DJS 372: 2023
ICS 13.310; 03.100.01; 03.100.30;03.120.01; 11:020

Draft Jamaican Standard

Specification

for

Correctional Services - Health and Wellness

BUREAU OF STANDARDS JAMAICA

COMMENT PERIOD:
31 DECEMBER 2023 – 29 FEBRUARY 2024

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Bureau of Standards Jamaica
6 Winchester Road
P.O. Box 113
Kingston 10
JAMAICA, W. I.
Tel: (876) 926 -3140-5/ 618 – 1534 / 632- 4275
Fax: (876) 929 -4736
Website: www.bsj.org.jm
E-mail: info@bsj.org.jm

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This standard was circulated in the draft form for comments under the reference DJS 372: 2023.
Jamaican standards establish requirements in relation to commodities, processes and practices, but do not purport to include all the necessary provisions of a contract.

The attention of those using this standard specification is called to the necessity of complying with any relevant legislation.

Amendments

No.	Date of Issue	Remarks	Entered by and date

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Foreword

The Ministry of National Security (MNS) proposed that National Standards for correctional services be developed with the support of the Bureau of Standards Jamaica (BSJ). In keeping with its mandate, the BSJ agreed to facilitate local participation in the development of National Standards for correctional services in Jamaica through establishing a Correctional Services Technical Committee (CSTC). The CSTC was established to develop and promulgate standards for the correctional service industry in keeping with regional and international normative standards.

The Technical Committee (TC) is comprised of members from a wide cross-section of ministries, agencies and disciplines, the private sector, and academia. The TC recognizes the issues relating to health and wellness within the correctional setting that needs to be addressed; therefore, a working group was established to develop a standard that provides guidance on how to treat these identified gaps and meet the needs of all stakeholders within the correctional setting.

The Standard for Health and Wellness in Correctional Services was prepared by the BSJ's CSTC, working group four (WG4) - health and wellness. This standard is a part of a suite of Jamaican standards that are first of its kind developments intended for use by correctional institutions in Jamaica.

This standard is voluntary.

Committee representation

The preparation of this Standard for the Standards Council, established under the Standards Act of 1969, was carried out under the supervision of the Correctional Services Technical Committee which at the time comprised the following members:

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Acknowledgement

Acknowledgement is made to the Correctional Service of Canada (CSC), Jamaica's National Council for Drug Abuse (NCDA), Ministry of Health and Wellness (MOHW), U.S. Department of Justice and Substance Abuse and Mental Health Services Administration (SAMSHA), the International Organization for Standardization (ISO) for the use of their material, and the United Nations Office on Drug and Crime (UNODC) for the use of the material taken from the Beijing Rules, the Havana Rules, Criminal Justice Handbook Series, the Convention on the Rights of the Child (2007).

Related documents

This standard makes reference to the following:

(a) Correctional Service of Canada (CSC), Mental Health Strategy, December 2018

(b) International Organization for Standardization, ISO 9001, Quality Management Systems—Requirements, 2015

(c) National Council for Drug Abuse/Ministry of Health and Wellness (NCDA/MOHW), Jamaica's Manual on the Policies, Guidelines and Standards of Care in the Treatment of Substance Related Disorders, (unpublished) 2022

(d) Public Health (Food Handling) Regulation, (1998, 2000), JAMAICA https://laws.moj.gov.jm/legislation/subsids/P/The%20Public%20Health%20Act_0.pdf

(e) Substance Abuse and Mental Health Services Administration (SAMSHA), Crisis Intervention Team, retrieved from https://www.samhsa.gov/

(f) United Nations Office on Drugs and Crime, The United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders with their Commentary (The Bangkok Rules), Resolution adopted by the General Assembly on 21 December 2010 at the sixty-fifth session

(g) United Nations Office on Drugs and Crime, The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), General Assembly resolution 70/175, annex, adopted on 17 December 2015

(h) U.S. Department of Justice/ National Institute of Corrections (NICs), Correctional Health Care: Guidelines for the Management of an Adequate Delivery System, 2001

(i) U.S. Department of Justice, Trauma Informed Correctional Care, 2017, retrieved from https://www.justice.gov/archives/ovw/blog/importance-understanding-trauma-informed-care-and-self-care-victim-service-providers#:~:text=Trauma%2Dinformed%20care%20emphasizes%20creating,experience%20after%20a%20violent%20crime

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Jamaican standard specification for Correctional Services - Health and Wellness

1. Scope

This document specifies the national standard for health and wellness as it pertains to clients of the correctional services. It recognizes the client as a patient ensuring that access to quality healthcare is not limited and accounts for specialized needs. The standard also encompasses health promotion and wellness, primary healthcare, mental health, suicide prevention, nutritional needs, physical activity requirements, and substance misuse services.

2. Normative references

The following documents are referred to in the text in such a way that some or all of their content constitutes requirements of this document. For dated references, only the edition cited applies. For undated references, the latest edition of the referenced document (including any amendments) applies.

- JS 364: 202X, Jamaican Standard Specification for Community-based correctional services

- JS 365: 202X, Jamaican Standard Specification for Institutional correctional services

- JCP 10: 202X, Jamaican Standard Specification for Correctional services for women

- JS 371: 202X, Jamaican Standard Specification for Correctional Services for Children

3. Terms and definitions

For the purpose of this standard the following definition applies:

3.1. **case management**

Structured system exists that clearly details treatment pathways processes. This is documented, and clearly communicated to stakeholders.

3.2. **case record**

Comprehensive, factual, and sequential record of clients' condition and the treatment and support offered.

3.3. **client**

Person sentenced or remanded to the professional care, custody, and supervision of the correctional services.

3.4. **communicable disease**

Illnesses that spread from one person to another or from an animal to a person or from surface or food.

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3.5. **lux**
A unit of illumination.

3.6. **non-communicable disease**
Diseases that are not spread through infection or through other people but are typically caused by unhealthy behaviours.

3.7. **patients**
One admitted to the medical unit or utilizing medical services at the correctional, community or hospital level.

3.8. **suicide prevention**
A set of strategies and programme designed for prevention of self-harm or injury in addition to attempts on life whether intentionally or unintentionally.

3.9. **trauma informed care**
Assessment and intervention practices that recognize and prioritize trauma informed health care, involves the use of a 'strengths-based' delivery system that understands and responds to the needs of clients and staff who have experienced trauma.

3.10. **ward**
One who has been admitted to the care of the state or government and is often used to refer to minors. Those considered wards of the state or government are under the custody of the government and the government is responsible for the totality of their care, needs and safety.

4. Context

4.1. **The Client as a Patient**

a. Rights based approach and access to quality health care.

4.1.1 Without exception, quality health care shall be a fundamental right for all clients of the correctional service. The client shall be treated as a patient upon accessing health care services both internal and external to the correctional services.

4.1.2 The client shall be afforded the same rights as all patients including the rights to:

i. Safety;
ii. Confidentiality;
iii. Autonomy;
iv. Beneficence;
v. Nonmaleficence;
vi. refuse care and services;
vii. be able to access external consultation where applicable; and
viii. have access to emergency services and evidence-based medical practices, regardless of religion, age, gender and sexual orientation & identity.
ix. Dignity
x. Accessibility

4.1.3 The client shall be provided with timely access to both preventative and curative health

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care services designed to provide and promote healthier lifestyle practices and improvement to both quality and quantity of life.

4.1.4 The correctional services shall have primary responsibility for the health, wellness and safety of its clients and shall ideally bear all necessary health related expenses. Additionally, the client shall be provided with access to healthcare services equal to that of community standards.

NOTE Healthcare services include but are not limited to specialized services related to ophthalmic, dental, nutritional, surgical, radiological, sexual health and mental health needs including treatment for substance use disorders.

4.1.5 The clients shall be given the right, regardless of gender, age or sexual orientation & identity to confidentially report incidences of violence, trauma, sexual assault or rape that occur within the institutions or while they are incarcerated without fear of ostracization, reprisal or negative consequences.

4.1.6 On discharge from, or transfer between institutions, a comprehensive medical examination and summary of medical care shall be documented to ensure quality and continuity of care.

NOTE This medical examination should include assessments for labour fitness, dietary needs and may take into consideration any special needs or concerns in addition to the summary of medical care.

4.1.7 Clients shall not be the subject of any unreasonable medical or scientific research.

NOTE Reasonable research is defined as where informed consent is given by the client and where approval has been given by a properly constituted health research ethics committee.

5. Confidentiality

5.1 The health information of a client shall be kept confidential. All staff and visiting professionals and organisations shall adhere to anonymity and confidentiality requirements.

5.2 Staff shall ensure that clients are aware, from the time of admission, that all evaluations and counselling contents and documentation are handled professionally, respectfully and confidentially. The clients shall also be informed that such material shall be shared with the correctional services interdisciplinary team. Clients shall sign a waiver on admission to permit the sharing of confidential information outside of the correctional network. Someone with rights of decision making may sign for a client who is mentally or physically incapacitated or a minor.

5.3 Client's medical information shall be kept private and confidential, and shall only be subject to disclosure if required or authorized by law.

6 Primary Health Care

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6.1 **Health care in Correctional Centres**

6.1.1 Every correctional centre shall have the services of at least one general medical practitioner and other suitable personnel trained in health care along with the necessary administrative support.

6.1.2 Professional groups providing health and wellness in correctional centres, shall adhere to national standards of practice and to international rules, guidelines and recommendations for treatment and care.

6.1.3 Client (adults and wards) shall be seen by a Medical Doctor on admission to theInstitution, ideally within 24 to 48 hours of admission. Clients shall be referred to, and seen by other specialized health professionals (psychiatrists, etc.) as needed, ideally within 14 days of admissions.

6.1.4 At a minimum, every client shall be medically reviewed annually, to increase screening for early disease detection and to ensure continued good health. Clients with known chronic illnesses or other health challenges shall be reviewed as needed, in accordance with their health treatment plan.

6.1.5 All health and wellness professionals within the correctional centers shall adhere to the policies relating to smoking and substance misuse.

6.1.6 All health and wellness professionals shall adhere to national codes of professional and ethical practice, standards of quality of care and regulatory matters and shall be held to the same standards and measures of quality assessment utilized in other public health services.

6.1.7 All health and wellness service providers shall be aware of the prevailing health policies and priorities of the island, and their relevance to the systems and structures for which they are intended.

6.1.8 Every client shall have access to evidence-based health services provided by a competent, registered health professional who will provide a standard of health services comparable to that of the general community.

6.1.9 Notwithstanding the limitations of the local-community health service, clients shall have 24-hour access to quality health services.

NOTE This service may be on an on-call or stand-by basis.

6.1.10 The needs of the clients vary widely, and the health services provided to them shall be timely and flexible. That is, the service shall accommodate urgent, non-urgent, complex, chronic cases, and preventive health care needs.

6.1.11 There shall be protocols used by the health service providers in the correctional centres to identify patients who have urgent health needs and facilitate them for the appropriate care.

6.1.12 Primary health care in the correctional centres shall be accessible to all clients at all hours, whether at the correctional centre or at an external institution.

6.1.13 Every client or ward shall have access to the services of specialist medical practitioners and services relevant to their needs. Referral to such services shall take account of community standards of health care.

6.1.14 All clients or wards who have a medical complaint shall be seen by a health professional at intervals appropriate to the diagnosis and prognosis in each case, according to good medical practice.

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6.1.15 The clients shall be transferred to an external health facility if he or she can no longer be treated by the health professional in the correctional centre.

6.2 Continuity and Coordination of Care

6.2.1 The clients shall be provided with care for his/her medical needs from admission until they are released. Additionally, if the client is transferred to another institution, the care received shall be consistent with the care previously received.

6.2.2 A system to review and follow up tests and results shall be established as a duty of care to clients.

6.2.3 There shall be engagement with other health services providers to provide services that are not available at the correctional centre. This will assist in facilitating comprehensive care to the clients.

6.2.4 Each client and ward shall receive, where applicable, a discharge medical review, and summary of medical care in preparation of their release from the correctional centre.

NOTE The discharge medical review includes a list of any necessary medications or treatments, necessary referrals for continued care within the community, and copies of any relevant investigations or findings that may be necessary for continued care.

6.2.5 Case records and information shall be available to facilitate continuity of care. Adequate referral letters and release reports shall be produced in an accurate and timely manner in accordance with discharge policy and with the client's consent.

6.2.6 Referral documents shall be developed and utilized for integrating the care of the client between internal and external health care providers. The referral document shall contain sufficient information to allow the external health care provider to provide continuous and effective care to the client.

7 Health Records

7.1 A health record shall be developed for each client, and shall contain the client's demographic information, medical history (to include current medications), allergies, consultations notes, referrals and test results.

7.2 The medical record of each client shall be carefully and confidentially stored for a minimum of ten (10) years post discharge according to government standards.

7.3 Documents shall be standardized across facilities within the institution's system and medical records must include the following data:

1. General demographic information;
2. Previous and past medical history inclusive of medication;
3. Previous and past surgical history;
4. Past, previous or current history of mental illness;
5. Past, previous or current history of substance use and misuse;
6. Any allergies or negative drug reactions;
7. Social and family history (dynamics included); and
8. Any relevant history of major trauma or injury.

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7.4 Case records shall meet the following requirements:

a. Entries shall be signed legibly (clear name and professional designation) with the date and time of the consultation or session included in the record.
b. The diagnosis given to clients shall be clearly indicated in the records.
c. Details shall be provided on all clients' individualized treatment plans, including assessment, results of other tests or procedures, and range of treatments and interventions undertaken, other agencies or organisations involved, relevant correspondence (including relevant telephone numbers), ongoing progress and release planning.
d. Notes shall be taken of interdisciplinary case conferences, consultations, and feedback on participation in group treatment programmes.
e. Corrections shall be made with a single line through an error with the corrected text entered nearby. Each correction must be dated and initialled by the corrector.

7.5 If a medical or psychiatric emergency occurs, confidential case material may be shared with external agents without the clients' permission. These issues shall be covered in the health services' confidentiality policy and ethical code.

7.6 An effective system shall be in existence to store dedicated records, with special emphasis on confidentiality and accessibility.

7.7 Filing protocol shall exist with a file naming convention to prevent case file mismanagement and allow for distinction between clients with similar antecedents.

7.8 Attendance registers shall be treated with confidentiality and handled only by designated personnel.

7.9 Case records or information managed through computer information systems shall be secured and confidential.

7.10 Case records and other client information shall be securely stored in sealed envelopes when being transported, and only authorized persons shall have access to information about patients.

7.11 Case records or reports shall be stored in secure cupboards or cabinets.

7.12 A health service provider shall document in a client's health record any delay between a request for healthcare and the provision of that care. This shall include the reasons for the delay.

7.13 The Institutional Management shall review with a view to effecting an immediate decision, medical advice given by relevant health experts. A copy of the health professional's report shall be placed on the client's medical file.

7.14 Confidential case material shall never be available for public display.

7.15 Informed consent shall be sought from clients when confidential information and material is shared with bona fide health and social services professionals operating outside the centre.

EXAMPLE (referral agents or guardians, and educational authorities in the case of children and adolescents).

7.16 The treatment provider may encourage a client's participation in research or other non-treatment activities only when the client has given a written fully informed consent. When such activities are deemed to have harmful consequences to a client then his or her participation shall not be encouraged.

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7.17 A policy and procedural manual governing mental health services shall be developed, and the policies and guidelines for case identification and management shall be updated at a regular specified interval and dispensed accordingly.

8. Health Care Facilities

8.1. **Staffing**

8.1.1. The Management team shall ensure that the health service within the correctional facilities provide a safe and effective environment for patients and staff. There shall be consulting room, examination room, etc. Additionally, the areas must be fitted to protect the privacy of the client if it is necessary for him or her to undress for a clinical examination (eg. adequate curtain, screen, gown, or sheet).

8.1.2. The physical condition of the health service area shall be conducive to confidentiality and privacy without compromising the occupational health and safety of the staff or the clients accessing health services.

8.1.3. If the healthcare staff includes clients as workers, they shall be given access to appropriate training programmes and meet any continuing education requirements. They shall be trained in proper record keeping, filing and management as would other healthcare staff.

8.1.4. A client to the medical unit who does not want the inclusion of a client in their medical review and examination process, or the handling of their records, shall have the right to ask that the client be excused, as they would with other healthcare staff, (where there are other options for care).

8.1.5. Hand cleansing and toilet facilities shall be readily available for staff and clients visiting the health service area.

8.2. **Safety and Security**

8.2.1. Provisions to ensure safety of the healthcare staff (which often include civilians) is of critical importance, and may include the addition of panic buttons and audio communication networks, (where an escort or security personnel may not be in the examination room, for example when the client is exposed for medical examination). If a safety concern or misconduct does arise, it shall be documented and reported to the appropriate staff and officials immediately.

8.2.2. Emergency response policy and services plans shall be known to all staff within the healthcare department, to ensure that in the event of an emergency the response is effective, appropriate and timely.

8.3. **Medications**

8.3.1. Medications shall be organized and kept in a manner that ensures their safe handling and dispensing. Records shall be kept ensuring adequate control and accountability for all medications, and shall be inspected at least quarterly, to ensure these standards are maintained.

8.3.2. On prescription or medical request for medication, a client shall receive those medications within a timely manner to ensure the standard of care is maintained.

9. Reporting

9.1.1. Where the death of a ward or client occurs, the death and circumstances

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surrounding the death shall be comprehensibly documented and reported. Investigations into the cause of death may include autopsies or Coroner reports, and the institutions management shall make efforts to facilitate this process.

9.1.2. Critical incidents report such as death and suicide attempt shall be reviewed within 24 hours.

9.1.3. The next of kin of the deceased shall be informed within 48 hours.

10. Specialized Medical Services

10.1. ***Specialized Services for Female Clients***

10.1.1 If a female client requests that she be examined or treated by a woman physician or nurse, a woman physician or nurse shall be made available, to the extent possible, except for situations requiring urgent medical intervention. If a male medical practitioner undertakes the examination contrary to the wishes of the woman prisoner, a woman staff member shall be present during the examination.

10.1.2 Only medical staff shall be present during the medical examinations of the female client, unless the doctor is of the view that exceptional circumstances exist, or the doctor requests a member of the correctional services staff to be present for security reasons or the female client specifically requests the presence of a member of staff.

10.1.3 If it is necessary for non-medical staff to be present during medical examinations, such staff should be a woman and examination shall be carried out in a manner that safeguards privacy, dignity, and confidentiality.

10.1.4 Female clients who are admitted to the correctional facility, shall be screened for the following health related issues: communicable diseases; the presence of sexually transmitted infections (STI); blood borne diseases; HIV (pre and post counselling shall be provided); mental health care needs, including post-traumatic stress disorder and risk of suicide and self-harm.

10.1.5 Additionally, screening shall also include their reproductive health history, including current or recent pregnancy, childbirth, and any related reproductive health issues; the existence of drug dependency, sexual abuse or any form of violence that they may have suffered prior to admissions; pregnancy; postpartum depression, cervical cancers, and contraceptive medications shall be continued.

10.1.6 If the existence of sexual abuse or other form of violence before or during incarceration is diagnosed, the female client shall be informed of her right to seek recourse. The female client shall be fully informed of the procedures and steps involved and assistance shall be provided to access legal services.

10.1.7 Special consideration shall be given to female hygiene including the provision of menstrual sanitary products and access to clean water for both drinking and sanitation purposes, especially for those who are pregnant, menstruating, lactating, or formula feeding.

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10.1.8 Prenatal and postnatal assessment, care, treatment, and accommodations shall be made available to female clients, where practicable.

10.1.9 Arrangements shall be made for clients to give birth in a hospital outside the correctional centre; however, if a child is born in the correctional centre, this fact shall not be recorded on the birth certificate.

10.1.10 If a female client is accompanied by a child, that child shall also undergo health screening, preferably by a child health specialist, to determine any treatment and medical needs. Suitable health care, at least equivalent to that in the community shall be provided.

10.1.11 If the child of a female client resides with her within the correctional centre, special consideration shall also be given towards the maintenance and provision of hygiene products of the child including diapers, wipes or cleansing cloths and access to clean clothing and protective wear (hats, blankets, socks, etc).

10.1.12 The right of a female client to medical confidentiality, including specifically the right not to share information and not to undergo screening in relation to their reproductive health history, shall be respected at all times.

10.1.13 Individualized, gender-sensitive, trauma-informed and comprehensive mental care and rehabilitation programmes shall be made available for female clients with mental health needs.

10.1.14 Correctional centre staff shall be made aware of time when female clients may feel particular distress, so that they can be sensitive to their situation and ensure that the female client is provided with appropriate support.

10.1.15 HIV programmes shall be responsive to the specific needs of the female client, including prevention of mother-to-child transmission. Initiatives on HIV prevention, treatment, and care, such as peer-based education shall be encouraged and supported.

10.1.16 Institutional management shall provide or facilitate specialized treatment programmes designed for women substance abusers, taking into account prior victimization, the special needs of pregnant women and women with children, as well as their diverse cultural backgrounds.

10.1.17 Institutional management shall develop and implement strategies, in consultation with mental health professionals and social welfare services, to prevent suicide and self-harm among the female client population. Additionally, appropriate gender-specific and specialized support to those at risk shall be included in the comprehensive policy of mental health care in correctional services.

10.1.18 Preventative health care measures of particular relevance to the female clients such as screening for breast and gynecological cancer, shall be offered to female clients on an equal basis with female in the community.

*10.2.**Specialized Services for Male Clients***

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10.2.1. Specialized care services for male clients include access to screening services for prostate disease in addition to regular general medical screening services for non-communicable and communicable diseases.

10.2.2. Traumatic injuries are more common in male clients, so special attention shall be paid to resultant medical needs arising from a history of injury, especially orthopaedic injuries, with access to specialist care as needed.

*10.3.**Specialized Services for Elderly Clients***

10.3.1. As clients age, their risk for non-communicable diseases is expected to rise and with that their medical needs are also expected to rise. Elderly clients shall have access to increased medical screening in keeping with community standards and personal needs.

10.3.2. Elderly clients are also more likely to need access to ophthalmic and optician services, to improve vision and through this improve their quality of life. Elderly clients shall have access to prescription glasses and ophthalmic medical treatment as needed, in keeping with community standards and personal needs.

10.3.3. Elderly clients may also require aids to enhance hearing to improve their ability to communicate, where needed auditory aids like hearing aids shall be supplied. The ability to communicate is not to be underestimated as the ability to communicate well improves not only mental but physical health and well-being.

10.3.4. Elderly clients are at increased risks of falls and have mobility related needs and issues. Accordingly, special care shall be made to ensure that the institutions are accessible to these clients by providing mobility aids like walkers, walking sticks and wheelchairs where needed. If an elderly client is unable to care for him/herself and meet their own basic needs, they shall be provided with access to suitable care and a caregiver.

*10.4.**Specialized Services for Wards***

10.4.1. Immunization and appropriate vaccination are an integral part of health and wellness, especially in the ward population where school-aged children may enter the care of government and institutional care. Where possible and available, immunization records shall be reviewed in accordance with the Ministry of Health & Wellness guidelines and updated accordingly.

10.4.2. Congenital abnormalities or diseases, that are due to genetic, familial or develop shortly after or during birth are most often picked up during childhood and adolescence and can impact growth and development. Early detection and appropriate treatment and management, improves quality of life and health. Screening methods for children shall include appropriate screening questionnaires, including evaluation and investigation for communicable or infectious diseases, haematological, cardiac, respiratory and developmental disorders.

10.4.3. Developmental and medical milestones are to ensure and track that the growth and development of children and adolescents are appropriate. They may include markers for height, weight, intellectual and mental development and blood pressure, and shall be used to screen for undernutrition, overnutrition, stunting, early onset

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hypertension (which may require screening for secondary causes of hypertension and increase the risk of development of other non-communicable diseases like diabetes) and intellectual and mental illnesses and delays (which may require specialized educational interventions where applicable).

10.4.4. Rheumatic Fever is an inflammatory disease that often develops in childhood and adolescence as a result of incomplete or improper treatment of strep throat or scarlet fever, it can result in inflammation of joint and heart tissue, leading to the development of Rheumatic Heart Disease, which can cause serious heart disease, especially to the heart valves. Prevention of Rheumatic Heart Disease post Rheumatic Fever, involves Penicillin injections every three to four weeks, until the person reaches about 21 years old (sources vary). If Rheumatic fever is suspected all efforts shall be expended to prevent the development of Rheumatic Heart Disease.

10.4.5. All wards shall be screened for substance use and misuse, as they may be used as coping mechanisms for trauma or abuse or mental illnesses. Generally speaking, the longer one has a substance addiction, the harder it is to abstain from the substance and the more detrimental the substance is to mental and physical health, and well-being.

*10.5.**Specialized Services for clients with Disabilities***

10.5.1. Clients with a disability shall have regular access to necessary specialized health care services and programmes,

10.5.2. Clients with a disability shall be accommodated in a safe, secure environment which provides them with assistance to adjust to the institution environment, accessibility, and with programmes, which address their individual needs and their offending behaviours where possible.

10.5.3. Clients with disabilities shall be provided with mobility aids as required, and assistance with their basic personal needs.

11. Wellness

11.1. The client shall be provided with healthy living lifestyles designed to improve overall physical health and mental well-being towards improving their quality of life.

*11.2.**Hygiene***

11.2.1. The client shall be provided with institution health care services - as appropriate acting in conjunction with other authorities - to supervise catering arrangements (quantity, quality, preparation, and distribution of food) and conditions of hygiene (cleanliness of clothing and bedding; access to running water; sanitary installations) as well as the heating, lighting and ventilation of cells.

11.2.2. All clients shall have regular access to cleaning and sanitation products and services which shall include access to regular vector and vermin control, which greatly reduces the risk of transmissible and contagious diseases.

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11.2.3. All clients shall have regular access to potable water for drinking and sanitation purposes, including bathing and regular handwashing, which greatly reduces the risk of transmissible diseases especially foodborne illnesses.

*11.3.**Nutrition***

1. The Right to Basic Health and Wellness

11.3.1. All clients shall be provided with healthy, balanced, and nutritious meals and snacks to meet their minimum nutrient and energy requirements, according to the Recommended Nutrient Intakes and Population Nutrient Intake Goals for the Caribbean (see Appendices). Cycle menus shall be developed using the Food Based Dietary Guidelines for Jamaica (see Appendices) and shall be reviewed at minimum once yearly by a Registered Dietitian, or Registered Nutritionist.

11.3.2. Site visits with inspection of food stores, food handling and preparation areas and distribution practices shall be conducted by the Registered Nutritionist or Registered Dietician at least once per quarter for each institution.

11.3.3. All new clients shall undergo basic nutrition screening, that is body mass index to ascertain their nutritional status, and if necessary, the subjective global assessment to determine their level of malnutrition (if necessary).

11.3.4. Clients with nutritional deficiencies and or special dietary requirements, such as those with chronic kidney disease and cardiovascular diseases shall be referred to a Registered Nutritionist or Registered Dietitian, in collaboration with the General Medical Practitioner or Specialized Medical Team, for nutrition assessment and management. Dietary provisions and exceptions shall be made where medically needed or required for religious or ethical reasons.

2. The Right to Safe Food and Water

11.3.5. All foods for human consumption shall be received, handled, prepared and administered under strict sanitation guidelines, and at the correct temperatures.

NOTE In this context "food" includes water, ice or any substance manufactured, prepared, sold or represented for use as food or drink, or flavouring or condiments used in or with the preparation of food, as stated in the Public Health (Food Handling) Regulations, (1998, 2000).

11.3.6. All food service facilities shall meet the following minimum operational health and hygiene standards as detailed in the Public Health (Food Handling) Regulations, (1998, 2000):

1. There is adequate ventilation.
2. The establishment has lighting intensity;
    a. of at least 110 lux at a distance of 89 centimetres above the floor, above all its walk-in refrigeration units and above dry food storage areas and in all other areas and rooms, during cleaning and sanitization;
    b. of at least 220 lux at surfaces where food is provided for consumer self-service, including buffets and salad bars or where fresh produce or packaged food is sold or offered for consumption;
    c. of at least 220 lux inside equipment such as reach-in and under-counter refrigerators;

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d. of at least 220 lux at a distance of 89 centimetres above the floor in all areas used for hand-washing, warehousing and equipment and utensil storage, and in washroom; and
e. at least 540 lux in any area where a food handler is working with food or working with utensils or equipment such as knives, slicers, grinders or saws;

3. where any light bulb or light fixture is suspended over any area where there is food or food is likely to be placed, that bulb or fixture is adequately protected to prevent contamination of food;
4. the floor is impervious, durable, non-slip, free from cracks and crevices and constructed in such a manner as to facilitate easy cleaning;
5. the walls and ceiling are durable, clean, in good repair and with washable surfaces which are painted with paint of a light colour;
6. there are adequate toilet facilities for employees and customers of each sex which are conveniently located, accessible and in good sanitary condition and repair;
7. there is an adequate supply of potable water throughout the food handling establishment;
8. there is at least one hand-washing station installed and maintained-
   a. for every forty square metres of floor space; and
   b. in each principal area where food is handled, prepared, stored or served, and that every hand-washing facility is equipped with hot and cold water, a soap dispenser, a waste bin and either an electric hand blower or disposable paper towels for drying hands after washing;
9. there are changing rooms and restrooms with storage cupboards for employees of each sex;
10. there are adequate suitable racks, stands or shelves for the storage of food and that the rack, stand or shelf nearest the floor is not less than 15.2 cm therefrom;
11. all food is stored in such a manner as to be protected from contamination and deterioration. Food should be stored at a height of not less than 60.96 cm above the ground or flooring;
12. in relation to processed food, a valid certificate from the Bureau of Standards Jamaica signifying compliance with the Standard Specifications for Processed Food: General is displayed in a conspicuous place in the food-handling establishment;
13. the food-handling establishment is free from pests and vermin;
14. the food establishment is located in suitable surroundings;
15. public health requirements have been met; and
16. written instructions, if any, issued by the Medical Officer (Health) or Public Health Inspector have been complied with.

11.3.7. All persons handling food, including kitchen staff and food service managers shall maintain good hygiene and health, and have the necessary permits and provisions as detailed in the Public Health (Food Handling) Regulations, (1998, 2000).

11.3.8. All storage areas, including cold storage and dry storage shall maintain the correct temperature, sanitation and hygiene standards and shall contain adequate suitable

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racks, stands and shelves to protect against contamination and deterioration of foods as detailed in the Public Health (Food Handling) Regulations, (1998, 2000) indicated below:

1. No food which is unfit for human consumption, or which has been condemned as being unfit for human consumption shall be manufactured, stored or prepared.
2. No food shall be stored in such a manner that any undesirable flavour or odour is absorbed in the food.
3. Food shall not be:
    a. stored or prepared in any place through which a vent or waste pipe for a water closet or urinal passes or which is near to such vent or waste pipe;
    b. stored or kept in any place where the following are stored or kept-
    (i) animals, poultry or hides;
    (ii) chemical or toxic substances or any similar substances.
4. All perishable foods shall be kept refrigerated at a temperature not higher than 4.4°C.
5. All frozen food shall be maintained at a temperature of no more than 18°C.
6. Hot food shall be maintained at a temperature of no less than 63°C.

11.3.9. All food preparation and service areas shall maintain the sanitation and hygiene standards, including temperature control, spacing as detailed in the Public Health (Food Handling) Regulations, (1998, 2000).

11.3.10. Kitchens, freezers, refrigerators, areas of food handling and preparation shall be inspected for sanitation, and to ensure that hygiene and cooking standards are being maintained and that waste is being disposed of regularly and appropriately. Areas shall be inspected to ensure that there is no spoiled or contaminated food.

11.3.11. All kitchen appliances and food-handling and preparation equipment shall be maintained and keep in good working order in compliance with the Public Health (Food Handling) Regulations, (1998, 2000).

11.3.12. Food inventory shall be done according to the 'first in, first out' principle.

11.3.13. There shall be proactive maintenance and pest control systems.

*11.4.**Physical Activity***

11.4.1. Clients shall have access to recreational time or time specifically allotted for improving physical health through physical activity. In keeping with the World Health Organization's recommendation for physical activity, adopted by Jamaica, adults shall do at least 30 minutes of moderate to vigorous physical activity at least 5 days per week to gain some health benefits. The space must accommodate a variety of physical activities (cardiovascular, strength and flexibility activities).

12. Health Promotion and Education

12.1. Institution management shall ensure that health education, prevention and promotion interventions are provided to the clients. All clients shall be provided with advice on preventing communicable diseases, including advice on avoiding sexually transmitted diseases, HIV infections and hepatitis, as well as the harm caused by smoking and drug use. As far as practicable, correctional centres shall provide and promote a smoke and drug free environment.

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12.2. Clients shall be provided with sufficient information about the purpose, importance, benefits, and risks of the treatment to be provided to enable them to understand and make informed decisions about their healthcare.

12.3. An institution's health care service shall ensure that information about transmittable diseases (in particular hepatitis, AIDS, tuberculosis, dermatological infections) is regularly circulated, both to clients and to institution staff. Where appropriate, medical control of those with whom a particular client has regular contact (fellow clients, institution staff, frequent visitors) shall be carried out.

12.4. All clients and wards shall be supported in adopting healthy behaviour, including appropriate levels of physical activity and a balanced diet.

12.5. Institutional management shall provide initiatives to promote the health of correctional services staff and clients.

12.6. Health promotion and prevention of disease information shall be provided to all clients in ways understood by everyone.

13. Communicable Diseases

*13.1.**General***

As the clients have no control over the environment, they are at greater risk of contracting communicable diseases, which result from interactions between agents and hosts but are influenced by factors such as financing of health care services and institution Management practices.

13.1.1. Communicable diseases in correctional centres cannot be successfully controlled through isolated clinical interventions. For the benefit of clients, wards, correctional staff and society in general, concern for health must be integrated into broader public policies that affect correctional centres. Accordingly, there shall be cost-effective interventions with a solid evidence base for controlling communicable diseases.

13.1.2. Where a client is found to have an infectious disease, the client shall be managed by health services so as to minimise the possibility of contamination of the institution environment and, where clinically appropriate, before the client is permitted to mix with other persons and enter the normal institution routine.

13.1.3. Clients who are isolated for health reasons shall be afforded all rights and privileges that are accorded to other clients, where practicable and so long as such rights and privileges do not jeopardise the health of others.

13.1.4. Health professionals shall advise the Institutional Management whenever it is considered that a client's physical or mental health has been, or will be, injuriously affected by continued admission, or by any condition of admission, including where a client is being held in separate confinement.

*13.2.**Tuberculosis***

13.2.1. To prevent the spread of tuberculosis, the following standards shall be maintained:

1. the living areas shall effectively ventilated and allow natural sunlight were possible, as this naturally reduces the spread of droplet diseases.

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2. the living areas shall be regularly sanitized and cleared of infectious food and other waste to reduce the likelihood of food and water borne illnesses.
3. vermin and vector control shall also be regularly conducted to reduce the incidence of vector borne diseases.
4. clients shall be allowed to spend time outside of their cells or dormitory to encourage healthy physical activity.
5. clients with symptoms shall be immediately referred to health care workers and isolated, thus reducing the amount of time people who are infectious spend with other clients, which can therefore be an efficient measure for controlling tuberculosis and other communicable diseases spread.
6. Upon admission to the correctional centres, all clients shall be offered 'opt out' testing for tuberculosis using international screening guidelines, Mantoux (tubercilin skin tests) placement and sputum testing where indicated.

*13.3.**HIV/AIDS***

13.3.1. In developing responses to HIV/AIDS in penal institutions, programmes and services shall be responsive to the specific needs of women, including prevention of mother-to-child transmission. In this context, the correctional services authorities shall encourage and support the development of initiatives on HIV prevention, treatment and care, such as peer-based education.

13.3.2. Correctional centre staff shall be provided with ongoing training in the preventive measures to be taken and the attitudes to be adopted regarding HIV-positivity and given appropriate instructions concerning non-discrimination and confidentiality.

13.3.3. The Department of Correctional Services shall be represented on any national HIV and AIDS coordinating committees.

13.3.4. Issues within correctional centres shall be a part of the agreed action framework for HIV and AIDS.

13.3.5. There shall be constant monitoring and evaluation of clients/wards diagnosed with HIV and AIDS.

13.3.6. Upon admission to the correctional centres, all clients shall be offered 'opt out' testing for Human Immunodeficiency Virus (HIV) and Syphilis (VDRL) which aids in both reduction of transmission and early diagnosis and treatment.

13.3.7. Appropriate counselling shall be provided both before and, if necessary, after any screening test for HIV/AIDS.

13.3.8. Clients living with HIV are to be provided with medication, upon arrest and incarceration.

*13.4.**Coronavirus***

13.4.1. The protocols for the coronavirus are that of any airborne or droplet pathogen and will be used as an example to represent other airborne or droplet viruses like the influenza virus, rhinoviruses, adenoviruses etc.

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13.4.2. Poor ventilation, lack of sunlight and virus killing uv rays, poor sanitation and hand hygiene all contribute to the spread of airborne and droplet viruses. To help reduce the spread of droplet pathogens these issues, where seen, shall be corrected.

13.4.3. Persons suffering from infectious symptoms, especially those with fever, cough, sneezing, vomiting and diarrhoea shall be identified, given access to masks where applicable, and given hand hygiene and means to sanitize their surroundings. If it is deemed necessary for the ill patient to be isolated, it shall be done at the earliest possible time and ideally post confirmatory testing. Social distancing or separation guidelines of six (6) feet apart shall be maintained when deemed necessary by medical personnel and health officials and authorities.

13.4.4. The area in which a patient is sent to be isolated shall maintain health and wellness standards, have proper access to sanitation and hand hygiene, be well lit and ventilated, have adequate waste disposal for both infectious and non-infectious waste and ideally be free of vermin and vectors. A patient shall not be isolated for longer than what is medically indicated, and this shall be based on international and local best practices and guidelines.

13.4.5. A patient in isolation, shall have access to nutritional food and constant potable water, medicine and relevant treatment and shall not be scorned or treated in a discriminatory manner. The standard of care given shall be equal to community standards and shall include external referral and notification of relevant health authorities where applicable.

13.4.6. If protective gear is required, including but not limited to face mask, face shields and disposable gowns, they shall be supplied to the correctional staff and the healthy and ill client population as needed.

13.4.7. Sanitation of general areas and areas used for isolation and treatment of sick clients shall be cleaned regularly according to the standards and guidelines outline by the local and international health authorities.

*13.5.**Chickenpox***

13.5.1. The protocols for the Chickenpox are similar to other 'pox' based diseases that are spread through both direct or contact spread and droplet spread, like for example monkeypox. All droplet precautions shall be maintained as these diseases, typically have a prodrome or early infectious period with respiratory symptoms and the possibility of droplet transmission.

13.5.2. For reduction of direct contact transmission, reduction of over-crowding (including maintenance of separation guidelines, for example keeping social separation of up to 6ft) and isolation when necessary.

13.5.3. Appropriate medical and treatment shall be given in accordance with community standards and medical best practice and guidelines. Additional measures involving use of light covering to cover rashes, maybe employed if the covering is clean, changed regularly and disposed of safely and carefully as medically indicated.

13.5.4. Direct contact with lesions and rashes shall be limited and only conducted with appropriate precautions and protective gear, including gloves, facial protection and disposable gowns as needed or indicated.

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13.5.5. There shall be regular sanitation and cleaning, ideally with wet cleaning methods to reduce the reduction of aerosolizing skin cells and associated germs, increasing the risk of transmission.

*13.6.**Bacterial Conjunctivitis (PINK EYE)***

13.6.1. Precautions to control the spread of Bacterial Conjunctivitis, involves measures to reduce direct contact with infected persons or surfaces.

13.6.2. This includes quick identification of potential cases, with early treatment (as medically indicated and recommended) and possible isolation measures shall be put in place to ensure regular hand washing and sanitation of potentially exposed surfaces and contacts, including proper waste disposal.

*13.7.**Vector Borne Diseases***

13.7.1. To reduce the transmission of vermin or vector borne diseases, several measure shall be enstated but not limited to regular waste disposal, and removal of waste products, clearing possible sites of stagnant water collection to reduce the mosquito reproduction, clearing old furniture, boxes etc that can be rodent nesting sites and regular vector control processes like fogging and rodent baiting at regular intervals in compliance with health inspection guidelines.

*13.8.**Food and Water Borne Diseases***

13.8.1. Food and waterborne diseases can lead to widespread gastrointestinal and parasitic diseases within correctional institutions that can cause severe dehydration and require hospitalization in children, elderly and pregnant clients.

13.8.2. All clients and staff shall ensure to engage in hand-washing before and after food handling and after leaving bathroom facilities.

13.8.3. All clients and staff shall ensure that proper sanitation of food preparation, handling and storage areas and other utensils and containers takes place, as this greatly reduces the risk of contracting food-borne diseases and reduces food-contamination.

13.8.4. Food shall be prepared and cooked according to best practice guidelines, ensure that all food is appropriately cleaned and prepped and fully-cooked and meats reach the correct internal temperatures, to reduce the risk of parasitic and food borne infection.

13.8.5. Food shall be stored appropriately, to ensure that things that are to be kept frozen or cold are stored at the correct temperatures to prevent spoilage and contamination. Dry goods and non-refrigerated food products shall be stored in clean areas, that have measures to prevent vermin contamination (ideally non-chemical methods).

13.8.6. Water shall be stored in clean sealed drums if intended for drinking and use in cooking. Water shall be cleaned and sterilized according to best practice guidelines, including boiling or other sterilization methods.

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13.8.7. No spoiled or contaminated water or foods shall be knowingly served to any clients or wards.

14. Non-communicable Diseases

14.1. Clients shall be regularly screened for non-communicable or chronic illnesses as indicated. If a client enters the correctional services with a non-communicable illness, they shall be maintained on their medications and monitored in accordance with local and international guidelines, equal to that of community standards.

14.2. Where applicable dietary modifications, exercise allowances and other lifestyle modifications shall be made if it is medically indicated and recommended in accordance with the standard of care for a particular non-communicable illness.

15. Dental and Optical

15.1. Institutional Management shall facilitate all client healthcare needs as indicated, this includes dental and optical or ophthalmic needs.

15.2. As clients aged the need for glasses and other ophthalmic interventions for cataracts or glaucoma or retinal disease related to non-communicable illnesses, clients shall have access to these services as needed whether by referral to external healthcare facilities or by use internal resources and specialists.

15.3. Institutional Management shall provide clients with preventative and corrective dental care, including dental carries and abscesses, extractions, etc, as needed. However, If the institutional dental services are unable to provide the level of care a client needs, they shall be referred externally as needed.

15.4. Dental facilities shall be properly equipped to maintain professional and community standards including the addition of specialty equipment like sterilizers for non-disposal dental equipment, dental chairs and other dental materials. They shall also be provided with adequate personal protective gear (gloves, masks, disposable gowns, and face shields) where applicable.

16. Mental Health and Substance Use Disorders

*16.1.**Screening and Assessment***

16.1.1. Mental health and substance misuse screening is necessary to determine service level and assign the client to the appropriate interventions along the continuum of care. Screening must be efficient and timely, and adequately capture the scope of concern for identification of current or previous mental health illnesses or challenges and/or the need for more detailed assessment. Mental health screening shall be a component of the general assessment, ideally administered to all institution populations upon institutional entry.

16.1.2. Staff conducting screening shall be knowledgeable of and competent in administration of standardized mental health screening tools. Staff shall be able to recognize when a client may necessitate further screening and assessment based on

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client presentation and/or from information given to staff and or treatment provider.

16.1.3. Treatment providers may be staff or externally contracted individuals who are qualified and experienced in administration of screening/assessment.

16.1.4. Screening and assessment documents shall be placed in the client's file and properly secured. Access shall be limited to specified authorized personnel. Clients who are diagnosed with a severe psychiatric illness shall be managed by an appropriate tertiary or specialist health care facility.

16.1.5. Clients who are diagnosed with mental illness or an intellectual disability shall be provided with appropriate management and support services.

16.1.6. Screening and assessment results depicting a need for immediate and urgent care shall be treated with reasonable expediency.

16.1.7. Persons shall not be remanded to the correctional centre solely for psychiatric or intellectual disability assessment.

16.1.8. Where a client is released from the correctional centre and is under medical or psychiatric treatment, where appropriate, Institutional Management shall make arrangements with a suitable facility for the continuation of such treatment after release.

16.1.9. Mental health and substance misuse screening services shall include screening for Post Traumatic Stress Disorder related to a prior history of sexual, emotional or physical abuse, paying special attention to signs of self- harm, eating or post-partum disorders and substance misuse and offering access to support, counselling and treatment where needed. Female clients shall be offered access to the full array of mental health services as their male counterparts, including access to anger management therapies and substance misuse treatment and counselling services.

*16.2.**Assessment for Substance Misuse***

16.2.1. Substance misuse in the institution is against institution rules. By implication, the fact that a client has substances available to them means that there has been a breach of security. The institution staff shall report any knowledge of both substance use and supply. To work effectively, service providers need to be able to talk with clients about using substances while in the institution. However, they are required to breach confidentiality and report any knowledge relating to the supply of substances within the institution.

16.2.2. Clients within the correctional institution have the same right to medical confidentiality as clients in the community. Therefore, information relating to their medical treatment and care must be kept confidential and access only granted to those with the appropriate authority.

16.2.3. Confidential information may only be disclosed to a third party with the clients expressed consent. Any policy or protocol shall also make explicit the sanctions for any staff, agency or organisation found to be in breach of the agreed confidentiality policy.

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16.2.4. There are exceptions when it may be required that confidentiality be breached e.g.

i. When there is a threat to institution security.
ii. When a client is at risk of harming himself/herself or another person.
iii. When there is knowledge of an offense that is to be committed.
iv. When disclosure is made regarding an offense for which someone has not been convicted.
v. Information is obtained related to the use of substances within the institution.

16.2.5. Service providers (including medical staff, institutions, and external agencies providing treatment) have to report information regarding actual substance use by individual clients to institution authorities.

16.2.6. At the outset (i.e. on assessment) for any treatment or intervention, clients must be aware of the rules governing confidentiality and how these apply. It is good practice for a client to sign a confidentiality form confirming their understanding of the policy.

17. Treatment Planning

17.1. Treatment plan shall be prepared for each client and created to meet their multiple intervention needs.

17.2. There shall be regular monitoring of progress to inform necessary updates and adjustments to the treatment plan.

17.3. A regular interval shall be established for the monitoring, evaluating and updating of treatment plans.

18. Case Management

18.1. A structured system shall exist, that clearly details treatment pathways processes. This shall be documented, and clearly communicated to clients.

18.2. Protocols shall be in place, to detail clear procedures to handle varied circumstances and events that can occur in relation to a client's treatment.

18.3. The client shall be referred to other mental health and medical services, and any additionally available and relevant services and programmes as needed, that may improve mental health outcomes.

18.4. An aftercare plan shall be crafted to ensure continuity of care upon client discharge from the institution into the community.

19. Suicide Prevention

19.1. Suicide prevention includes prevention of self-harm or injury in addition to attempts on life whether intentionally or unintentionally.

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19.2. Staff, not limited to but including treatment providers and institutional staff, at various levels shall be trained to identify, monitor, report and intervene as is appropriate, in situations when suicide risk and self-harm is suspected or evident.

19.3. Guidelines shall be in place to govern the appropriate accommodation or transfer of care for clients at high risk of suicide or self-harm, or attempted suicide or self-harm activity.

I. Clear and meaningful communication between correctional and health staff about a client's status.

II. This shall consider maximum interaction with and monitoring by treatment staff for administration of intervention in a safe environment minimizing isolation.

III. Transfer of care may include but not limited to hospitalization as per institutional guidelines.

IV. Protocols shall exist to address suicidal behaviour, self-injury prevention and management of clients:

A. This includes early detection of suicide risk and self-harm activity.

B. Standardised tools for detection and monitoring are available for trained staff to administer.

C. Detailed documentation of all potential, attempted or completed suicides.

D. Debriefing measures in place to address psychological needs of staff and clients in the event of an attempted or completed suicide.

20. Trauma Informed Care

20.1. Trauma informed health care involves the use of a 'strengths-based' delivery system that understands and responds to the needs of clients and staff who have experienced trauma. It emphasizes that there is a physical, psychological and emotional need to feel safe for both trauma health care providers and trauma survivors. Trauma informed health care also involves avoidance of practices and institutional standards, that may re-expose individuals to trauma, and involves a partnered approach in the development and evaluation of services, especially those within correctional centers and institutions (SAMHSA, 2014).

20.2. Treatment providers and support staff shall be trained to recognize and identify and respond to trauma symptoms.

20.3. New clients shall be screened for trauma histories, that shall incorporate a trauma-informed approach is incorporated in screening and interviews, with evidence-based interventions applied as needed, maintaining standards at community levels.

20.4. Institutional Management, medical and mental health professionals shall also recognise the possibility of secondary traumatization in staff with established means to address such occurrence.

21. Crisis Intervention

21.1. Standard Operating Procedures (SOPS) shall be developed to direct intervention and response to crisis. These procedures shall clearly outline the process from crisis

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identification to resolution, and highlight the necessary and available resources and measures to be put in place.

21.2. Staff and treatment providers shall be aware of, trained and capable to enact their respective roles and responsibilities to deliver crisis intervention. Staff shall also be periodically trained in verbal and non-verbal de-escalation techniques.

21.3. The SOP shall govern protocols for interaction with organisations, externally contracted treatment providers outside of the institution who are critical to execution of the crisis intervention and response.

21.4. All instances of crisis occurrence and intervention shall be appropriately documented, and the records kept according to record-keeping and filing standards.

21.5. Potential crisis risks and behaviours may include but not limited to:

i. Risks: Suicide threat, attempt, or harm to self; threat or attempt to harm others; unable to care for self; presence or use of weapon.

ii. Behaviours: Severe, depressed mood; illogical thinking or talking; suicidal talk; abnormal behaviour or appearance; suicidal gesture(s); hearing voices or hallucinating; signs of alcohol or illegal drug use; anxious or excited; paranoid or suspicious; aggressive or threatening actions or speech; possible developmental disability. (SAMHSA, 2018)

22. Therapy and Counselling

22.1. Techniques and standards for therapy and counselling shall be evidence-based interventions that are applied appropriately in response to the client's level of need and risk.

22.2. Therapy and Counselling shall be carried out by qualified competent individuals with documented proof of their medical competency and training.

22.3. Training in psychological skills, including training in cognitive behavioural skills, activities to improve self-esteem, training for enhancing thinking skills and training in how to manage anger shall be provided to all clients and wards.

22.4. Therapy and Counselling shall be administered in a respectful and culturally appropriate manner.

23. Continuum of Mental Health Care

23.1. A mental health treatment plan shall be in place that clearly specifies the monitoring and evaluation tools and criteria that will be applied; frequency and personnel responsible for execution.

23.2. Health care processes shall be reviewed at regular pre-determined timelines, and/or as demanded by exigent circumstances that may arise.

23.3. Treatment plans shall be respectful and provide culturally appropriate care to patients. Clients shall be aware of their right to discrimination.

23.4. There shall be documented procedures in place to manage situations where a client refuses or objects to mental health or medical treatment or an intervention deemed necessary by medical or mental health professionals. This process shall include detailed documentation of refusal and subsequent steps to manage the issue, whether the refusal request is acceded to, or not, by treatment provider.

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23.5. Staff through training and experiences shall have cultural awareness and sensitivity to the mental health issues that concern clients.

24. Discharge Planning

24.1. There shall be a clearly defined process of what constitutes a discharge from care and treatment.

24.2. A client discharge whether by choice, completion of treatment, death, transfer, etc shall be documented indicating date and circumstances of said discharge process.

24.3. An aftercare plan for clients shall be discussed and documented prior to discharge and initiated upon discharge.

25. Resources

Adequate staff, space, equipment, supplies as determined by the health authority shall be provided for the execution of health care delivery.

26. Competence

The Institutional Management shall ensure that all staff, volunteers and contractors providing health care services to the clients are sufficiently competent to deliver effective health care services based on their education, training and experience. Additionally, all staff, volunteers and contractors must be adequately oriented in the relevant policies and procedures of the correctional facility before being deployed to work with the client.

27. Training

There shall be adequate developmental training opportunities provided for medical staff on risk, needs and changes of correctional health care services. This shall be inclusive of specialized services offered to ageing clients, female clients, juvenile clients, clients with mental health challenges, dental challenges, and substance misuse. Records of the training shall be maintained by the Institutional Management.

28. Communication

A comprehensive health care communication protocol shall be developed to communicate and engage with each patient in a manner that is understood by each patient.

29. Specialized Treatment

Clients who require specialist treatment shall be immediately transferred to specialized facilities.

30. Notification

There shall be a clearly defined policy and procedures for notification of the client's next of kin in case of serious illness or injury.

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END OF DOCUMENT

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Standards Council

The Standards Council is the controlling body of the Bureau of Standards Jamaica and is responsible for the policy and general administration of the Bureau.

The Council is appointed by the Minister in the manner provided for in the Standards Act, 1969. Using its powers in the Standards Act, the Council appoints committees for specified purposes.

The Standards Act, 1969 sets out the duties of the Council and the steps to be followed for the formulation of a standard.

Preparation of standards documents

The following is an outline of the procedure which must be followed in the preparation of documents:

1. The preparation of standards documents is undertaken upon the Standard Council's authorisation. This may arise out of representation from national organisations or existing Bureau of Standards' Committees of Bureau staff. If the project is approved it is referred to the appropriate sectional committee or if none exists a new committee is formed, or the project is allotted to the Bureau's staff.

2. If necessary, when the final draft of a standard is ready, the Council authorises an approach to the Minister in order to obtain the formal concurrence of any other Minister who may be responsible for any area which the standard may affect.

3. The draft document is made available to the general public for comments. All interested parties, by means of a notice in the Press, are invited to comment. In addition, copies are forwarded to those known, interested in the subject.

4. The Committee considers all the comments received and recommends a final document to the Standards Council

5. The Standards Council recommends the document to the Minister for publication.

6. The Minister approves the recommendation of the Standards Council.

7. The declaration of the standard is gazetted and copies placed on sale.

8. On the recommendation of the Standards Council the Minister may declare a standard compulsory.

9. Amendments to and revisions of standards normally require the same procedure as is applied to the preparation of the original standard.

Overseas standards documents

The Bureau of Standards Jamaica maintains a reference library which includes the standards of many overseas standards organisations. These standards can be inspected upon request.

The Bureau can supply on demand copies of standards produced by some national standards bodies and is the agency for the sale of standards produced by the International Organization for Standardization (ISO) members.

Application to use the reference library and to purchase Jamaican and other standards documents should be addressed to:

Bureau of Standards
Jamaica 6 Winchester
Road
P.O. Box 113,
Kingston 10
JAMAICA, W. I.

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