OFFICIAL REPORT
AITHISG OIFIGEIL

# Criminal Justice Committee

**Wednesday 3 September 2025**

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

# Wednesday 3 September 2025

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## CRIMINAL JUSTICE COMMITTEE
**21st 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:**

Dr Catriona Connell (University of Stirling)
Dr Lesley Graham (Scottish Health Action on Alcohol Problems)
Marianna Marquardt (Scottish Families Affected by Alcohol and Drugs)
Haydn Pasi (Sacro)
Gillian Reilly (NHS Scotland)
Hamish Robertson (The Wise Group)
Dr Craig Sayers (National Prison Care Network)

**CLERK TO THE COMMITTEE**

Stephen Imrie

**LOCATION**

The David Livingstone Room (CR6)

# Scottish Parliament

## Criminal Justice Committee

*Wednesday 3 September 2025*

*[The Convener opened the meeting at 09:31]*

## Decision on Taking Business in Private

**The Convener (Audrey Nicoll):** Good morning, and welcome to the 21st meeting in 2025 of the Criminal Justice Committee. I very much hope that everybody has had a good summer. We have received no apologies.

Our first item of business is a decision on whether to take in private item 3, which is a review of the evidence that we will hear today. Do we agree to take that item in private?

**Members** *indicated agreement.*

## Substance Misuse in Prisons

09:32

**The Convener:** Under our next item of business, we will continue our inquiry into the harm caused by substance use in Scottish prisons. Today's session gives us the opportunity to take evidence from two panels of witnesses with experience of rehabilitation, throughcare and post-release support. I am very pleased to welcome: Gillian Reilly, head of service for the alcohol and drug partnership executive at NHS Scotland; Haydn Pasi, head of the national voluntary throughcare partnership at Sacro; Marianna Marquardt, policy and research officer at Scottish Families Affected by Alcohol and Drugs; and Hamish Robertson, director of data and insights at the Wise Group. You are all very welcome, and I thank you for joining us this morning.

I refer members to papers 1 and 2, and I thank those witnesses who have provided written submissions. I intend to allow up to 80 minutes for this session.

As ever, I will begin with an opening question. The focus of today's session is, as I said, rehabilitation, throughcare and post-release support, however, I will open up with a general question just to set the scene. I will come to Hamish first and then work across the panel, asking you for your thoughts and comments.

To what extent is substance use in prison driven by supply-side issues—for example, the availability of drugs, illicit medication trading and the lucrative market associated with drug supply in prison—set against the demand-side issues such as boredom, trauma and self-medication? Again, to what extent is substance use in prison driven by that demand and supply effect, and what further steps can be taken to address the supply side specifically?

**Hamish Robertson (The Wise Group):** Good morning and thank you for inviting me to give evidence. Some of my remarks will draw on our 12 years' experience of delivering the new routes service, which was a national throughcare service for male prison leavers. We can draw on quite a lot of data from there and also from the Fraser of Allander Institute's long-term independent evaluation of the service.

Regarding substance use in general, over 12 years the new routes service supported almost 11,000 people, 80 per cent of whom reported having such issues. The evidence from that longish period of time showed that the primary drivers were on the demand side: people predominantly reported that they had been using substances prior to their incarceration and that

such use was exacerbated during their period in custody.

Supply-side factors clearly make a contribution, too. I can give one example. When we looked at the 2023-24 data, we saw that although about 85 per cent of participants said that their knowledge and understanding of the pros and cons of substance use had been improved through working with the new routes service, only 28 per cent actually made progress on that while they were in custody. Despite the service's mentors doing a lot of work to engage individuals with in-prison recovery cafes, addiction teams and national health service teams, any progress made in custody was not as good as it could have been. A lot of progress was made following prisoners' release, where there is wider access to community activities and there is more freedom and opportunity for people to work holistically on the issues that cause substance use. That all suggested to us that the supply in prisons meets and exacerbates demand rather than creating that demand in the first place.

Steps could probably be taken, and I can give one example of those if that is appropriate. We work out of HMP Addiewell to deliver a throughcare service on behalf of Sodexo, which commissioned that service after spotting certain gaps in its provision. Interestingly, almost all the work that Sodexo runs there—including work from faith-based groups, education, training and throughcare—is geared to the recovery pathway within the prison. The vast majority of challenges in running a prison relate in some way to substance abuse, so Sodexo has geared almost all its prison delivery around ensuring that people are well embedded in the recovery pathway.

We work across about 20 prisons in the north-east and north-west of England. Both privately and publicly owned prisons down there seem to be moving in a similar direction and gearing almost all of their work to recovery pathways.

**The Convener:** Thank you for that. I am sure that we will come back to how to tackle the demand side of the issue.

**Marianna Marquardt (Scottish Families Affected by Alcohol and Drugs):** A view that has come from the families' perspective is that it can be quite difficult to separate supply and demand, which work together to shape what substance use looks like in prisons. Supply can change or exacerbate what substance use looks like for people, but the demand side is key. People are always looking for a way to escape trauma and boredom and to adjust to the prison environment. From speaking to families we know that there will always be someone who wants to make money by supplying that demand, so addressing the demand side is key.

For example, someone might enter prison with an alcohol problem but, because they cannot access it there, and due to the ready availability of spice or synthetic cannabinoids, will resort to using those substances instead. They will come out of prison with problems with those, or with more complex needs that it might not be possible to address in the community, which can then feed into a cycle of going in and out of prison.

That perhaps shows how supply and demand can work together. I do not have much expertise in what can be done about supply, but families have said that working to address demand is a key part of tackling substance use in prisons.

**The Convener:** It is interesting that you refer to the complexities around co-dependency—for example, where somebody comes into prison using alcohol and how that bears out in a shift towards using other substances. I am sure that we will come back to that.

Does Pauline McNeill want to come in at this point?

**Pauline McNeill (Glasgow) (Lab):** Yes—I want to ask Marianna Marquardt a question.

You talked about trauma and boredom, which are running themes. The committee has been exploring issues around the availability of rehabilitation programmes and individuals having things to do in prison. I get a lot of letters from prisoners who say that they are not getting access to rehabilitation. We know that prisoners are spending too long in cells because of overcrowding. Is it time to try to solve that side of the problem by giving them things to do and to aim for? That could make a difference to the demand for drugs in prison.

**Marianna Marquardt:** Absolutely. A key point in our discussions with families was the need for purposeful activity, routines and, for many people, not being kept in their cells for long periods of time—up to 23 hours a day, in some cases.

What has come out of those discussions is the need to address staffing and resourcing issues and their impact on people's ability to access activities. If there are not enough staff, or if they need to be directed elsewhere, that can have an impact on people's ability to access mental health groups, appointments and visitation.

I do not know whether this is completely relevant to your question, but I highlight the stigma around what is needed for people who are using substances. Access to peer support and third sector-facilitated groups and activities is an essential aspect of their mental health—it is not a privilege, as some people have said. Families have given examples of various situations in which people have been caught with drugs, or using

them, or they have had altercations, and they have then had their access to visitation, activities and meetings revoked because that is considered to be a privilege, when it is actually an essential part of people's health and recovery.

Family inclusion and being able to see and communicate with family members is an essential part of not only families' wellbeing, but the wellbeing and recovery of people in prison. Family involvement is known to be essential.

I may be rambling on, but my point is that rehabilitation and recovery need to be holistic and therapeutic, and people—especially families—are not seeing that consistently across the estate.

**Pauline McNeill:** Giving prisoners something to do is not just about rehabilitation. You talked about boredom. Presumably, if we are interested in getting people off drugs in prison, ensuring that they have something to do might be an aspect to look at. Is it fair to say that?

**Marianna Marquardt:** Absolutely.

09:45

**The Convener:** Thank you for that. I will bring in Haydn Pasi on the original question about the context of supply and demand. What are the drivers from your perspective?

**Haydn Pasi (Sacro):** Our experiences align with much of what has been shared today. Many of the people whom we support have a background of experiences of trauma, which is where that demand stems from: people are using substances as a coping mechanism in response to that trauma. We would therefore champion the suggestion of a focus on reducing demand by increasing prevention and early intervention and by providing much more readily available access to treatment and the holistic treatment that Marianna Marquardt mentioned that is not purely medical, but brings in the strength of recovery groups, peer support, throughcare provision, third sector organisations and the productive use of time that Pauline McNeill talked about. Having meaningful activities to engage in is critical in giving people the ability to rehabilitate and recover safely, and preventing the use of substances as a coping mechanism.

We deliver workshops with people with lived experience. We have often heard that the length of time that people spend in their cell, isolated and experiencing boredom, is detrimental to their mental health. We know that mental health drives a lot of people's use of substances, so we advocate for better use of productive time while people are in custody, particularly for the remand population. We hear of many individuals who are held on remand for long periods of time experiencing uncertainty about how long they will be there. That is hugely problematic for their mental health and ability to cope with their time in custody. They also do not have the same access to programmes and activities, so they are not able to engage in things such as work parties. They do not have that routine, and we hear that that is extremely challenging for them.

Individuals on remand often describe the experience of custody as one of torture. It is not humane. They feel that they have a loss of agency and choice in what is happening to them. They are not involved in the decisions that are being made about how they use their time, and they are unable to contribute to shaping what that meaningful activity would look like. Instead, their experiences are often dictated to them. I am sure that people would agree that that would be hugely compromising to someone's mental health, which we see ultimately contributing to the use of substances. We strongly advocate for a systemic shift in how we approach people who are held in custody, as well as for addressing some of the alternatives to custody and preventing people from going into the justice system in the first place.

**Gillian Reilly (NHS Scotland):** I am head of service for alcohol and drug services in Glasgow City Council, so I am more familiar with throughput and people coming out of prisons. However, the pathways to addictions are similar for people in the community and people in prisons, although the loss of liberty is more condensed, and I do see the areas of difficulty that the witnesses have been speaking about.

I agree that we need more services in prisons to support prisoners and to look at the activities that they are doing. As part of community services, we can offer input into prison systems, but the issue that we have is space. We have asked whether we can come in but it is really difficult. We have a recovery cafe in one of the prisons, but that is a pilot and we want to continue it. With the development of prison services within NHS Greater Glasgow and Clyde, we hope that that will be taken into consideration.

We will probably go on to talk about medication assisted treatment standards, but the walkthrough is trauma-informed. We need to have the space, the staffing levels and SPA support to be able to deliver that. I agree that more needs to be done to support the loss of identity that people experience and the boredom around that. If we can get access and get those services in place, that will provide throughput and enhance things for people when they are liberated and back in the community.

**The Convener:** On the physical space issue, would it be fair to say that there is a real desire

across services to support work in prisons but that there is a practicality issue?

**Gillian Reilly:** Yes. We have asked, but the capacity is just not there. My colleague, who is head of service for prisons and police custody, will be at a later committee session. We work very closely together as heads of service in Glasgow city in order to support each other and the policies that are implemented. We want to see that work in prisons, and the alcohol and drug recovery services and ADP in Glasgow City are very much behind that.

**The Convener:** Thank you for that. It was interesting to hear that, because I am not aware of it coming up before.

**Rona Mackay (Strathkelvin and Bearsden) (SNP):** To be very brief, I will pretty much echo what you said, convener. I do not think that anybody in the prison service would disagree with a word that you said, because everybody agrees on that issue.

Over the years, there has been a steady drop-off when it comes to those services being able to happen. In my estimation, it must be as a result of prison overcrowding and pressure on staff. Do you agree with that, Gillian? You are nodding. That issue obviously has to be addressed.

**Liam Kerr (North East Scotland) (Con):** Good morning, panel members. I go first to Marianna Marquardt. I suspect that Haydn Pasi, based on something that she said earlier, will want to follow up on it.

The committee has heard evidence of a link between substance use in prisons and mental health challenges. Your response to the call for views raises the lack of mental health services and also suggests that there is a

"lack of integration between substance use and mental health services in prison."

Can you expand on that for the committee? In particular, what impact does inadequate provision have on prisoners and their families?

**Marianna Marquardt:** It can be difficult for families to know exactly what treatment and support looks like for their loved ones in prisons, but they do know that there is no holistic way to approach mental health and substance use together. On the impact side of things, we see in the community that people reach a breaking point because they are unable to have both those needs met. If someone has trauma or mental health needs or conditions, that causes them to use substances or spurs on that use. If that is not addressed, they will continue to use substances, which can cause mental health crises or cases of psychosis.

Those crises can have an impact on people in prison because they can end up self-harming, in hospital or hurting others. Families are left to deal with the impact of that. They have anxiety and do not exactly know about their loved ones' wellbeing, but they know that something is wrong, especially if the substances that the person is using have changed. They can perhaps tell from speaking to them that something is not quite right—the person might be acting differently or be in a state of stress—but they do not know exactly what is causing it. All that the family members know is that the person's mental health is suffering and they cannot do much for them. That puts pressure on loved ones and causes anxiety.

Those are real cases of people in prison who are being harmed physically and mentally, and family members have to deal with the fallout of it, and yet, the distance means that they cannot help in the way that they could in the community. That is one of the main impacts on family members.

**Liam Kerr:** I understand. Before I bring in Haydn Pasi, I will press you on something, Marianna. In your response to the call for views, you said

"that you can only have a drug worker or a mental health worker, not both."

I found that quite interesting, and I think that the committee will as well. Will you explain how that operates in practice?

**Marianna Marquardt:** I am not an expert on how that actually looks in prisons; it is something that we have heard when speaking to families. I do not know the mechanisms of integration but, as far as we know from speaking with families, that has been their experience.

**Liam Kerr:** I understand—I am grateful, thank you.

**Haydn Pasi:** Before I share my views, I can comment on that experience as well. I have a quote from a woman we worked with in our previous throughcare service, the Shine women's mentoring service. She told us of her experience of needing to be clean—abstaining from substance use—to be able to access mental health support. Her words were that that created a catch-22 situation. She was ineligible for mental health services because she was actively using substances, but, in order to be able to stop using substances, she required mental health support. You can see in practice how that could be challenging for people. Although that is one woman's experience, I am sure that that would be echoed across the many thousands of people we work with.

I agree that there is an overlap between mental health needs and substance use. We see a

prevalence of mental health needs across the cohort of individuals with experience of the justice system that we support and we see the impact that those needs have on them, particularly given the significant waiting times to be able to access mental health support and specialist support. Post-pandemic, we have seen an increasing complexity in the mental health needs of the people we work with and greater demand for those services.

As a throughcare provider, the impact of that can be extremely challenging, because we are often expected to bridge that gap and hold the mental health support that people may need in that time. That is not an adequate service for the complexity of the mental health support that is required. That is why we seek to work in partnership with specialist services. However, if people experience long waiting times when they come out of custody and do not have mental health support in place pre-release, it is often not appropriate for us to take on those cases as a throughcare provider, because we cannot address and respond to the complexity of the mental health need.

Many of the people we work with have diagnoses of particular mental health disorders—for example, there is a high prevalence of personality disorders in the female population. That can make the presentation of individuals quite challenging for us in relation to difficult behaviours, and it can be challenging for us to understand their needs and be able to respond to those. We strive to provide that support but it is critical that we are able to do that alongside the specialist services. We see the need for greater and more readily available access to mental health support and for pre-release planning to identify such needs earlier and ensure that it is aligned, so that we can undertake the partnership working to provide holistic support around individuals.

We also hear many individuals tell us that prison can be used as respite, because they are ultimately struggling to cope in the community. We want to avoid a scenario in which anyone feels that prison is a safer environment because it offers three meals a day and a roof over their head. However, when people are dealing with extreme mental health challenges and do not have support available, they struggle in the communities in which they reside. I hope that members agree that it is not appropriate for individuals to have to use prisons as respite.

Sometimes, there is a lack of training available for staff in the Scottish Prison Service and the wider communities on understanding mental health issues and how people present. What we sometimes hear from the people we work with is that there are cultures and attitudes that are not supportive for people who are struggling with mental health issues, and that can lead to a lack of trust. That could be people and services not trusting the individual and people in custody not being trusted in respect of their experiences when they are seeking support, but it can also be that individuals lack trust in wanting to engage with services and feeling able to ask for support. If they do not have that trust or genuine relationships, there can be a fear of repercussions. That is something that we advocate against.

As a throughcare provider working with people while they are still in custody, we often advocate on their behalf—and see positive results—but we should not have to do that when that person has already asked for such help first. We see that as part of a wider cultural issue about understanding mental health and the needs of the population.

10:00

**Liam Kerr:** I understand. Thank you.

I am going to move to Gillian Reilly for the next question, but, if anyone else wants to come in on it, please indicate and I will bring you in.

The committee has heard that the SPS is looking to move to a focused day model, with staffing concentrated on weekday daytime hours and most prisoners locked up in their cells between 5 and 8 in the evening. What do you think will be the impact of their being locked up during those times, particularly in terms of substance misuse? Are there any mitigation strategies that the SPS should be considering during evenings and weekends to ensure that those hours do not become peak times for substance misuse?

**Gillian Reilly:** I am sorry, but I am not that familiar with the focused day model. I do not know whether someone else can answer that question.

**The Convener:** I think that Hamish Robertson wants to interject.

**Hamish Robertson:** I will answer your question in a second, Mr Kerr, but, first of all, I want to add on a response to the previous question.

To put this into perspective, I would just mention that, with regard to the overlap between mental health and substance misuse, the Fraser of Allander Institute looked at 12 years-worth of data from the new routes service and found a near-100 per cent overlap between the two issues. It is the same with services provided in the community; we have data from another service that shows that someone who presents with an addiction challenge is five and a half times more likely to have a simultaneous mental health challenge. I just wanted to put that into perspective for the committee.

Just to add to your evidence, I also point out that, on the point that Haydn Pasi and Marianna Marquardt made about people accessing both services simultaneously, I made a similar comment, so that is three out of four people on your panel saying the same thing. It was very common to hear of mentors advocating for someone's access to a mental wellbeing service and being told, "No, we cannot take that person until their addiction is sorted." So, three out of your four witnesses have given you some strong evidence in that respect.

It all speaks to the need for better joined-up care at source. Back at the beginning of 2024, we went through a huge exercise, looking at service redesign and what the optimal throughcare service should look like across the country. It involved about 140 different organisations; the views of 110 people with lived experience being brought in; and 20 stakeholder engagement meetings to design how such a service should work. One of the strongest findings that came out of those hundreds of conversations was that the delivery of a large throughcare service should include building in not just mental health and substance use services but housing services—that was the third issue—at source, instead of being done as an addition. Again, those were the three biggest issues arising from all those conversations and that research, and they all overlap. Therefore, instead of just dealing with them after the fact, we need to design a system in which service and system integration happens at the start and at point of source.

I will, if I can, briefly touch on your other question, Mr Kerr. I talked about this a little bit earlier, when I mentioned Addiewell. When I went to Addiewell a few months ago to understand their model of recovery, something that came up a lot was that many of their interventions around recovery happen in the evenings and at weekends. I cannot tell you whether the same thing happens across the rest of the prison estate in Scotland, but on the assumption that it does, I would say that, if the weekend activity were to be moved into a focused day model and the same amount of activity happened but was just compressed into the week, it might mitigate such a move. However, if it were to result in less activity, that would inevitably affect people's wellbeing. The impact would probably be seen in higher tensions in the prison, which would have unintended consequences that I am sure that other panel members can give you a better indication of.

**Liam Kerr:** Haydn Pasi, do you want to come in on this?

**Haydn Pasi:** Yes. Similarly to what Hamish Robertson has shared, we are aware of the plans in response to the increased prison population. We know that there is greater need for appropriate staffing levels in the establishments across Scotland. In particular, we are experiencing quite long waiting times to make appointments for people whom we are due to meet—in some establishments, we have waiting times of three weeks for appointments, of which there are just three available for all service providers. People are fighting over those appointment spaces, which means that, if we do not successfully achieve one, we wait a further three weeks.

We know how limited the time is to plan for somebody being liberated, particularly for the remand population. In many instances, we would not have three weeks to wait to be able to see that person before they are due to be released. Significant staffing pressures are putting a strain on our service provision, and that has an impact on the people whom we are working with.

Additionally, we are experiencing a lot of cancelled appointments on the day of the appointments. In some instances, they are being recorded as refused appointments, which, as we are a voluntary service, has a detrimental impact. People might perceive that the individual does not want to come and work with a throughcare service; in actuality, the appointment has been cancelled due to staffing issues, but that is not being recorded.

We understand the need for improved staffing provision in the establishments, and we advocate for that. However, we are concerned about any potential detrimental impact of the focused day model. At this stage, we do not have a clear understanding of what it will mean in practice. We have been informed that two establishments already operate a focused day model, which has been maintained since the pandemic, when they introduced the new staffing provision. However, we are still experiencing challenges around appointments, and we would hope that that would be improved. What we ask is that partner organisations are consulted in the process of the focused day model implementation, so that we are able to ensure that it will not have a negative impact.

On the points that have been made previously, we have concerns about the unproductive use of time for people when we know the importance of engaging in meaningful activities, not only those activities that are delivered in the prison but those in relation to access to visits with people's family members and loved ones—such visits often happen after working hours or on the weekends to allow families to be able to come and meet people—in order to retain access to children and people's wider social support network. We would hope that that would improve as a consequence of the focused day model.

**The Convener:** We are aware that the SPS has recently moved to a focused day model, so we will be looking for a wee bit more detail from it on that.

**Ben Macpherson (Edinburgh Northern and Leith) (SNP):** Good morning, panel members. Thanks for your evidence so far. I want to go back to areas of questioning that were put earlier. Haydn Pasi has talked compellingly about the need to have good use of time in the prison estate, and there has been a lot of discussion across the panel about how people are supported in the community when they are released from custody.

Another element that feels worth emphasising, and I would be interested in your reflections on it, is that, although people's time needs to be filled and used effectively towards recovery and wellbeing in custody and on release, there are actors in the community and in the estate who are looking to fill that time differently for their own interests—I am talking about organised crime, in particular—to get people addicted or into debt, or to keep them on that pathway if they already are in that situation. However, we have not heard any reflections on that challenge today, and I wonder whether you want to add anything on that point.

**Hamish Robertson:** I would love to come in, but my knowledge of organised crime and the supply side of it is such that I would probably be making an assumption or estimation, which might not help you. I probably do not have a huge amount to add.

**Gillian Reilly:** On the community side, in the Glasgow alcohol and drug partnership, there is a strong focus on working with Police Scotland and local councillors on any significant pockets of increasing crime or activity that get brought to us. We work together to try to tackle those issues.

In relation to people who are using drugs and alcohol in the community, the focus—aside from being on organised crime—is on how we can get them into treatment instead of them going down the route of criminal activity. As an ADP, we also highlight to the police any new waves or trends that are happening, while trying to support the individuals involved. We have partnership working with the police around any new or additional crime activities that are pertinent to alcohol and drug recovery services.

**Marianna Marquardt:** I do not have much expertise in the wider systemic issues of organised crime groups. However, in relation to how that trickles down to families, people have talked about instances of being financially exploited, about having to react to their loved ones in prison having debt and about the impact that that has on families who are having to pay for drug debts without necessarily knowing where that money is going. There is an unknown element to that. They know that their loved one could be at risk or they are being told that that is the case, which, of course, creates more stress and anxiety, and that is exacerbated by the fact that family members do not necessarily know what is going on inside prison. I hope that that shows the human impact of the organised crime element. I do not have much to say beyond that.

**Ben Macpherson:** I was just reflecting on the fact that there are actors who are trying to pull people into addiction at the same time that services are trying to fill their time with other activities, including rehabilitation. That is important for us to consider.

**Sharon Dowey (South Scotland) (Con):** Going back to the support that is offered in prison, what support is currently offered to people who are in prison in relation to substance use, whether that is drugs or alcohol? What roles do peer support programmes, peer mentors and recovery cafes play in prisons? Is the support consistently available to everyone across the prison estate? What do you think should be expanded? I will ask Gillian Reilly to answer first.

**Gillian Reilly:** The current services that are offered in prisons would come under Rhoda Macleod, the head of adult services, who will speak at one of the next committee meetings, so I will pass over to Haydn Pasi.

**Haydn Pasi:** I am happy to come in on that. Although we are not directly involved in the delivery of peer programmes, we are rooted in relational practice, which is aligned with the approach of using peer groups to build positive relationships. The experiences of those with lived and living experiences is really important in the peer recovery aspect. It helps to build trust and genuine, authentic and credible relationships. We find that modelling positive relationships is very important.

Going back to Ben Macpherson's question, I would comment on the importance of such positive relationships in trying to mitigate or prevent the harms from individuals who seek to encourage others into offending or reoffending behaviours. We see really positive examples of peer recovery across prison establishments, and we are aware of all the services that exist and operate in the different prisons. However, we find the challenge to be around the lack of consistency.

We work across 16 prison establishments as we are focused on short-term and remand populations, and we see very different approaches, as well as availability and who can access services, depending on whether they are sentenced or on remand. Those types of programmes are often considered optional and nice to have, as opposed to a critical component

of supporting people with recovery, particularly when we know the prevalence of the need across the justice cohort. We therefore advocate for better availability and consistency.

10:15

Our approach is to embed lived experience in all the work that we do, and we encourage lived experience recruitment, to ensure that we have people who have previously experienced that support delivering it. We welcome the work that the recovery communities and cafes are doing across Scotland and hope to see more of that, and to work with them in partnership.

**Sharon Dowey:** Can you comment further on why there are inconsistencies? All the prison estate is now run by the SPS. We have heard a few times that there are issues with prisoners on remand. Do you have any insight into what the inconsistencies are, and are you aware of any work that is being done to address the issue with prisoners on remand?

**Haydn Pasi:** We have positive working relationships with the SPS as a key partner in our throughcare service, and we have regular contact with it in response to any issues or challenges that we experience. However, we often find that underpinning some of that inconsistency is the fact that the SPS operates with independent prison governors, and decisions are made at a local level. We heard today about some of the staffing constraints, which we view as one of the critical factors in whether programmes can be run and whether they are delivered regularly. The space issues that we heard about today might also limit the populations that can access services.

We know that there are challenges around risk management in prison establishments. We are experiencing high volumes of people being transferred across establishments, which is detrimental in a number of ways to the people who are being supported and to our throughcare provision. We know that some of that is about trying to better manage risk in prison populations. Rather than people being held in the prison that is closest to them, they are sometimes being held significant distances away, which has a consequential impact on the availability of family support.

The inconsistency is sometimes driven by local decision making and the availability of resources for support. Different organisations and providers operate across local communities; we welcome that place-based approach, but there are funding constraints across Scotland, which means that many brilliant services that would be providing support are no longer able to do so, or they are having to pare back some of their programmes. An example is that Sacro part funds the reintroduction of Street Soccer Scotland's work in prisons. It has a prison programme in place, which we have been developing in the past year. However, it is only able to do that in certain establishments with certain populations at certain times. The offering cannot therefore be consistent without the resources and funding to do so. When there is a reliance on third sector organisations to provide support, we welcome the opportunity to do so with our expertise, but we need appropriate funding to be able to do that.

We want to avoid people experiencing a postcode lottery or a prison lottery, depending on which one they go into. We find that the impact of transfers means that people are sometimes removed from their positive supports. They might have been engaged in a programme in the establishment that they came into, and then they are moved for a reason that is not always to do with themselves but due to the management of cohorts, and they have a negative experience because they lose that support. Being transferred across the country also impacts on access to healthcare appointments and many other things.

**Sharon Dowey:** Thank you. Marianna, do you have any comments?

**Marianna Marquardt:** Haydn covered it thoroughly, but I suppose on the back of that is the importance of the third sector workforce in delivering peer support and holistic support. It is vital to have prison staff and medical staff resource in prisons considering all the plates that they have to spin and all the other issues that they have to deal with each day. However, something that came out of discussions with families is how practical it is to expect prison staff to be able to deliver holistic and therapeutic support under all those pressures. We should focus on funding and resourcing the third sector to enable it to be embedded across the estate to provide consistent peer support. That is all that I have to say on that.

**Sharon Dowey:** Hamish, do you have any comments?

**Hamish Robertson:** I have a couple of small points to add. There absolutely are inconsistencies across the estate, partly down to the factors that have been mentioned already. I agree with Haydn Pasi's assessment that local governance means that things are different in each prison, which poses a number of challenges.

Things are funded at a local level because they are necessary, and there are different needs in different places, so that is totally appropriate. However, we should strive for greater co-ordination of what is there. It is not necessarily an issue that there are inconsistencies—consistency is not strictly necessary—provided that each

prison has the right services that it needs at the right time. Appropriate join-up is necessary to do that correctly, in order to understand what is going on and who is being referred where and for what.

We were very fortunate in that the data capture across the new routes service was best in class—we were told that by the partners with whom we worked. That meant that we were able to see, and tell people, what was happening.

The data ended up covering more than 4,000 different organisations over 10 years in which mentors were assertively supporting people to engage, so we knew exactly where, at what time and through which organisation a prisoner or a prison leaver had been supported to access a service and what the outcome was.

The SPS and other national players are well placed to put in place measures to allow that type of data to be captured nationally. I am not sure that the issue is so much whether or not there is consistency—it is more about whether the right services are available in the right prison at the right time, and whether there is overall visibility of who is being supported where.

**Sharon Dowey:** I come back to Gillian Reilly. The committee received a written submission from Glasgow ADP, which mentioned that

"Healthcare teams are overwhelmed by an open referral system and caseloads that outweigh community service."

Can you tell us a wee bit more about the open referral system and how that impacts on healthcare teams?

**Gillian Reilly:** Do you mean the healthcare teams in the community?

**Sharon Dowey:** Yes.

**Gillian Reilly:** We currently have self-referral pathways into our alcohol and drug recovery services. The demand on services has increased, as have case loads, across alcohol and drug recovery services and mental health services.

To go back to the earlier point about alcohol and drug recovery services and mental health services working together, we have been working on that. People feel—I have certainly heard this from reference groups—that they are not able to get treatment from mental health services if they are actively using alcohol or drugs.

In Glasgow city, we have been working in partnership. Part of my role relates to specialist mental health services and unscheduled care along with alcohol and drug recovery services. I am committed to bringing both mental health services and ADR services together.

We have developed a new way of working and a new interface document that looks at a model that manoeuvres people through general practitioner and primary care services, supported by other services if there are addiction issues. It is about seeing what the primary problem is at the time. Other services can be brought in, including mental health services, so service users can manoeuvre through different service areas. With that, we hope to prevent the build-up of case loads, as other services can be brought in to treat a specific condition—whatever the priority is—that someone is experiencing.

That has been signed off and will go out to all our staff groups. It is about ending the exclusion and—taking on board the point from the Mental Welfare Commission—the barriers to people accessing services if they are under the influence of drugs and/or alcohol. We have made a commitment across Glasgow that that should not prevent people from accessing services.

We have had commitments from Police Scotland, our acute colleagues in emergency departments, alcohol and drug recovery services and community mental health teams to ensure that there is 24-hour provision for someone who presents with a mental health problem and is currently using alcohol or drugs or is in recovery. In a way, that will allow us to move people into the most appropriate care that they need at the time, thus freeing up time to assess other service users who come into alcohol and drug recovery services and mental health services, which are both struggling with demand and capacity at present.

**Sharon Dowey:** I am interested in what you said about 24-hour cover. Is there enough cover at weekends and in the evenings?

**Gillian Reilly:** In Greater Glasgow and Clyde, we have 24/7 mental health assessment units. There is also our crisis outreach alcohol and drug recovery service, which is open seven days a week. That is based in the mental health assessment unit, because we acknowledge that, usually, about 60 to 70 per cent of people who come through services have solely a mental health problem and about 30 to 40 per cent have a mental health problem combined with an alcohol and drug use history.

When we initiated the mental health assessment units, alcohol and drug recovery services were very much part of the work. During Covid, our ADRS staff helped to staff the day centre, so we had a lot of experience in alcohol and drug recovery to deal with crisis presentation. The crisis outreach service for ADRS that we developed was also implemented at that time.

Both have been shown to be very successful, in that patients can have direct care straight from emergency services. Rather than sitting in accident and emergency for five or six hours

before someone sees a doctor, whether that be because they are under the influence or in a chaotic situation and experiencing thoughts of self-harm, that person can be brought down to the mental health assessment unit and be seen by registered nurses within roughly 15 minutes of arrival. That allows police, ambulance and emergency department staff to move on and manage the other people that are coming through. Likewise, the patients that come through the service feel that it is a much quieter environment—there are not as many people, and they appreciate that they are not sitting in a busy A and E department.

We very much work together with the alcohol and drug recovery services. During the night, we have the mental health assessment units, and the seven-day service for urgent follow-up has the crisis outreach service—the alcohol and drug recovery crisis team. We also have mental health crisis services, which work seven days a week. Those are linked into the mental health assessment units that cover Greater Glasgow and Clyde and its four emergency departments.

We will therefore always have an overnight service that we can refer to the next day, be that a public holiday, a Saturday or a Sunday, or a Tuesday afternoon. Alcohol and drug recovery will have its own care team. We will also always have a community service that can go out and actively follow someone up until their main care team is back online on a Monday or after a bank holiday.

I know that that was a long-winded answer, but I would say that we have the cover that you asked about.

10:30

**Sharon Dowey:** Thank you for that. I will pass back to the convener now.

**The Convener:** I was away to pull us back into the prison estate, but that was very interesting to hear, Ms Reilly.

Ben Macpherson and Pauline McNeill have a couple of supplementary questions. Ben can come in first, and I will then hand over to Pauline. After that, I will bring in Rona Mackay.

**Ben Macpherson:** I was interested to hear the reflections about the importance of the third sector, and I note what was said about the appropriateness of having differentiated services available for different places. The discussion about the importance of the third sector highlighted the point that, in creating joined-upness—I think that that was the phrase that was used—resourcing and sustainability of funding are perhaps issues. We are committed, across the Parliament, to a preventative approach to numerous issues, including when it comes to reducing offending and reoffending. How impactful could an additional allocation of resource on a sustainable basis be for the third sector in facing the challenges that we are considering today? Haydn Pasi and Hamish Robertson have talked about that in particular.

**Hamish Robertson:** The obvious answer is that the third sector would welcome any additional funding that is there—but that is probably a more trite response than you were looking for. What such an approach would look like, what the resource would be and where it would be targeted are absolutely the questions to ask.

Working within the sector and being involved in the criminal justice voluntary sector forum, where a group of third sector organisations is working in this space, the biggest challenge that I see is that, in general, a lot of money is wasted with short-term funding. In making decisions, public servants do not get the biggest bang for their buck when money is offered on a short-term basis, because they lose all the economies of scale around the start-up of a service. If something has just one year of funding, 10 per cent of the budget can be spent on setting it up, and 10 per cent of the budget might be used in shutting it down. If it runs for 12 months, the staff who come in will broadly be less effective in their first three or four months in the job and, in the final two or three months, they will be worrying about whether they will still have a job.

Although this is not always the case, we often do not need as much money in the system if it is spent over a longer period. If something is going to happen for three or five years, say, that generates a substantial amount of savings, efficiency, optimisation and better-quality working, and brings much better outcomes.

**Ben Macpherson:** There is also the difference that preventative spend can make through savings in the criminal justice system more widely.

**Haydn Pasi:** I would agree with Hamish Robertson's reflections. Over the past 13 years of throughcare delivery, we experienced the challenges that Hamish has reflected on, particularly for our staff cohort, in that both the Shine mentoring and new routes services were subject to annual funding. Upside, the new voluntary throughcare service, is funded by the Scottish Government, and we welcomed its being funded for three years in principle. We had an uplift in budget from what was previously in place for Shine and new routes. However, the scope of the new service provision is greater, in that we are working with males on remand and offering support for up to 12 months, as was recommended by Community Justice Scotland and the Scottish Government.

The budget that is available for throughcare support is not enough to reach the total eligible population. We have an annual budget of £5.3 million, and Community Justice Scotland conducted some work that evidenced the need for more than £19 million per annum to support that population. Therefore, my comment is more about where you would want to target additional resource. We know that we need more money in order to reach all the people who need support. Remand is extremely challenging and we do not have sufficient time to plan for releases. The people being released are not prepared themselves, and we see the impact that that has on them. Over the years, we have experienced a churn of individuals who, unfortunately, are going in and out of the system, which is not positive for anybody.

We would welcome better targeted efforts to reduce the remand population in and of itself, but we would also welcome holistic support for people to wrap around a preventative approach—that is, a prevention strategy—to avoid individuals needing to come into custody in the first place. We would welcome any additional resources to support the third sector in order to increase the high-quality support that we are seeking to provide to individuals across the country.

**Ben Macpherson:** Thank you.

**Pauline McNeill:** I want to ask about the plan for the new Barlinnie prison, which is much further away than everybody would like. The plan is that we will eventually have a prison that has a higher capacity than the current Barlinnie prison. That is my understanding, because I have asked the Government some questions about it.

For a start, you would like to think that that would help reduce overcrowding overall, although it might not. Is it too early to say whether it will give third sector organisations, which are the backbone of all this work, a chance to deal with the drug problem in prison in a better way, because there will be more space and the staff will be able to concentrate a bit more on how they can assist prisoners, rather than what they are doing right now, which is dealing with daily pressures that are caused by overcrowding? We want to ensure that no violence erupts because of the conditions that prisoners are being held in. Have you given any thought to how things might work in future?

**Haydn Pasi:** I am happy to comment on that. We have had recent meetings about the new HMP Glasgow and HMP Highland, which will replace HMP Inverness, because we are keen to be involved in the planning. We currently have two dedicated full-time staff members at HMP Barlinnie. In most other establishments, we have either one full-time or one part-time worker, who covers multiple establishments, whereas we have increased resource in Barlinnie due to the capacity issue.

In the conversations that we have had, we have had confirmation that HMP Glasgow's capacity—the number of people who will be held in that establishment—will be the same as that of HMP Barlinnie. The space of the prison itself might be different, but, as of last week, that was the advice that we were provided with.

We are aware that the population of HMP Highland will be double that of HMP Inverness, so we are looking at—

**Pauline McNeill:** From memory, the figure that we currently have for capacity at Barlinnie is 900. Is that right?

**Haydn Pasi:** I do not have the figures to hand.

**Pauline McNeill:** I expect the figure for HMP Glasgow would be nearer to 1,300.

**Haydn Pasi:** I could not comment on that. It could be that HMP Barlinnie's official capacity is closer to 900, but its current capacity is actually higher because of the increase in doubled cells and other measures.

**Pauline McNeill:** It could be, yes.

**Haydn Pasi:** That will be mirrored in the new establishment, which should be built to support all those individuals. We are aware that HMP Glasgow's capacity will be the same as the current number of people in HMP Barlinnie, but HMP Highland's capacity will be double that of HMP Inverness. From a capacity point of view, that has a direct impact on us, because we will need to support that population, which will have impacts on our staffing.

We welcomed the introduction of HMP Stirling, where a trauma-informed, therapeutic approach to the establishment was taken. That was mirrored by the community custody units for women, although the original recommendation was for five community custody units and, as far as we are aware, there are currently only two and we are not aware of there being plans for the further three. That limits the ability of the units to have the effects that they were intended to have, such as keeping people in their community so that they have access to their local community rather than having to travel.

We would welcome HMP Glasgow and HMP Highland adopting a similar approach to that adopted by HMP Stirling, which has a more therapeutic environment and enables people to access better support while they are there. That is a better use of time, which should, we hope, prevent increased risk of harm.

**Pauline McNeill:** Thank you.

**Rona Mackay:** I want to ask about recent research that has shown that women have different pathways into substance abuse from those of men. As we know, many women are victims of domestic abuse, which leads to their dependency. Are there different ways of treating women and giving them support for their addiction issues in prison, and are they sufficient? In what way do treatment and support differ from what men receive?

**Haydn Pasi:** I am happy to comment, although others might want to come in. My experience is predominantly from our past delivery of the Shine women's mentoring service, which supported women in the justice system for 13 years. Upside is in its very early stages as a national service, and we work across all genders and cohorts, but we do not yet have established learnings from trends and insights.

Speaking specifically as a representative of Shine, we are acutely aware of the prevalence of trauma in women in the justice system, particularly those who have experienced domestic abuse. There is evidence of the prevalence of head injuries that women have experienced as well as of the complex mental health needs that I mentioned earlier. The complexities of the support that is required exemplifies the vulnerabilities of women.

As I just said, we welcome HMP Stirling and the CCUs as trauma-informed environments, and we hope that there will be more support for that approach.

Our experience is that women have different needs in terms of how support responds to their experiences of trauma. Many of the women who are in prison establishments are also victims of offences, so we would welcome a gendered specialist approach to supporting women as well as making specialist services available to support them.

**Rona Mackay:** Are you saying that those services do not exist at the moment?

**Haydn Pasi:** From a throughcare perspective, we feel positive about the fact that we have retained the staff who were involved in the Shine women's mentoring service. That means that, although we are now working at the national level, we retain what we have learned in the past 13 years about the different needs and experiences of women who come into prison and how that impacts them, given their experiences of often being the primary caregiver and being separated from their children. We have that specialism and there are specialist services in communities, but we want them to be joined up and more readily available to women. We also want them to be better trained in understanding women's experiences and the stigma and discrimination that they face as people in the justice system.

I mentioned the volume of transfers. HMP Stirling is an admissions prison and we hear that it can be quite destabilising for women to come into an environment such as HMP Stirling, which offers a different space, and then be moved to other prisons. As we have heard from many colleagues, transfer is another destabilising juncture that can increase the vulnerability of and risk of harm to those women, which could contribute to some of the coping mechanisms that we have heard that women require to respond to trauma.

**Rona Mackay:** Does anyone else want to comment on that?

**Gillian Reilly:** I spoke about having access to space in prison services, and one of the areas that the recovery community is going into is the new women's prison, the Lilias centre. That seems to be working well. On additional funding for the third sector and women's services in general, the charity Tomorrow's Women operates in the justice system.

We know and acknowledge that there is a 70 to 30 per cent in males and females accessing alcohol and drug recovery services. My colleague is absolutely right that there are different pathways into recovery, and it is about the specific support that women need to make it through recovery.

The recovery communities are well supported by females who have made that journey—

**Rona Mackay:** There is peer support there.

**Gillian Reilly:** Yes.

**Rona Mackay:** We talked earlier about the lack of overlap between support for mental health and support for addictions. Do you think that that comes together more for women, given the trauma that most of them have experienced?

10:45

**Gillian Reilly:** Yes. In Glasgow, we are specifically considering women who are really complex and difficult to engage with, and we are looking to build access to emergency mental healthcare to ensure that there is a pathway. If women come in, we can build a suite of services around them and ensure that they have access to that, because we recognise that there is a lot of trauma and self-harm.

Another issue with women accessing services is childcare facilities; their inability to access childcare puts up a barrier. However, I have been to several recovery cafes and they are amazing and uplifting—there are kids everywhere.

**Rona Mackay:** I have been to one in Low Moss, and it is the same—it is a family setting.

**Gillian Reilly:** I would like us to make a change to those percentages with regard to male and female access to alcohol and drug recovery services.

**Rona Mackay:** That is interesting. Hamish Robertson, do you want to come in?

**Hamish Robertson:** Yes—I will add a bit to that. There is absolutely a need, within the overall cohort of women, to have in place slightly different support. Women need safe women-only spaces in a lot of cases. As Gillian Reilly and others on the panel have rightly pointed out, women are generally the primary caregivers in many cases, so there is a significant impact on families when they are incarcerated.

In addition, however, I point out that every cohort has different needs, and sometimes gender-specific definitions do not, ultimately, serve us that well. Some men have the same needs as some women, in the same way that some women have different needs from other women.

It is more effective—and I think that the outcomes are generally shown to be better—where services and systems are designed to be purposefully adaptable to the individual presenting needs of the human that is in front of us, rather than their being predesigned because we are expecting that person to be a man or a woman, or whatever. It is slightly better to design models that can flex in flight and respond to the emergent and changing needs of our complex cohort.

**Rona Mackay:** Given the high proportion of women who are victims of domestic abuse or trauma, it is important that they are recognised. As Gillian Reilly pointed out, there is a definite need there.

**The Convener:** We are just about to come up to time, but I am keen for the committee to cover a few more issues. If the witnesses are okay to carry on for maybe another five to 10 minutes, that would be helpful for us. With that, I bring in Katy Clark.

**Katy Clark:** I, too, was going to ask the witnesses about women.

Given everything that you have said, is it fair to say that the new prison at Stirling and the two new women's custody units have put a lot more focus on these issues, and that the fact that they are new facilities has been positive for the direction of travel?

**Haydn Pasi:** We have seen very positive evidence from the introduction of the community custody units. It took time—initially, they were operating below capacity, because an assessment process needs to be completed to identify who is suitable for and eligible to be in a community custody unit. Towards the end of our time delivering the Shine women's mentoring service specifically, they were operating at much greater capacity, and we were seeing really positive outcomes. We attended events in the community where women were able to share their experiences and contribute to programmes on employability, on education and on greater access to services.

So, yes, the focus on trauma-informed and custom-built environments such as HMP Stirling and the CCUs has been positive.

With regard to Hamish Robertson's point about being able to respond to individuals and provide person-centred care, we would welcome seeing those types of environments across the whole of Scotland in order to better support men and women.

**Katy Clark:** We talked about meaningful activities earlier. I get the impression that, although it is not quite a postcode lottery, the picture in different parts of Scotland is variable. The pressures in different prisons are very different, and the overcrowding in some prisons is far more extreme than in others. During Covid, prisoners were generally not allowed out of their cells.

I often get the impression from speaking with prisoners and their families that what is happening in prisons varies. The picture is not uniform, and there are pockets of good practice—perhaps in Stirling and the two women's custody units, and no doubt in many other places. Is that your experience? Is that a fair comment on the issue?

**Haydn Pasi:** Yes. We see brilliant pockets of best practice across all the establishments, for different reasons. A role and opportunity that we have with Upside, which is a national service that works across those establishments, is to try to identify best practice and share learning. We do a lot of advocating, influencing and championing in that regard.

I agree that people in different establishments have different experiences. As I have mentioned throughout this meeting, the transfers are indicative of that, because if someone is in only one establishment and has not been in custody before, they do not know how things operate elsewhere. However, when they are moved, they have such a varied experience.

If we have staff who are based in all prisons and we regularly come together as a collective to reflect, we are able to hear and evidence those differences. We bring the SPS into those meetings with our prison staff team and it is part of them, which means that it directly hears what has been

learned, and we use that to create positive change. The SPS also sits on our new strategic action group for wider systemic change. We take the learning from our lived experience forums directly to the SPS and the Scottish Government as our funders. We do our best to advocate for better consistency in learning from good practice.

**The Convener:** Throughout our inquiry, we have discussed medication assisted treatment standards in the context of the prison estate. I am interested in the views of the witnesses on how well MAT standards are being implemented in prisons. Is it likely that the Scottish Prison Service will meet its anticipated implementation date of April next year? If not, what barriers are being faced? I will bring in Gillian Reilly first.

**Gillian Reilly:** The MAT standards have been fully implemented in the community. We received additional support and funding to implement that, which provided us with the project management that we needed in order to deliver. Prisons and custody units have not had that additional funding.

There is a MAT standards implementation group for prisons. Almost all the standards have an amber rating, and work is going on to achieve the standards in full. One of them has a green rating: MAT standard 8, which is for access to advocacy and welfare rights. Such support is well provided for in prison services.

I will defer giving any further detail on individual MAT standards to my colleague, who will be before the committee, as she will be covering that.

**The Convener:** Thank you—that is very helpful. As no one else wants to come in, I will bring in Fulton MacGregor.

**Fulton MacGregor (Coatbridge and Chryston) (SNP):** It has been an interesting evidence session.

One of the biggest challenges that came through in our call for views—we have heard this in the Criminal Justice Committee several times—is the availability of and access to housing upon release from prison. That includes people returning to their previous environment and peers. I used to work as a criminal justice social worker before becoming an MSP, and I know that that is a big issue. People who come out of prison are continually going back to the places and people who got them into trouble in the first place.

How can those barriers and challenges be dealt with? Does more need to be done around that issue? If we consider housing specifically, will you talk about the sustainable housing on release for everyone—SHORE—standards and how you believe that they currently work in practice? As Haydn Pasi is nodding, I will come to you first. Do not nod—that is the key thing to remember. [*Laughter.*]

**Haydn Pasi:** I will remember not to nod now; I have learned my lesson. I was just agreeing with your reflections around the challenges with housing and the impact that that has for people on release. We have certainly experienced that issue over a number of years and continue to see it, particularly with the housing crisis across Scotland and the increased number of local authorities that are facing those challenges, with a shortage of supply.

Linked to that is our strong recommendation for better pre-release planning, specifically to address housing as one of those key factors, as we know that for individuals to have a safe and suitable house to return to is an extremely protective factor in their recovery, resettlement and reintegration into their community. Therefore, we really advocate for a better provision of housing.

In relation to some of those specific barriers, one of the things that we see as a throughcare provider is that people do not know their rights, so we have a big advocacy role to play in that regard. Indeed, even though the SHORE standards exist, people are not informed about them and do not know what those standards mean for them in plain language that they can understand and through which they would feel able to advocate for their own rights.

In particular, drawing again on our experience from the Shine service, with women who were often being returned to housing where they were at increased risk—whether from a previous partner who posed challenges or from being placed in unsuitable accommodation far from their support network and children, which caused increased harms for them—we really want to advocate for people being better informed about their rights so that they can challenge when they do not experience the appropriate care that they should.

We welcome the ask and act duty, which will mean that people who are returning to communities can go to another local authority area and should have appropriate provision of housing. However, we know that, often, people's support network is in their own community, and that can also bring challenges. The fact that many local authority areas are experiencing a housing shortage means that, even though the SHORE standards exist, there is a lack of supply to be able to help people to have the housing that they require.

The inconsistencies in relation to what is available is an extreme challenge, and there is also a lack of knowledge about what the SHORE standards mean in practice. As a service provider, we do our best to support individuals to navigate

the real challenges when accessing housing. In one local authority area, there are now more than 67 housing associations, and each has its own application process. As you can imagine, for someone coming out of custody, there are many practical matters to address on the day of release, as well as the emotional challenges; for them to try to navigate 67 different housing applications is impossible, and our staff tend to be the ones who support them to do that.

However, that is challenging for us from a resourcing perspective. A colleague of mine made more than 100 calls to a housing provider—last week, I think—to try to get an answer on the phone for someone who was supposed to be returning to a tenancy but was not provided with any keys or fobs to access the property and, ultimately, would have to breach their order to be able to get access to housing.

It is not straightforward, but something as simple as having a telephone number for housing makes a huge difference, whereas, currently, we have email addresses and there are no responses. We would welcome some practical measures to address that issue, as well as, I hope, better availability of housing and increased understanding of people's rights to access it.

**Hamish Robertson:** For context, around 84 per cent of people who leave custody need accommodation support. Although that is an issue across Scotland, the rate is about 30 per cent higher for people who are leaving custody. Also, the issues are slightly more acute, as we have just heard from Haydn Pasi.

I can give you an example of a bit of best practice that worked quite successfully. I know that the Barlinnie throughcare group, in combination with the new routes service and the Glasgow homeless team, ran a project up until March—it might still be under way—which created a pathway for housing directly out of prison. For every short-term prisoner who was being released from Barlinnie and returning to Glasgow, a process was put in place to ensure that, first, they were on the case load of the housing team; secondly, that they were on the new routes case load; and that, thirdly, they were met at the prison gate by a new routes mentor on their day of liberation, to take them either to the housing office if necessary or directly to a tenancy when one had been secured. That simple example cost practically zero extra money; it simply joined up the three parts of the system that needed to be joined up at that source.

I grant that there are housing stock challenges across the country. For example, we did a bit of work out of HMP Perth. People were going back to Fife after being released from the prison, but the challenge was that Fife has next to no available housing stock. No amount of co-ordination can produce a house out of thin air, but at least there are examples of places where really good co-ordination happens.

11:00

The bit that came out of the research that we did 18 months ago was the need to co-ordinate housing at the point at which people come out of custody, so that throughcare support is in place. Housing should be built into the throughcare model at that point rather than being an add-on. As I said, housing, mental wellbeing and substance use are the three biggest issues. If you get housing wrong, you spend the rest of your time playing catch-up with somebody on release.

**The Convener:** Marianna Marquardt, do you want to come in? We are slightly short of time, but from your organisation's perspective, do you want to make any comments on the issue of release and the challenges that people face?

**Marianna Marquardt:** I cannot speak specifically on housing or on the SHORE standards, but I know that, for families, it is similar to what they experience when their loved ones are discharged from hospital into the community. If there is no thorough planning, or the release is unexpected or changes are made to it, families are often the first port of call for their loved one and must ensure that they are safe.

The issue is often that people, upon release from prison, are quite far away from their families, especially if their families are in rural or remote areas. Family members might be elderly, have mobility issues or not drive, so if planning is not in place, it can cause a lot of stress for families who are unable to go to their family member in order to care for them when they come out of prison.

I was having a discussion with a staff member about cases in which family members are not there to ensure that their loved one is safe. Their loved one might have to stay elsewhere or be put in difficult or dangerous situations, and the family member might not know exactly what they can do. Therefore, it is important to consistently involve families in discussions about release in order to ensure that such unexpected changes do not impact them, especially elderly or young people who might not have as much choice on how to help their loved one.

**The Convener:** You have helpfully highlighted the physical and practical challenges of the release process itself—thank you.

I will draw this part of the session to a close, as none of witnesses want to make a final comment. There is always lots that we do not have time to cover, but I thank you all very much for your

attendance today. You have given us lots to think about as we begin to shape our report.

I will suspend the meeting for five minutes to allow for a changeover of witnesses.

11:03

*Meeting suspended.*

11:13

*On resuming—*

**The Convener:** We move on to our second panel of the morning. I am pleased to welcome Dr Craig Sayers, clinical lead for prison healthcare at NHS Forth Valley and for the national prison care network; Dr Lesley Graham, a retired public health doctor and founding member of Scottish Health Action on Alcohol Problems; and Dr Catriona Connell from the University of Stirling. Welcome to you all, and thank you very much for your attendance. Thank you also to those witnesses who have provided written submissions.

We are looking to spend around 80 minutes on this evidence session. I will get things going with my usual opening question. I will perhaps come to Dr Sayers first, and I will then move across to Dr Graham and Dr Connell.

We have heard a lot of evidence throughout this inquiry, and we are keenly aware that the primary focus of our evidence has been on the use of drugs in prisons. It has been less to do with the use of alcohol or some other complex issues around co-dependency, the use of alcohol and its impact, particularly in the justice system. Could you perhaps set the scene by setting out whether illicit alcohol in prisons is indeed an issue in Scotland? Is there adequate and consistent screening, and is there early identification of alcohol use disorders at admission? What support and service provision is available in prisons and, more broadly, in the community?

That is quite a big question. I will bring in Dr Sayers first to kick things off.

**Dr Craig Sayers (National Prison Care Network):** My main remit is working within the prison, so I am probably better placed to talk about that side of things. Illicit alcohol use in prison is not really a problem. The odd batch of Christmas hooch is brewed but, as a rule of thumb, examples of that are few and far between. It does not cause massive problems with patients collapsing. It is not that it never happens, but it is certainly not a big problem.

The issues that we face regarding alcohol are more about the admissions process. That is where we see acute withdrawals. As a doctor in the community, we would never advise an alcohol-dependent patient to suddenly stop drinking. Work is done with the patient to taper it down. If someone is arrested, there is an immediate loss of access to alcohol. By the time a patient has spent a weekend or an overnight stay in police custody and has gone through court and then arrives at prison, they may be demonstrating acute physical problems.

If you will indulge me, I will speak a little bit about the national prison care network. We know about alcohol, but it is a matter of getting harder data on where we are and where we would like to be. At the request of the Scottish Government, the network was asked at the start of 2023 to develop a target operating model, or a TOM, as we call it. None of us had ever heard of a target operating model, so we researched what it is. The aim of a TOM is to outline where we are now, the future state that we would like to achieve and what will be needed to deliver that vision. We looked at lots of recommendations. There are countless publications from the Scottish Government, fatal accident inquiry determinations and publications by His Majesty's Inspectorate of Prisons for Scotland and the Mental Welfare Commission. There are more than 500 recommendations for prisons to adjust how they care for patients under a number of themes. At a time when prisons are struggling with population numbers and staff recruitment and retention, it is unrealistic to consider 500 potential recommendations.

For the target operating model, the team gathered 52 subject-matter experts. We had 14 focus groups with prisoners throughout the prison estate, across six prisons, involving a variety of male and female prisoners, young offenders and short-term, long-term and top-end prisoners, to get real feedback on where we are and on the key themes where things need to be changed. More than 90 change ideas were generated from those meetings. By involving those key stakeholders we got a top 20. Within that top 20, alcohol and drugs were identified as the areas of greatest need and the areas where greatest change was required.

In considering the future state that we are aspiring to for alcohol in prisons, we came up with the following things to deliver in all prisons. We are looking to ensure that there are approved assessment tools to assess for alcohol withdrawals objectively at the point of arrival into custody; to determine the need to start detox medications and ensure that the assessment tools and treatment are implemented by all prisons; to use screening tools such as FAST, the fast alcohol screening tool, and AUDIT, the alcohol use disorders identification test, as soon as is practical on admission or immediately afterwards so as to identify those with problem alcohol dependency; to work with partners within the prisons to deliver alcohol brief interventions; to identify people with

primary alcohol dependency, as opposed to co-dependency; to ensure that there are services available to provide appropriate psychosocial interventions and pharmacological interventions; and to introduce evidence-based treatments for liberation, such as Campral or Antabuse. Those are the key things that we are looking to prisons to deliver in relation to alcohol specifically.

Among those 20 key recommendations, we have more than 100 key points against which we want prisons to benchmark themselves. After a year of developing the TOM and getting agreement on draft processes, each prison was asked to benchmark itself against the criteria for their prison and alcohol service delivery. There are nine board areas with prisons and, at that point in April 2024, 100 per cent of those services were being delivered in four board areas, 83 per cent in one, 67 per cent in another, 50 per cent in two more, and only 17 per cent in one board area. We therefore had an objective picture of where we were across the prison estate with regards to alcohol.

Every six months, we use the target operating model and national groups to share best practice with areas that are struggling, such as the 17 per cent area, and provide advice and support from areas that have reached 100 per cent by saying, "This works for us; maybe you will want to try this." Every six months, prisons also re-benchmark themselves against all the criteria in the target operating model.

The latest data is from April this year, which was 12 months on. At that point, five boards were delivering 100 per cent of the alcohol-specific targets, two boards were delivering 83 per cent, and two boards were delivering 50 per cent. We can therefore see that there has been an improvement. The expectation and purpose of the TOM is to ensure that all boards are delivering 100 per cent of the targets.

The national prison care network is a strategic network and boards do not answer to us. We make best practice recommendations, but it is not our role to monitor the boards. That is done by HMIPS visits and fatal accident inquiry recommendations.

That is where prisons are. On what we are looking to deliver, we are getting there. In more than half the board areas, the key assessments of admission and the delivery of appropriate treatment are there, as is medication on release. However, a few board areas still need to get up to full capacity.

**The Convener:** Thank you for those helpful opening remarks. What you seem to be saying is that it is not so much about the illicit use of alcohol in prisons; the focus needs to be on the management of individuals who have been impacted by alcohol use, and on making effective interventions and supporting them while they are in prison and, I presume, after release.

**Dr Sayers:** Yes.

**The Convener:** Right. The TOM supports that delivery.

**Dr Sayers:** Yes.

**The Convener:** Great. Thank you for that. There is lots for us to think about. Lesley, over to you.

**Dr Lesley Graham (Scottish Health Action on Alcohol Problems):** Thank you for inviting me today. We hear less about alcohol use in prison because it is out of sight for much of the time. As Dr Sayers said, there is some illicit alcohol use in prison. The Scottish prison survey says that 17 per cent of prisoners report having used illicit alcohol while they were in prison, but it does not say how often or how much. The trouble is that it is out of sight; it is not in front of everyone's faces as drug use is, so there is a risk that it is forgotten.

The service provision is there, as is the TOM, as Dr Sayers outlined. HMIPS standard 9.7 looks specifically at alcohol services. There is also other monitoring of what alcohol services are being delivered in Public Health Scotland's drug and alcohol waiting times, which show a slightly concerning picture in that, for example, from 2023 to 2024, there were 187 referrals to alcohol specialist services in prisons in Scotland.

There are around 15,000 individual prisoners per year, and we know that one third of those—31 per cent—will be alcohol dependent, so there appears to be a treatment gap there. We also have data gaps. That is just one aspect of it, but do we know whether screening is being delivered? We were counting the delivery of alcohol brief interventions but that ceased in 2021—that was Public Health Scotland. There is also an issue with transparent governance and accountability. We have some systems in place, but the TOM is a self-reporting mechanism. HMIPS will go round each prison, but it is not real-time monitoring.

Those are some of the issues that we need to consider when we think about the alcohol problems of those who come into the prison setting.

**The Convener:** Thank you. The issue of waiting times was certainly raised as a challenge by the previous panel, and I presume that that has been made slightly more acute because of the pressures on the prison estate with regard to the population. However, we will probably come back to that.

At this point, I will bring in Catriona Connell.

**Dr Catriona Connell (University of Stirling):** Good morning, and thank you for inviting me along today.

I am a health researcher looking predominantly at the health of people who come into contact with the criminal justice system, but with more of a focus on their journey out of prison and their supervision in the community. I will do my best to contribute to that part of the discussion, in particular.

I cannot speak specifically to the issue of alcohol use in prison, but one of the challenges—and I think that Craig Sayers and Lesley Graham have alluded to this already—is not knowing the exact number of people affected who are in custody or who they are, as that can limit our ability to provide services. It is exciting to hear that screening is increasing and improving all the time to allow us to do that work.

The most recent Scottish study, which was published by a colleague of mine in 2011—so quite some time ago—estimated that around 73 per cent of people admitted to just one prison had alcohol problems. In other words, three quarters of that prison population had problems with alcohol use. Obviously, the vast majority of them—indeed, almost all of them—will be released back into the community, where the availability of and access to services will be the same for them as it would be for you or me. It would be general community drug and alcohol services that people would access.

I have not been able to share this publicly, as it is still being peer reviewed—I think, though, that it is available to committee members—but we have done a little bit of work on access to services on release, particularly for substance use although not narrowed down to alcohol alone. We looked at the reasons for people having contact with services in the run-up to their imprisonment, and we found that about a third of people in custody had had previous contact with alcohol and drug services; we also found that the vast majority of them had had their alcohol use recorded. Whether their use was problematic was unclear, but everyone known to services had had that recognised.

Therefore, just to echo what Lesley Graham has just said, I think it important not to lose sight of the fact that alcohol is in there, too, even though substances such as drugs might be presenting as more urgent issues. The issue is often in the background, and services and practitioners need the skill set and awareness to address both aspects. Even if it looks as though imprisoned people are not drinking, the problem has not necessarily gone away, as can be seen in the incidence of contact with services on release, which is much higher amongst people who have been in custody compared with similar people who have not.

That is all I really want to say at this point about available support in the community.

**The Convener:** Thank you for that. It was really helpful.

I will bring in Pauline McNeill in a second, but before I do so, I want to come back to Craig Sayers and his opening remarks about the TOM, the monitoring of it and delivery against it. In the quite significant evidence that we have received from the Scottish Recovery Consortium, it comments on alcohol harm as well as drug harm and makes a recommendation in relation to

"Alcohol Use and Treatment Gaps",

saying:

"The recommendation for a rapid review of alcohol services"—

which it also refers to in its evidence—

"is particularly relevant given the high prevalence of alcohol-related harm in prison populations. The Committee's inquiry into substance misuse should consider alcohol alongside illicit drugs when assessing treatment capacity and service design."

Is there any response that you would care to make to that, just in the context of what is already happening?

11:30

**Dr Sayers:** As I said, when we worked with the key stakeholders—the experts in the field—alcohol was not pushed aside; it was there along with drugs as part of the strategy for the future state.

I think that the danger is in missing the patients when they are in. I believe that we deal with them well on admission; indeed, we have the assessment tools to identify acute need. Delirium tremens, which happens with severe alcohol withdrawals, still has a significant 20 per cent mortality rate, but there has not been an alcohol death on admission, so I think that we deal well with that initial high-risk period. There are now treatments for liberation and that aspect is improving. Although I know that it is probably not happening across the board for all areas—which might be one of the deficiencies—we see an increase in those percentages and most areas now provide those treatments.

The key area is the interventions and support during the other period—the time of the sentence. Ultimately, alcohol is not being used by our patient group in the same way as drugs. It is not being used for fun; it is a coping strategy. If that is somebody's coping strategy outside to cover their traumas, those traumas are there and need dealing with when that alcohol is not available. We

need to be aware—particularly with regard to population pressures—of patients who are acutely unwell when they are admitted to jail. Although we do the initial treatment and we might have them on the case load, due to the population demands, there is a lot of movement around the prison estate. It is very feasible that people move from one establishment to another and that they appear to be fine and not unwell at the point of arrival. If those patients do not raise their hand as needing help, it is feasible that some of them will go under the radar.

Drug misuse continues at a far higher level in prisons. We often—in fact, daily—run into patients under the influence of substances and pick them up as we go along. My concern from an alcohol perspective is about the key things that we want to be there in the future. They may already be there in most health boards and prisons. We need to ensure that people do not fall through the cracks—that we do not miss them—and that all the services are there.

**The Convener:** That is really helpful, thank you for that. I will bring in Pauline McNeill for a follow-up question on that point and will then bring in Liam Kerr.

**Pauline McNeill:** Good morning. Dr Lesley Graham, you are absolutely right that a lot of the discussion about prison management has been about drugs, and it is really important that you are here to talk about the prevalence in issues around the management of those people who are dependent on alcohol.

The committee has been trying to learn a bit more about how prisons run and how drugs get into prison. We know a lot more now, but I wonder whether you want to comment on how it is happening. Is it happening a different way? For example, we know that drones are used for drugs. The general public are always mystified; people think that it is easy and ask why we cannot just stop drugs coming in. However, we realise that it is a really difficult thing. The comings and goings in the prison service—the deliveries for the kitchens for example—and the advent of drones make the job of the prison service much harder. I just want to get your views on that.

**Dr Graham:** Well, I actually worked in the Scottish Prison Service for a couple of years and I had a similar question. How come drugs are getting in? They are much smaller than alcohol—it is not like a bottle of vodka or such like—so there are ways and means. When I was working in the SPS, I wanted to try to introduce a supply of books from publishers, as they were getting them—I had been reading the HMIPS's report of HMP Barlinnie, which talked about purposeful activity and so on. So, I was on the verge of getting a constant supply of books, but that was just at the point when drugs were coming in on paper, and the risk assessment thought that the risk of that was too much at that time.

As in the community, the kind of drugs that are coming in are increasingly powerful—we see that out on the streets. We have just received the "Drug-related deaths in Scotland" report figures, which are thankfully 13 per cent down compared to last year, but still the highest in Europe. However, it is not only about that difference but about the various ways in which drugs, because they are much smaller, can be concealed and get in, whether through the prisoners, visitors, members of staff or drones and so on. It is really hard.

As the previous panel talked about, if there is demand, and there is a lack of purposeful activity, alongside boredom, stress, mental health problems and so on, there will be supply.

**Pauline McNeill:** Can you tell us anything about how alcohol gets into prisons, rather than drugs?

**Dr Graham:** Sorry. I thought you were talking about drugs.

**Pauline McNeill:** I used the example of drugs, because we have been hearing about that.

**Dr Graham:** To my knowledge, I do not think that any large quantities of alcohol come into the prison setting, but Craig Sayers will be able to speak to that. It tends to be illegal hooch that prisoners brew themselves, with the risk of producing methanol. There is a big problem in Russia, for example, with illegal alcohol, and we know that methanol can cause blindness, coma or death, so it poses a risk.

**Dr Sayers:** I agree. I have never been aware of alcohol being found or any patients reporting it having come into a prison; it is all hooch that is brewed in cells. Just prior to Christmas, a particularly strong batch was made in Glenochil that resulted in six people going into hospital and 20 others needing to be monitored. It was not just the alcohol—the patients told us that they had put what they called "tizzy dots" into it, which they believed to be etizolam. We do not yet have the toxicology report on that. Patients will not necessarily use only alcohol; sometimes, other substances may go into it.

**Pauline McNeill:** Does that mean that someone who comes into prison who is dependent on alcohol but does not have access to it is likely to find something else?

**Dr Sayers:** Absolutely. I am very familiar with patients who have been purely alcohol dependent and then seek other substances that give the same effect. As we mentioned at the outset, alcohol may be a coping strategy for trauma and stress. If that stress is unmasked because patients

do not have their substance that they use to push the stress down, they can seek a substitute.

**Pauline McNeill:** When they come out of prison, they would then have to be managed as a drug user, whereas, when they went into prison, they were an alcohol user.

**Dr Sayers:** There is a variation. If some patients are in prison for short sentences and use only illicit substances, whether that is spice derivatives, benzodiazepines or opiates, they might just need a bit of support while in prison to get them off them so that they do not have a co-dependency on their release. Other patients may have easy access to substances in some establishments and, on transfer to another establishment, if they are not able to get them, for the first time, they may put their hand up to ask for help. They may have been using illicit substances for six, nine or 12 months, which creates a new problem for us to deal with.

**Liam Kerr:** Dr Connell, alcohol problems are a significant issue in prison. You referred to a 2011 report, but a report by Scottish Health Action on Alcohol Problems, "Alcohol (in)justice", published in 2024, has broadly similar figures: 63 per cent of people in prison have alcohol use disorder and 31 per cent are dependent on it. For people who are in prison who have alcohol issues, are the impacts on their mental and physical health similar to those who are presenting with drug issues? If not, how are they different?

**Dr Connell:** That is a challenging question for me to answer my own. As in the community, the health impacts of alcohol and drugs can differ. I might pass that to my colleague who works in the prison setting for comment.

**Dr Sayers:** Dr Graham, you have first dibs.

**Dr Graham:** We are both clinicians. I will comment on the general impact of alcohol. What is crucial is that we have the opportunity when people are in the justice system—not just in prison—to detect problems, intervene and produce better outcomes, not only for the individual, but for their families and the community. We can help to reduce re-offending, health inequalities and the cost to the system. The cost of alcohol-related crime is roughly £200 million per annum. We have a big opportunity.

When it comes to the general impacts of alcohol, according to the World Health Organization, there are more than 200 conditions, diseases and injuries and accidents that can happen as a consequence of alcohol, so it has a devastating effect. We are not talking only about alcohol withdrawal and dependent drinking; alcohol causes liver disease, alcohol-related brain damage, cancers and so on. There is a huge opportunity to address the impact of alcohol while people are in prison. The issue is not the acute drinking per se; it is the damage that alcohol does to individuals.

**Dr Sayers:** I echo that. As we have mentioned, drugs and alcohol are used as a coping strategy, not for fun. The removal of either of those unmasks the same mental health problems and the same traumas. The mental health conditions that people suppress with a substance, whether that is alcohol or drugs, are the same and need to be managed in the same way once that substance is not there.

As Lesley Graham mentioned, alcohol and drugs result in different physical conditions. With drug injecting, we see more hepatitis and deep vein thrombosis, as well as complications such as abscesses, and, with alcohol, we see chronic liver disease and alcohol-related brain disease. Although the pathologies might be slightly different, both groups are poor engagers with community health services and their GPs. In the prison setting, we have an opportunity to address those health issues that have gone unidentified or unmanaged while people have been in the community. The conditions might be slightly different, but the way that we deal with them is very much the same.

**Liam Kerr:** You spoke about people using substances as a coping strategy. Earlier, we heard that there is relatively little opportunity for prisoners to access alcohol, but there might be opportunities for them to access to drugs. Is there any evidence to suggest that people with alcohol issues replace alcohol with drug use while they are in prison?

**Dr Sayers:** Yes. I cannot give you hard numbers, but, anecdotally, I am aware of numerous patients who have done that. As someone who delivers addictions clinics throughout the Forth Valley estate, I know that that is not uncommon. I can think of three or four patients in the past three or four months who have transferred from another establishment to which they were admitted with only alcohol dependency, and who had never had a history of illicit drug use, but who, because of the lack of availability of alcohol and the easy availability of substances such as buprenorphine, which is an illicit opiate, became daily dependent on them when they were transferred to our establishments.

There is significant variation in buprenorphine, the oral version of which is prescribed across the estate. With the MAT standards, we hope to get more uniformity by moving towards the injectable preparation, which cannot be diverted, but there are certain establishments that are still high prescribers of the oral form. When a patient is transferred to a prison with low prescribing of that, they will suddenly not be able to access it and will put up their hand for help. That is when we find out

the patient's history, which might be that they started using the substance a month after entering prison and had been using it daily for the past six, nine or 12 months.

I have a significant number of patients who were not dependent on illicit drugs pre-custody, but whose dependency has developed in prison.

**Liam Kerr:** Following on from that point, I have a question for Dr Graham about consistency of support in the prison system for people with alcohol use disorders. In your submission, you suggest that there is no consistency of support across the estate, and you refer to a lack of overarching standards and accountability. How inconsistent is the provision of that support? What solutions do you think need to be put in place? You referred to mutual aid and peer recovery networks, which the committee would be particularly interested to hear about.

**Dr Graham:** When the prison healthcare network was set up back in 2011, when the NHS took on prison healthcare, I was involved in that, and we came up with a set of guidelines on a model of care for substance misuse, which covered drugs and alcohol. That is no longer extant. It sounds as though it has been replaced by the target operating model, to an extent. The monitoring of the TOM that Craig Sayers mentioned involves a self-assessment, so it is not necessarily hard and fast.

11:45

The drug and alcohol information system—DAISy—which is the Public Health Scotland system for specialist treatment is up and running and prisons are involved. That system should be able to tell you the number of referrals into specialist alcohol services and should be able to follow a person's case episode, including, in theory, transfers from prison. It should also be able to follow any person who is still in alcohol treatment out into the community so that there is continuity of care after release.

I am not aware of that system being fully reported on. We can certainly look at the numbers going into specialist treatment and at the waiting times to get into that treatment, but the journey through treatment is not there, which supports what I said earlier about data gaps. If we had that data, we would be able to get a far better picture of what is actually happening.

Regarding governance and accountability, the SHAAP report, "Alcohol (in)justice", mapped out the whole justice system. I know that this committee is focusing on the prison setting, but it is important to remember that there is a whole justice system and that we would rather not have so many people going into the prison system, which is under extreme stress and pressure. It is important to look for earlier opportunities to detect problems and to intervene to signpost people into treatment, using diversion, liaison, community payback orders and so on.

It is hard to know what is happening in the system as a whole because different parts of it have different governance arrangements, which we set out in our report. His Majesty's Inspectorate of Prisons inspects every prison and health standards there are inspected in partnership with Healthcare Improvement Scotland. SHAAP is calling for whole-system governance and accountability. Critically, that must be transparent so that there is public-facing reporting of what is, and is not, happening. We are calling for the Scottish Government to take a lead on that. I have recently discovered that there is a cross-portfolio group on health in justice, but, although the previous health collaboration and improvement board had publicly available minutes, I certainly could not find any record of meetings of the new group.

Another positive improvement that has happened in the past two years is that all health boards and health and social care partnerships are required to have executive leads for health in justice. They meet six-monthly with input from prison governors and others, including Police Scotland. That is a really welcome improvement, but, again, I could not find any public record of the minutes of meetings or of any plans.

The Scottish Government is coming up with a national specification that will set out what is expected in drug and alcohol services across Scotland. We are still waiting for that, but it should come out this year. We are calling on the Government to use that as an opportunity to develop standards right across the justice system.

That is our proposal for tightening up governance and accountability.

**Liam Kerr:** Thank you. The 2020 Cochrane review referred to mutual aid and peer recovery networks and seemed to find them very positive. Would you mind talking about those? I think that you are suggesting that those should be more prevalent.

**Dr Graham:** Absolutely. We heard from the previous panel about the important role of the third sector and non-governmental organisations. There is certainly an appetite to get Alcoholics Anonymous and other recovery providers into prisons, and to set up recovery cafes. That would help with the continuity of care. If someone is already in a recovery community within prison, they can make connections with recovery communities after release.

That takes us back to the difficulty of getting time and space for organisations to go into prisons or to be escorted to and from the spaces that they would use. SHAAP certainly knows that AA and other mutual aid networks are very keen to do as much as they can.

**Rona Mackay:** Good morning. Dr Sayers, in your opening statement, if I understood it correctly, you alluded to the fact that the service provision may be a postcode lottery. Is that true?

**Dr Sayers:** Yes. Certainly for the key criteria that we want all prisons to deliver at the initial assessment, there was quite a significant variability as to where prisons were. As I say, we now see an improvement every six months. There are still a couple of shortfalls, but we have to realise that these requests to improve are among a long list of things to improve and that there are competing interests. It is heartening to see the improvement—not just in this area but in other areas—but, yes, there is variation in certain prisons.

**Rona Mackay:** Do you get enough information about prisoners' condition on admission? Do you find that the records are not up to date? For example, do you find that someone has an alcohol problem but it has not been recorded?

**Dr Sayers:** No. The admission process is very good at identifying problems. By and large, patients do not tend to feel the need to hide any alcohol or drug use from healthcare staff. As a rule of thumb, they are looking for help, particularly if they are experiencing withdrawals.

The admission process is electronic these days. I am not very information technology savvy, but it basically walks you through the admission process, which includes drug and alcohol sections, so you cannot forget to ask them. There is a push button where you have to answer.

**Rona Mackay:** That is great.

Dr Connell said that it is estimated that 73 per cent of people going to prison have an alcohol problem, which is high. Dr Sayers, are there enough practitioners around to deal with that? Is there a waiting list for you to help people when you know that they cannot just suddenly cut off and need withdrawal treatment?

**Dr Sayers:** Yes. From a withdrawal treatment point of view, nobody is missed. Every patient is seen on the first night by a nurse. We use the objective assessment tools to measure withdrawals and initiate treatment if that is required. The following day, those patients have a fuller assessment. Patients do not want to go into a half-hour admission when they have been at court all day. We do the must-do things that night, which includes identifying acute withdrawals, and there is a fuller consultation the following day.

A patient may not have been in withdrawal on arrival to custody, but they may have developed withdrawal overnight, so it is a second opportunity to initiate treatment. They are then picked up by the substance use team to undertake FAST and AUDIT scores in order to identify problem drinking. At that point, we offer harm reduction brief interventions and try to engage those patients into on-going support and further psychosocial interventions if a patient is going to be with us for a longer period.

My worry is that that is where we will miss patients for a couple of reasons. If a patient is in for a two or three-week remand, they may not want to engage at that point. After those two or three weeks, they may be physically fine. They may transfer establishment, go to court and come back with another sentence. Suddenly, they are in the system but may now not be on somebody's radar because they have moved establishment and are not presenting acutely as unwell. We need to identify a better way for the FAST and AUDIT tools that identify problem drinking patients who are looking for help to keep them engaged in help.

That brings other issues. If we have significant numbers—and we will have—of patients who are suitable for healthcare intervention on an on-going basis and who want that, the infrastructure and the prison regime limit what we can deliver in several days.

**Rona Mackay:** That was my next question. Is enough being done in the justice system to help?

**Dr Sayers:** There are barriers and frustrations for us all. I will speak as a GP who does my general clinics and the pain and addictions clinics. I know how many patients I can list a day. I am available to consult all day, but the prison regime is such that I cannot see patients all day. I could be seeing patients from 8 am, but what they call moving the route and getting people to the work party or purposeful activity or education takes precedence, so it is perhaps 9 o'clock when I start getting patients. Then, by quarter past 11, patients are moving back. They then have to be fed, they do lock-up numbers and they have to have exercise. Then, in the afternoon, they move back to their purposeful activity, so it might be 2 o'clock before I am seeing patients again. I miss big chunks of the day.

However, some prisons facilitate patients coming to us throughout the day. If there could be an assurance that we would have patient delivery throughout the day, we would be more efficient in the use of our time. It would mean that we would not have 10 people trying to deliver clinics in six rooms during that two-hour window of

opportunity—we could spread them throughout the day.

We could explore digital IT and in-cell telephony if there are periods when I cannot get prisoners. That was also the ask from the patient group in the focus group sessions that I mentioned for the TOM—they were looking for in-cell communication and telephone communication. That would replicate what happens outside.

If we could be more efficient, we would not need more staff and money; we would just not be wasting time.

**Rona Mackay:** That is interesting. Do you have any contact with families?

**Dr Sayers:** Not really, to be honest—not in the prison.

**Rona Mackay:** You do not have time.

**Dr Sayers:** I have attended as part of the death in prison custody action group's work with Families Outside, but I would not say that I have contact with families on a day-to-day basis.

**Rona Mackay:** Dr Connell, you mentioned in your submission that alcohol and drugs issues were not really being reflected in the number of community payback orders. Will you say a bit more about that? Is that being neglected when payback orders are given, in that there does not seem to be any direction for recovery?

**Dr Connell:** There are quite a few challenges in the use of community payback orders. They are community sentences that are given and they can be made up of a number of requirements, most commonly social work supervision. However, they can also include things such as alcohol and drug treatment, mental health treatment, unpaid work and offending behaviour programmes.

I observed that, in the 2023-24 figures, only 1 per cent of community payback orders included an alcohol treatment requirement. It was a similar figure for drugs and only 0.1 per cent for mental health. That does not necessarily mean that people on a community payback order are not receiving support; they may well still be accessing support or being supported by their social worker.

However, in some of the more qualitative work that I have done, I have found that there is an issue in which some people face extreme barriers to independently accessing support. It is not in large numbers, but some people appreciate being mandated to attend. That enabled them to say to their peers, "I did not choose to do this, but I have been told to." Others then reflected that that was actually really good. So, for some people, the community payback orders are potentially beneficial.

I have only anecdotal reports from different people, but the reason why such requirements are not used more potentially relates to not wanting to coerce people into treatment. Although we mandate that people must attend other behavioural programmes, there are concerns about the quality of the treatments and that they might not be available, which would mean that someone was being set up to not complete their order. I would certainly be interested to know a bit more robustly why such community payback orders are not used as much.

Another big challenge in community justice is data—as a researcher, you would expect me to talk about data. It is about knowing what the outcome of the treatment orders are, whether people successfully reduce their drinking and avoid further reoffending and whether there is an impact on families. Some of that data may well be out there, but it will most likely be held at the local authority level in 32 local authorities—

**Rona Mackay:** It is not accessible.

**Dr Connell:** No, it is not. In the more structured piece of research that we did looking at the international literature on mandatory drug and alcohol treatment—where that was mandated by a court as part of a community sentence—we could not find any evidence that it has had an impact on general alcohol or drug use or on health. That is not to say that it does not but, in the research, people are not measuring the health impact of those health-related interventions. Similarly in Scotland, we do not have that knowledge. However, it would certainly be an interest of mine and the team to find that out if we can.

**Rona Mackay:** That is interesting. Thank you.

Dr Graham, do you want to come in?

**Dr Graham:** I agree with everything that Catriona Connell said. Prior to community payback orders coming in, we had probation orders. Thirteen per cent of probation orders mentioned alcohol. As soon as CPOs came in, the level dropped to 1 per cent and it has remained at that level ever since.

12:00

I was actually working in the alcohol policy team in the Scottish Government for a couple of years when the legislation was being drawn up, and there was a debate about that. The law says that, in order to get treatment, the person must be alcohol dependent, which is a clinical condition with various criteria attached to it. It is not hazardous or harmful drinking; it is alcohol dependency, and that needs to be diagnosed. At the time, I suggested that we could broaden out the criteria to include hazardous and harmful

drinking. Many alcohol-related crimes are due to people binge drinking and so on—we know that around 31 per cent of offenders say that they were drunk at the time of their offence, so there is a lot of it going on.

People need to be diagnosed. That means that, when someone appears in front of a sheriff, arrangements need to be made for a clinician in a specialist service to see that person and make that diagnosis. There also needs to be treatment lined up. We know that there are waiting times for and struggles with community addiction services, but that treatment needs to be ready to go. Also, critically, the person needs to consent to it. Those are the three criteria that the law lays down.

There was a move to more swift and effective justice with CPOs—that was one of the directions of travel of penal policy at the time. Perhaps an unintended consequence of that, and of the sheriff trying to keep things moving along, is that sheriffs are not attaching an alcohol treatment requirement to orders.

As Catriona Connell alluded to, there might also be a reluctance to set someone up for treatment. However, the issue is not only that they might not get the treatment but that they might be unable to comply with that stricter treatment order. If they fail, they will breach their CPO and will potentially end up in prison.

**Rona Mackay:** That is really interesting—thank you for that.

**The Convener:** I suppose that that speaks to some of the issues that came up in the earlier session around knowledge not only of a person's rights but of advocacy—that is, the importance of an individual for whom there are potential risks associated with non-compliance with an order or programme understanding those risks. That is where advocacy comes in. Should we be looking at that, in relation to not only drug harm but alcohol harm?

**Dr Graham:** Do we need that in the community? Definitely. As I said earlier, it should be right the way through the justice system. That is part of the work that SHAAP has been doing. We have been working on alcohol in the justice system for the past three years—we have done desktop research and produced a report. We held a big symposium with about 120 attendees. Now, we are in the phase of trying to raise awareness—we were delighted that there was a round-table debate in the Parliament.

We are also going out to other players in the justice system. In particular, the judiciary tends to have to watch what it says and does in relation to policy. However, we have been raising awareness of what alcohol-related harm is and what it looks like. We have spoken to the Crown Office and Procurator Fiscal Service and to the Judicial Institute for Scotland. That is, if you like, a reverse advocacy—we are trying to advocate that alcohol harm, and people in the justice system with alcohol problems, should be taken seriously, and to talk about what more could be done.

In relation to people coming out of prison, the Scottish Prison Service had an excellent service—the throughcare support officers scheme, which you might have heard of. It has been formally evaluated very favourably. Under the scheme, prison officers were trained to follow someone through the prison and act in an advocacy way when the person was getting in touch with housing, trying to get their work and pension organised and so on. The scheme was well received not only by the related services but by those coming out of prison. Unfortunately, the scheme was stopped. That was a really positive example of advocacy.

**The Convener:** Thank you. Do you want to come back in, Rona?

**Rona Mackay:** I just have a question that I forgot to ask Dr Sayers.

Do you have an approximate figure for the gender balance—a male-to-female ratio—of the people whom you are helping to treat?

**Dr Sayers:** In the Scottish prison population, around 5 per cent are women.

**Rona Mackay:** Five per cent.

**Dr Sayers:** Yes. It just so happens that in our Forth Valley area, we have HMP Stirling—or Cornton Vale, as it was. Therefore, we receive all women in Scotland, apart from those in the very north who go to the local prison. Moreover, most will now transfer to Polmont, which, again, is within our catchment area. As a result, we have a disproportionately high female-to-male number compared with other places.

**Rona Mackay:** But the figure is still disproportionate compared with male dependence.

**Dr Sayers:** Yes. I should say that Glenochil has an all-male population of 800.

**Rona Mackay:** Okay. Thank you.

**The Convener:** I want to ask a little bit about your views on the Prison Service's alcohol and drugs strategy, which I do not think that we have covered yet—I might have missed it. Before I do so, though, I note that, in one of her previous responses, Lesley Graham raised the question of what more can be done and, perhaps, who should be involved. I do not want to go off on a completely different tangent, but I am interested in whether the industry has a role here, given the context within which you have been discussing alcohol harm issues.

**Dr Graham:** Do you mean the alcohol industry?

**The Convener:** Yes.

**Dr Graham:** I do not believe—and we in SHAAP do not believe—that the alcohol industry should be involved in developing any sort of health policy, as there would be a conflict of interest there. As you might know, we in SHAAP, along with others, came up with the idea of minimum unit pricing for alcohol in our report in 2007. We worked really hard to advocate for MUP to be brought in, and thankfully, we had a sort of visionary Government that saw the potential of such a move. However, it was a real struggle, and I have to say that the alcohol industry were the ones that then took us to court. From personal experience, then, I am rather wary of bringing in the alcohol industry, particularly with such a vulnerable population. That is my personal view.

**The Convener:** Thank you.

Coming back to the Prison Service's alcohol and drug recovery strategy, I am interested in whether you feel that the alcohol aspect of that strategy sufficiently addresses the issues that we have been talking about. Should alcohol harm be the subject of, say, a separate approach? Are the policies and guidance that are already in place—as we know, there are a lot of them—translating into consistent practice? We might have touched on that already in relation to consistency and sustainability of services. Moreover, is there sufficient understanding among, expertise in and training for the health professionals who are dealing with and supporting the cohort of the prison population impacted by alcohol harm?

I have asked a few questions there, but I am just interested in finding out how well the strategy is working. Craig, do you want to come in first?

**Dr Sayers:** I will hand over to Lesley Graham shortly, but what I would say is that the strategy is quite a high-level document that sets out a general and holistic aspirational approach. As with the TOM, it is about where we want to be—the future state—but I find that the strategy itself does not contain the detail that would be helpful for other services. It is holistic in the sense that it mixes drugs and alcohol together, and says, "These are the services that we wish to be provided." Indeed, because it does not go into any detail, there is probably no great benefit to the strategy separating drugs and alcohol. It is a high-level document that covers both things.

What would be desirable from a healthcare perspective is for the strategy to have a few more details about what the Scottish Prison Service staff would be delivering. After all, it makes much reference to working with partners, whether they be third sector agencies or healthcare staff, but it does not specifically say, "This is what we will do." Not knowing that makes things very challenging for health boards.

We are all on restricted budgets, and we are all trying to manage many conditions in prison. The question is: who do we employ? Only when we know what will be delivered by other agencies—the SPS or third sector organisations—can we recruit appropriately. If low-level psychosocial interventions and brief interventions are going to be delivered by operational staff as part of the SPS's strategy, we can focus on higher-level specialist expertise. However, if the SPS is not going to deliver those, boards will have to cut their cloth accordingly and recruit staff to cover that level of intervention, which might then reduce the availability of high-level specialist intervention.

**The Convener:** Following on from that, we have a set of MAT standards for tackling and addressing drug harm. This is probably quite a crude question, but is there something worth looking at with regard to having a set of MAT standards for alcohol?

**Dr Sayers:** Very much so. We have established a MAT standards thematic group to consider the issue, because the MAT standards probably need to look slightly different in prison, for several reasons, including bullying, which I mentioned, and the concealment and diversion of oral and mucosal buprenorphine. The National Institute for Health and Care Excellence—NICE—recommends that, in high-risk environments, there should be a move towards injectable buprenorphine. Most prisons already take that approach, but I think that it would be good if our MAT standards gave definitive guidance to prescribers that that is the preparation that they should be using.

I see no reason why we should not have parallel standards with regard to alcohol prescribing. We have assessments at the start of someone's time and have guidance on how to prescribe as part of a fixed-dose regime to deal with withdrawals, and how to introduce treatment at the end. Campral and Antabuse are the two common medications that are used. Antabuse should be initiated under specialist services, but most prisons are covered by GPs, often locum GPs, who do not specialise in alcohol dependency, and I understand why there may be some reluctance from doctors without the relevant expertise.

Campral is used to diminish cravings, so most of us lean towards prescribing that, as it is quite safe if someone drinks on top of it. However, if someone drinks on top of Antabuse, it can cause flushing, collapse and even death. Given that a prisoner will have gone through a period of forced abstinence and that, the minute they walk out the door, alcohol is available everywhere, what level of confidence can we have that someone who was

initiated on Antabuse would not return to alcohol on release? I can see why some prescribers might pull back from prescribing it. However, if we had more specialist input at the point of release and could enter a specialist service, prescribers might be more willing to initiate Antabuse. If MAT standards identified specialist community services and included better links with ADPs, that would be helpful.

In short, yes, I think that it would be good to have prescriptive guidance for alcohol management, particularly at the end of the journey.

**The Convener:** I do not want to hog the floor, but I will ask a final question.

The previous panel of witnesses talked about the challenges around release, specifically in relation to access to housing and the continuity of care, and the issues around someone going back into their old environment and peer group that might have been a contributory factor to their going to prison. Are the same challenges associated with alcohol harm?

**Dr Sayers:** Very much so. Patients tell us that homeless accommodation goes not to their peer group but to other patients who present as homeless.

Drink is all around and, if you have an alcohol dependency, it is incredibly hard in that early stage to refrain from returning to alcohol use, and homelessness is a huge risk factor. There are no court services that would help with that. In an ideal world, we would have what we might call an "airport lounge", which would be an area where those who have been released following appearances involving drugs or alcohol could address issues with housing, benefits or their currently active acute medical problems.

The issue is not unique to prisons, as people go from police stations to courts as well. Not having such a facility is a missed opportunity to pull a huge group of patients into services. I know that that option is not cheap, but it is desirable.

12:15

**The Convener:** I am interested in what specific support is provided by Upside, the national throughcare service, and other third sector providers for those who use substances—actually, I have gone on to the wrong question and have my numbers muddled up.

Could you tell the committee anything about the prison to rehab pathway? Is it used in practice for those who have alcohol use disorders in prison? What residential and community recovery models are available in the community for people who use alcohol?

**Dr Sayers:** I asked my team to give me numbers about prison to rehab, specifically for alcohol. I will leave Lesley Graham to give the big numbers, because she has them.

I hold a weekly meeting online with my three prisons to address new prescriptions, changes in prescriptions and patients of concern. I start patients who go to rehab for alcohol on Campral or Antabuse, but I am conscious that I do not hear very much chat about the issue, which is why I asked to get the numbers back.

Ten rehabs are available. There was a comment about access in remote and rural areas—my geography is not great, but one is in the Hebrides, so there is certainly some remote and rural access. However, my substance lead informed me today that our two biggest prisons, Polmont and Glenochil, have never referred somebody to rehab specifically for alcohol.

**Dr Graham:** The prison to rehab pathway, which was set up in 2021, is monitored by Public Health Scotland. It produces reports that say how many places have been funded, and there are different funding sources. From April 2021 to the end of March 2025, there were 3,266 placements overall—that includes the community and prison. I have emailed Public Health Scotland and not heard back yet, but I understand that, of the 3,226, 186 are prison to rehab places.

The community rehab places—that is, for residential rehab overall, as part of the drugs mission and so on—are broken down by substance of use. That means that you can get a breakdown by alcohol and drugs, and the slight majority is actually for alcohol. Unfortunately, the prison to rehab data is not broken down by substance type. It might be that that can be done, but it is certainly not reported. I could follow up and see whether Public Health Scotland can break that data down and get back to the committee.

**The Convener:** It would be interesting to have a little more detail about that and to see the breakdown. That would be welcome—thank you.

**Dr Graham:** Okay.

**Rona Mackay:** Dr Connell, you mentioned the lack of data. Has any data been collected on deaths in custody due to alcohol, or deaths that are directly or indirectly related to that after release? Do you have any such data?

**Dr Connell:** Any death in custody would be subject to a fatal accident inquiry, which would look into the causes and context. Some University of Glasgow colleagues did a thematic review of deaths in custody and found that none of the cases specified alcohol. In a number of the cases, substance use was identified, but they were not broken down by substance. Given the lesser

availability of alcohol in custody, it is probably unlikely that alcohol was the main cause of such deaths, although there will have been people among those numbers who had alcohol problems.

On release from custody, we did some preliminary work that looked at our cohort, and we found that about 9 per cent of people will have lost their lives in the four years following release, and more than half of those deaths will have been related to substance use. We have not yet broken that down by drugs or alcohol, but, given the complex needs of the population, lots of use of multiple substances and co-occurring mental health problems, it is probably there, but we have not done that yet. When we compared that to a similar group of people who had not been in prison, it was about four times more likely, which is similar to the data that was published in 2015 by Lesley Graham and colleagues, which found that drugs, alcohol and mental health were the most common causes.

**Rona Mackay:** That data has not been extrapolated to show alcohol-related deaths solely. Dr Sayers, do you have any follow-up on the work that you do on that?

**Dr Sayers:** Yes, but again, I will be drifting from alcohol. I have been working in prisons for 25 years—I know that I do not look old enough—and one of my concerns is that there was never a drug death in the first 10 or 12 years. It was unheard of. However, in the past five to 10 years, it has become a worrying thing, with numbers going from nothing to two to five to seven to 14. That is a reflection of the toxicology post-mortem results, but alcohol has never really come back to us from those. We are seeing the newer synthetic cannabinoids and the longer-acting, more potent benzodiazepines. The opiate is still the key drug that is identified, but we know that fentanyl is now in the system. Nitazines are also increasing. Some of the nitazines are 500 times the strength of heroin and, although we are educating our patients, they are not really thinking, “Oh, I will just take a five-hundredth of what I usually take.”

We are identifying opiates as our greatest concern. We are working with the Scottish Prison Service to encourage officers to use nasal naloxone. I saw that some fantastic work was done by officers in Low Moss who carried body cameras and we saw them using it in action. I hope that that will mirror what the police have done, where there is confidence, and that, maybe a couple of years down the line, officers will all carry it without batting an eyelid, but there is a journey to get there.

However, on whether alcohol is being directly tested for, no, that is not coming up in the Scottish Prison Service’s drug data. It is very drug based.

**Fulton MacGregor:** You have already touched on my question in your answers, but it will give you an opportunity to put anything additional on the record in response to a specific question. Are there any differences in the support needs for those folk with an alcohol use disorder who are leaving prison and going back to the community, as opposed to those with other substance misuse issues? Is there anything specific that we should know about alcohol misuse?

**Dr Graham:** One big difference immediately post-release is the risk of death from drug use or the risk of an overdose. That is not so much the case with alcohol, although Craig Sayers alluded to the potential risk of death if someone has Antabuse. That is one of the major issues, and that is why we have been pouring lots of effort nationally into providing naloxone on release from prisons; that has really ramped up. The Scottish Drugs Forum has been doing lots of peer support for all of that.

Beyond that, apart from specialist treatment, which will be different for drugs and alcohol, and the different health needs that we have outlined, the drivers of drug misuse are often the same as those of alcohol misuse. It is childhood trauma, for example. One in four people in prison say that they are care experienced, and one in two say that they have had physical abuse as a child. That high level of trauma, social exclusion, poverty, unemployment and so on that drive people to substance misuse will still be there when they come out of the gate, along with issues such as mental health and housing. Although there are important differences, there are as many, if not more, similarities.

I go back to the point about alcohol deaths. I had a look at a big review of deaths in custody that was done in 2021 by Her Majesty’s Inspectorate of Prisons for Scotland. Following that, the Scottish Government set up a deaths in prison custody action group, which did a deep dive into the data. From 2012 to 2022, there were 350 deaths in prison custody. Many of those were called natural deaths—that does not mean that it is natural to die at age 50 from a heart attack—but 48 of them were poisonings. Although the group did not say that there was no alcohol involved, the majority, if not all, of those 48 deaths were due to drugs. Those are some hard facts.

I have also checked with Public Health Scotland, which now regularly gets data from the Prison Service. Every quarter, it gets the data from the prisoner records system—PR2—and it has permission to link it to not only health data but mortality data. Therefore, if you wanted to ask the question about alcohol-related deaths post-prison release by time period, Public Health Scotland could do the analysis.

Catriona Connell kindly alluded to some research that I led on when I was working in the Prison Service. We examined that. There were more drug deaths, but there were alcohol deaths in the population post-release. If the committee wants to follow that up, I can find out about it.

**The Convener:** That is an interesting response.

**Dr Connell:** I will comment briefly on community support for people with alcohol needs. One of the challenges is that it is not just about alcohol. A lot of other things are going on and services are not necessarily set up to cope with that. They are not optimally set up for people who are also trying to find a place to live, whose address might change and whose lives could be quite disrupted. Services often find it challenging to flex and roll with that, which can make it challenging for people to sustain their engagement.

I did some work outside the central belt in areas that were not really rural and remote but which were more remote than Glasgow and Edinburgh. One of the challenges was the consistency of what was available, particularly support for and from people with lived experience. There were some pockets in the north-east where there was nothing like Alcoholics Anonymous that people could get to unless they had a car and travelled an hour or so to the nearest city. There are some pockets where there are missing services, but there are also some communities that do not want peer support and where there are different cultures in relation to access to support.

There is definitely a need for many things for many people and services that can cope with people who are dealing with challenging circumstances.

**The Convener:** That is an interesting point.

We are coming up to time. Before I invite the witnesses to make any final comments on anything that we have not covered, Sharon Dowey has a question.

**Sharon Dowey:** I have a small question for Dr Graham about help and support within prisons. The written submission from SHAAP mentions that 6 per cent of respondents in the 2024 prisoner survey who had received support for alcohol consumption when they arrived in prison said that it was helpful but 3 per cent who had received support said that it was not helpful. Do you have any more detail on why they did not think that it was helpful?

**Dr Graham:** No, I do not have any details. It is a self-report by prisoners.

The prisoner survey has been a great thing. It was set up in the late 1980s when there was a lot of unrest in prisons to try to understand why that unrest had built up and what could be done in future. It has been a tremendous thing over the past 20 or 30 years. We managed to put health questions into it, such as the audit score for alcohol. We also measured wellbeing.

However, it is a paper-based system and, over time, the response rate has fallen right down to 30 per cent, which from a scientific perspective is less robust than one would hope for, and the drug and alcohol sections in the surveys of prisoners who respond tend not to be complete. Therefore, I would not put much emphasis on what I could say or not say by drawing on those surveys. I would look to more routine data such as the drug and alcohol waiting times and the Barlinnie inspection report from November 2024, in which prisoners reported long waits for addiction services.

As Craig Sayers said, the admission process is robust. The matter is also written into prison rules. However, when someone comes into prison, the first thing that they think is not, “I must bring up my alcohol problem.” We need to go round and round in a spiral and keep revisiting prisoners during their progression to see whether now is the time for them to bring that up and seek help.

**The Convener:** I bring this evidence-taking session to a close. I thank the witnesses for attending. We have picked up a lot of very helpful details.

Next week, we will continue to take evidence as part of the inquiry and we will focus on prevention and enforcement.

12:31

*Meeting continued in private until 13:00.*

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