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Criminal Justice Committee

Wednesday 24 September 2025

Session 6

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Pàrlamaid na h-Alba

Wednesday 24 September 2025

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CRIMINAL JUSTICE COMMITTEE

24th 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)
*Jamie Hepburn (Cumbernauld and Kilsyth) (SNP)
*Fulton MacGregor (Coatbridge and Chryston) (SNP)
*Rona Mackay (Strathkelvin and Bearsden) (SNP)
Pauline McNeill (Glasgow) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Angela Constance (Cabinet Secretary for Justice and Home Affairs)
Alison Crocket (Scottish Government)
David Doris (Scottish Government)
Richard Foggo (Scottish Government)
Philip Lamont (Scottish Government)
Maree Todd (Minister for Drug and Alcohol Policy and Sport)

CLERK TO THE COMMITTEE

Stephen Imrie

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

Criminal Justice Committee

Wednesday 24 September 2025

[The Convener opened the meeting at 10:01]

Interests

The Convener (Audrey Nicoll): A very good morning, and welcome to the 24th meeting in 2025 of the Criminal Justice Committee. We have apologies from Pauline McNeill; Fulton MacGregor is joining us online; and Sharon Dowey is slightly delayed in her arrival.

I extend our congratulations to our colleague Ben Macpherson MSP on his new ministerial role and thank him for all his work in committee.

I also welcome Jamie Hepburn MSP to the committee. We look forward to working with him, and I ask whether he has any relevant interests to declare.

Jamie Hepburn (Cumbernauld and Kilsyth) (SNP): My only interest that might be relevant to the work of the committee is my membership of Amnesty International.

The Convener: Thank you. That is noted.

Substance Misuse in Prisons

10:02

The Convener: Our next item of business is the continuation of our inquiry into the harm that is caused by substance use in Scottish prisons. Today, we have an opportunity to take evidence from the Scottish Government and I am very pleased to welcome the following witnesses: Angela Constance, Cabinet Secretary for Justice and Home Affairs; Maree Todd, Minister for Drugs and Alcohol Policy and Sport; James McClellan, deputy director, community justice division; David Doris, prison policy team lead, criminal justice division; Richard Foggo, director of population health; and Alison Crocket, whole systems unit, drugs policy division. Thank you for joining us.

I refer members to papers 1 and 2. I intend to allow up to 90 minutes for the session.

I invite the cabinet secretary and the minister to make a short opening statement.

The Cabinet Secretary for Justice and Home Affairs (Angela Constance): Good morning, convener, and thank you very much for the opportunity to appear before the committee. I thank the committee for accommodating my request to move this session from last Wednesday, due to stage 3 of the Victims, Witnesses, and Justice Reform (Scotland) Bill. That is much appreciated.

I very much welcome the committee's inquiry into drugs in prisons, which recognises the significance, harmful impact and dynamic nature of issues that relate to illegal drug and substance supply in prisons, including concerns about the rise in strength of synthetic drugs, the impact on people in prison—and, of course, prison staff—and the importance of access to effective rehabilitation and support, on which, I am aware, you have taken evidence.

As the committee is aware, there is a high and complex prison population, and issues that relate to preventing supply, keeping people safe and managing the impact of substance use in prisons is demanding, to say the least, for the Scottish Prison Service as well as for our national health service colleagues and other partners. I put on record my thanks for the hard work and dedication of the staff in those organisations in keeping safe the people in our care as well as their colleagues.

The health and wellbeing of those in the care of the Scottish Prison Service is a key priority. Having been Minister for Drugs Policy and now Cabinet Secretary for Justice and Home Affairs, I have a strong appreciation of the importance of a strategic approach across health and justice. I

know that the committee is interested in how the health and justice portfolios are co-ordinating to reduce deaths and support recovery, and in how lived experience and evidence are being embedded in strategy.

As you may be aware, I chair a cross-portfolio ministerial group on prisoner health and social care, which provides clear leadership and helps to ensure a joined-up strategic approach to health and social care in prisons. The vision for justice provides an overarching strategic approach, including focusing on person-centred approaches to reduce crime and harm in our communities and support rehabilitation by the most effective means possible. Our national mission to reduce drug deaths continues to focus on a public health approach to improve the treatment and care provided for people with drug issues. The Scottish Prison Service's 10-year drug and alcohol strategy, which was published in February, sets out a framework for improving the outcomes of people in custody.

I am sure that you will want to ask about a range of issues in more detail, convener, and I look forward to the committee's questions, but first, I hand over to Ms Todd.

The Minister for Drug and Alcohol Policy and Sport (Maree Todd): I, too, thank the committee for the opportunity to be here. I will say a few words about the progress that is being made in providing appropriate and timely treatment to those in the prison estate with drug or alcohol issues. However, it is important to acknowledge at the outset the recent drug and alcohol-related death figures. Far too many lives continue to be lost to substance misuse, and that has to remain at the forefront of our response.

We know that around two fifths of those in prison self-report problematic substance use prior to imprisonment. Prisons should therefore be somewhere where substance use is dealt with both sensitively and effectively and, on that point, the medication assisted treatment implementation support team is working to deliver a programme of support for justice and custodial settings. The MAT standards reinforce a rights-based approach for people and the treatment that they should expect, regardless of their circumstances or where they are.

On recovery work, we provide funding to the Scottish Recovery Consortium to embed a person-centred, recovery-focused approach that benefits prisoners, families and staff. That continues into transition and resettlement back into the community. As I am sure that members know, we have expanded access to naloxone to all prisons and we are funding the Scottish Drugs Forum to deliver peer-to-peer naloxone supply within the estate. We have also made funding available to the prison-to-rehab pathway that enables suitable and motivated individuals to access residential rehabilitation immediately on release from prison.

Providing support to those with drug or alcohol issues is not distinct from providing them with other healthcare. As a Government, we have supported the national prison care network to develop a target operating model for healthcare delivery in prisons. That sets out a nationally consistent service model for the delivery of the range of clinical services that are provided in prisons, including drug and alcohol services. Despite the very challenging operating environment, I am encouraged to see steady progress in the number of services that have been implemented across the prison estate.

I also highlight that the period that our national mission covers will conclude next year, but we are currently developing a refreshed alcohol and drug strategic plan to continue the important work to address the alcohol and drug-related challenges that Scotland faces, and I expect the plan to be published early next year.

I hope that I have given the committee a flavour of the activity that is taking place. I look forward to taking questions on anything that I have said or any other related issue.

The Convener: Thank you. I will start off, and I will stick with the minister. It was helpful to hear your update on the specific matter of healthcare in prisons. As you will imagine, we have taken quite a bit of evidence on the healthcare support that is available in prisons.

Of course there are challenges with that at the moment, not least by virtue of the size of the prison population. NHS and health and care partnership representatives have told us that prison healthcare can often be limited by operational constraints. In his evidence, Dr Craig Sayers from NHS Forth Valley noted that, although he is present from 8 am to 5 pm on weekdays, he can see prisoners only during relatively short windows, because of officer availability and the natural constraints that can emerge in the prison estate. However, he also told us that, in some prisons, there seems to be more flexible access, which he believes we should look to make more standard. That would allow NHS staff to see more patients and to provide better care.

Would you care to respond to that? What commitment can the Scottish Government give to engaging with the SPS and NHS Scotland on how a more effective model that builds on the important service that is there already could be embedded in prisons?

Maree Todd: Certainly. I will bring in Richard Foggo to tell you a bit more about how we are approaching the issue.

The cabinet secretary mentioned our ministerial cross-portfolio group on prison healthcare. The Scottish Government has worked closely with the SPS and the NHS to develop a target operating model for service delivery. There are undoubtedly constraints in the prison system and in the healthcare system. In health, there are also staff shortages and workforce challenges when it comes to recruiting the multidisciplinary team for the prison estate. A full multidisciplinary team is required. All of us in the room understand well the complex multimorbidity of people in prisons, who, in general, tend to have more illnesses and to be older than their years, so there are lots of health challenges with that population.

I will hand over to Richard Foggo to explain how we have come up with the target operating model and how we are working to embed it in the prison estate. It is a complex challenge.

Richard Foggo (Scottish Government): Good morning, and thank you for the invitation.

As the committee heard last week, including from colleagues in NHS Forth Valley, there is an issue with consistency. That is why we have established a series of oversight and improvement measures, both at ministerial level and through the Scottish health in custody network, which is looking at consistency. At the moment, for the first time, a systematic look is being taken at the emerging practice and at how we can flex across the prison estate to ensure that best practice is implemented. Instead of relying on individual establishments to take the initiative, there is now a process whereby experts such as Dr Sayers come together to make sure that that practice is identified.

Last week, one colleague suggested that we could look at other jurisdictions and asked whether the system in Norway was a good model. The target operating model gives us the opportunity to find the best practice that is appropriate to Scotland and to apply it. We have a three-year implementation phase for that, and we are about halfway through. About 70 per cent of it has been implemented. About 12 of the 30 change recommendations in the target operating model are relevant to alcohol and drugs.

Among the key issues that the target operating model is trying to address are those that relate to the workforce. For the first time, we have a full audit of the entire clinical workforce that works in prison healthcare, which includes those who work on mental health and alcohol and drugs. That is allowing us to identify, from a national perspective, where the vacancies are. If the flexibility that Dr Sayers mentioned is limited by workforce issues, the target operating model will enable us to take a national approach that could help us to support NHS Forth Valley.

The other barrier that the target operating model is trying to address is the underlying data and the clinical system infrastructure. Again, we have significantly invested in that from a national perspective. As you might understand, the actual limitations include the systems that operate in primary care, and the general practice information technology model is being updated. The situation in prisons is distinctive, but we are trying both to address flexibility in the workforce and to ensure that the infrastructure is there to support the delivery of the target operating model.

10:15

Angela Constance: I will briefly add to that. It is of fundamental importance to me, particularly as the chair of the cross-Government ministerial group, to knit together that collaboration between our national health service and the work that the Scottish Prison Service facilitates.

The committee will have heard me say before that, irrespective of where a citizen is residing, whether that is in the community or in custody, the equivalency of service and support in healthcare is imperative.

There are obvious changes and demands in and around delivering services in the context of safe and secure prisons, but, with regard to that collaborative work, what is being rolled out now is an improved healthcare referrals process. There is a revised memorandum of understanding between the Prison Service and the NHS. Crucially—and this is important in relation to the multi-agency working that Ms Todd referred to—more joint training is now taking place between the Prison Service and the NHS. That may sound like a technical point in relation to a target operating model, but I cannot, for a minute, underestimate the importance of getting consistency in the delivery of healthcare to our prisoners at a national level.

The Convener: By way of a follow-up, it is very helpful to understand a bit about the target operating model, because I do not think that that has been raised in evidence so far. It is good to understand that that approach is being used in order to promote service delivery. I do not want to complicate things, but how does that tie in with the MAT standards and how they are being rolled out across the prison estate?

Maree Todd: Again, Richard Foggo can come in on this, but yes, they do tie in. Addictions were identified as one of the key themes in the target operating model. The implementation and

embedding of MAT standards is a key part of ensuring that that approach works effectively within the system.

Richard Foggo: It might be helpful to the committee's evidence gathering for us to provide you with a specific briefing on the delivery of the target operating model. There are multiple workstreams that may give you some comfort that concerns are being addressed, and we can certainly follow up to make sure that you have that information to hand.

The target operating model is looking to the future—to that consistent multi-agency approach. Our ambitions for MAT are part of that, so they are absolutely designed to be complementary. We would expect the target operating model to be delivered at a point that would allow us to deliver on the MAT standards commitment.

The Convener: Thank you for that offer. That would be really helpful, just so that we can get our heads around how everything intersects.

I will bring in Liam Kerr.

Liam Kerr (North East Scotland) (Con): Good morning. The committee has heard a great deal of evidence that the single biggest influence on substance misuse in prisons is overcrowding, which is due to issues such as reduced resources, staff capacity or time spent in cells. The cabinet secretary will have seen Teresa Medhurst saying just today in *The Scotsman* that overcrowding means that

"prisons are simmering on the brink of a crisis",

as well as pointing out that the early release schemes have failed to address the matter. What actions will the Government take to address overcrowding, and when will those actions deliver a genuine reduction in numbers? Will the Government try another early release scheme?

Angela Constance: Mr Kerr is quite correct to point to the impact of significant overcrowding on prisoners, staff and access to drug treatment, as well as to other forms of rehabilitation. Overcrowding puts the system under immense stress.

I would be the last person in the room—and, I suspect, the last person in the Parliament—to ever demur from the serious and significant challenge that we face with a prison population that, as I have said on a number of occasions, is too high. Our prison population needs to be sustainable, because ultimately that is what keeps our communities safe; our prisons need to be able to accommodate those who pose the greatest risk.

I respectfully remind the member that every time that I have taken action I have reminded Parliament that there is no one solution. Early emergency release provides temporary relief. The Prisoners (Early Release) (Scotland) Act 2025—and the programme known as STP40 that it brought in—reduces the prison population in a sustained way by 5 per cent from what it would otherwise have been.

I, too, would quote Teresa Medhurst, who also said in *The Scotsman*:

"I am grateful for the leadership and support we have received from the Cabinet Secretary ... and colleagues in the Scottish Government. Were it not for the emergency early release programme last year, and the Prisoners (Early Release) Scotland Act, which came into effect this year, our situation would be far worse."

I accept that that in itself is not good enough, though, so I reassure the committee that I am intensively engaged with the Scottish Prison Service. I have always proactively kept Parliament up to date with the situation, and that will not change. Should new measures be required, I will announce them in Parliament, as I have always done.

I am perhaps going to be a little bit cheeky now, Mr Kerr. I have not walked away from my obligations to take action, but other members in the Parliament have often balked at such actions. I suggest that doing so is perhaps for political expediency instead of prioritising the safety and security of prison staff and managing a very high and complex prison population.

Liam Kerr: Let me throw that back to you, cabinet secretary: which new measures are you proposing, precisely? I fear that you might have avoided the question that I started off with, which was whether there would be another early release programme.

Angela Constance: Actually, Mr Kerr, I answered your question when I said that I was intensively engaged with the Scottish Prison Service. That work will be built on through engagement with trade unions, victim support organisations and other justice partners. If further measures are necessary, I will, as I have always done, communicate them to Parliament as a whole and explain any action that I believe is required and why that action is necessary at any point in time.

Liam Kerr: I will move on, but before I do so, I would just remark—because I think that we would all accept that there is overcrowding—that I was simply trying to establish what is being done to bring that overcrowding down. I certainly do not question the engagement that the cabinet secretary is having, but I think that people outside need to see real change.

Angela Constance: They do, Mr Kerr, and I hope that you will hang on to that thought,

particularly when the sentencing and penal policy commission reports later in the year.

Liam Kerr: You mentioned, rightly, drug treatment earlier. With regard to the number of people entering prison in the first place, the committee has heard evidence of the low number of community payback orders with drug, alcohol and mental health treatment requirements, and we have seen data that shows that lower numbers of drug treatment and testing orders are being imposed than there were before Covid. Why is that? Is the Edinburgh Bar Association correct to say that, in Edinburgh, a DTTO—which was an alternative to custody—has not been available since 2023? What is the Government proposing to do instead?

Angela Constance: There is a lot in that question, Mr Kerr, so I hope that the convener will bear with me.

The latest figures show that in excess of 15,000 community payback orders have been issued across Scotland. Let me stress that I am very supportive of drug testing and treatment orders when they are appropriate for an individual. The latest figures show that, in 2023-24, there were 280 such orders; they are, by their very nature, a much more discrete intervention, and they obviously involve the courts. Their implementation also varies across the country, which has presented challenges in getting a firm view of their effectiveness.

I have visited drug courts that monitor drug testing and treatment orders, and I know that they have been very successful in helping many people turn their lives around. They are, like all community interventions, delivered locally, so I am very aware of the decision that Edinburgh services took and the impact that that had on East Lothian and Midlothian. I should stress again that these are local decisions.

The orders are effective for many people. The completion rate for a DTTO is around 51 per cent, with 75 per cent of those finishing without any breach. As I have said, the evidence on them is a bit complex.

The great strength of a community payback order is that it can be tailored to the individual. One thing that the sentencing and penal policy commission is looking at is how not just custody but community disposals are used. Why a comparatively low proportion of additional conditions that are specific to drug and alcohol treatment and mental health are put on community payback orders is an interesting question. I am not necessarily saying that that is right or wrong, because sometimes we forget to look at treatment and support in a much broader context. Treating someone's addiction could be better than treating their trauma. We also need to consider employability, support with life skills and daily living, addressing the specifics around offending behaviour and any underlying attitudes as well as treatment of mental health and addiction issues.

As I have said, it is difficult to say at this point whether that is a good or a bad thing. We need to understand it more, but I can say that the strength of a community payback order is that it can be tailored to the needs of an individual.

Liam Kerr: I am very grateful for that. Perhaps, after this evidence session, the cabinet secretary or officials could send the committee data on the use of DTTOs by sheriffdom, so that we can see whether Edinburgh is an outlier as well as what is happening across the country.

Angela Constance: I think that Edinburgh is an outlier, but we will send you information on that. Perhaps Ms Todd's team can help. We will be more than happy to do that.

Liam Kerr: The committee would be very grateful. Thank you for that.

For my final question, I will stay with you, cabinet secretary. The committee has heard evidence that there are simply not the required resources when it comes to what prison officers and NHS staff need to address this issue in prisons. The committee has heard that the impact on those who work in our prisons is physically, mentally and emotionally exhausting, and I know that the cabinet secretary has seen Teresa Medhurst's comments in *The Scotsman* today on that matter. What is the Scottish Government doing practically to ensure that sufficient funding is available to provide the resources required? Do Teresa Medhurst's warnings have any influence on the cabinet secretary's thinking in relation to the upcoming budget?

10:30

Angela Constance: Of course they do—they always do. I will address the specific point about the budget and Scottish Government actions, but, first, I want to put on record that I recognise that prison officers, as well as other Prison Service staff and NHS colleagues in our institutions, do a difficult and, at times, dangerous job.

On the budget, I point out that, in this financial year, there was a 10 per cent uplift for the Scottish Prison Service, following an uplift of nearly 10 per cent the previous year. We are investing nearly half a billion pounds in our prison service. Prison officer numbers have increased; today, the number sits at 3,797 people. However, I am conscious that resource is about more than top-level financial investment; the issue is also how we use our resources.

I am sure that the committee will have seen that we successfully reached a two-year pay deal for prison officers in the Scottish Prison Service. That was on a par with the deal on the agenda for change; I was pleased to secure it, and I hope that it speaks to my commitment to prison staff and my arguing the case for them in the budget process.

I am conscious that you asked about Scottish Government action, but a point that I would make—because I think that our trade union colleagues would be quite miffed if I did not—is about the Prison Officers Association's 68 is too late campaign. Prison officers cannot retire until they are 68, which I find incredible and horrifying. As many of you will know, a few decades ago, I was a prison social worker; I cannot imagine being a prison-based social worker at 68, never mind a prison officer. There is work to be done there at a United Kingdom level, because there was an omission of the unique position of prison officers from the Hutton pension review.

I just want to put that on record, because I think that the Prison Officers Association would wish me to do so.

The Convener: I will bring in Rona Mackay in a second, but, first, I will completely change the line of questioning.

We have heard a lot about the different ways in which drugs and substances are coming into prisons. Currently, one of the main ways is through the use of drones. Can either the cabinet secretary or the minister update the committee about communication with the UK Government on extending the no-fly zone regulations for prisons that are in place in England and Wales? As I understand it, some work has been going on to look at how those can be extended to Scotland.

Angela Constance: I am happy to do that. I will start by being fair and balanced: when I found out about the regulations that apply in England and Wales, I was a wee bit miffed that Scotland had been treated as an afterthought, because aviation—civil aviation, air navigation and all the rest of it—is reserved. Nonetheless, engagement between my officials and UK Government officials has been constructive. We are asking the Ministry of Justice to be a sponsor and to make a recommendation to the Civil Aviation Authority.

It is one of many tools. I do not want to say that everything would be solved or that the job would be done if those regulations applied to Scotland. It would help with drone activity, the impact of which is exceptionally concerning, but I am aware that the supply of illicit drugs to prisons is constantly evolving, which means that we constantly have to reappraise the tactical and operational approaches. Nevertheless, that would definitely help and, thus far, engagement at official level has been positive.

I have also taken the opportunity to write to the new Lord Chancellor, Secretary of State for Justice and Deputy Prime Minister, David Lammy, to welcome him to his new role and to raise the issue.

The Convener: Is there any idea of a timescale for that? A timely resolution would be good.

Angela Constance: That is a fair point, and it is why I took the opportunity to write to the new Secretary of State for Justice for England and Wales. My officials may have some insight as a result of their engagement.

David Doris (Scottish Government): I cannot say anything specific at the moment. We are engaging with our UK colleagues. An amendment is being made to the regulations, and we are examining whether there might be an opportunity to piggyback on that or whether it might have to be done via other regulations.

Our understanding is that the procedure that was used down south was fairly unusual, so we are investigating how that came about and how we can most efficiently support our UK colleagues to progress the matter. There would be a need for technical geomapping information from SPS regarding sites, locations and distances from prison, and there is also a need to consider exemptions, so a few things have to be bottomed out.

The Civil Aviation Authority has a lot of expertise and experience in that area, so there would be a joint project to work through that. We still have to get a clear sense of timescales, because the MOJ and other colleagues have existing priorities and commitments. We need to identify the most efficient way to do that, but we want to do it as soon as is practicable.

Rona Mackay (Strathkelvin and Bearsden) (SNP): I have some questions about throughcare and release, but, before I ask those, I have a question for the minister about something that came up at last week's meeting and that was certainly news to me and to most committee members. We heard about a drug called Buvidal. It is apparently seen as some sort of wonder drug for stabilising people for a few days, but its use is quite patchy and it is not widely available. Can you expand on why that is? Is it due to cost or availability?

Maree Todd: Buvidal is, or should be, available all over Scotland. The Scottish Medicines Consortium has assessed it and has made recommendations about where and how it should be used.

Please indulge me, because I am a pharmacist as well as a Government minister. In some ways, it can be seen as a wonder drug. It is a little bit different to other opioid substitution therapies because it is a mixed agonist-antagonist, which means that it has some inherent, built-in protection against overdose. That is really important for the prison population, given the recognised risk of overdose immediately after liberation from prison.

The generic name is buprenorphine, and Buvidal is the brand name. It is a long-acting injection, which means that it is given by injection at intervals and reduces the need for individuals to present daily at a chemist's, which can be quite degrading. Some people find that a supportive intervention, whereas others find it degrading and feel that it interferes with their getting on with rehabilitation and resuming caring duties, employment, volunteering or whatever else they need to do on liberation from custody.

The fact that it is a long-acting injection means that it is impossible to divert, which is another advantage. I would not call it a wonder drug, but the inability to divert it is a real advantage when decisions are being made on the best choice of opioid substitution therapy—given that, globally, the evidence is very strongly in favour of opioid substitution therapy and shows that it reduces deaths, harm and criminality and helps people to recover and stabilise. In the most recent detailed interrogation of drug deaths data, we found that 53 per cent of people who died had methadone in their system, but 40 per cent of the individuals who died after taking methadone were not prescribed it. There is a level of diversion in the system that is dangerous and contributes to drug deaths. That is another reason why long-acting buprenorphine, which cannot be diverted because it is injected into the patient, has an advantage over other forms of opioid substitution. The MAT standards make it very clear that individuals who are receiving the medication and accessing healthcare should be a part of the decision-making process around which drug is right for them.

Rona Mackay: That is really interesting. I was going to ask whether buprenorphine is the new methadone, but you have explained the difference. Who prescribes buprenorphine, and why is it not more widely available? Is it due to cost?

Maree Todd: There are cost implications. We can write to you with what the SMC said when it assessed buprenorphine's role in therapy. It did not say that it is the first line of action across the board, but it said that it is a very suitable alternative for those for whom methadone is not the appropriate drug. Although there are cost implications—as always with these things—the drug acquisition cost has to be balanced against the economic value. Work is going on to understand how much advantage there is to using methadone compared to using long-acting buprenorphine.

Rona Mackay: So, there is work to understand what the outcomes are.

Maree Todd: Yes. A lot of work is being done. The Scottish Drugs Forum recently did some peer research on long-acting buprenorphine, which talked about the fact that buprenorphine tends to make people more alert and awake. That goes back to its being a mixed agonist-antagonist: it has some blocking effects and also acts directly on the receptors, which means that people are more alert. Some people really struggle with that, and that was picked up in the peer research. It can be very difficult for people who—I suppose you could describe it this way—have been anaesthetising themselves to life for a very long time to suddenly be aware of their circumstances, and they need intensive psychological support through that stage. To go back to your question around the economics, having a drug on which people are more alert has obvious implications for their working, caring and resuming their role in society.

There will be significant differences between the two. There are also significant differences in the amount of health professional time that is required for either prescription. A methadone prescription generally requires to be frequently written and frequently reviewed, and there is a cost to supervision within the community. The costs for a long-acting injection are lower, but the costs of the psychological support that is required might be higher—although you might get significantly better outcomes. All of that is being examined at the moment, and there is a keenness to understand it across the UK.

Last week, when I met UK ministers, there was a great deal of keenness to understand all of that rich information with a view to making recommendations. In Scotland and Wales, Buvidal is reasonably widely used—we can get you the statistics if neither of my officials can provide you with them now. It is significantly less frequently used in England, and English colleagues have advocated that it should be used more, because it clearly has a role and some advantages over the alternatives.

10:45

On how it works in Scotland, I have heard anecdotally that different health boards have concerns about the arrangements for prescribing long-acting buprenorphine on discharge and on liberation from custody. However, my concern and the Government's concern is that drug prescriptions should not be changed for bureaucratic or administrative reasons on

discharge from prison, which is recognised as a high-risk period. Changes to medication in that period should happen for clinical and personal reasons that are agreed between the individual and the clinician who is prescribing for them, because the risks in that period are well acknowledged.

Rona Mackay: That explanation was really helpful.

Regarding throughcare and release, minister, you talked in your opening statement about treatment plans for prisoners on liberation and so on. Can you say something about the number of people who need to access those plans? Is the service there for them? Are there people who are slipping through the net or unable to access those plans?

Maree Todd: Alison Crocket might be able to give you more detailed information. We are certainly seeing third sector organisations and recovery communities putting in a lot of work to reach into prisons and support people as they transition and are liberated from custody. Our data shows that, in the really high-risk liberation period, we are seeing fewer drug deaths than previously, so our work is having some impact.

Alison Crocket (Scottish Government): I am just looking at my numbers. We give the Scottish Recovery Consortium about £630,000 a year to run services including recovery cafes in a number of prisons in Scotland. Its work is essentially about acknowledging that it is a difficult time, because many people who are released very quickly from prison relapse and go back in. It is about working with people while they are still in prison, identifying their support networks for when they get out and linking them into outside recovery networks so that, on the day that they are released, they are already connected to organisations and can continue to get support, which interrupts the in-and-out cycle that so many people experience.

This year, the Scottish Recovery Consortium has expanded that service. I have details in my notes somewhere, but I will not rustle through them while you wait. We can certainly provide you with the specific prisons.

Rona Mackay: Thank you very much. That is really helpful.

Cabinet secretary, the Bail and Release from Custody (Scotland) Act 2023, which most of us here worked on, sought to address housing issues, the lack of medication in the community and the need for all the throughcare things that we want. Some of the provisions are still to be implemented, so they will perhaps be a booster when they are fully up and running. Could you bring us up to speed with what is happening with the act?

Angela Constance: Progress has been made with the implementation of the Bail and Release from Custody (Scotland) Act 2023. If you recall, part 1 was the new bail test, and that was implemented in May. You might recall that a section 102 order was required from the UK Government to ensure that our bail test did not inadvertently have consequences for extradition procedures.

Part 1 of the act has been fully implemented. That also enabled justice social work to contribute to bail decisions if it has information. Obviously, the court can also make requests of justice social work.

Parts of part 2 have been implemented. During the passage of the act, particularly at stage 3, there were amendments to lengthen the time between commencement and the publication of the national throughcare standards, in acknowledgement of the amount of work that needs to be done in relation to that.

Section 12 contains the duty to engage in release planning, and we are looking at a space for commencement of that. The duty is about putting an obligation on named partners—it is a lengthy list that includes local authorities, health boards and Police Scotland—to comply with any request from the Scottish Prison Service to engage

"in the development, management, and delivery of release plans".

Some of that work has happened in practice through the STP 40 programme and earlier release programmes, so there has, in some ways, been a bit of a trial run. However, we are making plans for the commencement of section 12.

Section 13 relates to the national throughcare standards. During the passage of the act, we made it clear that there would be two years between commencement and the publication of those standards. We are engaged in the work with partners and we are liaising with the Scottish Government legal directorate on a timeframe for commencement. There are two phases to that work. As you might recall, the commitment was for the standards to be co-produced by partners and for there to be public consultation. There is a lengthy list of partners with whom the Scottish Government must engage, including the voluntary sector, which is positive. There is research being undertaken that will have to be brought to a conclusion as well. Phase 2 is the full, 12-week public consultation. The clock will start ticking when we lay the commencement order.

Rona Mackay: Thank you. It is encouraging that all of those things are taking us in the right direction and we are on the right trajectory to relieve some of the long-standing issues.

The Convener: The remand prisoner population comes up a lot in committee. We know that access to support and recovery activities for the remand population is reduced compared to that for the convicted population. At the moment, a significant proportion of the prison population is made up of remand prisoners. Do you have any update, cabinet secretary, on how that is being managed?

Angela Constance: The starting point is continuity of care and grasping the golden opportunities when individuals reach the point—which is often their lowest point—of recognising the changes on which they must embark. When people have those moments, we have to be ready to grasp them and we have to keep a hold of people in those times. Continuity of care is of fundamental importance, and it is a key part of the Scottish Prison Service's drug and alcohol strategy.

There can be challenges for remand prisoners. Individuals on remand have access to addictions healthcare in prisons, which is different from recovery cafes and engagement with the recovery movement. One of the remarkable changes in prisons that I have seen over the past 25 years is the on-site presence of the voluntary sector and the recovery community—not just people with lived experience of addictions but those who have previously been in the criminal justice system and who have experienced imprisonment. They have been able to access prisons to be peer mentors and to engage with people, and that is a remarkable turnaround from a number of years ago.

There are some good examples of establishments that have been able to support remand prisoners in accessing recovery: Stirling and Kilmarnock, and also Greenock, if my memory serves me correctly. The Prison Service continues to scope new ways of working so that people on remand can access opportunities. That is challenging, given the number of prisoners on remand and the increase in the number of long-term prisoners, where a range of statutory obligations apply. The prison rules for remand prisoners are different, because they are untried. It is all caveated around the ability of people on remand to participate in education or work, while the situation is different for sentenced prisoners.

The Convener: There is an issue around transfer between prisons, which does not just apply to the remand population. The committee has heard about the impact of what are often last-minute transfers of individuals. That can happen for all sorts of different reasons, but what came across, in particular, was the disruptive impact that a transfer can have on somebody who uses substances but who is stable, for instance. They might have become quite stable and settled, but then, for no reason that they are aware of, they are transferred. I know that that is an operational requirement at the moment. Do you have any comment on any options to reduce or address that in the context of what we are discussing today?

Angela Constance: I very much recognise the impact of transfers, particularly if they are done without much warning. They are disruptive for the individual and their care, as well as for families. I am sure that you have heard evidence about that.

On person-centred care and continuity of care, the target operating model should help to provide consistency. It might not be the most politically sexy thing to talk about, but the improvements that are being made to clinical IT are important for the transfer and sharing of information. Right now, however, because of overcrowding and the work that the Prison Service has to do to keep serious organised crime nominals apart from one other to reduce the risk of violence or to reduce the risk of collaboration among some of those individuals, there is little scope for flexibility in adding in a very vulnerable and complex population when the prisons are full.

To pick up on your point about remand prisoners and throughcare, convener, the new national throughcare contract has enhanced investment to give enhanced capacity and, for the first time, it will enable male remand prisoners who have been released to be supported.

11:00

The Convener: The point that you made about clinical IT systems and clinical information has certainly come up with regard to having timely access to clinical information when a transfer is taking place. Thank you for that point.

Katy Clark (West Scotland) (Lab): I want to ask about drug deaths in custody in prison. There are unacceptably high levels of drug deaths, and no death is acceptable. One witness told us that

"We have not looked enough at the drivers of the increased number of deaths in prisons."—[*Official Report*, *Criminal Justice Committee*, 4 June 2025; c 47.]

It would be interesting to know whether you agree with that statement and to hear your thoughts on what the drivers are. Do the determinations of fatal accident inquiries give us some of the insights that we need? I appreciate that you have already referred to the rise in the strength of the drugs that are in prisons, cabinet secretary—I do not know who would be best to comment on that first.

Angela Constance: I will start, particularly because Ms Clark has spoken about fatal accident inquiries, and because the cut and thrust of the question cuts across all drug deaths. I agree entirely with the need for more accountability and

transparency to drive a better understanding and, therefore, more systemic improvements regarding deaths in custody.

The number of deaths in custody in the last calendar year was 64, which was the highest ever. The figures tell us that, for the year before that—2022-23—30 per cent of deaths in custody were probable suicides, 15 per cent were due to drug misuse and 21 per cent were due to circulatory system health problems. Because of our older prison population, there is a high degree of natural causes among those figures. However, I will caveat that, because we see vast health inequalities in our prison population, which should not be ignored in any shape or form.

In my response to the fatal accident inquiry and the statement that I made to the Parliament on the FAI findings on deaths in custody with regard to William Lindsay and Katie Allen, I made a commitment to establish a national oversight mechanism. That will enable scrutiny of fatal accident inquiry determinations and oversight of implementation. It is accurate to say that, right now, there is no independent dedicated national oversight body that is looking at the broader framework and scrutinising these deaths in regard to analysis, public reporting and reporting on what the trends are.

This is not just about FAIs and deaths in custody. The same could be applied to NHS significant adverse event reviews and the "Death in Prison Learning Audit & Review"—the DIPLAR. I am talking at length—forgive me, convener.

Right now, I am exploring whether we can establish an independent national oversight mechanism without primary legislation. That is quite complex; the work is on-going and we are in the guts of it just now.

In the meantime, there is the ministerial advisory board, which will meet for the second time tomorrow and which I chair. That board is a small panel of independent experts that oversees the implementation of the FAI recommendations that I have committed to. It also means that there is something in place while we work on the national oversight mechanism.

Katy Clark: It is clear that you are involved in a range of work, involving many agencies and individuals. As you say, you are also looking at the recommendations and attempting to implement them. I appreciate that you are not at the end of that work but, based on the work that you have done so far, what would you point to as being the major drivers for the increase of drug deaths?

Angela Constance: It is hard to isolate that, apart from the obvious factors of the increasingly innovative methods of illicit supply in our prisons and the strength of those somewhat novel substances. In the work that the Prison Service has done, engaging with the Leverhulme research centre for forensic science in Dundee, sometimes it cannot be established what the substance actually is.

The danger to individuals associated with such substances, which are not only in our communities but in our prisons, requires strong public health messaging. The level of danger and distress that those drugs cause to individuals is alarming. I visit prisons all the time and—I will put it this way—I had both the challenge and the privilege of seeing some footage of an individual who had consumed a substance. The degree of personal distress to that individual was a sight to behold, but their behaviour would change very quickly from being distressed, to agitated, to angry. It requires several staff at any one time to care for such an individual.

There is an element of the unknown in those substances, which is why the testing that is done at Dundee university is important. I am sure that Ms Todd will have something to say on this as well—those man-made, synthetic substances are potent and dangerous, and they have upped the ante on the challenge that we face. The situation is very different from what it was 15 or 20 years ago with cannabis, heroin or opioids. The substances that are having a catastrophic impact on individuals in our care are the synthetic opioids, benzodiazepines and drugs that we do not know what they are.

Katy Clark: You made that point clearly, right at the beginning of the evidence session. Liam Kerr also raised the issue of overcrowding—we have heard evidence that the boredom that people face and the lack of meaningful activity are another driver that drives people to drugs.

We have heard evidence that toxicology results of drug tests can generally take up to 18 months, which can delay learning. Are you looking at that? Is that an accurate reflection of the situation?

Maree Todd: I can certainly check what our recent data shows. We are able to get access to some toxicology almost instantaneously. I have spoken before in the chamber about the incident that we faced in March, in which a batch of opiates contaminated with synthetic opiates came in to Scotland and there quickly began to be overdose incidents in our community, including in the Thistle centre in Glasgow.

Because those people were using in a supervised drug-consumption facility, it was possible to resuscitate them. They provided samples of the drugs that they had been using, which were very quickly analysed, and that meant that detailed information went out very quickly, using the Public Health Scotland rapid action drug alerts and response system, to ensure that every

part of Scotland was aware of the risks from synthetic opioids.

With regard to drug testing, we are able to access information quite quickly, but there might be challenges with regard to post-mortem toxicology, which is slightly different, because there are often challenges with identifying substances. These nitazenes are incredibly potent, so they are present in very small quantities in a person's bloodstream. The detection threshold has to be very low, so detection can be difficult. There are also challenges in that the ever-evolving synthetic market means that, even as we develop a test for them, more nitazenes are always appearing.

Richard Foggo has something to say specifically on the toxicology, but I will go back to your point about the increasing drugs deaths in prisons. I think that other witnesses at this inquiry have said that the use of drugs in prisons often mirrors what is happening in the community, and what we are seeing in the community is a really significant threat from the rise in synthetics. Looking back over the past five years that the mission has been on-going, we can see that, initially, we were very much up against opiates, but quite quickly, synthetic benzodiazepines came on to the market, caused challenges and contributed to deaths.

We have also had a rise in synthetic cannabinoids, which are significantly more potent and cause harm and can cause sudden death. We now have these exceptionally potent synthetic opioids—nitazenes. They were developed about 60 years ago, but it has never been possible for them to be used safely because they pose such an incredible overdose risk. They are causing real challenges for us. The thing to understand is that they cause challenges in how we disrupt supply, too. It is not just that they have different effects on our bodies when they are taken but that, as one paramedic said to me when they were training me in the use of naloxone, the potency is such that what used to fit into a suitcase now fits into a matchbox. That means that we now need an approach that is different to the traditional way in which we disrupted supply, and that is the case in our prisons as well as in the community.

With regard to how we deal with that, we have a naloxone programme in prisons. There are challenges with benzodiazepine overdoses. There is not a straightforward antidote that can be used outside a clinical setting, although that is being investigated and trialled—the University of Edinburgh is doing research into that. There are certainly challenges with the impact of taking synthetic cannabinoids and reversing the effects that those have on your body. However, we have an antidote that can be used for opiates. We have ensured that that is available throughout the prison service, and it is being used, at times, in prisons, so prison officers are trained in naloxone administration.

However, that is a solution to only one drug, and members will have heard, in relation to all the alerts that have been in the public domain over the past few months, that nitazenes are so potent and so dangerous that people are needing repeated doses of naloxone, which means that anyone who is administering naloxone is having to administer quite a lot more of it for quite a lot longer than they would have had to do for conventional opiates. As I keep saying in my role, we need to be agile and to recognise that things change, and we need to respond to those changes—and that is exactly the same in the prison system as in the community system.

Richard Foggo: On the question of consistency of practice, on the NHS side, there are many reasons why a formal determination through toxicology could take some time, but we cannot wait—we need to be agile—so it might be helpful to share with the committee the toolkit that NHS teams have to ensure consistency in the network, in addition to RADAR, so that NHS and clinical teams are ready to respond, given that these things can sometimes happen in more than one establishment. The toolkit for NHS teams is deployed across all the clinical teams in prisons, which is about sharing practice and how to respond quickly, and that is separate from getting toxicology results. I am happy to send the toolkit to the committee, so that you can consider whether it is adequate and covers your questions.

11:15

Katy Clark: That would be extremely helpful. Any further information about delays that could be addressed would be of interest to the committee.

Fulton MacGregor (Coatbridge and Chryston) (SNP): Good morning. My apologies for not being at the meeting physically and for joining remotely. The session has been very useful, with both the cabinet secretary and the minister bringing in their vast experience, which is reflected in some of their answers. The exchange between the minister and Rona Mackay about the impact of the drugs that we heard about at last week's meeting was particularly helpful.

My question is for the cabinet secretary and relates to opportunities in the community, when offenders are likely to approach services either for the first time or on repeat occasions. I want specifically to home in on when people present to services with alcohol problems and that is the main issue in their offending. Are there opportunities to do more to support people at the

point at which they present to services, to avoid further offending?

Angela Constance: The short answer is yes. Over the past few years, I have been actively engaged in ensuring that statutory criminal justice social work and social work more broadly are on a firmer footing. New measures have been taken, such as work that has been done on bursaries and graduate apprenticeships, to ensure that we have a workforce supply and that people are being trained, which is very important. There are particular demands on social work as a profession and there are concerns about retention, particularly of newly qualified social workers.

Mr MacGregor will be aware that, over the past two financial years, we have increased investment in community justice by £25 million to a total of £159 million. I am determined that we continue to invest in and grow community justice services overall, because we know that community interventions are more effective in comparison to short-term custodial sentences. I also want to point to the importance of the voluntary sector. There has been a cross-Government commitment and there should also be a commitment across Governments, both local and national, to support and utilise the potential of the voluntary sector where we can.

The national mission funding and support that goes to alcohol and drug partnerships and other grass-roots organisations creates good opportunities for partnership working with voluntary and statutory agencies and places for referral. There is another point about voluntary aftercare, but I will leave my remarks there, convener.

Fulton MacGregor: Thank you, cabinet secretary. Your answer leads me to my next line of questioning. As you articulated, it is often the case that many different services and agencies—statutory, third sector and others—are involved with people when they present with issues relating to alcohol. Is there a case for more of an oversight and accountability system in such situations? Like you, I have worked in the field, and I am not saying that there is no oversight of the work that is going on, but there can be instances of people—whether in a health service, charitable organisation or social work organisation—doing their own thing. Is there a case for more oversight in relation to that?

Angela Constance: I hope that the new national social work agency, and other measures, will help in that regard. In response to your earlier question, I failed to mention the importance of the work that Ms Somerville is taking forward on the fairer funding pilot, which is around multiyear funding for the voluntary sector. My personal view is that accountability should be seen as a positive and not something to fight against or be defensive about.

You raised the point about many services potentially being involved with an individual. That is very positive, but we always have to guard against people being passed from pillar to post. We need clear lines of accountability and responsibility. Ms Todd and I can see that work taking place through the strategic justice and healthcare work that we are involved in, which is being pursued in detail by the national leadership group, where senior officials from justice and health are getting on with the nitty-gritty. Oversight of that work sits with ministers. That is quite a general response to quite a general question—I hope that I have not missed a specific point that you wanted to raise about accountability.

Fulton MacGregor: No, that is fine, cabinet secretary. I am happy with that response. Convener, I have one further question.

The Convener: I will first bring in the minister to respond, and then you can come back in, Fulton.

Maree Todd: It is probably useful to put on record that the Scottish Government is developing a national service specification for drug and alcohol treatment in Scotland, alongside guidance that has been informed by the UK-wide clinical guidance for alcohol treatment. That will aim to provide clarity on the types of treatment that should be available. The national specification will set out the types of treatment and recovery service that should be available across Scotland. It will also provide impetus for improved joint working between the public sector, third sector partners and everyone who needs to collaborate in order to improve outcomes for the individuals who are affected. That will apply in custody in prisons, as well as in our hospitals and primary care.

Fulton MacGregor: My final question is probably for the cabinet secretary again. It relates to some of the evidence that we heard from the prisons, in which they more or less said—this might not be an exact quote—that alcohol is no longer a major issue within prison estates, and that, occasionally, there might be some hooch around at Christmas time. That was almost a direct quote from one of the witnesses. However, they said that, in general, alcohol has been overtaken by drugs—synthetics, in particular—as has already been outlined today. Is the Government interpreting that alcohol is no longer the issue in prisons that it used to be? How is that affecting or impacting policy decisions on drug and alcohol use in prisons?

Angela Constance: In the illicit supply of substances, it is quite correct that it is less about hooch, as Mr MacGregor said, and much more about the very dangerous synthetic opioids that

are making their way into our prisons and having an impact on the prison population, similar to what is happening in the community.

Nonetheless, alcohol remains a feature in offending behaviour. There are people who are poorly on admission to prison because they are not getting access to alcohol, and there might also be issues to do with withdrawal and people who will need care and treatment as a result. If alcohol is a factor in someone's offending behaviour, they will benefit from access to the recovery community or other rehabilitative-type opportunities related to their offending behaviour.

It is not that alcohol is not an issue, because if it was an issue for an individual in the community, it is an issue in prison. There is then a risk that needs to be addressed while in custody and that needs to feature in any release planning for that individual. That might be in the conditions that the Parole Board sets or in the more detailed throughcare planning that takes place for individuals.

Maree Todd: I will emphasise exactly the same points. Alcohol is definitely a feature in offending behaviour. For many people coming into custody, there might be a need for medical detoxification on admission. That illustrates very clearly that abstinence is not recovery. While people are in prison, they might not be able to access alcohol, but that does not mean that the problem has gone away. It needs to be dealt with during their time in custody and needs to be anticipated as a problem on release from custody.

We have some good work going on with recovery communities reaching into prisons. There are long-established routes for organisations such as Alcoholics Anonymous to come into prisons and do peer support work, which can then continue when people are on the outside. We also have some good work going on on the prison-to-rehab pathway, which covers alcohol as well as drugs. Alcohol certainly is an important factor.

Alcohol is simply a drug. If people are abstinent for a period of time, on liberation the risks of consuming and overdose are high. That risk needs to be acknowledged and planned for. During their stay in prison, they might have reduced their tolerance to alcohol and not be able to consume the levels of alcohol that they were consuming in advance of admission to the prison estate, so they might face some enhanced risks on liberation that they are not aware of.

Fulton MacGregor: I strongly agree with the sentiments that have been shared, and it was a good opportunity for that to be put on the record.

The Convener: I am aware that we are coming up to time, but I would like to give everybody a chance to come in with their questions. If the panel is willing to bear with us, we will stretch the meeting by another five to 10 minutes.

11:30

Sharon Dowey (South Scotland) (Con): The committee has heard from various witnesses that vapes are a prominent issue in relation to how prisoners can ingest substances. The Prison Officers Association mentioned in its submission to the committee that staff feel as though the prison estate, by allowing the use of vapes, is providing prisoners with the tools to misuse substances. Have there been any constructive discussions between the Scottish Government and the SPS regarding the issues associated with vapes and how they can be addressed? Do you believe that the policy on vape usage in the prison estate needs to change, and if so, what changes need to be made?

Angela Constance: I have seen that evidence, and I will certainly discuss the issue further with the Scottish Prison Service. As you will appreciate, I engage very regularly with the chief executive and other senior staff, so I acknowledge that I have seen that evidence. Ms Todd is a bit more of an expert on vapes in the real world than I am.

Maree Todd: I answered a question in the Parliament recently about the selling of vapes that contain synthetic cannabinoids to children over social media. There is undoubtedly a market out there for vapes that contain drugs other than nicotine. In harm reduction terms, vaping nicotine is less harmful than smoking nicotine, and I imagine that that is why there is a difficulty in assessing how nicotine substitutions should be available in prisons and how to reduce the risk of access to drugs that are unintended, as well as nicotine.

Sharon Dowey: Is the SPS looking at its policy for vapes in prisons?

Angela Constance: I was just saying to you, Ms Dowey, that I will discuss the matter further with the SPS.

Sharon Dowey: What has been done to protect staff from the vape smoke and illegal fumes that they are exposed to when prisoners are vaping illicit substances? There are concerns about adequate provision of personal protective equipment for prison officers when they are required to enter prison cells after substances have been used or smoked. This is my final question. How is the Government working with the NHS and SPS to ensure that the health and welfare of all staff is safeguarded?

Angela Constance: In general terms, the health and welfare of prison staff is a matter that I discuss with the chief executive of the Prison

Service. It is a matter that she raises with me. It is a factor in the issues around overcrowding and staff resilience, for example. The specific issue that you raise is, of course, a purely operational matter, but I know that there are very specific procedures and guidance for staff when they have to have contact with a prisoner when fumes or illicit drugs are involved, because one of the issues with those novel substances is that they can be absorbed by the skin. There are procedures around when to engage in those circumstances, and there are procedures around how that should be approached and the equipment that is required. I can ask the Prison Service to supply me and the committee with a more detailed account of the specific procedures that are in place.

It is an important point that speaks to the change and increasing challenge associated with drugs. It is not just about people ingesting something into their body that has an impact on their behaviour. It is about the ingestion of substances that have a direct bearing on the health and wellbeing of prison officers. I have certainly had constituency cases raised with me about the impact on prison staff and on their health of being in close proximity to fumes and so on.

Maree Todd: I can certainly look into that. The issue of the risks of passive inhalation was raised at the cross-party group last week, and I made a note to look at what evidence we have on that. I will look, from a health perspective, at whether there is any elucidation with regard to the risks of passive inhalation of these substances.

Sharon Dowey: That would be good, and it would be good to get more information, if it is available, on PPE and whether there are any barriers or cost implications, so that we can ensure that staff get the PPE that they need.

Rona Mackay: In her opening statement, the cabinet secretary made a point about staff training. Prison officers have a huge responsibility when people come into the prison who might already be addicted to substances. I know that this is an operational matter, but prison officers in the UK receive much less training than prison officers in a lot of other countries—I think that it is only around six weeks, although I know that training is on-going in the job. Given the even more dangerous environment that prison staff are working in now, is the training sufficient for them to cope?

Angela Constance: That is an operational matter, and I am not sure that you necessarily want a politician or former social worker to talk in detail about the exact training that should be given to prison officers. That said, I have visited the SPS college and had the pleasure of meeting new recruits on more than one occasion. What I have observed is that the Prison Service is certainly recruiting a greater diversity of people, by which I mean people from different backgrounds. As you would anticipate, the Prison Service often attracts people who have worked in the military, but I have observed that there is a growing number of people who have worked in the care sector or with children, and I think that that blend is quite important.

The old terminology—this is very outdated language, so I apologise—was that, for criminal justice social work and the Prison Service, it was about care and control. These are controlling institutions, but it is also about the care that is provided, so people need to be safe and secure. Prison officers need to be able to prevent violence, but they also need to be able to respond to violence.

I have also seen mock operations to train prison officers to deal with disruption. The SPS has a facility, which, by chance, is in my constituency, in Fauldhouse, where more operational and tactical training is provided. That is part of the on-going training and development of officers who are given specialist training, because some officers will carry out specialist roles, should that be required, in the prison that they work in or in another prison.

The training is always evolving. For example, the SPS has developed pain-free control and restraint, which came about through its work with and concern about young people. That training has attracted a lot of attention internationally, and that matter is kept under review.

I am very cognisant of the demands on Prison Service staff and of the strains and stresses that they experience, which is probably putting it mildly. We must have acuity with regard to ensuring that we retain experienced staff, because the mix of old and new is really important. I do not imagine that this will surprise colleagues, but the number of prison officers has increased. There is often much talk about the public sector workforce, and rightly so—this is a workforce that has increased from 3,462 prison officers in 2023-24 to 3,797 today.

Rona Mackay: Thank you.

The Convener: We will finish the evidence session with a question about stigma. The minister spoke earlier about the national mission on drug deaths. Within that, there has been a lot of work done with regard to the national collaborative's charter of rights for people affected by substance use. During our evidence sessions, we have heard about the issue of stigma. In the context of the prison environment, stigma and judgment, by prison officers and staff, have come up as barriers. We know that that happens, and there is a lot of work on-going to address that.

I want to ask the minister for an update on the work on the charter of rights, which was featured heavily during the recent Scottish Drugs Forum national conference. To add to that, we have taken evidence from family members who have raised concerns about the lack of accessible information, both for them and for their loved ones in prison. Again, it is about the issue of rights and us respecting rights. What update can the minister provide on that?

Maree Todd: It is clear that stigma prevents people from accessing the treatment that they need. It prevents them from asking for help and from getting the help that they not only need but have a right to. It is a serious issue that cuts across the work of the national mission.

There is work going on. Since I have come into this role, I have recognised that work on stigma probably needs to be done at a population level, but we probably also need to start with certain communities. I hear very clearly from the work and the analysis that is being done among communities and people who are affected by substance use that health professional stigma is a significant challenge that they face. I am reflective about the specific actions that we can take to try to reduce that challenge.

The charter has involved powerful and important work. A lot of upholding of rights starts with people knowing that they have rights and that they are able to articulate that when they are asking for help and support. Working with people with lived and living experience is how we will close the implementation gap, which is the torment of most Government ministers' lives. We have great and lofty ambitions and ideas, and what we see is largely absolutely outstanding. However, what happens on the ground and at the coalface does not always reflect that ambition. Involving people with lived and living experience will help us to get that right in the first place—to get our policy right, get our legislation right and get our frameworks right, and then our feet can be held to the fire on delivery.

I am very thoughtful about the issue of stigma. This is probably an opportunity to put a challenge to the committee about how institutional and systematic stigma can be. I go back to the earlier exchange that I had with Rona Mackay about the availability of Buvidal on discharge from prison. I have heard that point raised before, and my immediate thought as a health professional and as a minister was, "Why would somebody's medication be changed on discharge for bureaucratic and administrative reasons and not clinical reasons?" I am not confident that that would happen if we were talking about an antihypertensive drug or an asthma drug, rather than a drug that is used to maintain someone's stability and which is a well-recognised and well-evidenced treatment for drug dependence. It is important that we reflect on that.

There are all sorts of things that happen to people who have substance use challenges that would not happen to the rest of the population. It is worth us considering and reflecting on that. There is a double stigma for people who have been in the justice system. As the cabinet secretary said, our citizens have a right to access the same quality of healthcare wherever they live in Scotland, whether they are in custody or whether they are in the community.

The Convener: Thank you very much for that answer. I realise that we have slightly overrun, so I will bring the evidence session to a close. Thank you all very much indeed—this has been an informative session. We will have a suspension for five minutes to allow the minister and her officials to leave.

11:46

Meeting suspended.

11:54

On resuming—

Subordinate Legislation

Proposed Draft Regulations: Hate Crime and Public Order (Scotland) Act 2021 (Characteristic of Sex) Amendment Regulations 2026

The Convener: The next item of business is consideration of the Scottish Government's consultation on a super-affirmative instrument that will add sex to the list of protected characteristics for the offences that are outlined in the Hate Crime and Public Order (Scotland) Act 2021. I clarify that we are not approving the Scottish statutory instrument today; this is an opportunity to ask the cabinet secretary some initial questions. I refer members to paper 3. I invite the cabinet secretary to make a short opening statement outlining her plans for the consultation, after which we will move to questions.

Angela Constance: Thanks, convener. As the committee is aware, the Scottish Government intended to legislate for a misogyny bill in this parliamentary session. However, I announced on 2 May that, due to the complexity of this area of law, and the clear and unambiguous provisions that would be needed, which would include the policy implications of the Supreme Court judgment of 16 April, there would be insufficient time for a bill to be finalised and introduced. That was also exacerbated by the short time left in this parliamentary session along with a packed legislative timetable.

I was also clear that I did not want a gap in the criminal law protections for women and girls and that, therefore, I would produce an SSI to add the characteristic of sex to the Hate Crime and Public Order (Scotland) Act 2021. As you said, convener, that SSI is subject to the super-affirmative procedure, which allows for thorough scrutiny before any legislation is finalised. Therefore, the required consultation seeks views on the draft policy of the SSI. We will, of course, carefully consider all feedback and views, including those of the committee. That process will inform the final SSI that will be laid in the Parliament.

The changes that are being consulted on will ensure that the criminal law protections for women and girls are the same as those that are provided through the 2021 act for other characteristics, such as age, race and disability. As the characteristic of sex will be added, men and boys will also be protected. However, we know that women and girls suffer significantly more from threats, abuse and harassment based on their sex, so they are likely to benefit most from those new protections and be able to report matters to the police.

The legislation will make it an offence for a person to stir up hatred against women and girls. Where an offender is motivated by, or demonstrates, malice or ill will towards women and girls in committing a criminal offence, that offence will be aggravated by prejudice relating to the characteristic of sex.

I consider the measures on which we are consulting to represent a significant step forward in strengthening legal protections for women and girls and ensuring that our justice system can respond appropriately to hate crimes that are motivated by prejudice on the basis of sex ahead of any misogyny bill that a future Government could introduce.

I am happy to take questions, convener.

The Convener: Thank you very much, cabinet secretary. We know that the consultation is under way and I think that I am right in saying that it closes around 10 October. Can I ask you for a wee bit more detail on the consultation process? Specifically, who are all the stakeholders who are being consulted?

Angela Constance: Of course. Anyone with an interest is welcome to respond to the consultation. It launched on 28 August, the same day that the draft SSI was published. On the Scottish Government citizen space website, there is the draft SSI and text to explain the small number of policy choices that have been made. My officials proactively sent that information to bodies on the hate crime strategic partnership group and those who had responded to the consultation on the proposed misogyny bill.

The Convener: Thank you. I will open it up to questions from other members.

12:00

Liam Kerr: Good morning again, cabinet secretary. When the hate crime bill was being discussed, I recall that I was very critical of the Government for leaving sex out of it. Even then, I argued that there was a need for something more to be considered, and it seems that the working group on misogyny and criminal justice in Scotland has sympathy with that approach. In your view, what is lost by using the SSI as a mechanism for this rather than a stand-alone bill? Does the Scottish Government have any plans to revisit the issue of a misogyny bill in future?

Angela Constance: I appreciate the question. I will not rehearse the arguments that were made at the time when the hate crime legislation was passed; I was not prepared to leave a gap in the

law and in existing hate crime legislation for women. That does not mean that a future Government will not take forward a misogyny bill but, right here and now, I have come to the conclusion that, to put it bluntly, I am not having a gap in the law for women. That is my straightforward view.

The Hate Crime and Public Order (Scotland) Act 2021 deliberately left a power to address the issue. The definition of sex fits well with the hate crime framework, in that it minimises any overlap with other characteristics, although there is always the potential for overlap. At the end of the day, it felt to me as though the gap that had been left was not justifiable, and I wanted to address it before the end of the parliamentary session.

Misogyny legislation differs from hate crime legislation in that the former is specifically gendered legislation and is a more nuanced approach. Baroness Kennedy led some excellent work to lay out the extent of the misogyny and harassment that women face in this country, if anyone was in any doubt about that.

It is complex legislation—I wish it was not thus, but it is. When 16 Scottish Government bills and 15 members' bills are still to come to a conclusion before purdah, there is a practical reality that is regrettable. I do not think that Baroness Kennedy's work in the area will be lost. In my view, there is an opportunity for us to strengthen the law with the SSI, and it is important that we do it because, I repeat, I am not having a gap in the law for women.

Liam Kerr: I welcome that approach. The working group reported in 2022 and the Government responded in April 2022. What has been done between then and now that will, I hope, allow a future Government to pick up and run with the ball on a misogyny bill?

Angela Constance: Extensive policy development work has been done. In a minute, I will ask Mr Lamont to give people a feel for the size and scope of it. The issue is complex. As it is criminal law, any misogyny bill needs to have clear and unambiguous provisions. That has been central to considerations in the Government.

Such a bill must also include the policy implications of the recent Supreme Court judgment. At one point in time, we were waiting on that judgment; we now have it, which means that further work is required. It is accurate for me to say that Baroness Kennedy's working group left some matters to legislators. I am not saying that she was wrong to do so—it is entirely fair and credible—but some matters were left to legislators to address in and around a misogyny bill, and we have not concluded that policy work.

Philip, would you like to add anything?

Philip Lamont (Scottish Government): Yes, just briefly. The main outward-facing thing that the Government did was to develop draft provisions based on Baroness Kennedy's report. That is what has changed since 2022. In relation to your question, Mr Kerr, about how the bill could be picked up, there are draft provisions, but they need to be finalised and refined. That is the progress that has been made. As well as the policy blueprint, there are draft provisions in the public domain.

Liam Kerr: That is very helpful, thank you.

I have one final question. What does the Government project will be the impact on prosecutions from making this change, and how will resource be scaled as a result?

Angela Constance: Although we have an informed view of the matter, it is hard to give you a precise figure. Based on other jurisdictions where similar laws exist, with a range of hate crime provisions, we would expect—although this is a very rough figure—around 5 to 10 per cent of cases to be attributed to malice, ill will and harassment of women based on their sex. However, as I said, that is a rough figure.

Much of the pain around resource in relation to hate crime legislation has already been resolved. We continue to engage with Police Scotland on the work that it will need to do to upgrade and update its training guidance.

Liam Kerr: Thank you.

Katy Clark: I agree that there should not be a gap in hate crime legislation, so it is quite right that the Scottish Government is coming forward with proposals. Leaving aside all the debates around the misogyny bill for now—I appreciate that we may come back to that in relation to new offences and that these proposals are perhaps a different and additional approach—I note that Engender thinks that

"the hate crimes model was not designed to address the nature and scale of"

violence and discrimination against women. Moreover, the working group said that it would be very difficult to prove that a specific act had happened based on sex.

Does the cabinet secretary agree with those points? If so, how has that element been taken into account in the drafting of the SSI? Has there been consideration as to whether it is simply a matter of slotting in the word "sex", which seems to be the case in the SSI, or whether the matter needs to be addressed in a different way, with further redrafting? Did the cabinet secretary grapple with or have discussions with officials about the issue?

Angela Constance: In short, yes. The hate crime legislative framework is a proven model for providing legal protections. Although there might be a range of views on the approach that was taken, or, indeed, on our not being able to progress with the misogyny bill, I am taking some comfort from the recognition that there is a gap in hate crime legislation and that it needs to be addressed. Of course, it is never as simple as just slotting things in. Philip, would you like to speak to that, since you have done the slotting in?

Philip Lamont: To a certain extent, the approach is driven by the enabling power in the act. Therefore, there is not much flexibility for the Government to do anything other than add the characteristics and decide other minor matters, such as whether the protection for freedom of expression in the act applies. I am sure that the Delegated Powers and Law Reform Committee would have words with us if we did more than that. It is the framework that we have and, as the cabinet secretary said, it will close the gap that exists in hate crime law for women and girls.

Katy Clark: That is helpful. It seems that there really is not very much flexibility around that, given how the original legislation was drafted.

Perhaps you have considered, especially given some of the complexity of such issues, how the change will be addressed in the training of the police and other agencies that are responsible for implementing the new provision. Has there been discussion about that?

Angela Constance: Of course, because these are serious, important and sensitive matters that are not without their complexity. Given the journey that we have travelled with hate crime law and its implementation, I do not expect to need to resolve any further knotty issues, but we will continue to engage with Police Scotland. I also have a series of engagements with other parties, some of which you have mentioned, that are understandably disappointed that the misogyny bill is not proceeding at this time.

Katy Clark: I understand. Is any further guidance likely to be provided for the implementation?

Philip Lamont: The act does not allow the Government to issue statutory guidance, but I am sure that, as happened with the hate crime act, information will be provided about what the change means for people, so that they can understand their new protections. That will definitely be part of implementation.

Angela Constance: That speaks to the broader issue, which is that legislation alone does not always change people's behaviour or rectify the experiences that women have in our communities. We have just had a session about a completely different matter that touched on the need for people to know and exercise their rights.

Katy Clark: Thank you.

Jamie Hepburn: My questions relate more to the context in which we should consider the regulations, which are clearly at the draft stage—we will come to the specifics in due course. We have found at least one person who can testify to this point, as Mr Kerr said that, at the time of the bill's passage, he thought that this should be included in primary legislation, and I recall that some constituents who got in touch with me at the time of the bill's passage suggested something similar. My first question, therefore, is whether we should bear that in mind as part of the context. Yes, we took the approach that we could do it through secondary legislation, but at the time of the bill's passage there was a cohort that said that we should do this.

I clearly understand your wider point about the misogyny bill but, given that the Parliament legislated for the provision that enabled the Government to bring forward the order, do you think that it is important that we consider it on its own merits, irrespective of whether such a bill comes forward?

Angela Constance: Yes, I do. I am conscious that no issue is considered in a vacuum and that many of our stakeholders campaigned for misogyny legislation. However, I believe that filling the gap in the hate crime legislation is a step forward.

The new protections for women and girls might have a bearing on any future work and reduce the size and scope of a misogyny bill. We operate in an environment in which we are highly sensitive to the range of views on the matter. Many of our stakeholders and partners fought very hard for a misogyny bill, so I understand their disappointment. However, as Mr Lamont said, the scope of the SSI—what the legislation allows us to do—is quite specific, and I am very appreciative of the opportunity to lay it.

12:15

Jamie Hepburn: Having recently been involved in the legislative agenda, I can certainly testify to the challenges around progressing additional primary legislation between now and the end of the parliamentary session.

A potential misogyny bill is clearly not possible in this session, but you referred to filling the gap. We will probably get more into this when we consider the regulations in more detail down the line, but could you perhaps speak a little bit more about what the SSI means in practical terms and how it fills the gap? I understand that this might be

difficult to answer, but what types of incident will be captured by the law that are not, as it stands, and how prevalent are such incidents?

Angela Constance: We currently have hate crime legislation that rightly offers people protections based on age, disability, religion, race, transgender identity and so forth. Protections include stirring up hatred offences, which are where threatening or abusive behaviour or communication is essentially targeted at people because of their protected characteristic, such as sex, race or disability.

Also, aggravated offences, which add in the scope to convict on offences aggravated by malice and ill will, are really important, because if an offence is already being committed and it has been motivated by hatred towards women and girls, that should rightly be recorded and taken into account, for example, in sentencing, and it is a salient matter for the court to decide on.

The Convener: Thank you very much.

To finish off, I have a more practical question, which is in regard to the future timetable beyond the closure of the consultation period. Will the responses to the consultation be published online and will there be an opportunity for the committee to be provided with an update on potential changes or alterations after the consultation?

Angela Constance: In response to the process point, the consultation will end on 10 October. The responses will then be published, provided that respondents have given their permission. There will need to be an analysis of the information that we have received, including a form of statistical analysis, as there always is with such consultations.

Then, in due course, we will write to the committee, whether any changes are made to the final SSI or not. I want to lay the SSI before Christmas so that it can be addressed in early 2026. I certainly hope that it will be laid before the February recess, which is when I am aiming for.

The Convener: Thank you very much to the cabinet secretary and her officials. That brings the public part of our meeting to a close.

Next week, we will again hear from the cabinet secretary, this time on a package of legislative consent memos for the UK Crime and Policing Bill.

12:20

Meeting continued in private until 12:54.

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