CJ/S6/25/23/2

Criminal Justice Committee
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Inquiry into the harm caused by substance misuse in Scottish prisons: analysis of the call for views

Introduction

The Criminal Justice Committee launched its call for views on their Inquiry into the harm caused by substance misuse in Scottish prisons on 16 May 2025. It closed on 22 August 2025.

The intention of this paper is not to be exhaustive, rather it is to provide an overview of the main themes raised in the submissions. The submissions are published online.

While there was an overwhelming focus on drugs in the responses, where alcohol has been specifically mentioned it is included separately within that section of the report.

Responses

The Committee received 32 submissions to the call for views. Of these submissions, 20 were from organisations, with the rest from individuals. These individuals included those with:

- experience of imprisonment
- experience of a family member's imprisonment
- experience of working in a prison
- academic expertise
- professional experience (a medicinal chemist, child and adolescent psychotherapist and intelligence analyst).

Some individuals had more than one of these experiences.

It should be noted that not every respondent answered all of the questions.

Analysis of responses

Below is an analysis of the responses to the call for views grouped in terms of the themes the inquiry is focusing on:

- existing reports
- early intervention / diversion

- how drugs and other substances get into prisons
- rehabilitation and support for people using drugs in prison
- support after release from prison (throughcare and aftercare)
- learning from other countries.

Existing reports

The UK National Preventive Mechanism (NPM) raised concern in their response that recommendations in reports are being accepted in principle by the Scottish Government but are not being implemented. The Scottish Recovery Consortium also raised this issue when they gave evidence to the Criminal Justice Committee on 4 June 2025. Following this session they submitted additional evidence to the Committee which has been include in the call for views. This includes a list of relevant reports, policies and research. Some of the reports provided by both the UK NPM and the SRC are listed here are examples:

- Understanding Substance Use and the Wider Support Needs of Scotland's Prison Population (2022)
- Co-Occurring Substance Use and Mental Health Concerns in Scotland: A Review of the Literature and Evidence (2022)
- The Way Ahead: Recommendations to the Scottish Government from the Rapid Review of Co-Occurring Substance Use and Mental Health Conditions in Scotland (2022)
- Joint review of diversion from prosecution (2023)
- HMIPS Young People's Experience of Scottish Prisons (2024)
- Review…Recommend…Repeat… An assessment of where human rights have stalled in places of detention (2024)
- HMIPS Thematic Review of Prison-Based Social Work (2024)
- Audit Scotland Report on Drugs and Alcohol Services (2024)
- Recommendations made in HM Inspectorate of Prisons for Scotland (HMIPS) inspection reports: Publications | HMIPS.

Relevant policies highlighted by the SRC in their submission include:

- Medication Assisted Treatment (MAT) Standards (2021)
- Public Health Scotland Health and Justice Programme Strategy (2022)
- Scottish Government Mental Health and Wellbeing Strategy (2023)
- Scotland's Population Health Framework (2025–2035)
- Scotland's public service reform strategy: Delivering for Scotland (2025)
- What Works to Reduce Reoffending (2025).

Early intervention / Diversion

While the call for views focused on the harms caused by substance misuse in prisons, a number of respondents also provided information on how they thought that this issue needed to be considered at an earlier point – either in terms of addressing substance use more widely or diverting people from imprisonment.

> "However, it is important to say that tackling drug harm that happens in prison is also about breaking down the barriers people face outside of prison, either upon leaving prison or before they even present to the justice system. As one family member said: "We need to change the systemic issues which are making people get into drugs. We need to see drug use as a symptom of the root cause"." (Scottish Families Affected by Alcohol and Drugs (SFAAD))

In terms of diverting people from prison this was spoken about in general terms of simply reducing the number of people who are imprisoned as well as considering specific aspects such as diversion, supervised bail, the use of drug and alcohol courts and Drug Treatment and Testing Orders (DTTOs), and reducing short-term sentences and remand, where community-based alternatives to support people exist. The Criminal Justice Voluntary Sector Forum (CJVSF) gave examples of Barnardo's Court screening support service in South Ayrshire and Structured Deferred Sentences.

Turning Point Scotland and the CJVSF raised the issue of prison not being the right place to address the complex drivers of drug use, and that instead there should be a focus on community alternatives. However, Turning Point noted that the budget for their 218 service (offering an alternative to custody) was cut by around 50%, and they decided not to bid for the tender following this. In their submission they ask "why – when we know punishment does not work, when we know that services like 218 are cheaper and more effective – are we not diverting funds to these and similar services?"

The CJVSF highlighted the Scottish Government review of community sentencing options for people with substance use problems which found there was a gap between the number of people recommended for community-based treatment orders by social workers and those that actually received them. They also highlighted tensions between the principles of recovery and treatment and the criminal justice system's focus on compliance and enforcement.

The UK NPM highlighted the 2023 Joint review of diversion from prosecution which encouraged increasing diversion from prosecution in relation to substance misuse, in keeping with it being addressed as a health issue under a human rights-based approach.

How drugs and other substances get into prisons

While this section of the call for views focuses on the supply of substances into, and around, prisons, a number of respondents highlighted the link between this supply and demand within a prison. The following are some of these responses:

> "If there is demand for drugs, then someone will meet that demand." (Individual respondent with professional experience)
>
> "There are three main areas which must be acted upon to fully address substance misuse in prisons and help people in recovery: supply reduction, demand reduction and harm reduction. The approach must be balanced in the prison context. Too much attention on supply reduction misses critical systemic issues about why people use illicit substances in prisons and potentially diverts resources from people and activities into hardware." (UK NPM)

What drugs are being found in prisons

In terms of being able to assess what types of drugs are being found in prisons, the Leverhulme Research Centre for Forensic Science at the University of Dundee test drugs samples from non-judicial seizures across all SPS establishments. They noted in their submission that:

- Synthetic Cannabinoid Receptor Agonists (SCRA) (commonly known as 'spice') have been the most commonly detected compound throughout the project, accounting for 51% of all positive samples (1346 out of 2632).
- Benzodiazepines are the next most commonly detected compounds in the SPS project, accounting for 22% of all positive samples (587 out of 2632).
- Opiates/opioids have been detected in 5% of positive samples (142 out of 2632) cocaine in 3% (126 out of 2632) and steroids in 4% (111 out of 2632).
- In this project, nitazenes have been detected in mixtures with synthetic cannabinoids (n= 6) and benzodiazepines (n= 5). There have been no detections of nitazenes in the project since 2022.
- In the first year of the project (2019), positive samples consisted predominantly of paper and card (84 %) and this trend continued throughout 2020 and 2021. Following the introduction of the photocopying of mail in November 2021 this changed. E-cigarettes are currently the most detected positive sample format (59%), followed by powders/waxy substances (33%).
- In late 2024, HMP Perth installed secure window grilles and as a result reported no drone breaches following their installation.
- The Centre provides sustained technical and analytical support to the Scottish Prisons Rapiscan User Network, a collaborative group that meets monthly.
- The Centre is working in partnership with SPS to develop a standardised fast-track sample submission form, designed to enable efficient prioritisation and processing of high-importance cases, for example when someone has been hospitalised.

Illegal drugs

Respondents spoke of a number of different ways in which drugs were entering prisons. This included the use of drones, being thrown over the walls and substances being introduced by visitors, prison staff, health staff, contractors or people in prison themselves on their return to prison (e.g. from a previous release, court, hospital visit or work placement). The influence of organised crime was mentioned by some respondents, including their targeting of vulnerable prisoners or staff.

Respondents stated that substances could be soaked into paper, hidden in books and that clothing and shoes could be impregnated to conceal substances. SPS has introduced measures to tackle these methods by photocopying all mail which enters the prison (except legal correspondence) and washing all clothes that are sent in before they are given to the person in prison.

The increase in synthetic drugs and the increased use of vapes, as outlined in the Leverhulme Centre's response above, were also highlighted by respondents.

In terms of synthetic drugs, it was noted that compared to less potent substances a much smaller amount is required to produce a much larger number of doses. The Royal Pharmaceutical Society (RPS) also raised the issue that sniffer dogs are not always able to detect novel substances as they are not trained to detect these, and that there is also risk to harm from the dogs in detecting particularly potent synthetic opioids. Technology can also be limited in that new and emerging drugs are not part of routine testing and can go undetected.

Glasgow City ADP noted the impact of the introduction of vapes, allowing the development of different drugs specifically to be smoked in these as this was easier to conceal. The RPS also stated that drugs are increasingly smuggled into prison using vaping devices and e-liquids and that detection of these are difficult because "there are no effective in-field detection tools for e-liquids". They note that "immunoassay and ion scanners would presumably work" but that these are limited for synthetic cannabinoids and are more effective for known drugs.

Prevention

Glasgow City ADP noted in their response that the greatest impact on preventing drugs entering prisons came from:

- SPS dog handlers
- searching informed by intelligence
- SPS drone in use.

Though they also stated that with only one set of police drone equipment to track and prevent drones entering the estate this reduced its effectiveness.

The use of window grilles was also mentioned as having an impact, as was the use of searches. However, in terms of searches of SPS staff, Glasgow City ADP noted there was an issue with this as it was carried out by their SPS colleagues and that

there was “a perception that staff are reluctant to subject their colleagues within SPS to the same level of scrutiny as health staff or external contractors”. They recommend that searches are carried out by independent, external staff.

The use of technology (e.g. drone jamming equipment) was mentioned by other respondents as a way of tackling drugs entering prisons, as was the need to ensure staff receive regular training and regularly use the technology that is currently in place. The UK NPM also mentioned the role of Rapiscan machines and other scanners in preventing contraband entering establishments.

In terms of what more could be done to tackle drug smuggling into prisons, someone with experience of working in a prison stated the following:

> “Closed visits. Isolating new admissions for a significant period before “allowing them to mix with the general population to discourage smuggling.”

A respondent with experience of a family member’s imprisonment and of working in prisons themselves stated that:

> “Desperate people will always find methods to use and access drugs. By putting grills on windows will reduce drones, but increase pressure on visitors and family members or more importantly staff being pressured.”

In terms of family members, someone with experience of a family member’s imprisonment felt that there was too much of a focus on visitors and the risk from them rather than on staff and the potential for them to introduce substances into the prison.

Some respondents focused on staff when asked about what more could be done to make it more difficult to introduce substances into prisons, including in terms of “building trust and support” for staff who may have been approached or are involved in bringing drugs into prisons, as well as in terms of staff vetting, testing and searching.

The CJVSF also highlighted the need for an evidence base to any responses put in place to prevent drugs entering prisons stating:

> “They [their members] also emphasised that it is essential that robust evidence is the basis of any effective policy and operational responses to preventing and interrupt drugs from entering prisons in Scotland, rather than preconceived assumptions that can contribute to further stigma.”

The need for data was something the UK NPM mentioned in their response, recommending improved data collection on how drugs enter prisons, including transparency around the efficacy of scanners, searches, and other measures.

In the submission by an individual respondent with professional experience they highlighted some technological advancements that have been introduced in Australian prisons including:

- electronic prisoner mail

- direct credits to prison trust accounts where prisoners' family members and associates have to register to send money to a prisoner and confirm their identity and register a bank account.

Security vs human rights

The UK NPM stated that there required to be a balance between security and human rights when trying to prevent illicit substances being smuggled into prisons.

> "One concern we have in current practice is that in prisons with equipment [such as Rapiscan scanners], which can detect illicit substances, negating the need for routine strip searching, prisoners are nonetheless routinely searched after being scanned by the equipment. We believe this may breach these individuals' rights to privacy as well as their dignity, and the impact of this is both reduced trust and sense of safety, as well as wasted time that could be put to better use."

Prescription drugs

The RPS raised the issue of prescription medicines in prisons stating:

> "There is also the "legitimate" supply chain of prescription medicines such as gabapentinoids and benzodiazepines, where people in prison may use some and sell the rest. Diversion of prescription medicines is a potential issue and there needs to be an awareness and education of healthcare professions in general."

They also noted that people in prison were able to use everyday toiletries and household items to produce products with psychoactive effects or that enhances the effects of another drug, therefore not requiring any 'illegal' substances to be brought into the prison.

Alcohol

While most of the focus of the questions, and responses, in the call for views were on drugs, Scottish Health Action on Alcohol Problems (SHAAP) did highlight that given this over-shadowing of alcohol by a focus on drugs and a lack of available literature on alcohol use in prisons that "it is difficult to state with confidence how alcohol enters or is produced in prisons". Though the Scottish Prison Service's Prison Survey 2024 did show that 17% of respondents reported having consumed illicit alcohol during their time in prison.

The RPS did include information about alcohol in their submission stating that "through fermentation of bread and grapes for example, people in prison are able to produce alcohol which can enhance the effects of other prescribed medication and non-prescribed substances".

Impact of drugs and other substances in prison

Why people use substances in prison?

A number of respondents noted that boredom was a significant reason people used substances in prison:

> "A lot of prisoners state their use starts or escalates through boredom." (Individual with experience of working in a prison)

> "The issue of boredom is misunderstood – as to how pervasive boredom is on your health. Not being able to provide constructive, meaningful activity to help people be well – that's what's underestimated in the prison system… This should be about enabling people to remain well, to build up better resilience while being in prison, and to cope better upon leaving prison" (SFAAD)

Other aspects which were mentioned as reasons for using substances in prison included:

- the prison environment and difficulty adjusting to it
- overcrowding/overpopulation
- trauma
- mental health
- isolation
- withdrawal
- peer pressure
- limited health services and rehabilitation opportunities.

SFAAD's response drew on the experiences of those with experience of a family member's imprisonment where there was substance use:

> "Some people get into prison and they don't have an addiction but they have one when they come out, because they can't cope."

> "When you think about people who are continuing to reoffend and are in and out of prison for years, you can imagine the state they're in when they're in prison. So naturally, they're going to be doing something to escape that feeling for a period of time."

Impact of substance use in prisons on prisoners and the prison

Health

Respondents set out a range of health impacts from substance use in prisons. They advised that the use of drugs, particularly synthetic substances, could result in overdoses, psychosis, psychotic episodes, increased suicide ideation, seizures, cardiac arrest, erratic and violent behaviour, serious respiratory effects, blood borne

virus transmission and can exacerbate or cause a deterioration in existing mental health issues. The risk of suicide and death from drug use was also mentioned.

Camarus (a pharmaceutical company working to improve outcomes in opioid dependence) stated that the "risks are amplified when synthetic opioids are involved" and that this was "particularly in unregulated environments with inconsistent access to care such as prison". One individual respondent with experience of working in a prison stated that as there was no nursing provision overnight that this meant that patients could not be reviewed, and even during the day, there were "multiple emergency situations" with "limited nursing/healthcare resource".

Other respondents (including an individual with experience of working in a prison and Change Grow Live) also highlighted the increased risk where synthetic drugs are being used in terms of people being unsure what they were taking and that the strength and potency of synthetic drugs can differ significantly between batches. They noted the long and short-term effects of these substances are unknown, with Change Grow Live stating that the "risk profile is greater than with traditional drugs" with "urgent improvements to harm reduction, training, surveillance, and clinical response capacity are needed to mitigate this evolving threat".

In terms of mental health specifically, substance use and mental health problems were noted to reinforce each other, which "can lead to disengagement from treatment and support services, worsening symptoms, and increased risk of harm" (Camarus). They went on to note the importance of ensuring the MAT standards are implemented to address this. There is more information on the implementation of the MAT Standards in the relevant section below.

Stigma

While the stigma experienced by those who use substances is not directly related to their being in prison, it can be experienced in a specific way while in prison.

The SFAAD response noted that families they work with have said that having a history of drug use can lead to their loved ones being labelled as having "drug-seeking behaviours" and that this can impact on how they are spoken to or what kinds of treatment they can access. They spoke about this sometimes resulting in them not being taken to activities or groups, "saying things like he's not going in there, cos he takes drugs".

The family members also spoke of how the stigma that is already in communities manifests when in a "microenvironment like prison, where they are building their own hierarchies, that stigma is multiplied, and you see how it affects people in prison and their family members".

The Royal Pharmaceutical Society (RPS) advised that stigma can present a significant barrier to seeking help. This can come from "avoid[ing] seeking support or disclosing drug use due to concerns about extended incarceration or punitive responses". They stated this can contribute to the use of new psychoactive substances which are not typically included in routine drug screening and therefore it is easier to evade detection. When released they note the stigma of being an "ex-prisoner" may then make individuals reluctant to engage with treatment services.

Drug debts / exploitation

A number of respondents raised the issue of substance use in prisons on the issue of drug debts and exploitation:

> "One of the main issues with drug use in prison is drug debts. Prisoners can incur a significant debt from using drugs in prison and failure to pay can result in violence and intimidation of prisoner's family on the outside." (Individual with experience of working in a prison)

A respondent with experience of a family member's imprisonment noted that these debts could result in the risk of the person in prison being required to smuggle or hold drugs in their cells.

The further exploitation of people in prison was mentioned by an individual with experience of working in prison and Glasgow City ADP who raised the issue of vulnerable people in prison potentially being used to test drugs on in the prison.

Respondents also raised the issue of drug debts leading to bullying within the prison and Glasgow City ADP also raised the issue of this behaviour extending beyond the prison with families also being threatened as well as staff coercion.

The SFAAD responses highlighted the impact accumulating drugs debts can have on families stating:

> "The other thing to get drugs now, is the drug dealer gives their bank details, and the family member has to transfer money over to the bank account. Or if the dealer needs new trainers, well whoever owes them money needs to get their family members to send them trainers, and then they give them to the dealer. Then that's their debt paid. How come they [prison staff] don't ask about where the new trainers came from?"

Other impacts

Other impacts of substance use in prisons that were mentioned by respondents include:

- relationship breakdown with other prisoners, staff and family members causing isolation
- impact on progression and parole where drug use leads to rule breaches, extended time in custody of missed chances for parole and rehabilitative programmes
- the imposition of sanctions such as cell confinement and withdrawal of recreational access which can affect mental health and wider wellbeing as well as work towards rehabilitation and addressing the drivers of offending behaviour.

Impact of substance use in prisons on family members of people in prison

SFAAD and Families Outside provided responses which drew on information obtained from family members of people with substance use issues who had experienced imprisonment and staff who worked with these groups.

Both organisations highlighted that the separate experiences of a family member's substance use or imprisonment can affect family members physically, mentally and financially and impact on family dynamics. When they are combined, however, these impacts can be compounded.

The impact on families was also mentioned by an individual respondent with experience of a family member's imprisonment as well as working in prison. They noted the emotional toll that families could face, including shame, guilt and worry for the person in prison and the impacts on relationships through broken trust or feelings of abandonment by children.

The main impacts on families raised in the responses are set out below:

Contact

Restrictions around contact and communication with a family member in prison can add to mental health pressures, financial difficulties and make it more difficult for families to set boundaries and protect themselves in ways that they can when someone is in the community.

> "It's different than when the person is out and about in the community and you can see them […] The lack of information, not knowing whether your loved one is safe or not, not knowing if you can trust what they're telling you on the phone. It's very terrifying for families. Finally after managing to live your life and lessen the impact your loved one's substance use has on the family, suddenly you go back to step one. When they ask you for money on the phone in prison, you can't see them, so you don't know what's going on. We have some families that spend their salaries in a month and they say 'They're asking me for money for this and that and I don't know what's going on'." (SFAAD)

Families Outside noted instances where visits (including children's visits) have been cancelled, in effect, as a punishment for substance misuse. These visits can be cancelled at the point the family has already attended at the prison, with no explanation given. As well as the distress this causes to families it also has cost implications.

Families Outside advised that the 'privilege' of children's visits has also been removed for some families that they work with, for up to a month at a time. This was felt to be punishing the child, despite the incorporation of the UNCRC which means that adult criminal justice agencies are now required to uphold the rights of children with a parent in the system, ensuring their best interests are considered and their voices heard in all decisions affecting them, directly or indirectly.

Families Outside also advised that families are impacted during the visits process where they feel that there is a strong assumption that families who visit are a key way of drugs entering the prison. They stated there is a "security theatre" approach when it comes to substance misuse in prisons creating a negative experience for families and their connections with their loved one in prison.

Lack of information

The lack of information for families, particularly in terms of someone's wellbeing in prison, and help to navigate the prison system was mentioned in the SFAAD response as something that needed to be addressed. This will apply to family members of people in prison more generally, though may have specific aspects related to substance use in terms of concerns around safety and wellbeing. SFAAD mentioned the need for consistency in provision of information across the estate.

Financial impact

In terms of the financial impact on families, Families Outside noted that through their direct work with families they are aware that "families can feel coerced or be blackmailed into sending money to the person in prison or to unknown bank accounts". The family members do not know whether this money is being used for drugs. Families Outside also advised of instances where items that are posted in to the prison do not get passed on to family members where it is said that drugs are detected on the item (including items sent directly from retailers), but no further information is received and family members can be financially affected by this.

Impact at release

Families can also be impacted at the point of release with Families Outside highlighting the emotional, financial and practical support that can be provided by families on someone's release. Where substance misuse is an issue, they note that this can bring additional responsibilities for families at this point.

Stigma

Families in the SFAAD and Families Outside responses spoke of their experiences of stigma, noting that substance use itself is already highly stigmatised but that where someone is also in prison this creates a "double stigma". One SFAAD staff member stated:

> "Some of the families we are supporting talk about that double stigma, if their loved one is caught up in addiction but also in prison. There's that sense of hopelessness, and even at times they come along to our support groups, and they feel very supported and like they can talk openly about the addiction. But sometimes it's talking about imprisonment where they feel they might be holding back a little bit because they feel like the others don't relate."

As noted in further detail in the section above, Families Outside report that families can feel stigmatised at visits where there is an assumption that they are bringing in drugs. They state that they often hear from families that stigma acts as the biggest

barrier to families seeking and accessing support when a member is in prison and that substance misuse also carries significant stigma.

Families Outside went on to note that where families experience stigma and discrimination in interactions with prison staff this can pose a barrier to them accessing support for the family member in prison. For example, where someone may have concerns about a love one's mental health and wellbeing or substance misuse they may be reluctant to call the SPS Concern Line because they do not want their family member to get into trouble, they do not trust that the prison will respond appropriately or they worry their family member will be angry about the consequences/observations. They stated that there has been a lack of appropriate implementation of the Concern Line and there are inconsistencies in delivery across the estate.

Impact of substance use in prisons on prison staff

While most of the responses focused on the health risks to the person in prison, the risk to the health of staff was also mentioned, with staff being exposed to drugs and becoming unwell. Glasgow City ADP highlighted the impacts on healthcare teams specifically, stating:

> "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."

An individual with experience of working in a prison noted that the working conditions for healthcare staff "can be both physically, mentally and emotionally exhausting". They also highlighted the high risk on inhaling substances and that "contingency planning to allow NHS staff to work/administer medication away from direct prisoner areas to reduce the risk of inhaling substances" was needed.

Impact of substance use in prisons on prison safety

When asked about the impact of substance use in prisons on safety, a number of respondents mentioned the risk of violence due to drug use, particularly synthetic drugs. This could see people become violent with other prisoners, prison staff and those working with other agencies in the prison. The UK NPM highlighted that prison overcrowding can intensify the risk for prisoners and staff.

An individual with experience of a family member's imprisonment and working in a prison, stated in their response that "prison is currently not safe for staff or prisoners". They went on to state:

> "The shift in drug trends means those actively using are not in control of their behaviours and these drugs tend to heighten anger in men and women and they become aggressive. The number of overdoses has also increased meaning those sharing cells are witnessing trauma every day."

The RPS noted that certain substances, particularly synthetic cannabinoids and cathinone analogues, are "strongly associated with heightened aggression, disinhibition and episodes of extreme violence" and that "individuals under the influence of these drugs may exhibit erratic and uncontrollable behaviour".

Respondents mentioned the fact this made prisons harder to manage and that doing so took time and resources. An individual respondent, with experience of a family member's imprisonment, stated:

> "It takes away resources from rehabilitation, education and training that's needed for life after sentence is completed and the staff needed for that."

In terms of safety for prison staff, some respondents raised the issue of potential increases in approaches from organised crime groups due to the levels of substance use in prisons.

Respondents also thought about safety more widely than just physical safety. Turning Point Scotland and the CJVSF spoke about how the prevalence of drugs and alcohol could "create an unsafe setting for people who are working to remain abstinent". Turning Point Scotland went on to state that this highlights "the importance of pathways into substance-free areas for those who wish to access them" and "demonstrates how prison is rarely the best environment to achieve the aims of recovery, rehabilitation, and preparing for a life away from offending on release".

Rehabilitation and support for people using drugs in prison

When considering how to reduce substance use in prison, Change Grow Live stated that "reducing drug use isn't simply about reducing access – it's about increasing access to effective support".

The Correctional Service of Canada in their submission highlighted the four pillars in the Canadian drug and substances strategy which are prevention, treatment, harm reduction and enforcement.

The RPS also highlighted that it is not enough that supports and services are there, but that there must be clear information available to people in prison about how to access the support that is in place.

The questions in this section of the call for views asked about:

- what support people who had experienced substance use in prison had received
- how easy it is to access help for substance use in prison and if that support is working well
- what extra support or action could help make prisons safer and reduce the harm caused by substances.

Specific questions were also asked about the role medication or harm reduction approaches could play, how mental health and addiction services could work better together and about the implementation of the MAT Standards in prisons.

Many of the responses focused on the barriers to being able to do the work that was needed and what could be done to improve things. One family member who responded as part of the SFAAD submission felt that some progress had been reversed as a result of COVID-19, with cuts to courses and opportunities not being reinstated, long waiting lists, referral processing times, staff shortages and programme changes due to COVID still in place.

This section of the report is set out under the following themes and sets out the issues or barriers and what needs to be done:

- Workforce and resources
- Purposeful activity
- Addiction services
- Recovery / peer-led models
- Medication
- Harm reduction
- Mental health
- MAT Standards
- Prison culture
- Inconsistency
- Short-term / Remand prisoners
- Alcohol
- Other issues.

Lived experience

When considering what improvements can be made to the support provided in prisons, and in the section below on support after release from prison, some respondents highlighted that residents in prison and those with lived experience must play a role in any discussions.

> "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." (Glasgow City ADP)

An individual with experience of a family member's imprisonment as well as working in prisons also stated that "lived experience voices are rarely placed at the centre of policy and practice, despite their unique ability to connect and inspire change".

Data / Monitoring

The UK NPM raised the issue of the lack of data that is available in terms of understanding the harms caused by substance use in prisons. They highlighted that the Ministry of Justice publishes Safety in custody: quarterly update" for England and Wales and said if a similar set of data existed in Scotland and included information relating to the use of drugs, drug finds and other relevant data that this would be valuable information.

Workforce and resources

Issues raised around the workforce and resources applied to resources in terms of staff and space within the prison, with the issues around workforce relating to SPS, NHS and the third sector. It went beyond simply the need for greater numbers of staff, with one respondent (Penal Reform Solutions) raising the issue that people must feel safe enough to access the support even where it is available and accessible.

The following, however, illustrate the issues caused where there are insufficient staff:

> "Some people don't get out at all, especially if they're short-staffed. If a prisoner needs to go somewhere, and there's not an officer there to take them, it's because they're short staffed. So say a prisoner has an appointment with a worker, if there's not a member of staff there to take him, then he doesn't get to see them." (SFAAD)

> "Staffing resource is stretched within SPS and NHS PHC [prison healthcare]. 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 […] 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." (Glasgow City ADP)

> "…access to specialist addictions nurses can vary across the prison estate, with challenges in recruitment and retention." (RPS)

SFAAD went on to note, however, that developing a workforce that knows how to support people through complex and traumatic situations "requires more than just hiring more prison officers and training them to undertake an increasingly complex set of issues".

To deliver long-term, holistic support, there was said to be a need to resource professionals and organisations that provide this, with one person who contributed to the SFAAD response stating:

> "This is a workforce development issue, and I don't think we should expect prison officers to work with that level of complexity – within their remit and along with other things. So this is a resourcing issue. … This is about skill, people's wisdom of experience, and their commitment."

SFAAD noted that the expectation should not be on prison officers or NHS staff to deliver therapeutic work around mental health and substance use and that instead this type of support is coming from third sector organisations or faith groups, and that this needs to be better funded.

Turning Point Scotland also raised the issue of resources in terms of requiring there to be a "genuine commitment" to the SPS Alcohol and Drug Recovery Strategy 2024-2034 and "investment to implement it properly". The RPS also mentioned the Strategy, noting that it "makes a significant shift towards a public health and human-rights based approach". They went on to state, however, that "while the strategy is ambitious and well-intentioned, several issues affect its effectiveness". These include, the high prevalence of substance use in prisons, the rise of potent synthetic substances, a lack of data on substance use and treatment outcomes in prisons and concerns about whether staff in prisons are adequately equipped to deliver trauma-informed and compassionate care.

In terms of resources and funding for the third sector in particular, CJVSF members spoke of the "opportunities to scale up person-centred and effective third sector support within prisons, but that it is challenging to raise funding to deliver programmes in prisons as some traditional independent funders will not fund prison work. The members believed that the Government should fund the work taking place in prisons.

The Royal College of General Practitioners (Scotland) (RCGPS) also raised their concern at the high turnover of GPs and other healthcare professionals in prisons as well as persistent workforce shortages.

Purposeful activity

Many respondents mentioned the importance of purposeful activity as a way of reducing substance use in prison through tackling the boredom that can be a significant factor in people's decision making around taking substances (as set out above). This included education, training opportunities and exercise, improved family visits and communication with family, as well as access to modern technology to occupy people.

> "To prevent drug use from taking hold or escalating, it is essential that prisons offer structured, purposeful activity – such as education, training, and exercise – alongside accessible and effective drug treatment services, including both pharmacological and psychosocial interventions." (Change Grow Live)

> "Having meaning and engaging with things that are purposeful is very important for [people in prison]. But that's one of the hardest things to provide, because they've got reduced hours now where they can engage with activities and often there's not enough staff." (SFAAD)

> "This prison's routine allows prisoners to vegetate behind their doors and destroys their mental health, forcing prisoners to self-medicate to manage mood and emotions." (UK NPM – Respondent to HMIPS pre-inspection survey, 2024 HMP Grampian)

Turning Point Scotland set out Prisoner Survey 2024 findings that showed that 15% of people reported that they had not left their cell for at least an hour the day before because no activities were offered. More than a quarter of survey respondents said that work or education activities they signed up for were cancelled or cut short at least once a week.

The Prisoner Survey 2024 found almost 70% of survey respondents reported they were 'rarely' or 'never' offered activities in the evenings such as recovery groups, hobbies or exercise. Glasgow City ADP raised the issue of lack of staff and the 35-hour reduced working week for SPS staff which was having an impact on lock-up times, which could be from 4.30pm to 7am at weekends.

An individual with experience of a family member's imprisonment and of working in a prison, called for there to be minimum regime standards guaranteed and to legislate for a minimum time out-of-cell and access to purposeful activity, with HMIPS monitoring.

Addiction services

While some of the sections below have looked at specific addiction services, the UK NPM response provided some data in terms of addiction services generally highlighting the issues with the accessibility and quality of healthcare in prisons. This data came from HMIPS pre-inspection surveys between 2022 and 2025:

- More prisoners found it quite difficult or very difficult to access additions services in prison (31.5%) as compared to very easy or quite easy (28.4%).
- More prisoners rated the quality of addiction services very good or quite good (27.8%) as compared to quite bad or very bad (25.9%).
- 31.6% of prisoners with a self-declared need for support for drug use said they had not received this support since arriving in prison; Of the remaining 68.6% who had received support, with two-thirds said the support was helpful.
- 44.7% of prisoners with a self-declared need for support for alcohol use said they had not received this support since arriving in prison; Of the remaining 55.3% who had received support, with two-thirds also said the support was helpful.

The UK NPM also highlighted the human rights-based obligations on the Scottish Government to ensure that these treatment and support services for those with

substance use issues in prison are provided consistently and on an equivalent basis to community-based services, with a continuity of care on transfer or release from prison.

Recovery groups / Peer-led models

In the additional evidence document submitted by the SRC after their evidence session with the Criminal Justice Committee, they set out for each prison across the estate what is working well, an overview of the recovery activity taking place in each prison and areas for development.

In this additional evidence they noted that many prisons how have dedicated recovery officers, recovery hubs and peer-led activities. Though went on to say that provision varies across establishments due to staffing shortages, operational pressures and geographic isolation (especially in rural prisons).

The importance of these recovery groups and specific recovery areas, as well as having increased access to these supports, were mentioned by a number of respondents.

> “Dedicated recovery areas in prison settings would allow prisoners the opportunity to engage in meaningful recovery support and would aid the reduction of drug use in prisons.” (Individual with experience of working in a prison)
>
> "Each wing should have their own group work done on their own wing. (Individual with experience of a family member’s imprisonment)
>
> “Where possible, psychosocial support should be accompanied by dedicated recovery spaces which can enable people to engage with drug and alcohol treatment and recovery service services.” (Change Grow Live)

The importance of peer-led recovery models was also mentioned by the RPS who stated that this should be promoted and CJVSF members who stated that “one of the powerful ways to reduce harms from problematic substance use is to prioritise and embed lived experience and recovery support within prison life and on release”.

The SRC and CJVSF members also noted the importance of these recovery and peer-led support activities being available during weekends, evenings and public holidays to meet the realities of what people need and the vulnerabilities and risks that are particularly present at these times.

The CJVSF highlighted examples of good practice in this area in HMPs Low Moss and Grampian and the Community Custody Units, however, noted inconsistency across the prison estate and differences in prioritisation between prisons. The SRC also set out examples of good practice being in place across the prison estate that saw a strong peer-led culture (including the return on placement of residents in HMP Castle Huntly) and staff engagement, integrated recovery hubs, active community partnerships and innovative approaches being used.

The CJVSF and SRC set out the following barriers to this type of provision, including:

- geography, where less recovery services are available in rural areas
- limited peer-led activity in some prisons and residential areas
- challenges for third sector partners getting access to people and appropriate spaces in prisons for recovery activities – recovery hubs are often shared with other departments and this can limit access
- inconsistent provision of staff roles such as recovery officers
- prison staff “buy in”, awareness and training in terms of the recovery model and recovery principles
- disincentives for attending recovery sessions (e.g. wage deductions)
- barriers to accessing community recovery support post-release, particularly where someone is from outside of the local area covered by the prison.
- recovery being treated in a silo, where NHS teams do not always communicate well with recovery teams.

CJVSF members noted that one of the most effective ways to embed recovery in prisons is to increase the availability and accessibility of employability and training pathways for people in prison to provide recovery support.

The Correctional Service Canada’s submission and the linked documents they included noted that “a recovery orientation recognizes that recovery is a non-linear process, and as such, individuals receiving opioid agonist therapy (OAT) are not "fired" or penalized for not achieving treatment goals or for relapsing to substance use”.

Medication

The call for views specifically asked respondents for their views on what treatment with medication should look like in prisons.

Firstly, respondents mentioned that people should be provided with any medication they require swiftly after their admission to the prison. One respondent with experience of working in a prison noted that having a fast-track process so that people could be seen and assessed for opioid substitution therapy (OST) quickly could reduce illicit substance use.

In terms of accessing medication while in prison, most respondents who answered the relevant questions in this section believed that medication should be available to those in prison with issues around substance misuse. Although one individual with experience of imprisonment and who advised they were a recovering addict did not agree that methadone should be available.

In terms of illustrating the importance of OST, the RCGP noted that evidence suggests that the introduction of OST in prisons in Scotland has contributed to a significant reduction (by approximately two-fifths) in drug-related deaths in the 12 weeks following release. They also noted that, while causality cannot be definitively established, that the study also found that people receiving OST in custody “experienced a marked reduction in the risk of in-prison mortality”.

Most respondents, however, highlighted the importance of OST as part of a range of supports that are available. Some highlighted the need to provide psychosocial support as well as 'pharmacological therapies' (e.g. methadone and buprenorphine). Some raised concerns about over-prescribing in prison without also providing well-rounded support.

> "We regularly see guys coming out with prescriptions that they weren't on before, and to be honest, some of them shouldn't even be on a script considering the substances they're using. For example, it's not an opiate, but they're still coming out on a methadone prescription. I'm worried people are too quick to prescribe, rather than therapeutic work." (SFAAD discussion group member)

> "While access to treatment, such as OST, is a crucial part of support, it forms just one part of a holistic, wraparound approach to care for those with support needs. Other forms of support are critical to deliver alongside, such as trauma-informed mental health support, peer-led support, and psychosocial interventions. (Camarus)

Documents included with the Correctional Service Canada's submission note that "effective OAT incorporates physical and mental health care and harm reduction delivered in an integrated fashion (not provided sequentially)".

Some respondents specifically spoke about the use of Buvidal / buprenorphine, with an individual professional respondent stating it "should be explored further" and would "reduce the stigma of going to get daily methadone". The RCGPS stated a monthly injection could "mitigate[e] the potential risk of coercion to divert or misuse medication".

The RPS stated:

> "A long-acting buprenorphine formulation has driven significant transformation across Wales, with encouraging results and sustainable funding. While the uptake and evaluation in Scotland are ongoing, early clinical observations suggest that many patients are voluntarily transitioning from methadone or other oral/sublingual options to this buprenorphine formulation, as it helps stabilise their condition, reduce drug-seeking behaviours, and improve reintegration outcomes." (RPS)

Document links included with the Correctional Service Canada's submission noted that the Canadian Research Initiative in Substance Misuse (CRISM), National Guideline for the clinical management of opioid use disorder "strongly endorses opioid agonist treatment (OAT) with buprenorphine/naloxone or buprenorphine extended-release (Sublocade) as the preferred first-line treatment when possible".

Difficulties in getting certain medication in prison were included within the UK NPM submission, with a respondent to an HMIPS pre-inspection survey stating the following:

> "[Prison] doctors can't prescribe [a] certain medication I would get in the community … and had to self-medicate. In constant pain and can't get the

> medication I need, overdosed [several] times. If I were to get prescribed medication I need wouldn't have to take the risk of overdosing. No wonder people are risking their lives just to have a normal day." Respondent, 2024 HMP Grampian pre-inspection survey

While there are no medication treatments available for those using new psychoactive substances (NPS), the UK NPM highlighted that where there is a perception by people in prison that there are no treatments available for those who use NPS that this can result in people not disclosing their substance use at all.

Respondents also mentioned the need for continuity of care in terms of medication when someone is released in prison in this section of the call for views. This is covered in the section below on support after release from prison.

Harm reduction

In relation to harm reduction measures in prisons, the RCGPS noted the recommendations of the World Health Organization, the United Nations Office on Drugs and Crime, and UNAIDS, which "advocate for the implementation of harm reduction measures in prison settings as an essential public health intervention".

The UK NPM also highlighted that the Scottish Government has an obligation to protect people's right to life, and that this includes taking measures to increase the life expectancy of people who use drugs. Part of this involves providing adequate services on drug use prevention and harm reduction measures.

Education was mentioned by some respondents, with Glasgow City ADP stating that "more work is required to develop appropriate recovery supports and harm reduction messaging/interventions around the changing drug trends". This was in terms of the synthetic substances that are being smoked in vapes to allow people to make informed decisions and understand how to reduce risks. The RPS and an individual with experience of working in a prison stated there was a need to provide increased education on synthetic substances to people in prison with the latter stating this would "improve prisoners' knowledge, awareness and safety". Though Turning Point stated in their response that there was "effectively no safe way to take drugs like synthetic cannabinoids".

Related to education was Turning Point Scotland's mention of the delivery of brief interventions by qualified staff.

While the call for views mentioned needle provision as an example of a harm reduction measure, Glasgow City ADP stated that IV drug use is not a widespread issue within prisons currently. Another harm reduction measure that was mentioned by Turning Point Scotland was the provision of safer inhalation equipment with a respondent with experience of a family member's imprisonment saying that prisons should have "drug free wings".

A number of respondents mentioned the good practice of the provision of naloxone or Nyxoid to people on their release from prison. Glasgow City ADP highlighted that the Prison Harm Reduction Team in their area are providing around 50% of people with Nyxoid on their liberation from prison.

Turning Point Scotland stated in their submission that they would like to see a greater investment in harm reduction, noting that "there has been an over investment on medication at the expense of harm reduction – the problem being that we are not adequately addressing changing patterns of drug use (e.g. the rise in synthetic drugs)".

The need to do more harm reduction work was also mentioned by an SFAAD discussion group member who fed into their submission:

> "We have to be realistic – there are going to be drugs taken in there. We do harm reduction in the community. Why aren't we having more harm reduction workers in prisons? There are probably a lot of people who have spent the majority of their adult life in prison and have never had the opportunity to talk to somebody about harm reduction. It's about having the right workers and interventions to help people make informed choice, rather than doing what you've always done."

Mental health

The call for views specifically asked respondents how mental health and addiction support services could work better together in prisons.

The main themes within this section of the responses were the need for greater integration and joined up working between mental health and substance use services, rather than silo working. This was in recognition that the two remain "deeply interconnected" and that substances can be used to deal with trauma, anxiety or depression. Respondents also noted that access to these services is a right rather than a privilege.

In terms of the importance of having more integrated services, organisational respondents spoke about having multi-disciplinary teams and these being co-located (along with the required investment) and mental health and addiction services assessing someone together on their entry to the prison and that there should be one shared care plan.

Change Grow Live noted that mental health and substance use are often addressed separately in the prison system, that "individuals with co-occurring conditions can frequently fall between services" and "referral pathways can be unclear and responsibilities can be passed between teams". They stated that "governance and funding structures should reflect this integration, rather than commissioning services in silos".

Glasgow City ADP raised the issue that prison healthcare staff are not able to access the health IT systems used in the community which makes it difficult to get all the information they need to make an appropriate assessment of someone's mental health. They state that "all areas use different IT systems".

A respondent with experience of a family member's imprisonment noted the inconsistency across prisons and that in some you either get a drug worker or a mental health worker, but not both, going on to state that if you are in addiction "they see you as chasing something like drugs".

The SFAAD response also highlighted the stigma and judgement that can be displayed where substance misuse and mental ill-health co-occurs, as well as the lack of mental health services in prisons:

> "There's a lack of mental health services, that's my experience. My son has been in and out of prison for six years, and there's no mental health support. When you're using drugs and you go to speak to a mental nurse, you're just seen as having drug-seeking behaviours."

In terms of being able to work in this more integrated, joined up way, CJVSF members noted that there are a variety of policies, reviews and work underway that would offer opportunities to work in this way:

- National Drugs Mission Plan 2022-2026
- Scotland's Mental Health and Wellbeing Strategy
- Rights, respect and recovery: alcohol and drug treatment strategy
- SPS Mental Health and Alcohol and Drug Strategies
- Independent Review of the SPS suicide prevention strategy, Talk to Me (ongoing)
- Internal Review of The SPS Anti-Bullying Strategy, Think Twice
- National Trauma Transformation Programme.

The SFAAD response set out that families generally felt that substance misuse and mental health are misunderstood, and that recovery groups or other activities centred around wellbeing were treated as a privilege.

> "[My loved one] was supposed to be attending weekly mental health sessions, but he had had an altercation with someone else who was going to the same sessions, so they decided he was no longer allowed to attend sessions. They deemed it was a privilege and something they could take away from him. But it wasn't a privilege in my eyes, it was something needed to keep him alive!"

> "I totally agree there is a lack of person-centred training, but I also think there is a lack of policy directives to say that these sessions are not a privilege and that they are a fundamental part of the wellbeing of someone who is in prison, for whatever reason – we are not here to judge someone. That is a minimum for human rights […] Without these policies, training won't work to make sure people are actually following guidance."

Other issues

Other issues about the provision of mental health services in prison related to resourcing. Glasgow City ADP illustrated the current issues with resources in their response. Across the four prisons in their area there were 4,250 referrals to their team of 15 mental health nursing staff in the year up to 30 June 2025. These all require to be triaged. They stated that staff report these numbers to be "unmanageable with their current staffing resource", going on to state that "this

pressure exacerbates tensions within the team and delays access to mental health support and alcohol/drug supports".

While not specifically relating to delays in accessing mental health care, information included in the UK NPM submission from an HMIPS pre-inspection survey highlights the issue with delays in healthcare generally:

> "Healthcare in this prison is very bad and it can also take two-and-a-half to three months to see a doctor and then no help comes out of it." Respondent, 2024 HMP Barlinnie pre-inspection survey

A lack of trauma-informed working in prisons was also raised, with the Glasgow City ADP noting that where the SPS concentrate on numbers and cell allocations that this "is not trauma informed" with cell sharing significantly affecting individuals' wellbeing. An individual respondent, with experience of a family member's imprisonment and working in prisons, stated that "mental health and addiction services need to merge into a trauma-responsive model, where the person isn't passed back and forth but supported as a whole human being". Change Grow Live also stated that "substance use and poor mental health are often treated punitively rather than therapeutically in prisons" and that this can lead to disengagement with services.

The importance of ensuring there is trauma-informed care in place was also raised by an academic with experience of working in a prison who noted that in prison people can then face new traumatic experiences. With drug use serving as a coping strategy, they stated:

> "Without trauma-informed care, drugs may again become a powerful but harmful way to cope. This cycle underscores the importance of embedding trauma-informed approaches in both prison and community services, ensuring that treatment addresses not only the chemical dependency but also the underlying psychological wounds that drive vulnerability to relapse."

MAT Standards

Respondents were asked whether the MAT Standards were being fully implemented in prisons.

Generally, respondents were positive about the MAT Standards, though less so around their implementation One individual with experience of imprisonment and who advised that they were a recovered addict responded that the Standards were "enablement".

In terms of whether the MAT Standards were being fully implemented in prisons, one individual respondent with experience of imprisonment and another with experience of a family member's imprisonment responded "no", while another individual respondent, with experience of a family member's imprisonment and of working in a prison, stated "absolutely not".

They went on to state that "funding is not yet in place to support the SPS". The Glasgow City ADP also raised the issue of funding, stating:

> "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."

The RPS noted that "implementation of MAT standards in prisons has not progressed in parallel with the community due to the unique challenges in establishing these in a prison environment" and that it "has been inconsistent". Glasgow City ADP in their submission stated that healthcare teams in prison "require the resources, space and support to build confidence and competence to deliver the MAT standards".

One respondent with experience of working in a prison stated the MAT Standards have been implemented:

> "To the best of our ability with the limited resources we have."

The RPS provided an update on progress, stating:

> "A baseline data collection exercise of each of the prisons readiness for implementation has been undertaken and will be published. The MAT Standards Implementation Support Team for Prisons (MIST Prison) has been tasked by Scottish Government to progress implementation within prisons, with stakeholder groups convened to assist in delivery. HIS undertake the inspection of healthcare provision in prisons on behalf of His Majesty's Inspectorate of Prisons Scotland (HMIPS) and review the progress of its implementation as a core part of the inspection."

The formal benchmarking and reporting by Public Health Scotland of MAT Standards in justice settings will begin in 2026. The 2024/25 benchmarking report notes that work to date has focused on mapping, system development, and knowledge sharing, but has not yet progressed to full data reporting or systematic benchmarking across prison settings.

CJVSF members gave examples of where the MAT Standards are not currently being met:

- medication options in prisons are generally methadone or Buvidal
- people are taken off regular medication, including gabapentin, because they are seen as "commonly abused" medications but are not offered alternatives
- people being transferred where the same options are not available despite them doing well on a particular prescribed regime for medication assisted treatment.

Though the RPS also stated that some of their members have said that elements of the standards as drafted "are not applicable to the prison setting". They were put in place to mirror community practice but that "there isn't any clear description of what the 106 individual elements of MAT within the prisons look like".

RCGP Scotland noted in their response that the high turnover of GPs and other healthcare professional staff within the prison system "is hindering the effective

implementation of the MAT standards". They advised that strengthening links with local Health Board substance misuse teams, or integrating prison healthcare services with these teams, "may enhance the consistency and quality of MAT Standards delivery across the prison estate".

Prison culture

Prison culture, and the punitive response that can be taken to substance use in prisons, was mentioned by some respondents, most notably the CJVSF. CJVSF members stated that:

> "…for there to be meaningful change, there still needs to be significant transformation to the culture of the custodial environment. Whilst there are various programmes that seek to provide meaningful rehabilitative and recovery support, punitive custodial policies, practices and culture can come into direct conflict with the rehabilitative and trauma-informed aspirations."

SFAAD also mentioned prison culture in their response:

> "What you do clearly see is there are people [working in prisons] that are truly good people and invested in trying to make a difference, but sadly there are also a lot of people that are just turning up for a salary and not really invested in people. So then you have this kind of lottery where you have some very vulnerable people that will encounter that. It doesn't take much to undo [all of the good work being done] with someone who is dismissive. I think that's going to be a really hard culture to shift."

The CJVSF provided an example of where this punitive approach can be seen specifically under the SPS Management of an Offender at Risk due to Substance Use (MoRS) framework, and in particular the Under the Influence policy. They stated that an accusation from prison staff of substance use can result in a punitive response rather than an offer of support, where someone can be confined to their cell and have privileges such as visits and recreation removed. They noted that "rather than supporting people and addressing underlying causes, these punitive approaches can further isolate, criminalise and exacerbate harm".

The UK NPM also raised concerns with the MoRS policy in respect of whether it is being implemented effectively in the current conditions within prisons and issues with its application not being in line with SPS policy requirements. They noted their concerns had increased as the number of individuals being placed on MoRS has risen.

Camarus also stated that a barrier to seeking support was the "fear of punishment such as segregation and seclusion following disclosures of drug use". With the UK NPM stating that "a punitive approach to drug use can inhibit the building of trust and supportive relationships with staff which is crucial to recovery". An individual with experience of a family member's imprisonment and of working in prisons noted that "punishment doesn't make people stop using drugs, it only enhances their desire to use. I have 42 feedback answers on all of these questions and all men say the same thing".

The UK NPM and CJVSF members noted that a human rights and public health approach must be embedded into prisons, with “a growing body of legislation, policy and guidelines” to support this in Scotland being in place. They highlighted the Charter of Rights for People Affected by Substance Use (launched in December 2024) as something where there are opportunities for it to be implemented in justice settings to ensure people are aware of their rights and the support available to them.

The need to address the stigma around drug use and to treat it as a health rather than disciplinary concern was also raised to ensure that people feel they can seek support for substance misuse. RCGP Scotland noted that to do this involves “challenging the attitudes of some prison staff”.

Inconsistency

An issue mentioned by a number of respondents was the inconsistency of help across prisons in Scotland.

The response from SFAAD noted that there were examples of good practice and recent improvements but that these were not replicated across the estate. The RPS also noted that research has shown that access to help for substance use in Scottish prisons had improved but that it had also shown that “challenges remain in ensuring that support is both effective and consistently available”.

Change Grow Live stated that access to support for substance use in Scottish prisons “is inconsistent and varies significantly between establishments”. This is in terms of:

- timely access to OST and choices of pharmacological treatment, which can be limited by prescribing cost pressures
- 1:1 counselling, groupwork and trauma-informed care
- recovery cafes, mutual aid groups and peer-led models

The CJVSF stated in their response that there was inconsistent care and support geographically between prisons and local health boards and Alcohol and Drug Partnerships. Their members raised concerns regarding the “significant risks and impacts” arising from this lack of consistency.

The impact of this inconsistency can be felt particularly where someone is transferred between prisons meaning that “people have reported losing valuable recovery support altogether after being transferred to prisons where no such provision exists, leaving them without continuity of care at a critical time”. (Turning Point Scotland)

Short sentence / Remand

The specific experiences of short-term and remand prisoner was mentioned by a couple of respondents.

The SFAAD response noted the experiences of people with a family member in prison and their view that there is an unequal response across the population with

only “a small crowd” of people able to get therapeutic help, and that people on longer-term sentences are likely to be prioritised over those on short-term sentences.

> “It’s a revolving door, that’s what it’s like. My son has been in and out of prison for fifteen years, and the longest sentence he’s had in the fifteen years was the year he was on remand. The rest has been three-month sentences or six-month sentences. So the time he went in on the three-month sentences and made the referral, he was out in eight weeks and by the time he was out the referral hadn’t even been seen. … People with long-term sentences get priority over short-term, and short-term sentences go up to three years. So if your son or daughter is going in for short-term sentences like three to six months, there’s no chance of getting help.”

Change Grow Live also highlighted that with sentences of 12 months or less this “often is not enough time to deliver full and effective treatment and support”.

The SFAAD response also set out the views of family members in terms of those on remand:

> “I don’t believe that people that go in on remand should be locked up for 23 hours a day and let out for 1 hour.”

Alcohol

While many of the responses focused on the use of drugs, though some could be applicable to the use of any substance, SHAAP did highlight the specific requirements in terms of those with an alcohol misuse disorder.

They set out some of the data that they felt showed that there is a problem with addressing this issue:

- low levels of delivering Alcohol Brief Interventions in justice settings (29% in prison and 3% in police custody) compared to an assumed level of 63% of individuals in prison having an alcohol use disorder

- a fall in referrals to drug and alcohol specialist treatment in Scottish prisons from 1,047 in 2017/18 to 549 in 2021/22, and that only 4% of those eligible were referred to alcohol services in 2024

- unequal access to AA programmes across the prison estate.

SHAAP noted that in order to reduce the use of alcohol by people in prison that they must have access to “appropriate treatment and support at all stages of their contact with the justice system”.

They went on to state that:

> “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 […] 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 CJVSF also noted that, in relation to alcohol, their members raised concerns regarding "a lack of appropriate psychological and social support in detoxification on entry to prison, which comes with significant health and mental health risks".

SHAAP highlighted that in order to develop recovery pathways which reflected this specific population then the data gaps in relation to alcohol use identified in the recent Scottish Government substance use and wider support needs assessment needed to be addressed.

Turning Point Scotland also noted that they had anecdotal evidence that people who have been in prison have not been able to access Disulfiram (Antabuse), which has, in some cases, led people to turn to drugs instead.

Other

Other areas raised in terms of providing support for people using substances in prisons included:

- Banning vapes

Glasgow City ADP noted that this would reduce the harm caused by synthetic drugs being smoked but would have unintended consequences.

- Blood borne viruses (BBV)

RCGP Scotland stated that to reduce the harms associated with drug misuse requires addressing the disproportionately high prevalence of blood-borne viruses in the prison population. They noted that:

> "Public Health Scotland recommends opt-out BBV testing for all individuals entering custody, with annual testing for those serving sentences longer than 12 months. Immunisation against hepatitis B should also be considered as part of a comprehensive public health approach within the prison setting."

The UK NPM and Hepatitis C Trust also highlighted the importance of BBV screening on entry to prison and that this was followed by a "robust drug treatment programme" as well as education and training for prisoners and staff.

The Trust went on to note that:

> "We would also encourage healthcare staff to be allowed to work more proactively, such as visiting landings, rather than just expecting prison residents to schedule and make their own way to appointments."

The Hepatitis C Trust operate peer programmes across prisons in the rest of the UK and stated that they have begun conversations with HMP Edinburgh and would like to see their programme rolled out to more prisons in Scotland.

- Neurodivergence

An individual respondent with professional experience highlighted the issue of the overrepresentation of neurodivergent people in prison and the impact of this on substance use. They stated that where people were assessed for ADHD then an "appropriate pharmacological and psychotherapeutic treatment would be expected to lower illicit drug use amongst those identified as having ADHD". This would address the core ADHD symptoms of impulsivity and risk-taking which they noted make both the acquisition and use of illicit drugs more problematic and reduce the need to self-medicate where other appropriate supports were in place.

- GPs

The RCGP highlighted issues with the process of promptly identifying people with substance misuse issues on their entry to custody, stating:

> "GPs working in prison settings reported that clinics were often squeezed into short time frames amongst other competing scheduled and unscheduled tasks such as parole reports and medical emergencies. Longer consultations would allow GPs to better evaluate and support prisoners with substance misuse problems."

- Human rights

The UK NPM response noted that Scotland has binding human rights obligations to ensure dignity, humane treatment, and access to healthcare for those in custody and that these must underpin all responses to drugs in prison.

Good practice

Examples of good practice that were shared included:

- the introduction of Lead Nurse roles
- the expansion of multi-disciplinary teams
- the use of trauma-informed care and harm reduction services
- the Sycamore Tree Programme
- the Prison to Rehab Pathway
- giving people in prison the opportunity to attend Recovery Walks or events in the community
- the opening of Community Custody Units (such as the Bella Centre in Dundee and the Lilias Centre in Glasgow)
- naloxone training and provision of naloxone kits on release
- BBV testing.

While not an example of good practice that is already in place, the UK NPM highlighted some key suggestions made by Health Improvement Scotland (HIS) to address the challenges in healthcare delivery in prisons identified during HMIPS or HIS inspections:

- embedding healthcare into prison operational planning, including by protecting clinical time consistently across all prison
- prioritising scalable digital health solutions to reduce delays and improve access, including remote consultations, digital triage, or shared care records
- considering what a sustainable, resilient and equitable model of prison healthcare would look like, given the rising population, increasing complexity of needs, and operational constraints.

Support for family members

An individual with experience of a family member being in prison (though who does not use substances) spoke about having had no support to stay in contact while their family member was in prison.

In terms of more positive experiences, two respondents spoke about the importance of prison visitor centres, with Families Outside noting the importance of Family Contact Officers in the prisons, though stating that this support was not consistent across the estate.

Families Outside noted that families faced financial, geographical and logistical barriers to maintaining contact with someone in prison. This was generally rather than specifically with a focus on someone who also has substance misuse issues.

To address these barriers, they noted that the following is required:

- a review of the Help with Prison Visits Scheme, and additionally greater promotion and awareness of this scheme
- requirement for an assessment of the potential impact on family contact before someone is transferred to another prison for administrative reasons
- local consideration of public transport arrangements in relation to visits
- accessibility for prisons to be added to any future National Transport Strategy
- Community Justice Partnerships to add transport issues and accessibility to prisons to their agenda and plans
- an expansion of the Sacro prison visiting travel service or equivalent models.

SFAAD noted in their response that providing families with more information to help them navigate the prison system and know if their family member was safe would ease some of the impacts on them. They also highlighted that “families have a right to be involved in the decisions that affect them, however this is not their experience”.

Support after release from prison (throughcare and aftercare)

Biggest challenges

A number of respondents noted that the weeks immediately after release from prison are some of the most dangerous for people with a history of drug use. Social Work Scotland (SWS) pointed out that while some challenges can be the same for everyone across the prison population that different groups of people may have different needs, stating:

> "…the support needs of those serving short and long sentences are likely to be variable and needs to be taken into account when matching to services. Long term prisoners may be more institutionalised and may require focused support in order to reintegrate back into their community".

The top three challenges listed by respondents to the call for views were:

- housing
- continuity of care
- going back to the same community or peers on release.

Housing

A significant number of respondents mentioned the challenge of housing in terms of there being a lack of stable housing or someone being homeless on their release from prison. They noted that this could push people back into associating with people using illicit substances in the community, affect people's ability to access GPs and substance misuse support services, and negatively impact their ability to reintegrate back into the community and reduce the risks of reoffending and substance use.

> "It [housing] is a key protective factor in recovery, wider health and well-being, reintegration into the community and in reducing reoffending. Some of the highest risk contexts include people being released onto the streets, into a hostel, or into a boarding house, where people are faced with going straight back into a substance using community." (CJVSF)

> "Change Grow Live staff have reported that people often fail to attend community appointments after release, despite being frequently arranged ahead of time. This is particularly common in instances where people are discharged into homelessness or unstable accommodation." (Change Grow Live)

> "A lack of stable accommodation often results in individuals having no fixed address, which not only limits their access to healthcare but also makes it difficult for GPs and other healthcare professionals to maintain contact and offer ongoing support." (RCGPS)

SWS stated that “the implementation of the SHORE standards across all of Scotland would be meaningful” but that “the current shortage of affordable housing is concerning”.

Continuity of care

A number of respondents mentioned the issues around continuity of care when people with substance misuse issues are released from prison. This can relate to being able to access community substance use services, GP care or MAT prescribing, or the lack of a general bridge to the community. Respondents noted this could be down to a lack of services or the time taken to be able to access the services.

> “Change Grow Live staff also report that many prison leavers struggle to re-engage with community services. In some cases, they are unable to access GP care or MAT prescribing for days or even weeks.” (Change Grow Live)

> “Liberation Gap: Even when people do access some form of support inside, the bridge to community is broken. On release, they often face homelessness, unemployment, stigma, and the immediate temptation (or pressure) to return to substances. Without continuity of care, gains made inside collapse quickly." (Individual with experience of a family member’s imprisonment and working in a prison)

Going back to the same community and peers

Returning back to the same community with the same peers was mentioned by a number of respondents. An academic with experience of working in prisons noted that returning to the same environment can trigger craving and relapse due to neurobiological responses to being in the same local area with housing, people and places linked to previous use.

An individual with experience of a family member’s imprisonment and working in prisons also stated that:

> “Returning to the same neighbourhood often means returning to the same circles of friends, dealers, and triggers. Without strong support, it’s very hard to resist.”

Other challenges

A number of other challenges were mentioned by respondents, including:

- stigma / social exclusion

“Families, employers, and communities may not be ready to welcome someone back, especially if there’s a history of broken trust. Stigma makes it harder to seek help, get housing, or secure work, feeding the cycle of relapse.” (Individual with experience of a family member’s imprisonment and of working in a prison)

- finances

"Accessing benefits – people cannot submit a benefits claim in advance in preparation for their release. Rather they must wait until they have been liberated to the community before making a claim which places additional pressure on individuals with limited/no resources." (Adult Justice Services, City of Edinburgh Council)

"…having adequate personal identification to access benefits and open bank accounts" (CJVSF)

- accessing healthcare

"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." (Glasgow City ADP)

- appointment pressure / chaotic lifestyle

"Appointments pressures - people often have many issues they need to attend to on their day of release for example, securing housing and welfare benefits in addition to managing their healthcare needs. Attending numerous appointments in a short space of time can be overwhelming, particularly where an individual is navigating their rehabilitation without community support. Many services operate on an appointment only basis where motivation and willingness to engage are measured by appointment attendance; those arrangements place pressure on individuals who may struggle to cope, increasing their risk." (Adult Justice Services, City of Edinburgh Council)

- mental health / trauma
- loss of positive connections (from within prison – e.g. recovery cafes, education, supportive groups)
- unidentified drug dependency (developed while in prison)
- lack of access to throughcare support
- differences in geographic entitlement
- a variable availability of drug testing in the community, despite some people on statutory orders being required to undergo drug tests as a condition of their parole.

These challenges, along with a loss of tolerance or abstinence while in prison, can lead to an increased risk of overdose, relapse or reoffending on release. A number of the respondents highlighted these risks in their responses when talking about the challenges people face on leaving prison.

> "In clinical practice, it is not uncommon to encounter individuals who have undergone complete detoxification while in prison, only to relapse or overdose shortly after release—often after being offered substances at no cost on release as a "gift". This underscores the urgent need for targeted education, post-release support, and robust prevention strategies to safeguard individuals during reintegration. (RPS)

> "Early reentry stressors (housing, finances, family conflict, supervision demands) activate stress systems that heighten craving and impair self-control, compounding the impact of cues and contexts." (Academic with experience of working in a prison)
>
> "This discontinuity [in care] often results in relapse, overdose, or reoffending, especially when combined with housing instability or missed prescriptions." (Change Grow Live)

Are services working

In their response to the question of whether services are working, Camarus provided the following statistics which they stated "suggest considerable work is needed to improve provision":

- the risk of drug-related death is 7.5 times higher in the first fortnight after release than at other times at liberty
- 1 in 200 people released from prison with a history of heroin injection die from a drugs-related death within four weeks of leaving prison.

An individual with experience of imprisonment and who advised they were a recovered addict also stated in their response that it is not just a case of whether services are working but that people also need to be informed of the help that is available for them.

Some of the issues that were raised by respondents as to why services are not working include:

- Barriers to accessing services

These were noted to be practical barriers such as not having ID, a phone or digital access which can make "simple tasks like attending appointments or applying for benefits become major hurdles".

CJVSF members also noted challenges and barriers in terms of there being effective referral pathways for reintegration support in the community, for example, "not being referred to treatment in relation to alcohol, or patchy connections with the community within and across prisons."

- Unplanned release / Release on a Friday or Bank Holiday

Some respondents highlighted issues where there was an unplanned release and there was minimal time for planning or awareness by services, or where someone was released on a Friday or Bank Holiday where there was not the same access to health or support services.

In terms of Friday/Bank Holiday releases the CJVSF submission noted that the Prisoners (Control of Release) (Scotland) Act 2015 allows applications to bring forward a prisoner's release by up to 48 hours, however this only applies to limited cases. They have experience of applications being declined, despite, in one

example, the rationale being that it would enable the person to be admitted straight to their residential rehabilitation service.

The provision of the Bail and Release from Custody (Scotland) Act 2023 that would prevent prisoners not being released on certain days of the week has still not been brought into force.

- Implementation

Camarus noted that in terms of two positive initiatives in Scotland (the Sustainable Housing on Release for Everyone (SHORE) standards and Take Home Naloxone (THN) programme) there were issues with implementation.

They stated that for the THN programme "there are barriers in implementation both within prisons and on release in terms of uptake, operational factors, and engagement" with a significant variation in implementation across the prison estate.

In terms of housing, they provided figures that 49% of the Scottish prison population report losing their accommodation while in prison, with around 5% of the total homelessness applications (equivalent to over 1,800 individuals) being made by prison leavers in 2018-19. They stated that implementation of the SHORE standards is "seen as far from complete".

- Inconsistency

Inconsistency in provision was mentioned by a number of respondents. This included the RPS, SWS and family members and staff who had contributed to the SFAAD submission who stated, "support both in prison and following release is highly inconsistent across Scotland".

Positive aspects of the Prison to Rehab pathway were mentioned, with most estates engaging in this and that there were now dedicated workers within prisons to facilitate referrals. However, the Glasgow City ADP noted that "the best are the ones with dedicated and consistent staff" and CJVSF members noted that the provision was "inconsistent across the prison estate".

The CJVSF also stated that:

> "Waiting lists for access to substance misuse treatment remains a problem and is not equally available across geographical areas. Anecdotally, members still hear of people committing offences in the belief that they will have access to treatment faster in prison than they do in the community."

On top of this inconsistency, SWS stated that the stigma attached to being an "offender" or "ex-prisoner" could make accessing even the universal services that are there more challenging.

- Communication

Communication was mentioned in terms of that taking place between prison healthcare teams and community-based services, including general practitioners,

substance misuse teams, and mental health providers, and was said to be “often inadequate” (RCGPS).

CJVSF members noted something similar in their response in terms of the connection to community support services relying on strong communication with prisons and community partners. They went on to say that this connection also required prison staff to have knowledge of what services existed in the local area, as well as “clear points of contact” and “building partnerships and relationships” with these services.

Examples of good practice

Respondents provided examples of good practice in the area of throughcare and support when someone is leaving prison, either by their own organisation or others. These included:

- Change Grow Live’s Edinburgh and Midlothian Offending Recovery Support Service – this can start in police custody cells, continue inside prison and extend post-release into the community with a consistent worker throughout
- the Prison Casework Team in HMP Barlinnie hold weekly meetings with partners to review cases of anyone being liberated into homelessness in Glasgow
- the 8-week programme run by The Croft in HMP Barlinnie where people have the chance to link in with services that might be relevant to support them on release
- the School of Recovery run by SISCO and accredited through Fife College
- the Community Custody Units (Bella and Lilias) – men should have similar options
- the Prison to Rehab pathway
- the multi-agency release planning processes in place at HMP Grampian
- where throughcare involves “walk[ing] with someone from custody into community”
- the National Naloxone Programme (though issues were raised with this as set out above)
- Upside.

What more could be done

Respondents offered a large number of varied suggestions within this section of the call for views. The summary of these below is not comprehensive but highlights the main areas and themes that were covered by the responses.

Continuity of care

The topic that was mentioned by the most respondents in this section was ensuring there was a continuity of care when someone was released.

> "In short, release without continuity of care is like pushing someone off a cliff and hoping they can fly." (Individual with experience of a family member's imprisonment and working in a prison)

This focused on ensuring there was an immediate connection into mental health, addiction support and peer/community support. This included the need to ensure that people were released with access to their prescription and ongoing treatment, without any interruptions.

> "Where possible, individuals should leave prison with an appointment at a community service, confirmed housing arrangements, and someone to meet them at the gate. Integration authorities, ADPs, and health boards must be held accountable for ensuring these transitions are effective. Recovery doesn't begin or end at the point of release." (Change Grow Live)

To ensure this, the Glasgow City ADP stated there should be improved access to third sector in-reach in prisons so that people could establish relationships with community supports before they were released. A barrier to this was the lack of space for third sector services to use in prison and prison staffing.

The RPS noted the role community pharmacy could play in ensuring this continuity of care is in place, stating:

> "Community pharmacy is well placed to support people who have been in prison who require medication assisted treatment. To address variation in delivery across Scotland, local commissioning of services for people who use drugs could be replaced with a nationally negotiated community pharmacy service, informed by the MAT standards and the April 2024 HIS recommendations on service standards."

They also went on to state:

> "Consideration should also be given to making access to continuity of treatment available through the out of hours services. Currently these services will not provide access to treatment for those who have been liberated at a time when continuity of opiate agonist treatment is unavailable. Community pharmacy independent prescribers may be well placed to assist in filling this gap in service provision, with the appropriate digital connectivity to prison healthcare."

The need for adequate planning was also mentioned by Turning Point Scotland and the CJVSF. They noted the plan should begin well before liberation ("much earlier than 6, or even 12 weeks, before a person is released, and potentially even from day one of someone entering prison") and should support people to manage housing, benefits, education, employment and ongoing treatment on release. The CJVSF highlighted the multi-agency planning meetings in HMP Grampian as an example of good practice.

In the Correctional Service Canada's submission, they noted that "a meeting of the Treatment Team will take place 6 months prior to release to develop a transition plan for the individual's return to the community".

While Turning Point Scotland highlighted Upside, the national throughcare service that they are a part of, they note that it “does not reach everyone and gaps in throughcare remain”. An individual with experience of a family member’s imprisonment and of working in a prison stated that since the suspension of the prison Throughcare Support Officers (TSOs) in 2019 that “many leave custody without secure housing, ID, or treatment continuity. Current throughcare is still not effective”. They went on to state that “instead of giving someone a leaflet, staff should take them directly to community appointments, recovery cafes, or peer mentors on the day of release”.

Adult Justice Services at the City of Edinburgh Council noted that currently people cannot be provided with the certainty they need in relation to their housing and benefits due to “the shortage of affordable housing” and that the “benefits system processes do not currently facilitate this”.

Another barrier to the provision of this continuity of care was noted by Camarus to be “the fact that prisons sit between national and local planning structures which leaves priorities to be set on a prison-by-prison basis and “a lack of consistency in accountability”. They stated that better joined-up working is required between prisons, community health services like ADPs and homelessness support services.

Camarus also stated that the Scottish Government should “ensure monitoring and reporting of the proportion of prison leavers with a continued treatment need who are accessing community treatment services within three weeks of release, mirroring the approach taken in England, which would allow improved accountability and progress monitoring”.

The RPS highlighted the need for integration or information sharing between services to ensure that there was this continuity of care. They also highlighted the importance of the digitisation of care, stating:

> “Furthermore, digitisation of care coordination is crucial, especially for young people whose records are often fragmented across services due to heightened data protection. Lack of communication between mental health, substance use, and acute care teams results in missed opportunities for early intervention. For example, hospital admissions during weekends can be high-risk: junior doctors are frequently unaware of a patient's substance use history or are unable to administer appropriate doses without confirmation, increasing the risk of overdose or illicit drug use on the ward. To mitigate this, a digitally connected system linking hospitals, third-sector providers, community pharmacy and prescribing clinics is essential. This would allow clinicians to safely assess, coordinate care, and avoid both under- and over-treatment. Facilitating seamless information sharing between custody and community-based services is equally critical in preventing lapses in treatment and supporting recovery.”

The need for targeted health advice to be provided around the risk of relapse and overdose prior to release, as well as ensuring there was an increased promotion of naloxone training and kits as well as improved consistency in the provision of take-home naloxone kits were also mentioned.

The RPS also highlighted that the Advisory Council on the Misuse of Drugs (ACMD) offers strategic guidance on reducing drug-related harm during transitions between custody and community. They noted that despite its publication date, the document contains numerous actionable recommendations aimed at improving continuity of care and reducing drug-related harm.

Glasgow City ADP, SWS and the CJVSF all mentioned the Bail and Release from Custody (Scotland) Act 2023, highlighting that it contains relevant duties of engagement in release planning processes, including allowing people to register with GPs while still in prison, however these sections are still not in force.

Related to ensuring this continuity of care is ensuring there are adequate funding and resources in place, something mentioned by three respondents in this section in relation to the SPS, third sector and in terms of prison-based social work. SWS put this in the context of "investing to save in order to address substance use both in custody and community".

Mentors / Peer / Recovery networks

Respondents also mentioned the importance of the role having a mentor or an ability to work with people with lived experience or in the recovery community for peer support. They said these pathways and connections should be increased. This included through the role of recovery cafes in prison, where the Glasgow City ADP stated that there needed to be "better engagement opportunities within prison to work on recovery capital and create established pathways into recovery on liberation".

The Glasgow City ADP stated:

> "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."

Housing

Some respondents mentioned housing as an area where more could be done. This included that stable and permanent accommodation was required (made by an individual with experience of working in a prison) and that "despite the SHORE Standards, we still see the majority of people we support being released into homelessness and/or unsuitable housing" (Turning Point Scotland). They went on to state that:

> "The right housing is crucial for maintaining stability, but being placed in temporary or hostel-style accommodation, or having no home at all, is putting people at high risk of relapse and harm. This is a serious concern, and we call for a stronger and more consistent implementation of the SHORE Standards,

> with clear accountability and monitoring to ensure that nobody leaves prison without suitable housing."

The CJVSF raised the issue of the Housing (Scotland) Bill, currently at Stage 3. They noted that it:

> "…includes provisions relating to homelessness prevention and placing "ask and act" statutory duties on public bodies, including the Scottish Prison Service when a person leaves prison. During the Bill's progression, some members expressed cautionary support of the proposals, for example the benefits of prevention at an earlier stage and the involvement of other public bodies. However, significant concerns were also expressed with regards to the resourcing and implementation of the proposed new duties, and how they would be monitored and enforced."

Short sentence / Remand prisoners

The specific situation with people on short sentences and remand was mentioned by four respondents in this section. They noted that particular attention must be paid to these groups of prisoners when considering throughcare and support with substance use at the point of liberation. Glasgow City ADP noted that while people with short sentences are eligible for voluntary throughcare "they are not engaging" and that the process needs to be considered, while the CJVSF stated that there needed to be more recovery support for remand prisoners.

Alcohol

Looking at alcohol use in particular, SHAAP stated that there needed to 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". The CJVSF stated that wraparound psychological and social support was needed, particularly in the lead up to release and post-release.

SHAAP noted that draft UK Alcohol Treatment Guidelines have been published (with full guidelines to follow and that the Scottish Government plans to use this as the basis for developing a National Service Specification. SHAAP stated that 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" and highlighted their Alcohol (In)justice position statement in terms of this.

Families

In terms of what more could be done to support family members where someone has substance misuse issues and is in prison Families Outside highlighted a number of actions they believe would address specific impacts for families of substance misuse in prisons. These included:

- improved information sharing with families (subject to consent to share
- more information available for the support that is available for family members experiencing the imprisonment of an individual with substance misuse issues

- provide opportunities for families to share information and be involved in decisions regarding the care and support their oved one is receiving
- the importance of contact and visits should be consistently recognised and supported across the prison estate
- improve the visiting experience for families and greater financial and practical support for visits
- introduce Child Impact Assessments and Family Impact Assessments when decisions are being taken by the SPS.

An individual with experience of a family member's imprisonment also called for families to be involved more.

Other areas

A number of other areas were mentioned by participants, with varying levels of detail around these. They included:

- a greater use of digital technology (in prison and in the community) as a way of offering support, enhancing wellbeing and monitoring the risk of overdose
- increasing provision for carrying out drug testing in the community, which some people on statutory orders are required to undergo as a condition of their parole
- co-design and co-delivery of services
- more education/employability/volunteering opportunities
- swifter and wider access to mental health supports
- increase the prison to rehab scheme
- make addiction services more accessible
- build rehab in prison wings
- use the risk-needs-responsivity (RNR) model as a guide for structing support in prisons and in re-entry services
- ensure people understand their right to access services, with a change in the culture from criminalisation and stigma towards public health and human rights
- improve the effectiveness of throughcare into community health and drug services for those with Hepatitis C (The Hepatitis C Trust highlight their 'Through the Gate' work in England and would welcome this being introduced in Scotland).

Learning from other countries

Respondents highlighted various examples from other countries, with varying levels of detail. These are not summarised in any depth here, but are available, as in order to fully consider the practices in other countries and any potential for implementation in Scotland significant further work would be required. The inclusion of these

examples is only based on information provided by respondents and no further comment is provided on them.

Portugal was mentioned in terms of its work to take a public health approach to drugs while Norway was mentioned as an example of a country with an effective and humane prison system, with low conviction rates.

Families Outside mentioned initiatives in Greece, Ireland and Camden County, New Jersey as offering examples of good practice.

Estonia and Switzerland were also mentioned as having positive policies.

The Uganda National Medical Alliance for prisoners' Support (TUNMAPS) responded to the call for views and set out key lessons for Scotland from the learning in Uganda.

The Correctional Service Canada responded to the call for views and was mentioned by the Glasgow City ADP has a positive international example. They advised that they treat substance use as a health issue and that their approach to substance use and harm reduction includes:

- providing opioid agonist therapy – medications to reduce withdrawal symptoms and cravings
- prison needle exchange program
- overdose prevention service where individuals can use substances under the supervision of a healthcare professional to prevent overdoses
- the Self-Management and Recovery Training (SMART) program that helps people recover from issues related to substance use through peer support, self-empowerment, and practical skills
- other peer support and harm reduction services (e.g. naloxone and fentanyl test strips).

They provided information on relevant policies in this area:

- Guidance on Opioid Use Disorder (OAT) Program: August 16, 2021 - Canada.ca
- Canadian Drugs and Substances Strategy.

Therapeutic communities in the USA and Europe were also mentioned as offering “intensive, long-term behavioural therapy and support, showing success in reducing reoffending and drug use post-release” (SWS). HMP Grendon, in England, operates as a therapeutic community.

Respondents drew up some key themes across the examples provided which included:

- integration of health and justice services
- professional development and inter-agency coordination

- person-centred, holistic approaches to drug treatment in prisons
- equivalence between healthcare (including drug treatment and harm reduction) in the prison and in the community
- taking a public health approach.

Resources

Respondents provided a list of resources, including UN standards and international good practice, when aiming to address drug-related harm in the context of the criminal justice system:

- the Global Commission on Drug Policy's 2024 report Beyond punishment: From criminal justice responses to drug policy reform
- UNODC-WHO International Standards for the Treatment of Drug Use Disorders
- Treatment of substance use disorders in prison settings: statement by the UNODC-WHO Informal Scientific Network, UN Commission on Narcotic Drugs
- the UN Standards Minimum Rules for the Treatment of Prisoners
- the UN Standard Minimum Rules for Non-Custodial Measures (Tokyo Rules)
- the UN Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (Bangkok Rules)
- UNODC Handbook on strategies to reduce overcrowding in prisons
- the World Health Organization (WHO) framework, The WHO/Europe Health In Prisons Programme (HIPP).

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