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RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

PRISON
QUALITY NETWORK FOR PRISON MENTAL HEALTH SERVICES

Baseline Audit:
Mental Health and Substance Misuse Provision in Welsh Prisons

Aggregated Findings

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The artwork on the cover of this report was created by a patient at Heatherwood Court secure hospital (2019).

INTRODUCTION

This baseline audit of Welsh prison mental health services and substance misuse teams was commissioned through RCPsych Wales as part of the Prison Partnership Agreement between Welsh Government and HMPPS.

The work has been designed to identify similarities and differences between models of care across Welsh prisons, consider where services are performing well and why, and identify thematic areas which may require additional resource or support.

The audit was conducted against existing standards developed 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.

This Report

This report aims to summarise findings from reviews of the five prison mental health and substance misuse teams in Wales (considering HMPs Usk and Prescoed as one team covering two prison sites).

It presents an analysis of how well member services are performing against the quality standards, as well as areas of best practice identified and recommendations relating to commonly unmet criteria.

Recommendations have been designed to support Welsh Government in making decisions regarding the funding and support available to prison mental health and substance misuse services based on themes arising across the visits. Service-specific recommendations were provided for clinical teams as part of their local reports. The purpose of these recommendations was to support teams to review their own areas for improvement and to continuously improve the quality of care that they provide.

Quality Network for Prison Mental Health Services

The Quality Network for Prison Mental Health Services (QNPMHS) was established in 2015 to promote quality improvement within and between prison mental health services across the UK. It is one of almost 30 quality and accreditation programmes within the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI).

Membership of the wider network is voluntary and subscription-based. Participating services engage in an annual process of self- and peer review against an evolving set of evidence-based quality standards through which QNPMHS aims to:

- Promote quality improvement
- Share best practice
- Encourage a culture of openness
- Help services plan improvements for the future
- Allow services to benchmark their practices against other similar services
- Demonstrate the quality of the care provided.

KEY MESSAGES AND RECOMMENDATIONS

This audit covers all prisons within Wales. There are several key messages and five specific recommendations.

Prison mental health and substance misuse teams are encouraged to:

- Work collaboratively with colleagues in the wider prison to deliver training and improve mental health awareness
- Participate in programmes to improve understanding of diverse populations and how to deliver culturally competent services
- Identify and develop supervisors to ensure clinical supervision is delivered on a monthly basis
- Implement personal safety protocols to ensure staff feel supported when visiting patients on the wings, including having access to keys, radios and alarms

Welsh Government and HMPPS are encouraged to:

- Conduct further quality audits in future to monitor the effectiveness of any changes implemented

The audit identified five recommendations to improve mental health and substance misuse provision within Welsh prisons.

1. **Enhance substance misuse provision by increasing investment in specialist staff and expanding access to evidence-based treatment to promote an integrated approach to rehabilitation**

2. **Conduct a review of skill mix in the context of each prison's population to identify where input from clinical disciplines, such as psychology and psychiatry, may need to be introduced or increased**

3. **Strengthen and formalise care pathways for neurodivergent individuals in prisons by establishing clear standards, dedicated screening and assessment processes, and integrated support plans**

4. **Ensure healthcare teams have appropriate clinical working environments by investing in adequate rooms for confidential consultation, secure access to computers and clinical systems, and safety equipment such as radios and alarms**

5. **Implement adapted assessment processes for individuals over 50 in prisons, including screening for cognitive impairment and social care needs, and establish a formal care pathway to ensure consistent support and management**

METHODOLOGY

Self-Assessment

Introductory calls were held with mental health contacts from all six prisons in Wales to outline the purpose and process of this baseline audit. The contacts were then provided with a self-assessment bundle which included the following documentation:

- Excel workbook including 238 mental health and substance misuse standards (Annexe A)*
- Contextual information form
- Evidence checklist.

The Excel workbook required self-rated scores (of 'Met', 'Partly Met', 'Not Met' or 'Not Applicable') to be added against each standard, as well as commentary to contextualise these scores where appropriate. Teams were encouraged to reflect candidly on each criterion and consider not only if it was 'Met', but also if it could be evidenced in practice.

The contextual information form asked the mental health staff about their current service context, including metrics around caseloads and waiting times; key achievements, challenges and priorities; and their staffing complement.

The evidence checklist required teams to submit anonymised documentation to demonstrate compliance with a selection of nine standards covering topics such as patient involvement, provision of information, and joint working across agencies.

Teams were given two months to complete and submit all documentation within the bundle.

***To note:** The full set of quality standards includes 22 standards around provision of 24-hour mental healthcare in prisons for services with inpatient provisions or enhanced care facilities, however, as none of the Welsh prisons offers this, these standards have been excluded for the purpose of this report.*

The Review Process

Roughly one month after completion of each team's self-assessment, an in-person visit took place at each of the prisons (Figure 1). These lasted one day, from 09:30 - 16:30, with the exception of HMPs Usk and Prescoed who received a combined 1.5-day visit due to their mental health team working across both environments. Visits were carried out between September 2024 and July 2025.

Visiting review teams comprised either four or five professionals including two consultant forensic psychiatrists, one or two clinical representatives from the NHS Wales Joint Commissioning Committee, and a representative from the quality network.

Figure 1. *Map of Wales demonstrating the prison locations*

Each visit followed a similar timetable and included the following elements:

- Meeting with managers within the mental health team
- Meeting with frontline staff members from the mental health team
- Meeting with partner agency representatives from the wider prison establishment
- Meeting with substance misuse staff
- Group or individual interviews with patients
- Tour of the healthcare environment
- Review of relevant documentation
- Preliminary feedback meeting.

For HMPs Usk and Prescoed, interviews with patients and the tour of the environment were carried out at both premises to understand where differences of experiences may arise.

Review team check-ins were factored in throughout the visits to allow time to discuss scores and findings. Scores of 'Met', 'Partly Met', 'Not Met' or 'Not Applicable' were allocated to each standard based on triangulation of all information obtained.

The preliminary feedback meeting at the end of each visit provided an opportunity for reviewers to share key achievements and challenges identified during the review day with members of the host team, as well as recommendations as to how the challenges might be addressed.

Local Reports

Within one month of their review visit taking place, the key contact(s) from each of the prison mental health teams were provided with a local report, summarising their performance against the standards, achievements, opportunities for improvement and recommendations. Each service was considered within their own local context (such as the populations served) to ensure findings were bespoke and relevant, bearing in mind their individual differences.

Reports were drafted by the QNPMHS network representative before being shared with other members of the review team and proofed by other network staff to ensure fairness and consistency. Prison contacts were then given one month upon receipt of their draft to provide any comments regarding factual accuracy.

A detailed timeline of the full methodology can be found in Annexe B.

EXECUTIVE SUMMARY

This section provides an overview of how the Welsh prison mental health and substance misuse teams performed against the quality standards.

The overall percentage of fully met criteria by each prison spans from 41% to 89%. When taking into consideration any non-applicable standards, this range becomes 41% to 90%. The average compliance across the five prison teams is 61%, as indicated by the final bar marked 'TNS' (total national sample) on the graph in Figure 2 (not including consideration of non-applicable standards).

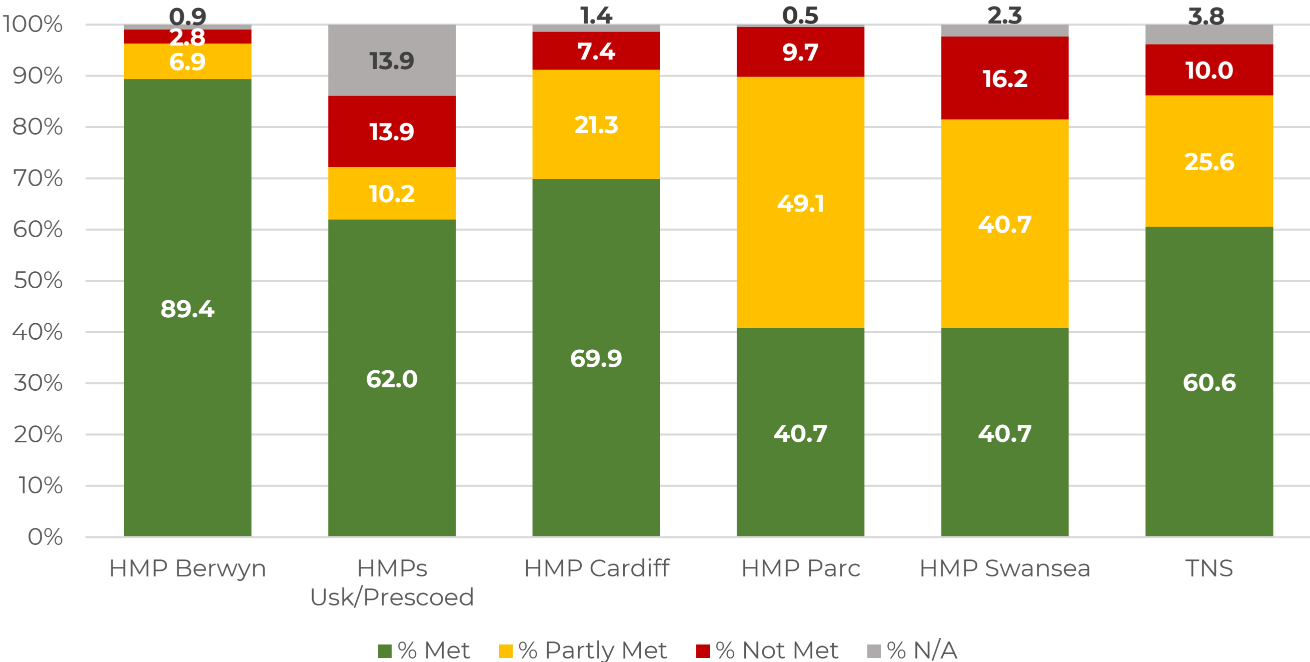


Figure 2. *Percentage of met criteria by service against Total National Sample (TNS)*

Of the 216 total standards, 123 were categorised as 'Mental Health' (MH), either being drawn from existing QNPMHS standards or additional as included by Welsh Government, and the remaining 93 were categorised as 'Substance Misuse' (SM), drawn from the Substance Misuse Treatment Framework (2024)[1].

The percentage of fully met Mental Health standards ranged from 54% to 81%, with average compliance of 62.8% (Figure 3).

Two standards were felt not to be applicable for some or all prisons within this category:

- **Standard 73 [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:

[1] Substance misuse treatment framework for children and young people: integrated impact assessment [HTML] | GOV.WALES

- 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 for all prisons as male-only establishments**

- **Standard 113 [2]:** Where specialist interventions exist within prisons, a joint working protocol exists, with shared formulations and meetings in place.
  Guidance: This could be Offender Personality Disorder (OPD) pathways, Psychologically Informed Planned Environments (PIPES) and Therapeutic Communities. **– N/A for HMPs Berwyn, Usk and Prescoed, and Cardiff due to absence of specialist interventions**

Taking these non-applicable standards into consideration, the percentage of fully met standards within this category ranged from 54% to 83%.

A summary of all standards categorised as 'N/A' can be found in Annexe C.

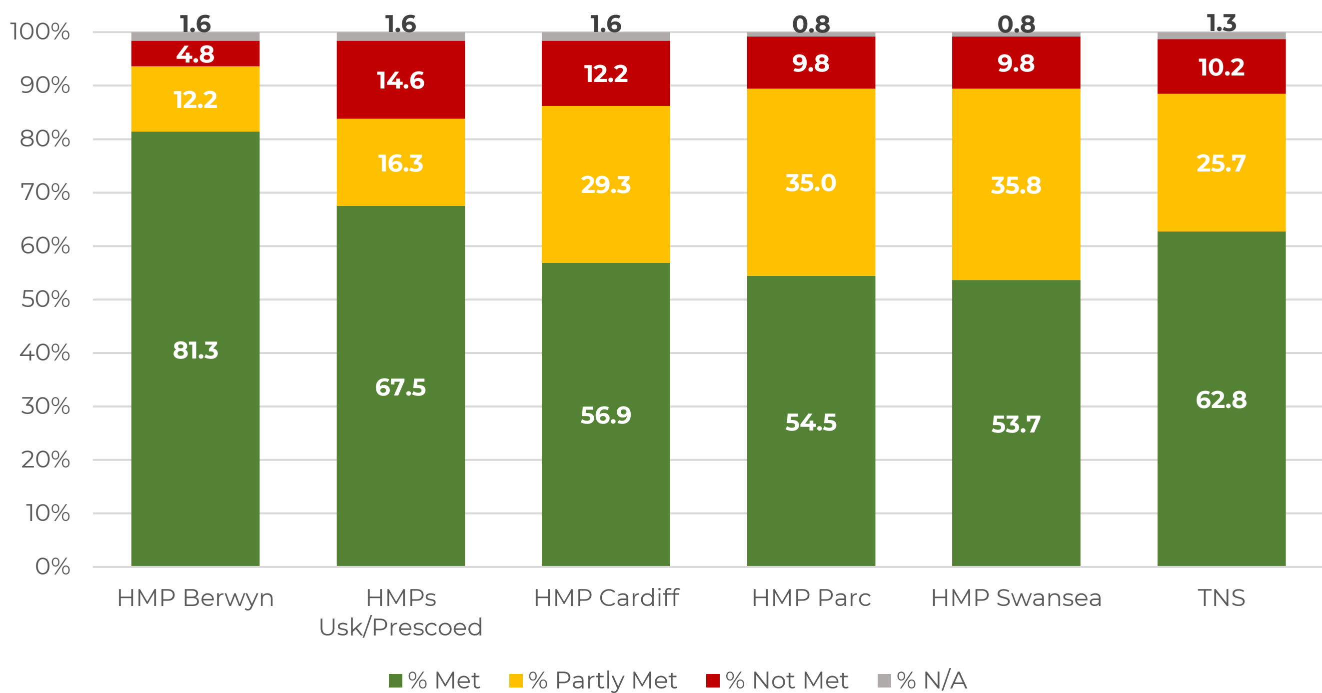


Figure 3. *Percentage of met Mental Health criteria against Total National Sample (TNS)*

The percentage of fully met Substance Misuse standards ranged from 24% to 100%, with an average of 57.7% (Figure 4). This broad range appears to correspond to the highly varied levels of SM provision and dedicated team time across the prisons.

Of particular note are HMPs Usk and Prescoed, for whom over 30% of the standards within this category were not applicable to their offering. 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.

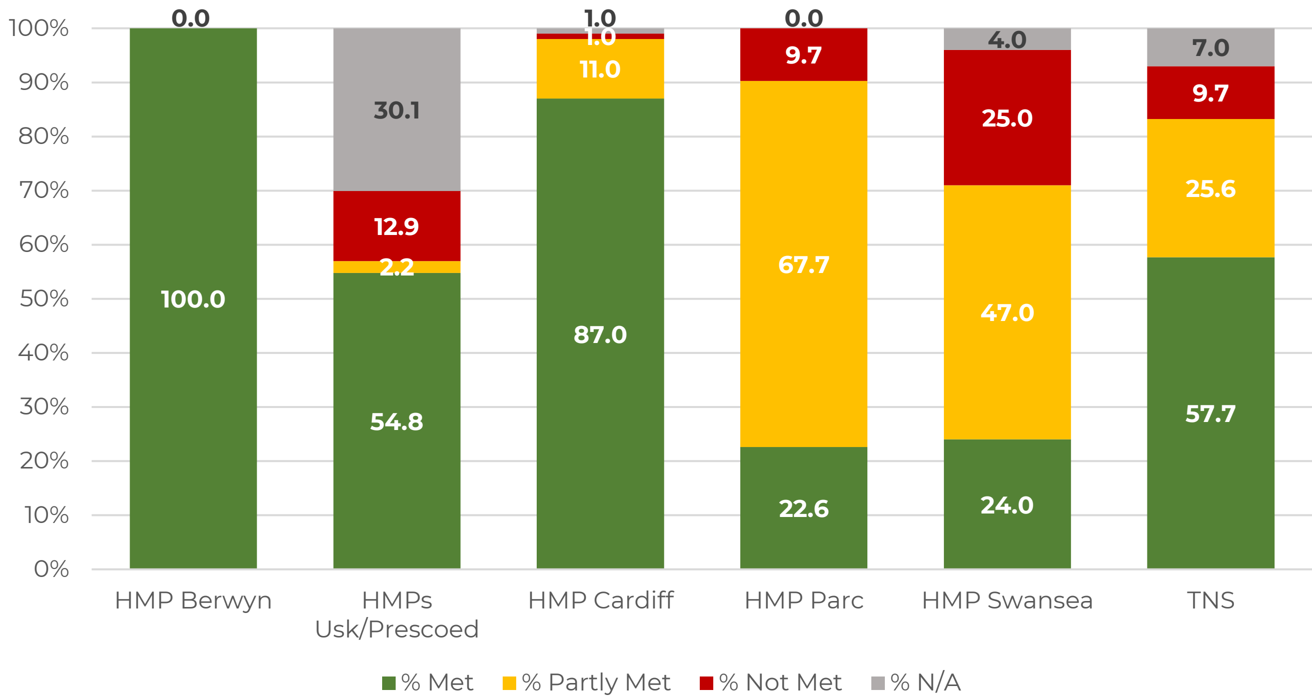


Figure 4. *Percentage of met Substance Misuse criteria against Total National Sample (TNS)*

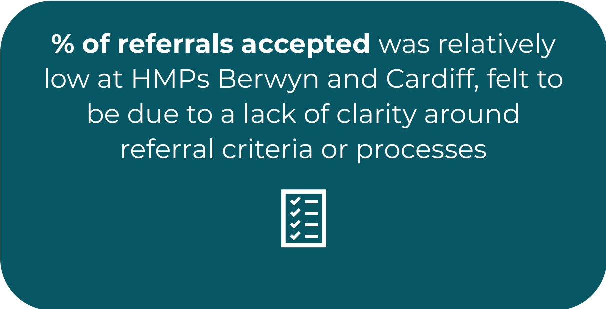
CONTEXTUAL DATA

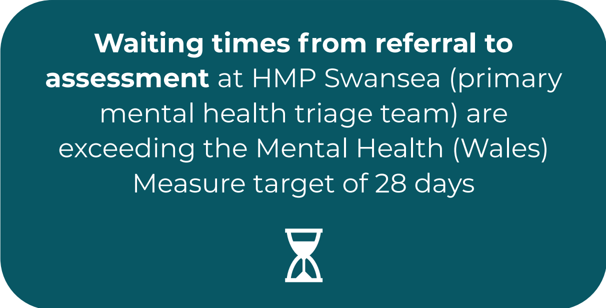
This section provides an overview of the contextual information gathered from services reviewed as part of the baseline audit.

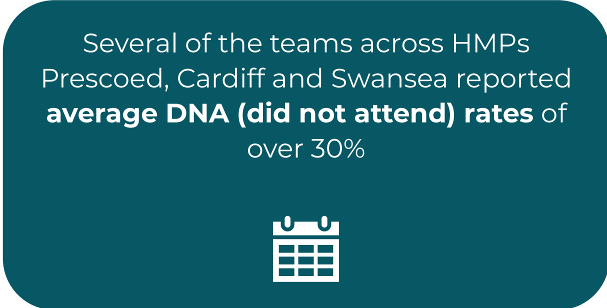
SERVICE INFORMATION

Due to the significant differences between healthcare structures, staffing complements, and prison populations, it is not possible to draw meaningful comparisons between metrics such as caseload sizes and waiting times. As such, this information will be presented as submitted by each respective prison (Figure 5).

Several areas of particular note were identified:







STAFFING

Data were collected on the staffing whole time equivalent (WTE) of each service which can be found in the table in Figure 6. The data for HMPs Usk and Prescoed have been combined due to one team working across both prisons.

	HMP Berwyn	HMP Usk	HMP Prescoed	HMP Cardiff	HMP Parc	HMP Swansea
Prison type	Category C Rehabilitation and resettlement	Category C Treatment and resettlement	Category D Open/ resettlement	Category B Remand	Category B Adult, YOI, and vulnerable prisoners	Category B Remand
Population size	2,106	274	206	671	1,800	446
Team description	Primary care (MH); secondary care (MH); groups	Combined with HMP Prescoed	Combined with HMP Usk	Primary care (MH); secondary care (MH); psychiatry; ADHD	Secondary care MH in-reach team; primary care (MH)	Primary care crisis team; EMDR/CBT; counselling; secondary MH care (in-reach team); veterans
Exclusion criteria	No diagnostic service for ADHD	None	None	Primary diagnosis of LD or substance misuse; ASD without underlying mental illness	Men under the age of 17 years and 10 months	In-reach team will only work with men under Part 2 of the Mental Health Measure Wales
Referrals accepted (%) *Average over past 6 months*	TAG referrals – 91% Community triage following self-referral – 40.5% Substance misuse – 100%	100%	100%	72%	Not provided	Primary MH triage – 95-100% Crisis team – 90% EMDR/CBT/ counselling – 100%
Team caseload *Average over past 6 months*	Primary care (MH) – 27.7 Secondary care (MH) – 55 Substance misuse - 35	47	33	Primary care (MH) – 26 Secondary care (MH) – 28 Psychiatry - 46	In-reach team - 75	Primary MH triage – 5 Crisis team – 43.2 Counselling – 4 Veterans – 21 EMDR/CBT - 3
Waiting times: referral to assessment (days) *Average over past 6 months*	Routine assessments – 14 Urgent part assessments – 7 Substance misuse - 1	15	14	28	21	Primary MH triage – 32 Crisis team – same day
Did not attend (DNA) rates (%) *Average over past 6 months*	Mental health – 5.95 Psychiatry – 14.3	6.6	47	Anxiety management group – 36 Psychiatry clinic - 26	10	Primary MH triage – 32 Crisis team - 2

Figure 5. *Contextual data collected from each prison team*

Staffing	HMP Berwyn	HMP Usk/Prescoed	HMP Cardiff	HMP Parc	HMP Swansea
Nursing	17	0.4	4	29 across all of healthcare (3 within in-reach team)	5 (crisis team)
Psychiatry	1.8 consultant 0.2 forensic psychiatrist	0	0.5	0.8 across adult, old age and CAMHS (0.2 within in-reach team)	0.1 (in-reach caseload only)
Psychology	1.6	0	0	0	1 (in-reach caseload only)
Occupational Therapy	0	0	2 (1 working as a primary mental health practitioner)	0	1 (in-reach caseload only)
Social Work	0	0	0	0	1 (crisis team)
Support Workers	10	0	0.8	11 across all of healthcare	6
Admin	2	0	1	5 (1 within in-reach team)	26 hours per week
Substance Misuse	7 nursing 2 admin 8 caseload holders 6 programme facilitators	0	1 practitioner	0	1 band 6 nurse – all other support incorporated into core nursing and medical workload
Other	1 psychosocial co-occurring practitioner	0.4 criminal justice liaison service practitioner	1 counsellor	0	0

Figure 6. *Staffing data collected from each prison team*

Substance misuse (SM) provision

Of the five services reviewed, only **HMP Berwyn had a full clinical team** dedicated to supporting prisoners with their substance misuse and addiction.

HMPs Cardiff and Swansea have single practitioners managing SM needs, but caseloads for both were notably high and staff members were often contending with competing demands on their clinical time.

There is **no dedicated clinical SM team within HMPs Parc, Usk or Prescoed**.

Dyfodol, the national psychosocial intervention service for offenders with alcohol or substance misuse, was established across all prisons visited. The initiative was widely praised by healthcare staff, prisoners and representatives from the wider prison establishment, however, it was recognised that Dyfodol should not take the place of active clinical intervention where this was needed.

Joined-up care

By having team members dedicated to substance misuse support, services can offer a more holistic approach to supporting patients with co-morbid diagnoses that addresses the full range of their needs

Staff support

SM practitioners frequently reported having high caseloads and limited (or no) access to appropriate clinical supervision, both of which have potential to lead to increased burnout

Distinction of team roles

Pressures in the wider healthcare team due to vacancies, sickness and acuity meant that single practitioners were often drawn into other clinical duties leading to de-skilling

Communication

Communication between SM/MH and Dyfodol could be improved. In some instances, messages about shared patients were sent via kiosk without context or joint input leading to mis-communication and blurring of roles

Good practice example:
The service has a strong emphasis on what works best for the individual. There is a broad therapeutic offer for patients seeing the substance misuse team and the team works closely with other agencies to meet need. – ***HMP Berwyn***

Commonly unmet standards: Substance misuse

Standard 10 [1]: Drug testing is undertaken as part of initial assessment using the Health Board approved point of care testing kit.

- ⇒ **Fully met by two teams (40%)**
- ⇒ **Partly met by two teams (40%)**
- ⇒ **Not met by one team (20%)**

Standard 13 [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 five 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.

- ⇒ **Fully met by one team (20%)**
- ⇒ **Partly met by three teams (60%)**
- ⇒ **Not applicable for one team (20%)**

Standard 58 [1]: 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.

- ⇒ **Fully met by two teams (40%)**
- ⇒ **Partly met by one team (20%)**
- ⇒ **Not met by two teams (40%)**

KEY THEMES ARISING

Multi-disciplinary (MDT) input

All prison services reviewed followed a **predominantly nurse-led model**. Access to additional disciplines was identified as a challenge for the majority of teams, with only two of the five having access to psychology or occupational therapy.

Staff members spoke of psychiatry input also being limited and, in some cases, recently reduced, leading to **delays in medication reviews**.

The team covering HMPs Usk and Prescoed comprises just two 0.4 WTE practitioners (one a nurse by background; one an occupational therapist). This lean structure means that staff have to **seek multi-disciplinary input from an external criminal justice liaison service** to ensure assessments and care plans address their patients' needs.

Further information about team complements can be found in **Figure 6**.

Therapeutic offer

Single-discipline approaches can result in a narrow focus of care and failure to address underlying issues such as trauma and social reintegration

Risk of harm

A lack of diverse expertise can mean risk assessments are incomplete and early warning signs may be missed. Delays in medication reviews can also lead to increased acuity and challenges in managing more unwell patients

Operational strain

Without integrated expertise, crisis management becomes reactive, consuming resources and disrupting prison regimes

Continuity of care

Without collaboration between disciplines, care can become siloed and fragmented which may have implications for continuity, especially regarding transition planning

Good practice example:
The team has prioritised improving integration of the service into wider Health Board structures, for example, by having a slot on the local forensic team's weekly meeting agenda, allowing for full MDT input into complex care and transition planning. ***– HMPs Usk and Prescoed***

Commonly unmet standards: MDT input

Standard 55 [1]: Service users are provided with responsive, appropriate and seamless interventions and care that reflects their physical, social, psychological needs and preferences.

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.

The assessment must consider and record the most appropriate or preferred treatment and care, irrespective of whether that treatment is available.

II. Following Comprehensive Assessment, a Care Plan is agreed between the treatment provider and the service user

III. Mechanisms must be in place for the systematic review of care plans (minimum 3 monthly) with the service user.

IV. Revised care plans, findings and outcomes should be agreed between the treatment provider and the service user.

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:

- 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

⇒ **Fully met by two teams (40%)**
⇒ **Partly met by one team (20%)**
⇒ **Not met by two teams (40%)**

Standard 154 [1]: 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.

Guidance: This should include specialists who can undertake assessments and provide treatment/therapy relevant to the needs of the patient group.

⇒ **Fully met by one team (20%)**
⇒ **Partly met by four teams (80%)**

KEY THEMES ARISING

Neurodiversity

All prisons now have a **Neurodiversity (ND) Support Manager** responsible for implementing a whole-prison approach to neurodivergence across education, skills, and work. Their role includes improving processes for identifying neurodivergent individuals, training and upskilling staff, and identifying reasonable adjustments to enable full participation in the prison regime and sources of support.

However, the healthcare services are **not commissioned to carry out formal ADHD, ASD, or learning disability assessments or diagnose**. While some can prescribe medication for ADHD, access to specialist pharmacists varies, and there is a notable lack of specialist interventions within the prison setting.

For example, in Cardiff, the service has **exclusion criteria** where individuals with a primary diagnosis of learning disability or autism (without an underlying mental illness) are not eligible for support from the mental health team. This highlights gaps in specialist care for neurodivergent prisoners.

Equity of access

A lack of formal specialist pathways means neurodivergent prisoners are systematically disadvantaged compared to those with other mental health conditions

Continuity of care

Prisoners with existing diagnoses are often unable to continue their treatment plan within the prison system, leading to unmet needs and worsening symptoms

Rehabilitative outcomes

Improved collaboration between ND Support Managers and mental health around reasonable adjustments and tailored interventions would support participation in education, skills, and work programmes

Staff training

Mental health staff expressed a wish for more training in recognising and supporting autistic patients and those with a learning disability or ADHD

Good practice example:
The crisis team has a pot of money available to them to support training and development, e.g. Masters' courses. Their manager was described as "supportive" in upskilling them in areas of interest such as autism and ADHD. ***– HMP Swansea***

Commonly unmet standards: neurodiversity

Standard 21 [1]: All information is provided to patients in a format they can easily understand.

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.

- ⇒ **Fully met by two teams (40%)**
- ⇒ **Partly met by two teams (40%)**
- ⇒ **Not met by one team (20%)**

Standard 149 [2]: 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.

Consideration will be made for neurodivergent people who may have sensory needs. For instance, lighting (window light where possible); quiet (reduced distraction).

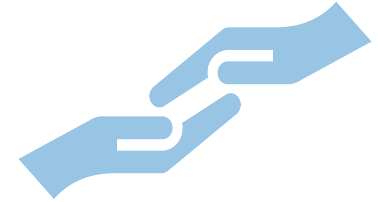
- ⇒ **Fully met by two teams (40%)**
- ⇒ **Partly met by three teams (60%)**

Standard 173 [1]: Staff are trained and fully informed about the assessment and management of mental health presentations in people with learning difficulties and neurodiversity.

Guidance: For neurodiversity this should include sensory issues, and reasonable adjustments.

- ⇒ **Fully met by one team (20%)**
- ⇒ **Partly met by four teams (80%)**

KEY THEMES ARISING



Collaborative partnerships

Partner agency representatives from the wider prison were spoken to as part of each review day. The majority were complimentary of their respective mental health and substance misuse teams but acknowledged that **capacity was limited**.

Representatives expressed a need for **more formalised training** on common mental health problems, how to identify early warning signs, and how/when to refer to the team. Some fed back that **referral processes were not clear**, and that they relied on informal relationships with mental health colleagues to pass on information on an ad hoc basis.

Mental health awareness

Partner agency representatives lack confidence in recognising symptoms of mental ill health and how to manage associated risks, particularly where already identified by the MH team

Clarity of processes

Clear, consistent referral processes help partner agencies to understand pathways and reduce inappropriate referrals

Delineation of roles

Having identified points of contact and clear roles within the mental health team provides clarity for colleagues in the wider prison around who is best placed to respond to queries or requests

Support techniques

Training prison staff in basic support techniques can help to create a sense of safety and containment for prisoners who begin to feel mentally unwell while on the wings

Good practice examples:

Partner agencies highlighted the new duty worker role, which appears to be working effectively. The allocated person will attend any ACCTs scheduled for the day and act as main point of contact via radio for prison officers, responding to queries and requests for advice. ***– HMP Cardiff***

The Partnership Board has recently been reinstated, bringing together managers from each team and block within the prison. This was previously used to discuss day-to-day challenges but is now being utilised as an opportunity for the team to raise any longer-term needs and concerns via an effective channel. ***– HMP Parc***

Commonly unmet standards: collaborative partnerships

Standard 30 [1]: There is a clear and consistent process for staff within the prison to refer individuals directly to the mental health team.

- ⇒ **Fully met by two teams (40%)**
- ⇒ **Partly met by one team (20%)**
- ⇒ **Not met by two teams (40%)**

Standard 110 [2]: The team supports the establishment in the provision of mental health awareness training for prison staff in accordance with NICE guidelines 66 (2017).

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.

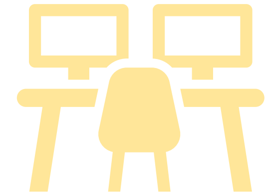
- ⇒ **Fully met by one team (20%)**
- ⇒ **Partly met by one team (20%)**
- ⇒ **Not met by three teams (60%)**

Standard 111 [2]: 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.

Guidance: Where integrated healthcare models are in place, the policy will detail effective multi-professional working and collaboration.

- ⇒ **Fully met by two teams (40%)**
- ⇒ **Partly met by two teams (40%)**
- ⇒ **Not met by one team (20%)**

KEY THEMES ARISING



Environment and facilities

Staff spoken to as part of the review process frequently commented on **challenges accessing IT resources and rooms for clinical consultations**. While all teams had designated office space, usually as part of the wider healthcare area, many operated a first-come, first-served policy when it came to securing desk space or confidential rooms.

Team members described often having to visit patients in their cells or listeners' suites on the wings, often **without adequate measures in place to ensure their safety** such as radios or sufficient numbers of keys.

The bigger prison services also outlined challenges due to the scale of the site, such as being able to **communicate effectively with colleagues** in other blocks and ensuring **timely access to notes systems**.

Clinical availability

Hot-desking and the geographical spread of large sites mean staff spend time searching for space or travelling between blocks, reducing time available for clinical work

Communication

Difficulty accessing IT systems and notes delays information sharing, impacting continuity of care and risk management. This can result in missed alerts, duplication of work, and inconsistent treatment plans

Patient confidentiality

Lack of private consultation rooms can reduce therapeutic engagement and deter patients from disclosing sensitive information or feeling able to speak freely

Staff safety

An absence of safety measures for staff visiting patients outside of the healthcare wing can lead to an increase in incidents, burnout, and low morale

Commonly unmet standards: environment and facilities

Standard 147 [2]: There are designated rooms for the team to run clinics and one-to-one sessions.

⇒ **Fully met by two teams (40%)**
⇒ **Partly met by three teams (60%)**

Standard 149 [2]: 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.

Consideration will be made for neurodivergent people who may have sensory needs. For instance, lighting (window light where possible); quiet (reduced distraction).

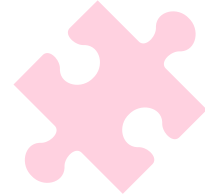
⇒ **Fully met by two teams (40%)**
⇒ **Partly met by three teams (60%)**

Standard 152 [2]: 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 video calls.

Guidance: This will need to be supported by wider developments regarding data sharing and IT systems.

⇒ **Fully met by two teams (40%)**
⇒ **Partly met by three teams (60%)**

COMMONLY UNMET STANDARDS: Additional areas



Older adults provision

None of the services reviewed had an adapted assessment process in place as standard, including consideration of **early cognitive impairment** or **related social care needs**, for individuals over the age of 50.

Rising prevalence of co-morbidities within older adults was noted as a challenge, particularly in prisons with increasingly ageing populations such as HMPs Usk and Prescoed.

Staff support and supervision

No services were able to facilitate **monthly clinical supervision** for all mental health or substance misuse staff. Access to line management supervision, designed for discussion around development and performance, was more variable.

Several teams spoke of supervisors being **inexperienced or lacking specialist knowledge** in mental health or substance misuse, for example, if sitting within the wider healthcare team.

Cultural awareness

Initiatives such as Diverse Cymru's Cultural Competency Workplace Good Practice Certification Scheme aim to raise awareness about the **inequalities faced by Black, Asian and Minority Ethnic communities** in day-to-day life.

Currently, none of the prison teams is engaged in this programme or similar, and staff **lack confidence and expertise** in delivering culturally-sensitive care.

Trauma-informed practice

Although services generally reported conducting assessments in a manner that was sensitive to potential exposure to trauma, only one team said they had been **trained in trauma-informed approaches.**

Furthermore, there appeared to be a correlation between teams' access to **psychology input** and confidence in recognising and supporting people with a history of trauma.

COMMONLY MET STANDARDS:
Areas of good practice

Patient experience

The majority of patients interviewed **spoke positively of their experience** when accessing the mental health or substance misuse teams. Many described feeling listened to and felt their **individual needs were taken into consideration** during the care planning process.

When asked what could be improved, the most common response was simply that they would like increased funding and resource so that more people could access support when needed.

Inter-agency working

Partner agency representatives from all six prisons found the work of the MH and SM teams to be invaluable, and **appreciated opportunities to work together**, such as Safer Custody and Single Point of Access Meetings.

Mental health staff are committed to **attending Assessment, Care in Custody, and Teamwork (ACCT) meetings** to provide crucial input into identifying and managing safety concerns.

Preparing for discharge

Standards around discharge planning and transfer of care were consistently met by the majority of teams. There was good evidence of involvement with and handover to the receiving prison or service, supporting **continuity of care** and enabling **appropriate follow-up arrangements**.

Plans included consideration of **ongoing medication and housing arrangements** for individuals of no fixed abode.

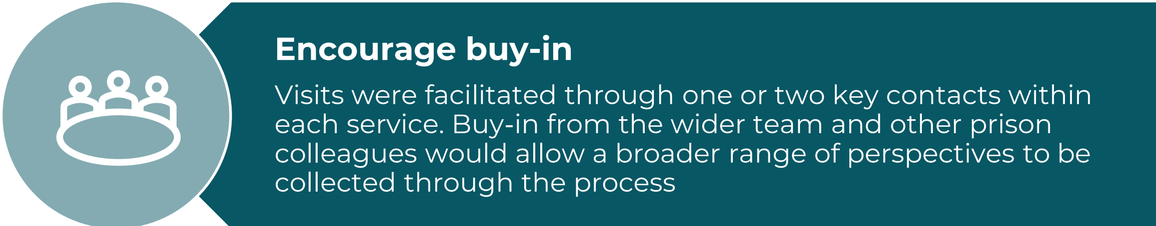
Follow-up for DNAs

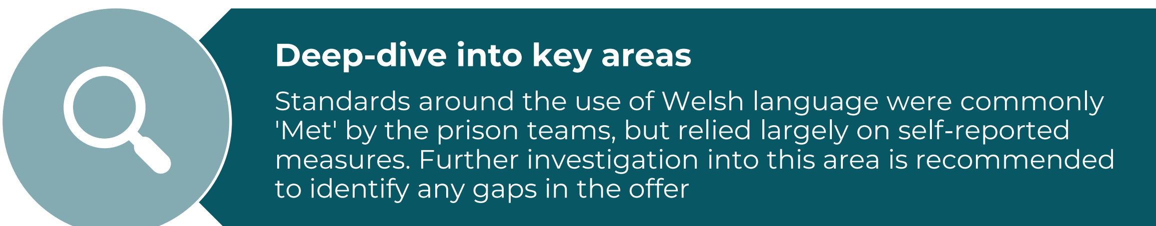
All teams were able to outline their **proactive approach to following up patients** who did not attend (DNA) an appointment, taking into account the individual's history and any risk factors identified.

Some staff described how they would work closely with officers on the wing to **develop a joined-up approach** to improving or sustaining engagement.

RECOMMENDTIONS FOR FUTURE AUDITS

This report represents a snapshot in time as to how the mental health and substance misuse teams in Welsh prisons are both operating and performing. Further audits are encouraged to assess the effectiveness of any changes made as a result of the recommendations provided.





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