Criminal Justice Committee
Wednesday 3 September 2025
21st Meeting, 2025 (Session 6)

Tackling Harm from Substance Misuse in Scottish Prisons – Session 3

Note by the Clerk

Introduction

1. At its meeting on 30 April 2025, the Criminal Justice Committee agreed to undertake a short inquiry into the harm caused by substance misuse in Scotland's prisons. This follows a recommendation from the Scottish Parliament's People's Panel, which raised concerns about the increasing prevalence and potency of synthetic drugs in prisons, the impacts on both prisoners and staff, and the adequacy of rehabilitation and support systems.

2. The inquiry was formally launched on Friday 16 May 2025, alongside a public call for views. The Committee invited written submissions until **Friday 22 August 2025**.

3. The Committee has held its two preparatory evidence sessions in May and June (28 May and 4 June). The Committee heard from different bodies on the scale of substance misuse in Scotland's prisons, and how public services, policing and the justice system currently respond to it.

4. Key areas of focus in this session today will be split across two panels. The themes are split across the two panels below.

5. Panel 1 - Throughcare and In-Custody Rehabilitation. Members will hear evidence on:

    - The availability, quality and consistency of rehabilitation services across the prison estate.
    - Implementation of Medication-Assisted Treatment (MAT) Standards – particularly Standards 5 (prison healthcare integration) and 9 (continuity of care on release).
    - Issues of continuity between prison and community-based services will be examined, with particular focus on the practical barriers for third-sector organisations.
    - Support for people leaving custody at short notice, including those on remand.
    - Geographic variation between urban and rural throughcare provision will be considered.

6. Panel 2 - Alcohol Harm and Community Reintegration. Members will hear evidence on:

- The distinct challenges of alcohol misuse compared to drug misuse in the prison context.
- The adequacy of treatment and recovery options for alcohol dependence in custody, and the availability of post-release services, will be explored.
- Monitoring and prevention of alcohol-related deaths following release from custody.
- The value of long-term recovery models, including residential and community-based approaches.
- Broader ideas on what more the justice system can do to reduce alcohol-related harm and support reintegration.

Evidence

7. The Committee will take evidence from the following panel of witnesses—

   Panel 1

   - **Haydn Pasi**, Head of National Voluntary Throughcare Partnership (Upside), Sacro
   - **Gillian Reilly**, Head of Service for Alcohol and Drug Partnership Executive, NHS Scotland
   - **Hamish Robertson**, Strategic Development Lead, The Wise Group
   - **Marianna Marquardt**, Policy and Research Officer, Scottish Families Affected by Alcohol and Drugs

   Panel 2

   - **Dr Lesley Graham**, retired public health doctor and founding member of Scottish Health Action on Alcohol Problems
   - **Dr Catriona Connell**, Senior Research Fellow, University of Stirling
   - **Dr Craig Sayers**, Clinical Lead Prison Healthcare NHS Forth Valley

8. See **Annexe A** for details of written submissions from Scottish Health Action on Alcohol Problems, Glasgow ADP, and SACRO.

Actions

9. Members are invited to discuss issues related to rehabilitation, throughcare and post-release support with the witnesses.

Clerks to the Criminal Justice Committee
August 2025

Annexe A

Written submission from Scottish Health Action on Alcohol Problem

How drugs and other substances get into prisons

Q1 How do drugs and other substances get into Scottish prisons? (For example: through the mail, using drones, being smuggled in by visitors or staff.) Who is mainly responsible for bringing them in (for example: organised crime groups)?

This consultation about substance use in prisons is focussed on illegal drugs. However, SHAAP firmly believes that alcohol should be addressed as part of the inquiry given the high prevalence of alcohol use disorder in the prison population. Dealing with alcohol use disorder amongst prisoners is not given the priority it merits, yet if alcohol use disorder was addressed properly not just in prison but throughout the justice system, there would be enormous benefit. This would not just be felt by the individuals concerned, but by families and communities and also by the prison service because it would reduce re-offending and therefore reduce pressure on the overstretched resources of the police, courts and prisons. We have outlined our reasoning below, recognising that the questions about illegal drugs do not lend themselves to answers about alcohol. We would respectively direct the committee to SHAAP's September 2024 publication "Alcohol (In)Justice: position on people with alcohol use disorder in the justice system."

Almost two thirds (63%) of people in prison have an alcohol use disorder, with almost half of those (31%) possibly dependent on alcohol.[1] This compares to 22% of hazardous or harmful drinkers in the population as a whole.[2] Risk of death from alcohol causes is three times higher in men and nine times higher for women who have been in prison than for the general population.[3]

The Scottish Prison Service's Prison Survey 2024 showed that 17% of respondents reported having consumed illicit alcohol during their time in that prison. [4] However, given "the available literature on alcohol use in prisons is sparse and often overshadowed by a drugs-focus" [3] it is difficult to state with confidence how alcohol enters or is produced in prisons. The survey showed that 55% of the respondents said they used alcohol in the community prior to imprisonment, with 49% respondents saying they used drugs. 31% reported that they were under the influence of alcohol at the time of the offence. [4]

This demonstrates the impact that alcohol has on people's lives and offending behaviour, and the opportunity that prison affords for supporting people to address alcohol use disorders.

[1] https://www.gov.scot/publications/understanding-substance-use-wider-support-needs-scotlands-prison-population/

[2] https://www.gov.scot/binaries/content/documents/govscot/publications/statistics/2023/12/scottish-health-survey-2022-volume-1-main-report/documents/scottish-[3]

https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2022/09/understanding-substance-use-wider-support-needs-scotlands-[4]

https://www.sps.gov.uk/sites/default/files/2025-04/Prison%20Survey%202024.pdf

Q4 What are the best ways to reduce the use of drugs and other substances by people in prison?

People entering prison often have a range of physical and mental health issues, and it's vital that if someone is dependent on alcohol and their supply suddenly stops that this is safely managed – to not do so risks serious health implications including death.

On admission to custody, patients with alcohol dependency are assessed to ascertain any clinical evidence of physical withdrawals using objective scoring tools. When clinically indicated, a medication reduction regime is prescribed to treat withdrawals and prevent complications associated with abrupt discontinuation of alcohol including seizures and delirium tremens (the latter still having a significant mortality rate of around 5%). Patients identified with alcohol dependency are also provided with Vitamin supplementation.

In order to reduce the use of alcohol by people in prison, whether when serving their sentence or upon release, prisoners must have access to appropriate treatment and support at all stages of their contact with the justice system.

Coming into contact with the justice system provides an opportunity to recognise and address alcohol use disorders, including offering treatment and support, and this opportunity should be utilised to improve outcomes for people with alcohol use disorders. This may be one of the first opportunities individuals who have previously not engaged with healthcare or support organisations have had to address their alcohol use disorder. Yet people in the system are not always likely to get the support they need.

There is an abundance of policy and guidance on how people with alcohol use disorders in the justice system – particularly in police custody and prison – should be afforded treatment and support, from guidance on alcohol, drugs and tobacco health services in police custody and prisons through to more recent broader approaches to justice like the Public Health Scotland Health and Justice Strategy and the Bail and Release Act.

Yet to date, this does not always translate into consistent practice on the frontline to support people with alcohol use disorders. There is no overarching set of frameworks or standards which distils this into a practical approach that results in

improved experiences for people, their families and wider communities. Neither is there a clear mechanism of accountability for the whole system in its entirety, as it relates to people with alcohol use disorders, despite the prevalence and impacts of alcohol use disorders amongst people in the justice system.

The Scottish Prison Service's Alcohol and Drug Recovery Strategy has four key priority areas

• Implement MAT Standards

• Develop recovery pathway

• Tackle stigma to reduce health inequalities

• Lived/living experience

Notably, the first priority area does not relate to alcohol as there are no equivalent MAT Standards for alcohol use.

In order to develop recovery pathways which reflect specific population needs the data gaps in relation to alcohol use identified in the recent substance use needs assessment should be addressed. This would be expected to result in an expansion of services and also a considerable expansion of mutual aid such as peer recovery networks.

Impact of drugs and other substances in prisons

Q6 Aside from health problems, what other effects does drug use have on people in prison?

It should be noted that people in the justice system and prisons experience high levels of disadvantage, including trauma, Adverse Childhood Experiences and mental health conditions: 25% of people in Scottish prisons are care-experienced, 47% have experienced physical abuse in childhood, and around a third (34%) of people lived with someone who was a problematic drinker during childhood.[5] A 2022 study commissioned by the Scottish Government found that the prevalence of mental health needs is significantly higher in prisons than in the general population.[6] There are also significant disadvantages in the prison population in other areas, namely: housing, finance, and health literacy. People with Foetal Alcohol Spectrum Disorder (FASD) are also overrepresented in the justice system. [7] People in the justice system additionally experience high levels of other health conditions and poorer overall wellbeing than in comparison to the general population.[8]

[5] https://www.sps.gov.uk/sites/default/files/2024-02/17thPrisonSurvey_2019_Research.pdf

[6] https://www.gov.scot/publications/understanding-mental-health-needs-scotlands-prison-population/

[7] https://pubmed.ncbi.nlm.nih.gov/22032097/

[8] https://pubmed.ncbi.nlm.nih.gov/31583401/

Rehabilitation and support for people using drugs in prison

Q13 How easy is it to access help for drug or substance problems in prison? Is that support working well?

In the 2024 Scottish Prisoner Survey, when asked if they had needed and received support for alcohol consumption since arriving in the prison, 6% said “yes, the support is/was helpful” and 3% said “yes, but the support is/was not helpful”. 7% answered “no, but I need this support”. [4]

The 2019 survey showed that nearly one fifth (19%) of prisoners who took part were worried alcohol would be a problem for them when they got out.[5]

Forty one percent of participants said that if they were offered help for their alcohol use disorder (both inside and outside of prison) that they would take it.[5] However, only 22% of participants reported that they had been given the chance to receive treatment for an alcohol use disorder during their sentence (down from 25% in 2015 and 23% in 2017).[5]

For Alcohol Brief Interventions (ABIs) in justice settings, delivery sits at about 29% in prison and 3% in police custody (based on 2019/20 data when assuming 63% of individuals have an alcohol use disorder). Referrals to drug and alcohol specialist treatment in Scottish prisons has fallen significantly in recent years – treatment referrals for alcohol and co-dependency fell from 1,047 in 17/18 to just 549 in 21/22.[9] Furthermore, only 4% of those eligible were referred to alcohol services in 2024 [10] Reasons for this decline are being investigated as part of a wider work by Public Health Scotland (PHS) looking into falling alcohol referrals to Alcohol and Drug Partnerships.

Additionally, of the over 12,000 community payback orders imposed in 2021-22, only 1% received alcohol treatment as part of the order.[11]

As aforementioned, it is vital that mutual aid and peer recovery networks are expanded, as well as access to more formal support. A 2020 Cochrane review found AA programmes to be at least as effective as other treatments in reducing alcohol use and improving mental wellbeing, and more effective than alternatives in sustaining continuous abstinence. However, there is unequal access to AA across Scotland (see Table 1.) [12]

Table 1

HMP | Weekly | Monthly

Addiewell | 2 | 0

Barlinnie | 3 | 0

Castle Huntly | 1 | 0

Cornton Vale | 0 | 0

Dumfries | 0 | 0

Glenochil | 1 | 0

Grampian | 2 | 0

Gateside | 2 | 1

Portfield | 1 | 0

Kilmarnock | 2 | 0

Lillias Centre | 1 | 0

Low Moss | 1 | 0

Perth | 0 | 0

Polmont | 0 | 0

Saughton | 1 | 0

Shotts | 1 | 0

Research into AA in prisons has also found that where attendees have consistent access to meetings, reports suggest reduced cravings, stronger coping strategies and improved engagement with other rehabilitative programmes. Participants who continue AA after release credit it with helping them secure employment, rebuild family relationships and remain sober in the community. [13]

[9] https://publichealthscotland.scot/publications/national-drug-and-alcohol-treatment-waiting-times/national-drug-and-alcohol-treatment-waiting-times-1-october-2023-[10]

https://publichealthscotland.scot/publications/national-drug-and-alcohol-treatment-waiting-times/national-drug-and-alcohol-treatment-waiting-times-1-july-2024-to-[11]

https://communityjustice.scot/wp-content/uploads/2023/03/CPO-Annual-Report-2021-22.pdf

[12] https://pubmed.ncbi.nlm.nih.gov/32159228/

[13] https://www.shaap.org.uk/justice-series-the-power-of-community-in-recovery-strengthening-alcohol-support-across-scotlands-criminal-justice-system/

Support after release from prison (throughcare and aftercare)

Q17 What are the biggest challenges people face after leaving prison – especially when trying to recover from drug use or stay safe?

In the 2019 Scottish Prisoner Survey, nearly one fifth (19%) of prisoners who took part in the survey were worried alcohol would be a problem for them when they got out.[5] There must be comprehensive, proactive pre-release planning, to ensure people leaving prison are automatically given the right support to prevent relapse, and easily accessible follow up care. Please see more information regarding this in our answer to question 21.

Other views

Q21 Is there anything else you'd like to say about drug and substance use in prisons, or how it affects people?

In 2007/8 an estimated £17.2million was spent on criminal justice social work for alcohol-related crimes, and the estimated cost to the criminal justice system in response to alcohol specific crime is between £86.2 million and £197.3 million, with a mid-point of £141.8 million.[14] However, it should be noted that these statistics have not been recalculated since 2007/8 and therefore the true current figure is likely much higher.

This spending is in the context of a criminal justice system which is under immense pressure. Scotland has the highest imprisonment rate in Western Europe, with over 150 individuals per 100,000 population entering prison in 2021-2022.[15] The Scottish Parliament's Criminal Justice Committee stated in November 2023 that the funding situation in the Scottish criminal justice system is unsustainable and requires a new approach.[16] In May 2024, the Justice Secretary, Angela Constance MSP, made a statement to the Scottish Parliament outlining the extreme constraints the Scottish Prison Service is under and measures she intends to undertake to release prisoners to ease pressure on the service.[17]

Now that the draft UK Alcohol Treatment Guidelines have been published (with full guidelines to follow),[18] the Scottish Government plans to use this as the basis for developing a National Service Specification. This is an opportunity to publish a clear specification for justice settings as well as develop standards for alcohol treatment and support at each stage of the justice system. A "standard" is a statement, outlining principles of care which should underpin all support for people experiencing problems with alcohol. Standards are based on evidence, and should cover the key

issues for safe, effective, non-stigmatising, trauma informed and person-centred care and treatment. As well as outcomes for the individual affected, the new standards should set out service specifications including staffing and training requirements to help meet these outcomes and align with or be part of the National Service Specification for Drugs and Alcohol that the Scottish Government is planning to develop.

SHAAP believes the implementation of these standards must then be measured and a system for accountability to Ministers must also be put in place for each individual standard, and as a whole at a national level.

The following outlines potential standards (or in some cases, policies) that if taken forward, could make a significant impact. These standards should be guided and underpinned by a set of overarching principles, including those of trauma informed care, safety, choice, collaboration, empowerment, trust, and the right to health.

The standards relating to prison and thoroughcare will be most relevant for this consultation, so we have only expanded on those.

1. Police Contact

2. Police Custody Centres

3. Crown Office and Procurator Fiscal Service (COPFS)

4. Diversion/liaison

5. Court

6. Community Sentencing

7. Prison

Stage of Journey

Someone with an alcohol use disorder enters prison/a Young Offenders' Institution.

Current Approach

The Scottish Prison Healthcare Network previously published guidance [19] for the delivery of substance misuse services which includes recommendations for the delivery of ABIs in prison and custody settings, but this is no longer in use.

Aspiration

Scottish Prison Service staff and NHS healthcare staff must be trained in treating someone thought to have an alcohol use disorder in a non-stigmatising manner, recognising the complexity of life circumstances and trauma the individual is likely to

have experienced. Everyone who is placed in custody should be screened for alcohol use using a validated tool (such as AUDIT or FAST), and appropriate action taken in response (motivational interviewing through to treatment, introduction to recovery communities and peer support through to psychological treatment).

Services should be working to HIS/HMIPS standards for inspection - standard 9.7 [30] which covers alcohol and drugs: “Everyone who is dependent on drugs and/or alcohol receives treatment equitable to that available in the community, and is supported with their wellbeing throughout their stay in prison, on transfer and on release.”

Where NHS healthcare staff, the police, prosecutors, or court has identified an alcohol use disorder, this information should be automatically shared with prison admission staff with clear and efficient information sharing processes in place.

When someone with an alcohol use disorder is placed in custody, a risk assessment of withdrawal should be carried out by a clinical member of staff at the reception stage, and an agreed protocol for managing potential withdrawal must be implemented involving regular observations by trained prison staff, communicated to the clinical staff responsible so that medically assisted withdrawal can be put in place if necessary, and a protocol for transfer to hospital should this be necessary (for extreme intoxication or for withdrawal).

The underlying causes relating to an individual’s alcohol use disorder should also be explored and addressed, as recommended through the Prison Healthcare Target Operating Model. [20]

Whilst in prison, there must be access to recovery communities and where prison or healthcare staff have identified someone with an alcohol use disorder whose health is at particular risk they should be referred to the mental health nursing team or alcohol treatment and support service.

An individual’s alcohol use disorder must be on all relevant records so that as they then progress through the courts and any future sentencing, appropriate support and services are put in place at each stage.

Standards for prisons, YOIs and custodial sentences should be developed by HIS and HMICS/HMIPS with input from experts by lived experience and ADPs.

Oversight and governance

Scottish Prison Service; HMIP/HIS; NHS; IJBs/ADPs.

8. Throughcare/ liberation from prison Stage of Journey

Someone with an alcohol use disorder is liberated from prison.

Current Approach

People are provided with a plan in place for managing their alcohol use disorder upon release, including in line with the Scottish Government Prison to Rehab Protocol.[21] However this is currently only used in limited circumstances.

Aspiration

Starting at reception, a multidisciplinary plan for ongoing care, multiple transfers, and through care should be put in place which is developed throughout the person's time in prison to ensure that appropriate support is in place for liberation. This plan should include signposting to support services, automatic referral into alcohol treatment and support through to rehabilitation upon liberation. Plans for liberation should be shared with primary care.

People should leave prison with a clear plan in place for managing their alcohol use disorder (such as relapse prevention), harm reduction advice, appropriate medications and a clear referral pathway for treatment/ support, information on and links to recovery communities and aftercare after liberation from prison - which they can continually access after release to improve their health and reduce chances of reoffending whilst under the influence of alcohol. This should build on the Scottish Government's Prison to Rehab Protocol, should be integrated with other services and support designed to address factors related to the alcohol use disorder, and throughcare should apply to all people in prison including people on remand.

Accountability and Governance

SPS; HIS/HMIPS.

Accountability and Governance of the System as a Whole

Despite the existence of a number of frameworks and policies already in place surrounding the care of people with alcohol use disorders in the criminal justice system, there are major gaps in implementation and a lack of clarity around governance and accountability, with multiple agencies providing oversight. Separation of powers and independence of decision-making between the organisations and bodies involved in the justice system can pose a challenge for overall coordination of care and support. These issues must be addressed with urgency to ensure that people with alcohol use disorders coming into contact with the justice system have the best opportunities to access treatment and support. A standard approach to identifying and treating/supporting alcohol use disorders at each stage of the justice journey is necessary with clear accountability and oversight.

Oversight of the development and subsequent performance against these standard approaches so that they enable coordinated pathways of care is key.

This should be carried out by a Scottish Government-led working group which reports to the Cabinet Secretary for Justice and Minister for Drugs and Alcohol, who are then held jointly accountable by an annual report to the Scottish Parliament. In turn, there should be clear accountability for local provision. This work should be aligned with the forthcoming National Service Specification for Drugs and Alcohol. Justice settings should be considered and these standards reflected in the needs

assessment and strategic plans of Alcohol and Drug Partnerships, Community Planning Partnerships, Health and Social Care Partnerships, and Children's Services Planning Partnerships.

It should be noted that each section of the justice system has its own statutory partners, powers and duties, and it is understood that in cases, a standard is not the right concept/descriptor of accountability and governance. However, in these cases the governance and accountability initiatives should be underpinned by the same values and principles as described above and facilitate coordinated pathways of care.

In conclusion, while there is good practice taking place with regards to the treatment of alcohol problems within the prison estate, this is piecemeal and severely lacking in government oversight. SHAAP is calling for a nation, standardised approach which ensures that everyone in or leaving prison in Scotland can access treatment and support where and when they need it.

[14] https://drugslibrary.wordpress.stir.ac.uk/files/2017/03/SGalocohol_cost_to_society.pdf

[15] https://fraserofallander.org/wp-content/uploads/2023/06/Perspective-2-Criminal-justice-and-the-costs-of-offending.pdf

[16] https://www.parliament.scot/about/news/news-listing/current-funding-model-for-justice-sector-is-unsustainable-and-must-change-say-holyrood-committee

[17] https://www.parliament.scot/chamber-and-committees/official-report/search-what-was-said-in-parliament/meeting-of-parliament-16-05-2024?meeting=15860&iob=[18]

https://www.gov.uk/government/consultations/uk-clinical-guidelines-for-alcohol-treatment

[19] Drugs, Alcohol and Tobacco Health services in Scottish Prisons: Guidance for Quality Service Delivery, February 2016. [No longer available online].

[20] Unpublished document

[21] https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2023/03/prison-rehab-protocol/documents/prison-rehab-protocol/prison

Written submission from Glasgow ADP

Impact of drugs and other substances in prisons

Q5 What are the main health risks linked to drug use in prison – especially newer synthetic drugs?

Residents report using drugs when they are locked in their cell to reduce their chance of being caught while intoxicated. This has serious health implications.

Stakeholders report an increase in people placed on Management of Offenders at Risk of Substances (MORS) and requiring transport out of the estate to A&E. They also report an increase in non-fatal overdoses and the amount of naloxone that staff are having to use to prevent overdose.

The compounds found in cannabinoid vapes and other synthetic drugs vary widely (around 36 different types identified by Dundee University lab) and therefore, the effects that people experience are also very variable. Reports include complete blackout, erratic behaviour, serious respiratory effects, drug induced psychosis, increased suicidal ideation and seizures and dependency.

Q6 Aside from health problems, what other effects does drug use have on people in prison?

There is an increase in associated violence between the residents which can often be linked to drug debts. There is also pressure on vulnerable residents to carry or bring in drugs for others There are reports of vulnerable residents are being picked to test new batches of drugs.

Drugs are also often used as currency within the estate.

Issues include; debt, bullying, breakdown in family relationships, poor mental health and suicidal ideation, assaults, families being threatened, staff coercion.

Q7 How does drug use affect safety inside prisons – for both prisoners and staff?

The erratic behaviour experienced while under the influence, particularly from synthetic substances, is not only a health risk to the residents but also a risk to the health and safety of staff managing them during these times.

The ratio of health staff to patients is lower in the prison estate than in the general population. Difficult clinical decisions about who needs to go to hospital are potentially being impacted by these resourcing pressures.

Healthcare teams are overwhelmed by an open referral system and caseloads that outweigh community service. This and prison overcrowding negatively impacts outcomes for residents and increases pressures on existing staff.

Q8 What extra support or action could help make prisons safer and reduce the harm caused by drugs and other substances?

• Regular and structured focus groups with residents in each establishment, particularly those who have lived experience of synthetic drug use, mental health struggles, or suicidal ideation. Their insight is crucial in shaping meaningful, effective responses. Including them not only strengthens the relevance of interventions but also empowers individuals to be part of the solution. We recommend that any national or local strategies emerging from this work include a resident consultation process at every stage.

• People report boredom is causing a lot of the drug use. More activities would tackle this however there are not enough staff. SPS have reduced the working week to 35 hours which is having an impact on lock-up times. Lock-ups can be from 4.30 pm - 7am at the weekend.

• Banning vapes would reduce the harm caused by synthetic drugs being smoked in these vapes but will have unintended consequences.

• Staffing resource is stretched within SPS and NHS PHC. Increased resources would improve outcomes for residents as well as improve joint working between the two services.

• Prison healthcare nursing staff are one team and are expected to address physical health, mental health and addiction issues. They are exposed to frequent traumatic events within their working environment, including self-harm and suicide. These issues affect staff burnout. Working within the prison is an exceptionally litigious environment that affects the management of patients and staff.

• Sustainable funding for a range of third sector in-reach services is required. Increased resources for drug and alcohol support services, and better access to residents to offer support would improve access to treatment options.

Improved access to third sector support services will offer a tailored range of support options to residents and reduce pressure on SPS and PHC staff.

Finding space for these supports within the prison estate can often be an issue.

Resident engagement was carried out by the Scottish Recovery Consortium and SISCO (https://sisco.org.uk/) and will be submitted in separate submissions.

Results of the most recent SPS Prison Survey might be of interest and can be found here:

https://www.sps.gov.uk/about-us/our-latest-news/publication-prison-survey-findings

Support for people affected

Q9 How does someone using drugs in prison affect their own life, their family, and what happens when they're released?

Resident engagement was carried out by the Scottish Recovery Consortium and SISCO (https://sisco.org.uk/) and will be submitted in separate submissions.

The health and social implications of use have been outlined in previous questions. The impact on families will be outlined in subsequent questions.

It is also worth noting that if someone is caught with a substantial amount of drugs, this could result in extra charges. It is also possible for someone to leave prison with a drug dependency or drug debt that they did not have when they were initially incarcerated.

Q10 If you have a family member in prison, what support (if any) have you had to stay in touch with them?

In Glasgow City the Croft project is funded to "support families and other individuals adversely impacted by a family member going to Prison. They often serve a sentence of their own and there is clear evidence that a family members' involvement in the justice system can have wide ranging impacts upon family members …

Families of individuals involved in the justice system can experience a variety of impacts upon their lives and family functioning. Changes to financial support and income may result in families being at risk of losing housing. Some families may also experience isolation, exclusion and stigma by association.

At the Croft, operating from a base at HMP Barlinnie, we support people in these situations with practical and emotional support as well as signposting to other services that can assist them." https://www.thecroftfamilysupport.org/

Q11 Have you or your family experienced stigma, discrimination or been treated unfairly because of drug use in prison?

Resident engagement was carried out by the Scottish Recovery Consortium and SISCO (https://sisco.org.uk/) and will be submitted in separate submissions.

Families report feeling pressured into paying into several commissary accounts, potentially funding the purchase of drugs or other debts. Families are not reporting instances of bringing in drugs to the Croft team.

The Croft service users report a level of acceptance, stigma is normalised. Families report people developing new drug dependencies in prison, reports of use developing out of boredom, and families concerned for their loved one's welfare. It was mentioned that visitors are aware they are under surveillance when on the premises in case they are carrying substances which can add a level of anxiety to visits.

Q12 If you've used drugs while in prison, what help have you had for your recovery, mental health, or to get ready for life after prison?

Resident engagement was carried out by the Scottish Recovery Consortium and SISCO (https://sisco.org.uk/) and will be submitted in separate submissions.

Rehabilitation and support for people using drugs in prison

Q13 How easy is it to access help for drug or substance problems in prison? Is that support working well?

Resident engagement was carried out by the Scottish Recovery Consortium and SISCO (https://sisco.org.uk/) and will be submitted in separate submissions.

Services report accessing support for drug and/or alcohol problems can be very challenging for residents. It is easier to engage with people who are already receiving Medication Assisted Treatment. Reaching new people is difficult due to staff resources, the requirements for access to interview/group rooms and privacy to support patients.

PHC Teams require the resources, space and support to build confidence and competence to deliver the MAT standards.

Q14 What part should treatment with medication (such as methadone) and harm reduction approaches (like needle exchange) play in helping people in prison?

Residents should have access to the same standard of treatment and care in prison as people in the community. While people are in prison, there is a good opportunity to engage in treatment and care services. There needs to be investment in prison drug and alcohol services to support this.

More work is required to develop appropriate recovery supports and harm reduction messaging/interventions around the changing drug trends. People need harm reduction information on the synthetic substances they are smoking in vapes to make informed decisions and understand how to reduce risks. IV drug use is not a widespread issue within prisons currently. The Prison Harm Reduction Team operating in NHS GGC are providing around 50% of people with Nyxoid on liberation, this is an example of good practice.

Q15 From your experience, are the Medication-Assisted Treatment (MAT) Standards being fully followed in prisons?

There has been no investment from Scottish Government to support Prison Healthcare to implement the MAT standards, which has led to continued inconsistent adherence to MAT standards across the estates. There has been a good uptake in Buvidal which has improved the choice of treatment. There continues to be very limited options and support for people with a history of alcohol use.

Q16 How can mental health and addiction support services work better together in the prison system?

In the board-wide NHS GGC prison estates, there are 15 mental health nursing staff covering the estates (this includes HMP Barlinnie, Low Moss, Greenock and Lilius). In the year from 1 July 2024 to 30 June 2025 there were 4250 referrals to the team for mental health support. All of these referrals need to be triaged. Staff report these numbers to be unmanageable with their current staffing resource. This pressure exacerbates tensions within the team and delays access to mental health support and alcohol/drug supports.

PHC staff are not able to access the health IT systems used in the community. This makes it very difficult to get all the information they need to make an appropriate assessment of someone's mental health. All areas use different IT systems.

SPS concentrate on numbers and cell allocation – this is not trauma informed. Cell sharing affects individuals wellbeing significantly.

Support after release from prison (throughcare and aftercare)

Q17 What are the biggest challenges people face after leaving prison – especially when trying to recover from drug use or stay safe?

Those involved in the consultation felt the biggest challenge facing people leaving prison was homelessness. People are returning to the community and spending time in emergency accommodation which is not the stable environment needed for recovery.

People can be institutionalised when they are liberated and require support to break this cycle.

People also struggle to get a GP when they return to the community, as they need to wait until they have an address in the local area to attempt to register, and there can be issues with GPs not having capacity for new patients.

Other issues raised include: lack of access to throughcare support, getting liberated on a Friday, staff being unable to register people with a GP before their release, lack of financial pressures, unplanned liberation, differences in geographical entitlement, communication and joint working with community services, and the distance people need to travel to return home.

Q18 Are the services that help people after prison release working well, and if not, how could they be improved?

Services and supports raised during consultation included:

• The Prison Casework Team in Barlinnie holds weekly meetings with partners to review cases of anyone being liberated into homelessness in Glasgow,

this is to ensure people are linked with services like ADRS and DWP, as well as beginning section 5 paperwork to secure a tenancy.

• Prison to Rehab scheme: most estates are engaging in this, but the best are the ones with dedicated and consistent staff. Need to consider clinical input to assessments.

• The Prison Harm Reduction Team in NHS GGC supplies Nyxoid to people on liberation. This is an important harm reduction intervention.

• The Croft run an 8-week programme in Barlinnie where people get the opportunity to meet as many services as they can. These are group sessions that give people the chance to link in with services that might be relevant to support them on release. It has also been successful in supporting people to secure accommodation.

Issues for consideration

• consider Court/Criminal Justice to Rehab to work with people before they end up in prison eg Diversion, Supervised Bail, DTTO etc

• Recovery Cafes in prison - better engagement opportunities within prison to work on recovery capital and create established pathways into recovery on liberation

• Lived Experience pathways – need to improve accessibility for people in prison to work with people with lived experience for peer support and connection to improve outcomes

• Throughcare Pathway & Support on Release (Pre-planning): needs to begin as early as possible (SACRO, Upside, 3rd Sector etc)

Q19 What more could be done to make sure people still get the support they need with substance use after leaving prison?

Improved access to third sector in-reach would allow people to establish relationships with community supports before they are liberated and ease the transition back home. The lack of space for third sector services to use in prisons hampers this work; more space is needed for private consultations and increased SPS staffing to facilitate this.

People with short sentences are eligible for voluntary throughcare but they are not engaging- need to consider the process.

The Bail and Release Act would allow people to register with GPs while still in prison, but currently staff can’t formally register them before release; implementation of this Bill is key.

The Scottish Recovery Consortium spoke to people in Glasgow about what is most important to them on liberation - the priority was having someone with lived experience in the community upon release, who could help with the multiple diverse needs.

• Someone with local knowledge and connections, who can link with housing, benefits, recovery support, third sector and psychosocial support etc.

• This reduces feelings of judgement and provides a point of contact so individuals feel less alone, and more able to access the support available.

• Someone who knows about local services and processes that could help individuals navigate what are seen to be overly complex and opaque systems.

Resident engagement was carried out by the Scottish Recovery Consortium and SISCO (https://sisco.org.uk/) and will be submitted in separate submissions.

Learning from other countries

Q20 Are there examples from other countries that show a better way to deal with drug use in prisons? What can Scotland learn from them?

Norway's prison system is renowned as one of the most effective and humane in the world. Norway has one of the lowest recidivism rates in the world; in 2018 the reconviction rate was 18% within two years of release, with a recidivism rate of 25% after five years.

How Norway turns criminals into good neighbours - BBC News

Other views

Q21 Is there anything else you'd like to say about drug and substance use in prisons, or how it affects people?

No.

A Thematic Review of Prisoner Progression in Scottish Prisons: Short Summary:

https://prisonsinspectoratescotland.gov.uk/sites/default/files/publication_files/HMIPS%20-%20Progression%20Review%20Report%20-%20Short%20Summary.pdf

Written submission from SACRO

Rehabilitation and recovery in custody, throughcare and continuity of support on release

This submission is provided by Sacro as lead partner of Upside, Scotland's national voluntary throughcare partnership. We support people leaving short-term custody and remand to rebuild connections, stabilise health and finances, and sustain change in the community. Our evidence reflects what we hear from people we support and what our staff see day to day across multiple establishments and local areas.

Executive summary

- Recovery must be treated as core to safety and rehabilitation in custody, not an optional add-on.
- Ensure risk procedures support, rather than limit, individual choice and control.
- Access to recovery support is inconsistent across the prison estate and frequently disrupted by transfers. Every transition adds risk to recovery.
- Alcohol harms are under-recognised and under-resourced compared to drug treatment. People frequently detox without structured support and then face heightened risk at and after release.
- Demand for drug, alcohol and mental health support outstrips supply in custody and the community. Long waits for clinical interventions and for residential rehabilitation undermine progress made in prison.
- Trust is fragile. People often withhold information or engage at a surface level because they do not believe services will help or keep them safe. Trauma-informed practice is unevenly distributed and not yet embedded.
- Continuity is a significant weakness. Information sharing and joint planning between prison health, mental health, addictions, housing and benefits teams is variable, with gaps and duplication common.
- Medication Assisted Treatment (MAT) Standards are improving access to Opioid Substitution Therapy (OST) in custody, but implementation is uneven, especially at reception, during transfers and at liberation. Bridging scripts and warm handovers are not guaranteed, especially for those on remand.
- Housing remains the pivotal barrier to sustaining recovery on release. A lack of settled options, limited Housing First capacity and prolonged stays in unsuitable temporary accommodation place people back in environments where drug use is prevalent and vulnerabilities increased. Even where a tenancy exists, poor quality or an unsuitable location can undermine recovery without the right tenancy-sustainment support.
- Peer recovery is a growing strength inside and outside custody. Where supported, it offers relational, credible help that people trust.
- Advocacy changes outcomes. Most people are unaware of their rights and routinely secure entitlements only after a third party intervenes. There is limited accountability when rights are not upheld.

About Upside

Upside is a national, voluntary throughcare service that supports people on remand and those serving short sentences. We work alongside statutory, third and independent sector partners to coordinate practical help with housing, health, income, and relationships, and to maintain momentum built in custody. Our model is relational, trauma responsive and strength based. Support duration is longer than previous national throughcare provision, and we operate a continuous improvement approach that learns from people's experiences and from staff feedback.

Access to recovery services in custody

People access recovery support in multiple ways. Care pathways include prison addictions teams, mental health teams, NHS healthcare, third-sector services, chaplaincy, and peer recovery groups. In practice, access depends on three variables: availability, consistency and trust.

- Availability: clinical and therapeutic capacity is stretched. There are waiting lists for counselling, mental health input and group work. Alcohol support is particularly limited compared to drug treatment.
- Consistency: approaches differ across establishments. Transfers interrupt programmes and prescribing, and can sever links with peer groups and family visits. Re-starting assessments delays progress.
- Trust and trauma: many people do not disclose needs or only engage superficially. They fear stigma, repercussions or that nothing will change. Trauma-informed interaction exists largely in name only.
- Holistic need: the dominant focus remains symptom management, particularly opioid substitution, with less attention to underlying causes or the holistic approaches required to sustain recovery. Recovery is not one size fits all; people define and pursue it in different ways and at different paces.
- Peer recovery: where supported to operate safely, peer-led groups provide credible hope and practical help. They are often the most trusted gateway to further support.

Transitions back into the community

Transitions are the highest-risk period for relapse and harm. Sustained progress depends on the quality of planning, including a participatory process and person-centred goal planning that starts early and aligns actions to the person's goals, priorities and pace, alongside reliable delivery of practical essentials.

- Planning: remand releases are often unplanned. People leave without housing arranged, without access to income and with poor continuity of care. Upside now supports remand cohorts, including males from July 2025, which has placed significant extra demand on the service. Uncertainty is one of the biggest challenges for people on remand and this significantly impairs the ability for services to conduct release planning and achieve engagement pre-release, limiting the opportunity for a supported transition.

- Continuity of healthcare: access to prescriptions, including OST and mental health medication, is inconsistent on release. GP registration prior to liberation is a positive development but not yet universal in practice.
- Housing: lack of settled housing and limited Housing First capacity result in long stays in unsuitable temporary accommodation, commonly alongside active use. This undermines recovery work done in custody.
- Money and essentials: delays in benefit claims and lack of immediate subsistence can push people back to survival strategies that jeopardise recovery.
- Relationships: family and pro-social ties are protective but can be weakened by inter-prison transfers and distance from home. Restoring safe connections needs deliberate planning.
- Advocacy: people frequently secure what they are entitled to only when an advocate intervenes. Without advocacy and a trauma-informed culture, rights can be difficult to exercise and there is limited accountability when they are not upheld.

Joined up care and the roles of third-sector and public bodies

The current system operates as parallel tracks rather than a single pathway. Duties of care are often bounded by the prison gate. Information sharing is inconsistent and duplication is common. Third-sector providers bridge gaps through advocacy and coordination, but structural solutions are required.

- Single shared plan: people benefit from one person-centred recovery and resettlement plan, co-produced with the person and owned across prison health, mental health, drug and alcohol services, housing and community partners, with robust information sharing arrangements.
- Minimum standards: a clear baseline for release planning and for day-one essentials will reduce variation and close gaps for remand and short sentences but implementation in this area of the Bail & Release act has not yet begun.
- Governance and variation: SPS sets national expectations but governors shape practice locally. Experience varies by establishment, including access to groups, appointments and peer recovery.
- Early intervention: planning should begin at reception and include prevention, not just risk management. Holistic approaches need equal weight to risk processes.

Medication Assisted Treatment (MAT) Standards in custody and on release

Implementation has delivered progress but remains uneven across the pathway. The key issues we see are at reception, during transfers and at liberation.

- Reception and assessment: timely access to OST is better, but trauma-responsive assessment and clear communication about choices are not consistent. Many people still feel treatment is something done to them rather than with them.

- Transfers: medication continuity can be interrupted by moves between prisons. Re-assessment and delays create risk, discomfort and disengagement.
- Liberation: bridging prescriptions and warm handovers to community prescribers and pharmacies remain variable. People can still leave prison without medication in hand or without a confirmed appointment.
- Alcohol treatment: alcohol harm is not addressed with the same priority as drug treatment. People often detox without structured follow-up, increasing risk on release.
- Mental health: access to psychological therapies and dual-diagnosis support is limited. Physical health is prioritised over mental health and recovery despite clear interdependence.

What works and emerging strengths

- Relational practice: consistent relationships with staff and peers build trust and improve engagement.
- Peer recovery: peer-led groups in custody and the community create credible pathways and hope.
- Practical basics: securing ID, GP registration, safe accommodation and immediate income reduces the potential for relapse and reoffending.
- Warm handovers: joint appointments and in-person introductions to community services improve uptake and retention.
- Longer support windows: sustained throughcare beyond the first weeks helps people navigate setbacks and maintain momentum.

Recommendations for the Committee and partners

- Make recovery a core outcome in SPS performance frameworks and inspections, with specific measures for access, continuity and engagement quality.
- Prioritise implementation of partnership approaches including the SHORE standards and release planning duties with robust information sharing arrangements across prison health, mental health, drug and alcohol services, housing, DWP and third-sector partners.
- Ensure transfers are clinically reviewed wherever someone is in active treatment or structured recovery, with a confirmed handover plan and no interruption to care.
- Guarantee continuity of care at liberation, including same-day supply or bridging prescriptions, confirmed community appointments and pharmacy handover.
- Resource alcohol treatment on a par with drug treatment in custody and the community, including structured detox and follow-up.
- Introduce clear accountability routes when rights and entitlements are not delivered, including accessible independent advocacy.
- Prioritise trauma-responsive and relational practice across SPS, NHS and partner services, with supervision to sustain it.
- Invest in trauma-responsive prevention and early intervention that tackles the drivers of substance use and justice contact, including childhood adversity,

poverty, mental ill-health and social disconnection; deliver this across family support, inclusive education, youth mental health, primary care and safe community spaces, co-designed with people and families and with clear routes into recovery support before crisis.

Upside will continue to work with SPS, NHS partners, local authorities and community partners to improve continuity of care and outcomes. We welcome the Committee's focus on rehabilitation and recovery and would be happy to provide further detail or examples at oral evidence.