OFFICIAL REPORT
AITHISG OIFIGEIL

DRAFT

Criminal Justice Committee

Wednesday 17 September 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 17 September 2025

CONTENTS

CRIMINAL JUSTICE COMMITTEE

23rd 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:

Sarah Angus (Scottish Prison Service)
Suzy Calder (Scottish Prison Service)
Rhoda MacLeod (Glasgow City Health and Social Care Partnership)
Leona Paget (Falkirk Health and Social Care Partnership)
Linda Pollock (Scottish Prison Service)

CLERK TO THE COMMITTEE

Stephen Imrie

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Criminal Justice Committee

Wednesday 17 September 2025

[The Convener opened the meeting at 10:00]

Substance Misuse in Prisons

The Convener (Audrey Nicoll): A very good morning and welcome to the 23rd meeting in 2025 of the Criminal Justice Committee. We have received no apologies this morning. Fulton MacGregor joins us online.

Our first item of business is the continuation of our inquiry into the harm caused by substance use in Scottish prisons. Today, we will take evidence from the main public bodies responsible for such matters, and I am pleased to welcome our witnesses. Leona Paget is prison healthcare lead, Falkirk health and social care partnership; Rhoda MacLeod is head of adult services, Glasgow city health and social care partnership; Linda Pollock is deputy chief executive, Scottish Prison Service; Sarah Angus is director of policy at the SPS; and Suzy Calder is head of health and wellbeing at the SPS.

I refer members to papers 1 to 3. I intend to allow up to two hours for this evidence session.

I will begin with an open question, starting with Leona Paget on my left and working my way across the panel. We have heard evidence that strategies do not always translate into a change in practice and that there are often issues with implementation. Can you set out how you intend to ensure that the necessary strategies are implemented? Indeed, is implementation possible, given the current prison population levels?

Leona Paget (Falkirk Health and Social Care Partnership): I think that it is possible to implement strategies. Indeed, I would say, as a lead for prison healthcare, that we need those strategies in order to ensure that our staff teams and all our agencies and partners are working in the same direction.

There are many strategies that we need to work towards, including mental health and prevention of suicide strategies, strategies for physical health, strategies for rehabilitation, and so on. However, in order to implement them fully, we need collaboration at every level, from the top right down to the bottom, to ensure that we are working towards the same aims or as collaboratively as possible. We all need to know what each partner or agency is trying to do and what their aims and objectives are so that we can work together.

The Convener: Thank you very much.

Rhoda MacLeod (Glasgow City Health and Social Care Partnership): Good morning. I agree that strategies are absolutely necessary, but there are challenges with implementation. For example, we have the medication assisted treatment standards, which help us manage and support such treatment in prisons as well as in the community, and I know that work is commencing just now that is focusing on prisons and on how we can implement the MAT standards in the fullest way. There is also work to be done on connectivity with community services, particularly around liberation.

However, some of the challenges in prisons are different from those in the community, and the committee needs to give some thought to that. The type and nature of substances that are used in prisons is quite different from the type and nature of those that are used in the community—they are not entirely different, but there are differences.

It is our experience in NHS Greater Glasgow and Clyde that there are resource issues for services in the SPS and in the health service that relate to how to effectively address the substance misuse challenges that we have across our prisons

We work very hard in partnership with the SPS. There is good, close partnership working, which is essential when implementing any strategy. However, there are unique challenges that need to be given careful consideration. Something might come out of that partnership working that identifies a particular strategy for how we should deal with substance abuse challenges in the prison setting.

The Convener: I might come back to a couple of those points, Rhoda.

Linda Pollock (Scottish Prison Service): Good morning. Thank you for having us today and for undertaking the inquiry. The Scottish Prison Service welcomes the interest that the committee is taking in substance misuse in prison, all the evidence that you have taken and the views that you have heard from our colleagues, including those in the third sector. In everything that we do, we seek to improve the care that we give to people, and we are very keen to hear your findings and the evidence that has come through.

I will let my colleagues pick up on our alcohol and drug recovery strategy.

As Leona Paget and Rhoda MacLeod said, the implementation of every strategy has to be done in partnership with our colleagues in the national health service and the third sector. Across the estate, we try very hard to work towards that.

However, overcrowding has an impact on how much we can do day to day.

I know that a number of committee members were able to visit HMP Edinburgh and that the convener and Liam Kerr were able to go to HMP Grampian, so you will have seen for yourselves the impact that overcrowding has. I also know that, last week, you heard from our colleagues in the Prison Officers Association. I hope that you have seen at first hand how much our staff care about the people in our care and how much of our work is dependent on relationships.

The implementation of a lot of our strategies is dependent on building relationships and on having the time and capability to do that. However, our prisons are so full—there is overcrowding and prisoner numbers are very high—that that job is made even harder. In particular, the substances that are coming in and being misused make it more difficult for us and all our partners to prevent and identify issues and care for people. I am sure that we will pick up on overcrowding as well, which has a significant impact on how we deliver our strategies.

The Convener: We are interested in what that impact is, and we will tease that out during the meeting.

Sarah Angus (Scottish Prison Service): Good morning, everyone. It would be naive of anybody to think that a strategy, policy or something written on a bit of paper will magically translate into implementation. The SPS is absolutely aware of that and, as the director of policy, I am also aware of it in what we write. That is why it is important to me, the people in my directorate and the organisation, that we embed strategy and our policies into operational reality, that we look to understand what impact we are trying to achieve and that we look to measure that impact.

I understand that the committee will want to focus on our alcohol and drug recovery strategy, but as my colleagues have mentioned, it is also clear that implementation is about relationships and mental wellbeing. There is no easy way to address everything together. The SPS has to ensure that our policies talk to each other. That is a key focus at the moment, and it will be a focus in future, so that we can simplify things and bring them into operational reality.

Relationships are key—not only relationships with our partners, but relationships with the people in our care. That theme runs through the development of all our policies. If we do not understand the relationships with our partners or those between us and the individuals who are in prison, we will not achieve operational implementation of our policies.

The Convener: Suzy Calder, you are last but not least.

Suzy Calder (Scottish Prison Service): Good morning. It is nice to be back. We have two key strategies—the alcohol and drug recovery strategy and the mental health strategy. The committee will be aware of those as part of its inquiry. They are both critical, and if you have read them, you will note that there is an overlap and an interface on how we develop and implement recovery. As Sarah Angus outlined, it is about how we ensure that implementation works at the local level and operationally.

Both strategies were drafted following extensive consultation with a range of partners. Nothing can be written or implemented in isolation; we require buy-in and support from all our colleagues in both statutory and non-statutory organisations to support implementation.

Although it might be really challenging, there is a reason why both are 10-year strategies. They are ambitious and can be flexed to ensure that we underpin them with clear baseline activity to support people.

We want to highlight that, although the strategies have only just been published, the work is on-going and the recovery activities that already exist within the organisation reflect the ethos and principles that are embedded in them. At the moment, our teams are working on a realistic implementation plan in partnership with all our colleagues, including, in particular, our operational colleagues, and looking at what is and is not possible. Our team is also working on demystifying some of the language in the strategies to show what things would look like in practice—what a recovery intervention might look like, how a cafe might be involved in recovery or where our partners from Alcoholics Anonymous sit, for example.

It should not feel as if one person or one part of the organisation is delivering the strategies. That is clearly challenging and it is difficult to do a lot of the work when people are really busy, but some parts of the strategies focus on how staff interact with people and build relationships, which is at the root of everything that we do.

The Convener: I have a couple of quick follow-up questions for Rhoda MacLeod and Linda Pollock.

Rhoda said that it is not always the case that what is happening in communities is replicated in prisons. We have heard that throughout our inquiry.

We talk about the public health approach that we are seeking to take to tackle substance use in Scotland. We want to make our strategies and

policies fit with a public health approach that meets the needs of people who are impacted by substance use, but is that really being delivered in prisons? That may be a question for Linda, but I am interested in hearing from Rhoda because she brought up that issue.

Rhoda MacLeod: We take a harm-reduction approach, as happens in the community, because that is the public health approach. The evidence that I submitted describes some of the services that exist for people who have taken illicit substances, the follow-up work that we do on referral into harm-reduction services and the purpose of the work that we do with individuals.

Our addiction teams do a lot of work that takes that approach in prison healthcare. We ensure that people who come into prison with addiction issues are appropriately managed and get the treatment that they require.

However, there is something unique about the drugs that come into prisons. My SPS colleagues are in a far better position than I am to talk about that, but, in my experience, there is something unique about the substances that come into prisons and about how behaviour within the confined space of the prison setting presents challenges that are different from those in the community.

Both SPS officers and our staff from the national health service feel a sense of responsibility to respond. Lots of illicit substance use goes on in the community, but we do not know about it because we do not have health professionals in everyone's houses, saying, "Please don't do that." The confined nature of the prison setting presents a different challenge, and I am not sure that the public health approach, in and of itself, is adequate in addressing some of the challenges that we face.

The Convener: That is helpful.

10:15

Linda Pollock: To build on what Rhoda MacLeod said—with which I completely agree—our current strategy, which Suzy Calder spoke about, takes a public health, rights-based approach. That is what we want to do: we want to care for people with our partners, look at harm reduction and build support around a recovery model.

As Rhoda pointed out, the other angle that we in the Prison Service have to look at is prevention, particularly when it comes to illicit substances. You have had evidence on that—you have seen some of the damage that drones can do. As Rhoda said, a substance that comes in can very quickly go a long way in a prison. We therefore have to work on prevention in close partnership with our colleagues in the police and other justice agencies. I imagine that, as Rhoda said, that is different from the community model. It is certainly one of the challenges that we have in the Prison Service.

The Convener: Thank you. Katy Clark, are you interested in coming in?

Katy Clark (West Scotland) (Lab): I want to come in on a different issue.

The Convener: In that case, I will bring in Rona Mackay, who has a follow-up question.

Rona Mackay (Strathkelvin and Bearsden) (SNP): Good morning. On the question of this being a public health issue, families have reported that prison visits, including some visits by children, have been cancelled as a punishment for somebody being under the influence of substances. Do you recognise that as something that you know is happening? It would seem to be at odds with some of the ways in which we are looking at the issue.

Linda Pollock: I ask my colleague Sarah Angus to pick up on that, because I can understand why it has felt like a punishment. I ask her to talk through what the policy is and how it interplays.

Sarah Angus: It is not something that we recognise in our family strategy. We have a lot of supports around visits. Our family contact officers do good work with families. In our family visitor centres' engagement with people, that issue does not necessarily come up as a theme. The biggest theme is usually the medication regime. I would need to follow that up, but I think that the result of work on the issues that arise in visitor centres is being published.

As Linda Pollock noted, at times, any operational response will feel to families like a punishment. In an operational response, we may have to manage somebody on closed visits for a period of time, for example if there is suspicion that drugs are being introduced in that way. You will have heard from previous witnesses that the introduction of drugs can be done in numerous ways—one of those is through visits, and that will continue to be a consideration for us when it comes to our security response. There is no easy answer.

Rona Mackay: I totally understand that. However, in the instance that I am thinking of, it seems like a punishment for substance use within the prison, rather than a punishment for bringing in drugs. That seems punitive, which is why I ask whether you are aware of its happening.

Linda Pollock: When we suspect that somebody is under the influence, they will be put under observations. Our policy is that, for their

safety and that of those around them, we do not always allow visits at that point. I can understand how that feels from a family's point of view.

Rona Mackay: Would why someone was not allowed a visit be communicated properly to the family?

Sarah Angus: It should be communicated properly. If there are instances in which that has not happened, we would look to engage with the family and address their complaints.

Liam Kerr (North East Scotland) (Con): Good morning. Linda Pollock, as you will be familiar from the session last week, the committee has heard that overcrowding is perhaps the single biggest influence on prison officers' ability to effectively manage substance misuse in prisons, due to capacity and resource management. Despite the early releases over the past 12 months, the prison population is now at its highest weekly level since April 2014—at about 8,350, give or take. How does the SPS plan to manage and address that overcrowding, in both the short and the long term, and how will those plans impact on the SPS's ability to manage and prevent substance abuse in the system?

Linda Pollock: The figure is 8,395 today, so you are bang-on correct. We have significant concern about the number of prisoners that are in our estate across Scotland, and we will take every opportunity to raise that concern. We are working very closely with not just our Scottish Government colleagues but all justice partners to understand the system, what is happening—particularly with court backlogs and the increase in long-term sentences—and what we, as an operational service, can do to respond to it.

The committee will be very aware, and will understand, that what we can do is limited, that we receive the people that the courts send to us, and that we have taken a number of actions with regard to how we use our estate in order to maximise space. Members will also be aware that we have taken the step of having men on short-term sentences in HMP Polmont. We have been able to open up more space in Grampian. It is very sad that we have more than 1,400 men in Barlinnie—the prison is sitting at 140 per cent capacity. We are very concerned about the overcrowding, the impact that it has on us and what operational levers we can use to respond to that.

When our chief executive met with the committee in Grampian, she talked about the introduction of a focused day model as one of the things that we could do to try to provide stability in the organisation. That was a change from the regime and roster approach, in order to try to maximise the number of hours throughout the working day during which people in custody could access services. We sought to bring that forward as a national project—the Prison Officers Association was here last week and spoke to that. When we looked to take it forward as a national project, we heard very clearly from our trade union partners in the Prison Officers Association that it should be done at a local level, that the level of oversight involved in bringing it in as a national project would be unhelpful, and that, due to the local nature of prisons and to local partnerships, the project would be better tackled at a local level.

We have therefore changed what we are focusing on. We are now looking at a regime and roster review that will be undertaken by each establishment, working with its trade union partners, NHS colleagues and other third sector partners. We will look at what we can do to maximise that time during the day. We will look at how we can change staff rosters in order to have more staff on during the day so that we are able to provide, importantly, more time out of cells for people, because we know that where we are now is not good for anybody. Due to the numbers of prisoners, we are having to regularly change regimes. That does not give stability to the people in our care or to our staff, which builds up frustration. To provide more stability across the estate, we want to work in partnership to look at how we maximise that time so that we can have a regular offer to people who are in our care, so that they know what they are getting—and our staff know what they are turning up to do—every day. That will now be taken forward with each plan. There will still be national support for that work; our headquarters team is there to support it and to provide national parameters for it.

From speaking to His Majesty's chief inspector of prisons and to Nancy Loucks, from Families Outside Scotland, I know what concerns people will have. How do we address those concerns? How do we make sure that we still have, and that we maximise, family contact time? The committee will have seen the model when it visited Grampian. HMP Dumfries has recently moved to that model, and it has been able to report improved family access time and has noted a decrease in sick absence—so, improved staff attendance—which is helpful from that point of view.

Importantly, the new model will stick to the 35-hour working week that we introduced last year. That is one of the few things that we can do, within our operational ability and the constraints that we have, to try to make things safer for people. We are working with Government and partners to look at what the longer-term model could be. We also work very closely with our colleagues in His Majesty's Prison and Probation Service in England and Wales. We are not alone in this situation—they are in a very similar situation to us. We

regularly compare what we and they are doing in order to see whether there is anything else that we could be doing.

We are pleased that there is a review of sentencing and penal policy, and we look forward to hearing what that will say. The committee will know that we have a concern about the number of remands within the Scottish system, and why it sits so stubbornly high, and about the use of short-term sentences. We know that a lot of the growth in that number has been due to the use of long-term sentences as well—we are seeing that drive. Alongside that are the needs that people coming into our care have when they are in prison for such long sentences. I promise that I will stop speaking soon.

We are really pleased with the support from the Scottish Government to be able to build in Highland and Glasgow. You will have seen the facilities that we have: we are holding men in Barlinnie in conditions that are shameful. It is important that we build better facilities and we are grateful for the support to be able to do that. They will provide more space, albeit limited amounts, and, importantly, more humane conditions for the people in our care.

It is a difficult, long-term problem that Scotland is experiencing, which is also being experienced in England and Wales and other countries across Western Europe, particularly given court backlogs and the rise of longer-term sentences.

Liam Kerr: I am grateful for that very full answer. I will interrogate it slightly, if I may. You mentioned remand prisoners. Off the top of my head, 1,800 of the total of 8,300 prisoners are on remand—I am sure that you can give me the exact figure. Presumably, they present a specific issue in relation to overcrowding and the management thereof. Can you detail that?

Linda Pollock: I will not give you an exact number but around 27 per cent of prisoners are on remand. The number for women is always higher, which is concerning. You are correct that people on remand present different challenges in relation to overcrowding. It is not uncommon for people to be on remand for up to two years while they await their sentence. Access to services is challenging for people on remand and so is the consistency of knowing when people are going to be with us and for how long, and when they are likely to be liberated. That uncertainty is an additional challenge in trying to organise a regime and support for the people in our care. We do not know what is going to happen to them next, which makes it harder to work with people and to plan appropriately for them and for ourselves, in terms of how best to support them with services.

The Convener: Rhoda MacLeod wants to come in on that.

Rhoda MacLeod: The impact that overcrowding has on NHS services is considerable. We cannot flex our service to move it up and down as the numbers move up and down. Our service establishment and staff are static. When we face a situation in which there is overcrowding, that makes the delivery of NHS clinical care more challenging than it ordinarily is. Combining that with situations that can arise in relation to substance misuse, the impact is significant. It affects our ability to deliver routine, general care on a daily basis.

I am sure that the committee has heard already about the impact of overcrowding on people's mental health. It is a vicious cycle. I want to highlight that it is a significant challenge to our ability to deliver good, high-quality, consistent healthcare.

Leona Paget: I back up what Rhoda has said. I do not believe that overcrowding has been the biggest influence on substance misuse—substance misuse has always been there, throughout prison history. In various focus groups, prisoners have always said that it is because of the boredom and lack of purposeful activity, and sitting in their cells, locked up, for long periods. I have psychiatrists, psychologists and doctors waiting around because we do not have the access to prisoners so that they can come to us to be seen in the health centre. That is curtailed in the daily routine.

Substance misuse has always been there and we are always contending with it. More overcrowding has helped with access to drugs and, as we touched on before, with the type of drugs that are coming through. There is more psychosis and there are more safety issues for prisoners and staff. Rona Mackay talked about family visits being cancelled—the only ones that I know of having been cancelled have been when the drug psychosis has been so off the scale that the prisoner has been a danger to themselves and would not be in a fit state to be taken up to the visit. I want to highlight the boredom and the lack of jobs or things to do.

10:30

Liam Kerr: That was really helpful and, in fact, reflects other evidence that we have heard throughout the inquiry.

Sarah Angus, I have a similar question for you. The committee has heard about a lot of good work that the SPS has been doing to address the supply of substances into the estate. Obviously, the SPS and other agencies are also looking to address demand and the reasons underlying it.

Given that you are in a somewhat challenging funding environment, how does the SPS balance spending between addressing the supply issue and, at the same time, trying to address the demand issue?

Sarah Angus: I will probably bring in my colleague Linda Pollock to talk about some of the financial aspects.

You have talked about a challenging environment. We have just heard from NHS colleagues that they, too, are finding it challenging, particularly in light of the high population levels that we are experiencing in prisons, and I am sure that the some of our third sector partners will say the same thing when it comes to the services that they can offer.

A core purpose of the Scottish Prison Service is to address, and to look to address, rehabilitation and to have an impact on recidivism. That is our job, and we expect to be able to do it. Yes, things become more limited when we have high population levels, but we and our partners are still doing good work. Therefore, we would see the balancing of that money as part of our operational function.

Suzy Calder might want to come in on this, too, but we facilitate alcohol awareness groups and substance misuse programmes. Some relate directly to offending behaviour, while others take a more supportive approach with regard to addictions. We also work with third sector partners to facilitate recovery cafes in quite a number of our establishments, and we have had a long-standing relationship with Alcoholics Anonymous and facilitate sessions for it. I would also mention our chaplains, who are excellent in providing pastoral care and support to people.

When we talk about people's overall case management and wellbeing, we are talking not just about assessment. A lot of time is spent assessing people through the courts, through the system and then through to parole, and a real focus for us is not just that assessment, but relationships and intervention. After all, assessments will never change if people cannot get to the actual doing of anything.

I come back to my earlier point about policies and making sure that they are talking to each other. We have quite a significant bit of work under way on pathways; the committee will probably have heard the terms "case management" and "integrated case management" used with regard to prisons, and that is all about looking at our convicted population and their needs. We do focus on needs with regard to risk reduction and then movement to progression and, one hopes, the testing phase, depending on the sentence, but we also want to ensure that a person has a plan in place around them that is not just focused on reducing reoffending but embodies health needs and wellbeing aspects.

At that point, we would look at the activities that we have. We have talked about boredom, which has certainly featured in the feedback that we have received from all people, including individuals themselves. It is one of the reasons why, when we are looking at designs for new prisons, we are focusing on how we maximise opportunities and how we develop our running of prisons in a way that offers the biggest opportunity.

All of those things are difficult with a high prison population, but we cannot just sit under that issue when it comes to our on-going plans. We realise that things are challenging, because of the population, but, as an organisation, we have to continue to move forward with our planning and development, alongside our plans for trying to address the population issue.

Linda, do you want to say anything?

Linda Pollock: The short answer is that every public body will always say that if it had more resourcing, it could do more. With the settlement that we have, we have been able to do a lot of prevention work. Committee members will have seen some of the body scanners that we now have, as well as other equipment that we have to identify substances or stop them coming into prisons. You saw the window grilles that we have put up at HMP Edinburgh, which we are looking to roll out further. We have been able to do various things. I also note the very close working relationship that we have with Police Scotland on prevention and the support that the police provide. We work in partnership to try to prevent substances from coming into prisons and to respond once we have identified substances.

Katy Clark: The committee has met small groups of former prisoners in private to discuss their experiences of drugs in prisons, and one of the people whom we met told us that, originally, he had been expected to serve a nine-year sentence but, in reality, had served 27 years in prison due to drug issues and drug use. Do you recognise that scenario? Will you tell us a bit more about how possession of drugs is dealt with in the prison system? Perhaps Linda Pollock might be the best person to come in on that.

Linda Pollock: I will ask my colleagues to support my answer. That is a really sad case to hear about. I am not sure that we regularly see that sort of sentence increase over such a period, but I am looking to Sarah Angus and Suzy Calder to see whether they have anything more to say on that.

Sarah Angus: From my practical experience from working in prisons, that is not something that I would necessarily have seen or heard of as being routine. However, as practitioners, we all see people coming back to prison in that cycle of offending and re-offending. A witness in one of your earlier evidence sessions noted that, with the criminalisation of drugs, drug use linked to offending can have a really big impact on people's lives. We are acutely aware of that.

Katy Clark: Without focusing on the specific example that I mentioned, as it might be an extreme one, can you give us a bit more information about how possession of drugs is dealt with in prisons? It might have all sorts of consequences, including on length of sentence.

Sarah Angus: Possession of drugs is reported to the police.

Katy Clark: So it is treated as a criminal matter. I understand.

We have heard a lot of evidence of inconsistency of practice across prisons and, in particular, inconsistency of provision of medication, recovery and other support services. The Scottish Recovery Consortium has said that there should be a minimum set of standards across prisons. What is your response to that?

Suzy Calder: To set the context, I would note that we have prisons across the whole of Scotland, and there are different services in each area, so there will not be uniformity in the types of services available. We work with different NHS boards, and they have their own challenges and their own structures for delivering care.

We work very closely with our colleagues to try to have core, consistent principles across all areas that allow for access to recovery interventions, and my NHS colleagues can say more about the medical and clinical aspects of that. We work really hard on ensuring access to the same types of intervention, even if they are delivered by different services. After all, different areas have different services; more remote areas, for example, will not have some of the national organisations. The Scottish Recovery Consortium is engaging with us in our work on understanding recovery as well as in our training of officers, and that is all about trying to ensure consistent understanding and awareness of the complexity of supporting someone whose drug or alcohol use is a key issue.

We are looking to deliver the same messages and ensure that the same communications go out, and we need to work with all our partners so that we cover the key principles of what good recovery or good access to service looks like. Our NHS colleagues on the panel can say more about the clinical aspects and consistency in the delivery of medication, which you mentioned in your question.

Rhoda MacLeod: If people are using substances in prison, it can have a direct impact on their medication regime, so, for safety reasons, we have to review that. In NHS Greater Glasgow and Clyde, it is usually a general practitioner who does that review, and it can happen over a period of days, depending how long the episode of drug use continues.

We closely monitor people who are using drugs. Obviously, we want people to be back on their own medication regime as quickly as possible, but we have to balance that with risk, which usually means that people end up being put on supervised medication. People do not like that—and I understand that—but we cannot ignore the fact that they have taken an illicit substance, and we do not know what it might do to them if they were to continue their medication unsupervised.

Our ethos is always to get people back to managing themselves as much as they can; after all, they are adults, so that is what they should be doing. However, we have to balance the risks. We work closely with people known to our addiction service, who continue to get support with that, and our work with people in the mental health team in the prison continues, too.

We have, as I think that I mentioned earlier, a small health improvement team delivering harm reduction services. The referral rates to the team are high, but often, those high numbers relate to people being referred more than once—they are repeat referrals into the system. People get referred; we do a piece of work on them, there is another incident or episode—and so it goes on. Lots of work and activity go into supporting people who are taking and misusing illicit substances in the prison, and we are striving to support them to come off the substance and to change that behaviour.

Leona Paget: Substance misuse is such a complex area, and there are inconsistencies, starting from when people come from the community and go into court. Could we start using drug treatment and testing orders and other methods to prevent them from coming into prison? This is all about transition of care. People might start drugs in prison because of boredom, or drugs might be brought in as payback, but we need to ensure that there is transition of care for those who come to us as well as for those who are going back out to whatever service we are going to transfer them to.

We have touched on this with the different health boards. We are very good at prescribing Buvidal in Forth Valley, but a lot of communities cannot do that. It is a matter of getting a minimum

set of standards and consistency, and looking at the whole patient pathway from beginning to end. Even if there is a revolving door—say, if people carry on getting intoxicated more than once or twice, or if they have more episodes in prison—we need to pick that up and tailor a package of care for each individual. However, we must ensure that we can get access to them for enough time, and that is all about consistency and working together; the NHS and the prisons cannot do that by themselves.

We all have to decide what the best package of care is, and what different elements each partner can cover. Could SPS do low-level care, and could the NHS then come in and provide more specialised care? What kind of resource do we need? We have resource that is sitting there, but it might not be getting utilised. This is not all about saying "Give us extra money", although that would be helpful. It is about whether we are using that resource in the best way for patient care and staff care.

Katy Clark: You have made the point about access and organisation more than once in your evidence today, and we have also heard a lot of evidence about the lack of continuity of care and inconsistencies throughout the system in relation to throughcare and release. We have heard many examples of very good practice in some prisons, but clearly it is not uniform, and there are some very bad examples, too. Can you tell us a little bit about how you think good practice can be shared across the estate?

Perhaps you can also pick up some of the points that have already been made about whether the problem is lack of resource or cultural, and about whether we are not organising ourselves well enough to ensure that we are able to deliver, for example, the throughcare and release planning that is needed. As we know, the evidence shows that the more planning for release that is done, the more successful that release is and the less reoffending that takes place.

Who would like to respond to that?

10:45

Sarah Angus: I am happy to start, but I am sure that other people will want to come in.

On the first point, the alcohol and drugs strategy is about getting that framework of consistency. However, in relation to your first question, the question is how operational implementation could work in practice. We want a broad level of consistency, but we also have to recognise that there are very different communities in Scotland, and our prisons cover the whole of Scotland. That means that, at times, there will be inconsistencies, because the needs of the prison have to be matched. It is all about working as an organisation to understand where our differences lie, be that in population or location, and working with our health colleagues to understand their assessment of the needs. I agree with having consistent standards—that is important—but I caveat that slightly by highlighting the fact that there will be geographical differences.

Katy Clark: Is the fact that we have such inconsistency of practice due to a lack of resource, or is it a cultural or organisational problem? I do not know whether Suzy Calder has a view on that.

Suzy Calder: Do you mean in terms of throughcare?

Katy Clark: It is not just about throughcare—I have raised the experience of prisoners both serving their sentences and coming to their release. There seem to be inconsistencies of approach throughout the estate. Is it fair to say that?

Suzy Calder: There are inconsistencies, but we have evidence of good practice that we should—and do—strive to build on. Where we have examples of the kind of work that you have seen at HMP Grampian, it is about sharing the principles of that learning and what that looks like with the other establishments. Different boards and establishments might work through that in different ways, but there are certainly lots of positive examples that we should celebrate and make more evident.

There is still work to do on that, but we do share a lot. Our governors in charge have regular meetings at which they talk about practice in their area, their services and the partnerships that they have, to build that knowledge and background.

We also have a suite of support and recovery workers across the estate, whose job is to come together and share best practice from their perspective. They have a forum at which they talk about how what is happening in one area can happen in another, and how they share information. However, we can always do more, and we strive to build on that practice.

It is critical that we get the throughcare element right. In that respect, I would highlight our more recent work and engagement with Upside, our third sector organisations and our NHS colleagues to ensure that there is no break in treatment and that prescribing can be managed.

It is always complicated, given that there are so many people. They might be sat in, say, Forth Valley, but their home area might be Highland or the Borders. How do we ensure co-ordination with community services that are not their local services from their own board area? We do a lot of good partnership working on that and ensure that

those discussions have taken place before somebody comes out.

The organisations also work as part of the national prison care network to pull together best practice and look at opportunities to build shared policy and the shared development of practice. There are a number of areas to highlight here.

Sharon Dowey (South Scotland) (Con): Good morning. You mentioned the use of preventative measures to stop drugs getting into prison in the first place. However, we have also heard that prison staff are increasingly being targeted to bring substances into prison. We are aware that training on professional boundaries is in place, but how serious a problem is corruption? Does more need to be done to address the issue?

Linda Pollock: Corruption is an issue in a number of organisations. We take it very seriously and work with our partners on it. The number of staff who are corrupted is very small, but that does not mean that it is not a serious problem. We take it very seriously. As you mentioned, all staff go through training on our anti-corruption policy.

With regard to intelligence, we work closely to share information across establishments. Last week, the committee heard from Jim Smith, who is head of our public protection unit. He oversees all that work on a national level, which involves working closely with Police Scotland. We take a number of steps in that area.

Likewise, we have been working with HMPPS in England and Wales to understand where it is in that regard and what more we can do. We are always looking to see what more we can do on staff corruption. Our staff do not want drugs to enter prisons, because that makes everyone's life more difficult, and they are very good at speaking out when they are aware of issues or have concerns. As you know, we have a national tactical search unit, which includes dogs. There are a number of avenues through which we are able to search for, prevent and identify corruption where we believe it to be an issue, and we work with the police and other agencies to tackle that.

Sharon Dowey: Do staff feel able to access support if they are targeted? I imagine that that would be scary.

Linda Pollock: I know from experience that, where it has happened, they have been able to speak up and access support. Our Prison Officers Association colleagues spoke about the fact that the threats from serious organised crime are greater than they used to be. Alongside our partners, we are taking that very seriously. Last week, mention was made of the role of the serious organised crime task force, which the cabinet secretary and the Lord Advocate co-chair, and in which partner agencies are involved.

We continue to speak to staff and to raise with them the avenues for support. We are vigilant and ensure that local support is in place for them. If they have concerns or are worried about things, support should be in place, but they should also be very clear on how to raise issues or concerns.

Sharon Dowey: In the call for views, Glasgow city alcohol and drug partnership suggested that searches of prison staff should be carried out by someone "external" rather than their own colleagues. Do you have thoughts on that?

Linda Pollock: I saw that, and I am not sure that I quite understood the premise behind it. Our staff are trained to do searches, and we have a number of mechanisms in place. We have the national tactical search unit, which includes dogs. I am interested in why the ADP said that and am keen to understand why it thinks that external staff would be appropriate and would have the right skill base to do it. We work very hard to ensure that we conduct searches with all the resources and options that we have in place to stop drugs entering prisons.

Sharon Dowey: Do you have enough dogs in the estate? Dogs were used at Kilmarnock prison before it was brought back into the Prison Service.

Linda Pollock: The dogs got to stay. In the national tactical search unit, we have drug dogs that work as part of a specialised team. When it comes to what is required, we keep all those options under review. I will check with prisons to see whether they have enough, but it has not been raised with me that they require more dogs.

Sharon Dowey: An issue that came up in last week's session was the fact that, when prison staff do searches, whether they are looking for weapons or drugs, those need to be completed by somebody of the same sex. I asked about the use of a wand. When you go through airport security, somebody of the opposite sex can do the search, because they do not actually touch you as they use a wand. Do the prisons have a same-sex policy for searches? Are you looking at that? What problems does that approach raise in the prison estate?

Linda Pollock: Searches need to be conducted by members of the same sex, including when a wand is used. We regularly move staff around to ensure that we have the right staffing complement to be able to conduct searches. We work nationally with all our establishments to ensure that we consider the staffing complement as part of our daily planning, which involves ensuring that we have the right mix of people to undertake all the required duties.

I saw some of the comments that were made at last week's meeting, but we are confident that we can move people around. We are very proud of

the fact that, as an organisation, we have more women working for us. I do not see that as an issue at the moment, and it is not one that has been raised with us.

Sharon Dowey: It is great that you have more females coming in, but the same-sex requirement could hinder the job that staff do. We have heard about the overcrowding. If you want to prevent items from being moved across the estate but female officers cannot go in and do their job, that could be a problem. Are you looking at that policy? What is the reason behind it? When staff use a wand, they do not put their hands on people. We have male-bodied prisoners in the female estate, so why can female officers not perform a check if that does not involve touching the prisoner?

Linda Pollock: The prison rules say that using a wand would be an extension of the arm—

Sharon Dowey: We were told that last week—

Linda Pollock: I know that you went through all of this in the previous evidence session. The policy does not present an operational issue in relation to the deployment of our staff. As always, we keep all these things under consideration. We would look into the policy if, when we spoke to our senior management across establishments, they said that they had an issue with staff deployment. I saw and heard the evidence that was presented last week, but the issue is not one that is being raised by governors across our establishments.

Sharon Dowey: So, as far as you are concerned, it is not an issue and you are not looking at the policy. Is that correct?

Linda Pollock: We keep all policies under review. If we needed to change the policy, there is a process that we would need to go through, because the prison rules are set in legislation. It would be possible to do that if there were evidence for that and a proposal was made. We would not say no to anything; if a need was presented and we had the evidence, we would work through that. My answer is not, “No, we’re not doing it,” but that it has not been raised with us as an issue. If it were, we would want to consider that.

Sharon Dowey: Thank you.

The Convener: Before I bring in Pauline McNeill, I want to let you know that there is a slight issue with some of the windows opening—I think that they have a mind of their own. We are arranging to get them closed, but it might get a bit noisy while we are doing that. There we go—they are closing now.

Pauline McNeill (Glasgow) (Lab): Right on cue.

Good morning. I want to further explore the issue of overcrowding and what leads male prisoners in particular to start taking drugs when they had not previously done so. You heard me gasp when you said that there are 1,400 male prisoners in Barlinnie—that is utterly shocking. I feel for the prison staff who operate in that environment, and for the prisoners.

Why is Barlinnie the prison where you put everybody? Is there a reason why that prison is so overcrowded? That must surely have an impact on the wellbeing of the male prisoners and lead to them taking drugs.

Linda Pollock: I will bring in my colleague Sarah Angus, who has operational experience of working in Barlinnie, in a moment. You will have seen the media articles last week that had a particular focus on Barlinnie. It is the prison that is able to flex the most. Therefore, when other prisons reach their capacity or are unable to reach their capacity, people will be diverted to Barlinnie because of the ability to double up in the cells there. Because of its location and that flex, more prisoners will go there than to other prisons.

Sarah Angus: That is true. Offering flex has been a historical purpose of Barlinnie. It previously offered more flex than it does now, because the mix of the prison population is now more complex. We have mentioned the point about serious and organised crime, which makes the situation more difficult to manage—there was evidence on that in previous evidence sessions. Therefore, it is now harder for Barlinnie to flex as much as it used to.

Pauline McNeill: That is clearly not the case. You have 1,400 prisoners in Barlinnie, but there were only 1,300 the last time I looked at the figures. You have 100 more prisoners now. You say that it does not offer as much flex as it used to, but—

Sarah Angus: One of the issues will always be the courts. Glasgow has one of the busiest courts, so admissions to Barlinnie can jump significantly. Having worked there—Rhoda MacLeod and her staff will testify to this—I know that there can be a significant jump in the number of prisoners on a Monday night. That is a concern, and it is one of the fundamental factors behind the case for HMP Glasgow, because the situation is unsustainable.

Pauline McNeill: I hope that we do not end up in the same position of one prison being overloaded in a week.

I want to ask this next question from the point of view of prisoners. God help the prisoners who have to serve their sentence in those conditions, compared with those who might be in slightly better conditions in the prison estate. Does that get taken into account when you are managing the jail?

11:00

Linda Pollock: We look across the whole of the prison estate at a national level. Every morning, we have the numbers for every prison, and we have a national team that looks at movements across the prison estate. It looks at a range of risk indicators for each establishment. As I know was in the articles that came out last week, 10 of our prisons are at red capacity. That means that 10 of our prisons—all of our major, large prisons—are struggling for space, for staffing and for access to services. I think that HMP Inverness is likewise sitting at about 138 per cent against its design capacity.

At a national level, we regularly look to move people in order to get a balance across the estate, so that the numbers are managed in the best possible way in the conditions that we are under. We absolutely accept that those are not the best conditions for people in our care or for our staff.

Pauline McNeill: I know that you share my concerns, and I appreciate that you do not make the decisions, but I am trying to understand what you are doing to compensate for the experience of prisoners who are trying to stop going on drugs or to get off drugs, or who want to look after themselves while they are serving their sentence. That is what I am really interested in.

Linda Pollock: We have been trying to flex within our resources, by putting additional staff and support into halls where we can offer that. That goes back to my earlier comments about the regime and roster approach across establishments, and our efforts to open up more during the day and have more staff available to provide more services to support people. We recognise that, with those numbers, the service that people are receiving has been diminished. For those reasons, we are considering how we can address that from an operational point of view.

Pauline McNeill: This question is for Leona Paget. In answer to some questions, you talked about the psychiatrists and psychologists you work with. I took that to mean that it was perhaps a struggle to get prisoners out to get health treatment. Is that what you meant?

Leona Paget: That is because of the routine throughout the day. I can have consultants and nurses waiting to see prisoners but, because the day is so busy, and because the number of SPS staff is slightly reduced because of the overcrowding—they have pulls from other things—prisoners are not being brought to the health centre. With my resources, I try to get them up to the halls so that they can see prisoners and have more access. It is all about access.

At the weekends, staff do an 8-to-5 shift—although I would much rather that it was a seven-day service, from Monday to Sunday. They have their core duties, such as issuing medications and dealing with emergencies, as well as trying to deal with the mental health triage. For my teams in Forth Valley, mental health and substance misuse is an integrated team. None of those problems ever goes away, but I would say that direct access has reduced significantly with the overcrowding. I have three prisons: Stirling, Glenochil and Polmont. The situation is perhaps not so bad in Stirling, because of the smaller numbers, but it is a question of access. I have public money sitting around doing nothing; it is one of the resources that I could definitely use more efficiently.

Pauline McNeill: Are you able to comment at all on the impact that that has on the prisoner who cannot get their appointment?

Leona Paget: It makes the waiting list longer while we are still up against targets that we are trying to push towards. Every prisoner who comes into our admitting prisons has to be seen the next day, and if they have substance misuse issues or blood-borne viruses, those services are all opt-out services. It is a case of reducing the risk as much as we can, to ensure that nobody is missed out. It is the same if we come across the same prisoner who ends up in the MORS—management of offender at risk due to any substance—system on drug observations. If that happens two or three times, we ask why. So, we put in more resource.

It is a case of flexing our services as much as we possibly can. I end up downgrading some services to increase others. As I said before, I would like to have consistency, the resource and the best use of time, but the SPS has priorities and I have priorities for my teams. It is about finding a way forward so that we can use all the resources as efficiently as possible. It is also about access.

Pauline McNeill: You said that prisoners who are misusing substances must be seen the next day.

Leona Paget: Yes—if they are being admitted. There is a checklist for admission. We are very good at admission; we have very good processes.

Pauline McNeill: That is a good thing. I thought that you suggested earlier that other prisoners were not getting their appointments because—

Leona Paget: That is if they have been in for a while and are going through their pathway. In HMP Glenochil, for instance, where there are 750 prisoners, 90 prisoners will go through the health centre every day, and more referrals come through day in and day out. A general practitioner can access a prisoner from half past nine until 11 o’clock—that is two hours. From 11 o’clock until half past 1 there is nothing, and from half past 1 until 4 o’clock there is access. If we could use that

time more efficiently, we would get through more. My staff are there, and they can carry on seeing prisoners, but if they cannot get the prisoners to the health centre or I cannot get access up to the halls—

Pauline McNeill: That affects the process.

Leona Paget: Yes, because the prison staff have to do other things.

Pauline McNeill: Rhoda MacLeod, do you want to come in?

Rhoda MacLeod: I concur with what Leona has said. Some of that is outwith the control of the SPS because unexpected things happen in prisons, such as lockdowns, and they impact on our ability to deliver healthcare; we have to accept that.

In NHS Greater Glasgow and Clyde, we have regular discussions with prison governors about making sure that we maximise the use of resources. There is no doubt that that is a challenge for us. There is a particular issue with oral health and dentistry. We can have a dentist come in but the patients do not get seen. That is not necessarily to do with the substance abuse that we are discussing this morning, but it is to do with the way that the system works and how it impacts on our ability to deliver healthcare. Routine stuff is the first stuff to go, but it is also what people require and need.

The admissions process is very good. When somebody comes in, nursing staff go through a clear process and people are seen by the GP the next day. However, as I mentioned earlier, when it comes to illicit substances, people have to be seen if they are on medication, and that kicks back other people's routine appointments. We therefore re-evaluate our clinical provision constantly, on a daily basis. That is in every prison; it is not unique to one. I imagine that that happens in prisons across the country where we deliver services.

Pauline McNeill: I am interested in prisoners who are not currently on drugs but who might be struggling with not getting their health appointments while they are serving their sentence in overcrowded conditions. Does that add to the problem of drug use in prisons?

Rhoda MacLeod: I do not know whether we can come to that conclusion. We cannot ignore any factor. Earlier, Katy Clark asked about three variables, and my thought was that all three matter. We cannot rule anything out, but I would not want to conclude that people not getting their health appointments increases drug use. It increases complaints and frustration, and people get angry about the fact that they wanted to see somebody but did not manage to get their appointment.

In some respects, we have a bigger challenge with getting people out to hospital for secondary care appointments. That is another challenge for us, although, again, it is separate from this discussion.

I would not draw that conclusion, but we cannot rule anything out, because we are trying to deliver services in a complex environment. Both organisations face cultural challenges. Suzy Calder mentioned that the SPS has to engage with a variety of health boards, and they all work in different ways. There will be slight differences in how Leona's team and the team that I manage go about their daily work. We also have to flex because we are working in different prison environments of different sizes with different numbers, so how we deliver services changes. Depending on the population, including whether it is a women's prison or a male prison, we provide different services.

Security, control and maintaining good order are important priorities for the SPS, because if good order is not maintained, it is impossible for us in the NHS to deliver services. There are not insignificant challenges with that, because our agendas and priorities are different, but we work closely with SPS colleagues to overcome those challenges.

Pauline McNeill: Thank you.

The Convener: Liam Kerr wants to ask a question, and then I will bring in Ben Macpherson.

Liam Kerr: My question is for Linda Pollock, and is entirely related to what Pauline McNeill said about Barlinnie. Having visited Barlinnie several times, I recognise exactly what she was talking about, particularly with regard to doubling up. One might theorise that, when two people share a cell of the size and style that we have in Barlinnie, the availability of substances and the pressure to use them and to get involved in their distribution might increase. However, I do not know that, so my question is: has any research been done—or is any proposed—on the impact, either on substances or more widely, of prisoners doubling up in cells? If there were such research, and it showed significant negative impacts, that might be quite powerful when it comes to policy making.

Linda Pollock: I am looking to my colleagues to see whether any such research has been done.

Suzy Calder: I am not aware of any direct research on the impact of doubling up. We have feedback through our surveys and engagement with people that suggests that, for some people, doubling up has a very positive impact. Having a kind of buddy in the cell can be a protective factor for some individuals, but there is no research that I am aware of that gives clarity about key themes or which makes recommendations.

We know that there will be a mix of experiences—for some, the experience will be positive and for others, it will be negative—and we have some anecdotal evidence and feedback from those with lived experience. However, we do not have any formal research. We could engage with our colleagues in HMPPS on some of the experiences elsewhere beyond our own jurisdictions, and any best practice that might have come out of that. Obviously, the difficulty lies with the cell type and the space that is available.

Sarah Angus: I would just add that there is a difference between double cells—or buddy cells—which have appropriate space, and what are designed as single cells in Barlinnie.

Liam Kerr: Rhoda, do you want to respond?

Rhoda MacLeod: On a related matter with regard to research, I believe that the committee has had a discussion about vapes—it was maybe last week—and I think that it would be worth while to get some research on whether there is a correlation between the increase in drug misuse in prison settings and the introduction of vapes when we brought in smoke-free prisons in 2019. This is anecdotal, but we think that there has been an increase in drug use in prisons and that it is related to vaping. However, we cannot come to that conclusion, because we do not have the hard evidence. That would be a valuable piece of research, and I do not think that it would take that long to do it.

Our medical or clinical response to people has been very influenced by the fact that people are ingesting drugs through vapes. Leona Paget might want to say a bit more about the clinical impact and how we manage people who are under the influence after taking stuff, perhaps through vaping.

Leona Paget: I agree. It was great that we were able to stop smoking overnight in prisons; we thought that the roofs were going to come off, but then vapes came on the scene. Over the past couple of years, though, the number of people who have been put on MORS has definitely increased. We keep those statistics for the prison network.

Another thing that I have noticed anecdotally is that, since we changed the population at Polmont and brought in adult males—we always had women and young offenders there—the number of people on MORS has gone up hugely. There can be 35-plus prisoners on MORS observations on a Friday and Saturday. My team has been feeding back that, because there are more adult males who are supplying drugs, more of the youngsters are getting them. The youngsters say that they are taking drugs because of boredom. There has definitely been a huge influx.

11:15

Across Glenochil and Polmont, there has been an increase in the number of people on MORS observations and the number of prisoners who have reacted in a way that meant that they needed hospital admission. There have been incidents in which the Scottish Ambulance Service said that it cannot take more than two prisoners. My staff then have to deal with prisoners who are very unwell and who should actually be going to hospital.

It is more about the national picture. There is also a question of how we deal with such incidents as they come up on Fridays and Saturdays. It has been on-going since last Christmas, when there was a bit of ethanol, hooch and drugs. Even in the past couple of weeks, different types of drugs have been noted coming in. There has been some heroin, which we had not seen for a long time, on top of synthetic benzos and synthetic cannabinoids. There is a whole mixture together—some meds that are going around just now have an effect that is 500 times stronger than heroin, and our guys are unconscious and having to be taken to hospital.

Vapes are a huge issue. Prisoners are also now starting to use the sublingual method, which is when they start rubbing the drugs on their gums if they have not got their vapes—security around vapes has been a bit better in the past wee while. They are always two steps ahead of us. We will never stop drug use, but the issue is a bit about overcrowding, a bit about vapes and a bit about the ease of drugs coming in—drugs on paper and drugs in clothing. Whatever we try to do, there is always another way that drugs come in. However, I think that doing some research, including on vapes, would be a good idea.

Liam Kerr: Thank you.

Ben Macpherson (Edinburgh Northern and Leith) (SNP): My question relates quite well to what has just been discussed. This issue has been directly mentioned and alluded to a number of times this morning, but is there anything more that you want to emphasise regarding concerns about the nature of the substances that are coming into the prison system now? There are synthetic substances that are often more dangerous and potent and in smaller amounts. We have heard a lot about that challenge in our evidence. Is there anything more that you would like to say about it?

Secondly, there was an interesting discussion just a few moments ago about the differences in service provision. One would expect that, due to health and social care partnerships being different in different parts of the country. One striking thing that we have heard in this inquiry is that it is actually a positive thing for there to be

differentiation between services in the country, and that it is good to have a specific ability to provide certain services in certain places, both in prison and outwith it, in the community, to provide support for substance abuse and recovery.

However, are there any common gaps across the country that we should be aware of? As we went into the inquiry, my concern was that there might be gaps in certain places, given that there is differentiation without a consistent approach across the country. Is there any reassurance that the way that things are going right now is sufficient? That would be welcome. Alternatively, are there areas in which you think that X service should be delivered across the country but is not being delivered at the moment? I hope that that question makes sense.

Sarah Angus: We have all heard a lot about the concerns regarding synthetic substances, and we should absolutely be concerned. It was previously noted that we understood what to expect in the past, but things are now much more unpredictable. My colleagues in the Prison Officers Association and my operational colleagues who were at the committee last week have noted that the substances that individuals are taking are unpredictable. Sometimes, people will not know what they are taking, which is a real concern for them and their health. It is a concern for our staff, because what they are faced with each day is unpredictable, and it is the same for our NHS colleagues.

The situation is concerning. I was interested in Dr Victoria Marland's evidence on the difference between what is in prisons and what is outside them. It speaks to the constant battle and how, when one route closes, another one might open up. Dr Marland talked about mail being photocopied and the increase in vapes. Nothing can be seen in isolation and we cannot view things that happen in the prison setting as separate from what is happening in our communities. If we could wave a magic wand and solve the drug problem across Scotland, we would not be seeing the same issues. However, we have a unique operational environment and synthetic cannabinoids are certainly a concern.

I welcome the fact that you note that differentiation can be a positive thing, and I agree with that, but it is important to have a framework of standards. There are local issues and we can look for an opportunity to solve them at the local level, but we also have to keep a keen eye on the national level and the bigger trends.

I have forgotten your third point.

Ben Macpherson: You have covered it. It was about how concerned you are about synthetic drugs now and in the future, whether there is anything positive to emphasise about differentiation of services within and outwith prisons, and whether there are any gaps.

Sarah Angus: Oh, yes—gaps. You will not be surprised to know that, as somebody who works in the Prison Service, I think that anything for which you cannot define risk will always be a concern. The work with the University of Dundee through the contract gives us as an organisation a good grasp of what is happening and also provides evidence internationally. I am always impressed by what people on the ground, our policy colleagues and our partners are doing in respect of that.

There seem to be some gaps, which is why we want our alcohol and drug strategy to have a real focus. The committee has heard evidence that there is a gap in alcohol interventions. That is why alcohol is in the title of the strategy—it is so that we can be sure that we are not missing anything.

I will bring in Suzy Calder, who has specific expertise and can give examples.

Suzy Calder: From our perspective, it is critical that, as far as we can, we keep abreast of the types of drugs that are coming in and what might be coming in future so that we can prepare staff as far as possible. Our work with Public Health Scotland and its rapid action drug alerts and response system is also critical to the conversations that we have about what comes back from the University of Dundee and our colleagues in the police, and what is happening in other jurisdictions to give us a sense of the route that the drugs are taking and what types of drugs are coming. For example, the experience of NHS Forth Valley might not have been felt by NHS Grampian, so how do we share that information so that people are aware of what the presentations might be and, therefore, what our interventions might be?

We have also been doing a lot of work with our ambulance colleagues on ensuring that we have better connections across all areas. Ambulance staff see people and their presentations on the ground and in the community, day in and day out, so they can influence what works and what does not work, and how we share that information is important. We have quite a bit of work to do.

As for gaps, there will not, as we will all acknowledge, be 100 per cent access to all services in all areas at all times. That is a gap. We are working with prison-to-rehab pathways and trying to encourage those for whom that will be the route to liberation on to those pathways, but there will never be enough spaces. We always want to do more; our alcohol and drug strategy is ambitious, because if we can aim for that ambition, we can deliver a really good service.

It is difficult to identify gaps, because everybody's needs are different. I would say that the presentation of information and advice for those in our care in prison settings has to vary from what we see in the community. As Rhoda MacLeod said, we see everybody who is using in prison, but in the community, we do not, so the information exchange has to be different.

We also need to think about the risks that are associated with the types of substances that come in to us, and the fact that their format can increase those risks. We know that if a drug comes in, say, a powder format, the dosing will be difficult, and people are more likely to take way more than they had been considering. Similarly, if the time that it takes for somebody to feel the effect is drawn out, they will often take more to try to get to it—by which time, they will have overdosed, because of the cumulative effect.

This is a challenging and complex area that we are working in. I have worked in drug services for decades now, and I think that the problems that we have now are way more complex than we had before. We have heard from NHS colleagues that it is really quite unusual to see heroin, in its purest form, coming into prison; the synthetic drugs are way more prevalent, and they are more challenging for us to deal with.

Indeed, it is challenging for individuals to understand what they are taking. They do not know what it is, and they do not know the impacts that it is going to have. Therefore, it is a constant challenge, or battle, to try to get ahead of the game and ensure that we are putting the right information out there for everybody, to support them in their recovery and their decision making. It is a challenge that we face all the time in the conversations that we have.

The issues that we have in our local incident management are about learning, sharing and trying to look for ways of pre-empting things and promoting positive outcomes. However, it is a constant daily challenge, particularly for our staff.

Ben Macpherson: Thank you. Does anyone else want to come in?

Leona Paget: With regard to concerns about drugs, we do not really know what we are dealing with, day in, day out, and it changes. Like Suzy Calder, I have worked with addictions for decades. When it was just heroin, diazepam or benzodiazepines such as Valium or whatever else, we always had treatments for reducing their use in individuals, and we could give them a withdrawal regime. However, with the drugs that are coming through the door now, there is no withdrawal regime, let alone treatment for when they fall unconscious and we are trying to bring them back to consciousness. If they have to go to acute services, even our acute colleagues do not know what they are dealing with. We have no way of bringing them back round, whereas with heroin or opiates, we could use naloxone.

The bigger picture is that we just do not know what the drugs are and what effect they are going to have, because they affect each person differently. As Suzy Calder has said, some of our men—and women—are taking what they think is their normal dose if it is, say, a powder, or if it is on paper, they will take an inch square or something the size of a postage stamp. Sometimes, though, they are taking five times the amount just to get the effect. We never know what we are having to deal with or work with when we are trying to get them back to a state of health; we have had people who had to be intubated for five or seven days and whom we did not think would be able to breathe again, all because we did not have any idea what drugs they had ingested or inhaled. It is a huge concern.

When it comes to gaps, I definitely think that there are gaps around Buvidal. It is injected once a month; there is no bullying with it; and it gives people the clear-headedness that they need to get on with what they deem a normal life. Access to Buvidal should be the same across Scotland, both in the community and in prisons, to ensure that we have that transition of care. It should not just come down to the sorts of local budgets that Rhoda MacLeod and I have. We will have £150,000-worth of Buvidal going out every month, but there is always the pressure to save money.

The issue is also about mental health resources, given that mental health and addictions go hand in hand. It is about having that community resource before someone comes to prison and when they go out of prison. When people come into prison, they get a really good level of service. In most cases, what we provide is way above what they will get out in the community. There might be a little bit too much hand holding, but we want to promote responsibility, as they have to be adults when they go back out. We give a high level of service for substance misuse and mental health. When they go out, that consistency is lost again.

11:30

Ben Macpherson: Thank you all—that was very helpful.

The Convener: Before I bring in Rona Mackay, I will ask a follow-up question. You are aware that we had representatives of the Prison Officers Association Scotland before the committee last week. They spoke about the pressures on prison officers and staff at the moment, not least because of the prison population issue. One of the things that the association called for was a return to 24/7

nursing provision in prisons, just to cope and to support the management more fully with the impact of drug misuse. That would be a significant resource commitment, so I am interested in your views on that, Rhoda. I can see that you wish to comment.

Rhoda MacLeod: Yes, it would be a significant resource. My preference would be for that to be focused on the daytime, rather than having a nurse sitting in a prison waiting in case something happens. You would need to have two individuals, because it leaves somebody vulnerable otherwise. For example, it could mean a nurse sitting on their own in Barlinnie. That used to happen, but we stopped doing that shift pre-Covid—perhaps around 2017. We took that nurse out, because they would literally just sit there. People are locked up in their cells, and staff do not have access. An NHS member of staff would not be able to go in and out of cells without going through a process with SPS colleagues if somebody was in trouble.

We have an out-of-hours GP service, which the SPS has access to if it is concerned about anyone. Telephone advice can be provided, or the doctors can come in if that is absolutely required. Most often it is telephone advice. If we were to consider what is required out of hours overnight, the activity numbers would probably be very low, and they would not merit a member of staff sitting waiting for something to happen. I can understand where the question is coming from, because that level of provision would give an extra layer of security. However, from a best-value point of view, I am not sure that that is something that we would want to support.

Leona Paget: We have to decide what model of care we want NHS colleagues to provide within the prison regime and what model of care you want SPS colleagues to provide. I agree with Rhoda MacLeod that it would be far better to have a seven-day service with the same hours from Monday to Sunday. Mental health issues and substance misuse do not stop, but having such a service would be a waste of resource overnight. Are we treating prisoners as being in their place of residence? We are still supposed to be promoting that responsibility. We have had the same arguments about them having their own medication. I think that there should be more of a push for them to have more medication themselves, because they have to go out and look after themselves and be responsible for themselves. Some do not do that so well.

If we have a seven-day service with a daytime resource, ensuring that we are doing recovery and holistic wellbeing, we have to decide whether we want more primary care from my teams or we are going more towards acute services, with 24/7 provision.

There would be the same arguments around mental health. My mental health nurses cannot provide hands-on treatment if somebody is going through a psychotic phase; we have to section them out to mental health hospitals to be looked after appropriately. That is where we have to be mindful of the different tiers and the different models of care, considering what our colleagues outside a prison are for.

I do not think that prisoners should be treated any differently from how they would be treated if they were staying at home. They should have the same access to services as you and I do—which would be out-of-hours or 999 services. We try to keep them within prison for as long as we can, so that they are not just going back and forth, because we do not want that ping-pong. I still think that prisoners should have that free-flowing movement of the same type of care that you and I would get.

Rona Mackay: I will pick up on what has been said, and this is probably a question for Rhoda MacLeod and Leona Paget. In an evidence session last week, we heard that people with substance addiction issues could not access mental health care, which I found surprising. In its submission, Glasgow health and social care partnership said that that does not happen. Will you clear that up for us and talk about what the complexities are?

Leona Paget: I can definitely say that, in Forth Valley, where there are three prisons, substance addiction issues would never prevent people from accessing mental health care—my team is integrated. Mental health and addictions always come hand in hand, but it is about looking at the person as an individual and tailoring a proper package of care for them. They can self-refer whenever they want regarding mental health, sexual health or addictions—there are no blockages.

Rona Mackay: There is an overlap, then—one does not block out the other.

Leona Paget: It does not.

Rona Mackay: That is encouraging. I am particularly thinking about women who are in prison. So many people have mental health issues and substance abuse issues when they come into prison, so I was concerned when I heard that that might be the case.

Leona Paget: We would look at the person as a whole; we would not just pick out certain parts.

Rona Mackay: It depends on individual needs.

Leona Paget: Yes.

Rona Mackay: That is really good.

Leona Paget: It also depends on what the person wants at that time. They may not be ready to do some further work in a particular field, or they might not be ready to do some low-level work. It depends on where the person is in their journey.

Rona Mackay: But there is not a policy that says, "You have addiction issues, so you will not—"

Leona Paget: No, not at all.

Rhoda MacLeod: I concur with that, and it is the same in Greater Glasgow and Clyde. We do not have integrated teams, but they are co-located, they work together closely and they are not mutually exclusive.

Rona Mackay: Great—that is good.

With the crisis of drugs in prisons—I suppose that you could call it that—do prison staff have suitable training to deal with all the eventualities that occur, which might be medical, or even to deal with their own psychological issues due to what they have to deal with? Is the training up to it?

Linda Pollock: What you heard from our colleagues—representatives from the Prison Officers Association spoke about that at last week's evidence session—related to the change that there has been in the role of prison officers over time. You have heard that we want to focus on relationships and that people are finding things to be unpredictable. Gillian Walker, the governor who spoke last week, talked about staff not always knowing what they will be opening up to in the morning and how people will be presenting.

You will know that we are seeking to be a trauma-informed organisation. We have changed our training, particularly for new starts who are coming in but across all levels of our staff, to consider the training that we provide in relation to trauma, substance misuse and naloxone. We are clear that our staff are not medical—that is not what they are there to do; it is what our NHS colleagues are there to do, but we can work with them and also with the third sector. However, our training has certainly changed to support the changing role of prison officers and the numerous asks that we put on our staff on a daily basis.

Alongside that, we are working to ensure that there are spaces for staff to be able to recover and respond to what they see. Our staff care about the people who are in prison, and it can be traumatic to see those people present in the way that they do and go through the things that they do. We have been focusing on that and working with our trade union partners on what more support we can give to staff in their establishments and also nationally to support them with what they are dealing with.

We hope that changing the working model will allow people to have more time off—we have seen that in Dumfries and Grampian. Staff still work within the 35-hour working week, but the model gives them longer periods of time off to recover and restore. We are conscious that what we are asking of our staff on a daily basis is different from what it was before, and things are very pressurised just now.

Rona Mackay: Thank you. I have a fairly random question, but I will be interested to hear your responses. We are aware, and you will be aware, of the different model and culture of prisons in Scandinavia—for example, in Norway. I am not suggesting for a minute that things could change overnight here with our overcrowded prisons, but would you look to Scandinavia to pick up instances of good practice, albeit that they are in a different environment?

Linda Pollock: We are keen to learn from other jurisdictions. We engage through the EuroPris network, which brings together a lot of European jurisdictions to learn from them. We are always keen to see other models, what they are looking at and how we can learn from them. We also reach out to other jurisdictions for learning and best practice. We recently had the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment doing an inspection, and we asked those representatives for specific examples of good practice that they had seen during the inspections so that we can learn from them. We are always looking to see what we can learn from other nations.

Rona Mackay: It seems as though radical transformational change would have to happen here for us to get to the conditions and culture that they have in some of those countries. That is not what we have now. We seem to have been operating in the same traditional way for a long time, albeit that staff are now trained differently. I hope that all that comes at some point, but it is not going to happen overnight, that is for sure.

Rhoda MacLeod: Some of the great work that has been done with the community custody units for women tells us a bit about how things could be done differently. However, that service is hugely resource intensive. It is a fabulous service for 24 individuals at any one time in Glasgow, and 16, I think, in Dundee, but it is unrealistic to think that Scotland could also build lots of those units for male inmates. However, there is something to be learned from that about how we can take that approach in a sensible way—

Rona Mackay: In a gradual way.

Rhoda MacLeod: Yes, and work towards what our prison system could look like. Also, Leona Paget is absolutely right to talk about what the health component of that would be so that we can deliver best outcomes for everyone, because that is what we are all here to achieve.

Rona Mackay: That is interesting. Thank you.

The Convener: I wonder whether I can just come in with a question. Linda Pollock talked about the importance of relationships, and the critical role of the relationship between a prisoner and a prison officer or a member of staff has come up throughout the inquiry. However, we have heard in evidence about the disruptive nature of prison transfers. We understand the reasons for transfers, but they can have unintended consequences and the potential to disrupt relationships that are working well. Is that something that you are aware of? Are there ways in which transfers can be kept to a minimum and the benefit of relationships can be considered when a transfer is being proposed?

Linda Pollock: I will ask my colleagues to come in, but we recognise that we are undertaking far more transfers than we want to. Because of overcrowding and people being involved in serious organised crime, we need to keep people separate and move them around. We are doing far more transfers than we would like to.

There is work that we could do on transfers, and I also think that they can be beneficial for some people, but I will ask my colleagues to pick up in a bit more detail on how we support continuity of care where we can.

Sarah Angus: It will depend on the reason for transfer. When it is unexpected and in response to an incident or difficulties with managing different groups or enemies, it will feel disruptive and work will have to be done to ensure that there is continuity with care and case management. In other areas where we do transfers, it might be because of progression or potentially to access limited interventions. Those transfers are made with consideration of a case and the needs of the individual. There are two sides to the issue. An unexpected transfer will absolutely feel disruptive, but other transfers might be at the heart of decision making about supporting somebody's progression.

The Convener: We understand the geographical model of the prison estate, and the fact that people from the north-east will end up in HMP Grampian, for example. We heard a counterargument from some prisoners about the benefit of being accommodated in a prison that is outwith their home area. That is perhaps to do with family complexities, family breakdown and some of the dynamics that can be difficult for a prisoner. It is interesting to hear that that can be considered in the transfer policy.

11:45

Sarah Angus: You speak to the point that people are individuals and everybody's circumstances will differ. That is why it is important for us to have time for positive relationships, rather than having to deal with the transactional duties that overcrowding brings. When you have those relationships, you will understand better. Prison might seem to be a difficult and structured environment, but there are always opportunities for those relationships to bring about creative solutions. That does not always bring about the solution that somebody wishes. Transfer decisions are sometimes made because of risk and risk reduction, but relationships are certainly key.

Leona Paget: I just want to come in on the question about therapeutic relationships. When people are going to be transferred, I would welcome the SPS discussing their healthcare needs and their care with the NHS to look at, for example, hepatitis C treatment, which is a 13-week treatment. Pre-Covid, we used to be included in many discussions because it costs a lot of money per month for that person and if they go to certain health boards, that treatment might be stopped. We need to make sure that that transition also occurs with their addiction services.

Normally, my team will find out that somebody has been transferred to Low Moss or HMP Perth, and it is not until they have gone that Perth health centre will phone. It is not that we cannot share the information, but it would just be good to have that communication before the transfer, so that we know whether it would be beneficial for them to move, and at least get their care package pulled together so that it can be passed on.

The Convener: It is helpful to understand that. There might be a delay, but it is not insurmountable, if you like.

I want to finish up with a couple of questions, and the first comes back to the focused day model. When we kicked off our meeting, Linda Pollock outlined where the focused day was going. To be a bit daft lassie, could you explain the terminology around regime and roster operational review? For the clarity of members, what does that mean?

Linda Pollock: As I said, we looked at a national project called the focused day. In discussion with our trade union colleagues, we have changed that to be local and to focus particularly on the regime and roster. We are looking at it slightly differently, but with the same overall objective of achieving increased stability, security and continuing our offer for those who are

in our care and for our staff. The focused day will look specifically at staff deployment, including the hours that people work on a daily basis and on a shift basis over the week, and at how we can maximise the time and have more staff available during the day to allow them to provide more services, to work with partners and bring people to more services. That is why it will be looked at locally.

As you will know, every prison has a very different make-up. For example, I know that Gillian Walker, the governor of HMP Shotts, said last week that the service that is required for long-term men will be different from what the short-term inmates in Polmont require. It is about looking at the needs of the cohorts in each prison at a local level, and specifically at the staffing model that it uses on a daily basis.

The Convener: Will that still mean that there is a likelihood that prisoners will be locked up for longer? Even though you are looking at how you can maximise the effectiveness of your staff deployment, is there still a risk that, inevitably, people will be locked up for longer than you would want?

Linda Pollock: As an organisation, we accept that people are being locked up for too long at the moment. We are trying to tackle the fact that people are being locked up during the day, when they should be going to services that we are not able to offer just now. That will mean being locked up more in the evening, but there will be a guaranteed offer within the working day to ensure that people have more access.

We will want to keep that under review, because it is very much a tactical response to the numbers that we have within our care just now. We commit to keeping things under review, but we want to try to increase the offer of time spent outside cells because we know that we are not consistently able to deliver that at the moment.

The Convener: I have a final question about the MAT standards before I bring in Rona Mackay. Rhoda, the alcohol and drug recovery strategy rightly states that the implementation of MAT standards in prisons is a priority, with the aim, as I understand it, that that will be completed by April next year. We have heard evidence that that is quite an ambitious target, so I am interested in your view on whether that is realistic.

Rhoda MacLeod: Work has commenced with the national MAT implementation support team to look at how we implement that. To be fair, some of it has already been implemented, so we are not starting from ground zero. There was quite a lot of work to benchmark ourselves against the MAT standards when they first came out. We have achieved some of them, but it is a bit like painting the Forth bridge: we have to constantly make sure that we are staying on top of that and not letting anything slip. The April 2026 target might be a bit ambitious, but the work to try to achieve that is on-going.

The Convener: Rona Mackay, do you want to come in?

Rona Mackay: Yes, briefly. I am interested in demographics. Are you able to give us a picture of the average age of offenders going into Polmont who are dealing with substance abuse or substance addiction? Is that different from the situation at Barlinnie? I am trying to get an impression of whether more young people are dealing with that or whether it generally affects middle-aged and older people.

Leona Paget: I do not have any statistics. Do you, Suzy?

Suzy Calder: I do not have any official statistics.

Rona Mackay: Does anything jump out to say that it is mostly middle-aged people?

Suzy Calder: No, but, if you look at the age profile of people who have problems as a result of drug and alcohol use, you will see that the key population is people in their mid-20s to mid-30s. That is where we see the highest numbers. We try to track what that looks like, but I do not have any statistics that I can share with you today.

Rona Mackay: Can you say anything about whether the problem definitely affects older people or whether you have an alarming number of young people coming in? Does anything jump out?

Suzy Calder: We are aware of the risks for all those who come into prison, because they all have their own histories and trauma that bring them in. We recognise that the risk factors are different for everyone and we try not to focus too much on particular age groups, because we might lose sight of others who are also at risk. We deal with people as individuals, as our health colleagues said earlier, and it is important to understand where each person is at and what we can do to meet that.

The Convener: There are no more questions from members and I do not see any of the panel members asking to say to say anything in conclusion. I thank everyone for their contributions to a really interesting meeting.

I suspend the meeting for five minutes to allow the panel members to leave before we consider a negative Scottish statutory instrument in public and then finally move into private session.

11:54

Meeting suspended.

12:03

On resuming—

Subordinate Legislation

Firefighters' Pensions (Remediable Service) (Scotland) Amendment (No 2) Regulations 2025 (SSI 2025/187)

The Convener: Our next item of business is consideration of a negative statutory instrument. I refer members to paper 4, which sets out the purpose of the instrument. The Delegated Powers and Law Reform Committee made no comments on the substance of the instrument; rather, its comments related to minor defective drafting. If members do not wish to make any other recommendations in relation to the instrument, are we content for it to come into force?

Members *indicated agreement.*

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

12:04

Meeting continued in private until 12:50.

Official Report
Room T2.20
Scottish Parliament
Edinburgh
EH99 1SP

Email: official.report@parliament.scot
Telephone: 0131 348 5447

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba