# EQUAL OPPORTUNITIES COMMITTEE

Tuesday 21 April 2009

Session 3

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## EQUAL OPPORTUNITIES COMMITTEE
**6th Meeting 2009, Session 3**

**CONVENER**

*Margaret Mitchell (Central Scotland) (Con)

**DEPUTY CONVENER**

*Marlyn Glen (North East Scotland) (Lab)

**COMMITTEE MEMBERS**

*Malcolm Chisholm (Edinburgh North and Leith) (Lab)
*Willie Coffey (Kilmarnock and Loudon) (SNP)
*Bill Kidd (Glasgow) (SNP)
*Hugh O'Donnell (Central Scotland) (LD)
Elaine Smith (Coatbridge and Chryston) (Lab
*Bill Wilson (West of Scotland) (SNP)

**COMMITTEE SUBSTITUTES**

Johann Lamont (Glasgow Pollok) (Lab)
Mary Scanlon (Highlands and Islands) (Con)
Margaret Smith (Edinburgh West) (LD)
Shirley-Anne Somerville (Lothians) (SNP)

*attended

**THE FOLLOWING GAVE EVIDENCE:**

Dr Andrew Fraser (Scottish Prison Service)
Heather McCabe (Alcoholics Anonymous)
Lesley McDowall (Scottish Prison Service)
Ruth Parker (Scottish Prison Service)
Naomi Robertson (Open Secret)

**CLERK TO THE COMMITTEE**

Terry Shevlin

**ASSISTANT CLERK**

Rebecca Lamb

**LOCATION**

Committee Room 2

# Scottish Parliament

## Equal Opportunities Committee

*Tuesday 21 April 2009*

[THE CONVENER *opened the meeting at 10:01*]

## Decision on Taking Business in Private

**The Convener (Margaret Mitchell):** Good morning, everyone, and welcome to the sixth meeting in 2009 of the Equal Opportunities Committee. I remind all those present, including members, that mobile phones and BlackBerrys should be switched off completely, as they interfere with the sound system even when they are switched to silent.

We have received apologies from Elaine Smith.

Agenda item 1 is a decision on whether to take business in private. Do members agree to consider the committee's draft annual report in private at future meetings?

**Members** *indicated agreement*.

## Female Offenders in the Criminal Justice System Inquiry

10:01

**The Convener:** Under item 2, the committee will take further oral evidence in its inquiry into female offenders in the criminal justice system.

I remind everyone that the remit of the inquiry is to

"assess the prison experience for, and background of, female offenders, particularly the extent to which prison helps to prevent women from re-offending."

The specific theme of today's meeting is to establish the support that is available to women in prison, given their profile, and to discuss whether that support is adequate to meet their needs.

The committee has received written evidence that says that many female offenders share a similar profile or background in that, often, such offenders have been sexually or physically abused, have drug or alcohol addictions, have been involved in prostitution or have mental health problems. Today, a range of witnesses will be able to describe the support that they provide to female prisoners and how effective it is.

Without further ado, I welcome our first panel of witnesses, who will cover issues such as mental health. Dr Andrew Fraser is director of health and care at the Scottish Prison Service and Ruth Parker is the Scottish Prison Service's acting addictions adviser.

Broadly speaking, what is the intended aim of providing programmes to female offenders in prison? Is it realistic to think that those programmes will have any meaningful impact on reoffending rates, for example?

**Dr Andrew Fraser (Scottish Prison Service):** I will answer first; Ruth Parker could then perhaps continue.

The theory is that unless the problems that affect women as they come into the system are sorted out—those problems are primarily drug problems, but they are also mental health problems—those women will not be in a state of mind to engage in any other interventions that will reduce the risk of their reoffending in the future. Therefore, I regard interventions to deal with mental health and drug issues as fundamental and basic to a regime of care and support that will wind up with lower risks of reoffending in the future.

**The Convener:** Do you see any initial barriers to achieving that intention? What, if anything, gets in the way of achieving the results that you would like to see?

**Dr Fraser:** One factor is the burden of the problem. Drug problems are almost universal and the vast majority of offenders have a mental health problem. We are geared up to appreciating the burden of care need, but the women's needs are complex and are not necessarily well articulated or easy to tease out, because they come along with other expressed needs, such as housing needs or despair. Problems are not just crisply expressed as mental health and addictions.

Addictions are often prominent and immediate issues, because they come with dependency problems and withdrawal symptoms. In many ways, mental health problems are more deep seated and can present in many manifestations. Given that and the many other layers of need, we often never know which need should come first. However, addictions are often high up the list.

**The Convener:** Are prisoners compelled to undertake programmes?

**Dr Fraser:** Fundamentally, no. The punishment is going to prison. Prisoners are entitled to care—we have an inescapable duty of care towards them—but they have the choice of whether to take up treatment options. We cannot coerce them, but an element of need must be addressed. Sometimes, prisoners cannot engage in mental health treatment because they lack insight or because they do not perceive mental health to be the major and immediate issue for them. If prisoners have severe and enduring mental illness—such people form the minority with mental health problems—their insight is impaired anyway. That is difficult to tease out straight away.

**The Convener:** How far does that go? Does that constitute a lack of capacity?

**Dr Fraser:** Yes—it can.

**The Convener:** We will ask specific questions about mental health later, so I will not go into that too much.

**Bill Kidd (Glasgow) (SNP):** Dr Fraser said that a significant number of inmates have mental ill health. What degree of mental ill health would someone have to display to be placed in an environment for patients with mental health problems rather than in prison?

**Dr Fraser:** There are two broad types of mental health problem. One is severe and enduring mental illness, which is normally understood to be schizophrenia or psychosis—the two conditions belong together—or manic depression. That is characterised by a loss of contact with reality, a loss of insight and so on. That affects 6 to 9 per cent of women and 3 to 9 per cent of all prisoners—the figure is slightly higher among women.

The majority of prisoners—especially women prisoners—have other mental health problems of varying degrees, which are mainly depression, anxiety and stress related. It might be argued that people with severe and enduring mental health problems would be better placed in a hospital setting. Such people were the subject of an HM prisons inspectorate for Scotland report that was issued in December, which recommended that they should—largely—be in a hospital setting. I take issue with that on the fact that, sometimes, we cannot tease out whether the mental health problem or the offending problem was prominent. However, if somebody has a severe and acute mental health problem, they are better off if they are looked after in hospital, and we arrange that. We have a close relationship with the secure mental health estate and such prisoners would be transferred to a hospital under the Mental Health (Care and Treatment) (Scotland) Act 2003.

**The Convener:** The question was generic; we have questions on mental health that will cover the specific point later.

**Malcolm Chisholm (Edinburgh North and Leith) (Lab):** Perhaps I should keep my question until later; I realise that we will ask about mental health. My interest is in an issue that runs through the inquiry—forgive me for asking one question that relates to mental health, but it might not be asked later. Will you comment generally on the mental health profile of women in prison as distinct from men in prison? The committee has a running interest in the similarities and differences. If you give a brief answer on that, I will not mention mental health again until the appropriate time.

**Dr Fraser:** I preface my answer by saying that we have about 400 women in prison—the figure was 399 this morning. They are the most chaotic and deprived of prisoners and have the most multilayered experience of poverty and ill health. It is difficult to compare those women with 400 men in the prison service who are as chaotic. There might be 400 comparable men but, if we compare all women to all men in prison, we find that the women have much more profound issues and a common experience of mental health problems. Further, the reasons for those problems are more to do with being victims, experience of abuse and very poor past circumstances. It is difficult to give a clear answer on whether women have an even worse experience than men but, in general, they do.

**Malcolm Chisholm:** That is helpful.

**The Convener:** We are very interested in the mental health issues, which is why we will ask specific questions on that later.

The aim of the programmes that we have discussed is to stop reoffending, yet many

prisoners can simply opt out of them. What is your take on that?

**Ruth Parker (Scottish Prison Service):** Given the high number of women who arrive in custody with drug and alcohol problems, we want to encourage those individuals to work with us. We encourage them to access the services that are delivered through our national contract with Phoenix Futures. Through the induction process, all prisoners are encouraged to attend a harm reduction awareness session.

**The Convener:** How are they encouraged?

**Ruth Parker:** As part of the national induction programme.

**The Convener:** Are there specific incentives for people to attend the programme?

**Ruth Parker:** It is not a programme as such—it is an awareness session. Prisoners are encouraged to go to the induction to find out what services are available in prison. That involves introducing them to addiction services. We have a national contractor to provide services—Phoenix Futures—as well as various health services. The induction process is an opportunity for prisoners to find out what services are available in their prison, how to access them, what the criteria are—for example, the sentence range for prisoner programmes—and how to link in with services in the community, such as in-reach services and throughcare services when prisoners are on their way out. We encourage as many prisoners as possible to go along to the induction.

Phoenix Futures delivers the harm reduction awareness sessions, which are about education and awareness and the good, the bad and the ugly of drugs and alcohol. The sessions encourage individuals to access further services such as assessment of needs, one-to-one or group work, and wider prisoner programmes and approved activities. The sessions advise those who have committed offences as a result of drugs and alcohol about the benefits of accessing services and how doing so will significantly reduce future reoffending.

On arriving in the prison, 53 per cent of prisoners admit that they have been under the influence of drugs. A recent prevalence study found that 71 per cent of prisoners have illegal drugs in their system. It is a priority for us to encourage prisoners to go along to the sessions and access services and, generally, they do so. The services are well received in Cornton Vale—prisoners understand the benefits.

Our strategy is focused not only on treatment and interventions, but on security and encouraging a structured regime. Managing drugs coming into the prison can be an issue. We have various security issues.

**The Convener:** We will move on to that. You have answered the generic question about what the programmes are intended to do. Marlyn Glen will follow up on the extent to which they achieve success.

10:15

**Marlyn Glen (North East Scotland) (Lab):** We are all aware that hard statistics are necessary to ensure that we secure resources. Is it possible to measure objectively whether your services have, over time, improved inmates' behaviour or attitudes upon release compared with their behaviour or attitudes on admission?

**Dr Fraser:** We conduct surveys of service use and uptake. In the case of substance misuse, we aim for free or stabilised status. We also survey the proportion of people who have substances in their system on leaving prison. There is a sharp drop in that figure compared with the proportion with substances in their system on admission: from about 70 per cent to around 38 per cent. I think that that is right.

**Ruth Parker:** That is the overall figure.

**Dr Fraser:** Mental health is a bit more difficult to measure, but we ask women whether they feel better about themselves when they leave than they did when they arrived. Early surveys considered men and women and showed that about 80 per cent felt better about themselves on release. However, it is not only about the effect of prison on mental health; it is also about the effect that the stigma of coming into prison and the shock of imprisonment may have on mental health.

There are many extraneous influences on performance measures that relate to mental health and wellbeing but, generally speaking, women tend to feel better at the end of a sentence than they did at the beginning of it. That is because they have settled into a regime but I hope that it is also because other interventions that we have offered have benefited them.

**Marlyn Glen:** To find out whether there was a long-term effect, you would have to do follow-up work on the same women.

**Dr Fraser:** Yes. So far, we have not done that; we have only considered reoffending rates. There are many influences on why people reoffend, never mind why they feel the way they feel, have poor mental health or use illegal substances. Because women's needs are multilayered, complex and often profound, it is difficult to tease out the major influence on how they get on after they leave prison.

**Marlyn Glen:** Yes, it is difficult.

Are you unable to provide any services that would benefit the inmates?

**Dr Fraser:** There are always things that we would like to do that we do not do. Looking at our performance internationally—which we do—we do pretty well. We are proud of what we try to achieve in Cornton Vale. It is a remarkable institution for its effect on women's mental health and its ability to address substance misuse.

That said, we could always do more. I would like to do more on throughcare, which is about beginning regimes that continue through into the community. We would like to know more about people when they come in—that perhaps anticipates later questions. If we were to link up with what the police, courts and national health service do, we could do a lot more and do it sooner.

We have identified mental health needs for specific groups, such as survivors of sexual abuse, sufferers of post-traumatic stress disorder and those with abnormal grief reactions. Those matters are on the edge of the overall burden of poor mental health with which we try to cope. They need specific attention, but we try to cope with them amidst the huge burden of mental ill health that the women experience.

We have achieved a lot, but we would like to do more. There are always opportunities to do more.

**Marlyn Glen:** What about the addiction side?

**Ruth Parker:** Dr Fraser touched on throughcare. For me, it is much more about working between prison and the community. We need to share information and ensure that our interventions are delivered not only in the prison but in the community so that we can continue throughcare. Work to enable that is on the horizon through the development of alcohol and drug partnerships in community justice authorities.

**Marlyn Glen:** The committee has been told that many inmates, such as short-term and untried prisoners or women on remand, have limited or no access to services at Cornton Vale. Given the length of their sentences and the obvious pressure on prison resources, is it realistic to expect that short-term prisoners' offending behaviour can be challenged while they are in Cornton Vale? Could you give us some clarity about how long some women are in prison? How long is a long-term sentence, and how short is a short-term sentence?

**Dr Fraser:** The technical term "long-term prison" means a sentence of four years and longer; very few women are doing that. Forty per cent of women in prison on any one day are serving sentences of fewer than six months or are on remand. That is a big wedge of the prison population. That is on one day, but the turnover of that short-stay population means that those people form the substantial majority of prisoners in any one year.

What can we do for them that we are not doing at the moment? As I said earlier, those prisoners' needs are complex and profound. It takes time to get to know them and to assess them, and we can do harm by making specific interventions too early. We do not want to do that. We want to get to know them, to see what drives them, and to find out what they are prepared to accept. I believe that we do what we can to address their needs. We say explicitly that some things are not on offer to women who are staying for a short period or for an indeterminate period, which is the case with remand. What we do is appropriate and safe in the circumstances. Resources come into it, but they are not the prime consideration.

**Marlyn Glen:** I find it quite confusing that you cannot do much with short-term prisoners. I totally understand what you are saying about people who are on remand or untried and how they might not get a prison sentence, but if short term means up to four years, that could mean someone being in prison for three and a half years. That is quite different; it would seem to be a good length of time in which some work could be done.

**Dr Fraser:** Yes; sorry. There is a gap between the six months and the four years. Short-term prisoners who are serving between six months and three and a half years are offered a lot more than those who stay with us for very short periods. Ruth Parker can help us here.

**Ruth Parker:** When someone comes into prison to serve more than a remand period, for example, that is an ideal opportunity to offer routes into treatment and to encourage them to work with our services, and we do that. As has been said, we need to ensure that the women are motivated so that we get a positive outcome. We encourage them and explain the benefits.

Those who are serving a sentence of anything more than six months can generally access our prisoner programmes, which are more in-depth programmes on offending behaviour and further education awareness. Many programmes that are on offer in Cornton Vale are female specific, and information is available on them. Some of them are about drugs and alcohol, and clearly we want to encourage individuals whose crimes have involved drugs and alcohol to access those programmes.

**Marlyn Glen:** Thank you.

**The Convener:** The submission that we received from Families Outside refers to a pilot for a women offenders programme, which I believe was modular and specifically targeted at very short

sentences. When people are in prison every day for six months, which is roughly 180 days, but we do nothing with them to address their literacy and numeracy, that is such a waste. When the Justice 1 Committee did some research on that, the conventional wisdom that resources should be targeted at people who are serving very long sentences was turned on its head; it should be the other way round. Resources should start to be piled into those people who are in prison every day for six months, although of course resources then become an issue.

**Ruth Parker:** In general, prisoners who are serving sentences of more than 31 days can access education and addiction services. The prisoner programmes have to be offered to people who are serving longer sentences, because the programmes are more intense and concentrate on offending behaviour. A programme needs to be in place for a long period if it is to have a positive outcome.

**The Convener:** If interventions during shorter sentences are not being made, because they are not deemed to be worth while or because there are not sufficient resources, are you able to say that such interventions would not have a dramatic effect and would not help—if only as a signpost to other services?

**Ruth Parker:** We make interventions. As I said, there is a national contract for addictions; there is a similar approach to education. If an individual accesses a service while they are in custody we make the effort to link them up with services in the community, through our throughcare services.

**The Convener:** Does that happen even if someone is serving a very short sentence? For example, would a person who was serving a sentence of three months have access to such services?

**Ruth Parker:** They would not have access to in-depth prisoner programmes, but if they wanted to access education awareness group work we would do our utmost to link them into community services, so that that work could continue.

Throughcare addiction services are available to prisoners whatever their sentence length. If someone wants to access services to do with learning skills, employability or addictions, or has problems with housing, for example, we try to support them by linking up with community services. We bring throughcare workers into the prison for case conferences. We share information and pass on assessment information that we have, to enable transition to the community on liberation. We take that approach whatever the length of sentence.

**The Convener:** If you had unlimited resources, what would you do differently, given the current prison population?

**Dr Fraser:** We would put greater investment into ensuring throughcare, in partnership with the NHS and other agencies, so that if we started a particular intervention we could be sure that it would continue when the individual returned to the community.

The vast majority of health and addictions services are on offer to people however long their sentence is. Whether a person is in prison for three weeks or three years, they get the full panoply of services, because we address needs as they come up. However, we have trouble addressing issues that take a long time to sort out. In the community, we would not put a person who had a drug problem on a particular course of treatment and support unless we had got to know them quite well, which could take a month or two—or three, in some cases. Similarly, we would not want to put a prisoner on a particular course unless we knew them well enough to be able to support them in the direction that they wanted to take. We would need to know that the approach was going to be effective.

You asked what we would like to do more of. When we open up someone's ideas on past abuse, grief or bereavement we are opening a can of worms, which we do not want to be shut when the person is released into the community. There needs to be a clear assurance that intervention will continue and the person will remain in touch with someone who is capable of supporting them through to closure of the issue that they have disclosed and started to address.

The vast majority of services that are available to people in our area are available whatever the sentence length. We must also bear in mind that someone who is sentenced to six months serves only three months, which is only 12 weeks. That is not long.

**Ruth Parker:** I reiterate what Dr Fraser said. A thorough assessment is required before many programmes can be accessed. We need the information that tells us whether a programme will be appropriate, particularly if it relates to wider offending behaviour.

Prisoners who have been sentenced to six months or over can access approved activities, and anybody who is serving 31 days or more can access other education awareness programmes. All other services are about linking with throughcare services, bringing in-reach services into the prison and sharing information with community services as far as possible.

10:30

**Hugh O'Donnell (Central Scotland) (LD):** I apologise if this question is naive, but is mandatory drug testing compulsory for people on remand and, if so, does that give you helpful information about people's drug use? Would it be helpful for disposals if compliance with a programme was part of the sentence and was reflected in the length of the sentence? Would a positive report from you about remand prisoners buying into programmes be an incentive for them to become involved in the various programmes to which they have access?

**Ruth Parker:** It would be helpful for prisons to have further background information from the courts on people's issues when they enter our custody and during the initial screening and assessment process. We carry out drug testing for three specific reasons: first, for clinical prescribing on admission—if somebody has a drug or alcohol problem, we carry out the appropriate tests in order to support them; secondly, to assess the risk posed in transferring individuals and to allow us to use negative tests to motivate individuals to continue to participate in prisoner programmes; and, thirdly, to identify the prevalence of drug use across the prison estate.

We do not refer to mandatory drug testing now because it is about addiction testing. We test for specific reasons rather than doing mandatory drug testing, which is more of a punitive approach. We look to provide therapeutic support and to treat rather than punish those with drug and alcohol problems.

**Bill Kidd:** From what has been said so far, it is obvious that a number of our questions will be cross cutting. As has been said, many female offenders have multiple problems, such as drug and alcohol addiction and experience of sexual abuse. Naturally, therefore, working with other agencies is greatly to be desired. Are there barriers to sharing information with those agencies? For example, I do not know about data on prisoners who are patients. Is it difficult to deal with other agencies because you are institutionally not set up to do so?

**Dr Fraser:** Yes, there are barriers. To be candid, one of our frustrations is at the lack of information sharing. There are reasons for that, though, and I would never blame the Data Protection Act 1998 for anything. The Scottish Prison Service is a different provider from the NHS, so there is no automatic flow of health care information, for example. However, many women want a service, so they will disclose. If we have the patient's consent, there are no problems and off we go.

Our other barrier, though, is information systems, which are not well developed in prisons for health care and addictions, and which are certainly not capable of talking to outside systems. Our flows of automatic or on-request information are not as fluent as they could be, which creates problems. In an ideal world, we would quickly improve that situation. However, systems outside in the community are not perfect either. Information flows and consent are hurdles that we can cross, but it is work in progress. The two big themes for improvement in my job are throughcare and information flow.

**Bill Kidd:** I will follow up on the throughcare element. Some of us visited the 218 centre in Glasgow. I was impressed by the set-up there, in particular for people coming in on a daily basis for support, treatment and care. Do you work closely with that organisation for people once they have been released from prison? I do not know whether this is possible under the remedies from the courts, but is it possible for those people to use the day care facility at 218?

**Dr Fraser:** I am not in a position to answer that. Lesley McDowall, who is giving evidence after us, will know what happens in that regard. My understanding is that, up until now, 218 has served as a disposal from the court, as an alternative to a prison sentence, so it is not a question of one and then the other. However, there is no barrier in principle to handing somebody on from one agency to the other.

**Bill Kidd:** To maintain the throughcare element, I was thinking.

**Dr Fraser:** That would be effective.

**Bill Kidd:** This is not quite on the same subject, but if there were more community prisons, what impact would the dispersal of prisoners have on the services that you could provide at Cornton Vale? Do you require to have a certain number of prisoners in the system to be able to afford the care that you provide at the moment?

**Dr Fraser:** The issue has come up on a number of occasions in previous evidence sessions, and I would subscribe to the view that there must be a balance between the scale of the operation that is being run and the menu of possible interventions on offer. The smaller the number of people in a particular women's unit, for instance, the greater the risk that the quality of the regime suffers and the breadth of what is on offer narrows, which would mean that it would not be possible to access the same opportunities that are available at Cornton Vale—the interventions are available in two places, but largely at Cornton Vale.

I do not know whether there is a magic number in that regard, but it is necessary to strike a balance with family relationships, which mean so

much, particularly for people who live a substantial distance from Cornton Vale. Sustaining a meaningful relationship is much more important than the individual interventions that we might be discussing this morning. It matters. Motivation is everything to people who are engaging in programmes and treatments.

We do not yet have a formula for the ideal size of units and their proximity to women's communities, but we will be working on that as the estate develops, with particular reference to the Grampian prison, which is under development at the moment.

**Bill Kidd:** You will know the reason for the question. Some female prisoners have been transferred from Cornton Vale to Greenock. Inverness prison has also been used as a facility and, although it is not being used at the moment, it is maintained in case it is required to address any potential overexpansion in the number of prisoners at Cornton Vale. That might bring some of the people who are serving sentences closer to the areas where they come from, and it could bring them greater family support. Is that a good route to go down, or is it not viable, because it would make it impossible to deliver all the services that are provided at the moment in a centralised manner at Cornton Vale?

**Ruth Parker:** The answer to that is twofold. My understanding is that the decision to house some prisoners at Greenock to assist with overcrowding at Cornton Vale is based on postcodes. Throughcare services are therefore much more available to prisoners from that area. The throughcare links are beneficial. There is also a need for sufficient numbers to allow services and interventions to be delivered effectively and cost effectively in the unit. In the past, because individuals were not motivated enough to get involved in the programme and because, as a result, the numbers in the unit were very small, it was not always cost effective to deliver it. The number of people will have to be large enough to allow it to be delivered.

**Dr Fraser:** I do not think that the balance is as critical with health and addictions interventions as it is with other interventions. I am going a little outside my range but, in prisons, some of which such as Inverness and Aberdeen are really quite small, work-related and employability activities require women to work in groups separate from men. The security implications of such separation mean that the regime is limited. As far as health and addictions interventions are concerned, group treatments might well be missed out but, given that many of the interventions are on a one-to-one basis, there would be no detriment to women from living close to where they come from, no matter how small the unit might be.

**Bill Kidd:** I realise that the prison estate is limited by economic and other factors. I take it, therefore, that you do not believe that more staff resources would be available at Cornton Vale, which is the central prison unit, if there were more community prisons outside the central belt.

**Dr Fraser:** The truth is that women are very high users of services, which means that any dispersal will have an impact. However, given that at the moment we are talking about six, 12 or 18 prisoners—there might be more than that when Grampian prison is built—there will probably be no impact on the number of whole-time equivalent nurses, addiction workers and so on. There is a marginal effect on the resources that will be required, but it is not really measurable in terms of large numbers of people and support services.

**The Convener:** You believe in principle that it is better for women to be dispersed to areas that are nearer to their communities and families and, indeed, that such a move would have the most impact on motivation and so on.

**Dr Fraser:** Speaking from a health, wellbeing and addictions perspective, I absolutely and definitely believe that. However, a balance needs to be struck when other elements of the regime come into play and there is a need to maintain women's safety and separation from the men.

**The Convener:** Does the fact that some women simply do not take up the programmes create something of a chicken-and-egg situation? I wonder whether those women would have more motivation in a community setting, which in turn would address the problem of economies of scale.

**Ruth Parker:** I certainly agree, if they are supported and encouraged by their families to address their offending behaviour. As Dr Fraser has pointed out and as has been borne out by evidence from Cornton Vale, the majority of women need to be managed through one-to-one support.

**The Convener:** That is helpful.

**Marlyn Glen:** With regard to your comments on improving information flow, is this simply an information technology problem that could be sorted out by putting in a new system, which would obviously cost money, or is the issue more fundamental? I am interested, for example, in the pilot in Tayside, in which the police are bringing NHS medical teams into custody suites so that they can pick up records from general practitioners, find out information about medication that people might be on and so on. After all, we are not talking only about mental health problems; people might have other long-term health problems and require particular medication at particular times.

**Dr Fraser:** That is the direction in which we want to go and, ideally, such an approach should not stop at police custody suites but continue into prison. Of course, linking up the systems presents all sorts of technical challenges, but we have nothing against that if the interests of care are served. There are many reasons why that should be the case and why, given the patient's consent to share information, there should be no barriers. It is true that women have reservations about people getting to know that they have been in prison if we ask their GP, but many of them—particularly those who suffer from addictions and need to have immediate access to continuing addiction treatments—have an overriding need for intervention that means that they will see the sense in our sharing information. The practical effect of the barriers is not as great as you might imagine it to be.

10:45

**Marlyn Glen:** A layperson would be surprised to learn that someone who was on continuing medication did not get access to that medication when they were in a police cell and, even if that were sorted out, did not get access to it in prison until they had been assessed and diagnosed again. Most laypeople would understand the importance of medical throughcare.

**Dr Fraser:** It defies logic but, as soon as someone is taken into custody, they disappear as far as the duty of care of the NHS is concerned, and the police's forensic medical examiners have to delve into the patient's health records, at the discretion of the NHS, to find out what has been going on. That has to be done, as they cannot necessarily take the patient's word for it with regard to what treatment they are receiving—you will know that people do not always remember the exact dose that they are supposed to be taking.

We need much better and faster ways of finding out the information than we have at the moment. Of course, the police often have to deal with these people over the weekends, which is even more challenging.

**Marlyn Glen:** That is a massive problem. The committee has not touched on it to a great extent, but perhaps we should consider it in a bit more depth. When we visited Cornton Vale, we had a look at one of the cells that was adapted for prisoners with disabilities, and I was concerned about whether someone who was a wheelchair user or needed medication would be able to live as independently as others in the prison and be able to care for themselves and so on.

**Dr Fraser:** We are keen to do as much as we can for people who are disabled. It is also true that many of the people whom we have in prison have been with us before, which means that, in many cases, we pick up where we left off as we have their care needs in our own memory bank. However, it is sometimes quite a challenge to find out what has been going on with people who have not been in prison before as we have to start from scratch.

**Willie Coffey (Kilmarnock and Loudoun) (SNP):** Do we know what the rates of reoffending are for the sentence groupings of offenders—those who receive sentences of less than six months, those who receive sentences of up to four years and so on?

**Dr Fraser:** Yes. Broadly, the longer people stay in prison, the less likely they are to come back. Why is that? Partly, it is an age effect. People who stay a long time in prison get older, and the older people are, the less likely they are to reoffend. Age is probably more important than the type of offence, in many cases.

We have the statistics that you ask about. People in certain categories of offending are more likely to come back to prison. Also, the pattern is that those who come back are more likely to come back again and again.

**Willie Coffey:** As the convener said earlier, it seems that the repeat offenders are those who receive short sentences. It is therefore quite hard for us to see why those people would not be subject to more intensive work. I heard what you said about it being difficult to work with people whom you see for only a short time, but it strikes me as obvious that more work should be done with that group of people to try to overcome that.

Earlier, you said that 80 per cent of people feel better about themselves on leaving prison. However, how many of those people came back?

**Dr Fraser:** You have heard in other evidence that people come to prison for various reasons. One of those reasons is that some people think that they will get a better deal in prison. In many ways, some people have an incentive to go to prison. I will not go into the reasons for that, but it is true for a certain section.

At the risk of being controversial, I would ask why people who are given short sentences go to prison at all. A prison sentence can disrupt what can be, at worst, a very fragile existence. One reason why they come back to prison is that, because we have disrupted the thread of their lives, they experience huge difficulties in re-establishing themselves in their families. That is a much greater problem for women than it is for men. It is no surprise that if they cannot reintegrate, they reoffend because that is one way of getting out of the situation that they are in. For all sorts of reasons, they might seek oblivion through drugs, which cost money, so they need to

find money in order to take the next dose of drugs. That is only one thread of the argument about why people come back to prison.

All of us must understand that what drives people to crime is a complex issue, but the main driver is poverty. Those who commit crime have an extremely poor quality of life. I would not like the committee to think that the regime that we offer prisoners is so attractive that it makes them want to come back.

**Willie Coffey:** Would someone who received prison sentences of less than six months on multiple occasions—perhaps three or four times—receive little or no intervention work? I am interested in finding out whether the frequency with which people receive short sentences, with the result that no intervention work is carried out with them, might be a reason for their continued reoffending.

**Ruth Parker:** That could be part of the reason for it. We mentioned the need for people to be motivated and how we try to motivate people to get involved but cannot make them get involved. Some offenders opt out and just remain in custody without taking part in any intervention programmes, but that is not to say that we do not encourage them to do so. As part of our integrated case management, we encourage all prisoners to participate in interventions that will benefit them and meet their needs; all prisoners are offered such interventions. Each prisoner's record will say when they were offered an intervention, why they rejected it and what was done to encourage them to take it up. Regardless of their sentences, prisoners are offered interventions continually, because the same issues are identified through the needs assessment process.

**Willie Coffey:** That touches on Mr O'Donnell's question about whether that might become part of the sentence in future.

My final question at this point is on post-release support. What work is done with prisoners when they are released? Once they are in the community, what work is done with them to prevent them from coming back to prison?

**Dr Fraser:** Through the throughcare addiction service, more work has been done on addictions than on almost any other work stream. Prisoners feel more confident about continuing with an addiction programme when they leave prison than they do about almost any other agency link-up, whether with housing, employment or health care. We could always do better, but our work on addictions is one of the better spots of light.

I would like to think that sentence management—in other words, a custodial portion followed by a community-based portion—would include care and support and some of the other elements of rehabilitation, and that that would be part and parcel of a much more sophisticated approach to getting people to play out their autonomy rather than to lose their liberty, regain it, then make all the mistakes that they made before, or have the choice to make those mistakes again. I think that the caring services could fulfil part of that role. There is a lot more to do on that, but we have made substantial inroads.

It is fair to say that the more severe a prisoner's health care problem—whether it is a mental health problem or a chronic disease such as hepatitis C—the more likely it is that it will be picked up by services in the community when they return to the community.

You raised the issue of short sentences, which is relevant to those with episodic problems or personal chaos in every dimension—criminal behaviour, health care uptake and addictions. It is difficult to organise the lives of such people, because their horizons are short and their motivation is lacking. That is part and parcel of the bad scene in which they are involved.

**The Convener:** I have a question for Ruth Parker about throughcare. According to one school of thought, if we take people with a drug addiction away from where they developed that addiction, they have a better chance of keeping off drugs, being crime free and contributing. According to another school of thought, that is not really the case. Where do you stand on the issue?

**Ruth Parker:** There are issues associated both with keeping people in the place where they developed their drug problem, but where they have the support mechanism of family contact, and with moving them to another area. The individuals concerned must make a choice; some choose to move. When they do, we do what we can to support them, through various addiction networks across Scotland. There are hurdles that must be overcome in relation to housing, tenancy and accommodation. We must ensure that they have the stability to be able to move.

**The Convener:** Do you have an opinion either way, or do you think that it depends on the individual?

**Ruth Parker:** It depends on the individual, who must make a choice. We can only advise them on how we can support their choice, help them to make the right moves and put in place the services that they need. We have done that in the past.

**The Convener:** I asked the question because I have visited the 218 centre, which is firmly of the view that to move people away is not to address the problem. The centre thinks that, if people cannot return to the community and be drug free, they have not addressed their addiction. It makes

the point that people's companions in taking drugs are not friends and that they would not spend time together if they were not linked by drugs. That diminishes to some extent the force of the argument that people must move away.

**Ruth Parker:** I agree with the point that you make, but sometimes individuals move not because they cannot address their offending behaviour and drug problem but because their domestic situation in the area may be the reason why they are taking drugs or alcohol. We must deal with the whole package and give people appropriate support and services to enable them to do that.

**The Convener:** We must identify the underlying causes so that we can get to the root of the problem.

**Ruth Parker:** Certainly.

**The Convener:** That is helpful.

**Hugh O'Donnell:** Dr Fraser mentioned short-term sentencing, which we often term the revolving door. Is there any information on the revolving escalator and the extent to which disposals increase with the number of visits?

**Dr Fraser:** Are you asking whether the length of sentence increases the more often people go to prison?

**Hugh O'Donnell:** I have some sympathy with your view on the value of short sentences. If someone goes to prison for six months and suffers the consequences of that short sentence, do you find that they later come back for nine or 12 months on an escalating basis?

**Dr Fraser:** Yes.

**Hugh O'Donnell:** How common is that?

**Dr Fraser:** We get all sorts of patterns—you have described one of them. In the jargon, we sometimes say that people are serving life sentences in instalments for repeated petty crime. In many cases, an increased tariff is imposed for roughly the same or slightly more severe offending. Attached to that pattern are personality disorders and impulsive behaviour. My clinical colleagues try hard to motivate such people, but it is difficult to get behind their behaviour and to help them see that it is in their interests to clean up and to adopt a law-abiding lifestyle. Many take the view—they are being realistic, rather than fatalistic—that we should wait until people have got through their 20s, when they are old enough and mature enough to be told that there are other ways of living their lives. I hope that I do not sound fatalistic, but in many ways that is a classic pattern of repeated offending and increasing tariff that we see a lot of.

11:00

**Hugh O'Donnell:** I observe that you have quite an age range of prisoners in Cornton Vale. To what extent do prisoners have input into the age appropriateness of any programmes and services that are offered to them?

**Dr Fraser:** I conducted a small study in which I asked older prisoners about their experience of prison, including a group in Cornton Vale who were in outstandingly poor health. Whereas the men marched or sauntered in, the women came armed with wheelchairs, Zimmers and so on—their health status was dreadful. There were very few of them because it is a small population, but the overall impression I got was that they did not want to be regarded as old; they wanted equal opportunities, regardless of their age. Although they displayed seniorship to the younger women—there is a mother-daughter relationship—they wanted to be part of an integrated community, rather than apart. Although they wanted to do age-appropriate things at quieter times, they wanted to be part of the mainstream of the community in the main part of their lives.

When quizzing management about how they adjusted to the needs of older people, I heard that they tried to be fair and not ageist in providing opportunities and that they offered older people what we might call slower streamed times when they had opportunities to do age-appropriate things with others of a similar age.

**Hugh O'Donnell:** How did the younger prisoners respond to the same question?

**Dr Fraser:** There are more of them. In fact, prison is mainly streamed for the younger prisoner. The modal age is 23 to 25 and the ages of the rest of the prisoners fall on either side of that range. Prison is largely structured around the needs of that group, but that approach allows for a wide age range to be dealt with. That is a challenge, but most prisons manage it. We already have an age bar for younger offenders, but I would be reluctant to have a separate, higher age bar after which offenders graduate to yet another institution. The evidence is also against that.

**Malcolm Chisholm:** On the same subject, what is your response to the recent inspectorate report on young offenders in adult establishments? It was my understanding of that report that things are worse for the young women in Cornton Vale, which does not have the special services for young people that male prisons have. The report seemed to say that things are worse for the young. Does that ring true in relation to Cornton Vale and the equivalent male prisons, or would you challenge it?

**Dr Fraser:** That takes us back to an earlier point that was made when we talked about community-

facing prisons, for example in Aberdeen and Inverness. There are very small numbers of young adults at those prisons—eight non-convicted people under 21 and 26 sentenced young offenders. Again, with low numbers there is a risk of there being a poor-quality regime for those prisoners because of the general need to cater for large numbers within a tightly resourced envelope. We will have to address such risks as a result of the inspectorate's report, which was certainly a wake-up call.

On the other hand, the other two establishments that cater for young men manage to offer specialised services. It is possible to deal well with small numbers of particular types of people, and that is now the challenge for Cornton Vale.

**Ruth Parker:** Some addiction services that are specifically for young people—the enhanced addiction casework services—are delivered in those establishments. Regardless of which interventions are delivered, they are provided to meet the specific needs of a specific age group. For example, we make the EACS available to young men regardless of whether they are in Polmont or Friarton, which was one establishment that was highlighted. However, we do not have in place reporting mechanisms that tell us who are young people and who are adults, so we have a bit of work to do in that regard.

**Hugh O'Donnell:** I want to move on to another area. Dr Fraser has clearly illustrated the difficulty involved in teasing out complex issues. It is our understanding that no speech, language and communication therapy services are available in Cornton Vale. Does that impact negatively on your ability to tease out whether people have difficulties in that regard? How easy is it for people to access the services that you offer, or even to express their needs? What is Cornton Vale doing about that lack of service?

**Dr Fraser:** I noted the written evidence from the speech and language therapists. It is fair to say that in an ideal world we could do more; we could have people from more disciplines coming into the prison and so on. However, other therapists who did not submit written evidence, such as occupational therapists and physiotherapists, go into prisons on an as-and-when basis. We have arrangements in place for therapists, mainly from the NHS but also from local authorities, to come in occasionally to help us meet individuals' needs.

I accept that quite a few women could benefit from speech and language therapy, but, although that ranks among our priorities for what we would like to develop, it is not the highest priority. When I talk about people expressing mental health needs, their communication abilities would be part of the package. I do not doubt that speech and language therapists have something to offer, but a number of other therapy options also occur to me. We are looking for a service, of which speech and language therapy might be a part.

**Hugh O'Donnell:** I would have thought that someone's ability to engage in basic levels of communication would be critical in identifying their other needs. It strikes me that that would be a critical element in assessing incoming prisoners, so there should be a focus on it. You seem to be saying that speech and language therapy is part of a suite of services and that it is not in any way prioritised.

**Dr Fraser:** We have a lot of competing priorities, especially among the women. There are very high levels of need. I accept entirely that the issue that you identify is critical for some women, but we endeavour to address it through good engagement and good relationships. There is no doubt that therapies of various types could help us do better. We will try to improve in various ways, partly through the transfer of responsibility for health care to the NHS, and developments in speech therapy could well be a part of that.

**Marlyn Glen:** I want to follow up what Hugh O'Donnell said. The fundamental point is that a person needs good oral communication skills if they are to take part in all the rest of the therapies. If someone is trying to express their needs, but they have difficulties with literacy, numeracy and communication, they will not want to engage, because they cannot hear or understand what is being said and they cannot explain their needs. The message that we are getting from specialists is that speech, language and communication therapy is fundamental and that, without it, some people will reoffend because they cannot engage with any of the services that are on offer.

**Dr Fraser:** That is a fair point, but we pick up people's speech, language and communication problems through a variety of routes, such as assessment, education, psychology services and so on—and we try to address them through various means, including therapy.

**The Convener:** We will move on. Do you consider that there are some women in prison with mental health problems who should not be there?

**Dr Fraser:** Do you mean specifically from the point of view of mental health and mental illness?

**The Convener:** I mean from the point of view that they have mental health problems that should be treated elsewhere, not in the prison setting.

**Dr Fraser:** Yes, there are a few. We have quite a good relationship with forensic mental health services. When we detect that someone has a severe and acute mental health need, they will be assessed and will go to hospital. My colleague Lesley Graham audited that area a couple of years

ago. The delays are minimal, and the results are certainly better than those from studies in other countries.

Since the implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003, 19 women have gone from Cornton Vale to secure mental health care in the NHS estate. Of those, nine had been convicted and 10 were on remand. We have to ask why the 10 on remand came to prison at all. It would be better for their mental health problems to have been detected and addressed through police and court routes. However, courts use prison as a setting in which to assess people; that is, they remand them in custody, pending a background psychiatric report. Prison is a setting for containment prior to proper disposal. We get a number of people who are very, very ill and who should go straight to hospital rather than prison.

**The Convener:** Is there sufficient capacity outside Cornton Vale to deal with those prisoners? For example, in the case of violent prisoners, I understand that Carstairs no longer takes women prisoners.

**Dr Fraser:** Yes. Scotland has an appropriate level of provision. We have discussed long and hard whether we should have high-secure provision for women in Scotland, and the assessment is that we should not, but that we should rely on single-case referral to an English facility in the rare instances when someone requires high-secure care. The capacity for caring for women in the medium-secure and low-secure estate in the NHS in Scotland is adequate.

**The Convener:** What proportion of the women that we are talking about could be treated in the community, and what proportion would need some supported help, whether in high-secure provision or in hospital?

**Dr Fraser:** We must bear in mind the fact that quite a small number of those women have severe and enduring mental illness. A large number of people with mental illness do not necessarily require in-patient care, in the health care sense; they require care in the community of varying levels, including quite intense care. The international statistic is that up to 12 per cent of women in prison require high levels of almost in-patient care for their mental health problems.

I think that the proportion in Scotland is lower because we have adequate health care provision and a responsive health care relationship. Generally, our level of health care provision for people with mental illness is reasonable, although I would like fewer people with severe or significant mental health problems to come to prison in cases in which those problems have been picked up as the major element behind their offending.

**The Convener:** We understand from the written submissions that at least 80 per cent of the women in Cornton Vale have mental health problems.

**Dr Fraser:** Yes.

**The Convener:** Of that proportion, how many should not be there? How many of those women could be treated in the community and how many would require support at various levels?

**Dr Fraser:** I am picking numbers out of the air. Broadly speaking, of the 70 or 80 per cent with mental health problems, 1 or 2 per cent should be in hospital rather than prison. A further 8 or 10 per cent would, I would hope, be satisfactorily dealt with in the community, highly supported by the NHS and other agencies. For them, their mental health problem is the more prominent problem—it is an offending problem. For the rest—the majority—their offending is more prominent than their mental health problem. The problems co-exist—they might drive the offending but they are not what made the person do the crime. It is a chicken-and-egg situation—it is sometimes quite difficult to detect which comes first. However, prison is there for people who have committed crimes, and one of the many complex problems that they have can be a mental health problem.

11:15

**The Convener:** Are you saying that that is the case for about 11 or 12 per cent of the 80 per cent?

**Dr Fraser:** Yes. Their cases would be negotiable between the health and criminal justice sectors. The remaining offenders would definitely be in the criminal justice sector, although whether they should be in prison is another issue.

**The Convener:** There is a concern that prison is an easy option when dealing with people with various problems such as mental health problems. We are not quite sure what to do with them, so we put them in prison—the figures indicate that.

**Dr Fraser:** I subscribe to that view and I am concerned about that, too. However, I think that the problem affects a minority of cases, not the majority.

**Malcolm Chisholm:** In your experience, do some women with mental health problems experience a deterioration in their mental health while they are in prison, or do you think that the opposite happens because of the care that you provide for them?

**Dr Fraser:** It is a mixed picture. For many women, the experience of losing their liberty for the first time is traumatic, although it is less traumatic the next time that they come into prison

because they know what they are coming into. The experience is more traumatic for women than for men because of their loss of place in their social setting. The majority also have children, and if there is one relationship that means a great deal to many women it is their relationship with their child. That should be a much more important consideration in sentencing decisions.

Women's mental health can take a serious downturn when they come into prison. On the other hand, it is a subsidiary job of prison to lessen the impact and to be as humane and decent as possible to women. I think that, largely, Cornton Vale achieves that. It is a humane institution that deals with people in a decent way, minimising the damage that women have already experienced.

**Bill Wilson (West of Scotland) (SNP):** You talk about children in the context of whether prison makes the mental health of prisoners better or worse. What do you think might be the effects on the mental health of the children of prisoners?

**Dr Fraser:** The experience is universally devastating unless the relationship between the mother and the child is an abusive one, which it is in a small minority of cases. Lesley McDowall could talk to you about that. The experience is dreadful for a child who cannot understand what has happened. Often, the women are young with very young children and it is not a situation that can be explained to the children, as they are below the age at which they could understand it. A substantial number of children lose their mothers to prison each year—the number runs from three figures into four figures. That is a remarkably damaging statistic for which prison is responsible.

**Bill Wilson:** Is any help offered to those children at the time?

**Dr Fraser:** Families Outside does a great deal to ameliorate the situation, but the majority just have to get through it. The children go to live with their grandparents or their aunts or they go into care. A very small minority—about 11 per cent—go to live with their fathers. Often, that happens at very little notice.

**Bill Wilson:** Is it possible that such a traumatic experience can affect the offending behaviour of those children when they are older?

**Dr Fraser:** Definitely. I cannot enumerate that, but there is definitely a possibility that it can create another generation of offenders.

**Bill Wilson:** Would you say that it is important to provide a more effective system of help for those children when their mothers are jailed?

**Dr Fraser:** Yes. That is paramount.

**Malcolm Chisholm:** I want to ask about medication. The committee has been told that there can be a delay between women coming into prison and contact being made with their general practitioner to obtain details of their medication needs. Are there any means by which inmates' medication needs can be established more quickly, so that there is no risk of their health being jeopardised?

**Dr Fraser:** The current process is a facsimile process, as a paper trail is needed for prescribing decisions; however, it is slow and cumbersome. A quick response is sometimes received, but that does not always happen and there is progress chasing to be done, among all the other things that the health centre does. There are frustrating delays in finding out about people's medications.

There is also a fixation with addiction-related prescribing—for the drug that people need to have for the next day—perhaps at the expense of other drugs that have been prescribed. That is a frustrating issue that perhaps goes back to our earlier theme of sticky points in the information flow into and out of prison.

**Malcolm Chisholm:** Is it the case that the women will often not have been in contact with the health service previously about mental health issues? Does lots of new medication need to be prescribed for mental health issues?

**Dr Fraser:** That happens in a very small minority of cases, but mental health treatments are usually started in the community and continued in prison. We do not get to know people well enough—especially short-stay prisoners—to be confident enough to prescribe a course of mental health treatment for them that might last quite a long time. If their needs are acute, we will certainly assess and treat them early, but one would want to wait before prescribing for longer-term needs, such as fluctuating depression or anxiety. For instance, the majority of our prescriptions for anti-depressants continue treatment that was started in the community. That is why it is so important to know what medication people are on and the accurate dose of that medication when they first enter prison.

**Hugh O'Donnell:** On the same issue, I have a tighter and perhaps more narrowly focused question about time-contingent medications, such as those for Parkinson's disease. Such medications can vary depending on the patient and where the condition is within the cycle. How does the prison medical service cope with such individualised requirements?

**Dr Fraser:** We try our best. Certainly, nurses pick up very early on whether people need critical treatments—such as for diabetes, which is another example—for which it is essential to get treatment established early. However, I have come across instances in which there have been critical delays

and harm has resulted. Interestingly, about 18 months ago I had an inquiry from the wife of someone with Parkinson's disease who was likely to come into prison. She wanted assurance that he would continue to receive treatment. In such exceptional instances, we can tip off the prison that the person is likely to enter to ensure that the prison staff are aware of the issue. Any communication like that is very welcome. We do our best to address individual needs. Parkinson's disease is quite unusual because it is typically associated with old age. Few people of that age come into prison without our knowing about them.

**Willie Coffey:** I have a question for Ruth Parker about drug addiction. In her opening remarks, she said that just over half the women who come into the prison have drugs in their system when they are admitted. Are we winning or losing the battle against drug addiction during their stay? To what extent does the availability of illegal drugs within the system undermine the efforts to tackle the problem?

**Ruth Parker:** Let me just correct your first statement. I said that 71 per cent came into the prison with illegal drugs in their system and 53 per cent reported that drugs were linked to their offence.

On the issue of winning the battle, I think that we are making positive inroads and that we have positive outcomes in relation to that 71 per cent. A recent study on those leaving the prison revealed that 32 per cent tested positive. That indicates a 39 per cent reduction during prisoners' stay in Cornton Vale. Therefore, there appear to be positive outcomes from our work.

On the security issue with drugs, yes, it can be difficult to maintain a drug-free establishment. We are committed to stopping illegal commodities coming into the prison and we have robust systems in place to detect illegal drugs and to deter people from bringing them in. That is part and parcel of the wider package. Clearly, requiring closed visits and denying females the opportunity to have a structured and normalised regime would require us to put in place quite an oppressive system. We try to provide normalisation, while balancing that with security. Both things need to run in parallel so that we can have the positive aspect of drug rehabilitation.

**Willie Coffey:** Did you say that around 30 per cent of women leave prison with illegal drugs still in their system? Have I picked up correctly what you said?

**Ruth Parker:** Yes.

**Willie Coffey:** I understand what you say about a regime that is too prohibitive, but what additional things can or should be done to reduce that figure further?

**Ruth Parker:** It was said earlier that we do not track individuals from admission into the prison estate to liberation. We probably need to concentrate more on tracking people and on who accesses our interventions and programmes. We should concentrate much more on working in partnership with community services, continuing in the community what has been done in prison and bringing into prison services for those who are already in treatment on admission.

Statistics from our prisoner survey indicate that prisoners who already receive support would like that support to continue. In relation to information flows, court reports and communications from services providers, it would be helpful to continue work on prisoners who come into custody rather than start again, and to continue in prison treatment from where it left off in the community and, likewise, to continue treatment in prison into the community. We do some such work already, but far more of it would produce far more positive outcomes generally throughout Scotland for the national population. That would require us to work far more closely with community justice authorities and the revised alcohol and drug partnerships, and we would need to meet people's information needs and link into services on a prisoner's liberation. The community and the prison need more robust pre-release arrangements.

**Bill Wilson:** If I understood you correctly, you mentioned a 39 per cent reduction in the number of women who leave Cornton Vale with drugs in their system. It seems to me that if Cornton Vale has been successful in reducing the quantity of drugs that is available there, there is a possibility that that 39 per cent reduction could be due to fewer drugs being available as opposed to the effectiveness of addiction services in tackling addiction. Without follow-up data on women's behaviour six months down the line, say, it seems to me that there is no way of knowing whether your addiction-tackling services have been effective. Is that overstating the situation?

**Ruth Parker:** No. We need to take into account not only drug treatments and the deterrents that we have in place to stop drugs getting into the prison, but the complex issues that contribute to people's addictions and offending behaviour and the wider essential services that are available. It is difficult to make measurements, but I agree that we need to do so alongside our colleagues in the community and to track individuals not only throughout their prison term, but after they have been liberated. We need to consider the successful cases.

**Dr Fraser:** The SPS would like prison to be the place where people decide to give up their drug habit, but for a large number of prisoners, prison is quite a short-stay setting. We would like to be part

of the solution, and we are certainly working more and more closely with community-based drug agencies to deliver that. However, it must be recognised that we are talking about a chronic condition for many prisoners that props them up while they deal with all the other things going on in their lives.

We are not fatalistic about the matter. We try to reduce the supply of drugs into prisons and meet the demand for services, but we are part of prisoners' overall outlook on drugs, and drugs are the main means that they have of getting through things. I am not trying to understand prisoners to the $n^{th}$ degree. We are trying to address the drug problem, but we are part of a network in which the woman is at the centre, of course, and she must decide that she is fed up with her lifestyle and to move on to another lifestyle. We are there to help, support, motivate and—I hope—be part of the solution to get people off drugs and to stay off them.

**The Convener:** We have heard the fairly shocking statement that many women prefer to go into Cornton Vale, as it is almost a respite from the chaotic and pretty horrific lives that they lead outside. To what extent is that true, in your experience?

11:30

**Dr Fraser:** It is very true for a defined number of women—I hope that Lesley McDowall, who is on the next panel, will help you out with a more accurate figure. It is not just a Scottish phenomenon—which is not to deny that it is a very disturbing phenomenon—that people find prison to be a place of asylum as well as punishment, where they can get away from and restructure their lives. They can seek the help that they have found difficult or have not had the time or presence of mind to find. In many cases, help comes to those who are in prison whether they like it or not, whereas much more effort is required to get in touch and stay in touch with services in the community. The equation is different. People come to prison, and sheriffs send them there in a patrician way, because they think that help is at hand there.

**The Convener:** Is there a lack of alternatives to prison that provide one-stop respite and prevent people from reoffending?

**Dr Fraser:** Yes. There is a lack of personal security in the community and of quality in people's lives. There is also a lack of community-based—perhaps residential—alternatives. It is striking that the pile of submissions—or the electronic equivalent—that the committee has received reveal that in Scotland, the 218 centre is the only show in town. We need many more services like it. They may be costly, but there must be something other than prison for people who need time out, respite and residential care.

**Ruth Parker:** I endorse Dr Fraser's comments. One of the key factors is an individual's motivation to become involved with residential facilities. The 218 centre in particular is key to achieving success when people are willing and realise that the time is right to address their problem.

**Hugh O'Donnell:** To what extent has there been a reduction in the number of illegal substance finds in Cornton Vale? Have the finds involved illegal substances or prescription medication that was being used by the person to whom it was issued?

**Dr Fraser:** I will make a general comment while Ruth Parker ferrets through her papers. Of the drugs that are found in people's possession or in their system, most is cannabis. However, when people come in, the balance is much more heavily tipped towards class A drugs, such as heroin and cocaine. Quite a significant number continue, in and out of prison, to use illegally acquired prescription drugs such as diazepam. The profile in prison is that diazepam and drugs like it are almost a constant, whereas heroin and opiates largely disappear—the rump comprises prescribed opiates such as methadone. Cannabis is much more commonly evidenced in prison and when people are on the way out. It may not be a particular comfort to look at the whole profile of drug use, but in prison the balance is much more heavily weighted towards cannabis and—to my mind—less hazardous drugs.

**Hugh O'Donnell:** That is surprising. My understanding—to return to the old MDT terminology—was that class A substances remain in the bloodstream for a short period of time and are therefore chosen over cannabis, which has a longer lifespan and is more readily identified with MDT. However, you seem to be saying that it is the reverse in Cornton Vale.

**Dr Fraser:** There are two reasons for that. One is that drugs services have addressed the class A problem through methadone substitution and other means of addressing opiate addiction. The other is that the removal of mandatory testing and the sanction that came with it removed the perverse incentive that you mention to go to class A drugs and away from cannabis. Because the consequence of being found with cannabis aboard is not what it was, we are finding more of it.

**The Convener:** That completes our questioning.

**Hugh O'Donnell:** Ruth Parker was going to give me some figures.

**The Convener:** Sorry, Ruth.

**Ruth Parker:** I have a couple of points. A recent snapshot revealed that 26 per cent of all prisoners use methadone prescribing in response to opiate addiction, which is a fairly high figure. I do not have the details on seizures, which I think Hugh O'Donnell asked about, but the number of drug finds has reduced significantly in recent years. That is partly to do with our positive and robust security systems, which involve working with law enforcement agencies. We take a twin-track approach by working on security and intelligence, as well as on treatment and reducing demand and harm.

**Hugh O'Donnell:** I am interested in those figures, so perhaps you could get them to us.

**Ruth Parker:** Would you like the figures to be sent to the committee?

**Hugh O'Donnell:** That would be helpful.

**The Convener:** That completes our questioning. Do the witnesses have anything to say in conclusion?

**Dr Fraser:** In relation to Bill Wilson's questions, I want to underline the importance of putting children into the equation in sentencing women, no matter whether the women have drug and mental health problems. I was surprised not to see that point in a submission to the committee from a children-centred non-governmental organisation—I think that it was Action for Children Scotland. The effect on children of imprisoning their mothers is profound and damaging and ensures the creation of the next generation of offenders. One way of cutting into the inequalities cycle is to tackle the critical element of parents and people who are about to be parents, and to deal with people who are separated from somebody who means a huge amount to them, usually a young child.

**Ruth Parker:** The larger the number of short sentences, the less able we are to involve staff in treatment and rehabilitation interventions. Sometimes, we have to take staff from that crucial work to manage the custody and order side of the business and to support transitions to court or throughout the estate. Short sentences have a detrimental effect on drug rehabilitation, as they divert staff from that intervention work.

**The Convener:** That goes back to resources.

**Ruth Parker:** Yes. The issue is resource allocation. We have to deploy staff to service prisoners who serve very short sentences. There is churn as people go to and from court, in and out of prison, and through the reception process. Our resources would be far better employed in delivering treatment and rehabilitation programmes and other interventions.

**The Convener:** I thank both our witnesses. We have had a comprehensive session and the committee is grateful for your attendance.

11:38

*Meeting suspended.*

11:45

*On resuming—*

**The Convener:** It is my pleasure to welcome our second panel of witnesses, who will cover sexual abuse, domestic abuse, prostitution and addiction. We have Naomi Robertson from Open Secret; Lesley McDowall, who is the head of care at Cornton Vale; and—sitting in the middle—Heather McCabe, who is a prison liaison officer with Alcoholics Anonymous.

We will start with the same generic questions that we asked the previous panel. Broadly speaking, what is the aim of providing programmes for female offenders in prison?

**Lesley McDowall (Scottish Prison Service):** As Dr Fraser and Ruth Parker said, programmes—and especially the female-specific programmes that are offered in Cornton Vale—are intended to address addictions and offending behaviour. Those are the main programmes that are delivered by programme staff who are employed by the Scottish Prison Service. Other programmes of shorter duration are delivered by non-governmental organisations and other staff in the prison, including the mental health team.

**Naomi Robertson (Open Secret):** Open Secret supports women who have experienced sexual abuse and other forms of abuse. We know that a high percentage of women in prison have experienced sexual abuse. We take a person-centred approach to what has happened to them, the impact that it has had on them, how they have coped and how they want to cope more positively in the future. We examine the whole package—we do not consider just the history of abuse, because abuse affects all areas of a woman's life. We must examine the impact of that abuse and consider a package of support to move those women forward.

**The Convener:** Will you quantify the percentage, which you said is high?

**Naomi Robertson:** The most recent report estimated that between 80 and 85 per cent of women in Cornton Vale had experienced abuse. I am not sure, but I do not think that that percentage has been reviewed.

**The Convener:** That percentage is very high.

**Heather McCabe (Alcoholics Anonymous):** Our aim is to bring the message of Alcoholics

Anonymous to the still-suffering alcoholic. Many women in Cornton Vale have problems with alcohol. With many of the people who are identified as drug users, we find an underlying alcohol addiction. Our aim is to strike while the iron is hot. Many such women are in crisis and are discovering things about themselves that they did not know. We also support members who have relapsed or who have engaged in offending behaviour off their own bat and have ended up in prison. We support an abstinence programme and we try to improve people's lives.

**The Convener:** How realistic is it to expect the services that you provide and other services to have a significant impact on reoffending?

**Lesley McDowall:** The approach must be holistic. As Naomi Robertson said, we cannot consider somebody just as a survivor of childhood sexual abuse or as an addict; we must address every part. As the committee has heard, many of our women have mental health problems and an addiction and are survivors of childhood sexual abuse. They also have children and have family and parenting issues. All those issues must be considered together to reduce reoffending. Addressing just a single part more than likely will not succeed; we need to consider each part to achieve a solution that reduces reoffending.

**Naomi Robertson:** We must hope that it is realised that what is done will be effective. That is not to say that everyone who looks for support because of a history of sexual abuse will stay out of prison. When we consider people's past, we appreciate that there is no magic wand, plaster or quick fix. If prisoners ask for support and a referral comes from them, we must hope that their motivation to participate in counselling and support, to make positive changes and to look at their history will have an effect and that they will succeed on the road to recovery.

**Heather McCabe:** I must shed a ray of light and say that the majority of women who follow our programme and stay within Alcoholics Anonymous do not reoffend. However, the majority of women who turn up do not stick with us and are not, at the time, willing to put in the work. Nonetheless, we hope to plant a seed so that, when they really hit rock bottom later on in their lives, they come back. The main idea for us is that when somebody stops drinking and using drugs alongside drink, the behaviours that go along with that stop.

**Marlyn Glen:** Is it possible to measure objectively whether your services have, over time, improved inmates' behaviour or attitudes upon release compared with their behaviour or attitudes on admission?

**Lesley McDowall:** I do not have statistics on that, because we do not follow the women once they go into the community. However, of the women who come back to us—for example, due to outstanding warrants—who were with us for less than a year, we have noticed an increase in the number who engaged with services and who come to us clean. As a result, they are aware of what is required of them when they return to custody, and they continue with their methadone scripts and continue to engage with services while they are in custody. There are therefore some measures of success, but we do not follow the women for a significant period after they leave us to quantify which interventions are the most successful.

**Naomi Robertson:** The difficulty is quantifying the effect of the services that we deliver, because much of the data are qualitative. They are about improvements in self-esteem and confidence or the difference between someone believing that they will achieve and assuming that they will fail. They are about the difference between somebody looking for an abusive relationship and understanding that they are worth more than that and looking to make appropriate connections in the community.

As our service progresses, we evaluate its impact on confidence, self-esteem, understanding of available support, coping strategies and self-worth. In the majority of cases, the prisoner will say, "I am beginning to feel more confident, feel like I have self-esteem and understand that there are people to help me. I do not need to take drugs to forget or cope with my memories or to drink to the point where I cannot remember. There are other ways of doing this."

A difficulty arises when the women are released. Ours is a prison-specific service for Cornton Vale, but we operate in other parts of Scotland. We now have a service for people who were abused in care, which enables us to refer them from throughout Scotland. Much of the time, we refer them to another agency, so they start counselling with us and are then referred for community support. That can be difficult for women who are on shorter sentences, because they start the process in Cornton Vale and want to continue with the same counsellor, which is just not possible. Counselling takes time and trust and requires rapport to be built up. If women on short sentences had community sentences, there would be much more scope for longer and more intense engagement and for an abuse counsellor to follow their progress in the community.

**Heather McCabe:** Obviously, as Alcoholics Anonymous is an anonymous fellowship, we do not track people or keep numbers in the way that other services do. However, if the girls want, we can arrange to pick them up at the gate or meet them at the nearest transport venue and take them to an Alcoholics Anonymous meeting. If they

decide to stay with us and practise the programme and principles that are laid down, they have a 24-hour support network that is absolutely free and is available in every town and city throughout the world. Because we are just a group of people—it is like a massive group of friends who have a common aim—there is a lot more support and nurture, which helps with all the other things. Once somebody gets sober, they are more able to think for themselves and deal with all the other issues than if they are trying to deal with things while they are still covering up the problem. It is a bit of a chicken and egg situation at times, but they give themselves a sporting chance.

**The Convener:** It was interesting to read in your submission that the process is not just about getting off drugs but about giving something back by helping other people, which is how you developed the 24-hour support network.

**Heather McCabe:** Absolutely. The first step of the 12-step programme is to stop drinking and using. The programme is abstinence based. The next 10 steps are about sorting your head out, adjusting how you react to things and becoming a valued member of society. Those steps help you to sort your life out, so that you do not fall into debt or resort to drink, drugs, sex, chocolate, shopping or any of the other things that can be extremely addictive and are a danger for anyone who is an alcoholic. The last step involves giving away what was given to you. That is what enables you to maintain your own sobriety, and it is an enlightening process. You might think that you would become a teacher, but you actually learn more about yourself and help yourself more than the person you are trying to help.

**Bill Kidd:** Earlier, we talked about the fact that many female offenders have multiple problems. Various agencies and people interact in different ways in their efforts to help those women. You might not keep figures, but you have relationships with various groups. Does Alcoholics Anonymous face any particular barriers in dealing with people's issues in the prison system? In Scotland, women do not face difficulties in relation to being moved between institutions, because there is only one institution for them, but are there problems when they leave prison? I know that you have said that you pick up people and help them out, but some people who leave prison lose touch with the organisations that helped them when they were inside. If they decide that they want to get back in touch, do they face any problems in doing so?

**Heather McCabe:** I can speak only for AA. Our telephone number is in every phone book and on the walls of every doctor's waiting room. If they want to come back, they are free to do so at any time.

**Naomi Robertson:** Confidentiality is a crucial part of the work that Open Secret undertakes. At the beginning of their first session, the women are advised that confidentiality will be maintained unless they are at risk or someone else is.

Cornton Vale is very good at information sharing. We were given the opportunity to opt in to the mental health team's multidisciplinary meetings, at which people in the prison and from various agencies come together to consider specific people's issues. When I attend those meetings, I do not have to give a full and graphic history of the people I am dealing with, but I can outline issues such as whether they are struggling with their confidence or having extreme flashbacks, which enables the prison to monitor their mental health in relation to self-harm and so on, and to offer on-going support when they are released into the community. When they leave prison, they are made fully aware of our services, including the service for those who were in care. Like AA, we are contactable in the usual way.

**Lesley McDowall:** We encourage external organisations that work with women to continue working with them when they are sent to prison, especially when they have been given a short sentence. The last thing that we want to do is destabilise someone who has a therapeutic relationship with a key worker or organisation, so we engage with them to get as much information as we can when we are caring for those individuals.

We work in partnership with many organisations. On prostitution, we work with Routes out of Prostitution and the passport project. A new project in Edinburgh called the willow project will work with women who are involved in prostitution or who are at risk of becoming involved in prostitution.

Various groups, such as Rape Crisis Scotland and Circle, come into the prison to work with women. If women engage with such groups while they are in prison, they are more likely to continue to access their services when they are outside. That approach has been shown to be much more successful than one in which women are simply given a signpost to services, because more than likely they will not turn up for the first appointment as they do not feel comfortable doing so.

12:00

A recent survey that we did found that less than 48 per cent of the women whom we surveyed access any health services whatever. Women who will not access even health services are not likely to access other services. If a woman starts a relationship with a service while in prison, they are more likely to continue with it when they leave.

Our biggest problem is to do with having a national facility, as Naomi Robertson said. Some services that we use are not Scotland-wide and there can be gaps in services depending on the postcode to which the woman returns. On occasions, women have changed their address after being liberated in order to access the service that they want. That is especially the case with addiction services: women have moved house just so they can access what they consider to be a better addiction service.

**Bill Kidd:** Would it help women to continue to access services if community prisons were spread throughout the country, or at least if there were an additional couple of prisons, in the north or in Greenock, for example? Support can be disjointed if a woman is in Cornton Vale one day and back home the next, where services are not necessarily available. If prisons were more community based, would services be more likely to be available locally?

**Lesley McDowall:** There are definitely benefits to short-term and remand prisoners of remaining in the area from which they come, in that services that are already working with them find it much easier to access them. Access to families also brings benefits. It has been shown that women are more likely to succeed if family links are continued or strengthened, and it is easier to do that if a woman remains in the area that she comes from. For women serving longer-term sentences, I would be concerned about the capacity to mirror the expertise that there is in Cornton Vale. It might be hard to mirror female-specific programmes on mental health, for example, in very small groups.

**Bill Kidd:** Might there be resource implications for long-term prisoners if there were more community-based prisons, because the sizes of the groups involved would not allow for expenditure on services?

**Lesley McDowall:** Yes.

**Marlyn Glen:** I am concerned by what you said about the postcode lottery that means that some women have moved house so that they can access services. Can the committee have more information about such service gaps?

**Lesley McDowall:** We can certainly compare the addresses that people give on admission with the addresses that they give on liberation, and we can explore the reasons why people move. The situation that I described applies especially to people who go back into the community on a methadone programme. It is not unheard of for people to move so that they can access a prescriber.

**Marlyn Glen:** It would be useful to have information on that.

**Bill Wilson:** We have heard much about prisoners who serve short-term sentences of less than six months and prisoners who are on remand. Many services are available to them, but some services are not. That was explained in part when we were told that it is not possible to intervene unless the service has a good understanding of the individual—leaping in with one's big tackety boots might do more harm than good.

Lesley McDowall said that an individual who has contact with a service while in prison is much more likely to use that service when they leave prison. Is it therefore important that very short-term prisoners and remand prisoners have at least some contact with services, perhaps not to ensure that there is effective intervention while they are in prison but to increase the probability of their contacting the services when they leave prison, or would such short contact not increase the likelihood of their accessing services?

**Lesley McDowall:** Any contact is good contact. In my experience—I have worked in Cornton Vale for 12 years—in the first month of their sentence prisoners are still coming off illicit substances, and it is difficult to make assessments at that point. In the next two months, they are usually fighting their own demons—their main focus is on seeking drugs, so it is difficult to get them to engage. However, if community services have sufficient resources to send someone into prison to make the first contact with an individual, that will benefit the person when they leave prison.

**Hugh O'Donnell:** We heard from the previous witnesses this morning that illegal substances are still getting into prisons. Is alcohol getting into our prisons?

**Lesley McDowall:** It does not come in—it is made in prisons. That does not happen often—the process is quite technical—but the girls have creative ways of making what is referred to as hooch. Because the fermentation process is so long, hooch is usually captured before prisoners have had a chance to consume it. Alcohol does not come in—the only alcohol in prisons is stuff that is made there.

**Hugh O'Donnell:** I guess that you know whether there is a still from the amount of rice and potatoes that are purchased in the canteen.

**Lesley McDowall:** Yes—the potatoes and sugar start to go missing from the cookhouse.

**Hugh O'Donnell:** That is fair comment.

My follow-up question is directed at both Heather McCabe and Lesley McDowall. Given the restricted availability of alcohol in prison—for obvious reasons—do you find that people who enter prison with a single addiction to alcohol are

tempted to move on to illegal drugs, which may be more readily available?

**Lesley McDowall:** In my experience, that happens on occasion. When women have a single addiction to alcohol, it is usually directly related to the crime that they have committed—they state that they were drunk when they committed the crime. The majority of those women just want to get on with their sentence. However, a minority may look to use illicit substances, especially if alcohol is a coping mechanism. If we remove alcohol and give them nothing else, they may seek another coping mechanism. The majority of women who are addicted only to alcohol tend to seek help through programmes and AA, which visits Cornton Vale, instead of seeking another addiction.

**Heather McCabe:** Lesley McDowall has provided a great demonstration of what we do. If we take alcohol away from an alcoholic and they have no coping mechanism, things really start to fall apart. The purpose of the AA programme is to provide such a mechanism. That is why every alcoholic who comes on to the programme is on it for the rest of their life.

My experience is that girls who are addicted purely to alcohol tend to stay that way, rather than moving on to other substances when alcohol is restricted. However, most of them already have other addictions, so it is a matter of shifting sands. Because people are desperate and unable to cope with their lives, they will take whatever is going. The reports that I have received indicate that hooch was available at Cornton Vale but it was less than pleasant.

**Malcolm Chisholm:** When people first look at the question of female offenders, they are struck most by the statistics on sexual abuse that Naomi Robertson quoted. We must seek to understand that issue as much as possible. The situation is complex, so I am probably asking an impossible question, but is the problem usually the combination of sexual abuse with the drug or alcohol addiction that follows from that, or is there something about the experience of sexual abuse that can lead to offending irrespective of whether drugs or alcohol intervene?

**Naomi Robertson:** The answer to that probably has two prongs. It is an extremely complex question, to which there is no direct answer. Many women who have been abused will use drugs and/or alcohol to cope because they are not aware of other supports that are available. As a result of trying to cope with their sexual abuse, they might get a drug addiction, which has to be paid for, so they move into offending; because the memories of the abuse remain, they need more drugs, which leads to more offending. It becomes a vicious cycle.

I reiterate that women who have suffered sexual abuse and chosen alcohol as their coping mechanism tend to be so focused on that way of dealing with the issue that they do not even consider touching drugs. Do not get me wrong—a lot of women who have suffered sexual abuse vent how they feel in many different ways, from the use of drugs and alcohol to self-harming behaviour and aggression. However, women who focus on a specific way of coping tend to be blinkered about it. They use alcohol, for example, because that is how they have always coped, but they will not touch drugs because they are not into them. They have a specific way of dealing with the issue.

Does that answer the question?

**Malcolm Chisholm:** To a large extent.

As a supplementary, to what extent do the women with whom you deal have access to services before they come into prison? In some cases, is the service that you provide the first that they encounter?

**Naomi Robertson:** A lot of the women will have made a previous disclosure, usually to a family member. They might not have been believed, or the issue might have been swept under the carpet. The attitude is, "Child abuse is a dirty subject—we don't talk about that", and people do not like to hear terms such as "rape" and "sexual assault". A lot of the time, the women in question come from very difficult backgrounds—they might have had drug-abusing parents or lived in poverty. Many of the women in Cornton Vale come from such backgrounds, although abuse happens across the spectrum.

One question that we ask the women when we first meet them is how aware they are of the services that are available to them. Most are not really aware of them: they say, "What do you mean? I take my drugs and that's how I cope." It is not that the services that are available—including ours—are not well advertised or good at promoting what they do; it is simply that the women have not been in an environment in which someone has said to them, "Hang on a minute. That has happened; this is who you speak to."

Alternatively, the first time that women disclose the fact that they have been sexually abused might be in prison. It might have been their deep, dark secret for many years, which they reveal only when they come to prison. In a way, that is strange, because we would not expect prison to be the environment in which they disclosed what had happened to them, but in prison they feel safe, secure and protected from the outside world and their abuser. When someone offers them a service, they say, "Yes, please", because they suddenly realise that there are other ways of coping.

**The Convener:** Could I get your definitive view on the community prison option as opposed to the one-stop shop, which, in effect, Cornton Vale is? If resources were not an issue, where would you fall on that?

**Lesley McDowall:** I do not think that there is a requirement to have lots of community prisons. As has been said, women who come from the north-east and do not get visits very often really struggle. When Inverness took women prisoners and there was an area in Aberdeen to which women could go back to receive accumulated visits, they lived for that—it was what kept them going. We do not currently have that, and I see the effect that that has on women. Giving women the opportunity to access more visits from their families can only be a good thing, especially if they are short-term prisoners or are on remand. I still have concerns about whether the same level of expertise could be provided in other prisons as is provided in Cornton Vale.

**The Convener:** That is for long-term prisoners.

**Lesley McDowall:** Yes.

**Naomi Robertson:** I reiterate what Lesley McDowall said. The difficulty with community prisons is to do with resources, expertise and long-term care. In an ideal world, money would not be an issue, but we all know that it is.

I would not want a postcode lottery to develop. Greenock prison is now taking females, and some women who recently came to me for support have now gone to Greenock. We are holding discussions with that prison and will deliver a service there. However, the people who are moving from Cornton Vale to Greenock are doing so because they live near Greenock prison—it is in their postcode—and despite the fact that they might have to wait slightly longer for services that, even if they could not be delivered tomorrow, are in place and available at Cornton Vale.

The other issue is perhaps a bit controversial. I have spoken to a number of the women with whom I work long term and have good trust. On community support, they say honestly, "As much as it's horrible to be away from my family in Aberdeen when I'm in Cornton Vale, my motivator is my children and getting back to my family and out into the community." A number of the women indicated that their concern about community prison is that it would be too easy because they could go into prison on a short-term sentence and see their family regularly. That is the women's view, but it is not necessarily my opinion. However, the concern is whether we can say that female offenders—and male offenders—will get exactly the same service in every community prison.

12:15

**The Convener:** Will the view vary from woman to woman? You heard from some women that there would be a lack of motivation because community prison would be too easy. However, could it provide motivation for others? That is what we heard from the first panel.

**Naomi Robertson:** There is no definitive answer. If we want to know what female offenders want, we should talk to them, because the women are honest. They are clear about what is right and wrong for them. Some will prefer to go to Cornton Vale because it offers so much support and expertise in one place. Women come into Cornton Vale because they know that they can get support that is not in the community or for which they would have to wait a long time in the community. Resources in Cornton Vale are offered free and the women come in to get help and get better, as they put it, and to go out again. They will not necessarily sustain their improvement in the community, but they think, "Cornton Vale has everything I need—all the services and the expertise." As Lesley McDowall said, it is difficult to replicate that service across Scotland.

**Bill Wilson:** If I understood you correctly, Naomi, you said that some women feel that they have a greater incentive to sort out their problems because they are isolated from their family by being in Cornton Vale. However, we heard evidence earlier that imprisoning women can have a damaging effect on their children. Being isolated from her family might provide an incentive for a woman, but it could have a greater effect on her children.

**Naomi Robertson:** Absolutely.

**Bill Wilson:** A balance must surely be struck between the view that the mother will be back more quickly because she has the incentive to solve her problems and the potential for her imprisonment to cause so much damage to her child.

**Naomi Robertson:** Oh God, absolutely—we must consider the global picture. The impact on the child must be foremost in the mind when considering what supports are in place. I am simply trying to impart some of the women's views, which stunned me when I heard them. I said that being close to their families is surely better, but they said that, although they want to be closer to their families, they are not convinced that they would be as motivated in that case to access resources and that they are concerned about the level of resources in the community.

**Bill Wilson:** I am sure that the women are aware of the effect on their children, but are they aware of how great the effect might be? If they are keen to get back to help their family—that is

clearly a major issue for most of the women—I presume that an awareness of the effects on the children would be an incentive for them, too. Or would that just cause depression and more problems for the women?

**Naomi Robertson:** No. Part of my work is helping women understand the impact that their offending behaviour, irrespective of whether it was precipitated by sexual abuse, has on everybody else. For example, we consider positive and negative relationships and how the woman's behaviour has impacted on her and her family. In the beginning, some of them do not realise what the impact is. They will say, for example, "Mummy is in hospital" or "Mummy is away on holiday" and think that they have dealt with it. The issue is getting them to understand the impact that their imprisonment has on their children. The understanding is immediately apparent with some women, who say, "I can't believe I've done that to my children and I need to get back to them now", but it takes longer for others.

**The Convener:** Do you want to add anything, Lesley?

**Lesley McDowall:** We do parenting work through the Aberlour Child Care Trust. We have a joint programme with it for women to consider the impact of their drug taking and offending behaviour on their children.

Women will sometimes mention the fact that, because they are away from home, they feel happier opening up and disclosing things. They feel safe to be away from the abusive partner. We might discuss what services women can access in their community, but they often do not have a choice in their own community; the only time they can choose to access such services is while they are in prison because that is the only time they feel safe. For some women, the distance of miles makes them feel safer, able to disclose things and able to access services, as their partner will not know about it.

Prostitution is one of the main issues. At the moment, about 15 per cent of our women will report being involved in prostitution, although I am convinced that the actual figure is much higher. There are two reasons why women do not report it. One is fear of their children being removed from them if they say that they are involved in prostitution. The second is fear of the partner. If a woman is involved in prostitution, it is not just their own drug habit that they are funding; they are usually also funding a partner's drug habit. The fear that he will find out that they are talking to an organisation that is seeking to get them out of the sex industry or prostitution is too big a fear for them.

The distance sometimes makes women feel safe. Their period in prison is the one time when they actually have some control over their life and some choices. At that point in their life, they have to think about their own choices, and in the long term they hope that there will be a positive impact on the child.

**Bill Wilson:** I would like to be reassured about one thing—I am sure that the answer will be yes. I take it that, if a woman says to you that she is relieved to be in prison as she is away from the area where she has come from—she is away from the abusive partner—some action is taken immediately with social services regarding the protection of the children.

**Lesley McDowall:** Yes.

**Naomi Robertson:** Absolutely.

**Bill Wilson:** Clearly, the children will now be considered to be with a possibly abusive—

**Lesley McDowall:** That situation does not arise on many occasions. In a survey about six or seven months ago, we asked every woman who came in whether her partner was in prison or had ever been in prison. More than 80 per cent of the women said yes. A similar survey was done at Glenochil, and only 13 per cent of men said that their partner was or had ever been in prison. That shows how big an impact there can be.

If the partner of a woman who comes into prison is in prison himself or has been in prison, the impact on child care is huge. In a lot of cases, the partner will not have any custodial rights over the child if the woman is not in the home. That brings its own issues: the child might be removed from their home to go either to an extended family member or, if there is no extended family member, to social services care.

To return to your question, if any woman discloses that her children are currently with somebody who has been abusive, the situation is investigated immediately.

**Naomi Robertson:** That applies across the board among different services—everyone operates on that basis, according to a public protection policy.

**Hugh O'Donnell:** Scotland is becoming an increasingly culturally diverse country, with substantial immigrant populations. What special facilities, if any, do you provide for black and ethnic minority women, particularly with regard to cultural expectations and requirements? The question is for any of the witnesses.

**Lesley McDowall:** We have a business improvement manager who is responsible for all black and minority ethnic women and any foreign national women to ensure that, where possible,

the appropriate services are put in place, such as interpreting and translation. Work on all our documents is under way—health care documents, certainly, are now translated into about 18 different languages, and much of our induction paperwork is now being translated into several different languages.

Problems arise in cases in which individuals on remand do not speak any English at all. There can be real problems with communication, especially if the issues are cultural. Some women might disclose absolutely nothing, and they might have no trust in anybody at all, so it can be very difficult. It can be distressing for staff, too, when they are trying to care for somebody but they do not know what their needs are or whether there is something that they could or should be doing for them. There are opportunities, and the services exist, but my feeling is that a lot of the women concerned do not access the available services, either through choice or because they do not understand what is there for them.

**Heather McCabe:** Our literature can be accessed in many different languages. Because we deal with only one issue, it does not matter where you are from or what language you speak—none of those things is especially relevant to us.

**Naomi Robertson:** At the moment, our literature is in English only, which we will need to address. As yet, I have not come across a referral of someone who did not have a good enough command of the English language to undertake the counselling process. Counselling is all about communication, and research shows that trust, rapport and an appropriate relationship need to be built for it to be effective. If an interpreter is involved with the counsellor and the client, the loop is lost and the situation can become difficult. We need to consider that scenario. Potential clients are foreign national women who have experienced significant abuse abroad, and the difficulty is that they are unable to access the service because of a communication barrier. I have dealt with a couple of women whose command of the language has been good enough to start a rapport, and we have just taken things more slowly—it is a slower process to ease them in.

**Bill Wilson:** You say that counselling is about communication. Concerns have been raised by speech and language therapists that there are not enough of them in prisons. Do you have a view on that?

**Naomi Robertson:** That has not been an issue for me. As I said, it is for the prisons and outside agencies to communicate with one another. If I identified a need, I would approach the mental health team and ask for some support to be set up. I am sure that that would be well received.

**Lesley McDowall:** I agree that we need to develop speech and language therapy services in prison, especially because of the number of people with learning disabilities and a very low intelligence quotient who enter prison. I would like to develop those services further, and we have been looking at engaging with some providers, but the problem is that not many have the funding to come into the prison setting.

**Heather McCabe:** Once again, we are lucky because we are so massive: we use sign language interpreters if required and we produce our literature in a dyslexic-friendly style and on tapes and compact disc, too. We cover that issue.

**Naomi Robertson:** Again, it comes back to funding and how far you can stretch the budget. As a service, we want to do everything that we can to facilitate counselling and support. The question is whether we can fund producing material in different languages and using interpreters.

**Willie Coffey:** I have a question for Lesley McDowall. Dr Fraser and many others said that by far and away the biggest proportion of repeat offenders comes from the groups of women—and indeed men—who receive sentences of six months or less. If in the prison service we cannot tackle reoffending among those serving short-term sentences, how best can it be done? Are there any lessons from or parallels with Europe in how other countries deal with reoffending among those serving short-term sentences?

**Lesley McDowall:** As I said earlier, we need to take a much more holistic approach because women offenders have so many complex issues. We cannot deal with just one of those issues; we have to deal with them all. We need to look to community services, such as the community links centre in Edinburgh, which is a one-stop shop. The service that a woman is most likely to engage with when she leaves prison is for addictions. If, when she goes to access an addictions service, abuse counsellors, mental health and alcohol services are within the same centre, she is more likely to access all those services and therefore less likely to land up in prison again.

We have to look at preventing women from coming into prison in the first place and at diversions from custody rather than trying to deal with their issues once they get to prison. I offer an effective addiction service to people in prison because I have a captive audience who do not miss appointments or give 100 reasons why they should not engage with the services. That service is extremely effective for the individual while they are in prison, but there is an impact on families and the wider community. While the person is in prison, the service is excellent, but we need to look at mirroring that service in the community and

making it as easy as possible for women to access it.

12:30

I have heard women say that they will be struck off if they fail to turn up for one appointment in the community. We have to get past these things, and we have to become much more realistic. It might take eight appointments for the woman to turn up. She should not be struck off the service and be told that the doors are closed to her and that she has gone back to the bottom of the list, because, to her, there are good reasons why she has not turned up eight times. A lot of women say that, if they have missed their previous two appointments through no fault of their own, they are too scared to turn up for the next appointment in case they get into trouble or somebody judges them.

We have to make services much more accessible, such as by making them available in the evening. A lot of these women are sole carers for their children, so they cannot access services at the times that they are currently available. We have to be much more flexible in making services available in the community.

I have heard women tell me that they have stood in court and asked to be sent to prison because they know that that is the one place where they can access all the services and that they will get cleaned up and sent back out the door again. They know that they are safe there.

**Willie Coffey:** Might a community sentence be a more effective way than a prison sentence of six months or less of dealing with women in these circumstances?

**Lesley McDowall:** Yes, because if attending those services was made mandatory, it would be more likely to happen. The males in the women's lives might want them to remain in the community for child care reasons or because they are providing income, so they will ensure that the women attend services in the community, because, otherwise, they will end up in custody.

**Naomi Robertson:** It goes back to what I said earlier about sentences of six months or less. If women are given community sentences, with a stipulation that they link up with services, that allows for continuity of care and the establishment of trust with counsellors, which means that the same counsellor can provide the service on a long-term basis. Counselling cannot be never-ending, but, for a lot of these women, there is a longer timeframe for getting themselves sorted. We cannot just say to them, "That's our 12 weeks up; on you go." At that point they might just be getting to the stage where they can begin to deal with the abuse, get their head straight and move forward. If they are in the community, they can get the longer-term care that many of them need.

**Hugh O'Donnell:** There have been increasing reports, particularly in the more lurid bits of the media, about consumption of alcohol by females. Are you seeing a change in the pattern of alcohol consumption by females? Is it age related? Is it connected with the types of crimes that are being committed? Is there more violent crime and less acquisitive crime?

**Heather McCabe:** I never ask the girls about the crimes that they committed. Sometimes they volunteer the information, but it does not matter to me why they are there. I do not know whether there is a big media drive to change the way that alcohol consumption by females is portrayed or whether that reflects exactly what is happening with younger women. I am not the person to tell you whether the pattern of consumption has changed. The people who come through our door are at the end of their tether and have the choice between getting sober, going insane and being locked up in a psychiatric institution for the rest of their lives, as opposed to having a short stay, which many of them have already had, going to jail or dying.

An increasing number of young women are coming in. I came in at 21 and I had a life expectancy of 25 as a result of alcohol—providing that I did not get myself killed in another way or kill myself. I would not say that it is due to culture, though. In my experience, it is due to alcoholism, which is an illness or a disease; it is not about the drinking culture, which is a separate thing that can bring about alcoholism later. Alcoholism is very much akin to diabetes in that it is caused by a defective enzyme—either there is not enough or it does not work. Someone can either be born like that—as I believe that I was—or they can develop the problem later through abuse of alcohol, so that when they start drinking they cannot stop. It is as though their feet are nailed to the floor.

That is only half of the problem, though, and it is the easy part to deal with. I would question how true it is to say that an addiction programme is effective in an abstinence-based environment. As soon as a person is kicked out of prison, three months after they come through the door, the first thing that they do is go to Haddows. The next thing that they do is pick a fight, fall over or shout at somebody in the street in Bridge of Allan, which does not go down very well. They never get home. I see many girls who have been kicked out on a Friday morning back in prison on Monday or Tuesday. I ask them what happened and they say, "I've got this tag. It's the tag's fault." It is everybody else's fault. The number of girls who do not get home is astonishing.

As an organisation, we do not have an opinion about what other people should be doing to stop that. We do what we do and we are open for anybody to join us.

**Hugh O'Donnell:** Thank you for that and for your honesty.

**Naomi Robertson:** I can speak only about the past year. As an organisation, we are concerned not with what the person has done but with what has happened and what we can do to support them. Within the prison environment, we conduct a risk assessment that looks at the person's history and what they have been convicted of. There are a notable number of young women whose offences relate to substance misuse—particularly alcohol abuse. They get angry and get into fights, and the situation can get out of control very quickly. I would not like to say whether that is a cultural issue.

A lot of the young women with a history of abuse are at the angry stage. Nobody prevented what happened to them and they hate the world—the anger is very deep set in them. Given what we know about the culture at the moment and what we are seeing in the wider community, the problem is probably aggravated by cultural factors. They are surrounded by people urging them to have one more drink, saying that it will help them. People might also push the angry mindset and tell them that it is okay for them to be angry, saying that they will feel better if they hit someone. A cultural element is probably involved, but how we should address that is another matter.

**Hugh O'Donnell:** Indeed.

I have a final question on the psychological impact of sexual abuse—indeed, any abuse—in terms of people's potential for being abused subsequently and their being more prone to becoming a victim. Evidence from a survey that Glasgow City Council conducted seemed to show that women who had been sexually abused had subsequently been sexually abused, or approached in an inappropriate sexual manner, in Cornton Vale. As far as I am aware, the survey did not specify who had made such approaches. Does the fact that prisons are intense places to be make people who have a history of sexual abuse more vulnerable to subsequent abuse?

**Naomi Robertson:** You are talking about people in the community and in the prison.

**Hugh O'Donnell:** Yes.

**Naomi Robertson:** I reiterate that we try to steer away from the word "victim" and talk instead about the survivor of abuse. "Victim" is a negative word and we are trying to empower the woman.

Research history and my experiences in Cornton Vale show that someone who has been sexually abused tends to be vulnerable to subsequent abuse. That is not to say that a person who has been sexually abused will continue to be sexually abused, though. There may be one instance of abuse and the person has the right support and is able to move forward. The kind of women who we are seeing in Cornton Vale have not had such support and tend to be more vulnerable. Many of the women with whom I work have experienced multiple cases of abuse, which started at an early age. Someone has seen that vulnerability within them. I could argue all day, every day, that it is possible to see the vulnerability. There is a drop in self-esteem and confidence. You will hear someone say, "I was abused as a child. My partner's all right. He beats me Monday to Saturday but he doesn't do it on Sundays, so he's really quite nice." They say that and they believe it.

Others will make comments such as, "What am I supposed to say?" When we say, "Do you want to have sex?" and they say no, we say, "Well, no is the answer." They have not understood their power, their control and their identity within relationships. It would be a generalisation to say that if someone has been abused they are likely to be abused again, but the risk is significantly higher because they are in that cycle.

**Lesley McDowall:** Although there are few sex offenders in the female prison population, certain individuals display predatory traits. They are good at seeking out the most vulnerable. We have a high number of survivors of childhood sexual abuse, who have low self-esteem and tend to be in unequal, unhealthy relationships. They can tend to migrate towards those individuals, who have quite a lot of influence within certain groups in the prison.

I could believe that there is a report stating that there are prisoners who have been abused by other prisoners while in Cornton Vale. However, that is not something that we ask about—the prison does not seek that information. However, if we had information about abuse, we would investigate it further and consider putting in measures to safeguard the women concerned.

**Naomi Robertson:** Lesley McDowall made the point that I was about to make. If somebody made that kind of suggestion in a counselling session, we would explore it with them: "What does that mean? How do you feel?" If there was any suggestion of risk, appropriate action would be taken.

Jail is a difficult environment. People talk about jail love—some people, because they are lonely or they seek companionship, make a conscious decision to have relationships in jail. There is a fine line between whether that is a choice that they

are making or whether someone is dominating them, violating them or trying to abuse them.

**The Convener:** Thank you. That concludes our questions. Would you like to add any closing remarks?

**Lesley McDowall:** We do not ask our prisoners about domestic abuse as they come in. I do not know when would be an appropriate time to ask whether they have been victims of violence. However, we ask about prostitution.

Caledonia Youth, which has been working with us for the past two years, said that 70 to 80 per cent of women will self-disclose during counselling that they have been subjected to violence, whether as a child in a violent household or as the direct victim of abuse. Unfortunately, despite having tried for two years to get a national programme to come to Cornton Vale to work with women who are victims of domestic abuse, I have not been successful. The funding does not exist in the community to provide someone to come into the prisons.

At the moment, the only place that provides anything is Stirling Women's Aid, which is for women who are going back to the Stirling area. Sometimes a woman chooses to change address so that she can access that service—increasingly, we are finding that women move back to or ask to move into the Stirling area because it provides that service. We are on its doorstep, and in order for a woman to continue using that service she will move into the Stirlingshire area.

12:45

**Heather McCabe:** Returning to the issue of addiction, using is only the tip of the iceberg. The real problem lies in the mental side of the issue. If you can fix that, the addiction will effectively be gone—or dealt with, rather than gone.

**Naomi Robertson:** I reiterate the need for sustainability of the service. We are a voluntary organisation, funded through survivorScotland. Although that money has been well appreciated and well used, it will run out. These women have had extremely chaotic lives, extremely difficult experiences and significant trauma over many years. When they come to Cornton Vale, they are saying, "Yes, please help me. Give me support." We need to move towards some sort of stability or statutory funding. We need to be able to say, "Yes, we will be here for three years or six years." We need the women to know that the support is there and that it will continue.

**The Convener:** Thank you. There was a powerful message there, not only about resourcing the services that you provide in the prison but—crucially—about maintaining that care when the women are released. The session has been extremely worth while and I thank the panels for attending.

*Meeting closed at 12:46.*

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