Understanding Substance Use and the Wider Support Needs of Scotland's Prison Population

Appendices

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Appendix A. Research design

Methodological approach

Study methods

The first stage of our work on the study involved a review of literature. Recent and prominent literature on this area were identified by the research team and compiled into a rapid literature review. There was a focus on recent literature and literature that was Scotland specific. Recent literature on this area is limited and there were time constraints on this project which necessitated a more concise literature review. The structure of the proposed research was followed in the literature review with an attempt to focus on the three key areas (alcohol, drugs and smoking).

The original study design included a desk-based review and synthesis of all available (published) datasets. This was quickly augmented by a high-level strategic review of how healthcare data is gathered and used. Emphasis was given to a qualitative assessment through a set of semi-structured interviews (n=8) with healthcare practitioners and others from Scottish Prison Service (SPS), the Scottish Government and Public Health Scotland (PHS).

The subseqent, and core elements of this study, utilised several qualitative approaches comprising of:

1. semi-structured interviews with a broad and purposeful sample of professional stakeholder groups (n=36);

2. a short-life working group with a diverse range of professional stakeholders from key partners in SPS, NHS, and the Third Sector (n=10); and

3. semi-structured interviews with those who have lived and/or living expereince, including those who currently live in a Scottish prison (n=15) and those who have lived in a Scottish prison within the last twelve months (n=6).

Attempts were also made to identify suitable family members through study information being shared with prison visitor centres and also through distribution to other organisations that support famiilies of those affected by substance use or families of people in prison. Despite some initial interest from a number of family members, none were conducted. This is noted as a study limitation in the main report.

These approaches were supplemented with a rapid literature review, a review of existing (published) data, and a mapping exercise.

The context of the COVID-19 pandemic necessitated a flexible approach, with all working group sessions and semi-structured interviews conducted remotely[1], either through Microsoft Teams or via phone call, depending upon interviewee preference.

[1] Due to the Scottish Government pausing all face-to-face research as a result of the COVID-19 pandemic.

All participants received a Participant Information Sheet in advance of the scheduled working group session or interview, which the researcher reviewed with them. All participants completed and signed a consent form. All interviews and working group sessions were audio-recorded and transcribed[2].

All qualitative data from interviews and working group sessions has been analysed thematicaly by the study team. The results are presented in Chapter 3 of the main report.

A mapping exercise was also conducted through the review and analysis of Alcohol and Drug Partnership (ADP) Annual Reports to the Scottish Government for 2019/20.

Interviewing approach

Topic guides were developed by members of the research team for use with all four interview groups and focused on the key study research questions. All topic guides were then shared with a Lived Experience Panel (convened by the Scottish Government) as well as with the wider research team and the RAG for feedback, prior to final amendments being agreed.

A senior member of the research team undertook a comparison of the first tranche of both lived experience and professional stakeholder interviews to ensure a consistency of interviewer approach and that appropriate data was being collected.

Working group approach

An initial plan for conducting three working group meetings was expanded to four meetings. The content and level of participation in each meeting is described below:

- Meeting #1 – Conducted at the start of the study to discuss and agree relevant 'starting points' for the needs assessment (i.e. what we already know) and also identification of key areas for investigation in study. This group met for 1 hour 50 mins and was attended by **eight** participants.
- Meeting #2A – Conducted at the mid-point of the study to focus on in-prison issues (substances of use, data and information sharing, workforce considerations, partnership working, examples of good practice). This group met for 2 hours 15 mins and was attended by **six** participants.
- Meeting #2B – Conducted at the mid-point of the study to focus on throughcare, remand, housing issues and family considerations. This group met for 2 hours 15 mins and was attended by **seven** participants.
- Meeting #3 – Conducted at the endpoint of the study to reflect on overall findings and key messages from the fieldwork. This group met for 2 hours 30 mins and was attended by **eight** participants.

[2] More information on transcription services used

Analysis

Transcripts of interviews with those currently (or recently) living in prison were anonymised and initially analysed. A coding framework was developed from this and confirmed in discussions with research team members. Transcripts were uploaded to NVivo (Version 12) and subsequently analysed and coded by another member of the research team. This coding process began before all interviews had been undertaken. During this period the team held a 'triangulation' meeting to ensure an iterative understanding was established among the final interviews, the initial analysis, and the emerging themes from early NVivo coding. While triangulation has different meanings in different contexts, in qualitative data analysis, it is a useful tool for quality assurance and 'cross checking' (Bryman, 2016). A template for analysis was constructed by the researchers with *a priori* themes. Initial codes were informed by these themes and additional codes and sub-codes added as themes emerged.

A thematic approach was adopted for the analysis of key professional stakeholder interviews, which utilised some obvious priori codes focused around: substance use (patterns and consequences); and organisations (policies, procedures and partnership working). A range of emergent new meta and micro codes was subsequently developed. This work was supported by several whole team conversations, working group sessions and bespoke conversations with key informants to affirm or refine the thematic analysis framework.

In the process of analysis two theoretical frameworks helped us to understand the context and challenges faced in bringing together the myriad of considerations:

- Systems Theory[3] models ask us to consider a system, such as a prison in the context of its own function, its networks and wider environment, sometimes referred to as micro, meso, macro, exo, and chrono systems. In this context each prison is a relatively closed system operating with a degree of autonomy, and then to some extent SPS too. However both are porous rather than entirely closed systems. As a network each prison has its own internal patterns, and more generally is subject to a range of interactions from local community partners to national government policy. This becomes important in also understanding that the drug use and needs of those within Scottish prisons has a clear pre and post gate influence and is not solely that of time served.
- Zinberg's 'Drug, Set and Setting' model[4]. This model helps us understand that the nature, functions, and consequences of use are also contextual bound to three considerations: (1) the type of drug being used, strength and means of administration of; (2) those within whom the drug is being used; and (3) the place/context within which the drug is being used. Thus it is important to realise that the current specifics of what alcohol, vape, prescribed drug use, Novel Psychoactive Substances and Street Benzos are being used, how and why they are being used and the problems that arise from this are specific to the prison system. Use is bound up and takes place

[3] An introduction to Systems Theory in Social Work
[4] Zinberg, N.E. (1984). Drug, Set, and Setting: The Basis for Controlled Intoxicant Use.

amongst a very specific set of peers and is not done within the same freedoms of choice that might occur in the community.

Study governance

Needs assessment methodology is not categorised as 'research' by the Medical Research Council, so there was no requirement for NHS ethical approvals. However, all Health Boards have their own Research and Development protocols which necessitated consultation, and in some instances, written approval.

Ethical approval for the involvement of Dr Wulf Livingston and Professor Madoc Jones in the study was provided by the Glyndwr University's Research Ethics Sub-Committee (reference: 490) on 5th November 2021[5].

[5] This ethical approval process will also help facilitate any peer review concerns that might arise in seeking post report publication in academic journals.

Appendix B. Language considerations

We have made a conscious effort to reduce the volume of jargon in this report. We have also chosen to use language that emphasises the individuality, equality and dignity of people rather than defining people primarily by a problem or issue that can have negative associations. In particular, we want to highlight the extensive work that is being led by the Scottish Government[6], the Drug Deaths Taskforce[7] and other organisations across Scotland, such as the Scottish Drugs Forum[8] in this regard. Through consideration of the common term 'prisoner' (and particularly in relation to those who use substances) we have chosen to use the following phrases, 'people who are currently living in, or have recently lived in, prison', 'individuals who experience problems with substances', and 'individuals with lived or living experience'.

We want to emphasise the importance of language in helping to challenge and reduce the pervasive stigma that is still attached to being a person who experiences problems with substances. For example, we consider terminology such as 'misuse' or 'abuse' to be stigmatising and should not be used, in line with guidance from the Global Commission on Drug Policy[9]. We have the sense that the current conversation and priority is focused around whole populations and wellbeing (i.e. a continuum of users and non-users). We therefore purposely refer to 'substance use' and not 'misuse'.

[6] Via a current extensive advertising campaign which has received broad Scottish and UK-wide media coverage. Examples include: 'Stop saying junkie' plea to end addiction stigma ; 'Junkie' Scotland: Adverts aim to end stigma over alcohol and drug problems ; Scotland seeks to ban words like addict and alcoholic under plan to tackle drugs death crisis

[7] A Strategy to Address the Stigmatisation of People and Communities Affected by Drug Use

[8] Tackling Poverty & Stigma, Scottish Drugs Forum

[9] The World Drug Perception Problem, Global Commission on Drug Policy

Appendix C. Qualitative themes and examples

Professional stakeholder interviews

Macro Theme	Micro Theme	Qualitative Examples
Prison is the wrong starting place	Decriminalisation / depenalisation	‘How do we keep people [who use substances] out of prison in the first place? … Because if we can do that then we’re not having these conversations.’ [Key Stakeholder interviewee 13] ‘The countries that have been successful in reducing their prison population, predominantly that’s been by depenalisation and decriminalisation … you can begin to solve many of these problems by providing a completely different approach to alcohol and substance misuse.’ [Key Stakeholder interviewee 18] ‘You’re in your cell for 23 hours of the day. That cannot be conducive to helping people move on with their lives.’ [Key Stakeholder interviewee 22] ‘We’re sending people to remand more often, so that says that we’re not keeping people out of prison.’ [Key Stakeholder Working Group member]
	Substance use as a coping strategy rather than ‘the problem’	‘If we keep focusing on only drugs and alcohol, we’re not going change the system. Is there a more holistic way that we can assess an individual, rather than what we see them to be, and that’s a pain in the ass because they’ve committed an offence and they’re taking drugs?’ [Key Stakeholder interviewee 12] ‘Most addicts I know are just trying to scrimp and scrape and get a tablet to go behind the door [of their prison cell] and not feel or deal with reality of the lives just now.’ [Key Stakeholder Working Group member]
Implementation of MAT standards	An opportunity, but a much harder ask in prison	‘So, the timeline is that from April 2022, Medication Assisted Treatment [MAT] standards have to be implemented. I would say in the prisons you’ll be lucky if it’s implemented by April 2023.’ [Key Stakeholder interviewee 02] ‘So, one of the things from that is about immediate access to prescribing, so same-day prescribing. That can be a challenge in a prison setting because their systems aren’t connected up. [Key Stakeholder interviewee 22] ‘So, there are things within the prison service that are going to make implementation of MAT standards more difficult. They just need to change the way of working in order to be able to implement those.’ [Key Stakeholder interviewee 22]
Policy Perspectives	Long way to go	‘[The Misuse of Drugs Act] It’s antiquated, it’s out of date, it’s seriously not helpful, and it undermines a public health approach.’ [Key Stakeholder interviewee 22]
	Opportunity of devolution	‘Strategically I think that we’re not taking advantage of the fact that it’s a new administration that has already been in post for 14 years, came in with a sweeping majority, and has an opportunity to do culturally unacceptable things.’ [Key Stakeholder interviewee 18]

	Coordination of policy work	'I think the high priority that drug deaths is now given means that other areas of government need to work with us … Ministers meet quite regularly particularly around mental health issues and that's quite a regular ongoing occurrence now which is really helpful.' [Key Stakeholder interviewee 11]
	Role of Courts and Sheriffs	'I remember being in a meeting with sheriffs maybe four or five years ago and I referred to them as a stakeholder and they took umbrage at that..' [Key Stakeholder interviewee 04] 'The drug court in [name of city], the sheriffs there were absolutely brilliant in learning about the people that were continually coming in front of them.' [Key Stakeholder Working Group member]
	Prevention first, punishment / protection second	'What I'm suggesting is that it should be a national prevention service. [Key Stakeholder interviewee 21]
Systemic complexities	Local, regional, and national planning frameworks	'You perhaps use the justice system to help the public health agenda as opposed to the justice system competing with the public health agenda.' [Key Stakeholder interviewee 04]
	Autonomy of Governors in Charge (GiCs)	'They [GiCs] are all their own wee kingdoms and fiefdoms and there isn't that crossover of consistency.' [Key Stakeholder interviewee 02] '…but we've received a bit of pushback from them [GiCs]. So, they're not quite engaging in the way that's been signed up by SPS headquarters.' [Key Stakeholder interviewee 02]
	Geographical variations	'We've got [name of rural area] and [name of city]. If you look at the likes of [name of prison] they've got maybe ten, twelve areas going on either side of… and to get them all round the table discussing individual cases would be a major job compared with what we do. We've got the same people coming to our CMB [Change Management Board] on a weekly basis, so we've got a good relationship with them.' [Key Stakeholder interviewee 19]
	ADPs	'There's enough complexity [for ADPs] as it is without having that problem [Prisons] as well.' [Key Stakeholder interviewee 11] 'What I found is, up in [Place], we worked really closely with alcohol-drug partners … we basically pay lip service to it. We've got a seat on the ADP, but we do nothing about it.' [Key Stakeholder interviewee 07] 'I think it probably does need to be higher on the [ADP] agenda. I think the challenge comes when you're thinking about how to respond in the prisons, you need a different set of stakeholders round the table.' [Key Stakeholder interviewee 11] 'I think it depends on whether the ADP is led by NHS or whether it's led by local authority. So, I think there's a structural problem with the ADPs.' [Key Stakeholder interviewee 12] 'In some areas of the country the planning of prison treatment doesn't sit with the ADP, partly because the treatment system is integrated into mental health and sort of primary care structures and therefore isolating the drugs and alcohol bit isn't very helpful [Key Stakeholder interviewee 11]

		‘So there is a sense of well, what is the role of an ADP here?’ [Key Stakeholder interviewee 11] ‘. It was a talking shop and we seemed every month it was the same things being discussed with very little … I’m starting to understand the context in which they operate in because the prison service is quite nimble and manages things quite quickly … we’re very, very task orientated … So it was a bit frustrating initially when everybody else wasn’t like that, but I think I appreciate the environment they’re in, so it’s very difficult.’ [Key Stakeholder interviewee 01]
	Finance	‘If you follow the money on these things, the money for throughcare sits with community justice. It doesn’t sit with ADPs. [Key Stakeholder interviewee 11] ‘The funding is siloed, therefore does that lend the service to be siloed?’ [Key Stakeholder interviewee 04] ‘If you start to put funding into throughcare and funding into prison treatment, the concern is that your counterparts in IJBs or health boards or community justice, might start seeing the opportunity to start withdrawing from that funding.’ [Key Stakeholder interviewee 11]
	Culture clashes	‘I think SPS were wounded with the NHS process, and let’s face it, that’s 10 years ago… why it’s a mess, because they’ve never done any of the … groundwork in the original to say, “We’re having two different cultures coming in together here.”.’ [Key Stakeholder interviewee 12]
Non-substance use specific needs	General needs	‘It is the Holy Trinity … GP, housing, benefits. And that doesn’t happen for people … Without those things you may as well just not let them out.’ [Key Stakeholder interviewee 23] ‘But that’s the group. Multi-complex, often long-term needs that are really hard to get into.’ [Key Stakeholder interviewee 04] ‘For me there needs to be a broader focus, and it’s not just in drugs and alcohol. So, how do you communicate with somebody who’s got a brain dysfunction, or who has got an inability to cognisantly take information in? How do you speak to them about their drug and alcohol problem when they’ve not been fully assessed?’ [Key Stakeholder interviewee 12]
	Housing	‘So the main issue that we found… we started to go into the prisons and people were really concerned about where they were going to be [living] upon release.’ [Key Stakeholder interviewee 10] ‘Where’s the first place they go? Well off-licence usually because they’re so overwhelmed with emotions and mostly fear when they come out of prison that they’re looking for some sort of self-soothing and we know where that leads them to. And if we don’t get them within the first 24 hours of a friendly face, somewhere safe to live and a warm meal… do you know what I mean? And who could blame them?’ [Key Stakeholder interviewee 23] ‘[Supported release/tenancies] There’s less non-fatal overdoses, they’re not in and out of prison, there’s no police disturbances. So, when you look at the whole cost for the city council, it’s massive savings.’ [Key Stakeholder interviewee 08] ‘Now, on black and white, on paper, we are supposed to be told three or four days prior to liberation, but because of availability that’s not always guaranteed. So, when we are picking up on liberation, we

	are actually having to phone while we drive back through to [city name] to find out where this person is going. Again, you can be phoning and phoning and get nowhere.' [Key Stakeholder interviewee 08]
SHORE standards	'So the SHORE standards were signed up to by Housing and Justice Services. It's not been signed up by any other services within social work and the Health and Social Care Partnership.' [Key Stakeholder interviewee 10] 'it's different across the different prisons … I'm very aware that I've got an officer going into two prisons and will spend at least a day in each of them each week and will do face-to-face and that person getting libbed [liberated] there will get that type of service, but they won't if they're in [prison name].' [Key Stakeholder interviewee 10]
Concerns about release into homelessness	'So, they may leave with all the best intentions to not use again, but you're released from prison and you're back directly into the community that you were in before.' [Key Stakeholder interviewee 22] 'We can only do so much unless the conditions change for the individual outside. We can't build houses for them.' [Key Stakeholder interviewee 07]
Mental health	'The majority of people in prison having significant mental health issues, trauma. All that doesn't go away because you're in a prison setting. In fact, it can be enhanced as well when you're in that setting.' [Key Stakeholder interviewee 22] 'I certainly don't think we've got a proper drug needs assessment … We seem to be behind the curve in terms of meeting people's needs..' [Key Stakeholder interviewee 05] 'There's a mental health nurse which is pretty similar to the substance misuse nurse. She's inundated. She's basically giving out medication instead of seeing people for mental health issues.' [Key Stakeholder interviewee 19]
Connectivity and finance	'Because you're being forced and being pushed into that, to use that, it's just like, "What do I do?" They don't even have the knowledge to set up an email address to register for Universal Credit.' [Key Stakeholder interviewee 08] 'But the problem is you'd get out and you'd just see so many hurdles, especially the day you get out. You've got to sort out your housing; you've got to sort out your benefits.' [Key Stakeholder interviewee 06]
Emotional intelligence and regulation	'We know it's a high-risk time as well for suicide, so if you're feeling suicidal plus you're in major withdrawals, it's not exactly a good combination. So, there's a lot of things going on for people in that first couple of days, definitely.' [Key Stakeholder interviewee 22]
Loneliness and lack of connections	'But loneliness, no one talks about loneliness. Somebody returning to the community after time inside, they are lonely and disconnected.' [Key Stakeholder interviewee 21] 'I never think it's just about the drugs. I always think it's about the lack of connection.' [Key Stakeholder interviewee 21]

		‘Because we always talk about reintegrating people into society, but a lot of the times they were never really integrated in the first place.’ [Key Stakeholder interviewee 22]
	Dentistry	‘Working in the prisons, we know that there’s a lot of substance misuse, and it’s generally that population that you really do see the effects in teeth. Sometimes you can’t get them because they’re on MORS or something, where they’re locked down in their cell because they’re usually out of it on spice and stuff.’ [Key Stakeholder interviewee 31] ‘In the mouth, in terms of what we see, is somebody who’s got alcohol, substance misuse, there’s a lot of tooth surface loss, a lot of wear. There can be a lot of sensitivity.’ [Key Stakeholder interviewee 31] ‘On admission the people with the poorer dental disease that have been on the outside, and drug use on the outside coming into prison, at least initially no longer having access to that they suddenly realise that they do have a sore mouth, and they haven’t actually realised because of their drug use…’ [Key Stakeholder interviewee 31]
	Life skills and basic needs	‘But I don't know why it’s taken all this time to finally have a post for someone teaching people life skills … We’ve got an officer that just started … full-time, and their role is as life skills and citizenship officer, which is amazing.’ [Key Stakeholder interviewee 05] ‘We provide shelter, we provide food, we provide security, we provide a safe place, and allow them to start working up the other rungs of the ladder … However, when they’re liberated, if there’s none of those fundamental things in place, they’re going to start taking steps back a way to put those things in place for themselves and stop working on the things they’ve already been working on.’ [Key Stakeholder interviewee 07]
Substances and substance use	Coping Mechanisms	‘I mean, I’m sorry, if I was in jail 23 hours a day and I was in that situation, I’d probably want to medicate against it as well … unless you are a much better person than me?’ [Key Stakeholder interviewee 21] ‘I think there will probably always be the desire for drug use in prisons, just because of the nature of where people are, trying to get through the day.’ [Key Stakeholder interviewee 22]
	Prominent Substances	‘There’s a huge problem with the illicit substance use across the whole prison estate. It is mainly etizolam and spice.’ [Key Stakeholder interviewee 02] ‘But more recently though, like the spice and stuff like that had just completely overrun the place … it was everywhere. You could be in a hall with 62 boys and maybe 45 to 50 of them are all taking it.’ [Key Stakeholder interviewee 06] ‘It’s the worst it’s ever been just now. There’s three months to go, but it’ll be the worst it’s been since this MoRs [SPS’ Management of Offender at Risk Due to Any Substance policy] took off.’ [Key Stakeholder interviewee 19] ‘They’re not taking heroin now. They’re taking a whole range of other things that actually require a different intervention, and you cannot mandate people out of addiction…’ [Key Stakeholder interviewee 21] ‘I miss the days of heroin. I miss being able to see somebody if they were like unconscious you could administer naloxone, you knew what you were doing with that. Legal highs and etizolam, you’re

	playing blind and it's really hard to stop an overdose.' [Key Stakeholder interviewee 30]
Unidentifiable Substances	'People might be getting this stuff in thinking that it's a synthetic cannabinoid, using it and it's etizolam, and then of course having a major reaction because they may be on other depressants like methadone or whatever as well.' [Key Stakeholder interviewee 22]
Harm	'Obviously they're coming in various strengths. There's some crazy strengths a lot now. It seems to be getting stronger and stronger. They're hallucinating. They're basically locked up for their own safety and other people's safety.' [Key Stakeholder interviewee 19] 'The issue here is that you've got a lot of vulnerable, damaged people who don't care if they live or die.' [Key Stakeholder interviewee 24]
Availability	'it's more availability than drug of choice.' [Key Stakeholder interviewee 23] In Scotland, you don't see spice use much outside of prisons at all. Why would you? Because there are benzos. It's not a drug that people really seek out, in my opinion.' [Key Stakeholder interviewee 24]
Legal Loopholes	'The drugs became embedded into the culture because it was very difficult for the authorities to do anything about it legally.' [Key Stakeholder interviewee 24] 'So, you had this window of opportunity which then created more innovation, because you knew you could do it, and therefore the market becomes more innovative than it ever' [Key Stakeholder interviewee 24]
Unpredictability of Substances	'They don't have an understanding of what they're taking. They generally think that they're taking proper diazepam and Valium.' [Key Stakeholder interviewee 02] 'Benzos continue to be particularly problematic in terms of incident management and supporting people and making people very unwell very quickly … So at the moment our big focus is on helping people understand the dangers' [Key Stakeholder interviewee 20]
Benzodiazepine	'It's starting to come back together again. The market's started to converge again in terms of benzos.' [Key Stakeholder interviewee 24]
Blotters	'Potent drugs, you can put them onto blotters and have an effect. It's just that you'd have to have so much of it in one go for some drugs because it's not potent enough. So, it's to do with the potency, which is why you have LSD on blotters.' [Key Stakeholder interviewee 24] '…if you look at when they're getting their drug tests, predominantly this type of paper… well it's got a mixture of all sorts of drugs in it.' [Key Stakeholder interviewee 19]
Heroin	'It's like when I first started going to jail there was heroin in the halls.. Whereas now you don't really see it at all in the prisons. It's all jail meds.' [Key Stakeholder interviewee 06] 'Yes, heroin is still available, but on a much smaller scale.' [Key Stakeholder interviewee 23]

	Alcohol	‘In [Prison name] at the moment there’s also a good wee few batches of illegal hooch on the go.’ [Key Stakeholder interviewee 02] ‘We’ve had alcohol in custody recently.’ [Key Stakeholder interviewee 20] ‘But before it used to be like maybe they’d brew hooch and stuff like that. It seems to be… well not non-existent but it’s very rare that that happens nowadays.’ [Key Stakeholder interviewee 19] ‘Yes, people do still make hooch. In fact one of them was just talking to me about that this week.’ [Key Stakeholder interviewee 23] ‘I think they probably think there can’t possibly be alcohol in the estate. I think it’s less visible for us, but it’s not that it’s not there.’ [Key Stakeholder interviewee 17a]
	Lack of Alcohol Support	‘Very little attention paid to the psychological support required. There are some groups that would run but ongoing, tailored, and person-centred work is severely lacking. I have heard that some folks will use alternative substances to manage their sentence.’ [Key Stakeholder interviewee 17a] ‘I think people don’t do the preparation for release about alcohol and where it sits in someone’s recovery because they assume, wrongly, that they’ve had six months in the jail, they’ve not been drinking, it’s no longer an issue.’ [Key Stakeholder interviewee 17a]
	Alcohol post-release	‘They walk to [name of Off Licence] from [name of city]. It’s en route. They can’t get to the town centre without walking past [name of Off Licence], so they go to [name of Off Licence], and they’ll pick it up.’ [Key Stakeholder interviewee 17a]
	Tobacco	‘It went smoothly actually. They all can buy vapes and e-cigarettes on the canteen and that. There’s very rarely any tobacco been caught in possession with other prisoners.’ [Key Stakeholder interviewee 19]
	Vapes as Tools	‘With the introduction of smoke-free prisons we’ve also introduced a method for people to take these new kind of legal or paper because of the use of vapes. So vapes have become the kind of method of delivery … for substances within custody’ [Key Stakeholder Working Group member] ‘Because of the residents having access to vapes, it’s actually made it a lot easier to smoke NPS and spice and all that kind of stuff.’ [Key Stakeholder interviewee 02]
Substance use specific needs – in prison	Entering prison	‘Whether it be peer navigators, people with lived experience, and the whole gamut of, sometimes people just need information and advice, sometimes people might need independent advocacy, sometimes they might need a lawyer. We’re still back at that place that actually all the evidence says we’ve more chance of somebody coming through and recovering if you have an established relationship and they trust you. I definitely think there’s something in that for navigators, definitely, about that peer support and that navigating the journey, and that human rights piece.’ [Key Stakeholder interviewee 12]
	No reward / incentive for honesty	‘So, the idea that you can punish someone out of taking an illegal drug, meanwhile holding them in arcane conditions where one of the few ways out and the way to cope with trauma and distress is to take

	drugs, because it works and you know it works, then I just find it just unbelievable.' [Key Stakeholder interviewee 18]
Coping Mechanisms	'So I've got two competing sets of rules – the rules around surviving in this environment and the rules that are laid down to me by SPS. He said the two things are not compatible because you have to break the rules to survive and then you don't get your parole.' [Key Stakeholder interviewee 23] 'So, first of all you've got the prison rules, which I say are no longer fit for purpose. So, part of the prison rules are that you cannot take substance misuse. You can't traffic it in, you can't have it when you're in there, and if you do you get solitary confinement, and that's what happens. The days of solitary confinement increase for each subsequent offence, shall we say.' [Key Stakeholder interviewee 18]
Punishment	'…a thing that the SPS need to address. We can't continue to penalise people for using drugs in prison when you're the ones that can't keep the drugs out.' [Key Stakeholder interviewee 22] 'I mean, staff need to start seeing that someone being honest is an opportunity to intervene." Current thinking, or previous thinking, would suggest that there would be intelligence put in. There would be a suspicion of drugs test put in for, and there would be a narrative put in which would be what's called an adverse circumstance.' [Key Stakeholder interviewee 07]
Continuity of Prescribing	'Sometimes on the going in process it's difficult because staff at the prison can't get a clear confirmation of that person's prescription really quickly, so that sometimes takes time.' [Key Stakeholder interviewee 22] 'But the times that I've been in prisons and spoken to staff, they do get it sorted within a couple of days, but that couple of days can feel like months for that person who's on the other end of that.' [Key Stakeholder interviewee 22] 'But so many times it's not a planned release. So, people go to court, and they'll be released from court. Then, even the health staff within the prison don't know that the person's been leaving that day.' [Key Stakeholder interviewee 22]
Pain Relief	'Prescribers looking at those prescriptions within the prison setting and properly reviewing people's pain needs, chronic pain needs, and a lot of prescriptions were removed from people who were on that in a prison setting.. Our concerns around that would be that people's pain is still treated seriously, and that people aren't seen to be drug-seeking, and they're trying to get drugs, because people are often in extreme pain and some of the drugs that they're on are masking that pain. [Key Stakeholder interviewee 22]
Continuity of Prescription	'People are still being withdrawn from treatment when they enter prison… … This isn't just about OST. This is about mental health medication. This is about anti-depressants. This is about medication that you and I could be on, and we should get access to, and the continuity of care between the community and prison is not good.' [Key Stakeholder interviewee 12]
Prescription Matching Drug Use	'I think we have an opiate service.' [Key Stakeholder interviewee 21]

	Harm Reduction	‘So, we pluck them out the sea, we dry them off, we dress them warmly, we give them a nice meal, and then we throw them back in.’ [Key Stakeholder interviewee 18]
Throughcare and liberation	Through the gate support and continuity	‘There’s a lot of them just need reminding of their plan. A lot of them do want to stay away from the drugs, they want to fill their time, not hang about with other offending peers [Key Stakeholder interviewee 19] ‘[Availability of services] … but that of course depends on how focused you are on recovery for leaving the establishment and what is in place for you upon you leaving.’ [Key Stakeholder interviewee 20] ‘, an individual leaving here who is going back to their partner or spouse and they have got their scripts organised and they’re going to continue working with Narcotics Anonymous in the community and they are very well versed in their needs and supports and triggers and they’ve got some ongoing throughcare whereas if it’s someone else who’s leaving us but has not got any housing for example or any employment opportunities and they’re leaving here and they’re going to a homeless shelter instead of going to a nice council area where they’re going to do everything they can to support you, you end up sleeping on a church floor in [city name], I think the chances are that you’re not going to have the structures in place to be able to continue that journey of recovery.’ [Key Stakeholder interviewee 20]
	Throughcare Officers	‘People’s just basic needs. So, when we had those throughcare support officers for a while, they were doing some really good work in ensuring that people did have somewhere to go, sorting out their benefits on release, all of that side of things.’ [Key Stakeholder interviewee 22] “I don’t think there’s any support, as far as I’m aware. It did all draw back at the beginning of Covid when they got rid of the throughcare officers.” [Key Stakeholder interviewee 30] ‘I think I should maybe say I think the drugs deaths in the community have shot up since the throughcare support service stopped. I think there’s a connection there.’ [Key Stakeholder interviewee 19]
	Prison to Rehab Pathway	‘And some prisons have engaged in it and we’ve had some small successes.’ [Key Stakeholder interviewee 23] ‘…that he had engaged in that conversation with his social worker and this is what I want and they had just told him that’s not possible.. Well you obviously have bail or parole conditions and you’ll be bailed to an address and we can’t bail you to a rehab. You’ll have to go to a hostel.’ [Key Stakeholder interviewee 23] ‘. Pre-COVID, very few. People didn’t have the opportunity of coming direct from prison, for example, or as an alternative to prison. We would maybe have one in 30, so three to five per cent. Now, we’re easily running at between 10 and 20 per cent.’ [Key Stakeholder interviewee 09] ‘There’s still people come in and say, “Oh, I’ve got a punishment,” and I’m like, “No, you’ve not got a punishment. Nothing in here is about punishing people.’ [Key Stakeholder interviewee 08] ‘Mistrust ... You have people transfer, really, what you just talked about there, where they keep their head down. You know, can feel intimidated, not necessarily by people but by the situation. Don’t trust people as much, or maybe don’t trust themselves within this environment, and that transfers when they come into the rehab as well. You know, they’re immediately suspicious, if you like, perhaps,

		of people who are trying to support them' [Key Stakeholder interviewee 08]
Specific populations	Remand	'So, as of today there are 32 per cent of female population on remand, which is catastrophic, and 29 per cent of the male population on remand. That is the highest population ever in history.' [Key Stakeholder interviewee 21] '... What have I got today? I've got 114 in today. I've got 67 remand prisoners [60% of total population], so the bulk of that group that we're holding are actually that remand population.' [Key Stakeholder interviewee 25] '…in some technicality way they're under the care of the procurator fiscal rather than us.' [Key Stakeholder interviewee 20] '… there's not a lot for the remand population and these are people that are really high at risk of being liberated from court and going back into the community and potentially taking drugs ...' [Key Stakeholder interviewee 20] 'They're not like the rest of the prison population that once they're convicted we're then obligated to put as much support packages in place for individual people and the individual needs, but that doesn't really happen in the remand hall.' [Key Stakeholder interviewee 20] 'They don't have personal officers in the remand hall. They don't have go-to areas for support in the remand hall..' [Key Stakeholder interviewee 20] '...it is almost like they sit in limbo…for up to a year … [and they say] they cannae access services.' [Key Stakeholder interviewee 27c] 'But you're crisis managing within the closed establishments a lot of the time, especially amongst the short-term population. Very little you can do with them.' [Key Stakeholder interviewee 07] 'I don't think it's the right place for them to actually address their substance use, because people that are going on remand might not get any contact with the NHS services because they're in for too short of a period' [Key Stakeholder interviewee 08] 'Remand is being used because we don't know what level of drug services we want, and I don't think it's a unique correlation They know that they're probably going to go to jail again because they need to get drugs because they're not getting the services.' [Key Stakeholder interviewee 21]
	Women	'The female population it's an internalised ... It generally manifests itself in self-violence, self-harm, and that is generally, in my experience, underpinned by horrendous trauma that's been over an extended period of time, and in prison itself retraumatised again because of the separation from family and community and support networks.' [Key Stakeholder interviewee 25] 'So, the female estate is very soft and it's…very care-informed, like there's a much softer approach to it.' [Key Stakeholder interviewee 28]
	Young People	'So, sentencing policy and the changing to sentencing policy means that the ones who shouldn't be here are not here. But the ones who shouldn't have been here, most of the time they were actively engaged. They wanted to have a relationship with staff. They skipped up the route and filled it with education, social work, faith spaces or activities were full. So, staff had a pretty positive time … The other two doors they opened; they got a complex child. Mental health, violence, complex needs, physical issues … So, they are locking up the right people, but now the needs of those people are significantly greater than what it was 10 years ago … We have a lot

		of children that have come from a care background who don't have a lot of support.' [Key Stakeholder interviewee 26] 'The only other thing … working with young people is probably about five to 10 years behind working with women.' [Key Stakeholder interviewee 26] 'The difference is a lot of it is recreational, and boredom, and passing the time whilst they're in custody. We don't class them or see them as being addicted..' [Key Stakeholder interviewee 29] 'We've actually recorded one young person in the throes of being under the influence of spice to show him, because it was quite bad, to show him the effects, and he just laughed.' [Key Stakeholder interviewee 29]
The Future	It can be done	'This shouldn't be too much for us to manage [across just 15 prisons and 9 Health Boards].' [Key Stakeholder interviewee 11]

Lived experience interviews

Macro Theme	Micro Theme	Qualitative Examples
Impacts of trauma and loss	Trauma	'My dad was a drug user. He had HIV. He was HIV-positive. My uncles and that, they've died through drugs and blood-borne viruses and things like that, so I've seen quite a lot through drugs.' [RLJD03] 'There were just certain things that I hadn't dealt with, like my mum died, my dad died and my little brother died, all while I was taking drugs … I didn't actually notice that my mental health wasn't where it was supposed to be.' [Lived Experience interviewee 13] 'I lost my mum and dad to lung cancer within a month of each other, just a few years back. It was just my mum's remembrance there on Monday.' Lived Experience interviewee 02] 'I was sixteen-year-old and as I said, I got sexually assaulted by two different prison officers. And the wee guy that was next-door to me, he killed himself … being in prison brought it all back, because I'd basically forgotten about it.' [Lived Experience interviewee 03]
Structural issues	Poverty	'I had to go to a homeless unit… as soon as you go to a place like that, you're surrounded by drugs and alcohol, and you find it hard to stay off it. It's the wrong place to be going.' [Lived Experience interviewee 04]
	Need for support	'I said, "I need something. I need help for when I get out" … because this isn't working, I'm just coming in here, jail, getting out, then I'm out, a few weeks and bang – I'm in jail again.' [Lived Experience interviewee 02]
Mental Health	Impact of time in custody	'They put you into the prison and it hits you … depression and mental health.' [Lived Experience interviewee 05] 'There's a lot of vulnerable people within prison, right? … they look too far ahead, and their fate overwhelms them.' [Lived Experience interviewee 06] 'Mental health is a big problem within prisons, and it's an underlying problem that's not really addressed … a lot of these substances will mask mental health as well.' [Lived Experience interviewee 15] 'It's easy time if you're under the influence. If you're lying in your bed gauching [under the influence of drugs, typically opioids] all day, you're not doing time.' [Lived Experience interviewee 03]

		‘One of my wee pals who I’ve done a lot of time with, he was smoking paper for months and he just flipped his nut. I mean the wee guy just went psychotic … he started having paranoid delusions basically … The wee guy’s into Carstairs [the State Hospital] the now because of it.’ [Lived Experience interviewee 10]
Prison culture	Coping strategy	‘It became part of the prison culture … everything’s like an evil version of Groundhog Day … and the atmosphere can be quite poisonous and nasty and evil. So, if you can’t escape that physically, you’re going to try to escape it mentally, aren’t you?’ [Lived Experience interviewee 06]
	Legal highs	‘I genuinely think that the number one problem for the Scottish Prison Service now is that legal high stuff.’ [Lived Experience interviewee 14]
	Harm	‘Whoever they [dealers] needed beat up or slashed … it was easier to pay an addict something that was cheap, so it just brings a lot more violence into the jails and a lot more kind of carnage to be honest.’ [Lived Experience interviewee 14] ‘I’ve had a few funny turns off it as well, I’ve stopped breathing and that off it a couple of times.’ [Lived Experience interviewee 12] ‘He took a pipe in the rec [recreation] room. He started screaming and freaking out ... he actually took a heart attack that night. He got a pacemaker put in after that.’ [Lived Experience interviewee 02]
	Prejudice	‘If you’re taking drugs, right, anybody with any morals would view it as… it’s an illness. Then you get prejudiced members of staff who see it as you’re deliberately breaking the rules, and you’re being disrespectful, blah, blah, blah, and you get treated as such eh?’ [Lived Experience interviewee 06] ‘Certain members of staff will tar everybody with that same brush. Whether you come in and you’re seeking help or whether you come in and you’re not seeking help.’ [Lived Experience interviewee 13]
Patterns of substance use	Community Substance Use	‘Before I got the jail it was crack cocaine, street Valium, etizolam, sometimes heroin. You know what I mean? It was pretty chaotic.’ [Lived Experience interviewee 04] ‘I was using Valium and I was using speed, coke, I was using alcohol. I was mixing them together. I wasn’t just using one. I was mixing them together because it was just completely blanking my mind from what was happening in everyday life.’ [Lived Experience interviewee 05] ‘I came in and there was in an awful state – I was still on the methadone programme, but I had been taking heroin, a lot of crack and street Valium, any Valium in fact.’ [Lived Experience interviewee 12] ‘… heroin, Valium and then obviously I dabbled in illegal highs and everything else that goes about.’ [Lived Experience interviewee 08]
	Availability	‘Probably the two years before I got sent to prison it was non-stop, like constant… if I couldn’t get my hands on my drug of choice, I’d just take whatever else was available.’ [Lived Experience interviewee 14] ‘I’d always done drugs in jail, whether that be prescription drugs, non-prescription drugs, legal highs, whatever was floating about the jail … I was for a while a specific drug user, but then I became like a poly drug user and would just use anything.’ [Lived Experience interviewee 13]
	Since Liberation	‘I’ve not been really using anything. Well I have, I’ve been dabbling here and there but it’s not like every single day. I’ve had a bit of crack.

		I've had a couple of Valium here and there, and some weed, some cannabis.' [Lived Experience interviewee 02] 'I got out and then I sort of… I just ended up with a few people who I should have stayed away from and got right back into it … I was like "No, I cannae do that anymore. I cannae." Everything I'd done in the prison to get myself fit and healthy and that again, I couldn't do it again.' [Lived Experience interviewee 04]
	Committing Crimes	'I committed an assault and robbery through drugs.' [Lived Experience interviewee 04] 'It could range from anything - it could be anything. It could be assault, assault, and robbery. If I take any Valium, that's when things start going wrong.' [Lived Experience interviewee 02] 'I suppose for ages I've been in the jails that long, been in and out that long and it's all kind of been… all my charges have really been drug-related or… they've all been drug-related in fact and it's always been.' [Lived Experience interviewee 12] 'My ex-partner and I got involved in stashing drugs and the s*** hit the fan.' [Lived Experience interviewee 03]
	Premature Death	'Yeah. I need to, aye. I need to turn it around. I've seen too much chaos with drugs, too much…. I dinnae want to end up back in a jail getting a big sentence, or even worse in the grave.' [Lived Experience interviewee 04]
	Paper	'I remember guys totally going mental with officers ... "I want my mail; I want my mail." Now, the officers ken what they f****n' want their mail for. But that just shows you how mental they are; they're standing at the gates, shouting for their mail.' [Lived Experience interviewee 03] 'These guys are all taking legal highs for one reason only - to circumvent the drug tests. That's about it. Whereas beforehand, before the drug tests, guys were smoking hash, guys weren't smoking smack, but the drug tests came in, guys started smoking smack to circumvent drug tests.' [Lived Experience interviewee 10] 'For the size of a postage stamp, you'd have to pay £10 for it … it just depends how strong the spice was. If it wasn't that strong it would last you ten minutes. If it was strong, it'd maybe do you the night.' [Lived Experience interviewee 02]
	Street Valium	'There was one point that I'd got a bundle of tablets for somebody and they were left at a certain place and I picked them up and I got paid in Vallies [Valium]. It was desperation.' [Lived Experience interviewee 03] 'A lot of people don't realise etizolam's in street Valium anyway, but when I came in like I thought the etizolam would just have been like Valium and I took it and I OD'd last Christmas, well last Boxing Day and I had to get the naloxone jag twice in this jail and I got taken into hospital, so they kind of saved my life here and that and brought me round.' [Lived Experience interviewee 12]
Substance Use Treatment	Treatment Options	'The system. It's methadone or Espranor.' [Lived Experience interviewee 02] 'But what a difference it was being on the Suboxone from being on the methadone. You kind of get the majority of your function back and hopefully sometime soon I can get onto the Buvidal injections which means I'm not even having to go to the chemist anymore.' [Lived Experience interviewee 14] 'Well I think methadone's the wrong choice to put anybody for heroin because a heroin habit, if you're rattling, you're only going to be rattling for maybe a week, whereas you go on methadone and you

	come off it, you're rattling for months … A lot of people stay on methadone because they know how hard it is to come off.' [Lived Experience interviewee 08]
Choice	'I've asked to reduce on my own and like I think I started reducing maybe about six months ago and it's taken them… it's like to reduce you, they tell you they want to dip test you every time you want to come down however many mls and it's like so it takes four or five weeks for you to get a dip test and then you need to wait another probably week after that so you can come down that 10ml and then when you want to come down whatever again, you go through the whole process again, so it stalls all the time.' [Lived Experience interviewee 12] 'But they try everything they can to keep you on that [OST], which in my opinion isn't right. If somebody's ready to come off it and they've thought this through and they've got a plan in place, that plan should then be getting put into action. They can't make a decision for an adult if the adult's made a decision. That's my opinion on it.' [Lived Experience interviewee 08]
Self-detox	'I basically tapered myself down, as in I felt very, very bad. I felt very, very lethargic coming off it ... I was supported. The drug workers came to see me more or less every second day. They actually tried to advise me. I was coming down too quickly as far as they were concerned, they actually gave me a programme that they felt was reasonable.' [Lived Experience interviewee 10]
Access	'When I tried to get access to the methadone programme in [name of prison], I asked how long does it take? On average, between six and eight weeks. Six months of being in [name of prison], and I still hadn't accessed the methadone programme.' [Lived Experience interviewee 06] 'The first time I got put on methadone it took me a year which was quite long.' [Lived Experience interviewee 08]
Success of Methadone	'It (methadone) stopped me being active within the drug world in prison.' [Lived Experience interviewee 10]
Culture of Silence	'There's not much help. If you go to the doctor's and tell them that you've been smoking that legal high, ken, they don't give you any help. There's no meds they can give you. They just basically turn their back on you, sort of thing.' [Lived Experience interviewee 02] 'I knew guys that could have got support, but they've took it but they're too feart to say to them that they're on the paper, to get the support, because you know, they're too feart in case they got taken off their methadone or ken, you know what I mean… If they're on scripts?' [Lived Experience interviewee 07]
Punishment	'"Look, if you're taking any anti-psychotic drugs, if you're taking legal highs, if you're taking anything like that, you need to let us know and we'll give you help." Right? … couple of guys went down, asked to give them help and what they did was put them in The Digger [segregation unit] - and gave them nothing.' [Lived Experience interviewee 07]
Continuity of Care	'I was on methadone. I hadn't had my methadone for four days at that point and then I still never got it for another three or four days after that. I was on 100mls and that's how they started me back down on

		40[mls] because I hadn't had it for that long.' [Lived Experience interviewee 12] 'So by the time I got to prison, I no longer had a prescription for it [methadone]. So when they sent the fax through to the doctor, the doctor sent the fax back through and said, "Oh he didn't pick it up for three days so he's no longer got a prescription." So it was 11 days before they put me back on it, but that was down from 80ml to nothing for 11 days.' [Lived Experience interviewee 14]
	Withdrawal	'Horrific. Especially at night. I felt like I'd had things crawling up and down your spine. I was having to go in the shower at three in the morning, four in the morning just to kind of… I couldn't sleep, I couldn't focus on anything. I couldn't… it was worse than… I'd say it was definitely worse than the heroin withdrawal was. The staff on the wings didn't really seem overly bothered. It's like it wasn't their job to help you get back on your meds if you get what I mean.' [Lived Experience interviewee 14]
	Through the gate (intake)	'You sit down with a nurse for about two minutes and she asks you a couple of questions, charts your height and takes your weight, that's it.' [Lived Experience interviewee 08] 'I wouldn't even say it was a five-minute question and answer session.' [Lived Experience interviewee 12] 'Now when I got arrested because I was heavily intoxicated when I got put in the police station, I was three days in there without getting any methadone because then they didn't know what to give. So by the time I got to prison, I no longer had a prescription for it. … it was 11 days before they put me back on it.' [Lived Experience interviewee 14] 'I think it could just be better if as soon as you went in the reception, when you see the wee nurse and that, is you see the mental health worker.' [Lived Experience interviewee 04]
	Homeless Accommodation	'The only support I do get is from the staff that's actually in the hostel. I think my mental health's getting worse. I've not left my room in basically three weeks. I've only come out, went to the chemist, and come back.' [Lived Experience interviewee 02] 'I've got problems ongoing. I'm fighting depression due to the things that happened years ago, things that have happened. I'm just waiting to see a psychologist as well … I should be on antidepressants. I phoned the doctors the other day. I'm not actually even signed up with a doctor anymore.' [Lived Experience interviewee 03] 'I was hearing voices and they were getting louder and louder and I wasn't getting peace from them.' [Lived Experience interviewee 01]
Community Reintegration Services		'It's been brilliant. If it wasn't for [name of service], then I think I would have been drinking, do you know what I mean, but I'm glad I'm not … They were brilliant with us … I was getting a lot of trust off them. Then they started believing that I would do it.' [Lived Experience interviewee 06] 'He was quite supportive, on about... He knows maybe a couple of agencies that I can phone for a job and that.' [Lived Experience interviewee 07] 'Like people with depression and mental health, because they're the main things that hits you inside prison, and as soon as you come out you get accepted into a group like that, where everybody's trying. It's like it just makes you feel better.' [Lived Experience interviewee 05]

Physical health needs	‘I go to hospital every week for a bandage I need to get done on my leg, a compression bandage and so it took me a wee while to go and see them but now I’m out there every week and I just feel it’s helping my leg heal up and that.’ [Lived Experience interviewee 11] ‘I nearly died in prison at one point and had to be given a liver and obviously I live with that.’ [Lived Experience interviewee 09] ‘Physical health… I think it’s a disgrace … I had a stroke four years ago in this prison … I was an inmate, and I got downgraded to [name of Prison] … all sorts of promises were made when I was in the rehab centre that I’d get this help, I’d get that help. I was given no help at all. I was just left and abandoned.’ [Lived Experience interviewee 10] ‘Sometimes you’re waiting a week to a week and a half to sometimes see a nurse in here. And to see a doctor it’s like you need to go through the nurse to get to see the doctor. They’ve obviously got the thing set up for the way they do stuff, but it’s not set up the best way, I don’t think.’ [Lived Experience interviewee 12]
Psychosocial interventions	‘The only help I’ve ever had in here is speaking to people at the recovery café that have kind of been in the same position as myself or been through something similar and that’s probably the only… and it’s because a lot of the boys have been in the jail as well or sometimes people they come in from outside that they’ve kind of been through it as well. … definitely a benefit that recovery café. I think it’s the only thing in here that’s actually working or doing anything for anybody to be honest.’ [Lived Experience interviewee 12] ‘I think they could be doing with some of sort of café opened up, like a recovery café which has sort of got to be led by prisoners.’ [Lived Experience interviewee 11] ‘They put me in contact with AA in Dundee, and AA in Dundee said, “We’ll come in to see you.” They spoke with the prison, and we’re getting meetings organised. Well, they’re every fortnight for the time being, but initially it was myself and another lad, and now there’s five guys going to it.’ [Lived Experience interviewee 15]
Harm reduction	‘I suppose the only thing that I’ve got involved in in the jail is the… I got… I’m one of the peer naloxone champions. See the naloxone jag they’ve done an initiative in here where it was like a few of us got trained up to kind of give people training for that for first aid. I think it was just because I got involved in that because of what happened to myself and it’s like I lost my partner when I got to jail in 2013 through drugs as well. So one of them, if she’d have got that, she’d probably be here.’ [Lived Experience interviewee 12] ‘I’m a peer [mentor] for the new guys that come up here … We speak about overdose prevention, sort of dos and don’ts if you find somebody kind of like unconscious or whatever … speak about naloxone, NPS awareness, what are the signs and symptoms of overdoses, blood-borne viruses … [you know], it’s just basically harm reduction.’ [Lived Experience interviewee 11]
Relationships with staff	‘There is a good lot of them that are really… there’s a lot of them that will go that extra mile as well and they’ll keep making sure you’re okay and that. So quite good that way.’ [Lived Experience interviewee 11] ‘I suppose it all depends … You’ll get some staff that are all right. You’ll get some staff that are just ticking boxes and you’ll get some staff that are just… they go out of their way to be a pure idiot. I suppose that’s the same as anywhere, but it shouldn’t really be the place for that to happen.’ [Lived Experience interviewee 12] ‘I tend to get on with the majority of staff simply because of the fact that is I can be civil; I can get on with it. I don’t raise my voice; I don’t

	get angry. I just get on with it. I just sit and listen to their explanations and I get on with it. If I disagree, I explain it. I tell them I disagree and I explain why I disagree. So aye, I'm fine with the staff.' [Lived Experience interviewee 10] 'Because they would just blatantly lie to you. Anything to have an easy time, they would just come up with an excuse of, "We'll look into it. I'll see what I can do. We'll get you your tablets. There'll be some there." There were a couple of times as well, I got my tablets and then they've turned up and it was like either there or later that night. It was really slapdash. Don't get me wrong; again, they were short-staffed some of the times as well. They were under a lot of pressure, especially Barlinnie. That was medical staff and the prison officers.' [Lived Experience interviewee 03]
Future improvements	'It's all about if the jail was overcrowded or they're understaffed. I mean, that has an effect. [Lived Experience interviewee 06] 'There needs to be drug-free sections. There needs to be things like that, Beth. Everybody's mixed up together just now; long-term prisoners like that, and some of these long-term prisoners, I've seen guys getting put in hospital for £5 and £10.' [Lived Experience interviewee 07] 'So there's not enough information about the drugs that are actually available that they take in the jail and the availability and help.' [Lived Experience interviewee 12] 'It would be more helpful having more staff that are … trained in substance misuse things … the drug workers are only here Monday to Friday through the day and … at night-time if somebody's got an issue or whatever it can be quite hard for them to get the help that they need.' [Lived Experience interviewee 11] 'They've got AA, they've got CA and… The only one I really can think of is guys coming off the smoking. So it's the nicotine patches, the nicotine vapes basically, that's about it in prison.' [Lived Experience interviewee 10]
Impact of COVID-19	'Because I was going through that before COVID, it's like I felt like I was one who's already dealt with it, so I was there to help people and support people to say, "Look, it's hard to start off with, but you'll just get used to it." [Lived Experience interviewee 05] 'There's vulnerable people in prison and they're always looking for company. They don't want to be on their own. So, when you lock them up early that means they're on their own for longer, which makes them more vulnerable, right?' [Lived Experience interviewee 06] 'The new Governor brought in big TVs and Xboxes and things like that to put in all the sections. [Lived Experience interviewee 07] The pandemic got used as an excuse for everything in here.' [Lived Experience interviewee 08] 'During the pandemic you were able to get virtual visits, so obviously outside that, there'd be FaceTime to use and then obviously you could use your mobile phone, you could use the jail phone, so aye you could get plenty of contact, that's not an issue.' [Lived Experience interviewee 08] 'COVID's impacted the prison quite badly because in regard to drug use and stuff like that, it's stopped a lot of services being able to come into prison and they obviously can't get access to a lot of the prisoners obviously for meetings and stuff like that and that's in regard to NA, AA, CA, whatever it may be.' [Lived Experience interviewee 09] 'There were no work parties to go to, so you were just locked up for basically 23 hours a day ... after a couple of months of it, guys

	actually preferred being locked up. The guys preferred having the peace and quiet. So I got adapted to the situation.' [Lived Experience interviewee 10] 'Anything you want, "No, we cannae get it. COVID." … Get as much drugs as you want, but nothing for your health.' [Lived Experience interviewee 03]

Appendix D. Healthcare data collection and analysis

Approach to data analysis

Item	Description
Overall Considerations	• Key to a strategic approach to data usage is the efficient collection of data, effective analysis, and the sharing of findings with those who need to know. • Good practice recommendations[10,11] propose that public sector data should be accurate, valid, reliable, available in a timely manner, relevant and complete, findable, accessible, interoperable, and reusable. These characteristics are referred to when assessing current systems, processes outputs and outcomes.
Methodological activities	• A high-level strategic review was undertaken of how substance use and related health data were gathered and used, with the emphasis on a qualitative assessment. This was done through a small set of qualitative interviews (**n=8**) with healthcare practitioners and data experts from SPS, Scottish Government and Public Health Scotland. Those interviewed were identified based on their role and likely knowledge. In consequence, the findings from these interviews should be considered indicative only, although it is worth noting that there was considerable agreement amongst interviewees on the primary issues. Furthermore, it was not possible to undertake a comprehensive survey of all arrangements in all prisons. • This approach was necessary because it was quickly evident that deficiencies in existing systems meant comprehensive, unified, and meaningful substance use and related health data would not be available for Scotland's prison population. A fundamental issue is that current substance use and related health data are held by the individual Health Boards serving their local prison(s) and are not brought together in a single unified dataset.
Research Questions	• Do current systems gather sufficient health data on admission to prison, and is this then meaningfully analysed at a high level to ensure the system can respond to the needs of those living in Scotland's prisons who use drugs and alcohol? • Do systems gather and analyse sufficient data to evidence that the identified health needs of those who use substances are being addressed safely and effectively throughout their time in prison? • Are high level health insights regarding the needs of individuals who live in Scotland's prisons who use substances being shared with relevant others, so that they can provide complimentary interventions and security measures that maximise best outcomes and the smooth running of individual prisons and across Scotland's prisons? • Are individual and collective data and insight effectively communicated to community services so that they can seamlessly continue healthcare and related delivery on release? • What improvements could be made to data systems and what would be priorities for improvement? • What barriers could there be to realising improvements?

[10] A Framework For Action: Data Standards In Scotland's Public Sector
[11] HM Government Information Principles. HM Government

Summary of current available data sets

Data set	Content (what it does)	Characteristics or value (data standards)
DAISy (Drug and Alcohol Information System)	• The Scottish Government's Drug and Alcohol Information System is a national database developed to collect drug and alcohol referral, waiting times and outcome information from staff delivering specialist drug and alcohol interventions. • It was rolled out in Scottish prisons from April 2021[12].	• All prisons should now be inputting information into the system. But, at time of writing, the reporting function of the system is severely constrained. • Because of a lack of current reporting and data available for analysis we are unable to pass judgement on the future role and value of the system.
PR2 (SPS Prisoner Records Database)	• SPS operates a case recording system which utilises a 'Conditions' and 'Risks' matrix system. The individual profile can note health issues – e.g. 'drug problem'. This record is created and maintained by SPS and there is no link to prison Healthcare systems. The PR2 database is the 'go to' source of information for frontline SPS staff.	• An individual's NHS Healthcare data are not routinely shared by Healthcare with SPS staff. • The PR2 system has weaknesses that undermine its current value to supporting those who use substances. For example, the 'Conditions' fields are broad. 'Drug Problem' is a crude description that gives no context / insight into the nature and extent of the problem and substances used, nor recent adverse events. • We heard of concerns regarding the quality of recording in PR2 and whether records are up-to-date. There does not appear to be a systemic approach to audit records to confirm accuracy and completeness. • Because PR2 does not offer any context regarding a current health issue, and information can be out of date or miscoded, its ability to assist SPS staff support individuals' day-to-day is compromised. If 'Conditions' and 'Risks' are not appropriately assessed, recorded, and updated there is a risk that front-line staff and SPS management are unsighted on current risks to individuals, staff, and the prison population as a whole.
Vision	• The 'Vision' system is the core healthcare database system used by NHS providers in Scotland's prisons.	• Some stakeholders had concerns regarding the quality of coding (which they suspected was due to variable inputting from staff). It was reported that it can be difficult to find, collate and analyse information.
NHS healthcare data	• This is held by the NHS and is not routinely shared with SPS.	

[12] Drugs and Alcohol Misuse, ISD Scotland

Paper-based records	• Information on Opioid Substitution Treatment [OST] prescribing is recorded on paper-based systems and stands out with the Vision system.	• A lack of electronic prescribing was identified as a significant weakness which, amongst other things, undermines the ability to communicate information speedily and accurately to and from community services. • Prison Healthcare Teams can require access to external systems, for example at reception, but not all teams have access to all relevant systems.
Public Health Information Dashboard (published by Public Health Scotland) [13]	• This covers eight datasets with a heavy emphasis on substance usage related data.	• Whilst the dataset topics are highly relevant and could provide valuable insights, at this time a number of qualifications mean their potential is not being fulfilled. The datasets are currently of limited value or deficient for the following reasons: o The bulk of the data presented is too historic to be of day-to-day value in understanding the current Healthcare situation in prisons. o The individual datasets are not linked, so cannot be interrogated for patterns and trends across healthcare drivers. o There are question marks over the accuracy of the data. o The promise of a 'dashboard' is not fulfilled. There is no real time data and no analysis that presents 'warning lights' based on real time analysis. o There is no unified dataset that confirms systemic, nor individual prison's fulfilment of HM Inspectorate of Prisons for Scotland's Standard 9 - Health and Wellbeing.[14] • Consequently the data presented fails to meet characteristics of accuracy, reliability, availability in a timely manner, completeness, interoperability, and re-usability.
The Scottish Prisons Survey	• The biennial Survey is undertaken in each of the 15 Scottish prisons and involves all those held in custody in Scotland.	• The Survey has a number of objectives: o to make use of respondents' perceptions of service-delivery and service-quality in business planning; o to provide those in custody with an opportunity to comment on a range of issues that impact on their experience in prison; o to allow staff to get a better understanding of how the halls they manage compare to equivalent halls and in so doing to provide a tangible way to help share items of 'best practice'; and o to allow the SPS, through repetition of the same questions, to track progress (or the lack of it) across the various dimensions that are included in the Survey.

[13] Prison Health Information dashboard, Public Health Scotland
[14] Inspecting and Monitoring: Standard 9: Health and Wellbeing, HMIPS

	• The Scottish Prisons Survey was last published in 2019 and is of very limited value to understanding prison healthcare. The survey was voluntary15 and initial enquiries of SPS established that it would not be possible to interrogate the database for profiling risk groups or linkages.

Additional commentary on available data

Available data	Stakeholder and researcher views on available data
Initial health assessment	• Overall, stakeholders were of the view that the Health Assessments undertaken at reception into prison were adequate to provide a baseline understanding of an individual's health and health care needs. Data is logged on the NHS Vision system. • However, to gain the fullest insight into healthcare needs at reception it can be necessary to access other systems – e.g. an individual's Emergency Care Summary. Although no known impediment was identified, not all SPS prisons have enabled access to all relevant sources.[16] Such access could, for example, flag up recent overdoses.
Aggregating initial health assessment data	• We found no sources that provide an aggregated picture of the health of Scottish prison population at the point of reception. This appears to be due to the fractured nature of the information collection systems. The potential consequences are that Scottish Government, Public Health Scotland, SPS and Health Boards are unsighted on global health issues in the population and are unable to fully assess health needs and how they might be changing. At this time, there appears to be an undue reliance on qualitative insights from healthcare teams.
Identifying and meeting Healthcare needs - post reception through to liberation	• The general weaknesses of data systems are relevant throughout the individual's sentence and through to liberation. This section focuses on the capability of the systems to identify and respond to changes in health, and any systemic gaps in understanding relevant to substance use. • The evidence from practitioners was that systems for the management of those on OST are appropriate and function satisfactorily. • However, one interviewee estimated '70% of the prison population use substances but only 23% are receiving OST'. Critically that leaves the outstanding challenge of understanding the health care needs of those who are not accessing substance use treatment options but who are likely using substances, primarily benzodiazepine derivatives and Novel Psychoactive Substances (NPS). Some interviewees identified this group as at greatest risk of harms. The illicit nature of this activity means that accurate data on the substances in use and prevalence amongst the population would not be available without a compulsory drug testing programme. • Consequently, where there is a significant adverse event such as an overdose, existing data systems cannot be relied upon to offer Healthcare staff reliable insight into what substances may have been taken, which in turn will compromise the ability to make informed decisions on treatment. • We did not find evidence of healthcare data being regularly analysed and reported upon for significant changes in the treatment needs of all those using substances,

[15] Casting doubt on the likelihood of individuals declaring illicit drug taking activity.
[16] Individual prisons were not audited.

	or the prevalence of those needs - either at individual prison or national level. There was a general recognition that Healthcare teams and SPS would benefit from more up-to-date information being routinely available but interrogating existing systems can be an onerous task. • Some interviewees commented on analytical work that had been undertaken, but these were 'look back' exercises - e.g., a local historic review of overdoses. Although not to be discounted, such exercises are of limited value if the substances being consumed, or their potency, are rapidly evolving. • We conclude current systems do not meet the data principals of offering relevant information in a timely manner. This undermines the safe and effective day-to-day treatment of those individuals who use substances.
Clinical governance / Healthcare standards	• Sound quantitative and qualitative data is essential to provide effective clinical governance. Without it the quality and effectiveness of interventions cannot be judged. We sought to: establish the extent to which data was used in clinical governance; identify examples of clinical governance arrangements; and identify whether there was local variation. • Clinical governance arrangements appear to vary from prison to prison. Clinical Governance is the responsibility of the individual Health Boards, which brings scope for variation in approach and the level of priority and scrutiny given to the specific needs of the prison population; some implied that those individuals who are living in Scotland's prisons could be a forgotten population for some Health Boards. • There are Health and Wellbeing standards that prisons are required to fulfil, and these are assessed by a combination of Board self-assurance statements and inspections conducted by Healthcare Improvement Scotland[17]. However, we are not aware of any national review conducted by HIS, HMIPS, SPS or Scottish Government that evidence compliance with these standards across all prisons. • We heard of positive and proactive arrangements in some prisons – such as fortnightly team-based case reviews – but also concerns that not all prisons had effective clinical governance arrangements. • One interviewee cited an example where clinical governance had identified a significant weakness in practice: o *'We had an issue for a while in recognising and accepting 'non-responsive' as a Non-Fatal Overdose. This was not seen as an Adverse Event by the nursing team.'*[18] • It was also commented that systems were not always the issue, lack of staffing and large caseloads could also have an impact. • We conclude that that there is a lack of adequate data and a lack of assurance that reliable clinical governance systems are universally in place. It is known that those who use substances are more likely to have compromised mental and physical health but, at this time, systems do not appear up to the challenge of evidencing that safe, effective, and person-centred care is routinely delivered to them, whichever prison they are in.
To what extent are high level insights appropriately shared for maximum benefit	• We asked interviewees to what extent health data was shared with SPS on a regular basis, to facilitate the care and management of a prison's population. The universal answer was that Healthcare data was not routinely shared. o '[Referring to Scotland's prisons] *I'm not aware of anywhere where there is consistent sharing of Healthcare information*'. • We had anticipated SPS management would receive regular bulletins on the health of the population in their care, but our interviews indicate this is not

[17] As part of the wider HM Inspectorate of Prisons (HMIPS) for Scotland monitoring regime.
[18] Consequently, it would not be recorded on Datix, the NHS system used to record and analyse patterns of adverse events and risks.

	embedded at the level of individual prisons nor nationally. This is particularly surprising, given the known high prevalence of problematic substance use, or mental health issues or dual diagnosis. • Such information would be of value to SPS at a national level, and to other stakeholders such as Public Health Scotland and Scottish Government. The National Prison Care Network would also be a natural forum that could lead interrogation of this and propose actions arising. ○ *'Information sharing should not be difficult. We could share with 'mandated' approaches. The NHS can be overly cautious* [regarding information sharing].' • There was anecdotal evidence that historically SPS shared more data, more often, with external stakeholders; however the details of what was shared and with what frequency was not available to us. The reasons why less data was shared now were unclear, but it was speculated by one interviewee that this may be due to an unwillingness on SPS' behalf to be open to scrutiny.

Constraints on communicating with community services to maximise for seamless care	• There were examples of positive links to community services. HMP Perth have initiated 'Persons of Concern' reviews which have strengthened community links for those at high risk on liberation. But these rely heavily on the insights of staff, i.e., qualitative data.
	• However, a number of issues were identified that constrain the ability to fully communicate relevant information to community services in a timely manner. These were:
	  ○ Unexpected liberations catching out services and thereby undermining effective handovers.
	  ○ Paper-based recording of OST and a lack of electronic prescribing.
	  ○ Local variation, tensions, and inconsistencies in the links to community services.

Priorities for improvement	• Priorities identified for data system improvement are ensuring individual systems, such as Vision and PR2 are fit for purpose and that there is better integration between systems. Moving to electronic prescribing is also a priority for some interviewees.
Barriers to realising improvements	• There are significant barriers to prison and prison Healthcare systems being able to provide reliable and timely insights to inform Healthcare decision-making and minimise risks. The scale of investment and work that will be required to ensure all systems, in all health boards and prisons, are fit for purpose, well integrated, well-managed and utilised to the fullest cannot be underestimated. Furthermore, the troubled history of DAISy development and implementation would suggest that even if further steps are taken, there are no guarantees they will be implemented smoothly. • Some suggested there needs to be cultural change as well as improvement in data systems, with partners in both the NHS teams and SPS being more open to sharing and scrutiny in general. • There will also require to be a clear and agreed specification of what improvements are required and by whom. There has not been a coherence to data systems development. Local arrangements have prevailed, primarily and understandably driven by the need to integrate with community services. However, if the Prison Healthcare Standards are to be implemented there is a strong case for SPS / HIS and Scottish Government setting minimum standards regarding what Healthcare data should be collected and reported on within prisons, and by SPS as a whole.

Summary

Based on the above evidence, our assessment is that NHS Prison Healthcare systems are potentially deficient in respect of:

- Accuracy and Reliability.
- Completeness and availability in a timely manner.

The PR2 has potential weaknesses in respect of:

- Accuracy, reliability, validity, and completeness.

These weaknesses indicate non-compliance with Scottish Government's aspirations for data quality standards[19], and the complexity and lack of integration of systems implies there will be significant challenges to remedying these deficiencies. The current situation presents risks that healthcare needs may not be met, with the potential for adverse consequences. There are also corporate operational and reputational risks for SPS and Health Boards, and for Scottish Government as overseer of both.

However, we were advised by stakeholders that a Prisons Digital Health & Care Systems Provisioning Programme is underway. The programme's ambition is to identify options for delivering integrated clinical IT systems to improve patient care and information sharing, including during transitions into and out of custody. The programme will oversee the delivery of an integrated solution for: a patient management system; medicines prescribing, administration and stock control; and continuity of care and access to patient clinical history.

[19] A Framework For Action: Data Standards In Scotland's Public Sector, Scottish Government

Appendix E. Mapping of ADP annual returns

ADP	Prison in ADP area/most commonly used by ADP population	Naloxone	Working with community justice partners	Pathways and Protocols Upon Arrest	Pathways and Protocols Upon Release
Angus			Justice in Angus Council Children and Justice Directorate	Depending on if the individual is known to Justice Services the Case Manager or the police will liaise with local services.	“On the day of release the worker will contact drug and alcohol services to advise of the individual’s and to relay any relevant information to the individual and provide an opportunity for the individual to raise any concerns with their key worker/prescriber.”
Argyll & Bute			Community Justice	Custody to Custody pathway established alongside We Are With You.	Prisoners from this area can be held in a few different prisons as there is no prison in this local authority. The ADP and the Community Justice Coordinator are working to build pathways for those from this area.
Borders			Links with Justice Social Work.	An arrest referral scheme has been developed.	“Voluntary throughcare”
Clackmannanshire and Stirling	HMP&YOI Cornton Vale HMP Glenochil HMYOI Polmont	Forth Valley prisons (3) offer naloxone on release. Naloxone data is shared quarterly with the ADP.	Stirling Transitions and Re-Integration Support.	Referral to local services happens through the arrest referral service.	Resource was developed for all individuals eligible for early release during the pandemic.

Dumfries and Galloway	HMP Dumfries	Offered on release	Joint working project with Community Justice Partnership and Violence Against Women and Girls.	Police custody staff offer an arrest referral service.	Multi Agency Community Reintegration Board is in place at HMP Dumfries which partners with many organisations on the outside although this is only for those whose residence is in D&G and who are held in HMP Dumfries.
Dundee			Community Justice	Custody nurses are supplied by prison healthcare, but it is unclear if this is for custody settings or not.	Individuals will transition from Prison healthcare to community Integrated Substance Misuse Services and a prescription is established at the community pharmacy prior to liberation, people are reviewed by community services within one week of liberation.
East Ayrshire	HMP Kilmarnock	Those open to addiction services are offered Naloxone on release (Kilmarnock).	Links to Community Justice Ayrshire, We Are With You and Sacro.	The Diversion from Prosecution Service works to identify those needing to be diverted from Criminal Justice.	"Safe talk" offered on day of release facilitated by NHS Addictions Service staff. The individual will then be allocated a named worked who will follow up with them two weeks after release.
East Dunbartonshire	HMP Low Moss	Naloxone provided on release and Naloxone education offered at induction (Low Moss)	Alcohol and Drug Recovery Service and Prison Release Operational Group.	No residents are held in custody in this local authority area.	Justice Social Work and Homelessness services are informed of scheduled releases. Releases are also discussed at the multi-agency meeting.
East Renfrewshire	HMP Low Moss	Naloxone provided on release and Naloxone education offered at induction (Low Moss)	Community Justice Partnership (this seems to be a training connection with CJP providing training for the ADP).	"Much work is undertaken to divert people… from the criminal justice system at various points."	"Prison Health Care staff liaise with relevant community services/staff from both statutory and third sector agencies to ensure continuity of care and treatment for individuals with drug and alcohol concerns." Possibility of peer mentoring in the future.
Edinburgh	HMP Edinburgh	Unclear and sporadic distribution.	Community Justice	"This is in place and there is capacity funded	"A dedicated Offender Recovery Service is offered to all prisoners returning to

				for working with those identified as being in need while in custody, but in practice relies on individual relationships and referrals, rather than being fully systematic. Accessing all those in custody has been challenging."	Edinburgh, and arrangements are in place for continuity of prescribing and other treatment."
Falkirk	HMP&YOI Cornton Vale HMP Glenochil HMYOI Polmont		Falkirk Community Justice Partnership.	Referral to local services happens through the arrest referral service.	Resource was developed for all individuals eligible for early release during the pandemic.
Fife	HMP&YOI Cornton Vale HMP Glenochil HMYOI Polmont		Community Justice Partners are on ADP.	There is no current bespoke service. This is being developed.	NHS Addiction Service take lead responsibility for the treatment of those liberated. There is also peer to peer support with Phoenix Futures.
Glasgow	HMP Barlinnie	Promotion of Naloxone within prisons and peer Naloxone plans are underway.	Community Justice Glasgow team, some of these sit on the ADP. They answer to the Glasgow Community Planning Partnership.	The Positive Outcomes Project works with individuals at the point of arrest.	Prison Health Care links directly with Glasgow Alcohol and Drug Recovery Service on schedules releases.
Highland	HP Inverness	Provided on release (Inverness).	SPS partners, Community Justice Partnership, NHS Highland Drug and Alcohol Recovery service, Highland Council Housing	Referrals to Highland Alcohol and Drugs Advice and Support Service are made by the police. A New custody link project is also being set up.	Referrals are made to local community support providers e.g., Arrows or Moray Drug and Alcohol, Lochaber Hope, Osprey house.

			Department and third sector (unclear on details).		
Inverclyde	HMP Greenock	Harm reduction training offered which includes Naloxone training. Naloxone kits given to those who have completed the training and those commencing ORT (Greenock).	Community Justice Partnership.	A Complex Needs Team is currently under development to replace the previous Positive Outcomes Project team.	Voluntary Throughcare Network makes contact with individuals twelve weeks before release to develop individual support plans.
Lothian	HMP Edinburgh	Local authority community justice teams offer pre-liberation and liberation Naloxone provision.	Community Justice	The EMORS Fresh Start Arrest Referral Service supports those being held at St. Leonard's Police Station or Dalkeith Police Station.	
Mid and East Lothian (MELDAP)					"No 11 Allocation Meeting. This visionary forum brings together Health, Substance Misuse Service, Social Work, Housing, voluntary through care and third sector agencies and considered bespoke packages of care/support/treatment to individuals who used No 11."
Moray	HMP Inverness HMP Grampian				Monthly pre-liberation surgeries are held in HMP Inverness. SHINE provides support for women leaving HMP Grampian.
North Ayrshire	HMP Kilmarnock	Naloxone offered on release and pilot of	Justice Social Work Services links for		"Safe talk" offered on day of release facilitated by NHS Addictions Service staff. The individual will then be allocated a

		nasal naloxone begun (Kilmarnock).	those on Community Payback Orders.		named worked who will follow up with them 2 weeks after release.
North Lanarkshire	HMP Shotts	Naloxone training and packs offered in the lead up to liberation (Shotts).	Addiction Recovery Teams, Police Scotland, Lanarkshire Gender Based Violence, Keep Well Team, North Lanarkshire Leisure and Well Connected.	The Addiction Recovery Teams engage with individuals at the point of arrest if an individual self refers or is referred by Police Scotland or Social Work.	“referrals to appropriate Tier 1 or Tier 2 addiction agencies are made prior to release to ensure that support is received in a timeous manner”
Orkney	No prison in area	Naloxone provided by local Criminal Justice Service works.	Orkney Communities and Community Justice Partnership	All individuals who enter local custody are offered an Alcohol Brief Intervention.	“The Criminal Justice Service in Orkney would only have contact with those subject to statutory license and referral would be made by the allocated supervising officer to alcohol/ drug service if required.”
Perth and Kinross	HMP Perth	Twice weekly meetings with those with planned liberation dates. Naloxone provided at these.			“Partnership between Community Substance Use Services and Prisoner Healthcare continues to be developed” Tayside Council on Alcohol offers 1:1 Mentoring for Men who are involved with CJS or the Prison Service.
Renfrewshire			Renfrewshire Council Criminal Justice teams.	A court based social work arrest referral process is available.	Referrals are made to the Alcohol and Drug Recovery Service to ensure contact on the day of release. Those subject to MAPPA arrangements are referred to higher tier services.
Shetland ADP			Health improvement team	“Upon arrest, people are signposted to appropriate services by police.”	The Local Author offers voluntary throughcare after writing to individual to give an appointment on the day of arrival in Shetland.

South Ayrshire			Strong relationship with Community Justice Ayrshire.	Those who report substance dependency on arrest with see a Police Casualty Surgeon. Once in custody they are connected with a peer worker.	“Safe talk” offered on day of release facilitated by NHS Addictions Service staff. The individual will then be allocated a named worked who will follow up with them 2 weeks after release.
South Lanarkshire	HMP Addiewell	Naloxone and nasal Naloxone offered to all liberated individuals (Addiewell).	Community Justice Scotland and the Beacons.	Individuals are signposted or referred to the Beacons.	“Social work services offer support in the form of voluntary through care. With consent these service users can be signposted to reintegr8 (funded through ADP), the Beacons, the wise group or SHINE supports.”
West Dunbartonshire			Third sector addictions service (unclear which one), Criminal Justice Social Work team and Community Payback Team. Dumbarton Area Council on Alcohol.	An Arrest Referral Scheme with Clydebank Custody Suite is being developed.	Addiction supports are continued following release with West Dunbartonshire Drug and Alcohol Service.
West Lothian	HMP Edinburgh	Change Grow Live offer Naloxone pre and post liberation.	Third Sector Community Justice Forum	Change Grow Live Arrest Referral Service offers face to face consultations and assessments.	“Offer gate pick-up and support client to pre-arranged community appointments for example, JCP, GP registration, prescription pick-up, housing and help settle within own home or temporary accommodation, offer Naloxone/IEP to client and family member/friend where appropriate and agree next community appointment as per Throughcare Service, work closely/jointly with partner agencies.”