

ANNEXE A:

Quality Standards for Prison Mental Health and Substance Misuse Services

This set of quality standards was developed as a framework against which all prison mental health and substance misuse services in Wales were assessed.

They are based on existing standards owned by the Quality Network for Prison Mental Health services which have been adapted to capture services in Wales more effectively. New principles have also been incorporated for both mental health and substance misuse teams with involvement from RCPsych Wales, Welsh Government, and the NHS Wales Joint Commissioning Committee.

The standards comprise 16 domains:

1. Assessment
2. Integrated care planning
3. Treatment and recovery
4. Clinical pathway for the treatment of alcohol dependency
5. Medication management
6. Clinical pathway for the treatment of drug dependency
7. Screening, diagnosis and treatment for infectious disease
8. Collaborative partnerships
9. Discharge and transfers
10. Patient experience
11. Environment
12. Workforce
13. Leadership and governance
14. 24-hour mental healthcare*
15. Welsh/preferred language
16. Additional (Welsh Government)

**As none of the prisons in Wales had an inpatient mental health facility, this domain was not applicable for any services.*

Each standard is categorised as type 1, 2 or 3. Definitions of each category is as follows:

- ⇒ **Type 1:** Essential standards. Failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment.
- ⇒ **Type 2:** Expected standards that most services should meet.
- ⇒ **Type 3:** Desirable or aspirational standards that might be outside the control of the service.

1. ASSESSMENT

Number	SMTF/ MH	Type	Standard
Reception and assessment			
1	SMTF	1	Assessments should be undertaken in a suitable, safe and private environments, as set out in the National Institute of Health and Care Excellence, 2019. Health of people in the criminal justice system.
2	MH	1	As part of the formal reception and induction process, every person receives a first and second stage health assessment that incorporates a mental health screen (NICE guideline 66, 2017). During the initial mental health assessment, individuals with identified neurodivergence will have reasonable adjustments made where required. <i>Guidance: This includes questions and actions relating to learning disabilities and neurodevelopmental disorders. Patients may need support for communication or adjustments to environment for sensory needs.</i>
3	SMTF	1	All services should undertake substance misuse assessment that as a minimum includes the relevant domains contained within the WIISMAT assessment tool which includes the NHS clinical alcohol assessment tool AUDIT. In line with the UK Guidelines on Clinical Management of Drug Misuse and Dependence, assessment should be undertaken across four domains: drug and alcohol use and dependence, physical and mental health, social functioning and criminal involvement.
4	SMTF	1	Where a comprehensive substance misuse assessment and integrated care plan has been completed in the community, for Welsh residents using the WIISMAT tool, this should 'travel' with the individual regardless of setting to ensure efficiency, continuity of care and prevention of repeat assessment.
At first reception/initial assessment			
5	SMTF	1	First-stage health assessment, a combined physical and mental health assessment (including physical health, alcohol use, substance misuse, mental health, self-harm and suicide risk) and toxicological drug screening is undertaken by an appropriately trained healthcare professional, identifying immediate health and safety issues to be addressed at second health assessment as well as priority physical and mental health needs to be addressed at subsequent clinical appointments. <i>Guidance: See also standard 17.</i>
6	MH	1	All practitioners carrying out the initial mental health assessments are competent to assess problems that commonly arise, and have knowledge and awareness of mental health diagnoses and pathways within the service.

7	MH	1	<p>During the initial mental health assessment, individuals over 50 years old receive an older adult assessment, and reasonable adjustments are made where required.</p> <p><i>Guidance: Patients may need a full physical health review by a general Practitioner (GP) or further full mental health assessment by psychiatrist to identify long-term conditions, early cognitive impairment or referral to social care team for long term care planning.</i></p>
8	MH	1	<p>Patients have a comprehensive evidence-based assessment which includes their:</p> <ul style="list-style-type: none"> - Mental health and medication; - Psychosocial and psychological needs; - Strengths and areas for development; - Risk to self and others; - Intellectual and developmental disabilities; - Substance misuse. <p><i>Guidance: Standard mental health assessment tools are used and they are compliant with the National Institute for Health and Care Excellence (NICE) guidelines.</i></p>
9	MH	1	<p>The assessing professional can access notes about the patient (past and current) from primary care, secondary care and other relevant services.</p> <p><i>Guidance: Notes, including those available from community services, should be accessed for all patients known to mental health services and where notes are available, including how up to date the information is and how it was gathered. Resources / templates could be developed here to support this standard, and the care and treatment planning process.</i></p>
10	SMTF	1	<p>Drug testing is undertaken as part of initial assessment using the Health Board approved point of care testing kit.</p>
11	SMTF	1	<p>If the person is taking any prescribed medicines or over-the-counter medicines, staff must:</p> <ul style="list-style-type: none"> - Document any current medicines being taken and generate a medicine chart. - Refer the person to the prescriber for appropriate medicines to be prescribed, to ensure continuity of medicines. - If medicines are being taken, ensure that the next dose has been provided. - Let the person know that medicines reconciliation will take place before the second-stage health assessment. <p>If the person is not taking any prescribed medicines or over-the-counter medicines, record that no action is needed.</p>
12	SMTF	1	<p>Continuity of care must be ensured for the PCIP entering or transferring from one criminal justice setting to another including access to their current Integrated Care Plan and clinical records (including medications and outstanding medical appointments), assessments (substance misuse, mental health and risk assessments) and treatments. If an individual is in receipt of Opioid Substitution Therapy (OST) and entering or transferring, the prescription should continue until the opportunity for the second-stage health assessment, substance misuse assessment and any other assessments required, are complete.</p>

13	SMTF	1	If the PCIP is entering prison with evidence of opioid withdrawal and is not in receipt of OST – during the first night in prison, emerging withdrawals should be managed, through provision of symptomatic medications, and dependence assessed and treated. Opioid dependence on the first day or night in prison should result in initiation of OST, with regular monitoring and enhanced observation over the following 5 days of stabilisation in line with UK clinical guidelines. The aim should be provision of rapid assessment and treatment 24 hours a day, resulting in a reduction in risk to individual PCIPs awaiting assessment and OST initiation.
Within 7 days of reception			
14	SMTF	1	Following first-stage assessment on reception, monitoring and review of emerging withdrawals and their identification and management is essential. Clinical reviews, undertaken by a suitably trained health professional, should be held at least twice daily over the first few days. An increased frequency of review is required for complex cases. Frequency of review is determined by clinical assessment.
15	SMTF	1	PCIP entering or transferring between prisons have a medicines reconciliation carried out before their second-stage health assessment (Quality Standard 1 Substance Misuse Service and System Improvement: Core Standards for Substance Misuse Services in Wales), to ensure that people continue to receive the medicines they need and reduce the risk of harm caused by delayed or inappropriate medication, particularly for those with chronic conditions.
16	SMTF	1	PCIP have a second-stage health assessment to follow up on issues identified at first health assessment and to ensure correct and timely treatment and support provision. Keyworker or representative/s from the psychosocial team should be present as appropriate to avoid duplication and provide a more person-centred approach. Complex and co-morbid issues can be discussed in detail, follow-up screening and tests can be undertaken and treatment and support provided. During the second-stage health assessments, the following should be completed: - Mental Health Assessment; - Physical Health Assessment; - Cognitive Impairment Assessment.
17	MH	1	A physical health review takes place as part of the initial assessment, or as soon as possible. <i>Guidance: This may be completed by the physical health team, or as part of the reception process when the person first enters prison. The physical assessment is key in light of the increased risk for individuals with mental health problems having related physical health issues.</i>
18	MH	1	Patients have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers risk to self, risk to others and risk from others.
19	SMTF	1	The assessment and care planning process is sensitive to an individual's potential exposure to trauma (see section 2.4 of the SMTF).

20	MH	1	<p>All secondary care patients have a documented diagnosis and a clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.</p> <p><i>Guidance: The formulation includes presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate.</i></p>
21	MH	1	<p>All information is provided to patients in a format they can easily understand.</p> <p><i>Guidance: This includes different languages, and easy-to-read / pictorial formats. Inclusive communication approaches are used to ensure patients understand key information. Consideration must also be given to the needs of those with sensory loss, and those where the person's preferred language is not English or Welsh, and be in line with the Accessible information Standard.</i></p>
22	MH	1	<p>The service provides information about how to make a referral and waiting times for assessment and treatment.</p> <p><i>Guidance: This information is provided to the patient and to agencies who regularly refer.</i></p>
23	MH	1	<p>Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes the following:</p> <ul style="list-style-type: none"> - Their rights regarding admission and consent to treatment; - Rights under the Mental Health Act; - How to access advocacy services; - How to access a second opinion; - Interpreting services; - How to view their records; - How to raise concerns, complaints and give compliments.
24	MH	1	<p>There is a clear system for the management of referrals.</p>
Immediate intervention			
25	SMTF	1	<p>Involve other expertise in the assessment of the person, including mental health and risk of suicide or self-harm. In line with the Royal College of Psychiatrists Standards for Prison Mental Health Services and the new standards for mental health services for prisons in Wales, the assessment should involve a multi-disciplinary team including representatives of services/teams providing psychosocial support where separate from the health teams.</p> <p>Focus on the initiation of a prescribing intervention to reduce substance-related harm and to act as a gateway to other interventions.</p> <p>Use motivational interviewing techniques to increase engagement in the assessment and subsequent treatment process.</p>
26	SMTF	1	<p>Substance misuse, be it alcohol and/or drug dependency, is an evidenced trigger for increased risk of self-harm, suicide or violence. Safer custody teams will take a lead on assessment and management of these risks, including creating Assessment, Care in Custody and Teamwork (ACCT) assessments.</p>
27	SMTF	1	<p>Supporting the development of positive relationships through referral to peer mentoring schemes (such as Listeners), enabling family and key relationships involvement in assessment, and incorporation of positive relationship development in integrated care planning, can all assist in identifying and addressing the risks of self-harm.</p>

28	SMTF	1	For the PCIP with identified complex needs, including co-occurring mental health, assessment by an appropriately qualified individual, for example a registered mental health nurse with substance misuse specialty, or joint assessment with substance misuse and mental health practitioners, is required, and in accordance with NICE guidelines 66 (2017).
29	SMTF	1	For the PCIP new to services or with unidentified or undocumented complex needs, initial assessment should be undertaken by an appropriately qualified individual as outlined above.
30	MH	1	There is a clear and consistent process for staff within the prison to refer individuals directly to the mental health team.
31	MH	1	A clinical member of staff is available to discuss emergency referrals during working hours.
32	MH	1	Urgent/crisis assessments are undertaken by the team within 48 hours and routine assessments within 5 working days.
33	SMTF	1	Wide ranging cultural needs should be determined at the earliest opportunity in order to facilitate effective communication and engagement with the individual. Identification through the assessment process of the PCIP with specific cultural and complex social needs is particularly important, as evidence indicates that failure to do so may result in early disengagement from treatment and support if these needs are not met. <i>Guidance: Specific cultural needs may include language, experience of trauma, cultural identity, gender and sexuality and societal norms, values, beliefs and attitudes.</i>
Following completion of assessments			
34	SMTF	1	Following completion of the assessment, the healthcare professional should: - Review the person's first and second stage health assessment records, medical history, GP and vaccination records and: - Refer the person to the GP or a relevant clinic if further assessment is needed. - Arrange follow-up appointment/s if needed. <i>Guidance: Follow-up healthcare reviews are planned at a suitable time based on clinical judgement, taking into account the age of the person and length of their sentence. .</i>
35	SMTF	1	Individuals entering or transferring between prisons are tested for blood-borne viruses, vaccinated for hepatitis B and sexually transmitted infections in line with routine opt-out testing protocols and targets. Healthcare professionals in prisons should ensure people coming into prison are screened for Tuberculosis (TB) within 48 hours of arrival. Report all suspected and confirmed TB cases to the local multidisciplinary TB team within 1 working day. Ensure that all PCIP, including those with complex health and social care needs have Prison Offender Manager to ensure integrated care delivery and to maintain ICP records For PCIP who may be in prison for less than 1 month, plan pre-release health, substance use and dependence and social functioning (housing, finance, employment, education and criminal justice) assessments during the second-stage health assessment and ensure co-ordination by the Prison and Community Offender Managers and updating of the ICP.

Arrangements for the assessment of former users of secondary mental health services			
36	MH	1	Local mental health partners take all reasonable steps to agree arrangements for responding to requests for assessments from former users of secondary mental health services and the making of referrals following such assessments - Mental Health (Wales) Measure (2010).
37	MH	1	Arrangements are made in writing. Once initial arrangements have been agreed and put into writing, they can subsequently be altered, provided that partners agree and record the alterations in writing.
38	MH	1	Arrangements should ensure that assessments are provided in a timely manner, which should be consistent with response times for requests for assessments from GPs or other referrers. Local mental health partners may include standards for response times for assessment within their written arrangements. Where such response times are included it is expected that these should, at a minimum, match the usual standards for community mental health teams – namely that emergency referrals are to be seen within 4 hours of request, urgent referrals within 48 hours of request, and all other referrals within 28 days of request.
39	MH	1	Any failure to agree arrangements must follow protocol as stipulated in the Code of Practice 2012, Mental Health (Wales) Measure 2010. <i>Guidance: Where an individual who has received secondary mental health services whilst in prison in Wales is subsequently released and takes up or returns to usual residence in Wales, they will also be eligible to seek an assessment from secondary mental health services in the local authority area in which they are usually resident at the time they make that request.</i> <i>Where an individual received secondary mental health services in a prison outside of Wales, their eligibility for further assessment will depend on whether those services are recognised for the purposes of Part 3 as secondary mental health services.</i>
Ongoing review and evaluation			
40	SMTF	1	As circumstances change from community to prison and vice versa, as a minimum, an evaluation should be completed every 3 months or whenever a substantial change occurs thus providing the most up to date version of current history.

2. INTEGRATED CARE PLANNING

Number	SMTF/ MH	Type	Standard
Care planning			
41	SMTF	1	Integrated care planning provides a mechanism to facilitate and monitor delivery of equitable, seamless and high quality health and social care. This may be achieved at the micro or personalised level through individualised care plans.
42	SMTF	1	Integrated care planning allows for the development of care pathways and monitoring of progress for treatment, care and support, with active involvement with the individual PCIP (Person Currently in Prison), covering the four main domains outlined in the assessment process, specifically drug and alcohol use and dependence, physical health, mental health and social functioning including involvement with criminal justice.
43	SMTF	1	The integrated care plan (ICP) provides a single reference point for any and all of the providers involved in the care of the PCIP both in custodial settings and in the community.
44	SMTF	1	The Integrated Care Plan will outline all treatment and support including all medicines prescribed consistent with clinical diagnoses.
Treatment system design for substance misuse and mental health			
45	SMTF	1	Treatment System Design should include all tiers of treatment, demonstrating Integrated Care Pathways (ICP) and access points, ensuring: <ul style="list-style-type: none"> - The needs of diverse groups are taken into account appropriately and demonstrate compliance with relevant legislation. - The needs of vulnerable groups are taken into account appropriately and demonstrate compliance with relevant legislation.
46	SMTF	1	Planning and delivery of treatment ensures timely and equitable access to services. <ul style="list-style-type: none"> - Full compliance with the reporting requirements of the Welsh National Database for Substance Misuse (WNDSM). - A service user access policy that has been developed and agreed with service users is published.
47	SMTF	1	Effective information systems and integrated information technology is used to inform and support the planning and delivery of treatment services: <ul style="list-style-type: none"> - All comprehensive assessments must include as a minimum the domains contained within the Welsh In-depth Integrated Substance Misuse Assessment Tool (WIISMAT). - All assessments must be capable of being shared and utilised between treatment providers. - Information sharing protocols are in place between service providers within a treatment system (including providers of supporting services such as housing) which are subject to systematic testing and review.

48	SMTF	1	<p>In the absence of an existing comprehensive integrated information management system, the establishment of robust information sharing protocols and access to appropriate clinical systems is essential.</p> <p>The Wales Accord for Sharing of Personal Information (WASPI) provides framework documentation both for Data Disclosure Agreements (DDAs) for the uni-directional sharing of personal information from one organisation to another, and Information Sharing Protocols (ISPs) allowing for multi-directional information sharing of personal information between organisations.</p> <p>All organisations have a common law duty of confidence as well as specific requirements under the UK General Data Protection Regulation (EU) 2016/679 and the Data Protection Act 2018 to ensure that confidential information is processed lawfully and protected from inappropriate disclosure.</p>
Individuals in contact with community-based substance misuse services and/or criminal justice services			
49	SMTF	1	<p>These individuals should have an up-to-date Integrated Care Plan (ICP) in place prior to and available at point of reception in prison.</p> <p>The ICP should include a record of all assessments and actions based upon the assessments, currently medications and treatment plans including those related to substance misuse and/or co-occurring mental health and physical health.</p> <p>This ICP should be stored on the existing electronic management systems, for example: Palbase, PARIS, Welsh Community Care Information System (WCCIS) or equivalent.</p> <p>Where the ICP is not routinely available via shared information systems, a copy of the ICP should be sent electronically to the Prison Health Services immediately on request, or provided to the individual prior to transfer to prison as a hard copy if possible and appropriate, to ensure continuation of care.</p> <p>A record of current medications and prescriptions should also be accessible to the prison healthcare teams via access to the Welsh Clinical Portal. All diagnoses, treatment and support should be documented on SystemOne and the ICP updated following any changes, further assessments or treatment activity.</p> <p>Upon release from Prison, the updated ICP should be issued from the Prison Offender Manager to the individual, the Community Offender Manager and all other relevant health and substance misuse related services to which the individual PCIP has consented to share, to ensure continuity of care.</p>
Individuals not in contact with community-based substance misuse services and/or criminal justice services			
50	SMTF	1	<p>An ICP should be developed at point of reception to prison and informed by medication and prescription details available via Welsh Clinical Portal and the initial and second health assessment. Responsibility of developing, updating and maintaining the individual's ICP lies with the Prison Offender Manager and should be revisited following each MDAT.</p> <p>Upon release from Prison, the updated ICP should be issued from the Prison Offender Manager to the individual, the Community Offender Manager and all other relevant health and substance misuse related services to which the individual PCIP has consented to share, to ensure continuity of care.</p>

Individual care plans			
51	MH	1	<p>Every patient is fully involved with the development of their care plan – and has a written care plan (which includes both substance misuse and mental health), reflecting their individual needs. Staff members fully collaborate with patients when developing the care plan, with patients offered a copy.</p> <p><i>Guidance: The care plan clearly outlines:</i></p> <ul style="list-style-type: none"> - Agreed intervention strategies for physical and mental health; - Measurable goals and outcomes; - Strategies for self-management; - Any advance directives or statements that the patient has made; - Crisis and contingency plans; - Review dates and discharge framework to ensure continuity of care once back in the community.
52	SMTF	1	<p>A process is in place to ensure that the PCIP is able to communicate their views in relation to their Integrated Care Plan (ICP) and treatment and be involved in decision making regarding their care. The PCIP should receive feedback to understand the rationale for decisions made, which should be documented.</p> <p>The ICP should be routinely updated following regular MDAT meetings to ensure that even in the event of a rapid transfer in to, or between, prisons or release from prison, the ICP is up to date and may be used to ensure continuity of care.</p>
53	SMTF	1	<p>The integrated care plan (ICP) addresses the full range of needs, is effectively coordinated and communicated with all agencies and family/ caregivers, where possible. The ICP should be regularly updated, on at least a three-monthly basis or sooner in the event of significant change in circumstances, for example, incarceration, transfer or release. The ICP should be monitored and updated by the POM and should have coordinated transition arrangements to community services, over time with clear engagement.</p>
54	MH	1	<p>Where applicable, patients should receive an initial Personalised Care and Support Planning meeting within the first 28 days, at three months and every six months thereafter, or whenever a significant transition occurs.</p> <p><i>Guidance: The review could be part of the Care Programme Approach (CPA), Promoting Quality Care (PQC), Care and Treatment Plan (CTP) or equivalent processes.</i></p>

55	SMTF	1	<p>Service users are provided with responsive, appropriate and seamless interventions and care that reflects their physical, social, psychological needs and preferences.</p> <p>I. All individuals entering structured treatment modalities receive a comprehensive assessment of need that as a minimum includes the relevant domains contained within the WIISMAT assessment tool.</p> <p>The assessment must consider and record the most appropriate or preferred treatment and care, irrespective of whether that treatment is available.</p> <p>II. Following Comprehensive Assessment, a Care Plan is agreed between the treatment provider and the service user</p> <p>III. Mechanisms must be in place for the systematic review of care plans (minimum 3 monthly) with the service user.</p> <p>IV. Revised care plans, findings and outcomes should be agreed between the treatment provider and the service user.</p> <p>V. Referral and information sharing protocols must be in place for responding to an individual's non-substance misuse specific needs. As a minimum this must include:</p> <ul style="list-style-type: none"> • Pregnancy / support during the perinatal period • Co-occurring mental health needs • Child Protection • Protection of Vulnerable Adults • Housing • General health including oral health • Education • Substance Misuse
Complex care and multiple dependencies			
56	SMTF	1	<p>Poly-drug use and the multiple dependencies including illicit drugs, prescription medications (including NMPDU) and alcohol represent challenges in the treatment context, requiring specialist skills in assessment and management.</p> <p>Polypharmacy should be minimised. Careful assessment of the level of dependence to each substance is required and may require time to establish, particularly as opioid dependence symptoms may mask alcohol and other drug dependencies.</p>
57	SMTF	1	<p>Associated with poly-substance use is increased risk when prescribing sedating medications, risk of drug-drug interactions, risk of overdose and impact on mental health. With co-morbid severe poly-drug and/or alcohol dependence, multidisciplinary decisions involving the patient need to be taken, recorded and reviewed frequently adopting a graduated approach.</p>
58	SMTF	1	<p>Where clinical assessment indicates concurrent opioid, benzodiazepine and alcohol dependence, close monitoring, management and review is required throughout stabilisation and initial treatment phases. Suicide and self-harming behaviours are associated with Benzodiazepine withdrawal and as such a multidisciplinary team approach is recommended. Detoxification for complex and poly-drug dependence, e.g. concurrent alcohol and benzodiazepines detoxification may require inpatient services.</p>

Co-occurring substance misuse and mental health			
59	SMTF	1	<p>In line with NICE quality standards, PCIPs with suspected or confirmed severe mental illness must:</p> <ul style="list-style-type: none"> - Be asked about their use of alcohol and drugs; - Not be excluded from mental health services because of coexisting substance misuse or from substance misuse services because of coexisting severe mental illness; - Have a care coordinator working in mental health services when they are identified as needing treatment from secondary care mental health services; - Be followed up if they miss any appointment.
60	SMTF	1	<p>Individuals with complex needs, including mental health conditions and/or cognitive impairment are identified early in their treatment journey as part of the assessment process.</p>
61	SMTF	1	<p>When a mental health condition is identified through assessment, the PCIP should be involved in decision making, to identify the benefits of a referral for assessment and treatment with specialist mental health services.</p>
62	SMTF	1	<p>Where feasible, treatment for individuals with comorbidities are best provided by one comprehensive service, however, it maybe that separate specialist interventions are required. Where this is the case, emphasis should be placed on robust collaborations and clear and timely communication, including documentation on the ICP, between all services involved in the individual's treatment.</p>

3. TREATMENT AND RECOVERY

Number	SMTF/ MH	Type	Standard
Beginning treatment			
63	MH	1	<p>Patients are offered information about their mental health conditions and treatment in a way that is understood and retained.</p> <p><i>Guidance: This could be verbal, written or digital. Verbal information could be provided in a one-to-one meeting with a staff member or in a psycho-education group. All written information should be written using inclusive communication approaches.</i></p>
64	MH	1	<p>Patients are given information on the intervention being offered and the risks and benefits are discussed with them. This is recorded in clinical records.</p>
65	MH	3	<p>Patients are managed under the Stepped Care Model for People with Common Mental Health Disorders (NICE guidelines 41, 2011).</p> <p><i>Guidance: The model presents an integrated overview of the key assessment and treatment interventions that are service specific.</i></p>
66	MH	2	<p>Patients have access to low-level interventions (this includes steps 1 and 2 of the Stepped Care Model) and a range of psychological therapies. These interventions are delivered by an adequately trained and supported mental health professional.</p> <p><i>Guidance: The interventions and therapies are adapted to the needs of the prison environment. For example a remand environment delivers standalone sessions and psychoeducation support.</i></p>
67	MH	1	<p>Patients begin evidence-based interventions, which are appropriate for their bio-psychosocial needs, within an agreed timeframe.</p>

68	SMTF	1	<p>Offering a range of psychosocial treatment, support and interventions, not just pharmacotherapies, is an essential element of substance misuse treatment provision.</p> <p>For many substances there are no pharmacotherapy options, for these substances psychosocial interventions form the primary interventions. These substances include: cannabis, cocaine, amphetamines and many of the new psychoactive substances (NPS). Where pharmacological interventions are available and do have a role, for instance in opioid substitution treatment (OST), psychosocial interventions enhance treatment outcomes.</p> <p>Effective psychosocial interventions should include the following key elements: Therapeutic alliance between a healthcare practitioner and their client, use of evidence based interventions, adequate staff competencies' and supervision, and monitoring and review system of agreed treatment goals and outcomes.</p> <p>The identification of relevant psychosocial interventions should begin at the assessment stage and be carried forward to inform the clients care plan.</p> <p>Effective interventions should be structured and goal driven within an agreed care plan. This, alongside positive reinforcement of change, developing coping skills and monitoring and review of the effectiveness of interventions, should help maintain engagement.</p>
69	MH	1	<p>The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews.</p> <p><i>Guidance: Referrals that are urgent or that do not require discussion can be allocated before the meeting.</i></p>
70	MH	3	<p>Where applicable, patients are supported to be fully involved in their own assessment of secondary mental health needs during the formal review process. (RCPsych, 2020)</p> <p><i>Guidance: The review could be part of the Care Programme Approach (CPA), Promoting Quality Care (PQC), Care and Treatment Plan (CTP) or equivalent processes.</i></p>
71	MH	1	<p>For any formalised review of patients on the secondary care caseload, as a minimum there should be a representative from the prison mental health team and the prison. The local community mental health team should be invited.</p> <p><i>Guidance: The review could be part of the Care Programme Approach (CPA), Promoting Quality Care (PQC), Care and Treatment Plan (CTP) or equivalent processes.</i></p>
72	MH	1	<p>The team follows up patients who have not attended an appointment/assessment. If patients are unable to be engaged, a decision is made by the assessor/team, based on patient need and risk, as to how long to continue to follow up the patient. This is clearly documented in the multi-disciplinary team meeting and patient records.</p>
73	MH	1	<p>In female establishments, there is a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes:</p> <ul style="list-style-type: none"> - Assessment; - Care and treatment (particularly relating to prescribing psychotropic medication); - Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.

4. CLINICAL PATHWAY FOR THE TREATMENT OF ALCOHOL DEPENDENCY

Number	SMTF/ MH	Type	Standard
Continuation or initiation of treatment			
74	SMTF	1	<p>PCIP with alcohol dependence are more likely to have complexity in the form of poly-substance use and co-occurring mental health conditions.</p> <p>For individuals entering the prison system and already in receipt of prescribed medication for alcohol dependence in the community, continuity of medication should be ensured until full assessment and agreement by the MDT.</p>
75	SMTF	1	<p>On arrival, healthcare will have carried out an assessment of the severity of dependence and of withdrawal symptoms and any past history of severe withdrawals. Ongoing monitoring should be provided by the Registered General Nurse (RGN) or Healthcare Support Worker. If there is further deterioration and the Patient group Directions (PGD) (night of admission) or prescribed (thereafter) benzodiazepines do not rapidly resolve the issue, then the PCIP should be admitted to hospital as an emergency.</p>
76	SMTF	1	<p>For all individuals entering prison, during the first-stage assessment process, those reporting weekly consumption of 15 or more units of alcohol and/or scoring 20 or more on the AUDIT assessment tool should be considered for treatment and support for alcohol dependence issues.</p>
77	SMTF	1	<p>In line with UK clinical guidelines (currently being updated), following initial assessment, assisted withdrawal and detoxification should be initiated on the first night of custody following objective evidence of alcohol withdrawal, using benzodiazepine (chlordiazepoxide or diazepam) in line with prescribing protocols.</p>
78	SMTF	1	<p>If seizures are experienced in acute alcohol withdrawal, there should be the offer of a quick-acting benzodiazepine, such as lorazepam, to reduce the likelihood of further seizures, and the withdrawal medication regimen should be reviewed.</p>
79	SMTF	1	<p>In PCIP with delirium tremens, offer quick-acting benzodiazepine, oral lorazepam. If declined, offer parenteral lorazepam or haloperidol in line with NICE guidance. If alcohol withdrawal seizures develop in a person during treatment for acute alcohol withdrawal, review their withdrawal drug regimen.</p>
Continuation of detoxification			
80	SMTF	1	<p>Following initiation of assisted alcohol detoxification, and as per standard clinical prescribing protocol, fixed-dose medication regimen dose should be titrated up to level of severity of alcohol dependence, and gradually reduced over 7-10 days to prevent further alcohol withdrawal recurrence. For PCIP with severe alcohol dependence, the clinical team should consider use of Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-Ar) tool.</p>

81	SMTF	1	Where the PCIP has co-morbid alcohol and benzodiazepine dependence, increased doses of benzodiazepine medication will be required throughout the detoxification treatment process (initial daily dose based on the requirements for alcohol withdrawal plus the equivalent regularly used daily dose of benzodiazepine) with one, rather than multiple benzodiazepine being used throughout treatment. In this context, detoxification regimen are extended, lasting two to three weeks or longer.
82	SMTF	1	To support and follow on from the assisted alcohol withdrawal treatment, a structured programme of psychosocial support should be put in place, including individual, group psychosocial support and therapy and psychoeducational interventions. Psychological therapies should include cognitive-behavioural, behaviour or social network approaches.
83	SMTF	1	The assessment process for the use of psychosocial support and interventions should include identification of treatment goals, strengths and risks, both within the prison environment and in the community, including relationships and wider social environment. For an individual PCIP with mild to moderate alcohol dependence with complex needs or severe alcohol dependence, offer opt-in intensive and structured psychosocial support along with a focus on building resilience and relapse prevention.

5. MEDICATION MANAGEMENT

Number	SMTF/ MH	Type	Standard
84	MH	1	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded.
85	MH	1	The safe use of high-risk medication is audited at a service level, at least annually. <i>Guidance: This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines, gabapentinoids and stimulants for attention-deficit/ hyperactivity disorder (ADHD).</i>
86	MH	3	Psychotropic prescribing rates (antidepressants, antipsychotics, ADHD, anxiolytics, hypnotics) are regularly monitored and reviewed. <i>Guidance: This includes regular reports from the pharmacy team, with findings being discussed at a local or directorate meetings.</i>
87	MH	2	For patients prescribed medication, annual medication reviews are in place (NICE guidelines 5, 2015; NICE guidelines 87, 2018).
88	MH	1	A system is in place for recording non-compliance with medication. <i>Guidance: Guidance is available to the team on the management of medication and how to deal with non-compliance.</i>
89	MH	1	Compliance with medication is recorded as part of the patient's care plan and this is reviewed on a monthly basis, or more frequently where required. <i>Guidance: The team proactively follows up with patients who fail to collect or take their medication and this is included in their care plan.</i>
90	MH	3	There are clear written protocols outlining prescribing responsibilities between psychiatrists, GPs and nurse prescribers. <i>Guidance: Clinicians refer to 'Safer Prescribing in Prisons: Guidance for Clinicians, Second Edition' (RCGP, 2019).</i>

91	SMTF	1	<p>Diversion of medication to individuals who have not been prescribed, or non-medical prescription drug use (NMPDU) within the prison environment is common and represents distinct challenges in management across the prison workforce. Implications including those related to the prescribed individual not consuming medication, represent a challenge to health care and other prison staff with potential for unmanaged physical and mental health disorders.</p> <p>For those consuming NMPDU, there is the risk of development of dependence and of acute poisoning, contraindications with other prescribed medications and potential for fatal drug poisoning.</p> <p>Diverted medications include, but are not limited to, benzodiazepines, gabapentinoids, opioid analgesics and those used in opioid substitution treatment including methadone and buprenorphine. Motivations may include self-medication, alleviation of withdrawal symptoms or to prolong the effect of other substances or medications.</p> <p>The HMPPS Prison Drugs Strategy outlines what should be ensured in order to address the risk of diversion of prescribed medication within prisons (See Section 2.3.6 of SMTF).</p>
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6. CLINICAL PATHWAY FOR THE TREATMENT OF DRUG DEPENDENCY

Number	SMTF/ MH	Type	Standard
Initiation of treatment for drug dependence - opioids			
92	SMTF	1	<p>Continuity of care across community, criminal justice and custodial settings is vital in the provision of opiate substitution treatment (OST), to prevent fatal drug poisonings and a return to, or increased use of illicit opioids and poly-drug use.</p> <p>Where a PCIP is already in receipt of OST (methadone or buprenorphine) prescription and recent compliance with supervised consumption confirmed, the prescription should be continued within the police custody setting and actions recorded on the individual's Integrated Care Plan.</p> <p>Where a PCIP is in receipt of OST prescription but does not require supervised consumption or recent compliance with supervised consumption cannot be confirmed, induction on to OST should be carefully managed as per Substance Misuse Detainees in Police Custody: Guidelines for Clinical Management.</p>
For those already in receipt of Methadone OST prescription in the community			
93	SMTF	1	<p>In line with UK clinical guidance for drug use and dependence for all PCIP on a community methadone prescription and received into the prison, the prescription should be continued and available on the first night in prison.</p> <p>See section 2.3.1.1 of the SMTF for detail on care and treatment.</p>
For those already in receipt of Buprenorphine OST prescription in the community			
94	SMTF	1	<p>Those already in receipt of and stable on Buprenorphine OST are able to continue within the prison setting, particularly if they have received a short prison sentence/are soon to be released from prison. Continuity of prescription is subject to confirmation of specific criteria.</p> <p>See section 2.3.1.2 of the SMTF for detail on care and treatment.</p>
For those already in receipt of Buprenorphine OST prescription in the community			
95	SMTF	1	<p>Those already in receipt of and stable on Buprenorphine OST are able to continue within the prison setting, particularly if they have received a short prison sentence/are soon to be released from prison. Buprenorphine prolonged release injecting (Buprenorphine) may be administered by a health care professional as a weekly or monthly subcutaneous injecting.</p> <p>Buprenorphine may be introduced into pre-release planning pathways in prisons in Wales, where its use is agreed between patient and community services following release.</p>

For those not already in receipt of OST prescription in the community

96	SMTF	1	<p>In line with UK clinical guidance for drug use and dependence, first night assessment for prescribing and management of withdrawal symptoms is required, to ensure equivalence with community services. Treatment regimen, including prescribing of OST, will be informed by the first-stage assessment process on reception as well as:</p> <ul style="list-style-type: none"> - Toxicological results - knowledge of any recent treatment from police cells - past knowledge of the patient in prison - information from community drug and alcohol teams, community pharmacy, and community criminal justice services, available on first day through shared care portal <p>In addition, and in line with MHRA advice, it is recommended that an Electrocardiogram (ECG) be undertaken on PCIP being initiated or prescribed OST.</p> <p>See section 2.3.1.4 of the SMTF for specific details on the management of signs of opioid withdrawal.</p> <p>Issues and concerns regarding opioid withdrawal should be communicated by the clinical health care team to the wider prison to ensure safe planning use of distraction techniques (listeners, ACCT etc), consistent with the whole prison approach.</p> <p>Whilst prescription of hypnotics is not routinely recommended for insomnia in the prison environment due to the risk of dependence, interaction between opioid agonists and high 'currency value' amongst prisoners, guidelines indicate the use of time-limited short-acting hypnotics or sedating antihistamine medications for the treatment of insomnia.</p> <p>See section 2.3.1.4 of the SMTF for specific treatment for those with uncertain opioid dependence.</p> <p>Induction of OST – methadone or buprenorphine?</p> <p>The SMTF sets out the numerous considerations that should be addressed prior to initiation and maintenance prescribing of OST within the prison environment. (See page 40: Section 2.3.1.4 of SMTF). This includes a specific focus on induction of OST, enhanced observations, and details regarding dosage of Methadone, Buprenorphine, and Suboxone (Buprenorphine and Naloxone).</p>
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For those already in receipt of Buprenorphine OST prescription in the community

97	SMTF	1	<p>Those already in receipt of and stable on Buprenorphine OST are able to continue within the prison setting, particularly if they have received a short prison sentence/are soon to be released from prison. Buprenorphine prolonged release injecting (Buprenorphine) may be administered by a health care professional as a weekly or monthly subcutaneous injecting.</p> <p>Buprenorphine may be introduced into pre-release planning pathways in prisons in Wales, where its use is agreed between patient and community services following release.</p>
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Opioids: maintenance and detoxification			
98	SMTF	1	<p>Once induction and stabilisation has been achieved for those not in receipt of a community OST prescription, and stabilisation achieved for those continuing a community OST prescription, further discussion and agreement is required between the PCIP and prescriber on the clinical pathway for longer term treatment and accompanying psychosocial therapeutic support.</p> <p>Whilst stabilisation and maintenance of OST addresses one element of withdrawal from opioids, the clinical pathway should seek to improve and optimise treatment outcomes across all assessed domains including drug and alcohol use and dependence (including psychological dependence), physical and mental health, social functioning and criminal involvement.</p> <p>One clear consideration is that of maintenance of OST or detoxification during the current prison sentence. Ongoing review is required especially if there are any changes to prescription medication provided to the individual PCIP.</p> <p>Psychosocial support and interventions: The assessment process for the use of psychosocial support and interventions should include identification of treatment goals, strengths and risks, both within the prison environment and in the community, including relationships and wider social environment.</p> <p>For individual PCIP with mild to moderate opioid dependence with complex needs or severe opioid dependence, offer intensive and structured psychosocial support along with a focus on building resilience and relapse prevention.</p> <p>Prior to release, and to ensure continuity of care and support positive treatment outcomes, plan reengagement with community drug teams (CDT), and other relevant community services, ensure contact with identified CDT keyworker and establish psychological interventions are able to continue in community, identify key services and interventions in the assessment six weeks prior to release and subsequent assessments to release, and update the ICP accordingly.</p> <p>All prescriptions and identified psychosocial interventions should be recorded on the electronic ICP and the Day of Release care plan to ensure continuity of care.</p>
Treatment, detoxification and psychosocial care pathway for drug dependence – Benzodiazepine and Z-drugs			
99	SMTF	1	<p>For PCIP with dependence, management of withdrawal is required and treatment and care planning should be informed by the assessment process.</p>

For those already in receipt of Benzodiazepine prescription in the community and those with evidence of Benzodiazepine dependence

100	SMTF	1	<p>The SMTF sets out that Benzodiazepine dependence should be established through assessment and what this should be informed by (Section 2.3.3.1 of SMTF).</p> <p>Withdrawal symptoms may take more than 72 hours to be established, may result in serious medical problems including seizures and PCIP will require regular and close observation and monitoring.</p> <p>For PCIP with primary benzodiazepine dependence, and in those with severe co-morbidity including anxiety and depression, stabilisation of physical and psychological health issues should be prioritised, to support the potential for a successful subsequent gradual reduction detoxification regime from benzodiazepines.</p> <p>For PCIP also in receipt of maintenance OST prescription, the OST dose should be maintained and kept stable throughout benzodiazepine reduction period.</p> <p>In line with UK Clinical Guidelines and based upon clinical judgement and thorough assessment, there may be some instances for continuation of maintenance and longer-term prescribing of benzodiazepines.</p> <p>With the exception of those meeting the UK Clinical Guidelines criteria and where there is evidence of benzodiazepine dependence, an assisted-withdrawal regimen should be prescribed and initiated on the first day, in line with current guidance, usually diazepam.</p> <p>UK Clinical Guidelines for long-term, sedative-hypnotics withdrawal regimen in the community should also be followed in the prison setting (Section 4.10.1.3 Detoxification). However, it must be noted that withdrawal from Benzodiazepines is associated with risk of self-harm and suicidal ideation and as such, careful monitoring and consideration of a more gradual reduction regimen is recommended, alongside communication with wider Prison environment and ACCT process.</p> <p>In addition, and in line with criteria noted above, all existing mental health conditions should be addressed prior to commencement of a benzodiazepine assisted-withdrawal regime.</p> <p>Psychosocial support and interventions:</p> <p>The assessment process for the use of psychosocial support and interventions should include identification of treatment goals, strengths and risks, both within the prison environment and in the community, including relationships and wider social environment.</p> <p>For individual PCIP with benzodiazepine dependence and those with mild to moderate dependence with complex needs offer intensive and structured psychosocial support.</p> <p>Prior to release, and to ensure continuity of care and support positive treatment outcomes, plan reengagement with community drug teams and other relevant community services, ensuring contact with identified keyworker and establish continuity of psychological interventions. Key services and interventions should be identified in the assessment six weeks</p>
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			<p>prior to release and subsequent assessments to release, and the ICP updated accordingly. All prescriptions and identified psychosocial interventions should be recorded on the electronic ICP and the Day of Release care plan.</p>
Initiation of and treatment for drug dependence – stimulants including cocaine			
101	SMTF	1	<p>Withdrawal from stimulants is commonly associated with depression and as such, close monitoring is required alongside consideration of ACCT completion to assess risk of suicide and self-harm. As stated in the UK clinical guidance, there is no evidence that anti-depressants have an effect on stimulant withdrawal symptoms.</p> <p>Due to the nature of prolonged and problematic stimulant use, a range of physical and psychological health issues may also require treatment including oral health/dentition, nutrition, severe acute insomnia, bacterial injecting-related infections, and co-occurring acute and chronic psychiatric conditions including psychosis requiring medical interventions.</p> <p>Careful assessment and more structured care planning will be required for individuals with severe drug dependence and with complex and co-morbid issues. Individual PCIP with severe and persistent psychotic symptoms may require psychiatric admission.</p> <p>For PCIP with a history of both opioid and stimulant use, particularly cocaine/crack, optimal OST has been shown to be effective in supporting reduction and cessation of stimulant use. However, for those with severe stimulant dependence, additional stimulant specific psychosocial interventions are required. Substitute stimulant prescribing, for example, with dexamphetamine, is not supported by the evidence base and as such should not be undertaken unless the PCIP is already in receipt of a community prescription.</p> <p>Due to the risks outlined above, and the additional risk of cardiovascular complications and sudden death due to intracranial bleeds, thrombosis or cardiac arrest, all PCIP with a self-reported history of regular and heavy stimulant use including cocaine and amphetamine, and a positive drug test for stimulants, should be admitted to the healthcare unit, assessed and monitored over the first three days of prison entry, including neurological observations and blood pressure monitoring for signs of hypertension.</p> <p>Any medical concerns should result in full medical assessment with continued admission or transfer to hospital in the community as required in accordance with clinical judgement and governance arrangements. Dependent on withdrawal symptoms, appropriate short-term symptomatic prescribing should be considered in line with clinical judgement.</p> <p>On presentation of psychosis, severe agitation or suicidal ideation, either within first few days of sentence or at any point in the prison stay, a full mental health assessment is required, treatment and support provided, ACCT completion/update and the individuals ICP updated.</p> <p>The assessment process for the use of psychosocial support and interventions should include identification of treatment goals, strengths and risks, both within the prison environment and in</p>

			<p>the community, including relationships and wider social environment. For individual PCIP with stimulant dependence, and those with mild to moderate dependence with complex needs, offer intensive and structured psychosocial support.</p> <p>Prior to release, and to ensure continuity of care and support positive treatment outcomes, plan reengagement with community drug teams and other relevant community services, ensure contact with identified keyworker and establish continuity of psychological interventions in community, identify key services and interventions in the assessment six weeks prior to release and subsequent assessments to release, and update the ICP accordingly.</p> <p>All prescriptions and identified psychosocial interventions should be recorded on the electronic ICP and the Day of Release care plan to ensure continuity of care.</p>
Initiation and treatment for drug use – Synthetic Cannabinoid Receptor Agonists (SCRAs)			
102	SMTF	1	<p>Synthetic Cannabinoid Receptor Agonists (SCRAs) pose particular and unique challenges for the prison environment, with SCRAs the most prevalent group of NPS drugs in prison, and poly-pharmacy the norm. Acute Intoxication and chronic use of SCRAs can result in: Neurological, cognitive and psychiatric symptoms and physical symptoms (See section 2.3.5 of SMTF).</p> <p>In addition, SCRA use may precipitate psychotic symptoms caused by underlying mental health conditions. Given the complexity of symptoms, cessation of SCRA use is required in order for effective assessment to be undertaken, and initial treatment is focused on management of the presenting symptoms.</p> <p>Intensive monitoring and observation of the individual is required whilst acutely intoxicated with symptomatic treatment, typically in the form of short-term use of a major tranquilliser, anti-psychotic medications, or with particular caution, brief use of a benzodiazepine, based upon clinical judgement.</p> <p>Emergency care and hospitalisation, including psychiatric admissions, may be required and use of the National Early Warning Score (NEWS) 2 126 is recommended to standardise care. Assessment and longer-term management of symptoms will require physical and mental health assessment and update of ICP as appropriate.</p>

Diversion of medication within prison

103	SMTF	1	<p>Diversion of medication to individuals who have not been prescribed, or non-medical prescription drug use (NMPDU) within the prison environment is common and represents distinct challenges in management across the prison workforce. Implications including those related to the prescribed individual not consuming medication, represent a challenge to health care and other prison staff with potential for unmanaged physical and mental health disorders.</p> <p>For those consuming NMPDU, there is the risk of development of dependence and of acute poisoning, contraindications with other prescribed medications and potential for fatal drug poisoning.</p> <p>Diverted medications include, but are not limited to, benzodiazepines, gabapentinoids, opioid analgesics and those used in opioid substitution treatment including methadone and buprenorphine. Motivations may include self-medication, alleviation of withdrawal symptoms or to prolong the effect of other substances or medications.</p>
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7. SCREENING, DIAGNOSIS AND TREATMENT FOR INFECTIOUS DISEASE

Number	SMTF/ MH	Type	Standard
Blood-borne viruses			
104	SMTF	1	<p>Routine opt-out confidential testing for blood borne viruses: hepatitis B, hepatitis C and HIV and provision of hepatitis B vaccination should be undertaken at reception, first and/or second-stage assessment in line with NICE quality standard QS23157 and in accordance with Welsh Health Circular WHC/2017/048.</p> <p>All PCIP should be offered blood borne viruses (BBVs) screening which should be undertaken using point of care (POC) testing and diagnosis for Hepatitis C where available, and dried blood spot testing (anti-body and confirmatory PCR) for hepatitis B, hepatitis C (where POC not available) and HIV. BBV testing 'grab bags' should be made available in all reception/healthcare suites. In line with BBV testing in the community, the BBV testing protocol should be followed, and the shared ICP portal checked for history of BBV testing and treatment in the community.</p> <p>The BBV (hepatitis) care pathways should ensure they act in line with NICE guidance (See section 2.6.1).</p> <p>In the case of a positive HIV test result, testing and treatment should be in line with BHIVA standards of care for people living with HIV.</p> <p>Following receipt of BBV laboratory test result, the results must be entered onto the medical records and the shared ICP portal. For all positive test results, recorded referral to clinical treatment must be made and outcome of referral, with named responsible clinician, recorded.</p> <p>Treatment options and commencement will be subject to clinical judgement and PCIP preference, influenced by factors including length of sentence and other physical and mental health assessment and treatment priorities. In the event that treatment is not initiated, referral to treatment in the community must be made and recorded on the shared ICP portal to ensure no loss to follow-up. Successful treatment completion, or failure to complete treatment must also be recorded on the shared ICP portal.</p>

Tuberculosis (TB)			
105	SMTF	1	NICE guidance sets out the steps prisons should take to ensure proper assessment, care and treatment for prisoners.
Sexually-transmitted infections			
106	SMTF	1	<p>Prison health care services should act in line with NICE recommendations for the physical care of people in prisons.</p> <p>Key recommendations from the Sexual Health Review in Wales, and the resultant Sexual Health Service Specification endorsed by the Welsh Government state the need for delivery of bespoke sexual health services within prisons based upon regular audit and assessment of need, in order to address existing inequities in sexual health provision. These specifications set out what Health Boards are required to provide, either directly or through contract (See section 2.6.3).</p> <p>See section 2.6.3 of the SMTF for specific detail on assessment for risk and screening for STIs.</p>

8. COLLABORATIVE PARTNERSHIPS

Number	SMTF/ MH	Type	Standard
Joint working arrangements			
107	MH	2	<p>There are written policies in place for liaison and joint working with substance misuse services and primary care in cases of co-morbidity in accordance with NICE guidelines 57 (2016) and 66 (2017).</p> <p><i>Guidance: This can be an individual policy or included as part of a wider operational policy.</i></p>
108	MH	1	<p>There a regular complex care or multi-pathway meetings involving mental health, primary care and substance misuse to share information and develop management plans.</p>
109	MH	2	<p>There are contracted agreements for joint working with primary care to ensure high standards of physical healthcare and mental healthcare for patients with co-morbid physical and mental health problems.</p> <p><i>Guidance: Where integrated healthcare models are in place, there are clearly outlined roles and responsibilities in place for patients with co-morbid conditions.</i></p>
110	MH	2	<p>The team supports the establishment in the provision of mental health awareness training for prison staff in accordance with NICE guidelines 66 (2017).</p> <p><i>Guidance: This could include the direct involvement of the team in delivering training sessions, or the team has input into the development of training content and learning materials.</i></p>
111	MH	2	<p>The team has a policy on inter-agency working across criminal justice, social care, physical healthcare and the third sector within limits of patient consent, confidentiality and risk management.</p> <p><i>Guidance: Where integrated healthcare models are in place, the policy will detail effective multi-professional working and collaboration.</i></p>
112	MH	2	<p>There is a joint working policy between the establishment, primary care, substance misuse services and the mental health team on the control and management of substance misuse and substances.</p> <p><i>Guidance: Where integrated healthcare models are in place, there are clearly outlined roles and responsibilities in place for patients who are under the care of various teams.</i></p>
113	MH	2	<p>Where specialist interventions exist within prisons, a joint working protocol exists, with shared formulations and meetings in place.</p> <p><i>Guidance: This could be Offender Personality Disorder (OPD) pathways, Psychologically Informed Planned Environments (PIPES) and Therapeutic Communities.</i></p>

114	SMTF	1	<p>Collaborative multidisciplinary and multiagency working is facilitated through regular virtual and/or in-person multidisciplinary-multiagency team (MDAT) meetings led by the offender manager. Representation at MDAT should involve all those providing the PCIP's care including but not limited to: prison officer/keyworker, substance misuse services, mental health services, psychology, physical healthcare, including for treatment of infectious disease (BBV, TB, STIs), housing/resettlement and probation.</p> <p>Meetings should be standardised and minuted to ensure effective information sharing is embedded throughout the process. Services not able to attend the meeting should submit formal updates to inform the decision-making process.</p>
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9. DISCHARGE AND TRANSFERS

Number	SMTF/ MH	Type	Standard
Substance misuse: six weeks prior to release			
115	SMTF	1	<p>Planning support around release should occur at least six weeks prior to planned release and encompass four key domains:</p> <ul style="list-style-type: none"> - Substance use (drug and alcohol) and dependence, including continuity of prescribing and psychosocial support and overdose/relapse prevention (including a discussion about take home naloxone). - Physical health particularly continuity of treatment for chronic diseases including blood borne viruses, Sexually Transmitted Infections (STIs) and TB. - Mental health. - Social functioning and support including housing (see Chapter 3 Resettlement of the SMTF) relationships, financial management, education and/or employment and engagement with criminal justice.
116	SMTF	1	<p>Representatives from prison health service, Prison Offender Manager and community-based keyworkers should be included in the multidisciplinary team (MDT) assessment and planning process along with the PCIP. The assessment should inform review and updating of the integrated care plan held by the POM.</p>
117	SMTF	1	<p>For individuals being discharged from Prison, arrangements for continuity of OST need to be in place and confirmed by all parties, including the Prison and Community Offender Manager and community prescribing services including those commissioned by the Paediatric Critical Care Society (PCCS) and HMPPS, prior to discharge, and stated in the ICP. These arrangements should be agreed in the MDT and noted on the alcohol and substance use assessment and ICP to ensure continuity of care and support.</p>
118	SMTF	1	<p>Led and managed by the POM, the MDT should confirm development and formal, consensual agreement, of a 'day of release plan' including accommodation, prescription plan, provision of take-home naloxone for PCIP and family (if appropriate), probation and health appointment.</p>
119	SMTF	1	<p>Individuals being transferred or discharged from prison are given a minimum of 7 days' prescribed medicines, with the exception of opiate substitute therapy (OST) or an FP10 prescription. This ensures PCIP have an adequate supply of medicines until they can get more at the prison they are transferred to, or until they can get the next prescription after their release.</p>
120	SMTF	1	<p>All prescriptions and identified psychosocial interventions should be recorded on the electronic ICP and the Day of Release care plan to ensure continuity of care.</p>

Release planning			
121	SMTF	1	Prior to release, and to ensure continuity of care and support positive treatment outcomes, plan reengagement with community alcohol teams (CAT), ensure contact with identified CAT keyworker and establish that psychological interventions are able to continue in communities, identify key services and interventions in the assessment six weeks prior to release and any subsequent assessments to release, and update the electronic ICP accordingly.
122	SMTF	1	Prior to release, relapse prevention medication regimen, such as acamprosate, naltrexone or Disulfiram, should be considered following comprehensive medical assessment in line with NICE guidance. All prescriptions and identified psychosocial interventions should be recorded on the ICP and the Day of Release care plan to ensure continuity of care.
At the point of discharge/transfer			
123	MH	1	The process for referral and transfer of patients under Part 3 of the Mental Health Act follows the Good Practice Procedure Guide (NHSE, 2021)
124	MH	1	When a patient is transferred to another establishment, the mental health team provides a comprehensive handover to the receiving establishment's mental health team before the transfer takes place. <i>Guidance: Where a transfer is not known, the handover is provided to the receiving team as soon as they are made aware.</i>
125	MH	1	An identified key worker and/or responsible clinician from the receiving service are invited to discharge/release planning meetings. This includes a formalised review of care for patients on secondary care caseload. <i>Guidance: The review could be part of the Care Programme Approach (CPA), Promoting Quality Care (PQC), Care and Treatment Plan (CTP) or equivalent processes.</i>
126	MH	1	There is a robust transfer process to either a receiving prison or the community mental health team for patients who require continued care and follow-up support following release or transfer.
127	MH	1	On discharge from the team, patient information is provided to the receiving primary care or mental healthcare service.
128	MH	1	The team contacts the patient and/or the new care coordinator/service provider within 14 days of release/transfer from the establishment. <i>Guidance: This includes communication in person, by telephone, email or in writing. This can be an administrative task.</i>

Unplanned release from prison			
129	SMTF	1	Unplanned release from prison for those on remand who, following a court hearing are released from court, represent a clear challenge to continuity of care from Prison to community. All individuals should have undergone assessment and whether treatment has been initiated and ceased or is ongoing, treatment details including psychosocial and pharmacological treatment should already be present on the shared ICP. For relevant PCIP i.e. those on remand, risk assessment and planning for unplanned prison release should form part of the assessment process including details of overdose and relapse prevention, training and signposting to relevant services for the provision of take-home Naloxone (intranasal and/or intramuscular), emergency housing and continuity of care through community prescribing and support services including those services commissioned by PCCS and HMPPS.
Support for resettlement: accommodation			
130	SMTF	1	Ensuring appropriate and sustainable accommodation following release from prison is critical to continuity of care and support. The SMTF sets out what the Existing Strategic Framework seeks to achieve. The Welsh Government, HMPPS and Local Authorities have developed a Framework for Wales – the Accommodating Offenders in Wales: Strategic Framework (in prep, 2022), setting out the collaborative strategic approach required to prevent and address homelessness for all Welsh Prison Leavers, by identifying and collaborating with statutory, private and third sector partners and building on the opportunities from probation reforms in Wales from 2019 onwards.
Community Resettlement Services (CRS)			
131	SMTF	1	As part of the Probation Reforms, there are now 4 new providers of resettlement support. These are NACRO (men) and Nelson Trust (women) in North Wales and Forward Trust (men) and PSS (women) in South Wales and Dyfed Powys. They will be the liaison point between HMPPS and Local Authorities Homelessness Teams where someone is identified as likely to be homeless on release.
Accommodation pathway coordinators			
132	SMTF	1	HMPPS and the Welsh Government are jointly funding 6 Accommodation Pathway Co-ordinators and 1 Senior Probation Officer. These roles will contribute to the successful rehabilitation and reintegration of those leaving custody into the community with the aim of reducing reoffending. The posts will work closely with all internal and external partners, agencies and stakeholders who are involved in delivering the Accommodation Pathway.
Multi-Agency Public Protection Arrangement (MAPPA)			
133	SMTF	1	Work is ongoing to ensure a uniformed referral process into MAPPA across Wales, and that there is consistency in the application of the Housing (Wales) Act 2014, to ensure equality for all.

Accommodation and employment			
134	SMTF	1	<p>The provision of housing alone will not reduce offending. Providing someone with a home, skills and employment gives the highest chance of successfully making positive life changes. HMPPS in Wales will identify employment opportunities which also provide housing solutions.</p> <p>HMPPS will work closely with the Welsh Government and other relevant stakeholders to identify employment opportunities and create training environments within our prisons which prepare individuals for that employment on release.</p>
Women in justice and youth blueprints			
135	SMTF	1	<p>The Accommodating Offenders Framework Wales will align with both the Women in Justice and Youth Justice Blueprints. The Framework will also support approaches working to prevent youth homelessness and designing support packages that address issues unique to young people and those with low maturity and or learning disabilities.</p>
Ending Homelessness Action Plan, Rapid Rehousing Transformation and Housing First			
136	SMTF	1	<p>The Rapid Rehousing approach differs from the current service model only in that a greater emphasis is placed on moving people more quickly into permanent housing solutions rather than allowing multiple temporary accommodation stages which are often linked to 'housing readiness' or good behaviour.</p> <p>A key element of Rapid Rehousing will be Housing First services which are targeted at the most complex individuals or people. Similarly to Rapid Rehousing, but on a more intensive scale, Housing First prioritises rapid access to a stable home for a homeless person and enables her or him to begin to address other support needs through coordinated wraparound support and case management.</p>

10. PATIENT EXPERIENCE

Number	SMTF/ MH	Type	Standard
137	MH	1	Patients are actively involved in shared decision-making about their mental and physical healthcare, treatment and discharge planning and supported in self-management.
138	MH	2	The service asks patients for their feedback about their experiences of using the service and this is used to improve the service. <i>Guidance: This might include patient surveys or focus groups.</i>
139	MH	1	Patients are treated with compassion, dignity and respect. <i>Guidance: This includes respect of a patient's race, age, sex, gender reassignment, marital status, sexual orientation, maternity, disability and social background.</i>
140	MH	1	Patients feel listened to and understood by staff members. <i>Guidance: Efforts and adjustments are made for patients with communication difficulties. There should be specific consideration of patients with neurodivergent conditions, sensory loss and where English or Welsh is not their preferred language.</i>
141	MH	1	Confidentiality and its limits are explained to the patient verbally and written information is offered. Patient preferences for sharing information with third parties are respected and reviewed regularly.
142	MH	1	The patient's consent to the sharing of clinical information outside the team is recorded. If this is not obtained the reasons for this are recorded.
143	MH	1	Patients know who is coordinating their care and how to contact them if they have any questions.
144	MH	2	The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation.
145	MH	1	The service engages with programmes and partners such as Diverse Cymru's Cultural Competency Workplace Good Practice Certification Scheme to ensure the prison estate understands and is delivering for its diverse population.

11. ENVIRONMENT

Number	SMTF/ MH	Type	Standard
146	MH	2	Patients are able to attend appointments with the team at the scheduled appointment time.
147	MH	2	There are designated rooms for the team to run clinics and one-to-one sessions.
148	MH	2	There are designated rooms for the team to run group sessions.
149	MH	2	<p>All interview rooms are safe. This includes the rooms being situated close to staffed areas, having an emergency call system, an internal inspection window and the exit is unimpeded. Objects cannot easily be used as weapons.</p> <p>Consideration will be made for neurodivergent people who may have sensory needs. For instance lighting (window light where possible), quiet (reduced distraction).</p>
150	MH	1	Clinical rooms are private and conversations cannot be easily over-heard.
151	MH	1	The team has dedicated spaces and meeting rooms for confidential working.
152	MH	1	<p>There are sufficient IT resources (e.g. computer terminals, adequate data speeds) to provide all practitioners with easy access to key information, e.g. information about services/conditions/treatment, patient records, clinical outcome and service performance measurements. Staff also have access to online conferencing applications (e.g., Microsoft Teams) to facilitate remote meetings and videocalls.</p> <p><i>Guidance: This will need to be supported by wider developments regarding data sharing and IT systems.</i></p>

12. WORKFORCE

Number	SMTF/ MH	Type	Standard
153	SMTF	1	<p>Investing in workforce development can have a range of positive effects in the services provided and benefits to both the employer and employee, including improvement in staff morale and promoting job satisfaction.</p> <p>Providing additional knowledge and skills, can also drive improvements in work practices to meet and exceed quality standards.</p> <p>Having a workforce development-training plan can also assist in the retention of staff, as well as making future job opportunities more attractive to prospective applicants benefiting recruitment processes. Any such development plans should follow an informed and strategic approach.</p>
154	MH	1	<p>The multi-disciplinary team consists of or has access to staff from a number of different professional backgrounds that enables them to deliver a full range of treatments/therapies appropriate to the patient population.</p> <p><i>Guidance: This should include specialists who can undertake assessments and provide treatment/therapy relevant to the needs of the patient group.</i></p>
155	MH	1	<p>The service has a mechanism for responding to safer staffing issues, including:</p> <ul style="list-style-type: none"> - A method for the team to report concerns about staffing; - Access to additional staff members; - An agreed contingency plan; - An overdependence on bank and agency staff members results in action being taken.
156	MH	1	<p>When a staff member is on leave, the team puts a plan in place to provide adequate cover for the patients who are allocated to that staff member.</p>
157	MH	1	<p>Prescribers can contact a specialist pharmacist to discuss medications.</p>
158	MH	1	<p>There is a clearly identified clinical lead for the team.</p> <p><i>Guidance: The clinical lead has overall responsibility for the clinical requirements of the service.</i></p>
159	MH	2	<p>There are written arrangements and processes in place which ensure that specialist mental health advice can be accessed out of hours.</p>
160	MH	2	<p>There is a minimum of monthly multi-disciplinary team clinical meetings, which are recorded with written minutes.</p>

161	MH	1	<p>There are processes and initiatives in place to support staff health and well-being.</p> <p><i>Guidance: This includes:</i></p> <ul style="list-style-type: none"> - Providing access to support services; - Monitoring staff sickness and burnout; - Encouraging staff to take scheduled breaks; - Assessing and improving morale; - Providing wellbeing programmes; - Monitoring turnover; - Reviewing feedback from exit reports and taking action where needed.
162	MH	1	<p>All permanent full-time staff within the team receive a full local prison induction within 28 days of commencing employment and before being issued with keys.</p> <p><i>Guidance: This includes key security, prison awareness, the prison processes on managing self-harm and suicide (such as ACCT, SPAR Evolution) and personal protection, or equivalent.</i></p>
163	MH	1	<p>New staff members, including bank staff, receive an induction based on an agreed list of core competencies.</p> <p><i>Guidance: This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.</i></p>
164	MH	1	<p>All staff who use an electronic patient recording system receive formal training and are competent in its use. For example, SystemOne training.</p>
165	MH	1	<p>The team receives training consistent with their roles on risk assessment and risk management. This is refreshed in accordance with local guidelines. This training includes, but is not limited to training on:</p> <ul style="list-style-type: none"> - Safeguarding vulnerable adults and children; - Assessing and managing suicide risk and self-harm; - Prevention and management of aggression and violence.
166	MH	1	<p>Staff have an understanding of Trauma Informed Care and have the opportunity to access training on this practice, in line with the Trauma Informed Wales Framework.</p> <p><i>Guidance: Where staff have received the training, they are able to demonstrate how this has influenced their practice.</i></p>
167	SMTF	1	<p>Trauma-informed approaches training should be provided to staff across services to ensure development of necessary competencies, enabling staff to recognise and work effectively with trauma symptoms and behaviours, to promote inclusion and facilitate positive change. Alongside, this package of training it is recommended that there be a continued personal development pathway for individuals within special interests in substance misuse support.</p>
168	MH	1	<p>Staff receive training consistent with their role and in line with their professional body. This is recorded in their personal development plan and is refreshed in accordance with local guidelines.</p>
169	SMTF	1	<p>The Royal College of Nursing, the Royal College of Psychiatrists and the General Medical Council set out the training, standards and outcomes and registration requirements for medical professionals through to postgraduate education including training for specialisms.</p>

170	SMTF	1	<p>There is an important role for non-clinical workers who work alongside healthcare in prison to deliver education about substances, harm reduction messages and wider dissemination of consistent messages, as well as to contribute to the health and well-being of individuals in prison. As such, training on substance misuse and related issues should not be limited to healthcare and substance misuse staff, but should also include prison officers and prisoner peer mentors who are able to offer timely and pragmatic information and brief interventions, as needed.</p> <p>All prison officers should have a basic knowledge and understanding of substance misuse, harm reduction and related issues, alongside the Prison Officer Entry Level Training (POELT).</p> <p>Providing this training across all the prison estate and professional disciplines will facilitate the building of more constructive relationships with people in prison.</p>
171	MH	1	<p>Staff receive training on the use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).</p>
172	MH	1	<p>Staff receive statutory and mandatory training.</p> <p><i>Guidance: This includes equality and diversity, information governance and basic life support.</i></p>
173	MH	1	<p>Staff are trained and fully informed about the assessment and management of mental health presentations in people with learning difficulties and neurodiversity.</p> <p><i>Guidance: For neurodiversity this should include sensory issues, and reasonable adjustments.</i></p>
174	MH	1	<p>All staff members receive an annual appraisal and personal development planning or equivalent.</p> <p><i>Guidance: This contains clear objectives and identifies development needs.</i></p>
175	MH	1	<p>All clinical staff members receive individual clinical supervision at least monthly or as otherwise specified by their professional body.</p> <p><i>Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications. The activity should offer the supervisee an opportunity to reflect upon their practice and to think about how their knowledge and skills may be developed to improve care.</i></p>
176	MH	2	<p>All staff members receive monthly line management supervision.</p> <p><i>Guidance: Supervision forms a part of individual performance management and discusses organisational, professional and personal objectives.</i></p>
177	MH	1	<p>All staff members who deliver therapies and activities are appropriately trained and supervised.</p>
178	SMTF	1	<p>Peer supporters should be provided with training in core skills, including; communication, problem solving and specific needs of the scheme. Supervision should be set up for all peer supporters.</p> <p>Substance misuse is an area of work that requires a non-judgemental and pragmatic approach. It is recommended that staff engage in reflective practice to support the delivery of best practice in this area of work with peers.</p>

179	MH	2	Staff members are able to access reflective practice groups at least every six weeks where teams can meet to think about team dynamics and develop their clinical practice.
180	MH	1	<p>Staff members are able to take breaks during their shift that comply with the European Working Time Directive.</p> <p><i>Guidance: They have the right to one uninterrupted 20-minute rest break during their working day, if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.</i></p>

13. LEADERSHIP AND GOVERNANCE

Number	SMTF/ MH	Type	Standard
Safety			
181	MH	1	Staff members can quickly and effectively report incidents. Managers encourage staff members to report this and staff members receive guidance on how to do this.
182	MH	1	Staff members who are affected by a healthcare related serious incident are offered a debrief and post incident support.
183	MH	1	Lessons learned from untoward incidents are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.
184	MH	2	There is a widely accessible complaints policy, for staff and patients, that clearly sets out the ways in which a complaint can be made, the process for investigation and how communication is managed throughout.
185	MH	1	Processes for dealing with internal complaints give prisoners confidence that matters are being resolved appropriately and enable prisons to improve their services.
186	MH	2	Complaints are reviewed on a quarterly basis to identify themes, trends and learning.
187	MH	1	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.
188	MH	1	The mental health team are involved in the prison process managing self-harm and suicide. They will attend review meetings for all newly opened cases, for all reviews for anyone on their caseload, and where required and relevant to attend. Refer to standard 72 where there is a refusal of support / refusal of services. <i>Guidance: This refers to Assessment, Care in Custody and Teamwork (ACCT), SPAR Evolution or equivalent processes.</i>
189	MH	2	There is a representative from the mental health team who attends the prison governance meeting to support the prison with self-harm and suicide, e.g. Safety and Intervention Meeting (SIM).
190	MH	1	There is a clear process to follow when visiting patients outside of clinical rooms to ensure the staff feel safe when working with patients.
191	MH	1	The team communicates any information that might affect a patient's safety across relevant agencies and care settings, within the limits of confidentiality and patient consent.
192	MH	1	Staff members follow inter-agency protocols for the safeguarding of vulnerable adults and young people. This includes escalating concerns if an inadequate response is received to a safeguarding referral.
193	MH	1	The team understands and engages in policies on food refusal and mental capacity assessments, including sensory issues from neurodivergent conditions.

194	MH	2	<p>The team understands and engages in policies on Multi-agency Public Protection Arrangements (MAPPA).</p> <p><i>Guidance: For example, Multi-Agency Public Protection Arrangements (MAPPA), Public Protection Arrangements Northern Ireland (PPANI) or equivalent.</i></p>
195	MH	1	<p>Team members, including bank and agency staff, are able to identify and manage an acute physical health emergency.</p> <p><i>Guidance: Such as initial Cardiopulmonary resuscitation (CPR).</i></p>
196	MH	1	<p>When mistakes are made in care this is discussed with the patient themselves in line with the Duty of Candour agreement (or equivalent).</p>
Strategy			
197	SMTF	1	<p>A Commissioning Strategy, annual delivery and expenditure plans are in place, agreed and published.</p> <p>Health Board strategic and related annual delivery and expenditure plans reflect an assessment of need with intended measurable outcomes, incorporating prison health care and transition from and back into the community.</p>
198	MH	1	<p>A representative of the team is part of the establishment's clinical governance and quality processes.</p>
199	MH	2	<p>Patients are involved in the governance and development of the team.</p> <p><i>Guidance: This includes representation from a patient or a patient representative in governance meetings and/or direct consultation with the patient group on areas of development.</i></p>
200	MH	2	<p>The service has a strategic managerial meeting, at least annually, with all stakeholders to consider topics such as referrals, the clinical model, service developments, issues of concern and to re-affirm good practice.</p> <p><i>Guidance: Stakeholders should include staff member representatives from across the care pathway, as well as patient representatives.</i></p>
201	MH	1	<p>Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that the team find accessible and easy to use.</p> <p><i>Guidance: Where health policies are used, these are accessible to staff when working in the prison.</i></p>
202	MH	2	<p>Services collect information and data to evaluate their own performance and measure improvements. This data is shared with key stakeholders, the organisation's board and staff.</p> <p><i>Guidance: This could include Key Performance Indicators (KPIs), diagnosis timeframes, transfer and remission timeframes, diversity and accessibility etc. This information could be gathered as part of the contract review data.</i></p>
203	MH	2	<p>The team understands and engages in policies on reporting intelligence according to the establishment's security reporting system.</p>
204	MH	3	<p>The team engages in service relevant research and academic activity.</p>

14. 24-HOUR MENTAL HEALTHCARE

Number	SMTF/ MH	Type	Standard
205	MH	1	<p>There is an agreed operational policy which includes the following areas:</p> <ul style="list-style-type: none"> - Admission and discharge criteria; - Admission decision making, including out of hours; - Leadership of the service, including clinical and discipline; - The clinical model of the service, including therapeutic activities and prescription/administration of medicines; - The process by which other prisons may refer to the unit when it operates as a regional resource; - The process for liaising with families; - Follow-up arrangements.
206	MH	1	<p>Patients have a comprehensive assessment which is started within four hours and completed within 48 working hours. This involves the multi-disciplinary team and includes the patient. An immediate care plan is completed which includes:</p> <ul style="list-style-type: none"> - Mental health and medication; - Physical health needs; - Risk assessment, including risk of suicide.
207	MH	1	<p>The purpose of the admission is explained to the patient and an assessment of their capacity to consent to admission, care and treatment is completed within 24 hours of admission.</p> <p><i>Guidance: This relates to mental health admissions only.</i></p>
208	MH	1	<p>Managers and practitioners have agreed weekly clinical review meetings.</p>
209	MH	1	<p>Activities are provided seven days a week.</p> <p><i>Guidance: This can include occupational therapy, art/creative therapies, non-therapeutic activities and in cell activities.</i></p>
210	MH	2	<p>Each patient receives a pre-arranged one-hour session at least once a week with their key worker (or equivalent) to discuss progress, care plans and concerns.</p>
211	MH	1	<p>Clinical outcome measurement data is collected at two time points (admission and discharge) as a minimum, and at clinical reviews where possible.</p>
212	MH	1	<p>Discharge planning begins at the first review and outcomes for discharge are agreed.</p>
213	MH	1	<p>Every patient is engaged in active conversation at least twice a day by a team member and this is recorded in patient notes.</p> <p><i>Guidance: This is an opportunity for patients to discuss any issues or difficulties they are experiencing.</i></p>
214	MH	3	<p>There is a weekly minuted community meeting that is attended by patients and staff members.</p> <p><i>Guidance: This is an opportunity for patients to share experiences, to highlight issues on the unit and to review the quality and provision of activities with staff members.</i></p>
215	MH	1	<p>Risk assessments and management plans are updated according to clinical need or monthly, at a minimum.</p>

216	MH	1	Patients are able to access safe outdoor space every day and should be encouraged and supported to do so.
217	MH	1	<p>Patients have their medications reviewed at least weekly. Medication reviews include:</p> <ul style="list-style-type: none"> - Assessment of therapeutic response; - Safety; - Side effects, with a clear care plan to manage them when they occur; - Adherence to medication regime. <p><i>Guidance: Side effect monitoring tools can be used to support reviews.</i></p>
218	MH	1	The team keeps medications in a secure place, in line with the organisation's medicine management policy.
219	MH	1	<p>There is a clear policy agreed with the establishment concerning the management of violence and aggression within the unit. This includes:</p> <ul style="list-style-type: none"> - The roles of discipline staff and healthcare staff; - The use of restraint; - Reviews following episodes of restraint in the unit; - Audits of restraint.
220	MH	1	<p>There is a clear policy regarding the use of rapid tranquilisation within the unit, which includes the issue of consent.</p> <p><i>Guidance: This includes PRN medication.</i></p>
221	MH	1	<p>An audit of environmental risk, including ligature risks, is conducted annually and a risk management strategy is agreed with the establishment.</p> <p><i>Guidance: Any problems are recorded and reported to the establishment's senior management personnel.</i></p>
222	MH	1	There are agreed minimum staffing levels that include at least one qualified nurse present on all shifts.
223	MH	2	<p>The unit is staffed by permanent staff members, and bank and agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need.</p> <p><i>Guidance: The use of agency staff is monitored on a monthly basis. An overdependence on bank and agency staff members results in action being taken.</i></p>
224	MH	1	Arrangements are in place to ensure that a doctor is available at all times to attend the unit, including out of hours.
225	MH	1	Patients are not discharged from the inpatient facility without the consultation of a mental health professional and/or duty healthcare manager.
226	MH	2	The operation of the unit is explicitly included in the commissioning specification.

15. WELSH/PREFERRED LANGUAGE

Number	SMTF/ MH	Type	Standard
227	MH	1	Services comply with their legal duties in relation to the Welsh language and ensure that the Welsh language is treated no less favourably than the English language. Services should also provide access to interpretation and translation (including BSL) where the person's preferred language is neither English or Welsh.
228	SMTF	1	Under commitments set out in the HMPPS and MoJ Welsh Language Schemes, and under the Welsh Language Standards for the health boards, Welsh speakers should be made aware of the rights and opportunities available to them to receive information in Welsh.
229	MH	1	Prisoners are aware that they are able to communicate in Welsh with each other and with external contacts.
230	MH	1	There is a continuous process in place to collect current data on the language skills of prison staff, and it should use that data to plan services for Welsh speakers, including raising prisoners' awareness of the opportunities available to use Welsh with staff.
231	MH	1	People currently in prisons are aware that they have the right to complain to the Welsh Language Commissioner about matters relating to the Welsh language, and staff should facilitate any complaint a person wishes to make.
232	SMTF	1	Staff are made aware of the need to make the 'Active Offer' (providing a Welsh language service without service users having to ask for it) and encourage providers to actively encourage their workforce to develop capacity to use Welsh in the workplace.

16. ADDITIONAL (WELSH GOVERNMENT)

Number	SMTF/ MH	Type	Standard
233	WG	1	<p>On reception all individuals are asked about any requirements they may have, relating to the 9 protected characteristics under the Equality Act. Reasonable adjustments are made in order to meet any identified requirements.</p> <p><i>I.E. Age, disability, Gender- affirming surgery, marriage, pregnancy and maternity, race, religion and beliefs, sex, sexual orientation.</i></p>
234	WG	1	<p>Staff are trained to be culturally aware and competent so that the differing cultural needs of the prison population and the staff within prisons can be identified and met.</p> <p><i>Diversity, equity and inclusion training for staff should highlight issues such as unconscious bias, recognition of different cultural and religious holidays, equal pay and conditions of work etc. There should be evidence of diversity and inclusive policies within the prison.</i></p>
235	WG	1	<p>There are processes in place to ensure that delayed transfers to hospital, under the Mental Health Act, are kept to a minimum.</p> <p><i>The prison is able to escalate delays and highlight potential delays to relevant Health Boards/Joint Commissioning Committee so that potential delays can be avoided and actual delays are progressed in a timely manner.</i></p>
236	WG	1	<p>There are processes in place to ensure that ligature anchor point risks are identified and identified risks are mitigated via appropriate interventions.</p> <p><i>Evidence of Ligature risk assessment tool in place. Tool is completed/updated every 6 months or following any ligature incident. Evidence of mitigating interventions such as Ligature maps, individual patient observations, planned estate works etc</i></p>
237	WG	1	<p>The prison mental health team have processes in place to ensure that links with Health Board Mental Health services are maintained so that seamless transition between services is maintained on admission and discharge between services.</p> <p><i>Staff are aware of who to contact in Health Boards and how to contact them. Evidence of external teams' involvement in MDT meetings etc.</i></p>
238	WG	1	<p>There are systems in place to ensure that patients suffering from or potentially suffering from Organic Mental disorders, such as Acquired Brain Injury, dementia etc, receive appropriate assessment and treatment to meet their needs.</p> <p><i>Evidence of specialist assessments, staff who are able to undertake such assessments, care plans that are produced in order to meet any needs identified needs, links with external specialised teams.</i></p>