



Assessment of health services to prisoners in Andorra

2009



ABSTRACT

Andorra has a single prison centre, La Comella Prison, which was inaugurated in 2005. On 31 December 2007, it had 67 prisoners, representing 54% of the overall institutional capacity of 125. In 2008, at the time of the visit, the prison population rate was 80 per 100 000 of the national population.

At the request of the Government of Andorra, and under the terms of the Biennial Collaborative Agreement between the two parties, the World Health Organization (WHO) Regional Office for Europe agreed to make an assessment of the health services provided to prisoners in the Principality. The WHO Regional Office for Europe was represented by Dr Lars Møller, manager of the Health in Prisons Project, and Dr Andrew Fraser, Co-director of the WHO Collaborating Centre for promoting health in prisons, London, United Kingdom.

The evaluation mission took place on 2 and 3 October 2008 in Andorra la Vella.

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Introduction

The Andorran Ministry of Justice and the Interior (MJI), under whose jurisdiction prison health is regulated, has expressed its commitment to advancing the health systems as well as service and programme delivery throughout the justice system. At the request of the Government of Andorra, and under the terms of the Biennial Collaborative Agreement between the two parties, the World Health Organization (WHO) Regional Office for Europe agreed to make an assessment of the health services provided to prisoners in the Principality. The WHO Regional Office for Europe was represented by Dr Lars Møller, manager of the Health in Prisons Project, and Dr Andrew Fraser, Co-director of the WHO Collaborating Centre for promoting health in prisons, London, United Kingdom.

The evaluation mission took place on 2 and 3 October 2008 in Andorra la Vella.

Remit

The remit was:

- to assess the health and health care service arrangements for prisoners in Andorra
- to assess the extent to which current arrangements meet the needs of prisoners in Andorra
- to make useful and practical observations and suggestions for further improvements.

Background

Andorra has a single prison centre, La Comella Prison, which was inaugurated in 2005. On 31 December 2007, it had 67 prisoners, representing 54% of the overall institutional capacity of 125. In 2008, at the time of the visit, the prison population rate was 80 per 100 000 of the national population, of whom 8 were women. Dispersed over four floors, La Comella Prison consists of a unit for each of the following prisoner groupings: sentenced males; unconvicted males, including pretrial detainees, remand prisoners and inmates in protective custody; all female prisoners; all minors; and individuals in isolation.

The most up-to-date prison demographics for the Andorran prison system were obtained in 2007. These show that the median monthly rates of imprisonment increased over the year, with a range of 42 (February) to 71 (November). Indeed, while the total sentenced population remained largely stable throughout 2007, the number of unconvicted prisoners rose steadily over the year, exceeding the number of sentenced prisoners after March. Further, the closed regime of La Comella Prison recorded an inmate population increase of 65% in January 2008 compared to the previous January. Much of this was attributable to high levels of incarceration of unconvicted males.

The composition of the Andorran prisoner population is very heterogeneous in terms of age and sex. Prisoners aged between 22 and 35 represented the largest proportion of the overall prison population in 2007, accounting for 60% of the closed regime and 50% of the open regime. Furthermore, 89% of both closed and open regime populations consisted of inmates over the age of 22. In comparison, minors and young prisoners (aged between 18 and 21) constituted significantly less of the cumulative prison population. In the closed regime, the proportion of

minors was 1% and that of young prisoners, 10%. In the open regime, minors comprised 2% and young prisoners 5%. Notably, all minors and young prisoners were male. The total female prison population corresponded to 10% of the prison population for 2007.

Andorran prisoners made up only 18% of the combined prison population in 2007. Spanish (31%) and Portuguese nationals (28%), however, contributed significantly to the prison population. The remaining 15 countries of origin each accounted for 5% or less of the cumulative prison population for 2007. The percentage of inmates with sentences of up to one year varied such that a third of prisoners of Portuguese nationality had sentences of less than a year compared to approximately a quarter (46%) of Andorrans and a half (54%) of Spanish nationals. In contrast, 41% of Portuguese, 38% of Andorran and 26% of Spanish prisoners were serving prison sentences of between 1 and 3 years.

In June 2007, MJI established the Department of Penitentiary Institutions to replace the existing internal regulations governing the former prison, Casa de la Vall Prison, and corrections personnel. The Department sought to balance the human rights of prisoners as stipulated in the Constitution and international conventions, while instituting and operationalizing a legally recognized regulatory and disciplinary procedure. In this manner, a system-wide legal instrument was created so as to facilitate the reintegration of prisoners into the community. The policy incorporates social, education, labour and health aspects. With regard to health, Penitentiary Law 4/2007¹ stipulates that prisoners have the right to health and personal integrity, medical attention, psychological services and appropriate diet, hygiene and living conditions exercised according to the principle of "limited exceptionalism" and the provisions of national and international law. In the same month, an evaluation of the prison health programme in Andorra was concluded. Subsequent to this, the national prison administration endeavoured to modify prison health programmes and budget allocations in accordance with the findings.

Context

Health policy and health care reforms

The arrangements for health policy, strategy and delivery of health care in Andorra have seen rapid changes over the past 15 years. Policy rests with the Government. The health status of the Andorran population is good, and general health and health care arrangements reflect a prosperous, small European state. There is a strong primary care sector and a single acute care hospital nearby in Escaldes-Engordany, catering for all specialties apart from cardiothoracic, neuro- and maxillofacial surgery.

Health services are commissioned through a mixture of public and private arrangements. The Prison Service provides primary health care to prisoners. For all other health matters, the public health system is commissioned through the Andorran Health Care Service (Servei Andorrà d'Atenció Sanitària – SAAS). Health insurance covers 75% of health care costs. For those unable to pay the remaining 25%, the State covers these costs. This is the case for prisoners who require specialist care. Prisoners who require specialist care not available in Andorra go to centres in either France or Spain on a "voluntary" basis, as they are not recognized as prisoners in other countries. These arrangements are currently under review by the MJI.

¹ Llei 4/2007, de 22 de març, qualificada penitenciària (BOPA Núm. 36 de 25.4.2007)

Criminal justice policy

The MJI is responsible for policy relating to the criminal justice system. It is responsible for all service provision within the single central prison, on the margins of Andorra la Vella. Recent changes have placed the central prison under the Department of Penitentiary Institutions in order "to reintegrate the prisoners in all different fields". Responsibility for prisoner service provision includes health and health care in custody, while separate arrangements apply for people in police custody.

The maximum period of police custody is 72 hours. Thereafter, pretrial and convicted prisoners must be held in the central prison. The central prison is a modern institution with capacity for 125 prisoners, separated into 4, soon to be 5 groups: adult male remand, adult male convicted, women, open regime and young people.

Penal policy stipulates that no custodial penalties may be of less than three months. Andorrans who have a job and are serving short sentences can be assigned to an open regime. Non-Andorran citizens must serve custodial sentences under closed conditions. The maximum sentence is approximately 12 years. There is no provision for life sentences.

Prisoners of all categories, including those serving long and short sentences and sentences for sex offences, are held in the same conditions. There are two separate areas in the convicted men's section. Other sections are for unconvicted male adult prisoners, women and juvenile offenders.

At the time of visit, there were 66 prisoners – 58 men and 8 women. One prisoner was an inpatient in the hospital, in a specially assigned two-bed unit.

The age range of prisoners was between 17 and 72, with most prisoners aged between 20 and 35. Andorrans constituted the majority of prisoners, but there was also a very high foreign population. The most common foreign nationalities were Spanish, Portuguese, Romanian and Chinese.

Most of the prisoners were serving sentences for financial crimes or drug trafficking, with a small minority convicted of violent crimes, sex offences and murder.

The central prison was built and completed in 2006 on steep ground above the city of Andorra la Vella, with four levels. The prison offices are on the top level, the reception area and service departments are on the next level, and residential work and exercise areas are on the bottom two levels. A young offenders' unit is currently under construction on the upper level.

The prison design gives the impression of space within a tight site, with good indoor living conditions for prisoners, although conditions in the reception and segregation areas are basic. Standard cells accommodate three people with triple bunk accommodation and in-cell toilet and shower. The accommodation is air conditioned and has a good outlook over the city.

The work areas are next to the living areas. Prisoners are expected to eat in their cells. Outdoor exercise areas are small, reflecting the limited ground available to the prison. They are clean and well kept. There is also an indoor fitness centre and most prisoners use this every day for about one hour.

Catering arrangements are contracted, with prisoners working in the kitchens under the supervision of the contractor. The food is good (paella, salad and crème caramel were served during our visit), with a daily budget of €10.50 per prisoner.

Within each regime, there is full segregation between sexes, with the exception of adolescent males and females (aged 14–18). Women can keep their children until they are four months old. Mixing of different offender populations within the adult men's unit takes place after risk assessment and under close supervision, with significant reliance on camera surveillance. Open conditions – the *regin obert* – entail the prisoner sleeping in the prison and spending the day at work.

Visits take place under "closed conditions" on a one-to-one basis for most prisoners. There are four rooms for family visits, intended for conversation and social exchange. There are no intimate family visits.

Visits to foreign nationals are unusual, given the distance that visitors would have to travel. Foreign nationals experience a great deal of isolation throughout their stay in prison.

The management of the prison is headed by the Director. The Deputy Director is thus able to focus separately on security and regimes/reintegration. The Director intends to conduct a further reorganization of prison personnel to focus on reintegration processes, with a staff cluster to oversee the functions of health, education, labour and social work.

Health care

The health care model used in the central prison is that of enhanced primary care. The centre of care is in a pleasant health centre environment next to the reception area, comprising a clinic room for medical consultations, a small room for addiction treatments, a combined nurses' clinic room and dental suite, a staff room, a pharmacy cupboard, sanitary facilities and an x-ray room (not in use). There is a small waiting area.

The core permanent medical staff consists of three nurses, with a further two nurses contracted to the SAAS. Part-time contracted appointments are as follows:

- two doctors for one day each a week for approximately two hours and on-call;
- a pharmacist who attends once a week;
- a dentist who attends once a fortnight;
- a psychologist who attends once a week for approximately 3 hours, accommodating up to 20 consultations a week;
- a social worker for two days a week; and
- a teacher.

Health professionals from other disciplines, including psychiatry, attend as and when required.

Prisoners are reportedly seen by the nursing staff immediately on admission to the prison and assessed according to standard and detailed arrangements. They are offered voluntary testing for various matters. A doctor is required to see them within 24 hours of admission. There are typically up to five new prisoner admissions per week. Prisoners can also visit the nurse in the

first instance for any matter: s/he will refer the patient to other specialists, including the doctor, as appropriate. According to the prison management, there are rarely any problems with this arrangement.

Prisoners in the open facilities use the public health care system, as they only stay in the prison at night; the open facilities are used only for citizens of Andorra and they all have health insurance.

Personal health information is held in the prison medical records system, which is separate from the national public health system. It is well structured for admission purposes. At the time of the assessment, there were no statistics available on activities in the health centre, nor were there protocols for matters such as detoxification. However, a standard referral sheet was used, for instance, for mental health referral to a psychologist or psychiatrist. Waiting times are reportedly almost nonexistent. The general impression of the WHO assessment team was that access to somatic health care – at every level: nursing, medical, specialist and health care – is as good as that available to any person in the community. Treatment for alcohol and drug abuse focuses only on opiate dependency with methadone substitution therapy as the only treatment provided. Treatment for mental health problems is provided by a psychologist working three hours a week in the prison, in addition to the nurses and prison doctor. There are no group therapy sessions for prisoners. Occasionally, depending on the urgency and seriousness of the request, patients are transported to hospital. Urgent and emergency referral can be arranged at virtually no notice. The police are able to provide security for prisoners outside hospital (and also provide guards for prisoners in inpatient hospital facilities). Prisoners are embarrassed by the security arrangements associated with hospital attendance. This could act as a deterrent to attendance at hospital appointments. There is said to be no waiting list for treatment for either the general public or for prisoners.

Clinical protocols

Care for long-term conditions appears to be satisfactory. The general impression is of a well run health centre. The health of prisoners is generally fairly good. The prison population consists largely of young men who do not seek health care often.

There are no set protocols for prime risk conditions of prisoners, such as suicide risk on admission, addictions or serious infection. However, addictions and infections are covered in the standard assessment on admission.

There are well understood methods of assessment and referral for mental health, but not all are formalized in writing.

There are well understood arrangements for referral and continuation of the methadone programme for opiate dependency, but no other service for dependency on other drugs, alcohol or tobacco. The most commonly used drug in Andorra is cocaine but 80% of the patients in the addiction centre are referred because of an alcohol problem. Heroin users predominantly smoke rather than inject the drug. The addiction centre, under the SAAS, is responsible for the methadone programme in the prison and prisoners are required to come to the addiction centre when needed. Contact with the addiction centre goes through the prison doctors – there is no direct contact between the nurses and the addiction centre. At the time of the visit, only two prisoners were receiving methadone. There is no drugs-free treatment provided and no group therapy in that respect.

Pharmacy services were introduced to the prison in the past year, partly in response to concerns about the arrangements for prescribing. The service has yet to be fully integrated into overall provision within the health centre.

Referral protocols for planned care outside hospital are well understood and mainly take place through the doctor. The doctor is familiar with all other doctors in the Principality and is in regular contact with his medical colleagues who service the prison.

Relationships with secondary care are said to be very satisfactory in general. Relationships with community-based services are based in the hospital centre, where there are day facilities for mental health and addictions (see later for potential developments in these relationships and services).

There is an inreach service encompassing mental health, dentistry and general nursing within the prison. However, there is no such inreach service for addictions. Outreach services for prisoners are limited.

Given the relatively small prison population, critical incidents and deaths are very rare. It is therefore difficult to assess the system for professional review and development. However, there was a critical incident on the night before the visit: a medical emergency which was evidently very well managed.

Health protection and sanitary arrangements

At the time of the assessment, prison conditions, in terms of health protection and sanitary arrangements, were of a very high standard. The prison was also very well cleaned and kept. Food hygiene arrangements were subject to external inspection and appeared to be very satisfactory. The catering facilities were of a very high standard and the quality of prisoners' food (which we sampled) was excellent. Policy, practice and arrangements for the assessment and control of bloodborne viruses are covered in the next stage of development. Compared to other European countries, the apparent incidence of injecting drug use and sharing needles is low in Andorra, as most drugs of addiction are smoked, rather than injected. The incidence of HIV is low, and that of hepatitis B and C is uncertain. We did not see any statistics on sexually transmitted diseases or other sexual matters. The incidence of tuberculosis is also low – six cases in the Principality in 2007, five of which were Andorrans, and one a foreign national. None of these cases affected prisoners. Arrangements to assess and prevent the spread of bloodborne viruses and sexually transmitted diseases in prison are at an early stage. A methadone programme is available to prisoners, but drug-free treatment, other drug types, and barrier protection against sexual diseases and injecting diseases, are not available to prisoners.

Health promotion

The general ethos of the prison was very positive, with good order, respectful relationships, and positive and attentive staff; and a very high level of professionalism was evident. Prisoners looked clean, tidy and generally content.

We did not assess the general training of staff in health matters, but understand there to be a basic level of understanding and appreciation of the role and importance of health care within the overall provision of prison services.

Training of health professionals

Within the prison, training appears to be unstructured. Given the very small number of health staff working in the prison, this is perhaps not surprising. The majority of clinical staff engage in clinical practice, both inside and outside the prison, and stay abreast of clinical developments generally. Recent developments on addictions have been well embraced by prison-based nursing staff and there is both an appetite and a need for training in other areas such as mental health. There also appears to be a need for training in management and teamwork, given the challenging environment, the particular circumstances of prison health care and the relatively large number of visiting professionals who have varying levels of experience with the prison environment. Subject to further developments, this range of health professionals may expand further. The nurses said that they sometimes feel isolated, without any close connection to the public health system.

We also discussed examples of health education for prisoners, particularly in the area of addictions. This is a promising area of practice for future development.

Food, physical activity, and matters related to risk behaviour in drug-taking have been discussed before. Alcohol is generally not available to prisoners in custody, however, several people commented on problems with alcohol intoxication among people in the open regime when returning at night.

We discussed access to translation for prisoners who did not speak local languages and who needed to access services, including health care. This is generally satisfactory. A number of ad-hoc arrangements are available for people who do not speak the local language. Many of the remaining prisoners speak Catalan or Spanish as second languages. Failing that, fellow prisoners are in some cases willing to translate. Chinese prisoners often speak English. Portuguese and other foreign nationals commonly worked in Andorra prior to their arrest and are therefore able to speak the local language quite fluently.

The assessment team was informed that the majority of prisoners smoke and, as in the rest of the Principality, are allowed to do so freely, but only in the common zones and the outside area. There appeared to be no desire for a smoking cessation campaign in prison and none is on offer, other than the encouragement of spontaneous efforts by other prisoners.

Health care governance

Responsibility for health care for prisoners, both in prison and in the hospital, is a matter for the MJI. The hospital and other health professionals are reportedly fully reimbursed for services to prisoners, with the exception of methadone treatment. Management of prisoners in hospital is shared – with security provided by the police and clinical matters dealt with by the hospital. People with opiate dependency attend addiction clinic appointments in the hospital.

Once a month there is an organized staff meeting for all the health staff to discuss both organizational problems and prisoners.

At the time of visit, health statistics were not available for most matters relating to prisoners. We assessed the following:

- the general level of health among prisoners is relatively good (compared to other prison populations, if not to the general Andorran population);
- most prisoners are young and male, and make little use of services; and
- in common with most other prison populations, their main health problems are:
 - mental health;
 - addictions, primarily drugs and alcohol;
 - risk of infection through drug use, high-risk sexual behaviour, and generally poor health experiences – the main infection risks are believed to be hepatitis C, hepatitis B, HIV and tuberculosis (at the time of visit there were no prisoners with either HIV or tuberculosis);
 - chronic physical illnesses; and
 - acute illnesses.

There was an apparent discrepancy between prisoner health needs and the provision of services, which are mainly structured for primary care (admission assessment and clinical complaints); mental illness and opiate assessment. Needs-based assessments are thus warranted.

Links with other parts of the health and criminal justice systems

Links with other parts of the criminal justice system (police and courts) appeared to be good, with a satisfactory flow of clinical information from the police service concerning people at risk, as and when required. The police are used for all escorts to medical treatment appointments outside the prison.

Links with other parts of the health system seemed very good generally, although there were problems at the governmental level in securing arrangements for exceptional matters which required transfer of patients outside the Principality. However, such transfers do, reportedly, take place according to patient need and the Government is working to establish robust bilateral agreements on the matter.

Links with secondary care are said to be very good in general and occur at a doctor-to-doctor level.

Care entitlement for foreign nationals is satisfactory in both the prison and the hospital. Continuity of care for this subgroup is not deemed possible, given that most foreign nationals are deported immediately on release.

We did not, on this visit, test the views of patients or the involvement of patients in decisions about their care.

Through-care arrangements

Arrangements to ensure continuity of care from prison to the community are generally satisfactory. Patients sought care, and medical links were close enough to ensure familiarity with issues of critical importance to prisoners and the public health system. Generally, there was little

evidence that patients requiring continuing care disappeared from health care in the Andorran community. Arrangements for foreign nationals are likely to be less satisfactory, although some through-care links were said to exist.

Links between health and non-health sections of prison regimes are mainly maintained through monthly meetings attended by the Director and all other care groups. There are apparently occasional case conferences for individuals who pose particular problems but there is a general lack of structure for the management of conditions and problems in between the monthly meetings. There was an appreciation of the need for cross-disciplinary work. Much of this currently occurs by telephone within the health care team but formal meetings within the prison and across "reintegration" functions was not evident during the visit.

General findings

In general, we were impressed with the health and health care services available to prisoners in Andorra. There was a high level of appreciation within the Justice and Health Ministries, good leadership by the Prison Director, high standards of professionalism and good attitudes across all health professionals who are engaged with prisoners in every setting; highly motivated care professionals from other disciplines whom we met; and a willingness to seek improvements where possible.

The commitment and calibre of all staff whom we met was commendable. This included security staff. The facilities are of a high standard. Patient flows responded to health needs. There was appropriate protection of confidentiality with regard to personal health information. The level of resources devoted to health care in prisons was satisfactory.

We also noted the particular circumstances of Andorra. It is a small principality; personal links act in favour of good health care. There is a high degree of social cohesion, family cohesion and focus on work as a means of reintegration. There is also an appreciation that the supports for regaining a place in society include good health care, social work, education and labour advice. The integration of community and state functions in supporting these was impressive. Whereas state arrangements in larger countries rely on formal mechanisms, it is appropriate for Andorra to look to its community ties and close cohesion to deal with the challenges we identify in this report.

In conclusion, therefore, prison health care has strong foundations and is performing well in Andorra. We commend all those involved in and committed to it.

Improvements – recommendations

We now identify key measures that would further health and health care provision for prisoners.

1. **Needs-based assessment.** We recommend that health care service provision to prisoners be planned on the basis of need with regard to the individual and the prison population in its entirety.

a. **Quantitative.** We recommend that health information be collated to produce up-to-date statistics on key health indicators:

- i. on admission;
- ii. at each primary care appointment with nursing staff, medical specialists, dentists and other health professionals;
- iii. on assessment and referral for mental health care, including diagnosis or treatment for mental disorders and addictions;
- iv. on the occasion of critical incidents such as significant self-harm and inpatient care.

b. **Qualitative.** A representative sample of the prison population (controlled for gender, ethnicity and age) should be questioned on their perceived health needs. Appropriate prisoner feedback mechanisms should be provided to allow prisoners to evaluate their experiences with the prison health system.

c. **Suggestion of indicators** include:

- i. standardized measures documenting significant health concerns and diagnoses, separated by category:
 - 1) somatic diseases, including communicable and noncommunicable diseases;
 - 2) mental diseases (e.g. depression, anxiety, post-traumatic stress disorder and schizophrenia) and addictions (especially drugs and alcohol);
 - 3) risk assessments (e.g. nutritional status and current or previous suicidal inclination or self-harm);
 - 4) socioeconomic situation and life circumstances (e.g. lifetime incidence of abuse or trauma, educational status, prior high risk sexual or drug behaviour);
- ii. assessment of the different needs of particular sub-groups:
 - 1) men;
 - 2) women, including in terms of their mental health (e.g. lifetime substance use and traumatization) and sexual and reproductive health (including pregnancy and menstruation);
 - 3) children, including age-appropriate child and adolescent development and educational needs;
 - 4) culturally and linguistically diverse populations, including accessibility of services.

Information on health needs should guide the development of health services in response to these needs. We consider that the prison health service should, in particular, address and further structure its care for people with addictions and make adjustments to the structured care for mental illness. It should plan to introduce multidisciplinary care that includes clinical meetings between staff disciplines, encompassing reintegration staff and the Clinical Manager (see point 2 below).

We recommend that the prison ethos be based on holistic individual development rather than merely the treatment of disorders. In this manner, prisoners' strengths and health are prioritized. This will better facilitate the reintegration process. To this end, we encourage the adoption of measures that foster mental and physical well-being, trauma processing, capacity building, skills development and resilience training. Prisoner empowerment and ownership of health needs are central to this process. They can be achieved through such activities as prisoner-derived health education, awareness programmes and health promotion.

2. **Effective management structure and governance.** There should be formalized directives for the clinical management of prison health care. We consider that the level of investment in health care in the prison is generally satisfactory and that any marginal increase should go to the organization of clinical care and the provision of mental health and addictions services.

A clinical manager based in the prison should be appointed on a half- or full-time basis. The Manager, who should be a clinician, should ensure not only the coordination of services but also the setting and assurance of standards for quality of care and health care delivery across disciplines for people who have complex needs. He or she should be responsible to and have regular contact with the Director or his/her representative in matters of general and clinical management. The Clinical Manager should oversee the completion of needs assessments and the creation and coordination of individual treatment plans in consultation with individual prisoners and the appropriate services.

3. **Integration of services, structures and programmes.**

- a. **Linkage between prison health and public health.** We recommend that the Justice and Health Ministries consider the merits of aligning the financial, managerial and clinical resources for prisoners with the public health system, in place of the current separate and/or shared arrangements.
- b. **Linkage between prison and community services.** We recommend greater integration between prison health care services and other health care service provision within the Principality. Generally there are good links at both the formal and informal level. We recommend particular development of links with:
 - i. police custody;
 - ii. the Community Mental Health Service and the Addictions Clinic, encouraging both prison inreach and outreach, sharing of staff resources and professional development; such partnerships would also assist the prison health service in covering all aspects of mental health and addiction including, but not limited to, psychotherapy, detoxification, drug-free treatment, group and peer-based therapy; the staff of both the Community Mental Health Service and the Addiction Centre should be able to provide the treatment within the prison;
 - iii. training and professional development services to provide up-to-date instruction for prison staff and consultants working with prisoners; professional training should also be available on all health matters, especially nurse training in multidisciplinary clinical management, team work, mental health and a continuing commitment to developing addictions expertise;
 - iv. informal health care structures: family and peer support should be encouraged and facilitated to promote well-being and to maintain/establish relationships.

c. **Linkage between in-prison services and programmes.** We recommend multisectoral programming and service provision to address prevention, promotion and therapeutic needs through horizontal, information-sharing processes. This would increase efficiency and avoid duplication. One example would be partnerships between health and education staff. This may involve the development of health promotion materials, by prisoners, facilitated by teachers and clinicians.

4. A focus on mental health and substance use.

- a. Needs-based service and programme development based on best practice models.
- b. Regularly updated individual treatment plans drawn up in consultation with prisoners and based on prisoner needs.
- c. Appropriately directed and managed service delivery. This includes multi-entry point accessibility for prisoners, a serviceable referral system and a feedback system to involve necessary staff in developments. We recommend that psychologists, social workers, occupational therapists or other staff should refer prisoners to the Clinical Manager as required. There should also be an avenue for self-referral by prisoners. The Clinical Manager can then contact the Community Mental Health Service or Addictions Centre. All relevant staff may then develop/modify a treatment plan.
- d. Adequate coverage of services for prisoners affected by mental illness, substance dependency and trauma.
- e. A range of therapeutic options including, but not limited to, substitution maintenance therapy, detoxification, drug-free treatment, psychosocial programming, trauma psychotherapy and group and peer-based learning and therapy.

Annex 1

VISIT PROGRAMME

Biannual Collaborative Agreement between Andorra and the WHO Regional Office for Europe
2008–2009

Health in prisons
Andorra la Vella (Andorra), 2 and 3 October 2008

Thursday, 2 October 2008	
08:30	Meeting point at the Carlton Plaza Hotel
08:45–09:45	Meeting with Mr Xavier Bardina, <i>Secretary of State of the Interior</i> and Ms Carme Pallarés, <i>Director of Health</i> and welcome by Ms Montserrat Gil, <i>Minister of Health, Welfare, Family and Housing</i> Ministry of Health, Welfare, Family and Housing
09:45–10:30	Meeting with Ms Carme Pallarés, <i>Director of Health</i> , Ms Rosa Vidal and Ms Anna Pons from <i>Prevention, Promotion and Health Surveillance Service</i> and Ms Cristina Vilanova from <i>Sanitary Resources Service</i> of the Ministry of Health, Welfare, Family and Housing Ministry of Health, Welfare, Family and Housing
11:00–13:00	Meeting with Mr Frederic Gutiérrez, <i>Director of Prison Centre</i> . Visit of the prison centre of Andorra Andorran Prison Centre
13:00–14:30	Lunch Andorran Prison Centre
14:30–15:30	Meeting with nurse's board and chemist of the Prison Centre Andorran Prison Centre
15:30–16:00	Meeting with the physician of the Prison Centre Andorran Prison Centre
16:00–16:30	Meeting with social education and social worker's board of the Prison Centre Andorran Prison Centre
16:30–17:00	Meeting with the psychologist of the Prison Centre Andorran Prison Centre
Friday, 3 October 2008	
09:30	Meeting point at the Carlton Plaza Hotel
10:00–13:00	Meeting with Ms Carme Pallarés, <i>Director of Health</i> and Mr Ramon Cereza, <i>General Director of the Andorran Health Care Service (Servei Andorrà d'Assistència Sanitària – SAAS)</i> and various staff of SAAS and visit to the hospital (Hospital Nostra Senyora de Meritxell – HNSM) and the <i>Unit of Addiction Care (Unitat de Cures Addictives – UCA)</i> Andorran Health Care Service Centre and HNSM building
13:00–14:00	Workshop lunch with Mr. Xavier Bardina, <i>Secretary of State of the Interior</i> , Ms Carme Pallarés, <i>Director of Health</i> and Mr Frederic Gutiérrez, <i>Director of Prison Centre</i> : discussion and first exchange of impressions about health and prisons in Andorra. <i>How is it? How it works? What to improve?</i> Follow-through of the WHO mission.

Annex 2

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Ms Angelina Santolària, Head of Health Addiction Unit, General Hospital
Ms Anna Insa, Nurse Director, General Hospital
Dr Joan C Miralles, Prison Doctor
Dr Josep Ramos, Prison Psychologist
Ms Anna Ibañez, Prison Nurse
Ms Desirée Fernández, Prison Nurse
Ms Ingrid Millat, Prison Nurse
Ms Sílvia Rodríguez, Prison Social Worker
Ms Anna Pallarés, Prison Pharmacist