Summary and conclusions

1 Research question and research set-up

By order of the Ministry of Justice research institute ITS has carried out research into the correlation between supply and demand of judicial second-line medical care. This research deals with somatic second-line medical care for detainees.
The following question was central to the research:

> *What do judicial institutions and chain partners expect from second-line medical care, to what extent can a penitentiary hospital meet these needs, and how could supply and demand be better geared to each other?*

The research was carried out by means of four sub-researches.

Document analysis
Firstly, a concise document analysis was carried out. The literature and documents consulted were mainly research reports, referral and admission protocols and annual reports. Attention was also paid to relevant laws and regulations, as well as international treaties.

Qualitative interviews with key informants
In addition, qualitative interviews were held with key informants. These key informants originated from all parties involved: policy makers, judicial institutions, chain partners and medical care providers. In total 25 interviews were held.

Questionnaire
Furthermore, a written questionnaire was distributed amongst all locations of the judicial institutions (PIs and HoDs, TBS-clinics, JDCs, and deportation and detention centers)[1]. The questionnaire included questions about background characteristics of the institutions, referrals to the second-line for outpatient care, admission of detainees to a hospital and the aftercare provided by the penitentiary hospital in Scheveningen. Near the end of June the questionnaire was sent to a total of 105 locations. The final response amounts to 58 returned questionnaires (59 percent).

Registration
In order to get a more objective insight into the demand for judicial second-line medical care, a registration system was developed. All judicial institutions were asked to keep track of a number of details for 11 weeks, concerning all cases with an indication for admission within the second-line because of a somatic disorder. This includes emergency admissions, single day admissions and admissions for more than one day. A total of 184 registration forms were returned.

[1] PI: Penitentiary Institution
HoD: House of Detention
JDC: Juvenile Detention Center

2 Judicial second-line medical care

Execution of detention sentences
Within the Netherlands the Agency of Correctional Institutions (Dienst Justitiële Inrichtingen - DJI) is responsible for the execution of detention sentences and restrictions of freedom. The execution of detention sentences and restrictions of freedom takes place within the following institutions:

- The prison sector: penitentiary institutions;
- The Juvenile Detention Centers sector: detention and treatment institutions;
- The TBS sector: TBS-clinics;
- The Special Facilities Directorate: detention and deportation centers.

The research was aimed mainly on these institutions. In addition, the so-called chain partners were also involved with the research, which means the police and the Royal Dutch Military Police (Koninklijke Marechaussee, KMar), since detainees in police cells may also be referred to the penitentiary hospital.

Right for medical care
In addition to the execution of detainees' detention sentences and restrictions of freedom, DJI is also responsible for their daily care. This includes an obligation to provide medical care for detainees. This medical care is subject to the so-called equivalence principle: The medical care provided in judicial institutions should be equivalent to medical care in civilian society whenever possible. The right of detainees for adequate medical care has been laid down nationally and internationally in a number of treaties and laws. International agreements that apply include the Standard Minimum Rules for the Treatment of Prisoners, and the European Prison Rules. In the Netherlands the right for medical care has been laid down in the laws of principles for penitentiary institutions, juvenile detention centers and TBS-clinics.

Execution of judicial second-line medical care
The need for second-line medical care for judicial institutions is met by the penitentiary hospital of Scheveningen and civil hospitals. Penitentiary institutions are bound by the rules for the referral of detainees to the second-line as laid down in the Regulation Selection, Placement and Transfer of Detainees from August 15, 2000. In principle, detainees that need to be admitted to a hospital will be admitted to the penitentiary hospital. Whenever a detainee needs to be admitted, the penitentiary institutions must at all times contact the penitentiary hospital to confer about admission. Only when it is medically necessary and admission to the penitentiary hospital is not possible or desirable, may the director of a penitentiary institution decide to have the detainee admitted to a civil hospital. For TBS-clinics, Juvenile Detention Centers, police en KMar there are no regulations regarding referral to the second-line.

3 The penitentiary hospital

Capacity
The penitentiary hospital has the status of a House of Detention and has 56 hospital beds, spread over three sections. There are ten wards with three beds. There is no mixing as far as the gender of the detained patients is involved. In addition, there are 20 single rooms, including two maximum security cells and nine cells for TBC-patients. Furthermore, there are six intake cells for observation of food and drink-refusers and consultations and the like.

In 2005 a total of 723 detained patients were admitted, 357 of whom were admitted via the waiting list, and 366 were (semi) emergency cases. The vast majority of the patients admitted originated from the penitentiary institutions. The average occupancy rate for 2005 was 83 percent with an average occupancy of 46.4 patients a day. On average the detained patients stayed in the hospital for 22 days.

Staff

The penitentiary hospital has four doctors. One of them is a surgeon. The other three are general practitioners and no specialists. Except for the surgeon, all specialists are hired when needed. Most specialists come from the Bronovo Hospital in The Hague. In principle each specialism is available on demand for detainees, but structural agreements have been made with some of the most common specialisms:

- The lung doctor, internist and gynaecologist have a weekly consultation hour;
- The surgeon performs surgery every week;
- The ENT-specialist usually performs surgery every eight weeks;
- The orthopaedist on average performs surgery five to six times a year.

In addition, the penitentiary hospital has a staff of 34 nurses for 30.4 fte.

Care provision

The penitentiary hospital is a medium-care hospital, as it lacks high-care facilities, such as an intensive care (IC) or a coronary care unit (CCU). Furthermore, the hospital has no emergency room (ER) and no means for advanced diagnostics, such as endoscopy, CT-scan or MRI. The penitentiary hospital admits stable detainees who need non-emergency somatic care. The admission of a detainee must be preceded by a hospital indication or nursing home indication. It mainly involves:

- Relatively simple, planned surgical procedures, such as groin hernia, abdominal hernia, septum correction, sinus pilonidalis;
- Post-surgical care;
- Consultations and check-ups;
- Observation of food and drink refusers;
- Observation and treatment of detainees with internal disorders, in particular diabetes mellitus;
- Pre- and post-partum care;
- Treatment of tuberculosis (TBC).

4 Supply and demand for judicial second-line medical care

In the analysis of the demand for judicial second-line medical care from PIs, TBS-clinics, JDCs and detention and deportation centers, it is important to distinguish between outpatient care and care that requires admission of the patient. With outpatient care there is no need for admission, and the treatment or consultation take place at the hospital, after which the patient may usually leave the hospital right away.

4.1 Outpatient care

Demand for outpatient care
Judicial institutions have great demand for outpatient care. Based on the data from the questionnaire it can be calculated that detainees make use of outpatient care at the hospital almost 18,000 times a year. Outpatient care is provided almost exclusively by civil hospitals. The questionnaire shows that 63 percent of the medical services never contact the penitentiary hospital when outpatient care is concerned.
The specialisms referred to most when outpatient care is concerned, are surgery, internal medicine and orthopaedics. The most common indications for which detainees are referred to an outpatient care facility are infectious diseases (HIV, hepatitis), fractures and broken bones, heart conditions and diabetes.

The supply of outpatient care
The penitentiary hospital hardly plays a role in outpatient care. In 2005 it provided outpatient care for 863 patients. These patients originated almost exclusively from the PI Haaglanden, location Scheveningen and the UNDU[2]. Due to the nature and the location of the penitentiary hospital it is not likely that the penitentiary hospital will ever play a larger role in outpatient care. The penitentiary hospital is a medium-care hospital and has no specialists of its own, apart from a surgeon. Therefore it cannot provide all outpatient care. An additional problem is the transport of patients to the hospital. The Transport and Support Service (Dienst Vervoer en Ondersteuning – DV&O) provides transport for the detainees but cannot guarantee that a detainee will arrive at the hospital and be picked up again at a certain time. Therefore a detainee would have to be admitted to the hospital for one or more days for even a short outpatient visit.

4.2 Admissions

The demand for admission capacity
The data for the number of admissions per year vary greatly. The calculated number of admissions based on the questionnaires is many times higher than that from the registration forms; approximately 2,200 and 1,135 admissions per year respectively. It should be noted that the research period for the registration forms coincided with the summer holiday. This is not a representative period as the medical services are not fully manned and the number of admissions is generally lower in these months.
The questionnaire as well as the registration forms show that the number of admissions to civil hospitals is 1.5 to 1.8 times that at the penitentiary hospital. According to data from the penitentiary hospitals they have admitted a total of 723 detainees in 2005. Based on this number it may be concluded that approximately 1,100 to 1,300 detainees per year are admitted to a civil hospital. So in total about 1,800 to 2,000 detainees per year are referred to second-line medical care for admission because of somatic complaints.

Admissions according to type of judicial institution based on the registration research
The deportation and detention centers send the majority of their detainees to the penitentiary hospital (54 percent); 42 percent is sent to a civil hospital. This may be explained by the fact that these centers see relatively high numbers of food or drink refusers. The penitentiary institutions

[2] United Nations Detention Unit

refer the majority of their detainees to a civil hospital (56 percent) and 35 percent goes to the penitentiary hospital. The TBS-clinics and juvenile detention centers make much less use of the penitentiary hospital. Most of their detainees go to a civil hospital. About three quarters of the detainees from TBS-clinics goes to a civil hospital; 16 percent goes to the penitentiary hospital.

Admissions according to admission indication based on the registration research

Detainees are mostly admitted to a civil hospital for surgery (59 percent), treatment (61 percent) and examination/diagnostics (67 percent). Detainees who need to convalesce generally go to the penitentiary hospital (67 percent). In cases of post-operative care, childbirth and nursing the percentages are fairly evenly distributed amongst admission to a civil hospital and the penitentiary hospital.

In the case of the specialisms IC/CCU, ER and ophtalmology patient are never referred to the penitentiary hospital. With cardiology and urology this only happens in limited cases; 7 percent and 12 percent, respectively. In the case of the other specialisms most patients go to a civil hospital, but still a quarter to one third of them go to the penitentiary hospital. Internal medicine forms an exception to this trend. Detainees with an internal complaint are in most cases admitted to the penitentiary hospital.

Admission indications with a high level of urgency are referred to a civil hospital in almost 70 percent of the cases. In the case of medium urgency the admissions are evenly distributed amongst civil hospitals and the penitentiary hospital. Admissions with a low level of urgency are generally referred to the penitentiary hospital (54 percent).

Reasons for admission to a civil hospital

The registration forms show that 57 percent of the detainees are referred to a civil hospital for admission. Medical services were asked about the reasons why they send these detainees to a civil hospital rather than the penitentiary hospital. This question was also posed in the written questionnaire. According to the registration forms the most important reason for the institutions to refer to a civil hospital is an emergency admission (50 percent). Many other cases concern a single day admission (30 percent) or specialisms the penitentiary hospital cannot offer (15 percent).

The results of the questionnaire also indicate emergency admission as the most important reason (78 percent) to refer detainees to civil hospitals. Other important reasons are that the penitentiary hospital cannot offer the required specialism (37 percent) or is too far away (34 percent). In contrast with the registration forms, a reason the questionnaires mention far more often is the fact that the penitentiary hospital has no beds available; 52 percent versus 4 percent.

5 The image of the penitentiary hospital

Interviews with representatives from the judicial institutions reveal that staff at the institutions have a negative image of the penitentiary hospital concerning the possibilities for placing patients there. According to the institutions the penitentiary hospital hardly ever has room when they call for an admission.

The discrepancy between the results of the registration forms and the questionnaire concerning the possibility to place patients in the penitentiary hospital may be caused by this negative image of the penitentiary hospital. The registration research is based on actual data: the number of admissions in a particular period. The results of this research show that the penitentiary hospital in most cases does have room. The questionnaire research, on the other hand, is far more

opinionating in nature, as the subjects are asked for their opinion. The questionnaire shows that people feel the penitentiary hospital hardly ever has room when they offer a patient for admission. Because the penitentiary hospital only has a surgeon of its own, and other specialisms need to be hired, there is a waiting period for most admissions. In these cases the patients may be admitted, but usually end up on a waiting list. Medical services may interpret this as the fact that there is no room at the penitentiary hospital.
Another fact that contradicts the image that there is never room at the penitentiary hospital comes from the questionnaire. For when a patient needs to be admitted, 80 percent of the judicial institutions contact the penitentiary hospital for admission. Of this 80 percent three quarters indicate that the contact actually leads to the patient's admission to the penitentiary hospital.

6 Conclusions

In this paragraph the research questions will be answered. They will be answered in the same order that was used to categorize the research questions.

6.1 Supply and demand

As far as outpatient care is concerned, the penitentiary hospital cannot meet the demand for it from the judicial institutions. This is inherent in the nature and location of the penitentiary hospital. For it only has its own surgeon. All other specialisms are hired externally and are not always available. Because of the organization of the transport with DV&O and the distance from most judicial institutions to the penitentiary hospital, excluding PI Haaglanden and the UNDU, it is not possible to drive detainees to the penitentiary hospital and back to the institution again in one day. This results in detainees being admitted to the penitentiary hospital for several days for a simple consultation or check-up. This is why the judicial institutions almost exclusively use civil hospitals for outpatient treatments and consultations.

The judicial institutions' demand for capacity for emergency admissions can be met only to a limited degree by the penitentiary hospital. This is also inherent in the medium-care nature and the location of the penitentiary hospital. Specialists, apart from the hospital's own surgeon, are not always available, and the distance and the transport to the penitentiary hospital constitute a considerable obstacle when patients need to get to the penitentiary hospital in time for emergency treatment.

The demand for non-emergency treatment can only be met by the penitentiary hospital to a limited degree. Being a medium-care hospital, it is not equipped for complicated or high-risk procedures. For such procedures patients have to be referred to the Bronovo Hospital in The Hague. Furthermore, the penitentiary hospital only has a surgeon of its own, and has to turn to specialists from the Bronovo Hospital for other specialisms. As a result there is a waiting list for many procedures.

6.2 Referral and admission, policy and practice

For the judicial institutions the penitentiary hospital fulfils an important role in the admission of patients who have been treated in a civil hospital but cannot be nursed in the institution itself after their discharge from the hospital.
There are, however, frequently patients in the penitentiary hospital who should not be there, according to the hospital. In particular, these are detainees who need to be nursed or convalesce. The penitentiary hospital considers itself to be a temporary detention center. Detainees go to the hospital temporarily and once they have been treated they should go back to their institution. But the institutions frequently try, sometimes put under pressure by the board, to get patients who need nursing admitted to the penitentiary hospital. In such cases it is a matter of false indication, as there is no medical necessity. The (re)location of detainees also poses a problem when they (still) need some care or are handicapped. The institutions are said to be reluctant to take such detainees back again. This does, however, mean that a detained patient wrongfully keeps a bed occupied at the penitentiary hospital.

Detainees who need to be nursed or convalesce also pose a problem for the judicial institutions. The latter are not geared towards offering basic care, such as help with activities of daily living (ADL), offering nursing care (observation and regulation of diabetes, stoma care and wound nursing, amongst others) and housing the handicapped. Especially many older institutions are less accessible for the handicapped and chronically ill, for instance. And offering ADL-help is not part of the core tasks of the medical service and the penitentiary institution workers (PIWs).

The penitentiary hospital is the only hospital in the Netherlands that offers admission capacity for the observation and treatment of TBC-patients, food and drink refusers and so-called malingerers who use their health to obtain certain privileges.

The penitentiary hospital has the status of a House of Detention (HoD) and as such is the only hospital in the Netherlands to offer admission capacity for maximum security or aggressive detainees. Furthermore, admission to the penitentiary hospital is cost effective for the judicial institution, as there is no need to hire extra security at the civil hospital.

The interviews with key informants and the written questionnaire suggest that the penitentiary hospital does not communicate well with the judicial institutions. Many medical services are not aware of what is possible at the penitentiary hospital and what is not, and are not informed about the amount of time patient have to wait before they can be helped when they have been put on the waiting list. This leads to the image that ‘nothing is possible’ at the penitentiary hospital, and that ‘there are never any beds available’.
One of the causes of the bad communication is the lack of central policy, which leads to both the individual judicial institutions and the penitentiary hospital pursuing an autonomous policy of their own. The policy of the penitentiary hospital is based on the medical world and aimed at the treatment and an efficient flow of patients, and is therefore in principle a dynamic policy. The policy of the judicial institutions, on the other hand, is aimed at detaining detainees. These are two separate cultures that collide at certain areas.

No policy has been formulated at a central level concerning referral of detainees to judicial second-line medical care, distinguishing between outpatient care, and emergency and regular admissions. As a result, all institutions act at their own discretion when it comes to referring patients to second-line medical care.

Despite the criticism of the penitentiary hospital it is, in the eyes of the judicial institutions, an essential part of judicial medical care, and the vast majority of the institutions consider the penitentiary hospital to be far from redundant.

7 In conclusion

The research was carried out because the penitentiary hospital appears insufficiently capable of meeting the need for second-line medical care of judicial institutions and chain partners (police, KMar and UNDU). According to them the hospital often has no room or lacks the necessary expertise. DJI wishes to improve the correlation between supply and demand of second-line medical care.

The bottlenecks with judicial second-line care mentioned in this report can for a large part be related to the historically grown situation that the penitentiary hospital is a medium-care hospital. By the way, it is unknown what exactly a medium-care hospital should offer, as there are no clear criteria.

The penitentiary hospital only has one surgeon of its own and lacks IC or CCU facilities. For virtually all other specialisms as well as complex procedures the hospital needs to turn to the specialists and the capacity of the Bronovo Hospital. These are, however, only available to a limited degree. This results in waiting lists for many procedures. The population is too small, however, to set up a full-fledged high-care hospital for detainees.

The location chosen for the penitentiary hospital makes it less suitable for outpatient treatment and emergencies. The distance from the judicial institutions to the hospital is simply too great. Although it remains to be seen whether this could be solved by choosing a more central location for the penitentiary hospital. The distance to many judicial institutions would still be too great.

The penitentiary hospital constitutes an essential link in the chain of judicial medical care, because it offers capacity as a House of Detention to admit and treat detainees. Part of the judicial institutions' dissatisfaction with the penitentiary hospital could be taken away by a more customer friendly and communicative policy on the part of the penitentiary hospital: explicit information about what is possible at the penitentiary hospital and what is not, clear information about admission procedures, and unambiguous communication about waiting lists.

In order to modernize or extend the services of the penitentiary hospital it might be considered to join forces with an existing high-care hospital, at a central location in the country. The penitentiary hospital could then function as a penitentiary division that may use all facilities and specialisms already available at the hospital. But even with a construction like this, a great number of judicial institutions will continue to use the facilities of a local hospital. The distance will still be an obstacle for outpatient care and consultations, as well as emergency admissions.

Another solution might be to maintain the penitentiary hospital as a medium-care hospital and optimize the preconditions. The preconditions concern:

- Specialisms; expanding the number of specialisms at the hospital, with an internist, for example. Another possibility is to hire other specialists more frequently.
- Regulations; it is remarkable that it has been laid down that penitentiary institutions should initially always turn to the penitentiary hospital for medical treatment, while the possibilities for treatment are limited.
- Communication and information; the field does not have an adequate image of the possibilities and limitations of the penitentiary hospital. There is considerable room for improvement in the communication concerning this towards the judicial institutions and chain partners.