OFFICIAL REPORT
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Criminal Justice Committee

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Session 6

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CRIMINAL JUSTICE COMMITTEE

17th Meeting 2025, Session 6

CONVENER

*Audrey Nicoll (Aberdeen South and North Kincardine) (SNP)

DEPUTY CONVENER

*Liam Kerr (North East Scotland) (Con)

COMMITTEE MEMBERS

*Katy Clark (West Scotland) (Lab)
*Sharon Dowey (South Scotland) (Con)
*Fulton MacGregor (Coatbridge and Chryston) (SNP)
*Rona Mackay (Strathkelvin and Bearsden) (SNP)
*Ben Macpherson (Edinburgh Northern and Leith) (SNP)
*Pauline McNeill (Glasgow) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Suzy Calder (Scottish Prison Service)
Stephen Coyle (Scottish Prison Service)
Detective Chief Superintendent Raymond Higgins (Police Scotland)
Kirsten Horsburgh (Scottish Drugs Forum)
John Mooney (Public Health Scotland)

CLERK TO THE COMMITTEE

Stephen Imrie

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Criminal Justice Committee

Wednesday 28 May 2025

[The Convener opened the meeting at 10:01]

Decision on Taking Business in Private

The Convener (Audrey Nicoll): A very good morning, and welcome to the 17th meeting in 2025 of the Criminal Justice Committee. We have received no apologies. Fulton MacGregor is running slightly late due to train issues, but he will join us shortly.

Our first agenda item is a decision on whether to take in private item 4, which is our review of today's evidence. Do we agree to take that item in private?

Members *indicated agreement.*

Substance Misuse in Prisons

10:01

The Convener: Under our main agenda item, we will begin to take evidence as part of our new inquiry into the harm that is caused by substance misuse in Scottish prisons. The purpose of the initial session is to tease out some of the main issues that we will want to explore more fully during our inquiry.

I am pleased that we are joined by a panel of witnesses who will help to get us started. I welcome Detective Chief Superintendent Raymond Higgins of Police Scotland; John Mooney, consultant in public health, Public Health Scotland; Kirsten Horsburgh, chief executive officer, Scottish Drugs Forum; and, from the Scottish Prison Service, Stephen Coyle, head of operational delivery, and Suzy Calder, head of health and wellbeing. You are all very welcome.

I refer members to papers 1 and 2, and I thank those witnesses who provided a written submission in advance of today's evidence session. I intend to allow up to two hours for the session. I will start with an opening question, which I will put first to Stephen Coyle, then to Detective Chief Superintendent Higgins and then to Kirsten Horsburgh.

Will you give the committee a general idea of the prevalence of drugs and drug use in prisons at the moment, including what type of drugs are being used, how they enter prisons, what efforts are made to prevent that and whether that picture has changed in recent years or is changing now? Is it improving or is it getting worse?

Stephen Coyle (Scottish Prison Service): Good morning. The prevalence of drugs in prison very much reflects the prevalence of drugs in the community. Prisons are part of, and do not sit aside from, the community, and the level of availability and type of drug that is available in a prison mirrors its environment. Suzy Calder would probably be better placed to provide an idea of the context of drugs in prisons, given that that is her area of expertise. We can come on to that in a second.

With regard to the measures that we take to prevent the introduction of drugs, there is a range of physical and dynamic responses at strategic and tactical levels. At a strategic level, we work with our justice partners—Police Scotland, in particular—on the intelligence picture to understand the who, what, where and why of the drugs that are moving through the prison estate and court system. To address that at the point of entry to a prison establishment, we have X-ray machines at the front of house for people who are

visiting the prisons, and we have body scanners for people who are coming into custody and moving through reception.

We have a range of dynamic measures. Rather than go into the depths and details of those measures, because some are security sensitive, we can extend an invitation to the committee to visit an establishment, so that you can see the measures in situ and we can discuss them there at greater length.

Working on the intelligence picture involves taking a daily view of which drugs we understand to be in the prison and how we combat that and remove them. We have taken a range of issues into account—in particular, the way that drugs come into the prison. That can be through secretion on an individual, whether that is through the court side or through the front door, with a visitor to the establishment. Drugs have also been introduced through the impregnation of articles that come into the prison. For example, when prisoners' property comes in, drugs might be soaked into clothing. A range of other methods are used, such as throw-overs, which is when prisoners are expected to go around the establishment to pick up a package that has come over the wall. You will be well aware of the increasing use of drones in the past three or four years, because that has been well publicised.

If the committee were to visit an establishment, we could talk at length with you about the range of measures that we use. We have taken technological measures to address those issues and we have also installed low-tech responses such as grills on windows, because drones are flown up to windows.

We work in conjunction with our Police Scotland colleagues to build an intelligence picture, so that we know the what, where and why of the drugs that are coming through the system. Suzy Calder will perhaps be able to give us the context of the drugs that we are seeing in custody.

Suzy Calder (Scottish Prison Service): I am happy to give a bit of an overview. We have a partnership with the University of Dundee, which tests the substances that we send and gives us an understanding of what we are seeing.

There is a real mix of different substances: synthetic cannabinoids are prevalent, as is the case elsewhere, and we see things such as bromazolam and benzodiazepines and a whole range of other drugs, such as cocaine and steroids. The synthetic drugs that come over cause issues, and the impact on the individual depends on the drug's presentation and how it physically fits the individual. The drugs come in a range of presentations and formats, such as paper, card, powder or a waxy substance. People use lots of different methods, including vapes, to take them, but they tend to use more than one substance and are not dependent on a single drug.

We also know that people do not know what exactly they are taking when they get the drugs, because they might think that they are getting one drug, but it will be something quite different when it comes in. Our relationship with the University of Dundee is really critical to tracking the trend of what is going on and what drugs people are having. We do not see many nitazene compounds—Kirsten Horsburgh will be able to give you a bit more flavour on those, and John Mooney can speak on what is happening more widely.

However, we are alert to what is happening in the community. We engage closely with our public health colleagues in order to know what the drug trends are and what might be happening, so that, when we see the impact of such drugs on individuals, we can start to think about how we support those in our care, share harm reduction information with them and ensure that everybody is aware of what is going on.

The Convener: Thank you.

Detective Chief Superintendent Higgins, as we know, Police Scotland and the SPS work closely together, in particular on intelligence and information sharing. My question was about the prevalence of drugs and drug use in prisons and the types of substances. What can you add, from your perspective, to the updates from Stephen Coyle and Suzy Calder?

Detective Chief Superintendent Raymond Higgins (Police Scotland): Good morning. Stephen Coyle and Suzy Calder have provided considerable detail, so I cannot add a huge amount in relation to the specific types of drugs. I can say that moving towards understanding what types of drugs are prevalent in our communities and sharing that information across health partners as well as partners in the prison service is key, so that we have an early warning about the drugs that we are likely to see and can identify them. If a trend changes in a particular area of the country, it will impact one or two of our prison establishments, and then we will see some prevalence in our wider communities.

As Stephen Coyle has clearly articulated, information and intelligence sharing is absolutely critical, both at a local level and at a more strategic regional and national level, so we can understand what the threat looks like, from the people who are involved in bringing those products into prisons to those who enable or co-ordinate that. Although a lot of the activities have not changed greatly, the

challenge is always evolving, as we have seen recently with the prevalence of drones.

In relation to prevention, it is key that we work together, so we not only carry out initiatives with local establishments but also ensure that the strategic work—which Stephen Coyle and I will be involved in—takes place across establishments and is not limited to, for example, Kilmarnock or Dumfries.

The Convener: Thank you.

Kirsten Horsburgh, you have been at the committee previously and have shared very helpful information, so I will hand over to you, particularly with regard to what is coming into prisons.

Kirsten Horsburgh (Scottish Drugs Forum): Good morning. I appreciate the opportunity to speak to the committee. The Scottish Drugs Forum is an organisation that advocates for evidence-based drugs policy based on public health, human rights and harm reduction. From that perspective, the presence of drugs in prison is really a by-product of the criminalisation of people who use drugs.

A huge majority of people in prison will not necessarily pose a risk to the general public but are in prison because their drug use is criminalised. If we are really serious about getting to the bottom of the issue of drugs in prison, we need to consider our approach of sending to prison people who use drugs, and look at wider aspects, such as diversion schemes and alternatives to custody. We would be supportive of decriminalising people who use drugs.

On your question, a lot of the information that I will share is based on our work in prisons. We have a variety of projects—primarily our peer naloxone work in prisons, which involves staff going into prison to train people there to train their peers in overdose prevention and the use of naloxone. As part of that work, we have conversations with people in prison about the very questions that you are asking.

Consistently, people tell us that the most prevalent drugs are, as other witnesses have mentioned, synthetic cannabinoids, benzodiazepines and opioids, which are taken in a variety of forms—mostly through vapes, but they can also be swallowed in hot drinks, and we should not shy away from the fact that injecting drug use still happens.

On drugs getting into prison, we hear a lot from people about intimidation—bullying people who are being released, with the intention that they will quickly re-enter prison, bringing drugs back in with them. A lot of the criminal networks have an influence around that. I am sure that we will come on to some of the challenges that people face around accessing help later, so I will stop here for now.

The Convener: John Mooney, I do not want you to feel left out with regard to the opening question. Perhaps you can pick up on the point that Stephen Coyle and Suzy Calder made about the fact that what we are seeing with regard to drug harm and drug use in prisons is almost a reflection of what is going on in communities. Are you picking that up in a lot of the work that is being done to track trends and the types of substances that are coming into the system?

10:15

John Mooney (Public Health Scotland): I caveat my reply by saying that I am in the presence of a lot more expertise than I have on the prison side. On the medication assisted treatment standards, our MAT implementation support team has been implementing the standards in community settings. That is where the bulk of our MAT standards work has been happening, but we have a programme of work that is just starting in prisons. In some ways, prisons are the canary in the coal mine, because we sometimes see the early signs of what is happening in communities in prisons. That might be because there is enhanced intelligence on prisons, and, as Suzy Calder mentioned, there is access to drug testing at the University of Dundee. Often, what we see in prisons might then become more widespread in the community. That seems a bit counterintuitive, but that has been the case.

On the prevention strategy for tackling drugs deaths, prison release is the key area, because people who are being released from prison are one of the highest risk groups. However, there are other causes of premature death in prisons that we are all aware of. Those are the broad parallels in our areas of work.

The Convener: I would like to go back to a point that was made about the close working relationship between the Scottish Prison Service and the University of Dundee, particularly the Leverhulme research centre for forensic science, which is based at the university. The SPS submission refers to the University of Dundee providing valuable insights into the extent and nature of the illicit drugs that are being used in prisons.

I do not need to tell anyone about the financial situation that Dundee university is facing, and I do not expect you to comment on that. However, given the value of the work that the university does in conjunction with the Prison Service, how much of an impact might any change in that arrangement have on the work that you are doing

on tackling drug harm in the Scottish Prison Service estate?

Stephen Coyle: I am not aware of any contractual elements that are being impacted by the financial situation that you have described, so I cannot comment further at this stage. However, we can come back to the committee with an indication of what the impact might be.

In recent years, the Dundee university work has been absolutely invaluable in helping us to structure our strategies and tactics and to understand what the SPS response needs to be to what we find in custody, what that means for those who are living in our establishments and how we can provide the best level of care. The university is an absolutely key partner in that conversation.

Suzy Calder: That is one of the sources from which we get information about the drugs that are used in prisons. It is not the only source of information that we rely on. Kirsten Horsburgh has referred to the work that the Scottish Drugs Forum does and the feedback that it gets directly from individuals. We also work with the rapid action drug alert and response system in the community to work out what drugs are out there. There is a range of sources of information that come together. Dundee university is critical in determining exactly what is in the substances that we find, but it is not the only method that we rely on to understand drug use and its impact on people in prison.

The Convener: Are you saying that there are other centres that could replicate the work that the research centre at Dundee university is doing?

Suzy Calder: No, sorry—that is not what I am saying. I am just saying that we gather our information in a variety of ways in order to understand the impact of substances and which substances people think that they are taking when they are in prison. The work that Dundee university does provides an opportunity to test those substances, but we also get direct feedback from those in our care who are directly impacted.

The Convener: Thank you for that helpful clarification.

Liam Kerr (North East Scotland) (Con): Good morning. Stephen Coyle, I was interested in your earlier answer. I sat on the Criminal Justice Committee for a while and then left for a few years, and I have been back for about six or seven months. When I came back, I was struck by the progress that has clearly been made—for example, the deployment of Rapiscan body scanners. I also recently visited a prison that has anti-drone technology, and I see from a recent report that that has been very successful. However, drugs and substances are still getting into prisons. What more could be done, technologically or resource-wise to keep drugs out of prisons?

Stephen Coyle: The strategies that we are deploying with regard to developing technological responses to how drugs are entering prisons are probably all that we can currently attain with the resource that is available. As you will have seen, serious and organised crime groups are at the centre of the organisation of the commodities that enter prisons. Over the past three or four years, SPS has seen an increase in the number, and level of seniority, of the nominals that we have in custody and an increase in the influence of those groups.

With regard to technological responses, perhaps we need to think about a different strategic response that is about how we manage the influence of those who are able to introduce drugs into prisons. Again, that means working with our Police Scotland colleagues, particularly with regard to serious and organised crime groups, on the strategies that we employ. We need to understand what those behaviours look like and how we can respond to those elements, because the ways in which drugs come into prison are as they are—it is through secretion on an individual, impregnation of articles that are coming into the prison or the low-tech approach of throwing something over the prison wall for someone to pick up. We also need to respond to the use of drones. Those are the principal ways that drugs come into prisons, and I do not see those changing. With regard to what our responses to those look like, we are doing our very best with the resources that we have. We need to change the narrative about how we look at the intelligence and how we prevent those who have influence from introducing drugs into establishments. That is probably the next step in dealing with the challenge.

Liam Kerr: I will throw that question to Detective Chief Superintendent Higgins in two seconds, but, first, I want to follow up your answer, Stephen. A couple of times, you said that you are doing the best that you can with the resource that is available. This committee is about talking to the Government and saying what we as the Parliament need to be doing to help you, which begs the question of what further resources you need. Has that been quantified or established, and is that something that you can share with the committee, so that we can take that forward?

Stephen Coyle: That is not something that I can immediately share the detail of, because I do not have it in front of me. However, I am happy to provide that to the committee in due course.

With regard to the resource, the key challenge is the high cost of technological responses to, for example, drone technology. If you have been to a

prison establishment, you will have seen the kit that we use—the body scanners—to respond to somebody who is secreting something on their person. As you are aware, what we are able to capture with the Rapiscan system provides us with the detail of what is actually in our establishments. Enhancing any of that would require resource input. I am happy to, in due course, provide the committee with a detailed breakdown of what we think that that might look like.

Liam Kerr: That would be helpful.

Detective Chief Superintendent Higgins, Stephen Coyle's answer begs the question of what the police are able to do at the front end to target those who are introducing drugs into prisons. So that the committee fully understands, what is the role that is played by serious and organised crime?

Detective Chief Superintendent Higgins: Because of the success in recent years in the disruption of key nominals in serious and organised crime who have a significant level of influence, they are now present in our estate—because they have been arrested locally or nationally, or internationally and have been brought back to Scotland. That presents an issue in relation to our understanding of their capability and our response to it, which involves sharing our information and intelligence in partnership with Stephen Coyle and his team. We are responding locally, regionally and nationally across our establishments. The capability of those individuals is significant, and we are always learning.

There have been good instances of significant disruption, and we are continuing to learn about what technology can deliver across our estate. The challenge in our response is to have preventative aspects in that technology. We also need to ensure that we are joined up on the Scottish footprint and, because of the reach of a small number of those nominals, are able to bring a United Kingdom-wide or even international understanding of their capability to our local establishments. We continue to evolve that understanding, share that information and look at measures that we can use, including intelligence analysis products and infrastructure that can disrupt drones. The technology is evolving for prevention and for targeting activity in our establishments, and we share that information with the SPS.

We could always do with more resource. I can confidently say that the organisations that are represented on the panel today will always aspire to having more resource. Sometimes, that resource can involve technology or analytical products, as opposed to people. We are always trying to develop our approach in partnership, so that the intelligence information that we are learning from and sharing is as current and up to date as it can possibly be.

Kirsten Horsburgh: I add that, on the flipside, when we are looking at how we stop drugs from getting into prison, we—and the committee—could also look at the future of resourcing out-of-prison alternatives. If we want to stop drugs from getting into prison, we should look at how to stop putting people who use drugs into prison. In my opening statement, I mentioned decriminalisation and diversion schemes. There is no data on how we are utilising our recorded police warning system, and it is difficult to understand whether it is reaching the people that we intend it to reach.

In relation to drug courts, we should consider resourcing treatment and support for people for whom being in a prison environment is inappropriate, if there are alternatives in terms of out-of-custody options.

Liam Kerr: When you said that there is no data on the use of the recorded police warning system, what did you mean?

Kirsten Horsburgh: We have no idea how that system is operating in practice. Previously, we have tried to access data on how many recorded police warnings are being provided and under what circumstances they are being provided. The Lord Advocate's decision to provide recorded police warnings for all classifications of drugs was a huge policy shift, yet we have no understanding of whether it is reaching the people who are at most risk of harm, the most vulnerable and the most marginalised. Are the warnings given on the basis of an individual police officer's decision at the time, or is there an agreement or policy about how the warnings are operated?

When we have discussions with people who use drugs in various locations across the country, we hear very different stories about how those warnings are implemented. For such a big policy shift, it is really disappointing that we are not able to follow its direction and to see whether it is making an impact.

The Convener: Sharon Dowey and Pauline McNeill have a couple of supplementaries to Liam Kerr's questions.

10:30

Sharon Dowey (South Scotland) (Con): In relation to that last comment from Kirsten Horsburgh, does Detective Chief Superintendent Higgins have any comment to make on why there is no data on the recorded police warnings?

Detective Chief Superintendent Higgins: I have to be honest: that is not in my area of expertise, but I would be happy to speak to our criminal justice colleagues about that and report

back, if that is what you would like. It would be no problem for me to take that action and see what data is available.

The Convener: I am sorry to interrupt, Sharon, but I certainly think that the committee will pick up on that point. I sense that there might be correspondence from the committee on that. Liam Kerr has picked up a very important point there.

Sharon Dowey: This question is to the Scottish Prison Service. I do not know which one of you will want to pick this up, but I would like some information. Ambulance call-outs to HMP Kilmarnock increased by 231 per cent between 2023 and 2024, following nationalisation. The figures that I have say that there were 106 ambulance call-outs to HMP Kilmarnock in 2024, compared with 32 in 2023 and 14 in 2022, when it was run privately.

Do you know any of the reasons why there would be such an increase in ambulance call-outs? Was the prison doing anything differently when it was run privately that has changed since it went to SPS? Can we take any learnings from that?

Suzy Calder: I do not have the detail to hand on the breakdown of ambulance call-outs, so I cannot comment on what they were about. The reason for call-outs can vary depending on who is in the prison's care, so the ambulance call-outs that we are referring to may not all be drug related. I would need to be able to break down those figures before I could comment directly on that.

When we have areas of harm or incidents of a few people being affected by drugs, we work very closely with our ambulance colleagues to ensure that that care is in place. The operational side of how HMP Kilmarnock now operates sits in Stephen Coyle's side of the organisation, and I am on the policy side.

We are certainly very happy to look at ambulance call-outs. It is one of the areas that we investigate, and we work closely with our ambulance colleagues on what is happening and what the impact is. Were the people transferred for a particular reason, and where did they go? How long were they away? We would need to work that out as well.

I do not have with me the breakdown of all the ambulance call-outs across the estate, but I am happy to have a conversation with HMP Kilmarnock to establish what might be different there. I cannot think of what might be different there or what it might have done differently with regard to ambulance call-outs, but I will check that.

Sharon Dowey: It seems to be a huge rise. There were 49 call-outs in the first three and a half months of 2025 alone. There has been a huge increase in the amount of call-outs in the time between when the prison was privately run and now, so it would be interesting to see whether there is a difference in the amount of drugs that are getting into HMP Kilmarnock now.

Stephen Coyle: There was not a long lead-in period for HMP Kilmarnock's transition from being a private entity back to being part of the Prison Service. In relation to the adoption of Kilmarnock's operational delivery, there has been no change in its approach to business since it was in the private environment; it has just adopted SPS systems.

Picking up on Suzy Calder's point, many of the decisions taken at the point when ambulances are called for are decisions of the national health service provider, not necessarily of the prison. It would primarily be the NHS provider that would request an ambulance to come in, because, obviously, it will have to consider whatever people present with.

As Suzy said, we could take away those figures and do a deep-dive analysis of them to give you that understanding.

Sharon Dowey: Yes, could you bring that information back to the committee, so that we can see whether there is a difference and what the reason is?

I will quickly ask about something else. You mentioned window grilles. A BBC article says:

> "Stopping the drones getting in has become a priority and six months ago Perth Prison introduced secure window grilles. As a result, there have been no drone breaches within that period."

It goes on to say that you have now put them in Edinburgh and Glenochil prisons. If there were no drone breaches in that period, why have we not put window grilles into every single prison?

Stephen Coyle: There are two aspects to that. First, to go back to Mr Kerr's earlier point, the issue is about resources and the cost that is attached to doing that. The establishments where the grilles were initially placed were particular hotspots, as we had to tackle the obvious problem in those environments first. If we had the resource, we would apply that technology in all prisons.

Secondly, a window grille is a low-tech response—

Sharon Dowey: But it has been effective.

Stephen Coyle: It prevents access to the window so that the occupants of that room cannot access what comes over with the drone but it will not stop drones from coming in to the estate. As I am sure that the chief superintendent will attest to, the capacity of drones and the payload that they can carry have significantly increased over time. Even if drones are not going in through the

windows, they can still drop packages into an establishment to be picked up by another method. We are preventing an obvious method of introduction by putting grilles on, but they will not prevent drones from coming in.

Sharon Dowey: I will move on to alcohol use in prisons. Although much of the focus in relation to substance use in prisons is on drugs, could you advise the committee whether alcohol is also an issue, whether illicit alcohol is produced in prisons and what has been done to tackle the matter?

Suzy Calder: Illicit alcohol use is not prevalent to nearly the same degree as drug use, but we are aware that it takes place on occasion. The work that the Prison Service is doing through our alcohol and drug strategy focuses on how we support those people who come in with existing alcohol-related problems and who need support during their care with us. That is so that we do not lose sight of the impact on them of being removed from what they use as their drug of choice in the community when they come into prison. That can be a really difficult transition.

Our alcohol and drug strategy is very much focused on looking at all the substances that people might use when they come in and at ways in which we can support them and put in place recovery packages, to try to prevent alcohol being an on-going problem when those people go back into the community. We do not see illicit alcohol use to the same degree as we might see drug use, but I cannot say that we do not have any alcohol on the estate. Illicit alcohol and hooch might appear, but the issue is not as prevalent.

Sharon Dowey: Do you have specific treatments for alcohol misuse?

Suzy Calder: We work very closely with our NHS colleagues who provide the interventions around alcohol and drug treatment, and third sector organisations are also involved at local level in different establishments. Depending on which area of the country the establishment is in, different third sector organisations will offer interventions around alcohol support as well.

Sharon Dowey: Do those interventions work? I am just asking because, obviously, some people do not enter prison as drug users but they leave prison as such. We do not put enough focus on alcohol treatments. Is there any evidence that people move from alcohol abuse to substance abuse?

Suzy Calder: I do not have any evidence that that is happening, but I could not say that it does not. I do not have any evidence to suggest that it is a significant problem.

Could we do more around alcohol intervention? Absolutely. A needs assessment was undertaken a few years back, when Figure 8 Consultancy was working for the Scottish Government. A number of people who had described that they had an alcohol problem in the community when they came into prison identified that, because alcohol was not the source of their issues, they were not necessarily accessing support—they felt safe and alcohol was not a trigger at that point.

We need to do an awful lot more work around how to support people who have an existing alcohol problem to do the work while they are with us, so that there is less chance of relapse when they go out. However, we recognise the challenges for people and the triggers around that. For some people, a prison can sometimes feel like a safe place. When they go back out into the community, issues around access to housing and employment and all the other triggers that exist might have an impact and lead to relapse and a return to drinking. However, we should not exclude alcohol interventions from the support that what we offer.

Sharon Dowey: In your submission, you said that the use of e-cigarettes or vapes is

"the contributing factor to the increase in drug taking in prisons".

Are the drugs coming in via the vapes? You said that saturated items are coming into the prisons. Are individuals using the vapes to smoke them, or do the drugs actually come in with the vapes?

Suzy Calder: They use the vapes to smoke them.

Sharon Dowey: So, the vapes are not actually coming in with drugs in them.

Stephen Coyle: No. The vapes are used as a method to take the drugs.

Sharon Dowey: If someone is caught bringing in items that are saturated in drugs into a prison or giving them to prisoners, is there any penalty or action? Do we catch people who put drones into prisons? Is any action taken against them? What is the penalty for that?

Stephen Coyle: It depends on who is doing it. If it is somebody who is in custody, we can take measures with Police Scotland to charge them for the introduction of drugs; if it is a member of the public, we refer the case. If we catch somebody who is introducing drugs into the establishment, it is a matter for Police Scotland, as it would be for any other criminal investigation.

Regarding items that are being sent to the prison, the challenge is establishing the source. If training shoes, clothes or any other item are being sent to a person in custody, we have to establish the origin—where the parcel or package has come

from. If we cannot clearly identify the individual who has sent the item, we confiscate it.

We have taken measures, because a lot of material comes in. We are negating some of the access points by which stuff might come into the establishment and shutting those avenues down. For example, when people in custody order electrical goods, such as radios, we have taken the step to use a dedicated supplier, so the prisoner cannot secrete items and can order the product only through the prison system. We have moved to photocopying all incoming mail, because paper was being saturated. As Suzy Calder said, items such as cardboard and card were saturated. Clothing is probably the item that is least obvious to members of the public, but it can be saturated, and when the person receives it, they put it in the sink and use water to desaturate its contents so that they then have a product.

When you visit an establishment, I will be happy to speak about the measures that we have taken to combat such things. We could show you how we go about it in practice.

Sharon Dowey: That would be good. Detective Chief Superintendent Higgins, do you want to comment on whether there are any penalties for someone who is caught sending in a drone or bringing drugs into prisons? Is a penalty or charge used as a deterrent? If there is no deterrent, people will continue to do it, so is something in place that prevents them from wanting to?

Detective Chief Superintendent Higgins: The penalty is determined when the case is presented to the court. As Stephen Coyle said, we work with our Scottish Prison Service colleagues as often as we can to investigate, detect and report the circumstances of who is involved in committing offences, which we then report through the criminal justice process.

The penalties are outwith my knowledge. If the committee determines that we should look at penalties, we will work with the Crown Office and Procurator Fiscal Service and return on that point. The people who have been through the system have been reported, but a balance must be struck around sufficiency of evidence, proportionate investigation and so on. We will always look to investigate such cases, because of the harms that drugs introduce to establishments.

Sharon Dowey: Do you want to comment on that, Kirsten?

The Convener: I am sure that we will come back to the issue later. We will move on, if you do not mind.

Pauline McNeill (Glasgow) (Lab): Good morning. The evidence session has been very informative so far. I want to continue on the theme of how drugs get into prisons. That is what the public want to know. They do not understand the complexity of what you are dealing with or the different ways that drugs get into prisons. I will continue Sharon Dowey's line of questioning on the use of drones and your successes in tackling that, which was good to read about.

10:45

Stephen Coyle, you said that, sometimes, drones will drop drugs packages outside the prison windows. How do criminals communicate with prisoners? How do prisoners know where the packages are and who they are for? How does the communication network work, and are you able to subvert it in any way?

Stephen Coyle: As we have spoken about this morning, communication is done through organisations such as serious and organised crime groups. They organise drops through their own network, which permeates the prison system, and might be done through communication that takes place during visits or phone calls. It is beyond our capability to know how they actually arrange it. Unless you are able to prevent communication, you will not be able to stop those arrangements being made.

Depending on the intelligence picture that we build up with Police Scotland colleagues, we might have an idea of when a package might arrive. However, the majority of the drones are flown between 10 pm and 3 am, and we have no prior knowledge of what is coming in and when. The anticipated receiver will obviously expect something to be coming. We have seen lights being switched off and on as a signal to indicate the window where the drone is expected to arrive. Beyond that, we do not have an understanding of how it is arranged.

Pauline McNeill: Do prisoners routinely use mobile phones?

Stephen Coyle: They do not use corporately sponsored phones. However, they do use illicit ones, so that is an obvious communication route. You are aware that we issued mobile phones in the post-Covid period, but those were withdrawn as we moved to the cellular telephony solution. Obviously, a mobile phone in the prison can be used to communicate with the person who is flying the drone or even with the organisation behind that.

Pauline McNeill: Suzy Calder, I think, described the different ways that drugs can enter prisons. Do you have a focus on any of those in particular? For example, do you focus on exchanges during visits or on drones?

Stephen Coyle: No, we look at the issue across the board. There is not one particular avenue—all avenues are fair game with regard to the introduction of drugs. I go back to the example that we gave of photocopying mail. That drives different behaviours, so the paper might now come in on a drone instead. I referred to the payload of drones and the weight that some of them can carry—they can lift 10kg or 11kg—so combating the paper-based approach by photocopying mail just means that the impregnated product will now come in on a drone. It might be in tablet form or in a powder, for example, but you can see the weight of paper that a drone can carry. I go back to Suzy Calder's point that the strength of drug that can be attained with an impregnated product is considerable when compared to tablets or powder.

Pauline McNeill: Detective Chief Superintendent Higgins, you might not be able to answer this, but the committee would like to know whether there have been convictions for the use of drones. If there have been cases in which you had an idea who was behind it and you reported it, there must have been convictions.

Detective Chief Superintendent Higgins: I will need to come back to the committee with the specifics. I am happy to look at that from a UK perspective, if we do not have the data for Scotland. We find that the enabler is often an individual who is co-ordinated by organised crime groups. We can look at that, and I am happy to report back.

Pauline McNeill: Thank you.

I have spoken to many families, including a couple of families of people who have died in custody, who have said that their loved one was not a drug user and did not have a drug addiction before they went into prison. The committee has raised concerns about this many times. We know about the really hard job that you have in maintaining order in prisons when they are overcrowded, but some prisoners are spending 23 hours in a cell. That must have an impact on their mental health. They are not doing recreational activities, for example. What is leading to drug use by those prisoners and are you dealing with them in specific ways, or is it all the same strategy? What Kirsten Horsburgh is describing is the situation in relation to people who were drug users in the community, who offended as a result and ended up in jail. However, there is still a significant proportion of prisoners—you can correct me on the figure, but I think that the survey shows that it is about 17 per cent—who were not drug users when they went into jail.

Suzy Calder: From our perspective, it is really important that we put in place a range of options and support mechanisms for those who come into prison, particularly around their mental health and wellbeing. In recent months, we have published the alcohol and drugs strategy and the mental health strategy. Both those strategies focus on a whole-prison approach—how someone is supported throughout the whole of their day, through access to education, support, advice and NHS colleagues. It is about ensuring that we address their wellbeing, make a positive impact and make positive interventions available to create a space in which they are able to look after their own wellbeing and feel content and happy—as happy as they can be in a prison setting. People should be supported and they should know where to go for that support.

From a prison perspective, the personal officers work very hard with individual prisoners and try to identify what areas of support they might need while they are with us. That might mean referring them to NHS, third sector or wider support to try to reduce the risk that they will initiate a drug problem while they are in the prison setting. It is very difficult to identify all the areas that we would need to identify in order to prevent that from happening full stop. However our efforts and our strategies are very focused on prevention. They interact, in terms of creating hope and connectivity, and we think about stigma and discrimination, and about the provision of safe spaces, which means looking at opportunities for people to talk about their recovery and to engage with peer mentors and with recovery-type interventions.

Even if people are not using drugs, they should be able to access support, including access to the Samaritans and Breathing Space. We create all those options for people. However, the most important thing is the relationship with the individual so that they can say to us that they feel at risk of using drugs or think that they might use drugs. If we can get into the preventative space—

Pauline McNeill: Is that how it works? Does someone who has not been a drug user have to come to you and say, "I feel at risk"?

Suzy Calder: It is a two-way conversation between the personal officer and the individual who they are supporting.

Pauline McNeill: So, if you see someone who has been locked up in a cell—or, in Barlinnie, doubled up in a cell—and who might be at risk, do you identify them as such? Obviously, a significant number of prisoners are at risk, which could be for a variety of reasons.

Suzy Calder: That relies on everybody having knowledge of the individual and the support that they might require. It relies on our NHS and third sector colleagues, and it relies on prison officers. It often relies on the person who is sharing a cell with them or someone who might know them. It

also relies on being able to engage with families so that they can highlight concerns. As you are aware, we have a concern line that families can access and tell us if they are worried about their loved one, so sometimes that is the way in which the information comes in. We are talking about a very complex scenario; if there was an easy solution to prevent someone from taking drugs, we would absolutely use it.

Pauline McNeill: Sure, but, as a complete layperson, I would have thought that there must be some obvious triggers. Are there no identified potential risk factors, such as being in a cell for that length of time and the boredom that comes with not having anything to do? Would that be regarded as a risk factor for someone who was not previously a drug user?

Suzy Calder: Those things could be risk factors, especially if it is someone's first time in custody. What their day and regime feel like can be quite a culture shock. There are risk factors such as someone not having access to their family, or having a fall-out with them. All those things could be risk factors. Therefore, our relationship with them and having those conversations is critical. The most important thing that our officers can do is build relationships with those who are living in prison, so that we can identify where things have changed for them and where things are difficult. Officers get to know how somebody is doing day by day. However, I do not have an easy solution to prevent what you are suggesting.

Pauline McNeill: Sure.

My final question is perhaps for Stephen Coyle to answer. I am just trying to build up a picture of the previously non-drug-using cohort. To your knowledge, are they targeted by criminals outside the jails?

Stephen Coyle: No, there is no evidence—or none that I am aware of—that would suggest that they would be identified as a market, if that was what you were suggesting. There is no evidence to suggest that that is the case.

The Convener: Rona, did you want to ask a follow-up question on that before I bring in Katy Clark?

Rona Mackay (Strathkelvin and Bearsden) (SNP): I will come in afterwards, please.

The Convener: Okay; over to Katy Clark.

Katy Clark (West Scotland) (Lab): Thank you. I want to ask about support for those using substances in prison or, indeed, on release. Can the panel members set out the programmes and supports that are in place for prisoners who wish to address or manage their substance use, whether that is drugs or alcohol? Is the level of provision adequate for the number of people who need to access such services? I do not know who feels best placed to come in on that.

Suzy Calder: It will need to be a combination of us. Kirsten Horsburgh will have wider and direct knowledge of the services that the Scottish Drugs Forum offers.

There is a range of support options for people. The most obvious one is access to the NHS for those who require medical support through medication assisted treatment. The individual will be involved in the programme of work with nurses in the prison establishment. In 2011, we transferred care to the NHS, and all the boards have that.

Different establishments have different levels of access to recovery-type interventions. We have recovery spaces where people go to get broader support. There are peer mentors; there is access to the Samaritans; and Breathing Space will be coming on stream to support people. There are third sector organisations that do broader skills support and engage with people on group work.

Could we do more? Absolutely. Should we be able to do more? Absolutely. Our strategies set out the opportunities to build on what we already do. I think that we would all like to do more in terms of interventions to support people. For those who come into prison already on medication, there should be a seamless process for the NHS to pick that up and support them through that and back into the community.

11:00

We have pre-liberation meetings with people to make sure that referrals are in place for any additional needs that we identify that they will have when they get out, that we have sorted out their housing and that we have engaged with all of our community partners, including those in the NHS, to make everything happen. However, we could always do more, and I am sure that Kirsten Horsburgh will note that individuals would like more support.

Our strategies are now in place, and we have new leads for alcohol and drugs, and one for our mental health strategy. They have come into post in the past six months. It will be their job to engage with all of the partners to see what is possible and how we could engage more effectively, and to continue to push recovery as the key area of work that we should be doing across the whole prison, and not only in one particular aspect of it. People should not have to opt into recovery; it should be available to all.

Katy Clark: Would any of the other witnesses like to add anything?

Kirsten Horsburgh: I can add something from the perspective of some of the peer research and work that we have done in prisons on the medication assisted treatment standards. Some of that has been done in the open estate and some has been done in other prison establishments.

Suzy Calder painted a good picture of how the approach should operate in practice, but, as with anything, there are issues. The first one, going back to the start, concerns how people access support. Prisoners who are using substances say that the potential for punitive sanctions to be imposed is a barrier to their openly asking for support. In addition, the people who were interviewed spoke of a culture of stigma and discrimination and mentioned concerns about how they will be treated by staff if they opened up about using substances, and there is also the impact of what their peers might do if they report drug use.

Another issue is that accessing treatment can be problematic. People report long waiting times and difficulties in accessing specific treatments.

Katy Clark: Can you give a bit more detail on that? The committee is aware of the more general issue with access to treatment and programmes in prison. How long are people having to wait?

Kirsten Horsburgh: I do not know the specifics of timings—Suzy Calder might have further information on that. In the community, the MAT standards indicate that a person should receive treatment on the day that they request it, and that is certainly not the case in a prison environment, so there are disparities.

People also report barriers to accessing Buvidal, which is a long-acting injectable medication. Although a number of people in prison receive that, people still report that there can be some challenges in accessing it. There is a feeling that the prison establishment might think that it is operationally easier to manage the prison when people are on Buvidal than when they are on methadone, so there are some questions about whether taking Buvidal is a true choice for prisoners.

There are also some issues around timeliness, particularly with Buvidal. The injection is required to be repeated within a certain period of time, and people report often having to wait longer than they should. In addition, some people in the open estate report that it is sometimes not provided ahead of home visits. On the train on the way here, I read some harrowing stories from people about the personal impact of that. Somebody spoke about not having their dose before going on their home visit and then not feeling like they could properly engage with their grandchildren because they were feeling withdrawal symptoms, but having to push through it regardless. Obviously, the easiest thing would have been for them to use drugs, but, if they failed a drugs test when they went back into the prison environment, that could lead to years being added on to their sentence or other punitive measures, such as being returned to closed conditions.

There are many barriers to people accessing support. A culture shift is needed, as there must be a move away from punitive measures.

The Convener: John Mooney, do you want to come in on that?

John Mooney: The move away from more punitive measures that we have seen in the community is probably still to be reflected in prisons, which backs up much of what Suzy Calder said about the anecdotal reports and experiences of many people who have had custodial sentences.

We certainly look forward to the MAT standards process becoming embedded in prisons, so that we are able to increase the immediate treatment and recruitment rates and smooth out issues with accessing treatments such as Buvidal. For all the potential pitfalls of overly focusing on a medication assisted treatment model, such issues have been addressed in the MAT system with substantial success, and we hope to replicate that in the prison estate.

Katy Clark: Has any work been done to quantify what additional resource would be needed to adequately help those who are seeking that treatment? Have any panel members done any work in that area, or is the feeling that the service is often not adequate just based on anecdotal evidence?

Suzy Calder: Questions about access to medication assisted treatment would need to be posed to our NHS boards, as they deliver on that aspect. They are the ones that would identify what additional resource might be required in order to meet need or reduce the existing wait times that Kirsten Horsburgh has heard about through her networks. It is for the boards to determine how they do that consistently.

Katy Clark: We do not have anybody here today from a board, but we have Public Health Scotland. John Mooney, do you want to come in on that point?

John Mooney: Our emphasis has been on implementing MAT standards in the community, so there is a little bit of running to catch up in prison and justice settings. We hope that the improvements will be rolled out in due course.

Katy Clark: You have to deal with two main situations: one in which someone is trying to get help, and another in which somebody is not

necessarily trying to get help at all. Could you give a bit more detail on the harm reduction programmes and services that are in place for substance users who want help and are seeking an abstinence route, in prison and on release? Could you add any more to what has already been said about those who want to stop?

Kirsten Horsburgh: People have certainly reported that it is difficult to access detox options in a prison environment. Some risks are associated with detox, particularly around the release period. Normally, healthcare services try to retain somebody on a prescription if they are looking to come off it towards the end of their sentence, because of the risks that arise in that period. We know that people are much more likely to experience an overdose in the first four weeks after their release from prison.

Continuity of care in the community is important. However, there are still communication issues when it comes to community services being able to access the same medications that an individual was on in prison—that is particularly the case with Buvidal. There are, therefore, still issues around detox in the community setting, because, although the prison might provide such medication, the community setting might not, so the options are reduced.

Suzy Calder: To add to the continuity point, through the prison to rehab protocol, we are supporting people to go directly into rehabilitation services on their release day. That network is also available for people to continue their recovery and support.

Katy Clark: Thank you.

The Convener: I am just jotting down your last point, Kirsten. I did not quite appreciate that options such as Buvidal are available in prison but not in the community, so thank you for raising that.

Ben Macpherson (Edinburgh Northern and Leith) (SNP): Good morning. I have a few follow-up questions relating to some of what my colleagues have raised and what you have helpfully relayed to us.

On the prevention of substances entering the estate, Mr Coyle, it was interesting to hear your comments about the difference that the bars on the windows have made. Is the intention to make sure that they are installed in all the prison establishments across Scotland in due course, given the meaningful impact that that has had where it has been done?

Stephen Coyle: The three pilot sites are Glenochil, Edinburgh and Perth. Boringly, the answer to the question would be, yes, we would extend that to the full estate if the resources were available, but that is not the case at the moment. We are having to manage the other sites in the way that we were doing in those three prisons prior to the grilles being installed.

The grilles are having an impact, but we will wait to see what that means in terms of driving the introduction of substances in a different manner—as I said earlier, if we prevent the drones from getting in, it may drive the activity in a different direction. I am trying to anticipate what that will look like in relation to the routes that I have already described.

Ben Macpherson: I fully appreciate that installing the grilles is not a panacea, but it is interesting and helpful to understand the impact that it has had. The committee will be interested to know how those considerations move forward beyond that trial.

Mr Mooney, you talked about the challenge on release. Do you want to say more about working with community partners on that challenge? Can more be done with stakeholders on how we support people who are coming out of the estate with addiction and mental health issues?

John Mooney: Absolutely. There is a wide appreciation of the fact that release from prison is a particularly high-risk period for people, because their drug use may have been controlled in prison but then they are exposed to a less controlled supply outside, with higher concentrations and so on.

There has been a particular focus on the issue in recent months because the early release policy has led to an increase in the number of people being released from prison. That imposes an extra burden on local specialist substance use support services, which, in the current constrained economic times, can have issues with providing access to treatments.

Buvidal is an effective alternative to methadone, but it is a degree more expensive. There is a degree of ambiguity around who covers the costs of Buvidal when people leave prison and are transferred to community settings, as that can lead to an increase in the drugs budget. Alcohol and drug partnerships have been picking up that cost in the past year or so, but, as a prescribing cost, it should go to the health boards and the integration joint boards. I believe that the chief pharmacist has sent a letter to boards to remind them of that. There are still issues with continued treatment, including Buvidal and probably also other treatments.

Ben Macpherson: Can that letter be shared with the committee?

John Mooney: I would have to check. The letter was in preparation for many months, and I know that the alcohol and drug partnerships were

certainly keenly waiting on it. I will find out whether it has actually gone out and get back to the committee.

Ben Macpherson: Kirsten Horsburgh, you talked about what I would argue is a perplexing situation in which we are sending people with addictions to prison, rather than treating them for that addiction. I appreciate that there is a political difference in relation to the Misuse of Drugs Act 1971 and its consequences.

You mentioned that people who are already suffering from addiction are going to prison, and you talked about the need for provision for treatment in prison and on their release. However, we have also heard today—I think that Suzy Calder touched on this point—that people's drug addiction can be initiated in the estate. I appreciate that it is difficult to quantify, but do you have an idea of how many people already have an addiction as they come into the estate compared with people who develop an addiction during their sentence? Is that data available?

11:15

Suzy Calder: I do not have the data around people who begin their addiction in prison, but we can confidently say that a majority of people who come in will have had some challenges in their community around drug use, to varying degrees—some have ingrained dependence and some less so, but a lot of people come into the prison estate with pre-existing concerns around their drug or alcohol use.

That is why it is critical that we have that relationship with our community partners, to ensure that we pick up the information around someone's community engagement and support them when they come into prison. In order to understand and support the person when they arrive at our door, we need that information from our community partners.

Ben Macpherson: Do you want to say any more on that, Kirsten?

Kirsten Horsburgh: In relation to people who are coming in, you will have the numbers from the prevalence testing. To go back to the point about people who start their drug use in prison, as you know, it is an environment where there is a pretty wide availability of drugs. We talked previously about triggers and what might be going on in somebody's life. People have their own vulnerabilities in relation to things such as anniversary dates or children's birthdays and so on, and they see other people using drugs, perhaps for escapism or to deal with their current situation; it is no surprise, therefore, that when there are so many drugs in prison, people look to that option to manage their situation.

All of that goes back to that wider systemic failure. You asked the question about substance use on release. The issue is not so much about somebody linking up with their substance use provider but more about housing, benefits and the whole throughcare process, which is not meeting people's needs. More work needs to be done on the wider support for people who are leaving a prison; it should not be only about people getting their prescription, which has loads of different complexities involving issues such as pharmacies refusing to take on people's prescriptions, which means that nurses have to scrape around to find a prescriber for the person. My background is working in an NHS drug treatment service, and we faced issues around communication—a person would just appear and we did not know that they were being released, perhaps because they were on early release. There is a communication issue with regard to getting it right for people.

Ben Macpherson: Some of the answers have touched on the issue of the success that Police Scotland has had in tackling organised crime in our country—indeed, it is prevalent in all that we have discussed. Do you want to say any more about the impact of having more organised crime groups in our estate?

Stephen Coyle: To reiterate what we said earlier, there has been a proliferation in the past three or four years of senior nominals who are involved in the whole chain from supply to distribution and that has an impact in relation to the introduction of commodity, not only in a prison but in the country. The fact that those people are in prison is not a barrier for their continuing their operations, and that is a particular challenge.

Rona Mackay: I would like to ask about the impact on prison staff and other prisoners, but, before I do so, I would like to pick up a wee bit on Ben Macpherson's earlier question. I was really interested in what Kirsten Horsburgh said at the start of our session about not believing that people with drug use or addiction problems should be in prison. I totally agree with that. I am very interested in the issue of women in prison, the majority of whom are there with mental health or addiction problems, and I totally agree that they should not be there. Kirsten also said that she would be in favour of decriminalising drug use, and I want to ask John Mooney whether he agrees with that.

John Mooney: There are definitely benefits in moving towards a less criminalising approach to tackling drug use. The wholesale decriminalisation of drug use would potentially introduce other issues, but there is certainly a case for having a much less criminalising approach.

Rona Mackay: We should be looking at that.

John Mooney: I take my hat off to the police I have worked with—in the north-east and elsewhere—who have really enlightened approaches to tackling drug use and are moving towards harm reduction. There have been great strides towards what we might call a lower criminalisation ethos around drug use.

Rona Mackay: Thank you for that. Stephen Coyle or Suzy Calder, will you comment on the impact on prison staff of having to deal with this issue and on the impact on other prisoners who do not use drugs but might be affected by it? Do you feel that your front-line staff and NHS healthcare staff have enough training in it?

Suzy Calder: The issues in prisons around drugs are a concern for us all and, in particular, for the staff who, from day to day, might witness people being intoxicated or under the influence of substances and, sometimes, being critically unwell. Their behaviours can be quite difficult to manage, and a prison setting can be a difficult and scary place in which to work.

Recently, we set up a national drug incident management team, in which we engage with our partners across the police, the third sector, public health and other organisations including the Scottish Ambulance Service. Around the table, we look at the national response to incidents or to situations when a cluster of people are using, because those can be a crisis point for folk.

At the local level, we have a problem assessment group. For example, if three or four affected staff have had a difficult time over a weekend because a number of folk were using substances and were under the influence, and their behaviours were difficult to manage, we will pull a group together. We will speak to the staff involved—including our NHS staff—to hear what happened, what they saw, how they felt and what we could do to help them. As a wider group, we are able to wrap around support for those staff. We often hear that they feel exasperated because they cannot help, or they were unable to help at that time. They might have feared that somebody could die—that is often a real fear for staff. It is a difficult place for them to be in.

With those groups, we can get support from our wider network of colleagues and consider what additional harm reduction work we can do. For example, we have had the Ambulance Service come in and work with our staff to reinforce existing training, particularly on naloxone. We bring in different organisations to work with staff so that they can hear about that. Our staff also have access to wider support through our occupational health provision.

As I say, there is wider support for staff, but we should not undersell how difficult it is for an officer to come in and witness what they see. People are often unconscious, or dipping in and out of consciousness—at times appearing fine and then very quickly deteriorating. That creates a lot of anxiety for all staff concerned.

Rona Mackay: Is the training keeping up with the changes in drugs as they evolve, so that prison staff are aware of different reactions that could happen? Does that training start right from when staff come into the Prison Service? Is that part of the training module?

Suzy Calder: Elements of the training for recruits cover that. Because we now have an alcohol and drugs strategy and a mental health strategy in place, we are working with college staff on identifying training needs for our own staff and more widely, and on considering how we might address them. We work quite closely with our NHS colleagues, who also deliver some training. However, we need to do more. It is a very fast-paced, evolving problem. What we might have seen six months ago is not necessarily what we are seeing now.

Rona Mackay: That was my point. Is the training keeping up with those changes?

Suzy Calder: We rely quite heavily on the information and advice that we get through our public health colleagues, and we work quite closely with organisations at the local level to make sure that information is being passed on. We communicate those messages, but it is very difficult to get ahead of the game on that. Sometimes it is difficult to predict what might be coming in the next two or three months so that we can make sure that our officers are armed.

Rona Mackay: It undoubtedly must be a huge pressure on staff.

Suzy Calder: It is a huge pressure. We try to give people direct access to us as well; they can come to our health team at our headquarters and ask questions, and we will go out and source information. We try to be proactive and pre-emptive about putting information on our SharePoint for people to access. However, it is incredibly difficult, and we could do more to try to keep up with that. Identifying our training needs will give us a good feel for where the critical points are, what we can do, and what we could do differently. All of that comes with resource implications, though. There is also an impact from population numbers being quite high and staff feeling overwhelmed with the various priorities that they have to deal with from day to day. Prison is a difficult place when it comes to drug and alcohol issues.

Rona Mackay: I can imagine. I will ask Detective Chief Superintendent Higgins about the same aspects. Are the police keeping up with the

changing market in drugs out there? How can we deal with that, and how can we detect those drugs?

Detective Chief Superintendent Higgins: We probably have a very similar experience. We proactively try to inform people as much as we can. There has to be a whole-system approach across communities to capture the trends that we see locally and nationally. If I am honest, quite often those trends will come from the big cities down south. We have to make sure that we are plugged into that information and are sharing it. Sometimes it can be a challenge to do that for the types of drugs that are starting to be prevalent within our communities and to disrupt the supply of them as early as possible so as to reduce their harm. Our approach must also involve educating our front-line officers and staff, including on dealing with members of the community who are in crisis, when we are going into houses and so on.

Rona Mackay: Do you give refresher training on that?

Detective Chief Superintendent Higgins: Through various different means and mediums, we try to share that information. A lot of the time, information will come in and we will put out a requirement, saying, “This is what we’re seeing.” There is a significant body of work across the UK—not just in Scotland—on early notification of trends. For example, project housebuilder, which focuses on the harm presented by substances such as nitazenes, involves a very well-structured information-sharing process across our partners. There is also training for our staff on that aspect.

Rona Mackay: That is encouraging to hear. I will quickly go back to Kirsten Horsburgh on the women in prison element. Far too many women who are in prison have addiction and drug problems, and the knock-on effect that that thaton children and families is horrendous. Often, those women are in for relatively minor offences—for example, shoplifting to feed their habit. Are they there because there is a lack of holistic care outwith the Prison Service for them to access?

Kirsten Horsburgh: That is definitely a symptom of the wider systemic issues involving drug treatment and the opportunities available to people. It requires really looking upstream at trauma, lack of opportunity and so on. I think that the situation absolutely reflects that. It goes back to my point about looking at out-of-custody options for people so that we focus more on treatment and support rather than on punitive measures and people being in prison.

11:30

I will add something to your discussion on workforce. We offer a range of training options across the prison estate and in the community. In a couple of prisons we have done workshops with NHS and SPS staff to identify their needs. That reflects what has been said about the need to have broader information.

In previous years, we have found that requests for our training have been made reactively rather than proactively. If there have been incidents involving several overdoses in a prison the staff there might ask us to do overdose training. However, we are now putting a process into place so that it is done regularly. Some prison staff commented that they have trained in specific restraint techniques for particular situations, but now they are extremely worried about using them in case they have some influence on a person’s breathing if they are using a particular substance. There is a lot of uncertainty, and there is a confidence issue.

Overwhelmingly, there is still a need to address stigma within the Prison Service and the police. I have had the task of delivering naloxone training across the prison estate and with Police Scotland, and I can attest that there is still an issue with a generalised stigma towards people who use drugs. There is definitely a need to focus on that, too.

The Convener: Before I bring in Fulton MacGregor, I want to pick up on the question about the impact on staff of caring for people who are living with drug harm. To what extent are overcrowding and the stubbornly high prison population making that situation more complicated or difficult, not just for prison officers but for other staff who work in prisons, particularly those who support people who are impacted by drug harm?

Stephen Coyle: I would categorise that as the primary risk that the prison environment faces. The pressure on services is driven by the sheer volume and demand. The demand far outstrips the availability of any support.

The Convener: Suzy, would you like to add anything?

Suzy Calder: No—that is the position. The more staff we have, the more we will be able to support those affected when resources are limited and there is overcrowding or a high number of people are in our care, as is happening at the moment. It is challenging for all services to be able to deliver the maximum that they would like to be able to.

Fulton MacGregor (Coatbridge and Chryston) (SNP): This has been a very interesting first session on this topic. My first point

is about custody being an outcome for people with addictions, which Kirsten Horsburgh spoke about. Rona Mackay and Ben Macpherson commented on it, too. However, rather than asking any more questions on that, I hope that the fact that there has already been a good discussion on that issue might lead to the committee doing further work on it. I would like that to be the case, because I completely agree with what has been said.

I was going to ask questions about staff, but Rona Mackay and the convener have already covered them. I was also interested to hear about the welfare considerations for staff who could be dealing with deaths in prison.

Another staff-related angle is the pressure on those who are working in the current context. It strikes me that your staff in prisons are dealing not only with a very vulnerable group of people but with organised criminals. When I think about prison staff, I always consider that they themselves are quite a vulnerable group, because organised criminals will go to all ends available to get their drugs into prison or wherever else. What support do you provide for staff to help them with managing the people that they might come into contact with? Do you have specific training for that, or is it more about providing support?

Ben Macpherson: Okay, thank you.

Stephen Coyle: We take a range of approaches to supporting staff: we share intelligence about who is in the environment, and we do risk assessments, so safe operating systems are in place when staff engage with individuals. Without going into the tactical aspects, a support mechanism is in place for staff, which ensures that they are very clear who and what is on their landings and what the capabilities are of the individuals who are on them. The intelligence picture is built by what the staff witness in their day-to-day interactions with individuals. The staff are well trained and well versed in the processes and barriers, so they know what an appropriate relationship is and where the challenge comes from.

That also has an anti-corruption element, which is due to what staff are exposed to, as you said in your opening statement. Addressing that is a constant challenge and part of the safe system of work and risk assessments that we have to carry out on a daily basis.

Fulton MacGregor: I can imagine. It sounds like you have quite good protocols and procedures in place for things that might happen in work. Is there any guidance in place for what staff should do if they are approached outside of work?

Stephen Coyle: The reporting mechanism is the same outside as it would be inside. I go back to my earlier comments: prison is part of the community, not set aside from it. You realise that staff will know people who are in prison. They will have been at school with them and live alongside them in the community, so they are well aware of the professional boundaries and where they come from. They have professional boundaries training as part of the overall awareness package so that they have the ability to carry out their duties unhindered and unfettered. If an approach is made on the outside, a clear mechanism sets out what staff have to do with such information.

Fulton MacGregor: Would that information be reported to you?

Stephen Coyle: It comes into the establishment in the first instance, and then we assess what needs to be done. A range of measures can be attached to the process, such as escalation to Police Scotland colleagues. Without going into the detail of what happens, we have had fairly recent examples of that, which we dealt with fairly successfully.

Sharon Dowey: Kirsten Horsburgh, I do not think that anybody disagrees that there should be diversion from prosecution and that more support in the community is needed for people who have addictions. However, in your evidence, you mentioned the words “punitive sanctions” quite a lot. You have also said that people have been put into prison for drug offences. Is there any data about why people have been sent to jail? I am interested to know whether you mean that people have been sent to jail for a drug offence alone, or whether it is because they have committed murder, raped somebody or assaulted somebody while on drugs.

I agree with Rona Mackay, who said that too many women are in prison, and many are in for shoplifting. However, I speak to retailers who work in shops, and they say the shoplifting is prolific. Usually, assault is involved, and people are charged with shoplifting multiple times before they go to jail. Is there any data on what people have been sent to prison for? Is it only drug offences that they are being sent for or, along with being addicted to drugs, have they done multiple other things?

Kirsten Horsburgh: That data is available, but I do not have it to hand. It is a known fact that many people who are in prison are in for non-violent drug-related offences, and substance use is the driving factor for their crime, which may be shoplifting or something else. We need to take a proportionate response.

The issue of punitive sanctions also relates to those who are in the prison environment. In prisons, the system that is in place might mean that, if somebody has been using drugs and people are potentially worried about it, the

individual gets their prescription withheld or stopped, or, if they are in open conditions, they might go back to closed conditions. It is well known that punitive policies and processes for dealing with drug use are not working, and it is well evidenced that that is not a good approach.

In the example that you gave of someone who has been a prolific shoplifter and has committed multiple offences, what support has been offered to them before they have ended up in prison? Has there been a good community response through measures such as diversion schemes and treatment support to address other issues in their lives that have led them to require to shoplift to fund their drug use?

Sharon Dowey: So, you are saying that there needs to be earlier intervention in the community to stop such people going down the route of committing multiple offences, which makes retailers victims, given that such people commit multiple offences before they are eventually sent to prison.

Kirsten Horsburgh: We need a bit of both, do we not? There needs to be a bit of everything.

Sharon Dowey: You mentioned police warnings. Is there any data that would enable us to see whether there has been any change in drug use or habits since recorded police warnings were introduced? I ask because, since those came into effect, green—I think that that is what it is called—can be smelled everywhere, whether you are walking along the street in cities or wherever. You did not used to smell it anywhere.

Since the practice of issuing police warnings came into effect, has there been a change in drug use? Have people started to think, "Oh, well—nothing's gonnae happen to me"? Has that encouraged people to have drugs, because it has no consequences?

Kirsten Horsburgh: That is certainly not what we hear from communities. If anything, people have not noticed the recorded police warning system having any impact at all, because it is not reaching the individuals we imagined that it would help.

We have previously asked for data on police warnings. I should make it clear that it is not the case that no such data exists, in case I came across as saying that there is none. There is some data on that, but when we have asked for it, we have been advised that a manual trawl through police records would have to be undertaken and that that was not feasible.

We definitely need to look at that as a policy response and see what impacts it is having. Is it having an impact on the people it might have been intended to help? Is it having an impact on sentencing? Is it having an impact on people attending court? All those questions are unanswered.

The Convener: Ben Macpherson wants to come in.

Ben Macpherson: Kirsten, you mentioned the fact that a wide range of considerations need to be taken into account in order to support someone who comes out of prison—in particular, they need to be given support to discourage reoffending and to help with any mental health issues or addictions. There is a lot of great work being done. For example, in my constituency, we have Circle Scotland and Fresh Start in the third sector, in addition to the statutory services.

For some time, members of this committee—in its present form and in previous incarnations—have talked about the need for support to be provided for people as they come out of prison. Of course the situation will be different in different geographical areas of the country, but do we need to give greater consideration to central services, collaboration between services or the use of a set procedure? A lot of great work is already being done, but we want to learn from our inquiry whether refinements can be made, whether we can have greater collaboration and whether there is a better way of achieving consistency.

Kirsten Horsburgh: We often talk about reintegrating people into the community when they were never integrated into it in the first place. We need to look at all the issues that you mentioned. Housing can be one of the most complex issues for people who have been released from prison. If they are in temporary accommodation or really unsuitable accommodation, that can fuel the chaos that was in their lives before they went to prison.

In a previous role, I worked with people who said that their lives in the community were extremely problematic. They would go into prison and have food available, be able to get qualifications and access to treatment and to build up potential work skills, but then they would come back into the community, be in temporary accommodation or sofa surf or stay with friends, and be heavily exposed to all the same risks and issues that they were exposed to previously, so support for people in that position is crucial.

I know that organisations from outside the prison work inside to try to smooth that process, but the throughcare—how we fully support people to make the best of going back into the communities where they will face the same problems that were there before they ended up in prison—really needs to be looked at.

11:45

Ben Macpherson: John Mooney, do you want to add to that?

John Mooney: I want to acknowledge the fact that one of the drivers for the medication assisted treatment standards is to address those wider issues that people face and not only that of prescriptions. MAT standard 8 concerns advocacy, including for housing and welfare support systems. It will be implemented in the next year or so and will apply to anyone who is affected by substance use, including people who are being released from prison. Those services are recognised to be needed, and investment is being made in them.

The Convener: I will stick with the issue of MAT standards, which we have touched on throughout the meeting. The SPS recovery strategy states that the MAT standards will be fully implemented by April 2026, in about a year's time. Obviously, we are in a difficult situation at the moment with regard to the prison population and the complexities to do with the fact that different, more toxic substances are finding their way into prison.

I will bring in Stephen Coyle and Suzy Calder to give us a bit of a progress update on the MAT standards and the work towards their being implemented by that date next year. I will also invite John Mooney to make a general comment about where we are overall with MAT standards in the prison context and aspects of that that we might not have covered.

Suzy Calder: Since the inception of the MAT standards, we have been working with our colleagues who have had the responsibility for their broader implementation. We already work closely with our NHS partners on elements such as access to treatment and the right range of treatment, which will include things such as the prison to rehab aspects. We also have the Scottish Recovery Consortium in all the establishments, which is looking at recovery from within. We are undertaking a range of interventions on the journey towards implementation of the MAT standards.

However, we are not solely responsible for delivery against the MAT standards. We are very much reliant on the support of our wider organisation and of our colleagues—particularly those in the NHS—to deliver on some of them. We are members of the MAT standards in justice group, and we engage with our colleagues more widely to ensure that that work is in place.

The critical thing for us was to publish the strategy and to have in place a lead for it. We have an alcohol and drug strategy lead whose responsibility it is to co-ordinate engagement and to ensure that we have the right parties around the table and that we are doing our bit from the point of view of what the SPS is responsible for. Responsibility for delivering the MAT standards cannot rest only with the SPS, without all our partners. That work involves a lot of resource and it has a big impact.

To say that all the MAT standards will be fully implemented and embedded by April 2026 is a very ambitious target, but we are working towards ensuring that we are on that positive journey forward. I could give you examples of our supporting interventions by the alcohol and drug partnerships—for example, through the ADP in Highland, a psychotherapist was appointed to support people in HMP Inverness. There are examples of local work that we are doing with our ADPs to progress towards full implementation. However, the responsibility for that will sit with John Mooney and his team.

John Mooney: As has already been alluded to, prisons present a number of additional challenges for the implementation of MAT standards. There is a broad consensus among those who are involved in implementing them in the justice sector that April 2026 is a rather optimistic target for the timeframe.

One thing to remember is that the implementation of MAT standards in the community was accompanied by a substantial injection of additional resources into alcohol and drug partnerships through the national mission funds, which are coming to an end in March 2026. There are already resource implications as a knock-on effect of that. Colleagues in the justice sector might make an argument for an increase in resources, given those additional challenges.

On the plus side, our written submission for this meeting mentioned His Majesty's Inspectorate of Prisons for Scotland standards 5 and 9. I was gratified to see that there is a substantial overlap between those standards and the MAT standards and, in particular, the human rights-based ethos of the MAT standards' implementation.

When it comes to the buy-in of prisons and the direction of travel, a significant degree of progress has been made, but there are unique features of the justice environment that might involve tweaking the thresholds that we use. Inevitably, the markers for how we measure and benchmark MAT standards are going to have to be slightly different in prison settings from what they are in the community. A substantial amount of that work is yet to be done or is in development.

With all those caveats, I still have an optimistic view, but there are challenges ahead.

The Convener: Thank you for that. I have a follow-up, which Kirsten Horsburgh can perhaps come in on. This is a big question: are the MAT standards still relevant? I am not suggesting that

they are irrelevant, but are they still relevant, given where things have shifted to and how they are shifting, particularly in the context of drug use or drug harm in prison? Is there anything that you want to add on how effective the MAT standards still are?

Kirsten Horsburgh: The reason that they were named "medication assisted treatment standards" is that they could encompass a variety of different drugs, although we have seen that, in the community, they have been heavily focused towards opiates. That is because, while we have opiate replacement therapy, we do not have replacement therapies for other drugs. There has been a shift in the community to much more cocaine and crack use, and there is no specific medication that can be provided to address that.

When we think about MAT standards in a prison context, there are different trends of drug use in prison. For instance, synthetic cannabinoids are the drugs that are most heavily reported to us, and, of course, there are benzodiazepines. There are potential prescribed treatment options for those and for some opiates as well. What we have not discussed in this meeting is the potential introduction of nitazenes into the prison environment. We have seen that the use of those is growing in the community, and although their use has not yet infiltrated into the prisons a great deal, there is nothing to say that that could not happen.

Earlier, we were given a perfect demonstration of all the different routes for getting drugs into prison. The SPS is in a very difficult situation. It might have responded to the use of drones by installing bars on windows, but people have moved back to old-fashioned methods, such as throwing things over the walls. People will adjust, depending on what the response is.

The fact that there are so many different routes increases the risks for people who use drugs in prison, because it means that they have to use their drugs in a different way, so it is more difficult for them to dose effectively.

With regard to the liquids that are coming into prisons or the waxy substances, which Suzy Calder referred to, that are being used in vapes, people report finding it very difficult to judge doses, so those substances are potentially having more severe effects. Ultimately, all those routes and all those responses have a negative impact on the people who are at the most risk of harm.

We need to have the uncomfortable discussion about what harm reduction in prison means. Does it mean providing safer injecting equipment or safer smoking equipment? Does it mean having discussions with people about how they can use their drugs more safely? We have discussions about overdose and naloxone, and there are excellent examples in prison of peer-led naloxone distribution to people the night before release. People in prison cannot access naloxone during their sentence, but they are anxious to call for help in settings in which somebody might be at risk. There is a lot for us to discuss about what a harm reduction response in prison actually looks like.

The Convener: Thank you for that—that was fascinating.

John, do you want to add anything on MAT standards and whether they are still meeting the needs of the work that is done in prisons?

John Mooney: Kirsten Horsburgh pointed out that there has been an overemphasis on opiate substitution therapy since the inception of the MAT standards. That is partly because of what is most easily measured and what is best evidenced, because another integral component of the MAT standards approach is wider harm reduction. Although there are not medication options—with the potential exception of the benzodiazepines, which are subject to a couple of pilot schemes in Scotland—the evidence base for the beneficial effects is still a bit equivocal.

Wider harm reduction can include specific measures such as cardiovascular health screening for people who use cocaine and more psychosocial types of intervention such as counselling approaches to reduce the harm from other drugs. There are not needle exchange programmes in prisons for the obvious reason that that would seem to condone drug use, but that is an omission in prisons that does not exist in the community, so a number of issues in relation to wider harm prevention could be thought through a bit better.

Therefore, the MAT standards are not irrelevant to prisons, but there is a lot of scope for adapting them and tailoring them much more closely to the needs of substance users in prisons.

The Convener: That was really helpful.

We are nearly at the end of the evidence session, but I have a question for Stephen Coyle, Suzy Calder and Detective Chief Superintendent Higgins. When there is, sadly, a death that is suspected to be the result of, or related to, a drug overdose, that must have a significant impact on staff, other prisoners and other people who work in the prison environment. I am interested to know about the impact that that can have on the whole prison population.

Suzy Calder: Any death in a prison is difficult and tragic—I think that we would all say that. When there is a drug death or a suspected drug death, that definitely has an impact on members of the wider community who are living around that

and on people's anxiety, because people build relationships with one another during their time in prison. Our staff also build relationships with the people who they look after, so a drug death is particularly difficult.

With regard to how people manage that, any death is difficult. I have been a nurse for 30 years, and I have never had to deal with a drug death face to face, so I can imagine how challenging it can be for the staff who go in and find that that has happened, because it is so tragic. The impact on the family and the wider staff is difficult. It is a very sombre moment. We put an awful lot of support around staff, and we have support from the chaplaincy, which does a lot of work with staff.

We also work very closely with the wider group of people who are living in that area. Lots of support is offered to them, because it will have had an impact on them—they would have seen the person the day before, for example. We try to wrap around all the support that is needed to give people the space to deal with it—and not only at the crisis moment, when there is lots going on. We tend to find that people are very respectful when the police and ambulance staff come in and they know that staff are dealing with the crisis. They are often very worried about the impact on the staff.

Therefore, there is a need for us to follow through with support, not only on the day in question, but on days beyond that, so that we keep in touch with people and ensure that they feel supported and that they know that they have access to someone to talk to about the grief that they might feel. Quite a lot happens with regard to the support that we provide.

12:00

The fact that partners such as the police might come in can raise anxiety. While we are trying to deal with a really sad situation, people get quite anxious, because there is a lot of activity and they are often shut behind their doors and not fully aware of what is going on. It is a difficult time; a death is incredibly tragic for everybody round about.

The Convener: Yes, of course.

I will bring in Detective Chief Superintendent Higgins. Police Scotland has a follow-up role, if you like, so it might be helpful for committee members to understand that role in the aftermath of a death that is suspected to be connected to a drug overdose.

Detective Chief Superintendent Higgins: We follow well-established protocols in relation to any investigation into a death; in this case, we are talking about drug-related deaths. We are also acutely aware of the impact on the community, which Suzy Calder has outlined. It can have an impact on the establishment, the community on the hall and the staff. A thorough dedicated investigation is needed, but we also need to be alive to the need for timeousness.

We have a victim and we need to support the people involved and their families with wraparound support. That includes providing current, reliable information to the families, carrying out a detailed investigation and reporting to the procurator fiscal, which will allow for further assessment and the establishment of a fatal accident inquiry.

For us, there is also a follow-up process to understand how the victim got the drugs and administered them and how the drugs got into the prison, to see whether there are any opportunities for us to disrupt that path and share our intelligence with colleagues in the prison as quickly and efficiently as possible.

The Convener: It is helpful for people to understand what that role looks like.

We are a couple of minutes over our time, but does anyone want to add anything that we have not covered? We have got off to a really good start.

John Mooney: With regard to harm reduction, substantial progress has been made on blood-borne virus screening in prisons and follow-up treatments. That is another important aspect of harm reduction that comes under the MAT standards, and prisons have been making good progress on that.

The Convener: Thank you for that. I thank you all for attending. I want to place on record our thanks to Inspector Susan Cook of Police Scotland for all her help as our liaison contact in Police Scotland. Susan is returning to front-line duties. We wish her well and thank her for all her support.

I now suspend the meeting for five minutes to allow our witnesses to leave the room.

12:03

Meeting suspended.

12:11

On resuming—

Subordinate Legislation

Firefighters' Pensions (Remediable Service) (Scotland) Amendment Regulations 2025 (SSI 2025/113)

Police Pensions (Remediable Service) (Scotland) Amendment Regulations 2025 (SSI 2025/114)

The Convener: Our next item of business is consideration of two negative statutory instruments, which relate to pensions for police officers or firefighters. In relation to the instrument on police pensions, I declare an interest as a retired police officer.

I refer members to papers 3 and 4, which set out the purpose of the instruments. I note that the Delegated Powers and Law Reform Committee made a series of recommendations about the drafting of both instruments, some of which the Scottish Government does not seem to have responded to. Therefore, irrespective of whether the committee agrees that the instruments should come into force, I think that we should write to the Scottish Government to ask why there has been no response. Do members agree to that proposal?

Members *indicated agreement.*

The Convener: As members have no other recommendations to make in relation to the instruments, are we content that they come into force?

Members *indicated agreement.*

The Convener: That brings the public part of the meeting to a close. Next week, we will continue to take evidence as part of our inquiry into the harm caused by substance misuse in Scottish prisons. We now move into private session.

12:13

Meeting continued in private until 12:41.

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