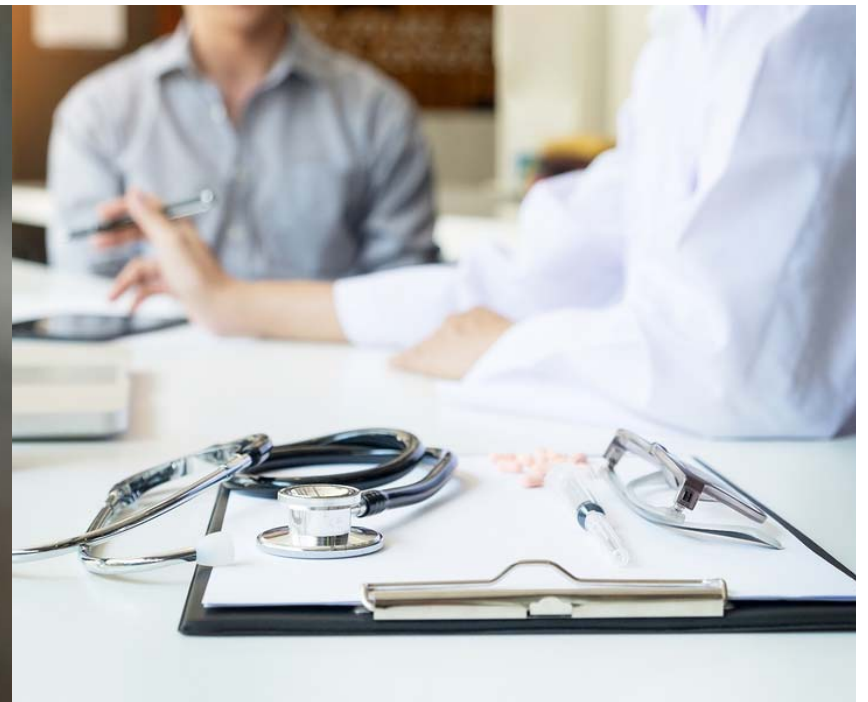


ORGANIZATION MODELS OF HEALTH CARE SERVICES IN PRISONS IN FOUR COUNTRIES



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Layout:	Ine Verhulst



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- **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.**
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LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
<i>FRANCE</i>	
APSEP	Association des Professionnels de Santé Exerçant en Prison – Association of Health Professionals Working in Prison
CGLPL	Contrôleur Général des Lieux de Privation de Liberté
DGOS	Direction Générale de l'Offre de Soins – General Directorate of Care Offer
DGS	Direction Générale de la Santé – General Directorate of Health
DSS	Direction de la Sécurité Sociale – Directorate of Social Welfare
DGCS	Direction Générale de la Cohésion Sociale – General Directorate of Social Cohesion
HCSP	Haut Comité de la Santé Publique – High Committee of Public Health
SMPR	Services Médico-Psychologiques Régionaux – Regional Medical and Psychological Services
IGAS	Inspection Générale des Affaires Sociales- General Inspectorate of Social Affairs
USMP	Unité Sanitaire en Milieu Pénitentiaire – Care Unit in Prison
UHSA	Unité Hospitalière Spécialement Aménagée – Specially Adapted Hospitalized Units
UHSI	Unité Hospitalière Sécurisée Interrégionale – Interregional Secure Hospitalized Unit
UMD	Unité pour Malades Difficiles – Units for Difficult Patients
<i>SWITZERLAND</i>	
ASSM	Académie Suisse des Sciences Médicale – Swiss Academy of Medical Sciences
AVS	Assurance Vieillesse et Survivants – Age and Survivors Insurance
BIG	Bekämpfung von Infektionskrankheiten im Gefängnis - Project of fight against infectious diseases in prisons
CCDJP	Conférence des Directeurs et Directrices des Départements Cantonaux de Justice et Police - Directors' Board for the Cantonal Justice and Police Departments
CDS	Conférence Suisse des Directrices et Directeurs Cantonaux de la Santé – Swiss Conference of Directors' Board for the Cantonal Health
CMPS	Conférence des Médecins Pénitentiaires Suisses – Conference of Swiss Penitentiary Doctors
CNPT	Commission Nationale de Prévention de la torture – National Commission for the Prevention of Torture



CPP	Code de Procédure Pénale – Code of Criminal Procedure
CPT	European Committee for the Prevention of Torture and inhuman or Degrading treatment or Punishment
CSFPP	Centre Suisse de Formation pour le Personnel Pénitentiaire – Swiss training center for prison staff
FES	Fédération des Établissements de privation de liberté Suisse – Swiss Federation of liberty deprivation establishments
GP	General Practitioner
LAMal	L'assurance maladie – Compulsory Health Insurance
SPC	Code Pénal suisse – Swiss Penal Code
SMPP	Service de Médecine et Psychiatrie Pénitentiaire – Service of Penitentiary Medicine and Psychiatry
SPS	Santé Prison Suisse – Health Prison Swiss
OEPSJ	Office for the Execution of Penal Sentences and Justice (in the Canton of Zurich)
WHO	World Health Organization

SCOTLAND

BBV	Blood-Borne Virus
CHP	Community Health Partnership
CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
GP	General Practitioner
HCNA	Health Care Needs Assessment
HCV	Hepatitis C Virus
HIS	Healthcare Improvement Scotland
HM	Her Majesty
HMCIPS	Her Majesty's Chief Inspector of Prisons for Scotland
HMIPS	Her Majesty's Inspectorate of Prisons for Scotland
HMP	Her Majesty's Prison
IS	Information System
ISP	Information Sharing Protocol



IT	Information Technology
MoU	Memorandum of Understanding
NHS	National Health Service
NHSGGC	NHS Greater Glasgow and Clyde
NPHN	National Prisoner Healthcare Network
NPM	National Preventive Mechanism
OPCAT	United Nations Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
PHAB	Prisoner Health Advisory Board
SGHSCD	Scottish Government Health and Social Care Directorate
SPS	Scottish Prison Service
SPSO	Scottish Public Services Ombudsman
TAS	Throughcare Addiction Service
UK	United Kingdom
WHO	World Health Organization

THE NETHERLANDS

DV&O	Dienst Vervoer en Ondersteuning – Transport and Support Service
DGV	Dienst Geestelijke Verzorging – Spiritual Care Service
EPD	Elektronisch patiënten-dossier – Electronic patient health record
GHB	Gamma HydroxyButyrate
JCvSZ	Justitieel Centrum voor Somatische Zorg – Judicial Center for Somatic Care
NIVEL	Netherlands Institute for Health Services research
NIFP	Nederlands Instituut voor Forensische Psychiatrie en Psychologie – Dutch Institute for Forensic Psychiatry and Psychology
PPCs	Penitentiair Psychiatrische Centra - Penitentiary Psychiatric Centres
PMO – PMZ	Psycho-Medisch Overleg – Psycho-Medische Zorg – Psycho-Medical Team – Psycho-Medical Care
TBS	Terbeschikkingstelling – Detention at the government's discretion



V&VN

Verpleegkundigen & Verzorgenden Nederland – Nurses and Care Assistants
Netherlands

ZZBI

Zeer Beperkt Beveiligde Inrichting – Very Limited Security Facility



■ SCIENTIFIC REPORT

1 INTRODUCTION

This chapter aims “to identify and analyse the organization models of health care services in prisons in four selected foreign countries likely to inspire the reform of the health care system in Belgian prisons. [...]”

The four foreign countries: France, the Netherlands, Switzerland and Scotland have been selected on basis of the following criteria:

- Feasibility (in the allocated period of time):
 - The official and grey literature is abundant and accessible;
 - The literature is written in language that is accessible to the researchers (English, French, or Dutch);
 - The researchers can rely on pre-existing networks;
- Relevance:
 - The four selected countries offer good practices in organisation of healthcare in prisons (see hereunder);
 - The selected countries are usually considered as sources of inspiration for Belgian policy makers, especially France and the Netherlands;
- Diversity:
 - The preliminary search showed that the selected countries provide different interesting scenarios for Belgium.

With respect to the subject matter of the transfer of prison health care to the Ministry of Health, France and Scotland present two different and interesting cases of transfer. France has a comparatively long - since 1994 - history of prison health under the authority of the Ministry of Health. Health care in each prison is provided on the basis of an agreed protocol with the nearest public hospital. Scotland's reform is much more recent (2011) but fully integrated under the rule of the NHS and its regional boards. Due to the organisation of its federated system, Switzerland can be seen as a laboratory of different configurations of reform/conservation of the present organisation of healthcare services in prisons. The Netherlands's choice to maintain the organisation of healthcare under the rule of the Prison Service (Dienst Justitiële Inrichtingen) and to organise a medical service in every prison provides an interesting counterpoint to the other cases.



2 METHODOLOGICAL CHOICES, LIMITATIONS AND ADJUSTMENTS

An **inductive, iterative and cumulative approach** has been chosen to integrate the different steps so that each data collection activity would build upon the others. This approach is justified by the exploratory and qualitative nature of this research theme focused on the analysis of four models of health care in prisons in four selected countries whereas the scientific literature is very scarce and scattered. It also grounded in our professional background as sociologists (4 of the 5 members of the research team are sociologists, the fifth one is a medical doctor, graduated in Public Health).

The **inductive** approach differs radically from the deductive one, which assumes that a well-identified general question is formulated from the beginning of the project, that particular questions are derived from it, that these particular questions determine how to gather, organise and analyse the data and how to organise the table of contents of the written report. To the contrary, the inductive approach assumes that the researchers gradually infer from the data the structure of the analysis and the report.

This is directly related to the **iterative** approach which implies the coevolution of questions and answers and can be enforced against the systematic approach. Andrew Abbott ¹ is convinced of the nonlinearity of library work. According to this author, the researcher is set “to seek material relevant to [the] puzzle [he’s interested in] in a pre-existing body of materials that is large and indefinite, but that may itself be organized, although in ways that are probably irrelevant to [his] puzzle”. This approach requires from the researchers what Andrew Abbot calls “getting to the needle shop” rather than looking for a needle in a haystack: browsing and scanning by eye both with regard to their project and to which material could be useful if they changed this project.

Our approach is also **cumulative** in the sense that it is organised in three complementary steps: grey literature, scientific literature, Policy Delphi. The data firstly collected in the grey literature has been confronted to and complemented by the analysis of the scientific literature. In the next stage these descriptions have been confronted to the relevant information and points of views held by a selection of stakeholders (adjusted Policy Delphi).

In this methodological approach each stage is not only an opportunity to collect new material but also a chance to validate previous stages.

2.1 Grey literature review

2.1.1 Collection of grey literature review

For the grey literature review, the following information sources were screened:

- Health administration and ministries official websites;
- Prison administration and ministries official websites;
- Control agencies websites;
- Parliament websites, in particular documents related to the transfer of competences;
- Human rights associations websites;
- Prison related international regulation bodies websites;

The role of “custodians” (experts in the field, members of the main administrations, associations etc.) is well-known as a key factor to facilitate access to materials. Key informants were therefore contacted by e-mail between December 2015 and March 2016. They were chosen either because of their scientific expertise or their professional involvement in prison health services. In addition, research by keywords in Google and snowball methods (consisting on consulting the references of any interesting document to identify new sources of information) were used all along the review process to complete our findings. The step-by-step process by country is detailed in Appendix 1.



2.1.2 Screening of grey literature review

According to Abbott ¹, to begin a research with library and internet materials, you need to formulate a few empirical questions backed up by some theoretical ideas. As a first step, the different members of the team discussed their previous knowledge of social and political dynamics in organisations and particularly in prison. As a result, the organisation of healthcare services in prison in the four countries has then been scrutinised following these different issues:

- Presentation of the prison and health care systems
 - Which organizations or agencies tend to be involved?
 - Which are the interfaces between the two systems?
 - What is the history behind this situation?
 - What are the main triggers and orientations?
- Cost evaluation and management
 - What cost information is available?
 - Who pays for the health care of detainees? Which insurance schemes are available in the country for this population?
- Collective action on the field
 - Who does what, and how do they do it?
 - What tools and methods are involved?
 - How are health services organised and delivered in prison at the primary and secondary levels?
 - How is cooperation between the different professions?
- Specific issues
 - What are the special challenges in each country regarding the organisation of health care in prison?
 - What good practices can be shared?

However, Abbott ¹ considers these first questions as a temporary scheme for reading and organising the material. He advises researchers to reorganise progressively their analyses frameworks (labels, titles, etc.) in order to gradually infer from the data the structure of the report and to integrate new elements whenever they might help to achieve the research goals, i.e. to inspire the reform of the health care system in Belgian prisons.

2.1.3 Organisation of grey literature review

Following the inductive, iterative and cumulative process we chose to adopt in this literature review, we wrote a first draft focused on grey literature, which has been compared to the structure of the Belgian literature review report and adapted according to the main issues raised by the comparison between our four countries of interest. The following structure has emerged from this incremental comparison process:

1. General presentation of prison and healthcare system

- 1.1 Main actors
- 1.2 Respective competences and coordination ways
- 1.3 Historical perspectives

2. Characteristics of the prisons and prisoners

3. Delivery of care

- 3.1 Introduction
- 3.2 Availability
- 3.3 Comprehensibility (specific health issues and specific groups)
- 3.4 Continuity of care
- 3.5 Reachability
- 3.6 Quality of care
- 3.7 Patient's rights
- 3.8 Financial aspects.



Since grey literature varies in quality and quantity from country to country and from subtopic to subtopic, in some cases we had insufficient information to describe every aspect. Most of the grey literature documents provides *ex post* narratives on reforms: they focus on their result and not on the process of reform, they present sometimes a sort of *ex post* justification, and they focus on catalysts for reform rather than on obstacles and challenges. To a certain extent, the scientific literature review helped us to fill in some of the gaps.

2.2 Scientific literature review

As the scientific literature is much more organised than the grey one, we opted in this case for a more systematic review, despite the impossibility to guarantee exhaustiveness, given the limited resources and time allotted to this research project.

2.2.1 Collection of scientific literature review

In order to collect scientific literature, six databases were systematically searched: PUBMED, PROQUEST/Social services, PROQUEST/Sociological abstracts, PROQUEST/ PsycINFO, PROQUEST/Health management, PROQUEST/ Political science. Specific thesaurus of each database (see below) were used to combine search terms associated with three parameters of our literature search:

- Topics of interest: Health administration, health services, healthcare organisation, health policy
- Context and population: Prison, prisoners
- Countries of interest: France, Scotland (UK in some databases), Switzerland, The Netherlands

The search terms are detailed by database in Annex 2.

2.2.2 Results

2.2.2.1 Pubmed

The Pubmed search strategy led to 207 references:

- France: 76 references (see Annex 3A)
- Scotland: 32 references (see Annex 3B)
- Switzerland: 53 references (see Annex 3C)
- The Netherlands: 46 references (see Annex 3D)

2.2.2.2 Proquest (five databases)

The Proquest search strategy in five databases led to 310 references (see Annexes 4A, 4B, 4C, 4D).

2.2.3 Screening of scientific literature review

A first selection was made by systematic screening of the titles and abstracts.

The following criteria were used to select references:

- The paper gives information about our topics of interest: Health administration, health services, healthcare organisation, health policy
- The paper gives information about our topics of interest in our countries of interest: France, Scotland (UK in some databases), Switzerland, The Netherlands
- The paper provides up-to-date information or relevant information about the historical process of reforms of healthcare in prisons
- The paper is accessible from one of the following University Library: ULB Library, ULg Library and UCL Library (feasibility criteria).

Annexes 5 and 6 present the selection process and the lists of results (Pubmed and Proquest).



2.3 Adjusted Policy Delphi

An adjusted Policy Delphi method was used to develop a deeper understanding of convergences and divergences on organisational and political reforms in health care services in prisons among the studied countries. We used this method:

- in order to check information collected by the literature review;
- in order to refine our interpretation of the national configurations susceptible to inspire Belgian policy makers.

The Delphi method, which is commonly used in health research, involves a multi-staged approach, with each stage building on the results from the previous². A Delphi study is “a robust method that uses expert judgements, and compares these judgements in several rounds with the aggregate judgements of other participating experts”³. The Policy Delphi is a modified version of the original Delphi technique and has been defined as “a systematic method for obtaining, exchanging, and developing informed opinion on an issue”⁴. According to Turoff⁵, whereas the Delphi technique is usually practiced to deal with technical topics and seek a consensus among homogeneous groups of experts, the Policy Delphi, on the other hand, seeks to give explicit attention to opposing views on major policy issues.

In addition to the purpose of “fact-checking” the information collected by literature review, the Policy Delphi’s purpose is to allow us to collect different views on policy issues regarding organisation of healthcare in prisons.

The data collection was planned in three steps:

Identification of national stakeholders in a selected number of foreign countries.

We identified relevant national stakeholders by consulting national official websites of Health Administration and/or Prison Administration and the concerned Ministries and associations (civil rights associations, etc.), by directly contacting staff involved in these organisations and our pre-existing networks in these countries, by identifying authors of the selected official and grey literature, and by using a snow-ball method, e.g. authors of important national or national reports on this as well as the authors of recent

scientific analyses in various countries. Representatives of human rights defence in prison have also be included in this pool of stakeholders.

Five to ten stakeholders by country were selected for their good knowledge and their strong commitment to the organisation of healthcare in prisons (cf. Annexe 9). We contacted them by email. We delivered to them a description of the purpose and methodology and asked for their interest in participating in this study. A second round of (e-mail and/or phone) contacts was necessary in some cases. Our goal was to obtain the active involvement of at least five stakeholders by country from different backgrounds: policy maker, administrative officer, health worker, civil right defender. These stakeholders were contacted several times:

1. to get their formal agreement or the name of a voluntary colleague;
2. to submit to them our analysis of healthcare organisation (fact-checking purpose) and ask them to provide us with a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis of this organisation in their country (collecting of different views on policy issues purpose);
3. to ask for further details, thanks them or remind them our request when needed.

We received a lot of very helpful and detailed answers from those contacted. However, it was impossible to collect information from the targeted five stakeholders in some countries (see Annexe 9). In particular, we had difficulties to consult Dutch actors. Different factors can explain this difficulty to get as many answers as expected:

- time constraints: due to the limited time allotted to this research, stakeholders were asked to answer to the consultation (see below) in only two weeks;
- lack of incentive: even if most of the contacted stakeholders are deeply involved in the field, the participation to this Policy Delphi was voluntary;
- lack of interest or subject considered “too delicate”: it is interesting to note that the more enthusiastic and detailed answers came from countries or regions where the transfer of prison healthcare to the Ministry of Health has (recently) occurred whereas the Netherlands and the German-speaking Cantons were less responsive.



We therefore had to adjust the Policy Delphi for the Netherlands by a long and deep face-to-face interview with Annet Slijkhuis, Head of Health Department, Ministry of Security and Justice and member of the WHO steering group in Prison and Health.

Anonymous based consultation

With the exception of the Netherlands, selected stakeholders were asked by email to answer an anonymous consultation about their national healthcare policy in prisons. These features are designed to minimize the biasing effect of dominant individuals, of irrelevant communications, and of group pressure toward conformity⁶. However, in order to acknowledge their participation, we asked the stakeholders if, after the consultation process, they wanted to be quoted and/or identified in the acknowledgments.

The consultation included two types of content:

- A major part of the consultation process survey was based on our analysis of literature and description of healthcare in prisons in each country: the selected stakeholders were asked to complete or rectify the information;
- The stakeholders were asked to express their own point of view on the policy issues selected during the literature review phase (see Conclusion points) by making a SWOT analysis of healthcare organisation in prison in their respective countries. Indeed the Policy Delphi aims to inform Belgian policy makers by identifying the main challenges faced by each of the four selected countries while organizing health care in prison, and by understanding key benefits and disadvantages of the national scenarios in the countries where they occur in the perspective of different stakeholders.

Following our inductive, iterative and cumulative approach, their comments, contributions and evaluation were directly incorporated (and identified as such) in the final report. According to the principles of the Policy Delphi method, particular attention has been paid to not smoothing out differences of opinion between the participants. Appendix 10 contains a full transcript of the full record of this SWOT analysis in the language(s) in which it was written.

Controlled feedback

The Policy Delphi method assumes to submit the result of the first consultation to the same pool of stakeholders for a second round consultation. However, due to time constraints, it was impossible to organise this second round. This is the second adjustment to the Policy Delphi method we had to do (along with the Netherlands case). The final evaluation of the report by the KCE and by a selection of national experts should contribute to the validation of the data included in this chapter.



3 FRANCE

MAIN FINDINGS AND LESSONS

- On 1 July 2016, there were 69.375 jailed persons in 190 prisons (+3,8 % against July 2015). Among those, nearly one third included accused persons. Nearly 11.000 additional persons were under electronic surveillance. The detention rate is 101 per 100.000 inhabitants^a.
 - **The law of 18th January 1994** on health and social protection makes prisoners part of the ordinary health system. Prisoners must be registered at the **Primary Fund Health Insurance** (CPAM, Caisse Primaire d'Assurance Maladie) relevant to their prison. Moreover, prisoners should access the same standard of care as any other citizen (law of March 2002).
 - General primary care within every prison is organized within the USMP (179 Unités de Soins en Milieu Pénitentiaire), and psychiatric care in the USMP or the SMPR (26 Services Médico-Psychologiques Régionaux). USMP and SMPR are managed by a neighbouring hospital. Hospitalization are organized either in the neighbouring hospital (for hospitalisation<48h), or in the UHSI (8 Unités Hospitalières Sécurisées Interrégionales, 182 beds) (hospitalisation>48h) or, for forced psychiatric hospitalization in the UHSA (7 Unités Hospitalières Spécialement Aménagées, 340 beds). More or less 55 000 medical extractions are performed every year (each costs 1.300€ and requires often three prison guards).
 - The medical teams are composed of general practitioners (both external and internal GPs), medical specialists (out of psychiatrists), dental surgeons and pharmacists. The para-medical teams are composed of physiotherapists, nurses, radiology technicians (whenever a radiology department is available), administrative and medico-social professionals. All of them can integrate an USMP on a voluntary basis, but they keep some guarantee of mobility between the different services of the associated hospital.
 - Psycho-medical teams (USMP and SMPR) can interact with the surveillance staff, and vice versa throughout a unique multidisciplinary commission (one has to be created into each prison)
 - Suicide risk assessment is a part of each prisoner's examination upon admission.
 - The standards for human resources provision are as follows (per 1000 prisoners): 3.4 GP, 0.5 specialists, 3.2 psychiatrists, 5.2 psychologists, 14.8 nurses, 7.7 psychiatric nurses, 1.6 dentists, 0.4 physiotherapists. In reality, professional attractiveness is low, and a significant proportion of posts remain vacant (e.g.
- **Control Bodies:**
 - The **CGLPL** (Controleur Général des Lieux de Privation de Liberté) focuses on detention, health prevention, prisoners' hospitalization, and staff working conditions that may impact the functioning of the institutions and the relationship with the prisoners. IT can perform scheduled or unscheduled visits at any time, day and night, in any custodial institution. A visit report including some recommendations should be sent to the concerned Ministers after every visit. This report can be published
 - Every individual or association, including prisoners, can refer to the National Rights Defender if they rights are presumably violated. The prisoners send 4000 referrals every year.
 -
 - **Shortcomings**
 - Chronic overcrowding jeopardizes health of prisoners
 - Professional attractiveness remains low. Staff is insufficiently trained. Continuous training is undersized and under-budgeted.
 - Health promotion and prevention are insufficiently developed by the CGLPL, although interesting tools are being elaborated, such as the methodological guide on health promotion in prison settings edited (Inpes 2014)
 - Health care offer is still incomplete (notably for psychiatric care) whereas UHSI are underutilized
 - There are regional disparities in health staff and care offer
 - The infrastructure and information systems are unsuitable; there is no effective epidemiological monitoring
 - Although the social protection is guaranteed for the prisoners, its implementation is sometimes confronted to practical difficulties
 - The cooperation among the various actors is sub-optimal, and the agreement frame between prisons and hospitals must be revised
 - The health system remains very dependent upon the prison functioning.

^a Data retrieved from the website of World Prison Brief: http://www.prisonstudies.org/highest-to-lowest/prison_population_rate?field_region_taxonomy_tid=14



5.5% for GP, 16% for psychiatrists, 7% for dentists). Medicine students can work in the USMP as part of their training. For prisons with >1000 prisoners, a head nurse is appointed. For prisons with > 1500 prisoners (or if medication cannot be provided every day), a pharmacy is then created.

- Prisoners must receive free care (Code of Criminal Procedure, article 380D). Health care is covered by the State (prison administration) through two mechanisms: a global contribution to social security paid at the central level (80 MEuros in 2012); reimbursement of what is not covered by the social security to hospitals (28 MEuros in 2012). Although the State should cover all costs, its part is only of 31% of the total because the budget had not been adapted, i.e. the social security currently bears the largest part. The costs of prison healthcare tripled between 1994 and 2012, rising from 113 MEuros to 344 MEuros. This is due to the development and diversification of the supply of care, but also to the constant increase of the prison population (more condemnation to prison term without remission and increasing length of prison terms).
 - To facilitate the implementation of the reform, a memorandum of understanding between prisons and health institutions was signed. From a practical and local view, **a methodological guide** (guide méthodologique relatif à la prise en charge sanitaire des personnes placées sous main de justice) was published and updated twice. This methodological guide is a reference document for all prison and health staff on the various aspects of health care in prison.
-



3.1 General presentation of prison and healthcare system

3.1.1 Main actors

3.1.1.1 Prison system

The French prison system is regulated by the Ministry of Justice and consists of 190 prisons spread across the French territory. These facilities are juvenile facilities, for minors (6); custodial prisons (*maisons d'arrêt*), for persons on custody and sentenced for less than two years (n = 98); security prisons (*maisons centrales*), for long term prisoners, i.e. sentences exceeding 10 years (n = 6); detention centers (*centres de détention*), facilities for sentenced to medium sentences (n = 25); and day-leave centers (*centres de semi-liberté*), facilities for persons receiving an sentence adjustment (n = 11). Nevertheless, the “centres pénitentiaires” include also both a custodial prison and a detention center, and at times also a security prison and/or a day center (n = 50)^{7 8}.

The General Controller of Detention Facilities (*Contrôleur Général des Lieux de Privation de Liberté, CGLPL*) was established by Law No. 2007-1545 of 30 October 2007⁹. This independent body controls the conditions of prisoners' treatment and transfer. Moreover, this institution is charged to ensure the application of the Optional Protocol to the Convention against Torture^b (OPCAT)¹⁰. As an independent administrative authority, the CGLPL may not receive any order from any other institution, and is appointed for a term of six years. The CGLPL can intervene at any time in prison or in health institutions hosting prisoners. Its mission consists of enforcing the fundamental rights as defined by international and national laws⁹.

3.1.1.2 Health care system

Since 1994, the responsibility to deliver health care in prison is managed by the Ministry of Health. Figure 1 displays the levels of the health care system in prisons. Medical services are provided by hospital practitioners assigned to the prison. This means that one neighbouring hospital delivers health care services for every prison, in the same conditions as they do to free citizens. Each hospital – named “associated hospital” hereafter – has set up a Care Unit in prison (*Unité de Soins en Milieu Pénitentiaire, USMP*) inside the prison¹¹. Second-line health care services requiring specialized material or hospitalization (for less than 48 hours) are delivered in the associated hospital. The discharge and the transfer of the prisoner could then be required to the UHSI (*Unité Hospitalière Sécurisée Interregionale*) for more than 48h hospitalizations^{11 8}.

One-day hospitalization for mental health reasons can be organized in USMP situated inside the prison. Forced psychiatric hospitalization is organized in the local psychiatric hospital or in one of the UHSA (*Unités Hospitalières Spécialement Aménagées*). Prisoners who need and want to be hospitalized for a mental health problem can be hosted in a UHSA⁸. Every USMP is strongly connected to their associated hospital and equally linked to the other services of the hospital. It could be considered a functional unit subordinated to a clinical service or department. Its activity is reported in the annual report of the associated hospital. The clinical service or department is often a health or emergency-SMUR service as they provide general medical services. The team is regulated by the hospital and by the SMUR service¹².

^b See the implementation manual of the Optional Protocol of the UN against Torture http://www.ap.t.ch/content/files_res/opcat-manual-english-revised2010.pdf



Like the USMP, the SMPR (Services Médico-Psychologiques Régionaux) is also part of the associated hospital and it provides psychological and psychiatric care. The decree n° 86-202 of 14 March 1986 guarantees the existence of at least one SMPR in every prison region. If no SMPR is available inside a prison¹³, psychiatric care is then delivered by psychiatrists of the USMP¹¹. In this case, if more particular care are needed, the psychiatrist could ask for the transfer of the prisoner to a SMPR (17).

USMP and SMPR provide therefore first and second-line healthcare services. As mentioned earlier, they are part of a hospital and can therefore be considered as hospital departments inside the prisons¹¹.

The third-line of health care delivery concerns the services requiring full-time hospitalization, and therefore discharge of the prisoner. For an emergency or when the patients' stay at the hospital is less than 48 hours, admissions will be facilitated by the associated hospital. The inmate is then placed in a secure room in which access to technical facilities of the hospital is easy and secure¹¹. A total of 235 secure rooms are available¹⁴. When hospitalization for somatic care is longer than 48 hours, it takes place in an Inter-Regional Secure Hospitalized Unit (Unités Hospitalières Sécurisées Interrégionales, UHSI), whereas full-time psychiatric hospitalizations are carried out in a Specially Adapted Hospitalized Unit (UHSA)^{11 8}.

The Units for Patients with complex care (Unités pour Malades Difficiles, UMD) receive only patients (prisoners or not) who may be dangerous for others¹⁵. There is sometimes confusion between UMD and UHSA. UHSAs do not have a security duty and are not adapted for difficult patients. The aim of UHSA is to respond to the care of prisoners and not to protect the society against dangerous persons^{13 8}.



Figure 1 – France – Three levels of care

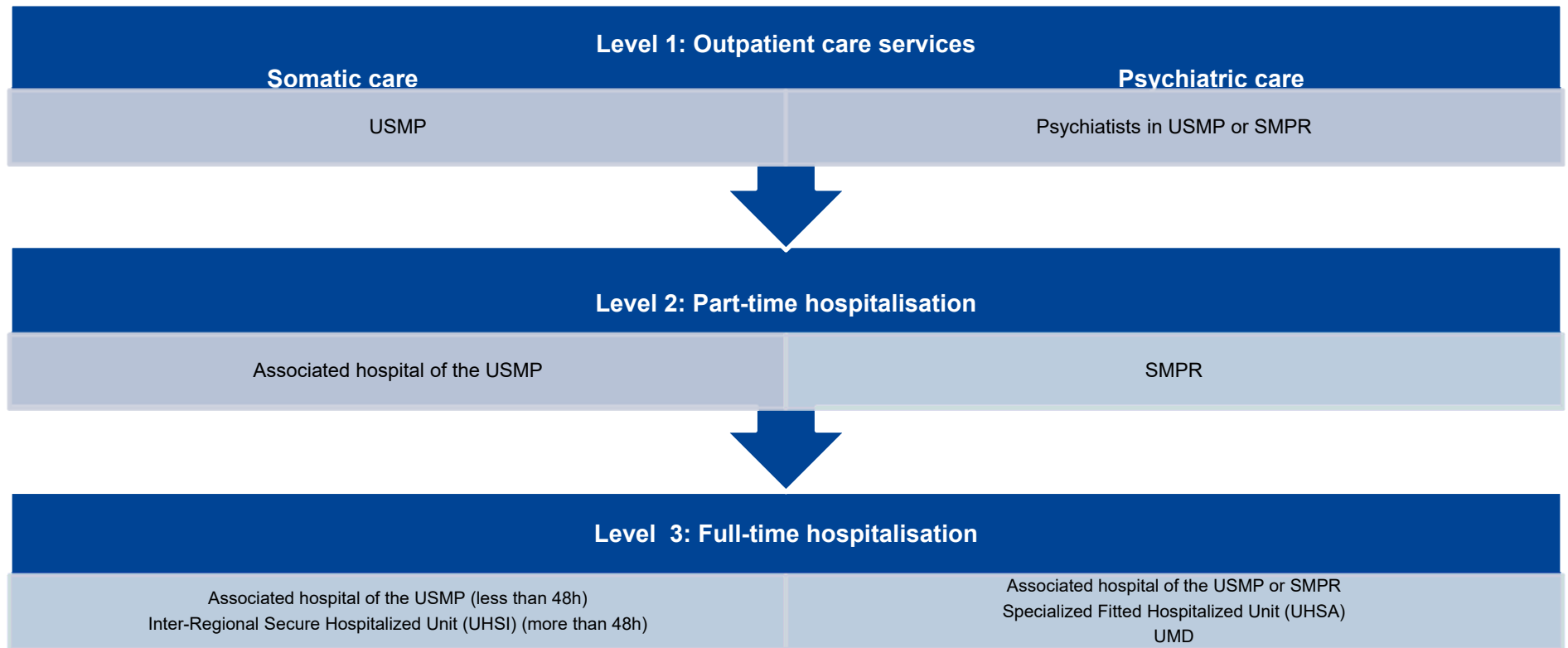
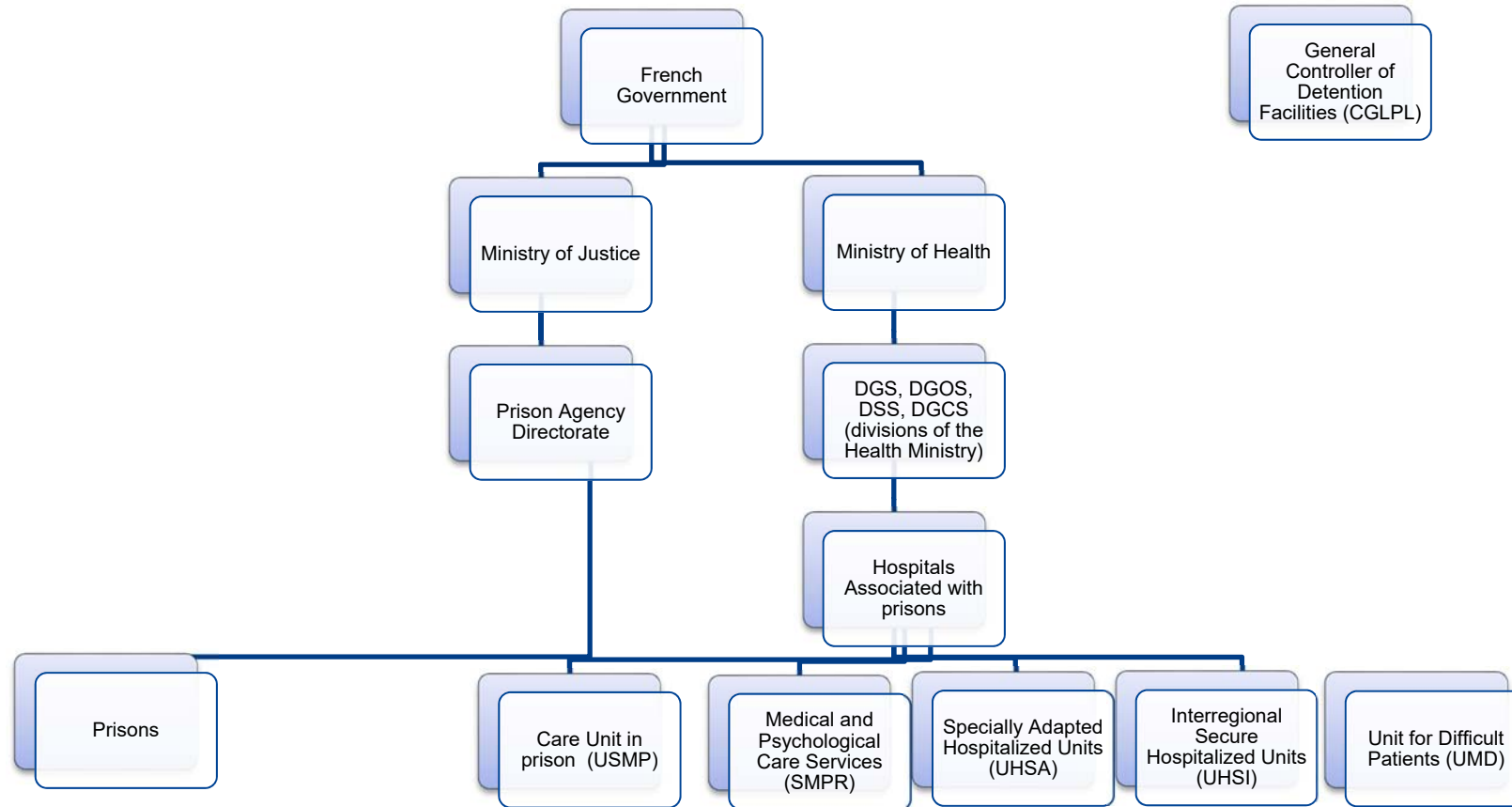




Figure 2 – France – Organization chart: Institutional framework^{cd}



^c Unit for Difficult Patients is not specifically devoted for prisoners but for any people who requires a specific level of care ⁸.

^d The divisions of the Health Ministry involved in the prisoners' health care are the DGS (Directorate General for Health), the DGOS (Directorate General of Care Offer, the DSS (Directorate General of Social Security) and the DGCS (Directorate General of Social Cohesion) ^{8 252}.



3.1.2 Respective competences and collaboration frameworks

At the Ministry of Health, the health policy is steered by a project manager, who has to set up a strategic action plan (the previous one was written for the 2010-2014 period, and the next one is being formalized in 2016). This plan has to be followed and coordinated by the general directorate of the Ministry of Health (DGOS, DGS, DSS, DGCS) and the Prison Agency. But actually, due to a lack of human resources since 2013, there is no institutional monitoring by the Ministry of Health¹⁶.

In the prisons, medical and paramedical staff working in USMPs perform general and specialized medicine (somatic and psychiatric care^e) consultations. These services include general medicine, dental services, specialist consultations, emergency practices, etc. In addition, doctors also practice their examinations and they visit the isolation quarter. Medical teams (USMP and SMPR) receive the list of confined prisoners every day and doctors see these prisoners at least twice a week. They need to control that isolating measures are not compromising the prisoner's health. If they estimate that the situation is dangerous, they can deliver a medical certificate to suspend the measure. The prison governor can also ask for an alternative measure when the prisoner's health is in danger¹⁷. This leads most doctors to feel they provide a guarantee for the Prison Agency. Some of them consider the isolating measures as an attack to the dignity of the person¹⁸, while the surveillance staff may advocate for the security issues to justify the use of confinement and disciplinary cells. The treatment of mental disorders is ensured by psychiatrists working in the SMPR or in the USMP¹¹. The psychiatric teams have not only a therapeutic mission, but they also work on prevention and health education. They work on suicide prevention, drug addiction problems, follow-up the prisoners who will be released¹⁹. Generally, doctors and psychiatrists are providing healthcare only to prisoners⁸. However, according to Manzanera and Senon (2004), the fact of working simultaneously with the general population and with prisoners ensures a better equity of treatment, especially in the field of psychiatry¹⁹.

^e If no SMPR is organised.

Psycho-medical teams (USMP and SMPR) can interact with the surveillance staff, and vice versa throughout a unique multidisciplinary commission (one has to be created into each prison). This commission is meant to meet at least once a month in order to assess the sentence execution of several prisoners. It is composed^f of a member of the prison management team, a member of the "insertion and probation" team, a prison guard, a member of the employment training service, a member of the education service, a psychologist and/or a member of the USMP^{8 20}.

3.1.3 Historical perspective

Before 1994's reform (when prisoners' health was still managed by the Ministry of Justice), inmates, at the time of their incarceration, were losing their rights to social security. The prison infirmary then provided first-line medical care, and the Ministry of Justice would pay for healthcare services provided by the medical and nursing staff. In the early 1980s, the Minister of Justice identified a key problem on the policy agenda: the inequity between free and imprisoned citizens regarding access to healthcare. Imprisonment would logically compromise free access to health. These increasingly important policy problems led the Ministry of Justice to a total transfer of health-and-prison services to the Ministry of Health¹⁸.

In the 1970s, a public debate took place regarding the independence of prisons' psychiatric services. An inter-ministerial circular "Health-Justice of the 28 March 1977" formally separates psychiatric care in prison from the Prison Agency. The circular No 1164 of the 5 December 1988 formalizes the ethical code and the independence of psychiatrists working in the prison setting¹³. Those are the foundations of the actual parting between health and justice in prison.

In 1984, the General Inspectorate of Social Affairs (IGAS) became responsible for monitoring prisons' healthcare services. In 1985, an infirmary in Fresnes Prison (close to Paris) was transformed into the first national

^f See the text of the circulaire here:
http://circulaire.legifrance.gouv.fr/pdf/2012/06/cir_35431.pdf



public health facility (hospital). One year later, 24 regional medico-psychological services (SMPR) had been created¹⁸.

In 1987, the "13.000 program" (referring to 13 000 beds) was set up²¹. It concerned the opening of 21 prisons where health care was trusted to private groups for a period of ten years. A bill of specifications for general medicine, nursing and dentistry targeted much higher quality standards than existing ones¹⁸.

In addition to these changes, three main strategic moments lead to the reform of the healthcare system in French prisons during the nineties.

Firstly, in 1989, the Ministry of Justice started working together with the Ministry of Health regarding the unceasing rise of HIV infection. As a result, HIV medical consultations in prisons were provided by specialized hospitals (in prisons with the higher number of cases). In 1992, three prisons decided to extend this system to the whole health care¹⁸. Secondly, during the same time, Veronique Vasseur, MD, chief medical officer of the Prison de la Santé in Paris, published a book regarding her own professional experience²². This book contributed to raise public awareness concerning the living conditions of prisoners in France. It also opened a window of opportunity to set the prison system on the political agenda. Thirdly, the High Committee of Public Health (HCSP) was commissioned by the General Attorney (Garde des Sceaux) and the Ministry of Health to set up the best strategy to manage prisoners' health needs.

In 1993, the HCSP issued a report²³ confirming the critical situation of French prisons concerning HIV, hepatitis B, hepatitis C, tuberculosis, and mental health disorders. The Committee considered that a reform had to take place in order to protect the general population since most of the prisoners were only complying with limited sentences. Guerin (2003), underlined the fact that *"with regard to the prison population, some authors wonder if taking into account the prisoners' health would find its justification only in the threat caused by their diseases to the general population"*¹⁸. These concerns were offering both individual and collective approaches based on specific public health principles such as: screening, education and prevention program; ensuring quality of care with comparable standards as those available in the general population and finally ensuring the continuity of care upon release from prison.

The reform focused on two priorities: 1) to associate every prison facility with a neighbouring public health establishment (hospital) which would be responsible for local healthcare delivery; 2) to guarantee the affiliation of every new prisoner to the general sickness and maternity insurance scheme¹⁸.

This reform was established by **the law of the 18th of January, 1994 on health and social protection. This law makes prisoners part of the ordinary health system.** Moreover, the Code of Criminal Procedure, under Article 380D, states that prisoners must receive free care. This principle was set up between 1995 and 1997, with the exception of the "13.000 program" prisons. It is worth mentioning that the implementation of USMP (Consultations and Ambulatory Care Units) in French prisons was not easy for prison guards who considered it as a loss of authority²⁴. There were some tensions between medical and penitentiary staff in the early years, especially about medical secrecy during consultations^{18 25}. The issue of information sharing between health professionals and prison or judicial staffs is highly problematic. "Especially because various procedures (the single interdisciplinary commission, the electronic liaison booklet, the orientation files) require the expert opinion of the doctor. The Article 105 of the Code of Conduct can then be used by health professionals, as this article states that "no one can be both an expert doctor and a treating doctor for the same patient" (59).

An alternative to this new configuration could have been an extension of the "13.000 program" (which satisfied the Prisons' administration system), i.e. delegating prison healthcare to private agencies. Nevertheless, specific reasons led to reject this option. Firstly, this private system had created problems such as a "turnover" in medical teams, lack of ties with the prison reinsertion services and remaining costs in the charge of the Prison Agency. Secondly, this system was contrasting with the French "regalian" vision of the State, where the State should normally be responsible for public health costs. Thirdly, the "13.000 program" didn't lead to a recognition of public hospitals as the references for healthcare services, whereas other already existing collaborations between some prisons and some public hospitals were positively evaluated¹⁸.



Although the 1994 reform is inspired by the “13.000” experience, it stands out as a result of the report published in 1993 by the High Committee of Public Health (HCSP). This report indicates some significant progress in the “13 000” prisons where caregivers and the medical equipment was evaluated as “globally satisfactory”. However, some problems are pointed out by this report: the continuity of care was not always guaranteed; external hospitalizations were still too numerous; and no institutional link existed between custodial caregivers and the outside healthcare networks. The lack of coordination between the “13 000” prisons and the external healthcare system appeared more serious in the detection and subsequent management of AIDS. Another problem frequently raised was the coordination between caregivers and prison staffs which seems insufficient and the absence of relations between health and social or services (the latter belonging to the Prison Administration). As a consequence of this evaluation, the High Committee of Public Health indicated in the reform of 1994 a convention system between prisons and public hospitals (9), and the “13 000 program” prisons were included in the 1994 reform in 2001, right after the expiration of the public-private contracts. Nowadays, public hospitals are still working inside prisons while remaining independent from the Prisons’ Agency.

With this reform, the proportion of staff per prisoners was increased. For example, in Fleury-Merogis (Paris region), the medical presence doubled after the 1994 reform. A full-time (doctor) is present for every 500 prisoners instead of 1000, the total number of nurses increased from 14 to 29 for 4000 prisoners on 1st January 1999, and 14 new pharmaceutical assistants were recruited ²⁶.

To facilitate the reform’s implementation, a **methodological guide** (guide méthodologique relatif à la prise en charge sanitaire des personnes détenues) was edited in 1994, and updated in 2005 and updated in 2012. It must be applied in every prison, associated hospitals, UHSA, and UHSI. The roles of these organizations and groups of actors are described very carefully, as well as the necessary tools, equipment, rooms among others. For instance, medication is now distributed in the cell by nurses, who are responsible for the patients’ follow up ¹².

In 2006, legal pressure led to the creation of 14 Specially Adapted Hospital Units (UHSA). These autonomous institutions are part of the general organization of psychiatric care ¹³. A total of 7 UHSA were built in 2014 ¹². They make it possible to hospitalize patients in a secure environment when suffering from a mental disorder. However, before 2006 the hospitalization was taking place in SMPR or in UMD, but the waiting lists were rather long. The UHSA were often been built next to a psychiatric hospital (and were often part of a university) ¹⁹.

In 2007, the General Controller (CGLPL, Law No. 2007 - 1545 of 30 October 2007) was created under the status of “independent authority”. Its missions and role are described further in this document ⁹.

Between 2010 and 2014, a strategic action plan sponsored by the National Prevention and Health Education Institute (INPEs) was established. In 2011, action 5.1 comprised an inventory of education and health promotion activities in prisons. It consisted of a national survey regarding USMP on prevention and education. The action 5.2 consisted of developing a reference document concerning health education and health promotion inside prisons. This tool aimed to be accessible for every stakeholder conducting health education and/or health promotion activities in prisons ²⁷.

According to the authors consulted during this research the transfer of prisoners’ health management to the French Ministry of Health, improved the quality and the continuity of care services, the use of modern techniques, and the numbers of the medical staff.



3.2 Characteristics of the prisons and prisoners

Table 1 – France – Number of prisoners⁹ in French prisons between 1998 and 2015 on 1st January

Prison	Accused	Sentenced
1998	21.591	31.984
1999	20.452	32.261
2000	18.100	32.126.
2001	16.107	31.631
2002	16.124	32.444
2003	20.852	34.529
2004	21.749	37.479
2005	20.134	39.041
2006	19.732	39.784
2007	18.483	41.916
2008	16.797	47.201
2009	15.933	50.243
2010	15.395	50.689
2011	15.702	51.272
2012	16.279	57.497
2013	16.454	60.340
2014	16.622	61.261

Source: ²⁸

⁹ People accused include person under electronic surveillance, outside placement or semi-liberty measure.

3.2.1 Facts and figures

On the 1st of January 2015, France (excluding Mayotte) had 66,380,602 citizens ²⁹. Among the 249,298 people accused or sentenced, 172,007 were placed in an open environment and 77,291 were registered in prison. Among the latter, 66,270 were effectively imprisoned. One percent of them were minors ³⁰ and approximately 18% were foreigners ³¹. In 2012, women represented 4% of the penal population ³². Between 2001 and 2015, the prisons' population has increased by over 30%.

The European Council pointed out in 2014 that the prison-overcrowding is a problem in France. On 1st September 2014, there was approximately 66 500 prisoners for 58 000 places, so a prison density per 100 places of 115. The surface area per inmate is 11. As a comparison, Belgium in 2014 had a prison density per 100 places of 129 ³³.

This growth and the overcrowding put healthcare organization and its services under pressure. Although some awareness exists regarding the precarious state of health of the French prison population, no systematic data has been yet collected concerning disease prevalence in prison^h.

In 2012ⁱ, more than half of the sentences were shorter than six months; the average length of a sentence was of 7.7 months; and 4% of the sentences were exceeding 3 years. Considering only convicted people of a first offense, the average duration of seclusion was of 5.9 months in 2010 (5.4 in 2004), while the average length of reoffenders' sentences was of 15.6 months (9 in 2004, which would mean an increase of 73%) ³⁴.

Most of the prisoners come from underprivileged populations and accumulate specific problems like drugs abuse, low access to healthcare, risky behaviours, or mental health disorders. The following table summarizes these situations:

^h Only some countries (such as the Netherlands, the United States, Canada, Australia, and New Zealand) have published specific systematic surveys concerning infectious diseases. (Godin-Blandeau et al., 2014)

ⁱ We could not identify more recent data.



Table 2 – France – Social problems experienced by prisoners

Education	Employment	Drug abuse	Housing	Mental Health
48% of prisoners have no qualifications	the employment rate before entering prison is almost 50%	38% of prisoners incarcerated for less than 6 months are suffering from drug problems and 30% are alcoholic	In 2011, 7% of the prisoners declared being homeless	40% of prisoners are depressed
80% of them do not have the "certificat d'apprentissage professionnel" (equivalent of the sixth year of professional education in Belgium (lower secondary level))			When leaving prison, 14% report having no housing solution	33% are suffering from generalized anxiety
27% are not able to read			25% people in homelessness housing centres were incarcerated at least one time	21% suffered of psychotic disorders
Among young people over 18, 80% have no diploma and 40% of them are not able to read				7% are schizophrenic

Source : ³⁴



Three statements should be emphasized:

- 48% detained people have no qualification;
- 80% of male prisoners are having some psychiatric disorder or are suffering from addiction;
- The suicide rate is 10 times higher than it is within the free population³⁴.

According to the theory of social inequalities and health, several factors increase the risk of early health problems, such as the lifestyle; a poor social, cultural, and economic context; exclusion; no granted access to health prevention and care³⁵. Furthermore, prison environment increases health problems through inactivity, confinement, lack of hygiene, breakdown of family ties, violence, etc. The length of the sentences and the ageing prison population reinforce these problems: about 15% of the prisoners are between 40 and 50 years old, a little less than 10% of them are between 50 and 60, and almost 4% of them are over 60. As a result, the number of chronic diseases is increasing³⁶. However, health prevention and education activities significantly increased but with some disparities between facilities (some prison don't organize any of these activities)¹¹.

3.3 Delivery of care

3.3.1 Availability

3.3.1.1 Health services

In 2015, the French prison system consisted of 190 prisons spread across the French territory. In 2014, there were 179 USMP, 26 SMPR, 7 UHSA (340 beds in 2013), an 8 UHSI (182 beds in 2013)^{37 38}.

3.3.1.2 Human resources

The medical teams are composed of general practitioners (both external and internal GPs), medical specialists (out of psychiatrists), dental surgeons and pharmacists. The para-medical teams are composed of physiotherapists, nurses, radiology technicians (whenever a radiology department is available), administrative and medico-social professionals¹². All of them can

integrate an USMP on a voluntary basis, but they keep some guarantee of mobility between the different services of the associated hospital¹².

The USMP is subordinated to the hospital department it belongs to. The head of the USMP is assisted by the GPs from its hospital (unless the structure is too small). Medicine students can be associated to the unit as part of their training. The medical teams appointed to the USMP combine their activities at the prison and at the hospital. This combination also ensures the (reasonable) staff rotation¹². Some health professionals might also work for several hospitals¹².

The growing need for new placement opportunities for primary care residents has opened the way to placements in prison health centres. The key points emerging from an analysis conducted by Amouyal et al. (2014)³⁹ are that these custodial internships offer a wide range of situations that were very similar to primary care in a public health context. They started up to learning how to manage complex situations; provided stronger orientation towards ethical health care; anchored a firmer belief in multidisciplinary teams; and raised the interns' awareness of the social role of primary care physicians. All residents considered this type of placement (towards the end of their training) to be a good preparation for their future primary care role, especially in the context of multidisciplinary practices.

Nursing staff (nurses)

Whenever a prison has more than 1000 prisoners, a head nurse is then appointed. Alternatively, the head nurse of the associated hospital guarantees this responsibility.¹².

Pharmacy

Whenever a prison has more than 1500 prisoners (or if medication cannot be provided every day), a pharmacy is created. A pharmacist is the person responsible for the pharmacy. He/she may work part time or full time and may be assisted by one or more pharmacy technicians¹².



Administrative staff

The administrative team manages the organisation of consultations and medical records. They ensure the transfer of information between the prison, the hospital and the external actors. They also provide some secretarial services to the General Psychiatry teams ¹².

Paramedical numbers increased between 1997 and 2012 much faster than the prisoners' population. However, some functions are running under shortage in certain geographic areas. This is partly due to a lack of attractiveness of the prison positions. However, no public action/decision was taken to reduce this under-staffing problem ¹¹.

3.3.1.3 The rooms

The Prison Agency provides some specialized rooms for the USMP. These rooms can also be used by the SMPR (psychiatric services). The housekeeping is provided by the associated hospital and its own cleaning team, or by a subcontractor. However, the Prison Agency reimburses the maintenance costs ¹².

Some minimum standards for the prison rooms have been defined by the annex 7 of the methodological guide published in 2004. However, in the oldest prisons, any building project (such as an extension) must be discussed with the hospital. Hygiene rules are similar inside the prison and at the hospital, and appeal to the Nosocomial Infection Committee could be made as often as necessary. This is why the prisoners never complete the cleaning tasks ¹².

3.3.1.4 Figures

By the 1st January 2015, the Prison Agency employed 36,535 agents, including 26,734 people active in surveillance staffs, and 4,538 people active in insertion and probation services.

Table 3 – France – Illustrative standards of Full-Time Employed professionals in 2004

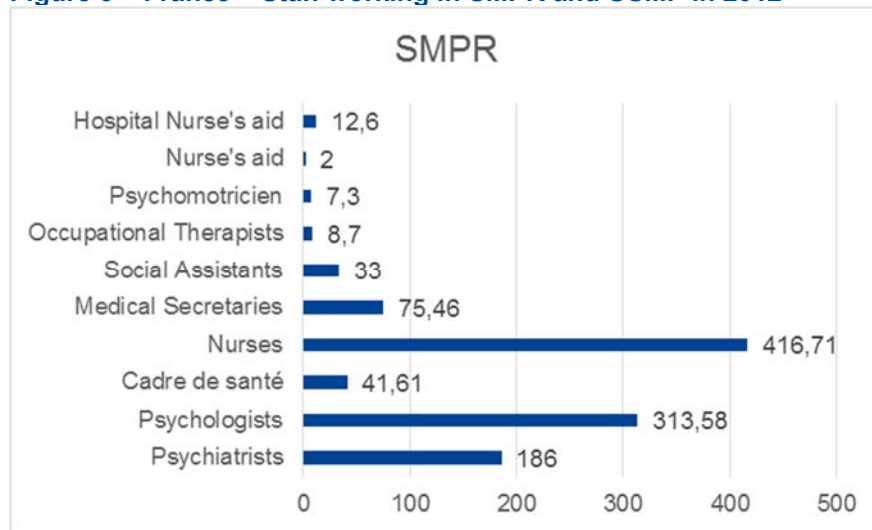
	Short Sentences Prison (for 600 places)	Mid or Long Sentences Prisons (for 400 places)	Mid or Long Sentences Prisons (for 600 places)
General Practitioners	1,21	0,57	0,8
Psychiatrists	1,5	0,7	1
Dentists	0,8	0,57	0,8
Pharmacists	0,23	0,143	0,2
Specialized doctors Physiotherapist Manipulators electro radiology	0,4	0,201	0,28
Nurses	8,05	3,818	5,29
Carers Pharmacy technician			
Psychologists	4,5	2	3
Medical secretaries	1,15	0,57	0,8
Dental Assistants	0	0	0
Total	17,84	8,572	12,17

Source : ¹² Figures are dated from 2004. No update was available in the 2012 version of the methodological guide.

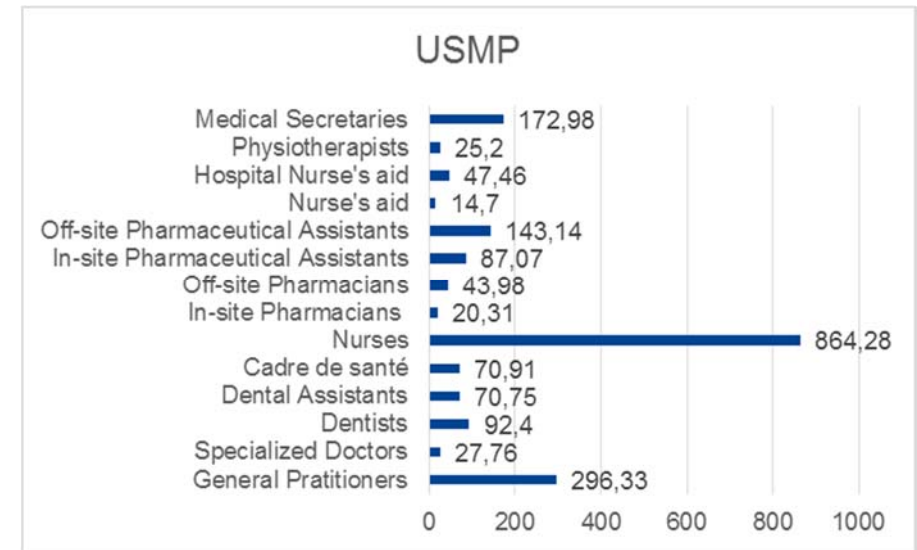
In 2011, as reported by the Court of Auditors (2014), the standards for human resources provision are as follows (per 1000 prisoners): 3.4 GP, 0.5 specialists, 3.2 psychiatrists, 5.2 psychologists, 14.8 nurses, 7.7 psychiatric nurses, 1.6 dentists, 0.4 physiotherapists. In reality, professional attractiveness is low, and a significant proportion of posts remain vacant (e.g. 5.5% for GP, 16% for psychiatrists, 7% for dentists) ¹¹



Figure 3 – France – Staff working in SMPR and USMP in 2012



Source: Prison Agency Direction, 2015, by e-mail.



Source: Prison Agency Direction, 2015, by e-mail.



Table 4 – France – Evolution between 1997 and 2001 of hospital staff of USMP and SMPR, full-time equivalent^j

Staff	Full-Time Equivalent	Employed	1997	2001	Evolution
Somatic Cares					
Medical	Budgeted		209,28	265,23	26,7%
	Ratio for 100 prisoners		0,48	0,56	16,7%
	Paid		199,9%	257,31%	28,7%
	Ratio for 100 prisoners		0,46	0,54	17,4%
Non-Medical	Budgeted		644,74	938,02	45,5%
	Ratio for 100 prisoners		1,49	1,98	32,9%
	Paid		636,86	910,20	42,9%
	Ratio for 100 prisoners		1,47	1,92	30,6%
Psychiatric Cares					
Medical	Budgeted		123,91	172,57	39,3%
	Ratio for 100 prisoners		0,29	0,36	24,1%
	Paid		114,31	146,10	27,8%
	Ratio for 100 prisoners		0,26	0,31	19,2%
Non-Medical	Budgeted		422,98	581,37	37,4%
	Ratio for 100 prisoners		0,98	1,23	25,5%
	Paid		394,32	561,82	42,5%
	Ratio for 100 prisoners		0,91	1,19	30,8%

Source: ¹⁸

Note: Three mails and a call to Prison Agency Direction have been made in order to obtain more recent numbers. Three answers pointed out the fact that these facts and figures weren't updated yet.

^j We can assume that the increase of the professional staffs was motivated by the increase of the prison population.

3.3.1.5 Restrictions in health care delivery due to human resources constraints

The APSEP points out the insufficiency in human resources in sanitary units, with frequent vacant positions due to the lack of attractiveness of the related activity. It also reports understaffing due to a number of positions calculated on the basis of the theoretical number of prisoners in an establishment and not on the real number of prisoners (16), as mentioned by the CGLPL (41). The latter highlights the lack of human resources in the psychiatric sector, with psychiatric teams dedicating a large part of their activity to people under a compulsory therapeutic measure. Moreover, the number and capacity of facilities dedicated to psychiatric care of detainees (SMPR and UHSA) are deemed insufficient by the CGLPL, leading to hospitalizations in general psychiatric hospitals in inappropriate conditions (41).

Despite the high prevalence of drugs inside the prisons, some authors have identified specific problems, such as insufficient prevention for drug abuse; lack of multidisciplinary work; or insufficient health resources available (26). For example, in the prison of Liancourt, 1.6 FTP was present in general medicine (but a 2.5 FTP was budgeted) and one psychiatrist was present half a day every day. No addiction expert was available, while the local centre for addiction care was given a 0.5 FTP educator ⁴⁰.

Both APSEP and CGLPL point out that the staffs are insufficiently trained and therefore, don't always understand the rules and the difficulties of the prisoners. The continuing training is reduced to some days in the year and the allocated budget to training is weak ^{16 41}.



3.3.1.6 *Outside regular hours*

The USMP teams work only during daytime. In specific prisons, the paramedical units can work during the weekends, and some on-call duty can be organized by the doctors of the USMP⁴². However, in most of the prisons, the USMP staff is not enough to ensure the permanence of care¹⁷. This organization requests a convention between the prison governor, the associated hospital and the service available during closed hours.⁴²

A hotline, run by the “centre of reception and regulation of SAMU 15 calls” (Emergency Service), is provided. This helps maintaining a listening watch, and obtaining the best medical diagnostic on a fast basis, while ensuring the availability of services outside the prison. If the patient is conscious, the phone is given to him, in order to ensure a direct contact with the coordinating doctor from the emergency centre, complying with medical secrecy. The doctor will then decide whether the prisoner has to be transferred outside the prison and if so, on its appropriate transport service. The prison team has to organize the escort to the hospital.

If the coordinating doctor considers that the intervention of a doctor in the prison is appropriate, he/she may then consult the local procedure which may consist on a call to local doctors-on-call, or in an obligation of the associated hospital to provide a doctor.

The doctor must then refer the patient towards the most appropriate hospital (as regards its proximity, the specialized equipment available, the availability of beds, etc.) that is not necessarily the associated hospital¹².

3.3.2 *Comprehensibility*

3.3.2.1 *Health prevention and promotion*

On a national level, since 2006, the Ministry of Justice and the Ministry of Health has been chairing alternately an inter-ministerial consultation¹¹. Later on, a national plan was launched: the “plan d’actions stratégiques 2010-2014”. Its 18 measures and 40 actions call for more standardization within procedure. This program aims to build six priority axes: knowledge of health, prevention / health promotion, access to health care, social safety package, education, health, safety and wholesome conditions of Prisons¹⁴. But the investment of regional health agencies remains uncertain and variable¹¹.

The first measure of this program is to set up a national system collecting strategic information in order to monitor the policies. This program also aims at integrating an epidemiologic monitoring with the existing data. Some specific actions consist in creating specific indicators to monitor chronic diseases and mental health problems; creating an observatory of prisoners’ health structures; improving the quality of the data about suicide in prisons and so forth¹⁴. However, the degree of implementation of these recommendations remains unknown to date.

On a regional level, following the provided methodological guide, the associated hospital is charged to organize an annual or multi-annual program for health prevention and education. It is meant to do so with the probation service, the prison governor, and some of the other partners. The steering committee must meet at least once a year. This program is registered in the regional health program. Associated hospital is nevertheless free to add complementary actions. The regional health agency is charged of financing the executive program¹⁷.

Health promotion and prevention are considered as insufficiently developed by the CGLPL, which however recognises that interesting tools are being elaborated, such as the methodological guide on health promotion in prison settings edited in 2014 by the French Institute for Health Promotion and Health Education (Inpes)²⁷. A lack of human and building resources put a brake on health promotion and prevention¹⁶.



3.3.2.2 Specific health issues

Mental health (suicide and internment)

With regards to suicide, the WHO (World Health Organization) established the profile of people at risk before imprisonment and provides a wide range of recommendations⁴³.

The following figure shows the suicide rates in some European countries in 2005. France had the highest rate with 21.2 suicides for 10 000 prisoners. As a comparison, the suicide rate in Belgium was of 15.2 for 10 000 in 2008⁴⁴ and of 16 in France in 2006^k.

Table 5 – France – European comparison of suicide rate in prison in 2005

	Number of suicides	Rate for 10 000 inmates
Germany	81	10,3
England	78	10,2
Spain	41	6,7
Finland	4	10,5
France	122	21,2 ^l
Sweden	7	9,9

Source: ⁴⁵

^k See the full report here: <http://drees.social-sante.gouv.fr/IMG/pdf/er702.pdf>

^l This figure was calculated by the Council of Europe SPACE with a population of 57 582 detainees incarcerated on 1th September 2005. It aims at showing how suicide could be seen as a policy problem at that time.

Table 6 – France – Evolution of suicides between 1997 and 2013 in prisons in France

Years	Number of suicides	Rate for 10 000 inmates
1997	127	22,3
1998	119	21,3
1999	125	22,6
2000	120	23,7
2001	104	21,5
2002	122	22,8
2003	120	20,5
2004	115	18,9
2005	122	20,4 ^m
2006	93	15,5
2007	96	15,2
2008	115	17,2
2009	122	18,1
2010	NA	18
2013	97	15,6

Source: ^{45 17 46}

The amount of suicides in prisons is particularly high in France when compared to other European countries. This rate has however declined but still remains high. Although the growth of the problem in France seems to have stopped since 2006, questions on the causes of this situation have been repeatedly raised⁴⁵.

^m This figure was calculated by Prison Agency on a basis of 59 791 detainees incarcerated (average of incarcerated population in 2005).



However, data suggests that prevention has improved over the last thirty years. Prisons have been opening up to civil society, NGOs and visitors entering daily into prison. However the response to suicide and its causes are complex and cannot be reduced only to the specific conditions in which the prisoner is living. Some researchers found that the outside world has an impact on suicides in prisons. The Prison Agency indicated a possible correlation between specific news in the lay society (such as a broadcasted trial) and the resurgence of suicides⁴⁵.

In 2007, a detection grid was established and is customary for newcomers in almost every prison⁴⁷ⁿ. Confronted with this high rate of suicides, the Attorney General (Garde des Sceaux) requested in 2008 an evaluation of the actions undertaken so far. Even when actors had implemented specific actions no scientific evaluation has been conducted since 2002. In 2002 and 2008 two studies were conducted which identified socio-demographic and criminal characteristics of prisoners who committed suicide. Currently, a multidisciplinary piece of work is being conducted in almost all prisons, but it needs to be more formalized. As a measure to prevent suicide, training for professionals with first aid techniques is planned. It already enabled some prison guards to save some lives by providing some immediate help.⁴⁵

Despite lower suicide rates, regional disparities remain concerning investment in suicide prevention. Individual support is difficult with the existing limited resources. Specific devices, such as for example isolation quarters, used by people who have shown aggression, are in opposition with suicide prevention. The placement in solitary confinement is accompanied by specific detention conditions, such as no cultural activities, no hobbies or work allowed, a walk of only one hour a day and no canteen use. The duration can last up to 45 days. The proportion of suicide in solitary confinement decreased of 16% in 2006-2007, 12% in 2008. Almost 19% of suicide attempts are done in solitary confinement cells, which represent only 2% of the prison cells⁴⁵.

Given that suicide rates increased again in 2008, the General Attorney (Garde des sceaux) launched a specific working group (the Albrand commission). In 2010, following the recommendation of this commission, a plan was set up⁴⁵. It was decided to allow use of video screening in special cells, to allow use of radio and telephone to break the isolation in punishment quarter, and to mobilize all involved actors, including family and co-prisoners as inspired from models in others European countries⁴⁸.

Four male prisons implemented a specific program aiming to prevent suicide. A total of 57 prisoners and 17 prison officers took part in this project on a voluntary basis. They were trained for first aid and accompanied by an external association. The program lasted one year and two suicides occurred during that time in the four settings. Both prisoners who committed suicide were not followed by a trained prisoner. This study demonstrates that prisoners found it more appropriate that peer prisoners, and not surveillance staff, are following and accompany suicidal prisoners. However, trained prisoners are keen to under-estimate the risk of suicide among other prisoners, in comparison to professionals⁴⁹.

In 2013, the number of suicides (97) decreased, with a rate of 15.6 per 10,000 prisoners⁴⁶.

Addictions (drugs and alcohol)

Opioid substitution treatment is common in prison in France. Generally, penitentiary teams assimilate substitution treatments (for example methadone) with withdrawal treatments⁵⁰. Nevertheless, researchers have ascertained the hypothesis that long-term consumption of benzodiazepine is not efficient against anxiety, insomnia and agitation. A physical dependence is recorded after some weeks of consumption. On the long term, the person could cumulate this dependence with dependence to others drugs. Therefore, a study about benzodiazepines prescription was done, with the aim to give less substitution drugs during the treatment. Of 473 prisoners, 222 were in a control group and 251 benefited of a multidisciplinary intervention. The interdisciplinary network, with the

ⁿ A copy of such a grid is available in the Annex I of the following article (47): <https://dumas.ccsd.cnrs.fr/dumas-00744281/document>



involvement of pharmacists, permitted to detect risk persons. The opioid dose given was significantly higher in the control group than in the group which benefitted from a multidisciplinary network.⁵¹

Another interesting study regarding drug consumption in prison was conducted in Liancourt's prison. In total, 381 (54.4%) of the 700 detained men, answered the survey. The results highlighted a deplorable situation. Generally, prisoners would continue their drug consumption in prison. 43.6% of them declared consuming at least one drug (not including alcohol; cannabis (38%), heroin (8%), cocaine (7%), morphinated drugs (7%), benzodiazepine (9%)) inside prison, whereas this percentage was 60.1% at entry. 3.2% (12/152) of prisoners not consuming any drug before the incarceration started consuming during their imprisonment. By nature: The policy for drug use reduction seems to be quite inefficient.

The drug use in Liancourt's prison is proportionally higher than in the general population. Alarmingly, no national data exist about drug consumption in prisons and results from this survey could not be extrapolated to France.⁴⁰

However, the presence of drugs inside prisons still remains a problem. Some "drugless sections" should be conceived and locally implemented⁴⁰, as some experimentation had already provided interesting results for reasonable budgets⁵².

Infectious diseases

A medical exam is organized at entry (in the first days) of the prisoner, with his/her agreement and a medical record is systematically written. The exam aims for finding contagious diseases, provides therapy to addict people and allows the continuity of care for people who are already under treatment. It is also an opportunity to update vaccinations or have a specialized consultation and orientation when psychiatric troubles, suicidal thinking or drug abuses are present. Note that the test for tuberculosis is an obligation for every prisoner. Other types of tests are conducted with the prisoner's agreement (HIV, Hepatitis C virus HCV, syphilis, chlamydia, gonococcus infection, etc.). HIV test must be proposed when risk-taking had occurred.¹⁷

To fight the development of sexually transmitted diseases, preservatives and lubricants are available for prisoners¹⁷. This methodological guide measure was tested through the nationwide survey ANRS PRI²DE, conducted at the end of 2009, which permitted collecting specific information regarding prevention and fight against HIV, HCV and other sexually transmissible diseases.⁵³ Results showed that preservatives for men were present in almost 95% of prisons, whereas preservatives for women are only present in almost 21% of prisons. Preservatives are however present only in USMP rooms in almost 80% of prisons. But as homosexuality in prison is often a taboo, some men are reluctant to ask for preservatives. Other interesting results showed that prevention programs and flyers for sexually transmitted diseases were present at entry into prison and during incarceration in almost 80% of prisons. Also 83% of USMP proposed a vaccine against HBV when the test was negative. A 47% of prisoners had no knowledge regarding post exposure prophylaxis (taking HIV medications within the three days of exposure)⁵³.

Another recent national survey on infectious disease was conducted in 2010, the PREVACAR study. It showed that more or less 70% of prisoners did the HIV test at the entry.³⁶ This survey also permitted to identify the characteristics of prisoners, especially those infected by HIV and HCV. On 2154 prisoners drawn at random, 2% were contaminated by HIV, and 75% of these 2% were under treatment. For the HCV, 4.8% were contaminated, with an important proportion of women (11.8%) compared to men (4.5%). Almost half of the HCV infected had chronic hepatitis, and 44% had or received a treatment against HCV. The HIV and HCV prevalence were about six times higher than in the general population. This situation could be explained by a higher proportion of drug consumers, by persons originated from abroad, where the prevalence of these diseases is higher, or by risk-taking behaviours. The previous data about prevalence of HIV and HCV in prison are dated from 1997 and 2003. Other data concerned only a local prison or a region.⁵⁴



The local survey conducted in the prison of Liancourt raised the issue that prisoners are more numerous to declare being infected by HIV, HCV or HBV than numbers referenced in the USMPs. Of the 450 conducted tests at the entry in that prison in 2010, 7 persons were HBV positive, 2 HIV positive, 12 and HCV positive. Either the patient did not know his/her serologic status properly, or the USMP had not detected or taken care of infected prisoners. The study PRI²DE showed that tests were proposed in 90% of prisons, but negative results were communicated to infected person in only 65% of prisons ⁴⁰.

Following the methodological guide, bleach water is given to limit infections by intravenous drugs. Tattoos or piercings are also targeted ¹⁷. The results of the Liancourt survey also showed that syringes and sniff kits are used, which is problematic ⁴⁰. Moreover, access to bleach water depends on the prison ⁵³.

3.3.2.3 *Specific groups*

Woman

No information was found.

Older prisoners

On the 1st of January 2012, 3.7% (2264 people) of inmates were over 60 years old. The proportion of seniors had almost doubled between 1990 and 2000. It remained stable between 2002 and 2012 (Ministry of Social Affairs and Health & Ministry of Justice, 2012)

The personal autonomy allowance (APA) may be granted to anyone over 60, who is in a frail state. The request must be made by the prison department for integration and probation (SPIP) in collaboration with the healthcare team. ¹⁷

Children

Some particular attention is paid to minors who require some multidisciplinary care. ¹² Care for children with their imprisoned mothers is not supported by the USMP but comes under the common law (except in

emergency cases). The mother can choose the doctor for her children and may assist during consultation. ¹⁷

Disabled people

The Prison Agency, in collaboration with the medical team, or the prisoner, may request the intervention of services for disabled persons. Taking into account local circumstances, a convention between the Prison Agency and these services must be drawn up. The costs of these services can be covered by a designated allocation for disabled persons. Moreover, adequate lodging facilities have to be provided for the release of disabled persons ¹⁷.

But for disabled persons (as well as for ageing persons), the implementation of adapted service is laborious, partly because of a reluctance to carry this out, but also due to the constraints of prison ¹¹.

The Apsep reports the lack of adequate cells for persons with reduced mobility and in the case of the oldest facilities, an inappropriate access for these persons.

3.3.3 *Continuity of care*

3.3.3.1 *Follow-up and medical information transmission*

The World Health Organization (WHO) advocates for considering prison health as a priority for the public health system ⁵⁵. A long-term monitoring of the health of prisoners is necessary. But as already said, in France, only isolated studies were conducted. There is no epidemiological surveillance of health in prisons. ⁵⁶

However, authors (both within grey literature and within scientific literature) explain that prisons are true incubators of serious communicable diseases like VIH and hepatitis C.

Finally, the most relevant tool, according to the WHO, the French “Cour des Comptes” and an interviewed doctor for this study appears to be conducting regular survey, considering that medical files are not standardized and generally not yet computerized.



The major themes studied could be:

- Overrepresented diseases in prison (HIV, drug addictions, etc.)
- General population diseases (ageing, chronic disease, etc.)
- Prison environment diseases (obesity, traumatology, dermatology, etc.)
- Psychiatric diseases ⁵⁶.

3.3.3.2 *Within the prison*

At entry, a consultation form of the USMP is completed. Nevertheless, this document is not standardized from one USMP to another. This does not enable comparison between USMPs, and inhibits the collection of data on a national level. ⁵⁶

For the continuity of care within the prison, a Framework Protocol is drawn up and a coordinating committee acts as a consultative committee between instances. A unique multidisciplinary commission also meets with the penitentiary director and representatives of different health services. The objective is to share information on the individual situation of prisoners, in order to provide tailored care. Common training courses are also organized to better understand each other's work and improve working relationships. ¹¹

A study published in 2015 reports that among 11 health units interviewed, only two had computerized medical files (often due to a computerization of the associated hospital). Access to all medical information of a single prisoner is complicated, because there are several specific files and professional subfolders (nurse, psychiatrist, psychologist, addiction specialist, dentist, pharmacist, etc.). Medical files are sometimes in separate rooms. This dispersion of files is sometimes present even if computer files are used, because communication between software does not exist ⁵⁶.

An IT management planning would be an improvement of the organization and operation of medical units. Nowadays, many incompatibilities are present, and they result in last minute cancellations. Otherwise, telemedicine could also be used in certain situations to reduce the workload ¹¹.

3.3.3.3 *From one prison to another (Entrance examination)*

A new medical exam is not necessary for transfers between prisons. The necessary medical information are transmitted (copy of the medical file) ¹⁷.

3.3.3.4 *From prison to the community*

The essential medical information for the continuity of care has to be transmitted to the doctor chosen by the released person ¹⁷.

However, continuity of care after discharge is difficult and undermines reintegration. The coordination is difficult when the geographic area is not the same as the prison ¹¹. Although a medical exam has to be done ¹⁷, a consultation one month before the release is not always organized. Equally, a lack of continuity of care may also happen when the prisoner doesn't know his rights well. This is damaging in the case of psychiatric conditions. Aftercare psychiatric consultations were held in some areas ¹¹. Another impediment to continuity of care is that the health care staff is not systematically informed of the release date of a prisoner.

Gaps in continuity of care upon release are indeed stressed out by the CGLPL, notably regarding psychiatric and addiction care but also "more generally with ambulatory medicine".

3.3.3.5 *Patients' rights regarding their medical files*

If requested by any prisoner or parents/tutor of a minor, the doctor provides the documents related to health (medical file). The conditions are the same as within free society ¹⁷.

⁵⁶ No information was found about the continuity of care between free community and prison (i.e. entrance examination).



3.3.4 *Reachability*

3.3.4.1 *Procedures to get medical attention (who decides and application procedures)*

To have a medical consultation, prisoners have a letter-box or they can address a request to a guardian ¹².

3.3.4.2 *Triage and waiting list*

Knowing that extractions are limited to hospitalizations, caregivers and nursing staffs select, on an emergency basis, the patients who will benefit first ¹⁸.

3.3.4.3 *Hospitalization*

As example, in Ile-de-France, the regional and national hospital of Fresnes is used to receive prisoners ¹¹. In UHSA and UHSI, the occupancy rate is about 90% ⁸. Transferring an inmate from prison to secure hospitals is difficult to carry out. It's due to poor coordination, low number of available escorts, denial of prisoners because of the living conditions were considered more difficult than in prison (smoking ban, no activities and walk, family separation (UHSA are not present in all regions)) ¹¹. Another possibility to facilitate the hospitalization process lies in the one-day hospitalization. The ambulatory anaesthesia makes it possible for the patient to go back to his/her cell right after a surgery intervention. But this practice demands a lot of attention for just one prisoner.

Indeed, a qualitative study conducted in 2009 among 11 prisoners hospitalized in UHSI, revealed higher security level when compared to prisons. The results indicate that the prisoners feel isolated, deprived of their property and their habits (many have a job in prison). For some of them, there is a sharp break with their relational and identity markers. They have a feeling of repression. For some, these measures seem disproportionate to their crimes ⁵⁷. Nevertheless, they feel that the care provided by the medical staffs is good. Relationships with caregivers are positive and inmates believe that their health problems are put before their criminal status. With the nursing staff, some do not feel cared for ⁵⁷. As for relations with the prison

staff, inmates are less unanimous, with a little less than half who considers that relations are worse than in their prisons. Finally, most respondents think that the surveillance staff do not interfere in relationships with the medical staff ⁵⁷.

If prison organizations are determined by security, health conditions are not optimal for the prisoners ⁴². Being imprisoned increases the risk for psychiatric and psychological affectations. Although hygiene conditions vary from a prison to another one, many skin contaminations like scabies do happen. Some cells are equipped with Turkish-way toilets (where the patient can't sit in during his/her convalescence). Every prison must offer a vacant cell to disable prisoners. This cell must be close to the USMP, with a dedicated nurse. USMP however are closed during the night and the surveillance staffs are not trained for medical care. Therefore, every patient needing a 24/24 medical surveillance has to be hospitalized ⁴².

3.3.5 *Quality assurance and control*

3.3.5.1 *Quality control bodies*

The General Controller (CGLPL) can intervene at any time in every place where some persons are deprived of their freedom by a legal or administrative decision. It could also be in health institutions that receive persons hospitalized without any consent. Its mission is to ensure the respect of fundamental rights defined by international and national laws including three axes: the rights to human dignity; a fair balance between the respect of human rights and other considerations of public order and safety; the prevention of any violation of the fundamental rights. The CGLPL focuses on detention, health prevention, prisoners' hospitalization, and staff working conditions that may impact the functioning of the institutions and the relationship with the prisoners.

The CGLPL can perform scheduled or unscheduled visits at any time, day and night, in any custodial institution. The CGLPL team can talk with everyone with confidentiality. Since the Act of 26 May 2014, the doctor-controllers can access to the information covered by medical secrecy, with the prisoner agreement. A visit report including some recommendations



should be sent to the concerned Ministers after every visit. This report can be published⁹.

Another control body is the *Défenseur des droits* (National Rights Defender). Created in 2011 and registered by the Constitution in 2008, it aims to defend human's rights and to allow an equal access to law and justice for everyone. Every individual or association can refer to the National Rights Defender if their rights are presumably violated. The prisoners send 4000 referrals every year, and this is 50 times more than the referrals sent by free citizens.

The Defender of Rights does not hesitate to take legal actions whenever a negotiated solution is not reached. It manages specific concerning issues on abuses in prisons, involving prison guard and/or management teams (corruption among guards, discretionary power of the governors, lack of surveillance, etc.). As an example, a dentist-surgeon post had been vacant for one year. The absence of a dentist aggravated the situation of a prisoner who then needed prosthesis. The National Rights Defender led to an agreement according to which the associated hospital took in charge the costs of the prosthesis. The National Rights Defender is also charged to care for the international conventions of the United Nations about handicapped people's rights⁵⁸.

3.3.5.2 *Other actors of evaluation and control*

In 2000, the National Assembly published a report qualifying overcrowding as an inhuman treatment⁵⁹. In 2004, the National Consultative Commission on Human Rights stated that France was late in terms of personal hygiene compared to other European states⁵⁹. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment also conducts visits in French places of deprivation of liberty.

The International Observatory of Prisons is an association aiming to “promote, throughout the world, the respect of incarcerated persons' rights with regards to international instruments on human rights⁶⁰”. It has had a

consultative status with the United Nations since 1995. The French section of this association was legally created in 1996⁶⁰.

The IGAS controls the implementation and evaluates the strategic action plan for prisoners' care organized by the Ministry of Health¹⁶.

3.3.5.3 *Guidelines*

The Ministry of Health and the Ministry of Justice published a methodological guide dedicated to the provision of healthcare to detainees. Its first version was written in 2004 and updated in 2012. This guide aims to be a reference document for every professional working in the judicial arena. It is a key tool easily accessible to professionals. It provides some prepared documents, forms and agreements^{12 17}.

The “plan stratégique 2010-2014” highlighted that professionals needed some tools for health promotion and health prevention in prisons. A reference guide was therefore created for healthcare prevention and promotion. After some indications regarding the legislative and institutional context, this reference guide provides a list of the actual field programs and identifies some efficient outputs. The many objectives (infectious risks reduction, physical activity...) and actions to be taken (relaxation workgroups...) reveal the numerous available strategies.

3.3.6 *Patient's rights*

3.3.6.1 *Medical secrecy*

The prisoner is a patient, according to the Law of 4 March 2002. The quality of healthcare services should be totally guaranteed for prisoners, although some limits make it impossible: the prisoner cannot choose his/her doctor^{42 61}.

^P Translation by the authors



The “Conseil d’Etat” concluded, on the 30th March 2005, to the legality of the Circular of the 18th November that the chief escort has to ensure that the security will not hinder the confidentiality of the medical interview. As a solution, an indirect surveillance could be done by a palpation of the prisoner before the medical examination takes place ⁴².

Nonetheless, some intimate consultations take place in the presence of the prison guards. This third person can jeopardize the doctor-patient dialogue and interfere with the provision of care ⁶². A research conducted in the university hospital of Montpellier revealed that health professionals very seldom ask the prison guards to leave the room. Sometimes, more than one guard (or policemen) attend the consultation or even the medical exam ⁶³. The request of surveillance by the guards or by the police should not be discriminating. For instance, during an operation under total anaesthesia or epidural, the risk of evasion seems impossible and escort does not have to be present in the surgery room ⁴². The patient's medical record should not be given to the doctor in a transparent plastic bag, with the diagnosis in the front page ¹⁸. Moreover, as noted by the CGLPL, confidentiality issues can also occur due to inadequate premises - such as consultation rooms with a window in the door – or due to the use of an interphone system to call the prisoners to the sanitary unit ⁴¹. As a last point, the medical information of the prisoner is collected into a recently created monitoring tool named GENESIS⁹ and the Prison Agency would like that care staffs could access to read or write information, to the detriment of the medical secrecy^{r 16}.

These examples can be considered as violations of the medical secrecy ¹⁸.

Some semi-directive interviews conducted in UHSI revealed that prisoners do not easily express their emotions and that psychological assistance may not be a priority for them. Therefore, the confidential doctor-patient dialogue must be protected in order to increase trust and comfort demands ⁵⁷.

3.3.6.2 *Prisoner's choice of medical care givers*

The prisoner patient can neither choose nor change his/her doctors, and no patient association play an intermediary role, as within the free society. Prisoner patients' freedom lies in the refusal of care ¹⁸. Nevertheless, this constraint does not seem to entail significantly health care utilization ⁶⁴.

3.3.7 *Financial aspects*

3.3.7.1 *Health coverage in prison*

All the prisoners benefit from social security for sickness and maternity care. They should not use money, no user fees, no flat fee on expensive acts and no medical franchises⁶⁵. This principle also applies to foreign prisoners⁶⁵.

Prisoners must be registered at the Primary Fund Health Insurance (CPAM, Caisse Primaire d'Assurance Maladie) pertinent to their prison, but the administrative registration is not immediate and can take up to several months. This can be problematic for inmates condemned to a short sentence and not having enough time to be administratively in order ⁶⁵. If no registration certificate can be delivered on time, a rupture of care might happen (leading to discontinuity of healthcare) as the released prisoner might not benefit from payment reduction on medical care and drugs ⁶⁵.

The state contributes in two ways to the social security of prisoners. Firstly, it financially ensures that every inmate receives the same coverage as any other free citizen. Secondly it co-finances the units and associated hospitals. The prisoners do not have to pay any contributions for their medical expenses. But the majority of the financial burden has been transferred from the state to the health insurers, which are regionalized. As a consequence, the regional financial system has become complex and slow ¹¹.

⁹ Gestion Nationale des personnes Ecrouées pour le Suivi Individualisé et la Sécurité.

^r On request of the French National Medical Council, the Council of State has taken position on this issue: http://www.sante-prison.com/upload/cnom_cir-15-12.pdf

^s No information was found on « Prisoners' complaints ».



3.3.7.2 Cost of USMP

Table 7 – France – Evolution between 1994 and 2002 in the amount allocated by the management of Hospitalization and Care Organization to the USMP (million €)

Year	Somatic care	Psychiatric care	Drug addiction	Total budget
1994	56,8	10,2		77,3
1996			1,58	81,3
1998		9,7		103,3
2000				100,5
2002	“programme establishment reinserted (+ 11 millions €)”	13 000”		134,5

Source: ¹⁸

Note: Three mails and a call to Prison Agency Direction to have more recent numbers. Three responses received but not yet an update.

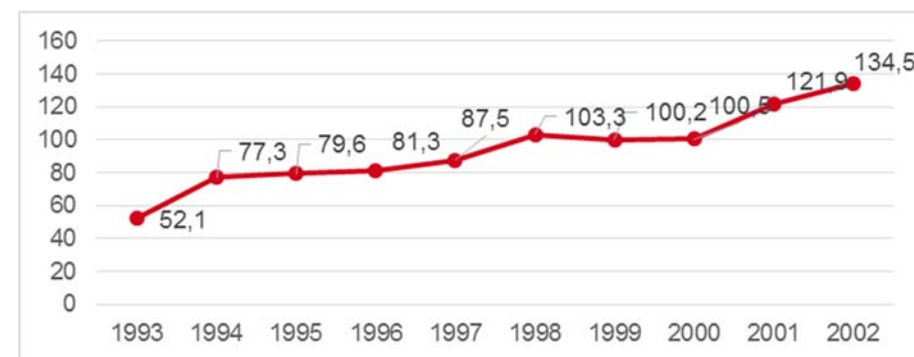
The Health Ministry decided in 1994 to grant a budget of € 67 million for the expenditure of USMP (personnel, functioning, equipment, etc.) and to complete the SMPR. At the same time, the Ministry of Justice invested 13.5 million euros to renovate the buildings. The methodological guide included two criteria to estimate the staff size in an USMP:

1. The category of the prison: short-term sentence prisons are experiencing greater inflows than prisons for mid and long-term sentences;
2. The category of the staff: general practitioners, dentists, specialists, nurses and pharmacy technicians have to be calculated for every 100 prisoners, pharmacist and medical secretary have to be calculated for every 200 inmates.

In 2001, for 100 prisoner, 0.54 full time employed was working in medical somatic care, 1.92 in non-medical somatic care, 0.31 in medical psychiatric care and 1.19 in psychiatric non-medical care ¹⁸.

However, these means were insufficient for surgeons, nurses and medical secretaries. In addition, some jobs were in short supply in some areas. That is why the financial resources were multiplied by 2.6 between 1993 and 2002. These funds were specifically given for hospitals delivering healthcare in prison ¹⁸.

Figure 4 – France – Amount allocated by the management of Hospitalization and Care Organization to the USMP between 1994 and 2002 (millions €)



Source: Three mails and a call to Prison Agency Direction to have more recent numbers. Three responses received but not yet an update.

As a one-off initiative, a study was also launched in 2013 to evaluate the amounts allocated to the activities of sanitary units. The results of this study are not yet available ¹¹.



3.3.7.3 *The construction of the Interregional Secure Hospitalized Unit (UHSI)*

The ministerial order of August 2000 asked university hospitals to establish eight UHSI. Their construction cost 44.2 million euros between 2004 and 2013. 182 beds are available ¹¹.

3.3.7.4 *The construction of the Specially Adapted Hospitalized Units (UHSA)*

The building process of some structures for the organization of psychiatric care reached 150 million euros, including 17 million euros for security purpose. The functioning cost reached 30 million euros in 2012. Their creation has helped to improve the supply and quality of care and their occupancy rate is (90) much higher than the occupancy rate of UHSI for somatic care ¹¹.

3.3.7.5 *About the management of costs by the social insurance funds*

The costs of prison healthcare tripled between 1994 and 2012, rising from 113m to 344m ¹¹. This is due to the development and diversification of the supply of care. In 1994, the state had to assume a 76% of the financial effort, with a closed envelope. But although the costs tripled, that closed envelope was not revised upwards. In 2012, the French State covered only 31% of the costs, and the balance was paid by the social insurance funds ¹¹.

Before the reform of 1994, the Ministry of Justice funded healthcare services, and the Region funded the infrastructures. After the 1994 reform, the healthcare funding was partly decentralized, passing to the general social insurance security, which is regionalized. This process involves some disparities between the Regions. Indeed, health services could vary between different regions, either due to overcrowding, more dated installations, labour shortage, or few financial resources. The situation is not yet optimal and essentially based on regions, hence a great difficulty to hold for improvements, because each situation is different. A risk of regress could be present in some areas ¹¹.

Given that the envelope from the State is closed, there is an increase of the financial weight on the Regions. Some of them had maybe to save money in some sectors, like prison buildings, materials, staffs, etc. or are limited in their investments. Therefore, regarding healthcare services, French prisoners are not on an equal footing, depending of the prison and of the Region they are located in.

3.3.7.6 *The extraction of prisoners to hospitals*

A medical extraction (more or less 55 000 are performed every year) costs 1.300€ and requires often three prison guards ⁶⁵.

**Table 8 – France – Total cost in personal guards and escorts for inmates hospitalized in 2006**

		Employee-Hours	Employee-Hours Cost (€M)	Affected Staff	Cost of Staff	Total Cost (€M)
National Police	Driving to care	101 712	2,839			2,839
	Associated hospitals					
	UHSI	462 491	12,908	113	4,650	12,90
	Paris Police Prefecture					4,650
		103 696	3,006			3,006
National Gendarmerie	Extractions	18 432	0,557			0,557
	Guard	17 681	0,534			0,534
Prison Agency	Extractions					10,31
	UHSI	371 541	10,314	144	6,761	6,761
General Total		1 075 553	30,157	257	11,41	41,56

Source: ⁶⁶

In order to avoid the intervention of different authorities for the extraction of prisoners, and subsequently facilitate the coordination and communication processes, an inter-ministerial decision was taken to accelerate the transfer of this task to the Prison Agency. However, the costs of the implementation are significant (3 million euros for UHSI for the new jobs and 60 million euros to equip local hospitals (rooms, weapons, vehicles, communications, etc.)) ⁶⁶

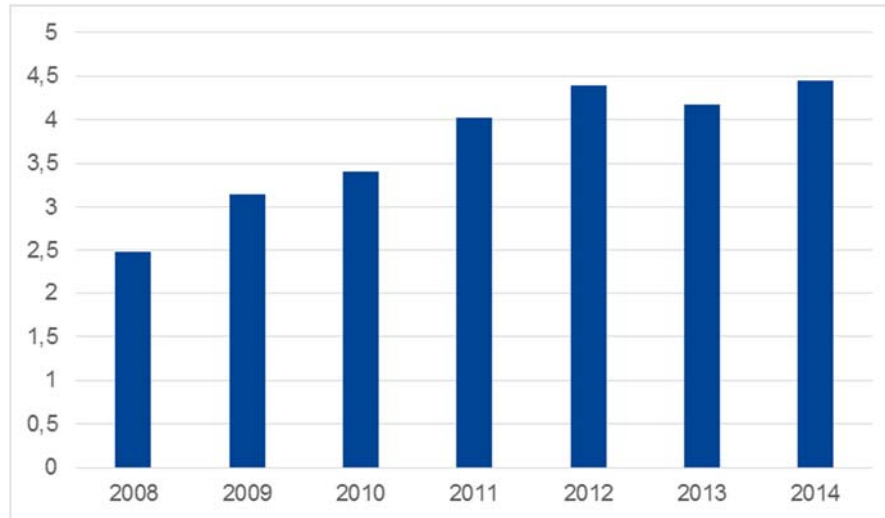
3.3.7.7 Cost of the General Controller of Places of Deprivation of Liberty (CGLPL)

The State also funds the CGLPL ⁶⁷.

Table 9 – France – Allocated budget to CGLPL in 2014

Staff cost	Total	3 462 797 €	77,6%
	Permanent	3 110 957 €	
	Occasional	351 840 €	
Functioning		999 983 €	22,4%
Total		4 462 780 €	

Source: ⁶⁷

**Figure 5 – France - Budget Evolution since the Creation of CGLPL (€M)**

Source: ⁶⁷

3.3.8 Overall appraisal

A recent report of the French Court of Auditors, while acknowledging progresses in the health care management since the 1994 transfer to the Ministry of Public Health, pinpointed a number of shortcomings in the current situation: health care offer is still incomplete (notably for psychiatric care), regional disparities in health staff, unsuitable infrastructure and information systems, and an hospitalisation plan to be improved ¹¹. Moreover, the report also emphasizes impediments against global care: although the social protection is guaranteed for the prisoners, its implementation is sometimes confronted to practical difficulties; the cooperation among the various actors is sub-optimal; a health system which is still very dependent upon the prison functioning. Finally, the French Court of Auditors makes 5 main recommendations to improve the health care in prisons:

1. Identify clear objectives of public health for prisoners, and these objectives should be part of the next general public health plan. The realization of the objectives should be assessed against indicators, and collecting these indicators assumes the setting up of an epidemiological monitoring.
2. To reinforce the health care offer, particularly for psychiatric care, which includes modernizing infrastructures and medical practice, and potentially allowing more funds for the social security.
3. To improve accessibility to health care by generalizing agreement protocols between health care teams and prison administration, and to consider setting up for prisoners genuine care pathways going beyond the time of release.
4. To reinforce the role of regional health agencies
5. To redefine the financing scheme, e.g. to include prisoners in the universal disease coverage.



4 SCOTLAND

PRISON HEALTH IN SCOTLAND: MAIN FINDINGS AND LESSONS

- There was an average daily population in Scottish prisons of 7731 individuals in 2014-2015 in 15 prisons. The detention rate was 145 per 100.000 inhabitants in 2014.⁶⁸
- The **responsibility of healthcare in prison** was transferred from the Scottish Prison Service (SPS) to the National Health Service (NHS) in November 2011, in line with the principle of equivalence of care and the will to tackle health inequalities, two priorities of the Scottish Government.
- The transfer of healthcare staff from the SPS to the NHS was seen as an **opportunity for career development** and therefore as a staff retention factor in prison setting. The transfer process went smoothly, with no major difficulties identified with regards to professional issues within the NHS and within the SPS. The whole reform process built on a national health service with a strong leadership.
- Success factors in the transfer included a strong leadership of the NHS, the writing up of a National **Memorandum of Understanding** (MoU) between the SPS and NHS Scotland for defining their respective responsibilities, as well as governance and accountability relationships, and the setting up of different **coordination and collaboration bodies** to ensure the continuous collaboration between the SPS and the NHS and to continue to improve prison health through various workstreams.
- **Regional Health Boards** are responsible for the planning and delivery of health services to the population in their respective territories, including prisons' population. Health and social care are integrated through partnerships between Health Boards, Local Authorities, health and social care professionals, the third sector, users and other stakeholders.
- Prison health system is based on **primary care**. There should be a multidisciplinary care plan for each prisoner, which will include the involvement of prison officers (as carers) where relevant, and should include details such as the condition/s to be addressed, agreed management including review and expected outcome. Any care plan should (as far as reasonably possible) (a) be agreed with the prisoner concerned, and (b) take account of the prisoner's family/social circumstances,
- Nurse practitioners play an important role in the delivery of **first line services**. There is generally no overnight duty. A part of the night shift officers were trained in advanced first aid and defibrillator use.
- **Second line services** are partially provided within the prisons through in-reach provision by specialists. If necessary, healthcare staff is entitled to refer prisoners to second line services outside prisons. The SPS is responsible for organizing the transfers.
- Healthcare related aspects of **prison inspection** is ensured by Healthcare Improvement Scotland (HIS), according to a formal Partnership Agreement between Her Majesty's Inspectorate of Prisons for Scotland – which is an independent body - and HIS. Besides this, healthcare related complaints are under the responsibility of the NHS. After having been through the NHS complaint procedure, if the complainant is not satisfied with the answer received, he/she can send a complaint to the Scottish Public Services Ombudsman (SPSO).
- Utilization of "Telehealth" in prison is under development, with one of the objectives being to reduce transfers to hospitals through support to decision-making and triage. Videoconferencing equipment is in place in 7 out of the 15 prisons (as of April 2016) - delivering "a range of services from forensic psychiatry to Tele-neurology" - and the provision of Cognitive Behavioral Therapies delivered by phone in 10 prisons.
- Shortcomings:
 - Gaps in access to mental healthcare providers, dentists and Allied Health Professionals are reported.
 - Ensuring 'throughcare' upon release remains instrumental and challenging.
 - Unmet needs regarding hepatitis C treatment due to resource limits were raised
 - Financial constraints in drugs budget at the Board level leading to issues in prescribing for GPs have been reported.
 - Issues with GP recruitment and retention partly due to remuneration are also reported.



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- Prisoners serving sentences of less than six months usually stay registered with their community practice. Prisoners serving sentences of more than six months are fully registered with the Prison Practice and deregistered from their community practice. Health care are free of charge within the NHS.
 - **Health promotion and prevention** are shared responsibilities between health and prison authorities. An integrative, 'whole prison' approach is recommended, as well as acknowledging that health services are one part of a wider range of stakeholders – including social workers, voluntary sector or the community. Suicide risk assessment is a part of each prisoner's examination upon admission.
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4.1 General presentation of prison and healthcare system

4.1.1 Main actors

4.1.1.1 Prison system

Within the United Kingdom (UK), Scotland, England and Wales, and Northern Ireland prison systems operate separately⁶⁹. The **Scottish Prison Service (SPS)** is an executive agency of the Scottish Government “legally required to deliver custodial and rehabilitation services for those sent to it by the courts”⁷⁰. The SPS is funded by the Scottish Government and accountable to the Scottish Cabinet Secretary of Justice^{70 71}.

Her Majesty Inspectorate of Prisons for Scotland (HMIPS) has “a statutory duty to inspect the condition in which prisoners are held and the treatment they receive”⁷². The Chief Inspector of prisons, whose role was “placed on a statutory basis by the Prisons (Scotland) Act 1989”, presents to the Scottish Ministers an annual report, which is then laid before Parliament⁷².

4.1.1.2 Health care system

Scotland defines its own health policies, independently from the other UK countries⁷³⁷⁴. The “development and implementation of health and social care” policy and the allocation of resources fall under the responsibility of the Scottish Government’s Health and Social Care Directorates, which also set “the strategic direction” for the **National Health Service** in Scotland (**NHS Scotland**). The Director-General of Health and Social Care Directorates is also the Chief executive of NHS Scotland, which “illustrates a close functional connection between policy making and implementation”⁷⁵. The NHS Scotland is composed of 14 regional NHS Boards, seven national Special NHS Boards and one public health body (NHS Health Scotland) supporting the regional boards⁷³⁷⁶. Each of these bodies is accountable to the **Scottish Cabinet Secretary for Health, Wellbeing and Sport**⁷⁵, who is assisted by the Minister for Public Health and by the Minister for Sport, Health Improvement and Mental Health. The Cabinet Secretary is also advised by the Scottish Government’s Health and Social Care Directorate.⁷³⁷⁶

The cabinet secretary for Health, Wellbeing and Sport is accountable to the Scottish Parliament. The latter comprises a Health Committee scrutinizing health related issues and playing a key role in health legislation⁷³.

Regional Health Boards are responsible for the planning and delivery of health services to the population in their respective territories, including prisons’ population⁷³⁷¹. On a local basis, health and social care are integrated through partnerships between Health Boards, Local Authorities, health and social care professionals, the third sector, users and other stakeholders⁷⁶. Thirty one local partnerships have been established⁷⁷. “Responsibility of integrated services and associated resources” can either be kept by the Health Board or the Local Authority; or be delegated to an Integration Joint Board, bringing together a variable number of local partnerships^{78 79}. Those partnerships fall under the joint responsibility of NHS Regional Boards and Local Authorities, in the framework of the “Public Bodies (Joint Working) (Scotland) Act 2014”⁸⁰.

The special boards are the following: NHS Education for Scotland, Healthcare Improvement Scotland, NHS National Waiting Times Centre, NHS24, Scottish Ambulance Service, The State Hospitals Board for Scotland and NHS National Services Scotland. Those boards are responsible for services best provided on a national basis, such as training for the NHS workforce, promotion of the reduction of health inequalities, the provision of health advice and information to the population and quality improvement^{81 73}.

NHS Health Scotland’s mission is “to reduce health inequalities and improve health”⁸², which includes supporting policy makers regarding prevention aspects of Scotland’s health policy and ensuring its implementation in collaboration with other NHS bodies⁸³.

The **State Hospitals Board for Scotland** became one of the Special NHS Boards in 1994^{81 84}. It is responsible for the delivery of care in special security conditions for people admitted under “The Mental Health (Scotland) Act 2015”^{85 84} - which amended “The Mental Health (Care and Treatment) (Scotland) Act 2003” - and related legislation⁸⁴. The State Hospital hosts **The Forensic Mental Health Services Managed Care Network**, in charge of bringing “a pan-Scotland approach to planning of services, patient pathways, strategic planning as well as teaching, training and research”⁸⁶.



Healthcare Improvement Scotland (HIS) bears the responsibility of “[driving] improvements in the quality of healthcare people receive by supporting and empowering people [...], delivering scrutiny activity [...], providing quality improvement support to healthcare providers, and providing clinical standards, guidelines and advice based upon the best available evidence”⁸⁷.

The voluntary sector also plays a role in the health system. **Voluntary Health Scotland** represents voluntary health organisations and promotes a greater recognition and involvement of this sector as a key partner in health⁷³⁸⁸.

4.1.2 Respective competences and collaboration frameworks

In Scotland, healthcare in prison has fallen under the responsibility of the NHS Scotland in November 2011. To support the transfer process and provide a collaboration framework between the SPS and NHS Scotland, a National Memorandum of Understanding (MoU) was established^t. This document defines their respective responsibilities, as well as governance and accountability relationships for prison health services⁷¹.

The MoU between the SPS and NHS Scotland builds on an agreement on common purpose, common values, service values, organisational values and staff governance. NHS, SPS and shared responsibilities are detailed and structured according to the following divisions⁷¹:

- Service delivery – Corporate
- Primary care services
- Mental Health
- Addictions
- Secondary care
- Legal and disciplinary matters
- IS and IT [Information System and Information Technology]

- Transport, escorting and prisoner location
- HR [Human Resources], recruitment, Staff Development and Communication

Essentially, in prison setting, NHS Regional Health Boards are responsible for delivering healthcare services equivalent to those in the community.

The SPS and individual prisons are for their part responsible for facilities management and structural maintenance of the health centre, as well as providing a carceral environment protecting and promoting health, among other things⁷¹.

Full details regarding the division of tasks are provided in the MoU (Annex 7).

It should be noted that Forensic Psychology within prisons is under the remit of the SPS⁷¹. According to the Health Care Needs Assessment (HCNA) published in 2012 by the NHS Board of Greater Glasgow and Clyde (NHSGGC) “the SPS Forensic Psychology service is offence-driven rather than health-driven, mainly does statutory work and rarely links in with health”⁸⁹.

At Regional Health Boards level, a “Joint Steering Group on Prisoners Healthcare” has to be set up and co-chaired by the Governor-in-Charge or Prison Director and the Health Board Executive Director⁷¹ in order to deal with joint governance aspects⁹⁰.

It was also concluded in the framework of the MoU that HIS would host the **National Prison Healthcare Network (NPHN)** “on behalf of the SPS and the Boards” and would support its work programme delivery, but would not be responsible for the decisions taken by this Network. The latter is defined in the MoU as “the mechanism to facilitate and disseminate the principles to be applied in the development of joint working arrangements, continuous quality improvement and performance measurement”, therefore playing a “national coordinating and strategic role”⁷¹. As defined in the MoU as well, the NPHN has to be composed by representatives of each Regional Health

^t This MoU is currently under review (source: J. Porter, NPHN, January 2016 and SPS, May 2016)



Board and of the SPS, as well as, among others, by Scottish Government representatives from Health and Justice Departments⁷¹. Initially set up for a period of two years in order to support the transfer process, the NPHN was further developed as a “means through which the Scottish Government agenda on health inequalities could be met for those in prisons”. The Network was then maintained but no longer formally hosted by HIS, and its new focus moved to “driving improvement [...] through a number of work streams with the role of recommending approaches to prisoner healthcare across the full spectrum including; mental health, through care, substance misuse and brain injury”. “At the point of the agreed continuation of the Network a new Chair was appointed, the NHS Director for Health and Justice who works within Scottish Government. It is to the NHS Director that the professional lead advisors report and it is NHS Director who chairs the Network Prisoner Healthcare Network Advisory Board”. (Correspondence with John Porter^v). Each working group works under its own terms of reference. The NPHN Advisory Board meets quarterly and its members are responsible “to report to their local board and organisations the outcome and actions from any meeting”⁹¹. Within the NPHN, the NHS Boards Leads Operational Group comprises representatives of each regional NHS Board with prison(s) on its territory. This standing group will “influence strategic thinking within their own Boards in respect of prisoner healthcare and in addition they will influence the strategic direction of the Network and the Advisory Board. [...] It will respond collectively to the development and review of national policy and to apply knowledge, understanding and influence when making recommendations on matters of prisoner healthcare that affect Scotland as a whole”⁹².

Another formal agreement defines HIS duty to assist HMIPS with respect to health-related aspects of prisons inspections⁷².

^u Reports of the different work streams are published on the NPHN website : <http://www.nphn.scot.nhs.uk/published-reports/>

^v National Nursing Advisor for the National Prisoner Healthcare Network (NPHN) since its creation to date

4.1.3 Historical perspective

4.1.3.1 Transfer process

Table 10 – Scotland – Timeline

Timeline	Transfer of competences- Main process steps
2007	<ul style="list-style-type: none"> Setting up of the Prison Healthcare Advisory Board Health Care Needs Assessment
July 2008	Approval of the transfer by the Scottish Ministers
March 2009	National Programme Board for Prisoner's Healthcare established
August 2010	Legislative amendment by the Scottish Parliament enabling the transfer
November 2011	<ul style="list-style-type: none"> Responsibility of prison healthcare transferred from the SPS to the NHS Set up of the National Prisoner Healthcare Network
November 2012	First round-table evidence session held by the Scottish Parliament
May 2013	Second round-table evidence session held by the Scottish Parliament

As mentioned, the responsibility of healthcare in prison was transferred to the NHS Scotland in November 2011⁷¹. Prior to the reform, offenders' health had been under the remit of the Health and Care Directorate of the SPS⁹³.



After Scottish Ministers had expressed in autumn 2005 “an interest in the transfer of responsibility for the healthcare of all prisoners” from the SPS to the NHS, the Prison Health Advisory Board (PHAB) was established in 2007⁹⁴⁹⁵. Its role was to investigate the relevance of this potential transfer and challenges to be addressed in order to support the decision making process for Cabinet Secretaries for Health and Wellbeing and for Justice⁹⁴.

4.1.3.2 Health Care Needs Assessment

During this ex-ante evaluation process, a Health Care Needs Assessment (HCNA) was conducted by a public health doctor and published in December 2007, focusing on main clinical challenges in Scottish prisons.

Those main clinical areas to focus on were determined in consultation with the SPS Health and Care Directorate. Various sources were used to proceed with the data collection and to ensure the triangulation of the findings. The main sources were SPS corporate information and publications, among which annual Prisoner Surveys (providing self-report information by prisoners), electronic disease registers, prescription records and annual audit of Health Care Standards run by the different prisons. According to the author, “evidence of likely under-diagnosing, under-recording and under-treatment” made a precise definition of health problems faced by prisoners in Scottish prisons difficult to reach. However, the multiplication of data sources and the triangulation approach allowed to reach an approximate picture of those issues. In addition, findings were discussed with SPS Health Centre Managers and with members of the SPS Health and Care Directorate⁹³.

The precarious environment from which most of the prisoners in Scotland were drawn was underlined, as well as the fact that in Scottish prisons, prisoners from ethnic minorities were represented in the same proportion as in the general population (3% versus 2%). Regarding epidemiological aspects, the report concluded that “the health of Scottish prisoners [was] worse than that of the general population across all of the domains

examined, with particularly high prevalence in addictions, mental health and dental problems” (see Table 11)⁹³

The SPS explicitly aimed at providing to the prisoners healthcare equivalent to that available in the community and consistent with national standards⁹⁶. At the time of this assessment, healthcare in prison, which was still under the responsibility of the SPS, was delivered in the framework of 13 SPS Health Care Standards, aiming at supporting the SPS to reach those objectives⁹⁶. They were stated as follows^{w 9397}:

1. "A Health Care Assessment of all prisoners from the community will be carried out on admission".
2. "The provision of Primary Care Services is available".
3. "To promote mental wellbeing and provide mental health care within an integrated multidisciplinary mental health service".
4. "A multi-disciplinary approach to the delivery of enhanced health and care services".
5. "The Healthcare of prisoners will be maintained throughout the transfer to other prisons and upon liberation".
6. "To develop and provide clinical services focused on preventing illness and promoting health".
7. "Access to a Blood Borne Virus Service will be available for prisoners".
8. "The provision of pharmaceutical services and safe management of medicines".
9. "To provide dental services comparable to those available within the NHS".
10. "The provision of evidence-based substance misuse management and support by competent, qualified and supervised professionals".

^w Those Health Care Standards were sub-divided into different criteria (from 10 to 39 criteria for each standards). Full details regarding these are available in the SPS Health Care Standards 2006⁹³⁹⁷



11. "The provision of health care facilities to ensure a safe and effective delivery of health care".
12. "Infection Control precautions will be applied by all Health Care Practitioners to the care of prisoners at all times".
13. "All SPS Health Care Records will be managed and maintained to a high professional standard".

An annual self-audit performed by each prison and reported to the Health and Care Directorate of the SPS allowed to monitor the establishments' compliance with these standards and to develop action plans *"to close any gaps in compliance"*⁹⁶.

Mental health, Stepped-Up Services and Health Promotion related Standards (number 3, 4 and 6) were the ones with the lowest levels of compliance. Compliance with different aspects of each standard is discussed in the Health Care Needs Assessment⁹³.

Stepped up services are defined by the SPS as *"care that extends beyond our normal primary care provision. Patients falling into this category are those who need an enhanced level of health and care initiated and led by the health professionals with operational and peer support"*⁹⁷.

Regarding mental health, despite the presence of Multi-Disciplinary Mental Health Team in each prison, delivery of "timely and quality service" remained challenging in some of them. This applied for instance to waiting time, to the scope of therapeutic interventions and to *"communication with external services providers for follow-up"*. Waiting times were also an area of concern regarding the delivery of routine and acute dental care.

As regards health promotion aspects, the lack of involvement of the prisoners and of formalised action plans were mentioned⁹³.

In addition, the report underlined some aspects of healthcare provision that were not covered by the healthcare standards but *"would be worth considering"*. Those included, among others, screening and management of chronic disease, patient participation and alternatives to medication for mental disorders and alcohol issues.

The need to comply with the principle of equivalence – *"the provision of services at least to a standard equivalent that in the community"*⁹³ – and therefore to close the so-called "equivalence gap" was emphasized as well. Similarly, taking advantage of incarceration to address health inequalities would allow to narrow the "inequalities gap"^{93,94}

Table 11 – Scotland – HCNA Epidemiological data (2007)

	Prevalence on admission to Prison	Prevalence in the Community
Alcohol problems	41% male/36% female	13% male/7% female
Illegal Drug Use	67%	8%
Smoking Rates	78% male	26% all
Hepatitis C	20%	1%
Asthma	12%	5.4%
Epilepsy	2.1%	0.7%
Chlamydia	12%	0.8%
Severe dental decay	29% male/42% female	10% male/3% female
Schizophrenia	9% male/36% female	0.5%
Depression	25%	5% approx
Personality disorders	66% approx	5% approx

4.1.3.3 Prison Healthcare Advisory Board Assessment

The PHAB was composed of NHS and SPS representatives, as well as Scottish Government advisors. Members were asked to examine the feasibility of the transfer on legislative, operational and financial aspects^{94,95}. The two volumes of their report were submitted to the Scottish Ministers.

The PHAB came to the conclusion that the transfer was feasible and that the *"the risk of maintaining the status quo [outweighed] the risks of transfer"*⁹⁵. However, a number of potential issues to be addressed in case of transfer of responsibilities were underlined.

"Drivers for change", justifying the potential transfer of competences, were listed as follows by the PHAB⁹⁵:



- **“Tackling Health Inequalities”**, in accordance with the Scottish Government priorities and strategic objective for health. Despite *“significant developments”* regarding the delivery of enhanced primary care by the SPS in the previous years, *“considerable further developments”* were deemed necessary to tackle *“inequalities and poor health”*.
- **“Sustainability”**: the delivery of healthcare by the SPS was not considered as sustainable mostly because of its limited scale, leading to a lack of attractiveness for the wide range of healthcare expertise needed to comply with national standards. The need for *“integration with wider community based services”* was underlined as well as a factor of sustainability.
- **“Meeting Accepted International Standards”**: regarding primary care services in Scottish prisons, members of the board pointed out the unmet international standards. The latter are:
 - Article 9 of the United Nation Basic Principles for the Treatment of Prisoners: “Prisoners shall have access to the Health Services available in the country without discrimination on the grounds of their legal situation”⁹⁸.
 - The Moscow Declaration, stating that *“penitentiary health must be an integral part of the public health system of any country”*⁹⁹.
- **“Independent Regulator’s Views”**: in his annual report for the year 2005/2006, HMCIPS called for an examination of *“the possibility of the provision of healthcare in prisons by the National Health Service”*. Among other things, he emphasized recruitment issues, delivery of care fragmentation and the lack of appropriate resources for SPS staff involved in healthcare, as well as the unmet international standards mentioned above¹⁰⁰.
- **“Accountability for Continuity of Care”**: the potential lack of adequately planned aftercare, due to the split responsibility of care between SPS and NHS boards, was highlighted. Ensuring a better continuity of care would *“help resolve lifestyle and addiction issues that affect offending behaviour”* and therefore reduce the risk of re-offending⁹⁵.

Legislative issues were examined by members of the PHAB, in collaboration with the Scottish Government Legal Directorate, Health and Justice Departments^{94,95}. The need for a legislative change to allow the transfer was pointed out. Indeed, in the framework of the Prisons (Scotland) Act 1989, the NHS was not entitled to be responsible for the whole range of healthcare services in Scottish prisons. Repealing of Section 3A (2) of this Act would *“enable the NHS to provide services through the duty on Health Boards under the 1978 National Health Services (Scotland) Act to provide medical services for the population resident in their area, which would include those resident in prisons in their area”*⁹⁵. Additional necessary legislative changes would be needed in relation to the previous exclusion of prisoners within dentistry, optometry and pharmaceutical care regulation⁹⁵.

As regards operational implications of the transfer, the report insists on the importance of good coordination and communication between the SPS and the NHS, as both parties had expressed concerns about the consequences that this transfer might have on their work and financing. An appropriate partnership between the two institutions would require a legal duty and a *“formal partnership agreement”* for that purpose⁹⁵.

As for clinical implications, NHS Regional Health Boards would become *“responsible for 24 hours clinical cover for prisons”*. The whole range of NHS services would be introduced in prisons, where national standards and guidelines would also apply. Work would need to be done in order to *“develop new and appropriate models of clinical service delivery”*, including *“integrated care pathways”*⁹⁵.

Regarding the consequences on human resources, they would apply to different staff categories involved in carceral healthcare services: SPS staff employed in SPS headquarters and in prisons, healthcare staff employed in private prisons, staff employed through SPS contracted services, including among others GPs, agency nurses and dentists. As SPS and NHS are distinct employers with their own terms and conditions of employment, the “Transfer of Undertakings (Protection of Employment) Regulation 2006” (or “TUPE” Regulation)¹⁰¹ would apply to directly employed healthcare staff, which represented most of the staff involved⁹⁴.

The added value of the transfer to the NHS regarding *“training and development opportunities”* for staff was also pointed out⁹⁵.



Financial implications of the transfer would result of the necessary additional funding to NHS boards in order to allow them to meet their “*legal obligations and good practice standards*” and to close the gaps identified by the HCNA⁹⁵. Estimates have been calculated taking into account the need to address legal obligations but also to fill equivalence and inequalities gaps^{x 94}. Beside the necessary additional funding, potential cost saving areas were identified as well, notably on prescription drugs and medical supplies thanks to the NHS buying power through a National Procurement process. Annual investment in prison healthcare was about £16m at the time of this appraisal, which represented an annual budget of £2,100 per prisoner place. Breakdown of this £16m budget is detailed in table 12.

Table 12 – Scotland – Summary of SPS Health Budgets – Actual 2006-2007 and Budget 2007-2008

Summary SPS Health Budgets	Actual 2006-07 £000's	Budget 2007-08 £000's
Medical Services	2,123	2,357
Family Planning	7	7
PTMO GP Medical Exam	9	4
Pharmaceutical Services		
-professional services	518	768
-supplies	2,059	1,920
Dental Services	478	561
Psychiatric Services	374	478
Chiropody	16	17
Physiotherapy	13	17
Speech therapists	18	22
Psychologists	6	7
Occupational Therapist		11
Ophthalmic Services	40	50
- Supplies	27	27
Agency Nurses	260	160
Enhanced Addictions Casework	2,217	2,252
SPS direct employees	7,185	7,393
Maintenance Health Equipment	82	91
Total	15,432	16,142
Notes		
1. Drug Testing performed in establishments not included in the above.		

Source: ⁹⁴

x See ⁹⁴ for a breakdown of the estimated costs needed to fill these gaps



On the whole, £4M to £8M additional investment were estimated necessary related to the potential transfer process. The PHAB deemed this amount “*relatively small in the context of the overall health budget*”, which was close to £10 billion at that time⁹⁵. Details on this financial implications assessment are available in the second volume of the PHAB report. Areas requiring further investments to address unmet needs were classified as follows: mental health care, dental care, long-term conditions, rehabilitation and recovery, preventive care programmes, information management and technology and clinical standards compliance⁹⁴.

The budget breakdown between the different Regional Health Boards would need to be split in a fixed part (allocated to running costs with little variation, such as administrative and management costs) and a variable part, depending on “*the size and the profile of the prison population*”⁹⁵.

Reviewing healthcare services would fall under the remit of NHS Quality Improvement Scotland (NHS QIS)^y with NHS Boards Clinical Governance Committees supervising governance arrangements in prison settings⁹⁵.

Taking into account the different elements described above, the PHAB came to the following recommendations:

“[...] it is recommended that Cabinet Secretaries note that:

- 1) transfer of responsibility for primary healthcare from the SPS to NHS Boards is feasible, and
 - 2) if Cabinet Secretaries decide that they wish to proceed with transfer,
 - preparatory work on the necessary legislative change should be authorised
 - a National Partnership Board should be formed to oversee the preparatory work for transfer, and
 - NHS Boards should be funded to meet the additional costs of meeting their regulatory and legal obligations”.
-

^y “Healthcare Improvement Scotland (HIS) was set up by the Public Services Reform (Scotland) Act 2010 and took over the functions of NHS Quality Improvement Scotland and the regulatory functions of the Care Commission

Following this assessment step, Scottish Ministers approved the transfer of responsibility in July 2008. In March 2009, a National Programme Board for Prisoners’ Healthcare was set up to overview the transfer process. The necessary legislative amendment was passed in August 2010⁷¹.

4.1.3.4 *Parliamentary review of the transfer*

After the transfer, two round-table evidence sessions were convened (on 20 November 2012 and on 28 May 2013) by the Justice Committee of the Scottish Parliament in order to investigate the transfer process¹⁰²¹⁰³. On the whole, though in its early stage, it was deemed to be positive, leading to improvements regarding different aspects of the delivery of care in prison, in good collaboration between the NHS, the SPS and others partners. However, it was still a work in progress and different challenges were still to be faced, such as securing the continuity of care or dealing with addictions issues¹⁰²¹⁰³.

One main challenge raised during the debate in 2012 regarded the place left to the voluntary sector in the process of transfer to the NHS. In particular, the case of the charity Phoenix Future, providing support to prisoners facing addiction issues in several Scottish prisons was discussed. It was argued by Phoenix Future that “*it would not reflect the best interests of those individual prisoners with drug, alcohol or smoking issues if their issues were seen as being wholly under the remit of healthcare services, because that is not how it is in communities*”. The transfer of competences has led to uncertainty regarding provision of services by this organization and therefore regarding its staff’s contracts. It was mentioned in the following round-table session in May 2013 that most of the Regional Health Boards, each defining its own addictions pathway, had or would soon stopped their collaboration with Phoenix Future. A part of its staff has been transferred to the NHS under the TUPE regulation¹⁰². The latter did not take part to this second parliamentary meeting¹⁰³. However, successful ongoing partnerships with other voluntary

in relation to independent healthcare services.” (<http://www.gov.scot/Topics/Health/Quality-Improvement-Performance/HealthCareImprovementScotland> , accessed on 23.01.16)



organizations were also highlighted, as well as the will to base addiction services on a multi-disciplinary model involving the third sector¹⁰².

It should be noted that the role of the voluntary sector is acknowledged, but not defined, in the MoU between the SPS and the NHS⁷¹.

Attention was also drawn, notably by Dr Lesley Graham who conducted the HCNA of 2007, to the difficulties of measuring prisoners' health outcomes – and therefore their potential improvement - because of the lack of a routine reporting system. The introduction of a new IT system (called Vision) in April 2012 was foreseen as a way of improving the record of health information¹⁰² as well as sharing of information between prisons and the community¹⁰³. However, there is still currently no national reporting from this system (Correspondence with L. Graham, April 2016).

4.2 Characteristics of the prisons and prisoners

4.2.1 Facts and figures

There are 15 prisons in Scotland, including one dedicated institution for young offenders in Polmont and two young offender institutions within Cornton Vale and Grampian prisons. The only establishment reserved for women is located in Corton Vale but several other prisons accommodate women^z⁶⁸. Among the 15 penitentiary establishments, 13 are publicly managed and 2 are privately managed by operators under contracts to the SPS⁷⁰.

Imprisonment rate in Scotland is one of the highest in the European Union, with a rate of 145 per 100 000 of total population in 2014. In the same year,

that rate was of 105/100 000 in Belgium and the lowest rate in Europe was found in Finland with 55/100 000⁶⁸.

Within Scotland, in June 2013, incarceration rate per 100 000 16+ population was varying from 49/100 000 in Aberdeenshire to 322/100 000 in Dundee^{aa}, with *“a strong correlation between imprisonment rates and area deprivation”*⁶⁸.

On 30 June 2013, the estimated population of Scotland was 5,327,700¹⁰⁴ and there were 7 883 individuals in Scottish prisons. In the same year, the total amount of receptions to penal establishments was 33,626^{bb}⁶⁸. The prison population was expected to remain stable in the following years – projections were made until 2023 - with an average daily population (ADP) of 7800 individuals⁶⁸. Compared to this estimation, the SPS reports lower figures for 2014-2015 with an ADP of 7731 individuals¹⁰⁵. In 2014-15, 19,7% (1525/7731) of the average daily population were on remand. Among the sentenced population, around 45% (2820/6205) of individuals had been given a sentence of four years or more (including life sentence). In the same year, 4.5% of the ADP were women and 6.8% were young offenders (under the age of 21), among whose 0.5% were women¹⁰⁵. Age distribution by sex on 30 June 2013^{cc} is illustrated in Figure 5.

More than 96% of prisoners in Scotland in June 2013 were categorised as “White”⁶⁸ (Table 13). The HCNA conducted in 2007 already pointed out the fact that, in Scottish prisons, prisoners from ethnic minorities were represented in the same proportion as in the general population (3% versus 2%)⁹³.

^z Substantial changes have been announced with regards to women in custody: see 4.3.3.3.1

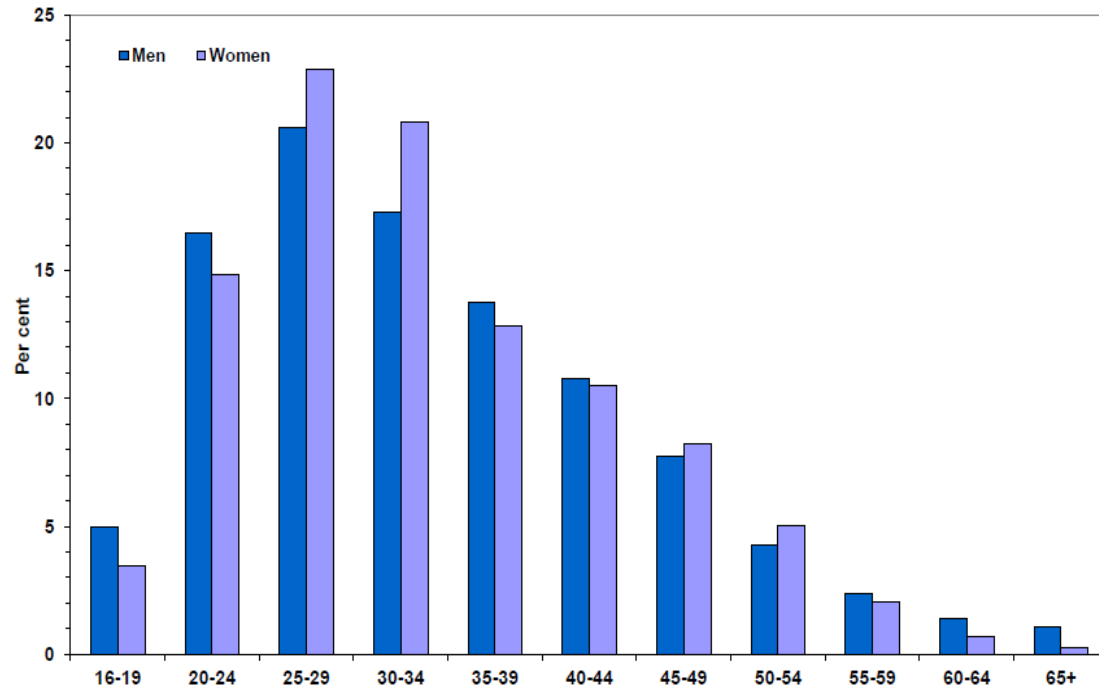
^{aa} “Rate for Scotland is based on the total national population estimate for the purposes of comparability”. Rates in Aberdeenshire and Dundee are based on the 16+ population⁶⁸. Those national and local rates are therefore not comparable as such.

^{bb} A detailed breakdown by year (from 2004-2005), by sentence length, by sex and between young offenders and others is available in “Prison statistics and population projections Scotland: 2013-14”⁶⁸.

^{cc} Breakdown not available for the year 2014-2015



Figure 5 – Scotland – Age distribution of prisoners by sex (30 June 2013)



Source: Prison statistics and population projections Scotland: 2013-14 (18 December 2015) ⁶⁸



Table 13 – Scotland - People in custody by ethnic origin on 30 June 2013

Ethnic background	Male	Female	All
White	7 181	422	7603 (96.4%)
Pakistani	66	2	68
Indian	11	1	12
Bangladeshi	2	-	2
Chinese	10	1	11
Other Asian	38	1	39
Black-African	44	2	46
Black-Caribbean	38	-	38
Black-Other	20	3	23
Mixed	19	4	23
Other	17	1	18

Source: ⁶⁸

4.3 Delivery of care

4.3.1 Introduction

4.3.1.1 Directions and guidance to Regional Health Boards

Regarding the provision of healthcare in prisons, NHS Regional Health Boards were provided by the Scottish Ministers with directions that came into force on 1st November 2011. Each Regional Health Board has the obligation to comply with these Directions and to make sure that “every person with whom [it] enters into arrangements to provide healthcare to prisoners in prisons is obliged to comply with PART 1 of these Directions so far as relevant to the services provided by such persons”¹⁰⁶.

In the first part of the document, regarding general issues, Directions are provided on the following elements ¹⁰⁶:

- The time limit within which every prisoner should be examined by a medical practitioner or nurse on reception into prison :
 - “(a) in the case of the prisoner’s reception into prison, other than on a transfer from any prison, within 24 hours of that reception; or
 - (b) in the case of the prisoner’s reception into prison on a transfer from any other prison, the delay can be 72 hours
 - (i) where an officer has reported that some cause for concern was apparent on reception, as soon as reasonably practicable and no later than 24 hours after reception; or
 - (ii) in any other case, within 72 hours of that reception”.
- The role of medical practitioners or nurses in case of restraints use, of cellular confinement of a detainee or of removal from association, including reporting to the Governor of the prison and to the health professional’s line manager “any deterioration in the prisoner’s health”. Regarding cellular confinement, “a medical practitioner or a nurse must visit the prisoner as soon as practicable and, in any case, no later than 24 hours after the notification of the imposition of that confinement” and thereafter “as frequently as the medical practitioner or nurse considers is necessary”.
- The duty for medical practitioners and nurses to notify certain matters to the prison Governor, such as unfitness to be placed in cellular confinement. If, according to a medical practitioner or nurse “(a) the prisoner is totally and permanently unfit to be detained further in prison; (b) the life of the prisoner is likely to be endangered by continued detention in prison; or (c) the health of the prisoner is such that the prisoner is unlikely to survive the sentence or the period for which the prisoner is remanded or detained, s/he must notify the Governor, the Health Board, and her/his line manager without delay”¹⁰⁶.



- The duty to have a care plan for each prisoner.

Additional guidance to the directions specifies that “this multidisciplinary care plan, will include the involvement of prison officers (as carers) where relevant, and should include details such as the condition/s to be addressed, agreed management including review and expected outcome. Any care plan should (as far as reasonably possible) (a) be agreed with the prisoner concerned, and (b) take account of the prisoner’s family/social circumstances”¹⁰⁷

The second part of the document addresses Primary Medical Services.

It describes:

- The detailed conditions under which contracts for the provision of primary medical services in prisons may be concluded by Regional Health Boards.
- The framework for provision of primary medical services, regarding for instance attendance at practise premises, standards for out of hours services and prescribing
- The required qualifications and training of medical practitioners and “any person to assist in the provision of primary medical services in prisons”
- The conditions for employing GP specialty trainees
- The duty to keep patients records and guidance on electronic records
- The responsibility regarding confidentiality of personal data
- Attitude towards gifts
- The duty to refuse any remuneration “from any patient of the practice”
- Issue of medical certificates

Additional guidance was also provided, to complete the Directions¹⁰⁷. The possibility to develop local MoUs to frame local partnerships within the national MoU is raised in the document, which also provides guidance on accommodation, clothing, hygiene, food and medical duty to advise the prison Governor in case of unfitness to work or take exercise. Process and division of tasks in case of necessary treatment outside the prison is described (see 4.3.5.3). Some details regarding multidisciplinary care plans to be provided to prisoners and the maintenance of a medical record are provided, along with a description of health professionals’ responsibilities in case of transfer between two prisons, discharge or temporary release, or in case of pregnancy (see 4.3.3.3.1)¹⁰⁷.

4.3.1.2 *Her Majesty’s Prison Barlinnie*

Health services in the publicly owned prison of Barlinnie will be taken as the main example regarding the delivery of health services in the following description. As each NHS Regional Board is responsible for the delivery of care on its territory, local arrangements are variable and the situation in HMP Barlinnie should therefore not be taken as a national standard. This description is largely based on the situation at the time of a local HCNA conducted from November 2011 to March 2012, after the transfer of responsibility⁸⁹ and was completed by other data sources^{108 109 110}.

Her Majesty Prison (HMP) Barlinnie is the largest prison in Scotland¹⁰⁸. It is located in Glasgow, in the area of the NHSGGC Board, which is also the largest Regional Health Board in terms of population. On 30 June 2012, it was responsible for the delivery of care to an estimated population of 1,137,320 individuals¹⁰⁴.

The turnover of prisoners in HMP Barlinnie is high with, for instance, 734 transfers (in or out) and 131 liberations during the month of January 2012. HMP Barlinnie was designed to house 1027 prisoners. However, in March 2012, there were 1467 individuals in this prison, accommodating male prisoners of all categories^{dd 89}.

^{dd} On the 15th of April 2016, HMP Barlinnie hosted 1227 prisoners (source: SPS by e-mail, April 2016)



4.3.2 Availability

4.3.2.1 Health services

At the time of the mentioned HCNA, HMP Barlinnie health centre was operating from 6.45 to 21.30 from Monday to Friday and from 8.30 to 17.30 during the weekends. There was a GP service every day, with three GPs each day on average, seeing around 300 patients per month. Five or six half-days were dedicated to routine care and admissions and there were evening sessions twice a week ⁸⁹.

The mental health team operated from Monday to Friday 8am to 4pm, without weekend provision and the addictions team operated on a daily basis, including week-ends.

Regarding in-reach provision, attention was provided twice a week by two psychiatrists and dental care was provided every day (Monday to Friday) for a total of around 200 patients per month. An optician and a podiatrist came every two weeks and visits from a gastroenterologist/liver specialist consultant and clinical nurse specialists were organised as a Blood Borne Viruses (BBV) out-reach service. Allied Health Professionals could attend prisoners on requirement.

Healthcare services were delivered either in the healthcare centre or in the Halls.

4.3.2.2 Human resources

There is no purchaser-provider split in the Scottish health system. Hospital and community staff is directly employed by Regional Health Boards and the pay rates of the different categories of NHS staff are defined on a UK basis ⁷³.

Primary care providers, such as GPs and dentists, are usually independent contractors under contract with NHS Boards which reimburse them for the services they provide for the NHS. However, GPs can also be salaried through GP practices or through employment by NHS Boards ⁷³.

In HMP Barlinnie, there was one Healthcare Manager for the prison, reporting to the Head of Prison Healthcare who has a remit for the whole Regional Health Board. Furthermore, four clinical managers had the responsibility of care in one or more of the six Halls of the prison. Their specialisms covered mental health, addictions and primary care ⁸⁹.

At the time of the HCNA in HMP Barlinnie, there were 24 practitioner nurses, three full time equivalent (FTE) mental health nurse, 0.2 FTE dual diagnosis nurse^{ee}, nine addictions nurses, four staff trained in sexual health including two BBV specialists, one nurse in learning disability, one infection control nurse, four healthcare assistants and three administrators.

4.3.2.3 Restrictions in health care delivery because of human resources constraints

In 2012, health and non-health staff from HMP Barlinnie and Greenock agreed that mental health teams were under-resourced compared to the needs, leading them to focus on triage and crisis interventions. Unmet needs were identified regarding for instance mental health promotion, primary care or SPS staff awareness of mental health issues ⁸⁹. In his 2011 full inspection report on HMP Barlinnie, HMCIPS recommended to increase the size of its mental health team, given the important needs in this field ¹⁰⁸. Under-resources services were underlined by the prisoners and the staff regarding dental health in HMP Barlinnie as well ⁸⁹.

Following its visit in 2012, the CPT recommended to Barlinnie Prison as well to create the equivalent of one full-time position for a psychiatrist and one full-time position for a dentist ¹⁰⁹, reflecting the issues raised above.

^{ee} Nurses aiming "to improve the support and treatment for individuals who have co-existing mental health and alcohol and drug difficulties, which is known as a dual diagnosis" (<http://www.dualdiagnosis.co.uk/>, accessed 27.01.16)



Gaps in access to allied health professionals – especially dietitians, speech therapists, occupational therapists and optometrists – were also mentioned by staff during the HCNA in NHSGGC⁸⁹. The lack of access to psychiatrists and to Allied Health Professionals was also reported in the field of addiction in a dedicated report released in February 2016 (see 4.3.3.2.2)¹¹¹.

4.3.2.4 Outside regular hours

There was a GP service every day in Barlinnie. A Saturday clinic was run for prisoners admitted from Friday night and a Sunday clinic was reserved for prisoners deemed to need urgent medical attention by a nurse practitioner performing a triage⁸⁹. A practitioner nurse was on duty overnight each day for advice and triage, with an on call Medical Officer accessible seven days a week. However, this was the only Scottish prison in which a nurse was present during the night^{89/109}. In other prisons, a part of the night shift officers were trained in advanced first aid and defibrillator use and the 24 hour medical cover was ensured through the on-call doctor¹¹⁰.

4.3.3 Comprehensibility

4.3.3.1 Health promotion and prevention

In Scotland, attention has been given to make prisons 'health promoting' places since 2002, when the SPS Health Promotion strategy put health promotion on the prison agenda for the first time. The transfer of responsibilities regarding healthcare in prison to the NHS has been seen as an opportunity to update those aspects of prison health. Though a number of health promotion activities were in place in Scottish prisons, they were *“often reported as being ad hoc, variable across the prison estate and rarely formally evaluated against their impact on prisoner health and wellbeing”*¹¹².

The two volumes report “Better health, better lives for prisoners: A framework for improving the health of Scotland’s prisoners” edited in 2012 provides a framework aiming to ensure that actions involving prisoners are taken to improve their health and wellbeing and those of their families and communities, in a health promotion and health improvement perspective¹¹²¹¹³. Emphasis is made on reducing health inequalities and the document is notably guided by the policy framework “Equally well”¹¹⁴¹¹².

An integrative, 'whole prison' approach is recommended to reach these objectives, in line with the three following key elements:

- *“Developing policies in prisons which promote health*
- *Promoting an environment in each prison that is actively supportive of health*
- *Prevention, health education and other health promotion initiatives which address health needs within each prison”*¹¹²

This framework underlines that health services are one part of a wider range of stakeholders – including among others, social workers, voluntary sector or Community Justice Authorities - having a role to play in health improvement. It should be noted that this publication results from the collaboration between the SPS, the Scottish Health Promotion Managers and the Scottish Public Health Network

Different “health promotion pillars” are listed, around which the framework is built¹¹²:

- “Reduce use of tobacco
- Reduce harmful use of alcohol
- Reduce harmful use of illicit drugs
- Improve mental wellbeing
- Increase uptake of healthy eating and reduce obesity
- Encourage better oral health
- Increase safer sex and better personal relationships
- Reduce transmission of blood-borne viruses
- Increase physical activity
- Improve parenting
- Management and prevention of long-term conditions”



Four horizontal 'unifiers' are also defined, in order to avoid treating the health pillars in a vertical approach ¹¹²:

1. “prisoner involvement
2. healthy prison policies and environment
3. links with community and public sector services including NHS health promotion services
4. measurable outputs and outcomes.”

More details are provided in this framework document on six “core recommendations” (regarding standards, training, referral to community services, impact assessments, personal planning and evaluation) and on interventions related to each of the eleven health areas mentioned above ¹¹².

At the level of prisons, a team dedicated to health promotion is in place for the three prisons of NHSGGC ¹¹⁵¹¹⁶. In HMP Barlinnie, a “Well man” clinic was run daily, providing health checks, support and follow-up if necessary ⁸⁹.

A gym and a fitness centre are available in the prison but due to the high number of prisoners, access was limited to around twice a week at the time of the HCNA. Cardiovascular equipment was available in the Halls and playing football was also possible ⁸⁹.

In the same prison, attention was given to always make at least one “healthy option” available in the menu and smoking cessation groups were run ⁸⁹.

4.3.3.2 Specific health Issues

The following clinics were available for prisoners on self-referral or on staff referral in HMP Barlinnie: mental health, addictions, BBV, learning disabilities, asthma, Well Man, hepatitis A and B, flu vaccination, diabetes and tissue viability^{ff 89}.

Mental health

“Restricted patients” are mentally-disordered offenders compulsorily detained in hospital for an indefinite period, usually after having committed an offence normally punishable by imprisonment. Discharge of those patients from the hospital is under the responsibility of the Mental Health Tribunal for Scotland ⁷⁶.

The State Hospital, located in South Lanarkshire, is the only high-secure mental health facility in the country ⁸⁴. There is no such high-secure structure for women, for whom a transfer to England can be arranged if needed. However, this situation put them at risk of spending long period in segregation units within prisons while waiting for the transfer to be possible, as noted by the CPT ¹⁰⁹.

As mentioned, the State Hospital is one of the special NHS Boards ^{84 76} and is therefore not a part of the SPS. There are three regional medium secure services and low secure services are available in most of Health Boards, as well as community forensic mental health and learning disabilities teams ⁸⁶.

It should be noted that a specific legal provision (Section 59A of the Criminal Procedure (Scotland) Act 1995, equivalent to the “Hybrid Order” in England and Wales) allows some Courts to order hospital admission in addition to a prison sentence to offenders. In this case, if hospital treatment is deemed unsuccessful or no longer necessary, the offender may be transferred to prison for the remaining time of his sentence. Though this provision is infrequently used, it raises issues on the position it places the psychiatrist

^{ff} “Tissue viability is a growing speciality that primarily considers all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers

and all forms of leg ulceration.” - (Tissue Viability Society 2009 cited by Health Improvement Scotland).



to, involving them in decisions regarding not only treatment, but also punishment¹¹⁷.

Suicide risk assessment is a part of each prisoner's examination upon admission. The "ACT 2 Care Suicide Risk Management Strategy" provides a framework for a multidisciplinary support to people at risk of self-harming⁹⁹
¹¹⁸.

In HMP Barlinnie, a dedicated team was in charge of different aspect of mental health care and management, which included ensuring the continuity of treatment (notably by contacting the community prescriber and appropriate services on admission and pre-release), taking part to the ACT 2 Care suicide prevention case conferences, running individual interviews and mental health clinics and facilitating multi-disciplinary mental health meetings⁸⁹.

In case of deterioration of a prisoner's mental health leading to the need of being detained under the Mental Health Act, the mental health team has a liaising role with the courts, psychiatrist, GP and Governor⁸⁹.

Moreover, a day care unit was available to all prisoners but mainly attended by prisoners referred by the mental health team. This unit was staffed by trained officers and a number of services provided by third sector organizations were offered, such as relaxation, drama and computer work¹⁰⁸.

⁹⁹ A new Prevention of Suicide in Prison Strategy is currently being developed by the SPS and should be published in 2016 (Sources: correspondence with E. Christie - SPS - and L.Graham)

^{hh} See also: <https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2016-03-29/2016-03-29-DATWT-Report.pdf> , <http://www.nphn.scot.nhs.uk/wp-content/uploads/sites/9/2016/02/20160226-NPHN-Substance-Misuse-Report-Final-v1.0.pdf>

Addictions (drugs and alcohol)^{hh}

In Scotland, the criminal justice system is used as a potential means of enhancing access to services and treatment for drug users. A range of interventions targeting them have been developed at different points of the judicial process – making the criminal justice system evolving as a “gateway to drug treatment” - in the community and in prison settings¹¹⁹.

Each year during one month, an Addiction Prevalence Testing is conducted in all Scottish prisons. During this month, the prisoners entering and leaving the prison are tested for the presence of illegal drugs. In 2014/15, 74% of the 1170 tests performed at prisoner reception were positive for drugs – including prescribed drugs for treatment purposes – and 70% were positive for illegal drugs (which included the illicit use of prescribed drugs, such as benzodiazepines or buprenorphine). The same year, 29% of the 616 tests performed upon release were positive for illegal drugs (13% were positive for illicit buprenorphine, 8% for cannabis, 7% for benzodiazepines and 6% for opiates)¹²⁰. Among the prisoners who responded to the SPS Prisoners Survey in 2015 – which had a response rate of 55% of all prisoners in Scotland – 40% declared being under influence of drugs and 41% declared being drunk at the time of their offence¹²¹.

Guidance for Quality Service Delivery regarding Drugs, Alcohol and Tobacco Health Services in Scottish Prisons was released in February 2016 by the NPHN. This report aims “to describe the current picture of the nature and scale of substance use in prisons in Scotland, map and review current service delivery and best practice, and to suggest recommendations on evidence-informed approaches likely to result in assisting recovery and reducing reoffending”. The intended audience for this publication is not only the NHS Boards but also the SPS, Alcohol and Drug Partnershipsⁱⁱ and a “wide range of health and justice decision makers and service deliverers”.

<http://www.healthscotland.com/uploads/documents/15165-Prison%20Health%20Needs%20Assessment%20for%20Alcohol%20Problems.pdf> , <http://www.scotpho.org.uk/downloads/drugs/SPS-Addiction-Prevalence-Testing-Stats-Final-2014-15.pdf> (Reports cited by L.Graham on proofreading)

ⁱⁱ “Local Alcohol and Drug Partnerships (ADPs) lead on assessing need and commissioning alcohol and drug services”¹¹¹



Authors recall that drug and alcohol use are major factors in offending behaviours and that *“effective treatment and recovery has the potential, combined with other behavioural and purposeful activity support, to reduce the likelihood of further reoffending as well as contributing to a reduction in health inequalities”*. The document notably contains three diagrams illustrating *“the recommended process for identifying, screening, assessing and providing health and social care interventions to address problematic drug [and alcohol] use”* and for smoking cessation. Furthermore, it provides high level recommendations to different key organizations and specific recommendations on drug, alcohol and tobacco control ¹¹¹.

In all Scottish prisons, the risk of alcohol or drug withdrawal is assessed by a nurse within a few hours after admission ¹¹¹. Support to prisoners facing alcohol issues in HMP Barlinnie included different types of pharmacological support as well as psychosocial support, such as alcohol awareness courses or motivational interviewing. At the time of the NHSGGC HCNA, prisoners’ alcohol misuse issues were supported by NHS staff but also by the charity Phoenix Futures and by Alcoholics Anonymous ⁸⁹.

The NHSGGC HCNA mentions recent data showing that more than 80% of prisoners upon admission and 10% on release from HMP Barlinnie were tested positive for illicit substances. In this prison, there were nine nurses specialised in addictions within the healthcare staff and an addiction clinic operated each day ⁸⁹.

In the week commencing on 26 October 2015, close to 20% of the prisoners in HMP Barlinnie were on opioid substitution treatment: around 16% were on Methadone and around 3% on Suboxone ¹²². Phoenix Futures – which had a national contract with the SPS until April 2013 – and others voluntary sector agencies also provided psycho-social support to prisoners with drug issues ⁸⁹.

Securing the continuity of care post-release is of particular importance regarding drug misuse. The Throughcare Addiction Service (TAS) was introduced in 2005 in Scotland^{jj} ¹¹⁹ and employs community workers in connection with the Criminal Justice Social Work Departments ⁸⁹. The TAS works with prisoners serving over 31 days in prison during the last six weeks of their sentence and the six weeks following their release ¹²³, except for women and young offenders for whom no minimum length of sentence is required. Prior to release, prisoners develop with the TAS a “Community Integration Plan” aiming to define how the addiction-related work started in prison will be continued back to the community ¹¹⁹. After release, the focus is on linking prisoners with their local Community Addiction Team or with the Homeless Addiction Team ¹²³.

Beside this, the National Naloxone^{kk} Programme has to be pointed out. This programme, which aims at preventing opiates overdose deaths, has been run since 2011. In Scotland, drug-related death (DRD) had been showing a “long-term upward trend” since 1997, leading to the setting up of a National DRD Database aiming to understand this phenomenon. It was shown that the people most at risk of DRD were 25 to 44 years old male, “living in the most deprived areas” and that most of DRD occurred *“in a home environment where there is often someone nearby, thus offering an important window of opportunity for someone to intervene and potentially save a life”*. Moreover, data showed that in more than two-third of the DRD cases, people had been *“in drug treatment, in prison or police custody or discharged from hospital in the six months prior to their death”*. The National Naloxone Programme basically consists of providing, after appropriate training, “take home” Naloxone (THN) kits to people at risk of opiate overdose, including some prisoners upon release. Families, friends and service workers can also benefit from the training. All Scottish prisons take part to this programme. In 2014/15, 878 THN kits were distributed in Scottish prisons^{ll}, among which 81% were recorded as a first supply, 15% as a repeat

^{jj} The Criminal Justice Social Work Statistics in Scotland 2014-2015 released in March 2016 reports that “while funding for this service was initially ring-fenced, it has been mainstreamed, and this type of service may now be delivered through a range of different routes” ²⁵³.

^{kk} “Naloxone is an opioid antagonist; a drug which can temporarily reverse the effects of a potentially fatal overdose with opioid drugs such as heroin or morphine” ¹²⁴.

^{ll} In the same period, 6 498 THN kits were distributed in the community



supply (compared with 35% in the community), 0.2% as a spare supply and 4% had an unknown status. In 9 cases out of the 133 repeated supply, the previous kit had been used on a person at risk. In the same year, approximately 25% of the kits were issues to women¹²⁴. The experts of the National Naloxone Advisory Group coordinate the programme and monitor its progress and delivery. The Information Service Division of NHS National Services Scotland ensures the delivery of an *“in-depth monitoring and evaluation programme, including measuring progress against a baseline measure”*. Other key elements of the programme include a national training and support officer, national training and information resources – such as an official website^{mm} – and a peer educator initiative. This programme is funded by the Scottish Government¹²⁵.

Infectious diseases

At the national level, the reported estimated prevalence of HCV infection on admission to prison was 20% in 2007¹²³. Reported prevalence figures were similar in 2012¹²⁶. A study based on prevalence data from 1990 to 2007 among injecting drug users in Glasgow estimated that imprisonment was an important risk factor for HCV infection and that this increased risk could have been attributed *“to increased risk behaviour in prisons (such as injecting or tattooing) or [...] to high at-risk behaviour following imprisonment as a result of an extended period of drug withdrawal during imprisonment”*¹²⁷. A more recent study estimated that the HCV infection incidence in prison settings was low. However, 8% (404/5076) of the prisoners responding to this survey reported having ever injected drugs in prison and 2.5% reported having injected in the period of incarceration during which they were taking part to it. Along those 58% reported *“injecting with needles and syringes previously used by someone else”*¹²⁶.

Upon admission to HMP Barlinnie, history of BBV was routinely checked and hepatitis B vaccination offeredⁿⁿ to unimmunised prisoners, under an accelerated course in order to make sure that it is completed. Blood testing for BBV was available for prisoners on self-referral. As mentioned, there

were four staff trained in sexual health. BBV and hepatitis A and B clinics were run every week and counselling services were available⁸⁹.

Moreover, visits from a Liver Nurse Specialist providing information and clinical assessment were organised as a BBV out-reach service. Prisoners with chronic HCV infection were offered antiviral treatment within the prison by a Consultant in infectious diseases working in collaboration with the prison health staff. Peer support services were also provided monthly⁸⁹.

Free condoms were available on request.

No data were found on tuberculosis screening or treatment.

On a policy level, regarding sexual health and BBV, the Scottish Government has issued a framework in 2011, updated in for the 2015-2020 period. In this document, the Scottish Government expresses its will to work with NHS boards and with the SPS in order to introduce opt-out testing for HIV and hepatitis B and C for each new prisoner¹²⁸.

4.3.3.3 Specific groups

Women

Regarding female prisoners, the guidance linked to the 2011 Directions to Health Regional Boards regarding healthcare in prison (see 4.3.1.1) specifies that:

“- A medical practitioner or nurse should notify the Governor if they believe that a prisoner is pregnant or if a prisoner is likely to give birth prior to the expected date of liberation or period of committal. The medical practitioner or nurse should give advice to the Governor if requested or as clinically considered necessary

*- A medical practitioner or nurse should arrange for the transfer of clinical responsibility of any prisoner who is pregnant, to a hospital outside the prison for the purposes of giving birth. The medical practitioner or nurse is not responsible for making transport arrangements.”*¹⁰⁷

^{mm} See the Naloxone website here: <http://www.naloxone.org.uk/>

ⁿⁿ Hepatitis A (which is not a BBV) vaccination was also offered



In 2011 a Commission on Women Offenders was set up by the Cabinet Secretary for Justice, following the publication in June of a follow-up inspection report on Cornton Vale Prison and Young Offenders Institute. This report notably underlined *“a serious problem with overcrowding in Her Majesty’s Prison (HMP) Cornton Vale and called for a national strategy to deal with the problem”*. The remit of this Commission was *“to consider the evidence on how to improve outcomes for women in the criminal justice system; to make recommendations for practical measures in this Parliament to reduce their reoffending and reverse the recent increase in the female prisoner population”*. The Commission report was then not only addressing health issues but comprised recommendations regarding health. Among those, a strong focus is made on improving and developing mental health services, taking into account the particularly high burden of mental health issues and history of physical and sexual abuse among women offenders. The strong link between offending behaviours and *“underlying issues, such as drug or alcohol addiction and mental health problems”* was highlighted by the Commission, which considered – regarding women repeatedly convicted for lower level offences – that those issues *“could be better addressed in the community”*. The Commission members acknowledged that *“there [were] some excellent examples of services which target the offending needs of women”*. However, they also underlined that *“women-specific services [were] not consistently provided throughout Scotland”* and that *“criminal justice services [were] not standardised”*.¹²⁹

In line with the Commission on Women Offenders’ recommendations, the Scottish Government announced “new plans for women in custody” in 2015, stating that *“Scotland [was] to adopt a new approach to dealing with female offenders with a move towards custody in the community, backed by targeted support to address underlying issues and action to reduce the numbers of women receiving custodial sentences”*. The Justice Secretary announced in January 2015 his *“decision not to proceed with HMP Inverclyde as a large national prison for women”*. The foreseen reorganization implies the creation of *“a new small national prison with 80 places [and of] five smaller community-based custodial units each accommodating up to 20 women across the country”*. The plan also includes the provision of an *“intensive support to help overcome issues such as alcohol, drugs, mental health and domestic abuse trauma which evidence shows can often be a driver of offending behavior”*.¹³⁰

HMP Barlinnie does not host women but other prisons give example of specific clinical care for women. In HMP Greenock for instance, “Well woman” clinics were run, providing smear and pregnancy testing, contraception and breast awareness⁸⁹.

Older prisoners

A part of the SPS 2013 Prison Survey addressed prisoners older than 50, highlighting some differences in terms of needs compared to younger offenders. Prison surveys aim to be *“a mechanism to inform and support the Service’s business planning process”*¹³¹. Although ageing of prisoners is identified as an emerging issue⁹⁰, few specific attention seems to have been given so far to older prisoners in the various policy frameworks consulted.

However, the SPS, which is responsible for Social Care is currently *“conducting a social care needs assessment to inform the development of a national high care needs strategy”* (Source: proofreading by the SPS).

Children

The Commission on Women Offenders also stressed the importance parenting support and of early years interventions to reduce the risk of future offending behaviours among offenders’ children¹²⁹.

A Mother and Baby Unit is available at HMP Cornton Vale, providing seven mother and baby spaces, staffed by trained nurses⁶⁹⁷⁰. Babies can stay maximum up to 18 months old⁶⁹

Services aiming to support parenting during children’s visit to HMP Barlinnie or in preparation for release were provided, involving the prisoners and their families, health and social care professionals, and SPS family liaison officers⁸⁹.

HMP Barlinnie was at the time of this HCNA the only Scottish prison to take part to the national “Positive Parenting Programme” (or “Triple P”) - providing individual or group courses to families - which was identified as an area of good practice by HMCIPS in his 2011 full inspection report⁸⁹¹⁰⁸.

The charity “Families Outside” is also involved in supporting prisoners’ families, in link with Triple P⁸⁹.



Disabled people

HMP Barlinnie building contained a facility dedicated to a residential care unit for vulnerable prisoners suffering from physical or mental health issues and/or learning disabilities. A learning disability clinic was run occasionally by a nurse, who could also provide individual support ⁸⁹.

4.3.4 Continuity of care

4.3.4.1 Follow-up and Medical Information transmission

The concept of “Throughcare” is defined as “the provision of a range of social work and associated services to prisoners and their families from the point of sentence or remand, during the period of imprisonment and following release into the community. The services have a primary objective of public protection, though they are also concerned with assisting prisoners to prepare for release and helping them to resettle into their community within the law”. Statutory assistance and supervision is provided to long-term prisoners, with non-mandatory involvement of the NHS. Prisoners serving shorter sentences (usually of six months to four years) are entitled to voluntary throughcare assistance. The lack of requirement for health assessments to be undertaken under throughcare arrangements, underlined in a report issued in 2014 by the Scottish Public Health Network, is considered as impairing an effective continuity of care ¹²³.

4.3.4.2 From community to prison

In his 2013-2014 report, HMCIPS highlighted, as a “*recurring feature*”, that “*too often important information on the Prisoner Escort Record form is communicated neither to the healthcare staff nor prison officers who are conducting initial assessments on admission at reception*” ¹³².

Upon admission to HMP Barlinnie, every prisoner went through a medical examination, usually performed by a practitioner nurse. This examination included the suicide prevention “ACT 2 Care” interview and the request for authorization to communicate with the medication prescriber (GP) in the community ^{89 109}. There could be a delay from several hours to several days before treatment verification could be made, potentially leading to treatment interruptions ⁸⁹. Health related data, collected during the health check upon

admission to the prison, were recorded in an IT system called GPASS (“General Practice Administration System for Scotland”) at the time of the HCNA. At that time, the lack of use of IT in the healthcare delivery process was underlined in the NHSGGC HCNA as potentially impairing the timely exchange of information. The GPASS has been replaced by the “Vision system”, which is one of the two main IT system used by GPs in the community. This system is shared between Regional Health Boards and Prisons, enhancing the continuity of care pre, during and post-imprisonment. However, records of prisoners serving sentences of less than six months and still registered with their GP practice are not transferred, in order to promote stability with their practice in the community (see 3.8.1). An electronic emergency care summary (including medication information) is available in any case ¹⁰³.

The way initial medical consultations were carried out in this prison was considered as a best practice by the CPT, with nevertheless improvements to bring regarding the recording of injuries ¹⁰⁹.

Reception facilities in HMP Barlinnie were pointed out as inappropriate repeatedly by HMIPS ⁸⁹.

4.3.4.3 Within the prison

Prescribed medications were dispensed by practitioner nurses and mostly delivered in the Halls except for controlled drugs and treatment for most diabetic people, which were delivered in the health centre. Opioid substitution therapy was generally managed in the addiction centre. Each night, prison officers had to deliver about 250 unsupervised medications (Ibuprofen and Paracetamol) in the Halls ⁸⁹

When prisoners had an appointment with the optician, the dentist, the podiatrist or at one of the clinics, the healthcare administration sent them a letter as a reminder ⁸⁹



4.3.4.4 From a prison to another

According to the “Provision of Health Care in Prisons Directions 2011” to Regional Health Boards, each prisoner must be examined by a medical practitioner or nurse after reception into a prison. However, the time limit within which this examination must be undertaken is different for prisoners transferred from another prison than for other prisoners. For the latter, examination must take place in the 24 hours following admission whereas it can be undertaken in the 72 hours following admission in case of transfer (unless any cause of concern noted by an officer at admission would justify an earlier examination) ¹⁰⁶

4.3.4.5 From prison to the community

NHS Regional Boards promote re-registration to GP practices on release for prisoners who had been deregistered during their imprisonment ^{123 133}.

HMP Barlinnie pre-release service was described in the NHSGGC HCNA of 2012. This service was organised by the rehabilitation and support officers at the prison “Link Centre”, where a wide range of agencies were represented. There, it was made sure that all the necessary referrals had been made before release ⁸⁹. In HMP Inverness, there are two Throughcare Support Officers, providing support to (ex-)offenders pre and post-release, therefore within the prison and in the community, where they “[act] as coach, mentor, role model and advocate, signposting them to appropriate community services” ¹¹¹. However, on the whole in Scottish prisons, throughcare remains a major issue, with variable success ^{102 123 134}. The NPHN addressed it through one of its work streams, which published a report dedicated to throughcare in January 2016 ¹³⁴. The recommendations included in this report are available in the Appendix (Annex 8).

The role of healthcare in offender reintegration was pointed out in a report released in September 2015 by the Scottish Government ¹³⁵.

4.3.4.6 Patients ‘rights regarding their medical files

Without mentioning specifically the issue of access to the medical record, the **Patient Rights (Scotland) Act 2011** states that “Health care is to allow and encourage the patient to participate as fully as possible in decisions relating to the patient's health and wellbeing” and “in relation to any related processes, taking all reasonable steps to ensure that the patient is supplied with information and support in a form that is appropriate to the patient's needs” ¹³⁶.

No specific data regarding access for the patients to their medical record in prison have been found.

4.3.5 Reachability

4.3.5.1 Procedures to get medical attention

At the time of NHSGGC HCNA, prisoners who wished to access healthcare services had to fill in a referral form accessible in the prison Halls. In case of reading or writing difficulties, they had to ask for support to other offenders, to officers or to the nurses during medication rounds.

4.3.5.2 Triage and waiting lists

After its visit in the UK conducted in September 2012, the CPT mentioned that in the prisons visited, including HMP Barlinnie, doctors were accessible within “a reasonable time”. However, the lack of access to non-emergency dental care and ophthalmological services for remand prisoners was underlined in the report following this visit ¹⁰⁹.

Unmet needs in dental care were already mentioned. Waiting time for this type of care was ten weeks for emergency or pain and much longer for routine care ⁸⁹.



4.3.5.3 Hospitalization

The 2011 Guidance to Health Boards describes the process and division of tasks in case of necessary treatment outside the prison. Essentially, clinical referral is under the responsibility of health professionals but the prison Governor is responsible for transfer arrangements¹⁰⁷.

Utilization of “Telehealth” in prison is under development in Scotland, with one of the objective being to reduce transfers to hospitals through support to decision-making and triage^{90 133}. One of the work streams set up upon creation of the NPHN was dedicated to “tele-mental health”. Videoconferencing equipment is in place in 7 out of the 15 prisons - delivering “a range of services from forensic psychiatry to Teleneurology” - and the provision of Cognitive Behavioral Therapies delivered by phone in 10 prisons^{oo}.

4.3.6 Quality assurance and control

4.3.6.1 Quality control bodies

The United Kingdom is a signatory to the United Nations Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), which requires a National Preventive Mechanism (NPM) to be in place in the States Parties to this Protocol¹³⁷. The objective of the latter is “to establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment”¹³⁷. Guidance is provided by the NPM to its members in order to ensure the independence of the NPM personnel¹³⁸.

Her Majesty Inspectorate of Prisons for Scotland (HMIPS) is one of the 20 National Preventive Mechanism bodies for the United Kingdom¹³⁹. Six of those bodies are Scottish, including the Mental Welfare Commission for Scotland¹⁴⁰. The UK NPM was set up in 2009 and releases a joint annual report since then which is presented to the UK Parliament¹⁴⁰.

HMIPS inspections are conducted under the following principles⁷²:

- “In carrying out inspections and in preparing reports, HMCIP will be independent of political influence, the Scottish Government Justice Directorate, the Scottish Prison Service and Governors-in-Charge of establishments.
- Inspection and the reports resulting from them will be balanced, fair and open.”

The annual report of HMCIPS is made public and is available on HMIPS website, as well as reports by establishment and thematic reports. As mentioned above, in his annual report for the year 2005/2006, HMCIPS called for an examination of “*the possibility of the provision of healthcare in prisons by the National Health Service*”¹⁰⁰.

Following the transfer of competences to the NHS, a Partnership Agreement between HMIPS and HIS regarding healthcare related aspects of prison inspection was signed in November 2013. This agreement establishes the framework of collaboration and communication between HMIPS and HIS and their respective roles and responsibilities following the considered transfer of responsibility⁷².

It should be noted that there was no legal transfer of responsibility or sharing of statutory functions between HMIPS and HIS under this agreement. HMIPS keeps its statutory duty, with the assistance of a healthcare professional from HIS “for the purpose of inspecting healthcare and substance issue services as part of the overall inspection”⁷².

^{oo} Source: Scottish Centre for Telehealth & Telecare, NHS 24, by email (April 2016)



Inspections are guided by a set of “Standards for Inspecting and Monitoring Prisons in Scotland” (revised in 2015). Each standard goes with a number of quality indicators. Standard 4 addresses “Health and wellbeing” and states: “The prison takes all reasonable steps to ensure the health and wellbeing of all prisoners”¹⁴¹. Related quality indicators are the following:

“4.1 There is an appropriate level of healthcare staffing in a range of specialisms relevant to the healthcare needs of the prisoner population.

4.2 Prisoners have direct confidential access to a healthcare professional.

4.3 Appropriate confidentiality of healthcare consultations and records is maintained in the prison.

4.4 Healthcare provided in the prison meets accepted professional standards.

4.5 Where the healthcare professional identifies a need, prisoners are able to access specialist healthcare services either inside the prison or in the community.

4.6 Prisoners identified as having been victims of physical, mental or sexual abuse are supported and offered appropriate treatment. The relevant agencies are notified.

4.7 Care is taken during the period immediately following the admission of a prisoner to ensure their health and wellbeing.

4.8 Care plans are implemented for prisoners whose physical or psychological health or capability leave them at risk of harm from others.

4.9 Healthcare staff offer a range of clinics relevant to the prisoner population.

4.10 Preventive healthcare practices are implemented effectively in relation to transmissible diseases.

4.11 Preventive healthcare practices are implemented effectively in relation to the maintenance of hygiene and infection control standards.

4.12 Preventive healthcare practices are implemented effectively in relation to the assessment, care and treatment of those at risk of self-harm or suicide.

4.13 Preventive healthcare practices are implemented effectively in relation to the care and treatment of those exhibiting self-harming and addictive behaviours.

4.14 Health education activities for both prisoners and staff are implemented throughout the prison.

4.15 Healthcare professionals working in the prison are able to demonstrate an understanding of the particular ethical and procedural responsibilities that attach to practice in a prison and to evidence that they apply these in their work.

4.16 Every prisoner on admission is given a health assessment, supplemented, where available, by the health record maintained by their community provider. Care plans are instituted and implemented timeously.

4.17 Healthcare records are held for all prisoners. There are effective procedures to ensure that healthcare records accompany all prisoners who are transferred in or out of the prison.

4.18 Healthcare professionals exercise all the statutory duties placed on them to advise the governor or director of any situations in which conditions of detention or decisions about any prisoner could result in physical or psychological harm.

4.19 Healthcare professionals fully undertake their responsibilities as described in the law and in professional guidance to assess, record and report any medical evidence of mistreatment of prisoners and to offer prisoners treatment needed as a consequence.

4.20 Effective measures that ensure the timeous attendance of appropriate healthcare staff in the event of medical emergencies are in place and are practised as necessary.

4.21 Appropriate steps are taken prior to release to assess a prisoner’s needs for ongoing care and to assist them in securing continuity of care from community health services.”¹⁴¹



Besides those bodies, independent observers of Visiting Committees for Scottish Penal Establishments conducted regular visits on a voluntary basis to prisons and the young offenders' institutions, in order to provide "a necessary outside perspective on [their] life and work". They were abolished in 2015 following a stakeholders' consultation process held by the Scottish Government and replaced by independent prison monitors^{pp}. The statutory responsibilities of the Visiting Committees were defined by law (Prisons (Scotland) Act 1989) and they were accountable to the Scottish executive. One Visiting Committee was appointed for each prison and young offenders' institution and the Committees submitted an annual report to the Cabinet Secretary for Justice providing their observations and recommendations¹⁴². However, in its 2013 report on the UK, the European Prison Observatory underlined that those Committees did not meet the OPCAT standards and could not be considered as having "the adequate level of independence", though improvements regarding those issues were foreseen⁶⁹.

4.3.6.2 Guidelines

Healthcare Improvement Scotland is responsible for the development of evidence-based advice, guidance and clinical standards (including Scottish SIGN guidance^{qq}) and for advising on the applicability of the NICE^{rr} guidance to Scotland⁷³⁸⁷. NHS Boards are expected to follow those national guidelines and standards⁷³, which are also applicable in prison settings. However, the applicability of some of these guidelines in the custodial setting can be challenging⁷⁴.

Moreover, NHS Education for Scotland has created an online support portal dedicated to healthcare staff working in custody and prison^{ss}¹⁴³.

4.3.6.3 National guidance

Beyond clinical guidelines, NHS boards operate within a framework provided by the Scottish Government health directorates, explicitly linked to the wider "National Performance Framework" which defines the key priorities leading to the creation of a "more successful country, with opportunities for all of Scotland to flourish, through increasing economic sustainable growth"¹⁴⁴⁷³. Social justice values have been core to the Scottish Government social policies and reducing health inequalities is one of the policy focus in the country, notably including explicitly the delivery of care in prisons in the wider strategy for health inequality reduction⁷⁴.

A number of documents were issued by the Scottish Government providing policy drivers and guidance regarding different aspects of healthcare, specifically geared towards prisons or applicable to them¹¹²¹⁰⁶¹⁰⁷¹⁴⁵¹²⁸.

For instance, care related to drug misuse in HMP Barlinnie is defined as based on an harm reduction model as outlined in NICE guidance and informed by the "Road to Recovery" framework¹⁴⁵ issued by the Scottish Government⁸⁹.

As mentioned, the NPHN also plays a specific role in providing specific recommendations related to prison health.

Moreover, "Local Delivery Plan Standards" are "priorities that are set and agreed between the Scottish Government and NHS Boards to provide assurance on NHS Scotland performance"¹⁴⁶. Some of those standards apply to prison health^{tt}.

^{pp} Source : proofreading by the SPS and L. Graham (citing <http://www.gov.scot/Resource/0045/00458838.pdf>)

^{qq} Source : proofreading by L. Graham

^{rr} National Institute for Health and Care Excellence (England and Wales) , <https://www.nice.org.uk/>

^{ss} Supporting Health Care in Custody and Prison portal: <http://knowledge.scot.nhs.uk/home/portals-and-topics/supporting-health-care-in-custody-and-prison.aspx>

^{tt} Source : Proofreading by L. Graham



4.3.7 Patient's rights

4.3.7.1 Medical secrecy

Data sharing process between the SPS and Health Boards is defined by an Information Sharing Protocol dated 19 June 2013, which is complementary to the MoU ¹⁴⁷. This binding agreement has several objectives, including supporting “*integrated care and case management*” and protecting confidentiality, in accordance with law and good practice, including the Data Protection Act 1998 and the Human Rights Act 1998. A list of other relevant legislation is provided in the document, as well as operational procedures and guidance ¹⁴⁷.

The kind of information to be shared is described and includes, among others, health risks (for instance communicable diseases), suicide risk management and social and safety risks ¹⁴⁷.

In this Protocol framework:

*“Both SPS and NHS Boards are under a Duty of Care to look after prisoners under their care. This Duty of Care provides the legal basis for the partners to share prisoners’ personal information **without** obtaining their consent where relevant and appropriate. Only the **minimum necessary** personal information consistent with the purposes set out in this document will be shared. Sensitive information shared will be the minimum required for the intended purpose”* ¹⁴⁷.

Prisoners must be informed about those information sharing processes and about their rights.

Health related information is to be treated as “*sensitive personal data*”.

The “*arrangements for the use and sharing of patient identifiable information across all NHS Scotland organisations*” are overseen by the so-called “Caldicott Guardians”, whose work is legally subject to the Data Protection

Act 1998. The Caldicott principles – also applying in prison settings – are the following ¹⁴⁷:

-
- Principle 1 - Justify the purpose(s) for using confidential information
 - Principle 2 - Only use it when absolutely necessary
 - Principle 3 - Use the minimum that is required
 - Principle 4 - Access should be on a strict need-to-know basis
 - Principle 5 - Everyone must understand his or her responsibilities
 - Principle 6 - Understand and comply with the law
-

In HMP Barlinnie, a system of “health care medical markers” was in place to ensure that specific needs or potential urgent action to be taken regarding some medical conditions were known by the non-healthcare staff. Those markers were registered in electronic prisoners records and noticed in writing to the relevant Hall staff, “*without breaching confidentiality*” ⁸⁹.

The NHSGGC HCNA mentions the fact that “*clinic lists are also posted on sharepoint for SPS staff to check*” ⁸⁹.

4.3.8 Prisoners' complaints

As defined in the MoU between the SPS and the NHS, healthcare related complaints are under the responsibility of the NHS, the SPS being responsible for non-health care related complaints ⁷¹.

“Arrangements for handling and responding to patient feedback” or complaints are specified in the Patient Rights (Scotland) Act 2011 ¹³⁶.

Regarding healthcare related issues, after having been through the NHS complaint procedure, if the complainant is not satisfied with the answer received, he can send a complaint to the Scottish Public Services Ombudsman (SPSO). Information leaflets about prisoners complaints and the prisoner complaints forms are available on the SPSO website^{uu} ¹⁴⁸ and

^{uu} Prisons complaints website: <http://www.spsso.org.uk/prison-complaints>



can be requested for in prisons ¹⁰³. The fact that the complaint process requires to fill in a form, therefore excluding people facing literacy issues, was underlined during the round-table hosted in the Parliament in 2013 ¹⁰³. The SPSO provides an Advice phone line freely and confidentially accessible for prisoners ¹⁴⁸.

4.3.8.1 *Detainee's choice of medical care givers*

Few specific data have been found regarding this issue. It does appear that most of the prisoners have no choice regarding medical care givers ⁸⁹. However, untried and civil prisoners^{vv} are entitled to ask the prison Governor for access to private medical and dental care, for which the NHS would not hold any responsibility ¹⁰⁷.

4.3.9 *Financial aspects*^{ww}

4.3.9.1 *Health coverage in prison*

The NHS funding depends on general taxation (for the main part) and on National Insurance Contributions, both levied by the UK Government. The aim of the NHS is *“to provide access to health care to all residents, irrespective of their ability to pay”*. Hence, all UK ordinary residents are entitled to health care under the NHS in Scotland and most of the services are free at the point of use. Access to health care for “overseas visitors” is subject to specific regulations and basically covers emergencies ⁷³.

Free access to the GP in the UK, including Scotland, is based on a registration to a GP practice on a geographical basis ⁷³. Prisoners serving sentences of more than six months are fully registered with the Prison Practice and deregistered from their community practice ¹²³. Prisoners serving sentences of less than six months usually stay registered with their

community practice, unless there is a clinical need to fully register them with the prison practice ¹⁰³.

4.3.9.2 *Health delivery costs*

At the time of the transfer, funding for the provision of healthcare in prison was allocated to NHS Boards “on a historic spend basis”. A budget review was conducted in June 2012 by the Scottish Government Finance Department, which concluded that the funding provided was adequate ¹⁴⁹.

In the community, resources for hospitals, health services and GP prescribing are allocated and divided between the 14 regional NHS boards according to a “resource allocation formula” ¹⁵⁰. However, the calculation of funding according to this formula would not be appropriate regarding prison healthcare. Indeed, it essentially allocates resources based on the population of the different health boards while some NHS boards host prisoners from across NHS Boards boundaries as nine of the 14 NHS boards have prison(s) on their territory. Therefore, as mentioned, prison healthcare budget was first an estimation and is now included in the baseline funding of the NHS Boards, without making use of the allocation formula^{xx}.

During the parliamentary review process, a financial review was undertaken as well, focused on costs for NHS Boards during the five months following the transfer. The Scottish Government had *“allocated funding of £8,961,000 for prisoner healthcare services for 1 November 2011 to 31 March 2012”*. The approximate average cost per prisoner for this period was estimated on the basis of the national prisoner population statistics for 2011-2012 and was £1,048. Provisional budget allocated to regional Health Boards and actual costs were compared and laid as described in Table 14. On the whole, *“the baseline funding provided to NHS Boards to support the transfer [...]”*

^{vv} Civil prisoners represented one single person among the prisoners population for the year 2013-2104 ⁶⁸

^{ww} Audit Scotland should have conducted a review of the financial implications of the transfer of responsibility from the SPS to the NHS by the end of 2016 (source: Audit Scotland)

^{xx} Source: Julie McKinney (on behalf of Christine McLaughlin) Directorate for Health Finance, The Scottish Government (by e-mail, April 2016)



[appeared] adequate at national level to support provision of existing services previously provided by SPS”¹⁵¹.

The full year forecast for 2012-2013 is presented in Table 15.

Table 14 – Provisional budget allocated to Health Boards (1 November 2011 – 31 March 2012)¹⁵¹

All figures £'000

	2011-12 5 months (1 November 2011 to 31 March 2012)			
	Budget	Actual costs	Variance	Variance (%)
Staff costs				
Nurses	2,767	2,727	40	1.4%
Other	1,737	1,615	122	7.0%
Sub-total	4,505	4,342	162	3.6%
Medical / Pharmacy costs				
Medical Services	1,174	1,088	86	7.3%
Pharmaceutical Services	222	226	(4)	-1.9%
Pharmaceutical Supplies	1,008	1,132	(123)	-12.2%
Dentist Fees and / or Salaries	286	306	(20)	-7.1%
Psychiatric Services	216	217	(1)	-0.5%
Other healthcare professionals	83	75	8	9.4%
Enhanced Addictions Casework	980	965	15	1.5%
Other	26	38	(12)	-48.5%
Sub-total	3,994	4,047	(53)	-1.3%
Other costs				
Rental of equipment	3	3	0	0.0%
Purchase of equipment	160	119	41	25.8%
Maintenance of equipment	44	41	3	7.3%
Clinical waste	22	19	3	13.1%
Depreciation	12	6	5	46.5%
IT	114	62	52	45.4%
Other	184	199	(15)	-8.0%
Sub-total	539	449	90	16.7%
Total costs	9,038	8,838	199	2.2%

Table 15 –Prisoner healthcare budget: 2012-2013 Full year forecast¹⁵¹

All figures £'000

	2012-13 Full-year forecast			
	Budget	Forecast costs	Variance	Variance (%)
Staff costs				
Nurses	7,728	7,841	(113)	-1.5%
Other	4,314	4,152	162	3.8%
Sub-total	12,042	11,993	49	0.4%
Other costs to NHS				
Agenda for Change	268	268	(0)	0.0%
Other	43	43	0	0.5%
Sub-total	310	310	0	0.0%
Medical / Pharmacy costs				
Medical Services	2,876	3,085	(208)	-7.2%
Pharmaceutical Services	1,376	1,311	64	4.7%
Pharmaceutical Supplies	1,848	1,988	(140)	-7.6%
Dentist Fees and / or Salaries	746	762	(16)	-2.1%
Psychiatric Services	553	553	0	0.1%
Other healthcare professionals	205	193	13	6.1%
Enhanced Addictions Casework	2,374	2,324	50	2.1%
Other	118	171	(53)	-45.2%
Sub-total	10,097	10,387	(290)	-2.9%
Other costs				
Rental of equipment	7	7	0	0.0%
Purchase of equipment	54	156	(103)	-190.6%
Maintenance of equipment	75	71	5	6.2%
Clinical waste	61	57	3	5.5%
Depreciation	53	44	10	18.0%
IT	312	268	44	14.2%
Other	219	224	(5)	-2.2%
Sub-total	782	827	(46)	-5.8%
Total costs	23,231	23,518	(286)	-1.2%



4.3.9.3 *Restrictions in health care delivery because of budgetary resources constraints*

The Scottish Government operates with a defined budgetary envelope. By definition, resources are limited. Few specific data were found on how this affects the delivery of healthcare in prison settings. However, different sources and experts report some limitations in care or medication provision linked to financial constraints.

Unmet needs regarding hepatitis C treatment in HMP Barlinnie and Greenock due to resource limits were raised (but not detailed) in the NHS GGGC HCNA ⁸⁹.

Regarding dental care, the NHSGGC HCNA reports under-resources services and substantial unmet needs, given the high demand and the poor dental health of prisoners ⁸⁹. It was specified during the first round-table session held by the Parliament that the NHS had decided to provide investment for additional dental sessions in Barlinnie ¹⁰².

Dr Campbell ^{yy} reports financial constraints in drugs budget at the Board level leading to issues in prescribing for GPs.

Beside this, according to Dr Campbell, “issues with GP recruitment and retention [are] partly due to remuneration” are also reported.

^{yy} Lead Clinician for Prison Healthcare within NHS GG&C and Chair of the NPHN Expert Advisory Group



5 SWITZERLAND

PRISON HEALTH IN SWITZERLAND: MAIN FINDINGS IN A NUTSHELL

- Switzerland has 114 prisons and 7 235 places, i.e. the average prison size is small. In 2014, 6 923 people were imprisoned in Switzerland (5 977 in 2004). This corresponds to an occupancy rate of 95.7%. 73% of inmates are foreigners, 4.7% are women (32 prisons in 2012), and 0.4% are minors (17 prisons in 2012). The detention rate is 85 per 100 000 inhabitants. The prison sector employed 4030 full-time positions.
- Switzerland is a **Federal State** composed of 26 cantons. Therefore, prison as well as healthcare system are framed by national, cantonal and inter-cantonal administrations and actors. This situation has led to the development of **local health systems** with different characteristics across the country ¹⁵², which includes the management of prison healthcare.
- Collaboration between prison and healthcare authorities differs from canton to canton. Although the principles of equivalence of care and independence of medical services are general, there are **two different main organizational models** in Switzerland:
 - Medical and nursing staff are in whole (German speaking Canton of Zurich) or in part (German speaking Cantons Solothurn, Bern and St. Gallen) employed **by prison authority or by justice**.
 - The whole medical staff is employed **by the health authority**^{zz} (like in the Vaudois and Geneva Cantons where **University** hospitals play a great role in healthcare organisation). Medical and nursing costs are covered by the LAmal insurance system.
- The SWOT analysis of the 2 collaborative models reveals that:
 - Although the first model facilitates close contact with patient and prison staff, the **lack of independency** of healthcare professionals and the **lack of healthcare strategy** and health staff management are obvious shortcomings. Financial restrictions that weighs on staff recruitment is a problem.
 - The second model, relying on the independency of healthcare professionals (no dual loyalty) should guarantee that **priority is given to medical decision** and confidentiality. **Attractiveness for medical staff is also deemed greater** because of opportunity for continuous, up-to-date training
- Innovations:
 - -A national interpreting phone service was created in 2011
 - -In Geneva, the prison medical service offers methadone maintenance treatments, distribution and exchange of needles and syringes for drug addicts, and distributes condoms
 - -Nurses have a gatekeeping function. They perform a health screening for each new inmate in the following 24 to 48 hours after admission, in order to identify health needs of prisoners requiring rapid medical attention or to ensure continuity of treatments
 - - HMT nurses and GP with local pharmacists have developed guidelines for prison staff facing "everyday problems" such as pain or small wounds
- Shortcomings:
 - Medications are distributed by security staff
 - There is a high number of consultation requests, which cannot always be honoured because of lack of transportation means or insufficient security staff
 - The transfer of information around the health of transferred prisoner is insufficient
 - The lack of trained professionals leads to the situations where medical tasks are taken by prison officers. That also undermines the principle of confidentiality and protection of professional secrecy.
 - The various medical stakeholders are not adequately trained for their mission.
 - Medical decisions are influenced by budget cuts (expensive drugs are not prescribed as treatment of hepatitis C, as well as preventive measures or vaccination). Not every detainee has access to health insurance, which leads to differences in care provision ¹⁵³.

^{zz} Source: SWOT analysis of the SPS



-
- Hindrances to extent the second model include prison staff fears to be cantoned in a repressive role and to lose control on the prisons, and healthcare professionals fears to add new functions and a new (unfamiliar) category of patients to their current workload.
-
- With regards to the delivery of healthcare in Swiss prisons, professionals are organized into associations and networks offering **practice sharing platforms**:
 - Conférence des médecins pénitentiaires suisses (CMPS): a forum for prison doctors regarding experiences with correctional partners, the authorities or political bodies
 - Académie Suisse des Sciences Médicales (ASSM),
 - Swiss Society of Forensic Psychiatry (SSPF),
 - Forum of prison nurses in Switzerland
 - Santé Prison Suisse (SPS): an interdisciplinary college, as well as the (first) national platform dealing with health issues in prisons in order to harmonize processes and patterns.

Guidelines produced by these associations and communication between actors are considered as important resources for a global enhancing of healthcare provision in prisons. For example, the **BIG Vade-Mecum** is a referential that proposes a framework of collaboration between the different involved actors (medical staff and prison staff) in specific situations (e.g. emergency, disease, drug, etc.) explaining the role of each one.

- The CAS (distance and continued education center) of the University of Geneva offers a one year continuing education certificate in health in prisons, to doctors, health professionals, social workers or other stakeholders in prisons. The training modules are: 1: legal and penal aspects, 2: prisons: organization and impact, 3: mental health and psychopathological aspects, 4: care, addictions and general internal medicine and 5: vulnerable populations¹⁵⁴. The Zurich University (ZHAW) offers another CAS about criminal law for persons working in this field.
 - Ambulatory or institutionalized health expenses are covered by health insurance in most cantons. Health insurance funds are private and detainees have the obligation to subscribe, as any other citizens. However, some cantons (Geneva) covers the health care cost directly via the HUG in the pre-trial setting and insures detainees in post-trial prisons. This decision was taken as most pre-trial detainees are undocumented migrants (65%) without health care coverage outside and the time of stay in pre-trial detention too short to evaluate effectively the insurance situation. In some cantons, the detainee has to auto-finance by his/her own means (franchise, quota, contributions to hospital staying costs) and other costs expenses that are
-



not covered by health insurance benefits (dental expenses, cost of glasses). If the inmate can't provide these costs on his/her own, in principle he/she is entitled to welfare benefits by performing a justified request to the competent organ of social assistance ¹⁵⁵.

- **Control bodies:**

- With regards to external control, the National Commission for the Prevention of Torture (Commission Nationale de Prévention de la Torture, CNPT) is an independent agency of the Confederation and the cantons, ensuring through regular visits and ongoing dialogue with the authorities, that the rights of detainees are respected. Through its concrete recommendations to the authorities, the CNPT contributes to the prevention of torture and inhuman or degrading treatment (153).
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5.1 General presentation of prison and healthcare system

5.1.1 Main actors

Switzerland is a Federal State composed of 26 cantons. Overall the latter enjoy a wide political autonomy, each of them having its own constitution, Parliament, government and courts¹⁵². Therefore, the Swiss government decides on strategic issues concerning health and justice. For the implementation, each canton has its own organizational and financial system. Therefore, prison as well as healthcare system are framed by national, cantonal and inter-cantonal administrations and actors.

5.1.1.1 Prison system

Regarding justice, the Swiss Confederation is responsible of the criminal law and procedures (Article 123 of the Constitution). The cantonal level is for its part responsible of the *“judicial organization, the administration of justice and the execution of sentences and measures”*¹⁵⁶.

The Confederation must ensure the conformity of justice practice with federal law and international law to which the country has committed. The Federal Office of Justice is the main actor in this field at the national level. As part of it, the Unit of the execution of sentences and measures is among others responsible for the funding of construction and restoration of custodial facilities for adults and minors, of pilot projects, and of the Swiss Training Center for Prison Staff (Centre suisse de formation pour le personnel pénitentiaire - CSFPP).

The organization of the cantonal criminal authorities falls within the competence of the cantons, which are required to execute the courts judgments. For that purpose, they can use establishments of open or secure custody, semi-detention facilities or external work. Separate sections for specific groups of prisoners can be organized by cantonal authorities, such as facilities for women or facilities dedicated to very long or very short sentences.

Whereas the cantons have the obligation of creating and running the custodial facilities, this obligation can be assumed jointly by different cantons, as all individual cantons are not in the capacity of running the different types of facilities necessary for the execution of sentences and measures. The 26 cantons organized themselves into three regional Concordats^{aaa} of execution of sentences and measures: the Concordat of Central and Northwestern Switzerland, the Concordat of Eastern Switzerland and the Concordat of Latin cantons. The cantons collaborate under the conventions agreed on within each of these concordats, which ensure a certain harmonization and coordination between the cantons. Collaboration can occur between the concordats as well, for instance in cases of imprisonment of women or young adults¹⁵⁶.

The collaboration between the cantons is also ensured through the Conference of Cantonal Justice and Police Directors (Conférence des directrices et directeurs des départements cantonaux de justice et de police, CCDJP).

The Permanent Committee of the CCDJP (the “Committee of Nine”), also ensures the cooperation and exchange of information between the concordats, notably by developing some common guidelines and non-binding recommendations¹⁵⁷.

With regards to external control, the Commission Nationale de Prévention de la Torture (National Commission for the Prevention of Torture, CNPT) is an independent agency of the Confederation and the cantons, ensuring through regular visits and ongoing dialogue with the authorities, that the rights of detainees are respected. Through its concrete recommendations to the authorities, the CNPT contributes to the prevention of torture and inhuman or degrading treatment¹⁵⁶.

5.1.1.2 Healthcare system

Political responsibilities in Switzerland regarding health are also shared between the Federal level (Federal Department of the Interior, Département

^{aaa} In Switzerland, a concordat is an agreement between several cantons; a set formed by several institutions²⁵⁴.



fédéral de l'Intérieur, DFI) and the Cantonal level (Cantonal Health Directors, Directeurs cantonaux de la santé) with respect to "*policy making, regulation and monitoring*". The cantons can also delegate a number of tasks to the communal level. On the whole, the cantons are very autonomous regarding the management of health on their territory. This situation has led to the development of local health systems with different characteristics across the country ¹⁵², which includes the management of prison healthcare.

Different instruments and institutions ensure the coordination between the Federal and the Cantonal levels, and within the cantonal level. The principal coordination instrument between the Federal and the Cantonal levels is the "Swiss health policy dialogue – permanent platform of the Confederation and the Cantons" ("Dialogue Politique nationale Suisse de la santé – Plateforme permanente de la Confédération et des cantons"), establishing a "*permanent and lasting dialogue*" between the parties ¹⁵⁸.

The Federal Office of Public Health (Office fédéral de la santé publique, OFSP) and the Federal Statistical Office (Office fédéral de la statistique, OFS), both being part of the DFI, also have a role to play in terms of coordination and collaboration. The OFSP represents Switzerland at the international level and shares with the cantons "*the responsibility of public health matters as well as the implementation of the national sanitary policy*"¹⁵⁹.

At the cantonal level, the Swiss Conference of the Cantonal Health Directors (Conférence Suisse des directrices et directeurs cantonaux de la santé) was created in 1919 to "*promote co-operation and common policies between cantons and in some cases, with the confederation*" ¹⁵².

With regards to the delivery of healthcare in Swiss prisons, professionals have organized into associations and networks offering practice sharing platforms:

- Conférence des médecins pénitentiaires suisses (Conference of Swiss Prison Doctors, CMPS), which the professional federation and representation of Swiss prison doctors. It is also a space of exchanges for prison doctors regarding experiences with correctional partners, the authorities or political bodies.
- Académie Suisse des Sciences Médicales (ASSM) and its central ethics committee which edicts standards and ethical guidelines for good medical practice in (prison) health care
- Société Suisse de Psychiatrie Légale (Swiss Society of Forensic Psychiatry, SSPF)
- Forum du personnel soignant des établissements de détention en Suisse (Forum of prison nurses in Switzerland):
- The purpose of the forum is to bring together the staff and to enable them to exchange about their practices by:
 - Defending and promoting the quality of health services as well as their specific and professional interests.
 - Increasing the awareness of the public authorities and executive bodies about the importance of skilled caregivers.
 - Developing standards and recommendations.
 - Organizing meetings.
 - Setting up collaborations with associations.
- Service National d'Interprétariat Téléphonique
- Santé prison Suisse (Health Prison Switzerland, SPS), an interdisciplinary college aiming to harmonize processes and patterns (cf. presentation below)



5.1.2 *Respective competences and collaboration frameworks*

Collaboration between prison and healthcare authorities differs from canton to canton. There is two different models (and a certain amount of 'submodels' – cf. Human resources) in Switzerland:

1. The whole medical staff is employed by prison authority or by justice (like in the German speaking Canton of Zurich) or the nurses are employed by the prisons, whereas the doctors are self-employed or employed by the health authority (like in the German speaking Cantons Solothurn, Bern and St. Gallen)
2. The whole medical staff is employed by the health authority^{bbb} (like in the Vaudois and Geneva Cantons where University hospitals play a great role in healthcare organisation).

5.1.2.1 *Strengths and weaknesses of the two models of collaboration*

Four persons have been asked to evaluate the models of collaboration in Switzerland by means of a SWOT analysis: Thomas Sutter from the Direction of Justice and Interior (Canton of Zurich), one person from the Santé Prison Suisse (this person required to stay anonymous), Dr Devaud from the CNPT, and Pr. Dr Wolff, head of the Service de médecine et psychiatrie pénitentiaires (Hôpital Universitaire de Genève) and member of the Conférence des Médecins Pénitentiaires Suisses, of the CPT and of the Central Ethics Committee de l'Académie Suisse des sciences médicales (ASSM).

Thomas Sutter comes from of a Canton where prison health care is still delivered under the responsibility of judicial authorities and he works in the Direction of Justice and Interior. He argues that the first model allows a close and permanent collaboration of all stakeholders involved, based on a greater communication. The person from SPS emphasizes also the fact that the first model facilitates close contact with patient and prison staff. According to these participants the equivalence of care principle is well-guaranteed.

However the SPS participant regrets that in this first model the prison authorities exert a control on medical staff as they are their employer and can influence the medical treatment by controlling finances. Regarding financial and human resources Thomas Sutter admits that there is an (negative) impact on waiting times, continuity and long-term perspective of healthcare where a doctor is not permanently present. The lack of sufficient places in hospital and psychiatric clinic is also emphasized as the separation between justice and health system in this first model requires complex negotiation and procedures between the stakeholders in this case.

Dr Devaud (CNPT) considers that the current financial restrictions that weighs on staff recruitment in this model might be an opportunity to switch for the second model. Indeed, she criticizes the first models because of the lack of nurse and medical knowledge, the lack of healthcare strategy and the lack of health staff management these models carries along according to her. She pleads for a harmonization at the federal level and for the adoption of the second model in the whole Switzerland.

The SPS interviewee as well as Pr Dr Wolff stress the independence of medical staff from prison authorities as the main advantage of the second model as it guarantees that priority is given to medical decision and confidentiality, reinforcing the detainees' trust in their doctor. The opportunity for continuous, up-to-date training of motivated, qualified and sufficient healthcare professionals is pointed as another great asset of the second model by SPS intervenant, Dr Devaud and Pr Dr Wolff. The latter also emphasizes "the stronger position for negotiating with judicial system and for the detection and reporting of violence by authorities". Finally Dr Devaud points that the second model allows the reimbursement of medical and (more importantly) nursing costs by the LAmal insurance system (see below) instead of being a financial burden for a penitentiary system under financial constraints and staff restrictions.

However, according to the SWOT analysis made by the Drr Devaud (CNPT), the process of harmonization towards the second model is threatened by fears of both the prison and the health partners. Doctor Devaud asserts that from the perspective of the penitentiary stakeholders there is a fear to be

^{bbb} Source: SWOT analysis of the SPS.



cantoned in a repressive role and to lose control on the prisons - a.o. by missing important information or by welcoming in the prison healthcare professionals without any experience of prison constraints - as well as to miss a form of professional valorisation linked to the delivery of nursing care. According to Dr Devaud, health stakeholders are for their part reluctant to add new functions and a new (unfamiliar) category of patients to their current workload. They are also circumspect about medical practice in the penitentiary environment^{ccc}. The “civil society demands for more security measures [and] revenge for the crimes committed” is also pointed by Pr Dr Wolff as a potential threat to good quality of healthcare provision in prisons.

The medical deontology provided by the ASSM, the scientific data and guidelines offered by the BIG project and the interdisciplinary work made by the SPS (see below) are considered as important resources for a potential reform and global enhancing of healthcare provision in prisons.

5.1.2.2 *Bridges between the two models of collaboration*

Beyond the differences between the two models of cooperation, collaboration between prison and healthcare services are framed in all the Cantons 1) by the principle of independence and equivalence of care promoted in particular by the Académie Suisse des Sciences Médicales (ASSM), 2) by a national interdisciplinary platform (the SPS), and 3) by some referentials (a.o. the BIG Vade-Mecum).

The guarantee of independence and equivalence of care

The Académie Suisse des Sciences Médicales claims that *“Irrespective of his particular conditions of practice, the doctor must enjoy a total independence from the police or prison authorities. His clinical decisions and any other evaluation regarding the health of detainees can be based only on strictly medical criteria. In order to ensure the independence of doctors working in police or prison facilities, any hierarchical or even direct contractual relationship between the latter and the institution should be avoided in the future.”*^{ddd} (Chapter 12 of the ASSM’s Guidelines).

In practice, doctors are exposed to a loyalty conflict between their professional duty to their patients and their duty to third parties, such as the prison authorities. It can be the case, for instance, in medical expertise situation or in case of treatment under constraint. Formal rules aiming to guarantee the principle of independence have been introduced in some Swiss prisons but this is not the case in all of them ¹⁵³.

Furthermore, according to the president of Santé Prison Suisse Dr. Bidisha Chatterjee, the collaboration of the prison and medical systems may lead to complications. She asserts in particular that the medical aspect is not a priority for judges and prosecutors. The two systems differ on their approach on how to assess the degree of seriousness and the degree of importance of a particular case. Following Dr. Bidisha Chatterjee, “The actors of the prison system have essentially a legal training and do not know about the medical subtleties. It is difficult to understand that prison care requires human and financial resources even if the person is only staying a few days in jail. GPs are perceived as outsiders. When health problems are less visible there is a misunderstanding on the part of prison authorities. Directors and detention officers know the importance of having a medical service but ignore its tasks: they have a wrong perception about quality of benefits, hours of work and costs of cares. Yet, doing an opening examination in the first 24 hours after admission of a prisoner permits to detect serious cases, avoiding it becomes worse, and saving considerable costs” (translated from 124).

^{ccc} Source: SWOT analysis (Threats) of Dr Devaud (CNPT).

^{ddd} Translation by the authors



According to the Directrice of Santé Prison Suisse (SPS)^{eee}, prison heads are not trained to evaluate the quality of health care, nor about the lack of medical staffs. Medical staffs also complain about a lack of communication with the prison heads. This lack of communication could lead to many departures of medical care givers ¹⁶⁰.

However, according to the ASSM, both principles of equivalence of care and independence can be respected if certain conditions are met^{fff}. Those conditions include appropriate infrastructure and resources, comprehensive care, a clear definition of tasks and responsibilities of each person involved in decisions regarding healthcare to prisoners, the professional independence of physicians (notably requiring pre-defined procedures “*in case of different opinions between health professionals and the prison authorities*”) and ensuring that every person involved in the prison administration “*is aware of the ethical and legal principles related to healthcare delivery in prison*” ^{153ggg}.

Annexes guidelines state that facing prison reality, it is necessary to have solutions for optimal working, with acceptable delegation possibilities complying with legal provisions ¹⁵³.

The BIG Vade-Mecum

This referential has been worked out in 2008 in a context of resurgence of infectious diseases. It is described later in this report (see below). It proposes a framework of collaboration between the different involved actors (medical staff and prison staff) in specific situations (e.g. emergency, disease, drug, etc.) explaining the role of each one ¹⁶¹. This partnership acted as a precursor of the collaboration framework initiated by the SPS.

^{eee} B. Chatterjee 's internist, and became a prison doctor in 2006 since 2008 she teaches at the Centre Suisse de formation pour le personnel pénitentiaire and she is part of the Swiss prison doctors committee. She was elected President of the SPS in 2012.

^{fff} No information was found about the extent to which these conditions are met in reality.

Santé Prison Suisse (SPS)^{hhh}

SPS is indeed the product of the BIG projectⁱⁱⁱ. Under the authority of the Conference of Directors of Cantonal Justice and Police (CCDJP) and the Swiss Conference of Cantonal Directors of Health (CDS), SPS is an interdisciplinary college, as well as the (first) national platform dealing with health issues in prisons in order to harmonize processes and patterns. Since 2014, SPS is being piloted for two years. It is subordinated to the Commission for the execution of sentences and detention facilities (Committee of Nine) and the directors of health (CDS).

The innovation lies in the fact that it is a national organization composed of representatives from different professional fields ¹⁶². The 12 members come from both the prison (Federal Office of Justice, Conference of Cantonal Prison Service, Federation of deprivation of liberty establishments Switzerland) and Health areas (Federal Office of Public Health, Association of Cantonal doctors in Switzerland, Conference of Swiss prison doctors, Forum of Prison Caregivers in Switzerland).

The objectives are 1.harmonizing care in prisons by setting minimum standards; 2. creating and maintaining an interdisciplinary dialogue between health professionals and prison. This, through: 1. uniform and accessible information; 2. protocols (medical, ethical, and organizational standards); and 3. consensus solutions. The Website is an interdisciplinary platform for discussion and identification of needs among professionals. SPS doesn't provide any health care in prison ¹⁶³.

The SPS is in progress. It is framing a network between health and prison stakeholders on five levels (see hereunder). The level 1 (policy) and the level 2 (professional associations) are already linked thanks to the composition of the SPS College (organizational affiliations). The level 3 is then the priority

^{ggg} Translation by the authors

^{hhh} Website of Penitentiary Health Switzerland <https://sante.prison.ch/fr/>

ⁱⁱⁱ Bekämpfung von Infektionskrankheiten im Gefängnis”: fight against infectious disease in prison. See section 3.6.2 “Guidelines for more details”.



of the SPS, as the platform aims not only to network SPS itself with the establishments, but also to connect establishments to each other. Each prison should have at least one interlocutor about health. Level 4 is about an enhanced integration of specific research topics in the future. Level 5 (international) is a perspective on long term.

5.1.3 Historical perspective

At the federal level, by the 90s, in the context of the AIDS epidemic but also transmission of hepatitis through blood way, the Federal Office of Public Health began to get involved in prison health. It has supported pilot exchange detention syringes projects and expansion of treatment with heroin. In 2005, studies have been commissioned and alarmed the authorities about prison health situation. In 2008, the BIG project was launched by the Federal Office of Justice and the Cantonal Justice and Police Departments. From there, SPS has been created¹⁶³.

Besides the federal policies, we will focus below on the process of reform in the Canton of Geneva. As mentioned earlier, there are indeed two different models of collaboration between prison and healthcare authorities in Switzerland. The Canton of Geneva has the appearance of a precursor of the second one where the whole medical staff is employed by the health authority^{jjj} and the prison health care system is independent of the cantonal justice.

5.1.3.1 Timeline

Table 16 – Switzerland - Timeline

Timeline	Main events (Federal)	Main events (Canton of Geneva)
1963		Creation of the of the first independent medical unit in prison, which was affiliated to the University of Geneva
90's	<ul style="list-style-type: none"> • Epidemic of AIDS and hepatitis transmission • Beginning of the Federal Office of Public health involvement • Exchange syringes pilot project and expansion of treatment with heroin in prison 	
2000		executive regulation on the organization and obligations of prison medicine in the Canton
2005	Some studies about health in prison take place	
2008	BIG Project: fight project against infectious disease in prison	
2014	SPS: national platform dealing with health issues in prisons in order to harmonize processes and patterns.	

^{jjj} Source: SWOT analysis of the SPS.



5.1.3.2 The Health Mobile Team of the Geneva University Hospitals

Historical framework

From 1963 to 2004, the University Institute of Legal Medicine in Geneva (IUML) was responsible for prison medicine in the canton of Geneva. Until 1998, the IUML was directly attached to the cantonal department of health. Then it became part of the University Hospital of Geneva, in the Department of Community Medicine, leaving prison medicine under the responsibility of the cantonal department of health. At that time in Geneva, legal medicine comprised forensic pathology, toxicology and psychiatry, prison medicine, health law, and medical ethics. The directors of the IUML and their collaborators initiated in the 70's academic activities on health law and ethics in prison health care. In her examination of the legal framework for prison medicine in the canton of Geneva, Elger¹⁶⁴ notes indeed that these collaborators "have engaged in the Council of Europe's drafting of recommendations on the ethical and organizational aspects of health care in prison and served as members or experts for the CPT (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment)". Besides, a prison medicine center was created in 2007 by the University Hospital. This center was attached to the Department of Community and Primary Care Medicine and to the Department of Psychiatry, of which the heads of service became responsible for prison primary care and psychiatric care programs¹⁶⁴.

IN 2008 the unit of penitentiary medicine of the Geneva University Hospitals (HUG) was mandated to re-organize and provide health care in all prison facilities of the canton. According to Rieder, Casillas, Mary, Secretan, Gaspoz & Wolff^{165kkk}, "up until 2008, prison health care had been organized in a variable and inconsistent manner: some prisons employed a nurse and/or a physician, while others had only the community emergency system as a resource. After an internal review between the local government, HUG

and the Geneva penitentiary office, the involved stakeholders deemed that the prison health system was currently insufficient and needed re-organization^{III} [...]. The purpose of coordination was to standardize prison health care activities in the whole canton, in order to achieve more consistent adherence to prison health guidelines and unit congruence regarding health-services offered". The geographical nearness and small size of Geneva's detention centres have been considered in this context as favourable conditions for the implementation of a health mobile team (HMT). Today, the penitentiary medicine unit is managed by the HUG, which is independent of prison administration and organized according to cantonal law, in compliance with recommended standards¹⁶⁵.

Facilitators and assets

According to B.S. Elger, Professor at the University Center of Legal Medicine of Geneva and Lausanne, "prison medicine in Geneva is noteworthy for two reasons: firstly, it is university-based; secondly, Geneva, is the world capital of human rights and the city where Jacques Bernheim developed the first prison medical service independent of prison and judicial authorities. Subsequently to the Geneva Declaration of 2012^{mmm} on health care in prison, cantonal laws and executive regulations were created. They now provide the legal basis for maintaining these standards and the organizational structure of prison medicine in Geneva"¹⁶⁴.

In Elger's opinion, the creation of the legal framework in Geneva was facilitated by several factors:

"Institute of Legal Medicine leaders' interest and work in prison health care and human rights.

Leaders in prison health for Geneva were engaged with the Council of Europe level, in the CPT for example, permitting a direct exchange of ideas.

^{kkk} These authors are hospital-based physicians in the Unit of Penitentiary Medicine, Geneva University Hospitals and University of Geneva,

^{III} No further detail was available about the reasons and objects of this re-organization process.

^{mmm} For further details, see http://www.hug-ge.ch/sites/interhug/files/structures/medecine_et_psychiatrie_penitentiaires/documents/declaration_de_geneve_fr.pdf.



In Geneva, for many years a university-based, comprehensive prison medicine team, including psychiatry, provided services to prisoners, rather than isolated practitioners. The attachment to the University assures independence and respect from the prison administration and judicial authorities.

Based on their expertise in health law, the directors of the Institute of Legal Medicine wielded significant influence on new cantonal laws related to health, including medical care for prisoners.

[...] Jean-Jacques Gautier, a banker who initiated the European CPT, worked in Geneva, a city with a humanitarian "spirit" rich in UN organisations, the International Committee of the Red Cross (ICRC), and NGOs active in the human rights domain"¹⁶⁴.

Legal framework

The legal framework in Geneva relevant to prison health care includes different cantonal laws and recommendations, which were progressively established over several decades^{164,166}. Article 30 of the "règlement sur le régime intérieur de la prison et le statut des personnes incarcérées" regulates "Medical control and hospitalisation". It stipulates that "the detainee undergoes a medical examination: a) at his request; b) if his health status causes a danger to him/herself or to others". It goes on to say that "in the case of emergency or medical necessity, a detainee can be transferred to the university hospital or to the psychiatric inpatient unit". Since 2000, these different regulations are summarized and supplemented in a detailed executive regulation which has the legal status of a decree of the State Council¹⁶⁶.

It refers directly to European soft law: the State Council decided that the organization of correctional health care in Geneva must follow the relevant recommendations from the Council of Europe. According to Elger¹⁶⁴ "The

State Council decree names and describes in detail the medical institutions responsible for delivery of health care to prisoners in Geneva, all under the responsibility of the department of health. All the medical units are part of the University Hospital". It also stresses that "prison medicine in Geneva must guarantee detainees access to therapeutic and preventive health care"ⁿⁿⁿ and describes in detail the way in which this should be done" (Ibidem).

In the author's opinion, the importance of the decree lies in the fact that it provides not only principles but also a very detailed description of measures, including preventive health care measures, and health care structures to be implemented under the responsibility of the cantonal department of health¹⁶⁶.

Independence

Medical independence is considered by Pr. Hans Wolff as "the most fundamental principle in prison health care as it is the most powerful tool to limit dual loyalty"^{ooo}. According to Elger¹⁶⁴, "Professional independence is achieved through complete separation of "power". The members of the prison administration and correctional officers are employed by the cantonal department of justice and police, which is responsible for correctional institutions. In contrast, the health care system, including the prison medicine units, is a part of the University Hospital of Geneva - a completely different hierarchy under the responsibility of the cantonal department of health".

This author asserts that the decree provides guarantees to the health personnel in case of future conflicts with the prison administration or judicial authorities: as a result of the implementation of an annual surveillance by the directorate general (meeting) and the cantonal government (report) the highest political structures are liable with respect to prison medicine¹⁶⁶.

ⁿⁿⁿ "Detainees are granted access to materials necessary to prevent the transmission of infectious diseases, including condoms and injection devices (syringe and needle exchange). The decree obliges the prison medical service to tell the prison director about conditions that might influence the health of detainees, including conditions related to nutrition, hygiene, and the

environment more generally. The decree also assigns to the medical personnel the task of regularly disseminating information about infectious diseases to detainees and prison personnel, especially about hepatitis, HIV, tuberculosis, and dermatological diseases"¹⁶⁴.

^{ooo} General comments on SWOT analysis.



However, according to Rieder *at al.* ¹⁶⁵ “independence” does not mean “avoidance.” Regular planned meetings between health care providers and prison directors are organized, where they jointly monitor and discuss any complicated cases that need special attention.

Geneva prison health reform was aiming “to guarantee prisoners access to a type of medical care that was independent of the judicial system and equivalent to the care provided to the general population”, including prevention and promotion of health according to the European CPT rules ¹⁶⁵. Three years after the creation of the HMT, according to Rieder *and al.* (2013), the following goals had been reached ¹⁶⁵:

“1. Access to a doctor is now guaranteed in every prison, regardless of the crime and socioeconomic status of the person.

2. Equivalence of care is fully observed (for example, whereas no patient had received antiviral hepatitis treatment before, four individual patients have now received antiviral therapy for hepatitis C since the HMT’s inception).

3. Patients consent and confidentiality is adhered to.

4. Preventive health care is offered on a wide spectrum with novel universal prevention programs [...]

5. Humanitarian assistance: the HMT advocates for populations with a history of vulnerability.

6. Professional independence.

7. Professional competence: health care is provided for by prison medicine experts, employed by the community’s central HUG health system.”

5.2 Characteristics of the prisons and prisoners

Switzerland has 114 prisons and 7235 places. In 2014, 6923 people were imprisoned in Switzerland (5977 in 2004). This corresponds to an occupancy rate of 95.7%. 73% of inmates are foreigners, 4.7% are women (32 prisons in 2012 ¹⁶⁷), and 0.4% are minors (17 prisons in 2012, ¹⁶⁷). The detention rate is 85 per 100 000 inhabitants. The prison sector employed 4030 full-time positions ¹⁵⁶.

5.2.1 Facts and figures

5.2.1.1 General characteristics of prisoners

Table 17 – Switzerland – Characteristics of prisoners

	2000	2015
Adults		
Number of prisons	145	117
Number of seats	6 610	7 343
Number of seats for 100'000 inhabitants	92	89
Occupancy rate	85.7%	93.7%
Number of detainees		
Total	5 663	6 884
Females' rate	6.4%	5.4%
Foreigners' rate	No data (2004:70.7%)	71%
Minors' rate	1.3%	0.3%
Kind of detention		
Preventive detention ^{PPP}	1 811	1 849

^{PPP} According to the Code of Criminal Procedure:” Pre-trial detention begins when the coercive measures court ordered and ends when the indictment is notified at the court trial, and when the accused begins to serve his custodial sanction prematurely or is released during the investigation.”.



Anticipated execution of a sentence ^{qqq}	539	876
Execution of a sentence	2 840	3 673
Coercive measure according to the aliens act	308	316
Another reason for detention	165	170

Source ¹⁶⁷

Table 18 – Switzerland – Age of detainees

	1984 AV*	1984 Rate	2014 AV	2014 Rate
<20	266	2.6%	352	3.8%
20-24	2'291	22.4%	1 650	17.9%
25-29	2'449	23.9%	2 046	22.2%
30-34	1'790	17.5%	1 629	17.7%
35-39	1'233	12%	1 096	11.9%
40-44	867	8.4%	915	9.9%
45-49	572	5.6%	654	7%
50-59	598	5.8%	692	7.5%
60+	160	1.6%	190	2%
Total	10'226	100%	9 224	100%

*Absolute Value; Source: ¹⁶⁷.

5.2.1.2 Nationality and residence status

Table 19 – Switzerland – Nationality

Only the nationalities with more than 100 individuals were selected in 2014.

	1984- AV*	1984- Rate	2014 - AV	2014 - Rate
Swiss	8 020	78.4%	2 879	31.2%
Algeria	34	0.3%	584	6.3%
Romania	9	0.08%	438	4.7%
Tunisia	73	0.7%	337	3.6%
Serbia	351	3.4%	336	3.6%
Nigeria	/	/	320	3.4%
Morocco	22	0.2%	291	3.1%
Italy	490	4.8%	252	2.7%
Albania	/	/	238	2.6%
Kosovo	0	0	227	2.4%
Portugal	44	0.4%	208	2.2%
Guinea	0	0	196	2.1%
Germany	201	1.9%	174	1.8%
France	206	2%	165	1.79%
Turkey	108	1%	159	1.7%
Gambia	0	0	119	1.29%
Macedonia	/	/	107	1.16%
Other	668	6.5%	2 194	23.8%
Total	10'226	100%	9'224	100%

*Absolute Value; Source: ¹⁶⁷

^{qqq} According to the Code of Criminal Procedure: "The direction of the procedure may allow the accused to run prematurely a custodial sentence or a measure involving deprivation of liberty if the stage of the proceedings so permits."



Table 20 – Switzerland – Number of inmates by type of detention and residence status

	2010 AV*	2010 Rate	2014 AV	2014 Rate
Preventive detention				
Total	1 894	100%	1 892	100%
Swiss	352	18%	367	20%
Foreign permanent resident population	411	22%	345	18%
Person in the asylum process	98	5%	98	5%
Foreigners: other and unknown	1 033	55%	1 082	57%
Execution of sentences and measures				
Total	3 839	100%	4 583	100%
Swiss	1 380	36%	1 463	32%
Foreign permanent resident population	889	23%	951	21%
Person in the asylum process	451	12%	727	16%
Foreigners: other and unknown	1 119	29%	1 442	31%

*Absolute Value ; Source: ¹⁶⁷.

5.2.1.3 Duration of imprisonment

Along with the decrease of the incarceration rate, the length of custodial sentences declined in Switzerland over the years (figures: 1985-2004):

- The total number of prison sentences up to 6 months decreased from 8'968 in 1985 to 3'730 in 2004, which is a decrease of 58%. If this trend also applies to Swiss citizens detained (76% decrease), however, the number of foreign nationals detained in Switzerland for less than 6 months increased by 10%;
- If the number of custodial sentences of 6 to 18 months who were actually executed went also down for the entire prison population (917 in 1985 to 625 in 2004, a 32% decrease) and for Swiss national prisoners (66% decrease), however, the number of foreign nationals

detained in Switzerland between 6 and 18 months increased by almost 40%;

- Similarly, while the total number of prison sentences of longer than 18 months decreased (413 in 1985 to 321 in 2004, a decrease of 22%), including for Swiss citizens detained (decrease 62%), there was a 57% increase in the number of foreign nationals detained in Switzerland for more than 18 months.

The rise of the incarceration rate only concerns foreign prisoners (16.5% between 1985 and 2004, while in the same period, the incarceration of Swiss detainees fell by 75%). This is especially downstream of the penal system that foreigners undergo harsher penalties and more effectively stay in prison. Indeed at the stage of the police, the proportion of foreign suspects recorded increased by 86% between 1985 and 2004; before the magistrates, the proportion of foreign prisoners has increased by 75%, while finally in Swiss prisons, the share of foreign prisoners has increased by 152% during the twenty year period ¹⁶⁸.

Table 21 – Switzerland – Duration of imprisonment

Duration	1985	2004	Global evolution	Evolution for swiss inmates	Evolution for foreign inmates
Less than 6 months	8 968	3 730	-58%	-58%	+10%
Between 6 and 18 months	917	625	-32%	-66%	+40%
Longer than 18 months	413	321	-22%	-62%	+57%

Source: ¹⁶⁸



5.2.1.4 Internment

Of the 144 internees at the end of 2013, 97% were men; ¼ were foreigners. Most were between 45 and 54 years old; 15 more than 65 years.

Table 22 – Switzerland - Interned detainees in Switzerland

2006 Old code	2013 New Code	2014
229	144	137

Source: ¹⁶⁹

On July 2015, the Federal Council published a report on internment in Switzerland. It is based on data collected by the Federal Statistical Office (OFS), by the Conference of Principals of Cantonal Justice and Police (CCDJP), and by the cantons. Besides the fact that the cantons give very little information, data from the CCDJP do not always agree with those of the OFS. Fluctuations may come from the fact that the status of some detainees has changed or because they have been transferred.

AC Menétrey-Savary mentions that with the transition from the old to the new Penal Code, the number of sentences to internment has felt, data from the Federal Council's report confirms this trend. Indeed, while there were 229 internees in Swiss prisons in 2006, there were more than 144 at the end of December 2013, of which 117 were former internees, under Articles 42 or 43 of the former code, whose continued detention had been decided in 2007.

The Federal Council's report does not say much about the conditions of detention of internees. The execution of sentences is under the responsibility of the cantons. Therefore, the Confederation does not have any data on the procedures for the execution of internment. Some of these detainees are in the "executing entities measures" but it is not clear what the term exactly covers. Internments numbers here are those of the CCDJP, dating from September 2014, and they report 137 internees (rather than 144), which surprises since no release of internment has been imposed since entry into force of the new code in 2007. However, it appears from these data that the vast majority of the internees are in closed prisons (112 of 137), while 25 of them have an open regime ¹⁶⁹.

5.3 Delivery of care

5.3.1 Introduction

Prisons are managed by 25 cantons (out of 26 cantons). The prison health care system in Switzerland depends on various stakeholders. Prisoners' access to health care is under the responsibility of the cantons (or even of the penitentiary institution in some cases) that organize and regulate medical and nursing services within their respective institutions. The complexity of cantonal structures and fragmentation in small detention units make difficult the application of national and international guidelines and rules ¹⁷⁰. Quality of care also depends on the number of detainees¹⁶².

5.3.2 Availability

There is no official or generalizable data about prison healthcare in Switzerland because this is a cantonal competence so that there are as many organizational patterns as cantons. SPS is building a health care database for each prison. 24 prisons have already answered the questionnaire and 9 prisons are doing it. The questionnaire aims at getting a global view and identifying some divergences. Each institution will receive a data sheet summarizing the main data regarding the prison¹⁷¹.

5.3.2.1 Organisation of Health services

Prison health care system is independent of the cantonal justice in four French-speaking cantons: Genève, Neufchatel, Valais and Vaud. In Genève and Vaud, services are organized by university hospitals. Neuchâtel and Valais have followed these models. This organization is quite new (2015 for NE, about 10 years ago for VS). (Source: Pr. Dr. Wolff by phone)

In some cantons, most GPs work in their own practice and they work in prison one or two half days a week. In other cantons however (Bale, part of Argovie, Thurgovie) the cantonal medical service provides health care inside prison. In some cantons (Bern and Zurich) GPs are employed by the Justice Department (Source: SPS President by mail).

People with a mental health problem are treated by a forensic psychiatry staff, responsible for directing therapies in a judicial context.



5.3.2.2 Human resources

The above-presented two different models of cooperation between prison and health authorities allowed the development of five ‘submodels’ of human resources organisation. In the first three situations described, prison health care is delivered under the responsibility of judicial authorities. In the fourth and fifth situations, health care is organized independently.

Medical Service of Pöschwies Prison - ZH (Canton of Zurich in German-speaking Switzerland, 450 prisoners)

The medical service is organized as any doctor's practice, headed by the chief doctor, who himself is under the responsibility of the prison director. It has three physicians (2 full-time jobs (FTJ)), two dentists (0.80 FTJ), five medical assistants (4.3 FTJ), two medical masseurs (0.6 FTJ) and two medical secretaries (0.5 FTJ). The medical service is constantly present, ensures emergencies, and supports inmates, as well as employees and visitors. Psychiatric services are provided by the department of psychiatry and psychology of judicial enforcement office of the canton of Zurich. According to the chief doctor, the equipment in place is sufficient for basic care. If necessary, further treatment (as examinations and treatments) is achieved in two hospitals ¹⁷⁰.

Health Service of the cantonal office of execution of sentences in Solothurn - SO (German-speaking Switzerland, 180 seats)

Inmates from the three institutions of the Canton of Solothurn are supported by a common health department under the responsibility of the cantonal office of the execution of sentences. A GP referent is present on part time in each prison. He carries out regular hours of consultation. About psychiatric cares, a hospital department holds a weekly consultation, or longer if necessary, in each prison. The substitute chief of the service referred to as "ambulatory", offers both light support (cuts) and heavy (reanimation). The medical service has 10 nurses (840%), each working on the three sites ¹⁷⁰.

Health Service of the of Altstätten Prison - SG (Canton of St. Gallen in German-speaking Switzerland, 45 seats)

The health service is managed by a nurse. A doctor's consultation is provided one afternoon a week, based on a previous fixed appointment. There is also a medical assistant (part time), a psychiatrist, and an additional nurse. The team is sufficiently large according to the practitioner. Emergencies are ensured by the practitioner, or by the regional emergency medical services. The practitioner also stipulates that most health problems are solved on the spot. And when this is not the case, they are referred to specialists or sent to the hospital ¹⁶².

Table 23 – Switzerland – Three healthcare services in short

	ZH	SO	SG
Number of establishments	1	3	1
Number of detainees	450	180	40-50
Number of GPs	3 (200%) 2 dentists (80%)	3 (currently 1 part time/establishment: consultations and emergencies)	1 part time (consultations and emergencies)
Number of psychiatrists	Inside service of psychiatry and psychology	3 part time for all establishments	1 part time
Number of graduated nurses	/	10 (840%)	1
Number of medical assistants	5 (430%)	/	1 part time
Presence of medical service	24hours/24, 365days/year (with post service)	7 days / 7	During the week, from 7 am to 16:30 pm

Source: ¹⁷²



P. Ullrich^{162 172} has interviewed the managers of these three first models in question about the advantage of their respective prison health care organizations.

These health services present the following advantages:

- A large and well-equipped service solves most problems on the spot.
- Qualified staff provides quality care.
- Sufficient size team can exchange and discuss issues.
- Collaboration with external specialists in a regional network.

The Medicine and Psychiatry Prison Service (SMPP) of the Vaudois University Hospital (+/- 900 detainees)

The Medicine and Psychiatry Prison Service (SMPP, Service de médecine et psychiatrie pénitentiaires) of the Vaudois University Hospital provides care services in the five facilities in the Canton of Vaud (western Switzerland) (outpatient nurses, somatic and psychiatric). It was created in 1995 by the political authority of Vaud. It depends of the University hospital of the canton¹⁷³. The service is also composed of two psychiatric units that support patients who are sent there for a while and patients on release with a mandatory monitoring imposed by justice. The SMPP also provides services in the police stations in the Canton of Vaud, where detainees are kept waiting for a place in prisons, sometimes up to 30 days. Many elective consultations require a transfer either to the hospital or to the Vulnerable Populations Unit of the hospital. The presence of a nurse is ensured during weekends.

Table 24 shows the evolution of the SMPP medical activity. Between 1997 and 2003, the prison population's rate was stable. In proportion of the admissions number, the number of intake examination has slightly decreased. GPs' consultations number has decreased to eighth whereas nurses' consultations have increased following almost the same proportion. Findings are the same about the quantity of hospitalizations that have decreased in favor of external consultations. The biggest change is at personal pharmacy level with an increase of almost three times¹⁶².

The health mobile team (HMT) of the Geneva University Hospitals (HUG)

Detention facilities in Geneva were considered too small to justify full-time local health teams at each site. Thus a mobile team was a fitting solution. A part-time, mobile, and easily accessible health team was set up to respond to prisoner health problems without requiring the continued presence of a doctor or a nurse. Because of their small sizes and the short travelling distances in the canton, the HMT was accepted as the best option. Indeed, it required less staff and equipment and allowed the communication of information between team members and coordination among the facilities thanks to its central structure. The HMT is multidisciplinary, composed of nurses, a GP, a psychiatrist, a psychologist, and a secretary. Access to dental care is also ensured through close collaboration with the dentists of Champ-Dollon. The team collaborates with the prison social workers, while maintaining professional confidentiality.

Nurses have a gatekeeping function. They perform a health screening for each new inmate in the following 24 to 48 hours after admission, in order to identify health needs of prisoners requiring rapid medical attention or to ensure continuity of treatments. For other consultations, patients are referred to health professionals within the HMT if deemed necessary by the nurse performing the entrance examination. If a specialist consultation is required, patients are referred by the GP.

The team works from Monday to Friday, from 7am to 6pm. It is based in the largest facility and visits the other facilities on a regular basis (pre-appointed days) with a frequency proportionate to each one's size and according to acute need. An interpreting service is used when needed¹⁶⁵.



Table 24 – Switzerland – Vaud Canton Prisons: evolution of the SMPP performances between 1997 and 2003

Number of	1997	2004
Detainees	2381	2568
Admissions	1837	2088
Detainees having an intake examination	1334	1273
Detainees having minimum one medical visit during the year	/	1553
GP or intern consultations	4083	3452
Nurse consultations	12600	15590
External consultations	389	491
Hospitalisations	94	48
Intake lung radio	588	453
Personal Pharmacy distributed	598	1677

Source: ¹⁷⁴

According to Pr. Dr. Wolff, Vaud and Geneva independent systems are much more attractive for well-trained doctors because they remain in the (public) health sector even when working in prison. The significant benefits of these systems are:

- Stability of personnel and good communication.
- Integrated dimension of medical services (SMPP) requires staff to be multipurpose and qualified.
- The academic affiliation helps in destigmatizing the prison environment with students because the prison context attracts really few professionals. It also guarantees the independence from the judicial and prison authorities, maintaining good collaboration with them. This affiliation also allows benefitting from the support of health actors (development, access to resources, monitoring procedures). This ensures the practice of medicine standards compliance.
- The assembling of somatic and psychiatric care in a single service allows links and viewpoints exchanges.

- Centralized organization in a hospital gives staff a career guarantee, because they can also change service if required. In terms of management, benefits are on invoice level, interface with health insurance, pharmacy, human resources, purchasing and management.

5.3.2.3 *Restrictions in health care delivery because of human resources constraints*

It is also more difficult to find health care workers in prisons rather than in ordinary hospitals, with the added difficulty of the particular prison context and the different provision of training, even if the workload is identical in and out of the prison (as a reminder, the occupancy rate in Swiss prisons doesn't reach 100%). But in comparison with ordinary hospitals, nurses have more responsibilities and they have to manage a wider range of cases and diseases. (Source: President of SPS by mail)

The health staff sometimes faces a higher number of requests for medical consultations, exceeding the capacities of their infrastructure. There are also limitations of transportation resources. Prison and police officers are needed to accompany prisoner patients to the inpatient and outpatient consultation structures. The overcrowding causes a relative shortage of prison officers which markedly limits the numbers of medical consultations in spite of available physician time ¹⁶⁶.

5.3.2.4 *Outside regular hours*

About medical presence in prisons, health care professionals are generally present from Monday to Friday during office hours, in some few prisons during the week-end as well, or in a hotline service. (Source: President of SPS by mail)

In the canton of Geneva, in case of acute medical situation, prison officers can call a nurse of the HMT for evaluation during working hours or the community emergency network at other moments. In case of emergency, they can call an ambulance at any time ¹⁶⁵.

HMT nurses and GP with local pharmacists have developed guidelines for prison staff facing "everyday problems" such as pain or small wounds, indicating appropriate measures to be taken according to the situation (from



“basic symptomatic treatment” to request for evaluation by the HMT or call to emergency services). During working hours, “the prison officers are encouraged to call the HMT for any prisoner medical issue if the next course of action is not obvious”¹⁶⁵.

5.3.3 Comprehensibility

5.3.3.1 Health prevention and promotion

From November 2001 to November 2005, Anne Iten and Bruno Gravier conducted a research on infections epidemiology and prevention in Western part of Switzerland prisons. At that time, the overall situation regarding prevention was deemed concerning, with account taken of the high infectious risks faced by prisoners. Prevention looked hard to apply and pilot programs were uncommon. About HIV, condoms were available in most prisons. Few places had developed structured information provision, neither for detainees nor for penitentiary officers. When information was provided, it was in a punctual and disparate way¹⁷⁵.

In the framework of the BIG project (see 5.3.3.2), Santé Prison Suisse, in collaboration with the Federal authorities and the Swiss Red Cross has edited in February 2014 leaflets in ten different languages providing information to the prisoners focused on communicable diseases. This document, available in paper format, is aimed to be distributed to each inmate 176. A leaflet is also available to prison officers, in French, German and Italian, partly to provide them with information to protect their own health and partly to provide them with information allowing them to take part to the risk reduction measures for prisoners 177.

5.3.3.2 BIG Project

BIG (“*Bekämpfung von Infektionskrankheiten im Gefängnis*”) is a project of fight against infectious diseases in prisons, launched in 2008 by the Federal Office of Public Health, the Federal Office of Justice and the Cantonal Justice and Police Departments.

The BIG project aims to improve and harmonize healthcare delivery in the following three areas:

- Epidemiological data,
- Information, education and communication,
- Prevention, detection and treatment.

BIG has developed the following instruments:

- Medical Forms.
- Vade Mecum on transmissible diseases and addictions in prison.
- “Health and deprivation of liberty” Brochure for inmates and prison staff
- Recommendations in 2013, one of which leading to the creation of the College dealing prison health issues (Swiss prison health, SPS) was created.
- A national interpreting phone service was created in 2011 to the prison health heads because of the finding of negative consequences of the language barriers on detainees health¹⁷⁸.

The implementation of BIG has followed 3 steps:

1. (2008/2009): assessment of the situation analysis of goals to achieve, the needs to be covered and feasibility of the measures in the areas of action and decision on what to do;
2. (2009): development of concrete measures;
3. (from 2010/2011): application in prisons of the developed measures¹⁶³.



5.3.3.3 Violence

As a part of preventive health care, there is a screening for violence at prison entry in the Canton of Geneva. The health care personnel look for visible injuries, encouraging inmates to report whether they encountered violence at arrest or during incarceration. If detainees agree, a physician carries out violence expert testimony evaluation. These certificates are sent to the department of justice and police and/or the prison director. The inmates may choose to remain anonymous. In the past, when this system was put into place a decline of violence by the police or correctional officers was observed¹⁶⁴.

5.3.3.4 Vaccinations against hepatitis A and B Virus (HAV and HBV)

According to a survey led by Gerlich et al.¹⁷⁹ – a standardized questionnaire was sent to 91 prisons in the German and Italian speaking parts in October 2004; 41 institutions (45 %) answered it – 77% of the institutions provided vaccinations against hepatitis A and 80% against hepatitis B. They were provided through either the request of the inmate (26/29) or the prison doctor's recommendation (26/32). There are different agencies supporting vaccinations financially. In most institutions, health insurance is mentioned as a possible funding source (93 %). In 38% of institutions the inmates themselves have to pay the costs in some cases. In 17% of the cases, the Cantonal department of justice funds vaccination, and in 12% of cases, it is the facilities. The main reason for not providing vaccinations, after inmate rejection, was that the costs were not covered. This was stated by 21% of institutions. A shortage of staff was also mentioned in 7% of institutions. Further reasons mentioned included; the lack of medical employees in the institution (2); an insufficient number of infected persons over the years (1); no explicit recommendation (1); no indication (1); and too short an imprisonment period (4). If a cycle of vaccination (two doses for HAV and three doses for HBV) was initiated but unfinished at discharge, 67% of institutions transferred their inmates to a service where the vaccination cycle could be finished. However, for 33% of institutions this was not the case. The reasons for not transferring an inmate are similar to the situation with initiated therapies. The main reason why vaccinations were not always carried out was the lack of staff or funding¹⁷⁹.

5.3.3.5 Drugs and infectious diseases

In Geneva, the prison medical service offers methadone maintenance treatments, distribution and exchange of needles and syringes for drug addicts, and distributes condoms; all supplied without charge¹⁶⁴.

5.3.3.6 Specific health issues

Mental health

Therapeutic measures

The judicial pronouncement measures have recently changed in the Swiss criminal landscape. The law sanctions in force since 1937 were revised in 2006, especially concerning the issue of internment (ordinary and life) resulting in more restrictive freedom deprivation.

Between 1985 and 2010, the measures imposed by the courts decreased overall by 50%, except in institutions. Outpatient treatment relating to 'abnormal' or mentally ill offenders have increased drastically.

**Table 25 – Switzerland – Evolution of measures ordered in Switzerland**

	Swiss Penal Code	1985	2010
Total number of sentenced persons (crimes and offenses)		46'437	92'964
Total pronounced measures		725	725
in % compared to total convictions		1.56%	0.78%
Type of pronounced measures:			
• Institutional therapeutic measure	59 SPC	33	134
• institutional treatment of addictions	60 SPC	277	143
• residential placement for young adults	61 SPC	71	38
• outpatient treatment	63 SPC	322	406
• regular internment	64 SPC	12	7

Source: ¹⁸⁰

For the execution of custodial measures (placements and internments), art. 74 SPC requires the respect of the basic principles of human dignity and proportionality about any further restriction of the prisoners' rights.

The separation of places of execution of penalties (regular facilities) and internment or confinement measures (therapeutic measures facilities) is required by art. 58 SPC. However, this principle of separation is not (or little) realized in practice for lack of adequate treatment facilities and because art. 59 al. 3 SPC allows the institutional treatment of mental disorders to take place in a prison. The center of measures Curabilis opened in 2014 in Geneva. It is a closed establishment for detainees under penal measures and with mental illness.

In principle, the implementation of outpatient treatment takes place simultaneously with the custodial sentence, which is imposed jointly, unless it is not consistent with the treatment: in this case, the judge may suspend execution of the custodial sentence in favor of outpatient treatment (art. 63 al. 2 SPC). The concept of treatment is interpreted very broadly. For the Federal Tribunal: *"Even the simple supervision of the author in a structured and supervised environment together with a relatively distant psychotherapeutic treatment is to be carried out, if it has a predictable effect of improving the condition of the person concerned, so that eventually their reintegration into society is made possible."*

The issue of offenders with mental disorders, and that of "dangerous" offenders covered mostly by very security-ridden measures, are considerable challenges of prison policy. Those issues strongly pervade the cooperation of criminal justice with doctors and psychiatric experts, because expertise is a compulsory measure in order to enable the judge to order a measure of security, including ambulatory (art. 56 para. 3 SPC)

To pronounce the measure of internment, Art. 56 al. 4 SPC requires the expertise to be made by an independent expert, which has not already treated the author of the offense. For the delivery of confinement for life, art. 123a para. 3 federal Constitution and art. 56 al. 4a SPC requires even the opinion of at least two experts, being independent one from the other, experienced and having never worked previously with the offender.

To face these challenges, Switzerland must seriously increase its training efforts (basic and continuing) in medicine, forensic psychiatry, law, scientific research and interdisciplinary collaboration between the various actors involved in the implementation of penal sanctions.

The law also requires regular assessment (guarantee individual freedom, art. 31 Federal Constitution) (at least once a year, art5 Chapter 4 European Convention on Human Rights) ¹⁸⁰.



Suicide^{rrr}

In Switzerland, the rule states that anyone arrested must be seen within 24 hours by a doctor or a nurse in order to determine if she/he has medical or psychiatric problems that require some care. The recommended review questionnaire includes some questions specifically focused on the risk of suicide. In practice, however, S. Arsever¹⁸¹ explains that it is not certain that this examination is as systematic as it should be because of to the lack of medical or nursing staff available. In the police prison in Zurich, a visit to the National Commission for the Prevention of Torture was necessary to implement four health questions in a form filled upon arrival by prison staff, with the possibility to contact a doctor in case of disturbing answers. In Geneva's Champ-Dollon prison, all detainees are seen within two hours after arrival. If this conversation leads to fear about potential danger of suicide, protective measures are taken, which may include psychological or medical treatment, or hospitalization and increased surveillance. Particular attention is paid during the stay, to the perpetrators of serious crimes. Sensitive periods are arrest, judgment and release. Personal events could act as a trigger as well, as a romantic break, a canceled or bad visit. Prison officers stand on the front line to detect suicide signs¹⁸¹.

Addictions

Prevalence

Infectious diseases linked to drug use are a problem in prison¹⁸². A study based on a review of medical files of all detainees attending the prison health service was conducted in 2007 in the remand prison of the Geneva district by Eytan et al.¹⁸³. It provided the first detailed description of the mental health problems for which detainees received care in the largest Swiss remand prison. It was also the first description of the association of the mental health problems with somatic health problems in a large sample of detainees. The findings confirmed the high prevalence of mental health

problems in this population and highlighted frequent associations with somatic health problems thus emphasizing the need for coordinated health care services in these settings¹⁸³.

Table 26 – Switzerland – Prevalence of psychological symptoms and drug abuse in a Geneva prison, 2008

Symptoms and substance abuse	Male	Female	Total
Psychological symptoms	45.3%	56.6%	45.8%
Tobacco	69.5%	59.2%	68.9%
Alcohol	42.7%	13.2%	41.2%
Cannabis	36.8%	19.7%	35.9%
Cocaine	27.5%	10.5%	26.6%
Heroin	17.4%	15.8%	17.4%
Benzodiazepine	31.9%	17.1%	31.1%

Source: ¹⁸³

Almost half (45.8%) presented psychological symptoms or complaints, women slightly more frequently than men (56.6% vs. 45.3% respectively). Smoking was highly prevalent in this sample (68.9%). Alcohol, cannabis, benzodiazepine and cocaine abuse were also frequent (41.2%, 35.9%, 31.1% and 26.6% respectively). Apart from heroine, all substance abuse problems were more frequent among men than among women¹⁸³.

^{rrr} Statistics are given on <https://www.bfs.admin.ch/bfs/fr/home/statistiques/criminalite-droit-penal/execution-penale/personnes-placees-detenus.assetdetail.1823695.html>



Several associations between psychological symptoms, substance use, age, sex and the most common general medical conditions are statistically significant. Compared with men, women more frequently required care for anxiety and less often for alcohol, cocaine, cannabis and benzodiazepines abuse. Younger prisoners were more prone than older ones to abuse of alcohol, cannabis and benzodiazepines and to adopt self-aggressive behaviors (for example scarification), while inmates aged 35 years or more complained more often of diverse psychological symptoms, including anxiety. Heroin and cocaine abuse was also more common in older prisoners than in young ones. Comorbidity between tobacco, alcohol and other substance abuse was very common. Past alcohol abuse was associated with a cohort of problems and behaviours, including insomnia, smoking and self-aggression. There are also several significant associations between anxiety, insomnia, various abused substances and general medical health conditions including skin, respiratory and circulatory problems ¹⁸³.

Depressive disorders were overrepresented among female prisoners. Personality disorders were more prevalent among younger prisoners. A history of alcohol abuse was associated with posttraumatic stress disorder, adjustment disorders and personality disorders. Smoking was associated with adjustment and personality disorders. Respiratory problems were associated with adjustment disorders ¹⁸³.

However, only prisoners with medical issues are described in the Eytan study. Another study based on the same database and led by Pr. Dr Wolff, includes the total prison population ¹⁸⁴. It provides a more nuanced view of mental health and addictions in the Geneva prison.



Table 27 – Switzerland – Frequencies of ICPC-2 coded health problems (Substance abuse, self-harm and psychiatric disorders) of 2195 medical files of detainees in a remand prison in Geneva, 2007

Category (common examples)	Males		Females		All detainees		Prevalence data: General population
	N = 2087		N = 108		N = 2195		
					N	% (95% CI)	
E. Substance abuse							
Substance abuse (licit)	1502	72.0 (70.0-73.9)	60	55.6 (46.2-64.9)	1562	71.2 (69.3-73.1)	
Tobacco (active)	1296	62.1 (60.0-64.2)	55	50.9 (41.5-60.4)	1351	61.5 (59.5-63.6)	29.3-37.2 [24]*
Alcohol misuse	750	35.9 (33.9-38.0)	13	12.0 (5.9-18.2)	763	34.8 (32.8-36.8)	3.9-4.8 [24]*
Benzodiazepine (not medically prescribed)	465	22.3 (20.5-24.1)	13	12.0 (5.9-18.2)	478	21.8 (20.1-23.5)	
Illicit drug use (active):	852	40.8 (38.7-42.9)	31	28.7 (20.2-37.2)	883	40.2 (38.2-42.3)	
Cannabis	605	29.0 (27.0-30.9)	19	17.6 (10.4-24.8)	624	28.4 (26.5-30.3)	9.3 [24]
Cocaine	418	20.0 (18.3-21.7)	10	9.3 (3.8-14.7)	428	19.5 (17.8-21.2)	2.8 [21]**
Heroin	255	12.2 (10.8-13.6)	14	13.0 (6.6-19.3)	269	12.3 (10.9-13.6)	0.7 [21]**
Illicit drug use (lifetime):	720	34.5 (32.5-36.5)	21	19.4 (12.0-26.9)	741	33.8 (31.8-35.7)	
Cocaine	673	32.2 (30.2-34.3)	17	15.7 (8.9-22.6)	690	31.4 (29.5-33.4)	2.8 [21]*
Heroin	369	17.7 (16.0-19.3)	17	15.7 (8.9-22.6)	386	17.6 (16.0-19.2)	0.7 [21]*
F. Psychiatry							
Depression	145	6.9 (5.9-8.0)	18	16.7 (9.6-23.7)	163	7.4 (6.3-8.5)	2-9% major depression [29]
Personality disorder	111	5.3 (4.4-6.3)	9	8.3 (3.1-13.5)	120	5.5 (4.5-6.4)	1-3% antisocial personality disorder [29]
Adjustment disorder	90	4.3 (3.4-5.2)	8	7.4 (2.5-12.3)	98	4.5 (3.6-5.3)	5-20% in individuals seeking outpatient mental health treatment [29]
Post-Traumatic Stress Disorder	22	1.1 (0.6-1.5)	0		22	1.0 (0.6-1.4)	1-14% [29]
Psychosis (schizophrenia, delirium)	17	0.8 (0.4-1.2)	4	3.7 (0.0-7.3)	21	1.0 (0.5-1.4)	0.2-2% schizophrenia [29]
Bipolar disorder	2	0.1 (0.0-0.2)	0		2	0.1 (0.0-0.2)	0.4-1.6 [29]

*Adults < 49 years

**Active and previous

source Wolff et al. 2011¹⁸⁴



Cannabis

Several studies suggest a high prevalence of cannabis use before and during imprisonment. According to one of them, detainees estimated the current use of cannabis use to be as high as 80%, and staff 50%. All participants had similar opinion on effects both at individual and institutional levels: analgesic, calming, self-help to go through the prison experience, relieve stress, facilitate sleep, prevent violence, and social pacifier. In addition to its soothing effect and benefits on social climate in prison, cannabis might be substituting or preventing other substance use, It has been considered to be less harmful than and preventative in detainees taking more harmful drugs such as heroin and cocaine. Participants also mentioned negative consequences as sleepiness, decreased perception of danger and social isolation, and dissatisfaction regarding the situation where cannabis is forbidden but detection in the urine was not sanctioned. However, the introduction of a more restrictive regulation induced fear of violence, increased trafficking and a shift to other drug use¹⁸⁵.

Opioid substitution treatment in a Geneva prison

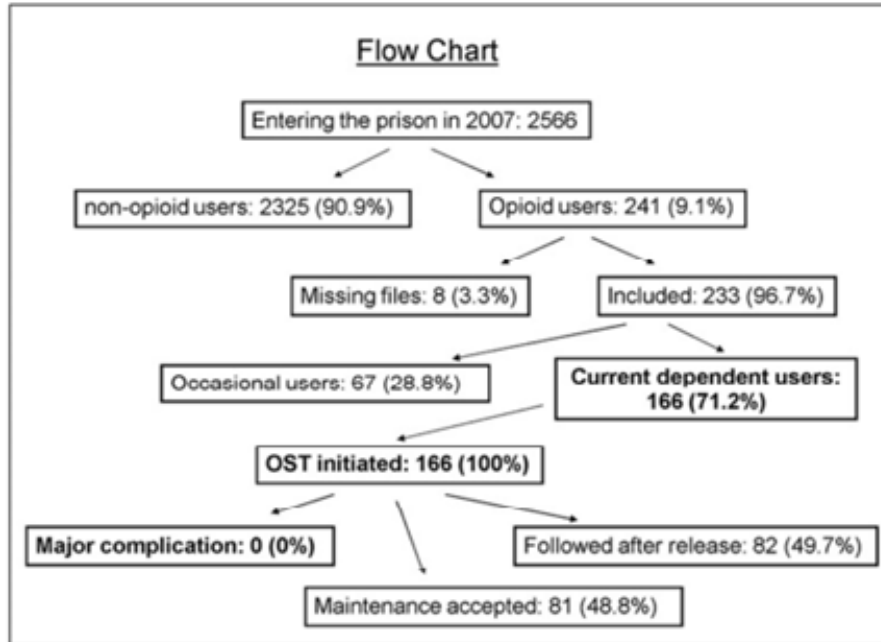
Opioid substitution treatment (OST) is not uniformly provided in all prisons as recommended by international guidelines. In the pretrial prison of Champ-Dollon^{sss} (Geneva) OST has been available since 1990. Before that time, methadone was available, but only for those who were already in substitution treatment or who were in acute withdrawal. Pre-trial prisons are characterised by a high turnover of detainees, which complicates healthcare organisation, particularly for vulnerable patients such as those with opioid addiction¹⁸².

In 2007, from a review of health records of 2566 detainees entering Switzerland's largest pre-trial prison, among 233 opioid users (9.1%) at baseline, 94.8% used other substances, and 39.9% had used drugs intravenously. Opioid dependence was confirmed in 71.2% of opioid users. Methadone was the treatment of preference, No serious side effects or death by overdose occurred. There was post release OST continuity-of-care for 49.7% of OST patients. The study has concluded the prescription of OST for opioid dependent detainees by trained physicians is feasible and safe in a pre-trial setting. The methadone dose was lower when compared with general OST treatment recommendations. Nevertheless, treatment was available in accordance with national and international guidelines. In prison OST offers access to a much needed and safe healthcare service for this vulnerable population. For opioid dependence, OST has proven to be a beneficial treatment among detainees, offering a risk reduction in overdose mortality after release from prison. The post release period is a particularly vulnerable transition time for prisoners. It carries a mortality rate that is 20 times higher than that of the general population. Because of that risk (especially in cases where prisoners have undergone forced detoxification during their prison stay), official guidelines recommend that all opioid dependent persons have access to OST and that complete tapering be avoided during imprisonment¹⁸².

^{sss} A study was lead in Champ-Dollon in 2007. It reviewed health records of 2566 detainees entering the prison.



Figure 6 –Switzerland – Flow chart of study population within the prison setting in 2007



Source:¹⁸²

Infectious diseases

In Switzerland, prevention policies exist but are unevenly implemented; a study by the University of Freiburg shows that Swiss prisons' anti-infection measures are not uniformly available. Since spring 2008, the Federal Office of Public Health (FOPH) has been conducting a series of Preventing Infectious Diseases in Prison investigations, addressing the question of how, in the future, infectious diseases can be fought successfully throughout the Swiss prison system ¹⁸⁶.

According to the Swiss Law on Epidemic Diseases, the Confederation and the cantons have a responsibility to undertake necessary measures against communicable diseases. This means that prisoners benefit from regular medical and nursing care if needed; in addition, their daily routines are regulated. This situation presents a good opportunity to show the prisoners ways to protect themselves and others. In the Schöngrün prison, for example, medical and nursing services are provided by four registered nurses and weekly physician appointments if requested. Furthermore, methadone and heroin are dispensed under controlled conditions to prisoners suffering from severe drug addiction. This is accomplished within the framework of the Swiss drug policy ¹⁸⁶.

It is of the greatest importance that the emergency team should be aware of the high prevalence of transmissible diseases in the prison population. On one hand, they must attempt to detect these diseases. On the other hand, they should use appropriate protective measures (isolation, mask, gloves) before starting treatment ¹⁸⁷.



Prevalence

According to a study^{ttt} 179, the weighted mean of the HIV prevalence rates was 2.5 %. This number was equally based on estimations and on actual serological tests, which, however, referred to known cases and were usually not based on routine screening. The weighted mean of HCV prevalence rates was 7.0 %. The reported prevalence rates were based on estimations in about 60 % of the facilities and in about 40 % on identified cases.

Screening

In almost all prisons serological examinations were not done routinely, but were provided when demanded by inmates or recommended by the medical service. Vaccination against hepatitis A or B infection and initiation of antiviral therapy was possible in most institutions. Conclusions: Most of the prisons investigated offered diagnostic and antiviral treatment for hepatitis virus and HIV infections. A reported problem was the discontinuation of ongoing treatments or vaccination cycles after discharge. In some cases deficient funding was an obstacle¹⁷⁹.

Almost all institutions offered HIV, HBV^{uuu} and HCV^{vvv} serological testing. In 3 institutions inmates could not be tested for HAV^{www}. The main reasons reported for not conducting serological examinations (aside from denied patient consent) were a lack of internal medical services and an absence of any medical examination. Other reasons included insufficient cost coverage and short periods of incarceration. Moreover, it was mentioned that in some cases, tests of earlier institutions were consulted and that the effort and the consequences of testing were not clear. In 63 to 88 % of the institutions, serological tests were done on the request of the inmate, and in 46.2 to 61 % on the recommendation from the prison doctor. Routine serological testing for HIV, HBV and HCV for all consenting inmates was done in only one institution. No institution routinely tested for HAV.

^{ttt} The study was realized in 2004, on the basis of medical staff and directors' information in 41 prisons of the German and Italian speaking parts. The aim of the study was to obtain an overview on diagnostic and therapeutic activities concerning hepatitis A, B, C virus and HIV in Swiss prisons.

Treatment

In 90 % (36/40) of the institutions the inmates had the opportunity to receive HIV antiviral therapy. For chronic HCV and chronic HBV infections, main institutions, offered antiviral therapy respectively. Of the few institutions that stated that it was not possible to provide treatments for all chronic infections, 3 stated that they transferred patients to other places when such treatments are necessary, while 2 others stated that the continuation of a treatment is possible, but that they normally do not initiate it. In all facilities, the diagnosis from the presiding doctor is required to initiate pharmacotherapy. In three institutions, a stay between 6 and 12 months was also a condition for initiating the treatment for chronic hepatitis virus infection. In addition, two institutions also mentioned an incarceration period of more than 6 months as a necessary condition for initiating the treatment for HIV. Most of the institutions were able to provide antiviral therapy for HIV or chronic hepatitis B or C infection, however others did not due to a lack of doctors, or because the costs were not covered. For hepatitis virus infections reasons for not offering pharmaceutical therapy are, funding problems were an obstacle for starting an antiviral therapy in more institutions than for HIV¹⁷⁹.

Pilot projects

Some pilot projects were implemented in the early nineties.

- Prison-based syringe exchange program via a distribution machine were implemented in Hindelbank (female prison) and Realta jail (male prison)¹⁸⁸. In Hindelbank no consequences on cocaine and heroin consumption's rates has been observed. In Realta exchange of syringes between inmates rate decreased after the program¹⁷⁵.
- The Kost project in Oberschongrün: heroin controlled distribution. Here, a doctor distributed sterile syringes to addicted prisoners upon request. Results were: no stress related to drug research; less somatic and psychologic complaints; same cannabis and cocaine consumption, no

^{uuu} Hepatitis B Virus

^{vvv} Hepatitis C Virus

^{www} Hepatitis A Virus



exchange of syringes, only one overdose mentioned; better invest and motivation about work from the participants than other addicted detainees.

- Bâle survey about AIDS and addiction prevention.

The prison-based syringe exchange programmes (PSE) were compared in Switzerland, Germany and Spain. Authors emphasized the need for collaborative effort in design and development between all groups affected by the programmes, and the need for integrating PSE within a wide range of education and harm reduction activities as it is in the community. Objectives of PSE was the reduction of blood-borne viral infections in prison. During the study, there were no new cases of HIV, hepatitis B and c infections in any prison. Rates of drug use reported from Hindelbank and Realta were stable or decreased ¹⁸⁸.

In 1998, relying on previous results, the director of the Public Health Federal Office has recommended in a letter to the Heads of Cantonal Justice and Police Conference “the integration of the distribution of syringes and free access to condoms in all establishments while still respecting the specific conditions in each of these”. In practice, recommendations are hard to apply because of several factors: prisons specific difficulties, reluctances from the officers, variability of cantonal policies, the lack of resources and the feeling of a fundamental contradiction between what is involved when respecting objectives of an effective prevention and the first mission of the penitentiary institution ¹⁷⁵.

Launched in 2008 by the Federal Office of Public Health, the Federal Office of Justice and the Cantonal Justice and Police Departments, the BIG (“*Bekämpfung von Infektionskrankheiten im Gefängnis*”)^{xxx} is currently the most significant project in Switzerland to fight against infectious diseases in prisons.

^{xxx} <https://www.bag.admin.ch/bag/de/home/themen/strategien-politik/nationale-gesundheitsstrategien/nationales-programm-hiv-und-andere-sexuell-uebertragbare-infektionen/zielgruppe-mit-erhoehtem-expositionsrisiko-achse2/bekampfung-von-infektionskrankheiten-im-gefängnis.html>

Medical research

A recent US report in the US has proposed changes to federal law in order to grant detainees access to medical treatment available only as part of a research project. Such experimental treatment can be lifesaving in some cases of multi drug resistant HIV. In Geneva, this access is granted. In order to prevent abuse, in Geneva the same standards for non-prisoner patients apply to research involving prisoner patients. Research is only permitted after the voluntary and informed consent of prisoners. The first and most important aspect to the granting of free and informed consent is that the equivalence and independence of non-research health care is guaranteed. Indeed, the obvious condition to ensure ethical research on prisoners is that there are no constraints or pressures. Prisoners might accept entry into a research protocol in order to receive good overall care (investigations, therapeutic interventions, monitoring and follow up) if health care provision for prisoners is inadequate ¹⁶⁶.

5.3.3.7 *Specific groups*

Woman

Concerning women, they have higher rates of somatic and psychic diseases. Furthermore, they have specific needs. In two prisons (Hindelbank, Lonay), children are welcomed until the age of three years. These elements are reflected in the presence of well-equipped services and a varied and numerous specialized staff (gynecologist, midwife, educator for young children).

Elderly female prisoners

Elderly female prisoners constitute a minority within a minority. Three layers of vulnerability have been identified from a qualitative study lead in two prisons: the “prisoner” layer; followed by the layer of “woman”; both of which



are encompassed by the layer of “old age. Based on vulnerabilities, interventions have been recommended addressing their social needs and health conditions.

- First, in light of the significance of social relationships, stronger emphasis on fostering social support networks should be put in place. As reassessing prison rules regarding visiting hours, number of visits, and security checks imposed for the visitors, as many of them could be aging parents of these prisoners or even their young (grand)-children.
- Second, educating security and medical personnel about gender and age-specific needs of prisoners is an important measure to implement in prison as perspectives on gender are known to influence how these prison personnel care for those incarcerated.
- Third, to date, handbooks for prison staff and policymakers exist that are gender-sensitive and built on a human rights approach. Their aim is to protect female prisoners from harm and violence in prison.
- Fourth, intervention is needed in the allocation of workplaces for elderly female prisoners that are age appropriate and sensitive to their health conditions. This might be a Swiss- specific intervention due to its work obligation irrespective of age.
- Fifth, the quality of prison health-care and access to outside services are important, taking into account gender and age-related patterns of health-care usage and needs.
- Finally, female prisoners in general and older in particular should not be further penalized for their small numbers by being incarcerated in structures that were not designed for them and not responding to their needs.

More gender-centred approaches do not necessarily increase economic costs. For example women are usually detained in higher than necessary security levels, which results in very high costs ¹⁸⁹.

Older prisoners

The part of people aged 59 and over in all persons convicted of crimes in Switzerland has increased steadily from 1990 (where they accounted for 2.7% of convicted) to 2012 (5.8% of convicted or an increase of 115%) ¹⁹⁰. The explosion in the number of seniors in prison is rather due to measures introduced in the Penal Code in 2007, including internment without releasing perspectives, than to demographic aging phenomenon ¹⁹¹.

For detainees themselves, consequences are the decrease of the work capacity and the decrease of relatives, both within and outside the prison. Autonomy decreases as well and mental suffering increases. The issue of end of life arises. The medical staff is not specifically trained for required old age cares. And institutions are often poorly suited for continuous or intensive care.

However specific arrangements have been made in two prisons. In 2011, the prison of Lenzburg opened a section for prisoners over 60 years, called "60plus". The section is mainly dedicated to prisoners serving long sentences or life imprisonment. The obligation to work is giving way to rehabilitation, socialization and recreation. In 2012, the 12 available beds were occupied. The section also hosts the youngest inmates requiring rehabilitation phase, or detainees with mental disabilities. While elsewhere the focus put is on the future reintegration into society, here the emphasis is on the capacity of detainees, e.g. in performing household tasks, allowing in that way a smooth ageing life despite incarceration. Autonomy is mentioned as a way of avoiding the use of help as long as possible. The section employs six people, including a manager and two people specifically trained in nursing. Collaboration exists with a nursing home which provides theoretical support and in which trainings take place. For the most serious cases, the Swiss Association of Home Help and Care Services is called. The psychologist, the psychiatrist and the chaplain of the prison are also involved in the 60plus section.

The risk related to specific older prison establishment would be the stigmatization and the distance with relatives because of the prolonged separation ¹⁹¹.



End of life

The number of detainees' deaths has increased in the last 10 years. In 2003, there were 16 deaths in total in prison, including 8 suicides, and in 2012 the total number of deaths rose to 29 (+ 81%), including 9 suicides. People in prison are not free to choose how and where they die. The issue of dying with dignity requires special attention in prison. In 2013-2015, a Swiss project led by the University of Fribourg and financed by the government focused on issues related to end of life in prison.¹⁹²

The oldest prisoner of Switzerland died in 2014 in the cellular unit of the University Hospitals of Geneva (HUG). He was 91 years old. He was suffering from advanced insanity and from a cancer in terminal phase. His request for an interruption of his deprivation of liberty for «serious grounds» and for «inhuman and degrading punishment» has finally been rejected by the highest Swiss Criminal Federal Court. From the perspective of art. 92 of the Swiss Penal Code, the Federal Court noted that the continued execution of a sentence is the rule and that his "interruption in the presence of serious cause should be exceptional." This ruling illustrates the extremely strong security position of criminal justice, under which must prevail "in the public interest to preserve the credibility of the prison system, the effectiveness of penalties and equal enforcement".

A working group was established in German-speaking Switzerland (Zurich and its penitentiary Pöschwies) and its mandate is to formulate concrete proposals for action. One possible option would be the creation of nursing homes ready for detainees requiring care - round the clock - adapted to their age and their physical and mental health. This is also a recommendation of the European Committee for Prevention of Torture (CPT, Council of Europe) since 2007 already¹⁹⁰.

Minors

According to a study that reviewed the medical files of all detainees (314) in a juvenile detention centre, most (89%) had a health assessment and 195 (62%) had consultations with a primary care physician; 80% of the latter had a physical health problem, and 60% had a mental health problem. The most commonly managed problems were skin (49.7%), respiratory (23.6%), behavioural (22.6%) and gynaecological problems (females: 23.9%); 13% females (no males) had sexually transmitted infections (STI), and 8.7% were pregnant. Substance abuse was common (tobacco: 64.6%, alcohol: 26.2%, cannabis: 31.3%). Most (88% of males; 95% of females) benefited from a health assessment during their detention. A quarter of these saw only the nurse whereas 195 adolescents (62.1%) had consultations with the primary care physician¹⁹³.

The primary care team works in close collaboration with a psychiatric team. The health service is attached to Geneva University Hospitals and is independent from the prison authorities. As recommended by the United Nations and the Council of Europe, all the adolescents admitted to the detention facility are offered an initial health evaluation by a nurse within 24 hours of admission. This evaluation acts as triage to identify any health problem requiring medical attention. It is also an opportunity for the adolescents to discover what medical help is available to them¹⁹³.

For these adolescents, the prison health service is often the first opportunity for an autonomous contact with health professionals. Offering primary care services that respond to health needs in a youth friendly manner can act as a positive experience on which the adolescent can build further relationships with the health system in the future (30). Offering health promotion programmes and promoting linkages with health services after their release can also do much to improve the health of these adolescents not only during their detention but also as they step back into the community¹⁹³.

Children^{yyy}



Disabled people^{zzz}

In the prison of Lenzburg some disabled detainees are incarcerated in the “60plus” section dedicated to elders ¹⁹¹.

5.3.4 Continuity of care

5.3.4.1 Follow-up and medical information transmission

B. Chatterjee (Director of Santé Prison Suisse) thinks that a unified e-health card for the overall health system in general should be ideal. Currently, the state council is thinking about an « e-health card » ¹⁶⁰. This is project of grouping of electronic health services. The information and communications technology (ICT) are used to improve health system processes as well as to network the players involved (Patients, doctors, therapists, insured, insurance companies, laboratories, pharmacies, hospitals and nursing staff).¹⁹⁴

The establishment of telemedicine^{aaaa} in prisons has been proven to increase appropriate access to care. It is promising for patients with chronic illnesses such as cardiopulmonary diseases and asthma, diseases from which many of the prison patients suffered. It has been shown that telemedicine reduces delays in the transfer of patients with potential exacerbations of chronic medical conditions ¹⁸⁷.

5.3.4.2 From community to prison

Entrance examination

At their arrival in prison, theoretically, health condition and personal situations of the detainee are the subject of an intake interview. In the early days, the prison doctor performs a medical examination. The forensic department intervenes in situations of mental or behavioral disorders. The medical community evaluates the work capacity and the maximal ability ¹⁵⁶.

In a remand prison, in 2008, 70 to 80% of the mean 2300 detainees admitted annually received medical care. All detainees admitted to the facility are submitted to a health care assessment by primary health care nurses within 24 hours of their admission. This assessment includes screening questions for the most frequent general medical conditions, infectious diseases, exposure to violence and suicidal ideation. When necessary, nurses refer detainees immediately to a physician ¹⁸³.

Regarding medical visits, the Canton of Vaud, for example, provides in its rules on the status of detainees (Article 14) a visit as soon as possible after arrival in prison, also after a transfer. The purpose of the visit is to detect medical conditions requiring care, traumatic injuries, communicable diseases, addictions, and to provide preventive level information on infectious diseases and the possibility of screening ¹⁹⁵.

In the Schöngrün facility (Canton of Solothurn), when entering the prison, all newly arriving prisoners are given a nursing admittance interview. This consists of questions about HIV and hepatitis infection; blood tests are not routinely conducted to check infection status but prisoners are encouraged to undergo voluntary testing. During the interview, a “Safer Sex” brochure (AIDS-Lilfe, 2003) is distributed to the prisoners, with further information available on inmates’ request at the prison’s health office. Solid information and education increase prisoners’ awareness regarding these diseases, increasing their willingness to be advised, undergo testing, and, if necessary, begin drug therapy ¹⁸⁶.

^{zzz} No more data

^{aaaa} It is a practice of medicine through telecommunications and technologies that enable afar health benefits and the exchange of medical information relating thereto²⁵⁵.

**Table 28 – Switzerland – Objectives of the intake sanitary examination**

<i>Individual immediate health</i>	<ul style="list-style-type: none">• Assessment of suicide risk ("shock incarceration")• Exploration dependencies and potential weaning symptoms• Evaluation of the prosecution of drug treatment (the principle of continuity of care)• Detection of consecutive injuries due to the arrest / incarceration• Underlining of known or unknown somatic and psychiatric disorders
Collective health security	<ul style="list-style-type: none">• Systematic search of active pulmonary tuberculosis
Preventive role / risk reduction	<ul style="list-style-type: none">• Screening for infectious diseases (HIV, hepatitis B and C)• Check immunization status, and catch-up vaccinations• Dispensation prevention and general advice messages on health and access to care• Distribution of a prevention kit (ointment and disinfectant solution, compresses, plasters, condoms)• Presentation of the syringe exchange program depending on institution <p>Detection of injuries and violence during arrest (Pont J, Stöver H, Gétaz L, Casillas A, Wolff H: Prevention of violence in prison - the role of health care professionals. Journal of Forensic and Legal Medicine. 2015 ;127-132)</p>

Source: ¹⁷⁰

5.3.4.3 Within the prison

In a remand prison, at any time, inmates can ask for medical consultation and are then addressed to a primary care physician or directly to a psychiatrist in case of obvious severe symptoms.¹⁸³

In the context of a study conducted in a remand prison, the medical files of all detainees attending the prison health service in 2007 were reviewed and coded using an international classification of primary care^{bbbb}. Note that 31.2% of detainees, seen only by nurses, had no medical file and were thus excluded from the analysis. The coding instrument has benefits for classifying problems that do not have a precise diagnosis. Indeed, both symptoms and diagnoses are taken into account. It allows ordering of clinical data in an episode of care structure. In several studies, the classification has been found to be adequate, reliable, and feasible for use in primary health care settings. The classification contains also chapters for psychological problems and for social problems. Components deal with issues such as preventive or administrative procedures, referrals and other reasons for encounter¹⁸³.

About medication, in the Canton of Geneva, its management was tailored to each facility, but never betrayed the core principles of prison health. Currently in some facilities, the nurses administer individual treatments twice a week to each patient. In other prisons, the nurses prepare the weekly pillboxes, leaving the wardens to present the boxes to the patient several times a day (and the patient takes his/her medications at that moment). In all cases, the wardens are solely responsible for identifying the patients and never for the content of the pillboxes¹⁶⁵.

^{bbbb} French version of the international classification of primary care, second edition (ICPC-2)



5.3.4.4 *From one prison to another*

During transfers, the accompanying staff carries drugs, without information on the patient nor the drug. In case of transfer of a prisoner from one prison to another also, the transfer of medical files, often written by hand, takes time, and medical monitoring is interrupted.¹⁶² The prescribed treatment is often questioned from one place to another and the continuum of care is undermined, mainly when the transfer operates between different concordats¹⁶⁰.

Still about Geneva, patients value the continuity of their treatments because the same medical file follows the patient upon transfer to another level of medical care or another detention facility in the canton; there is rarely the burden of “re-telling” their story to a new medical team or the re-negotiation of diagnostics tests and medicines. They express trust in the medical staff, citing the team’s independence of the judicial system and communication with other health services, as important factors¹⁶⁵.

5.3.4.5 *From prison to the community*

About infectious disease, according to a study^{cccc179}, in 87% of institutions, patients who started antiviral therapy during imprisonment were transferred to continuing treatment programs after being released. As an open question, the reasons for not arranging a transfer to a continued treatment place were asked for. A reason mentioned by 4 institutions was that the incarcerated person was considered self-responsible to contact a medical service himself after release. Another response was that the maintenance of therapy is difficult when the inmate is homeless or has no family doctor. Other reasons included was the absence of legal regulations, repatriation outside Switzerland (transfer in such cases is sometimes not possible) and a too short period of imprisonment¹⁷⁹.

^{cccc} The study was realized in 2004, on the basis of medical staff and directors’ information in 41 prisons of the German and Italian speaking parts. The aim of the study was to obtain an overview on diagnostic and therapeutic activities concerning hepatitis A, B, C virus and HIV in Swiss prisons.

In the case of the HMT of the HUG^{dddd} the health care staff communicates with all previous, present and future partners pertinent to the patient’s case (e.g. prison or community health services, addiction medicine, psychiatry or other specialty services, migrant care centers, non-government and charity organizations). These relationships have impacted the development of care plans for individual patients. An increase occurred in the number of pre-release meetings between patients, an HMT member and a community partner (meetings that focus on transition into the community following release). These efforts promote continuation of prisoner health care in the outside setting and reduce the stigmatization of ex-prisoner patients when they are treated in the local medical community (these patients become known entities in the community health system, instead of foreigners)¹⁶⁵.

5.3.4.6 *Patients’ rights regarding their medical fileseeee*

5.3.5 *Reachability*

5.3.5.1 *Procedures to get medical attention*

As observed by the CNPT during its visit in the prison of Champ-Dollon in 2012, to request for medical consultation, prisoners had to fill in a form available in the corridors and post it in a locked mailbox. The latter was checked twice a day by healthcare staff and nurses took care of “*analysing the requests, receiving the patients and refer them*” when appropriate¹⁹⁶.

^{dddd} Health Mobile Team of the Hospital University of Geneva

^{eeee} No data



5.3.5.2 Triage and waiting list

In the canton of Geneva, nurses of the HMT have a gatekeeping function. They perform a health screening for each new inmate in the following 2 hours after admission in the pre-trial (24 hours in post-trial detention), in order to identify health needs of prisoners requiring rapid medical attention or to ensure continuity of treatments. Patients are referred to health professionals within the HMT if deemed necessary by the nurse performing the entrance examination. If a specialist consultation is required, patients are referred by the GP ¹⁶⁵.

5.3.5.3 Hospitalization

In an emergency or complex treatment situation, detainees are transferred to hospital.

In French-speaking Switzerland, prisoners requiring special safety conditions are placed in a hospital cell unit, such as in the Cantonal Hospital of Geneva. (Source: President of SPS by mail)

In Switzerland, there are two medical prison wards, one in Geneva and one in Bern. The High Security Ward (BEWA) of the Inselspital in Bern is part of the Clinic for General Internal Medicine and is the only facility of this sort in German-speaking Switzerland. It was opened in 1971 and provides medical care to about 400 prisoners per year, from all of Switzerland. There are 13 beds. The High Security Ward is built both as a prison and as an emergency hospital. The medical staff and guards are specially trained for working with prisoners. Medical care is provided by somatic and psychiatric teams. The University Emergency Centre is responsible for the primary admission and investigation of all prisoners admitted on an emergency basis to the prison ward of the Inselspital. Apart from the prison doctors, this is the initial point of contact for prisoners and is an important component in the healthcare chain ¹⁸⁷.

A study took place in the University Emergency Center in Bern. A total of 1703 patients were analyzed. A retrospective data analysis comprised adult (age ≥16 years) prisoners admitted to emergency department, in transit to admission to hospital-associated medical prison ward, between 2000 and 2012. The most frequent reasons for presentation were psychiatric problems (43.4%), followed by the need for medical treatment (31.6%) and for surgical treatment (25.0%). Patients with medical problems were significantly older than patients with psychiatric and surgical presentations. Patients with psychiatric problems were significantly younger than those with medical or surgical problems. A total of 7.6% of patients were rehospitalised within the study period. Prisoners are a vulnerable minority group within our society with limited access to medical care. Transfer of information between the emergency department and prison staff should be promoted. The number of prisoners treated in our emergency center is rising, but is still only a small percentage (0.41%) of all consultations ¹⁸⁷.

Psychiatric problems were the most frequent reason for admittance into an emergency center. The high numbers of prisoners with psychiatric diseases has been repeatedly reported. There is evidence that psychiatric diseases in prison can be much more easily detected if standardized assessments are used. Because of the high prevalence of psychiatric diseases in prisons, it would be sensible to screen every prisoner admitted into the emergency center ¹⁸⁷.

The second most frequent reason for presentation to the emergency center was that the prisoner was suffering from an internal medical emergency. The high number of medical admissions may be due to a variety of factors, some of them social. About the prevalence of cardiovascular risk factors and the influence of prison, it has been shown that many women have a striking profile of cardiovascular risks when they are first admitted to prison. In this study, 85% of women smoked upon admission, 87% took no sort of physical exercise and more than 30% were obese ¹⁸⁷.



5.3.6 Quality assurance and control

5.3.6.1 Quality control bodies

The National Commission for the Prevention of Torture (Commission Nationale de Prévention de la torture, CNPT) was legally set up by the Federal law of the 20th of March 2009 on torture prevention. This Commission, financed by the Swiss Confederation, has the remit of independently “*examining regularly the situation of persons deprived of their liberty and inspecting regularly the facilities where those persons are or might be located*”, and of “*formulating recommendations to the relevant authorities in order (1) to improve the treatment and situation of the persons deprived of their liberty [and] (2) to prevent torture and other cruel, inhuman or degrading treatment*”^{fff}. It also has the duty of formulating observations and proposals regarding relevant legislations and to write an annual activity report which has to be publicly available. The law stipulates that this Commission has to be composed by experts with necessary competences and knowledge, including from the medical and psychiatric field. Both genders and linguistic regions of Switzerland have to be represented.¹⁹⁷

The Commission also publishes on its website reports on the visits and following visits conducted.

The Survey about BIG and SPS products in 2014 was addressed to professionals and stakeholders involved in the prison health sector. The aim was to assess existing products in their visibility, availability and accessibility and the quality and possible improvements. The purpose of the survey was also to identify needs. Although the whole quality of the products was considered good, the visibility of Health Prison Switzerland remains low.

The survey findings are:

- The survey has contributed to the SPS visibility.
- A request of a brochure "without speech" for detainees, both for illiterate people but also to meet the geopolitical variability of migration flows.
- The additional requests for publications from the professionals are related to employee health and to support relationships with inmates. The protection of the health concerns night work, stress management, emotional tensions, the balance between private life and professional life, and burnout. Support for detainees concerns mental health, medication (and the identification of competent staff) and management of hunger strikes.
- Those amongst the inmates identified with mental health (management of deprivation of liberty, sleep disorders), consumption of psychoactive substances (including amphetamine abuses) and a healthy diet, as well as tattoos, sports and physical activities.
- The staff request information broadcasting through the SPS Website about instructions, checklists, operating orders, training offers, and new publications¹⁹⁸.

A working group was established by the Commission centrale d'éthique de l'Académie Suisse des Sciences Médicales (Central Ethical Committee) to verify the timeliness and feasibility of ASSM Directives, for the practice of medicine to the detainees. Practical advices constituting an annex to the guidelines were then developed. This follows an order of the Federal Court after an inmate hunger strike.

In the case of the health care in Geneva Canton, (independent of the cantonal justice), formal methods of evaluation are in development. The medical staff has performed its health care delivery based on the following indicators¹⁶⁵:

- patient feedback during consults;
- discussions with part-time doctors based at each prison;

^{fff} Translation by the authors



- meetings with penitentiary office leadership at least every two months and almost daily exchanges with prison staff;
- provider reports within the HMT;
- increased communication and transition building with community health sites, who focus on issues like addiction (drug, alcohol, tobacco) and primary care services for the vulnerable.

It has notably led to the observation that smoking is banned entirely in the Geneva University Hospitals (HUG). Patients who want to smoke gather outside the hospital doors. The prison unit in the HUG opened in 2015 an outdoor yard attached to the unit where smoking is permitted. This construction responds to a longstanding requirement of the CPT which stresses the importance of at least 1h outside each day for prisoners.

International guidelines

Table 29 – Switzerland – International guidelines on health care provision to prisoners

International settings	Ethical and legal documents
United Nation	<ul style="list-style-type: none"> • Principles of Medical Ethics defining the role of physicians, 1982 • Body of Principles for the protection of all persons under any form of detention or imprisonment, 1988 • Standard minimum rules for the treatment of prisoners, 1955, 1977
Council of Europe	<ul style="list-style-type: none"> • CPT (European Committee for the Prevention of Torture and Inhuman or degrading treatment or Punishment), 2010 • COE Committee of Ministers recommendation No R(98)7 – Ethical and organizational aspects of health care in prison
World Medical Association	<ul style="list-style-type: none"> • Declaration of Lisbon on the rights of the patient • Declaration of Edinburgh on prison conditions and the spread of tuberculosis and other communicable diseases
World Health Organization	<ul style="list-style-type: none"> • Health in Prison program: A WHO guide to the essential in prison health

Source: ¹⁹⁹

Swiss Academy of Medical Sciences (ASSM)

In 2002 the Swiss Academy of Medical Sciences (ASSM) has drawn up guidelines for the practice of medicine to detainees and based on international recommendations. Those recommendations embody ethical principles, developed further. It guides practitioners about their tension between their medical obligations and public safety. These guidelines do not constitute binding law. But the doctor can be bound by a contract with the patient or by his adhesion to an association, such as the Swiss GPs Federation. The guidelines serve as a reference for judging whether a practitioner has violated its obligations when no respecting professional standards. This means a judge can rely on these guidelines to determine the care of a doctor during specific situation ¹⁵³.

Content of the ASSM directives ²⁰⁰:

1. General principles; concept of conscientious objection

The ethical and legal ground rules that govern medical activity, particularly in terms of consent and confidentiality also apply when the person is deprived of liberty.

In this case, however, the doctor often has to take into account the requirements of order and security, even if the goal must always be in favor of and maintaining the dignity of the patient. The adjustment can sometimes hurt the personal beliefs of the physician, and he must act according to his conscience and the rules of medical ethics and may refuse the expertise or clinical management of persons deprived of liberty unless it is responding to an emergency.

2. Conditions of examination

To facilitate the establishment of a climate of mutual trust, the physician must strive to preserve the environment and the dignity of the usual doctor-patient relationship.



When conducting the examination of a detained person, it should be in a proper place. The review should take place out of sight and hearing of others, unless otherwise requested by the doctor or with his consent.

3. Activities and expertise situation

Apart from situations of crisis or emergency, the doctor can't combine both the identity of therapist doctor and medical expert. Before any act of expertise, he must clearly inform the person that he/she is responsible for examining and that medical confidentiality does not cover the results of the examinations.

4. Disciplinary sanctions

Whenever the doctor is asked about the ability of a person to undergo disciplinary punishment, he adjudicates once the penalty imposed. Therefore his opinion only occurs in a second time and, if necessary, takes the form of a veto based on a strictly medical assessment.

5. Equivalence of care⁹⁹⁹⁹

The detained person has the right to care equivalent to that benefitted by the general population.

6. Coercive measures decided and applied by the police or prison authorities

When the doctor is called to inform competent authorities about the risks and consequences of a transfer stress on the health of a detained person, he/she must exercise with greatest caution and strive to meet beforehand, and wherever possible, the necessary information about the patient's medical history. The physician should take particular account of the intended means of transport, the probable duration of the transfer and security and containment measures that may be applied to the person.

Whenever the state of physical or mental health of the prisoner requires assistance or care or when the importance of containment and safety measures used is likely to incur a risk in itself to human health, this effectuates accompaniment by medical personnel, .

If the doctor believes that the means used to perform the measurement (eg gagging) pose a risk of immediate and major health to the patient, he must immediately inform the competent authority in the event that the means would still be used; he will then not assume responsibility for medical cases and therefore he should not assist.

7. Consent to medical treatment and under constraint treatment

As in ordinary medical situations, doctors, acting as an expert or therapist, are authorized to undertake a diagnostic or therapeutic procedure on a detainee in the case that he has given free and informed consent.

Any administration of drugs - especially in the case of psychotropic detainees - can be done with the consent of the patient and on the basis of a strictly medical decision.

In emergency situations and under the same conditions with a non-detained patient, the doctor can do without the patient's consent when the latter has a discernment of disability caused by a major psychiatric disorder with an immediate risk of aggressive acts. In such cases, the doctor is required to ensure that the detained patient receives appropriate medical follow-up. The medical use of physical restraints can be envisaged for a period of a few hours. In all cases of medical compression, the physician in charge is required to regularly monitor the implementation and justification; he must carry out close revaluations.

⁹⁹⁹⁹ See 3.7.1 for more details



8. Infectious diseases

In case of contagious disease, autonomy and freedom of movement of the inmate patient may be limited only by the criteria applicable to a population group living in similar conditions in close promiscuity (military unit, summer camp, etc.).

9. Hunger strike

In the event of a hunger strike, the detained person must be informed by an objective physician about the health risks of a prolonged fast. Their decision must be medically respected even in case of major health risks, when full capacity of self-determination was confirmed by a doctor not belonging to the institution.

If the patient falls into a coma, the doctor intervenes according to his conscience and his professional duty unless the person has left explicit instructions that apply in the event of loss of consciousness, even possibly followed by death.

Any physician who faces a protest fast must exercise strict neutrality towards the various parties and must avoid exploitation of his medical decisions.

Despite the refusal of food, the doctor ensures that food is daily proposed to the person carrying out the strike.

10. Confidentialities

Medical confidentiality must be respected according to the same legal requirements that apply to free persons (art. 321 CPS). Patient records must include the doctor's responsibility.

However, promiscuity created by life in prison, as well as the role of guarantor and often even care auxiliary played by prison officials or police may impose an exchange of health information between health personnel and staff of security.

In these circumstances, the physician must strive, with the agreement of the detained patient, to answer legitimate questions of every prison or police personnel.

When the inmate patient opposes disclosure in dangerous situation for the safety or for third parties, the doctor may ask to be released from his secret by the competent authority if he considers it his duty inform third parties. In such cases, the patient should be warned that a lifting of confidentiality was requested.

Exceptionally, where the life or physical integrity of a designated third party is seriously and concretely immediately threatened, the doctor may derogate from himself to medical confidentiality and directly notify the competent authorities, or possibly the third threatened.

11. Denunciation of potential mistreatment

Any signs of violence observed in a detained person during a medical examination shall be duly recorded.

This information must be transmitted without delay to the police or prison supervisors. The detained person has the right at any time to obtain a copy of the medical report to which it is subject.

When the detainee is formally opposed to the transmission of this information, the physician must weigh up the interests involved and, if appropriate, proceed under Chapter 10.

12. Medical independence^{hhhh}

Whatever the particular conditions of exercise (civil servant or public employee or private contract), the doctor should have total independence from the police or prison authorities. His clinical decisions and any other assessments regarding the health of detained persons may be based only on strictly medical grounds.

^{hhhh} See 1.2.1 for more details



To ensure the independence of physicians in police or prison, any hierarchical or even direct contractual relationship between them and the management of the institution should be avoided in the future.

The nursing staff can't accept medical orders if they don't come from the doctor (of the institution).

13. Training of healthcare professionals

Any future health care professional training for treatment of detained patients must be for the benefit of specific training about the mission of various institutions of deprivation of liberty, as well as the management of potentially hazardous situations of violence. Ethno-socio-cultural knowledge is also needed.

Patient autonomy and medical confidentiality are the basis. No medical care or assessments can be conducted on a detained person without his or her consent. In addition, information obtained from prisoners is subject to the same level of confidentiality as any other patient from the community at large. The principle of equivalence (equality of treatment) also governs the delivery of health care to inmates: "detained persons are entitled to the same level of medical care as persons living in the community at large." The principle is applicable in the case of prevention, diagnosis, therapy, nursing health care, informed consent, and medical confidentiality.¹⁹⁹

Training of healthcare professionals

The training of healthcare professionals can be considered as another part of the quality assurance of healthcare in prison. Prison authorities (in the framework of CSFPP) as well as the Geneva and Zurich Universities (in the framework of Continued education Centers (CAS)) deal with this aspect.

The CSFPP provides basic and continuing training to people working in the field of detention. At the operational level, it ensures uniform standards and content training.

The CSFPP offers specific modules about health in the three levels of training it provides:

- At the basic training level: psychology modules, medicine and psychiatry.
- In the training for managers: in deprivation of liberty health module (somatic health, health service and staff health, mental health, law governing the actions and referrals to risks).
- At the continuing training level: medical care supporting modules of prisoners with mental disorders, suicide prevention in prisons¹⁵⁶.

The CAS (distance and continued education center) of the University of Geneva offers a one year continuing education certificate in health in prisons, to doctors, health professionals, social workers or other stakeholders in prisons. The training modules are: 1: legal and penal aspects, 2: prisons: organization and impact, 3: mental health and psychopathological aspects, 4: care, addictions and general internal medicine and 5: vulnerable populations¹⁵⁴. The Zurich University (ZHAW) offers another CAS about criminal law for persons working in this field.



Santé Prison Suisse

SPS has assigned tools for detainees (e.g. "health and deprivation of liberty - Information for detainees), for prison staff (" Vade Mecum - infectious diseases and addictions in prison ", " Ebola: fair of questions "); and for health professionals (standardized –intake- forms, medical secrecy, ¹⁶³.

BIG vade-mecum

The Vade-mecum "infectious diseases and addictions in prison," had been published by the Federal Office of Public Health, as part of the BIG project. The goal is to harmonize practices for the prevention and management of prisoners' health by offering standards, and by promoting interdisciplinary exchanges between the various stakeholders.

Depending on topics, it is directed to health professionals, to stakeholders or to prison staff. In line with the desire to clarify the roles, recipients are identified at the beginning of each chapter. It can also serve as a teaching support for prison officers or caregivers training. Finally, it offers ways for networking. The Vade-mecum is divided into two parts: the standards and recommendations. Standards are an implementation of the recommendations on the infectious diseases and addictions. Recommendations are formulated in the way of objectives, according to the professional categories ¹⁶¹.

This referential covers several areas:

- Networking:
 - In order to ensure the continuity of healthcare and the networking: what do to at the arrival of the detainee, during the incarceration, in case of transfer, and how preparing the release.
 - Collaboration between each healthcare stakeholder including prison staff: tasks of each ones
 - Collaboration between direction and healthcare professionals: proceedings of a meeting
 - Access to sexually transmittable infections prevention materials
 - Transmission of information - substitution treatment

- Emergency:
 - Situations to be reported by prison staff (EG. Overdose, suspected infectious disease)
 - Tuberculosis
 - Protocol in case of intoxication/opioid overdose
- Medical standards and protocols: sexually transmittable infections, hepatitis C, replacement therapy, cocaine use, alcohol or benzodiazepines addiction
- Preventive measures:
 - Harms reduction
 - Vaccination plan
- Recommendations on infectious diseases and on psychoactive substances / addiction:
 - Reducing the risk of transmission, prevention
 - early detection and diagnosis
 - Treatment and care
 - Information, education. (Source: ¹⁶¹)

Interface between the execution of criminal penalties and social assistance

A working group consisted of the Swiss Conference Social Action Institutions and the Conference of Directors of Cantonal Justice and Police Departments has been set up in order to facilitate collaboration and specify institutional competences. It treats each thematic field on its legal basis and highlights the skills and requirements for entitlement to benefits, as well as recommendations ¹⁵⁵.



Drug delivery

The Cantonal Pharmacists Association has adopted in 2009 good practices, which are very helpful in prison. In theory, penal institutions have pharmacies, which are under the supervision of the cantonal pharmacists¹⁶⁰.

5.3.7 Patient's rights

In accordance with the health principles of equivalence of care, confidentiality, and autonomy, detainees should have the right to manage their own treatment. However, most of prison management partners did not accept this framework. Heads of facilities prefer total security and control of medication management. Informed consent for patients is required for every medical intervention that the team delivers per the same legal criteria employed in the community. However, violations of patient consent and decision-making are not uncommon in prison settings. Common examples are international cases of prisoner hunger strikers followed by forced feedings of these individuals. It represents a violation of the European Court of Human Rights (2005)¹⁶⁵.

In Geneva detainees have the option to go against medical advice and to refuse treatment even if this could imply serious health consequences. If possible and if the patient agrees, the prison physician in charge contacts the former treating physician and asks his/her opinion in difficult cases. As part of this approach, no forced screening for tuberculosis has taken place. Instead, as for non-prisoner patients in Geneva, if an infected prisoner exposes other persons to the risk of contracting tuberculosis, the only accepted measure is forced respiratory isolation in the hospital. In line with the respect for treatment refusals, no forced treatment for hunger strikers has been carried out in Geneva. Finally the medical personnel do not use restraints in the prison hospital unit. Use of force is only permitted in a transitory way lasting less than an hour to enable non-voluntary hospitalizations according to the criteria of cantonal law also valid for non-prisoner patients. These criteria include the fact that an emergency situation exists together with an important danger to the patient him/herself or to others, and the medical indication for psychiatric treatment. The use of restraints is avoided inside the hospital. Instead, detainees are transferred to a "calming cell" that is part of the psychiatric ward.¹⁶⁶

5.3.7.1 Equivalence of care

"The detained person has the right to care equivalent to those enjoyed by the general population" (Chapter 5 of the ASSM Guidelines). This relates to preventive measures, diagnostics, therapeutic or medical care corresponding to medical standard. Beyond access to care, it is also about respect of patient rights (self-determination, information, right to respect for privacy).

Barriers have been identified in the application of the equivalence principle: the higher prevalence of infectious diseases, addiction and psychological troubles. Specific efforts are required to ensure fitting medical care. The lack of trained professionals leads to the situations where medical care is taken by prison officers. That also undermines the principle of confidentiality and protection of professional secrecy. The various medical stakeholders are not adequately trained for their mission. Medical decisions are influenced by budget cuts (expensive drugs are not prescribed as treatment of hepatitis C, as well as preventive measures or vaccination). Finally, not every detainee has access to health insurance, which leads to differences in care provision¹⁵³.

This principle is recognized in the jurisprudence of the European Court of Human Rights, and in some cantonal rights (Valais, Geneva). Indeed, in Geneva, patient's consent is required for any medical intervention, meaning respect for treatment refusals according to the same standards used for patients in liberty. *"Forced feeding of competent detainees and forced screening for infectious diseases have not been practiced. Geneva offers voluntary and confidential screening to patients with risk factors for HIV, Hepatitis B and C, and sexually transmitted diseases according to the same rules as in the community"*. Most detainees are pleased to accept this offer. In the case of a refusal, health personnel inform detainees in detail about possible medical consequences for themselves and others, and document the content of the counselling in the medical record. Confidentiality is maintained strictly. Health staff doesn't transmit medical information to non-health staff. This last will only receive information that is necessary to protect their health¹⁶⁴.



5.3.7.2 *Medical secrecy*

Directly at the beginning of a situation the issue of the division of responsibility and exchange of information arise, in order to avoid confusion in the treatment of the detainee, and in anticipation of hard times. The information is limited to the necessary elements for a good execution of the sentence, respecting the health of the prisoner and safety requirements. Transparency exists, in respect of medical confidentiality. Doctors communicate to allow prison officers to take responsibility, and officers don't interfere by avoiding to give instructions in the medical field (independence principle), ensuring that meets the legal requirements, such as the ability discernment of the detainee. The prison service informs the inmate of his support in case of a hunger strike and doctors about the risks to health. This corresponds to an institutional recognition of his suffering by making him face his responsibilities ²⁰¹.

Medical secrecy weakens collaboration among stakeholders as to the assessment of risks in connection in the context of late penalty. Following a dramatic event, the council in Geneva has proposed removing medical secrecy in prison, for a benefit to society. *"Under the proposed revision of the Geneva Act of application of the Penal Code, any therapist in charge of a person sentenced to a penalty or a therapeutic measure would have the obligation to spontaneously forward to the authorities the information necessary for evaluation of his potential for danger"*. Sprumont emphasizes the negative consequences of the proposed measure. *"Once the obligation of information on the dangerousness of detainees requires that the therapist performs a form of expertise, he is considered as legally unfit to rule and is therefore he's required to recuse themselves. As a therapist he has to be empathetic with his patient that is the reason why he is disqualified to evaluate his potential for danger"*. Therapists might find themselves in a situation of permanent denouncement and this rule could overload the competent authorities in terms of the amount of information to analyze. Furthermore the relationship of caregiver / patient requires a relationship built on trust and confidentiality. In case of doubt in this regard, the patient could limit himself when sharing information about his condition, however necessary for his diagnosis or his treatment monitoring. The intervention of

the therapist then loses its effectiveness. The information obligation constitutes in that case an impediment to the exercise of their functions. Another side effect is the discouragement of professionals to work in prison because of an over-responsabilisation feeling ²⁰¹.

5.3.7.3 *Prisoner complaints*

Detainees can complain to prison heads, cantonal GP, Committee for the Prevention of Torture or Swiss Academy of Medical Sciences. (Source: President of SPS by mail)

5.3.7.4 *Detainee's choice of medical care giversⁱⁱⁱ*

5.4 **Financial aspects**

Each canton manages its own budget. As other fields, prison is a part of the cantonal security budget. There is no general financial model which means that payment and hierarchical affiliation of healthcare professionals varies from one canton to the other. (Source: Hans Wolff by mail)

5.4.1 *Health coverage in prison*

Cantonal execution of punishments services and city or municipality social services support the costs of health care in prisons. Cantons have different practices. Concordats develop directives, decisions and regulations to harmonize the execution of punishments and measures, such as the remuneration paid to detainees ¹⁵⁶.

The Interface between the execution of criminal penalties and social assistance specifies the following points ¹⁵⁵.

ⁱⁱⁱ No data



5.4.1.1 *Compulsory Health Insurance*

Persons living in Switzerland are subject to the obligation to subscribe a health insurance according to the Federal Law on Health Insurance (Loi fédérale sur l'assurance maladie, LAMal). This obligation also applies to detainees as long as they have a residence in Switzerland ¹⁵⁵.

There is no public health insurance system in Switzerland and there are several dozens of private health insurance companies, for-profit or not-for-profit. The LAMal has reinforced the regulation of health insurance companies and they are no longer authorized to have a for-profit objective and to conduct a risk selection with regards to the compulsory part of the health insurance ¹⁵².

The upkeep of the insurance coverage in case of illness falls within the competence of the cantons of civil residence of the insured person (art. 3 and art. 6 LAMal). The cantons shall designate the body responsible for carrying out this task within the canton. The competent body for compliance with the obligation to insure against the disease is not necessarily the same as the one granting social assistance.

The Swiss health insurance funds are private companies.

LAMal Art. 64 provides that the insurer reports debts to the competent cantonal authority (normally attached to the Directorate of Public Health of the canton of residence). Thereafter, the canton of residence supports 85% of receivables and announced.

Institutions for the execution of criminal sanctions are empowered to help prisoners without insurances. If the inmate lacks of resources, a justified request for support or premium reduction must be filed with the civil sector of the detainee. The LAMal premiums are not supported by social assistance ¹⁵⁵.

5.4.1.2 *Medical expenses*

Ambulatory or institutionalized health expenses are covered by health insurance in most cantons. However, some cantons (Geneva) covers the health care cost directly via the HUG in the pre-trial setting and insures detainees in post-trial prisons. This decision was taken as most pre-trial detainees are undocumented migrants (65%) without health care coverage outside and the time of stay in pre-trial detention too short to evaluate effectively the insurance situation. In some cantons, the detainee has to auto-finance by his/her own means (franchise, quota, contributions to hospital staying costs) and other costs expenses that are not covered by health insurance benefits (dental expenses, cost of glasses). If the inmate can't provide these costs on his/her own, in principle he/she is entitled to welfare benefits by performing a justified request to the competent organ of social assistance ¹⁵⁵.

5.4.1.3 *Hospitalizations*

This is the difference between the cost of medical care and the costs of security and surveillance measures. The resultant charge of ensuring the monitoring of people at risk of flight or danger to the community for institutionalized care in a hospital or in a psychiatric clinic are designated as additional security or surveillance or share of justice. These costs are borne by the cantonal authority of the prison, while the cost of institutionalized medical care cannot be brought to the charge of the enforcement of criminal penalties.

Fees are charged for hospital care to health insurance, if not: to residency canton, and if not again: the prison canton finances the difference ¹⁵⁵.

5.4.1.4 *Age and Survivor Insurance (AVS)*

Persons domiciled in Switzerland must pay a minimum annual contribution to the AVS. In principle, persons receiving labor remuneration are able to resolve these contributions on their own. To avoid gaps in contribution, the executing agency verifies whether to make such contributions. If necessary, it proceeds to transfer. If the inmate is not able to pay his dues, he can apply for a rebate with the Office of the AVS. These contributions are never funded by social support ¹⁵⁵.



5.4.1.5 Work of detainees

Earnings of detainees come from completed tasks, and from a fee for attending classes (Article 83 PC), the detainee being obliged to work (art. 81 PC). People in implementation of therapeutic or internment are encouraged to work, provided that their treatment allows it (art. 90 al. 3 PC). The amount of earning varies according to the service provided and the behavior of the detainee. The average is CHF 25 per day. Remuneration is divided into two parts. One part is available for personal expenses and free use (food, phone, training, medical care, LAMal, AVS, etc.) social obligations (job interview, indebtedness) and providing repair (for injured parties). The other part is blocked and paid at the time of release. The distribution between those two parts is fixed by concordats or cantons. With the agreement of the prison authorities the blocked part can be partly withdrawn ¹⁵⁶.

5.4.1.6 Illustrations

- Canton 1

If the detainee has no medical insurance, the canton pays the medical expenses. In a cantonal preventive prison, two-thirds of detainees have no legal status, so they are not insurable. Only a small part of the other third is insured. Because it costs a lot of money to identify them, the prison canton has chosen to take directly in charge medical expenses for all detainees.

- Canton 2

In a Canton, detainees are asked a CHF 5 fees for the first consultation. A positive point is the (little) incoming money is paid into a prison health care fund. A bad point is that some detainees renounce to medical consultation, with as a consequence more advanced diseases and worse control of infectious diseases.

(Source: Hans Wolff by phone)

5.4.2 Health delivery costs

5.4.2.1 Prison Healthcare in Neuchâtel Canton

The estimates were made according to two scenarios. With a hospital partnership with the Centre of Psychiatry of Neuchâtel (CNP), the main items are personnel expenses (CHF 1.667 million) and medical treatments not reimbursed by health insurance funds (CHF 414,000), for a total of 2,081,000 CHF. Without partnership, the total is 2,597,000 CHF. The amount of the second scenario is higher because some services could not be billed to health insurance companies.

The wide gap between 2014 and 2016 is explained by the lack of current resources relative to the number of inmates.

The connection to a hospital structure is essential for several reasons: the complexity of the issues, the institutional difficulties of recruiting health professionals, and financially, partnership would feed into certain acts of care sickness funds (benefits nurses) or reduce drug costs ²⁰².

Table 30 – Switzerland - Costs and estimation costs of prison healthcare in Neuchâtel Canton (NE) in CHF

	2014 SPNE	2016 SPNE	2016 SPNE+CNP
Personnel costs (including mandates independent GP)	894 000	1 677 000	1 677 000
Medical treatments (detainees in NE)	555 000	1 000 000	658 000
Medical treatments (detainees out NE)	790 000	760 000	760 000
Income / other reimbursements sickness funds	-574 000	-415 000	-1 004 000
Net expenses paid by the State	1 665 000	2 597 000	2 081 000

Source: ²⁰²



5.4.2.2 *Santé Prison Suisse*

As the CSFPP, SPS is funded through cantonal contributions set according to days of detention. SPS is not operationally involved in care. Nevertheless, it may be mentioned as an indication that the 2016 budget is CHF 220 000¹⁷¹.

Table 31 – Switzerland – SPS budget, 2016

Items	Costs, CHF
Internet	3000
Seminar	7500
Policy and professionals network	2000
Prisons network	5000
Fixed Operating Costs (staff, presidency, etc.)	184 500
Variable Operating costs (translating, secretariat, etc.)	9500

Source: ¹⁷¹



6 THE NETHERLANDS

PRISON HEALTH IN THE NETHERLANDS: MAIN FINDINGS IN A NUTSHELL

- **The prison administration** employs 10.120 FTEs and provides daily care for 10.500 inmates in 77 locations consisting of both detention centres (for adults held in pre-trial detention or serving short-term sentences) and prisons (for adults convicted of an offence, including 4 Penitentiary Psychiatric Centres, or PPCs). The incarceration rate is 62.9 prisoners per 100.000 inhabitants. The occupancy rate is 84.8%.
- Detainees are entitled to health care and the **DJI (Dienst Justitiele Inrichtingen) is responsible for the delivery of health care services** in the judicial facilities. According to its mission statement, the DJI strives to ensure that the medical care provided to prisoners is of a comparable standard to that available to the general population (“**equivalence principle**”).
- Every judicial institution (detention centres, remand prisons and detention centres for foreign nationals) has a medical service consisting of a manager, some judicial nurses, some judicial physicians, and some administrative staff. Only judicial physicians are not employed by the Prison Service but purchased (usually employed by an external organization). The others are civil servants. Altogether, they compose 66 multidisciplinary **Psycho-Medical Teams** (PMT - Psycho-Medisch Overleg / Psycho-Medische Zorg) with one or more psychiatrists, psychologists, doctors (202). The PMT manager is accountable to the prison governor, and administrative support.
- If primary healthcare offered inside the prison is not sufficient, prisoners can be sent to the **medical care centre (56 beds) of the prison of Scheveningen**. The Scheveningen Medical care centre seemed unable to meet the need for secondary care coming from all the Dutch prisons. The hospital does not always have sufficient bed space, or the required expertise. As a result, many prisoners are transferred directly to a civilian hospital.
- **Judicial nurse and triage:** Upon entering, every prisoner receives a medical intake by a nurse within 24 hours. This intake should always be approved by a doctor. The intake also determines on the basis of some questions whether the prisoner is eligible for screening for tuberculosis. A mobile X-ray unit (bus) comes once a week to every setting. Any prisoner complaining about some health problems first meets with a nurse who will orient the prisoner towards the
- **The Quality Act for Health Care Institutions (1996)**^{jjij} is an important legal framework for all organizations where medical professionals are working. This law defines some healthcare quality standards and places the responsibility for the provision of appropriate healthcare on care providers.
- Some improvements took place in the last ten years through to the creation of the **post of Head of Medical Services**, and the **further professionalization of staff (doctors and nurses)**. Prisoners’ healthcare became a real sub-discipline. Attention has been devoted to the training of **judicial nurses**, who are expected to refer patients to a qualified practitioner as necessary.
- Arrangements for the administration and dispensation of **drugs prescription** have been standardized, and access to the **Micro-HIS system of electronic medical records** still needs to be improved.
- **Main persistent problems are:**
 - Out-of-hours coverage (evenings, night-times and weekends): qualified doctor are not always available; medical records are not always complete;
 - The management and usage of the emergency pharmaceutical supplies should be improved;
 - Continuity of care before, during and after detention should be improved by ensuring that all relevant records and information are transferred efficiently, and by seeking closer contact with outside health providers (general practitioners and local authority health departments).
 - The medical files of the patients are too fragmented and complicated.
 - A detailed professional status should clarify the responsibilities and powers of and between the different care providers.

^{jjij} Wet van 18 januari 1996 betreffende de kwaliteit van zorginstellingen. URL: http://wetten.overheid.nl/BWBR0007850/geldigheidsdatum_11-01-2013.



physician (immediately during consultation schedule, or through telephonic consultation), or handle himself/herself if the problem is simple. In severe cases, an ambulance has to be called.

- **Health insurance:**

- Every prisoner entering a prison is required by the DJI to report to his/her insurance company that he/she is detained so that his/her health insurance is suspended. During his/her detention, the prisoner falls under the health insurance arrangements of DJI. He/She benefits from the government's health insurance, but not his/her family.
- When a prisoner's insurance is put into a sleep mode, every medical expenses is paid by the Ministry of Security and Justice. The benefits in the provision package (verstrekkingenpakket) (hospital care, aids, physiotherapy, dental care, etc.) are funded by the Prison Service (DJI).

- **Control bodies:**

- the Inspectorate of Security and Justice (IVenJ) acts as coordinating body;
 - the Health Care Inspectorate (IGZ);
 - the Inspectorate for Youth Care (IJZ);
 - the Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ)
-



6.1 General presentation of prison and healthcare system

6.1.1 Main actors

6.1.1.1 Prison system

17 million inhabitants are living in the Netherlands in March 2016. The DJI (*Dienst Justitiële Inrichtingen*) is the Dutch Department of Penal Institutions (Dienst Justitiële Inrichtingen, DJI), an agency of the Ministry of Security and Justice. The headquarter of this Agency is located in The Hague and consists of three divisions.

DJI DIVISIONS

Prison administration & Special facilities (detention and removal centres for foreign nationals)

Correctional institutions for juvenile offenders & Forensic care

Individual affairs (responsible for selection and placement of individuals)

Here are some characteristics of these four sectors.

- The prison administration employs 10.120 FTEs and provides daily care for 10.500 inmates in 77 locations. Both detention centres (for adults held in pre-trial detention or serving short-term sentences)^{kkkk} and prisons (for adults convicted of an offence, including 4 Penitentiary Psychiatric Centres, or PPCs) will be called “prisons” in this report.
- The correctional institutions for juvenile offenders employ 826 FTEs and provide daily care for approximately 500 young people (between 12 and 18 years of age, up to a maximum of 23) convicted of an offence. These young people are detained in 4 central government institutions (part of

the Ministry of Security and Justice) and 5 private institutions (purchased by DJI, but under their own management).

- The Forensic care^{llll} directorate employs 714 FTEs caring for approximately 700 patients who have been convicted and who require psychiatric care. Forensic care is delivered in 2 central government institutions (part of the Ministry of Security and Justice), 11 private institutions (purchased by DJI, but under their own management), the already-mentioned 4 Penitentiary Psychiatric Centres (PPCs - for adults who have been convicted and require psychiatric care). The average period of detention for a person in a PPC (in case of a forensic decision taken by the judge) is more than 9 years. Forensic care within the context of criminal law covers all mental healthcare and care for mentally-handicapped adult subject to criminal court orders, in addition to around over 1500 places for forensic care and ambulatory forensic care²⁰³, where patients are placed under hospital orders (TBS^{mmmm}).

Special facilities (or detention centres for foreign nationals being prepared for removal) were employing 850 FTEs in 2009²⁰³ⁿⁿⁿⁿ. These facilities were caring for approximately 650 inmates who were detained on the grounds of measures under administrative law because they had been refused entry at the border (Section 6 of the Aliens Act) or because they were living in the Netherlands illegally (Section 59 of the Aliens Act). The average period of detention was then of 72 days.

^{kkkk} There are three prisons for women.

^{llll} Forensic care is ordered by the judge and relates to the offense.

^{mmmm} There are 22 sanctions.

ⁿⁿⁿⁿ This population decreased drastically in the last three years as sending these people back to their home country is a very complicated process, rarely successful (Information provided by Miss Annet Slijkhuis, Head of the Health Care Department of the DJI, 08/05/2016).



6.1.1.2 Health care services

Detainees are entitled to health care and the DJI is responsible for the delivery of health care services in the judicial facilities. According to its mission statement, the DJI strives to ensure that the medical care provided to prisoners is of a comparable standard to that available to the general population²⁰⁴. The so-called “equivalence principle” was defined by the DJI in its 2006 healthcare vision note²⁰⁵.

The basic health care offer in Dutch prisons includes both primary (generalist) and secondary (specialized) healthcare services, similar to those offered by hospitals, clinics and nursing homes. Every judicial institution (detention centres, remand prisons and detention centres for foreign nationals) has a medical service consisting of a manager, some judicial nurses, some judicial physicians, and some administrative staff. Only judicial physicians are not employed by the Prison Service but purchased (usually employed by an external organization, like in Belgium). The others are civil servants. Altogether, they compose 66 multidisciplinary Psycho-Medical Teams (PMT - *Psycho-Medisch Overleg / Psycho-Medische Zorg*) with one or more psychiatrists (from the NIFP), psychologists, doctors²⁰⁶. The PMT manager is accountable to the prison governor, and administrative support⁰⁰⁰⁰.

Every team defines and coordinates the primary health services offered to the prisoners during - and eventually after, according to the prisoner’s needs – their detention. The hybrid position of these medical teams has been questioned by Moerings (2005: 441)²⁰⁷ as medical practice is subordinated to order and security management.

If primary and secondary healthcare offered inside the prison is not sufficient, regular hospitals are used for medical-specialist care. Some secondary health care is also provided by the medical care centre of Scheveningen. Scheveningen prison consists of a Penitentiary Psychiatric Centre (PPC), Very Limited Security Facility (ZBBI) and the Judicial Center for Somatic Care (JCvSZ). The Judicial Centre for Somatic Care (JCvSZ)

has 56 beds dedicated to prisoners who need non-emergency somatic care. It offers some post-operative care, initial treatment of tuberculosis, some nursing home care and general medical care (for eat and drink strikers, for example) that are beyond custodial medical teams’ capacity. Every Dutch prison can send some prisoners to this medical care centre. As a medium-care hospital, Scheveningen does not have any intensive care unit, neither cardiac nor emergency rooms. For urgent or complex operations, but also whenever the journey to Scheveningen is too long, prisoners are transferred to a regular civilian hospital^{204 208}.

The dentist also comes to most of the institutions. He has his own allocated treatment room or comes in one of the 3 dental buses²⁰⁹.

Finally, via the Spiritual Care Service, several faiths/religions are represented, such as the Roman-Catholic church, the Protestant Church, the Association of Humanists, the Muslims and Government Contact Body and the Jewish Congregation. Representatives of these various traditions are available to the detainees and are referred to as spiritual advisors²¹⁰.

6.1.2 Respective competences and collaboration frameworks

The Dutch situation is similar to the Belgian one, as the Department of Penal Institutions (Dienst Justitiële Inrichtingen, DJI) lies under the jurisdiction of the Ministry of Justice. The Dutch DJI is, like the Belgian Prison Agency, in charge of prisoners’ access and rights to medical health services. Responsible for the delivery of healthcare services in its judicial facilities, the Dutch policy strives to ensure that the medical care provided to prisoners is of a comparable standard to that available to the general population²⁰⁴. This so-called “equivalence principle” is encouraged at a European level.

⁰⁰⁰⁰ Information provided by Mr Michel Westra, Medical Advisor of the Health Care Department of the DJI, email of the 24/03/2016.



In the Netherlands, the articles 42 of the Prison Principles Act^{pppp}, 47 of the Judicial Facilities for Young Offenders' Act^{qqqq}, and 41 of the Penitentiary Psychiatric Centrum's Act^{rrrr} define prisoners' right to medical care.

Health care services offered by the DJI to Dutch prisoners consist of both somatic (doctors, nurses, dental care, prevention, Scheveningen medical care centre) and psychiatric care (first and second line mental health care in detention, forensic psychiatric care in and after detention). DJI has the obligation to provide good quality health care to its prisoners. The Principle Law for prison facilities, juvenile institutions and forensic clinics mentions the right to healthcare for every individual person and the obligation of the prison director to provide it.

The Quality Act for Health Care Institutions (1996)^{ssss} is an important legal framework for all organizations where medical professionals are working. This law defines some healthcare quality standards and places the responsibility for the provision of appropriate healthcare on care providers. Responsible care is defined here as good quality care, effective, efficient and patient-oriented and geared to the real needs of the patient^{tttt}. A key element of responsible^{uuuu} care is a systematic monitoring, control and improvement of care. Standards for the quality of health care in correctional institutions are also anchored in national and international laws and regulations, such as the European Convention on Human Rights (Art. 2, 5 and 15) and international law and conventions for the treatment prisoners like Standard Rules for the Treatment of Prisoners (adopted by the United Nations in 1984) and the European Prison Rules (Council of Europe, 1987,

2006). At national level there is the Constitution (art. 5, 10, 11 and 22 paragraph 1) and the national health care legislation.

The DJI provides a framework for the implementation of health policies that focuses on five areas (DJI, 2006, pp. 6-7):

1. A good psychosocial climate. Healthcare must be embedded in a good psychosocial climate. Damage as a result of being imprisoned must be minimized as much as possible. DJI promotes the quality of the psychosocial climate inside prison.
2. Tailored care. The opportunities and healthcare needs of the prisoners as well as the circumstances of the detention must be taken into account while delivering healthcare services. Special attention is given to the prisoners with mental illness and / or addiction.
3. Investing in the staff. The DJI aims to provide good quality and adequate availability of healthcare professionals in the judicial facilities. To this end, some requirements concern the level of expertise, skills and attitudes in relation to the profession. The level expected of the medical and nursing staff will sometimes rise above the level set out in the Act. In addition to the basic professional training, specific programs and courses are adapted to the work in a custodial facility.

^{pppp} Wet van 18 juni 1998 tot vaststelling van een Penitentiaire beginselenwet. URL: http://wetten.overheid.nl/BWBR0009709/geldigheidsdatum_21-01-2016.

^{qqqq} Wet van 2 november 2000 tot vaststelling van een Beginselenwet justitiële jeugdinrichtingen. URL: http://wetten.overheid.nl/BWBR0011756/geldigheidsdatum_21-01-2016.

^{rrrr} Wet van 25 juni 1997 tot vaststelling van een Beginselenwet verpleging ter beschikking gestelden. URL: http://wetten.overheid.nl/BWBR0008765/geldigheidsdatum_21-01-2016.

^{ssss} Wet van 18 januari 1996 betreffende de kwaliteit van zorginstellingen. URL: http://wetten.overheid.nl/BWBR0007850/geldigheidsdatum_11-01-2013.

^{tttt} This law was recently replaced by a new one: Wet van 7 oktober 2015, houdende regels ter bevordering van de kwaliteit van zorg en de behandeling van klachten en geschillen in de zorg (Wet kwaliteit, klachten en geschillen zorg). URL: <https://zoek.officielebekendmakingen.nl/stb-2015-407.html>.

^{uuuu} In the new law of 7 October 2015, "responsible care" was replaced by "good care" (Article 2), meaning "good quality and high level"; "sure", "client-oriented", "and respectful of the client's rights".



4. Healthcare infrastructure. The DJI realizes a nationwide, adequate and consistent supply of both regular and particular care regimes. These should have a good connection to each other, to Mental Healthcare, drug abuse treatment and other health institutions, and some relevant follow-up care should be offered after release. Cooperation with partners in infectious disease control is aimed at the prevention of infectious diseases, preventing the spread of infectious diseases such as AIDS, Tuberculosis and hepatitis, inside prison as in the free civil society. DJI adequately responds to changes in the demand for care, whether quantitatively, qualitatively or continuously.
5. Care continuity and follow-up. In the interests of healthcare, judicial facilities shall seek to ensure continuity of care through close coordination with partners in health care. Continuity of care contributes first to the individual's health and also to the reduction of recidivism.

In August 2013, a study lead by the Inspectorate for the Healthcare Services^{wvv} took place²¹¹. The quality of healthcare services was assessed as well as the access to healthcare services, the expertise of the medical staff, the transfer of medical information, and the security of medication. The results of this assessment show that a systematic screening of every new prisoner takes place within the 24 hours his/her arrival; that medical care is sufficiently accessible; that the transfer of medical information is adequate; and that a medication list is available for every prisoner. However, two questions are raised by the assessment. Firstly, the medical files of the patients are too fragmented and complicated. Therefore, the Inspectorate requires that prison governors implement some electronic medical records (or elektronisch patiënten-dossiers). Secondly, a detailed professional status should clarify the responsibilities and powers of and between the different care providers. The Penitentiary Nursing Care framework only defines globally the tasks of the different stakeholders, but not their respective expertise in concrete situations²¹². A significant step towards a professional status for the judicial nurses has been made in 2015²¹³.

^{wvv} This organism is independent from the Ministry of Justice. It promotes public health through advising the responsible ministers "and applies various measures, including advice, encouragement, pressure and coercion, to

6.1.3 Historical perspective

Two reports pointed out the lack of a health care vision by the DIJ in the late 1995²¹⁴ and 1999²¹⁵. These reports also critique the lack of a clear vision of care; the lack of formal authority in the medical service and a messy organizational structure; unclear job descriptions; the lack of attention to the continuity of care; incomplete patient files; under-developed quality. The nursing staff did also complain about heavy workload²¹⁶, low payment, unclear management and faltering communication. As a consequences of these reports and signals, the health care division of DJI launched a project entitled 'responsible medical care in prisons' in 2003. This project aims at formulating a vision, a policy, and some principles for health care delivery inside Dutch prisons²¹⁷.

At the heart of this project lies the already mentioned "equivalence principle", as well as 14 work processes (idem: p. 10).

1. The health situation and history of every prisoner are reported by nurses filling a standard form;
2. The doctor will assess the health status of every incoming prisoner on the basis of the file submitted by the nurse and, maybe, their own research;
3. When a prisoner asks for some medical care, the nurse guides him towards the appropriate medical appointment (nursing consultation, medical consultation, other practitioners' consultation, deal with repeated prescriptions), this under the responsibility of the doctor;
4. The nurse carries out the nursing consultation (according to the nursing standard);
5. The prison doctor performs the consultations according to the general practitioner-nursing norms;

ensure that health care providers offer only 'responsible' care. The Inspectorate investigates and assesses in a conscientious, expert and impartial manner, independent of party politics and unaffected by the current care system". URL: <https://www.igz.nl/english/>.



6. Every 'external' health/medical practitioner is supported by a nurse and a medical secretary; they provide continuity (for follow-up appointments) and coordination;
7. The nurses perform care and post cure;
8. During office hours, emergency care is provided by the nurse and the doctor;
9. Outside office hours, emergency care is provided by the GP, a partnership of Regional Prison Service with the municipal health service as a safety net;
10. The nurse provides coordination and alignment in the healthcare chain (transfer, attendance at prisoners' consultation, reporting to other departments, management and monitoring of the treatment);
11. The prison doctor provides socio-medical opinions regarding work disability, isolation, and aptitude for sports;
12. The nurse performs health education tasks under the responsibility of the prison doctor (education about infectious diseases, nutrition, vaccination);
13. The prison doctor, the nurse, the psychiatrist and the psychologist are involved in acute psychiatry;
14. The nurse, the assistant of the pharmacist and the Prison Service care worker contact the doctor and the supervising pharmacist before they dispense medicines.

In many cases, doctors are working in a prison besides conducting regular general practice. This led to a great diversity in recruitment and organization, partly because it was difficult to find new doctors and arrange the evening, night and weekend shifts. Another problem was the incapacity of the Prison Service to calculate and estimate the price of a consultation. As some

knowledge was needed about the rate and the workload of prison doctors and nurses, the NIVEL (the Netherlands institute for health services research) report aims at mapping the working process of the primary healthcare services inside prison ²¹⁷.

Another set of critics has been addressed towards the second-line healthcare services delivery. The Scheveningen Medical care centre seemed unable to meet the need for secondary care coming from all the Dutch prisons. The hospital does not always have sufficient bed space, or the required expertise. As a result, many prisoners are transferred directly to a civilian hospital. Aiming to improve the problematic connection between supply and demand, the DJI needed a research report mapping Dutch prisons' need for second-line healthcare services ²¹⁸.

The rules about the placement of prisoners in the medical care centre or in a civilian hospital are laid down in the Rules on selection, placement and transfer of detainees on 15 August 2000^{www}. According to these rules, prisoners can be placed in the medical care centre (Article 19) if they need some medical treatment for which hospitalization is indicated; if they are suspected of having hidden in their body some objects that can pose a serious danger to their health; if they require some extra medical care and can't therefore stay in prison. The medical service of the prison sending a prisoner to Scheveningen medical care centre must submit a request to the head of the medical care centre.

This report showed that Scheveningen Medical care centre could not meet the prison facilities' expectations. This was mainly due to both the nature and location of the medical care centre. Furthermore, because the medical care centre employs only one surgeon, other specialists were hired from outside and therefore not always available. Finally, the distance between most prison facilities and the medical care centre made it impossible to go and be back in one day. As a result, many prisons almost exclusively call

^{www} Regeling selectie, plaatsing en overplaatsing van gedetineerden, 15 augustus 2000, Nr. 5042803/00/DJI. URL: <https://zoek.officielebekendmakingen.nl/stcrt-2000-176-p9-SC25563.html>.



the closest civil hospital to transfer some prisoners (and some guards) when needed.

As a consequence of the already-mentioned reports, some steps have been made in the early 2000s to improve the quality of medical services inside penal facilities, as reported by the Inspectie voor de Gezondheidszorg. These improvements are partly due to the creation of the post of Head of Medical Services, and the further professionalization of staff (doctors and nurses). Prisoners' healthcare became a real sub-discipline. Attention has been devoted to the training of nurses, who are expected to refer patients to a qualified practitioner as necessary. Arrangements for the administration and dispensation of drugs prescription have been standardized, and access to the Micro-HIS system of electronic medical records has been improved whereby it can be used more consistently ^{204xxxx}.

Nevertheless, the Inspectorate's study reveals that a number of persisting risks with regard to:

- Out-of-hours coverage (evenings, night-times and weekends): qualified doctor are not always available; medical records are not always complete; the management and usage of the emergency pharmaceutical supplies should be improved. Therefore, the Inspectorate recommends that the prisoner must be enabled to speak directly (by telephone) with a qualified doctor or health professional.
- The management and usage of Micro-HIS information system should be improved (the patient's registration or complaints should be adequately recorded).
- The management and usage of the electronic Pharmaceutic system should be improved (when issuing prescriptions, the risk of errors, drug interactions and avoidable contra-indications do exist).

- Some prescription drugs are ordered and dispensed without the authorization of a qualified doctor (some prescription drugs are sometimes dispensed by prison staff who do not have adequate knowledge of their effects or side-effects. Every prescription must be authorized by a qualified doctor, and the prison staff should receive training in the effects and side-effects of medication.
- Continuity of care before, during and after detention should be improved by ensuring that all relevant records and information are transferred efficiently, and by seeking closer contact with outside health providers (general practitioners and local authority health departments) ²⁰⁴.

Various reports have also been written on Tuberculosis in detention ²¹⁹, on the Psychiatric Prison Centres ²²⁰, and on Forensic Care Quality ^{221 222-224}.

^{xxxx} A similar research was conducted in the six detention centres for foreigners and the results have been published ²⁵⁶.



6.2 Characteristics of the prisons and prisoners

6.2.1 Fact and figures

According to the “facts and figures based on 2013”²⁰⁹, the DJI manages 77 facilities^{yyyy} and is responsible for the custodial sentences and measures of more than 11.000 prisoners^{zzzz}. According to the European statistics, 4040 of them were serving pre-trial sentences by the 1st of September 2014^{225aaaa}. 93 % of them are men, and 7% are women; 75 % of them are less than 40 years old; 56 % of them were born in the Netherlands; and about 60 % of them are addicted to one or more substances^{bbbb}.

By the 1st of September 2013, 10.547 people were incarcerated in Dutch prisons (= 62,9 prisoners per 100.000 inhabitants; 84,8 density per 100 capacity)²²⁵. 46.3% of them were waiting for their final sentence. Their median age was of 33. 5.4% of them were female, and 22% foreigners.

The average length of imprisonment in 2012 was of 3.5 months. 67.3% of the prisoners have been condemned to less than 3 years.

6.2.2 Health coverage in prison

Every prison has its own medical team, composed of doctors and nurses. Their special position in the penal institution should be mentioned, as the medical team is one of the many departments within a prison. It is also the only department that does not focus on security. On a daily basis, doctors and nurses heavily depend on other departments, like prison guards, that are responsible for the security. The work (work schedule and workload) of every medical team is also determined by the organizational properties of the prison facility: the communication between the medical team and the

prison management team is meant to be open and fluid (this doesn't mean it is always the case); whenever the regime is more restrictive for prisoners (for example, if they have to stay inside their cell from 5 PM to 7 AM), the consultation schedule has to be adapted and the workload for the medical team tends to increase; generally, remand facilities have a higher turnover rate among their population than facilities hosting convicted prisoners; many new prisoners enter remand facilities (often late in the evening, or early in the morning), and most of the prison population is suffering of some addiction; administrative work is considered by the majority of the penitentiary nurses as a burden increasing with the size of the facility.

According to a research on their workload²¹⁷, the nurses of these medical teams devote on average 34 working hours per prisoner per year, while doctors devote less than 3 working hours per prisoner per year.

The Medical care centre in Scheveningen was employing 4 doctors and 34 nurses in 2006²¹⁸: 3 GPs and a surgeon. A doctor is always present during working hours, and another available on-call in the night. Consultations are organized with some specialists coming from the Bronovo Hospital in Den Haag: a pulmonologist, an internist and a gynaecologist hold weekly consultations; ENT doctor usually operates every eight weeks; an orthopaedic surgeon operates five to six times a year. Every practitioner is responsible for his or her own patients' care.

The 34 nurses of the Medical care centre were working 30.4 FTE in 2006 (idem). Six of them are working in the morning, six in the afternoon, and two in the night.

The Medical care centre has 56 beds divided into three sections. Twenty of these beds are located in single rooms and ten other rooms have three beds.

^{yyyy} A digital map is available here:
https://experience.grontmijservice.nl/geoweb5html5/index.html?viewer=digitale_landkaart_dji

^{zzzz} Every year, 45.000 new detainees are admitted. On average, there are 10.500 in detention on any single day. In 2013, the average stay for an adult inmate was 105 days; the average age of that adult inmate was 35; and the average cost of 1 prison place was €262per day²⁰⁹.

^{aaaa} No information was found concerning the distribution of the different types of prisoners (remand, sentenced, interned) in the different types of organizations (detention centres, prison, PPCs).

^{bbbb} Statistics provided by Mr Michel Westra, Medical Advisor of the Health Care Department of the DJI, email of the 24/03/2016.



In 2005, 723 detained patients have been recorded in the Medical care centre. Among them, 357 were recorded via the waiting list, and 366 were (semi) emergency cases. The average occupancy rate in 2005 was 83 %, with an average of 46.4 patients per day. The length of their stay was on average 22 days (idem: 51).

Healthcare services should be provided to prisoners according to a comparable standard to that available to the general population. The nature of their offense, length of their sentence, their nationality eventual (multi) recidivist status should play no role in the actual medical care prisoners can benefit. However, these factors as well as the presence of some addiction problems and/or psychiatric disorders determine the real assistance they should be provided, as shown by a specific research conducted on addicted inmates' medical care in 2008 ²²⁶.

According to the 2008 letter written by the Minister of Justice (229), an individual approach should be offered to inmates upon entry. Every one of them must be screened in a standardized way with respect to various needs in terms of risk management, sociability, suitability for multi-persons' cell and (forensic) care needs. This information must be processed in the detention plan drawn up for each prisoner. Over 14 days, the inmate must be monitored, and the findings must be recorded in a standard observation form. The available information can then be discussed in a multidisciplinary consultation of prison officers and medical professionals for the purpose of determining the appropriate treatment of a detainee ^{227cccc}.

^{cccc} No evidence was found regarding the actual implementation of these recommendations.

^{dddd} Mental health is much broader than the care delivered to mentally ill offenders. However, this section will focus on this topic rather than on the

6.3 Delivery of care

Upon entering, every prisoner receives a medical intake by a nurse within 24 hours. This intake should always be approved by a doctor. The intake also determines on the basis of some questions whether the prisoner is eligible for screening for tuberculosis. A mobile X-ray unit (bus) comes once a week to every setting. Any prisoner complaining about some health problems first meets with a nurse who will orient the prisoner towards the physician (immediately during consultation schedule, or through telephonic consultation), or handle himself/herself if the problem is simple. In severe cases, an ambulance has to be called.

The judicial nurse can also orient the prisoner towards a psychologist could also admitted lead to a psychologist. Once a week, every PMT meets to discuss about prisoners with (serious) mental health problems. When referring to a hospital takes the first place to the nearest hospital (secure). In ordinary civilian hospitals also investigate and, if necessary, place operations. If someone need care that cannot be delivered in a regular Judicial arrangement we have with the judiciary centre for somatic care (JCvSZ) in Scheveningen where 24 hour nursing care is available.

6.3.1 Specific Health Issues

Three specific health issues are regularly mentioned in the grey literature.

6.3.1.1 Mental Health ^{dddd}

The TBS (Terbeschikkingstelling), the modern revision of the TBR (Terbeschikkingstelling van de Regering) created by the psychopath act in 1928, was created to fight recidivism on prisoners with mental disorders. First, the prisoner receive a sentence, and afterwards, he is detained indefinitely for treatment in hospital order, for so long he is considered as dangerous for the society. Therefore, in the Netherlands, the mentally

mental health problems occurring in Dutch prisons, as the information about these problems was not identified.



disordered offender is first seen as a guilty person and then as a patient. There is no conflict in this. There is no a duality between responsible (prisoner) or not (mental disordered) ²²⁸.

There are 12 TBS hospitals where patients are transferred at the end of their sentence. Most offenders (approximately 60%) have been convicted of serious violent offences, and around 30% are sexual offenders ²²⁸. 75% of patients are diagnosed for abuse and dependence disorders. 65% of the sample has at least one other disorder (affective disorder, anxiety, etc.) than the substance abuse or disorder. 51% have an lifetime affective disorder. 41% suffer of alcohol dependence ²²⁹. The number of beds has increased, from 400 in 1975 to 1637 in 2006. There were 1581 TBS patients in 2006. This increase is due to the confidence of the Court in this system which protects the general population. The recidivism over 5 years has decreased from 52% in 1974 to 17% in 1998. There is no difference between high, middle or low secure institutions in TBS. The same clinical team follows all patients with a weak turnover that permits to better know the patients ²²⁸.

One psychiatrist and one psychologist assess the mental health of detainees each two years and the court decides if the prisoner could be released or not ²³⁰. After 6 years, an independent team of psychiatrist and psychologist assesses the patient and reports to the court. ²²⁸ The two independent experts don't only assess the mental health of the detainee, but also the harmony of the previous treatment. They could emit recommendations. The court will decide for a possible extension of the hospitalization, based on the last assessment, the advice of the hospital and the probation officer. If the three actors are not in accordance, the court will discuss with them behind closed doors and will take a decision ²³⁰.

To assess the TBS system, some studies were done by the Ministry of Justice since 1978. The latest was in 2005. 1798 prisoners were followed into five years cohort. Between 1994 and 1998, 27% of violent offenders discharged from TBS were arrested for another crime within 10 years, while 17% in five years TBS. For sex offenders, 11% versus 7% ²²⁸.

For patients for whom TBS program seems to be not efficient, 2 units for long stay were built in 2000. In these units, accent is placed on care and security. The patient has the right to appeal against this transfer ²³⁰.

But some problems of organization in TBS are revealed, like a stream of psychiatric assessment among detainees. The same questions are often asked, the same documents are filled, and this could demotivate or perturb the attention of the patient ²³⁰.

Another problem is the increase of the population of patients. In 1990, there were 527 TBS patients for 1581 in 2006 ²³⁰. In parallel, between 1974 and 1998, the mean duration of stay was 4.9 against approximately 7 years in 2005 ²²⁸. In long stay unit, the number of patients was 71 in 2001.

The Dutch system consists of first sending the offender to prison for a number of years and then for treatment to a secure clinical facility. "Legal rights of the patient under the TBS-order are protected by regular evaluations to help the court determine if the patient still poses a danger to society. These evaluations take place every two years, at the end of each extension period. Every six years an extra assessment by independent experts is obligatory. (...) This system is threatened by the qualitative and quantitative scarcity of properly qualified experts" ²³⁰.

6.3.1.2 Addictions (drug and alcohol)

A study was conducted at the end of the 1990's. It concerned people addicted for at least five years and that are arrested. The goals were to reduce drug related criminality, and rehabilitate the addicts. The persons have to be placed in long term treatment (one and half years to two years) instead of the typical nine months sentence in prison. Sixty percent of persons drop-out the program within three months, to be incarcerated. After 5 years, about fifty percent of participants are drug and crime free within the sixth months of the release. This is not substantially higher than voluntary programs. However, despite the low rate of success, this type of treatment is almost 40 percent more cost effective than policy of arrest, imprisonment, methadone, etc. ²³¹.

Other initiatives were ordered, like heroin or methadone distribution programs. No results are given ²³¹.



6.3.1.3 Others

The healthcare policy also implies some tuberculosis screening and provides some medical guidelines for the treatment of Hepatitis C, as well as on GHB (gamma hydroxybutyrate, i.e. an addiction).

6.3.2 Continuity of care

During the last century, the Dutch Drug Policy was renowned because of its pragmatic and liberal approach. By the past, with few exceptions, all arrests or imprisonments, completed by treatment programs were followed by new periods of addictions and crimes. The lack of training of prison staff, the short duration of imprisonment and the abundant availability explained partially the situation. Upon release from the prison, the person had to rely mostly on himself to find work, housing and restore his family relation ²³¹.

Some bottom-up policies were engaged. They varies a lot among agencies and municipalities. In 1992, several social work and mental health agencies became concerned about people with complex problems like drug using, homelessness, squatting, etc. that provoked local public disturbance. In Rotterdam, a wider group of social workers try to reach persons with difficulties. The philosophy of the method is that the worker is responsible to initiate a program, and not the patient/client ²³¹.

6.4 Financial aspects

6.4.1 Budget

In terms of national budget, the total DJI budget was € 2.2 billion in 2013 ²³². Out of this budget, € 750 million are allocated to the DJI health care process (out of which 600 are dedicated to forensic services) ^{eeeeee}.

The average cost per day of a place in a prison/detention centre is € 262; € 547 in a correctional institution for juvenile offenders; € 494 in a forensic psychiatric centre; € 398 for a place of care in a prison; and € 360 for a place of care in a healthcare institution (for example a psychiatric hospital).

The table below presents the equipment program costs. The item “Financing private establishments” mainly concerns the funding of private institutions for juvenile offenders and forensic psychiatric centres. The costs associated with the purchase of forensic care (incl. 24-hour care) is under the item “materiële programmakosten opgenomen”. The item “justitieel ingesloten” concerns the costs associated with the detention (food, laundry, medical care, hygienic care, creative education, etc.) ^{ffff}. The item “Other costs” primarily relates to the costs of judicial detainees ⁹⁹⁹⁹⁹ (including food, medical expenses, and creative activities).

^{eeeeee} See more about DJI here: https://prezi.com/sqamm93fk9_j/gedachtekaart-van-de-portefeuille-zorg-dji/

^{ffff} However, the table doesn't make any distinction between the costs for food and the costs for medical care/ equipment.

⁹⁹⁹⁹⁹ “Justitiële ingesloten” are imprisoned in “riksinrihtingen” (such as Forensisch Psychiatrische Centra).

**Table 32 – The Netherlands – Equipment program costs**

Tabel 01.6 Materiële programmakosten (x € 1.000)							
	2013	2014	2015	2016	2017	2018	2019
Financiering particuliere inrichtingen	299.740	323.624	304.171	317.554	310.073	306.392	306.392
Inkoopplaatsen forensische zorg	312.322	289.109	313.722	295.174	291.148	297.023	297.023
Huisvestingskosten Rijks Justitiële Inrichtingen (incl. bijdrage aan RVB)	359.908	326.229	339.754	316.983	313.024	308.052	308.052
Kosten justitieel ingeslotenen (rijksinrichtingen)	85.327	80.000	80.000	78.000	75.000	75.000	75.000
Overige kosten (o.a. kosten arrestanten op politiebureaus)	40.151	25.040	22.500	21.500	18.960	20.500	20.500
Totaal	1.097.449	1.044.002	1.060.148	1.013.212	992.205	990.966	990.966

Source: ²³³

6.4.2 Health insurance

Every prisoner entering a prison is required by the DJI to report to his/her insurance company that he/she is detained so that his/her health insurance is suspended. During his/her detention, the prisoner falls under the health insurance arrangements of DJI. He/She benefits from the government's health insurance, but not his/her family.

A medical provision package (verstrekkingspakket)^{hhhhh} was developed ²³⁴ in order to provide some tools that are paid from the central budget to the prisoners (194). That provision package is based on the basic package allowed to the ordinary citizen (who is compulsorily insured by an insurance company with a basic package). When a prisoner's insurance is put into a sleep mode, every medical expenses is paid by the Ministry of Security and Justice. The benefits in the provision package (hospital care, aids, physiotherapy, dental care, etc.) are centrally funded by the Prison Service (DJI). Basically a detainee doesn't pay anythingⁱⁱⁱⁱ.

^{hhhhh} The medical provision package consists in a document describing which service can be delivered by the medical department and which part is paid by the central department of DJI. It is based on the basic benefits package in society and aims to ensure that the State delivers an equivalent quality of care inside and outside prisons

ⁱⁱⁱⁱ Information provided by Mr Michel Westra, Medical Advisor of the Health Care Department of the DJI, email of the 24/03/2016.



7 CONCLUSION: CHALLENGES IN REFORMING HEALTH CARE SERVICES IN PRISONS

This report presents various aspects and subtopics we have identified as constitutive of healthcare in prisons in four countries. Due to the fragmentation of literature on the topics of interest (see Chapter 2), it proved unrealistic to expect an exhaustive portrayal of each country, which of course prevents a point-to-point comparison.

However this document provides substantial material to:

1. highlight six challenges in reforming health care services in prisons and how France, Scotland, the Netherlands, and Switzerland face them (pragmatic dimension);
2. highlight six comparative dimensions of a policy and organizational analysis (analytic dimension).

7.1 Six challenges in reforming health care services

Six challenges in reforming health care services in prisons have been observed in France, Scotland, the Netherlands, and Switzerland:

1. Building on the pre-existing Institutional Framework
2. Improving the Quality of Care Delivery
3. Tackling Health Inequities
4. Meeting the Specific Needs of Prisoners
5. Addressing Professional Practice Issues
6. Cost management

In accordance with the iterative process we choose to adopt in this report, these challenges were considered to organise the adjusted Policy Delphi in the research step following the review of literature process.

7.1.1 Building on the pre-existing Institutional Framework

Following the publication of international reports and recommendations, to improve the quality of care in prison has become a concern in several countries. The United Nations^{98,137,235}, the World Health Organization^{55,99,236}, the Council of Europe^{237,238} initiatives are frequently cited in the grey literature we analysed as drivers for change. The Moscow Declaration states that “penitentiary health must be an integral part of the public health system of any country”⁹⁹. The transfer of health-and-prison skills to the Ministries of Health is indeed considered as a principle of good governance⁵⁵, designed to improve healthcare. The arguments for integration include the independency of judgement of caregivers vis à vis the prison authorities, the capacity of such independent professionals to argue for public health measures, the expected enhanced trust and confidence of prisoners in health professionals, the co-ordinated response to infectious disease affecting both the prisoners and the wider community, the continuity of care inside and outside prisons for the prisoners, extensive opportunities for advanced training and research²³⁹. However, while the international recommendations guide and influence the national reforms, the domestic conditions and institutional framework also plays an important part. The transfer of responsibility for prison health to health ministries has been made in France, Scotland and in some Swiss cantons as well as in several European countries but not in the Netherlands, despite the advice given to that country by WHO to proceed to that transfer, as reported by A. Slijkhuisⁱⁱⁱⁱ,

In France the major reform in 1994 came from the public debate in the 1970s about the independence of prison psychiatry, and later on (in the 1990s) from a report confirming a critical situation in French prisons about addictive behaviors, HIV, hepatitis B and C, tuberculosis and mental health disorders²⁴⁰. Consequently, psychiatric care in prison was the first to be separated

ⁱⁱⁱⁱ Head of Health Department, Dutch Ministry of Security and Justice and member of the WHO steering group in Prison and Health



from the Prison Agency and, after an “interlude” in which health care was entrusted in some prisons to private groups for a period of 10 years (“13 000 program”), all somatic and psychiatric care in all prisons were finally placed under the responsibility of local hospitals. In this conditions, the main actors are the associated hospitals, acting under the responsibility of the *Direction Générale de la Santé* (Directorate General of health care provision).

In Scotland, the responsibility of healthcare in prison was transferred to the NHS in November 2011⁷¹ after Scottish Ministers had expressed in autumn 2005 an interest in it. The reform is the result of a long process of institutional concertation (see 4.1.3). The reform process was mainly supported by the legitimacy and institutional strength of the Scottish NHS, by the establishment of coordination structures between health and prison administration, at a national and at a local level and, as underlined by Dr Campbell^{kkkkk}, by the “political will for transfer to succeed”. Regional Health Boards became therefore responsible for the provision of care in the prisons located on their territory. Each Board operates independently regarding the delivery of care, which is seen as a weakness of the Scottish system by John Porter^{lllll}, pointing out challenges in communication between Boards and with other organisations. Another key informant pointed out the risk of fragmentation of prison health in the process of “moving the planning and delivery of prisoner healthcare from one organisation (the SPS) to 14 territorial Health Boards, 9 of which have prisons, with the remainder having returning ex-prisoners on release”. As the Boards are not accountable to the National Prisoner Healthcare Network, “success depends on strong leadership and partnership working” but achievements of the Network have not been evaluated by an external review. However, this network is acknowledged by different stakeholders from the clinical and the institutional field as one of the strengths of the Scottish system. Dr Campbell sees the integration of prison healthcare as a part of the larger NHS Board - “with attached Clinical Governance, Clinical Effectiveness, IT, recruitment and management structure” - as another strength of the Scottish system. However, she also reports “the lack of understanding of prison environment

in other parts of NHS, leading to communication and sharing of information issues”.

In Switzerland, the collaboration between prison and healthcare authorities differs from canton to canton. There are two different models: in the first one healthcare is still delivered under the responsibility of judicial authorities, in the second one health care is organized independently. The Geneva Canton is a noteworthy example of the second model. In the Geneva canton, prison medicine is handled from 1965 by university institutions (firstly by the University Institute of Legal Medicine in Geneva, then by both the University Hospital and the University of Geneva) and responsibility lies therefore with the cantonal department of health. This pattern originates mainly in the concentration of small prisons in the canton and the immediate vicinity of University. Healthcare professional organizations and universities played a key role in the integration between prison and public health services as they claim for the independence of medical staff from prison authorities as it guarantees that priority is given to medical decision and confidentiality, reinforcing the detainees’ trust in their doctor^{mmmmm}. Pr Dr Wolff also emphasizes “the stronger position for negotiating with judicial system and for the detection and reporting of violence by authorities”. The medical deontology provided by the ASSM, the scientific data and guidelines offered by the BIG project and the interdisciplinary work made by the SPS (see below) are considered as important resources for a potential national reform and global enhancing of healthcare provision in prisons. However, as each Swiss Canton is responsible for its own organization of prison healthcare, healthcare human resources are still part of the justice system in some Cantons (a.o. in Zurich). According to the SWOT analysis made by the Dr Devaud (CNPT), the process of harmonization towards an integration of healthcare management and delivery in Health administration and policy needs to overcome fears of both the prison and the health partners. Dr Devaud asserts that from the perspective of the penitentiary stakeholders there is a fear to be cantoned in a repressive role and to lose control on the prisons - a.o. by missing important information or by welcoming in the prison

kkkkk Lead Clinician Prison Healthcare, NHS Greater Glasgow & Clyde and Chair, National Prisoner Healthcare Network, Expert Advisory Group

lllll National Nurse Advisor, National Prisoner Healthcare Network

mmmmm SWOT analysis of the SPS intervenant and of Pr Dr Wolff.



healthcare professionals without any experience of prison constraints - as well as to miss a form of professional valorisation linked to the delivery of nursing care. According to Dr Devaud, health stakeholders are for their part reluctant to add new functions and a new (unfamiliar) category of patients to their current workload. They are also circumspect about medical practice in the penitentiary environmentⁿⁿⁿⁿⁿ. The “civil society demands for more security measures [and] revenge for the crimes committed” is also pointed by Pr Dr Wolff as a potential threat to good quality of healthcare provision in prisons.

In the Netherlands, healthcare in prison is still handled by the Department of Penal Institutions (*Dienst Justitiële Inrichtingen*, DJI). However, the publication of reports and signals in the early 2000s led to a project entitled ‘responsible medical care in prisons’ in 2003. This project aims at formulating a vision, a policy, and 14 work processes to improve the quality of medical services inside Dutch penal facilities²¹⁷. The Dutch situation is similar to the Belgian one, as the Department of Penal Institutions lies under the jurisdiction of the Ministry of Justice (MOJ).

Overall, the organization of prison healthcare, as it detaches itself from the apron strings of the prison institutions, is logically widely influenced by the characteristics of the national health system. For instance, the very fragmented Swiss health system is reflected in the different organization models applying to the delivery of care in Swiss prisons. Similarly, the structure and leadership of the Scottish NHS have imbued the reform process and the current prison health system. Therefore, we recommend that a reform of the health care system in Belgian prisons, to be effective, has to be built upon the strengths of the pre-existing institutional framework of the national healthcare system and overcome its weaknesses.

7.1.2 Improving the Quality of Care Delivery

As shown above, improving the quality of care delivery in prisons is an important driver for change: the four countries studied share the same

concerns about availability, comprehensibility, continuity, reachability and quality assurance in care delivery.

Different types of instruments are mobilised to do so, among which:

- Investment in human resources
- Adoption of standards
- Creation of national quality control bodies
- Subjection to the scrutiny of international control (through the CPT)
- Pilot projects

The transfer of responsibility for prison health to health ministries is often accompanied by a transfer or reallocation of human resources. In the context of a potential Belgian reform as this is the case in the studied countries, this raises the question of how to provide extensive opportunities for advanced training and career to the staff and management concerned. The opportunity for continuous, up-to-date training of motivated, qualified and sufficient healthcare professionals is pointed as a great asset of healthcare organization in the Swiss Cantons where it is administrated by the health system^{ooooo}.

The adoption of quality standards is one of the most commonly used instrument in the four countries. These standards might be defined in terms of principles (like the principle of equivalence of healthcare), or objectives to be achieved (like the PART 1 of Directions provided by the Scottish Ministers to the NHS Health Boards (see 4.3.1.1)) or procedural guidelines to be applied (like the DJI’s 14 work processes). These guidelines are either specific or similar to the standards which applied to the wider community. These standards can be compulsory – like the rules “Medical control and hospitalisation”, included in Geneva Canton’s legislation or the Quality Act for Health Care Institutions (1996)^{ppppp} in the Netherlands – or indicative. The adoption of standards (principles versus objectives versus procedural

ⁿⁿⁿⁿⁿ Source: SWOT analysis (Threats) of Dr Devaud (CNPT).

^{ooooo} Swiss SWOT analysis by SPS intervenant, Dr Devaud and Pr Dr Wolff.

^{ppppp} Wet van 18 januari 1996 betreffende de kwaliteit van zorginstellingen. URL: http://wetten.overheid.nl/BWBR0007850/geldigheidsdatum_11-01-2013



guidelines; specific versus similar to the wider community; compulsory versus indicative) could be crucial if the health care system in Belgian prisons has to be reformed.

The creation of quality control bodies is another part of the quality assurance system in some countries. The mission of these bodies is often linked to broader issue than quality assurance in care delivery. Independency is an important organisational principal of these bodies which can come in various forms: independent administration, independent agency, professional ethics committee, etc. The four countries analysed have signed and ratified the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) adopted in 2002 by the United Nations. They are therefore required to “designate or maintain” a National Preventive Mechanism (NPM) in the form of one or several independent visiting bodies¹³⁷. The Contrôleur Général des Lieux de Privation de Liberté (CGLPL, Controller-General of Places of Deprivation of Liberty, established in 2007) is the NPM for France. It is an independent administration whose mission is to ensure the respect of fundamental rights defined by international and national laws including three axes: the rights of human dignity; a fair balance between the respect of human rights and other considerations of public order and safety; the prevention of any violation of the fundamental rights. The CGLPL focuses on any people deprived of liberty, health prevention, prisoners’ hospitalization, and staff working conditions that may impact the functioning of the institutions and the relationship with the retained people. Another control body is the *Défenseur des droits* (National Rights Defender, established in 2011), which aims to defend human’s rights and to allow an equal access to law and justice for everyone. The Defender of Rights can take legal actions, including in the fields of health, whenever a negotiated solution is not reached. Her Majesty Inspectorate of Prisons for Scotland (HMIPS) is one of the 20 National Preventive Mechanism bodies in place in the United Kingdom, in line with the OPCAT requirements¹³⁹¹⁴⁰. HMIPS conducts inspections and prepares reports under the principle of “[independency of] political influence from the Scottish Government Justice Directorate, the Scottish Prison Service and Governors-in-Charge of establishments”⁷². Following the transfer of

competences to the NHS, a Partnership Agreement between HMIPS and HIS (Healthcare Improvement Scotland, part of NHS) regarding healthcare related aspects of prison inspection was signed in November 2013: HMIPS keeps its statutory duty, with the assistance of a healthcare professional from HIS “for the purpose of inspecting healthcare and substance issue services as part of the overall inspection”⁷². However, one of the respondents to the SWOT analysis pointed out as a weakness of the system “the limited set of standards for healthcare in the inspection process [...] [and the absence of] a scrutiny process for community based primary care in Scotland which could be applied”. In Switzerland the National Commission for the Prevention of Torture (Commission Nationale de Prévention de la torture, CNPT) has the remit of independently scrutinizing the detainees’ situation and the places of deprivation of liberty and of “formulating recommendations to the relevant authorities in order (1) to improve the treatment and situation of the persons deprived of their liberty [and] (2) to prevent torture and other cruel, inhuman or degrading treatment”⁹⁹⁹⁹⁹. It also has the duty of formulating observations and proposals regarding relevant legislations and to write an annual activity report which has to be publicly available. The law stipulates that this Commission has to be composed by experts with necessary competences and knowledge, including from the medical and psychiatric field¹⁹⁷. The CNPT visit reports usually include a brief description of the medical services provided in the visited prisons. Regarding healthcare in prisons, the system of regulation seems to be linked to local evaluation or professional organizations as early as the 1970s, the directors of the IUML and their collaborators, initiated academic activities concerning health law and ethics in prison health care. They have engaged in the Council of Europe’s drafting of recommendations on the ethical and organisational aspects of health care in prison and served as members or experts for the CPT (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment).

In the Netherlands, unlike in the three others analysed countries, the control body accountable for prison healthcare – the General Inspector for Health -

99999 Translation by the authors



is the same as for healthcare services in the community. This body is part of the 4 NPM in the country.

On the whole, the existence and work of these control bodies are widely acknowledged as positive factors within the different prison systems.

The countries analysed also mobilise another instrument to improve the quality of care delivery in prison: they carry out policy experimentation by pilot projects. Some of these projects change the institutional framework and establish themselves durably – like the BIG (“*Bekämpfung von Infektionskrankheiten im Gefängnis*”), a project of fight against infectious diseases in prisons, launched in Switzerland in 2008 that led to the creation of *Santé Prison Suisse* (Health Prison Swiss: SPS) - whereas other are retrospectively considered as a (mis)step in the reform process and are progressively abandoned – like the “13 000 program” in France (1987-1996).

The development of telemedicine is seen as an opportunity of improving access to care in certain situations for detainees. So far in France, the lack of long-term budget (beyond experimentation steps) and billing code linked to that kind of medical acts are pointed out as barriers to that development by the APSEP. In Scotland, telehealth in prison is also under development, with for instance, videoconferencing equipment in place in 7 out of the 15 prisons and the provision of Cognitive Behavioral Therapies delivered by phone in 10 prisons^{rrrrr}.

It should be noted that in the Netherlands, in the view of the Head of the Health Department of the MOJ, the overall good quality of care in prison is a factor explaining the absence of political will to proceed to a reform regarding healthcare in Dutch prisons.

Lastly, one of the important challenges for the future of healthcare services in prisons is the development of adequate and systematic collection of data.

The transfer of health-and-prison skills to the Ministries of Health can lead to “more analysis of the health needs of the whole prison population”²⁴¹: Control bodies produce periodical reports but these generally do not contain precise epidemiological data. One of the aims of the BIG project is precisely to improve and harmonize epidemiological data. But the general observation is that there is a lack of information²⁴². In Scotland e.g. the HCNA (2007) pointed to the difficulties of measuring prisoners' health outcomes – and therefore their potential improvement - because of the lack of a routine reporting system. Experts currently still reports this lack of appropriate data collection system in Scotland, but also in France. However, in France, the CGLPL reports that the French National Public Health Agency (Santé publique France^{sssss}) is currently^{ttttt} working on “the implementation of a sanitary information system which would improve the knowledge on detainees' health”⁴¹. Dr Sannier also report the “relaunch of studies on detainees' health (aiming to adapt care policies at local, regional and national levels)”, while pointing out the limited budget dedicated to those research. According to UNODC and WHO, “obtaining evidence that [integration of prison health in public health] results in better prison health is not an easy task. The reasons for this are the widespread lack of baseline health data in prison systems where health service provision is not the responsibility of health ministries, and the fact that the transfer processes are usually system-wide so that randomized controlled trials are not possible”⁵⁵. Another reason is that this is a shifting population, with large numbers of people entering prisons and/or being released.

We recommend that Belgium should adapt the above-mentioned instruments (investment in human resources, adoption of standards, creation of national quality control bodies, scrutiny of international control (through the CPT), pilot projects) to the Belgian situation and mobilise a mix of this instruments to improve the quality of healthcare.

^{rrrrr} Source: Scottish Centre for Telehealth & Telecare, NHS 24, by email (April 2016)

^{sssss} This agency was created in April 2016, “resulting from the merging of the French Institute for Public Health Surveillance (InVS), the French Institute for

Health Promotion and Health Education (Inpes) and the Establishment for Public Health Emergency Preparedness and Response (Eprus)” (<http://www.santepubliquefrance.fr/Infos/About-Sante-publique-France>)

^{ttttt} April 2016



7.1.3 Tackling Health Inequities

Tackling health inequities between the prisoners and the rest of the population is one of the motto of the adopted reforms. Prison medical services improvement and reform are considered as a public health opportunity to screen and treat a marginalised and diseased population otherwise very hard to reach²⁴³²⁴⁴. It is recommended in the Moscow declaration -issued in 2003 - to provide free of charge healthcare to the detainees⁹⁹.

The equivalence principle is a central element of the delivery of care in prison in the four countries analysed, including in the Netherlands and in the Canton of Zürich, where healthcare in prison still falls under the MOJ. This principle was also instrumental to drive the reform process where it has taken place. In Scotland, tackling health inequalities is one of the priorities of the Scottish Government, at a national level. The transfer process was seen as supportive to the Scottish health inequalities agenda^{94,95}, with which “the agenda for the [NPHN] ties”, as reported by J. Porter.

The financial access to healthcare services is one of the important challenges faced by the four countries. In 1994, France takes a landmark step by introducing free healthcare for prisoners. All the prisoners are benefitting from social security for sickness and maternity. The detainees do not have to pay any contributions for their medical expenses. Prisoners must be registered at the Primary Fund Health Insurance (CPAM) relevant for their prison. This system is highlighted by the CGLPL as a mean of integrating the prison health system to the common rights system. However, registration can take several months, which can be problematic for inmates condemned to a short sentence and not having enough time to regularise their administrative situation and obtain a registration certificate⁶⁵. Despite this theoretical access, the APSEP indeed points out difficulties in access to universal health coverage^{uuuuu} during incarceration, threatening the continuity of care upon release¹⁶. The Association also reports inequalities with regards to access to some health services for the detainees, e.g. a more difficult access to the new hepatitis C treatments, waiting times for a

specialised advice or for technical exams sometimes longer than in the community, lack of access to risk reduction programmes such as needles exchange.

Before the 1994 reform (when prisoners' health was still managed by the Ministry of Justice), the situation in France was very similar to the current conditions in the Netherlands: inmates, at the time of their incarceration, were losing their rights to social security. The prison infirmary then provided first-line medical care, and the Ministry of Justice was then paying for healthcare services provided by the medical and nursing staff. In the Netherlands, the principle of tackling inequalities is reflected very early in reports but these documents don't report any explicit related strategy.

In Switzerland the majority of prisoners does not satisfy the necessary conditions for receiving health insurance and disability coverage. Therefore, their situation depends on the canton to which they belong. Some of the cantons take charge of all the health costs, some of the others require a financial participation from the detainee.

In Scotland equal access to healthcare services is a public health policy priority, whether for the prisoners or the wider population. The aim of the NHS is “to provide access to health care to all residents, irrespective of their ability to pay”. Hence, all UK ordinary residents are entitled to health care under the NHS in Scotland and most of the services are free at the point of use⁷³.

To reduce the financial barriers to healthcare in prison is key to any reform process that aims to tackle health inequalities. This raises the question of access to social security or health insurance, of who and what this insurance covers and of the adjustment period that might be a threat to the continuity of care. More generally, a comprehensive primary care approach requires an effective collaboration between health and social care, especially as prisoners frequently come from deprived communities. In this respect, J. Porter highlights the Scottish Government strategy integrating health and social care (see 4.1.1.2) as a “significant opportunity to deliver care differently and more effectively”. The issue of housing upon release from

uuuuu CMU : couverture maladie universelle



prison was pointed out by Dr Campbell and by A. Slijkhuis. These reflections are consistent with the Scottish NPHN Throughcare workstream, pointing out imprisonment as an *“opportunity to engage with this marginalized population to improve their physical and mental health and well-being as well as address the wider social determinants of health”* ¹³⁴.

Along with the need to reduce financial barriers to healthcare, the countries have to face territorial inequalities, particularly regarding secondary care. In France, the inequalities in healthcare provision between prisoners held in different prisons remains because the quality of care depends largely on the voluntarism of the regional authorities and the local hospitals attached to the prisons. Furthermore, medical human resources can be inadequate with regards to the prisoners' needs, being another source of inequalities in access to healthcare, as underlined by the CGLPL and by Dr Sannier (in particular regarding dental and psychiatric care) regarding the French situation ⁴¹. In Switzerland the cantonal autonomy can also lead to territorial disparities as healthcare human resources and medical decisions are influenced by budget cuts (expensive drugs are not prescribed as treatment of hepatitis C, as well as preventive measures or vaccination) (118). In the Netherlands a set of critics has been addressed towards the second-line healthcare services delivery. The Scheveningen Prison Hospital seemed unable to meet the need for secondary care coming from all the Dutch prisons.

Prisoner's access to healthcare also depends on social acceptance issues. For example, in France, for confidentiality reasons, men tend not to ask for preservatives within their shared cells, as homosexuality in prison is often a taboo. In Scotland, the lack of requirement for health assessments to be undertaken under *Throughcare* arrangements, underlined in a report issued in 2014 by the Scottish Public Health Network, can also be seen as a problem of social acceptance ¹²³.

As most reforms focus on equivalent access to healthcare services, Charles and Draper ²⁴⁵ suggests that the drive for equivalence of process aimed by the transfer of responsibility for prison health to health ministries should be complemented by additional focus on achieving greater equivalence of health outcomes. Meeting the specific needs of prisoners is therefore another main challenges for improving healthcare in prison.

7.1.4 Meeting the Specific Needs of Prisoners

Due to various socioeconomic and behavioural (violence, drug and alcohol misuse, smoking, etc.) factors, prisoners worldwide tend to suffer a higher prevalence of various health problems than the general population, in particular:

- Infectious diseases (including HIV, Hepatitis B & C, Tuberculosis);
- Mental illness and suicide;
- Addictions
- Poor dental health

Furthermore, prison environment increases health problems through inactivity, confinement, lack of hygiene, breakdown of family ties, violence, etc. ³².

The prison overcrowding is likely to negatively affect this situation. In this respect, Switzerland distinguishes itself by an occupancy rate of 93.7%. As seen before, the fight against infectious diseases has been an important driver for change in this country in the recent year with the BIG Project. This project led to various information, prevention and promotion tools: medical forms, Vade Mecum on transmissible diseases and addictions in prison, "Health and deprivation of liberty" brochure for inmates and prison staff, etc. Besides, a national interpreting phone service was created in 2011 to the prison health heads because of the finding of negative consequences of the language barriers on detainees health ¹⁷⁸.

In Scotland, on contrary to the other countries, the incarcerated population is in certain respects rather similar to the general population: more than 96% of prisoners in Scotland in June 2013 were categorised as "White"⁶⁸. The HCNA conducted in 2007 already pointed out the fact that, in Scottish prisons, prisoners from ethnic minorities were represented in the same proportion as in the general population (3% versus 2%)⁹³. Besides, Scotland promotes the same standards in prison than in the wider community. However, the fact that prisoners usually have greater health needs than the general population is widely acknowledged ⁸⁹⁹³¹³⁴ and some specific measures have been taken to address those needs, such as:



- Suicide risk assessment is a part of each prisoner's examination upon admission (“ACT 2 Care Suicide Risk Management Strategy”)
- A range of interventions targeting drug users have been developed at different points of the judicial process – making the criminal justice system evolving as a “gateway to drug treatment” - in the community and in prison settings ¹¹⁹.
- The two volumes report “Better health, better lives for prisoners: A framework for improving the health of Scotland’s prisoners” edited in 2012 provides a framework aiming to ensure that actions involving prisoners are taken to improve their health and wellbeing and those of their families and communities, in a health promotion and health improvement perspective ¹¹²¹¹³.

Psychiatry has historically played an important role in prison health reforms in France. Therefore, mental and somatic care are delivered by different hospital departments. The psychiatrist teams have not only a consultation mission, but they also work on prevention and education. Attention paid to mental health is reinforced by the fact that France’s suicide rate is particularly high in comparison with other European countries - even if some progress has been made in recent years. Following the recommendations of the Albrand Commission (30), multidisciplinary work is in progress in almost all prisons, training for professionals with first aid techniques is organized and peer suicide program with inmates and professional as main actors have been implemented. The APSEP, however, stresses that despite the implementation of suicide prevention measures, a reflexion on the causes of this phenomenon and the way to act on them has not taken place ¹⁶.

More generally, the CGLPL highlights the lack of human resources in the psychiatric sector, with psychiatric teams dedicating a large part of their activity to people under a compulsory therapeutic measure. Moreover, the number and capacity of facilities dedicated to psychiatric care of detainees

(SMPR and UHSA) are deemed insufficient by the CGLPL, leading to hospitalizations in general psychiatric hospitals in inappropriate conditions⁴¹.

In order to meet the specific needs of prisoners, the selected countries develop national strategies and guidelines specific to prison health, dissemination of various information, prevention and promotion tools systematisation of screening process (mainly upon admission), multidisciplinary work, training for professionals, involving of all stakeholders (inmates, professional, community and family) in the fight against infectious diseases, addictions, mental illness and suicide.

The sharing of responsibility and roles between first and second line healthcare providers and healthcare institutions has to be taken into consideration as well. The CGLPL raises the issue of entrusting the responsibility of healthcare in prison to hospitals, whereas “the health mission in prison essentially consists of primary care”. According to the CGLPL, the collaboration between hospitals and the general practitioners (GP) hired to provide care to prisoners can be dysfunctional, with GPs poorly integrated and “not recognized by the institution, whose functioning is not well known by the GPs”. Beside this, the provision of care in prison settings is generally not a priority for the hospitals. Moreover, the latter are “centred on a curative approach and do not have a culture of health promotion and education which are necessary to promote in prison settings with regards to the specificities of the public concerned” ⁴¹.

This organisation is nevertheless reported by the CGLPL as a factor contributing to the continuity of care, as the hospital can provide care “before, during and after detention with, most of the time, a common medical record”. In addition, the same medical team can be in charge of the prisoners within the prison and in the hospital. On the contrary, the APSEP mentions the lack of a centralized IT medical records between the different penitentiary establishments. In Scotland, the inadequacy of the IT systems is also reported by Dr Campbell, with e.g. a lack of communication between the prison and the community IT systems. The physician also points out useful IT functionalities such as the ability to access prescribing information through the Emergency Care Summary^{www} and the ability to communicate between different services in the same Board through an intranet system.

^{www} See <http://www.gov.scot/resource/doc/143714/0036499.pdf>



Regarding health promotion within French prisons, the APSEP mentions steering committees organized in the establishments between sanitary units and the prison administration in order to define annual health promotion policy, as well as national guidelines published in 2014²⁴⁶ as positive elements¹⁶. Overall however, all stakeholders consulted deem health promotion and prevention insufficient in French prisons.

7.1.5 Addressing Professional Practice Issues

One of justification for reforming health care services in prison is the need that physical and mental illness should be managed by trained individuals²⁴³. This rises several issues:

- Distribution of roles and responsibilities between professional groups, including tensions around
 - professional independence
 - medical secrecy
- Lack of attractiveness of prison for health professionals

7.1.5.1 Distribution of roles and tensions

Dual loyalty can be defined as “*clinical role conflict between professional duties to a patient and obligations, express or implied, real or perceived, to the interests of a third party such as an employer, an insurer or the state*”²⁴⁷ cited by²⁴⁸. Among health professionals, a clear division of task is necessary to avoid dual-loyalty conflicts. According to Pont, Stöver and Wolff, the “*complete and undivided loyalty to their prisoners patients*” is to be acknowledged to health professionals involved in a care relationship, who should therefore not be involved in any task which could be contrary to the interest of the prisoners, such as medical expertise. Furthermore, these authors state that the risk of dual loyalty issues decreases when healthcare

services are independent of the prison authorities, the latter being responsible only for medical activities linked to security and forensic issues. In line with this, they strongly recommend the transfer of responsibility from prison to health administration where applicable²⁴⁸. Pr Dr Wolff also emphasizes “the stronger position for negotiating with judicial system and for the detection and reporting of violence by authorities”^{www}.

This type of transfer is often accompanied by a transfer of human resources. As stated before, extensive opportunities for advanced training and career are frequently part of the reform.

According to the International Centre for Prison Studies “*transferring responsibility for prison health care from the control of the prison system to the control of the health ministry is a complex process which is likely to affect a number of different interests and to bring together two groups with a very different professional view of the world. Existing prison health personnel are liable to feel threatened and to suspect they will be judged unfavourably by their colleagues who come in from outside. Other prison staff may resent working alongside colleagues who seem to be outside the chain of command and who are responsible to another body with different values*”²⁴¹.

In France, independence of prison healthcare from the Justice administration is mentioned as a strength of the system, by the APSEP, the CGLPL and by the head doctor of the prison administration. However, despite this formal institutional independence, the APSEP raises the growing influence of the Direction of the Prison Administration on health policy matters in prison. It gives the example of the “insistent request” from the prison administration to health professionals to make them use a new IT management system called “GENESIS”^{xxxx}, aiming to give them access to information on detainees but also to make them add information in the system, at the expense of medical secrecy.^{yyyy} The CGLPL notes as well the issue of the use of the prison administration IT system by health professionals. It points out the non-compliance of the right to secret on

^{www} Source : SWOT analysis.

^{xxxx} “Gestion Nationale des personnes Ecrouées pour le Suivi Individualisé et la sécurité”

^{yyyy} On request of the French National Medical Council, the Council of State has taken position on this issue: http://www.sante-prison.com/upload/cnom_cir-15-12.pdf



medical - but also penitentiary - information, as well as the non-respect of the circular requiring the consent of the prisoner regarding the exchange of information⁴¹. The difficulties met in applying ethical rules in “closed and confined spaces” - regarding the choice of the caregiver or regarding data confidentiality - is acknowledged as well by the head doctor of the prison administration.

Also in France, to facilitate the reform’s implementation, a methodological guide (*Guide méthodologique relatif à la prise en charge sanitaire des personnes détenues*) was written in 2004 and updated in 2012. This guide aims to be a reference document for every professional working in the judicial arena. It is a key tool easily accessible to professionals (4). However, it is clear that some causes of conflict and tension persist. According to the CGLPL, the priority given to security constraints is indeed a limiting factor in healthcare provision and a potential source of tension between prison and health staffs. The “pre-eminence of the security-oriented vision” makes the transfers to hospitals costly in terms of escort personnel, sometimes leading the prison administration to ask healthcare providers for justifications⁴¹.

The APSEP also underlines the fact that “the right of access to healthcare [can be] compromised by the prison administration for security reasons (medical interviews in the hospital in the presence of guards, use of handcuffs and shackles during hospitalizations, delays in access to hospital care due to a lack of human resources)”. These restrictions in access to healthcare due to the limited number of escort personnel is seen as a weakness of the French system by the head doctor of the penitentiary administration as well¹⁶.

Conversely, tensions can arise from the fact that caregivers put their patients on an equal footing and that health care services are sometimes better inside than outside prison²⁴⁰. Still according to the CGLPL the respect of medical confidentiality is “very unequal” from an establishment to another, due to different elements. Among those, the will to maintain good relationships between prison staff and healthcare providers is cited as a factor which may lead to a certain “confusion of roles” and to some abuses with regards to medical secrecy. This question is raised for instance regarding the surveillance of the sanitary units premises, within the prison or in the hospital. The CGLPL stresses the negative impact of those

breaches in confidentiality “in terms of detainees’ confidence in the healthcare system” and the fact that this situation sometimes lead them to refuse care. Another factor cited leading to this kind of situation is the assimilation by hospital doctors of “any prisoner to a dangerous person”, leading them not to ask the guards to leave the room during the consultation. Moreover, the CGLPL considers that “caregivers [are] instrumentalized around the notion of dangerousness”, e.g. being asked by the prison administration “to calm down unrests not linked with care, to ensure social peace” or being rested on to take decisions in terms of disciplinary measures⁴¹.

Requests for sharing of medical information – therefore sometimes shared - can also happen in the framework of multidisciplinary meetings gathering all stakeholders of the prison setting⁴¹. In the Swiss Canton of Geneva, there is a strong emphasis on professional autonomy of health workers: “Professional independence is achieved through complete separation of “power”. The members of the prison administration and correctional officers are employed by the cantonal department of justice and police, which is responsible for correctional institutions. In contrast, the health care system, including the prison medicine units, is a part of the University Hospital of Geneva - a completely different hierarchy under the responsibility of the cantonal department of health” (115). The ethical and legal ground rules that govern medical activity, particularly in terms of consent and confidentiality also apply when the person is deprived of liberty. The academic affiliation guarantees the independence from the judicial and prison authorities, maintaining good collaboration with them. However, the promiscuity of prison, as well as the role of guarantor and often even care auxiliary played by prison officials or police may impose an exchange of health information between health personnel and staff of security. In these circumstances, the physician must strive, with the agreement of the detained patient, to answer legitimate questions of every prison or police personnel.



According to the ASSM, both principles of equivalence of care and independence can be respected if certain conditions are met^{zzzzz}. Those conditions include appropriate infrastructure and resources, comprehensive care, a clear definition of tasks and responsibilities of each person involved in decisions regarding healthcare to prisoners, the professional independence of physicians (notably requiring pre-defined procedures “*in case of different opinions between health professionals and the prison authorities*”) and ensuring that every person involved in the prison administration “*is aware of the ethical and legal principles related to healthcare delivery in prison*”¹⁵³. Consultation bodies have been set up at central level, e.g. *Santé Prison Suisse* under the two-headed authority of the Conference of Directors of Cantonal Justice and Police (CCDJP) and the Swiss Conference of Cantonal Directors of Health (CDS). The medical deontology provided by the ASSM, the scientific data and guidelines offered by the BIG project and the interdisciplinary work made by the SPS are considered as important resources for a potential reform and global enhancing of healthcare provision in prisons.

In Scotland, the concept of equivalence of care is central, but the question of the independence of care (from prison administration) doesn't appear in the grey literature to be an issue in itself. To support the transfer process and provide a collaboration framework between the SPS and NHS Scotland, a National Memorandum of Understanding (MoU) has been established. This document defines their respective responsibilities, as well as governance and accountability relationships for prison health services⁷¹. A number of national and local coordination bodies ensure the smooth collaboration between the SPS and the NHS.

It should be noted that Forensic Psychology within prisons is under the remit of the SPS⁷¹. According to the Health Care Needs Assessment (HCNA) published in 2012 by the NHS Board of Greater Glasgow and Clyde (NHSGGC) “*the SPS Forensic Psychology service is offence-driven rather than health-driven, mainly does statutory work and rarely links in with health*”

⁸⁹. Data sharing process between the SPS and Health Boards is defined by an Information Sharing Protocol dated 19 June 2013, which is complementary to the MoU¹⁴⁷. This binding agreement has several objectives, including supporting “integrated care and case management” and protecting confidentiality. Unlike the Geneva Canton, “Both SPS and NHS Boards are under a Duty of Care to look after prisoners under their care. This Duty of Care provides the legal basis for the partners to share prisoners’ personal information without obtaining their consent where relevant and appropriate. Only the minimum necessary personal information consistent with the purposes set out in this document will be shared. Sensitive information shared will be the minimum required for the intended purpose”¹⁴⁷. At central level the NPHN plays a “national coordinating and strategic role” and should be composed by representatives of each Health Board and of the SPS, as well as, among others, by Scottish Government representatives from Health and Justice Departments⁷¹.

In the Dutch prison, the medical team is one of the many prison departments, the only one that does not focus on security. On a daily basis, doctors and nurses heavily depend on other departments, like prison guards, that are responsible for security. The work schedule and workload of every medical team is also determined by the organizational properties of the prison facility: the communication between the medical team and the prison management team should be open and fluid. The situation of these medical teams has been questioned by Moerings²⁰⁷ as medical practice is subordinated to order and security management.

Overall, the need for an effective collaboration between Health and Justice is widely acknowledged by experts in the different countries. At the operational level, the CGLPL recalls that the articulation between “healthcare and prison worlds” is difficult – although progressively improving - e.g. leading to situations in which prisoners do not go to their medical appointment because they are not aware of it, because the prison guard do not come to pick them up or because they have to go to the visiting room at the same time. Likewise, information on release or transfer is not always

^{zzzzz} No information was found about the extent to which these conditions are met in reality.



transmitted. However, according to Dr Sannier, prison officers are “increasingly aware of detainees’ health issues”. Good practice examples are also given by a stakeholder in Scotland, such as “mental health first aid training delivered to prison staff by NHS health improvement and mental health teams” or “naloxone awareness training delivered to prisoners and prison staff by NHS professionals”. In the same country, an “increasing convergence in both health and justice policy” was highlighted, the delivery of care in justice setting having a role to play both in health improvement and in reduction of re-offending.

7.1.5.2 Lack of attractiveness of prison for health professionals

From the point of view of health professionals, prison is not generally considered as an attractive workplace. Contrary to generally accepted ideas, it was noted in the case of prison mental health professionals that the recruitment and retention of staff are less influenced by financial constraints than by ignorance about the role of these professionals, preconceptions held about working in a prison; and poor quality of applicants whereas the health of the workers in such staffs are affected by intensified workload and work pressure²⁴⁴.

Various strategies have been explored and implemented in the countries studied to recruit and retain staff.

In France, each prison is attached to local hospital services (*Service médico-psychologique régional* (SMPR) and *Unité Sanitaire en Milieu Pénitentiaire* (USMP)). The attractiveness of prison for health professionals is moreover helped by the growing need for new placement opportunities for primary care interns. The key dimensions emerging from the analysis conducted by Amouyal et al. (2014)²⁴⁹ are that these custodial internships offer a wide range of situations that are very similar to primary care in a public health context; they open up to learning how to manage complex situations; they provide stronger orientation towards ethical health care; they anchor a firmer belief in multidisciplinary teams; they raise the interns’ awareness of the

social role of primary care physicians. The interviewed interns considered this type of placement (towards the end of their training) to be a good preparation for their future primary care role, especially in the context of multidisciplinary practices. However peripheral regions suffer from staff shortage due to a lack of attractiveness of the prison positions. Nonetheless, healthcare professionals having indeed chosen to work in prison settings, are described as “motivated and experienced” by the CGLPL, which also highlights the need for “spaces of reflection”, such as the APSEP and the ASPMP^{aaaaaa}, around the issue of professional practices linked with healthcare in prison. With regards to training, the APSEP mentions a project of a specific course for health professionals that would be run in few days, currently worked on by the Ministry of Health with the “Ecole des Hautes Etudes en Santé Publique”. However, the association questions the budget allocated by the Ministry of Health to the basic and continuous training of health professionals working in prison, which is overall deemed insufficient. The CGLPL raises the insufficiency of health professionals’ training, regarding the specificities of the penitentiary system and regarding health promotion and education^{41 16}.

In the Netherlands, health care was formerly provided by recent medical school graduates during their civilian service. The lack of experience of these workers led to the organisation of a specialised training and diploma for health care professionals in prison. Prisoners’ healthcare became a real subdiscipline.

In the Geneva Canton of Switzerland, the lack of enthusiasm is partially compensated by centralized organization in a hospital that gives staff a career guarantee: they can change positions if required. The academic affiliation also helps students in destigmatizing the prison environment. In contrast, budget cuts in the Cantons, where healthcare delivery is controlled by judiciary authorities, impact on waiting times, continuity and long-term perspective of healthcare where a doctor is not permanently present. The lack of sufficient places in hospital and psychiatric clinic is also emphasized as the separation between justice and health system in this model requires

^{aaaaaa} Association des Secteurs de Psychiatrie en Milieu Pénitentiaire (Association of Psychiatric Sectors in Prison Setting)



complex negotiation and procedures between the stakeholders in this case^{bbbbb}. Dr Devaud (CNPT) criticizes this model because of the lack of nurse and medical knowledge, the lack of healthcare strategy and the lack of health staff management this model carries along according to him. He pleads for a harmonization at the federal level and for the adoption of the second model in the whole Switzerland.

In Scotland, before the reform, the delivery of healthcare by the SPS was not considered as sustainable mostly because of its limited scale, leading to a lack of attractiveness for the wide range of healthcare expertise needed to comply with national standards. The reform was seen as a good opportunity to attract and retain staff as NHS is considered as a major employer offering interesting career development. The added value of the transfer to the NHS regarding “training and development opportunities” for staff was also pointed out⁹⁵. As SPS and NHS are distinct employers with their own terms and conditions of employment, the “Transfer of Undertakings (Protection of Employment) Regulation 2006” (or “TUPE” Regulation)²⁵⁰ applied to directly employed healthcare staff, which represented most of the staff involved⁹⁴. This transfer of staff has of course cost implications.

7.1.6 Cost management

Cost management and monitoring are other important challenges in the context of the described reforms.

In France, the costs of prison healthcare tripled between 1994 and 2012, rising from 113m to 344m¹¹ because of the development and diversification of the supply of care. In 1994, the state had to assume 76% of the financial effort, in the framework of a fixed funding envelope. But although the costs tripled, that fixed envelope was not revised upwards. In 2012, the French State covered only 31% of the costs, and the balance was paid by social insurance funds¹¹. After the 1994 reform, healthcare funding was partly decentralized, passing to the general social insurance security, which is regionalized. This process involves some disparities between the Regions.

Indeed, health services could vary between different regions, either due to overcrowding, more dated installations, labour shortage, reduced financial resources or, as noted by the APSEP, to the variability in the establishments and detainees’ characteristics (long versus short sentences, facilities dedicated to men, women or minors).

The provision of an annual funding envelope dedicated to somatic care in prison is seen as a positive factor in terms of flexibility by the APSEP. The dedicated budget having been transferred under the Ministry of Health is pointed out as well by the CGLPL as one element of the independence process from the MOJ having taken place. However, the CGLPL points out that due to budget constraints, resources are sometimes diverted from the prisons sanitary units they are usually allocated to, prison health not being a priority for the hospitals. Restrictions in hospitals’ budgets and in the prison administration budget (which can have an impact on the medical extractions capacities) are also underlined as threats to the system by Dr Sannier. Beside this, the APSEP reports the current work process of the “Direction Générale de l’Offre de Soins” (DGOS, Directorate General of Healthcare Provision) of the Ministry of Health regarding the revalorisation of the funding envelope of the sanitary units. The association states that a potential move to a fee-for-service funding would not be appropriate for the delivery of care in prison, which is “largely dependent of the prison administration organisation” and not akin to the delivery of care in the community.

In the Netherlands, there is a specific budget dedicated to healthcare in prison, managed autonomously by the Health Department of the Ministry of Security and Justice, which is seen as the main strength of the current system by A. Slijkhuis. The Health Department is however accountable to the Ministry of Justice regarding the expenditures.

As stated before, in Switzerland, Dr Devaud (CNPT) considers that the current budget cuts that weighs on staff recruitment in the first model (healthcare under authority of judicial administration and policy) might be an opportunity to switch to the second model (healthcare managed by the

^{bbbbb} Source: SWOT analysis by Thomas Sutter, from the Direction of Justice and Interior (Canton of Zurich).



health system) ^{cccccc}. He points that the second model allows the reimbursement of medical and (more importantly) nursing costs by the LAmal insurance system instead of being a financial burden for a penitentiary system under financial constraints and staff restrictions.

In Scotland, financial implications of the transfer were estimated prior to the transfer process with regards to the necessary additional funding to NHS boards in order to allow them to meet their *“legal obligations and good practice standards”* and to close the gaps identified by the HCNA ⁹⁵. On the whole, £4M to £8M additional investment were deemed necessary related to the potential transfer process. This amount was deemed *“relatively small in the context of the overall health budget”* by the PHAB ⁹⁵. Regarding the current situation, one of the respondents to the SWOT analysis for Scotland highlighted that *“health budgets [having] been protected in recent year [...] prisoner healthcare would have benefit from that shelter”*. Beside this, the stakeholder also underlined the *“commitment to no privatisation of the health service”* and the absence of purchaser/provider split as strengths of the

Scottish health system. However, the context of the *“ongoing economic climate [continuing] to put pressure on health funding is identified as a threat for the system, as well as the “wider UK Government welfare reform [that] may increase pressure on the most disadvantaged communities from which many prisoners come from”*. Moreover, even though still unclear, the fact that the Transatlantic Trade and Investment Partnership (TTIP) *“may affect provision of health services”* was mentioned. The potential competition against other NHS Boards priority was raised by John Porter as well.

In line with the lack of epidemiological information, there is a lack of information on the efficacy and the amounts invested to improve the quality of care delivery, to tackle health inequalities and to meet the specific needs of prisoners. However, in the countries and regions concerned by the integration of prison health in public health ministries, it is generally admitted that the reforms have served to reveal the dramatic underfunding of healthcare in prisons ²⁴¹ and to improve care delivery ^{55,241}.

7.1.7 Outline of six challenges in reforming health care services in prisons and lessons for the Belgian reform process

Challenges	Facilitating strategies and Lessons for the Belgian reform process
1. Building on the pre-existing Institutional Framework	To build upon the strengths of the pre-existing institutional framework of the national healthcare system and overcome its weaknesses
2. Improving the Quality of Care Delivery	To mobilise different types of instruments: <ul style="list-style-type: none"> • Investment in human resources (advanced training and career) • Adoption of standards <ul style="list-style-type: none"> ○ principles versus objectives versus procedural guidelines; ○ specific versus similar to the wider community; ○ compulsory versus indicative • Creation of national quality control bodies (focal point: independence) • Subjection to the scrutiny of international control (through the CPT) • Policy experimentation by pilot projects • Development of adequate and systematic collection of data (issue to be overcome: shifting population)

^{cccccc} Source: SWOT analysis by Dr Devaud (CNPT).



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3. Tackling Health Inequities:
- a. financial access
To facilitate access to social security or health insurance, meaning paying attention to who and to what this social security/insurance covers and to the adjustment period that might be a threat to the continuity of care.
 - b. territorial inequalities
To ensure the quality of care throughout the territory, tackling the disparities as healthcare human resources and medical decisions are influenced by budget cuts and paying particular attention to second- and third-line healthcare services delivery.
To pay attention in the reform process to the social taboos which affects the efficiency of health promotion and intervention programs.
 - c. social acceptance issues
-
4. Meeting the Specific Needs of Prisoners
- To fight against infectious diseases, addictions, mental illness and suicide in prison (health problems with a higher prevalence than in the general population):
- Systematisation of screening process (mainly upon admission),
 - Dissemination of various information, prevention and promotion tools,
 - Multidisciplinary work,
 - Training for professionals,
 - Involving of all stakeholders (inmates, professional, community and family) in the fight,
 - Additional focus on achieving greater equivalence of health outcomes.
-
5. Addressing Professional Practice Issues
- d. Distribution of roles and tensions
To avoid dual-loyalty conflicts for health professionals involved in a care relationship by not involving them in any task which could be contrary to the interest of the prisoners, such as medical expertise.
To ensure the independence of healthcare services of the prison authorities (complete separation of "power", completely different hierarchy).
To adopt a policy in the area of medical secrecy (e.g. in Switzerland, the ethical and legal ground rules that govern medical also apply when the person is deprived of liberty, health professionals are allowed to answer legitimate questions of every prison or police personnel with the agreement of the detained patient/ in Scotland the Duty of Care provides the legal basis for the partners to share prisoners' personal information without obtaining their consent where relevant and appropriate).
To ensure the collaboration of two groups (prison and health professionals) with a very different professional view of the world by adoption of:
 - a methodological guide (some prepared documents, forms and agreements);
 - a national memorandum of understanding (defining respective responsibilities, as well as governance and accountability relationships for prison health services
 - national and local coordination bodies ensuring the smooth collaboration between the two administrations.
 - appropriate infrastructure and resources,
 - a clear definition of tasks and responsibilities of each person involved in decisions regarding healthcare to prisoners,
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	<ul style="list-style-type: none">ensuring that every person involved in the prison administration “is aware of the ethical and legal principles related to healthcare delivery in prison”.
e. Lack of attractiveness of prison for health professionals	<p>To offer career guarantee by:</p> <ul style="list-style-type: none">giving opportunity to support for both the prisoners and to “typical” patients;permitting change positions if required;capitalising on the need for placement opportunities for care interns;developing clear arguments on the advantages of this type of placement (good preparation for future primary care role, especially in the context of multidisciplinary practices)pay attention to peripheral regions (risk of staff shortage);developing specialised training and diploma for health care professionals in prisonreducing the stigmatisation over the prison environment.
6. Cost monitoring	<p>To anticipate the fact that in most countries the reforms have served to reveal the dramatic underfunding of healthcare in prisons ²⁴¹.</p> <p>To develop adequate information and assessment system on the efficacy and the amounts invested</p>



7.2 Six comparative dimensions of a policy and organizational analysis

In addition to highlighting six challenges in reforming health care services in prisons, our report allows us to illustrate the salient features of the 4 countries and highlight the governance models of health care services in prisons on the basis of six analytical dimensions.

7.2.1 Policy problematization

A first dimension is linked to the problematization (Callon, 1986; Webb, 2014) of the links between health and prisons in the four case-study countries; this problematization entails discerning some of the reasons (discourses, principles, reports) that lead to set the issue of prison health care delivery on the policy agenda.

- In France, the 1994 reform took place after two problems had been identified and led to align prisoners' health services on the free citizens' health services. Firstly, in 1989, the Ministry of Justice resumed dialogue with the Ministry of Health about the continuous rise of HIV in prison. Secondly, in 1993, a critical report from the High Committee of Public Health (HCSP) was confirming some problems like addictive behaviors, HIV, hepatitis B and C, tuberculosis and mental health disorders (14). This report was therefore considering that a reform had to take place in order to protect the general population as most of the prisoners were making short sentences.
- In Scotland, the Prison Healthcare Advisory Board (PHAB, set up in 2007) identified some "drivers for change" in order to justify the potential transfer of competences from the Scottish Prison Service to the NHS (74) (75). Among their recommendations, the principle of equivalence of care and the will to tackle health inequalities were established as central, in line with the Scottish Government priorities. The NHS Scotland was perceived as more appropriate than the prison administration to meet these priorities.
- Switzerland is a complex country with a decentralized governance of health and prison services in twenty-six different Cantons. This would have necessitated a cross-cantonal analysis of health and prison

services to gain a federal view of the situation, which far exceeds the capacity of this project. We have therefore focused upon the case study of a particular Canton, Geneva, which has a specific history and political context as a pioneering Canton in human rights. In Geneva, there was a will to standardize and harmonize prison health care activities in the whole canton. In that way we can assume that the university-based prison medicine represented a guarantee of independence from prison administration and judicial authorities.

- A very different attitude can be found in Netherlands, where the DJI is still responsible for healthcare services delivery. This situation is similar to the contemporary Belgian situation and no trace of a potential reform was found, although the so-called "equivalence principle" was inscribed by the DJI in its 2006 healthcare vision note (172).

In the four country contexts, various problematization processes lead to the establishment of different kinds of links between health and prison systems. The French case is characterized by a reactive problematization, as a public concern is raised of health in prison through the issues of HIV. The Scottish case reveals an equivalence / normalization political discourse (Van Zyl Smit & Snacken, 2009), upon which health in prison is problematized. Geneva reforms are based on harmonization or standardization-based problematization (Bieber, 2010).

7.2.2 Policy design

A second transversal dimension is what we would call the policy structure or design. This second dimension relates to the type or form of policy inscription and structural alteration that was introduced in order to make links between prison and health care systems.

- In France, the relationships between Justice and Health Services are then inscribed in the methodological guide (5). Locally, every prison signs an agreement with a neighboring hospital for the delivery of prisoners' healthcare.



- In Scotland, the delivery of care to prisoners falls under the remit of NHS local boards. Moreover, the healthcare staff is independent of the prison administration. The collaboration framework between prison and health authorities is formally defined at a national level in political frameworks documents (57). A number of cooperation bodies are in place at national and local levels to ensure their collaboration and to continue to improve prison health through various workstreams.
- In the federal Swiss context, every canton has its own organizational and financial system for parliament, government, administration and justice. Prison health care system is only independent of the cantonal justice in four French-speaking cantons, such as Geneva, Neuchâtel, Valais and Vaud.
- In the Netherlands, similar again to Belgium, in every prison a local medical team is assigned and composed of some (sometimes judicial) nurses, GPs, psychiatrists, etc. In many cases, however, doctors are working in a prison besides conducting their own regular general practice. The DJI provides a framework for the implementation of health policies that focuses on five areas, such as “investing in the staff” (179) and a significant step towards a job description for the judicial nurse profession has been made in 2015 (182) by the Nurses and Carers Professional Association.

The policy designs in the French and Scottish cases reveal some similarities in that they externalize health care of prisoners into public health systems. Collaborations between prisons and health care units are formalized, and health matters are dealt with in other boards and decision-making organs than prison administrations. Moreover, in Scotland, there are new cooperation bodies put in place to regulate collaboration and there is a developmental aspect through workstreams. Four Swiss French-speaking Cantons externalize health care decisions for prisoners from Cantonal Jurisprudence, under which normally it would fall. In the Netherlands, medical care and medical care decisions in prison are localized within prison, with however externally active doctors.

7.2.3 Prisoners' health care process

A third comparative dimension deals with the organization of the different steps in the medical care process of prisoners.

- In French prisons, a medical examination is conducted with every prisoner at the admission. The GP can then decide whether some specialized care is necessary (withdrawal, psychiatric care, specialized somatic care, etc.).
- In Scotland, the prison health system is based on enhanced primary care. Nurses and practitioners play an important role in the delivery of first line services. Second line services are partially provided within the prisons through in-reach provision by specialists. If necessary, healthcare staff is entitled to refer prisoners to second line services outside prisons. The Scottish Prison Service is responsible for organizing the transfers.
- In Geneva, at their arrival in prison, theoretically, health condition and personal situations of the prisoner are evaluated during an intake interview. In the early days, the prison doctor performs a medical examination.
- In the Netherlands, every prisoner receives a medical intake by a nurse within 24 hours upon entering. This intake should always be approved by a doctor. If primary healthcare offered inside the prison is not sufficient, regular hospitals are used for medical-specialist care, and some secondary health care is also provided by the prison hospital of Scheveningen.

The intake or initial step exists customary in all four case studies: upon entering the prison, a medical examination determines the general health of the prisoner and is followed up in case of specialist care needs. This is done either by GPs in the French and Swiss cases, while nurses play a greater initial role in Scottish and Dutch prisons, where doctors step in at a later stage or if required. However, further medical care during and after detention is less standardized and documented. This raises an important question that is more haphazard and less known: how easy is it for prisoners to gain access to medical care in later years of (and after) imprisonment?



7.2.4 Professional interactions and development

A fourth dimension concerns the way professional interactions are dealt with or handled, and whether professional development of medical staff is provided or foreseen.

- In France, the volunteer is to put on an equal foot the care of prisoners and free citizen. Some tensions characterize the relationships between prison guards and medical staffs (16).
- In Scotland, the transfer of healthcare staff from the SPS to the NHS was seen as an opportunity for career development and therefore as staff retention factor in prison setting. The transfer process went smoothly, with no major difficulties identified with regards to professional issues within the NHS and within the SPS. The whole reform process was built on a national health service with a strong leadership.
- In French-speaking Swiss Cantons, a major difficulty lies in the coexistence of the prison and medical systems. For judges and prosecutors, the medical aspect doesn't seem to be a priority. One main issue was the creation of an interdisciplinary college "Santé Prison Suisse" in 2014, the first national platform dealing with health issues in prisons in order to harmonize processes and patterns.
- In the Netherlands, a specific training is organized for judicial nurses. However, the Penitentiary Nursing Care framework only defines globally the tasks of the different stakeholders, but not their respective expertise in concrete situations (181).

We can therefore see different logics to professional development policy of medical and prison staff, whereby in the French case the focus is upon non-differential treatment of prisoners, in contrast to the Scottish and Dutch orientations toward specific medical training for prison environments. In Switzerland, this leads even to the creation of a teaching unit for prison health, again with a focus upon harmonizing processes and practices. Having powerful medical national systems, such as is the Scottish case, and having procured their involvement in prison health can determine how prison health medical staff is orientated and developed. The problems or tensions seem to occur where this medical national system does not exist and is not

centrally governed, such as in the Swiss Cantons. The Judicial system therefore is governed by public health issues, which can result in preference of judicial over medical values in the treatment of prisoners. More generally, cooperation between medical and prison staffs might be problematic in every setting of every country.

7.2.5 Prevention policy logics

A fifth dimension examines how prevention policy is conceived and what logics it follows in the four countries.

- In France, during the last decade, prevention policy mainly focused on suicide, as the suicide rate of prisoners was higher than in other European countries (23) (33).
- In Scotland, attention has been given to making prisons 'health promoting' places since 2002, when the SPS Health Promotion strategy put health promotion on the prison agenda for the first time (91). The transfer of responsibilities from SPS to NHS has been seen as an opportunity to update and harmonize those aspects of prison health. Health promotion and prevention are shared responsibilities between health and prison authorities. A dedicated document edited in 2012 provides a framework aiming to ensure that actions involving prisoners are taken to improve their health and wellbeing and those of their families and communities (92). An integrative, 'whole prison' approach is recommended, as well as acknowledging that health services are one part of a wider range of stakeholders – including social workers, voluntary sector or Community Justice Authorities - having a role to play in health improvement.
- In Switzerland, BIG is a project fighting against infectious diseases in prisons, launched in 2008 by the Federal Office of Public Health, the Federal Office of Justice and the Cantonal Justice and Police Departments. This is in fact the only area of prison health, which is federalized. It aims to improve and harmonize healthcare delivery in epidemiological data, information, education and communication, and prevention, detection and treatment. With that purpose an extensive vade-mecum on "infectious diseases and addictions in prison" proposes a framework of collaboration between the different involved actors



(medical staff and prison staff) in specific situations (e.g. emergency, disease, drug, etc.) (130).

- In the Netherlands, cooperation with partners in infectious disease control aims at preventing the spread of infectious diseases such as AIDS, Tuberculosis and hepatitis, inside prison as in the free civil society (182).

We can see three different prevention policy logics. In France, a reactive prevention policy is mobilized towards high and worrisome suicide rates of prisoners. In contrast, Scotland, due to the strong involvement and leading governance of prison health by the national health system, prisoners have become health care beneficiaries, with their own set of requirements and needs that have become part of the public health plan. In the Swiss federal case, a similar taking into account of prisoners' health needs has occurred, however, in reaction to infectious diseases and addictions as part of a national project. This is also the case in the Netherlands with a strong anti-AIDS, TB and Hepatitis national medical policy project. Arguably, the Scottish prisoners have the added advantage of featuring amidst the public health care beneficiaries, whereas in the other case studies they appear as high-risk carriers of infectious diseases, therefore in a more target population perspective.

7.2.6 Control bodies and prisoners' rights watch

A sixth transversal dimension is dedicated to examining the prisoners' rights watch or follow-up.

- In the French case, the General Controller of Detention Facilities (CGLPL) can visit any places of deprivation of liberty at any times for random checks. Moreover, retained persons can address their complaints directly to that body (3).
- In Scotland, healthcare related aspects of prison inspection is ensured by Health Improvement Scotland (HIS), according to a formal Partnership Agreement between Her Majesty's Inspectorate of Prisons for Scotland – which is an independent body - and HIS. Besides this, independent observers of Visiting Committees for Scottish Penal Establishments conducted until 2015 regular visits on a voluntary basis to prisons. Today they are replaced by independent prison monitors.

Apart from those inspections healthcare related complaints are under the responsibility of the NHS. After having been through the NHS complaint procedure, if the complainant is not satisfied with the answer received, he can send a complaint to the Scottish Public Services Ombudsman (SPSO). In case of restraints use, of cellular confinement of a detainee or of removal from association, medical practitioners or nurse have the statutory duty to visit the prisoner.

- In Switzerland, the only tool of quality assurance or control is the National Commission for the Prevention of Torture. It has the remit of independently examining regularly the situation of persons deprived of their liberty and inspecting regularly the facilities where those persons are or might be located, and of formulating recommendations to the relevant.
- In the Netherlands, four bodies are designated as the national mechanisms for the prevention of torture: the Inspectorate of Security and Justice (IVenJ) acts as coordinating body; the Health Care Inspectorate (IGZ); the Inspectorate for Youth Care (IJZ); and the Council for the Administration of Criminal Justice and Protection of Juveniles (RSJ). Two additional associates should also be mentioned: the Commissions of oversight for penitentiaries are a supervisory system active in every custodial facility where they handle complaints and provide information to the relevant bodies; the National Ombudsman "investigates complaints where no substantive opinion can be given by inspections or other institutions" ²⁵¹.

Once, again, in line with other policy orientations, we can find an external and governmental body of control for French prisons, whereby prisoners have the right to complain directly to this body. The Scottish case reveals a particular division of health control and other prison restraints control and rights' defence. The HIS and HMI for Prisons ensures through the HIS that inspection is done for health improvement measures. There are different controlling and defence bodies, such as HIS, the voluntary based visiting committees for Scottish Penal Establishments, the Public Services Ombudsman, and also the statutory duty of medical practitioners/nurses to visit prisoners in case of restraints or cellular confinement. In Federal Swiss policy the only measure is against torture, which is controlled by a national commission.



7.2.7 Comparison table of 4 governance models of health care services in prisons on the basis of six analytical dimensions

	FRANCE	SCOTLAND	SWITZERLAND	NETHERLANDS
1) policy problematization	Reactive problematization	Equivalence / normalization	Harmonization / problematization	Status quo + Equivalence / normalization
2) policy design	Formalized externalization of healthcare services	Formalized externalization of healthcare services + cooperation bodies	French-speaking Cantons externalize health care decisions for prisoners	Medical teams are working at a local level
3) prisoners' health care process	Intake interviews conducted by GPs	Intake interviews conducted by nurses	Intake interviews conducted by GPs	Intake interviews conducted by (judicial) nurses
4) professional interactions and development	"non-differential treatment for prisoners" purpose	specific medical training for prison environments	creation of a teaching unit for prison health	specific medical training for prison environments
5) prevention policy logics	Reactive prevention policy (suicide)	Planning prevention: prisoners have become health care beneficiaries (part of the public health plan)	Reactive prevention policy (infectious diseases and drugs addictions)	Reactive prevention policy (anti-AIDS, TB and Hepatitis)
6) control bodies and prisoners' rights watch	CGPL	HIS and HIM + Ombudsman	National Commission against Torture	Four bodies + Local commissions of oversight + National Ombudsman



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