

ANNEXE A:

Non-Applicable Standards

This document summarises the standards scored as 'Not Applicable' broken down by service.

The total number of N/A standards per team is as follows:

Prison	N/A - MH	N/A - SMTF	Total N/A
HMP Swansea	1	4	5
HMP Cardiff	2	1	3
HMP Parc	1	0	1
HMP Berwyn	2	0	2
HMPs Usk and Prescoed	2	28	30

The full set of quality standards (Annexe A) includes 22 standards around provision of 24-hour mental healthcare in prisons for services with inpatient provisions or enhanced care facilities (standard numbers 205-226). As none of the Welsh prisons offers this, these standards have been excluded from this document and the above figures.

A significant number of SMTF standards were not felt to apply to the team at HMPs Usk and Prescoed. Being open/resettlement prisons, the people they work with have received treatment for their substance misuse at previous placements and do not require intensive support in this area.

It is important to note that some standards were scored on self-review information only, and a rationale for the score was not always provided.

HMP SWANSEA

Number	SMTF/ MH	Type	Standard	Peer review score	Comment/Rationale
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. 	N/A	HMP Swansea is an all-male establishment.
130	SMTF	1	<p>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.</p> <p>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.</p>	N/A	The prison has a resettlement team but healthcare do not routinely meet with them.
131	SMTF	1	<p>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.</p>	N/A	

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>	N/A	
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-judgmental 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>	N/A	<p>The service does not employ or work with peer supporters.</p>

HMP CARDIFF

Number	SMTF/ MH	Type	Standard	Peer review score	Comment/Rationale
73	MH	1	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: - 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.	N/A	HMP Cardiff is an all-male establishment.
113	MH	2	Where specialist interventions exist within prisons, a joint working protocol exists, with shared formulations and meetings in place. <i>Guidance: This could be Offender Personality Disorder (OPD) pathways, Psychologically Informed Planned Environments (PIPES) and Therapeutic Communities.</i>	N/A	There are no specialist interventions in place.
170	SMTF	1	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. 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). Providing this training across all the prison estate and professional disciplines will facilitate the building of more constructive relationships with people in prison.	N/A	This is not within the remit of healthcare.

HMP PARC

Number	SMTF/ MH	Type	Standard	Peer review score	Comment/Rationale
73	MH	1	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: - 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.	N/A	HMP Parc is an all-male establishment.

HMP BERWYN

Number	SMTF/ MH	Type	Standard	Peer review score	Comment/Rationale
73	MH	1	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: - 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.	N/A	HMP Parc is an all-male establishment.
113	MH	2	Where specialist interventions exist within prisons, a joint working protocol exists, with shared formulations and meetings in place. <i>Guidance: This could be Offender Personality Disorder (OPD) pathways, Psychologically Informed Planned Environments (PIPES) and Therapeutic Communities.</i>	N/A	None of these services is provided in HMP Berwyn.

HMPS USK AND PRESKOED

Number	SMTF/ MH	Type	Standard	Peer review score	Comment/Rationale
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.	N/A	HMPs Usk and Prescoed do not receive men directly from the community.
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.	N/A	HMPs Usk and Prescoed do not receive men directly from the community.
73	MH	1	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: - 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.	N/A	HMPs Usk and Prescoed are male-only establishments.

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>	N/A	HMPs Usk and Prescoed are not receiving prisons.
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>	N/A	HMPs Usk and Prescoed are not receiving prisons.
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>	N/A	HMPs Usk and Prescoed are not receiving prisons.
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>	N/A	HMPs Usk and Prescoed are not receiving prisons.
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>	N/A	HMPs Usk and Prescoed are not receiving prisons.
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>	N/A	HMPs Usk and Prescoed are not receiving prisons.

80	SMTF	1	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.	N/A	HMPs Usk and Prescoed are not receiving prisons.
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.	N/A	HMPs Usk and Prescoed are not receiving prisons.
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.	N/A	HMPs Usk and Prescoed are not receiving prisons.
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.	N/A	HMPs Usk and Prescoed are not receiving prisons.

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>	N/A	
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>	N/A	
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>	N/A	
95	SMTF	1	<p>Those already in receipt of and stable on Buvidal 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 (Buvidal) may be administered by a health care professional as a weekly or monthly subcutaneous injecting.</p> <p>Buvidal 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>	N/A	

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</p>	N/A	
----	------	---	--	-----	--

			<p>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>		
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>	N/A	
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</p>	N/A	

			<p>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>		
99	SMTF	1	For PCIP with dependence, management of withdrawal is required and treatment and care planning should be informed by the assessment process.	N/A	

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>	N/A	
-----	------	---	--	-----	--

		<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 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>		
--	--	---	--	--

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</p>	N/A	
-----	------	---	--	-----	--

		<p>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 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>		
--	--	--	--	--

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>	N/A	
-----	------	---	---	-----	--

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>	N/A	
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>	N/A	There is no dedicated substance misuse team. The mental health team works predominantly with primary care patients.
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>	N/A	None of the specialist interventions listed is offered within HMPs Usk or Prescoed.

117	SMTF	1	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.	N/A	
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.	N/A	HMPs Usk and Prescoed are not remand prisons.
135	SMTF	1	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.	N/A	HMPs Usk and Prescoed do not work with women or young people.
178	SMTF	1	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. 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.	N/A	The service does not employ or work with peer supporters.