the health care system within the penitentiary context - in which security is prioritized over care– makes the care providers strongly dependent of the understaffed security officers. This position is considered as one of the most important weaknesses of the penitentiary health care system.

Regarding non-human resources, the study suggests that the basic medical equipment in prisons is available, but it is evaluated by some stakeholders as outdated. Pharmacological treatment is available in all Belgian prisons and easily accessible. During the working hours, the preparation of medical drugs is mainly taken up by external pharmacists. In emergencies and during the evening/weekend, this task is mainly taken up by the nursing staff and/or security officers. Concerning the distribution of medical drugs, the role of the security officers is striking; in almost half of the prisons they are solely responsible for the distribution of medical drugs despite their lack of medical training. Alternative to the medical drugs provided by the prison pharmacy, over-the-counter medication can be acquired via the nursing staff or the 'medical canteen' (this latter is available in about three quarters of the prisons).

2.6.2 *Comprehensiveness*

With regard to comprehensiveness of care, the study unravels some problematic aspects within the health care system in Belgian prisons. In general, penitentiary health care appears to be limited to basic somatic (curative) care. An important lack with regard to comprehensiveness is the provision of mental health care. Mental health care seems to be highly focused on a pharmacological approach, while the offer of psychotherapeutic care (individual therapy as well as group programs) is often insufficient. This is a significant problem as mental health problems are highly prevalent among prisoners (internees as well as other prisoners).

Furthermore, the interviews pointed out that insufficient attention is given to preventive care (e.g. smoking, sexual health). Regarding the offer of health promotion programs in prison, the survey illustrates that the chief physicians mainly refer to the offer outside the HCS, and refer largely to the offer organized by NGO's on demand of the Federated states. Although an offer of health promotion should be present in all prisons, this is only mentioned by about a third of the respondents, which reflects the lack of knowledge between different caregivers working with inmates in the same prison. Nevertheless some positive aspects with regard to comprehensiveness are to be mentioned. Programs focusing on management of addictions seem however more widely available, as is the distribution of condoms, which are made available in quasi all prisons.

With regard to health screening programs in Belgian prisons, results show that screening appears to be mainly restricted to TBC screening. TBC screening is systematically offered both at a person's entry in prison, and during his/her incarceration. During the imprisonment other forms of screening, more specifically screening for HIV and hepatitis, are also offered.

2.6.3 Accessibility

The access to penitentiary health care in Belgium is based on three pillars: free access to care, a gate-keeping structure, and the inmate's access to extra-muros care and intra-muros cantine. The first pillar refers to the fact that prisoners have free access to health care (meaning that the state pays the health care costs). The second pillar implies that the inmates' access to secondary care is conditional upon a referral by a general practitioner (gate keeping system). The sole exception is psychiatry, where no referral from a GP is needed. Finally, inmates have the right to access their own extra-muros provider of care (however, approval of chief physician is needed and co-payment required in such a case), and to buy medical products at the medical cantine of the prison via private out-of-pocket payments.

Generally, access to care is perceived as positive by most respondents in the interviews. This mainly concerns basic somatic health care. Some even stress the fact that prison health care offers health care to individuals who often don't find their way to professional health care outside the prisons' walls.

However, several elements negatively influence inmates' access to health care. Firstly, waiting lists for access to specialised care such as the medical centres[dd], dentists, psychiatrists and extra-muros specialist care can be long. In this respect, their own workload plays an important role, as well as difficulties such as distrust and/or fear of extra-muros care providers regarding the penitentiary world may also hamper access to extra-muros health care. Secondly, transfers to extra-muros health care are difficult to organize as they imply extra efforts of the already overloaded security officers. Thirdly, interview respondents mentioned that health care services are sometimes 'misused' by the prisoners for non-medical reasons. This 'misuse' might actually reduce general accessibility to health care services, implying waiting times and short duration of consultations. In 71% of the investigated prisons there is no system of triage. However, this is often not a way of providing optimal accessibility. Fourthly, as care providers are dependent upon the security officers to meet the inmates and thus to perform their work, access to health care is also influenced by communication problems between care providers and the prisons' security personnel as well as the latter's understaffing. Fifthly, the tension between 'the logic of care' and 'the logic of security' in the penitentiary context may also have an impact on health care access. As security gets priority over care, care activities sometimes get to the second plan. Finally, the fact that the penitentiary world strongly relies on written communication (written demand for consultation, brochures...) might limit access to care for a substantial group of inmates (illiterate, foreign, and intellectually disabled).

2.6.4 Continuity

Continuity of care in prisons comprises two main aspects: the continuity of care within the prison walls and the continuity of care between the intra-muros and extra-muros world (transfers, intake and release).

The intra-muros continuity of care (continuity during the prisoner's detention time) is the first aspect covered by the study. The survey shows that out-of-hour care in Belgian prisons (care during weekend and at nights) is mainly taken up by the GPs that work in the prison. In a minority of the prisons, local GPs-on-call are involved in the provision of out-of-hours care. Out-of-hours requests for care and medical emergencies are triaged by either security officers or the nursing staff. An important threat to the continuity of care provided in prison are strikes: during strikes of the security staff, the provided care gets limited to the strict necessary care and very urgent cases. More specifically for the psychiatric annexes, the interviews showed that the continuity of care in the different psychiatric annexes is jeopardized by absence of care givers during the nights and weekends, and the irregular presence of psychiatrists.

Continuity of care not only depends on the presence of health care providers, information exchange also appears to hinder continuity of care. Only in a minority of the investigated prisons, meetings to discuss patients

[dd] During an interview it was stated that inmates are reluctant to go to these medical centres, because they 'lose' their cell when they are transferred. Consequently, they favour treatment within mainstream hospitals.

between different intra-muros providers of care are organised in a systematic way. The majority of the investigated prisons only report ad-hoc meetings, if such meetings get organised at all. Nevertheless, the universal use of one electronic medical file within all Belgian prisons (EPICURE) can be considered a strength. However, this positive element is counterbalanced by EPICURE's shortcomings. The system is not deemed to be user-friendly and consists low-quality information (e.g. due to the insufficient coding of the medical information) are identified as important shortcomings during the interviews.

Secondly, continuity of care across the prison walls is studied, and several difficulties in this context were uncovered. The exchange of information between intra-muros and extra-muros care providers, is described as being very difficult. The results of the study reveal that in most investigated prisons, there are no systematic contacts between internal and external care providers at intake or release. These contacts are rather ad hoc and conditional in nature. A crucial moment which challenges the provision of continuity of care are prisoners' transfers or releases. A recurrent complaint by care providers working in prisons is that they get either informed very late, or even not informed at all about the transfers and releases, which makes it difficult to streamline the exchange of medical information. The fact that most doctors do not systematically provide a referral letter to inmates, that foreign inmates do not necessarily have a general practitioner in Belgium, and that isolated and marginalised persons experience important difficulties to find access to health care outside the prison walls also hamper the continuity of care after the person released from jail.

Finally, the exclusion of the inmates from the national health insurance system might hinder continuity of care, since the reintegration in the 'mainstream' system might offer as an administrative barrier to access care outside the prison walls (during leave, after release…).

2.6.5 Quality of care

The respondents of the survey mention different strengths in the current penitentiary health care system, which contribute to the quality of care delivered in prisons. The widespread presence of guidelines and nursing protocols (on scabies and TBC) on the one hand and the systematic registration and evaluation of critical incidents on the other hand are perceived as strengths in the current system. However, these guidelines concern only a few health problems, the evaluation of the implementation of these guidelines and protocols (mentioned by only half of the investigated prisons) is not performed and the evaluation of the general care processes (mentioned by 30 % of investigated prisons) deserves further attention. Another contradiction related to quality of care is the organisation of the training of staff. While the majority of survey respondents state that training of staff is organized, the in-depth interviews with key informants highlight that time constraints limit the staff's possibilities to follow the training. Also the lack of training with regard to penitentiary health care in the regular training of health care providers (university or college) is criticized, as is the impossibility of the interim-nurses to participate to the organized training.

Finally, both the interviewees and the survey's respondents state that patient meetings uniting different care providers within one hospital are scarce and have an ad-hoc character, which could endanger the quality of provided care. This further highlights the difficulties in interdisciplinary work which is highlighted in the in-depth interviews.

Remarkably, half of the respondents reported incidents with medical drugs in the last three months. The respondents suggest that the intake of medical drugs under surveillance, which is already a widespread practice within prisons, could be a possible way to minimize these incidents.

Our results suggest the following investments to optimize quality of care

- Embedding training on penitentiary health care in the regular training of care providers and preparing them as such on the specific character of working in penitentiary health care (suggested by the key informants). This could answer the felt difficulties to recruit new staff willing to work in prison, which was reported in the survey.
- Facilitating all staff's possibilities to participate in the organized trainings.
- Facilitating interdisciplinary work, amongst others through learning more about each other's expertise and role within the care process (suggested by the survey respondents).

2.7 Strengths and limitations of the used methods and data sources

This study is the first to address the medical and organisational, aspects of the health care services in Belgian prisons in a comprehensive way to fill the knowledge gap, using a mixed method approach.

Each of the used methods have their limitations. However, by integrating the results of the different studies, it was possible to fully capture the current situation of the health care services in Belgian prisons. The qualitative study using semi-structured face-to-face interviews with 19 key informants provides more in depth information on the organisation of health care in the prisons, and on the strengths, weaknesses, threats and opportunities as perceived by the interviewed persons. Data on human resources in prisons, the available health care services, and care use is collected from the responsible authorities and pooled into one database. Missing data are gathered using a standardized written questionnaire that is send to all the chief physicians in Belgian prisons.

However, there are some limitations related to the secondary data and the data collected with the written questionnaire, and consequently to the conclusions based on those data. The available data on healthcare expenditure in Belgian prisons was scarce and several types of cost data at prison level were missing which lead to the need for making assumptions. Although these assumptions were based on previous research experiences, it is very likely that our estimates deviate, to some extent, from reality. The research team had no access to historical data, which made it impossible to investigate the evolution of healthcare costs and to make predictions for the future. A standardized written questionnaire was used to gather information about the missing data, but despite the fact that the responsible physicians know the situation in their prison well, and that they could also involve other staff-members to complete the questionnaire, it was still difficult to provide the research team with valid answers on several questions.

For further research, the authors advice that a comprehensive database is produced by centralizing all available data. Moreover, a prospective research design could be used with an inclusion of all aspects of a contemporary definition of health. There should be particular interest in both preventive as curative measures, social well-being and the mapping of prisoner characteristics like age and frequent pathologies. It would also be valuable for a future study to get an insight into the evolution of the budget and the different cost categories both globally and at an individual prison level.

REFERENCES

1. Watson R, Stimpson A, Hostick T. Prison health care: a review of the literature. Int J Nurs Stud. 2004;41(2):119-28.
2. Enggist S, Møller L, Galea G, Udesen C. Prisons and health. Copenhagen: WHO Regional Office for Europe; 2014.
3. WHO. Declaration on Prison Health as part of Public Health. In. Moscow: WHO; 2003.
4. Maculan A, Ronco D, Vianello F. Prison in Europe: overview and trends. Observatory EP, editor. Rome: Antigone Edizione; 2013.
5. van Mol F. De gezondheidszorg in de Belgische gevangenissen. Melle; 2013.
6. RIZIV, Dokters van de Wereld. Witboek ovr de toegankelijkheid van de gezondheidzorg in België. Brussel: RIZIV; 2014.
7. Penitentiaire Gezondheidsraad. Advies 2009/1 van de Penitentiaire Gezondheidsraad aan de Minister van Justitie betreffende de hervorming van de gezondheidszorg in de gevangenissen. Brussel: FOD Justitie; 2009.
8. Feron J-M. La santé en prison: Santé publique ou ministère de la Justice? Santé Conjugée. 2002(22):95-6.
9. Vander Laenen F. Memorandum naar een volwaardige gezondheidzorg voor gedetineerden en geïnterneerden in België. FATIK. 2015;31(145):28-30.
10. Koninklijke Academie voor Geneeskunde van België. Advies over forensische psychiatrie. 2014.
11. Cosyns P, Koeck S, Verellen R. De justitiabele met een psychische stoornis in Vlaanderen. Tijdschrift voor Psychiatrie. 2008;50(Jubileumnummer):63-8.
12. De Coninck G, Cosyns P, Harris F. Jaarverslag Centrale Toezichtsraad voor het gevangeniswezen. Brussel: Centrale Toezichtsraad voor het gevangeniswezeg; 2011.

13. Reflectiegroep zorg en detentie. Memorandum: Naar een volwaardige gezondheidszorg voor gedetineerden en geïnterneerden in België. 2014.

14. Cartuyvels Y, Champetier B, Wyvekens A. Social Defense in Belgium: Between Care and Security. An Empirical Approach. Deviance et Societe. 2010;34(4):615-45.

15. Cosyns P, Goethals K. Penitentiary Mental Health Care in Belgium. In: Konrad N, Völlm B, Weisstub DN, editors. Ethical Issues in Prison Psychiatry. Dordrecht: Springer Science+Business Medi; 2013. p. 145-51.

16. Boers A, Vandevelde S, Soyez V, De Smet S, To WT. Het zorgaanbod voor geïnterneerden in België. Panopticon. 2011;32(2):17-38.

17. Hardonk S, Devlieger P, Detraux J-J, Vrielink J, Mortelmans D, Van Hove G, et al. Les personnes handicapées en Belgique et le (non-)respect des droits de l'Homme et de leurs libertés fondamentales garantis par la Convention des Nations Unies relatives aux droits des personnes handicapées. Bruxelles: Centre Interfédéral pour l'égalité des chances; 2014.

18. Observatoire international des prisons. Notice 2013 sur l'état du système carcéral belge. 2013.

19. Vandevelde S, Soyez V, Vander Beken T, De Smet S, Boers A, Broekaert E. Mentally ill offenders in prison: the Belgian case. International Journal of Law and Psychiatry. 2011;34(1):71-8.

20. Batis N. Les détenus handicapés. Handicap + Prison = double peine? Liège: ASPH; 2014.

21. Kinna F, Cherbonnier A. Santé et Prison. Bruxelles Santé. 1999(16):6-13.

22. Corp. I. SPSS Statistics for Windows, Version 21.0. In. Armonk, NY: IBM Corp.; 2012.

23. Directoraat-generaal Penitentiaire Inrichtingen. Jaarverslag 2015. Brussel: Federale Overheidsdienst Justitie; 2016.

24. Maes E, Scheirs V. De Belgische gevangenispopulatie in cijfers. In: Daems T, Pletincx P, Robert L, Scheirs V, van de Wiel A, Verpoest K, editors. Achter tralies in België. Gent: Academia Press; 2009. p. 91-112.

25. Aebi MF, Delgrande N. SPACE I – Council of Europe Annual Penal Statistics: Prison populations. Survey 2013. Strasbourg: Council of Europe; 2015.

26. Verdot C, Godin-Blandeau E, Gremy I, Develay AE. Monitoring systems and national surveys on prison health in France and abroad. Eur J Public Health. 2015;25(1):167-72.

27. Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants (CPT). Rapport au Gouvernement de la Belgique relatif à la visite effectuée en Belgique par le Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants (CPT) du 28 septembre au 7 octobre 2009. Strasbourg: 2010.

28. Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants (CPT). Rapport au Gouvernement de la Belgique relatif à la visite effectuée en Belgique par le Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants (CPT) du 23 au 27 avril 2012. Strasbourg: European Commission; 2012.

29. Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants (CPT). Rapport au Gouvernement de la Belgique relatif à la visite effectuée en Belgique par le Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants (CPT) du 24 septembre au 4 octobre 2013. Strasbourg: 2016.

30. Jamoulle P. La prison ne s'arrête pas à ses murs. Santé Conjugée. 2002(22):74-7.

31. Salize HJ, Dressing H. Admission of mentally disordered offenders to specialized forensic care in fifteen European Union member states. Social Psychiatry and Psychiatric Epidemiology. 2007;42(4):336-42.

32. Verhaeghe M. Stigma, een wereld van verschil? Een sociologische studie naar stigma-ervaringen in de geestelijke gezondheidszorg. Gent: UGent; 2008.

33. Link BG, Phelan JC, Bresnahan M, Stueve A, Pescosolido B. Public conceptions of mental illness: labels, causes, dangerousness, and social distance. American Journal of Public Health. 1999;89(9):1328 - 33.

34. Schnittker J. Public beliefs about mental illness. In: Handbook of the sociology of mental health: Springer; 2013. p. 75-93.

35. Vander Laenen F, Casselman J, Klerkx J, Vermeiren R. Terwijl we achten op de FPC's: De organisatie van de forensische geestelijke gezondheidszorg Panopticon. 2011;32(6):43-8.

36. Penitentiaire Gezondheidsraad. Advies 2007/1 – Bevalling tijdens detentie. Brussel: FOD Justitie; 2007.

37. Reflectiegroep "zorg en detentie". Naar een volwaardige gezondheidszorg voor gedetineerden en geïnterneerden in België. Memorandum. 2014 25 juli.

38. Feron J-M. Les soins de santé en prison: une vue de l'interieur. Santé Conjugée. 2002(22):91-4.

39. Humblet D, Decorte T. Detentiebeleving door oudere gevangenen in België. Panopticon. 2013;34(4):267-83.

40. Pourveur N. Vieillir dans un lieu privatif de liberté: un nouveau défi pour les prisons [Web page].2015 [cited January 28th]. Available from: http://www.justice-en-ligne.be/article751.html

41. Penitentiaire Gezondheidsraad. Advies 2012/02 betreffende de gedetineerde patiënt bij levenseinde. Brussel: FOD Justitie; 2012.

42. Giele D. Vergrijzing van de gevangenispopulatie. Is een gevangenis voor oudere gedetineerden de toekomst voor België. Gent: U-Gent; 2015.

43. De Smet S, Vandevelde S, Verté D, Broekaert E. What is currently known about older mentally ill offenders in forensic contexts: results from a literature review. International Journal of Social Sciences and Humanity Studies. 2010;2(1):127-35.

44. De Ridder S, Beyens K. 'Illegalen' in de gevangenis. Een eerste analyse van de gevangenispopulatie in België op basis van de verblijfsstatus. In: Pauwels L, Saaske DK, Deltenre S, Elke D, Forceville J, Hardyns W, et al., editors. Criminografische ontwikkelingen III: van (victim)-survey tot penitentiaire statistiek. Antwerpen: Maklu; 2014. p. 175-99.

45. Demeersman T. Thuisloosheid na detentie. Leuven: Steunpunt Algemeen Welzijnswerk; 2008.

46. Van Haegendoren M, Lenaers S, Valgaeren E. De Gemeenschap achter de tralies. Onderzoek naar de behoeften van gedetineerden aan maatschappelijk hulp- en dienstverlening. Sociaal Economisch Instituut, Limburgs Universitair Centrum; 2001.

47. Zola IK. Culture and Symptoms--An Analysis of Patient's Presenting Complaints. American Sociological Review. 1966;31(5):615-30.

48. Ravindran N, Myers B. Cultural Influences on Perceptions of Health, Illness, and Disability: A Review and Focus on Autism. Journal of Child and Family Studies. 2012;21(2):311-9.

49. D'Houtaud A, Field MG. The image of health: variations in perception by social class in a French population. Sociology of Health & Illness. 1984;6(1):30-60.

50. Pierret J. Constructing discourses about health and their social determinants. In: Radley A, editor. Worlds of Illness. Biographical and cultural perspectives on health and disease. London & New York: Routledge; 1993. p. 9-26.

51. Blair A. Social class and the contextualization of illness experience. In: Radley A, editor. Worlds of Illness. Biographical and cultural perspectives on health and disease. London & New York: Routledge; 1993. p. 27-48.

52. Blaxter M. Health and lifestyles. London: Routledge; 1990.

53. Nuyens Y. De eerste lijn is krom. Deventer: Van Loghum Slaterus; 1980.

54. Schepers R. Ziekte en Zorg. Inleiding in de medische sociologie. Leuven & Voorburg: Acco; 2007.

55. Nettleton S. The sociology of health & illness. Cambridge: Polity Press; 1998.

56. Vander Laenen F. Memorandum: Naar een volwaardige gezondheidszorg voor gedetineerden en geïnterneerden in België. 2014.

57. De Maere W, Hariga F, Bartholeyns F, Vanderverken M. Gezondheid en druggebruik in het penitentiair milieu. Brussel: Federale Diensten voor Wetenschappelijke, Technische en Culturele Aangelegenheden; 2000.

58. Van Malderen S, Pauwels L, Walthoff-Borm C, Glibert P, Todts S. Druggebruik in de Belgische gevangenissen. Monitoring van druggerelateerde gezondheidsrisico's 2010. Brussel: Federale Overheidsdienst Justitie; 2011.

59. Todts S, Glibert P, Van Malderen S, Van Huyck C, Saliez V, Hogge M. Usage des drogues dans les prisons belges: monitoring des risques sanitaires. Bruxelles: SPF Justice; 2008.

60. Vyncke V, Hanssens L, Steenberghs E, Willems S. Onderzoeksrapport Gezondheidsprofiel Gedetineerden. 2015.

61. Van Cauter C. Schriftelijke vraag en antwoord nr. 0007. Zittingsperiode 53. 2012.

62. Stöver H, Weilandt C, Zurhold H, Hartwig C, Thane K. Final Report on prevent, treatment, and Harm Reduction Services in prison, on Reintegration services on release from prison and methods to monitor/analyse drug use among prisoners. Brussels: European Commission; 2008.

63. Anciaux B. Schriftelijke vraag nr. 5-5705 van de Bert Anciaux aan de minister van Justitie. Zitting 2011 - 2012. 2012.

64. Directoraat-generaal Penitentiaire Inrichtingen. Jaarverslag 2014. Brussel: Federale Overheidsdienst Justitie; 2015.

65. Penitentiaire Gezondheidsraad. Advies 2008/1. Overbrenging naar een ziekenhuis of verzorgingsinstelling Brussel: FOD Justitie; 2008.

66. Penitentiaire Gezondheidsraad. Advies 2008/3 betreffende de vooruitzichten inzake de ontwikkeling van de gezondheidszorg in de gevangenis. Brussel: FOD Justitie; 2008.

67. Penitentiaire Gezondheidsraad. Advies 2008/2. Nadere regels voor het bezoek van een door een gedetineerde vrijgekozen arts. Brussel: FOD Justitie; 2008.

68. Penitentiaire Gezondheidsraad. Advies 2009/2 betreffende "weigering van behandeling en behandeling zonder toestemming van de gedetineerde patiënt". Brussel: FOD Justitie; 2009.

69. Penitentiaire Gezondheidsraad. Advies 2009/4 betreffende ontwerp van ministeriële omzendbrief inzake het gebruik van de huisapotheek. Brussel: FOD Justitie; 2009.

70. Penitentiaire Gezondheidsraad. Aanpassing van het huidige electronisch medisch dossier (EMD) aan de normen gesteld door volksgezondheid en verwacht door de zorgverstrekkers van de dienst voor gezondheidszorg gevangenissen. Brussel: FOD Justitie; 2009.

71. Penitentiaire Gezondheidsraad. Advies 2012/01 betreffende psychiatrische zorg in de gevangenissen. Brussel: FOD Justitie; 2012.

72. Raadgevend Comité voor Bio-ethiek. Advies nr. 46 van 19 januari 2009 betreffende fertiliteitsbehandelingen op verzoek van een gedetineerde. Brussel; 2009.

73. Bertrand M, Clinaz S. L'offre de services faite aux personnes détenues dans les établissements pénitentiaires de Wallonie et de Bruxelles. Analyse 2013 - 2014. CAAP asbl,; 2015.

74. Welzijn en Samenleving. Hulp- en dienstverlening aan gedetineerden jaarrapporten 2014 [Web page].Brussel: Vlaamse Overheid;2014 [cited November 16th]. Available from: http://www4.vlaanderen.be

/wvg/welzijnensamenleving/hulpaangedetineerden/jaarverslagen/Paginas/default.aspx

75. Vanherk G, Paterson N. Hulp- en dienstverlening aan gedetenieerden strategisch plannen. Wat valt er te vieren, maar vooral: wat ligt er voor ons? FATIK. 2011;29(132):20-6.

76. Plettinckx E, Antoine J, Blanckaert P, De Ridder K, Vander Laenen F, Laudens F, et al. Rapport national sur les drogues 2014. Tendances et évolutions. Bruxelles: WIV-ISP; 2014.

77. Quoidbach R. Boule de Neige en prison. Santé Conjugée. 2002(22):97-101.

78. Dressing H, Salize HJ. Pathways to psychiatric care in European prison systems. Behavioral Sciences & the Law. 2009;27(5):801-10.

79. Taeymans B. Prévention SIDA en milieu carcérale. Santé Conjugée. 2002(22):102-4.

80. François A. Etude sur la sexualité en milieu carcéral belge. Liège: Université de Liège; 2015.

81. Michel L, Lions C, Van Malderen S, Schiltz J, Vanderplasschen W, Holm K, et al. Insufficient access to harm reduction measures in prisons in 5 countries (PRIDE EUROPE): a shared European public health concern. BMC Public Health. 2015;15.

82. Dockx J. Penitentiaire Gezondheidszorg tussen 2005 en 2015. In; 2015.

83. Favril L, Vander Laenen F. Een geïntegreerd drugsbeleid in de gevangenis: zorgen voor morgen. FATIK. 2013;31(140):15-20.

84. Vanhex M, Vandevelde D, Stas L, Vander Laenen F. Re-integratie van problematische druggebruikers tijdens en na detentie: aanbevelingen voor beleidsmakers. FATIK. 2014;31(143):19-22.

85. Kazadi T, Vander Laenen F. Het Belgisch penitentiair drugbeleid: sleutelfiguren uit de top kijken vooruit. FATIK. 2015(146):16-20.

86. Verbruggen F. Copernicus, Tantalus, Judaskus? Het kortwieken van de Basiswet Gevangeniswezen als voorwaarde voor haar inwerkingtreding. Ad Rem. Tijdschrift van de Orde van Vlaamse Balies. 2010;9:5-11.

87. Seyler M. Vivre avec son temps: les cantines des prisons. Deviance et Societe. 1988;12(2):127-45.

APPENDICES

APPENDIX 1. INTERVIEWGUIDE (DUTCH VERSION)

Algemene Introductie Interview

- Doel interview uiteenzetten: identificeren van de huidige knelpunten en de mogelijkheden tot verbetering(en)
- Methode: SWOT analyse van de gezondheidszorg voor gedetineerden in België
  - Uitleg SWOT: wat betekenen de gehanteerde woorden?

		Voor het Doel (i.e. kwaliteitsvolle zorg)	
		Hulpvol	Schadelijk
Organisatie (i.e. de gevangenis)	Intern	*Sterkte (S)*	*Zwakte (W)*
	Extern	*Kansen(O)*	*Bedreiging(T)*

- Gebruik van topiclijst aankondigen
- SWOT tabel en topiclijst tonen, en overhandigen (indien gewenst door de respondent)

Identificatie respondent

- Persoonsgegevens geïnterviewde opvragen
- Wat is uw precieze taak met betrekking tot gevangenen / in de gevangenis?

Identificeren van positieve elementen en opportuniteiten

- Welke positieve elementen kunnen er volgens u binnen de huidige penitentiaire gezondheidszorg ontwaard worden?
- Welke opportuniteiten kan volgens u de gezondheidszorg binnen gevangenissen bieden voor…?
- De gevangenen
- De zorgverstrekkers

- Gevangenispersoneel
- Anderen

Identificeren van knelpunten en mogelijkheden tot verbeteringen op het niveau van…

Health Care Needs & Provision

1. Algemeen

   Welke zijn op basis van uw ervaring de belangrijkste gezondheidsnoden van de gevangenen (in deze gevangenis[ee])?

2. Health Care seeking gedrag[ff]

   Welke zijn op basis van uw ervaring de voornaamste problemen en knelpunten wat betreft het health care seeking gedrag van gevangenen (in deze gevangenis)?

   Welke mogelijkheden tot verbetering ziet u op dit vlak?

3. Geboden gezondheidszorg (curatief en preventief)

   Welke zijn op basis van uw ervaring de belangrijkste problemen en knelpunten inzake de geboden gezondheidszorg?

   Welke zijn op basis van uw ervaring de mogelijkheden tot verbetering?

4. Relaties zorgverstrekkers – gevangenen

   Welke zijn op basis van uw ervaring de belangrijkste problemen en knelpunten wat betreft de relatie tussen zorgverstrekkers en gevangenen?

   Welke mogelijkheden tot verbetering ziet u?

5. Relaties tussen zorgverstrekkers onderling

   Welke zijn op basis van uw ervaring de belangrijkste problemen en knelpunten omtrent de relatie tussen zorgverstrekkers onderling?

   Welke zijn op basis van uw ervaring de mogelijkheden tot verbetering?

Work (Health Care providers)

1. Algemeen

   Welke disciplines (e.g. nursing, huisarts, ergo…) zijn in uw gevangenis tewerkgesteld?

2. Middelen en mogelijkheden (arbeidsomstandigheden)

   Welke zijn op basis van uw ervaring de voornaamste knelpunten en problemen wat betreft de middelen en mogelijkheden die de gezondheidszorgverstrekkers tot hun beschikking hebben?

   Welke zijn op basis van uw ervaring de mogelijkheden tot verbetering?

3. Arbeidsstatuut

   Welke zijn op basis van uw ervaring de belangrijkste problemen en knelpunten van het arbeidsstatuut van de gezondheidszorgverstrekkers?

   Welke zijn op basis van uw ervaring de mogelijkheden tot verbetering?

4. Relaties tussen zorgverstrekkers en de andere leden van het gevangenispersoneel

   Welke zijn op basis van uw ervaring de voornaamste knelpunten en problemen wat betreft de relatie tussen zorgverstrekkers en de andere leden van het gevangenispersoneel?

   Welke zijn op basis van uw ervaring de mogelijkheden tot verbetering?

5. Training en opleiding met betrekking tot penitentiaire gezondheidzorg

[ee] Toevoegen indien geïnterviewde op lokaal niveau (i.e. de gevangenis zelf) actief is.

[ff] Deze is formeel (zoeken naar professionele hulp), relationeel (hulp zoeken via vrienden, familie, medegevangenen…), of persoonlijk (zelfhulp).

Welke zijn op basis van uw ervaring de belangrijkste problemen en knelpunten wat betreft de training en opleiding inzake de penitentiaire gezondheidszorg?

Welke zijn op basis van uw ervaring de mogelijkheden tot verbetering?

Punishment

1. Verhouding tussen zorg en veiligheid

   Welke zijn op basis van uw ervaring de voornaamste problemen en knelpunten wat betreft de verhouding tussen zorg en veiligheid binnen de gevangenis?

   Welke zijn op basis van uw ervaring de mogelijkheden tot verbetering?

2. Rechten van de gevangen inzake gezondheidszorg

   Welke zijn op basis van uw ervaring de belangrijkste knelpunten en problemen wat betreft de rechten van de gevangen inzake gezondheidszorg?

   Welke zijn op basis van uw ervaring de mogelijkheden tot verbetering?

3. Bijdrage penitentiaire gezondheidszorg tot de re-integratie van gevangenen

   Welke zijn op basis van uw ervaring de belangrijkste problemen en knelpunten inzake de bijdrage van de penitentiaire gezondheidzorg tot de re-integratie van de gevangenen?

   Welke zijn op basis van uw ervaring de mogelijkheden tot verbetering?

4. Outro

   Wenst u nog iets toe te voegen? Is er een onderwerp dat u nog wenst aan te kaarten?

   Dankwoord en ‘nabespreking’

APPENDIX 2. SURVEY (DUTCH VERSION)

Studie KCE 2015_50_HSR: Gezondheidszorg in de gevangenissen

Geachte,

Dank voor het invullen van deze vragenlijst! Hierdoor draagt u bij aan de evaluatie van de gezondheidszorg binnen de Belgische gevangenissen.

Het invullen van deze vragenlijst neemt ongeveer een uur in beslag. Voor u aan de slag gaat, slaat u deze vragenlijst best op de harde schijf of het bureaublad van uw computer. Zo kan u de vragenlijst op verschillende momenten aanvullen zonder gegevens te verliezen.
Als u de vragenlijst volledig hebt ingevuld, kan u ze terugmailen naar dr. Gregory Gourdin (Gregory.Gourdin@ugent.be). Gezien de korte loopduur van dit project, zou het fijn zijn mochten we uw ingevulde vragenlijst nog deze week mogen ontvangen.

Nog enkele toelichtingen bij het invullen van deze vragenlijst:

1. Onderstaande vragenlijst is in eerste instantie aan u, hoofdgeneesheer van de gevangenis, gericht. Echter, u kan voor het invullen van bepaalde onderdelen de vragenlijst ook doorsturen naar een collega of medewerker vb. een verpleegkundige.

2. Uw anonimiteit wordt gegarandeerd – zie hiervoor het informed consent formulier aan het einde van deze vragenlijst. In het rapport dat wij bezorgen aan het KCE zullen alle verwijzingen naar namen worden verwijderd. Dit betreft dus zowel uw naam als namen die u eventueel zou vermelden in uw antwoorden. In het rapport kan wel mogelijks verwezen worden naar een individuele gevangenis (vb. “In de gevangenis van Beveren verloopt de bedeling van geneesmiddelen als volgt: ….”)

3. De vragenlijst bestaat uit gesloten vragen, met vaste antwoordcategorieën. Soms worden er extra duidingsvragen gesteld. Gelieve uw antwoord in het daartoe voorziene tekstvak te formuleren. Het elektronisch formulier laat u het toe uw antwoord uit te breiden; het tekstvak vergroot automatisch mee.

4. Vraag 6 is uitsluitend bestemd voor de hoofdgeneesheer. Vraag 6bis is uitsluitend bestemd voor de verpleegkundige.

Indien u vragen hebt bij het invullen van deze vragenlijst kan u steeds terecht bij dr. Gregory Gourdin (0475 653 002) (Gregory.Gourdin@ugent.be).

Onze oprechte dank voor uw medewerking!

Met vriendelijke groet

Het UGent-ULB onderzoeksteam:

Prof. dr. Sara Willems
Prof. dr. Pascal Semaille
dr. Gregory Gourdin
dr. François Felgueroso-Bueno

Voorafgaande vraag: Door wie werd deze enquête ingevuld?

1. Naam & Voornaam:
    a. Functie
    b. GSM:
2. Naam & Voornaam:
    a. Functie:
    b. GSM:
3. …

1. Beschikbaarheid van zorg en algemene organisatie

1.	**Naam gevangenis**	
2.	**Naam hoofdgeneesheer**	
3.	**Naam hoofdverpleegkundige**	
4.	**Hoeveel huisartsen werken er in uw instelling? (huisartsen die langskomen tijdens wachtdiensten niet meegerekend)**	
5.	**Hoeveel uren per week werken zij samen in totaal in de instelling?**	
6.	**Hoe zou u het aanbod aan huisartsgeneeskunde in uw instelling in het algemeen omschrijven?**	☐ Heel ontoereikend (1) ☐ Ontoereikend (2) ☐ Adequaat (3) ☐ Overaanbod (4) ☐ Groot overaanbod (5)
7.	**Is het moeilijk om huisartsen te rekruteren om in de instelling te komen werken?**	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)

8. Welke consultaties worden er in uw instelling aangeboden door geneesheer-specialisten?	- - - - - -
9. Welk technische onderzoeken kunnen in de instelling uitgevoerd worden?	
– Spirometrie	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
– Microscopie	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
– Radiografie (Specifieer)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
– Electrocardiografie	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
– Echografie (Specifieer)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
– Encefalogram	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
– Endoscopie (Specifieer)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
10. Hoe worden de medicijnen aangeleverd?	
- *Door een vaste externe apotheker*	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)

- *Door een externe apotheker volgens een beurtsysteem*	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
- *Door de externe apotheker van de gevangene*	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
- *Andere: (Specifieer)*	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
11. Door wie worden de dagdosissen klaargemaakt?	
Door een externe apotheker	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Door een apotheker in de instelling	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Door een arts in de instelling	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Door een verpleegkundige in de instelling	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Door iemand anders: (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
12. Door wie worden de dagdosissen overhandigd aan de patiënten?	
Verpleegkundige	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Penitentiair beambte	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Medegevangene	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Andere: (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☒ Weet Niet (3)
12. Welke medicijnen kunnen door de verpleegkundige toebedeeld worden zonder een voorschrift van de arts?	- - - - -

13. Kunnen gevangenen medicijnen rechtstreeks aankopen?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien ja: Hoe verloopt de aflevering (door wie en volgens welke procedure)
14. Welke medicijnen/medische producten kunnen rechtstreeks door de gevangene gekocht worden?	- - - - -
15. Hebt u weet van incidenten die zich in de voorbije 3 maanden voordeden m.b.t. medicatie (vb. toediening van verkeerd medicijn, verkeerde dosering, verkeerd tijdstip van toediening…)?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Ja, gelieve uw antwoord toe te lichten:
	Indien Nee, ga naar Vraag 17
16. Welke maatregelen worden er genomen om dit risico te beperken?	- - -
17. Worden bepaalde medicijnen onder toezicht ingenomen?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Nee, ga naar Vraag 20
18. Welke medicijnen worden onder toezicht ingenomen?	- - - - -
19. Waar vindt dit toezicht plaats?	
Op cel	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Op de verpleegkundige dienst	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Tijdens de medische consultatie	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)

Andere: (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
20. Zijn antiretrovirale medicijnen voor HIV beschikbaar?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
21. Zijn de behandelingen voor hepatitis B en C beschikbaar?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)

2. Toegankelijkheid

1. **Op welke wijze kan een gevangene aangeven dat hij een arts wenst te raadplegen?**	
Op papier	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Via elektronische weg	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Mondeling	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Andere : (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
2. Moet de reden voor de consultatie op de aanvraag aangegeven worden?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
1. Wie kan, buiten de gevangene zelf, de aanvraag invullen (vb. in het geval de gevangene analfabeet is , geen kennis van de gebruikte taal heeft)?	
Penitentiair beambte	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Medegevangene	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Verpleegkundige	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Andere: (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
2. **Via welk kanaal vindt de overmaking van de aanvraag aan de arts plaats?**	
Gesloten brieven bus door de verpleegkundige	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)

Gesloten brievenbus door de penitentiair beambte	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Persoonlijk overhandigd aan de verpleegkundige	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Persoonlijk overhandigd aan de penitentiair beambte	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Andere : (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
3. Wat is de gemiddelde wachttijd voor een consultatie bij de huisarts (in uren) ?	
4. Welke factoren beïnvloeden deze wachttijd?	
Aantal aanvragen	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Vertraging in de transmissie van de aanvraag	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Beslissing van de arts	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Inschatting door de penitentiair beambte	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Inschatting van de verpleegkundige	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Vertraging omwille van de activiteiten van de gevangenis	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Vertraging omwille van de activiteiten van de gevangene	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Gebrek aan personeel	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Andere redenen: (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
5. Is er een triage ?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Nee, ga naar Vraag 9

8. Hoe wordt deze triage georganiseerd?	
9. Welke zijn de voornaamste redenen voor extra-muros zorgverlening?	- - - - --
10. Worden bepaalde extra-muros zorgverleningen uitgesteld?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Nee, ga naar Vraag 14
11. **Welke zijn de voornaamste redenen om deze extra-muros zorgverlening uit te stellen?**	
Dagelijkse Quota overschreden (welke quota : gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
De mate waarin de patiënt een gevaar vormt	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Niet beschikbaar zijn van de penitentiair beambten	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Weigering door de hulpverlener	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Weigering door de patiënt	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Weigering door het ziekenhuis	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Andere: (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
12. Zijn er vaste ziekenhuizen/diensten waarmee u samenwerkt voor extra-muros zorgverlening?	
13. Kan de patiënt rechtstreeks een consult bij een arts-specialist aanvragen of kan dit enkel op verwijzing?	☐ Enkel op verwijzing ☐ rechtstreeks kan enkel naar een arts-specialist in de instelling ☐ rechtstreeks kan ook naar een arts-specialist extra-muros

	In dit laatste geval: ☐ bij alle specialismen ☐ bij een gelimiteerd aantal specialismen (vb. enkel bij oftalmoloog) - Namelijk: *(Gelieve in te vullen)*
14. Beschikt u over een register van de reden voor extra-muros zorgverlening?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Nee, ga naar Sectie 3
15. Kan u een kopij van dit register voor de laatste 12 maanden naar het KCE opsturen?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)

3. Omvang van zorg

1. Wordt de screening van volgende ziekten systematisch aangeboden bij het binnenkomen?	
Tuberculose	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
HIV	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Hepatitis B	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Hepatitis C	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Ander: (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
2. Wordt de screening van volgende ziekten regelmatig aangeboden tijdens de detentie?	
Tuberculose	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
HIV	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Hepatitis B	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Hepatitis C	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)

Ander : (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
3. Wordt de screening van volgende ziekten systematisch aangeboden bij het verlaten van de gevangenis?	
Tuberculose	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
HIV	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Hepatitis B	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Hepatitis C	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Ander: (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
4. Is er in deze gevangenis een programma voor gezondheidspromotie?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Ja, gelieve uw antwoord toe te lichten:
5. Is er in deze gevangenis een programma ter bevordering van het mentale welbevinden van de gevangenen?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Ja, gelieve uw antwoord toe te lichten:
6. Is er in deze gevangenis een psychologische consultatie voor patiënten met angsten of depressie?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Ja, gelieve uw antwoord toe te lichten:
7. Is er een specifiek programma voor verslavingen?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Ja, gelieve uw antwoord toe te lichten:
8. Is er een spuitenruilprogramma?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
9. Zijn er initiatieven gericht op het beperken van het delen en hergebruiken van instrumenten voor het tatoeëren, piercing, en andere vormen van huidletsels?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Ja, gelieve uw antwoord toe te lichten:

10. Bestaan er andere specifieke programma's (bv. Seksuele gezondheid) ?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Ja, gelieve uw antwoord toe te lichten:
11. Zijn er op verschillende locaties condooms beschikbaar?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Ja, gelieve uw antwoord toe te lichten:
12. Zijn er verenigingen of Ngo's werkzaam binnen het domein gezondheid, actief in uw gevangenis?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Ja, gelieve uw antwoord toe te lichten:

4. Continuïteit van zorg

1.	**Hoe wordt de dringende medische wacht georganiseerd tijdens de nachturen? Door:**	
	Beroep te doen op de lokale wachtdienst	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Beroep te doen op een andere arts dan die van de wachtdienst, namelijk (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Andere: (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
2.	**Hoe wordt de dringende medische wacht georganiseerd tijdens het weekend? Door:**	
	Beroep te doen op de lokale wachtdienst	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Beroep te doen op een andere arts dan die van de wachtdienst, namelijk (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Andere: (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
3.	**Hoe wordt de aanvraag behandeld wanneer een gevangene een arts wenst te spreken om niet-dringende medische redenen buiten de consultatie-uren van de arts in de instelling?**	
4.	**Is er permanent (24/7) een verpleegkundige aanwezig in de instelling?**	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
		Indien Nee, wanneer dan wel:
3.	**In geval van chronische ziekten, hoe wordt de opvolging van de zorg en tests gewaarborgd?**	
	Vervalboek (papier)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Vervalboek (elektronisch)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Elektronisch register	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)

Persoonlijke Referent:	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Andere: (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
4. Wordt bij het binnenkomen in de gevangenis de externe behandelende arts gecontacteerd om te informeren over medische antecedenten en lopende zorg?	☐ Altijd (1) ☐ Soms (2) ☐ Nee (3) ☐ Weet niet (4)
	Indien Soms, gelieve uw antwoord toe te lichten:
5. **Hoe vindt de overdracht van medische informatie plaats wanneer een gevangene naar een andere gevangenis wordt getransfereerd?**	
Via EPICURE	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Een medische samenvatting wordt aan de persoon meegegeven	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Via post, fax, telefoon	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Andere: (Gelieve in te vullen)	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
6. Hoe vindt de overdracht van medische informatie plaats bij het verlaten van de gevangenis?	
Medisch dossier overhandigd aan de persoon	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Voorafgaand contact met extra-muros huisarts	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
Contact achteraf door extra-muros huisarts	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
7. Krijgt de patiënt een aantal dagdosissen van zijn/haar medicatie mee bij het verlaten van de gevangenis?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Nee, ga naar Vraag 11
8. Voor hoeveel dagen?	
9. Bestaat er een overleg tussen de verschillende tussenkomende zorgverleners inzake de gevangene?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Ja, gelieve uw antwoord toe te lichten:

5. Kwaliteit van zorg

1. Bestaan er aanbevelingen voor goede medische praktijkvoering (EBM) binnen uw instelling?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Nee, ga naar Vraag 3
2. Voor de behandeling van welke gezondheidsproblemen?	- - - -
3. Bestaan er behandelingsprotocollen voor het verpleegkundig personeel (o.a. voor chronische pathologieën)?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
	Indien Nee, ga naar Vraag 6
4. Voor de behandeling van welke gezondheidsproblemen?	- - - -
5. Bestaat er een evaluatie van de opvolging van deze behandelingsprotocollen?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
6. Bestaat er een vormingsprogramma of bijscholing voor het verpleegkundig personeel?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
7. Patiëntenoverleg gebeurt…	☐ Systematisch ☐ Alleen in geval van problemen ☐ Niet
	Indien Ja: wie neemt hieraan deel?

8. Worden de zorgprocessen geëvalueerd?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
9. Worden critical incidents gemeld en geregistreerd?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
10. Worden critical incidents geanalyseerd en opgevolgd?	☐ Ja (1) ☐ Nee (2) ☐ Weet Niet (3)
11. Op welke wijze kan de gevangene zijn mening omtrent de kwaliteit van de zorg uitdrukken?	-

6. Algemeen (Voorbehouden voor de Hoofdgeneesheer)

a. Welke zijn de voornaamste problemen die u in uw praktijk tegenkomt? Gelieve de relevante antwoorden aan te vinken. Indien u dit wenst, kan u ook de lijst aanvullen indien de door u tegengekomen problemen niet in deze lijst voorkomen.

b. Welke oplossing(en) ziet u?

Voornaamste problemen die u tegenkomt in uw praktijk	Mogelijke oplossingen?
☐ Gebrek aan opleiding van het personeel	-
☐ Gebrek aan klinische en organisatorische aanbevelingen	- -
☐ Gebrek aan een duidelijke omschrijving van professionele rollen	-
☐ Gebrek aan medewerking vanwege het penitentiair personeel	- -
☐ Gebrek aan medewerking vanwege het verpleegkundig personeel	- -
☐ Gebrek aan financiële middelen	- -
☐ Gebrek aan globale ondersteuning	- -

☐ Probleem van dubbele loyauteit (Zorgcultuur vs. Veiligheidscultuur)	- -
☐ Dominantie van de Veiligheidslogica	- -
☐ Moeilijke toegang tot de tweedelijnszorg	- -
☐ Moeilijkheid om het beroepsgeheim te garanderen	-
☐ Gebrek aan informatie omtrent de datum van invrijheidsstelling van de patiënt	- -
☐ Andere: (Gelieve in te vullen):	- -

7. 6.BIS Algemeen (Voorbehouden voor de Verpleegkundige)

1. Welke zijn de voornaamste problemen die u in uw praktijk tegenkomt? Gelieve de relevante antwoorden aan te vinken. Indien u dit wenst, kan u ook de lijst aanvullen indien de door u tegengekomen problemen niet in deze lijst voorkomen.
2. Welke oplossingen ziet u?

Voornaamste problemen die u tegenkomt in uw praktijk	Mogelijke oplossingen?
☐ Gebrek aan opleiding van het personeel	-
☐ Gebrek aan klinische en organisatorische aanbevelingen	- -
☐ Gebrek aan een duidelijke omschrijving van professionele rollen	-
☐ Gebrek aan medewerking vanwege het penitentiair personeel	- -
☐ Gebrek aan medewerking vanwege de artsen	- -
☐ Gebrek aan financiële middelen	- -
☐ Gebrek aan globale ondersteuning	- -

☐ Probleem van dubbele loyauteit (Zorgcultuur vs. Veiligheidscultuur)	- -
☐ Dominantie van de Veiligheidslogica	- -
☐ Moeilijke toegang tot de tweedelijnszorg	- -
☐ Moeilijkheid om het beroepsgeheim te garanderen	-
☐ Gebrek aan informatie omtrent de datum van invrijheidsstelling van de patiënt	- -
☐ Andere: (Gelieve in te vullen):	- -

Informatie voor deelnemers aan het onderzoek:

Achtergrond van de studie

Deze studie wordt uitgevoerd door de vakgroep Huisartsgeneeskunde en Eerstelijnsgezondheidszorg, onder leiding van Prof. dr. Sara Willems, in opdracht van het FEDERAAL KENNISCENTRUM VOOR DE GEZONDHEIDSZORG.

Ter voorbereiding van een grondige hervorming van de organisatie van de gezondheidzorg voor gevangenen wil deze studie de huidige organisatie van de gezondheidszorg in de Belgische gevangenissen beschrijven in termen van beschikbaarheid, bereikbaarheid, continuïteit, omvattendheid en kwaliteit.

Wat kan u verwachten

Wij vragen u vriendelijk of u de tijd zou willen nemen om deze vragenlijst in te vullen. Dit zal ongeveer een 1 uur van uw tijd in beslag nemen. U mag voor het invullen van deze vragenlijst ook beroep doen op uw medewerkers en collega's.

Vrijwilligheid en vertrouwelijkheid

Het staat u volkomen vrij om deel te nemen of niet. U kunt weigeren deze vragenlijst in te vullen, zonder dat u hiervoor een reden moet opgeven. Als u toestemt, wordt u gevraagd de ingevulde vragenlijst elektronisch terug te sturen naar Gregory.Gourdin@ugent.be.

De inhoud zal in vertrouwen worden behandeld en anoniem worden verwerkt. In overeenstemming met de Belgische wet van 8 december 1992 en de Belgische wet van 22 augustus 2002, zal uw persoonlijke levenssfeer worden gerespecteerd. Als de resultaten van de studie worden gepubliceerd, zal uw anonimiteit verzekerd zijn.

Voordelen

Deze studie biedt geen medisch of ander voordeel voor uzelf, maar de bekomen resultaten kunnen leiden tot een verbetering van de gezondheidszorg voor gevangenen.

Goedkeuring onderzoek:

Deze studie werd goedgekeurd door een onafhankelijke Commissie voor Medische Ethiek verbonden aan het UZGent. In geen geval dient u de goedkeuring door de Commissie voor Medische Ethiek te beschouwen als een aanzet tot deelname aan deze studie.

Verdere vragen:

Indien u nog verdere vragen heeft over dit onderzoek, dan kan u hiervoor terecht bij Prof. dr. Sara Willems (09 332 39 84) (Sara.Willems@ugent.be), of bij dr. Gregory Gourdin (0475 653 002) Gregory.Gourdin@ugent.be).

Indien u beslist om deel te nemen, vragen wij u vriendelijk voor akkoord te tekenen.

Ik verklaar hierbij dat ik:

(1) ingelicht ben over de achtergrond, doelstelling, inhoud, duur en opzet van het onderzoek en dat men mij de mogelijkheid heeft geboden om bijkomende informatie te verkrijgen.

(2) totaal vrijwillig deelneem aan dit onderzoek.

(3) me ervan bewust ben dat deze studie werd goedgekeurd door een onafhankelijke Commissie voor Medische Ethiek verbonden aan het UZ Gent.

(4) de toestemming geef aan de onderzoekers om mijn resultaten op anonieme wijze te bewaren, te verwerken en te rapporteren.

(5) op de hoogte ben van de mogelijkheid om mijn deelname aan het onderzoek op ieder moment stop te zetten.

APPENDIX 3. DETAILED OVERVIEW OF MAIN PROBLEMS IN PENITENTIARY HEALTH CARE AS IDENTIFIED BY THE RESPONDENTS OF THE SURVEY (CHIEF PHYSICIANS)

Main problems faced in the daily practice (Head Doctor)	N: 25
Lacking financial means	17
Lacking information regarding the patient's release date	10
Problem of double loyalty (Care culture versus Security culture)	10
The personnel's lack of formation	9
Difficult access to secondary care	9
Difficulty to guarantee the professional secrecy	7
Dominance of the Security logic	7
Lack of collaboration from the penitentiary personnel	5
Lack of global support	5
Lacking clearly defined professional roles	5
Lack of time	4
Lacking clinical and organisational recommendations	2
Lack of collaboration from the prison's internal services	1
Lack of collaboration from the CMC	1
Electronic Medical file	1
Lack of meetings between the different actors	1
Everything is finally let off en decided by the management	1
No efficient psychological help	1
Long waiting lists at the CMC	1
Lacking collaboration from the nursing staff	0

APPENDIX 4. DETAILED OVERVIEW OF MAIN PROBLEMS IN PENITENTIARY HEALTH CARE AS IDENTIFIED BY THE RESPONDENTS OF THE SURVEY (NURSING STAFF)

Main problems faced in the daily practice (Nursing)	N: 15
Lacking financial means	8
Lacking information regarding the patient's release date	6
Dominance of the Security logic	7
Lack of collaboration from the penitentiary personnel	6
Problem of double loyalty (Care culture versus Security culture)	5
The personnel's lack of formation	5
Difficult access to the secondary care	6
Lacking clearly defined professional roles	4
Difficulty to guarantee the professional secrecy	3
Lack of global support	4
Lacking clinical and organisational recommendations	3
Lack of communication	1
Necessary to refresh the medical equipment and annexe	1
The nursing staff has to take up tasks for which they are not trained	1
Not being able to see the patients during the inmate 's call	1
Communication problems due to foreign languages	1
Lacking collaboration from the medical doctors	1