Inquiry into the harm caused by substance (mis)use in Scottish Prisons

We are the Royal Pharmaceutical Society, the professional membership body for pharmacists and pharmacy.

Our mission is to put pharmacy at the forefront of patient care.

Our vision is to become the world leader in the safe and effective use of medicines.

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We promote pharmacy in the media and government, lead the way in medicines information, and support pharmacists in their education and development

The RPS welcome the opportunity to comment on the inquiry into the impact of drug use and drug-related harm in Scotland's prisons and agree it is important to examine the effects on the health and wellbeing of people in custody, prison staff, healthcare and wider staff providing prison services.

Though the inquiry is into harm caused by "substance misuse" we feel it is less stigmatising to use "substance use" and will refer to it as such throughout our response.

This response was generated through feedback from our members who work within this field.

How drugs and other substances get into prisons

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

- Visitors and Family Members: Drugs are often concealed in clothing, food packages, or body cavities during visits.

- Mail and Packages: Substances can be soaked into paper, hidden in books and religious texts or disguised as legitimate items. Clothing and shoes can also be impregnated or conceal substances

- Staff Involvement: In rare but serious cases, corrupt prison staff may smuggle drugs

- Drone Deliveries: Increasingly, drones are used to drop packages into prison yards, especially in facilities with limited aerial surveillance via neighbouring housing estates for example.

- Body Packing and Ingestion: Individuals may swallow drug-filled balloons or insert them into body cavities before entering the prison.

- Legal Documents and Artwork: Papers laced with synthetic drugs like Spice can be passed off as legal correspondence or drawings.

- Released Inmates or Transfers: Drugs can be brought in by inmates returning from court, hospital visits, or transfers from other facilities.

- eLiquids used in vapes are also being used

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.

People in prison are also extremely knowledgeable about “cooking” using everyday toiletries and household items and combining them, through chemical reactions to produce a product that produces a psychoactive effect or enhances the effect of another drug.

Also, 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.

References:

NPS detection in prison: a systematic literature review of use, drug form, and analytical approaches https://pmc.ncbi.nlm.nih.gov/articles/PMC9545023/pdf/DTA-14-1350.pdf

Safer Prescribing in Prisons - Guidance for Clinicians https://www.rcgp.org.uk/getmedia/400e7a75-7b46-4a24-8151-d3ea4a2cf5a1/Safer-prescribing-in-prisons-v2.pdf

2. Are the current steps taken to find and stop drugs getting into prisons working well? What’s working, and what isn’t?

Body scanners and body searches can be successful in finding and stopping drugs getting into prison.

The use of window grilles is being tested as a means of reducing the ability of drones to deliver substances.

As prison staff are not allowed to open people in prison’s mail then detection of smuggling in the postal service can be challenging, but swabbing the contents without fully opening the mail can be successful.

Sniffer dogs can identify traditional drugs of abuse. However, there are limitations in the use of sniffer dogs with novel substances as they are not trained to detect these, with new compounds being continually developed. There is also risk of harm to the dogs, (upon leaking or porous packages or with external traces of drug) particularly in detecting very potent synthetic opioids such as carfentanyl.

Onsite detection using IMS (Ion Mobility Spectrometry) shows promise for real-time detection of synthetic cannabinoids (SCs) in various forms and is useful for rapid screening in prison environments.

Immunoassays have limitations; they are used in detecting opioids in urine and oral fluid tests, however, were not recommended due to poor sensitivity and specificity for detecting SCs, especially newer variants.

Technologies have their limitations and there is inconsistent investment across Scotland and the UK to adequately find drugs getting into prisons. There are new and emerging drugs that are not part of routine testing and go undetected through urine, through blood or mandatory drug testing in prisons.

Reference : NPS detection in prison: a systematic literature review of use, drug form, and analytical approaches https://pmc.ncbi.nlm.nih.gov/articles/PMC9545023/pdf/DTA-14-1350.pdf

3. What else could be done to make it harder for drugs and other illegal substances to get into prisons?

At the most fundamental level, to make it harder for drugs to get into prison, we need to reduce the number of people imprisoned. There must also be an effective means of identifying substances getting into prisons at source. There are a number of existing and emerging challenges in drug detection within prisons.

- E-Liquid and Vapes: Drugs are increasingly smuggled into prison using vaping devices and e-liquids. Detection is difficult because there are no effective in-field detection tools for e-liquids. Flavourings in e-liquids mask the smell of substances. Immunoassay and ion scanners would presumably work, the issue is that these are limited, particularly for synthetic cannabinoids, but they may be more effective for opioids and known drugs.

- Mail and Privacy Concerns: people in prison often receive paper mail, some of which may be drug-soaked. There have been legal barriers in opening mail/packages; courts have challenged the practice due to concerns about privacy and human rights. There have been reports of prison staff being harmed from hot scanning of

mail due to vapourised substances. Consideration should be given to digitising mail for people in prison for example receiving emails instead of physical mail could make it harder for drugs to be smuggled in.

- The Revolving Door & Profit Motives: some individuals intentionally commit minor offences to enter prison briefly and smuggle drugs. The profit margin for selling drugs within prison is high, incentivising this cycle of repeat entry. Disruption of this supply chain is critical for long-term solutions.

An additional perspective is understanding the reasons for the demand for substances in prisons – exploring the reasons that people in prison use illegal substances and addressing those may in some way contribute to reducing the demand.

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

The Scottish MAT (Medication-Assisted Treatment) Standard 6 Supporting documents - Medication Assisted Treatment (MAT) standards: access, choice, support - gov.scot (https://www.gov.scot/publications/medication-assisted-treatment-mat-standards-scotland-access-choice-support/documents/) advocates for a psychologically informed system that integrates routine psychosocial interventions, which is being adopted across communities and prison settings.

Drug use in prisons is often linked to factors such as boredom, trauma, and self-protection. Effective response requires combining psychosocial support with pharmacological therapies like methadone and buprenorphine. Approaches which educate and inform people in prison about the harms from novel psychoactive drugs and other illegal substances could be developed, including education on how to use the substances safely in the frame of harm reduction. Ensuring there is clear information available to people in prison about how to access support from the NHS services in prisons is important and considering how this information is communicated is important with consideration of peer delivered learning.

To strengthen recovery outcomes, a peer-led recovery model should be promoted, drawing on lived experience and incorporating counselling, education, and workforce development. Scotland's *National Drugs Mission Plan (2022–2026)* (*https://www.gov.scot/publications/national-drugs-mission-plan-2022-2026/)* and ACMD's *Whole-System Approach* (https://www.gov.uk/government/publications/a-whole-system-response-to-drug-prevention-in-the-uk) highlight the need for cross-sector collaboration, focusing on prevention rather than reactive measures**.**

The evidence base for some international models (e.g., decriminalisation or correctional reforms) remains limited. Nonetheless, rehabilitation programs, particularly for young people, consistently demonstrate positive impacts. Urgent action is needed to address the exploitation of minors in drug supply chains and ensure that rehabilitation is embedded within a coordinated, whole-system response.

Workforce Action Plan - Drug Deaths Taskforce response: cross government approach - gov.scot (https://www.gov.scot/publications/drug-deaths-taskforce-response-cross-government-approach/pages/9/)

Impact of drugs and other substances in prisons

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

Health risks can depend on the type of drug and on the route of administration of that drug.

We need to consider whether we are talking about the harms from one drug or from poly drug use, because many people in prison will be likely to be using more than one drug.

There is evidence Factors associated with drug use in prison: A systematic review of quantitative and qualitative evidence - ScienceDirect (https://www.sciencedirect.com/science/article/pii/S0955395923002955) demonstrating that people who don't use drugs prior to prison may start using during their prison stay and when they leave, so essentially they are a new user. Overdose can therefore be an issue with opioids for example.

There are harms associated with injecting including tissue damage, wounds, venous harm, blood clots and other vein damage.

Blood borne virus infections are an issue in injecting drugs and snorting substances (e.g. bleeding from nose or cracked lips).

Respiratory issues with smoking drugs.

Smoking substances also introduces risks of burns both from direct contact but additionally from surrounding materials catching fire (e.g. a spark igniting a fire on bedding).

With synthetic cannabinoids the main risks are psychosis, seizures, cardiac arrests and violent and aggressive behaviours. (Hancox JC, Copeland CS, Harmer SC, Henderson G. New synthetic cannabinoids and the potential for cardiac arrhythmia risk. J Mol Cell Cardiol Plus. 2023 Dec;6:100049. doi: 10.1016/j.jmccpl.2023.100049. PMID: 38143960; PMCID: PMC10739592). There is use of prescribed medication such as amitriptyline being mixed with spice and added to vapes for inhalation increasing cardiac risks.

Emerging drugs like xylazine and nitazenes may cause lethal overdoses as they are extremely potent.

Therefore, the type of drug will have an impact on other health risks with poly-drug use (e.g., opioids, alcohol, benzodiazepines) increasing risk of harm.

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

Individuals may accrue debt and then may face coercion, intimidation, and pressure to engage in further criminal activities**.** In addition to the immediate health risks associated with substance use and incarceration, the cycle of exploitation—particularly for those who repeatedly enter and exit custody—can have profound and enduring consequences. These impacts extend beyond the individual, affecting family dynamics, social relationships, and the person's ability to reintegrate into society through stable housing and employment. Such vulnerabilities require a comprehensive and trauma-informed response that addresses both the socioeconomic drivers and the long-term effects of criminal exploitation.

7. How does drug use affect safety inside prisons – for both people in prison and staff?

Certain substances, particularly synthetic cannabinoids and cathinone analogues such as Alpha-PVP and MDPV ("Monkey Dust"), are strongly associated with heightened aggression, disinhibition, and episodes of extreme violence. Individuals under the influence of these drugs may exhibit erratic and uncontrollable behaviour, often requiring multiple staff or prison officers to intervene safely. This creates significant operational challenges in custodial settings, where safety and control are paramount.

Moreover, the altered mental states caused by these substances can increase vulnerability to exploitation and manipulation**,** further destabilising prison environments and undermining rehabilitation efforts. The prevalence of such substances not only poses a threat to institutional order, but also increases the risk to staff and other people in prison. When we consulted with our members, we heard of instances where a higher-ranking person in prison will identify a lower-ranking person in prison to be given a new substance as a "tester" thereby protecting the higher-ranking person from potential harm and putting the lower ranking person at the risk of short and long term health harms. We are led to believe that this scenario describes "spice pigs".

Many substances are CNS depressant agents - which increase the risk of intoxication, and thus vulnerability to danger, as well as risk of choking, asphyxiation, overdose etc.

If people in prison are continuing to inject, the equipment for the injection of drugs may pose a particular risk through accidental or intentional skin puncture with contaminated sharps. The unavailability of new injecting equipment promotes re use of equipment hence increasing the risk of BBV transmission.

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

Funding for research that can provide the evidence based knowledge to inform the future actions and plans that will work.

Training is very important, especially training of healthcare professionals working within the prisons. There are still cases (though rare) of staff being corrupt and actually helping with smuggling of drugs.

People in prison can have access to prescription medicines that can be misused.

Focus on managing traumas and that will reduce the seeking of drugs. Providing meaningful activity, engagement, entertainment, sleep hygiene, cultural realignment, mutual support, contingency management, recognition of harms etc all contribute to the reduced seeking of drugs.

Naloxone distribution expanded to non-clinicians

Injecting equipment provision and safe disposal of contaminated sharps and safe prescribing remain essential

Consideration of recovery orientated systems in prisons where people in prison who stumble on their recovery journey are not further punished within the prison system and are supported within a different approach.

Support for people affected

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

Addiction is a chronic, relapsing condition with a complex and often prolonged recovery pathway. Its consequences are far-reaching, with the potential for lifelong physical, psychological, and social harm—including the risk of premature death.

Substance use significantly affects mental health; for example, cannabis-induced psychosis remains challenging to treat in clinical settings and can have enduring effects. Addiction can also contribute to cycles of criminal behaviour, financial debt, repeated incarceration, and ongoing disruption to family relationships. These issues further hinder individuals' ability to reintegrate into society, impacting their access to employment and stable housing.

The insights provided by Dame Carol Black, particularly in her 2021 independent review, remain highly relevant. Her work underscores the need for a whole-system approach to addressing addiction within custodial setting**s**, including recommendations to improve prevention, treatment, and recovery pathways in prisons.

Review of drugs: phase one report - GOV.UK (https://www.gov.uk/government/publications/review-of-drugs-phase-one-report)

Review of drugs: phase two report - GOV.UK (https://www.gov.uk/government/publications/review-of-drugs-phase-two-report)

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

Not answered

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

Stigma presents a significant barrier to seeking help, particularly among individuals affected by substance use. For instance, chronic ketamine use in young people can lead to severe urological complications, including

bladder damage or removal. However, fear of medical intervention and social judgment often deters them from accessing healthcare services, resulting in worsening health outcomes.

In custodial settings, stigma functions both within and beyond the prison walls. Individuals may avoid seeking support or disclosing drug use due to concerns about extended incarceration or punitive responses. This dynamic contributes to the rising use of new psychoactive substances (NPS), which are not typically included in routine drug screening—therefore perceived as a safer option for evading detection.

Post-release, many individuals experience a reluctance to engage with treatment services. The label of being an "ex-prisoner" carries substantial stigma, further complicating reintegration and recovery efforts. These overlapping issues highlight the need for trauma-informed, non-punitive approaches to treatment—both in custody and the community—to reduce stigma and promote sustained engagement with health and support services.

Stigma also affects healthcare staff. Recruitment to specialist healthcare professional posts in substance use can be challenging and with the additional stigma which comes from working within a prison environment, this can pose a further barrier to attracting and retaining staff.

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

Not answered

Rehabilitation and support for people using drugs in prison

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

Access to help for drug and substance use in Scottish prisons has improved in recent years, but challenges remain in ensuring that support is both effective and consistently available. (https://www.sccjr.ac.uk/wp-content/uploads/2022/03/Mapping-Drug-Use-Interventions-and-Treatment-Needs-in-Scottish-Prisons-A-literature-review_Final.pdf)

The Scottish Prison Service (SPS), in collaboration with NHS Scotland and third-sector organisations, has implemented a range of services aimed at addressing substance use:

Medical Assisted Treatment (MAT): MAT is widely available, including opioid replacement therapies like methadone and buprenorphine. However, uptake varies significantly between prisons—from over 35% in HMP Greenock to under 10% in others Alcohol and drug treatment in secure settings 2020 to 2021: report - GOV.UK (https://www.gov.uk/government/statistics/substance-misuse-treatment-in-secure-settings-2020-to-2021/alcohol-and-drug-treatment-in-secure-settings-2020-to-2021-report)

The reception process includes a health screening at which substance use issues would be identified and the person then connected with the relevant services. Where people coming into prison are already engaged in a treatment programme, that will be confirmed and continued within the prison. At any given time, there are circa 24-25% of the prison population in receipt of an opioid replacement therapy. Previous addictions prevalence testing would suggest that this number is low compared to the number who presented with substances in their urine and would be likely to benefit from an opioid replacement programme. Access to specialist addictions nurses can vary across the prison estate, with challenges in recruitment and retention. Help with drug or substance use problems is available through both the NHS and SPS, who work in partnership to address the needs of people in prisons. The SPS has a drug strategy detailing the support they offer to support people with substance use and drug issues.

Trauma-informed care and mental health services are increasingly integrated into addiction support. https://wrdnews.org/scottish-prisons-services-new-alcohol-and-drug-recovery-strategy-2024-2034/

Peer support and recovery communities are being promoted to help individuals build resilience and maintain recovery.

Throughcare and aftercare services aim to support individuals post-release, though access can be inconsistent.

The Alcohol and Drug Recovery Strategy 2024–2034 marks a significant shift toward a public health and human rights-based approach. It focuses on prevention, rehabilitation, and reintegration, aiming to provide care equivalent to that available in the wider community. https://www.sps.gov.uk/sites/default/files/2025-02/Alcohol%20and%20Drug%20Recovery%20Strategy.pdf

While the strategy is ambitious and well-intentioned, several issues affect its effectiveness:

High prevalence of substance use: A 2019 SPS survey found that 41% of people in prison had problematic drug use before incarceration, and 45% were under the influence at the time of their offence https://www.sccjr.ac.uk/news_item/mapping-drug-use-interventions-and-treatment-needs-in-scottish-prisons/

Synthetic drugs: The rise of potent synthetic substances has increased health risks and made detection and treatment more complex.

Limited data: There is a lack of consistent, up-to-date data on substance use and treatment outcomes in prisons, making it difficult to assess impact.

Staff training and capacity: While workforce development is a priority, there are concerns about whether staff are adequately equipped to deliver trauma-informed and compassionate care.

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

Medication-assisted treatment (MAT) plays a critical role in supporting individuals in custody, particularly those with substance use disorders. 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.

Nonetheless, managing individuals who continue to use illicit substances alongside their prescribed MAT remains a challenge—especially in cases involving high-dose injecting behaviour. These scenarios often require enhanced clinical oversight and multidisciplinary support.

The expansion in the use of naloxone has proved to be a life-saving intervention on a national scale.

To further enhance outcomes, it's essential to integrate mental health and addiction services within both custodial and community frameworks. A trauma-informed, recovery-oriented approach—coupled with peer support and harm reduction strategies—can significantly improve engagement, safety, and long-term rehabilitation.

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

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. 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.

Overall, implementation has been inconsistent, and this appears to be an area where further data collection and analysis would be beneficial to assess progress and identify opportunities for improvement. Additional evaluation or audits may be warranted to establish a clearer understanding of the current landscape. We would expect these to be published by HM Inspectorate of Prisons or by Healthcare Improvement Scotland.

Public Health Scotland have a key focus on reducing drug related deaths through the improvement of evidence-based population assessment and care as well as monitoring to inform benchmarking and multi-agency service provision and have provided a written statement: https://www.parliament.scot/-/media/files/committees/criminal-justice-committee/correspondence/2025/public-health-scotland-written-submission-28-may-2025-meeting.pdf

We heard from our members that there are some elements of the standards as drafted which are not applicable to the prison setting. Some elements have been put in place to mirror community practice, but there isn't any clear description of what the 106 individual elements of MAT within the prisons look like.

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

Integrated care models are essential for effectively supporting individuals with co-occurring mental health and substance use needs. While the term "dual diagnosis" is no longer widely used, the relationship between mental health disorders—such as psychosis triggered by drug use—and substance use remains deeply interconnected.

To address this complexity, shared care plans are crucial in ensuring consistent, person-centred support across services. The co-location of multidisciplinary teams can greatly enhance timely communication and reduce service fragmentation, which often contributes to treatment failure and repeated relapse.

A truly integrated approach—where psychosocial support is aligned with pharmacological interventions - is vital for achieving sustained recovery outcomes and preventing individuals from falling through gaps in care provision.

Support after release from prison (throughcare and aftercare)

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

The Advisory Council on the Misuse of Drugs (ACMD) offers strategic guidance on reducing drug-related harm during transitions between custody and community (https://assets.publishing.service.gov.uk/media/5f1704213a6f40727051b6da/CMD_Custody_community_transitions_report_June_2019.pdf).

Despite its publication date, the document contains numerous actionable recommendations aimed at improving continuity of care and reducing drug-related harm.

One of the most critical concerns during this transition period is the elevated risk of overdose post-release**,** largely due to reduced drug tolerance following detoxification in custody. Education and harm-reduction interventions are essential during this vulnerable phase.

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.

Throughcare is often fragmented, yet it should be seamless to support people in prison as they transition back into the community. Continuity in prescribing and care is especially critical during the first four weeks after liberation, when the risk of overdose and drug-related death is significantly heightened.

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.

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

Inconsistency across services continues to pose a significant challenge. Seamless shared care, supported by well-trained and proactive teams, is essential for ensuring effective transitions from custody to community-based support. When there is a lack of coordination or enthusiasm at the point of release—particularly in linking individuals to external services—the outcome can be detrimental for both the individual and the system. This disjointed approach not only leads to poorer recovery outcomes, but also increases long-term costs and strains on public services.

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

Throughcare and seamless transfers between services — combined with recovery-oriented systems — play a vital role in sustaining long-term recovery. The focus must move beyond initial stabilisation toward preventing relapse, and this requires a cohesive, proactive approach. Ensuring individuals are seen promptly following transitions (e.g. within 24 hours of release or referral) is one key strategy.

Further work requires to be undertaken to ensure that throughcare packages are in place for all those requiring support with substance use at their point of liberation. Particular attention should be paid to the remand population who can be released from court, making the arrangement of throughcare provision challenging. Significant work has been undertaken to ensure that those with known liberation dates receive the support required on transition back to the community. Learnings from this work should be built upon to provide equivalent throughcare for the remand population.

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.

There are practical frameworks already in place, such as sections within the RPS's *Medicines, Ethics and Practice* guide (MEP), which address common gaps in care—particularly around missed doses and the timely provision of opioid substitution therapy (OST). Delays in issuing prescriptions, particularly over weekends, can increase the risks of relapse. While informal support from compassionate staff—e.g. hand-delivering prescriptions—helps bridge these gaps, such reliance on individual goodwill is unsustainable. System-wide reforms are needed to ensure that care is responsive and continuous**,** rather than rigid and reactive.

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

Learning from other countries

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

It is important to examine international models when considering reform approaches to drug policy. Countries such as Canada, Portugal, and Sweden have each adopted markedly different strategies. For example, some nations have implemented zero-tolerance policies, while others have pursued regulation and market-based access as a means of harm reduction. The Portugal model, in particular, has provided valuable lessons in decriminalisation and public health-led interventions.

A helpful resource in this context is the World Health Organization (WHO) framework , The WHO/Europe Health In Prisons Programme (HIPP) (https://www.who.int/europe/teams/alcohol-illicit-drugs-prison-health/the-who-europe-health-in-prisons-programme-(hipp)) which offers a comprehensive international perspective and showcases a variety of policy approaches.

There is no single, evidence-backed model that universally guarantees success. As such, this area requires robust evaluation to guide future action. Far too often, interventions are implemented without sufficient assessment, or they are stalled due to limited funding—both of which hinder informed decision-making and the development of effective long-term strategies.

Roads-to-recovery-Nov-2023.pdf (https://www.smf.co.uk/wp-content/uploads/2023/11/Roads-to-recovery-Nov-2023.pdf)

Other views

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

As the professional leadership body for pharmacy, the Royal Pharmaceutical Society (RPS) champions equitable, evidence-based access to healthcare in all settings. Pharmacists are uniquely equipped to support harm reduction, optimise treatment, manage comorbidities, and provide person-centred care. RPS supports public health-led approaches to addiction—aligned with the ACMD's recommendations and the national strategy shift towards prevention and recovery. To shape this response we consulted with Board members, Fellows, members and pharmacist experts in the field of substance use and prison healthcare.

Our members told us that person-centred approaches to medication assisted treatment were crucial for people in prison and the growing sophistication of the development of novel psychoactive substances is a challenge to be addressed in designing rehabilitation models within the prison population.

Drug-related deaths after release remain disproportionately high in Scotland. Contributing factors include reduced tolerance, lack of continuity in care, and the impact of deprivation. Many individuals leave custody without stable housing, finances, or access to support services, creating dangerous gaps in care. Challenges include access to local services including prescribing, coercive exploitation by criminal networks, and service gaps at weekends or holidays.

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.