Drugs, Alcohol and Tobacco
Health Services in Scottish Prisons:
Guidance for Quality Service Delivery

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Executive Summary

The prevalence of substance misuse problems (problem drug use, alcohol use and tobacco use) of those in prison is high. The prison setting provides an opportunity to reach those who are ‘hard to reach’. If successful, effective treatment and recovery has the potential, combined with other behavioural and purposeful activity support, to reduce the likelihood of further reoffending as well as contributing to a reduction in health inequalities.

This report describes the current picture of the nature and scale of substance use in prisons in Scotland, maps and reviews current service delivery and best practice to suggest recommendations on evidence informed approaches likely to result in assisting recovery and reducing reoffending.

In highlighting areas of best practice, the report considers a number of themes, including goal setting, service user participation and choice, recovery and relapse prevention and recommends adoption of the treatment pathways to ensure consistency of approach.

The report is intended for use by NHS Boards, the Scottish Prison Service (SPS), Alcohol and Drug Partnerships (ADPs) along with a wide range of health and justice decision makers and service deliverers.

Information in this report is gathered from a range of sources, including:

- stakeholders at a National Prisoner Healthcare Network (NPHN) Substance Use seminar event held by the Substance Misuse Workstream in June 2014
- evidence from a service mapping conducted by the Substance Misuse Workstream
- desktop research, expert opinion and advice from the membership of the Substance Misuse Workstream, which includes strategic, clinical and cross-organisational support, and
- a series of local needs assessment visits carried out by NHS Health Scotland’s tobacco team.

Following analysis of the information gathered and mapping to accepted current best practices in the field of substance misuse, a number of substance-specific and high level recommendations have been indentified for NHS Boards delivering services and other key stakeholders. The high level recommendations identified for each stakeholder are listed below. Key organisations to which recommendations are being made to appear in brackets.

**High Level Recommendations**

1. Police custody, court reports and prisoner escort records should be consistently completed and shared to effectively inform prison reception screening, assessment, prescribing (where provided) and case management [NHS Boards, Crown Office and Procurator Fiscal Service, SPS].
2. Substance use and dependency should be identified and recorded from prison reception onwards and managed through the three pathways for alcohol, drugs and tobacco, with access according to need [NHS Boards].

3. All prisoners should be effectively engaged in a range of purposeful activity which strengthens recovery and reduces reoffending [SPS].

4. Substance Use services in prison should align to and meet national standards, such as the Quality Principles, Recovery Outcome reviews and relevant HEAT standards [NHS Boards]. A suite of Service Quality Indicators should be developed and implemented to support service improvement [NPHN, NHS Boards].

5. Data should be captured and shared where appropriate to baseline, measure and benchmark access, uptake, engagement, success and sustained recovery to inform local and national planning. The Outcome and Performance Indicators Workstream of the NPHN will specify the data to be captured [NHS Boards].

6. Costed options for national reporting should be developed [NPHN].

7. Capacity in prison substance use services should be adequately resourced to meet service demand and be delivered by trained and competent staff [NHS Boards].

8. Service user views should be gathered through a range of mechanisms to inform service planning and delivery, and their impact evidenced through both implementation and follow-up [NHS Boards].

9. A holistic, single service integrated release plan should be provided for prisoners with substance misuse which is informed by recovery and the social model of health. This plan will include: GP registration, skills for harm reduction and relapse prevention, access to mentorship and mutual aid, referral to health and local authority services, and support in their community of residence [NHS Boards].

10. Arrangements should be made to ensure that details of healthcare delivered in police custody suites can be accessed by prison-based healthcare staff, by a suitable IT linkage, to inform continuity of care [NHS Boards].

11. Arrangements should be put in place to ensure that the recommendations from the Substance Misuse Workstream report are implemented by NHS Boards [NPHN, NHS Boards, Scottish Government].
1 Introduction

The National Prisoner Healthcare Network (NPHN) has a national strategic co-ordinating role to support the delivery of high quality, safe, effective and consistent health and healthcare services to those in Scottish prisons. The network is a consortium of NHS Boards and other strategic partners and was set up following the transfer of the responsibility and accountability for the delivery of primary and community healthcare to those in prison in Scotland from the Scottish Prison Service (SPS) to the NHS on 1 November 2011. A Substance Misuse Workstream was set up in 2013, the topic having been identified as a priority by the NPHN (see Appendix 5 for workstream membership).

The prevalence of substance misuse problems\(^1\) of those in prison is high [1]. The prison setting is an opportunity to reach those who are ‘hard to reach’. If successful, effective treatment and recovery has the potential, combined with other behavioural and purposeful activity support, to reduce the likelihood of further reoffending as well as contributing to a reduction in health inequalities.

The purpose of this report is to describe the current picture of the nature and scale of substance use in prisons in Scotland, map and review current service delivery and best practice, and to suggest recommendations on evidence-informed approaches likely to result in assisting recovery and reducing reoffending.

The report also aims to improve outcome focus and impact within both health and justice settings through better information sharing, national monitoring and support for local evaluation of best practice. The report is intended for use by NHS Boards, the SPS, Alcohol and Drug Partnerships (ADPs) along with a wide range of health and justice decision makers and service deliverers. The content of this report includes information gathered from:

- stakeholders at an NPHN Substance Use seminar event held by the Substance Misuse Workstream in June 2014
- evidence from a service mapping conducted by the Substance Misuse Workstream
- desktop research, expert opinion and advice from the membership of the substance use workstream, which includes strategic, clinical and cross-organisational support, and
- a series of local needs assessment visits carried out by NHS Health Scotland’s tobacco team.

The report should also be considered in the context of the SPS Organisation Review ‘Unlocking Potential Transforming Lives’ 2013 [2]; Better Health Better Lives Health Improvement Framework 2012 [3]; and the NPHN activity on throughcare, mental health and performance in particular, alongside learning and emerging recommendations from the healthcare in police custody settings network to ensure consistency and mutual strengthening of impact [4].

\(^1\) For the purposes of this report substance misuse is defined as problem drug use, problematic alcohol use (hazardous/harmful use or dependency) and tobacco use.
2 Topic Focus and Context

2.1 Problem Drug Use

Scotland has a long-standing and serious drug problem. In 2008, the Scottish Government published ‘The Road to Recovery’ [5] in recognition of the need for a renewed national approach. The dedicated efforts of many frontline workers to tackle the problem had had some success, but very significant challenges remained. The Scottish Government advised that a fresh approach was required to address fully the needs of people with problem drug use, to help them recover and rebuild their lives. Based on consensus, and informed by the best available evidence, the strategy set out a significant programme of reform to tackle Scotland's drug problem and make a contribution to the Government's overarching purpose, which is to increase sustainable economic growth while also impacting upon the health of those with drug and alcohol problems. Partner agencies, along with prisoners, families and the recovery community working together in the interests of this population are also essential to reduce not only the consequences of continued drug use but also recidivism, as outlined in the national core indicators for Alcohol and Drug Partnerships [6].

At the time of publication of this report, an estimated 59,500 people were problem drug users [7]; 40-60,000 children were affected by the drug problem of one or more parent [5]; and in August 2015, 613 drug related deaths were reported by National Records Scotland (NRS) [8]. This has a significant impact on individuals, families and society, with an estimated economic and social cost of £3.5 billion per annum [9]. Drug use is a major factor in offending with Addictions Prevalence Testing (APT) on reception at prison indicating 70% of those tested in 2014/15 were positive for illegal drugs. The main illegal drugs detected were: benzodiazepines (46%), cannabis (42%), opiates (26%), cocaine (11%), methadone (9%) and buprenorphine (7%) [10]. It is anecdotally reported that steroids, particularly anabolic androgenic, are subject to misuse within the prisoner population. However, there is little formal evidence on the nature and scale of the problem.

Most custodial periods are relatively short and this only gives an opportunity to reduce the harms associated with drug use through a period of stabilisation, rather than a prolonged period of sustained recovery. However, the engagement opportunity which imprisonment provides can be used to maintain or initiate treatment, which is consistent with community-based approaches [11].

In 2014, NHS Health Scotland also published an Outcomes Framework for Problem Drug Use in Scotland [12] aligned to the four pillars (Prevention, Enforcement, Families and Recovery) and the strategic priorities in *The Road to Recovery* and building on the ADP Outcomes Toolkit (2009). This strategic outcomes logic model has mapped the agreed ADP Core Outcomes in order to demonstrate their role in contributing to the delivery of the national strategy and national high-level outcomes defined in the National Performance Framework. The premise is to tackle problem drug use by fully addressing the needs of people affected. Based on the concept of recovery, the policy sets out a programme of reform in the way that drug services are planned, commissioned and delivered to support people with problem drug use, to help them recover and rebuild their lives. Informed by the widely accepted association between deprivation and vulnerability
to problem drug use, the outcomes framework is based on the principle of proportionate universalism.

This concept has been defined in a recent briefing by NHS Health Scotland as: ‘resourcing and delivering universal services at a scale and intensity proportionate to the degree of need. Thus services are universally available and not only for the most disadvantaged, and are able to respond to the level of presenting need’. It is intended that the framework provides a planning resource for the design and delivery of services based on local assessments that determine the level and extent of needs of different groups to inform a targeted approach.

The Outcomes Framework for Problem Drug Use includes a specific nested model focused on enforcement, although all four nested models are useful in collating best evidence of effectiveness and as planning tools for improved outcome focus and impact. It also provides evidence and rationale for enforcement outcomes within the logic model provided in the framework which focuses on:

- community engagement and assets-based approaches
- integrated recovery-oriented services
- therapeutic services and diversion from prosecution
- holistic, whole-systems approach for person-centred care and management of offenders, and
- staff training and workforce development.

2.2 New (Novel) Psychoactive Substances

New Psychoactive Substances (NPS) are an emerging issue of critical concern to NHS Boards in delivery of emergency services and harm reduction approaches, to Alcohol and Drug Partnerships within communities and to services and security within prisons. The National Records of Scotland’s publication of Drug Related Deaths (2014) [8] showed there were 613 drug related deaths registered in Scotland, 86 more than in 2013. The number of deaths where NPS was present in the body has increased from 4 in 2009 (when the first Scottish deaths involving NPS were registered), to 11 in 2010, 47 in 2011, 47 in 2012, 113 in 2013 and 114 in 2014. NPS were implicated in 62 of the 114 deaths, and were the only substances present in 7 out of that 114.

Following an evidence review by Scottish Government Justice Analytical Services Division published in August 2014 [13], an Expert Review Group was convened to review the powers which are currently available in Scotland to tackle the sale and supply of NPS. The group split into three subgroups to look in more detail at Planning and Licensing, Consumer Protection and Trading Standards, and Criminal and Civil Law. It published its report on 26 February 2015 which was announced and debated in the Scottish Parliament [14], making six overarching recommendations [15]. These included developing a specific NPS definition that can be adopted across all areas of Scotland, the development of a national centre of excellence in detection and analysis of these substances, and agreement of information-sharing protocols. Other recommendations related to engaging with licensing authorities and ensuring that conditions and restrictions are attached when issuing public entertainment licences, developing a toolkit and operational guidance in association with partners to assist frontline trading standards...
staff in tackling NPS, and working in partnership with the Home Office work to develop new legislation on NPS. The Minister for Community Safety and Legal Affairs also announced his intention to establish and chair a Ministerial cross-party group to oversee the responses to NPS.

The Home Office New Psychoactive Substances Review: Report of the Expert Panel [16] was published on 30 October 2014 and, following one of the recommendations made by the Expert Review Group report, the Scottish Government is working closely with the Home Office on the detail of how legislation can work in the best interests of Scotland, and to ensure that those with an interest are engaged in its implementation. The Psychoactive Substances Bill [17] was published on 29 May 2015 and subject to parliamentary approval, it is anticipated that it will be implemented in April 2016.

There are challenges in responding to the emergence of NPS not least that evidence on the harms of NPS use is limited. However, there are indications that NPS can cause a range of physical and psychological symptoms, ranging from cardiovascular problems and seizures to psychological disorders such as anxiety, agitation, memory loss, depression and psychosis. These health risks vary depending on the manner and method of NPS consumed. There is very limited evidence available on the best means to manage NPS-related health issues within prisons, although some recent concerns have been voiced by the Prison Ombudsman for England and Wales regarding a potential link to fatal incidents in prison [18]. A working group of the NPHN is currently focusing on this issue and will be developing a series of recommendations by the end of 2015.

The Scottish Government is also in the process of commissioning further research to address some of the most important gaps in knowledge about NPS use in Scotland. The aim of the research is to provide data on the use, motivations and harms of NPS amongst a range of vulnerable groups, including vulnerable young people, injecting drug users, men who have sex with men, homeless adults and those in contact with mental health services. It is expected that the findings will be available in May 2016. NPS is an emerging issue in Scottish prisons. According to the 2013 Prisoner Survey almost a quarter of prisoners (23%) stated they had used legal highs before going into prison, with 8% stating they had used legal highs in prison [19].

2.3 Problematic Alcohol Use

Problematic alcohol use is a major public health problem in Scotland and the relationship between alcohol and crime, in particular violent crime, is strong. Just under half (45%) of Scottish prisoners report being drunk at the time of their offence [19]. Over half (59%) of victims of violent crime thought that the offender was under the influence of alcohol [20]. Nearly two fifths (32/83) of those accused of homicide in Scotland in 2013 were either drunk (30) or drunk and on drugs [21]. Nearly 70% of assaults in A&E are alcohol-related [22]. The consequences of alcohol-related crime affect individuals, their families, as well as the health and emergency services and wider society with costs of over £3.6 billion annually [23].

Nearly three quarters (73%) of prisoners have an Alcohol Use Disorder (AUD) with over one third (36%) likely alcohol dependent [24]. It should be noted that not all alcohol problems in prisoners are necessarily linked to their offending behaviour. Men who have
been imprisoned in Scotland were nearly three times (2.9) more likely to die an alcohol-related death with figures for women being nearly tenfold (9.3) [25]. As highlighted before, the prison setting provides an opportunity to detect, intervene and signpost into treatment those who are otherwise ‘hard to reach’. Although there is some evidence that prisoners may be unwilling to admit to having an alcohol problem [26], others are so, with 2 in 5 (415) of prisoners saying if they were offered help for their alcohol problem in prison, they would take it. Treating alcohol problems in prisoners not only has the potential to contribute to tackling health inequalities (prisoners are predominately from disadvantaged areas [27] which disproportionately suffer from alcohol-related harm [28]). There is no known prevalence of alcohol-related brain damage (ARBD) in Scottish prisons.

The Scottish Government, in its Action Plan Better Health, Better Care (2007) [29], had acknowledged the importance of alcohol problems in Scotland and outlined the need to improve prison health services, not only to tackle health inequalities, but also to consider what more could be done to ensure continuity of care during the transition between prison and the community. In addition their Ministerial task force report on health inequalities, Equally Well (2008), identified offenders as one of a number of particular groups in need of targeted interventions to address alcohol misuse.

The national alcohol strategy, Changing Scotland’s Relationship with Alcohol: A Framework for Action (2009) [30], outlined the Scottish Government’s commitment to work with partners to encourage the development of integrated care pathways for offenders and information sharing to ensure they receive continuity of alcohol support and treatment both in custody and in the community. Ensuring a person-centred, outcomes-focused approach to service delivery is one of the core ambitions of the Health Quality Strategy for Scotland (2010) [31]. The Quality Alcohol Treatment & Support (QATS) report [32], published in 2011, details a range of recommendations for improvements in alcohol service delivery and continues to inform access, outcomes and quality. Local Alcohol and Drug Partnerships (ADPs) lead on assessing need and commissioning alcohol and drug services. The ADP outcome on Community Safety (Communities and individuals are safe from alcohol and drug related offending and anti-social behaviour) recognises that addressing offender alcohol problems can contribute to this.

2.4 Tobacco Use

Smoking still remains the greatest cause of preventable death in Scotland with around 13,000 smoking-related deaths every year. The Scottish Government’s tobacco control strategy, Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland (2013) [33] outlines the importance of reducing health inequalities and the role and contribution that reducing smoking rates in the most deprived communities can make to this. This is reflected in the Scottish Government’s recent Health Improvement (HEAT) target for smoking cessation services, which since 2011 has had an increasing focus on successful quit outcomes by smokers living in their NHS Board’s SIMD 1 & 2 areas (or SIMD 1, 2 and 3 for island Boards). The 2015/16 Local Delivery Plan standard performance target (replacing the HEAT target) will now include all quits from prisoners. The inclusion of prisoners’ successful quit outcomes within the target emphasises the increased priority of this group, which is also highlighted in the Review of NHS smoking
cessation services (June 2014) [34]. Data in relation to smoking cessation quit attempts and outcomes is entered into the national smoking cessation database, managed and reported on by ISD.

Rates of smoking in prisons are extremely high. This has been consistently reported in the Scottish Prison Service (SPS) biannual surveys, with the 2013 survey reporting that 74% of prisoners smoked [19]. This contrasts with a prevalence rate of around 20% in Scotland as a whole, although this varies depending on social status with an average smoking rate of 35% in the most deprived communities². The more times an offender appears in custody, the more likely they are to smoke: 60% smoke who have never previously appeared in custody; 74% 1-5 times; 86% 6-10 times; 89% >10 times [19]. However, three out of five smokers surveyed expressed a desire to give up smoking (60%) [19].

The prison setting offers the opportunity to engage with hard-to-reach smokers and presents a location and time for smokers to access smoking cessation support. Successfully quitting smoking can result in a sense of positive achievement of a goal, and improved health outcomes for the prisoner, their families and the wider community [35]. The dangers of second-hand smoke are widely recognised and thereby the importance of smoke-free environments, particularly working within a smoke-free environment, is acknowledged as important to the health and welfare of staff and prisoners. This is core to the Healthy Working Lives (HWL) Award and is set out in the Scottish Government’s tobacco control strategy which contains ambitious aspirations for a smoke-free Scotland stating that:

“In line with developments across Scotland, creating a smoke-free prison service should be seen as a key step on our journey to creating a smoke-free Scotland.” [33]

In order to achieve this, the strategy identifies a joint action for Scottish Government, NHS Boards and SPS to agree a plan that sets out how smoke-free prison facilities will be delivered. An SPS chaired multi-agency strategic group is driving this plan and will deliver an options paper to Ministers early in 2016. The report of the Ministerial Group on Offender Reintegration recognises the work being undertaken to deliver the ambition of the tobacco control strategy for Scotland to achieve smoke-free prison facilities (see Appendix 4). Having a high quality and consistent national smoking cessation service on offer to all prisoners in Scotland is fundamental to progressing with these plans and NHS Health Scotland published a new prison smoking cessation service specification for use by all NHS Boards in June 2015. This was developed through a subgroup of the NHS Boards’ Smoking Cessation Co-ordinators’ Group.

3 Current Practice

This section draws together findings from a national stakeholder event held in June 2014; a stocktake (from a NHS perspective) of substance misuse services across the prison estate conducted by the NPHN which took place in summer 2014; a review of health record keeping by prison healthcare teams; and various data from national reporting (reports can be provided on request).

At the stakeholder event and at a subsequent event for the National Prison Health Improvement Group in December 2014, key work was showcased and while not claiming to be entirely representative of practice across the prison estate, has pointed to some examples of promising practice.

*Naloxone Ambassadors* – Peer Support in Overdose Prevention, HMP Addiewell

Lynne Wallace, Unit Manager at this establishment, presented on rapid progress in developing peer support capacity and improved supply of Take Home Naloxone (THN) on liberation from prison. Access to this service was through self-referral via the addictions team, an appointment with either a team member or a peer and training on naloxone along with provision of a THN kit in their personal belongings for liberation.

The establishment has three Naloxone Ambassadors who provide both an overview role in induction for new admissions and are engaged in the ‘Librite’ process (a package of assistance delivered at liberation). Over a period of a few months, 19 prisoners had been peer trained and an increase in supply of THN had been achieved to contribute towards the 25% target for prisons. The Ambassadors were also involved in delivering a local naloxone masterclass session to prison and community-based social work staff and training was being offered to prisoner’s families and friends to increase awareness and potentially extend naloxone supply and reach.

*Contact:* Lynne Wallace, HMP Addiewell Unit Manager, [Lynne.Wallace@sodexojusticeservices.com](mailto:Lynne.Wallace@sodexojusticeservices.com)
Alcohol Interventions Delivery in Prison Establishments – HMP Inverness

A survey of 75% of prisoners, published in May 2014 showed 59% were drunk at the time of their offence. All prisoners receive alcohol screening, medical assessment, core screen, review of nature of offence/ social work reports and appropriate referral. An approved activity alcohol awareness programme (22hrs) is run, co-facilitated by NHS and social work partners – target is 24 completed programmes per year. This includes behaviour change, health education, and relapse prevention in a structured approach. Liaison with Highland Criminal Justice Social Work provides 1:1 support for prisoners and prepares links to community interventions, three staff regularly link into the prison. An AA recovery group run by local volunteers meets twice per week in the establishment.

HMP Inverness have a ‘Lifeskills’ Officer in post who assesses the day to day skills that prisoners possess and runs various activities to close skills gaps. Examples being delivered include employability skills, budgeting, basic and healthy cooking, tenancy skills, driving skills and basic housekeeping. The courses continue to develop and evolve as new needs are identified.

In addition, HMP Inverness has two Throughcare Support Officers who make links to throughcare services in the community, provide support for tenancies pre and post-liberation and liaise with health and social work services on parenting and families. The goal is for improved communications and feedback on service improvement, collaborative work prior to liberation and follow-up in the community, to achieve better allocation of cases and learn and analyse what works. The two staff spend a large part of their time in the community with ex-offenders acting as coach, mentor, role model and advocate, signposting and linking them to appropriate community services.

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Following a 2012 local needs assessment showing high demand but low levels of access, smoking cessation services were improved to achieve consistency with community practice. A number of practical barriers and issues were overcome through dedicating a local lead role for tobacco, optimising use of group work to incorporate assessment and product distribution, and introducing a waiting list management tool.

Innovations to the service have included moving to rolling groups, piloting cut down to quit and drop in group for remand prisoners. Service improvement also focused on the use of incentives and resources such as quizzes, supply of fruit, oral health packs and extra PT sessions from quit week, to reduce stress and boredom. Across the three establishments (Barlinnie, Low Moss and Greenock), an overall quit rate of 25% was achieved (240 individuals with 211 achieving quit). Attention was also focused on transfer, liberation and throughcare to ensure consistency, follow-up and ongoing supply or products where required.

Other key aspects of success reflected upon included: a clear branding and identity of the service, consistent delivery, co-ordination within and across services and establishments, community links and staff health improvement.

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3.1 Admission Process/Problem Identification/Screening

All prisons operate a similar admission process. A nurse carries out a brief assessment at reception (within a few hours). This assessment identifies clinical risk such as risk of withdrawal (from drugs or alcohol), smoking status, medication requirements and suicide risk. All prisoners will have a further medical assessment by a doctor within 24 hours of arrival.

Although some prisons (8) use a validated screening tool for alcohol, such as FAST or AUDIT, this is not universal. Those who self-identify with drug problems undergo urine testing. Only two prisons use a validated screening tool for drugs (DAST/COWS). There is no formal screening for ARBD in Scottish prisons. There was no mention of the use of a clinical assessment tool for withdrawal (such as CIWA). Limited psychological screening was reported. There was agreement that problem identification/screening should also take place beyond reception and that management goes beyond detoxification to include maintenance and initiation of ORT, alcohol and smoking cessation services.

In 2013, 46% of prisoners self-reported that they had been assessed for drug use on admission, a 10% drop from 2011. Only a third (33%) of prisoners reported that they had been assessed for alcohol problems on admission, a fall from 37% in 2011 [19].

All prisons reported limited information sharing from the police custody or court settings and a minority reported difficulties when admitting a prisoner from another prison (a
'transfer'). These information-sharing challenges from the community to custody can delay safe guarding vulnerable individuals and prescribing of necessary medications for Opiate Replacement Therapy and alcohol treatment.

3.2 Service Access

Access to NHS specialist drug and alcohol treatment services in prison has been reported nationally as part of the drug and alcohol treatment waiting times HEAT (A11) target (now Local Delivery Plan Standard) to ensure that 90% of people receive appropriate treatment within 3 weeks of referral. From April 2014 to March 2015, at national level, 95.7% of prisoners received treatment within 3 weeks of referral, although some prisons fell below the national target of 90% and there continue to be some issues around data quality and compliance. This figure was 94.6% from January to March 2015. Further breakdown can be found in national reports [36]. There were reports of limited access to psychological therapies (prisons have been outwith the national HEAT target for waiting times for these), consultant psychiatry, mental health beds and to Allied Health Professionals.

3.3 Models of Care

At the time of the stocktake (summer 2014), most prison healthcare services had a defined model of care in place or were in the process of developing one. Many were being aligned to the wider NHS Board model and were to be needs led and person centred with interventions from harm reduction to recovery. Only one prison at that time (HMP Kilmarnock) reported following a wholly recovery-based model (the need to go ‘beyond health’, for example support for visits; purposeful activity in prison; and housing and employment post release), although other recovery model examples were mentioned at the stakeholder event. Peer support/education was being implemented in some areas. A 2015 informal review by SPS of peer support and mentorship activity across the prison estate has also captured a range of local arrangements with direct relevance to harm reduction (as described above in HMP Addiewell) and active promotion of recovery, for example particularly in HMP Perth. These provide good opportunities and infrastructure to enable successful management of alcohol and drug issues within prison and strengthen release planning and community links on liberation. The importance of person-centred care and user voices were also being recognised. Some areas gave examples of care pathways that had been developed which included community service in-reach and cross working with other services, for example police custody.

Challenges to effective models were identified such as lack of staff capacity and the high prisoner population and throughput ('churn'). One of the biggest barriers identified was the prison itself, both the environment (such as lack of appropriate space/facilities) and the regime (at times, the prioritisation of the establishment needs over the prisoner healthcare needs); the net result having neither the time nor space to meet demand. This is an example of the sort of issues which may be tackled locally through deployment of the Scottish Government’s Health & Justice Improvement Resource (Game) – see Section 4.3.2.3.

Health improvement in prisons is delivered through the Better Health Better Lives framework [3], which was developed in partnership with the NHS and launched in 2012.
The framework advocates the use of a whole prison approach to deliver improved health and wellbeing outcomes for prisoners, families and staff. Such an approach involves all aspects of the prison which touch on the wider determinants of health (such as education, and life-skills) while also addressing prisoners’ health needs through health promotion, health education, patient education and prevention.

The Better Health Better Lives framework supports national policy in a range of areas that affect health and wellbeing in prison such as problem drug use, tobacco use, alcohol problems and mental wellbeing. The importance of prisoner involvement in both the planning and delivery of action to improve health and wellbeing is recognised and promising practice is being shown here in various prisons across a number of areas, including peer support in Recovery Oriented Systems of Care and naloxone awareness. The opportunity for prisoners to be involved in the identification, planning and delivery of improved health and wellbeing outcomes is being further developed.

A National Prison Health and Wellbeing Group provides strategic support and direction to the implementation of the framework and this is chaired by a Governor in Charge with membership from key stakeholders. This includes representation from the NPHN, NHS Health Scotland and local NHS Boards and SPS staff from other relevant areas, including SPS College and a Trade Union representative. Multi-agency local health improvement groups should eventually support operational delivery across all establishments.

3.4 Interventions Delivered

3.4.1 Problem Drug Use

All prisons (15) reported providing prescribing for management of detoxification and on occasion initiation of ORT, maintenance prescribing, naloxone group training/provision on release and 1:1 support. Nearly all (12) prisons provided a harm reduction group. Seven prisons reported providing a harm reduction pack and two specifically needle exchange packs (issued on liberation). There was little evidence of peer support in prisons. Inconsistency of service delivery across the estate for drugs (in particular Opiate Substitution Therapy) was noted at the stakeholder event.

In 2013, a third (33%) of prisoners with drug problems said they had been given the chance to receive help or treatment for their drug problem, a fall of 8% since 2011, with 28% having received help/treatment, also having fallen by 8% from 2011 [19].

In 2013/14, there were 4,258 completed waits for specialist drug treatment services in prison (in 2014/15 this figure fell to 3,303)[36]. Assuming 20,000 people come into prison annually and 70% are positive for illegal drugs this would represent about 1 in 4 of those eligible entering into treatment. A point prevalence audit in 2014 showed over 22% of the prison population were on Opiate Substitution Therapy. In 2013/14, there were 1,077 naloxone kits issued in prisons compared with 746 the previous year, an increase of 44% [37].

3.4.2 Alcohol Problems

All prisons (15) reported providing prescribing for management of detoxification and 1:1 support. The next most frequent interventions reported were motivational interviewing.

(9); alcohol awareness/education (9) and relapse prevention group work (8) and Alcohol Brief Interventions (ABIs) (9). ABIs can be delivered in the prison setting as part of the national ABI Local Delivery Plan Standard for 2015/16 for wider settings. The national ABI report does not cite separate figures for delivery in prisons. Peer support was reported as available in only 4 prisons. Three prisons reported Cognitive Behaviour Therapy delivery.

Of those with alcohol problems, 31% reported being given the chance to receive help or treatment for their alcohol problem, a fall from 35% since 2011 with 1 in 5 (20%) having received help or treatment (23% in 2011) [19].

In 2013/14, there were 1,529 completed waits for specialist alcohol treatment services in prison (this figure fell to 1,340 in 2014/15)[36]. Assuming approximately 20,000 individuals come into prison annually and 36% of these are alcohol dependent, this would represent about 1 in 5 of those eligible entering specialist treatment) [24].

3.4.3 Tobacco Control

All prisons (15) were providing NRT, but a small number of NHS Boards do not have a dedicated prison smoking cessation service. As from April 2015, successful prison quits at 3-month follow-up has been included in the HEAT target for smoking cessation. The national report on smoking cessation published on 30 June 2015 includes reporting from prison services for the first time [38].

3.5 Needs Assessment/Healthcare Record keeping/Information Sharing

Generally, there had not been any needs assessment in the preceding year to the stocktake, although some NHS Boards had conducted them on or around the time of healthcare transfer in 2011 (for example, NHS Greater Glasgow and Clyde). Variation in healthcare recording practices were identified both in the stocktake and a review of healthcare record keeping, the latter also carried out by the National Prisoner Healthcare Network in 2014 (data not shown). Increased administrative time in entering the same information into both prison and health records was raised.

3.6 Staff Capacity/Competence

Specifically mentioned was lack of access to consultant psychiatrists (general and/or addiction) and to Allied Health Professionals. The high prevalence of substance misuse problems in prisoners was identified at the stakeholder event and it was raised that there was not enough staff to meet demand or provide a dedicated addiction service. See also Section 4.3.1.5: Staff Capacity & Competence.

The ambition of smoke-free prisons will require an increase in the capacity of NHS smoking cessation services to support the introduction of smoke-free policies.

3.7 Quality Improvement

Several NHS Boards had been utilising the interim quality indicators developed by the NPHN for regular or semi-regular reporting. There were no national Quality Outcome Indicators or national reporting to allow benchmarking between prisons and NHS Boards. A need for clearer outcomes was one view expressed at the stakeholder event.
This area has progressed since the introduction of the Scottish Government’s National Quality Principles: Standard Expectations of Care for drug and alcohol services (August, 2014) and development of a validated Recovery Outcomes Web tool is being piloted at the time of report writing. See Section 4.3: Measuring Quality, Assuring Delivery.

(The Report on Validated Recovery Outcomes Web Tool Pilot is available in October 2015.)

The NHS Health Scotland prison smoking cessation service specification includes key performance measures for NHS Boards to monitor their progress and appraise the quality of service offered to prisoners who smoke. These are included in Section 4.3.1.3.

3.8 Throughcare

The challenge for continuity of care beyond release was raised both in the stocktake and stakeholder event. The lapse of GP registration was seen as a particular issue, especially for continuity of medication provision. Drug related deaths (DRDs) immediately post prison release are a well-known risk, although overall mortality is also raised [39]. There were suggestions for local post release DRD audits as well as the need for awareness of local services for referral. Some areas reported instigating community health planning pre-release. Some of the new models of care mentioned above were implementing throughcare support officers\(^3\), either community based or prison service staff.

Following the stakeholder event, national web-based directories of alcohol, drug and recovery services were circulated to all participants, having been identified as a need – see Appendix 4.

\(^3\) Throughcare Support Officers will support offenders on their journey into desistance by working with them to prepare for and successfully make the transition from custody to community
4  Best Practice

4.1 Common Elements of Good Practice in Substance Use interventions

Ascertaining the effectiveness of substance misuse interventions in prison settings is difficult because the evidence base in criminal justice settings is relatively limited. The best available evidence suggests that treatment for drug problems in these situations should be using the appropriate substitute drug and maintaining this for a prolonged period, often at least 2 years [11]. Treatment should often continue, therefore, until and after discharge from custody with no interruption. Treatment for drug use should be seamlessly available during the transition and throughcare periods. Buprenorphine should be available as an alternative to methadone where appropriate [40, 41, 42]. Maximising the use of this opportunity to treat and engage with offenders further provides an effective, evidence-informed approach to reduce drug related deaths. Equally, for treatment of alcohol problems, the wider evidence base on effective interventions for general community-based populations (for example, Raistrick, Heather and Godfrey, 2006) [43] may be necessary to draw from.

The following section should not be taken as comprehensive, but more illustrative of the principles that would be important to consider when developing local substance misuse care pathways (SMCPs) and models of care for prison use. While this section will be presenting ideal scenarios there is a recognition that what is best practice for a local setting will need to be determined by a range of stakeholders in each context. It is also recognised that models of care developed will require to be sensitive to differing needs of prisoners based on, for example, sentence length, gender and co-morbidities.

4.1.1 Access, Screening, Triage and Assessment

An important aspect of the quality of services is that they should be accessible. This is reflected in Government targets (now Local Delivery Plan standards) for access to treatment for specialist drug and alcohol services (90% of people should wait no longer than 3 weeks).

Screening, particularly with a validated tool, enhances the detection of those with substance misuse problems and so the chance of engaging them in treatment. For alcohol problems, screening can be followed by an ABI where appropriate. Screening and treatment for ARBD will be addressed in a future report of the Acquired Brain Injury Workstream of the NPHN.

Triage assessment is a fuller assessment of substance misuse problems and aims to determine the seriousness and urgency of a person’s problems, including risk factors, and the most appropriate type of intervention. It also aims to assess a person’s motivation to engage in treatment.

Comprehensive assessment is targeted at those with more complex needs and those who may require structured treatment interventions determining the exact nature of the problem, other substance use problems, co-existing mental and physical health problems, social functioning, offending and legal problems, and a full risk assessment. Comprehensive assessment may need to be undertaken by different members of a multidisciplinary team and is best viewed as an ongoing process rather than a single
event (NTASM/DH, 2006) [44]. The development of a care plan would usually result from this assessment, but initial care plans can also be put in place after triage assessment. Assessing risk is an integral part of screening, triage and comprehensive assessment. Regular reviews as part of the national quality principles and recovery outcome measurements will also help to identify those prisoners who have relapsed or developed dependency for drugs, alcohol or tobacco during custody. These individuals may require initiation onto ORT, alcohol or smoking cessation.

An example of good practice in information sharing at the point of access has been developed in Glasgow courts where, due to time pressures in producing court reports intended to accompany individuals in their transfer to prison, an electronic information-sharing procedure was implemented with read receipts requested from prison staff to ensure safe and timely delivery of reports. This change sought to improve Act 2 Care and medication continuation.

4.1.2 The Stages of Change Model

The Stages of Change model is also discussed in Raistrick and colleagues’ review [43] as having ‘strong face validity’ as a rational approach to intervention. The Stages of Change model proposes that there are four main stages that a person will go through in relation to health-related behaviour change: pre-contemplation (including relapse), contemplation (including determination), action and maintenance (Prochaska and DiClemente, 1984) [45]. Two Readiness to Change Questionnaires have been developed from the Stages of Change model which can assist in assigning service users to the appropriate stages of change and both are widely used (Raistrick, Heather and Godfrey, 2006). Readiness to change was one of the strongest predictors of outcomes in Project Match (Babor and Del Boca, 2003) [46].

4.1.3 People with Needs in addition to Substance Misuse

Raistrick et al [43] describe this issue as drinkers with complicated needs and include people with mental health problems, co-occurring other substance use, and groups that may need social consideration based on gender, age, disability and homelessness. Given that co-morbidity of problem drinking and mental health problems is common, the authors suggest that mental health and addictions teams need to be competent in delivering integrated treatment. That said, two reports, Mind the Gaps (SACDM and SACAM, 2003) [47] and Closing the Gaps (Scottish Government, 2007b) [48], have drawn attention to evidence that those with complex needs could be better served by existing mental health or substance misuse services.

Given the known co-morbidity between mental health and substance use problems more broadly in prisoners (see Singleton, Meltzer, Gatward et al. 1998) [49], attention should be paid to ensuring that the chosen model of care provides for prisoners with intersecting health problems. There is insufficient evidence in Raistrick, Heather and Godfrey’s (2006) [43] review to support any particular model of integrated treatment for co-morbidity. However, there is theoretical and anecdotal evidence to favour an integrated or shared care approach. What is clear is the need to ensure that people with co-occurring health problems are not excluded from treatment.
Mental health problems and dual dependencies have to be recognised as ongoing problems and treated with a view to longer term outcomes rather than short term goals. For those with an opiate problems identified for the first time on reception, a suitable opiate replacement therapy should be available with the usual supporting framework. Naloxone should also be made available to all those leaving these settings at risk of opiate overdose [50].

4.1.4 Goal Setting

For problematic alcohol use, acceptance of an individual’s preference regarding the drinking goal (for example, abstinence or moderation) is likely to result in a more successful outcome. It is suggested that the moderation goal should be reserved for service users with less severe problems such as those identified as hazardous and harmful drinkers [43]. One advantage of recommending a moderation goal is to attract people to access alcohol interventions who may be deterred by a focus on abstinence. Generally, unless moderation is contraindicated due to medical problems which relate to alcohol dependence or because of circumstances such as pregnancy, specific drinking targets should be negotiated with each individual and carried forward into an agreed plan.

This provides a reminder that alcohol interventions must be connected to areas of life alongside a person’s drinking when planning and evaluating treatment. The targeting of physical health, vocational ambitions, social networks and friendships, living arrangements, offending behaviour and other substance use, for example, should be included in treatment plans in an integrated way.

In drug use management and reduction, as with alcohol use, Recovery Plans are an essential element of moving forward along a recovery journey. Recovery Plans as described in the National Quality Principles [51] (Scottish Government, 2014) should be person-centred and support those dependent on alcohol and/or drugs irrespective of their stage of recovery to plan holistic goals and move forward at their own pace. A range of treatment, care and recovery interventions should be put in place based on individuals’ beliefs, values and motivation to support their recovery journeys and should continue through custody and on returning to the community via a seamless process, ensuring goals and progress are maintained on liberation from prison. As with alcohol, relapse among the drug using prison population is part of Prochaska & DeClemente’s (1984) [45] cycle of change and can support continued learning, reflection and ultimately achieving overall wellbeing and long term recovery goals.

For tobacco control, there is no level of safe smoking, so smoking cessation is the best way to improve the health of a smoker. It is important to assess the prisoners’ needs and commitment to quit when they are first referred to the service. The most effective way of quitting is to use an appropriate pharmacotherapy together either group or 1:1 behavioural support. However, for many long term and heavy smokers, abrupt smoking cessation may be too challenging or unachievable. To help them achieve their goals it may be helpful to use a harm reduction approach, offering either behavioural support or pharmacotherapy to help the smoker make a short-term reduction in their smoking levels (cutting down to quit) in advance of making their quit attempt. It is also important to remember that prisoners making a quit attempt have many barriers to overcome and should be supported by any practical measures possible, such as being automatically
re-located to a non-smoking cell and ensuring there are appropriate diversionary activities to overcome boredom, stress and any craving for nicotine.

4.1.5 Service User Participation and Choice

Service users should be involved in choosing the form of treatment or interventions they receive for a range of reasons, including improving the prospects of successful outcomes [52]. Therefore, they need to be provided with accurate, objective descriptions of the available options in a form that they can understand. This has implications for prisoner populations who have greater literacy issues than the general population [53]. Individuals, including those in prisons, can be involved in a range of decisions regarding taking action to address alcohol or drug-related problems such as one-to-one versus group interventions, alcohol/drug-focused versus non-alcohol/drug-focused, low versus high intensity treatment and motivationally versus socially-based treatment. While local circumstances will almost always vary the likely options available, the principle of self-matching and individual choice should still be carried through a model of care to inform treatment planning and delivery.

Effective community examples exist for service user participation in substance use employing various methods, such as focus groups, peer research, online and peer advice working groups and service user membership within existing working groups. Organisations, such as the Scottish Drugs Forum, which has expertise in this area, may be able to provide consultancy and operational support [54].

One example of service user participation in the prison setting was provided by the Scottish Drugs Forum’s Big Lottery funded National Quality Development Programme, which now also has Scottish Government funding. The National Quality Development Team in 2012 consulted with health staff and individuals in prison custody on the quality of the treatment and care provision in the prison setting. On the basis of this, quality reports and follow-up input were provided to health leads for these prisons to improve treatment and care in prison custody.

4.1.6 Involvement of Families and Carers in Care and Treatment

Family members and close friends of people with drinking problems can be helpful in engaging the person in interventions and treatment and bringing about more favourable outcomes of treatment (Epstein and McCrady, 1998) [55]. The social environment, including social networks and families, needs to be considered central rather than purely focusing on the individual. Interventions that centrally include families can be important in their own right. This is closely connected to the point above on paying greater attention to a broader set of positive outcomes from treatment, in addition to reductions in alcohol use and reductions or abstinence in drug use, including effects on families and the wider social context. Natural recovery is a term used to describe recovery that is not dependent on formal treatment input and which is often mediated through mutual aid groups, peer support, family and friendships. While these issues have been considered to be important aspects of treatment, it is recognised that in the context of people in prison, the potential for including such approaches may be limited or not feasible. This is supported in the Scottish Government’s Quality Principles (2014) [51] where family inclusive
therapy is encouraged where possible. In the prison setting, family involvement not only helps occupying time whilst in custody but also aids individual recovery, reduces reoffending and supports families and children separated in the community.

For smoking cessation, there is evidence of the benefit of encouraging friends and family also to stop smoking at the same time to support the prisoner making the quit attempt. This can also help to create a smoke-free home, particularly when focused on protecting children from the harms of second-hand smoke and the benefits of growing up in a smoke-free environment.

4.1.7 Recovery

Recovery has been defined as: ‘voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society’ (UKDCP, 2008: 6) [56]. According to Malloch and Yates (2010) ([57], while recovery has ‘always been implicated, either centrally or on the periphery, of interventions in the drug and alcohol field, it has only recently been embraced by government as a key policy focus and placed at the forefront of policy documents’ (Malloch and Yates, 2010: 9).

In relation to recovery and recent policy, the Essential Care report (SACDM Integrated Care Project Group, 2008) [58] identified support services that would maximise opportunity for recovery for those with substance misuse problems and incorporated the principles set out in the national drug strategy, The Road to Recovery: A new approach to tackling Scotland’s drug problem (Scottish Government, 2008e) [5]. This strategy suggested that moving to an approach based on recovery would mean a significant change in both the pattern of services that are commissioned and in the way that practitioners engage with individuals. While this strategy placed drugs at the forefront of analysis, the stronger emphasis on outcomes and recovery, rather than treatment as the end goal, is also centrally relevant to discussions on the goals of alcohol-specific interventions. In terms of alcohol, the Scottish Ministerial Advisory Committee on Alcohol Problems (SMACAP) [59] commissioned the Essential Services Group to detail what range of alcohol treatment and support services is essential for local areas, what principles should underlie them and make recommendations for future development.

Recovery is the process through which an individual is enabled to move on from their problem drug use towards a drug-free life and become an active and contributing member of society [60]. However, progressing in recovery can include ceased sharing of injection equipment, reduced use of substances, stability through maintenance therapies, safer use of drugs, alcohol and tobacco as well as abstinence. Moving to an approach that is based on recovery will mean a significant change in both the pattern of services that are commissioned and in the way that practitioners engage with individuals [56, 61]. The strategy sets in train a number of actions to turn recovery into a reality. Core to this is the reform of the way that drug services are planned, commissioned and delivered to place a stronger emphasis on outcomes [62] and on recovery.

In practice, people can best be empowered to recover through the establishment of a Recovery-Oriented System of Care (ROSC). The underlying philosophy of an ROSC is that treatment, review and aftercare are integrated and priority is given to empowering people to sustain their recovery.
Distinguishing features of an ROSC include:

- being person-centred
- being inclusive of family and significant others
- keeping people safe and free from harm
- services that are connected to the community, and
- services that are trauma-informed and the provision of individualised and comprehensive services – such as housing, employability and education.

At its centre it has strength-based assessments, which take account of individuals’ recovery capital, and integrated interventions and services that are responsive to a person’s needs and beliefs. There is a commitment to peer recovery support services, and most importantly, it is inclusive of the voices and experiences of people, and their families, in recovery.

Numerous community examples exist for peer support with recovery cafes and networks in place and in development across Scotland. Some of these networks also have accredited training to recognise and enhance the skills of volunteers involved in running peer support networks. See Appendix 4 for the Scottish Recovery Consortium’s information on recovery communities in Scotland.

### 4.1.8 Relapse Prevention

Relapse prevention can mean a variety of different things, but usually refers to the work done with an individual post-detoxification or treatment aimed at preventing a return to harmful substance use; a treatment goal rather than a modality (although this does include interventions such as coping strategies and prescribing drugs such as acamprosate or ORT for replacement therapies). Raistrick, Heather and Godfrey (2006) [43] and Marlatt and Witkiewitz (2005) [63] note that relapse prevention principles should be incorporated into all specialist treatments for alcohol and drug problems in a variety of treatment settings and that it can improve psychosocial functioning as well as help with alcohol and drug-specific goals. For smoking cessation, transfer and throughcare are particularly important to ensure continuity of appropriate pharmacotherapy and support and also to prevent a return to smoking.

### 4.2 Prison Settings Pathways for Identification and Management of Drug, Alcohol and Tobacco Problems

Service delivery can be enhanced by the development of an integrated care pathway (ICP). The following section sets out ICPs for drugs, alcohol and tobacco respectively based on evidence-based effective interventions. Key within this process is good practice in information sharing; joint working between organisations; timely and comprehensive planning in advance of liberation as part of wider pre-liberation planning; and opportunities to support an individual’s recovery through a person centred and safe approach.
Problematic Drug Use Care Pathway

This diagram illustrates the recommended process for identifying, screening, assessing and providing health and social care interventions to address problematic drug use whilst an individual is residing in a prison establishment as part of their throughcare provision. Key within this process is good practice in information sharing, joint working between organisations, timely and comprehensive planning in advance of liberation and opportunities to support an individual’s recovery through a person-centred approach.

All admissions to prison establishment from Custody / Community / Care

Medical assessment for drug withdrawal

Confirmed as in withdrawal

Not in withdrawal

Is the prisoner already in drug treatment?

Not In Treatment

In Treatment

DAST Screening

If NEG

If POS

Self-Referral*

Prevention Information and advice

Triage: Prioritising Need, Initial Assessment, Simple Brief Interventions

Comprehensive Assessment and Care Planning & Programmes, including Liaise with SPS Staff / Information Share (Link to Tobacco and Alcohol Pathway as required)

- Extended Brief Interventions
- Evidence based group interventions
- Motivational interviewing
- Self-help/mutual aid/peer approaches
- Overdose Prevention Awareness
- Sexual Health Advice
- Purposeful Activity

Care plan dispatched to throughcare provider, client has a copy to take also.

Initiate Recovery Planning / Recovery Oriented System of Care

- Motivational enhancement
- Range of evidence based psychological therapies
- Prescribing of ORT and naltrexone
- Family Support
- Self-help/mutual aid/peer approaches
- Accredited prisoner programmes
- Therapeutic community settings
- 3 monthly reviews using Recovery Outcomes Tool

Integrated Pre-release Health Planning e.g. Referral to Community Addiction Services, GP Registration, Arrange Naloxone Supply for Liberation, Benefits Assessment, Housing support, health and social care needs, throughcare (Statutory or voluntary provision), Recovery Community & Mutual Aid, SMART Recovery

Support from gate and beyond; TCOs, Mentorship, Health & Social Care & 3rd Sector Follow-Up

All Local Protocols must be consistent with DoH Clinical Guidelines (Orange book): Drug Misuse and Dependence 2007* – Update due 2016 and NICE guidelines [CG52]

* At any point in a prisoner’s stay if they/others feel they have a drug problem and seek treatment or detox, they can enter or re-enter at assessment level.
Problematic Alcohol Use Care Pathway

This diagram (adapted from Parkes et al [24]) illustrates the recommended process for identifying, screening, assessing and providing health and social care interventions to address alcohol use whilst an individual is residing in a prison establishment as part of their throughcare provision. Key within this process is good practice in information sharing, joint working between organisations, timely and comprehensive planning in advance of liberation and opportunities to support an individual’s recovery through a person-centred approach.

All admissions to prison establishment from Custody / Community / Care

Addiction worker/ Addiction Nurse assessment for alcohol / drug withdrawal (CIWR – validated tool)

Has the prisoner been in treatment for alcohol addiction past/present?

- No
- Yes

Not in withdrawal

Initial screening using FAST Tool

Self-Referral

If NEG

If POS

Prisoner refusal

Safe management of alcohol withdrawal according to local protocols

AUDIT Score of 0-7

General awareness-raising of risks including harm

AUDIT 8+ (hazardous/harmful/dependent)

Triage** / initial assessment and prioritising need

Liaise with SPS Staff / Information Share

AUDIT 20+ mainly but not exclusively:

Comprehensive assessment and care-planning, Consider community assessment for short stay/remand (move to arrow to the right), Start Recovery Planning Process as per ROSC

Offer a range of Tier 3 and 4 evidence-based psycho-social interventions depending on prisoner need and preference (see Appendix 1)

- Motivational enhancement
- Range of evidence based psychological therapies
- Accredited prisoner programmes
- Therapeutic community settings

Consider clinical input including prescribing to support relapse prevention (e.g. Naltrexone, Acamprosate disulfiram) or other antagonist treatment and consider referral to other care pathways if appropriate e.g. Mental Health, Acquired Brain Injury and social care needs.

3 monthly reviews using RECOVERY OUTCOMES TOOL

Integrated Pre-release Health Planning e.g. Referral to Community Addiction Services, GP Registration, Housing support, Benefits Assessment, health and social care needs, throughcare (Statutory or voluntary provision), Recovery Community & Mutual Aid, SMART Recovery

Support from gate and beyond; TCOs, Mentorship, Health & Social Care & 3rd Sector Follow Up

All Local Protocols must be consistent with National Guidelines: NICE, SIGN, D o H.

*At any point in a prisoner’s stay if they/others think they have an alcohol problem they can enter or re-enter at assessment level.

** Triage is a critical part of the decision making process and includes determining the presence of other co-occurring social and health problems and the prioritisation of those that most need interventions in the context of high demand.
**Tobacco Use Care Pathway**

This diagram illustrates the recommended process for identifying, screening, assessing and providing health and social care interventions for smoking cessation whilst an individual is residing in a prison establishment as part of their throughcare provision. Key within this process is good practice in information sharing, joint working between organisations, timely and comprehensive planning in advance of liberation and opportunities to support a successful quit through a person-centred approach.

1. **Prisoners’ smoking status established at reception**
   - Non smoker
   - Non smoking cell

2. **Prisoners’ smoking status recorded on Vision by nurse using the assessment questionnaire**

3. **Is the prisoner a smoker already in treatment i.e. undertaking a quit attempt?**
   - Yes
     - Referral prioritised: continue and/or complete treatment
   - No
     - No – offer of service declined: prisoner details recorded for follow-up at a later date

4. **Follow-up with brief intervention: a smoker who wants to stop**
   - Yes
     - Assessment of the prisoner’s readiness and commitment to quit and prisoner’s referral prioritised
     - Follow-up or self-referral
   - No
     - Follow-up with brief intervention: a smoker who wants to stop

5. **Smoking Cessation Service**
   - Prescribe pharmacotherapy as per national Prison Smoking Cessation Service Specification and Intensive behavioural support for prisoners
   - Drop out
   - Successful quit

6. **Integrated Pre-release Health planning as part of ICM e.g.**
   - Referral to Smoking Cessation Services, GP Registration, health and social care needs, throughcare (Statutory or voluntary provision), Peer Support and Mentorship

7. **Transfer:**
   - To another prison
   - To hospital
   - Liberated to community – Support from gate and beyond: TCOs if provided, Peer Mentorship, TAS, The Wise Group, Positive Routes, Smokeline

**NB:** At any point in a prisoner’s stay if they feel they want to quit smoking, they can enter or re-enter at assessment level
In developing the pathways for this report, the parallels and similarities across these three distinct pathways were apparent and the wider context of an overall national throughcare pathway and work to strengthen this activity and the links to community health and justice services were noted. These could, therefore, be considered as ‘nested’ models of practice within an overarching wider national throughcare model and further work to develop this as the new health in justice landscape evolves would be most welcome to ensure a cohesive and integrated approach.

4.3 Measuring Quality, Assuring Delivery

4.3.1 Measuring Quality

4.3.1.1 The Quality Principles: Standard Expectations of Care and Support in Drug & Alcohol Services

The national Quality Principles were published by the Scottish Government in 2014 [51] and these set out standard expectations of care for drug and alcohol services users and their children. The principles outline quality measures for access, assessment, recovery plans, reviews, moving on, involving families and the needs of children.

At the time of reporting, ADPs are at initial stages of developing templates for ensuring ADP-commissioned services are meeting the Quality Principles. Simultaneously, the Scottish Government is finalising a work plan with the Care Inspectorate to validate the work of ADPs in evidencing the Quality Principles are being met within drug and alcohol services (see Appendix 2).

4.3.1.2 Measuring Recovery – Drug & Alcohol Information System and validated Recovery Outcomes Web tool

The Quality Principles set out an anticipated tool for measuring and reviewing recovery outcomes. The Scottish Government has now developed a validated and peer reviewed Recovery Outcomes Web (ROW) tool [64] which is, at time of reporting, being piloted for implementation purposes with Glasgow Addiction Services, East Renfrewshire, Aberdeenshire and Angus ADP services. The pilot’s report will be completed by Scottish Government in October 2015. The ROW tool is designed to show progress across the stages of seeking help, being assessed, starting to take action and make improvements in a range of 10 recovery outcomes such as substance use, offending, mental health and emotional wellbeing, occupying time and fulfilling goals. This tool will be embedded within the new Drug and Alcohol Information System (DAISy) [65] dataset for Scottish drug and alcohol services (which is expected to be operational in autumn 2016), producing separate reports for individuals and services on recovery outcomes. Any ADP area or prison without an outcomes tool will be requested to use the ROW tool to show progress for their service users. ADPs with a pre-existing tool are being supported to cross-reference existing outcomes measures with those of the ROW tool (see Appendix 2).

The DAISy dataset itself captures not only ROW tool information, but also existing SMR 25 A&B data entry for new referrals and reviews as part of the Scottish Drug Misuse Database (SDMD) and existing Drug and Alcohol Treatment Waiting Times Database (DATWTD) data to inform performance against the Local Delivery Plan Waiting Times
Standard [66]. DAISy will also capture information from dedicated alcohol services, which will require new reporting arrangements for services working with those affected by problem alcohol use.

4.3.1.3 Quality in Smoking Cessation Services

Smoking cessation services delivered by NHS Boards in prisons should be consistent with the specialist smoking cessation service delivered in the community, ensuring that it is person-centred and adheres to the evidence-based guidance in: A guide to smoking cessation in Scotland 2010 and the Addendum on tobacco harm reduction (2014) [67]. The guidance recommends that a specialist smoking cessation service is ‘a combination of multi-session intensive behavioural support together with pharmacotherapy.’

The national prison smoking cessation service specification published by NHS Health Scotland includes a number of recommended performance measures for NHS Boards to monitor their service performance (see Appendix 4). These are:

- prisoners’ awareness of smoking cessation service (measured through the biannual SPS survey)
- prompt access to smoking cessation service (measured by waiting times)
- uptake of smoking cessation service (measured by quit attempts)
- success of smoking cessation service (measured by percentage of carbon monoxide (CO) validated quits at 4 and 12 weeks), and
- demonstration of innovative practice, for example tests of change, partnership working, harm reduction pilots.

NHS Boards should also lead on the planning and delivery of this service specification. This includes:

- appropriate planning and management of resources (staff and budget) for delivery, including pharmacotherapy
- effective partnership working and collaboration with SPS and third sector
- providing training and support for staff
- promoting the service to ensure a high level of awareness with staff and prisoners
- reviewing and communicating local protocols to ensure effective delivery and throughcare on transfer or liberation, and
- regular review of service to ensure quality and effectiveness in line with performance measures.

4.3.1.4 Measuring for Service Improvement

In order to report on current service delivery it is necessary to have robust and timely information. Although there is a national IT system (Vision) used across the prison setting, there is no routine reporting at national level of overall prison health statistics. There is selected reporting from the prison healthcare setting to ISD national datasets such as the Drug and Alcohol Waiting Times Database, the Scottish Drug Misuse Database and the Take Home Naloxone reporting, statistics from which have been used throughout this report.
Treatment gaps are best assessed through full needs assessment. In 2007, prior to the transfer of healthcare to the NHS, a national needs assessment for health in prisoners was carried out [68]. A similar national needs assessment has not been repeated, although some have been carried out at local level [69] or on specific topics (alcohol) [70].

Driving service quality improvement can be facilitated by adopting and measuring key quality outcome indicators. An early workstream of the NPHN developed an interim set of Quality Indicators which are being used by some NHS Boards. As part of the work to produce this report, the Substance Misuse Workstream has developed proposals for updated Quality Indicators. These will be taken forward by the newly constituted Quality Indicators Workstream of the NPHN. These should ensure service user views are taken account of.

The suggested measures for service improvement in prison smoking cessation services are included in Section 4.3.1.3 above.

4.3.1.5 Staff Capacity and Competency

Planning for provision of substance misuse services should be balanced against the need in the population for those services. Service capacity can be defined as the total resources available to deliver services, including staff and equipment. A study [71] of the provision of specialist alcohol services in Scotland in 2012 found a Prevalence Service Utilisation Ratio (PSUR) of 1:4.3, in other words approximately 1 in 4 of those with alcohol dependency in the general population had accessed specialist treatment in 2012. The study also carried out capacity assessment exercises in 2 ADP areas, findings of which included that approximately a third of staff time was spent on direct service user contact. The methods described in the study could be applied to services in the prison setting. The box below describes a similar exercise to assess demand against staff provision. There has not been any assessment at national level of PSURs/staff capacity for substance misuse services in the prison setting.

In the ADP environment, a pilot took place in Borders ADP services to use the Scottish Government’s Quality and Efficiency Support Team’s (QuEST’s) Demand, Capacity, Activity and Queue tool known as the DCAQ tool. This was previously used only in mental health services. The tool uses existing information already collected or held within services and ADPs to calculate the amount of direct time staff have with service users and any unmet need in terms of whole time equivalent staff which may be required. With this tool, the purpose is not to reduce staffing or inject more staff resources, but to explore ways of focusing more of frontline staff’s time on direct service user work.

Following the Scottish Government work with Borders ADP [72], Edinburgh, Highland, Forth Valley and Aberdeenshire ADPs went on to conduct similar capacity and demand work, using the same DCAQ tool in many cases. This DCAQ tool could be a helpful tool for prison establishments.

The Scottish Government and COSLA’s Alcohol and Drug Workforce Statement, ‘Supporting the Development of the Alcohol and Drug Workforce Statement [73], is addressed to anyone who has a role in improving outcomes for an individual, families or
communities with problematic drug and alcohol use. The purpose of the statement is to:

- set out why action is required to develop the alcohol and drug workforce and to outline the important roles and contributions of those directly involved in workforce development
- acknowledge the need for strategic leadership and expresses the responsibilities of decision makers at national and local level, and
- set out learning priorities for all levels of the drug and alcohol workforce.

There are no national specified standards as to staff levels (WTE) for substance misuse services either in the community or prison service setting.

The NHS Health Scotland prison smoking cessation service specification includes a specific section on training. This identifies the importance of training, whether it is specialist training for smoking cessation advisors or brief intervention training such as raising awareness as well as the opportunities for peer support between prisoners.

4.3.2 Assuring Delivery

4.3.2.1 Alcohol Brief Intervention Delivery Local Delivery Plan Standard 2015/16

The Alcohol Brief Intervention (ABI) Local Delivery Plan Standard for 2015/16 states that NHS Boards and their ADP partners will sustain and embed ABIs in three priority settings (A&E, Primary Care, Antenatal) and broaden delivery in wider settings. At least 80% of delivery towards the standard is expected to continue to be in the priority settings and the standard allows for the remaining 20% to be delivered in wider settings which can include the prison and police custody settings. In view of the strong association between alcohol and offending behaviour, the emerging evidence of effectiveness in ABIs delivered within custody settings as reducing both alcohol consumption and recidivism [74] and the associated opportunity to target those from areas of economic deprivation, ABIs in the criminal justice setting have been identified as being a potential contributor to the wider setting proportion of the ABI standard. ABI delivery in prison, wider custody, and throughcare settings, as in all settings, should be in line with the ABI National Guidance 2015/16 [75], taking into account challenges around consistency of data gathering and reporting and staff training implications, and building in evaluation where possible. The guidance includes a section on criminal justice, acknowledging the opportunities presented in this setting for potential impact of delivery.

4.3.2.2 Smoking Cessation Delivery – Local Delivery Plan Standard 2015/16

The Local Delivery Plan Standard for smoking cessation in 2015/16 includes a specific action for NHS Boards to deliver an agreed number of smoking cessation quits nationally. The target is focused specifically on inequalities and, from 2015/16, all successful prison quits (at 12 weeks’ post quit) contribute to meeting the target. The prison setting, therefore, presents an ideal opportunity for NHS Boards to focus their efforts.
4.3.2.3 Improving Quality in Partnership

Building on the quality work above dedicated to improving alcohol and drug service delivery via ADPs, a national resource ‘The Drug and Alcohol Improvement Game’ was developed by the Scottish Government alcohol team and drugs policy unit based on the Scottish Government’s 3-Step Improvement Model for small tests of change using Plan, Do, Study, Act (PDSA) and Improvement Science such as Lean theory to reduce multiple steps, avoid duplication of effort, strengthen partnership and joint working, and deliver more measurable outcomes for individuals, particularly increasing recovery.

Based on this Drug and Alcohol Improvement Game a new Scottish Government Health & Justice Improvement Game resource [76] has been developed to consider a similar pathway to reintegration by offenders for use with ADP, NHS, SPS, Social Work, Third Sector, Police Scotland and justice colleagues. A pilot of the new resource was delivered in HMP Grampian in June 2015, with tests of change being planned, and with a view to further refinement through sessions in other establishments.
5 Recommendations

The following high level recommendations have been developed by the NPHN Substance Misuse Workstream to promote a consistent approach for prisoner health and wellbeing across the estate. These are driven by best evidence of effectiveness in data, assessment, prescribing, case management and recovery to ultimately contribute to a reduction on reoffending. Key organisations to which recommendations are being made to appear in brackets.

**High Level Recommendations**

1. Police custody, court reports and prisoner escort records should be consistently completed and shared to effectively inform prison reception screening, assessment, prescribing (where provided) and case management [NHS Boards, Crown Office and Procurator Fiscal Service, SPS].

2. Substance use and dependency should be identified and recorded from prison reception onwards and managed through the three pathways for alcohol, drugs and tobacco, with access according to need [NHS Boards].

3. All prisoners should be effectively engaged in a range of purposeful activity which strengthens recovery and reduces reoffending [SPS].

4. Substance use services in prison should align to and meet national standards, such as the Quality Principles, Recovery Outcome reviews and relevant Local Delivery Plan Standards [NHS Boards]. A suite of Service Quality Indicators should be developed and implemented to support service improvement [NPHN, NHS Boards].

5. Data should be captured and shared where appropriate to baseline, measure and benchmark access, uptake, engagement, success and sustained recovery to inform local and national planning. The Outcome and Performance Indicators Workstream of the NPHN will specify the data to be captured [NHS Boards].

6. Costed options for national reporting should be developed [NPHN].

7. Capacity in prison substance use services should be adequately resourced to meet service demand and be delivered by trained and competent staff [NHS Boards].

8. Service user views should be gathered through a range of mechanisms to inform service planning and delivery, and their impact evidenced through both implementation and follow-up [NHS Boards].

9. A holistic, single service integrated release plan should be provided for prisoners with substance misuse which is informed by recovery and the social model of health. This plan will include: GP registration, skills for harm reduction and relapse prevention, access to mentorship and mutual aid, referral to health and local authority services, and support in their community of residence [NHS Boards].

10. Arrangements should be made to ensure that details of healthcare delivered in police custody suites can be accessed by prison-based healthcare staff, by a suitable IT linkage, to inform continuity of care [NHS Boards].

11. Arrangements should be put in place to ensure that the recommendations from the Substance Misuse Workstream report are implemented by NHS Boards [NPHN, NHS Boards, Scottish Government].
In addition, the following are topic-specific recommendations:

**Drug Specific Recommendations**

1. All prisoners admitted to prisons should be assessed for problem drug misuse using a validated tool [NHS Boards].
2. Those screening positive or who claim to have a drug misuse problem should have their urine tested for the presence of drugs [NHS Boards].
3. Those who test positive for drug misuse, and are in withdrawal, should receive a prescribed protocol for safe management of withdrawal symptoms until confirmation of provision of a community-based opiate substitution treatment can be obtained or assessment for initiation of treatment can occur [NHS Boards].
4. Those in need of a specialist service should have access to a range of services equivalent to those in the community. Those in need of substitute treatment at any stage of their prison stay should have access to a range of opioid replacement therapies, including methadone and buprenorphine, as part of a supportive framework [NHS Boards].
5. NHS Boards must ensure that screening processes are in place to detect and manage Neonatal Abstinence Syndrome (NAS) in children born to drug dependent female prisoners, including appropriate throughcare [NHS Boards].
6. All prisoners should be offered opt-out testing for blood-borne viruses and assessed for access to local pathways for appropriate vaccination and treatment [NHS Boards].
7. There should be inter-agency information sharing for (suspected) cases of New Psychoactive Substances use or supply in the prison setting [NHS Boards].
8. Recovery planning based on a Recovery Orientated System of Care should be initiated [NHS Boards, SPS].
9. Integrated pre release planning, including statutory and voluntary throughcare should be undertaken, and where appropriate, the supply and training in naloxone administration should be made available [NHS Boards].
10. A range of trained and competent staff should be available including addiction psychiatrists and addiction psychologists. [NHS Boards].
11. Data should be recorded and appropriately shared, including contributing to the national data collection systems (Drug and Alcohol Waiting Times Database; Scottish Drug Misuse Database; Take Home Naloxone reporting) [NHS Boards].

**Alcohol Specific Recommendations**

1. All prisoners coming into custody from the community should be screened for hazardous, harmful or dependent alcohol use using a validated screening tool such as FAST or AUDIT [NHS Boards].
2. Those identified using FAST as having a problem may require further triage via AUDIT, or a comparable screening tool, to determine the degree of dependency and specialist treatment required. Those identified as having harmful, hazardous or dependent alcohol use should be referred for the appropriate tier of treatment using the Integrated Alcohol Care Pathway [NHS Boards].
3. Those who are in withdrawal should receive a prescribed protocol for safe management of withdrawal symptoms [NHS Boards].

4. Alcohol Brief Interventions (ABIs) should be available to prisoners from reception and throughout their stay in the prison setting [NHS Boards].

5. Prisoners should have access to the same range of interventions (as non-prisoners in an NHS Board area) to facilitate recovery in each NHS Board Area [NHS Boards].

6. Appropriate arrangements for throughcare should be made across the community – prison - community interfaces for those who come into prison having started on a programme to address their alcohol misuse or who are initiated into treatment when in custody, but released before completion of the relevant programme. [NHS Boards]

7. Arrangements should be established to ensure signposting to community service provision for those who do not wish to engage with services while in custody. [NHS Boards]

8. A range of trained and competent staff should be available, including addiction psychiatrists and addiction psychologists [NHS Boards].

9. Data should be recorded and appropriately shared, including contributing to the national data collection systems (Drug and Alcohol Waiting Times Database; national ABI report) [NHS Boards].

**Tobacco Control Specific Recommendations**

1. All prisoners coming into custody from the community should be screened for tobacco use [NHS Boards].

2. All prisoners should have timely access to smoking cessation services. This includes remand and short-term prisoners and requires NHS Boards to proactively manage waiting lists and provide a timeous service once a prisoner is referred [NHS Boards].

3. There is also a responsibility for SPS to work in collaboration with NHS Boards to support the delivery of prison smoking cessation services by ensuring adequate operational support, such as suitable accommodation for the group sessions, supporting prisoners to attend timeously and providing suitable alternative activities to prevent boredom and relapse [SPS].

4. Prison smoking cessation services should be equitable with community smoking cessation services (quality, access and choice) [NHS Boards].

5. NHS Boards need to ensure that resources are prioritised to meet the needs of potential users. This includes ensuring adequate resources such as staff, resources, marketing of the service, training of staff and an adequate prescribing budget [NHS Boards].

6. Appropriate arrangements for throughcare should be made across the community – prison - community interfaces for those who come into prison having started a quit attempt or are released before completion of their quit attempt [NHS Boards]

7. Data should be recorded and appropriately shared, including contributing to the national data collection systems (national smoking cessation database) [NHS Boards].
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69. Prison Health in NHS Greater Glasgow and Clyde, a health needs assessment (2012) available online at: [http://tinyurl.com/okgpp27]

70. Alcohol and Offenders Research Reports, NHS Health Scotland (2013) available online at: [http://www.healthscotland.com/documents/4932.aspx]


77. DANOS is not applicable in Scotland so the specific competencies are not detailed here. A publication by NHS Health Scotland (2010), Training needs analysis guide: Tackling the alcohol and drug problem in Scotland, details the competencies required for the alcohol and drugs workforce in Scotland. It specifically deals with criminal justice, as well as a range of other health and social care settings.
### Appendix 1: Tiered Interventions from MoCam

<table>
<thead>
<tr>
<th>Tier 1 Interventions: alcohol-related information and advice; screening; simple brief interventions; and referral</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition:</strong> Identification of hazardous, harmful and dependent drinkers, provision of information on sensible drinking, simple brief interventions to reduce alcohol-related harm, and referral of those with alcohol dependence or harm for more intensive interventions.</td>
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<tr>
<td><strong>Interventions:</strong> Commissioners need to ensure that a range of generic services provide as a minimum:</td>
</tr>
<tr>
<td>- Alcohol advice and information.</td>
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<tr>
<td>- Targeted screening and assessment for those drinking in excess of guidelines on sensible drinking and for those who may need alcohol treatment.</td>
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<tr>
<td>- Provision of simple brief interventions for hazardous and harmful drinkers.</td>
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<td>- Referral of those requiring more than simple brief interventions for specialised alcohol treatment.</td>
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<td>- Partnership or ‘shared care’ with specialised alcohol treatment services.</td>
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<tr>
<td><strong>Competency:</strong> At least minimal skills in alcohol misuse identification, assessment and interventions including those indicated by Drugs and Alcohol National Occupational Standards (DANOS) [77].</td>
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<tr>
<th>Tier 2 Interventions: open access, non-care-planned, alcohol-specific interventions</th>
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<tr>
<td><strong>Definition:</strong> Provision of open access facilities and outreach that offer: alcohol-specific advice, information and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment.</td>
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<tr>
<td><strong>Interventions:</strong> Open access facilities and outreach targeting alcohol misusers which provide:</td>
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<tr>
<td>- Alcohol-specific information, advice and support.</td>
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<tr>
<td>- Extended brief interventions and brief treatment to reduce alcohol-related harm.</td>
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<tr>
<td>- Alcohol-specific assessment and referral of those requiring more structured alcohol treatment.</td>
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<tr>
<td>- Partnership or ‘shared care’ with staff from Tier 3 and Tier 4 provision.</td>
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<td>- Mutual aid groups, for example Alcoholics Anonymous (AA).</td>
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<td>- Triage assessment.</td>
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<tr>
<td><strong>Competency:</strong> includes those required for Tier 1.</td>
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</table>
Tier 3 Interventions: community-based, structured, care-planned alcohol treatment

**Definition:** Provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned.

**Interventions:** Include:

- Comprehensive substance misuse assessment.
- Care planning and review for all those in structured treatment often with regular keyworking.
- Community care assessment and case management.
- A range of evidence-based prescribing interventions, in the context of a package of care including community-based medically assisted alcohol withdrawal (detoxification) and prescribing interventions to reduce risk of relapse.
- A range of structured evidence-based psychological therapies and support within a care plan to address alcohol and co-existing conditions when appropriate.
- Structured day programmes and care-planned day care (for example, interventions targeting specific groups).
- Liaison services, for example for acute medical and psychiatric health services and social care services.

**Competency:** Tier 3 services require competent drug and alcohol specialised practitioners who should have competencies in line with national standards depending on the type of alcohol treatment provided. Medical staff will require different levels of competency depending on their role in alcohol treatment systems and the needs of the service user.

Tier 4 Interventions: alcohol specialist inpatient treatment and residential rehabilitation

**Definitions:** Provision of residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare.

**Interventions:** Include:

- Comprehensive substance misuse assessment, including complex cases where appropriate.
- Care planning and review for all inpatient and residential structured treatment.
- A range of evidence-based prescribing interventions in the context of a package of care including community-based medically assisted alcohol withdrawal (detoxification) and prescribing interventions to reduce risk of relapse.
- A range of structured evidence-based psychological therapies and support within a care plan to address alcohol misuse.
- Provision of information, advice, training and ‘shared care’ to others delivering Tiers 1, 2 and support for Tier 3 services as appropriate.

Differences between Tiers 3 and 4 are most specifically the settings interventions are delivered in: Tier 3 incorporates community settings whereas Tier 4 incorporates residential/inpatient settings.

**Competency:** Tier 4 interventions normally require medical staff with specialist competence in substance misuse and a wide range of competencies as per national standards, as per Tier 3.
Appendix 2: Web Links

Web links to the National Quality Principles for Alcohol & Drug Services, The National Driver Diagram for Recovery Orientated Systems of Care and Validated Recovery Outcomes Tool

Recovery Outcomes Tool:  

ROSC National Driver Diagram:  

Quality Principles:  
Appendix 3: HMIPS Standards for Inspecting and Monitoring Prisons in Scotland (March 2015)

www.gov.scot/about/public-bodies/hmip/standards-guidance/standards
Appendix 4: National Directories of Treatment and Care Services and Recovery Groups

Drug Services:
www.scottishdrugservices.com/sdd/homepage.htm

Alcohol Services:
www.alcohol-focus-scotland.org.uk/alcohol-information/find-an-alcohol-service/

Recovery Groups:
www.sdrconsortium.org/index.php?id=347

Report of the Ministerial Group on Offender Reintegration:

Service Specification for Prison Smoking Cessation:
### Appendix 5: Workstream Membership

<table>
<thead>
<tr>
<th>Chair</th>
<th>National Prisons Pharmacy Adviser</th>
<th>Healthcare Improvement Scotland</th>
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<tr>
<td>Tom Byrne</td>
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#### Members

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<tr>
<th>Biba Brand</th>
<th>National ADP Delivery Advisor</th>
<th>Scottish Government</th>
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<tbody>
<tr>
<td>Dr Grace Campbell</td>
<td>Lead Clinician</td>
<td>NHS Greater Glasgow and Clyde</td>
</tr>
<tr>
<td>Hannah Cornish</td>
<td>Programme Manager</td>
<td>NHS National Services Scotland</td>
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<tr>
<td>Phil Eaglesham</td>
<td>Health Improvement Programme</td>
<td>NHS Health Scotland</td>
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<tr>
<td>Celia Gardiner</td>
<td>Health Improvement Programme</td>
<td>NHS Health Scotland</td>
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<tr>
<td>Dr Lesley Graham</td>
<td>Associate Specialist, Public Health</td>
<td>NHS National Services Scotland</td>
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<tr>
<td>Tom Jackson</td>
<td>Chief Officer</td>
<td>Glasgow Criminal Justice Authority</td>
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<tr>
<td>Elaine Lawlor</td>
<td>FVADP Coordinator</td>
<td>Forth Valley Alcohol and Drug Partnership</td>
</tr>
<tr>
<td>Dr Callum MacCall</td>
<td>Consultant Psychiatrist</td>
<td>State Hospital Board for Scotland</td>
</tr>
<tr>
<td>Victoria McDonald</td>
<td>Addiction, BBV &amp; Sexual Health Nurse</td>
<td>NHS Forth Valley</td>
</tr>
<tr>
<td>Ruth Parker</td>
<td>Head of Health &amp; Wellbeing</td>
<td>Scottish Prison Service</td>
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<tr>
<td>John Porter</td>
<td>Prison Healthcare Lead Nurse</td>
<td>Healthcare Improvement Scotland</td>
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<tr>
<td>Elaine Rankine</td>
<td>Specialist Pharmacist in Substance Misuse</td>
<td>NHS Lothian</td>
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<tr>
<td>Karen Rowell</td>
<td>Specialist Pharmacist in Substance Misuse</td>
<td>NHS Greater Glasgow and Clyde</td>
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<tr>
<td>Professor Roy Robertson</td>
<td>Chair of National Drug Related Deaths Group</td>
<td>The University of Edinburgh</td>
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<tr>
<td>Dr Craig Sayers</td>
<td>Clinical Lead Prison and Forensic Services</td>
<td>NHS Forth Valley</td>
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## Appendix 6: Acronyms

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<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tr>
<td>ABIs</td>
<td>Alcohol Brief Interventions</td>
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<tr>
<td>ADP</td>
<td>Alcohol and Drug Partnership</td>
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<td>APT</td>
<td>Addictions Prevalence Testing</td>
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<tr>
<td>ARBD</td>
<td>Alcohol Related Brain Damage</td>
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<tr>
<td>AUD</td>
<td>Alcohol Use Disorder</td>
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<td>AUDIT</td>
<td>Alcohol Use Disorder Identification Test</td>
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<td>CIWA</td>
<td>Clinical Institute Withdrawal Assessment for Alcohol</td>
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<tr>
<td>COSLA</td>
<td>Convention of Scottish Local Authorities</td>
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<tr>
<td>COWS</td>
<td>Clinical Opiate Withdrawal Scale</td>
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<td>DAISy</td>
<td>Drug &amp; Alcohol Information System</td>
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<tr>
<td>DANOS</td>
<td>Drugs and Alcohol National Occupational Standards</td>
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<td>DAST</td>
<td>Drug Abuse Screening Test</td>
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<td>DATWTD</td>
<td>Drug and Alcohol Treatment Waiting Times Database</td>
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<td>DCAQ</td>
<td>Demand, Capacity, Activity and Queue tool</td>
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<td>DoH</td>
<td>Department of Health</td>
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<td>DRDs</td>
<td>Drug related deaths</td>
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<tr>
<td>FAS/FASD</td>
<td>Foetal Alcohol Syndrome/ Foetal Alcohol Spectrum Disorder</td>
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<td>FAST</td>
<td>Fast Alcohol Screening Test</td>
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<tr>
<td>HEAT</td>
<td>Health Improvement, Efficiency, Access to Treatment, Treatment</td>
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<td>HMIPS</td>
<td>Her Majesty’s Inspectorate of Prisons for Scotland</td>
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<td>HWL</td>
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<td>Models of Care for Alcohol Misusers</td>
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<td>Neonatal Abstinence Syndrome</td>
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<td>NPHN</td>
<td>National Prisoner Healthcare Network</td>
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<td>NPS</td>
<td>New (Novel) Psychoactive Substances</td>
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<td>NRS</td>
<td>National Records Scotland</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>NTASM/DH</td>
<td>National Treatment Agency for Substance Misuse/Department of Health</td>
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<tr>
<td>PDSA</td>
<td>Plan, Do, Study, Act</td>
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<tr>
<td>PSUR</td>
<td>Prevalence Service Utilisation Ratio</td>
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<td>QuEST</td>
<td>Quality and Efficiency Support Team</td>
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<td>ROSC</td>
<td>Recovery-Oriented System of Care</td>
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<td>ROW</td>
<td>Recovery Outcomes Web</td>
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<td>SACAM</td>
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<td>SACDM</td>
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<td>Scottish Prison Service</td>
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<tr>
<td>THN</td>
<td>Take Home Naloxone</td>
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</table>
For more information about the National Prisoner Healthcare Network, please contact:

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