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

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The Scottish Government

Health and Social Care

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List of abbreviations

ADP	Alcohol and Drug Partnership. Alcohol and Drugs Partnerships are multi-agency strategic groups tasked by the Scottish Government with tackling alcohol and drug issues.
DDTF	Drug Deaths Taskforce. The Scottish Government established a Drug Deaths Taskforce in 2019 to support the delivery of the national 'Rights, Respect and Recovery' strategy.
IA	Integration Authority. The Public Bodies (Joint Working) (Scotland) Act 2014 required local authorities and health boards to jointly prepare an integration scheme. Each integration scheme sets out the key arrangements for how services are planned, delivered, and monitored within their local area.
MAT	Medication-Assisted Treatment Standards. The DDTF prioritised the introduction of standards for Medication Assisted Treatment (MAT) to help reduce deaths, and other harms, and to promote recovery.
MORS	Management of Offender at Risk Due to Any Substance. MORS is the Scottish Prison Service's current framework/policy for managing risks due to substance use across the prison population.
NHS	National Health Service.
NPS	New Psychoactive Substances. New psychoactive substances (NPS) are a range of drugs that have been designed to mimic established illicit drugs.
OST	Opioid Substitution Treatment/Therapy. OST involves replacing an opioid, such as heroin, with a longer acting but less euphoric opioid (e.g. methadone or buprenorphine).
PR2	Prisoner Records system (version 2). This is the main prisoner records system used by the Scottish Prison Service.
SPS	Scottish Prison Service.
TiPS	Tobacco in Prisons Study. The Tobacco in Prisons Study was published in January 2022 and reviewed the impact of the implementation of smoke free prisons in Scotland.
TSO	Throughcare Support Officer. The TSO scheme was operational across most Scottish prisons between 2015-2019. TSOs supported prison leavers during the transition from custody to community – offering practical support (e.g. with housing, medical provision and benefits arrangements).

Executive Summary

The last prison health needs assessment in Scotland was conducted in 2007 and a great deal has changed in the policy and service delivery landscape since then. This needs assessment is one of four prison population-focused commissioned studies. It explores the needs relating to alcohol, drugs, and tobacco use.

Substance use has long been a concern for the health and wellbeing of people living in Scotland's prisons, and the wider criminal justice system and remains a prominent challenge. Research indicates that individuals in prisons are more likely to have a substance use problem than to not have one. Treatment and support services for those who experience problems with substances whilst living in prison should be provided consistently across all prisons and on an equivalent basis to community-based services. Further there should be continuity of care both from the community into prison, following liberation, as well as between transfer from one prison to another.

Policy and political landscape

Substance use in prisons cannot and should not be divorced from the wider political and community landscapes. The complexity of these wider landscapes has often led Scottish prisons to become an isolated or peripheral partner in the development and delivery of substance use responses. Involvement in partnerships (such as Alcohol and Drug Partnerships, Community Planning Partnerships and Community Justice Partnerships) needs to be more consistent and purposeful rather than piecemeal, as it often is currently.

Existing evidence and data

There is a lack of existing, up-to-date literature on the extent and nature of substance use in Scottish prisons. There are also significant deficiencies and variations in existing substance use and related health data collection, analysis, sharing, and storage leading to significant difficulties in mapping across Scotland's prisons. Consequently, there is no universal or meaningful body of data to give an accurate quantitative overview. Only with a more accurate and consistent gathering of substance use and associated health data will the quantitative data produced by prisons and other partners be valid and of potential use.

Qualitative perspectives

In relation to the use of substances and support provided for those who experience problems with substance use, we heard a number of key messages that resonated across all those interviewed (whether from those with lived experience of from professionals).

Substance use

Our report takes cognisance of tobacco use and support within Scottish prisons. However, we have deferred to the extensive and recent evidence contained in the

Tobacco in Prisons Study (2022), that maps out the successful management of tobacco-free prisons across the country.

Whilst it is clear that there are instances of alcohol use within prison, along with specific support needs for withdrawal (detoxification) upon entry into prison, the unaddressed primary alcohol need is for psychological support in preparation for returning to the community, where alcohol is readily available.

Since the last needs assessment it is evident that the nature of drug use within Scottish prisons has changed dramatically. Where previously this would have been heroin orientated, it is currently dominated by a combination of Novel Psychoactive Substances, Cannabinoids and 'Street Benzos' (most commonly Etizolam). For most individuals, illegal and illicit drugs continue to be readily available. Consumption choices are directed by what drugs are available rather than by what people might use outside of prison. Drug use and supply remain intrinsic to living in prison, both in terms of how some people choose to cope with living in prison and their role status within the prisoner community. Substance use in prisons is connected to psychological dependency and emotional regulation that some people use to cope with pre-existing trauma(s) and the additional trauma of entering and adjusting to living in prison.

Support for substance use

There are a number of consequences of this situation. This often begins with a lack of treatment and support continuity leading up to prison entry (both in terms of community support and support whilst in police custody) and is often immediately followed by the need for improving comprehensive substance use related health assessments for all at prison reception. It also includes complex issues of prescribing (availability, choice, continuity, equitability, and timeous) throughout an individual's time living in prison, and particularly during preparation for release and reintegration back into community services. We heard a clear message that focussing someone's treatment or support solely on their substance use was *the wrong starting place*, meaning that critical support needs (such as housing, mental and physical health, harm reduction, and recovery) are all too often insufficiently addressed.

Conclusions and recommendations

Given the systemic complexities and challenges of partnership working that our review has highlighted, we have chosen to present our recommendations in two distinct groupings: (1) a small set of **four** high-level key recommendations (which are explicit in terms of the action required by the named organisations within the recommendations), and followed by (2) a larger set of **twenty-two** outcome-based recommendations, grouped around a series of themes reflecting the findings of the needs assessment. These recommendations describe a 'preferred future' which will only be achieved by **all** relevant stakeholders and partners working together in close collaboration. Our recommendation is that there should be coherent, national oversight and governance of progress towards achieving all of the outcome-based recommendations contained within our report.

Chapter 1: Introduction

The Scottish Government has committed to undertaking a comprehensive, national assessment of the health and social care needs of Scotland's prison population. The last prison health needs assessment was conducted in 2007 and a great deal has changed in the policy and service delivery landscape since then. This needs assessment is one of four commissioned studies[1] and focuses on an assessment of the needs of the prison population relating to alcohol, drugs, and tobacco use.

Background

Substance use has long been a concern for the health and wellbeing of people living in Scotland's prisons and remains one of the most prominent challenges to Scotland's prison system. People who live in prison are disproportionately more likely to use alcohol, drugs, and tobacco than those individuals who do not enter prison (Toomey et al., 2022). Crime and substance use are known to be closely associated[2]. Problemetic substance use often contributes to the factors involved in why someone is in prison and often continues (or for some begins) whilst living in prison (Carnie and Boderick, 2019).

Many people living in prison have substance use needs that pre-date their imprisonment and can stem from multiple factors, such as experiencing trauma and social and economic inequality (Devries et al., 2014; Najavits, 2015). Within custody, people experience limited access to family and community supports, bullying, and feelings of hopelessness which risks perpetuating and escalating substance use. The prevalence of substance use within prisons is a serious threat to the health of people living there and to general public health. It threatens the safety of prison officers and healthcare staff and creates challenges in terms of maintaining good order and discipline (O'Hagan, 2017). With the recent rates in drug-related deaths continuing to soar across Scotland, there is increasing pressure to take more urgent action to address substances and the harms that they present (NRS, 2021).

The exact picture of substance use in Scottish prisons is unclear. There is a lack of available data, which will be highlighted later in this report. Estimating the prevalence of substance use in Scottish prisons is therefore highly challenging, particularly in relation to drug use (Toomey et al., 2022). What is apparent though is that levels of drug deaths across Scotland are very high. In 2019, in reponse to the high levels of drug deaths in Scotland, the Drug Deaths Taskforce [DDTF] was established.[3] This group is made up of volunteer members who have been proactive about pushing for the implementation of the MAT [Medical Assisted Treatment] Standards.[4]

[1] The other three studies are: (1) physical and general health, including major clinical and long-term conditions, infectious disease, non-communicable disease, sexual health; (2) mental health; and (3) social care and support needs.
[2] The Scottish Parliament - Healthcare in Prisons
[3] Drug Deaths Task Force
[4] MAT Standards, introduced by the Scottish Government in 2021, are an evidence-based set of standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland.

Current substance use data often relies on self-reporting[5] or upon incident reports which do not present the full picture of substance use. In the most recent Scottish Prison Service [SPS] Prisoner Survey (Carnie and Boderick, 2019), 41% self reported that they engaged in problematic drug use prior to imprisonment; 45% had been under the influence of drugs, and 40% reported being drunk at the time of their offence. This is indicative of a high level of need.

People living in prison experience substantially poorer health than the general population, in part because of the high prevalence of smoking amongst those living in prison (Spaulding, 2018). High rates of smoking in prisons had been consistently reported in the SPS Prisoner Survey prior to the introduction of a smoke free prison environment (2018). The 2013 survey reported that 74% of people living in prison smoked which contrasts with a prevalence rate of around 20% in Scotland as a whole.

Whilst the prison system continues to be the host for many of those who are found to have committed substance related crimes, there have been increasing conversations about whether this is in fact the right place for them (Scottish Parliament, 2022). It has long been acknowledged that the opportunities and provisions for rehabilitation within a prison setting are limited (ibid.)[6]. So too there is a real sense that the revolving door of prisons can exacerbate and encourage substance use:

> *'We do not rehabilitate prisoners well, we do not prepare them for release well and we do not support them on release well, because our system is chock-a-block with people who should not be in it.'* (Professor Fergus McNeill, evidence provided to Scottish Parliament, 2022, pg. 11)

Alcohol and Drugs

Each prison in Scotland has developed its own policies and procedures to manage drug and alcohol use. In part this can be traced back to the NHS takeover of addictions work in Scottish prisons from Phoenix Futures (2011). In the absence of universal guidance, each NHS Board that had a prison in its catchment area decided what approach to take (NHS, 2016). One requirement, however, was that services should be available on an equitable basis to community-based services.

Whilst there are different approaches across prisons, there are a number of policies and documents that offer guidance to all prisons. One of these is the National Naloxone Programme which has been active in Scottish Prisons since 2011. This has provided all those leaving prison with Naloxone in an attempt to address opioid related overdoses upon release (Bird et al. 2014). As data collection for this study progressed, some respondents informed us that naloxone provision had continued to be developed. For example, intranasal naloxone is now offered, making it a needle-less product. Online service, training and learning opportunities have been expanded, and there has also been a move to educate and organise peer naloxone

[5] Self-reporting results in limited findings as, particularly in relation to substance use, it is uncommon for people to be completely honest in their self-disclosures and so results in data consisting of what people are willing to self-disclose.
[6] It should be acknowledged here that rehabilitation opportunities do vary across prisons and prisoner categories.

distributors and trainers, something which has enjoyed much success (DDTF, 2021).

Across Scotland, the SPS' Management of Offender at Risk Due to Any Substance [MORS] policy was introduced in December 2014. This guidance instructs prison staff on how to respond if they identify someone as being at risk from a substance and how healthcare staff should engage with the incident.

Rights, Respect and Recovery, Scotland's strategy for reducing drug and alcohol related harms and deaths, was published in 2018 (Scottish Government, 2018). The strategy provided a specific focus on prisons as one of the key organisations that should be involved in delivering on national substance use goals. In January 2021, the strategic approach was further enhanced through the announcement by the First Minister of a new 'National Mission' to reduce drug-related deaths and harms, supported by an additional £50 million funding per year (for the next five years).[7]

In response to the Covid-19 pandemic, the Scottish Government allocated £1.9 million to support people to switch to Buvidal as an OST treatment option (MacNeill, 2021). Buvidal is a longer-acting form of OST that means people can switch from a daily medication regime to only needing to take their presciption on a weekly or monthly basis. Intial small-scale feedback on Buvidal has highlighted its potential to support people to make positive changes to their lives and demonstrated it may improve outcomes for prison leavers, such avoiding relapses in the community or helping them look employment (MacNeill, 2020). Increasing the number of people being prescribed Buvidal in Scotland's prisons may also go some way towards alleviating the current burden placed on prison operations and healthcare by the daily administration of methadone.

Tobacco

SPS and partners have successfully delivered smoke free environments since November 2018. This change was introduced as part of a wider Scottish Government focus on changing smoking habits for future generations. In the lead up to, and in the aftermath of the introduction of a smoke free policy, smoking in prison has transformed from an under-researched and poorly understood policy area, to one which is underpinned by a rich literature base which engenders ongoing policy and practice conversations.

In January 2022 the final report for the Tobacco in Prisons Study [TiPS] was published (Hunt et al., 2022). The study documents the impact of smoke free prisons in Scotland. It indicates that smoke free prisons policy have quickly become the 'new normal'. Second hand smoking has been reduced by 90% and e-cigarette use has became commonplace.

TiPS was the first study internationally to explore this topic and did so extensively. As such it has not been appropriate nor useful for this needs assessment to

[7] National mission - Alcohol and drugs

replicate or duplicate evidence gathering with regard to current policy and programmes around Tobacco. Therefore, the team has focused on alcohol and drug use as a priority for the data collection for this project whilst considering the place of tobacco use alongside other substance use.

Study Aim and Objectives

The aim of this needs assessment study was to help the Scottish Government and its partners better understand what the healthcare needs of people with substance use problems living in Scotland's prisons are.

The specific objectives of the needs assessment were to:

1. Conduct a rapid review of the research literature from the UK and (if there is a strong rationale for it) comparable jurisdictions on the nature and extent of substance use needs and support within prison populations.
2. Synthesise available national and local-level data and research to report on the epidemiology of substance use experienced by Scotland's prison population, including newer trends such as New Psychoactive Substances [NPS] usage, compared to others in the criminal justice system (e.g. people serving community sentences) and the general population.
3. Map current models of substance use care/interventions within Scotland's prisons, how they interface with other healthcare interventions within prisons, and how they interface with community care models and services, including assessing aspects of treatment continuity, finding examples of best practice, and throughcare pathways during transition from custody to the community.
4. Assess the scope for the improved collection of routine data that can be made available to analysts, managers, and service providers for continued monitoring and analysis of support needs relating to substance use.
5. Offer insights for future data linkage and data collection priorities.
6. Include the perspectives of people with lived experience of prison and substance use to incorporate their views and insights.

Methodology

Study methods

The core elements of the study focused on qualitative approaches (comprising of: (1) semi-structured interviews with a broad range of professional stakeholder groups; (2) a short-life working group with a diverse range of professional stakeholders from key partners in SPS, NHS, and the Third Sector; and (3) interviews with those who have lived and/or living experience). These approaches were supplemented with a rapid literature review, a review of existing (published) data, and a mapping exercise (see **Table 1** below).

Although the original study design included a desk-based review and synthesis of all available (published) datasets, and that this would be expected to be seen within a Health Needs Assessment report, it is not included in the usual way in this report.

From our early review of available Scottish health datasets, it became evident that published healthcare data regarding substance use for Scotland's prisons was deficient and would not provide meaningful, real-time insights. We have included (see **Table 2** in **Chapter 5**) an overview of the available datasets (including comments upon their individual strengths and limitations), but have focused our approach on a qualitative high-level strategic review of how healthcare data is gathered and used in order to identify the areas where substance use data collection, analysis and linkaging needs to improve (see **Chapter 5**).

The context of the Covid-19 pandemic necessitated a flexible approach, with all working group sessions and semi-structured interviews conducted remotely or on the phone.

Full details of study methods and our approach to analysis is provided in **Appendix A**.

Recruitment, sampling, and activity completed

A summary of study methods, recruitment, sampling and activity completed is presented in the table below. Fieldwork activities took place between October 2021 and February 2022.

Table 1. Summary of study methods, recruitment, sampling and activity completed

Method	Description	Number
Rapid Literature Review	Literature on this area was identified by the research team and compiled into a rapid literature review, with a focus on recent and Scotland-specific literature.	
Short-Life Working Group	Through discussions with the study Research Advisory Group [RAG], suitable individuals were identified for participation in the short-life working group.	• Four meetings took place with a total of **10** professionals [SPS (**4**), NHS (**1**) and Third Sector (**5**)].
Semi-Structured Interviews (Lived and Living Experience)	Discussions took place with SPS, prisoner healthcare, and Third Sector organisations aimed at identifying people who are currently living in, or have recently lived in, prison, as well as family members.	• People living in a Scottish prison (**15**) • Recent prison leavers[8] (**6**)
Semi-Structured Interviews (Professionals)	A sampling framework for the recruitment of key (professional) stakeholders was developed by the project leads, with input from the wider research team and the RAG.	• Key informant interviews (**36**)
Review of data	Desktop review of available, relevant datasets. Semi-structured interviews with key data specialists.	• Key informant interviews (**8**)
Mapping exercise	Review of the collated results of data gathered for the Scottish Government's ADP Annual Review 2019/20 to identify information relating to criminal/community justice pathways and partnerships.	• Data was available for **29** out of the 30 ADPs across Scotland.

Language considerations

The world of substance use treatment is full of jargon and abbreviations. We have chosen to use 'people-first' language which emphasises the individuality, equality and dignity of people rather than defining people primarily by a problem or issue. 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 details of the considerations we have made regarding language, please see **Appendix B**.

[8] Those individuals who have left a Scottish prison within the preceding 12 months.

Chapter 2: Rapid Literature Review

- Substance use in prisons remains higher than in the community and is implicated in the high rate of avoidable deaths that do occur in Scottish prisons. Prisons are high-risk environments for substance use and risky behaviours. The nature of substance use in prisons is fluid.
- There have been significant and ongoing changes in Scotland's substance use policy and delivery plans for prisons over the last decade or so. Most recently there have been attempts to respond to the high rates of drug deaths with the formation of the Drug Deaths Task Force and the implementation of the MAT Standards.
- Scotland has had a smoke-free prisons policy since 2018 and this has been hailed as a successful and well-implemented change.

Introduction

Recent and prominent literature was identified by the research team and compiled into a rapid literature review. There was a further focus on literature that was Scotland specific.

Our review offers an overview of some of the available literature that indicates the current areas of interest and concern in relation to substance use and associated health and social care issues in Scottish prisons. It should be acknowledged, however, that the distribution of available literature across different substances is by no means equal. In the lead up to and aftermath of the smoking ban in Scottish prisons there was a significant amount of literature produced, whereas the available literature on alcohol use in prisons is sparse and often overshadowed by a drugs-focus.

Existing evidence

Alcohol and drugs

Problem drug and alcohol use remains higher in prison populations than in the wider community and 25-28% of those who access community-based substance use services have a history of offending (Rose et al., 2012). On average, 78% of prison admissions test positive for illicit substances at prison reception in Scotland (Scottish Government, 2018). This is higher in some prisons - with 86% of those presenting at Barlinnie testing positive for drug use (Ibid., 2018). Alcohol problems are under-recognised in Scottish prisons, although an estimated 20% of those living in prisons within Greater Glasgow and Clyde Health Board were alcohol dependent and half were intoxicated at the time of their offence (Scottish Government, 2019).

Around 83% of those who admit to using drugs in prison stated that their drug use had changed during their time living in prison (Toomey et al., 2022). The type of substances seen in prisons has changed in recent years with a move away from opioids as the prominent substance towards NPS (Ibid., 2022). The 2017 Alcohol

Use Disorders Identification Test[9] (AUDIT) revealed that 63% of those who live in Scotland's prisons had been drinking at 'harmful' or 'hazardous' levels, and that around a third were classed as alcohol dependant (SPS, 2019). There is evidence too to suggest that this rate is higher (around 73%) in remand populations (Graham et al., 2012).

Drug and alcohol use contributes significantly to prison death rates, particularly amongst those who are imprisoned for the first time (Sturup et al., 2018). Whilst the true numbers of deaths in prison that are related to substances is unclear, there is evidence to suggest that the rates are high and reflect the rates seen in the community. Drug deaths in Scottish prisons have increased in recent years (Toomey et al. 2022). Opioids remain the substance associated with the most drug-related deaths in Scottish prisons and for those who have been recently liberated (Toomey et al. 2022). Those serving prison sentences are significantly more likely to die an alcohol-related death in prison than those outside prison with the rate being three times higher for men and nine times higher for women (Alcohol Focus Scotland, 2021). Whilst the above literature reflected rates in the community at the time, they are now outdated and likely do not reflect the current picture, with drug deaths becoming more prevalent. The most recent UK data, although sparse, shows that in 2020-21 the number of deaths in the community attributed to drug overdoses increased from 99 to 146. Notably, 36 of these occurred within 28 days of release indicating the considerable risk to those who have just left prison (Ministry of Justice, 2021). Death rates amongst men during the first week following their release are 29 times higher than the general population and this is overwhelmingly the result of opioid toxicity (Page et al., 2018). As a response to these high rates, all Scotland's prisons have offered naloxone kits upon release since 2011. The number of naloxone kits distributed to prison leavers in Scotland increased by 16% between 2019 and 2020 (DDTF, 2021).

While there is a correlation between drug use and crime, it must be acknowledged that this is a complex relationship, and should not be construed as causal (Hammersley, 2008). A reported 38% of those in prison used drugs when committing their offence (Scottish Government, 2019). Substance use is a known risk factor for reoffending upon release, but both prison and community based programmes are known help reduce these reoffending rates. These programmes are most effective if in-prison support is followed up with aftercare post-release. Desistance[10] is also more likely when people receive treatment quickly and for as long as required (Ministry of Justice, 2013). Education too is a valuable treatment, particularly for those imprisoned for offences such as drink driving (Ibid., 2013). All prisons in Scotland at the time of writing provide acute detoxification from both drugs and alcohol and Opioid Substitution Treatment [OST][11] (Flanigan, 2020). Methadone remains the primary OST prescribed in Scotland's prisons unless an individual is already on buprenorphine (Royal College of General Practitioners, 2019).

[9] AUDIT is a ten-question alcohol harm screening tool developed by the World Health Organisation.
[10] Abstaining from committing crime following a period or pattern of offending.
[11] This is a recognised policy for at least some SPS establishments but we have been unable to confirm if this is consistently available.

Prisons are high-risk environments for drug taking with syringe sharing and reintroduction to drug use after periods of abstinence being noted (Kolind and Duke, 2016). In Scotland, some of the highest rates of Blood Borne Viruses are found in prison populations with there being a high likelihood that this is being amplified by intravenous drug use (Flanigan, 2020). In Scottish prisons, 19% of the population are positive for Hepatitis C Virus antibodies and half of these have a history of intravenous drug use (Ibid., 2020).

Beyond physical health, substance use in prisons is importantly linked to poor mental health amongst the prison population. Substance use and dependence represent the most common mental health needs in the UK prison population. Research indicates that individuals in prison are more likely to have a substance use problem than to not have one. Mental health statistics demonstrate a significant mental health crisis in prisons. Research into the English, male prison population has estimated that 70% of those in prison have 2 or more mental health diagnoses (Flanigan 2020, p 19). Poor mental health is also an indicator and catalyst for reoffending and for relapsing into problem drug and alcohol use following release from prison.

Smoking

Historically, around 85% of people in prison in the UK report smoking, a statistic that has stayed consistent over time (Baybutt et al. 2014). There was evidence to suggest that across Europe many people take up smoking in prisons (Ibid.). Pro-smoking cultures have also been identified in some prisons and tobacco is sometimes seen as central to certain elements of prison life (Brown et al., 2020).

In November 2018, Scotland was the first UK nation to fully implement a smoke-free prison policy (Brown et al, 2019). E-cigarettes and vapes are provided to those who live in Scoltand's prisons as an alternative. The decision was controversial at the time, however, with a significant number of those living in Scotland's prisons expressing their frustration and arguing that smoking is a pleasurable pursuit in a place where few others are available (Brown et al., 2020). The policy was also felt to reduce the limited freedoms that those in prisons had. There is currently no data available on smoking rates following release and how living in a smoke-free prison might impact on smoking habits back in the community.

Following the smoking ban, e-cigarettes have been available in Scottish prisons for purchase. Whilst the move to e-cigarettes in prisons is one that was made with the health of those inside in mind, there are still health concerns associated with smoking e-cigarettes, especially when this is as a replacement for smoking rather than an aid to quit (Brown et al, 2019). The long term effects of smoking e-cigarettes or vaping are unknown. However, the majority contain potentially unhealthy levels of nicotine which is a harmful and addictive substance.[12]

[12] NHS guidance available at this time indicates that e-cigarettes are less harmful than smoking. Using e-cigarettes to stop smoking - NHS

Conclusions

The exact scale and nature of substance use in Scottish prisons remains unclear and poorly understood. Whilst emerging literature does its best to track the patterns of substance use, this is subsequent to the patterns of use forming. This means that even the most up-to-date literature often does not offer a true indication of patterns of substance use. Therefore, making informed changes to service and treatment responses to ever-changing patterns of substance use can be difficult. There is a lack of literature and an overall lack of focus on alcohol use in prisons. Alcohol use in prison is often subordinate to and given less prominence than drug use with data seemingly hard to access and collect. More positively, the literature around smoking in prisons has developed significantly and there is increasing information both from before and after the introduction of smoke-free prisons in Scotland, demonstrating the role of smoking in prisons and the associated health concerns.

Chapter 3: Perspectives of professional stakeholders

- Stakeholders feel that prison is simply the wrong place to try and meet the multiple and complex needs that most of those who are in prison currently have. This is true of both the convicted population and the excessive remand population. In particular this is the case for those with substance use needs as to them substance use is generally a coping strategy and logical response to imprisonment.
- This needs assessment is taking place during a period of optimism for stakeholders, inspired by the implementation of the MAT Standards and the policy directions of the Scottish Government. However, this optimism is tempered by the view that further progress is needed.
- There remain a significant number of challenges for those using substances in prison including mental heath, lack of treatment and healthcare options and a culture of punishment for substance use disclosure.
- Moving away from a punishment-focused approach is key to supporting those using substances in prison and reducing the number of associated deaths.

Introduction

To address the corporate element of the health needs assessment, through representation of the views of a range of stakeholders and interested parties, **20** qualitative interviews were conducted with a range of executive and senior level stakeholders. Representatives from SPS with strategic, health, justice and governance remits were interviewed alongside representatives from the Third Sector, and bodies providing legislative and welfare oversight. A further **16** interviews were conducted among NHS, SPS, Local Authority and Third Sector staff with operational and/or support responsibilities.

A short-life working group was also formed with a diverse range of professional stakeholders from key partners in SPS, NHS, and the Third Sector. [**4** meetings involving different combinations of **10** professional stakeholders: SPS (**n=4**), NHS (**n=1**), and Third Sector (**n=5**)].

A selection of illustrative qualitative examples are included under each sub-heading, with a fuller sample of examples provided in **Appendix C**.

The wrong starting place

'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]

'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]

We heard many comments from stakeholders suggesting that the easiest and most obvious way of meeting the needs of individuals who experience problems with substance use was by not criminalising or imprisoning them. All stakeholders who participated in the study believe that prison is the wrong place to try and meet the range of intensely complex environmental, emotional, physical, psychological, and social needs that are present amongst those individuals living in Scottish prisons who experience problems with substances. This is true not just of the convicted population but also of the remand population, which has been increasing in numbers over recent years.

Further, there was consensus that viewing substance use as a 'problem', which the current system appears to do, is the wrong underlying assumption. For most, substance use is considered by them to be a coping strategy and often a logical response, both outside and inside prison to medicate the traumas of past and present experiences.

Implementation of MAT Standards

'In the prisons you'll be lucky if [MAT Standards are] *implemented by April 2023. They're so far behind. There's no way they're going to meet that deadline, or they will skewwhiff their KPIs and their figures to meet it, but in reality, that's not going to be the experience of the prisoner on the ground.'* [Key Stakeholder interviewee #02]

Respondents spoke at length, and in detail, about the opportunity that will come with the full implementation of the MAT Standards across Scotland's prisons. The strongly-held perception is that the MAT Standards, if fully implemented, will be a *game-changer* that address many of the issues highlighted within this report (particularly in respect to improving speed of access to treatment, continuity of treatment, and choice of treatment options).

However, from the current starting point, the implementation of MAT Standards within Scotland's prisons is viewed as a much harder challenge than community implementation. This was particularly reflected in terms of: issues of fragmentation and continuity in respect of OST delivery; a lack of clarity over responsibilities with regard to the implementation of the MAT Standards; and the need to ensure all prison-based staff have confidence in the ability to fully implement the MAT Standards.

Policy perspectives

'When you … look specifically at the impact of the Misuse of Drugs Act … it has a huge negative impact on people who are experiencing drug problems. It's antiquated, it's out of date, it's seriously not helpful, and it undermines a public health approach.' [Key Stakeholder interviewee #22]

We heard significant praise for the Scottish Government in relation to policy development and the perceived direction of travel, with particular mentions of:

- The implementation of MAT Standards.
- The importance of having a dedicated Drugs Minister.
- Welcoming additional Scottish Government investment into drug treatment over the next five years.
- Moves towards depenalisation and a public health approach to justice.

However, despite these positive developments, there was also a consensus that there is still a long way to go if Scotland is to view the issues relating to substance use not as a *problem* and from a basis of any better *starting place* (i.e. for meeting needs without the reliance on custodial sentences). Particular references were made to keeping those with complex needs, and who are not necessarily a threat to public/society, embedded in continuous community networks of treatment and support.

This consensus has implications for Scottish Government substance use work programme and policy responses, many of which are currently under intense public and policy review (Scottish Parliament, 2022). We heard multiple references to the notion that policy, notably crime and justice, should be calibrated towards prevention first and punishment/protection second, as this might promote early interventions that prevent or negate the need for more intrusive or harsher responses later on. However, for many, it feels the other way round at present. Respondents discussed the need for greater use of combinations of decriminalisation, depenalisation, community sentences and alternatives to imprisonment.

Scotland has high rates of incarceration compared to the rest of Europe and slightly higher rates than in England and Wales (ScotPHO, 2021). Within the Scottish prison population there are also comparatively high levels of substance use (Toomey et al., 2022). These are seen as symbols of existing approaches and systems that are struggling if not failing. The discourses on alcohol, through minimum unit pricing, and drugs, through conversations about deaths and drug consumption rooms, have become high-profile media and political topics in recent years. While there are limits to what the Scottish Government can do (i.e. due to devolution), many still feel that there are opportunities to do things differently in Scotland to the rest of the UK (for example, the lawful establishment of Drug Consumption Rooms – see Foster, 2021).

High drug death rates has brought a priority focus to co-ordinated policy work at governmental level. Considerable reflection was given in the majority of discussions about how policy needs to be more overt in keeping people who experience problems with substances out of prison, and how the role of **courts** and **Sheriffs** in meeting this need is critical.

Systemic complexities

'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]

Planning structures – where do prisons fit?

Significant attention in professional stakeholder interviews was paid to the complexities of existing systems and structures when trying to understand where prisons fit into a broader policy landscape. Recognition was afforded to how prisons do not fit neatly into local health and community planning structures. Nor do they sit comfortably within regional or national structures, given that individual prisons have different populations and catchment areas (e.g. some are local, whereas others take in people from across Scotland).[13] It was regularly noted that individual Governors in Charge [GiCs] have significant levels of autonomy and decision-making on how their prison is run.

There was recognition of the significant challenge and complexity for SPS to engage in local partnerships when prisons generally service populations from a wide range of geographical areas and not just the local community population. Moreover, the extent of this varies for different prisons, adding a further layer of complexity and making the task of achieving consistency across the country, in respect of engagement with local partnerships, more difficult. Some prisons, for example, are faced with having to negotiate and establish relationships with multiple Health Boards and Local Authorities to enable the delivery of in-prison and throughcare support services. This can create a de facto postcode lottery, where services available to people in different prisons are inconsistent and shaped by local partnerships and services which vary across the country (and where a person resides ordinarily). This complexity was noted as being more significant for the bigger urban prisons.

Respondents questioned who is ultimately responsible for substance use treatment in Scottish prisons and concluded that it appears to be a confused picture with uncertainty between respondents over the exact role of Alcohol and Drug Partnerships [ADPs][14] and Integration Authorities [IAs].

ADPs – where do prisons fit?

These systemic complexities are particularly felt when consideration is given to the place of prisons in the planning landscape of Scotland's ADPs. Given that ADPs

[13] Integration Authorities, Health Boards and Community Justice Partnerships hold statutory responsibilities for the provision of Prison Healthcare and coordination of through care.

[14] In 2009, the Scottish Government set out a framework for the delivery of alcohol and drug treatment and recovery services across the country. Key features of the framework included: (1) a dedicated partnership on alcohol and drugs operating in each local authority area, firmly embedded within wider arrangements for community planning, to be called an Alcohol and Drugs Partnership (ADP); (2) an expert local team supporting the operation of every ADP; (3) where a particular Health Board area includes more than one Local Authority area, appropriate co-ordination arrangements at NHS Board area level.

have a local agenda focus, whereas prisons a have regional, national and local focus, fitting prisons into this model can be difficult. The result has been mixed engagement experiences between prisons and ADPs as well as a lack of focus on prisons within ADP agendas and work plans.[15]

ADPs are often seen as a new cultural landscape for prisons to operate within, a contrast between doing by committee (the usual ADP approach), rather than a task-orientated approach (the usual prison approach). ADPs are also often seen as having, and focusing on, a wide range of community health related needs and do not, in the main, give due consideration to the needs of those involved in the criminal justice system and (in particular) prison populations.

Financial considerations

Thoughtful reflection was often provided in discussions regarding the importance of understanding funding structures and the challenges these provide for prisons. Mention was made of how '*following the funding'* helps to establish the behaviour and/or responses of different partners or partnerships (whether ADPs, IAs, Community Justice Partnerships [CJPs], Health Boards, or prisons).

In particular, it was noted that the current funding structures tend to prevent ADPs from taking responsibility and leadership where prisons are concerned. For example, there are fears that if ADPs start investing in prison-based services then counterparts in IAs or Health Boards or Community Justice partners might start withdrawing from their funding responsibilities.

It was noted by several stakeholders that 'investment' (i.e. time, commitment, energy), often only comes with the investment of money (funding). There was also some fear expressed about how SPS/GiCs will sometimes view outside funding as meaning that '*outsiders'* will have a say in what goes on in prisons.

Fusing organisational cultures

Consideration was also given by a number of respondents to the complexity of relationships and the challenges of fusing significantly different organisational cultures between key partners (SPS, NHS, Local Authorities, and Third Sector). Particular mention was given to the difficulties of merging the different cultural traditions of healthcare and addictions work, from the previous SPS and Third Sector led arrangements to NHS working practices. Although this change took place over a decade ago, the differences in culture resonate today and are seen to take multiple forms (such as communication, information sharing, and medical-led decision making).

[15] Some areas of Scotland have delegated Community Justice responsibilities to their Integration Authority so that the responsibility sits in one place. It only becomes the responsibility of the local ADP if the Integration Authority or Community Justice Partnership clearly passes this responsibility for decision making to the ADP.

Non-substance use specific needs

'But that's the group. Multi-complex, often long-term needs that are really hard to get into.' [Key Stakeholder interviewee #04]

Respondents placed greater emphasis on many non-substance use specific needs (highlighted below) rather than people's health needs directly concerned with or connected to substance use.

Housing

The biggest and most consistent need we heard expressed was housing upon liberation. The importance and benefits of having secure non-hostel/homeless residential status upon release was consistently emphasised, whether maintained or a new tenancy, through family, or via residential rehab.

Despite the existence of the Sustainable Housing on Release for Everyone [SHORE] Standards[16], it would seem that people leaving prison often have to take what is available on the day of their release. It was also noted that there is a need for greater sign-up and national consistency in how SHORE Standards are implemented.

Greatest concern was expressed over those individuals who are released onto the streets, into a hostel, or into a House in Multiple Occupancy [HMO], where they are faced with the prospect of going straight back into a substance using community.

The increased use of Housing First schemes[17] was viewed as a significant positive development in Scotland, particularly for those individuals who leave custody and have a history of substance use.

Mental health

Housing was very closely followed by concerns about the mental health needs of those who experience problems with substances[18]. These concerns are compounded by regular reports of significant capacity issues for mental health service provision within Scottish prisons[19].

Connectivity and finance

The extent to which some of the practical aspects of being released from prison, such as securing benefits or housing, had to be done online (and was therefore contingent on people having access to, and the literacy to use, a mobile device, mobile data, broadband etc.) was noted as a significant challenge for people leaving prison. Included in this was the necessity to have a bank account or an

[16] SHORE Standards
[17] Housing First - Homeless Network Scotland: we are all in
[18] The research team acknowledge the brevity of this particular section on mental health. This was a deliberate decision, to avoid repetition of messages that are contained in (1) the related Mental Health Needs Assessment, 2022, (2) co-occurring/psychiatric findings presented in further down in Chapters 3; and (3) mental health findings presented in Chapter 4.
[19] Research respondents provided consent for these findings to be shared and discussed with the research team at the University of Edinburgh who are conducting the concurrent Mental Health in Scottish Prisons Needs Assessment study.

address, both of which are often lost through time spent in prison. These challenges are also often compounded by transport issues including the distance people have to travel home from prison or if they were released from prison on a Friday or ahead of a public holiday. The latter means that people are often forced to go without accessing key services (e.g. OST prescriptions) at a time when they are vulnerable to relapse into the risky behaviours that led to their imprisonment or leads to them self-medicating, putting them at risk of overdose or even death.

Loneliness and lack of connections

A further unmet need that respondents talked about was a desire to feel human, loved, valued, connected, and to have a sense of hope. In a sense, none of these were viewed as being about the substance use itself, but rather about the social isolation that characterises people's experiences of imprisonment.

Dentistry

The importance of dentistry in helping and supporting individuals through and beyond custody was stressed across a number of conversations. Dental issues are noted as often being more acute for those with a significant history of substance use. It was also reflected that those individuals who use substances in Scotland's prisons are disproportionately locked down in their cells, when compared to other individuals, and therefore unavailable to attend all their dental appointments.

Poor dental health is common among people with a history of substance use problems. The pain caused by this is often a motivation for self-medicating and, combined with the self-consciousness caused by dental issues, can lead to mental health problems.

Life skills and basic needs

The opportunity available within prison to support people to develop life skills as well as basic literacy and numeracy skills was frequently commented upon.

There were numerous references to how prison provides people with basic needs such as shelter and food, which are important as the first building blocks required for rehabilitation and recovery. However, all too often these basic needs were reported as not being in place upon release, which could lead to the progress people have made in prison being undone.

Substance use in Scotland's prisons

'If I was in [a cell] *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]

We heard consistent views that people were using substances to help them cope with living in prison and could be understood as a logical response to life in prison. Examples given for why this was the case included, 'getting yer heid down', dealing

with peer pressure, and/or dealing with emotional, physical, and/or psychological pain.

Current patterns of drug use in Scottish prisons

It is evident from the extensive discussions we had around drugs that the type and nature of drugs being used in Scottish prisons has: (1) changed over time; (2) is rapidly changing at the moment; and (3) will likely continue changing in the future. For example, in years past, rates of smoking and of heroin use in Scotland's prisons were likely far higher than today, with heroin and tobacco now increasingly scarce commodities.

Working group members offered an overview of the drugs they believe are currently being used in Scottish prisons. These include: gabapentinoids, prescribed and street benzodiazepines (predominantly etizolam), and synthetic cannabinoids (predominantly spice). Key stakeholders also noted that there has been an increase in paper that has been soaked in illicit substances being sent into prison, mostly through the mail. There were reports that heroin is still available but the extent of this appears to vary and was debated by respondents. However, there was general agreement that it is much less available in Scottish prisons than previously. There were also some reports of low levels of cocaine availability. Whilst this might not provide a complete or indeed accurate picture of current drug use in Scotland's prisons, it gives a sense of what substances may be most prominent. These views were echoed across all interview groups.

Particular concerns were expressed about not knowing or being unable to distinguish between what substances were being soaked on the paper being sent to people in prison. It appears to be extremely difficult for the individuals taking these substances and prison staff to establish the exact nature and strength of these substances. Laboratory testing can establish retrospective patterns of use, but often the substances used do not show up on the more immediate random testing. Individuals and staff are reliant upon being informed of substance use patterns by the observations of recent users.

Respondents reported that the drug market in Scotland's prisons is based on availability rather than choice. The dominant illegal and illicit drugs available in Scottish prisons are reported to be:

- Novel Psychoactive Substances [NPS] / Cannabinoids (with the largest and most structurally diverse class of NPS being Synthetic Cannabinoid Receptor Agonists [SCRAs]); and
- 'Street Benzos' (most commonly Etizolam).

It was a prevailing view that 'Street Benzos' are causing widespread concerns and are the cause of serious incidents across the prison estate due to the unpredictability of what is being consumed. Questions were raised about whether this points to potentially more reckless patterns of substance use within Scotland's prison population and people are not put off by the risks of not knowing what they are consuming. No hard conclusions can be drawn from our study data in regard to

this, but it is noted as an area that is worthy of further exploration. Reports were also provided indicating that both NPS and Street Benzos are currently entering Scotland's prisons as liquids, either soaked in paper or clothes. Specifically, the use of blotters[20] was reported as being more common. Respondents expressed serious concern about the increase in blotters, particularly because they appear to be used to hold increasingly more potent substances.

Alcohol

Alcohol consumption appears not to be viewed as a problem within Scotland's prisons as it is less prevalent than other substances – and this is reflected in a significantly lower level of study data relating to alcohol compared to drugs. Having said this, we heard mixed reports about the extent to which alcohol, usually made illicitly by people in prison (commonly referred to as 'Hooch'), was available. The tradition of a 'Christmas brew' in prisons still seems to be in place.

Hooch in itself does not appear to be a significant issue within Scotland's prisons due to it being difficult to produce in large volumes. However, the health concerns from illicit alcohol are two-fold: (1) people not knowing what it is made of, and/or (2) people combining hooch with other substances, which in many instances the individual is also unlikely to know what they contain.

We heard some concerns about 'powdered alcohol' being consumed in Scotland's prisons and the potential for it to be distributed as a soaked liquid. Whilst this wasn't something that was thought widespread, it might become a trend in the future.

Prison policy is mostly concerned about confiscating and shutting down alcohol production, with less attention being paid to the impact that harmful alcohol use has on people's lives. The focus for those who enter prisons with a history of harmful or hazardous alcohol use is on physical dependency and medical management (i.e. medical support for either detox upon arrival or relapse prevention upon liberation). What appears to be less well covered is the help and support required for psychological dependency caused by dependent alcohol use, which is often related to underlying trauma.

This commentary highlights how time in prison provides a period of enforced abstinence for people with a problem with alcohol. However, it appears that there is currently insufficient help and support relating to how people will manage after they are released, when they have easier access to alcohol than in prison.

Tobacco

We heard many reports about the experiences of individuals (both staff and those living in prison) following the implementation of the smoking ban across Scotland's prisons in 2018.

Many respondents talked about their concerns when the initial policy had been introduced, but we heard that it had been surprisingly easy to implement, well met

[20] Blotter sheets are made by soaking the (blotting) paper in a solution of a particular substance. This allows the substance to absorb into the blotter paper. The paper can then be divided into squares or strips.

by those who are currently living in prison and generally resulted in health improvements [21]. Respondents felt that the lessons of good partnership working that enabled the implementation of the smoke-free policy to happen should be applied to other aspects of the prison system, such as the implementation of MAT Standards.

However, there has been a significant unintended consequence of the smoking ban, with people in prison using vape machines to smoke paper-soaked drugs. It was noted that one form of punishment used within prisons is the confiscation of vapes, which in the main is viewed as an unproductive and unnecessary approach.

Substance use specific needs – in prison

'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 … then I just find it just unbelievable.' [Key Stakeholder interviewee #18]

We heard very strong views about the need to focus attention on the support and information provided to individuals as soon as they arrive in prison, and that this needs to set the tone for the rest of their time in prison. This was often framed around the need to make greater use of those with lived experience as well as Third Sector agencies to help individuals navigate their way through their time in custody. Current arrangements appear inconsistent and mainly centred on the role of prison officers and prison healthcare staff. It was felt that initial assessments are too brief and insufficient to connect individuals with support options within the prison.

We repeatedly heard that there is no incentive for individuals to be honest with prison staff about their substance use. For example, it was described to us that no additional support or interventions were offered to people if they disclosed using substances and instead this was met with (futile) punishment. A punishment first approach to people disclosing substance use in prison was considered by all respondents to perpetuate stigma about those individuals who experience problems with substances. There was a palpable sense in discussions of how impossible it would feel to sustain abstinence in the current prison culture and environment. There was no acknowledgement or sense that either the punishment first approach or the ability to maintain abstinence needs to or will change any time soon.

One of the greatest concerns of all stakeholders was the lack of continuity of prescribing, both upon entry into prison and upon prison transfer. For example, it was common for people to experience delays in accessing existing prescriptions following prison entry or transfer.

Respondents discussed four further areas of needs that were substance use specific.

[21] For example some reported improvements in breathing issues.

1. Pain relief medication (for physical and psychological conditions) is often removed from those individuals who have a history of experiencing problems with substances as they are viewed negatively as 'drug-seeking'.
2. A lack of continuity and consistency of prescribing across prisons and Health Boards, and between prisons and the community.
3. Varying choice around prescribing options in some prisons (for example, sporadic availability of Buvidal across different prisons) and in particular treatment options beyond OST (such as the sporadic availability of recovery café's and a lack of alcohol-specific psychological interventions).
4. Variations in harm reduction approaches and expertise across Scotland's prisons.

Throughcare and liberation

'I felt when our [SPS] *throughcare support service was suspended in 2019 that my right arm had been cut off because they were my eyes and ears for what was actually happening beyond the prison gate.'* [Key Stakeholder Working Group member #03]

One of the most consistent messages heard throughout the study was the need for a diversity of 'through the gate' support for people during the transition from custody to community, and to ensure that release plans happen 'as intended'. This included the perceived need for expanded provision and improved coordination between the plethora of available statutory and third sector agencies. Comprehensive 'planned liberations' are viewed as current best-practice whereas in reality they are often reduced to date and diary management of release rather than supported liberation. For respondents, a lack of support planning often equated to increased vulnerability and subsequently an elevated risk of overdose or death for people leaving prison. Particular references were made to failures of prescribing continuity due to unplanned release.

We heard numerous references to the negative impact of ending the SPS Throughcare Support Officer [TSO] role, specifically that it had been a significant loss and denied prison leavers access to supportive staff who provided a beneficial service. We also heard how the TSO role had been symbolically important as they were the first extended venture into the community by SPS. To many this represented a breakdown of silos and establishing bridges and personal connections between prisons and communities. The TSO scheme was viewed as part of a widely held aspiration to make prisons more permeable, a common plea from respondents for future priority attention. Respondents were not all advocating for the TSO scheme to be reinstated as it was, but rather recognising that its removal had left a significant gap in provision and support. By contrast, we heard very little about the wide range of Third Sector and Criminal Justice Social Work services that are currently available across Scotland to support individuals upon release, possibly indicating a lack of visibility of such services and an inconsistency of connectivity with in-prison-based services.

Views were strongly expressed regarding the need to establish a more comprehensive system of throughcare. We heard regular discussions of the need to redefine 'throughcare' as a whole pathway (that begins before, during and after time spent in prison), and a pathway that should equally involve all relevant in-prison and community/community justice partners, rather than just the final few weeks in preparation for liberation, where prison staff are historically viewed as having the substantive role. This was epitomised by the sense that throughcare planning needs to start prior to an individual entering prison, with a consistent focus thereafter. In this regard, there was considerable support for the principle that prisons should be more permeable and responsibility for shared throughcare, i.e. prison staff working with services in the community; more community providers, families and peer led provision coming into prisons. It was felt that these kind of steps would create a less stark division between custody and community for people in prison. It could also create opportunities for people living in, and leaving, Scotland's prisons to access more employment and college activities in the community.

The implementation of the new 'Prison to Rehab Pathway'[22] has been welcomed, with one residential rehabilitation provider noting a significant increase in admissions (of prison leavers) as a percentage of their total population. However, many respondents suggested there was limited consistency and effectiveness of the pathway to date and were more cautious about how long it might take to fully implement.

One of the greatest challenges identified by interviewees for individuals moving from prison to rehab was an acknowledgement that the prison culture of rules and punishments often travels with the individual into the rehab placement. This leads to an expectation of punishment in a rehab setting and a wariness of being honest with staff and peers, which both work against the fundamental principles of the opportunities provided by rehabilitation programmes.

Distinct Populations

Various sub-populations of interest and concern were noted consistently through our evidence gathering. The most commonly mentioned groups were: (1) people on remand; (2) women; (3) young people; and (4) people who have diagnosable mental health conditions. These are discussed in more detail below. Other sub-groups that received some mentions were individuals from Eastern Europe who have very little or no grasp of English (indicating a need for translation support), as well as those who transition from being a young person to adulthood whilst in prison or across several prison sentences.

[22] Health & Social Care Analysis - Prison to Rehab Pathway

Remand

'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, so they're not getting the right support or help for their substance misuse.' [Key Stakeholder interviewee #08]

All professional stakeholders noted the seemingly ever-increasing remand population in Scotland's prisons [23]. To a great extent, people on remand were the sub-population that caused respondents the greatest concern, due to their high levels of risk and vulnerability. In part this was due to the emotional uncertainty and difficulty in accessing services that came with the unknown length of incarceration, and rapid returns to unstable community settings. There was general agreement that prison is not a conducive place for those on remand to address substance use issues. In particular, it was noted that SPS does not exercise the same responsibilities towards people on remand who experience problems with substances. It also has reduced ability to do meaningful work with those on remand when compared to the convicted population.

Respondents frequently described how people on remand have little access to the structured programmes and provision associated with continuity of case management approaches whilst in prison[24], which tends to lead to an operational culture of crisis and short-term management towards the remand population.

We also heard regular reports that invariably those on remand are more often involved in unplanned release/liberation, with less planned support available for a range of critical considerations, such as benefits, housing, networks, treatment, etc.

[23] At the time of writing, SPS Prison Population data showed that 1,972 people were on remand out of 7,481 individuals in custody.
[24] This was for a variety of reasons but first and foremost because there is no obligation on prisons to provide these to remand populations.

Women

'The female population … generally manifests itself in self-violence, self-harm, and … 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]

Women who live in Scotland's prisons were regarded by respondents to be highly vulnerable with significant levels of trauma experiences and victimisation across the population. It was noted that women in prison tend to use substances more collectively than men (i.e. use with others rather than in isolation).

There was consensus amongst all respondents that good progress has been made following the Angiolini report (2012)[25] in terms of decentralising provision for women and the development of smaller Community Custody Units.

Young People

'Sentencing policy and the changing to sentencing policy means that the ones who shouldn't be here are not here … So, they are locking up the right [young] 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 … working with young people is probably about five to 10 years behind working with women.' [Key Stakeholder interviewee #26]

There has been a significant shift in Scotland in recent years to divert young people away from prison, through changes in sentencing policy. However, having diverted more young people out of the criminal justice system, has left a smaller set of young people living in Scotland's prisons who have multiple and complex needs beyond substance use.

The needs of these young people has provided a different challenge to SPS and its partners, which has not been strategically prioritised in the way that progress has been made with the female population following the Angiolini report.

Multiple respondents noted that substance use issues among young people living in Scotland's prisons do not present themselves or come to the fore in similar ways to the adult population. For example, it was felt that young people often did not take substance use and overdoses as seriously as they should. Young peoples' seemingly different attitudes towards substance use provides a complex challenge of how to support them when compared with the adult population. There is also further difficulty added by the significant challenge of recruiting young person focused specialists to work with this population.

[25] Commission on Women Offenders

People with co-occurring and diagnosable mental health conditions

Various respondents noted that mental health needs were common amongst individuals living in prison who experience problems with substances. However, a distinct sub-group that have diagnosable (acute) mental health issues were identified as being inappropriately placed in prison. We heard reports that some individuals are inappropriately remanded to prison if there are no secure hospital beds available or that some people were being placed in prison as a result of a lack of appropriate community and/or psychiatric provision. This is considered as leading to significant levels of vulnerability for these individuals. Respondents were clear in their view that prisons should not be a place someone is sent for their own protection and that Sheriffs are sometimes considered as believing this to be appropriate.

Chapter 4: Perspectives of people with lived and living experience

- Lived-experience respondents reported high levels of trauma, bereavement, poor mental health and challenges with structural issues such as poverty and homelessness.
- Patterns of susbtance use often change or increase in prison compared to the community.
- Overwhelmingly substance use was described as a response to the monotony of prison life/culture and the mental and physical health challenges people face in prison.
- Treatment options were limited and delays in accessing prescriptions created significant challenges around detox.
- The availability of support and treatment options in Scotland's prisons is often inconsistent, inaccessible and rigid.
- Autonomy in treatment and support choices is limited and often those with lived experience didn't seek support for fear of punishment. Covid-19 has amplified all of these challenges.

This section provides the key messages arising from interviews with people currently living in one of Scotland's prisons **(n=15**) and people who have left prison within the last twelve months (**n=6**).

A selection of illustrative qualitative examples are included under each sub-heading, with a full sample of examples provided in **Appendix C**.

Impacts of trauma and loss

'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]

Respondent reports of substance use from an early age were characterised by trauma and bereavement as precipitating events. We heard that many had turned to substance use as of coping with the loss of loved ones. Others had adopted substances as a coping method for experiences of violence. Often those using substances had experience of generational trauma and parental substance use.

Structural issues

'I had to go to a homeless unit, and for a lot of people … 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]

Issues including a lack of suitable accommodation upon liberation were noted as significant contributing factors to continuing substance use and associated offending. Those with histories of substance use often found homeless accommodation challenging due to the easy availability of substances there, inhibiting self-detox or rehabilitation.

Mental health

'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]

Conditions in prison negatively impacted the mental health of those inside. For some, the prison setting itself increased depression, and this was combined with a feeling of being overwhelmed about the future. Mental health needs were often unmet and the prison environment aggravated symptoms. This was especially the case when the individual took NPS, which compounded mental ill health. For some, substance use became a method of coping with the prison environment and the boredom and repetitiveness of their time spent inside.

A prison culture of substance use

'[Substance use] *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]

'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]

According to interviewees, the increased use of NPS (which as described is commonly sent in paper that has been soaked) has had significant impact on prison culture. The rising use of NPS and the associated physical and psychological harms it causes has increased the prominence and visibility of a discreet drug using subculture within prisons. The demand for NPS was thought to be contributing to increased violence and disruption in prisons. It was reported that the use of NPS was met with prejudice and stigma which in turn limited the help that was offered to people using it.

We have noted a general preference among respondents for downers including benzodiazepines, heroin and other opioids, and alcohol, though stimulants, including cocaine and crack were also not uncommonly reported. Aside from individuals who recounted problems solely with alcohol, no interviewees reported using single substances. Polysubstance use was described as common both within prisons and in the community. Individuals who offered reasons for their substance use reported poor mental health, a desire to numb feelings, the effects of peer pressure and managing boredom and stress. Availability, rather than preference, dictated which substances people used in prison.

Substance use linked to offending

'It could range from anything ... It could be assault, assault and robbery. If I take any Valium, that's when things start going wrong.' [Lived Experience interviewee #02]

For many respondents their offending was linked to their substance use. Some committed crimes while under the influence and others were imprisoned for substance use-related crimes such as a theft and aggravated assault. Recent leavers and more prolific offenders feared the association between chaotic substance use, repeated prison sentences, and premature death. For those who had been in and out of the system over a long period this was something that they had seen play out with others they had known.

Patterns of substance use inside prison

'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]

Access to substances in prison dictated which substances were commonly used by people and availability and opportunity drove patterns of consumption. The example of the common use of paper/NPS was again dominant in these conversations owing to the ease with which it could be posted in undetected and its relative affordability. [26] Mirroring the prevalence and effects of illicit benzodiazepines in Scottish communities beyond prison walls, and the views of stakeholders, 'street valium' was also a commonly used substance by lived experience respondents.

[26] Photocopying of mail is becoming more common now following a change in prison rules last year.

Experiences of substance use treatment

'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]

Treatments discussed included medication-assisted (i.e., OST), mutual aid and therapy-based, both in prison and in the community.

Treatment options in prison

The most common treatment reported by respondents was OST. This included methadone and buprenorphine. Methadone was received in the traditional form of an oral solution. People were prescribed buprenorphine in three different formulations: Espranor (rapidly dissolving wafer), Suboxone (sublingual tablet with the opioid overdose reversal agent, 'naloxone') or Buvidal (long-lasting depot injection).

Autonomy/choice

MAT Standards place individual choice as central in the treatment of problem substance use. However, we heard of many occasions where there was perceived resistance from treatment providers to acknowledge individual choice relating to preferred medications, dosage, or indeed, a stated desire to exit treatment altogether.

Access

Access to substance use treatment and interventions were reported as being variable across Scotland's prisons. Variations related to differing access to the various forms of OST described above and addiction-related mental health specialists. Starting OST during a sentence was reported to be difficult and it took a long time to access. A lack of treatment options for those experiencing problems with NPS was also reported.

It is worth noting here that OST is used to treat those who use opiates. As noted previously, stakeholders perceived that the use of opiates in Scotland's prisons has been declining. There are no recommended prescription treatments for those experiencing harm and/or dependence as a result of NPS usage, which is currently the seemingly dominant prison substance use culture. Consequently, there was a perception amongst those in prison that no treatments were available for those who use NPS, which resulted in a culture of silence and an avoidance of disclosing substance use even when on OST. In part, this culture of silence was perpetuated by the punishments which often followed disclosures of drug use, including being segregated or secluded from everyone.

Continuity of care

Transitions between prisons were viewed as mostly acceptable in terms of treatment continuity. However, transitions into and out of prison were highlighted as key junctures where access to drug and/or alcohol treatment/prescribing was interrupted resulting in unmet needs. For many, a delay in receiving their prescriptions after being released meant that they experienced an unplanned detox resulting in physical and psychological harm.

Experiences of entering and exiting prison

The medical inductions people receive during prison reception were widely perceived to be too short and insufficient to meet people's needs, particularly relating to substance use and mental health.

Reports on throughcare and onward referral varied and experiences seemed to be impacted by where and when a person was released[27]. Accommodation was a challenge for some, with homeless accommodation impacting the wellbeing of those released into it. Some people struggled to access basic care upon release such as access to a GP.

Community reintegration services

> *'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]

Community reintegration services were successful at supporting the psychosocial needs of some recent prison leavers. Supported transitions, which included liaison with individuals prior to their release and pickups from prison, were particularly effective for protecting against immediate relapse into substance use. The practical support provided by these services included housing, help to initiate and maintain benefit claims, financial aid for transport, and guidance around locally provided training, development and employment opportunities, as well as service-delivered psychosocial support programmes. However, access to these reintegration support services appeared to be dependent on an individual's convicted status and the provisions available within a person's preferred Local Authority area of release.

[27] For example we found that some geographic areas were better suited to house individuals immediately or that if an individual was released to an area where they could physically travel to a pharmacy before the weekend then they didn't experience delays in their prescriptions.

Physical health needs

'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]

Among our lived-experience interview sample, care for established physical health conditions was reported as being generally acceptable, though Covid-related issues disrupted regular outpatient treatment. By contrast, responses to emergent health needs including appointment access, physical health check-ups and dentistry are often delayed, and these were exacerbated significantly during the pandemic. This said, living in prison could ultimately result in access to healthcare, and subsequently address some health conditions, which some people would not have accessed in the community due to their chaotic lifestyles and substance use. Examples of these included blood-borne virus screening and successful treatment for hepatitis C, wound care and rehabilitation following injecting related injuries and improved nutrition.

Psychosocial interventions

'The only help I've ever had in here is speaking to people at the 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]

Differences in psychosocial support for people experiencing problem substance use were noted across Scotland's prisons. Prisons operating recovery 'café' models were well received by people in prison, people reported how cafes often hosted psychosocial support and access to various mutual aid groups, yoga, and exercise. However, Covid-19 restrictions and related staff shortages often meant severe reductions in the services offered by the recovery cafés. Another form of support reported was substance use-related peer mentoring programmes that supported at risk individuals entering prison, while affording the mentors themselves opportunities to reinforce their own recovery.

Harm reduction initiatives

'I'm a peer [mentor] *for the new guys … 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 … it's just basically harm reduction.'* [Lived Experience interviewee #11]

Where discussed, harm reduction education was peer-delivered, with sessions covering topics such as, blood borne-viruses, naloxone training, NPS awareness and overdose prevention. According to respondents, some prisons devote time

during mandatory inductions for harm reduction training and education, while others offer courses on a needs-led basis to those considered to be most at risk. Several respondents also identified engagement with certain substance use specific programs as being beneficial for influencing parole decisions. Being a peer mentor had considerable significance in supporting individual recovery. Individuals reported drawing on their lived experience of overdose and harmful drug use and were grateful for the opportunity to help others.

Relationships with staff

'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]

Lived-experience interviewees indicated that relationships between staff and people in prison were largely functional, civil, and respectful. Individuals described how they would navigate their time in prison by knowing which officers to approach for assistance and when. It was generally acknowledged and accepted, for example, that the prison system was often stretched by overpopulation and staff shortages. This created an environment where needs were frequently prioritised by individuals in prison so as not to bother staff with less urgent issues. Some interviewees felt particularly stigmatised by some prison staff on account of their substance use. Relationships with healthcare staff were impacted by structural conditions, including staffing pressures, appointment processes and power dynamics perceived to be specific to criminal justice settings [28]. Of note however, was how respondents described relationships with specialist addiction and/or recovery staff, which were often distinctly valued, particularly by individuals engaging in substance use treatment and/or detoxing.

Future improvements

'It would be more helpful having more [prison] *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]

Addressing the overcrowding and long-standing prison staff shortages were highlighted as central to improving conditions in Scotland's prisons. Some interviewees suggested the prison population would be better managed by splitting those who are serving long compared to short-term prison sentences and establishing 'drug-free wings'. These ideas were highlighted as key to promoting safety in prison. Responsivity to health and psychosocial needs was further identified as an area for improvement. Tackling NPS usage was recognised by

[28] The relationship between a prison worker and those who were imprisoned was felt by respondents to be unique, and one which did not lend itself to open and vulnerable communication.

some as paramount to improving prison conditions and individual safety. People in prison suggested that training more prison staff in harm reduction and managing problem substance use would support these outcomes. It was also felt that drug treatment should be person-centred with options provided from a range of pharmacological and psychological therapies. Some individuals with varied experience across multiple Scottish prisons suggested that recovery café models should be employed as standard for meeting substance use needs. Greater in-reach twelve-step recovery fellowships was also noted as desirable for better outcomes. Lastly, support for nicotine dependence was identified as lacking with some respondents suggesting more options needed to be available to reduce examples of withdrawal and the attendant mental discomfort this brings.

Impact of Covid-19

'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]

People currently living in prison reflected on their resilience in relation to the changes to prison regimes during the pandemic, with some noticing little difference to their routines or service provision. However, concerns were voiced about the impacts of extended periods of 'lock-up' (more time spent in cells) for those already vulnerable to being overwhelmed by feelings of isolation and loneliness. Attempts to mitigate these negative impacts by individual prisons included the addition of large communal televisions, and games consoles which people could access in lieu of exercise and other forms of recreation.

Social distancing requirements and Covid-related staff shortages meant increased waiting times for appointments within prisons, while outpatient appointments were largely cancelled. Rapid increases in Buvidal prescribing were welcomed by people currently living in prison (due mainly to monthly rather than daily administration) and this transition from other forms of OST simultaneously satisfied public health requirements to reduce face-to-face consultations. The halting of in-reach twelve step recovery fellowships and other groups had a negative impact on people addressing their substance use problems.

While substance use support services were reduced, there was little evidence of Covid-19 restrictions impacting the availability of illicit substances in prisons (due to the flexibility and adaptability of those operating drug markets). Though challenging for some, visitation and telephone contact with loved ones continued through online platforms and the provision of mobile phones. Those released from custody during the pandemic, however, were impacted by reduced access to support and poor communication regarding the availability of all required services.

Chapter 5: Healthcare data collection and analysis

- There are significant deficiencies in existing substance use and related health data collection, analysis, sharing and storage leading to significant variations across Scotland's prisons, resulting in no universal or meaningful body of data to give an accurate overview of substance use among Scotland's prison population.
- Only with a more accurate and consistent gathering of substance use and associated health data will the quantitative data produced by prisons be usable and valid.

This chapter addresses research objectives 4 and 5:

- Assess the scope for the improved collection of routine data that can be made available to analysts, managers, and service providers for continued monitoring and analysis of support needs relating to substance use.
- Offer insights for future data linkage and data collection priorities.

Data sources

Part of our methodology for this project included a high-level strategic review of how healthcare data is gathered and used within Scotland's prisons. It was, however, quickly identified and confirmed by the views of key data informants that there are significant deficiencies in existing substance use data collection, analysis, sharing and storage. This means that data varies greatly across Scotland's prisons and there was no universal or meaningful body of substance use and related health data to give an accurate overview of substance use within Scotland's prisons. Moreover, on account of Scottish Government Covid-19 restrictions on research, which prevented in-person/physical access to Scotland's prisons, this project was unable to conduct screening exercises typically associated with prison health needs assessment research and could only rely on existing prevalence data.

Table 2 below provides an overview of the available and relevant datasets, along with commentary on the limitations of the datasets that were highlighted by the expert data informants interviewed.

This chapter is an abridged version of a fuller paper included in **Appendix D**.

Table 2. Existing substance use and related health datasets

System	Description	Limitations
DAISy (Drug and Alcohol Information System)	DAISy was rolled out across Scotland from April 2021 and should include information from prisons.	The reporting functions of the system are very limited.
PR2 (SPS Prisoner Records Database)	This is the "go to" source of information on health concerns for frontline SPS staff. PR2 uses a 'Conditions' and 'Risks' matrix where individual profiles can contain information on health issues.	The 'Conditions' are broad and the descriptions lack detail. There is no universal approach to recording information and no systematic auditing of the data. There is also no context given to the health issues noted. The data held on PR2 is maintained without any engagement with prison healthcare.
Vision	The core healthcare database system used by NHS providers in prison settings. Vision is where intake health data is logged.	Concerns have been raised about the quality of the coding on Vision. As a result, this system makes it difficult to find, collate and analyse data.
Paper-based records	Opioid Substitution Treatment prescribing is recorded using a paper-based systems.	OST data is not held on the Vision system, is not shared, and therefore is not accessible at the point of need.
Public Health Information Dashboard	Published by Public Heath Scotland. This covers eight data sets with a particular focus on substance use data.	Repackaging of historic data with limited day-to-day value. Unlinked datasets mean that patterns and trends are not accessible. Concerns about accuracy of data.
The Scottish Prisons Survey	This is a voluntary survey for those who live in Scotland's prisons to complete. It was last published in 2019.	Voluntary nature means that some individuals are potentially less likely to disclose illicit activity.
NHS healthcare data	This is held by the NHS and is not routinely shared with SPS.	

Results

The illicit nature of drug taking means that it is very difficult to collect accurate data on the prevalence and types of drug taking within Scotland's prison populations, without forced, compulsory drug testing and a universal and standardised way of conducting these tests.

Table 3 below indicates the results of a literature search for the prevalence of current or recent substance use problems across UK prison samples[29].

Table 3. Prevalence of current or recent substance use problems in UK prison samples

Condition type	No. Studies[30]	Prevalence (%)
Drug use disorder	3	35 - 67
Alcohol use disorder	8	33 - 81

Published substance use and related healthcare data for Scottish prisons is deficient and a number of issues require to be addressed if this is to provide valuable real-time insights. Data is often outdated meaning that its usefulness is severely limited when it comes to identifying and understanding drug use needs as these trends change quickly. There was a general view from respondents that data systems, reporting, and analysis could all be substantially improved.

Collectively the data systems we reviewed for this research are fragmented and fail to fulfil important data principles. Inputting is conducted by individual staff and we were told of concerns that there were significant variations in this. Information on OST prescribing is recorded on paper and is not kept within the general healthcare system (Vision). Individual datasets are not linked and so any patterns and trends cannot be identified.

The Drug and Alcohol Information System (DAISy) was rolled out across Scotland from April 2021 and all prisons should now be inputting information into it. However, at the time of writing, the reporting function of the system is heavily constrained. Due to the lack of current reporting and data available for analysis, we are unable to comment on the future role and value of the system.

At worst, current systems may provide false assurance regarding healthcare needs, thereby heightening risks. This is amplified by the challenges posed by SPS's Prisoner Records system, PR2, which remains the 'go to' source of information for frontline SPS staff despite it having no link to prison healthcare systems. Health assessment systems at reception are reported as adequate for providing a provisional understanding of someone's healthcare needs. However, there is no

[29] Conducted by the University of Edinburgh research team who have completed the Mental Health Needs Assessment study as part of the current and overarching Health Needs Assessment study of Scotland's prison population. Full details of the literature search conducted can be accessed in the Mental Health Needs Assessment report.
[30] Number of studies reporting prevalence in a UK general prison population.

aggregated intake data. There is scope to increase data sharing on cohorts of the prison population, without compromising patient confidentiality.

A lack of analysis of existing substance use and related health data, as well as a lack of sharing of any such data at individual prison and national level, means that significant changes in the healthcare needs of those who use substances whilst living in a Scotland's prison could potentially go undetected.

Current systems are not capable of confirming that prison Health and Wellbeing Standards are being met, and to date inspection arrangements have focused on individual prisons without evidencing national fulfilment. What's more, the data principles[31,32] of timeliness and relevance are not being met by current systems.

Summary

Regardless of context, and because of the behaviours involved, the collection of reliable and accurate data on substance use is challenging. However, there are steps that could be taken to ensure that the best data possible can be collected. The current haphazard and variable nature of all substance use and health related data collection should be addressed and potential options for data sharing reviewed. Whilst the illicit nature of some substances may make it much harder to gather accurate data, key stakeholders believe it is more likely that self-reporting will increase when punishment is no longer given for disclosure.

[31] Framework for Action: Data Standards in Scotland's Public Sector. Report to the Data Standards Team, Scottish Government. Anderson Solutions (Consulting) Ltd. October 2021.
[32] See HM Government Information Principles. HM Government. 2011.

Chapter 6: Service mapping

- Reporting of ADPs on partnership working and interventions within prisons is patchy and inconsistent, with wide variations in the depth, breadth and quality of reporting being provided.

This element of the study focused on addressing research objective 3:

- Map current models of substance use care/interventions within Scotland's prisons, how they interface with other healthcare interventions within prisons, and how they interface with community care models and services, including assessing aspects of treatment continuity, finding examples of best practice, and throughcare pathways during transition from custody to the community.

In undertaking our review, we were mindful of two other mapping exercises that were either currently in progress or planned, and have had meetings with the relevant stakeholders involved in these pieces of work to share findings and join up critical conversations:

- The MAT Standards Implementation Support Team [MIST] at PHS have been commissioned by the Scottish Government to undertake an assessment of readiness to deliver MAT in prisons. Healthcare Improvement Scotland have also been commissioned by the Scottish Government to develop a learning system to support the implementation of MAT Standards, including a specific learning system for their implementation in prisons.
- The National Prison Care Network, through its Mental Health and Substance Use Group, has committed to undertaking a mapping exercise to look at integrated and shared patient pathways for Mental Health and Substance Use where feasible and appropriate.

We have also taken cognisance of the recent study undertaken by the Scottish Centre for Crime and Justice Research titled, 'Mapping Drug Use, Interventions and Treatment Needs in Scottish Prisons: A Literature Review' (Toomey, 2022). The key findings of this piece of work, which resonate in their entirety with our findings, are summarised as follows:

- High numbers of those who enter Scottish prisons have drugs in their system and high numbers identify as having a drug problem.
- Nearly 40% report using illegal drugs whilst in prison.
- 83% of people[33] change their drug use whilst in prison.
- Benzodiazepines, opiates and cannabis are the most commonly used drugs in Scottish prisons.
- Opiate and alcohol only users tend on average to be older than non-alcohol and opiate users.
- Women are overrepresented in drug using populations in Scottish prisons.

[33] Who took part in the data collection.

- Between one-fifth and one-quarter of the Scottish prison population has an OST prescription. These rates vary greatly between estates though.
- Naloxone kits are available upon release to those leaving a Scottish prison. Generally women have higher uptake of these.
- Use of drugs often arises from boredom, limited regimes, and isolation.
- Buvidal was made available to all prisons during the Covid-19 pandemic.

Methodology and activities

This mapping exercise was based on data gathered for the Scottish Government's ADP Annual Review 2019/20 process. The purpose of an ADP annual report is to provide each ADP Board[34] and their partners with an overview of the wide range of services and activities undertaken in the previous financial year to help improve the lives of the people who have had or are experiencing substance use problems. They set out to measure progress against the Scottish Government's national drug and alcohol strategy *Rights, Respect, Recovery*[35], the DDTF emergency response paper[36], and *the Alcohol Framework* 2018[37].

Through the development and delivery of the local strategy, the ADP should identify where there are shared outcomes and priorities with other local strategic partnerships. In these cases they should develop shared arrangements to support delivery. As a result, minimum agreement to the strategic plan and arrangements for delivering should come from Community Justice Partnership; Children's Partnership; and Integration Authority.[38]

Information provided by each ADP was scrutinised to identify information pertaining to criminal/community justice pathways and partnerships, covering the whole journey for individuals entering prison, serving their sentence, and then returning to the community. The following headings, taken from the ADP Annual Review template, has been used to structure this mapping exercise.

- Representation at the ADP.
- Prison arrangements in place for naloxone.
- ADPs working with community justice partners.
- ADP contributions toward community justice strategic plans.
- Procedures for individuals with treatment needs in the criminal justice pathway (upon arrest).
- Procedures for individuals with treatment needs in the criminal justice pathway (upon release from prison).

[34] ADP Boards bring together local partners including Health Boards, Local Authorities, Police and Third Sector agencies.
[35] Scottish Government. 2018. *Rights, Respect and Recovery: alcohol and drug treatment strategy*.
[36] Scottish Government. 2020. *Preventing drug-related deaths in Scotland: emergency response strategies - January 2020*.
[37] Scottish Government. 2018. *Alcohol Framework 2018*.
[38] Scottish Government. 2019. *Partnership Delivery Framework to Reduce the Use of and Harm from Alcohol and Drugs*.

Data was available for 29 out of the 30 ADPs[39]. A summary of our findings and key messages is provided below, with a full analysis provided in **Appendix E**.

Results

28 out of 29 ADPs report strategic partnerships in the form of Community Justice Partnership representation and 18 of these ADPs report SPS representation (where there is a prison within their geographical area).

14 ADPs (who have a prison in their area) provided details of the arrangements currently in place for naloxone (see **Appendix E** for details of these arrangements). There is a variety of different arrangements in place, however, implementation is not seamless, and there is little consistency across the country.

All 29 ADPs reported having worked with community justice partners in regard to information sharing during 2019/20. A total of 27 ADPs noted that they had worked with community justice partners with providing advice/guidance. Just over half (16) ADPs reported that they had worked with community justice partners with coordinating activities and the joint funding of activities.

27 ADPs reported that they have locally agreed procedures in place for individuals with treatment needs upon arrest. Further scrutiny of responses indicates wide variation and little consistency across the country in this regard.

The same 27 ADPs also report that they have locally agreed procedures for individuals with treatment needs upon release from prison. Similarly, there are a wide variety of arrangements in place, however, there is no uniformity.

Summary

In undertaking our review, we were mindful of various other mapping exercises that are currently in progress. Once complete, they should be combined with the findings from this study to form a comprehensive picture of current activity. More importantly, the various exercises should be assessed to identify how improvements to continuity of treatment/support can be achieved consistently across Scotland to ensure that people who live in Scottish prisons and who experience problems with substances are afforded the same choices and quality of care.

[39] Scotland has 30 ADPs, all of which are based on Local Authority boundaries. There are 32 Local Authorities in Scotland. There are two areas where ADPs have joined across two Local Authority areas, hence why there are 30 ADPs and not 32. The two areas are: Clackmannanshire/Stirling and Mid/East Lothian.

Chapter 7: Report limitations

There are several limitations to the findings of this needs assessment, some of which have resulted from the continuing Covid-19 pandemic. Face-to-face research was not possible during the timeframe of this project. This required taking an adapted approach using existing and secondary data and undertaking data collection through remote methods only.

Recent literature on this area is limited and there were time constraints on this project which necessitated a concise and rapid literature review.

Moreover, on account of Scottish Government Covid-19 restrictions on research, which prevented in-person/physical access to Scotland's prisons, this project was unable to conduct screening exercises typically associated with prison health needs assessment research and could only rely on existing prevalence data. The prevalence of substance use needs could not be confidently nor accurately estimated in this research due to the lack of available and robust data. In the absence of estimates generated from Scotland's prison population, it may still be useful to consider the prevalence reported in the UK prison research literature to inform the planning of services.

Whilst it was possible to use phone and videoconferencing technology to gather the views and insights of individuals with lived experience of problematic substance use in prison, access restrictions to prisons and competition for private rooms for remote interviews meant it was not possible to obtain direct input from women currently living in prison. Despite numerous efforts, it was also not possible to speak with any family members of individuals currently or recently living in a Scottish prison who experience problems with substances. Consultation with these two groups should be prioritised in future research studies.

The professional stakeholders who engaged with this project have become familiar and relaxed in their use of videoconferencing technology. However, conducting interviews online was a barrier for some individuals with lived experience living in the community due to lack of access to the necessary technology and data/Wi-Fi packages, and reliance was given to phone interviews instead. The research team recognises that in-person interviews might have enriched the interpersonal connection made with these individuals.

Finally, this report highlights the substantial service and workforce pressures experienced by those working to support people living in Scotland's prisons. Not all health professionals who wanted to engage with this needs assessment were able to due to pressures on clinical services and staffing problems exacerbated by the pandemic.

Chapter 8: Conclusions

The headline message from this study is that prison is the wrong place to try and address the wide range of intensely complex environmental, emotional, physical, psychological, and social needs experienced by people in prison who have problems with substance use.

Evidence gathered through this study (and the concurrent Mental Health Needs Assessment study) indicates that individuals in Scotland's prisons are more likely to have a substance use problem than to not have one. Existing provisions for supporting and meeting the needs of those who experience problems with substances (whilst living in a Scottish prison) are inconsistent across the country. There are also inadequacies and deficiencies for individuals in relation to the continuation of their treatments and support – both from the community into prison, and back to the community following liberation, and when being transferred from one prison to another. There has been too much focus placed on throughcare arrangements as being the period immediately up to and post release, rather than over a longer period of time. This has been epitomised through an over emphasis on the role of prison (TSO) staff, over and above the role of other key provision by Third Sector and Criminal Justice Social Work across Scotland. All of this is reflected in the report's title and key findings which underline the need to redefine throughcare to include the whole criminal justice pathway and all relevant stakeholders.

There is a need to challenge underlying assumptions regarding substance use. In the main, substance use is viewed and treated within the prison system as a 'problem'. This is not suggesting that substance use is not problematic, but rather that substance use should not be problematised. For most, substance use is considered to be a coping strategy, both outside prison and inside prison to medicate the traumas of past and present experiences. Further, it could be argued (and we often heard) that using substances whilst in prison is considered to be a logical response to the traumatic situation that individuals find themselves in (e.g. 'getting yer heid down', dealing with peer pressure, and/or dealing with emotional/physical/psychological pain).

It is clearly important to know what substances are coming into prisons. However, the most prevalent substances currently in Scottish prisons are much less identifiable than the previously most prevalent substances (e.g. heroin), all of which sits in a much bigger marketplace of organised crime. The nature of the substance use inside Scotland's prisons does not fully mirror that on the outside and used in the community, either prior to or post release. The challenge is to apply an appropriate level and balance of resource and time to continually develop understanding, whilst avoiding the danger of constantly chasing rainbows. It was regularly noted that the substances being used in prison are those that are available, and of necessity, rather than always those of choice.

The primary needs of those individuals who use substances through their time in Scotland's prisons are not particularly substance use related. Substance use does come with consequences but it doesn't represent the real needs of individuals (particularly: housing, trauma, mental health, finance, and emotional intelligence/regulation). The needs should be about, and focused on, how individuals are best prepared for release – and that these preparations should start from the first moment an individual steps inside a prison. The dominant presentation of the majority of these non-substance use specific needs (i.e. housing) indicates that the discourse around 'substance use in prisons' needs to shift beyond criminogenic and health considerations to include significant regard for the social (justice) agendas. From a substance use point of view the biggest challenge is one of continuity of care/treatment (or lack of) through and beyond prison.

Prisons do not fit neatly into local health and community planning structures but also do not sit comfortably with national structures, given each individual prison has different population groups and catchment areas, and that individual GICs have significant levels of autonomy and decision-making in how their prison is run (priorities etc.). As a result, there is a lack of consistency on how substance use issues in prisons are managed, accounted for, and governed. This complexity more often than not leaves prisons as a fringe partners in structures such as ADPs.

There is also the complexity of relationships and different organisational cultures between key partners (SPS, NHS, Local Authorities, Third Sector). These relationships are not based on equal and reciprocal partnerships, so it is no surprise that solutions to the issues presenting due to substance use are neither co-designed nor co-produced.

Credit needs to be given to the Scottish Government in relation to substance use policy development and the perceived future direction of travel. The appointment of a dedicated Drugs Minister in 2021 has been welcomed along with the additional £250m investment into drug services over the next five years. The priority focus on implementing the new MAT Standards is seen as a 'game-changer' although there is a need to prioritise prisons in this regard as they have received less focus when compared to MAT Standards implementation in community settings.

The continued drive of the Scottish Government to pursue a policy of depenalisation has to be welcomed and encouraged, particularly as a key response to the substance use issues highlighted in this report. Depenalisation would provide a better starting place for meeting the wider needs of individuals who experience problems with substances. It would also facilitate a shift away from viewing substance use as 'the problem' towards a more holistic and person-centred approach of tackling the underlying traumas which are often at the root of why people use substances. However, despite some positive developments, there was consensus that more could be done to improve support for people with problematic substance use living in Scotland's prisons.

Chapter 9: Recommendations

Given the systemic complexities and challenges of partnership working that our review has highlighted, we have chosen to present our recommendations in two distinct groupings:

- Firstly, a small set (**4**) of high-level key recommendations (which are explicit in terms of the action required by the named organisations within the recommendations); and
- Secondly, a larger set (**22**) of outcome-based recommendations, grouped around a series of themes reflecting the findings of the needs assessment. These recommendations describe a 'preferred future' which will only be achieved by **all** relevant stakeholders and partners working together in close collaboration.

High-level key recommendations

Key recommendation 1: Better consistency and continuity of care should be achieved through the negotiation and agreement of a detailed partnership agreement between all the key partners involved in the commissioning and delivery of substance use services and supports across prisons (and wider criminal justice pathways)[40]. This new (substance use) partnership agreement should detail a core set of principles for working better together and will have the core aim of implementing improved and consistent practice as well as improving experiences for those individuals receiving support.

Key recommendation 2: A multi-agency, multiple and complex needs, working group should be convened by Scottish Government to operationalise the learning from this needs assessment (and should be combined with learning from the concurrent Mental Health needs assessment study). The group should include lived/living experience and family representation.

Key recommendation 3: There should be coherent, national oversight and governance of progress towards achieving all of the outcome-based recommendations (detailed below), through the instigation of an independent National Oversight and Assurance Group. The group will need to pay particular attention to the need for urgent action to address the significant data deficiencies highlighted in this report.

Key recommendation 4: By building upon the successful coordination and planning work adopted that led to Scotland's prisons becoming smoke-free, SPS, private prisons, and Integration Authorities should consistently and fully implement the MAT Standards across all of Scotland's prisons. This should include being evidenced through detailed consultation work with all key sub-groups of Scotland's prison population (i.e. male/female/young people and sentenced/remand populations).

[40] To include (but not be limited to): all Scottish Prisons, the National Prison Care Network, all Scottish Health Boards, the Criminal Justice Third Sector Forum (CJVSF), all Integration Authorities, and all ADPs.

Outcome-based recommendations

Outcome theme 1: The wrong starting place

- **Outcome-based recommendation 1.1**: The needs of all those who experience problems with substances are effectively supported in the community, reflected by Sheriffs and Courts utilising greater and broader use of diversionary measures to prevent individuals unnecessarily being sent to prison.

- **Outcome-based recommendation 1.2**: All stakeholder strategies and delivery plans reflect an understanding of a starting premise that substance use in Scottish prisons is an integral part of a coping mechanism to a range of complex issues (not withstanding that it causes a range of problems) and requires both psychosocial and medical intervention.

Outcome theme 2: Continuity of treatment and support

- **Outcome-based recommendation 2.1**: As part of the full implementation of MAT Standards there will be greater continuity of treatment for individuals between prisons (transfer) and between community and prison (into and out of custody).

- **Outcome-based recommendation 2.2**: For those moving through the criminal justice system, including into and out of prison, critical through-care support (in relation to family contact, housing, casework, legal issues, and managing benefits) is experienced continuously from arrest through to community reintegration.

Outcome theme 3: Policy perspectives

- **Outcome-based recommendation 3.1**: Substance use policy across Scotland's prisons and the wider criminal justice system have adopted a prevention-first approach, and fully co-ordinate and integrate with all relevant disciplines supporting multiple and complex needs. This should be evidenced across all levels of national, regional, and local planning frameworks.

Outcome theme 4: Systemic complexities

- **Outcome-based recommendation 4.1**: Prisons will be actively incorporated into all relevant local, regional, and national planning structures (especially ADPs, Community Planning Partnerships, and Community Justice Partnerships).

- **Outcome-based recommendation 4.2**: Integration Authorities are fully inclusive of Community Justice and prison partners, with the active involvement of all agencies in joint commissioning and leading to a visible use of pooled treatment budgets.

- **Outcome-based recommendation 4.3**: Whilst not disregarding the multiplicity of complex needs, there is a fully functional and integrated approach to address the consistent overlap between substance use and mental health.

Outcome theme 5: Non-substance use specific needs

- **Outcome-based recommendation 5.1**: Those entering and leaving prison do so with greater support for the maintenance of existing housing or provision of suitable housing upon leaving prison (to avoid them re-entering the negative cycle of substance use that is often associated with homelessness, temporary or unsuitable housing provision).

Outcome theme 6: Substances and substance use

- **Outcome-based recommendation 6.1**: Drug screening in Scotland's prisons is used to gain intelligence about, and understand the patterns of, substance use among the prison population, and to indicate opportunities to deliver health and psychological interventions.

- **Outcome-based recommendation 6.2**: Individuals who enter prison with a primary dependency (physical and psychological) on alcohol should have access to appropriate psychological interventions (as well as pharmacological).

Outcome theme 7: Substance use specific needs – in-prison

- **Outcome-based recommendation 7.1**: All individuals entering Scotland's prisons receive sufficient information and support to enable them to make informed choices about their prison-based care and treatment, including early conversations about support for abstinence and recovery, where appropriate. Those living in prison feel confident that disclosing substance use will lead to support and help as needed.

Outcome theme 8: Throughcare and liberation

- **Outcome-based recommendation 8.1**: Continuity of care is experienced before, during and after custody (through stronger and continuous case management, earlier planning for release, avoidance of Friday or Bank Holiday release, increased provision by statutory and third sector community-based services to engage with the needs of individuals throughout this process, working in co-operation with prison services and other justice services), such that individuals experience less pressure to use substances or to relapse following liberation.

- **Outcome-based recommendation 8.2**: The Prison2Rehab pathway is consistently available to people leaving all of Scotland's prisons, with good accessibility for all of those who require it.

Outcome theme 9: Specific populations

- **Outcome-based recommendation 9.1**: **Young people's** location of incarceration is close enough to their home to support continuity of care and their familial networks, reflecting the learning from the recent diversification of the female prison estate in Scotland, and contributing to the prevention of problematic alcohol and drug use.

- **Outcome-based recommendation 9.2**: **People on remand** have greater access to the range of substance use interventions and support that are already made available to the sentenced prison population.

- **Outcome-based recommendation 9.3**: The **female population** receive enhanced trauma-informed interventions to mitigate the need to use substances to cope with consistent underlying and existing traumas.

- **Outcome-based recommendation 9.4**: Individuals with **acute co-occurring psychiatric** and substance use needs are not remanded or sentenced to a prison environment, but rather are supported in specialist psychiatric or community provision.

Outcome theme 10: Workforce

- **Outcome-based recommendation 10.1**: There is a fully resourced, trained, and confident workforce, across sectors, who all consider working with substance use to be a legitimate part of their role.

Outcome theme 11: Recovery

- **Outcome-based recommendation 11.1**: Recovery and substance-free interventions are comprehensively developed across all of Scotland's prisons, with access available to all those who request them.

Outcome theme 12: Data

- **Outcome-based recommendation 12.1**: Data collection and monitoring arrangements are consistently supported and evidenced by a fulfilment of HMIPS Standard 9 (Health and Wellbeing) at all of Scotland's prisons and are reflected in a successful delivery of the Prisons Digital Health & Care Systems Provisioning Programme.

- **Outcome-based recommendation 12.2**: In moving towards a fulfilment of HMIPS Standard 9 (see 12.1 above), and in response to the high levels of risk carried within the prison system, the key health, social care, local authority, and justice partners routinely share common health and substance related data.

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