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Substance Misuse Treatment Framework

**Clinical Pathway for the
Management of Substance
Misuse in Prisons in Wales**

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“Substance misuse services and measures to address infectious diseases in prisons should be equivalent to the services provided outside prisons. This can best be achieved through close cooperation and communication between prison and community services.”¹

1 Background

In line with a ‘whole prison approach’ in prisons in Wales and England,² this substance misuse treatment framework provides guidance for the clinical treatment for substance misuse across all areas of prison, including prison health care services. A “whole prison approach to health and wellbeing is one where a focus on health, care, wellbeing and recovery is exemplified through the environment, regime and provision of services, and where these aspects of prison life actively support people to maintain and improve their health and prepare for their release. A whole prison approach begins with identifying and acting on people’s health and care needs upon entry into prison, including needs that may have gone unrecognised and/or been underserved.”³

Substance misuse and dependence, the use of drugs and alcohol resulting in harms to the individual and others, is prevalent both in the community and within the offender/prison estate across the UK. The use and misuse of drugs includes both licit drugs including prescription and over-the-counter medications, and illicit drugs including anabolic steroids and image and performance enhancing drugs, and (novel/new) psychoactive substances controlled by the Section 9, Psychoactive Substances Act 2016 as an offence of possession within a custodial institution.

Problem drug use estimates⁴ in Wales, including populations not in contact with any services, suggest the rate of problematic drug users in 2018-19 was 2.7% of the population aged 15-64 (95% probability interval 2.0 – 3.9 per 1000 population) equating to an estimated 53,000 individuals. Comparable rates of problematic alcohol use amongst the general population are not available for Wales, however, evidence from England⁵ suggested a rate of 1.4% alcohol dependent adults in the general

¹ WHO (EUROPE) Health in Prisons Project and the Pompidou Group of the Council of Europe. 2001. PRISONS, DRUGS AND SOCIETY. A consensus Statement on Principles, Policies and Practices. Available at: https://www.euro.who.int/__data/assets/pdf_file/0003/99012/E81559.pdf

² HM Prison Service. (2003). Prison Service Order (PSO) 3200 on health promotion. Available at: <https://www.gov.uk/guidance/prison-service-orders-psos>

³ UK Parliament, House of Commons Prison Health Committee. 2018. Breaking the cycle of disadvantage: a whole system approach. Available at: <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/963/96308.htm>

⁴ For the purposes of estimating, Public Health Wales utilise an adapted EMCDDA definition of problematic drug use, and in this context problematic drug use is defined as “injecting drug use or long-duration/regular use of opioids, cocaine (including crack cocaine), amphetamines and/or amphetamine-type stimulants”

⁵ Pryce R, Penny Buykx P, Gray L, Stone T, Drummond C, and Brennan A. 2017. Estimates of Alcohol Dependence in England based on APMS 2014, including Estimates of Children Living in a Household with an Adult with Alcohol Dependence: Prevalence, Trends, and Amenability to Treatment. Available at: https://www.sheffield.ac.uk/polopoly_fs/1.6935461/file/Estimates_of_Alcohol_Dependence_in_England_based_on_APMS_2014.pdf

population for the period 2014-15, and according to the National Survey for Wales, 18% of adults are hazardous or harmful drinkers.⁶

Drug markets in terms of availability, acceptability and potency, as well as the advent of new psychoactive substances including medicines new to misuse, particularly over the last decade, have resulted in dramatic changes and distinct challenges in terms of managing harms and adapting services. The changing profile of problematic substance use in the community is reflected within the prison populations, requiring an adaptive model of care over time. The harms associated with substance misuse include those impacting on physical health including acute toxicity, infection and premature deaths from poisoning, suicides, accidents or violence and assault and psychological harms, both acute and chronic, particularly amongst those with multiple and complex needs including mental health disorders.

Health and social inequalities exist in relation to prisoner populations, with higher rates of substance misuse and homelessness prior to incarceration; an estimated 25% of the UK prison population with difficulties in communicating and/or processing or learning new or complex information resulting in potentially increased vulnerability within the prison environment as well as on release; a higher prevalence and severity of mental health problems; a 50% higher mortality rate than the general population⁷ and a risk of suicide 3.7 times higher than the general population amongst incarcerated males.⁸

It is in this context that the Welsh Government, Her Majesty's Prison and Probation Service (HMPPS), Public Health Wales, Health Boards and Prison Health Leads developed a partnership agreement in 2019.⁹ The partnership agreement aims to drive improvements in the health and well-being of those held in Welsh prisons, recognising the unique statutory obligations of key partners, specifically HMPPS, Health Boards and Public Health Wales, and building on the shared objective of ensuring those in prison can live in environments that promote health and well-being and where health services can be accessed to an equivalent standard of those within the community. To achieve this all parties have agreed to work toward the objectives of the Welsh Governments [Well-being of Future Generations \(Wales\) Act 2015](#) and ['Prosperity for All: The National Strategy for Wales'](#) ensuring that prisons and health services in prisons:

1. Deliver quality health and care services fit for the future
2. Promote good health and well-being for everyone
3. Build healthier communities and better environments

⁶ Welsh Government. 2019. Statistical Bulletin SB41/2019. National Survey for Wales 2016-17 to 2018-19: Alcohol consumption prior to introduction of minimum price. Available at: <https://gov.wales/sites/default/files/statistics-and-research/2019-10/alcohol-consumption-national-survey-wales-april-2016-march-2019-646.pdf>

⁷ Revolving Doors Agency. 2017. Rebalancing Act: A briefing for Directors of Public Health, Police and Crime Commissioners, the police service and other health and justice commissioners, service providers and users. Available at: https://www.basw.co.uk/system/files/resources/basw_91153-9_0.pdf

⁸ Office for National Statistics. 2019. Drug-related deaths and suicide in prison custody in England and Wales: 2008 to 2016. Available at: [Drug-related deaths and suicide in prison custody in England and Wales - Office for National Statistics](#)

⁹ Welsh Government. Partnership agreement for prison health in Wales. 2019. Available at: <https://gov.wales/partnership-agreement-prison-health-wales>

The Partnership Agreement for Prison Health sets out four key priorities including the development of this Substance Misuse Treatment Framework (SMTF), as well as new standards for mental health services in prisons, and medicines management in prisons in Wales. Where appropriate, the standards for mental health services and medicines management are cross-referenced as part of this SMTF. The fourth priority, that of ensuring the prison environments in Wales promote health and wellbeing for all will provide additional prevention and wellbeing oversight and interventions to improve population health within the prison setting, including ensuring the environment is conducive to the delivery of this SMTF.

1.1 Purpose and structure

This document is designed to inform and assist health, social care and criminal justice planners and providers to design and deliver high quality, sustainable and equitable prevention and treatment services for those at risk of, or experiencing substance misuse issues in prison. This guidance document forms part of the suite of harm reduction and Substance Misuse Treatment Framework (SMTF) guidance for those working in Wales available at: <https://gov.wales/drug-misuse-dependency>

In Chapter 2, the clinical treatment pathway, from initiation and assessment to follow-on care and support following release from prison is outlined separately for both alcohol and drugs, including a section on co-occurring drug and alcohol dependence and mental health. As an individual may have both problematic drug and alcohol use, the assessment process and pathway is designed to be flexible and inclusive though to follow-on support and relapse prevention. Chapter 3 briefly outlines the guidance for resettlement. Chapter 4 provides a focus on the required workforce developments including realignment and training. In order to move to an equitable and seamless substance misuse service, substantial changes are required in relation to technological innovation, information governance and data flows covering both community and criminal justice settings. Chapter 5 outlines the requirements to access information systems to facilitate the delivery of an 'excellent, safe and equivalent service to that in the community'¹⁰ in relation to substance misuse and related health and social care requirements.

In Wales there are currently six male-only prisons. Wales has no prisons for Category A offenders or women's prison. Welsh female offenders must serve their sentence in English Prisons, predominantly in Eastwood Park, Gloucester. Male category A offenders and others will also be required to serve their sentences in prisons in England, returning to Wales on release, or potentially prior to release for male non-category A offenders. As such, this SMTF also gives consideration to addressing the

¹⁰ World Health Organisation. Health in Prisons. Available at: [Prisons-and-Health,-14-Drug-treatment-and-harm-reduction-in-prisons.pdf](#)

needs of men and women being resettled in to their communities¹¹ in Wales post-release, in line with the priorities set out in the Female Offending Blueprint for Wales.

1.2 Legislative context

The NHS (Wales) Act 2006 imposed a duty of co-operation on the NHS and the Prison Service with a view to improving the way in which their respective functions were exercised. The responsibility for health services in the public sector prisons in Wales was transferred from the Home Office to the Welsh Assembly Government in April 2003. In April 2006 this responsibility was devolved to the relevant Local Health Boards (LHBs). The relevant Health Boards are now:

- Aneurin Bevan Health Board - HM Prisons Usk & Prescoed, Monmouthshire
- Cardiff & Vale University Health Board - HM Prison Cardiff
- Swansea Bay University Health Board - HM Prison Swansea

In effect, under Directions, the LHBs became the 'responsible commissioner' for the prisoners in their locality, the only exception being prisoners transferred from prison to hospital under the Mental Health Act 2010. The commissioning responsibility in these cases remains with the prisoners' area of residence prior to imprisonment.

The exception to this arrangement is HM Prison Berwyn. HMP Berwyn was opened in 2017, with capacity for around 2000 category C prisoners from Wales and England, funded by the Ministry of Justice with a Memorandum of Understanding between HMPPS and Betsi Cadwaladr University Health Board for the prison of health care.

There is also one private sector prison in Wales - HMP/YOI Parc in Bridgend. The commissioning responsibility for primary healthcare in this prison rests with the National Offender Management Service (NOMS) and is delivered via their contract with the main operator of the prison. The responsibility for meeting the secondary and tertiary care health needs of prisoners, whether held in the public or the private sector prison estate, rests with the relevant health board.

The Equality Act 2010 puts a responsibility on public authorities to have due regard to the need to eliminate discrimination and promote equality of opportunity. This applies to the process of identification of need and risk faced by the individual and the process of assessment. No individual or group of individuals must be treated any less favourably than others in being able to access effective services which meet their particular needs

The Well-being of Future Generations (Wales) Act 2015¹² was enacted to improve the social, economic, environmental and cultural well-being of Wales. The Act

¹¹ Welsh Government and Ministry of Justice. 2019. Female Offending Blueprint for Wales. Available at: <https://gov.wales/supporting-female-offenders>

¹² Welsh Government, Well-being of Future Generations (Wales) Act 2015: The Essentials. Available at: <https://gov.wales/sites/default/files/publications/2019-08/well-being-of-future-generations-wales-act-2015-the-essentials.pdf>

establishes a statutory Future Generations Commissioner for Wales and Public Services Boards (PSBs) for each local authority area in Wales. Each PSB must improve the economic, social, environmental and cultural well-being of its area, including Prisons, by working to achieve the well-being goals. The well-being goals that have direct relevance to this document are:

A prosperous Wales - 'A society which develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities, allowing people to take advantage of the wealth generated through securing decent work'

A healthier Wales – 'A society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood'

A more equal Wales – 'A society that enables people to fulfil their potential no matter what their background or circumstances (including their socio economic background and circumstances)'

A Wales of cohesive communities – 'Attractive, viable, safe and well-connected communities'

The Social Services and Well-being (Wales) Act 2014¹³, imposes duties on local authorities, health boards and Ministers requiring them to work to promote the well-being of those who need care and support, or carers who need support. The term 'well-being' includes safeguarding, specifically the prevention of and protection from abuse, harm and neglect, but it also applies to the physical, mental and emotional well-being of an individual. The Act also sets out the responsibilities for social care within prisons. Under the Social Services and Well-being (Wales) Act 2014, local authorities have a legal obligation to assess the need for, and provide social care to, people whose needs make them eligible. This obligation applies to those in prisons and prisoners are entitled to have access to care provision that is the equivalent of someone in the community.

The Welsh Language Act (1993)¹⁴: Her Majesty's Prison and Probation Service's (HMPPS) Welsh Language Scheme and the Ministry of Justice's (MoJ) Welsh Language Scheme (1993) aim to ensure compliance with the principles of the Welsh Language Act (1993) by enabling everyone who receives a service or services from HMPPS in Wales to do so through the medium of Welsh or English according to their personal choice.¹⁵¹⁶

¹³ Welsh Government. Social Services and Well-being (Wales) ACT 2014: Available at: <http://www.legislation.gov.uk/anaw/2014/4/part/1/crossheading/overview/enacted>

¹⁴ The Welsh Language Act (1993): Available at: [Welsh Language Act 1993 \(legislation.gov.uk\)](http://www.legislation.gov.uk/ukpga/1993/58)

¹⁵ Her Majesty's Prison and Probation Service Welsh Language Scheme 2020 – 2023. Available at: <https://www.gov.uk/government/publications/hmpps-welsh-language-scheme-2020-to-2023>

¹⁶ Ministry of Justice Welsh Language Scheme. Available at: <https://www.gov.uk/government/publications/moj-welsh-language-scheme-2018>

HMPPS's scheme also details how it will promote the use of the Welsh language in Wales as required by the Act but also how it will do so in England. The MoJ scheme sets out that where services are to be delivered in Wales, it is mandatory for those services to be provided in Welsh and English as required.

The **Welsh Language (Wales) Measure (2011)**:¹⁷ All health boards in Wales must operate in accordance with the Welsh Language Standards under the Measure (2011). The duties which come from the Standards mean that health boards should not treat the Welsh language less favourably than the English language, and should promote and facilitate the use of the Welsh language. Health boards in Wales should enable everyone who receives or uses their services to do so through the medium of Welsh or English, according to personal choice. Alongside legislation to support the health and well-being of men in prison, there are three main statutes regulating the availability of drugs in the UK: **The Misuse of Drugs Act (1971)**,¹⁸ **The Medicines Act (1968)**¹⁹ and **The Psychoactive Substances Act (2016)**.²⁰

1.3 Strategic context

A Healthier Wales²¹ sets out an equitable 'whole system' approach to health and social care, within the context of prudent health care principles.²² The plan sets out a seamless system to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health to achieve more equal health outcomes for everyone in Wales.

Prison Drugs Strategy 2019 developed by the Ministry of Justice (MoJ) and Her Majesty's Prison and Probation Service (HMPPS) aims to reduce the misuse of drugs in prisons by restricting the supply of drugs through improved security, intelligence building and targeting criminal networks; reducing the demand for drugs in prison by developing more meaningful regimes environmental improvements; and, with health and justice partners, building recovery for prisoners who want to overcome their substance misuse within prison.

Welsh Government Substance Misuse Delivery Plan 2019-22²³ provides the national agenda on tackling and reducing the harms associated with substance misuse in Wales. The delivery plan is underpinned by five key aims:

- Preventing harm

¹⁷ Welsh Government, Welsh Language (Wales) Measure (2011). Available at: [Welsh Language \(Wales\) Measure 2011 \(legislation.gov.uk\)](http://www.legislation.gov.uk/welsh/2011/1/1)

¹⁸ Misuse of Drugs Act 1971. Available at: <http://www.legislation.gov.uk/ukpga/1971/38/contents>

¹⁹ Medicines Act 1968. Available at: <http://www.legislation.gov.uk/ukpga/1968/67>

²⁰ Psychoactive Substances Act 2016. Available at: <http://www.legislation.gov.uk/ukpga/2016/2/contents/enacted>

²¹ Welsh Government. 2019. A Healthier Wales: our Plan for Health and Social Care. Available at: [a-healthier-wales-action-plan.pdf](https://gov.wales/sites/default/files/publications/2019-04/securing-health-and-well-being-for-future-generations.pdf)

²² Prudent Healthcare, Securing Health and Well-being for Future Generations. Available at:

<https://gov.wales/sites/default/files/publications/2019-04/securing-health-and-well-being-for-future-generations.pdf>

²³ Welsh Government. 2019. Substance Misuse Delivery Plan 2019-2022. Available at: <https://gov.wales/substance-misuse-delivery-plan-2019-2022-0>

- Support for individuals – to improve their health and aid and maintain recovery
- Supporting and protecting families
- Tackling availability and protecting individuals and communities
- Stronger partnerships, workforce development and Service User Involvement

The delivery plan objectives include “Ensuring that all prisons in Wales (and HMP Eastwood Park women’s prison) have a coordinated, transparent and consistent service for those with substance misuse problems in prison, based on best practice”. To achieve this, the stated objective is to produce a standardised clinical pathway for the management of substance misuse in prisons in Wales, as well as discharge plans to ensure continuity of care, a priority of the Partnership Agreement for Prison Health.

The Welsh Government ‘Together for Mental Health: A Strategy for Mental Health and Wellbeing in Wales’ 2012²⁴ and Delivery Plan 2019-2022²⁵ outlines clear actions for people in prison including development of ‘consistent mental health, mental well-being and learning disability services across all prisons that are tailored to need though an agreed set of standards and indicators for mental health services in prison’, and to develop approaches to improve mental health support to youth and female offenders. There is also a commitment in the Mental Health Delivery Plan 2019-2022 to monitor the impact of the additional (£1 million per year) investment for primary healthcare in public sector prisons in Wales, which will include a focus on mental health and co-occurring substance misuse issues.

1.4 Prevalence of substance misuse and dependence amongst people currently in prison

According to the 2012 House of Commons Home Affairs Committee ‘Drugs: Breaking the Cycle’ findings,²⁶ drug use prior to and within prisons in England and Wales is a major problem with 70% of those engaged with the offender/prison estate reporting drug misuse prior to prison, of which 51% reported drug dependency and 35% injecting drug use. Alongside this, 36% reported heavy drinking with an estimated 16% as alcohol dependant. According to the Annual Prisoner Survey published in 2018/19 annual report²⁷ 28% of male respondents reported a problem with illicit

²⁴ Welsh Government Together for Mental Health A Strategy for Mental Health and Wellbeing in Wales. 2012. Available at: [Together for mental health: our mental health strategy | GOV.WALES](https://gov.wales/sites/default/files/publications/2012-01/together-for-mental-health-strategy.pdf)

²⁵ Welsh Government. 2020. Together for Mental Health Delivery Plan: 2019-22. Available at: <https://gov.wales/sites/default/files/publications/2020-01/together-for-mental-health-delivery-plan-2019-to-2022.pdf>

²⁶ House of Commons Home Affairs Select Committee on Drugs: Breaking the Cycle. 2012. Available at: <https://publications.parliament.uk/pa/cm201213/cmselect/cmhaff/184/18409.htm>

²⁷ Her Majesty’s Chief Inspector of Prisons for England and Wales. 2018/19 annual report. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814689/hmip-annual-report-2018-19.pdf

substances before entering their current prison, and 15% stated that they developed a problem subsequent to prison entry. Of all male respondents, 48% stated it was easy or very easy to obtain illicit substances within prison.

In recent years the issue of drug use in prisons, and initiation of drug use within prisons, has become increasingly challenging, highlighted by the advent and increased prevalence of use of Synthetic Cannabinoid Receptor Agonists (SCRAs). The term 'synthetic cannabinoids' covers all synthetic substances that bind to one of the two known cannabinoid receptors (CB1 or CB2).²⁸ Acute psychoactive effects and adverse physical effects of SCRA consumption include: changes in anxiety and perception, agitation, panic, dysphoria, psychosis and uncharacteristic behaviour. Adverse events necessitating intervention by Poison Control Centres, law enforcement, emergency responders and hospitals are increasing.²⁹ SCRAs are the most prevalent group of substances' identified in samples analysed by the WEDINOS project; found in 25% (n=123) of all prison samples (n=495) in 2019.³⁰

In addition to SCRAs, benzodiazepines are commonly found within prisons. Benzodiazepines are a class of chemicals used in the treatment of anxiety and sleep disorders. Benzodiazepines are agonists at the benzodiazepine site on the GABA-A receptor, resulting in an increase in gamma-aminobutyric acid (GABA). GABA contributes to motor control, vision, and many other cortical functions as well as regulating anxiety. Benzodiazepines may be prescribed for treatment of anxiety, insomnia, alcohol withdrawal, convulsions, and muscle spasm. Almost all therapeutic and adverse effects of benzodiazepines arise from their action on the Central Nervous System. Sixteen Welsh prison samples, analysed by WEDINOS, contained benzodiazepines with four substances identified, Diazepam, Etizolam, Alprazolam and Flualprazolam. A further two samples contained doxepin, a substance that has been commonly identified as a benzodiazepine substitute within the community market.

The Prison Drugs Strategy³¹ evidences this increased prevalence through positive random drug test results for opiates and cannabis with an increase of 50% (from 7% to 10.6%) in the five year period 2012-13 to 2017-18. Data from Public Health England³² highlight a ten percentage point increase in treatment presentations in prison for opiate and cocaine/crack use in two years 2015-16 to 2017-18.

The negative implications of drug initiation and use in prison go beyond that of development of use and dependence for people in prison, and include increased

²⁸ Auwärter, Volker & Dargan, Paul & Wood, David. (2013). Chapter 13. Synthetic Cannabinoid Receptor Agonists. 10.1016/B978-0-12-415816-0.00013-4

²⁹ Spaderna M, Addy PH, D'Souza DC. Spicing things up: synthetic cannabinoids. *Psychopharmacology* 2013; 228(4):525-40. doi: 10.1007/s00213-013-3188-4

³⁰ The WEDINOS project (Welsh Emerging Drugs and Identification of Novel Substances) tests substances to give individual users and others rapid and accurate information on substances, with the aim of harm reduction. WEDINOS website: <https://www.wedinos.org/>

³¹ Home Office. Prison Drugs Strategy. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/792125/prison-drugs-strategy.pdf

³² Public Health England. 2019. Alcohol and drug treatment in secure settings: statistics summary 2017 to 2018. Available at: [substance-misuse-treatment-in-secure-settings-2017-to-2018/alcohol-and-drug-treatment-in-secure-settings-statistics-summary-2017-to-2018](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/792125/prison-drugs-strategy.pdf)

levels of violence, bullying and debt both between individuals in prison and between individuals and prison staff..³³ Use of drugs, particularly of SCRA and unprescribed benzodiazepines, with the prison environment can also impact on mental well-being. As such, a 'whole prison' approach is required in relation to substance misuse, which addresses supply and demand as well as treatment.

1.5 Methodology

To oversee the development of the SMTF for Prison, the Prison Health Partnership Task and Finish Group (TFG) was established in July 2019.

The evidence within this document is drawn from a range of sources including bibliographic databases, National Institute for Health and Care Excellence, HMPPS, Welsh Government, Department of Health, Department of Justice, Home Office, Royal College of General Practitioners, stakeholder and evidence gathering events and key informant interviews. The databases and website sources included MEDLINE, MEDLINE Daily Update, AMED, BNI and EMBASE.

1.6 Roles and responsibilities

Given the complex nature of the prison estate in Wales, collaborative working between the Welsh Government, Health Boards, Substance Misuse Area Planning Boards, criminal justice, local authorities, primary care contractors and third sector organisations is essential for ensuring delivery and effective implementation of the SMTF for men and women in prisons and on transition to the community. Whilst responsibility with public sector prisons sits with the health board, National Offender Management Service (NOMS) is responsible for delivery of primary care within the private prison and a Health Board/HMPPS collaborative arrangement is required for HMP Berwyn. Multi-disciplinary working groups should ensure an action plan is in place focusing on areas for development within and across services providing a seamless whole prison/whole system approach to health and well-being for this population.

Organisation	Role	Responsibilities
Welsh Government	Oversight and support	Support full integration and implementation of appropriate information systems to facilitate timely information sharing between prison and community-based systems Support Health Boards and HMPPS in planning and the implementation of the

³³ HM Chief Inspector of Prisons for England and Wales Annual Report 2018–19 HC 2469. 2019. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814689/hmip-annual-report-2018-19.pdf

		SMTF and other prison health priority areas.
HMPPS – Prison service	Key worker Clinical care for substance misuse, co-occurring physical and mental health, and screening, diagnosis and treatment for infectious disease (with primary, secondary and public health colleagues)	Key working - undertaken by prison officers or prison custody officers to 'develop constructive, motivational relationships with people in prison' ³⁴ and to contribute to the work of the multidisciplinary/multiagency group to develop and update the integrated care plan. Clinical care – undertaken by the Healthcare services to ensure optimal health provision and continuing of care. Where the Healthcare professionals are employed by HMPPS, the clinical governance remains the responsibility of HMPPS.
HMPPS – Prison and Probation services	Case Management and co-ordination of care across prison and community environments by Prison Offender Managers and Community Offender Manager	Case Management ³⁵ – undertaken by Prison Offender Managers and Community Offender Managers to ensure development, maintenance and updating of the Integrated Care Plan both in the prison environment and in the community. Liaison with key worker, health care and lead on the collaborative and integrated multidisciplinary/multiagency working.
Health Board	Commission, funding, monitoring and evaluation of the implementation and delivery of the STMF and	Commissioning, and where relevant delivery, of specialist treatment and care for substance misuse and co-occurring mental and/or physical health and continuity of care between Prison and community services.

³⁴ Her Majesty's Prison and Probation Service. 2019. HMPPS Offender Management in Custody Model. <https://welcome-hub.hmpps.intranet.org.uk/wp-content/uploads/2021/06/OMiC-Male-Closed-Estate-Operating-Model-blueprint-version-2.pdf>

³⁵ Her Majesty's Prison and Probation Service. 2019. HMPPS Offender Management in Custody Model. <https://welcome-hub.hmpps.intranet.org.uk/wp-content/uploads/2021/06/OMiC-Male-Closed-Estate-Operating-Model-blueprint-version-2.pdf>

	other priority areas.	Where the prison-based Healthcare services are employed by the Health Board, the clinical governance remains the responsibility of the Health Board.
Local Authorities	Social services, social care, education and housing service contribution to provision to support social functioning and integration.	Under the terms of the Care Act 2014, and the Social Services and Well-Being (Wales) Act 2014, local authorities have a legal obligation to assess the need for and provide social care to people whose needs make them eligible to receive it. Care needs can be physical or arise from mental impairment. The obligation placed on local authorities also applies to those in need of social care in prisons, so that prisoners are entitled to have access to the equivalent care provision as someone in the community. ^{36,37}
Third sector providers	Arrest Referral, Courts and Prison Link Case management across custodial and community settings.	Working as part of the integrated multidisciplinary/multiagency team and provide psycho-social and harm minimisation support for individuals with identified substance misuse needs. Contribute to the integrated care planning and continuity of care alongside the Prison Offender Managers (POM) and Community Offender Managers (COM).

1.7 Definitions and key issues

Substance use and dependence - Substance use and dependence, previously referred to as substance misuse, 'refers to the harmful or hazardous use of psychoactive substances, including alcohol, licit and illicit drugs. Psychoactive substance use can lead to dependence syndrome - a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to

³⁶ Her Majesty's Inspectorate of Prisons & the Care Quality Commission. 2018. Social care in prisons in England and Wales. <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/10/Social-care-thematic-2018-web.pdf>

³⁷ Care Act 2014, c. 23. <https://www.legislation.gov.uk/ukpga/2014/23/contents>

drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state'.³⁸

People/person currently in prison (PCIP) - There has been a progressive move away from language that can be stigmatizing or discriminating^{39 40}, and, following the World Health Organisation 2013 style guidance⁴¹, a re-emphasis on the behaviour or experience of an individual (rather than on the behaviour defining the individual themselves) has led to adaption of the language used within the substance use field. Likewise, in the community, those accessing substance use and dependency services are referred to as service users or clients rather than patients. As such, rather than use of the term 'prisoner' and similar terminology, in this document the term 'Person/People currently in prison' or PCIP. This is consistent with previous widespread and generally accepted changes to terminology including Person/People who use drugs (PWUD) and Person/people who inject drugs (PWID).

The principle of equivalence – the provision to individuals in prison of care equivalent to that provided to individuals in the community, including evidence-based and clinically-effective interventions and pathways.⁴² This principle is central to the Partnership Agreement for Prison Health.⁴³

New or novel Psychoactive Substances (NPS) – According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA),⁴⁴ new psychoactive substances 'include both non-controlled and recently controlled new psychoactive substances, in particular (but not exclusively) synthetic cannabinoids, synthetic cathinones, new synthetic opioids and new benzodiazepines'. Within HMPPS and other organisations, these group of substances may now be referred to simply as psychoactive substances (PS).

³⁸ World Health Organisation. 2018. Available at: https://www.who.int/topics/substance_abuse/en/

³⁹ Words matter: a call for humanizing and respectful language to describe people who experience incarceration Tran et al. BMC International Health and Human Rights (2018) 18:41 <https://doi.org/10.1186/s12914-018-0180-4>

⁴⁰ Ellis E. 2014. Prisoner Studies Project: Language. Available at: <http://prisonstudiesproject.org/language/>

⁴¹ World Health Organization. WHO style guide. Geneva: World Health Organization; 2013.

⁴² Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

⁴³ <https://gov.wales/partnership-agreement-prison-health-wales>

⁴⁴ European Monitoring Centre for Drug and Drug Addiction. RAPID COMMUNICATION - New psychoactive substances in prison. Results from an EMCDDA trendspotter study. 2018. Available at: <http://www.emcdda.europa.eu/system/files/publications/8869/nps-in-prison.pdf>

2 Clinical pathway for management of substance misuse

Treatment and care in the prison environment should be in line with the Wales NHS Health and Care Standards.⁴⁵

2.1 Effective assessment and integrated care planning – Drugs and alcohol

“Tackling substance misuse needs commitment from across government and our partners delivering frontline services to ensure we reach and support everyone who is in need so that they get the right level of support, at the right time and in the right place.”

Substance Misuse Delivery Plan 2019-22⁴⁶

As outlined in the Welsh Government National Core Standards for Substance Misuse Services in Wales: ‘*Comprehensive substance use and dependency assessment should be coordinated, comprehensive, timely and collaborative, with the individual fully involved.*’⁴⁷ It should address substance use and behaviour, developmental needs, physical and mental health, risks and safeguarding, family functioning, educational attainment and any difficulties, vulnerabilities, resilience, resources and risks. Where substantial levels of use and dependency exist, there is greater likelihood of compounding other problems such as family breakdown, anti-social behaviour, educational and employment issues and mental health concerns.

Effective assessment adopting a ‘whole person’ approach is required to take in to account all factors influencing and influenced by substance use and dependency. Factors indicating substance-related risk may include previous overdose, deliberate self-harm and attempted suicide; emerging or co-existing mental health conditions including psychosis, post-traumatic stress disorder, personality disorder, autistic spectrum disorder, attention deficit hyperactivity disorder, learning disability; and co-existing physical health problems, both acute and chronic, particularly amongst the ageing cohort of individuals with long-term opioid dependency.

Assessment should include use of all substances including illicit psychoactive drugs and image and performance enhancing drugs (IPEDs), licit drugs including prescribed medications, prescription only medications (POMs) not prescribed to the individual, and over-the-counter medications (OTCs) and alcohol. Effective assessment facilitates short and long-term integrated care planning for the individual and those close to them both in the prison setting and in the community.

⁴⁵ Welsh Government. 2015. Health and Care Standards. Available at: http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf

⁴⁶ Welsh Government. Substance Misuse Delivery Plan 2019-22. Available at: <https://gov.wales/sites/default/files/publications/2019-10/substance-misuse-delivery-plan-2019-22.pdf>

⁴⁷ Welsh Government. 2010. National Core Standards for Substance Misuse Services in Wales. Available at: [:national-core-standards-for-substance-misuse-services-in-wales.pdf](http://national-core-standards-for-substance-misuse-services-in-wales.pdf)

In line with the HMPPS Offender Management in Custody Model⁴⁸, the Prison Offender Manager is responsible for development, review and updating of the Integrated Care Plan (ICP).

Ideally, the substance misuse assessment and care planning process will be undertaken with an identified named lead to ensure development of an effective therapeutic relationship with the individual PCIP from first contact.

- If the PCIP is already registered with a community-based criminal justice service and/or substance misuse service, this service should maintain contact and support through the Prison Offender Manager (POM). The service should continue to provide advocacy and continuity of care by ensuring effective communication and working with the POM, healthcare and other relevant prison services, during custody and through to release into the community.
- If the individual is not known to community-based criminal justice and/or substance misuse services prior to sentence, a POM should be allocated, and an integrated care plan developed with the PCIP and appropriate engagement from all relevant services. This ICP would then follow the individual back into community-based services facilitated by the POM.

Timely assessment incorporating clinical and psychosocial needs and goals should be undertaken once, preventing unnecessary repetition of personal information. This assessment should then be made available via effective information sharing protocols and information systems, to all those and only those involved in care.

2.1.1 Standards in assessment and integrated care planning

In line with the Welsh Government Core Standards for Substance Misuse⁴⁹ and minimum requirements to meet the standard:

Standard 2: A Commissioning strategy, annual delivery and expenditure plans are in place, agreed and published.

Health Board strategic and related annual delivery and expenditure plans should reflect an assessment of need with intended measurable outcomes, incorporating prison health care and transition from and back into the community. Treatment System design should include all tiers of treatment, demonstrating Integrated Care Pathways (ICP) and access points, ensuring:

⁴⁸ HMPPS. 2019. Offender Management in Custody Model. <https://welcome-hub.hmpps.intranet.org.uk/wp-content/uploads/2021/06/OMiC-Male-Closed-Estate-Operating-Model-blueprint-version-2.pdf>

⁴⁹ Welsh Government. Substance Misuse Service and System Improvement: National Core Standards for Substance Misuse Services in Wales. 2010. Available at: <https://gov.wales/sites/default/files/publications/2019-02/national-core-standards-for-substance-misuse-services-in-wales.pdf>

- iv. The needs of diverse groups are taken into account appropriately and demonstrate compliance with relevant legislation.
- v. The needs of vulnerable groups are taken into account appropriately and demonstrate compliance with relevant legislation.

Standard 5: Planning and delivery of treatment ensures timely and equitable access to services

- iii. Full compliance with the reporting requirements of the Welsh National Database for Substance Misuse (WNDSM).
- iv. A service user access policy that has been developed and agreed with service users is published.

Standard 6: Effective information systems and integrated information technology is used to inform and support the planning and delivery of treatment services:

- I. All comprehensive assessments must include as a minimum the domains contained within the Welsh In-depth Integrated Substance Misuse Assessment Tool (WIISMAT).⁵⁰
- II. All assessments must be capable of being shared and utilised between treatment providers.
- III. 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.

Standard 11: 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 WIISMAT⁵¹ assessment tool
- I. 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

⁵⁰ Welsh Government. (2008). Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT) and guidance for use Available at: https://www.researchgate.net/publication/301684587_Wales_Integrated_Indepth_Substance_Misuse_Assessment_Tool_WIISMAT_and_Guidance_for_use

⁵¹ Welsh Government. (2008). Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT) and guidance for use Available at: https://www.researchgate.net/publication/301684587_Wales_Integrated_Indepth_Substance_Misuse_Assessment_Tool_WIISMAT_and_Guidance_for_use

- 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 individuals' 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

For mental health and co-occurring substance misuse and mental health, the Royal College of Psychiatrists (RCP) have developed new universal standards for mental health services (REF) in the prisons in Wales, also a priority in the Partnership Agreement for Prison Health. These new standards are based on the RCP Standards for Prison Mental Health Services⁵² - and provide the following standards for assessment and care planning:

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). Guidance: This includes questions and actions relating to learning disabilities and neurodevelopmental disorders.
2. The mental health screening assessment is carried out by a competent mental health professional with experience of working with people with mental health problems within the criminal justice system.⁵³
3. The role of the team in the first and second reception screening process is clearly defined and in agreement with other health providers and the establishment.
4. There is a clear and consistent process for staff to refer individuals directly to the mental health team
5. A clinical member of staff is available to discuss emergency referrals during working hours.

⁵² Standards for Prison Mental Health Services – Fourth Edition. 2018. Quality Network for Prison Mental Health Services Editors: Megan Georgiou, Dr Huw Stone and Dr Steffan Davies. Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/prison-quality-network-prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2

⁵³ National Institute of Health and Care Excellence. 2017. NICE guideline [NG66]. Mental health of adults in contact with the criminal justice system. Available at: <https://www.nice.org.uk/guidance/ng66>

- 6 Emergency assessments are undertaken by the team within 4 hours, urgent assessments are undertaken by the team within 48 hours and routine assessments within 5 working days. Guidance: The term 'urgent' refers to an individual in a mental health crisis, or with rapidly escalating needs or presentation, and/or at risk of immediate harm to self or others.
- 7 The mental health assessment uses a standardised format, which includes a relevant previous history, an assessment of mental health, intellectual and developmental disabilities, substance misuse, psychosocial factors, risk to self and others. Guidance: Standard mental health assessment tools are used and they are compliant with NICE guidelines.
- 8 The assessing professional can access notes about the patient (past and current) from primary care, secondary care and other relevant services (NICE guideline 66, 2017). 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.
- 9 The team discusses the purpose and outcome of the risk assessment with each PCIP and a management plan is formulated jointly, involving the safer custody teams. This information should be shared appropriately with all those involved with care including prison offender managers (probation officers) to ensure management of risk inside and outside of the prison environment.
- 10 All secondary care patients have a diagnosis and a clinical formulation. Guidance: The formulation includes presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation should be devised.
- 11 When talking to patients, health professionals communicate clearly, avoiding the use of jargon so that people understand them.
- 12 Information is provided to patients in a format they can easily understand:

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. HMPPS's Welsh Language Scheme (Section 2, 66) states that they will work with the women's estate to ensure women are given the opportunity to declare a Welsh preference.

In accordance with the Welsh Language Standards under the Welsh Language (Wales) Measure (2011), health boards in Wales should enable everyone who receives or uses their services to do so through the medium of Welsh or English, according to personal choice.

Guidance: Information can be provided in languages other than English and Welsh and in formats that are easy to use for people with sight/hearing/cognitive difficulties or learning disabilities. For example; audio and video materials, using symbols and pictures, using plain English, communication passports and signers. Information is culturally relevant.

13 Clear information is made available, in paper and/or electronic format, to patients and healthcare practitioners on:

- A simple description of the service and its purpose;
- Clear referral criteria;
- How to make a referral, including self-referral if the service allows;
- Clear clinical pathways describing access and discharge;
- Main interventions and treatments available;
- Contact details for service, including emergency and out-of-hours details.

14 Patients are given verbal and/or written information on:

- Their rights regarding consent to care and treatment
- How to access advocacy services
- How to access a second opinion
- How to access interpreting services
- How to raise concerns, complaints and compliments
- How to access their own health records

15 There is a clear and auditable system for the management of referrals

16 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). Guidance: This can be an individual policy or included as part of a wider operational policy.

17 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.⁵⁴

2.1.2 Informed Consent

Within the assessment and Integrated Care Planning process, there should be clear evidence of informed consent to information sharing between clinical and other professionals involved in the provision of care and support to the PCIP, across both health and criminal justice services, within the prison environment and in the

⁵⁴ Royal College of Psychiatrists (DRAFT) Universal Standards for Mental Health Services in Prisons in Wales.

community. The consent process should take in to account the capacity to consent, and if necessary assessment under the Mental Capacity Act.

2.1.2.1 The Mental Capacity Act

Mental Capacity Act (2005)⁵⁵ facilitates the assessment of the individual's capacity to make decisions and is based on the 5 principles of:

- Presumption of capacity
- Individuals to be supported to make their own decisions
- A person is entitled to make an unwise decision
- Best interest principles
- Using least restrictive options

When assessing capacity under the Mental Capacity Act, the assessment of capacity has to be done by the decision maker, where the decision maker is the person deciding whether to take action in connection with the care or treatment of an adult who lacks capacity or who is contemplating making a decision on their behalf. Where the decision involves medical treatment – the doctor proposing the treatment is the decision maker.

2.1.3 Assessment

In line with the Welsh Government Substance Misuse Core Standards outlined in section 2.1.1, all services should undertake substance misuse assessment that as a minimum includes the relevant domains contained within the WIISMAT⁵⁶ 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,⁵⁷ assessment should be undertaken across four domains: drug and alcohol use and dependence, physical and mental health, social functioning and criminal involvement.

Assessments should be undertaken in a suitable, safe and private environments.⁵⁸

In undertaking a substance use assessment, a discursive, interactive and non-judgemental approach should be used to understand the issues from the person's perspective, whilst allowing the assessor to pass on information and advice.

Important aspects of the process should include:

- Level of knowledge of substances and associated risks
- Where, how and with whom they use substances

⁵⁵ <http://www.legislation.gov.uk/ukpga/2005/9/contents>

⁵⁶ Welsh Government. (2008). Wales Integrated In-depth Substance Misuse Assessment Tool (WIISMAT) and guidance for use Available at: https://www.researchgate.net/publication/301684587_Wales_Integrated_Indepth_Substance_Misuse_Assessment_Tool_WIISMAT_and_Guidance_for_use

⁵⁷ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

⁵⁸ National Institute of Health and Care Excellence, 2019. Health of people in the criminal justice system. Available at: <http://pathways.NationalInstituteforHealthandCareExcellence.org.uk/pathways/health-of-people-in-the-criminal-justice-system>

- Methods of use and drug of choice
- Whether substances are being used to control thoughts or behaviours
- Understanding and expectations of how substance use affects their lives
- Goals in relation to substance misuse and being drug and alcohol free

The substance use assessment process will often present opportunities for immediate intervention prior to the completion of the assessment process and the agreement of an integrated substance misuse care plan. In many cases immediate intervention is vital to the prevention of harm, thus must be acted upon. Examples of immediate intervention can include:

- Involving other expertise in the assessment of the person, including mental health and risk of suicide or self-harm. In line with the RCP Standards for Prison Mental Health services and the new standards for mental health services for prisons in Wales,⁵⁹ the assessment should involve a multi-disciplinary team including representatives of services/teams providing psychosocial support where separate from the health teams
- Focussing on the initiation of a prescribing intervention to reduce substance-related harm and to act as a gateway to other interventions
- Using motivational interviewing techniques to increase engagement in the assessment and subsequent treatment process

If occurring in the community prior to imprisonment, and where multiple agencies are involved, a lead agency should be identified to provide clarity for individuals, their families and carers. Involvement of families and carers in care planning and assessment is not only good practice but evidence supports more positive outcomes for the individual.

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. This requires a shared portal information system, for example, PALBASE, with the provision of updating the assessment and integrated care plan within the prison environment.

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.

For PCIP with identified complex needs including co-occurring mental health, assessment by an appropriately qualified individual, for example a registered mental

⁵⁹ Royal College of Psychiatrists and Quality network for prison mental health services. 2018. Standards for Prison Mental Health Services – Fourth Edition. Available at: [improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2](https://www.rcpsych.ac.uk/quality-network/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2) See also: Royal College of psychiatrists (DRAFT) Universal Standards for Mental Health Services in Prisons in Wales.

health nurse with substance misuse speciality, or joint assessment with substance misuse and mental health practitioners, is required.⁶⁰

For PCIP new to service or with unidentified or undocumented complex needs, initial assessment should be undertaken by an appropriately qualified individual as outlined above.

Risk assessment

PCIP are at greater risk of suicide and self-harm, particularly in the first few days and weeks of incarceration, post-sentencing, post-transfer and post-recall.⁶¹ Substance misuse, be it alcohol and/or drug dependency, are evidenced triggers 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. The role of offender management in custody also ensures that each PCIP has a keyworker and a Prison Offender Manager who would be a point of contact and would refer to suitable pathways to manage risk.

Supporting the development of positive relationships through referral to peer mentoring schemes such as Listeners and enabling family and key relationships involvement in assessment and incorporation of positive relationship development in integrated care planning can assist in identifying and addressing the risks of harm to self.⁶²

Cultural needs assessment

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 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.⁶³ Specific cultural needs may include language, experience of trauma, cultural identity, gender and sexuality and societal norms, values, beliefs and attitudes. All prisons are required to record data on those with a Welsh language preference and Welsh speakers should be made aware of the rights and opportunities available to them to receive information and services in Welsh under

⁶⁰ National Institute for Health and Care Excellence. 2017. Mental Health of adults in contact with the criminal justice system. NG66. Available at: www.nice.org.uk/guidance/ng66

⁶¹ Ministry of Justice. 2018. A review of Self-inflicted Deaths in Prison Custody in 2016. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/747470/review-of-deaths-in-custody-2016.pdf

⁶² HM Inspectorate of Prisons. 2016. Life in prison: peer support. A findings paper by HM Inspectorate of Prisons. Available at: <https://www.justiceinspectors.gov.uk/hmiprison/wp-content/uploads/sites/4/2016/01/Peer-support-findings-paper-final-draft.pdf>

⁶³ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

the HMPPS and MoJ Welsh Language Schemes. All health boards in Wales must operate in accordance with the Welsh Language Standards under the Welsh Language (Wales) Measure (2011) and enable everyone who receives or uses their services to do so through the medium of Welsh or English, according to personal choice.

Staff should be 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.

2.1.4 Process of assessment^{64,65}

At first reception:

- 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.
- Drug testing should be undertaken as part of initial assessment using the Health Board approved point of care testing kit. Whilst this is confirmation of use, it does not provide conclusive evidence of tolerance or dependence and must be used to inform wider clinical assessment of drug use and dependence. Whilst currently Prison mandatory drug tests require urine samples, use of oral point of care drug testing should be explored, requiring agreement across Wales, such as the ALLTEST DSD-8127 Construction drug test kit. Such a move would increase efficiency and provide a more acceptable test for PCIPs.
- Continuity of care must be ensured for 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

⁶⁴ National Institute for Health and care Excellence. Mental Health of adults in contact with the criminal justice system. NG66. Available at: <https://www.NationalInstituteforHealthandCareExcellence.org.uk/guidance/ng66/chapter/recommendations#identification-and-assessment-throughout-the-care-pathway>

⁶⁵ Royal College of Psychiatrists and Quality network for prison mental health services. 2018. Standards for Prison Mental Health Services – Fourth Edition. Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/prison-quality-network-prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2

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.

- If 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.^{66,67} 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:⁶⁸

- 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.
- PCIP entering or transferring between prisons have a medicines reconciliation carried out before their second-stage health assessment (Quality standard 1), 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.
- 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:

⁶⁶ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

⁶⁷ Public Health Wales. HMP Swansea Opiate Treatment Pathway Evaluation 2018-2019.

⁶⁸ National Institute of Health and Care Excellence. Physical health of people in prisons. Quality standard [QS156]. 2017. Available at: <https://www.nationalinstituteofhealthandcareexcellence.org.uk/guidance/qs156/chapter/Quality-statement-1-Medicines-reconciliation>

Physical health

- reviewing the actions and outcomes from the first-stage health assessment
- asking the person about:
 - any previous misuse of alcohol, use of drugs or improper use of prescription medicine
 - if they have ever suffered a head injury or lost consciousness, and if so:
 - how many times this has happened
 - whether they ever been unconscious for more than 20 minutes
 - whether they have any problems with their memory or concentration
- smoking history
- date of their last sexual health screen
- any history of serious illness in their family (for example, heart disease, diabetes, epilepsy, cancer or chronic conditions)
- their expected release date and if less than one month plan pre-release health assessment
- whether they have ever had a screening test (including, for women held in prisons outside of Wales, a cervical screening test or mammogram)
- whether they have, or have had, any gynaecological problems
- measuring and recording the person's height, weight, pulse, blood pressure and temperature, and carrying out a urinalysis

Based upon assessment of history of substance use and dependence, both alcohol and drugs, the following additional examinations, assessments, referrals and treatment may be required:⁶⁹

- Chest x-ray, ECG and pulmonary function tests (peak flow and FEV/FVC)
- Pregnancy test
- Blood tests to assess liver, renal and thyroid function and haematological indices
- Neurological examination if evidence of loss of sensation, convulsions, blackouts, organic causes of confusion and/or forgetfulness
- Detailed examination of gastrointestinal system including dentition

⁶⁹ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

- Treatment or initiation and continuation of injecting related complications including abscesses and deep vein thrombosis

Mental Health^{70,71,72}

- In addition to the use of specialist mental health trained staff in the assessment process, standardised use of the following tools are suggested, when supported by adequate clinical governance arrangements:
 - Screening for depression – Patient Health Questionnaire (PHQ-9)
 - Screening for anxiety disorders – Generalised Anxiety Disorder Scale (GAD-7)
 - Screening for Post Traumatic Stress Disorder (PTSD) – Primary Care PTSD Screen (PC-PTSD), PTSD Checklist Civilian Version (PCL-C) or Impact of Events Scale (IES-r)
 - Screening for eating psychopathology (Eating Disorder Examination Questionnaire (EDE-Q)
 - Consider using the Correctional Mental Health Screen for Men (CMHS-M) or Women (CMHS-W) to identify possible mental health problems if:
 - the person's history, presentation or behaviour suggest they may have a mental health problem
 - the person's responses to the first-stage health assessment suggest they may have a mental health problem
 - the person has a chronic physical health problem with associated functional impairment
 - concerns have been raised by other agencies about the person's abilities to participate in the criminal justice process
- N.B** When using the CMHS-M or CMHS-W with a transgender person, use the measure that is in line with their preferred gender identity
- If there is other evidence supporting the likelihood of mental health problems, or a male scores 6 or more on the CMHS-M, or a female scores 4 or more on the CMHS-W:
 - A practitioner who is trained to perform an assessment of mental health problems should conduct further assessment or;

⁷⁰ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

⁷¹ National Institute for Health and Care Excellence. 2017. Mental health of adults in contact with the criminal justice system. NG66.

Available at: <https://www.NationalInstituteforHealthandCareExcellence.org.uk/guidance/ng66/resources/mental-health-of-adults-in-contact-with-the-criminal-justice-system-pdf-1837577120965>

⁷² Royal College of Psychiatrists and Quality network for prison mental health services. 2018. Standards for Prison Mental Health Services – Fourth Edition. Available at: [improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2](https://www.rcpsych.ac.uk/quality-network/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2) See also: Royal College of psychiatrists (DRAFT) Universal Standards for Mental Health Services in Prisons in Wales.

- A practitioner who is not trained to perform an assessment of mental health problems should refer the person to an appropriately trained professional for further assessment
- Individual PCIP over 50 years old should receive an older adult mental health assessment⁷³

Cognitive impairment

Acquired or neurodevelopmental cognitive impairment and co-occurring substance misuse is prevalent amongst populations involved in the offender estate / prisons and is associated with poor retention in treatment and greater risk of relapse as well as poor interpersonal and social functioning. For PCIP with suspected or self-reported cognitive impairment, including learning disability and alcohol-related brain damage, the following screening tools are recommended:

- Montreal Cognitive Assessment (MoCA) – shown to identify impairment in populations with substance use, misuse and dependence
- Addenbrookes Cognitive Examination (ACE-III) – shown to be effective in assessing key cognitive domains potentially affected by drug and/or alcohol use
- Mini-mental State Examination (MMSE)
- General Practitioner Assessment of Cognition (GPCOG)

Post-completion of assessments:

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. See for example identifying people for full formal risk assessment for cardiovascular disease and risk assessment for type 2 diabetes.
 - Arrange follow-up appointment/s if needed.
- Enter in the person's medical record (and shared alcohol and substance use assessment / integrated care plan as appropriate):

⁷³ Royal College of Psychiatrists and Quality network for prison mental health services. 2018. Standards for Prison Mental Health Services – Fourth Edition. Available at: [improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2](https://www.rcpsych.ac.uk/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2) See also: Royal College of psychiatrists (DRAFT) Universal Standards for Mental Health Services in Prisons in Wales.

- all answers to the second-stage health assessment questions
 - health-related observations
 - details of any action taken
- Plan a follow-up healthcare review at a suitable time based on clinical judgement, taking into account the age of the person and length of their sentence.
 - 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.^{74,75,76}
 - Healthcare professionals in prisons should ensure people coming into prison are screened for Tuberculosis (TB) within 48 hours of arrival.⁷⁷ 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.

Assessment 6 weeks prior, and weekly to release:

- Planning support around release should occur at least six weeks prior to planned release and encompass four key domains:
 - Substance use (drug and alcohol) and dependence, including continuity of prescribing and psychosocial support and overdose/relapse prevention;

⁷⁴ European Centre for Disease Prevention and Control, European Monitoring Centre for Drugs and Drug Addiction. Public health guidance on prevention and control of blood-borne viruses in prison settings. Stockholm: ECDC and EMCDDA; 2018. Available at: <https://www.ecdc.europa.eu/sites/default/files/documents/Guidance-on-BBV-in-prisons.pdf>

⁷⁵ Public Health England. 2017. Summary report: National engagement event for blood-borne virus (BBV) opt-out testing in prisons in England, 2017. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/707591/Event_Report_FINAL.pdf

⁷⁶ Welsh Government. 2017. Welsh Health Circular WHC/2017/048. Attaining the WHO targets for eliminating hepatitis (B and C) as a significant threat to public health. Available at: <https://gov.wales/sites/default/files/publications/2019-07/attaining-the-who-targets-for-eliminating-hepatitis-b-and-c-as-a-significant-threat-to-public-health.pdf>

⁷⁷ National Institute for Health and Care Excellence. NICE pathways. Assessing physical and mental health of people in prisons and young offender institutions. Available at: <https://pathways.NationalInstituteforHealthandCareExcellence.org.uk/pathways/health-of-people-in-the-criminal-justice-system/assessing-physical-and-mental-health-of-people-in-prisons-and-young-offender-institutions#content-view-node%3Anodes-screen-for-tb-within-48-hours-of-arrival>

- 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**), relationships, financial management, education and/or employment and engagement with criminal justice.
- 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.
 - 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.⁷⁸
 - 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.
 - 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.

2.1.5 Integrated care planning

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. The meso or community/group-level, by providing care and support for groups of PCIP with a similar conditions, for example those identified with substance use concerns and dependence; through to the macro or population level, providing integrated care for

⁷⁸ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

the whole population with appropriate stratification of need across settings.⁷⁹ Ensuring clear mechanisms for reporting and monitoring relevant indicators of need at the micro and meso-levels evidences and enables effective and cost-effective assessment and planning at the macro-level (see Section D).

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, 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.⁸⁰

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. Following assessment of need, the POM should develop the ICP, negotiate and co-ordinate the delivery of multidisciplinary health and social care and support, with the authority to ensure successful delivery of the ICP.⁸¹ Use of appropriate and accessible clinical portals is essential to both the development and implementation of shared ICPs to ensure they can be accessed across settings by the range of services providers involved, and the individuals to which they relate. In order to facilitate this, it is essential that the NHS number, as unique identifier, is available for all those held in prison and that relevant healthcare professionals have read-only access to SystmOne outside of the prison setting, with the appropriate information sharing protocols in place. This is particularly important for the timely sharing of clinical records between prisons and secondary care teams providing specialist care, including Community Drug and Alcohol Services and Community Mental Health Teams, as well as GPs providing out-of-ours cover.⁸²

Many PCIP with identified substance misuse and dependence entering prison or being transferred, will have an ICP in place. This may be used to inform the assessment process and allow for reinvestigation of current goals. The POM, alongside discussions and agreement with the PCIP, is responsible for updating the ICP.

In the event that a PCIP does not have an ICP, the Prison Offender Manager along with the prison health care (physical and mental health) lead should develop the plan together with the PCIP. The ICP should be informed by and developed from the first and second-stage health (physical and mental health), social functioning and risk

⁷⁹ Curry N, Ham C. Clinical and service integration. The route to improved outcomes. The King's Fund; 2010. Available at: <https://www.kingsfund.org.uk/sites/files/kf/Clinical-and-service-integration-Natasha-Curry-Chris-Ham-22-November-2010.pdf>

⁸⁰ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

⁸¹ World Health Organisation, Regional Office for Europe. 2016. Integrated models of care – an overview. Available at: http://www.euro.who.int/_data/assets/pdf_file/0005/322475/integrated-care-models-overview.pdf

⁸² Public Health Wales. 2019. Response to the Health, Social Care and Sport Committee inquiry into provision of health and social care in the adult prison estate. Available at: <https://phw.nhs.wales/topics/prison-health-in-wales/hsp09-public-health-wales/>

assessment, existing or new alcohol and substance use assessment and other relevant assessments, alongside close discussion and agreement with the PCIP.

The ICP should address the full range of needs, be 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.

The ICP should include goals related to substance use and dependence including those related to treatment such as the provision of and engagement with structured psychosocial interventions and prescribing for dependence, including maintenance or detoxification and that this is agreed with the PCIP. It is important to ensure that agreed goals and actions, both short and longer term, are consistent and coherent across with between interventions, particularly in the event of a multi-agency response⁸³. All health and other professionals involved in PCIP treatment and support should be named on the ICP. To ensure effective communication and clear adherence to information governance requirements, the informed consent statement for the sharing of information must be included in the ICP.

The ICP will outline all treatment and support including all medicines prescribed consistent with clinical diagnoses. PCIP who are using both drugs and alcohol should be offered both drug and alcohol treatment (see section 2.5.1) and any PCIP smoking tobacco should be offered smoking cessation treatment and support which should be detailed in the ICP. When planning for prison release, the ICP should also include details of overdose and relapse prevention, training and provision of take-home Naloxone, including the offer of intranasal and/or intramuscular naloxone and additional sources of support with the community setting. A well designed, clear and up to date ICP based upon assessment evidence leads seamlessly to the individuals integrated care pathway across settings, supported by commissioned criminal justice providers in Wales, to ensure equitable and continuous care.⁸⁴

Unplanned prison release

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

⁸³ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

⁸⁴ Welsh Government. Integrated Care for Children and Young People aged up to 18 years of age who Misuse Substances. Available at: <https://gov.wales/sites/default/files/publications/2019-02/integrated-care-for-children-and-young-people-aged-up-to-18-years-of-age-who-misuse-substances.pdf>

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.

2.2 Clinical pathway for alcohol

2.2.1 Continuation or initiation of treatment for alcohol dependency

Incarceration, with high quality treatment and care, provides the opportunity for detoxification from alcohol, which may be experienced as far more challenging in community environments, due to lack of availability of alcohol in prison. However, PCIP with alcohol dependence are more likely to have complexity in the form of poly-substance use and co-occurring mental health conditions.⁸⁵ Within secure settings, alcohol-only accounted for 11% of treatments, with a further 18% of treatment involving alcohol and non-opiates. Substance misuse specialist treatment data in England indicate 41% of service users reported mental health issues, with the highest levels of need recorded amongst those with non-opiate and alcohol dependence.⁸⁶

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.

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.⁸⁷

In line with UK clinical guidelines⁸⁸ (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.

⁸⁵ Prison Reform Trust. Alcohol and Re-offending – Who Cares? Available at: <https://prisonreformtrust.org.uk/publication/alcohol-and-reoffending-who-cares/>

⁸⁶ Public Health England. 2019. Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2017 to 31 March 2018. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/752993/AdultSubstanceMisuseStatisticsfromNDTMS2017-18.pdf

⁸⁷ National Institute for Health and Care Excellence 2019. Alcohol use disorders – Assisted Alcohol Withdrawal. Available at: <http://pathways.NationalInstituteforHealthandCareExcellence.org.uk/pathways/alcohol-use-disorders>

⁸⁸ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

Evidence indicates that amongst untreated individuals, seizures from acute alcohol withdrawal may occur in around five% of individuals, usually within the first 48 hours of withdrawal.⁸⁹ 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 reviewed²². In PCIP with delirium tremens, offer quick-acting benzodiazepine, oral lorazepam. If declined, offer parenteral lorazepam or haloperidol in line with NICE guidance⁹⁰. If alcohol withdrawal seizures develop in a person during treatment for acute alcohol withdrawal, review their withdrawal drug regimen.

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.

As per NICE guidance⁷⁴ and ARBD SMTF (2020), PCIP should be provided with parenteral Thiamine (vitamin B1) following by oral Thiamine to prevent Wernicke-Korsakoff's syndrome.

2.2.2 Clinical pathway for alcohol dependency – detoxification

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.⁷⁴ For PCIP with severe alcohol dependence, the clinical team should consider use of Clinical Institute Withdrawal Assessment for Alcohol–Revised (CIWA-Ar) tool.

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.⁷⁴

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.

⁸⁹ Trevisan LA, Boutros N, Petrakis IL, Krystal JH (1998) Complications of alcohol withdrawal: pathophysiological insights. *Alcohol Health Res World* 22:61–66. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6761825/>

⁹⁰ National Institute for Health and Care Excellence 2017. Alcohol-use disorders: diagnosis and management of physical complications (2010, updated 2017) Guideline CG100. Available at: <https://www.NationalInstituteforHealthandCareExcellence.org.uk/guidance/cg100/resources/alcoholuse-disorders-diagnosis-and-management-of-physical-complications-pdf-35109322251973>

Psychological therapies should include cognitive-behavioural, behaviour or social network approaches.

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.

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.

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.⁹¹ All prescriptions and identified psychosocial interventions should be recorded on the ICP and the Day of Release care plan to ensure continuity of care.

2.3 Clinical pathway for drug dependence

2.3.1 Initiation of treatment for drug dependence - opioids

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. Robust evidence exists as to the protective nature of prison-based OST amongst opioid using and/or dependent PCIP in reducing drug related crime in prisons⁹² and in significantly reduced numbers of drug related deaths in the first month after release compared with non-prison-based OST cohorts.^{37,93} Appropriate OST within a prison environment can encourage treatment, reduce illicit drug use and associated harms within the prison setting and improve engagement with community services upon release back into the community.⁹⁴

Prior to prison reception, continuity of care should be maintained by health care professionals in police custody. Where a PCIP is already in receipt of OST

⁹¹ NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE 2019. Alcohol use disorders – Assisted Alcohol Withdrawal. Available at: <http://pathways.NationalInstituteforHealthandCareExcellence.org.uk/pathways/alcohol-use-disorders>

⁹² WHO Regional Office for Europe. 2010. Preventing overdose deaths in the criminal-justice system. Available at: http://www.euro.who.int/_data/assets/pdf_file/0020/114914/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf

⁹³ Mardsen J et al. Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England. *Addiction*. 2017 Aug;112(8):1408-1418. doi: [10.1111/add.13779](https://doi.org/10.1111/add.13779)

⁹⁴ Heidrich D et al. The effectiveness of opioid maintenance treatment in prison settings: a systematic review. *Addiction*. 2012 Mar;107(3):501-17. doi: [10.1111/j.1360-0443.2011.03676.x](https://doi.org/10.1111/j.1360-0443.2011.03676.x)

(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 individuals Integrated Care Plan.

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.⁹⁵

2.3.1.1 For those already in receipt of methadone OST prescription in the community

In line with UK clinical guidance for drug use and dependence⁹⁶ 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.

However, continuation at the same dose as that prescribed in the community should only occur if:

- The methadone OST is delivered under supervised consumption conditions
- The community dispenser is able to confirm the methadone prescription has been received regularly for the previous seven days
- The last supervised dose occurred within 48 hours
- PCIP treatment details are verified by the prescribing doctor or supervising pharmacist
- A drug test positive for any methadone metabolites
- No new clinical risk factors have been identified

The above criteria should be able to be met through timely provision and checking of the updated ICP via the electronic shared information portal (e.g. Palbase) at reception and the first-stage assessment. Following confirmation and documentation of checks, it is recommended that the first two days dosage is divided evenly in two and dispensed with at least six hours gap between doses.

Where the above criteria cannot be confirmed on first night but the drug test is positive for methadone metabolites, a 10mg dose should be provided with a further 10mg dose six hours later if evidence of withdrawal symptoms occur.⁷⁹ Once criteria are confirmed, the community dose should be prescribed.

⁹⁵ Royal College of Psychiatrists, Royal College of General Practitioners, Faculty of Forensic and Legal Medicine & College of Emergency Medicine. Substance Misuse Detainees in Police Custody - Guidelines for Clinical Management (Fourth edition) Report of a Medical Working Group. 2011. College Report CR169. Available at:

https://www.drugsandalcohol.ie/11497/1/RCGP_Substance_misuse_detainees_in_custody_4th_ed.pdf

⁹⁶ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

If a methadone prescription cannot be initiated on reception due to lack of available specialist clinical staff – Dihydrocodeine may be prescribed to provide short-term symptomatic relief from withdrawal symptoms, until such time as clinical staff are available and must be recorded on medical records.⁸⁰

2.3.1.2 For those already in receipt of Buprenorphine OST prescription in the community

As with PCIP in receipt of a methadone prescription in the community, 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 the following criteria:

- The Buprenorphine OST is delivered under supervised consumption conditions
- The community dispenser is able to confirm the prescription has been received regularly for the previous seven days
- The last supervised dose occurred within 48 hours
- PCIP treatment details are verified by the prescribing doctor or supervising pharmacist
- A drug test positive for any buprenorphine metabolites
- No new clinical risk factors have been identified

If a prescription cannot be initiated on reception due to lack of clinical staff – Dihydrocodeine may be prescribed to provide short-term symptomatic relief from withdrawal symptoms, until such time as clinical staff are available and must be recorded on medical records.

2.3.1.3 For those already in receipt of Buvidal OST prescription in the Community

As with PCIP in receipt of a methadone or Buprenorphine prescription in the community, 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.⁹⁷ Buvidal may be introduced into pre-release

⁹⁷ National Institute for Health and Care Excellence. 2019. Opioid dependence: buprenorphine prolonged release injection (Buvidal). Available at: <https://www.nice.org.uk/advice/es19/resources/opioid-dependence-buprenorphine-prolonged-release-injection-buvidal-pdf-1158123740101>

planning pathways in prisons in Wales, where its use is agreed between patient and community services following release.

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

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:

- 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

In addition, and in line with MHRA advice,⁹⁸ it is recommended that an Electrocardiogram (ECG) be undertaken on PCIP being initiated or prescribed OST, particularly those prescribed higher doses (above 100mg daily) due to the potential effect on cardiac function (resulting in QTc prolongation or delayed ventricular repolarisation).

Management of any signs of opioid withdrawal including vomiting and diarrhoea, anorexia, hypothermia, hypoglycaemia and insomnia should be actively managed to reduce distress, including the provision of adequate food, fluids and covers, quiet environments and relaxation classes, in-cell radio/television and carefully monitored prescribing of anti-emetic and anti-diarrhoeal medications as appropriate.⁹⁹ Issues and concerns regarding management of signs and symptoms of opioid withdrawal and distress 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.

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,¹⁰⁰ guidelines indicate the use

⁹⁸ Medicines and Healthcare products Regulatory Agency. 2006. Current problems in pharmacovigilance. Volume 31. Available at: <https://assets.publishing.service.gov.uk/media/547307e5e5274a1301000030/con2023860.pdf>

⁹⁹ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

¹⁰⁰ Dewa LH, Hassan L, Shaw JJ and Senior J. 2017. Insomnia management in prisons in England and Wales: a mixed-methods study. Journal of Sleep Research, 2017. Vol 26 (3) 322-329. Available at: <https://onlinelibrary.wiley.com/doi/full/10.1111/jsr.12503>

of time-limited short-acting hypnotics or sedating antihistamine medications for the treatment of insomnia.¹⁰¹

For those with uncertain opioid dependence, young people and those not wishing to detoxify with methadone or buprenorphine, use of Lofexidine may be considered for symptomatic treatment of withdrawal symptoms over 7-10 days with doses starting at 800mcg, increasing to a maximum of 2.4mg in split doses, followed by gradual reduction over subsequent days. At least part of the dose should be taken at night-time to offset opiate withdrawal related insomnia.¹⁰²

Induction of OST – methadone or buprenorphine?

As both OST medicines have a strong evidence base for effectiveness and cost-effectiveness for the treatment of heroin dependence^{88,103} and it is a requirement that funding is made available for treatment with both medicines there are a number of considerations that should be addressed prior to initiation and maintenance prescribing of OST within the prison environment:

- PCIP preferences based upon discussion with prescriber, relative benefits of both options and pre-existing experiences and beliefs
- Safety concerns within the prison environment including risk of diversion and overdose
- Clinical concerns including drug-drug interactions with other prescribed medications and pain management

To address potential concerns of diversion of OST within the prison, particularly Buprenorphine, use of rapid dispersal forms of buprenorphine - Buprenorphine oral lyophilisate (Espranor®) should be considered and is currently used within the prison estate and community where appropriate.

Induction¹⁰⁴

Induction of OST to opioid dependent PCIP should start at reception stage, with evidence of opioid positive urine drug screen and self-reported opioid use alongside evidence of opioid withdrawal symptoms and take place over at least a five day observed period to ensure thorough assessment and appropriate care and safety measures can be met including the risk of overdose and management and control of

¹⁰¹ National Institute for Health and Care Excellence (NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE). Insomnia. Revised 2021. Available at: <http://cks.NationalInstituteforHealthandCareExcellence.org.uk/insomnia#!management>

¹⁰² Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

¹⁰³ National Institute for Health And Care Excellence. 2007a. Methadone and buprenorphine for the management of opioid dependence. Technology appraisal guidance [TA114]. Reviewed 2016. Available at: <https://www.NationalInstituteforHealthandCareExcellence.org.uk/guidance/ta114>

¹⁰⁴ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

opioid withdrawal symptoms. All initial and subsequent OST treatment must be supervised consumption.

Enhanced observations should occur at least twice daily but preferably be unrestricted over the five days, with observations including peak plasma levels after 2-4 hours of last methadone / Buprenorphine dose. Any indication of over-medication or drowsiness following consumption of other psychoactive substances must result in withholding OST dose until medical reassessment.⁸⁸ This information must be clearly communicated with the PCIP prior to onset of induction to OST and form part of informed consent process.

Methadone

Within the first 24 hours, a maximum total daily dose of 30mg methadone should be provided, based upon clinical judgement, with consideration of split-dose regime for PCIP experiencing less severe opioid withdrawal symptoms, for example: day 1, 10mg; day 2, 10mg twice daily; and day 3, 10mg three times daily or 15mg twice daily. In the event that the recommended initial dose regime is insufficient to manage withdrawal symptoms, additional titration of 2-10mg per day can be considered, with split-dose regimes being preferred until clear evidence of stability has been observed on the stabilisation dose. A period of several weeks may be required to achieve safe optimal dosing. Average doses of methadone between 60mg and 120mg daily are generally recommended.¹⁰⁵

In line with UK clinical guidelines and clinical governance, for PCIP requiring higher doses of between 60-120mg methadone who continue to show signs of withdrawal, those who fail to stabilise and have co-morbidities, additional input and advice should be sought from addiction specialists/psychiatrists with prison experience.

Buprenorphine

Usually, initial dosing regimens will begin with a low dose of 4-8mg, with a careful titration balancing the aim of adequate dosing and agonist effect with the risk of precipitated withdrawal. This may involve flexibility and divided-doses of a number of 2mg tablets across day 1 and 2. Having established a daily dose that does not precipitate withdrawal, rapid titration up to recommended maintenance dose should be completed, based upon clinical judgement. Average maintenance doses of buprenorphine between 12 and

¹⁰⁵ Royal College of Psychiatrists, Royal College of General Practitioners, Faculty of Forensic and Legal Medicine & College of Emergency Medicine. Substance Misuse Detainees in Police Custody - Guidelines for Clinical Management (Fourth edition) Report of a Medical Working Group. 2011. College Report CR169. Available at: https://www.drugsandalcohol.ie/11497/1/RCGP_Substance_misuse_detainees_in_custody_4th_ed.pdf

16mg are generally recommended with titration and dosage regimen as per clinical guidelines.¹⁰⁶

Suboxone (Buprenorphine and Naloxone)

Induction on combined buprenorphine/naloxone treatment may also be considered and at the same induction and maintenance regime as Buprenorphine. This combined medication, when taken sublingually has the same action as Buprenorphine, however, if injected the naloxone is liable to precipitate opioid withdrawal, thereby deterring the PCIP to further opioid injecting, either within or post prison release.

2.3.2 Clinical pathway for drug dependence – opioids: maintenance, detoxification

Once induction and stabilisation for those not in receipt of a community OST prescription and stabilisation for those continuing a community OST prescription has been achieved, further discussion and agreement is required between the PCIP and prescriber on the clinical pathway for longer term treatment and accompanying psychosocial therapeutic support. 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.

One clear consideration is that of maintenance of OST or detoxification during the current prison sentence. The duration of maintenance and other treatment outcomes should reflect the PCIP preferences, which should be clearly recorded in the ICP following initial assessment and subsequent reviews to ensure up to date decisions and consents are clear. Engagement with psychosocial interventions and peer-based support, particularly with individuals with experience and history of drug dependence, may shape and inform an individual PCIP decision making over time. **There should not be any mandatory OST reduction regime**¹⁰⁷ except where it is clinically unsafe to continue (for example in methadone prescribing and abnormal ECG). Where there is very clear evidence of diversion it may become necessary to consider reduction or other change of OST.

Maintenance

¹⁰⁶ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

¹⁰⁷ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. (p.150) Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

Maintenance OST prescribing may either continue for the duration of the sentence and follow through seamlessly to the community setting, providing clinical through care, or continue only until the PCIP wishes, and provides informed consent, to undertake an opioid detoxification within the prison environment.

For maintenance OST treatment, daily dosage regimen of between 60-120mg of methadone or between 12-16mg of Buprenorphine are recommended, with higher or lower daily doses for some individuals based upon evidenced and recorded clinical judgement.

Ongoing review is required especially if there are any changes to prescription medication provided to the individual PCIP, including but not limited to benzodiazepines or other depressant drugs including pregabalin or gabapentin, or if recorded evidence indicates non-prescribed use of these or other types of illicit drugs impacting on the safety of pharmacological treatment.

Detoxification¹⁰⁸

Detoxification, a process to support 'safe and effective discontinuation of opiates while minimising withdrawals' ¹⁰⁹(p115), represents distinct challenges within the prison environment. Evidence indicates that PCIP with substance misuse and dependence conditions are especially vulnerable to self-harm and suicide within the prison environment, particularly within the first 28 days, risks which could be exacerbated by detoxification. In addition, PCIPs completing detoxification are at far greater risk of opioid overdose and death post-release, especially those whose release from prison is with sudden and unplanned.¹¹⁰

Consideration of detoxification should be based upon practical and safety criteria and informed discussion and agreement between PCIP and clinician following careful recorded confirmation of the following:

- Assessment of opioid dependence and the associated risk of opioid toxicity early in treatment
- Length of sentence or remand period, and the possibility of unplanned release
- Risks of self-harm, death or post-release overdose. The individual PCIP must be fully aware of the high risk of relapse, particularly following a change in circumstances, including release from prison

¹⁰⁸ The British Psychological Society and The Royal College of Psychiatrists. 2019. Opioid detoxification. National Clinical Practice Guideline Number 52. National Collaborating Centre for Mental Health commissioned by the National Institute for Health & Clinical Excellence. Available at: <https://www.NationalInstituteforHealthandCareExcellence.org.uk/guidance/cg52/evidence/drug-misuse-opioid-detoxification-full-guideline-196515037>

¹⁰⁹ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

¹¹⁰ The British Psychological Society and The Royal College of Psychiatrists. 2019. Opioid detoxification. National Clinical Practice Guideline Number 52. National Collaborating Centre for Mental Health commissioned by the National Institute for Health & Clinical Excellence. Available at: <https://www.nice.org.uk/guidance/cg52/evidence/drug-misuse-opioid-detoxification-full-guideline-196515037>

- The PCIP is able to move into a stable and supportive social situation following detoxification and release
- The PCIP is fully committed to the detoxification process and of remaining drug free post release, and plans are in place for continuing support and treatment during prison and post-release, recorded on the ICP
- A full programme of psychosocial and drug-free peer support is available during and after detoxification
- Support for relapse prevention and take-home Naloxone and overdose training is provided prior to release from prison for the PCIP and families. Detoxification resulting in abstinence from opioids can place PCIP at increased risk of post-release overdose.¹¹¹

Informed consent to detoxification includes recorded confirmation of discussion of the following¹¹²:

- the physical and psychological aspects of opioid withdrawal, including the duration and intensity of symptoms, and how these may be managed
- the use of non-pharmacological approaches to manage or cope with opioid withdrawal symptoms
- the loss of opioid tolerance following detoxification, and the ensuing increased risk of overdose and death from illicit drug use that may be potentiated by the use of alcohol or benzodiazepines
- the importance of continued support, as well as psychosocial and appropriate pharmacological interventions, to maintain abstinence, treat comorbid mental health problems and reduce the risk of adverse outcomes (including death)

Evidence does not support clinicians requiring, coercing or encouraging PCIP on stable maintenance OST regimes to start gradual reduction of OST. Evidence indicates coerced detoxification against the individuals will is likely to result in relapse and increased risk of harm and therefore should not happen.¹¹³

Inpatient opioid detoxification, with 24 hour medical/nursing care, should be provided for individual PCIP requiring high levels of ongoing medical and/or care due to significant and severe comorbid physical or mental health problems, or who need concurrent detoxification from alcohol or other drugs.

¹¹¹ World Health Organisation. 2014. Preventing overdose deaths in the criminal-justice system. Available at: [/Preventing-overdose-deaths-in-the-criminal-justice-system.pdf](#)

¹¹² The British Psychological Society and The Royal College of Psychiatrists. 2019. Opioid detoxification. National Clinical Practice Guideline Number 52. National Collaborating Centre for Mental Health commissioned by the National Institute for Health & Clinical Excellence. Available at: <https://www.nice.org.uk/guidance/cg52/evidence/drug-misuse-opioid-detoxification-full-guideline-196515037>

¹¹³ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

All individuals undergoing opioid detoxification should receive continued care, treatment and monitoring to support and maintain abstinence for at least a 6 month period.

Detoxification should be undertaken with the medications that the PCIP has been stabilised on.¹¹⁴

Detoxification process

If all the above conditions are met:

- Following stabilisation on methadone, a gradual reduction regime of around 5mg of methadone every one to two weeks should be followed, resulting in a total cessation of methadone within 12 weeks, depending on maintenance dose and clinical judgement. This regime may be subject to acceleration in the first few weeks at the PCIP request.⁹⁹
- For those detoxing from Buprenorphine, doses can be reduced by 2mg every two weeks with final reductions of around 400 mcg
- Symptomatic treatment of withdrawal (see also section 2.3.1.3) may include a range of medications prescribed in accordance with clinical guidelines to address symptoms including diarrhoea, nausea and vomiting, stomach cramps, abdominal and musculo-skeletal pain, agitation, anxiety and insomnia. Risks regarding supervision and polypharmacy must be noted and addressed. All symptoms and prescribing should be recorded on the medical record

Patients unstable on OST

As in community settings, if a PCIP experiences instability whilst on their maintenance or gradual detoxification OST regime in prison, for example where evidence of use of other drugs including opioids in addition, then review is required, and treatment should be optimised. The review should include the dose of OST prescribed as well as the psychosocial interventions and social support being provided.¹¹⁵ In the event of a PCIP being intoxicated, monitor closely prior to and during review process. OST prescriptions should continue following an episode of acute intoxication, positive drug test or period of instability. Cessation of OST prescription regime should not be considered and cannot be justified as it is likely to

¹¹⁴ National Institute for Health and Care Excellence. 2007a. Methadone and buprenorphine for the management of opioid dependence. Technology appraisal guidance [TA114]. Reviewed 2016. Available at: <https://www.NationalInstituteforHealthandCareExcellence.org.uk/guidance/ta114>

¹¹⁵ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

result in greater risk of harm to the PCIP in relation to withdrawal, increased risk of illicit drug use and overdose.¹¹⁶

Patients on maintenance or detoxification regime due for release¹⁰²

For PCIP who have successfully completed an opioid detoxification regime and aim to remain abstinent on release – relapse prevention support and ongoing psychosocial, social functioning and criminal justice support should be planned and recorded in the shared ICP and day of release plan. Take-home naloxone should be provided. The option of prescription of Naltrexone should be discussed with the PCIP and informed consent obtained if provided along with updated ICP recorded.

For those who have successfully completed a detoxification regime of both opioids and alcohol – along with continued psychosocial intervention, social functioning and criminal justice support, the provision of Naltrexone prescription should be discussed with the PCIP and informed consent obtained if provided along with updated ICP recorded.

For PCIP who have remained on a maintenance OST regime and have successfully stabilised but on a lower dose than that received in the community, planning, and OST prescribing should reflect the circumstances to which the PCIP will be released to and their expressed choice. It may be appropriate for people who have new or reactivated opiate dependence at any time during their stay in prison, to be inducted onto OST, at the time of discharge. People who are due to leave may need a higher dose on release to the community, both because of different levels of craving but also due to increased physical activity. It may also be a choice that fits with a patient's own goals and preferences. Appropriate dosing should be considered in order to reduce risks, alongside support and relapse prevention interventions to reduce the risk of return to illicit opioid use on release. This option will require monitoring both in prison and on release and should be discussed fully with the PCIP and professionals providing continued through care in the community in the six week assessment review and subsequent reviews prior to release, informed consent achieved and the shared ICP updated.

For PCIP who have remained on a maintenance OST regime at the same dose as that in the community, maintenance OST should continue in the community. This will need to be clearly stated in the six week assessment review and subsequent reviews prior to release and the shared ICP updated.

Psychosocial support

The assessment process for the use of psychosocial support and interventions should include identification of treatment goals, strengths and risks, both within the

¹¹⁶ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

prison environment and in the community, including relationships and wider social environment. 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.

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.

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.

2.3.3 Treatment, detoxification and psychosocial care pathway for drug dependence – Benzodiazepine and z-drugs

Use of benzodiazepine drugs in isolation and in combination with opioid and stimulant drugs is common, both as prescribed and non-prescribed/illicit drugs, and represent a challenge in treatment for both physical and psychological/mental health and wellbeing. For PCIP with dependence, management of withdrawal is required and treatment and care planning should be informed by the assessment process.⁵¹

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

Benzodiazepine dependence should be established through assessment and informed by:

- Prescribing history
- Self-report use of prescribed and non-prescribed use of benzodiazepines
- Drug testing
- Withdrawal monitoring

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.

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.

For PCIP also in receipt of maintenance OST prescription, the OST dose should be maintained and kept stable throughout benzodiazepine reduction period.

In line with UK Clinical Guidelines¹¹⁷ and based upon clinical judgement and thorough assessment, there may be some instances for continuation of maintenance and longer-term prescribing of benzodiazepines, for example in cases where there is:

- evidence of long-term previous benzodiazepine prescribing
- evidence of pre-existing and concurrent co-occurring mental health issues
- evidence of clear deterioration following previous benzodiazepine detoxification

With the exception of those meeting the above 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.¹¹⁸ Induction on to substitution dose of benzodiazepines, as with opioid substitution regimen, involves a balance of gradual dosage increases to reduce and prevent withdrawal whilst avoiding intoxication and as such involves close monitoring and assessment.

UK Clinical Guidelines⁵⁵ 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. 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. A more gradual reduction regimen, and close monitoring is also recommended for individuals with primary benzodiazepine dependence and those with diagnosis of epilepsy.

Psychosocial 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. For individual PCIP with benzodiazepine dependence and those with

¹¹⁷ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

¹¹⁸ Lingford-Hughes AR, Welch S, Peters L, Nutt DJ (2012) BAP updated guidelines: evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP. Journal of Psychopharmacology 26(7):899-952. Available at: <https://journals.sagepub.com/doi/pdf/10.1177/0269881112444324>

mild to moderate dependence with complex needs offer intensive and structured psychosocial support.

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.

2.3.4 Initiation of and treatment for drug dependence – stimulants including cocaine

A range of evidence supports the increased prevalence, use and dependence on stimulant drugs in the UK¹¹⁹ and as such, represents an increasing issue for treatment within the offender and prison estate, with a 10 percentage point increase in treatment presentations in prison for opiate and cocaine/crack use in two years 2015-16 to 2017-18. Unlike opioid and benzodiazepine dependence, psychosocial interventions including stress reduction, form the central intervention of treatment for stimulant dependence in the absence of specific pharmacological treatments to eliminate withdrawal symptoms.¹²⁰ However, based upon clinical judgement, provision of symptomatic pharmacotherapy and close monitoring may be required to reduce distress related to withdrawal. 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,¹⁰⁶ there is no evidence that anti-depressants have an effect on stimulant withdrawal symptoms.

Due to the nature of prolonged and problematic stimulant use, a range of physical and psychological health issues may also require treatment¹²¹ 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. 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

¹¹⁹ Public Health Wales, Welsh Government. Data Mining Wales - The annual profile for substance misuse 2018-19. Available at: <http://www.wales.nhs.uk/sitesplus/documents/888/Final%20Annual%20Profile%202018-19%20ENGLISH.pdf>

¹²⁰ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

¹²¹ Welsh Government. 2013. Substance Misuse Treatment Framework: Health and wellbeing compendium. Available at: [substance-misuse-treatment-framework-health-and-wellbeing-compedium.pdf \(gov.wales\)](http://www.gov.wales/substance-misuse-treatment-framework-health-and-wellbeing-compedium.pdf)

symptoms may require psychiatric admission. Antidepressant treatment for those with persistent depression, meeting diagnostic criteria, may be required.¹²²

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.¹⁰⁴

Assessment and healthcare monitoring from Reception

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. 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.¹⁰⁶ Dependent on withdrawal symptoms, appropriate short-term symptomatic prescribing should be considered in line with clinical judgement.

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. Historical mental health assessment outcomes, treatment and support should be available to healthcare staff on the shared ICP portal for reference.

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. Psychosocial interventions including provision of stress reduction interventions, prison listeners, individual and group support, should be made available once the PCIP has stabilised following entry to prison, and throughout the sentence. Prior to release, and to ensure continuity of care and support positive treatment outcomes, plan reengagement with community drug teams

¹²² Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

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.

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.

2.3.5 Initiation and treatment for drug use – Synthetic Cannabinoid Receptor Agonists (SCRAs)

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.¹²³ Acute Intoxication and chronic use of SCRAs¹²⁴ can result in:

Neurological, cognitive and psychiatric symptoms, including:

- Psychosis
- Disorientation, confusion, delusions
- Aggression to self and others
- Self-harm and suicidal ideation
- Panic attacks, anxiety and depression

Physical symptoms:

- Cardiovascular effects including tachycardia, hypertension, hypotension, chest pain and palpitations, myocardial ischaemia, myocardial infarction, ischaemic strokes
- Acute kidney injury
- Hyperglycaemia, hypoglycaemia
- Serotonin syndrome¹²⁵

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 focussed on management of the presenting symptoms.

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

¹²³ European Monitoring Centre for Drug and Drug Addiction. RAPID COMMUNICATION - New psychoactive substances in prison. Results from an EMCDDA trendspotter study June 2018. Available at: <http://www.emcdda.europa.eu/system/files/publications/8869/nps-in-prison.pdf>

¹²⁴ Abdulrahim D, Bowden-Jones O, on behalf of NEPTUNE group. Harms of Synthetic Cannabinoid Receptor Agonists (SCRAs) and Their Management. London: Novel Psychoactive Treatment UK Network (NEPTUNE), 2016. Available at: <http://neptune-clinical-guidance.co.uk/wp-content/uploads/2016/07/Synthetic-Cannabinoid-Receptor-Agonists.pdf>

¹²⁵ Novel Psychoactive Treatment UK Network NEPTUNE. 2015. Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances. Available at: <http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf>

a benzodiazepine, based upon clinical judgement. Emergency care and hospitalisation, including psychiatric admissions, may be required and use of the National Early Warning Score (NEWS) 2¹²⁶ 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.

2.3.6 Diversion of medication within prison

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. For those consuming NMPDU, there is the risk of development of dependence and of acute poisoning, contra-indications with other prescribed medications and potential for fatal drug poisoning.

The extent of, and motivations for, NMPDU have been evidenced in Wales¹²⁷ indicating that the practice is commonplace both in the community and prison environments, particularly amongst people using illicit drugs. 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.

In order to address the risk of diversion of prescribed medication within prisons it should be ensured:¹²⁸

- that safe, secure and appropriate environments are available to healthcare professionals
- that administration of medicines is appropriately staffed and monitored
- that healthcare staff and prison officers work effectively together to ensure medication is used appropriately
- that all prisons have a Medicines Management Committee to oversee, monitor and address barriers to effective practice in relation to the management of prescribed medications

¹²⁶ Royal College of Physicians. National Early Warning Score (NEWS) 2: Standardising the assessment of acute-illness severity in the NHS. Updated report of a working party. London: RCP, 2017. Available at: <https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2>

¹²⁷ May T, Holloway K, Buhociu M & Hills R. 2020. Not what the doctor ordered: Motivations for nonmedical prescription drug use among people who use illegal drugs. International Journal of Drug Policy. Available at: <https://doi.org/10.1016/j.drugpo.2020.102823>

¹²⁸ Her Majesty Prison and Probation Service. Prison Drugs Strategy. 2017. Available at: [prison-drugs-strategy.pdf](https://www.hmp.prisons.nhs.uk/prison-drugs-strategy.pdf)

2.4 Psychosocial Interventions

Background

The term psychosocial interventions refers to a broad range of processes aimed at psychological or social change. In the United Kingdom, there is a broad evidence base, alongside national guidance for the use of psychosocial interventions for the treatment and management of substance use problems.¹²⁹ Offering a range of psychosocial treatment, support and interventions, not just pharmacotherapies, is an essential element of substance misuse treatment provision.¹³⁰

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.¹³¹ However, effective treatment for all substance misuse problems includes psychosocial interventions.¹³²

Effective psychosocial interventions should include the following key elements:¹³³

- Therapeutic alliance, sometimes called the therapeutic relationship, this is the relationship between a healthcare practitioner and their client. The quality of this relationship can be a reliable predictor of positive treatment outcomes.¹³⁴
- Use of evidenced based interventions.
- Adequate staff competencies' and supervision (See Chapter 4 - Workforce realignment and development). This will ensure a balanced implementation of interventions and assure their quality.
- Monitoring and review system of agreed treatment goals and outcomes. This will allow for focus and re-focusing of the structure of interventions delivered and goals. Agreed goal directed work is associated with positive client engagement and better outcomes.

¹²⁹ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

¹³⁰ National Institute for Health and Clinical Excellence. Drug Misuse in over 16s: Psychosocial Interventions (Clinical Guideline 51). 2007. Available at: <https://www.nice.org.uk/guidance/cg51>

¹³¹ Amato L, Minozzi S, Davoli M, Vecchi S. Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification. Cochrane Database Syst Rev. 2011 Sep 7;(9):CD005031. doi: [10.1002/14651858.CD005031.pub4](https://doi.org/10.1002/14651858.CD005031.pub4).

¹³² Abdulrahim D, Bowden-Jones O, on behalf of the NEPTUNE Expert Group. Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances. Novel Psychoactive Treatment UK Network (NEPTUNE). London, 2015. Available at: <http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf>

¹³³ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

¹³⁴ Ardito, RB, and Rabelino, D. "Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research." *Frontiers in psychology* vol. 2 270. 18 Oct. 2011, doi: [10.3389/fpsyg.2011.00270](https://doi.org/10.3389/fpsyg.2011.00270)

The identification of relevant psychosocial interventions should begin at the assessment stage and be carried forward to inform the clients care plan. This may also include an onward referral or liaison with professionals who have more competencies, in delivering specific and appropriate psychosocial interventions.

Where multiple professionals are involved in an individual's treatment journey collaborative care planning should be ensured to facilitate the best possible outcomes and coherent goals. 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. There is evidence that routine review and feedback can lead to positive treatment outcomes.¹³⁵

When outcomes are not met it is important to utilise this information to identify any barriers to change and to also further build a positive therapeutic alliance through empathetic listening.

When offering psychosocial interventions consideration must be given to the appropriateness of an intervention in relation to a client's situation and if the interventions offered is acceptable to the client. Goals should be agreed between the Key worker, healthcare, prison and client, helping to build the therapeutic alliance and avoiding or allowing discussion of any feelings of coercion or external pressure that the individual might have. Services and healthcare workers should remember that goals and care plan should be bespoke to an individual client's needs, a "one-size" fits all approach is unlikely to have successful outcomes.

Psychosocial interventions do not have to be focused specifically on achieving abstinence from use of specific or multiple substances but can work towards a reduction in use to a less harmful level or use of substances in a less harmful manner.

If an individual is receiving prescribed medication, such as OST, it is essential that the goals of the psychosocial interventions are consistent with the prescribing goals to ensure a coherent treatment pathway.

Whilst addressing behaviour change it may be necessary to change or adapt psychosocial interventions for specific substances. Therefore substance misuse, health care and prison service workers should have adequate knowledge around substances and their specific effects and relevant risk management and harm reduction advice. Whilst dealing with poly-drug using individuals, each substance

¹³⁵ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

needs to be addressed, the primary focus can be adapted to the complexity and severity of use and current problems.

Individuals with co-occurring mental health and substance misuse conditions are more likely to have poorer health and social outcomes, and experience greater levels of stigma and inequity of access to health and related services than the general population. Within the prison population, the prevalence of complex needs and co-occurring conditions is greater than within the community with the circumstance of imprisonment providing additional risks for deterioration in existing mental health conditions and the development of new conditions.¹³⁶

Individuals using substances may present with cognitive impairment, and some may have learning disabilities. This is associated with poor retention and engagement, negative outcomes and increased likelihood of relapse. It is therefore necessary to consider making additional amendments to psychosocial interventions, such as:

- Shortening the length of sessions
- Increasing the frequency of sessions
- Involving a client's positive and supportive social network to assist with coping skills
- Use of mapping techniques such as International Treatment Effectiveness Project (ITEP) or Node Link Mapping (NLM), is a visual representation strategy for improving communication and decision making, it can be used either in group or individual settings.

Trauma and related issues

The assessment and care planning process should be sensitive to an individual's potential exposure to trauma. Traumatic experiences are events or an event that an individual experienced as causing emotional or physical harm. Trauma can have a pervasive and detrimental impact on an individual's cognitive, emotional and social functioning and developmental progress.¹³⁷ These symptoms may impact on their ability to engage with services and treatment outcomes.¹³⁸ Appropriate process should be in place to ensure access to and timely provision of specialist intervention if needed.¹³⁹

The experience of trauma may include events occurring in childhood, referred to as adverse childhood experiences (ACEs). These types of experiences include physical, emotional and/or sexual abuse, violence in the home, parental separation,

¹³⁶ Public Health England. 2016. Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure & detained settings to inform future health interventions and prioritisation. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/565231/Rapid_review_health_outcomes_secure_detained_settings.pdf

¹³⁷ Marusak, HA, Martin, KR, Etkin, A et al. (2015). Childhood trauma exposure disrupts the automatic regulation of emotional processing'. *Neuropsychopharmacology*, 1250-58. doi: [10.1038/npp.2014.311](https://doi.org/10.1038/npp.2014.311)

¹³⁸ Department of Health (2017) Drug misuse and dependence UK Guidelines on Clinical management p.41. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

¹³⁹ National Institute for Health and Care Excellence (NICE). NG116. 2018. Post-traumatic stress disorder. Available at: <https://www.nice.org.uk/guidance/NG116>

incarceration, mental illness or substance use.¹⁴⁰ Evidence indicates that individuals experiencing high levels and complex adverse experiences under the age of 18 are more likely to have contacted with criminal justice services, have been incarcerated,¹⁴¹ and been involved in more serious and repeat offending. In addition, adverse experiences and early trauma are associated with poorer physical and mental health across the life course, including vulnerability to health-harming behaviours including substance misuse.

2.5 Complex care and multiple dependencies

2.5.1 Prevalence

Within the prison environment, as in the community, individuals at particular vulnerability to harm include those with multiple dependencies and those with co-occurring substance misuse and mental health and/or physical health problems. Substance misuse treatment within secure settings¹⁴² indicate that for treatments for opiate use, 73% also involved crack cocaine, and 18% of all treatments involved both alcohol and non-opiates. Of those receiving treatment for substance misuse, need for mental health interventions was identified in 35% with non-opiate and alcohol dependence.

2.5.2 Poly-substance use and dependencies: assessment, treatment and detoxification

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. 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.¹⁴³ 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.¹³⁹

Where clinical assessment indicates a substantial dependence on benzodiazepines, alongside opiate or crack dependence, requiring treatment of withdrawals, a

¹⁴⁰ Ford K, Barton ER, Newbury A, Hughes K, Bezczky Z et al. 2019. Understanding the prevalence of adverse childhood experiences (ACEs) in a male offender population in Wales: The Prisoner ACE Survey. Available at: <https://phw.nhs.wales/files/aces/the-prisoner-ace-survey/>

¹⁴¹ Bellis MA, Ashton K, Hughes K, Ford K, Bishop J, Paranjothy S. Adverse childhood experiences and their impact on health-harming behaviours in the Welsh population. Cardiff: Public Health Wales; 2015. Available at: [https://www2.nphs.wales.nhs.uk/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/\\$FILE/ACE%20Report%20FINAL%20\(E\).pdf](https://www2.nphs.wales.nhs.uk/PRIDDocs.nsf/7c21215d6d0c613e80256f490030c05a/d488a3852491bc1d80257f370038919e/$FILE/ACE%20Report%20FINAL%20(E).pdf)

¹⁴² Public Health England. 2020. Substance Misuse treatment in secure settings: 2018 to 2019. Available at: <https://www.gov.uk/government/statistics/substance-misuse-treatment-in-secure-settings-2018-to-2019>

¹⁴³ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

benzodiazepine assisted withdrawal regime developed in conjunction with the clinical specialist and in line with current guidelines is required,¹³⁹ usually with Diazepam.¹⁴⁴

Where clinical assessment indicates concurrent opioid, benzodiazepine and alcohol dependence, close monitoring, management and review is required throughout stabilisation and initial treatment phases.¹³⁹ 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.

For treatment of concurrent opiate and alcohol dependence, alcohol-assisted withdrawal should be completed prior to any planned reduction in OST, except where there are clear clinical indications to do so. The stabilisation dose of OST should be maintained until alcohol detoxification is achieved. Only once the alcohol detoxification is complete should any opioid detoxification begin, following discussion and agreement with the individual and recording on the ICP.

If there is also evidence of dependence on sedative-hypnotic drugs, then this detoxification process should take place after the alcohol and prior to the opioid detoxification treatments. If the patient wishes, with clinical discussion and agreement, to undertake the opioid detoxification first, close monitoring and management will be required.

Individuals with poly-drug dependence, including opioid dependence, are amongst those most at risk of overdose and relapse following release. As such, consideration should be given to re-induction of OST prior to release.

2.5.3 Co-occurring substance misuse /mental health

Within the prison population, the prevalence of complex needs is greater than the community with the circumstance of imprisonment providing additional risks for deterioration in existing mental health conditions and the development of new conditions.¹⁴⁵

¹⁴⁴ Lingford-Hughes AR, Welch S, Peters L, Nutt DJ (2012) BAP updated guidelines: evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP. *Journal of Psychopharmacology* 26(7):899-952. Available at: <https://journals.sagepub.com/doi/pdf/10.1177/0269881112444324>

¹⁴⁵ Public Health England. 2016. Rapid review of evidence of the impact on health outcomes of NHS commissioned health services for people in secure & detained settings to inform future health interventions and prioritisation. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/565231/Rapid_review_health_outcomes_secure_detained_settings_.pdf

In line with NICE quality standards,¹⁴⁶ PCIPs with suspected or confirmed severe mental illness must:

- 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

It is essential that 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.¹⁴⁷ Individuals with complex needs are more likely to disengage early from treatment services if their specific needs are not met.

The identification of comorbidities can be problematic as some of the acute and chronic effects of substance use can mimic the symptoms of a mental health condition. Alternatively, a mental health condition may have a negative effect on substance use behaviours.

The prevalence of comorbidity within the substance misuse treatment population is relatively high; with the European Monitoring Council for Drugs and Drug Addiction estimating it to be around 50% of drug users also having a mental health condition in 2015.¹⁴⁸ There is also a very high prevalence of comorbidities in the prison population with a history of drug dependence is a significant risk factor in prison suicides.¹⁴⁹ Within the prison context, as in the community, there is a high degree of overlap in relation to responsibility for dual diagnosis management and care including primary and secondary mental health services, drug and alcohol treatment services, chaplaincy and peer support groups including Prison Listeners.¹⁵⁰

In the UK, evidence-based guidelines for the treatment of mental health conditions indicate that a substance misuse condition should not restrict an individual's access to the treatment usually provided by a mental health service.¹³⁶

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

¹⁴⁶ National Institute for Health and Care Excellence. 2019. Coexisting severe mental illness and substance misuse. Quality standard [QS188]. Available at: <https://www.NationalInstituteforHealthandCareExcellence.org.uk/guidance/qs188/chapter/Quality-statements>

¹⁴⁷ Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

¹⁴⁸ Perspectives on Drugs: Comorbidity of substance use and mental health disorders in Europe, EMCDDA, Lisbon 2016; https://www.emcdda.europa.eu/topics/pods/comorbidity-substance-use-mental-disorders-europe_en {accessed 8th July 2020}

¹⁴⁹ Office for National Statistics. 2019. Drug-related deaths and suicide in prison custody in England and Wales: 2008 to 2016. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/drugrelateddeathsandsuicideinprisoncustodyinenglandandwales/2008to2016>

¹⁵⁰ Ministry of Justice and Department of Health. 2009. A guide for the management of dual diagnosis in Prisons. Available at: [DualDiagnosisPrisons.pdf](#)

treatment with specialist mental health services.¹⁵¹ There is a growing research base for dual focus interventions, addressing both substance use and mental health conditions simultaneously, with evidence relating to its effectiveness available for dual treatment of depression, bipolar disorder and post-traumatic stress disorder. This may involve adaption of a single intervention, such as cognitive behavioural therapy, or the blending of two evidence-based interventions.^{152,153} Sequential models that prioritise the stabilisation of one condition over another, until the successful stabilisation of the first, are not recommended.

Where feasible, treatment for individuals with comorbidities are best provided by one comprehensive service, however, it may be 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.¹³⁶ This will require good working relationships and pathways with local providers, between and across prison and community-based substance misuse, mental health and criminal justice services.

Detailed management of substance use alongside specific co-existing mental health conditions are provided in the Clinical Guidelines on Drug Misuse and Dependence.¹³⁶ Components in the standard treatment of co-occurring mental health and substance use disorders include:

- Good case management, effective communication and assertive outreach for service user
- A focus on building and maintaining the therapeutic relationship, utilising a motivational approach
- A focus on retention in treatment, supported by a motivational approach and other behavioural interventions such as contingency management
- Treatments that develop resilience and self-esteem in addition to those focusing on symptom reduction
- Where indicated, simultaneously addressing mental health and substance use symptoms and stepping up intensity of treatment as required
- Multi-faceted treatment, with combinations of evidenced-based psychological therapies (and pharmacological therapy, are likely to result in the greatest efficacy.

¹⁵¹ Royal College of Psychiatrists and Quality network for prison mental health services. 2018. Standards for Prison Mental Health Services – Fourth Edition. Available at: improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2 See also: Royal College of psychiatrists (DRAFT) Universal Standards for Mental Health Services in Prisons in Wales.

¹⁵² Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (2017) Drug misuse and dependence: UK guidelines on clinical management. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

¹⁵³ European Monitoring Centre for Drugs and Drug Addiction. 2016. PERSPECTIVES ON DRUGS. Comorbidity of substance use and mental health disorders in Europe. Available at: https://www.emcdda.europa.eu/system/files/publications/2935/Comorbidity_POD2016.pdf

2.6 Screening, diagnosis and treatment for infectious disease

In relation to infectious disease, and due to the increased risk of infection and transmission, particularly amongst people with substance misuse disorders, NICE recommends that ‘people entering or transferring between prisons are tested for blood-borne viruses and assessed for risk of sexually transmitted infections’¹⁵⁴ and that ‘prison health services offer an interferon-gamma release assay (IGRA) test for TB to inmates who are in regular contact with substance misuse services, homelessness or other support services’. The IGRA screening should be incorporated with screening for hepatitis B and C, and HIV testing (see Section 2.6.1).¹⁵⁵

Active case finding at entry to the prison environment provides an effective and cost-effective mechanism for prevention of transmission within prison and communities, and for the diagnosis and treatment for those affected for communicable diseases including blood borne virus: hepatitis B, hepatitis C and HIV, TB and sexually transmitted infections (STIs): chlamydia, gonorrhoea, syphilis and trichomoniasis.¹⁵⁶

Routine opt-out testing offered on entry is associated with greater uptake than during sentence or post release for viral hepatitis and HIV and STIs. Rapid and non-invasive methods of testing are preferred for all testing and substantial improvements in uptake of testing have been shown following provision of education and peer-education interventions.¹¹³

Robust testing, record keeping and information sharing mechanisms and systems are required to ensure continuity of care, testing, diagnosis and treatment both across the prison estate and the community.

2.6.1 Blood borne viruses

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/2017/048.¹⁵⁸ People vaccinated against hepatitis B should receive the full course, which consists of 3 injections of hepatitis B vaccine over 21 days (zero, seven and 21 days) with a fourth dose

¹⁵⁴ National Institute for Health and Care Excellence. 2017. Physical health of people in prisons Quality standard [QS156]. Available at: <https://www.NationalInstituteforHealthandCareExcellence.org.uk/guidance/qs156/chapter/Quality-statement-3-Blood-borne-viruses-and-sexually-transmitted-infections>

¹⁵⁵ National Institute for Health and Care Excellence. Tuberculosis NICE guideline [NG33]. Updated 2019. Available at: <https://www.nice.org.uk/guidance/ng33>

¹⁵⁶ European Centre for Disease Prevention and Control and the European Monitoring Centre for Drugs and Drug Addiction. Systematic review on active case finding of communicable diseases in prison settings. Stockholm: ECDC; 2017. Available at: <https://www.ecdc.europa.eu/sites/default/files/documents/Systematic-review-on-communicable-diseases-in-prison-settings-final-report.pdf>

¹⁵⁷ National Institute for Health and Care Excellence. 2012. Drug use disorders in adults. Quality standard [QS23] Available at:

<https://www.NationalInstituteforHealthandCareExcellence.org.uk/guidance/qs23/chapter/Quality-statement-4-Blood-borne-viruses>

¹⁵⁸ Welsh Government. Welsh Health Circular. Attaining the WHO targets for eliminating hepatitis (B and C) as a significant threat to public health. Available at: <https://gov.wales/sites/default/files/publications/2019-07/attaining-the-who-targets-for-eliminating-hepatitis-b-and-c-as-a-significant-threat-to-public-health.pdf>

administered at 12 months after the first dose for the individual to be considered protected.¹⁵⁹

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.

In line with NICE guidance, the BBV (hepatitis) care pathways should ensure:

- Prisons Healthcare services should have a nominated NHS hepatitis lead in each prison
- PCIP with diagnosed hepatitis B and C are referred to, and treatment managed by the local hepatitis specialist treatment providers using in-reach services, in liaison with prison healthcare services. Investigations and follow-up should be undertaken in the prison if possible
- Prison healthcare services (coordinated with and supported by the NHS lead for hepatitis) should ensure that all PCIP are offered hepatitis B vaccination when entering prison and provided with a very rapid vaccination schedule (Engerix B® with three doses given at zero, seven and 21 days and a fourth dose should be administered 12 months after the first dose to provide longer term protection)¹⁶⁰
- All PCIPs who test for hepatitis B or C receive the results of the test, regardless of their location when the test results become available. If consent has been given, the results from hepatitis B and C testing may be provided to the PCIPs community-based GP.
- The NHS lead for hepatitis treatment in prisons should ensure continuity of hepatitis treatment through contingency, liaison and handover arrangements before the PCIPs release date, or before any PCIP receiving hepatitis treatment is transferred between prisons or removal centres. Once a PCIP has started treatment, it may be helpful to put them on medical hold to ensure continuity of care (which might be compromised by transfer between prisons).

¹⁵⁹ Public Health Wales. Hepatitis B: the green book, chapter 18. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/263311/Green_Book_Chapter_18_v2_0.pdf

¹⁶⁰ Public Health England. Hepatitis B: the Green Book, Chapter 18. Available at: <https://www.gov.uk/government/publications/hepatitis-b-the-green-book-chapter-18>

In the case of a positive HIV test result, in line with BHIVA standards of care for people living with HIV¹⁶¹ testing and treatment:

- Services that offer diagnostic testing for HIV should have an agreed pathway into specialist HIV care for people who are diagnosed HIV positive
- People who have a new diagnosis of HIV should expect to have their HIV status fully assessed, and support provided, by appropriately trained staff within 2 weeks of receiving an HIV-positive test result
- People who have a new diagnosis of HIV and have symptoms and/or signs potentially attributable to HIV (including those of primary infection) should be referred for urgent (within 24 hours) specialist assessment
- Partners of people who test positive should receive a prompt offer and recommendation of an HIV test through partner notification procedures
- People in prisons or other detention facilities should have a regular and continuous supply of ARVs alongside adequate access to an HIV specialist, and continuity of both treatment and access should be maintained when being moved between facilities. On leaving these facilities they should be provided with at least 1 month's supply of medication to allow continued adherence while making their own arrangements for a further supply and a booked follow-up appointment with an HIV provider. These arrangements should be included in the ICP with support from Community Offender Manager to ensure continuity of care
- All people living with HIV should be provided with equitable and non-discriminatory care across all healthcare settings. The standard of care delivered to people living with HIV should be the same, whatever their circumstances. People in prisons or in other closed settings, such as detention centres have the right to the same quality of care as other people living with HIV.
- In keeping with the management of other long-term health conditions, people living with HIV should be enabled to optimise self-management and access peer-support opportunities to promote their physical and mental health, and overall well-being

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. Treatment options and commencement will be subject to clinical judgement and PCIP preference, influenced by factors including

¹⁶¹ British HIV Association. 2018. Standards of Care for People Living with HIV. Available at: <https://www.bhiva.org/file/KrfaFqLZRIBhg/BHIVA-Standards-of-Care-2018.pdf>

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.

2.6.2 Tuberculosis (TB)

As per NICE guidance:¹⁶²

- Multidisciplinary TB teams, prisons, custody suites and healthcare services should have named TB liaison leads to ensure they can communicate effectively with each other
- Prison and custody suite healthcare services should develop a TB policy by working with the TB control board, and multidisciplinary TB team and the local Public Health Protection team. The TB policy should include follow-up communication and care when the test results for an individual tested in prison are received after the individual PCIP has been released or transferred.
- In prisons that receive PCIPs from high-incidence areas, prison health services should offer an interferon-gamma release assay (IGRA) test for TB to inmates younger than 65 years who are in regular contact with substance misuse services or other support services.
- PCIPs with positive IGRA test results should be referred to local multidisciplinary TB teams for further clinical investigations. These investigations should be done in the prison if practically possible.
- In testing for active TB, Healthcare professionals in prisons should ensure PCIPs are screened for TB within 48 hours of arrival. Prisons with Department of Health-funded static digital X-ray facilities for TB screening should X-ray all new PCIPs (including those being transferred from other establishments) if they have not had a chest X-ray in the past 6 months. This should take place within 48 hours of arrival.
- Prison health staff should report all suspected and confirmed TB cases to the local multidisciplinary TB team within 1 working day.
- Multidisciplinary TB staff should visit every confirmed TB case in a prison in their locality within 5 working days.
- If a case of active TB is identified, the local Public Health Protection Team, in conjunction with the multidisciplinary TB team, should plan a contact investigations exercise and consider using mobile X-ray to check for further

¹⁶² National Institute for Health and Care Excellence. Tuberculosis NICE guideline [NG33]. Updated 2019. Available at: <https://www.nice.org.uk/guidance/ng33>

cases. Isolation, management and treatment procedures should be followed in line with NICE guidance and protocols.

2.6.3 Sexually Transmitted infections

In line with NICE recommendations for the physical care of people in prisons,¹⁶³ prison health care services should:

- Ensure that people entering or transferring between prisons are assessed for risk of sexually transmitted infections and based on their sexual history, provide appropriate testing and treatment
- Offer people in prison information about sexually transmitted infections and available sexual health services
- Ensure that people in prison have discreet access to condoms, dental dams and water-based lubricants without the need to ask for them

Key recommendations from the Sexual Health Review in Wales,¹⁶⁴ and the resultant Sexual Health Service Specification¹⁶⁵ endorsed by the Welsh Government¹⁶⁶ 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. Health Boards are required to provide, either directly or through contract:

- Services which will offer testing for chlamydia and gonorrhoea as a minimum to all patients seeking health care with regards to a sexual health issue.
- Provide STI testing to low risk individuals who are requesting the service for peace of mind.
- Provide access to appropriate interventions to prevent illness and STI transmission e.g. Pre-exposure prophylaxis and post-exposure prophylaxis for HIV, in a timely manner as indicated in clinical guidelines.
- Manage patients diagnosed with gonorrhoea, syphilis or HIV in line with clinical guidelines. This is expected to be a specialist sexual health service.
- Encourage access to regular testing for all individuals at increased risk of infection.
- Assess the risk of coercion and exploitation in sexually active individuals.
- Deliver sexual health care in line with agreed professional standards (British Association of Sexual Health and HIV, Faculty of Sexual and Reproductive Healthcare and Royal College of General Practitioners).
- Ensure that, in order to minimise the risk of onward transmission, rapid treatment is provided and that partner notification is undertaken promptly

¹⁶³ National Institute for Health and Care Excellence. Physical health of people in prisons. Quality standard [QS156]. Available at: <https://www.nice.org.uk/guidance/qs156/chapter/Quality-statement-3-Blood-borne-viruses-and-sexually-transmitted-infections>

¹⁶⁴ Public Health Wales. 2018. Sexual Health Review 2017/18. Available at:

<http://www.wales.nhs.uk/sitesplus/documents/888/A%20Review%20of%20Sexual%20Health%20in%20Wales%20-%20Final%20Report.pdf>

¹⁶⁵ Public Health Wales. 2018. Sexual Health Service Specification 2018. Available at:

<http://www.wales.nhs.uk/sitesplus/documents/888/SH%20service%20spec%202018%28Nov%29.pdf>

¹⁶⁶ Welsh Government. 2019. Welsh Health Circular WHC/2019/011. Available at: <https://gov.wales/sites/default/files/publications/2019-05/implementing-recommendations-of-the-review-of-sexual-health-services-action-to-date-and-next-steps.pdf>

- Provide increased access to testing to enable early diagnosis and treatment of HIV which will prevent onward transmission.
- Ensure access to the full choice of contraceptive methods, maximising effective use of contraception and preventing unintended pregnancies.
- Ensure access to the full range of long-acting reversible contraception (LARC) without delay.
- Ensure access to unplanned pregnancy services in line with Royal College of Obstetricians and Gynaecologists and NICE guidelines.
- Ensure that all abortion services are provided locally unless in exceptional circumstances (such as very late gestations or serious medical conditions)
- Provide women with the contraceptive method of their choice (if clinically appropriate) prior to being discharged from maternity services. This includes intrauterine contraception and subdermal implants

Process

Assessment for risk, and screening for STIs including chlamydia, gonorrhoea, syphilis and trichomoniasis should be undertaken at reception / first assessment in line with NICE guidance¹⁶⁷ and alongside blood borne viruses including HIV.

Testing for syphilis may be undertaken alongside testing for blood borne viruses using the dried blood spot procedure. Testing for chlamydia, gonorrhoea and trichomoniasis should be undertaken using urine sample / swab techniques.

¹⁶⁷ National Institute of Health and Care Excellence. 2016. NICE guideline Physical Health of people in prison [NG57]. Available at: <https://www.nice.org.uk/guidance/ng57/resources/physical-health-of-people-in-prison-pdf-1837518334405>

3 Support for resettlement

Ensuring appropriate and sustainable accommodation following release from prison is critical to continuity of care and support. 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.

The Housing (Wales) Act 2014 sets out the legal definition of homelessness:

'Where a person lacks accommodation or where their tenure is not secure'

This includes those that are:

- Rough Sleeping
- Living in insecure/temporary housing (excluding assured/assured short-hold tenants);
- Living in short term hostels, night shelters, direct access hostels;
- Living in bed and breakfasts;
- Moving frequently between relatives/friends;
- Being unable to remain in or return to housing due to poor housing conditions; overcrowding; unaffordability; domestic abuse; harassment; mental; physical and/or sexual abuse;
- Accommodation not meeting the needs of people with physical or learning disabilities, sensory impairments or mental health conditions;
- Being threatened with losing their home and without suitable alternative accommodation for any reason, e.g. domestic abuse;
- Leaving hospitals, police custody, prisons, the armed forces and other institutions without a home to go to;
- Being required to leave by family or friends or due to relationship breakdown;
- Within 56 days of the end of tenancy, facing possession proceedings or threat of eviction.

This also includes sleeping in cars, tents, public transport, squatting, unsuitable non-residential accommodation such as a garage or shed, as well as staying in a refuge and 'sofa surfing'.

The Welsh Government's Programme for Government¹⁶⁸ includes a commitment to transform homelessness services during this Senedd term. This will likely include,

¹⁶⁸ Welsh Government. 2021. Programme for government 2021 to 2026. Available at: [Programme for government 2021 to 2026 | GOV.WALES](https://gov.wales/programme-for-government-2021-to-2026/)

changes to homelessness legislation which may impact on the intervention a prison leaver will receive.

There is extensive research to show the link between homelessness and re-offending and imprisonment.

Housing is one of the key elements required to ensure the successful resettlement and rehabilitation of prisoners. Prison leavers are disproportionately represented amongst the homelessness population. Prison leavers without suitable, safe, secure housing are more likely to reoffend, to relapse into substance misuse and to experience a decline in their mental health and wellbeing. Without stable accommodation, accessing employment and training opportunities is much more difficult.

The Existing Strategic Framework seeks to:

- Develop a reporting mechanism to describe the demand and profile for accommodation from prison leavers.
- Improve access to the private rental sector and registered social housing.
- Increase the commissioning and provision of specialist accommodation support for ALL types of prison leavers
- Review the resettlement pathway allowing for regional variation and support in-reach resettlement services.
- Engage with housing providers to challenge and reduce stigmatisation of prison leavers.

In order to:

- Ensure that nobody is released from the secure estate homeless
- To end the 'revolving door' custody - homelessness - custody cycle
- Provide housing that is suitable and meets their needs
- Ensure housing is affordable, sustainable and good quality
- Support individuals to sustain tenancies and to thrive in their homes
- Improve accommodation for MAPPAs cohorts including those going through Complex Housing Panels
- Support those moving from custody to Approved Premises (AP) and from AP to independent accommodation;
- Apply a trauma informed lens to the process of accommodating prison leavers and support the implementation of psychologically informed environments;
- Strengthening of delivery of services to people with mental health and/or substance misuse problems, including improved joint working between housing and mental health/substance misuse services

3.1.1 Community Resettlement Services (CRS)

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.

3.1.2 Accommodation Pathway Co-ordinators

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.

3.1.3 Multi-agency public protection arrangements (MAPPA)

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.

3.1.4 Accommodation & Employment

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.

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.

3.1.5 Women in Justice and Youth Justice Blueprints:

The Accommodating Offenders Framework Wales will align with both the Women in Justice¹⁶⁹ and Youth Justice¹⁷⁰ 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.

3.1.6 Ending Homelessness Action Plan, Rapid Rehousing transformation and Housing First

The Welsh Government published the Ending Homelessness: A high level action plan – 2021-2026¹⁷¹ which outlines the high level actions required to make homelessness rare, brief and non-recurrent in Wales. The action plan acknowledges

¹⁶⁹ Welsh Government and Ministry of Justice. Female Offending Blueprint for Wales. Available at: https://gov.wales/sites/default/files/publications/2019-05/female-offending-blueprint_3.pdf

¹⁷⁰ Welsh Government and Ministry of Justice. Youth Justice Blueprint for Wales. Available at: https://gov.wales/sites/default/files/publications/2019-05/youth-justice-blueprint_0.pdf

¹⁷¹ [Ending homelessness in Wales: a high level action plan 2021 to 2026 \(gov.wales\)](https://gov.wales/sites/default/files/publications/2021-05/ending-homelessness-in-wales-a-high-level-action-plan-2021-to-2026.pdf)

the role that health and criminal justice services will need to take to help prevent homelessness for those in the secure estate.

A key element of the Action Plan is the transformation of homelessness services in Wales, which is in itself a key Programme for Government commitment.

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. Given the need to increase the efficiency of the entire homelessness service in order to make the transformation, local authorities have a five year time period to make the transition.

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.

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4 Workforce development

4.1 Staff Training and Engagement

A whole staff approach

Investing in workforce development can have a range of positive effects on the services provided, and benefits to both the employer and employee, including improvement in staff morale and promoting job satisfaction. Providing training within the workplace can:

- Encourage employees to take an active interest in their continued personal development and progress
- Lead to expansion of the workforce skills sets
- Provide greater capacity and sustainability within the workforce
- Improve the organisations ability to respond to future skills gaps and responsiveness.

Providing additional knowledge and skills, can also drive improvements in work practices to meet and exceed quality standards.

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.

The misuse of substances is one of the biggest challenges facing the criminal justice system. The number of positive random drug tests for psychoactive substances controlled by the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016, increase by 50% between 2012/13 and 2017/18. It is recognised that a multi-faceted, whole system approach is required to address the issue of substance misuse.¹⁷²

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

¹⁷² Prison Drugs Strategy, HM Prison and Probation Service, 2019. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/792125/prison-drugs-strategy.pdf {accessed 18th November 2020}

Officer Entry Level Training (POELT). The POELT training¹⁷³ provides brief training the cover learning outcomes including:

- Some of the reasons why people take drugs
- Substances commonly used in prison
- Describe what a drug is and list the four main groups of drugs and their effects
- List methods of drug taking
- Identify items used in drug taking
- Describe some of the health harms arising from licit and illicit substance use
- Signposting prisoners into relevant treatment/recovery services
- State the different types of drug testing undertaken in establishments
- Describe the strategies that are in place to reduce supply and demand of drugs in prison

However, POELT training does not currently deliver any specific substance misuse training within the Exceptional Delivery Model, only being referenced and discussed in the Support and Advice on Sexual Health (SASH) /Mental Health and Searching elements. Providing this training across all the prison estate and professional disciplines will facilitate the building of more constructive relationships with people in prison.

The need for substance misuse training and education for all staff is further evidenced in the Prison Drugs Strategy, addressing demand for drugs stating that “reducing the demand for drugs relies upon ensuring that prisoners understand the consequences of drug use, both within the prison and the wider risks to themselves and their families.”¹⁷⁴ Therefore prison staff should be knowledgeable around not only the legislative and punitive consequences of substance misuse, but also the wider physical, psychological and social harms associated to substance misuse.

Substance misuse needs to be addressed holistically and there are many factors associated with use and misuse, including mental health needs and trauma. In line with the Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem, “In order for the workforce to be effective it needs to be competent in both mental health and substance misuse

¹⁷³ Her Majesty’s Prison and Probation Service Learning and Development. 2018. Prison Officer Entry Level Training - Core Curriculum V3.2. Available at: https://www.whatdotheyknow.com/request/565860/response/1357127/attach/5/Curriculum%20booklet%20v3.2.pdf?cookie_passthroug h=1

¹⁷⁴ Prison Drugs Strategy, HM Prison and Probation Service, 2019, page 15. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/792125/prison-drugs-strategy.pdf {accessed 18th November 2020}

practice.”^{175,p13} A whole staff / prison work force development plan facilitate progress towards ensuring equivalence of care for people within prisons to that provided in the community, allowing individuals access to pragmatic and timely information, brief interventions and treatment as needed.

Trauma-informed approaches training should be provided to staff across services¹⁷⁶ 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. Appropriate supervision and support should be provided with an awareness and sensitivity to symptoms of secondary traumatic stress.

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. It is recommended that where possible each shift has an identified lead who can act as a point of contact, information, advice and support for other prison staff and people in prison.

Peer Support

There are clear benefits of having a good peer support model within a secure setting, including having a positive impact on the attitudes, engagement and behaviour of the recipients.^{177, 178} Peers can often be easier to access for people in prison than professionals, making them a more readily available form of support.¹⁷⁹

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.¹⁸⁰ There is evidence that becoming a peer supporter can also have a positive effect on individual PCIPs in prison, for example, by enhancing confidence and self-esteem, improving

¹⁷⁵ Welsh Government (2015) Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem. Available at: <https://gov.wales/sites/default/files/publications/2019-02/service-framework-for-the-treatment-of-people-with-a-co-occurring-mental-health-and-substance-misuse-problem.pdf>

¹⁷⁶ Royal College of Psychiatrists and Quality network for prison mental health services. 2018. Standards for Prison Mental Health Services – Fourth Edition. Available at: [improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2](https://www.rcpsych.ac.uk/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2) See also: Royal College of psychiatrists (DRAFT) Universal Standards for Mental Health Services in Prisons in Wales.

¹⁷⁷ HM Inspectorate of Prisons, (2016), Life in prison: Peer support. Available at: <https://www.justiceinspectorates.gov.uk/hmiprison/inspections/life-in-prison-peer-support/> {accessed 25th November 2020}

¹⁷⁸ Royal College of Psychiatrists and Quality network for prison mental health services. 2018. Standards for Prison Mental Health Services – Fourth Edition. Available at: [improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2](https://www.rcpsych.ac.uk/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2) See also: Royal College of psychiatrists (DRAFT) Universal Standards for Mental Health Services in Prisons in Wales.

¹⁷⁹ Boudin, K. and Weinstein, C., 2010. Peer education in prison: A rights-based approach. *Rights-Based Approaches to Public Health*, p.321.

¹⁸⁰ Guidance: Peer support in prison, A summary of evidence relating to the effectiveness of peer support for prisoners, HM Prison and Probation Service, 2019; <https://www.gov.uk/guidance/peer-support-in-prison> {accessed 25th November 2020}

communication/organisational skills and behaviour, generating a positive self-image, increasing levels of independence, and gaining trust.¹⁷¹

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.

4.2 Competency in assessment, treatment and clinical practice

The Royal College of Nursing,¹⁸¹ the Royal College of Psychiatrists¹⁸² and the General Medical Council¹⁸³ set out the training, standards and outcomes and registration requirements for medical professionals through to postgraduate education including training for specialisms.

4.2.1 Supervision for non-clinical and clinical staff

Supervision sessions are an opportunity to reflect on practice in a supportive environment that facilitates learning from experience. It is through the process of reflection that the workforce can sustain and achieve high quality practice. Supervision should enable individuals a space to reflect on how the environment affects them should be embedded in a culture that promotes well-being for all. Supervision time for both clinical and nonclinical staff should be protected and undertaken on a regular basis. Supervision should be distinct and separate from line management processes.¹⁸⁴

All non-clinical staff should engage with regular individual supervision sessions. The Supervisor should be experienced and competent to provide support appropriate to the individual's role and signpost to relevant services and additional support where necessary. All clinical staff should have access to individual clinical supervision as per professional guidelines by an individual with appropriate clinical experience and competence.

¹⁸¹ Royal College of Nursing. Nursing in justice and forensic health care. Available at: <https://www.rcn.org.uk/clinical-topics/criminal-justice-services>

¹⁸² Royal College of Psychiatrists. Good Psychiatric Practice. College Report CR154. 3rd Edition. 2009. Available at: <college-report-cr154.pdf> (<rcpsych.ac.uk>)

¹⁸³ General Medical Council. Standards, guidance and curricula. Available at: [Standards guidance and curricula - GMC \(gmc-uk.org\)](Standards guidance and curricula - GMC (gmc-uk.org))

¹⁸⁴ Royal College of Psychiatrists and Quality network for prison mental health services. 2018. Standards for Prison Mental Health Services – Fourth Edition. Available at: improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2 See also: Royal College of psychiatrists (DRAFT) Universal Standards for Mental Health Services in Prisons in Wales.

5 Collaborative multi-disciplinary, multi-agency working and information sharing for continuity of care

5.1.1 Collaborative working

Collaborative multidisciplinary and multiagency working is necessary to achieve a whole prison approach and to ensure continuity of care across both prison and community settings. This can be 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.¹⁸⁵ 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.

A process should be in place to ensure that the PCIP is able to communicate their views in relation to their 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.¹⁷⁷ All developments in the PCIPs treatment, care and onward planning should be documented in the ICP and updated by the Prison Offender Manager and onwards to the Community Offender Manager.

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

5.1.2 Information sharing and data flow

In the absence of an existing comprehensive integrated information management system accessible to all involved in an individual's care within prison and community settings, the establishment of robust information sharing protocols and access to appropriate clinical systems is essential.

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.¹⁸⁶ 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

¹⁸⁵ Royal College of Psychiatrists and Quality network for prison mental health services. 2018. Standards for Prison Mental Health Services – Fourth Edition. Available at: [improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2](https://www.rcpsych.ac.uk/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-4th-edition.pdf?sfvrsn=465c58de_2) See also: Royal College of psychiatrists (DRAFT) Universal Standards for Mental Health Services in Prisons in Wales.

¹⁸⁶ Wales Accord for Sharing of Personal Information. Available at: <http://www.waspi.org/home>

confidential information is processed lawfully and protected from inappropriate disclosure.¹⁸⁷

5.1.2.1 Individuals in contact with community-based substance misuse services and/or Criminal Justice Services

For individuals in contact with community-based substance misuse services and/or criminal justice services, including those providing structured and unstructured treatment and psycho-social interventions, an up-to-date Integrated Care Plan (ICP) should be in place prior to and available at point of reception in prison. 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. This ICP should be stored on the existing electronic management systems, for example: Palbase, PARIS, Welsh Community Care Information System (WCCIS) or equivalent. 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.

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.

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. The updated ICP should include all treatments provided within the prison environment and current treatment plan, in addition to the actions and agreements made with regard to resettlement, social functioning and continuity of care and support.

5.1.2.2 Individuals not in contact with community-based substance misuse services and/or Criminal Justice Services

Individuals not previously in contact with community-based substance misuse services and/or criminal justice services will not have an Integrated Care Plan (ICP). 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

¹⁸⁷ Digital Health and Care Wales. Welsh Information Governance Toolkit – information sharing. Available at: [Information Sharing - Digital Health and Care Wales \(nhs.wales\)](https://www.nhs.uk/health-and-care-wales/information-sharing/)

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.

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. The updated ICP should include all treatments provided within the prison environment and current treatment plan, in addition to the actions and agreements made with regard to resettlement, social functioning and continuity of care and support.

7. Appendices

Appendix A - Mental Health (Wales) Measure 2010 Section 18 – Care and Treatment Plan

First-stage prison physical and mental health assessment table

Topic questions	Actions
Prison sentence	
1. Has the person committed murder, manslaughter or another offence with a long sentence?	Yes: refer the person for mental health assessment by the prison mental health in-reach team if necessary. No: record no action needed.
Prescribed medicines	
2. Is the person taking any prescribed medicines (for example, insulin) or over-the-counter medicines (such as creams or drops)? If so: <ul style="list-style-type: none"> • what are they • what are they for • how do they take them? 	Yes: 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 (see recommendations 1.7.10 and 1.7.11 in the NICE guideline on physical health of people in prison). Let the person know that medicines reconciliation will take place before the second-stage health assessment. No: record no action needed.

Physical injuries	
<p>3. Has the person received any physical injuries over the past few days, and if so:</p> <ul style="list-style-type: none"> • what were they • how were they treated? 	<p>Yes: assess severity of injury, any treatment received and record any significant head, abdominal injuries or fractures.</p> <p>Document any bruises or lacerations observed on a body map.</p> <p>In very severe cases, or after GP assessment, the person may need to be transferred to an external hospital. Liaise with prison staff to transfer the person to the hospital emergency department by ambulance.</p> <p>If the person has made any allegations of assault, record negative observations as well (for example, 'no physical evidence of injury').</p> <p>No: record no action needed.</p>
Other health conditions	
<p>4. Does the person have any of the following:</p> <ul style="list-style-type: none"> • allergies, asthma, diabetes, epilepsy or history of seizures • chest pain, heart disease • chronic obstructive pulmonary disease • tuberculosis, sickle cell disease • hepatitis B or C virus, HIV, other sexually transmitted infections • learning disabilities • neurodevelopmental disorders • physical disabilities? 	<p>Ask about each condition listed.</p> <p>Yes: make short notes on any details of the person's condition or management. For example, 'Asthma – on Ventolin 1 puff daily'.</p> <p>Make appointments with relevant clinics or specialist nurses if specific needs have been identified.</p> <p>No: record no action needed.</p>
<p>5. Are there any other health problems the person is aware of that have not been reported?</p>	<p>Yes: record the details and check with the person that no other physical health complaint has been overlooked.</p> <p>No: record no action needed.</p>
<p>6. Are there any other concerns about the person's health?</p>	<p>Yes: make a note of any other concerns about physical health. This should include any health-related observations about the person's physical appearance (for example, weight, pallor, jaundice, gait or frailty). Refer the person to the GP or relevant clinic.</p> <p>No: note 'Nil'.</p>

Additional questions for women	
7. Does the woman have reason to think she is pregnant, or would she like a pregnancy test?	<p>If the woman is pregnant, refer to the GP and midwife.</p> <p>If there is reason to think the woman is pregnant, or would like a pregnancy test: provide a pregnancy test. Record the outcome. If positive, make an appointment for the woman to see the GP and midwife.</p> <p>No: record response.</p>
Living arrangements, mobility and diet	
8. Does the person need help to live independently?	<p>Yes: note any needs. Liaise with the prison disability lead in reception about:</p> <ul style="list-style-type: none"> • the location of the person's cell • further disability assessments the prison may need to carry out. <p>No: record response.</p>
9. Do they use any equipment or aids (for example, walking stick, hearing aid, glasses, dentures, continence aids or stoma)?	<p>Yes: remind prison staff that all special equipment and aids the person uses should follow them from reception to their cell.</p> <p>No: record response.</p>
10. Do they need a special medical diet?	<p>Yes: confirm the need for a special medical diet. Note the medical diet the person needs and send a request to catering. Refer to appropriate clinic for ongoing monitoring.</p> <p>No: record response.</p>
Past or future medical appointments	
11. Has the person seen a doctor or other healthcare professional in the past few months? If so, what was this for?	<p>Yes: note details of any recent medical contact. Arrange a contact letter to get further information from the person's doctor or specialist clinic. Note any ongoing treatment the person needs and make appointments with relevant clinics, specialist nurses, GP or other healthcare staff.</p> <p>No: record no action needed.</p>
12. Does the person have any outstanding medical appointments? If so, who are they with, and when?	<p>Yes: note future appointment dates. Ask healthcare administrative staff to manage these appointments or arrange for new dates and referral</p>

	<p>letters to be sent if the person's current hospital is out of the local area.</p> <p>No: record no action needed.</p>
<p>Alcohol and substance misuse</p>	
<p>13. Does the person drink alcohol, and if so:</p> <ul style="list-style-type: none"> • how much do they normally drink? • how much did they drink in the week before coming into custody? 	<p>Urgently refer the person to the GP or an alternative suitable healthcare professional if:</p> <ul style="list-style-type: none"> • they drink more than 15 units of alcohol daily or • they are showing signs of withdrawal or • they have been given medication for withdrawal in police or court cells. <p>No: record response.</p>
<p>14. Has the person used street drugs in the last month? If so, how frequently? When did they last use:</p> <ul style="list-style-type: none"> • heroin • methadone • benzodiazepines • amphetamine • cocaine or crack • novel psychoactive substances • cannabis • anabolic steroids • performance and image enhancing drugs? 	<p>Yes: refer the person to substance misuse services if there are concerns about their immediate clinical management and they need immediate support. Take into account whether:</p> <ul style="list-style-type: none"> • they have taken drugs intravenously • they have a positive urine test for drugs • their answers suggest that they use drugs more than once a week • they have been given medication for withdrawal in police or court cells. <p>If the person has used intravenous drugs, check them for injection sites. Refer them to substance misuse services if there are concerns about their immediate clinical management and they need immediate support.</p> <p>No: record response.</p>
<p>Problematic use of prescription medicines</p>	
<p>15. Has the person used prescription or over-the-counter medicines in the past month:</p> <ul style="list-style-type: none"> • that were not prescribed or recommended for them or • for purposes or at doses that were not prescribed? 	<p>Yes: refer the person to substance misuse services if there are concerns about their immediate clinical management and they need immediate support.</p> <p>No: record response.</p>

<ul style="list-style-type: none"> If so, what was the medicine and how did they use it (frequency and dose)? 	
Mental health	
<p>16. Has the person ever seen a healthcare professional or service about a mental health problem (including a psychiatrist, GP, psychologist, counsellor, community mental health services, alcohol or substance misuse services or learning disability services)?</p> <p>If so, who did they see and what was the nature of the problem?</p>	<p>Yes: refer the person for a mental health assessment if they have previously seen a mental health professional in any service setting.</p> <p>No: record response.</p>
<p>17. Has the person ever been admitted to a psychiatric hospital, and if so:</p> <ul style="list-style-type: none"> when was their most recent discharge what is the name of the hospital what is the name of their consultant? 	<p>Yes: refer the person for a mental health assessment.</p> <p>No: record response.</p>
<p>18. Has the person ever been prescribed medicine for any mental health problems? If so:</p> <ul style="list-style-type: none"> what was the medicine when did they receive it when did they take the last dose what is the current dose (if they are still taking it) when did they stop taking it? 	<p>Yes: refer the person for a mental health assessment if they have taken medicine for mental health problems.</p> <p>No: record response.</p>
Self-harm and suicide risk	
<p>19. Is the person:</p> <ul style="list-style-type: none"> feeling hopeless or currently thinking about or planning to harm themselves or attempt suicide? 	<p>Yes: refer the person for an urgent mental health assessment. Open an Assessment, Care in Custody and Teamwork (ACCT) plan if:</p> <ul style="list-style-type: none"> there are serious concerns raised in response to questions about self-harm, including thoughts, intentions or plans, or observations (for example, the patient is very withdrawn or agitated) or the person has a history of previous suicide attempts. <p>Be aware and record details of the impact of the sentence on the person, changes in legal status and first imprisonment, and the nature of the offence (for example, murder,</p>

	manslaughter, offence against the person and sexual offences). No: record response.
20. Has the person ever tried to harm themselves, and if so: <ul style="list-style-type: none">• do they have a history of suicide attempts• was this inside or outside prison• when was the most recent incident• what was the most serious incident?	

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