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Annex 3 - Mental health minimum service requirements

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Healthcare	
1.	All patients must be offered a physical and mental healthcare screen by a GP under the requirements of detention services (Rule 34 for IRCs) within 24 hours of their arrival in the establishment.
2.	All practitioners carrying out mental health assessments are competent to assess problems that commonly arise and have knowledge and awareness of mental health diagnoses and pathways within the service.
3.	During the initial mental health assessment, individuals over 50 years old are offered an older adult assessment, and reasonable adjustments are made according to needs.
4.	There is a clear and consistent process for staff to refer individuals directly to the mental health team.
5.	Urgent care provision to be available seven days a week.
6.	Urgent assessments to be made within 24 hours.
7.	Patients should have a comprehensive evidence-based assessment which includes: • mental health and medication • psychosocial and psychological needs • strengths and development • risk to self and others • intellectual and developmental disabilities • substance misuse.
8.	The integrated mental health team should provide notes to the assessor and request those available from community services. These should be logged and checked how up to date the information is and how it was gathered.
9.	Patients receive a risk assessment and management plan which should be updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment should consider risk to self, risk to others and risk from others.
10.	Patients must be involved in the development of their risk assessment and management plan.
11.	Patients should have a complete assessment, taking a person-centred approach. Where a complete assessment is not in place, a working diagnosis and/or a preliminary formulation are devised.
12.	All information must be provided to patients in a format they can easily understand, such as different languages or easy-to read or pictorial formats.

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13.	The service should provide information on how to make a referral and waiting times for assessment and treatment.
14.	Staff members should talk through patient information with the patient as soon as possible. The information should include: • their rights regarding consent to treatment • how to access advocacy services • how to request a second opinion • interpreting services • how to view their records • how to raise concerns, complaints and give compliments.
15.	There must be a clear system for making referrals.
Treatment and recovery	
16.	Every patient should have a written care plan, reflecting their individual needs. Staff members should seek input from patients when developing the care plan and offer them a copy. This plan should outline: • agreed intervention strategies for physical and mental health • measurable goals and outcomes • strategies for self-management • any advance directives or stated wishes that the patient has made • crisis and contingency plans • review dates and discharge framework.
17.	Patients should be offered information about their mental health conditions and treatment in a format they can easily understand, such as different languages or easy-to read or pictorial formats.
18.	The patient should be given information on the intervention being offered and the risks and benefits are discussed with them. This is recorded in clinical records.
19.	A physical health review should take place as part of the initial assessment, or soon afterwards. All staff can signpost to a GP or other professional if required.
20.	Patients should be managed under the new models of care for people with common mental health disorders (NICE guidelines 41, 2011).
21.	Patients should have access to low-level interventions and a range of psychological therapies. These interventions must be delivered by adequately trained and supported mental health professionals. The interventions and therapies should be adapted to the needs of the patient and environment.
22.	Patients should be offered evidence-based interventions which are appropriate for their bio-psychosocial needs, to an agreed timeframe. Any exceptions should be documented in the case notes.

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23.	The team should meet at least once a week to discuss allocation of referrals, current assessments and reviews. Referrals that are urgent or that do not require discussion can be allocated before the meeting.
24.	The team must follow up patients who have not attended an appointment or assessment. If a patient is unwilling to attend, the team should decide, based on patient need and risk, how long to continue to follow up the patient. This must be clearly documented in the multi-disciplinary team meeting minutes and patient records.
25.	In establishments for women there should be a care pathway for the care of perinatal women (pregnancy and 12 months post-partum) to include: • assessment • care and treatment, particularly relating to prescribing psychotropic medication • referral to a specialist perinatal team or unit unless there is a specific reason not to do so.
26.	The service must meet the establishment's specific requirements for healthcare input as stated in detention service orders (DSOs).
Discharge and transfer	
27.	When a patient is transferred to another establishment, the mental health team must provide a comprehensive handover to the receiving establishment's mental health team before the transfer takes place. Where a transfer location is not initially known, the handover must be provided to the receiving team as soon as the original team become aware.
28.	An identified key worker or responsible clinician from the receiving service should be invited to discharge planning meetings. This includes a formalised review of care for patients on secondary care caseload. The review could be part of the care programme approach (CPA), promoting quality care (PQC), care and treatment plan (CTP) or equivalent processes.
29.	On discharge from the team, patient information must be given to the receiving primary care or mental healthcare service. If an individual is released from the IRC back to a community in England, with consent (if eligible) ensure a referral is made to their local RECONNECT and ensure the individual has the contact details of the service on release.
Safety	
30.	The mental health team must be actively involved managing self-harm and suicide risk through the assessment care in detention and teamwork (ACDT) process. They must attend review meetings for all newly opened cases, for all reviews for anyone on their caseload, and where required and relevant to attend.
31.	There must be a clear process to follow when visiting patients outside of clinical rooms to ensure staff are safe when working with patients.
32.	The team must communicate any information that might affect a patient's safety with relevant agencies and care settings, within the limits of confidentiality and patient consent.

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33.	Staff members must follow inter-agency protocols for the safeguarding of vulnerable adults and young people. This includes escalating concerns if an inadequate response is received to a safeguarding referral.
34.	The team must implement policies on food refusal and mental capacity assessments and record and carry out what actions need to be taken.
35.	The team must understand and implement relevant Home Office policies, e.g Rule 34, Rule 35 and the Adult at risk policy.
36.	Team members, including bank staff, must be able to identify and manage an acute physical health emergency, such as carrying out initial cardiopulmonary resuscitation (CPR).
Patient experience	
37.	Patients must be actively involved in shared decision-making about their mental and physical healthcare, treatment and discharge planning and supported in self-management.
38.	The service must ask patients for their feedback about their experiences of using the service and this should be used to improve the service.
39.	Patients must be treated with compassion, dignity and respect. This includes respect of a patient's race, age, sex, gender reassignment, marital status, sexual orientation, maternity, disability and social background.
40.	The patient's decision on consent relating to the sharing of clinical information outside the team must be recorded.
41.	The service must employ interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation.
Collaborative partnerships	
42.	The team must have a policy on inter-agency working across IRCs, social care, physical healthcare and the third sector; within limits of patient consent, confidentiality and risk management. Where integrated healthcare models are in place, the policy must detail effective multi-professional working and collaboration.
43.	There must be written policies in place for liaison and joint working with substance misuse services and primary care in cases of co-morbidity. This can be an individual policy or included as part of a wider operational policy.
44.	There must be regular complex care or multi-pathway meetings involving mental health, primary care and substance misuse teams to share information and develop management plans.
45.	The team must understand and implement policies on reporting intelligence according to the establishment's security reporting system.

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46.	There must be 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. Where integrated healthcare models are in place, there must be clearly outlined roles and responsibilities for patients who are under the care of various teams.
47.	The mental health team must provide mental health awareness training. The team can either deliver training sessions or input into the development of training content and learning materials.
Medicines Optimisation for IRCs	
48.	When medication is prescribed, specific treatment goals should be set with the patient, explaining the risks (including interactions) and benefits; a timescale for treatment should be set and patient consent recorded.
49.	The safe use of high-risk medication must be audited at a service level, at least annually. This includes medications such as lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines, gabapentinoids and stimulants for ADHD. This must include interactions with non-mental health medicines [1].
50.	Psychotropic prescribing rates of medicines such as antidepressants, antipsychotics, ADHD treatments, anxiolytics and hypnotics should be regularly monitored and reviewed.
51.	Patients who are prescribed medication are to receive an annual medication review (NICE guidelines 5, 2015; NICE guidelines 87, 2018).
52.	There must be a system for recording non-compliance with medication. Guidance must be made available to the team on the management of medication and how to deal with non-compliance.
53.	Compliance with medication must be recorded as part of the patient's care plan and this should be reviewed monthly, or more frequently where required. The team must proactively follow up with patients who fail to collect or take their medication, and record this in their care plan.
54.	There must be clear written protocols outlining prescribing and monitoring responsibilities when care us shared between hospital clinicians, psychiatrists, GPs and non-medical prescribers. Clinicians should refer to 'Safer prescribing in prisons: guidance for clinicians, second edition' (RCGP, 2019).
Environment	
55.	Staff must give patients the opportunity to attend appointments with the team at the scheduled appointment time, even if this is outside of unlock times.

[1] https://www.england.nhs.uk/publication/heath-and-justice-mental-health-services-safer-use-of-mental-health-medicines/

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56.	There must be designated healthcare rooms for the team to run clinics and one-to-one sessions.
57.	All interview rooms should feel safe to patients and staff. This includes the rooms being situated close to staffed areas, having an emergency call system, an internal inspection window and an exit which is unimpeded. There should be no objects present which could easily be used as weapons.
58.	Clinical rooms should be quiet and private, so that conversations cannot be easily overheard.
59.	The mental health team must have its own dedicated spaces and meeting rooms for confidential working.
60.	There must be sufficient IT resources (such as computers and adequate data speeds) so that all practitioners can easily access key information: on services, conditions, treatment options, patient records, clinical outcomes and service performance measurements. Staff must also have access to online video conferencing applications such as Microsoft Teams to facilitate remote meetings and videocalls.
Workforce	
61.	The multi-disciplinary team should consist of or have access to staff from professional backgrounds who have appropriate competencies. The skills mix should take account of relevant and current qualifications in line with their specific job role, so they can deliver a full range of appropriate treatments or therapies.
62.	The service must have a mechanism for responding to safer staffing issues, including: • a method for the team to report concerns about staffing • guaranteed cover if additional staff are needed at short notice • an agreed contingency plan. An overdependence on bank and agency staff may be considered a breach of contract.
63.	When a staff member is on leave, the provider must provide adequate cover for the patients who are allocated to that staff member.
64.	Prescribers should have access to a specialist pharmacist to discuss medications.
65.	There should be a named clinical lead for the team. This clinical lead will have overall responsibility for the clinical requirements of the service.
66.	There must be written arrangements and processes in place to ensure specialist mental health advice can be accessed out of hours.
67.	There is a minimum of monthly multidisciplinary team clinical meetings, which are recorded with written minutes.
68.	There must be processes and initiatives in place to support staff health and well-being. This includes:

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	• providing access to support services and wellbeing programmes • monitoring staff sickness and burnout • encouraging staff to take scheduled breaks • assessing and improving morale • monitoring staff turnover • reviewing feedback from exit reports and taking action where needed.
69.	New staff members, including bank staff, must receive an induction based on an agreed list of core competencies. This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.
70.	All staff who use an electronic patient recording system must receive formal training so they are competent in its use, for example, SystmOne training.
71.	The team must receive training appropriate to their roles on risk assessment and risk management. This training, which should be based on local guidelines, must cover: • safeguarding vulnerable adults and children • assessing and managing suicide risk and self-harm • prevention and management of aggression and violence.
72.	Staff must understand of the principles of trauma informed care and should be offered training on this practice.
73.	Staff must receive training consistent with their role and in line with their professional body. This is recorded in their personal development plan and is refreshed in accordance with local guidelines.
74.	Staff must receive training on the use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).
75.	Staff must receive statutory and mandatory training. This includes equality and diversity, information governance and basic life support.
76.	Team members must be trained and fully informed about the assessment and management of mental health presentations in people with a learning disability and neurodiversity.
77.	All staff members must receive an annual appraisal and personal development planning or equivalent. This should contain clear objectives and identify their development needs.
78.	All clinical staff members must receive individual clinical supervision at least monthly or as otherwise specified by their professional body.
79.	All staff members must receive monthly line management supervision. to manage individual performance and discuss organisational, professional and personal objectives.
80.	All staff members who deliver therapies and activities must be appropriately trained and supervised.

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81.	Staff members should have access to reflective practice groups at least every six weeks, where teams can meet to think about team dynamics and develop their clinical practice.
Leadership and governance	
82.	A representative of the mental health team must be part of the establishment's clinical governance and quality processes.
83.	The service must meet the establishment's specific requirements for healthcare input as stated in detention service orders DSOs.
84.	Staff members must quickly and effectively report incidents and receive guidance on how to do this.
85.	Staff members who are affected by a healthcare-related patient safety incident must be offered a debrief and post-incident support.
86.	Lessons learned from patient safety incidents are shared with the team and the wider organisation. There must be evidence that improvement has been made following incidents.
87.	The complaints policy for staff and patients must be easy for everyone to access and set out how a complaint can be made, the process for investigation and how communication is managed throughout.
88.	Complaints must be reviewed on a quarterly basis by the mental health team to identify themes, trends and learning.
89.	Staff members should feel able to challenge management decisions or raise any concerns about standards of care. They must be aware of the processes to follow when raising concerns or whistleblowing.
90.	Services should collect information and data to evaluate their own performance and measure improvements. This data must be shared with key stakeholders, the organisation's board and staff. This could include KPIs, diagnosis timeframes, transfer and remission timeframes, diversity and accessibility. This information could be gathered as part of the contract review data.
91.	The mental health team must take part in service-relevant research and academic activity.
Detention service orders and centre regime	
95.	The healthcare service must provide healthcare advice through attendance at management meetings, forums and for ad hoc requests.
96.	The provider must fulfil all obligations and responsibilities applying to the application of DSOs as they relate to health provision.
97.	Support and advice must be available to agencies and operational staff to support the health and wellbeing of patients within the context of local and national guidance for the management and disclosure of confidential information.

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98.	Input from healthcare must be provided in a number of IRC operational forums which include as examples the following: 1. daily directors' meetings and senior management board/team forums; 2. attendance at planned control and restraint interventions and incidents; 3. preparation of specific reports as required, i.e. death in detention reports, patient safety incident reports; 4. ACDT reviews.
99.	The healthcare service must work closely with other areas of the establishment regime and external agencies to ensure integration of patient focused care in line with IRC standards and mandatory obligations.
100.	Healthcare staff must attend the segregation or care and separation unit to see all detained individuals and complete a safety algorithm within two hours of an admission.
101.	Healthcare staff must attend daily clinical engagement and overview of any detained individuals held in segregation/care and separation unit.
102.	Provide constant supervision for patients at risk of harm to themselves where a clinical causation has been determined through a clinical assessment process.
103.	Participation in the ACDT process.
104.	Healthcare staff must attend all planned use of force situations and where possible attend when force has been used unplanned. Detained individuals must be seen within 24 hours of force being used.
105.	Healthcare staff must carry out the room-share risk assessment.
106.	All detainees will receive medical screening prior to any movement to ensure they are fit for transfer.
	Management and leadership
107.	The provider must deliver effective management support and professional leadership to staff. The healthcare manager has day-to-day operational responsibility for **all** healthcare services delivered within the establishment.
108.	All healthcare staff must have access to appropriate clinical and professional management and supervision.
109.	The provider must ensure that effective management and leadership are reflected in the roles of senior leaders of the service.
110.	The provider must ensure the management, administration and smooth running of all healthcare services and the healthcare centre.
111.	The provider must ensure working practice within the framework of local, national and best practice guidance on infection prevention control.

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112.	The provider must ensure patients are informed about the healthcare services available and waiting times or other essential information in a suitable format.
113.	Patients must be involved in consultation activities.

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