The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

JUSTICE COMMITTEE

Tuesday 20 November 2012

Session 4

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JUSTICE COMMITTEE
33rd Meeting 2012, Session 4

CONVENER

*Christine Grahame (Midlothian South, Tweeddale and Lauderdale) (SNP)

DEPUTY CONVENER

*Jenny Marra (North East Scotland) (Lab)

COMMITTEE MEMBERS

*Roderick Campbell (North East Fife) (SNP)
*John Finnie (Highlands and Islands) (Ind)
*Colin Keir (Edinburgh Western) (SNP)
*Alison McInnes (North East Scotland) (LD)
David McLetchie (Lothian) (Con)
*Graeme Pearson (South Scotland) (Lab)
*Sandra White (Glasgow Kelvin) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Frank Gibbons (HM Prison Barlinnie)
Dr Lesley Graham (NHS National Services Scotland)
Dr Richard Groden (Glasgow Community Health Partnership)
Marion Logan (Phoenix Futures Scotland)
Mark McEwan (NHS Grampian)
Brigadier Hugh Monro (Her Majesty's Chief Inspector of Prisons)
Ruth Parker (Scottish Prison Service)
Kirsty Pate (Willow Service)
Dr Gregor Smith (NHS Lanarkshire)
Peter Wilson (Scottish Prison Service)

CLERK TO THE COMMITTEE

Irene Fleming

LOCATION

Committee Room 1

Scottish Parliament

Justice Committee

Tuesday 20 November 2012

[The Convener *opened the meeting at 10:01*]

Prison Healthcare

The Convener (Christine Grahame): Good morning. I welcome everyone to the 33rd meeting in 2012 of the Justice Committee. I ask everyone to switch off mobile phones and other electronic devices completely, as they interfere with the broadcasting system even when they are switched to silent.

I have received apologies from David McLetchie.

Agenda item 1 is a round-table discussion on the transfer of prison healthcare to the national health service. Members will recall that the committee identified the issue as one to explore further.

It can be seen that our nine witnesses are interspersed—that is a wonderful word—among members around the table to encourage more open and informal debate. In fact, we want to hear more from the witnesses than from committee members. The witnesses are welcome to address one another directly if they want to add a point or to challenge. Initially, that should be done through me, but we usually find that a rhythm gets going, and we just leave people to it, as long as there is not a punch-up.

I will let everyone around the table briefly introduce themselves and say who they represent.

Jenny Marra (North East Scotland) (Lab): I am the deputy convener of the committee and a Labour MSP for North East Scotland.

The Convener: I should say that the microphones will come on automatically. We have a whizz kid working the switch.

Dr Richard Groden (Glasgow Community Health Partnership): I am the clinical director for Glasgow city community health partnership with responsibility for prison healthcare.

Roderick Campbell (North East Fife) (SNP): I am a member of the committee and the MSP for North East Fife.

Frank Gibbons (HM Prison Barlinnie): I am healthcare manager at HMP Barlinnie.

Colin Keir (Edinburgh Western) (SNP): I am the member for Edinburgh Western and a member of the committee.

Mark McEwan (NHS Grampian): I am the planning lead for prison health and police health in NHS Grampian.

John Finnie (Highlands and Islands) (Ind): I am a Highlands and Islands MSP and a member of the committee.

Dr Gregor Smith (NHS Lanarkshire): I am the divisional medical director of primary care in NHS Lanarkshire and a senior medical adviser to the primary care directorate of the Scottish Government.

Peter Wilson (Scottish Prison Service): I am the health strategy manager at the Scottish Prison Service headquarters.

Ruth Parker (Scottish Prison Service): I am acting assistant director of health and care at the Scottish Prison Service.

Sandra White (Glasgow Kelvin) (SNP): I am the MSP for Glasgow Kelvin.

Dr Lesley Graham (NHS National Services Scotland): I am an associate specialist in public health medicine at the Information Services Division.

Alison McInnes (North East Scotland) (LD): I am an MSP for North East Scotland.

Marion Logan (Phoenix Futures Scotland): I am director of operations for Phoenix Futures Scotland.

Graeme Pearson (South Scotland) (Lab): I am an MSP for South Scotland.

Kirsty Pate (Willow Service): I manage the willow service with NHS Lothian.

The Convener: I am Christine Grahame, the convener of the committee, and I represent Midlothian South, Tweeddale and Lauderdale. That is a very short title.

Before I open the discussion, I will quote from Dr Lesley Graham's report entitled "Prison Health in Scotland: A Health Care Needs Assessment". In the report, Dr Graham says of prisoners:

> "They are risk takers in every sense, with their liability to addiction, sexual disease, physical or emotional trauma, many with significant brain damage, and at a much higher risk of early death. The majority smoke, have drug problems and mental illness. A significant minority report alcohol problems and experience of abuse. Their lives are chaotic. Their health, in physical, mental and social dimensions, is poor. Experience of prison can erode, preserve or strengthen the first two, but reliably destroys social well-being."

That is some issue to tackle, and I thought that I would put that passage on the record because it encapsulates the situation that you all face.

I would now like you to discuss the benefits and disbenefits of the transfer of healthcare from the

SPS to the NHS. Are there any volunteers? This is like being at school. If nobody volunteers, I will pick somebody in a yellow jumper.

Graeme Pearson: Maybe I can ask a question. Healthcare has been transferred from the SPS to the NHS. What practical changes have been delivered? What challenges were identified at the outset?

The Convener: Before witnesses respond, I should thank you all for your helpful written submissions.

Marion Logan: Phoenix Futures has had a contract in Scottish prisons since 2005 to provide enhanced addiction casework services. We work with the type of individuals who were identified in Dr Graham's report, who have alcohol, drug and smoking issues.

On a practical level, the transfer of our contract from SPS to the NHS when healthcare transferred on 1 November last year has resulted in on-going uncertainty about the future of services, for our staff and for the thousands of individuals with whom we work.

Dr Smith: NHS Lanarkshire took on responsibility for HMP Shotts, and we found that we were looking after a fairly stable prison population, which allowed us to plan services more effectively for the longer term. The process of transfer was good. Work with the SPS and the various other partners who were involved in the transfer went smoothly. There was a spirit of partnership as we tried to develop services.

We have been striving to ensure that being in prison is no barrier to receiving healthcare and that what prisoners get inside Shotts is equivalent to what people get in the general population. I can give practical examples, if members would like me to do so.

The Convener: Please do.

Dr Smith: It is fair to say that dental care is of great importance to the prison population, for a number of reasons. We have brought the standard of care, and access to care in particular, much closer to the standard that the general population enjoys. As a result, the number of complaints about dental care has substantially reduced.

We have also tried to get addiction care much closer to the integrated community model that we have in Lanarkshire. We are taking small steps, but we are making progress.

Mark McEwan: I can make exactly the same point about dental care—indeed, we made it in our submission. We have not only increased the number of times that prisoners are seen by dentists but ensured that they are seen by community dentists from NHS Grampian, who have a particular interest in the homeless and substance-misusing population outwith the prison. Prisoners get similar care in the prison to what they would get outwith the prison, and there is throughcare because of prisoners' familiarity with practitioners.

That link is a key benefit of the transfer to the NHS. This is anecdotal evidence, but I think that it holds water. Female prisoners were sometimes reluctant to access services when they were out in the community and I have heard that some women tried to get back into prison so that they could access basic services. However, if a prisoner is provided with a service by someone who is branded "NHS", a barrier is broken down, and when they go out into the community they understand that the NHS provides their health services. The transfer has been good from that point of view.

The Convener: Dr Groden, are you wiggling your finger because you want to comment? Witnesses should make it plain to me when they want to come in, so that I know that they are not just nodding in agreement.

Dr Groden: There have been a number of developments in NHS Greater Glasgow and Clyde since the transfer, and they are on-going. One of the first big pieces of work was a health needs assessment, which was undertaken by public health specialists, to identify the needs of the population.

That particularly good piece of work has helped us to identify the learning disability support posts in prisons that are being advertised at the moment. Those people will not only identify and work with individuals with learning disabilities but raise awareness among the prison workforce, including by training SPS staff in identifying those who have learning disabilities and in how prisoners can access support and community services on their release.

We also deal with addictions. One of the advantages of our approach is that we have been able to select doctors on the basis of interviews and match some of the needs with some of their skills. Two of our general practitioners are very experienced community addictions doctors and are now working at Barlinnie and Low Moss. That added advantage supports the addiction services available in those prisons.

Those are just a few examples of the work that is being carried out.

The Convener: You said that you interviewed for those posts. What happened before?

Dr Groden: We interviewed the individuals on their transfer. For example, one doctor transferred under Transfer of Undertakings (Protection of

Employment) Regulations 2006 arrangements from Medacs Healthcare. An agency previously had the contract to provide medical cover to prisons. As I was not involved at that time, I do not want to comment on who was in the service or how stable the doctor population working in the service was, but when we took it over we held a recruitment exercise to get doctors to work in it.

The Convener: Perhaps someone else might be able to elaborate on that.

Mark McEwan: SPS had a number of national contracts for medical services including those provided by doctors. There would have been a similar national contract for dentistry, for example; indeed, the pharmacy contract is still continuing. At that time, it was not the responsibility of local boards but a completely separate thing.

Frank Gibbons: As a healthcare manager, I went through the transfer from the SPS to the NHS and now see significant improvements for prisoners with regard to, for example, the links that we can make with the health service. In particular, our new information technology systems mean that we can very quickly get information on prisoners who are coming in, which allows us to continue care and to link with those who provide care in the community. Similarly, the systems provide us with blood results and various other hospital results to allow us to treat prisoners far more quickly than we could have before.

Education for GPs and staff who provide nurse-led clinics, which is now on a par with that in the NHS, was hard to get under the SPS. We now have expertise in the services; indeed, as Richard Groden has pointed out, we found in our health needs assessment that many services that we were delivering were of a good standard, and we are now trying to improve our weaker areas. Some of the new IT systems, the education provision and the induction process that staff have gone through have empowered us in improving overall care.

The Convener: I take it that the induction process is similar to the interviewing process that Richard Groden referred to.

Frank Gibbons: Yes.

Peter Wilson: Just to clarify what happened prior to the transfer with regard to recruiting medical officers, I should point out that SPS's national contract for the provision of medical services in Scotland's publicly run prisons came to an end at the point of transfer and that it was then up to individual health boards to recruit doctors to provide services in the establishments in their patch.

The national contract for the provision of pharmaceutical services also transferred to the NHS. A number of different things happened with the provision of services: nursing staff transferred under Cabinet Office statement of practice arrangements; doctors finished providing services because of the contract; and the national contract for pharmaceutical services and the Phoenix Futures contract both transferred to health boards.

The Convener: I understand the legal aspects. However, is there any continuity? Will someone in prison be treated by the same GP when they leave prison?

Peter Wilson: As far as providing services is concerned, no.

10:15

Graeme Pearson: Just so we do not go off at a tangent in our thinking, will you clarify what you mean when you talk about pharmaceutical services?

Peter Wilson: The provision of professional services and of medicines.

Dr Groden: I can elaborate on the general practitioner provision, and who the GPs are likely to be.

We have a range of people in NHS Greater Glasgow and Clyde who work from two sessions a week up to full time. We also have a bank of locums who work in the community and are able to come in and supplement the numbers that we have in the prison or fill in any gaps that we have in the rota.

All of those doctors will be working as general practitioners, bar the two who work in addictions, and they also have extensive general practice experience. However, those GPs will not necessarily still be the individual prisoner's GP when they move back into the community.

Alison McInnes: There is a lot of evidence that there was a lot of unmet need and that the prison service was providing healthcare through triage and crisis intervention, so I am heartened to hear what you are saying about the more holistic approach.

Earlier this year, a prison visitor told me about the provision of dentists in Barlinnie and said that one of the prisoners had asked her to take up his case. We went to the health centre to check up on what we had been told. Although two dentists hold clinics in Barlinnie every day, there is a huge demand. Only those who are graded as emergency cases are seen immediately, and those who are graded as urgent cases have to wait longer. When we asked what constituted an emergency, we were told, "It's if your face is so swollen that you are having trouble breathing or they think septicaemia is setting in"—that is a

direct quote. I hope that things have improved significantly since then. I seek reassurance that proper dental treatment is available.

The Convener: Dr Gibbons might like to reply first, as he is from HMP Barlinnie.

Frank Gibbons: Dental services have been considered closely, and the NHS has recently decided to invest money in the provision of additional sessions in the afternoons. We hope that, over a six-month period, those additional sessions will bring down the waiting list.

We must also be clear about the fact that every prisoner lists themselves as an emergency and says that he has toothache because he thinks that that is a way of being seen more quickly. That causes a lot of problems for the guys who genuinely need to see the dentist. We are doing some educational focus sessions with the prisoners to get away from that culture, but the culture is well established and it will take some time for people to change the way in which they go about accessing the service.

Dr Groden: I would like to comment on dental emergency as a category. In the community, dental emergency constitutes severe pain or dental haemorrhage. Those are the only criteria for a dentist to see any patient as an emergency, and the treatment should be carried out within 24 hours—not immediately, which would be the case with a medical emergency. It is important to bear that in mind when we are talking about dental care in the prison environment.

Dr Smith: It is worth reflecting on Dr Groden's point, because it is important to remember that we are talking about equivalence of care. Although we want continually to improve our care in any dimension in which we deliver it, we should not set up an inequality in the provision of care. That is unrealistic.

Alison McInnes: Absolutely, but there is a long way to go before we get to that point.

We have heard the definition of emergency cases. What is the definition of urgent cases and what is the timescale for their treatment? Would you expect to meet those timescales in the prison as well as you would outside the prison?

Frank Gibbons: We try to ensure that emergency cases are seen within 24 hours. We also have provision during holiday periods to take people out to the dental hospital, should that be required. When normal Monday-to-Friday services are on, people are seen fairly quickly. Certainly, someone would be seen by a GP and given some sort of pain relief or analgesia if they had to wait from, say, a Saturday morning to a Monday morning.

The Convener: Dentistry is important but I want to move on to addictions, which is the major issue for us when we look at people who are churning through the system. I also want to look at mental health problems—separately perhaps—because that is a huge psychological and psychiatric issue.

Has the handling of those issues changed in any way since the transfer of the contract? Marion Logan is out of sync with everybody else here—that is not a bad thing and I would like to hear about it. You do not think that everything in the garden is rosy and that it has all been good. That is not special pleading, is it, on behalf of Phoenix Futures?

Marion Logan: No, it reflects the issue that we have within the prisons. It is a massive service, there is huge demand and on-going uncertainty causes issues.

The Convener: You make a point in your submission that the voluntary sector has in effect been ignored in all this and pushed to the side—I am paraphrasing. Would you like to talk about the interlinking between what is happening in the prison and what happens outside, particularly in relation to the addictions and throughcare, so that you can challenge some of the other people on the panel? I like a little bit of a fight—we want to hear about some of the difficulties, not just the benefits. There must be things that are not quite working.

Marion Logan: Ultimately, one of the expectations of the transfer was that it would improve throughcare in particular—it would improve that link between the healthcare aspects of dealing with addictions and the more holistic aspects of dealing with someone's on-going recovery. One of the unintended consequences of the transfer is that that has not happened.

The partnership that Phoenix Futures has had within the prisons with SPS staff, NHS staff and the other organisations that work in the prisons is really important. The point that I was making in the submission is that it would not reflect the community and it would not be in the best interests of those individual prisoners with drug, alcohol or smoking issues if their issues were seen as being wholly under the remit of healthcare services, because that is not how it is in communities.

The need for the voluntary sector to be part of an individual's recovery journey has been widely recognised, not least in the debate on the drugs strategy a few weeks ago that reinforced the road to recovery strategy. An unintended consequence of the transfer has been the on-going uncertainty regarding the continuation of the enhanced addiction casework service. Its continuation would mean that we do not end up with just a medical model for addiction work within the prisons.

Kirsty Pate: My comments are quite specific to the service that I manage. I do not have the breadth of knowledge to comment on the wider

debate that has been taking place here. The service that I manage provides integrated services. It is a real challenge for all of us within the NHS, the City of Edinburgh Council and the voluntary sector. We like to think that we are good at working together but it is very difficult. Providers often end up delivering services in parallel to one another rather than on an integrated basis. That is one of the issues that has been highlighted here—partnership working is very complex and very difficult.

Mr Pearson asked earlier about the practical changes and some of the challenges around the transfer. One of the continuing challenges is around partnership working and ensuring that the partners are equal, because essentially the bigger players in this area are used to being the bigger players. We are having to shift some of those attitudes. There are really good examples of where that has worked well. I like to think that the willow service is one example of that, but there are others.

The Convener: Which are?

Kirsty Pate: I can speak about willow in particular—

The Convener: You said that there are other examples—what are they?

Kirsty Pate: The 218 service in Glasgow is one. I do not want to talk about lots of services—I do not know enough details about them. However, willow and the 218 service have very close and integrated services. We sometimes see integrated services working really well in drug treatment and testing order services, too. There is a massive challenge around partnership working. It is not an easy thing for any of us, but there has been a lot of effort to move things forward. We have heard some really positive examples today of how that has worked well.

One of the continuing challenges will be the provision of equivalent care to a broad and complex population. Equivalence in care may not ensure equal outcomes for specific people in the population. People are taking account of that but it continues to be a challenge for us. Lesley Graham talked in her submission about outcome measures and indicators, and the issue of what success is. Some of what we are talking about today is fairly anecdotal because we do not have national indicators for success in this area. One of the challenges in that is ensuring that our outcome measures are gender specific, in that we ask the right questions to ensure that we get the correct answers on what progress is and what success will look like. That might mean asking different questions for women than for men, particularly on mental health and addictions.

The Convener: Why is returning to prison not mentioned as one of the things that can be measured? You were asked about measuring outcomes. One simple outcome to ask about is whether, despite all your endeavours, people go back to prison. That is easily measured.

Dr Graham: Returning to your initial comment about addictions, I draw the attention of the committee and others to a series of research projects that I commissioned, along with NHS Health Scotland, to look at alcohol problems in particular. “Prison health needs assessment for alcohol problems”, which was work led by the University of Stirling, is noted in the briefing paper. That evidenced a high prevalence of alcohol problems.

We looked at the literature on effective interventions because we recognised that there is a range of interventions—whomsoever they are delivered by. We interviewed staff and prisoners and there was recognition on both sides that alcohol had been in the shadow of drugs. There was a perceived lack of full integration of the service as it was delivered then. There was a sort of medical stream, then there was the addiction casework service stream—that is not to say that it should not have been so, but there was a bit of a disconnect. I see an opportunity here for addiction services to become fully integrated and for leadership to bring that about. I echo Kirsty Pate’s point about partnership working. Throughcare is another area that needs attention and effort.

Along with NHS Health Scotland and others I have been working since then with alcohol and drug partnerships and community justice authorities to try to get those strategic partnerships working. Indeed, on the back of that work, £750,000 was sent out to ADPs to enhance alcohol and prison work. Quite a lot of progress has been made in mapping out what the problems are and even setting out an effective model of care. That is on the alcohol side.

The main thrust of my submission is exactly what we have been discussing, which is how we measure success. I can speak to that now or come back to it later.

The Convener: Just go for it.

Dr Graham: One of the big questions is whether the health of prisoners is better, worse or the same. It was difficult enough when I was doing my prison health needs assessment in 2007, which I outlined in my submission. There was a lack of a fully electronic healthcare system across all the care that was being delivered. There have been steps forward, though, and I am happy to hear from Mr Gibbons that progress is being made. There is now a bespoke IT system called Vision, which is hosted by NHS Grampian. However, I

perceive that there are still gaps in the data that can be collected, particularly on mental health and some of the addictions. We do not have any reporting, other than health improvement, efficiency and governance, access and treatment—HEAT—standards, for what goes on in prisons. There is no routine reporting system.

10:30

The prison healthcare network that has been set up has just established a work stream. We have already identified a good few possible indicators—something like 60—that we could narrow down, so progress is being made but we cannot yet fully answer the question: has the health of prisoners stayed the same, got better or worsened?

The Convener: With a view to them not reoffending. Of itself, improvement in prisoners' health is a good thing but, as the Justice Committee, we are also considering reoffending.

Dr Graham: Absolutely. One of the principles of the work is that, by addressing health, healthcare needs and wider needs, we will have a triple win of reducing reoffending, reducing health inequalities and, we hope, improving the health and wellbeing of prisoners and their families.

Ruth Parker: I clarify that the enhanced addiction casework service was not provided in all prisons by Phoenix Futures. Initially, three prisons—Low Moss and the two private prisons, Kilmarnock and Addiewell—had other arrangements. However, the point is the service delivery rather than the provider. It is stated in the memorandum of understanding that health boards will continue to provide that service and how that happens in future will be entirely up to them.

I know that work is happening because I have been actively involved in work in Forth Valley NHS Board. I will share that model with the committee. It is about integrating the health services, the enhanced addiction casework services and the wider throughcare services and having a pathway of care from admission to liberation. It also takes into account the research that Dr Lesley Graham discussed, in particular, the alcohol research and the funding that has been allocated to alcohol and drug partnerships to support that.

Forth Valley NHS Board is currently sharing that work across alcohol and drug partnerships. It will also be shared with the network at the January meeting as a best-practice model. It is only in draft form at this stage, but it looks like something that health boards could adopt in their geographical areas.

The Convener: You did not mention what happens thereafter. You went from admission to—

Ruth Parker: Across the sentence.

The Convener: My understanding from reading the papers is that it takes months and months, if not years, of support to stop people simply regressing. What happens thereafter?

Ruth Parker: Absolutely. Part of the pathway is about multi-agency working and the wider holistic approach not only from the health and addiction services, but wider services. In prison, we call it integrated case management. That takes into consideration the individual, their needs and their family and wider training, employability and learning. It also goes into the throughcare services in the community.

Sandra White: I have been reading the submissions, which are interesting. There is certainly improvement with throughcare, but there is obviously a little bit of concern regarding Phoenix, the voluntary sector and the professional NHS sector.

I was interested in what Dr Graham's paper said about mental health and suicides. It was quite horrific to read about the risk of suicide among men in the prison population being 3.5 times higher than in the general population.

I have a question about research and throughcare. Ms Parker mentioned that a draft report is under consideration. When I was on the Equal Opportunities Committee, I visited Barlinnie and Cornton Vale to speak to prisoners.

We are talking about reoffending. How difficult would it be to keep track—that is probably the wrong phrase—of somebody with addiction problems that were certainly not cured but for which they got attention in prison so that we could produce a proper research paper? Can we track somebody who received medical attention and care in prison, whose health improved—obviously, it had to—and who was released and then reoffended? Is their addiction worse or less? How difficult would it be to produce a proper research paper to let us know exactly? The Justice Committee is looking at reoffending, but the wider issue is the health of the population.

Frank Gibbons: It would be good for the committee to recognise that the transition is in its early stages. It has been a significant and, particularly for staff, arduous change because of the scale of the changes. To return to Marion Logan's point, I do not see addiction services being based on a medical model in the future. The model will be multidisciplinary and will involve engagement with the third sector. People would welcome that, but I do not know whether we have yet identified a model that is absolutely perfect for all things—we are still working through some of the issues.

It is difficult to track prisoners. I can speak only about how busy Barlinnie is as a local prison. We

get prisoners from all over Glasgow who come in literally off the streets, and we have to try to trace where they have been. When prisoners come in, they are not always able to tell us where they have been. Some of them are intoxicated and some are in a fairly bad way.

We still have a piece of work to do with the Scottish Prison Service on the transfer of prisoners, as we are still getting prisoners transferred from Lanarkshire NHS Board and Ayrshire and Arran NHS Board to Glasgow, from the private prisons. When our numbers decrease, we take in more prisoners and it is the same with the Grampian region. If there are various estate issues within the SPS, we receive prisoners from all over Scotland.

Trying to tune into every prisoner's health board and addiction services provider is a very difficult task for our staff. There may be an opportunity in the future to look at healthcare in a more significant way in the transfer of prisoners. Just now, the transfers are based mainly on their security issues as opposed to their healthcare needs, and such an approach would be helpful in the future.

The Convener: As no one else wants to comment, I will bring in John Finnie, who has been waiting a while.

John Finnie: I will be unashamedly parochial. Inverness is mentioned in Ms Logan's submission. I am also grateful to Ms Parker for her comments. I read the Phoenix Futures submission as a promotion—I could say, cynically, that it is a bit of an advert—and I highlighted a couple of phrases that concerned me, one of which you have used this morning. You state:

"To assume that Prison Addiction Services are best run by the NHS without voluntary sector involvement negates the added value of having non-statutory involvement".

A bit more concerning, over the page you state:

"However, to assume this can be achieved without drawing on our wealth of experience, and to support our continued involvement in working with individuals on their recovery journey is to misunderstand both the recovery journey and the role different types of organisations have to play at different points of that recovery journey."

You would be surprised at the attention that people outwith the Parliament pay to the detail of specific issues; therefore, I must address the implication that the removal of Phoenix Futures from the provision of services in Inverness will result in some diminution of the service. I know that the reality is that NHS harm reduction, Phoenix and others are actively involved. Would you care to comment on that?

Marion Logan: My point is not that the NHS could not provide the same services and do the group work and the one-to-ones—the purpose of the service was to offer something different from what the NHS's addiction nurses are providing. I am thinking particularly of the role that methadone plays in the prisons. The point of my submission was to illustrate—as I have said before—that one of the unintended consequences of the transfer will be continued uncertainty. I take the point that the transfer is still in its early days and is massive, but—

John Finnie: I do not understand what the uncertainty is—maybe I should have said that. Where is the uncertainty?

Marion Logan: Our staff and the thousands of people whom we work with do not know how much longer we will be providing the service because there is uncertainty around the contract. We have been living with uncertainty since last year.

John Finnie: Is that not the case with most contracts in the voluntary sector?

Marion Logan: No. Most contracts have a start date and an end date. We had our end date, and now the question has been raised about whether what we understand about the contract is correct. My point is that the role that the staff play and the experience that they have gained is much valued within the prison estate. I am not saying that other providers could not provide the same service, but different organisations can have different roles within addiction services. On numerous occasions, the Government has recognised that the voluntary sector has as important a role to play as the statutory sector.

The Convener: I want to broaden out from Inverness and the services that Phoenix Futures provides. We have talked about the role of the voluntary sector—Mark McEwan wanted to say something about that.

Mark McEwan: I want to talk specifically about the expertise that is perceived to be at risk. Although I work in NHS Grampian, I have been working with a number of health boards on the issue that Ruth Parker outlined about the Lanarkshire model of looking at the whole pathway. NHS Highland has transferred in the staff from Phoenix under TUPE so that their expertise has been retained and developed.

One of the key issues for me is that the prisoner journey starts in the community and, for most, it ends in the community. They are arrested in between, and they go through the courts and the prison system, but they return to the community. That is why the system has to be integrated.

I am uneasy about the idea of a national contract with the voluntary sector because I would like to think that when prisoners are released from the prison setting, they get something similar in the community, and that will be difficult if the

national provider does not have a local community base from which to provide that. That is one of my on-going concerns.

The Convener: We are not just talking here about Phoenix.

Mark McEwan: No.

The Convener: I understand your point. You are talking about the voluntary sector and how localised provision would be useful.

Marion Logan made an interesting point about the voluntary sector. The scheme has only been running for about a year.

I ask Dr Groden and Dr Smith whether they want to hear the questions from Graeme Pearson, Jenny Marra and Roderick Campbell before they come in.

Dr Groden: Yes.

The Convener: I will take some questions then.

Graeme Pearson: I have a question about the submission from Dr Lesley Graham. In the middle of the second page, she indicates her involvement in the national programme board for prisoner healthcare and talks about reaching agreement

"that Performance Management for prisoner healthcare would be as for the NHS ... but ... not ... the objective of agreeing a set of monitoring indicators."

She goes on to say that it was "a high priority". Therefore, from December 2011 to the present day, performance management for prisoner healthcare was a high priority, but we seem to be waddling along and not getting very far. Given the statistics about suicide that are quoted on page 1 of her submission, to which Sandra White referred earlier, that seems to be a ridiculous thing to say.

In our discussions so far, we have talked about the movement of healthcare, and I believe that the changes that you are trying to bring in will be useful. I keep hearing about multi-agency integrated services, person-centred needs partnerships, multidisciplinary and holistic approaches, models, route maps, pathways and the journey, but I do not have the impression that we have a national strategy for dealing with prisoners' addiction needs, which seem to be one of the major reasons why they are in custody. Although you are all taking a bite of certain wee bits, and it is great that prisoners will get good dental care and so on, I do not see what we are doing about the major problem, which is that almost 25 per cent of the prison population have addiction issues.

10:45

We already know about the alcohol problems. Where is the move forward on that in the new NHS approach to healthcare in prisons? I do not see that issue as a problem for the NHS alone, but what will you do to move us forward effectively?

The Phoenix Futures submission mentions phrases such as "effective illustration" and

"served Scotland well over the past few years".

However, the number of problematic drug abusers in Scotland has risen from 55,000 a decade ago to 59,000, the number of methadone users in the country is rising and the cost attributed to that problem is growing exponentially.

I am sorry for depressing everyone around the table. I ask you to cheer me up and fill me with confidence by telling me that the collaborative approach has just not been mentioned yet.

The Convener: I agree with you, and I think that every member of the committee does. That is the real issue, and we should measure the outcomes at the end. The measurement should address the question whether someone is back in prison because of their addictions; we can then find out what is really going on. We have not got to that stage yet.

I will start with Marion Logan, but there are other people on the list. I will write their names down or I will get lost.

Marion Logan: With regard to the transfer, we were not starting from the beginning as we already had partnership linkages with a lot of other organisations. The throughcare arrangements—while they were not perfect in any part of the country—were able to link an individual with services in the community. Some of those arrangements, which were put in place to ensure that an individual's support and care continue on release, worked very well, and some needed to be improved.

One consequence of the transfer is that more individuals, particularly those who have not had any prior experience of working in a prison, are having to skill themselves up to deal with what that involves. The models were there and the throughcare arrangements were in place, so we were not starting from the beginning. It is disappointing that some of the models that are being discussed will not have anything new in them.

I also raise the point about record keeping and being able to evidence achievements. The prisons, and certainly the addiction services, comply with the HEAT targets that are set for waiting times. The Phoenix staff submit to those targets, so we get statistics on how quickly people are seen. The SMR—substance misuse record—25 database is also used in the community. Forms are completed, so there is information that allows us to look at the whole volume of work. A number

of organisations record outcomes information, so it exists. The question is whether, collectively, we are interested in looking at it.

The Convener: What about your success in ensuring that someone does not reoffend? What records are there on that?

Marion Logan: It would be possible to see that if the collective will existed among organisations to report that information. The information is collated using the various tools that are available in statutory and non-statutory services, but no one brings it all together to examine it and ask what it means. It tends to be reported on an individual organisational basis rather than on a collective basis. Every organisation would certainly be able to submit that information.

The Convener: I find that quite breathtaking, and that is where we come to the crunch. All that public money is being spent, and many people in the voluntary and statutory sectors are putting in a lot of effort. However, we are sitting here and no one can tell us how effective all that is—over a period of time—in addressing the issue of the revolving door into prison.

I see that Dr Graham might be able to help us.

Dr Groden: I have—

The Convener: You are on my list too, Dr Groden.

Dr Groden: I was just going to answer that very point.

The Convener: Did Dr Graham want to answer a different point?

Dr Graham: I wanted to go back to the lack of progress and how we measure outcomes.

The Convener: We will deal with the point about measuring reoffending first.

Dr Groden: I have some information on the effectiveness of opiate substitution therapy, particularly in Greater Glasgow and Clyde. Some of the outcome measures are the number of drug-related deaths, the number of deaths where methadone was in the person's system, and the healthcare and criminal justice costs for those not in treatment versus the costs for those in treatment for less than one year and those in treatment for more than one year. We can see the reduction. The information is in the 2009 report "Assessing the Scale and Impact of Illicit Drug Markets in Scotland", which was commissioned by the Scottish Government.

The outcomes are that the healthcare cost for those with drug addiction problems who are not in treatment is £3,005, which reduces to £1,536 for those who have been in treatment for less than one year, and to £1,173 for those who have been in treatment for more than one year. The criminal justice costs go from £12,713 to £1,536. Those figures, which were produced by the Scottish Government in 2009, evidence the benefit of substitute prescribing for this population.

Graeme Pearson: Dr Groden will know that drugs deaths have reached an all-time high in the past 12 months. I would not like to begin to visit the numbers that you have just quoted in terms of costs and so forth, because I think that guessology would be involved rather than science.

My question is not so much whether there are benefits in terms of financial savings, crime reduction and so forth, but where the collective strategy is, on all your parts, to reduce the problem. Let us accept that all that you have said is true, and that it has been a plus. How do we begin to deflate the problem, which we seem to accept is just part of life? How do we take everything that has been said in the past couple of hours and make it have an impact on the group that we are discussing, rather than merely managing the situation?

The Convener: Dr Groden, do you want to answer that before I go back to Dr Graham?

Dr Groden: I am happy to answer that. I think that there is a big opportunity. I accept that it takes time to influence a change, but we can do that by having a continuum of service.

As a GP in the east end of Glasgow, I see these individuals both in the prison setting and outwith it, and they do not change. It is the same people and there is a revolving door. You talked about further sentencing and the rates of readmission to prison. A number of these people are readmitted because of outstanding warrants; they are readmitted not because they have committed a further crime but because of something that they did before their previous admission. For me, there is something significant in that, given my experience of seeing these people. They come in and see me in my practice, then I do not see them for three months, and then they reappear.

We have communication with the Prison Service and we have tightened up the continuum of care within the prisons, with better contact with GP practices and those who deliver services to the community. That applies both at the point of entry into prison and when people are released, to ensure that they continue to receive appropriate care in the community setting, because it is when people are released that they are most vulnerable. We no longer let them go out and try to find their own GP, who may or may not be willing to prescribe methadone for them. They have a planned release in order to ensure that what is provided is better than that. There is an opportunity there.

We manage and are involved in delivering the continuum of services to these individuals in Greater Glasgow and Clyde. As Mr Gibbons said, the biggest challenge is when people move around the country. In such cases, there is a real difficulty in accessing services for them, because we are not familiar with the services throughout the country.

Graeme Pearson: But you accept that, as was mentioned earlier, there is an absence of what, for want of a better term, I will call performance indicators that reflect whether reoffending is reducing or otherwise. The absence of those indicators is quite incredible.

Dr Groden: I absolutely accept that, yes.

The Convener: So what do we do about it?

Dr Graham: I cannot answer the question about the lack of progress. The prisoner healthcare network has been taking that work forward, and it is not represented here today.

However, I believe that we have moved forward, particularly on the alcohol front, in relation to what works, the evidence and a way forward, which we are continuing to push. I agree that, although there is some evidence on outcomes and the prevalence of problems, as Ms Logan said, it is not comprehensively brought together and it is not complete. I would like that to happen.

On information on reoffending, there is the potential to bring the two areas together by linking the prisoner records system with healthcare systems and mortality information. That is the basis of the work that I did when I was in the Scottish Prison Service. When I went back into the NHS to explore whether I could do that in relation to monitoring the Scottish Government naloxone programme, I found that there were no permissions for that and that I could do it only while I was in the SPS. Although the Information Services Division has been working on that area, we must go into the Scottish Prison Service and manually search records, which is laborious. There is therefore work to do on information-sharing protocols between the Prison Service and the NHS in order to achieve what are common goals. I see a way forward, but the problem is getting there.

The Convener: I would like somebody to comment on that. It seems to me that what you describe should not be difficult to do. Can somebody from the prison side tell us how we go about doing that?

Peter Wilson: I will just explain where we were on healthcare records prior to the transfer. We relied heavily on a manual healthcare records system, which made it difficult to gather and interpret information. The introduction of the Vision system on 1 April this year will ensure a more consistent way of recording health information. However, that development has still a wee bit to go. We probably still do not have the software design to gather the right information for mental health engagement and addictions engagement. The system is currently not used for prescribing, and a manual prescribing system is still in place. The new IT system will replace that, although we still have a wee bit to go.

On the workstream for performance management, we must wait for the network to pull together the indicators in order to get a consistent model for recording information.

The Convener: It is breathtaking that there is still a manual prescription system. Sandra White has a question, but is it on that particular point? Jenny Marra and Rod Campbell are waiting.

Sandra White: It is on that particular point. My first question on the issue was about difficulties, but it seems that the NHS and the SPS are coming together on a records system, although the IT needs to be improved. Perhaps the committee could write to the Cabinet Secretary for Justice to chase up what is happening about the IT system. We need to have the records together. That would be a real improvement.

The Convener: Your suggestion about writing would follow on from this round-table discussion. Sometimes in these discussions little gems of suggestions float to the surface, and the one that you have made is one such.

Jenny Marra will be followed by Rod Campbell, after which I will take the other two witnesses, who have been waiting quite a while.

Jenny Marra: I want to ask about speech and language therapy provision in prisons. The committee had a round-table evidence session a few weeks ago in which we looked at prisoners' communication issues—language skills, confidence and all sorts of related things. What provision of speech and language therapy was there before the transfer? What plans are there for that therapy post the transfer?

Peter Wilson: I do not know whether I have the full details, but, prior to the transfer, a speech and language therapy service was available at Polmont prison and I think that there was a call-in service at Inverness prison. I do not think that there was much more in terms of consistent speech and language therapy services. However, if someone had a specific need in that regard, I am sure that health service colleagues would have engaged with them and tried to get a service brought in for them

The Convener: Before I let Jenny Marra back in, Dr Smith and Mr McEwan want to come in on that point.

Dr Smith: I will confine myself to commenting on the post-transfer aspect. It has been noted that services from allied healthcare professionals, including speech and language therapists, physiotherapists and occupational therapists, have increased and improved at Shotts prison in Lanarkshire since the point of transfer. However, much of that work is done through individual needs assessment. For example, if one of the clinicians closely managing patients identifies that an allied healthcare professional needs to become involved in an individual's care, they will come in to provide that care.

11:00

Mark McEwan: I was going to make exactly the same point, as that is what happens in Grampian. Perhaps this will cheer up Mr Pearson—

The Convener: I do not know whether that is possible, but go for it.

Graeme Pearson: Yes, go for it.

Mark McEwan: I will try my best.

In preparation for HMP Grampian opening at the end of the year, I am doing a review of all the services that we currently provide, and the involvement of the allied health professions is exactly as has been said. We have looked at what went on before and it was the same situation, in that services were provided almost as required. For speech and language therapy, generally the issue is to do with swallowing-related problems. In doing that exercise, I have found absolutely no problem in engaging fellow professionals on issues related to mental health, substance misuse and the whole range of services that we provide. If the transfer has done one thing, it has raised the status of prisoner health higher than I have ever known it over the past four or five years. Although some things may have been frustratingly slow in the first year, one good thing that the transfer has done is that it has raised the profile of prisoner health nationally across the health field—

The Convener: Is Graeme Pearson smiling now?

Graeme Pearson: Yes, that is true. I acknowledge that that is going on in prisons.

The Convener: Well, it was not a smile, but it was close.

Graeme Pearson: As good as it gets.

Mark McEwan: At any level, if I ask for engagement on a medical input, the medical directors are pushing each other out of the way to get there, and the same applies to dentistry, psychology and so on. I think that there is a very positive vibe around prisoner health at the moment.

Jenny Marra: Are Dr Smith and Mr McEwan both saying that a speech and language needs assessment is done of every prisoner in their care?

Dr Smith: No, I do not think that that is what I said. When an assessment of a prisoner is made and it is thought that the prisoner needs input from any particular type of professional, that professional will come in from the NHS family to provide the care.

Jenny Marra: How does that assessment come to be made? Does that happen on admission to the prison?

Dr Smith: I can speak for Shotts prison, which is slightly different from other prisons in that it has a long-term, very stable population. As healthcare needs arise or as people are assessed on admission, a care plan, if you like, is made for each individual. The relevant professionals who will be involved in delivering that care plan are identified and brought in.

The Convener: I think that Mr Gibbons wants to make a similar point about assessment.

Jenny Marra: Let me first just clarify something that Dr Smith said. He referred to assessments being made as healthcare needs arise. Where a prisoner is ill and is taken in for a medical assessment, a wider assessment might be made at that point. However, a prisoner could conceivably be in Shotts prison for 10 or 12 years with a very bad stutter or stammer that could be helped by speech and language therapy but a needs assessment might never be made. Is that correct?

Dr Smith: I suspect that the needs assessment would be made only if the problem was brought to the attention of the clinical staff working in the area.

Jenny Marra: Now that the prison health system has been transferred over to the NHS, is there scope or the budget to provide a whole healthcare needs assessment for every prisoner in the system?

Dr Smith: I think that the fiscal results of that would be quite challenging.

Frank Gibbons: I was going to make a similar point. We would normally pick up whether a prisoner has a specific need when they are admitted to prison or attend one of the on-going clinics, where people can be referred to the GP or nurse. If someone raised an issue, we would

certainly engage with any specialist service for them. That is how it would normally work.

Mark McEwan: I think that an assessment is made of every prisoner anyway, because when they enter the prison system they will see a member of the nursing staff and a doctor within the first 24 hours. That would be one of the first opportunities for an issue to be picked up. Obviously, there is also on-going monitoring of prisoners in that they can refer themselves and are under the general monitoring of the nursing staff within the prison.

Frank Gibbons: Going back to the point about the increased profile of prisoner healthcare—it has never been higher—I think that many of the managers who work in prison healthcare feel that the NHS coming in has empowered local management to push for changes that had been difficult when they were part of the SPS. That has been a positive step.

Lots of posts have come up in areas such as learning disability and alcohol services. In Glasgow, people are being appointed to look at improving services for people with learning disability and alcohol issues. Part of that improvement will be to try to carry out some quality research. Some of my colleagues care passionately about the people for whom they are trying to care and, as someone who works in a prison, it seems to me that the research that has been done has been based on England, Wales and here, there and everywhere. Historically, there has not been a lot of quality research in prisons, but I see a vast improvement coming. When that starts to take place, we will be in a much better position to form action plans.

Jenny Marra: You are talking about the available data, and it strikes me that, with the NHS coming in to provide the services, there is an ideal opportunity to create that evidence base and provide that data by doing a full healthcare needs assessment of every prisoner in our prison population.

Dr Graham: I will use the alcohol problem as an example. Every prisoner who comes in sees a nurse on reception and a doctor within 24 or 48 hours. However, on alcohol the question that has been asked is, "Have you got an alcohol problem? Aye or no?" That has been it. We have tried to say that that really is not enough because it does not unearth problems, and that the proper, validated screening tool should be used, which does not take very long. That is the recommendation that we have put forward in the model of care.

We also recognised that the timing of the assessment is important. When a prisoner comes in, the thing at the top of their mind is not "Oh, yes, I've got a bit of an alcohol problem." There is a similar situation with learning and speech difficulties. A validated screening tool is built into the assessment process. It may not necessarily be used at the point of admission—that may not be appropriate—but it should be used at some point.

The Convener: When are you going to put these recommendations forward?

Dr Graham: Do you mean the recommendations on alcohol problems?

The Convener: Yes.

Dr Graham: The research is reference 3 in my submission, "Prison health needs assessment for alcohol problems", which was published two years ago. We have been driving that forward with Health Scotland and the Scottish Government to promote that agenda with both the alcohol and drug partnerships and the community justice authorities. Indeed, we had another big meeting just last week. We are trying to promote that, along with what Ms Parker has been referencing, as joint working to get pathways in place. A lot of work is going on to push that forward.

The Convener: We are getting into jargon with words such as "pathways", although I am not blaming you for that. I think that you are saying that you have a recommendation that the series of questions that are asked at the assessment that Jenny Marra referred to should be more pertinent, instead of just asking for an aye or a no. Why can that not just be put into practice? What is the problem?

Dr Graham: That is up to health boards.

Ruth Parker: I mentioned the review and redesign of services that is happening in health boards across Scotland, which are at various stages. I cited Forth Valley NHS Board as being actively involved. It is taking forward the advice and recommendations from the research to include a more robust process at the admission stage to identify significant needs, particularly in relation to alcohol, and to be able to respond to that with appropriate intervention.

The Convener: Where will this end up? Who will sit on the relevant group? When will it actually be done?

Ruth Parker: It will be at different stages as health boards take it forward as part of the redesign of their services. I can only speak for the board that I have been actively involved with, which is NHS Forth Valley, and it is looking to take the work forward in, probably, 2013.

The Convener: Next year.

Ruth Parker: It is in draft form at the moment.

The Convener: Is it the same with you, Dr Groden?

Dr Groden: Yes. I want to highlight the keep well checks that are on-going in the prison establishment, which are part of the national keep well programme, covering such things as alcohol use. One challenge is always whether people come forward for the health checks—we are dealing with voluntary participation in those assessments.

The Convener: I want to keep to Jenny Marra's question, which is what questions are asked when prisoners, including returnees, come in for that assessment. It seems that some simple things could be asked to get a real answer, rather than a fantasy one. Does the panel have any other comments? What happens in Barlinnie prison? Are the right questions asked?

Frank Gibbons: The admission process and the questions that are asked are fairly comprehensive, but there is a need to review what is said at admission and then to provide more quality time with guys or ladies coming into prison. The admission process is very busy. For example, on a Monday between six and 11 o'clock—and sometimes up to midnight—Barlinnie receives up to 100 prisoners from the courts. You can imagine how quickly those admission processes take place. Guys come in who are fairly apprehensive and quite worried about what is going to happen to them; some of them have not been in prison before. That is not the right time or place to provide a quality service. You are trying to ensure that somebody is safe and to pick up whether there are any major, life-threatening issues, such as whether the guy is diabetic or has a nut allergy—all sorts of things are picked up by that assessment.

We know that the process is fairly robust and that it works fairly well, but you need a process coming behind that in order to do some of the qualitative work that is needed to follow that up. We need to form that strategy; Mr Pearson is right that there is a bit of work to be done on the model, but people are striving to get there.

There may not be a national strategy across health boards. What is suitable for the Highlands and Islands might not be suitable for Glasgow and how certain things are approached there. The approach might be slightly different in different areas. For example, long-term prisons take people who have already been in Barlinnie for a year and whose health problems are pretty much sorted before they go there, although of course they may develop problems when they get there. However, in local prisons, complexities can arise and the speed at which things happen is very fast. When you talk about a full prisoner assessment on admission, you must remember that some of those guys may be in prison for only 14 days before they are away again.

Jenny Marra: I did not necessarily mean on admission.

Frank Gibbons: Okay. You are right about people who have stayed with us for any length of time—we need to quickly develop models that meet the needs of different prisoner groups.

The Convener: If that is done in the prison is there a barrier to sharing that data with the health service?

Frank Gibbons: No.

Graeme Pearson: There should be none.

The Convener: There is no barrier with the NHS, which is providing the service, and there is linkage.

Dr Smith: That is an interesting observation. In a former life, I was a GP. At the time, I was aware that prisoners who came out of prison left with very little information about what happened in relation to their medical treatment during the course of their stay. The transfer of prison healthcare to the NHS offers us the opportunity to take a much more integrated approach.

The one word that I have used in relation to all the approaches to the transfer of prisoner healthcare is "consistency". We now have the opportunity to ensure that we offer the same approach to very high-risk individuals, whether they are seeking care in the community or in prison. Soon we will have the opportunity to do that with people who are in police custody, because the same service—health—will be responsible for looking after them. We will be able to communicate more effectively between the different aspects.

11:15

For example, if we give the alcohol and drug partnerships that exist in each board area responsibility for the delivery of care to people who have addictions, we will get a consistent approach not just in board areas but throughout the country, because everyone is following the same national strategy.

There is a tremendous opportunity, but it is right that what happens is measured in some way, and we need performance indicators to underpin such measurement.

Roderick Campbell: In her submission, Lesley Graham talked about mortality rates and said:

"The greatest number of deaths occurred shortly after release from prison".

What information do you have on causes of death? Now that the NHS is working in prisons, we are aiming for as seamless a transition as possible

when prisoners come out. Can you talk more about the conclusions on those mortality rates?

Dr Graham: Are you asking what the people who die shortly after coming out of prison are dying from?

Roderick Campbell: Yes.

Dr Graham: It is unfortunate that there is no routine reporting system. Research has shown that the causes of death are predominantly the ones that I mentioned. There is drug-related mortality. We have been monitoring that in relation to the Scottish Government's naloxone programme, because drug-related mortality in people who have recently been released from prison is a monitoring indicator. I am happy to report that the numbers have been falling. Ms Parker might back me up on that; it is emerging information.

As well as drug-related mortality, suicide levels are high. There is also alcohol-related mortality.

Roderick Campbell: Could we do more to tackle such issues during preparation for discharge?

Dr Graham: I am not at the operational front of things, but I am an ex-GP and I can speak from first principles. Prison is an artificial environment for people who have alcohol problems, and going back into the community presents many challenges to do with re-establishing relationships, employment, housing and so on. There is a high risk of relapse into heavy drinking. More needs to be done, not only on throughcare in general and looking at elements such as housing but on preventing relapse. There are various intervention strategies in that regard.

On drug-related mortality, the naloxone programme is in place and the SPS issues naloxone kits—naloxone is an opioid antagonist and can reverse the effect of overdose—so there is work on that front. I do not know what is being done on the mental health front.

Roderick Campbell: Are you optimistic that the death rate will fall? Will we see an improvement in the statistics?

Dr Graham: I wish that I could repeat the one-off piece of research that I mentioned. I had a vision of a prisoner healthcare database, so that we could run the figures at any one time. The approach would require a link between the SPS's prisoner record system and various healthcare records, not just those in the Vision system but hospital admission and mortality records. Such data would enable us to answer your question, but we do not have them.

The Convener: Alison McInnes, Graeme Pearson and John Finnie wanted to come in, but I wondered whether they would relinquish their chance to ask another question, unless they feel that they must say something. I want to ask all the witnesses what one thing they would want the committee to include in its short report. From what you have heard this morning and from your own perspectives, what should we be looking at? I do not mean that the committee should address only one aspect; I mean that I want to hear one suggestion from each of you.

Kirsty Pate: My comment follows on from the discussion that has just taken place—I did not have the opportunity to come in. People talked about speech and language problems, alcohol problems, drug problems and mental health problems. Different organisations get different funding streams to do different things, so they tend to report on different issues. A prisoner is a citizen who might have a broad range of problems, but we tend to report on individual problems. That is not the reality of that individual's life, because they live with those problems all the time.

I will try to be brief, convener. I absolutely agree that we should be able to look at offending outcomes for people, but we should also be able to talk about improvements in their mental health or their addictions, how they live their lives and how they function in general. At the moment, our funding streams do not allow us to report in that way. Instead of reporting through a national strategy, we all report on national outcomes through our CJAs, HEAT targets and suchlike. Leadership is now coming from the Cabinet Secretary for Justice, who supports the recommendation of the commission on women offenders that we start to work with people as individuals in places where they can access the whole range of services that have been picked up on. As a result, instead of people having to report on outcomes with specific regard to their funding, they can start to report on what are very varied and complex outcomes for individuals. The fact is that we need to recognise the complexity of the problems in this group.

My final plea to those who might get together to examine measurement tools is that we do not forget the specific needs of women in that population. In that respect, we need to ask different questions about mental health and trauma.

The Convener: The committee is well aware of that. As you know, we have paid huge attention to the issue of women offenders.

Marion Logan: My plea is for a continuing partnership between statutory and voluntary organisations in the provision of care and support for prisoners.

Dr Graham: I think that members know what I am going to say: I would like to see progress in measuring the health and healthcare needs of prisoners and the associated health and reoffending outcomes.

Jenny Marra: How?

Dr Graham: That is a long story.

The Convener: Well, we have not got time for it. Perhaps you can tell us about it in writing.

I take it that you also want more progress in research. I recall someone saying that, apart from your research, there has been only United Kingdom or English research on this matter.

Dr Graham: Evidence can be obtained from routine reporting, ad hoc pieces of work such as the prisoner survey and indeed research, all of which are important in their different ways.

Ruth Parker: We have an opportunity to introduce a circular model of throughcare, in which we not only make referrals to community services but get feedback to inform wider outcomes. I also suggest that the work that health boards carry out be used to track individuals' recovery through their sentence and when they go back into the community, and that health outcomes inform justice outcomes to reduce reoffending.

The Convener: Would it be possible to get a background paper on what NHS Forth Valley is doing in that respect?

Ruth Parker: Certainly.

The Convener: That would be useful.

Peter Wilson: Data sets should be improved a wee bit more, and the software for the Vision IT system should be significantly developed to ensure that all types of health interventions in prison are captured. If that happens, we will be able to share that information with community partners.

Dr Smith: Now that a good IT system has been established, I would like the data that we want to collate centrally and which we would use to benchmark ourselves against to be identified and agreed.

The Convener: Who would do that?

Dr Smith: It is not beyond the realms of possibility, but the co-ordination of such work will require some central resources.

Mark McEwan: Although a lot of really good stuff is going on in separate health boards, I would like that activity to be more joined up across boards. I also want to highlight the use of telemedicine, which I mention in my submission. I know that NHS Tayside is providing teleneurology in prisons; NHS Lothian is using telemedicine to provide forensic psychiatry; and NHS Grampian is looking to deal with the unscheduled element through telemedicine. I think that we can improve the service in that field but, as I have said, I want the good work by separate health boards to be drawn together.

The Convener: Do health boards not meet and share good practice? How would they draw that work together?

Ruth Parker: Through the network.

Mark McEwan: We should use the prison health network. We certainly need to be a bit more active in sharing good practice.

Frank Gibbons: There is a good opportunity. We are at a place where we could marry ideas and form a very positive model to take forward. Politically, people should not be put off some of the strategies that already exist, which my colleagues and I have found to be very effective. Substitute prescribing gets a very negative name because of the costs, for example, but I still remember the Prison Service before substitute prescribing, when conditions for prisoners were awful and deaths from suicide and self-harm were much higher than they are now. The number of such deaths is much lower now than it was 10 years ago. With some strategies, we should not throw the baby out with the bath water. There must be a measured approach, as some of the strategies that are in place are very effective.

Dr Groden: Throughcare is a key area but, coming up with something different, I think that we need to look at some of the processes we have inherited around prison healthcare that we have to follow as a matter of agreement. They take up a lot of resources that could be better channelled to delivering care to individuals rather than to just processing people through the system. Until we get national agreement on which processes we need and which we have done historically but could perhaps do in a different way or dispense with, we will always struggle with having enough resources and bodies to deliver the type of care that we all aspire to deliver and which we have heard about today.

The Convener: This is just an investigative and exploratory round-table discussion. If we were to return to the matter, when should we summon you back, as it were? When will things have moved on? You talk about boards speaking to one another, IT systems and so on. We may have preliminary thoughts, but what should the timescale be for seeing whether issues have moved on? We can all talk for ever, but let us get some progress.

Dr Groden: I think that the Justice Committee should set the targets, given that it wants to see change. If you want to see change, you should set

the targets for that. A realistic target would be to see progress within six months.

Ruth Parker: I would agree.

The Convener: We must think alike: I was thinking about six months. That is interesting. Having had this discussion, perhaps we would like to ask the same questions in six months' time, look at the record of what has been said and see whether there are the same answers.

Is there anything that any committee member was itching to ask but has not been asked, or will we move on?

Alison McInnes: I am sorry—I know that you want to move on.

I want to pick up on something that the chief inspector of prisons has regularly reported on in his reports on Cornton Vale, mental health issues, and the complex needs of women in Cornton Vale. He has often commented that there are people in Cornton Vale who ought to be receiving treatment elsewhere. It is clear that there were constraints in the old system. What capacity is there in the new provision of mental health services to deal elsewhere with the most complex problems in Cornton Vale? Is there enough dialogue to make that happen?

Frank Gibbons: I will answer that question in a broad sense rather than in relation to Cornton Vale.

The health boards are looking at training and education for prison staff and nursing staff—by which I mean non-mental health nursing staff, such as general nurses—to manage people with complex needs. We have quite a high population of people with behavioural issues who create many problems. In particular, many have a personality or borderline personality disorder. Money has been invested in specialising and getting training for staff in health boards to help them to manage people and improve that management, and I think that that will make a significant difference. There are also plans to link in with the duty forensic psychiatrists so that we can get out-of-hours services and things that would help us to deal with emergencies and getting people to hospital fairly quickly.

Before the transfer, one of the things that the NHS did quite well was that it identified people with acute mental illness and got them into hospital, but where there were doubts about their behaviour—particularly a personality disorder—the issue was always quite difficult. I can see huge improvements being made in that area, even through having a knowledge base that will help us to better manage people who might not be best placed in hospital but could be managed better in prison.

11:30

The Convener: We need to move on so, although Graeme Pearson and John Finnie are about to ask questions, I ask our witnesses to answer them in writing later—similarly, if they would like to answer Alison McInnes's question more fully, they could do that in writing, too. The *Official Report* will be available to read in a few days.

Graeme Pearson: My question for Ruth Parker might need only a one-line response. HM inspectorate of prisons for Scotland has reported that healthcare services in Dumfries operate under difficult conditions. Will someone in your organisation pick up on that comment and will they work through what those difficult situations are and repair them?

The Convener: That is certainly not going to be a one-word answer. I ask Ruth Parker to respond in writing.

John Finnie: In his submission, Mr McEwan said:

> "In common with other health boards, Grampian has promoted the re-registration of prisoners returning to communities among GP practices."

I recently dealt with a situation in which three practices were declining to register people on the basis that they did not have photo identification. Are there difficulties elsewhere?

The Convener: Those questions are on the record. Anyone who wants to answer them can write to the committee.

I thank our witnesses for their attendance. The session has been interesting. We were not seeking solutions today; we wanted only to hear about problems. We have heard about some and no doubt our witnesses will let us know if any have been missed.

The committee must decide whether to write to the minister to raise the issues or, alternatively, to write a little report. There is a lot to read, so I suggest that we have the discussion about that decision next week. Is that agreed?

Members *indicated agreement.*

The Convener: We will suspend for eight minutes.

11:32

Meeting suspended.

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11:38

On resuming—

Her Majesty's Chief Inspector of Prisons in Scotland (Annual Report 2011-12)

The Convener: Agenda item 2 is the annual report of Her Majesty's Chief Inspector of Prisons in Scotland. We will receive evidence from Brigadier Hugh Monro, whom I welcome to the meeting. I know that you sat through the whole of the previous part of the meeting on a very uncomfortable chair, Brigadier. We will do something about that. This is the first time that the committee has considered the chief inspector's annual report, but it is not the first time that the chief inspector has appeared before us. I welcome you back. We will start with questions from members—it is their turn this time.

Roderick Campbell: Good morning. I will kick off by asking a bit more about the personal officer scheme, which is referred to in the report. You suggest that the scheme is not working very well. Perhaps you can tell us why it is not working very well and what steps could be taken to improve it.

Brigadier Hugh Monro (Her Majesty's Chief Inspector of Prisons): Thank you for inviting me here. It is a great honour to be asked about the annual report and I thank Roderick Campbell for his question. The personal officer scheme goes to the heart of what the Prison Service is about in terms of rehabilitating prisoners into the community.

I heard something on the radio this morning about the mentoring of prisoners and the delivery of prisoners from prison back into the community, and I think that the personal officer scheme represents the Scottish Prison Service's contribution to that—and, by the way, it is free, because we are already paying for prison officers. In my view, it is a service that should be provided. I know that everyone in the Prison Service has agreed, yet in almost every prison that I go to, there are a number of things that I see are not happening.

First, I do not see prison officers who have been trained to do the job of personal officer, which I think needs a bit of training. Not all prison officers are ideal fits for such mentoring support, so I think that something could be done to train and encourage officers. That is an important aspect. The absence of that is one of the main reasons why the scheme does not work very well. The other main reason is that I do not think that managers in halls or unit managers more widely are prepared to supervise and to lead the scheme in a way that I think would make a dynamic difference. If we put all those elements together, we would have a much better system.

In addition, I do not think that the scheme should be confined to just those prison officers who work in the residential halls, which is currently the main intended practice. I think that any person who works on the staff in a prison may have a particular attribute that makes them effective in providing such support. Therefore, as well as a training process, there ought to be a selection process for how the scheme is best provided.

We need to put all that together and have properly trained and selected staff who are properly led and supervised. There also needs to be measurement. I do not see nearly enough measurement of progress on who is providing the scheme, who is looking after which prisoners and whether they are doing so in the most appropriate way. We must also look at how the prisoners do within prison—whether they go to work, education and so on—what their connections with their families are like and how they will progress once they get out into the community.

That is rather a lot, but it is absolutely fundamental to what the Scottish Prison Service should be doing in rehabilitating prisoners and delivering them back into the community.

Roderick Campbell: Will the Scottish Prison Service board and its new chief executive be receptive to those comments?

Brigadier Monro: I certainly think so. The context in which I have delivered the report, which is the third of the four that I am to produce in my period as chief inspector, is one of a new leadership for the Prison Service. The annual report that we are discussing is for last year, as it were—the year up until April 2012. Since then, we have seen a real difference in the direction in which the Prison Service intends to go, with the appointment of a new executive.

My personal view is that, once the governance of the board has been sorted out—which I know the chief executive is keen to do—and once we see how the board intends to take such issues forward, we will see a much bigger improvement in how the scheme is implemented. I also think that there will be an improvement in the training and development of the staff who will deliver it.

However, it is important to make the point that, as chief inspector, I inspect only what I see; I do not inspect good intentions or strategic plans. On this question and a raft of others, I can tell you only what I see and the evidence that I gather.

The Convener: Does anyone else have a question on the same topic—preparations for release and so on?

That not being the case, we will hear from John Finnie.

John Finnie: Good morning, Brigadier Monro. As a Highlands and Islands representative, I want to ask about legalised police cells, all but one of which are in the Highlands and Islands. What level of use do you understand is made of legalised police cells?

11:45

Brigadier Monro: The level of use is relatively low, so I have recommended that a number of police cells be closed, because I do not think that they are relevant. That is because of the contract for escorting prisoners from normal police cells to an appropriate prison. However, clearly in the Highlands and Islands and the Northern Isles, there could be a logistical problem that might be compounded by poor weather. For example, I personally inspected Kirkwall legalised police cell—I know that it is not in your area—and although, as far as I can remember off the top of my head, it had hardly been used in the previous 12 months, that does not mean to say that it should not be there. Where it is relevant and geographically sensible, such cells should continue.

I do not know if that gets to the answer that you wanted.

John Finnie: Yes, it does. The logistics of prisoner transfer are important so, given that Lochmaddy is in what we would refer to as the southern part of the Western Isles and that there are challenges in trying to get off the islands, why is there a recommendation to dispense with Lochmaddy?

Brigadier Monro: I will need to come back to you on that issue, but the level of use at Lochmaddy is particularly low and there was a feeling that prisoners could be flown out if necessary. However, I will come back to you on that, if I may, Mr Finnie. That would be the sensible thing to do.

John Finnie: Convener, may I ask a couple of other questions please?

The Convener: Certainly. No one is waiting with supplementaries.

John Finnie: A comment was made about outdoor exercise. I presume that there will be a follow-up inspection of that. Are records kept of people being exercised in the fresh air?

Brigadier Monro: Yes, indeed. When we make such a comment, we follow it up. I expect the Scottish Prison Service to run an action plan on each of my reports and we will look at those action plans. If we commented on outdoor exercise in a particular prison, we will follow that up, either formally, by going back to reinspect the prison, or informally, by keeping an eye on the action plan and visiting the prison just to double-check. I set great store by outdoor exercise and care about whether people are appropriately dressed, and so on, so I would go back and double-check that.

John Finnie: Finally, are you content with the lines of responsibility for someone who is in a legalised cell? Who is responsible for that person?

Brigadier Monro: I think that I will need to come back to you on that one. You are asking particularly about legalised police cells.

John Finnie: Yes, indeed.

The Convener: You can just write to the committee, Brigadier.

Graeme Pearson: I have a question about sex offenders. You make specific reference to what you call the penal cul-de-sac, with particular reference to Dumfries prison. Anecdotally, we know that there are other cul-de-sacs within the prison estate.

The general public is vexed by the threat from sex offenders, and the evidence is that they can be prolific offenders when they return to the community. Do you have any comments on the way forward in managing and dealing with sex offenders? Are you concerned about such penal cul-de-sacs creating new networks and associations among those who offend?

You also mentioned the reoffending programmes that are run in prisons. Do you have any evidence to indicate the success or otherwise of such programmes?

Brigadier Monro: I will start with the penal cul-de-sac. That comment was specifically targeted at Dumfries prison and the sex offenders who refuse to admit their guilt and have been sent there for that reason, and who were therefore not getting access to sex offender programmes that were, at that time, being run at Peterhead prison and are now run at Glenochil. I felt strongly that that was not a healthy way forward, either for the sex offenders or for the staff and the prison as a whole. I was trying to get the Scottish Prison Service to produce a strategy for managing sex offenders—at that stage there was not even a draft strategy—because I felt that all we were doing was shipping the awkward squad down to Dumfries and, as I said, that was not healthy. I am pleased to say that that has changed—there is certainly a draft strategy now. I would need to go back to Dumfries, which I am doing in January, to double-check that there has been some movement forwards on the issue.

On the penal cul-de-sac business, I go back to the point about mentoring. There is a danger that

we put certain prisoners into a place and leave them there. We secure them, as it were, which is fine, but that is not trying to motivate, lead and progress them. What I really worry about is that at some stage offenders will be released from those conditions directly back into the community. That does not seem to be a sensible way of progressing when those offenders should have had the benefit of a sex offender programme that would challenge their behaviour.

I do not produce solutions; I merely ask the questions. At what stage do we "test" sex offenders in open conditions? How do we do that without raising the risks associated with putting sex offenders in the public domain, not only in the public's perception but in reality? The counter to that is that if we release sex offenders directly from closed conditions, is not the risk just as high if not higher?

I take account of the multi-agency public protection arrangements—I am perfectly clear about those. We try to deliver those arrangements pretty well in Scotland but there are a lot of questions to ask, not just about the penal cul-de-sac but about how we get sex offenders back into the community.

That takes me on to the last point that you raised, which is the business of sex offender programmes. I cannot tell you, and no one has told me, how effective those programmes are at dealing with sex offenders and challenging their behaviour. No one has told me whether the programmes are worth while and what the reoffending rate is.

Sex offenders are extremely difficult to understand. The public find the subject extremely difficult to understand. That is why we need a bit of clarity on the issue. I would like to know more about risks—-whether we are raising risks and how we lower risks. I am not in any way trying to be an expert, but are sex offenders rather like alcoholics, in that abstinence is good for them—they will get that in prison, hopefully—but once they are released, their behaviour goes back to what it was before? Is it rather like an alcoholic visiting the pub outside the prison gates? I do not know the answer, and no one has ever explained it to me in a sensible fashion that is worthy of the public.

Graeme Pearson: Do you get the impression from the Scottish Prison Service that it attaches sufficient priority to the challenge that you have identified here and that it will respond to that challenge with the speed that you would welcome?

Brigadier Monro: We are in a better place than we were when I inspected Peterhead and Dumfries a couple of years ago. Obviously, we have moved the offenders from Peterhead to Glenochil and they now have their own residential block in Glenochil—they are in one place there. I need to go back and look at that.

The issue has at least been addressed by the Scottish Prison Service. A sex offender working group is looking at it and trying to sort out the cul-de-sac issue. I am not in any way suggesting that this is easy, because it is not. I find it difficult to understand the people who will not admit their guilt and are resolute in doing so. That is why we need to understand the issue better and why we need a strategy. I would like staff to be trained to deal with the issue. I will probably come back to staff training in relation to a number of issues, but staff must be trained to deal with sex offenders. How do they motivate someone whom they do not understand? How do they try to take them forward? Those are big questions, and I do not know what the answers are.

The Convener: Was there not a programme at Peterhead many years ago that involved special training, in which sex offenders first had to recognise that they had committed an offence? What happened to it?

Brigadier Monro: The sex offender treatment programme known as STOP, to which I think you are referring, has now moved into the Scottish Prison Service good lives programme, which is still very much in evidence. However, I have not seen evidence of how successful those initiatives are, and we are finding difficulties in trying to understand the issues and move forward. There is not only a training issue, but a throughcare issue.

Graeme Pearson: I acknowledge that it is a thorny problem that is not easy to resolve, and by no means do I feel that the organisation is reticent in dealing with it. However, given the on-going damage that those offenders do in our communities, which lasts a lifetime, I take it that you would agree that the issue—difficult as it is—needs some additional attention. Measuring what works, what is successful and how to assess risk properly when returning offenders to the community is an important priority that we should address as quickly as we can.

Brigadier Monro: Indeed, and I absolutely accept what you say about priority. That is why we have tried to make the issue a priority.

When I inspected the Castle Huntly open prison earlier this year, I was slightly surprised to find that there were only—I think that I am right in saying—fewer than five, and perhaps only two, sex offenders in the prison. However, in the previous 12 months we have released around 150 sex offenders directly from closed conditions, without testing them in open conditions.

I do not know whether that is right or wrong, but we need some evidence and some help with the matter of risk because, as you rightly point out, we do not have that.

Alison McInnes: Good morning. I have two separate questions.

First, you produced your second follow-up report on Cornton Vale earlier this year, in which you noted that unsatisfactory progress had been made on about a third of your recommendations. Since then, there has been a radical change of heart, which we have all welcomed. However, we need to caution against saying that everything is fixed. There is still a short-term problem at Cornton Vale, and I would be interested to hear about which issues you think still need to be picked up.

I was particularly concerned, as you were, by the use of the silent cells. I know that there is now a new separation and reintegration unit, but there has been an overreliance on such facilities. Although the fabric might have been improved, it would concern me if the mindset had not changed and the facility was still being used in the way that it had been previously. Do you share those concerns? Can you speak more generally about what we still need to monitor at Cornton Vale in the short term?

Brigadier Monro: It was recognised when I attended the committee meeting previously that huge progress has been made. I was interested to hear Kate Donegan's view on how the commission on women offenders—and also, I hope, the inspectorate's reports—has changed the landscape.

The Convener: We hope that the Justice Committee had a bit to do with it as well—you should not forget us.

Brigadier Monro: And the Justice Committee, convener.

The Convener: Alison McInnes was promoting the issue.

12:00

Brigadier Monro: I entirely agree with you, convener. The discomfort of my seat in the public gallery must have affected me. You had better strike that from the record. [*Laughter*.]

Your political support has been very important in that regard. I was interested to hear the discussion about mental health in the previous evidence session. In no other prison in Scotland is the mental health situation as stark as it is at Cornton Vale. In many respects, that is because—as someone said earlier—the women do not get into the services. They do not try to connect and sort out their own problems; those are very much on show. Those of you who have been to Ross house, for example, will know that it is a pretty discouraging scene.

I have been quite specific in my reports about mental health services at Cornton Vale. One issue has been the extent to which staff who are dealing with extremely challenging mental health issues are appropriately trained. There has been some progress, as the second follow-up report indicated, on mentalisation training and so on. However, we are dealing with really challenging people, particularly those who are in the separation and care unit. At some stage, a strategic judgment will have to be made about those very challenging mental health issues and whether we are prepared just to put those people in prison; to send them off to another institution to deal with their issues; or to invest in appropriate training and facilities for prisons. If one is going to build a new female prison, one might think about that. There is an issue with the training of staff and how they look after people with seriously challenging mental health issues.

The second area that we have been involved in has been the segregation of those challenging women. When I produced the reports, I had a particular concern about the so-called back cells, the cells in Younger house, which were utterly shocking and horrible to be honest. We have encouraged the creation of—and we now have—a new unit, which is real progress, but I question why it has taken us three years to get there given that a morning spent in one of those cells is too long. There is a fundamental question to be asked about that.

The other question about segregation is how long someone should sit in a segregation unit. I am talking not just about female offenders. As you and I know, there are women who have been there for over a year. In whose interest is that? It is certainly not in the interest of the offender; it is not in the interest of the staff; and, in my view, it is not in the interest of Scotland. It is shaming. In essence, we are accepting defeat and saying that we have failed to take the person on either clinically or by mentoring them and leading them to a better way. There are significant questions to be asked about the long-term segregation of people with mental health issues.

I do not know whether that answers your question.

Alison McInnes: Yes, very thoroughly. I have no doubt that your three reports on Cornton Vale were what sparked the change of heart. You are to be greatly thanked for the work that you have done. It is my view that it is an abuse of those individuals' human rights to keep them alone in their cells for such a long time. We need to pursue that, and your response has been helpful.

My other question relates to your annual report. You pose the question whether it is possible that the use of remand is increasing reoffending rates rather than reducing them. I would be interested in your thoughts on that point.

Brigadier Monro: We were at Clive Fairweather's memorial service last week. He produced the original report to which I referred in my annual report, and we should pay tribute to him for starting this off. It is interesting that an increasing number of people who have not yet been either proven guilty or sentenced are sitting in prison. I worry about that. As I say in my report, I worry about whether it is appropriate for them to be held in custody. I do not think that any of us would fuss about them being held in custody if it was entirely about safety and security. If it is in their own interests or those of the community that they be held in custody, I would not worry about it, but I do not know how many of the people on remand fall into that category.

If remand exists purely for administrative convenience—that sounds like a rather throwaway line, but we are talking about people who have a chaotic lifestyle, have probably committed a number of offences and have a history of failing to turn up to court—we must ask whether custody is the right way forwards. Are there not other ways of ensuring that the court's orders are adhered to? I have a concern about that.

I also have a concern about how people on remand are being treated in prison. Particularly if a prison is overcrowded, not as much direct intervention takes place with prisoners on remand as with other prisoners. I find that perplexing. As I think I say in the report, prisoners who are on remand have access to physical exercise in the gymnasium and, potentially, good access to their families—privileged access to families compared with other prisoners—but is it not an opportunity to intervene in other ways, particularly if they are younger people? If young people are in the last-chance saloon, remand gives us an opportunity to do something about it, whether they are guilty or not guilty.

The last piece is whether prisoners on remand have lost their house, their job or their family. Can we do remand in another way that means that they do not have to lose those three things and that allows them to carry on with their job or go to school if they are of that age? I do not know how we would do that; perhaps we would think about putting them in prison overnight.

We must address the issue differently. I am not trying to criticise the courts or suggest that the issue is easy, but we need to consider it practically and try to come up with better solutions.

Alison McInnes: Are you optimistic that dialogue will now happen or are you still uncomfortable about it?

Brigadier Monro: I do not inspect optimism.

The Convener: That is another person who will not smile, along with Graeme Pearson.

I have a supplementary question on remand. I go back to the days when Clive Fairweather was the inspector of prisons—we were at his memorial service together. He said exactly the same as you are saying 13 years later—which is a bit depressing—about the conditions for prisoners on remand being worse and there being too many people on remand. Also, 50 per cent of them are not convicted, so they have been in prison for a period although they are innocent.

I am not sure about this, but I do not think that tagging is used for people who are on remand. If they are not a danger to the public, could we use tagging and keep them in their jobs and with their families while they go through the court process?

Brigadier Monro: I am saying that we need to consider the matter much more widely. What are the opportunities for doing that? We should separate the people whom the court felt were a security or safety issue from those who were just troublesome in another way. I am sure that there are ways of doing that. We now have much more intelligent tagging systems that would fit that bill very well.

The Convener: Have you raised that anywhere?

Brigadier Monro: Not that specific question, convener. I can only report on the issues; I can only tell you what I see and write a report.

The Convener: I was asking whether there had been a response from the SPS or the Cabinet Secretary for Justice on alternatives to placing people in prison on remand. They are still innocent until proven guilty. There may be an issue about them being a danger to the public in certain circumstances, but in other circumstances there is not. Therefore, as long as we could track where they are—in their home or wherever—they could keep their jobs, especially because, as we now know, 50 per cent are not convicted at the end of the court process, so we bang up people who are innocent.

Brigadier Monro: I certainly had acknowledgement from the cabinet secretary and officials. I know that good work is going on in the Government to look at the issue, but I have not seen specific ways forward that are going to be implemented. All I can do is raise the issue, which I think is one that really needs to be tackled.

The Convener: We could raise it as well.

Roderick Campbell: Was records information made available to you that dealt with different categories of people on remand? For example, someone might be remanded because of the threat of potential intimidation of witnesses or because they might commit further offences. Did you get detailed information on different categories of remand prisoner?

Brigadier Monro: No, I did not. We looked at remand as a general category. The 50 per cent figure was approximate. I do not have a PhD in statistics, so I had to be careful about how I dealt with the information. I know that work is going on in the Scottish Government to look at what happens to remand prisoners but, rather like the reoffending rate, it is not an easy category to measure. That is why I was fairly approximate in my statistics. To answer your specific question, I did not see how many remand prisoners were in what might be called a particular safety or security category.

Roderick Campbell: Thank you. That is something that the committee could take up with the Scottish Government.

Sandra White: I intended to ask about overcrowding and the remand situation, so most of my questions have been answered, but I wonder why so many prisoners are on remand. I know that some are in and out because of being on bail. Do you have an answer as to why so many are on remand?

Brigadier Monro: I do not think that I have. I think that there are—

The Convener: Forgive me, but I think that that is a matter for the sheriffs and the judiciary to make decisions about.

Sandra White: I was going to come on to that, but I thought that I would ask that question just now.

The Convener: It is not really a matter for the chief inspector of prisons to know why a sheriff decided that somebody should be put on remand.

Sandra White: I will ask another question. Have you ever raised that issue with sheriffs, prisoners or anyone else?

Brigadier Monro: I have done so informally. One asks such questions in informal discussions with sheriffs, but I do not want to put sheriffs in an awkward position.

The Convener: We should not pursue this. It would be unfair to ask about informal discussions that the chief inspector has had with members of the bench.

Sandra White: I think that the answer is possibly that sheriffs and so on are not giving custodial sentences, but I will leave that aside. I have another question.

You referred to activities in prison. It has been suggested that remand prisoners cannot get involved in such activities because of the need to separate them from convicted prisoners. Overcrowding is also an issue in that regard. There is no legal requirement for remand prisoners to do work in prison. How could we get round that? The convener said that perhaps people could be tagged rather than remanded. Would it not be helpful for people, though, to be involved in activities in prison? How do we get round the difficulty of their not being able to be involved in such activities?

Brigadier Monro: This comes back to my points about mentoring and leadership. I have referred to the prison regime and having to keep remand prisoners separate from those serving sentences. In many respects, that is entirely right. Further, a number of those on remand do not want to engage in activities, and because they are not under sentence there is little effort to try to encourage them. I would like to see more encouragement. More outreach is perhaps possible, not so much for them to go into the education centre, but perhaps for education and encouragement to be offered to them.

I was interested to hear the committee's earlier discussion about addictions. Some remand prisoners may well have an addiction. Although the clinical medical services will deal with that and although individuals will be on methadone or whatever, there could be some engagement on alcohol and drugs. After all, if one hopes to get such a service outside prison, why cannot it be offered inside prison? I do not think that there should be any stigma attached to that.

12:15

We have to look at these people as an opportunity, not a threat. For goodness' sake, they have not yet been found—and might well not be—guilty. In any case, it does not matter; the police or the court has decided that they should be in prison, and there might be an underlying issue that can be dealt with. We ought to make an effort to treat these people as individuals and induct them into prison in a way that shows more of an understanding and at least makes an attempt to get them on the right course, if only to ensure that they are connected when they go back outside. I simply do not see enough of that going on.

Sandra White: Thank you very much. That was a very interesting point.

Jenny Marra: I have two questions, the first of which follows on from Sandra White's question. After visiting Castle Huntly, Perth, Polmont and

Cornton Vale prisons earlier this year, I was struck by the lack of what you call in your report "purposeful activity" as well as properly structured and thought-out rehabilitation programmes. I know that you have made some comments about the remand programme, but how satisfied are you in general with the rehabilitative programmes in our prisons?

Brigadier Monro: From a strategic point of view, I am not very satisfied at all with delivery. What is the point of prison? It has, of course, a safety and security element and a punishment element, but if we are to reduce reoffending and give people another chance they must have the very best possible access to purposeful activity that suits them as an individual to give them the best possible chance when they get out and to give the community the best possible chance of connecting with them to take them forward. I do not think that enough is being done about that.

Sometimes we use the word "rehabilitation" wrongly. I do not mean to stigmatise people with a general comment, but the term assumes that at one stage offenders had the proper foundations for a successful life. However, many of these people did not have such proper foundations. Many found education to be a challenge; many have got a drug and/or alcohol problem; and many might have had a pretty chaotic upbringing or lifestyle. Rehabilitation suggests that we take people back to where they were before, but the fact is that we need almost to start again and rebuild those foundations to ensure that when people come out of prison they have a much better chance of surviving.

My point, which I think you are throwing back at me, is that rehabilitation and the building of such foundations should be absolutely central to the functioning of prisons and that we should get the maximum number of people into work, vocational training or education. I note that the wage structure for prisoners is interesting. If they go into education, their wage drops. I find that rather bizarre.

Jenny Marra: From what you have seen in our prisons, what do you think is the best way of putting these programmes together? Do we need a national strategy? Should it be up to the individual leadership—by which I mean the prison governors—or is it incumbent on the colleges that have been tasked to deliver these programmes to do this? How far up the food chain should such a strategy go?

Brigadier Monro: If we had a national view about the point of rehabilitation and what it is trying to deliver, we might be able to measure that in a sensible way when people get back out into the community.

There is an issue about the contract for the education providers, Motherwell College and Carnegie College, which was signed just over a year ago. The contract is very much based on literacy and numeracy, but those issues are not always the problem. That kind of approach is very narrow; we should have taken a wider approach to education and learning and focused on what was most appropriate for the individual.

When I inspected Castle Huntly this year—I think that this is in the report—I specifically commented that the education centre in the open prison, at the end of the prison process, is still talking about literacy and numeracy. At that final stage, surely we should be talking about how we are going to deliver people into the community. If people have not learned to read and write by the time that they get to Castle Huntly, there is not much hope for them. We need to apply education and learning in the most appropriate way for the people whom we are talking about, whether they be young offenders or people who are getting out into the community.

There needs to be—I do not know whether strategy is the right word—not only delivery of what we are trying to do but measurement of the throughcare process. Again, as with many of the other things that we have been talking about, no one can tell me how well we are doing on this. The figures that I quoted in my previous report were really very low. At that stage, I think that the proportion of prisoners out at activities was 35 per cent at Cornton Vale and 50 per cent at Glenochil. If rehabilitation is so important, surely the figure should be up in the 80s and 90s. Everyone should be encouraged to participate in an activity either within their hall or elsewhere in the prison. If the figure is not up into the 80s and 90s, I think that we are failing.

I will make just one other point, which is about technology. Addiewell prison has technology whereby prisoners go to—you will have seen this—a hole in the wall where they can dial up their food menus, arrange their visits and book their activity for the week ahead. Because that technology has a database behind it, when I said to the people at Addiewell, "Your access to activities is at only 65 per cent, which is not good enough," they were able to increase that by 15 per cent by the time of my follow-up inspection because they could interrogate the database and do their timetabling better. In other words, they were able to get the right people to the right place at the right time. Ironically, only the private prisons have that technology with a database to manage prisoners. None of our new prisons has that new technology, so they are not able to interrogate the database and get the right people to the right place at the right time. That is a very local issue,

but in my view that is exactly the sort of spending that we should be encouraging.

Jenny Marra: Brigadier, can you give us your thoughts on the Government's proposal to change the arrangements for the prison visiting committees?

Brigadier Monro: I am not sure that I should; I can give a very short answer.

The Convener: You tease us by saying, "I am not sure that I should," but then go on to say something.

Brigadier Monro: The reason that I say that is because Professor Andrew Coyle is looking at whether I should take over the monitoring of prisons and have within the inspectorate, and under my charge, a prison monitoring service. I think that those arrangements have been made public, and I have said that I would be content to take that on under certain provisions. However, while Professor Coyle is doing his review for the cabinet secretary, I think that it would probably be wrong for me to go into any more detail, if that is all right.

The Convener: That is very diplomatic. In any event, I think that our committee will take evidence on what I believe will be an affirmative instrument on the prison visiting committees.

Colin Keir: In your response to Alison McInnes you mentioned that your report cites examples of good practice and not so good practice on family access. What is your view of the way in which those whom you have been critical of are taking on the issue of family visits and general interaction? Given those criticisms and the problems that have obviously been encountered, how do you think the forward planning on that is going?

Brigadier Monro: Thank you for raising the issue of family visits, which are a really important part of prison. I am absolutely clear in my mind that Scotland should be at the leading edge of family visits. We need to understand that it is not about arranging visits to prisons; it is about making a genuine attempt to rehabilitate prisoners into the community better, using families as the solution, not the problem. It is about making a genuine attempt to get everyone to understand how we can do that and about making a genuine attempt to engage with the families of prisoners in order to help them. The families may have issues around health or education or other wider aspects that visiting centres in prisons can help with.

It is absolutely central to what prisons are trying to do, so I was made very unhappy in the past, first by the real resistance to my proposal that every prison should have a visitor centre such as those at Edinburgh and Perth, because those centres are where we can support and help prisoners' families so much better.

There was also resistance in many respects to trying to make visiting facilities of a sufficient standard—that point is particularly relevant to Cornton Vale. Indeed, in some prisons the visit room arrangements were frankly shocking—Cornton Vale was a particular case and Aberdeen was an example until it produced a portakabin, which was much better.

Since April this year, with the new chief executive coming along, there has been a complete change. The resistance that I felt in the past has gone and we are now pushing at an open door. I spoke to Kate Donegan last night at the prisoner week service at Dunblane cathedral—a great event. I was particularly pleased to hear that the new visitor centre at Cornton Vale will be up and running quite soon. I am not quite sure exactly when "quite soon" is, but the situation is much better than it was. That will make a huge difference. Just the fact that the chief executive immediately accepted not only my recommendation but, in particular, Dame Elish Angiolini's recommendation on that was such a change in how the Prison Service views the issue that I am now optimistic—I am almost tempted to inspect that optimism.

To answer your question, we need to look at how to take that forward. First, we must ensure that there is provision in new prisons for a proper up-and-running visitor centre and I am glad to hear that there will be one at Grampian. I am sure that in any future prison there will be one—that will be a huge step forward. How we then backfill, as it were, older prisons will be difficult but it must be done. I have been to visitor centres in England. I think that I am right in saying that every prison in England has a visitor centre, but principally to process visitors rather than anything else. However, there they can use a portakabin. We do not have to have an architectural gem such as the one at Edinburgh prison to make a visitor centre—it can be a portakabin. We need to backfill all those old prisons that do not have a centre.

We also need to look at what those visitor centres are doing. I think that they need to do more than just provide a cup of coffee and an arm round a shoulder. This is where health and education can become part of the connections that we can make with families. These are families who are coming from, in many cases, the most difficult and challenging parts of Scotland so why do we not use those centres to try to support and help the families better? We need to take visitor centres a stage further forward—call them help centres or something and see whether they cannot do even better and produce a better result.

For example, I do a lot of dealings with Dyslexia Scotland. I come across a lot of prisoners who have dyslexia and who are often not properly assessed, so I have to take their word for it. I am told that dyslexia is often passed on from generation to generation. Why is there not, for example, at each visitor centre information for families about dyslexia? The children may well be dyslexic. Have they been tested?

There are lots of things that we can do with the centres. We need to have much more ambition about the way in which we deliver families into prisons and to make that more acceptable in future.

I am not sure whether that has answered your question.

Colin Keir: It sounded good enough for me.

12:30

The Convener: You mentioned that the family contact officer should be given a higher priority. Is there only one family contact officer in a prison or are there several? If they are not given a high priority, are they low down in the pecking order?

Brigadier Monro: It depends. Most prisons would, I hope, have at least two or three. Is that enough? It depends—how long is a piece of string? At Polmont, where there is quite a high parental interest in what is going on, I would like to see more. How do you keep family contact going with young people, particularly those who are under 18? I think that they have just increased the number of contact officers at Polmont.

I remember inspecting Glenochil and saying that it needed more family contact officers. It put more in place, but then, because it had a staff shortage, it had to take them away again. From that we can take away the fact that family contact officers are probably not the highest priority in the prison. Should they be? Yes. Given the answer that I have just given, I am absolutely convinced that that is the way forward. If we are really going to connect families with both prisoners and communities, we have to make a real change in the way that we take things forward.

The issue is not just about the prisoner but about the community and the prisoner's family within the community. At a service last night in Dunblane, I heard that, when prisoners are released from prison in Singapore, the community celebrates—people tie yellow ribbons round the old oak tree, and so on. We do not celebrate that at all. The community is not ready for that to happen; people are almost of the opposite view. I wonder whether, if we invested more in our families, we would be investing more in how communities deal with the whole situation in a more positive fashion.

Graeme Pearson: It may be that you have no advice to offer us, but I will ask my question anyway. A high proportion of people in our prisons come from a background of having been in care and having been looked after. Given the privileged access that you have had to prisons over the years and the knowledge that you have accrued, and in the context of everything that you have just said, do you have any advice for the committee about the linkage between children in care and how some of them come into the criminal justice system and prison? Are there things that occur to you that we should bear in mind in order to deal with that potential link? It seems that a high proportion of people who end up in Polmont have come from a care background.

Brigadier Monro: That is absolutely right. Although I do not inspect secure units, I have visited three such units. I sometimes wonder whether we are getting a real return on the considerable amount of money we invest in them and whether we need greater involvement from third sector organisations that could treat people as individuals in the community. I visit a number of third sector organisations who do precisely that: mentor in the community and try to help each person make progress. I am not sure whether that has answered your question about care, but I think that each individual child needs that help.

It is not clear to me—I have not seen the figures—how many young people in secure units go on to Polmont. I asked about that when I visited the secure units about two years ago. The precise figure was indistinct, but my impression was that more than 65 per cent were going on to Polmont. That seems a very high rate, given the investment in secure units and the process that goes on there.

That is not intended to be a criticism of secure units; it is perhaps a criticism of our lack of understanding of the data. Why are so many young people going on to Polmont? Is it because they have been given such long sentences that they will go there in any case? That would be understandable. Is it because they will reoffend if they go back into the community? If that is the case, we need to understand the figure a bit better.

Graeme Pearson: I understand your response and your perspective on the matter. It came as a shock to me to discover that the majority of children who are in residential care—outwith detention units—are there not because of criminality but because of a breakdown in family circumstances and other issues. What worries me is that a substantial number of children who go into care end up in the criminal justice system. In your journeys around prisons, have you gleaned

anything that would give us a hint about what we might do about that link? Once a child is in a detention centre, the deal is almost broken, as it were; I am thinking about an earlier stage.

Brigadier Monro: We worry about what young people in Polmont learn from one another, so we should perhaps have the same worry about children in care. There is the same issue in secure units. A person might go to a secure unit—or into care, I guess—because of a behavioural problem or other underlying issue that is not a criminal justice issue, and they might well then meet people who come from a criminal background, who are—I put this in inverted commas—"bad". In that case, is it wise to put people in such a situation?

That is where we perhaps need a third sector approach. For example, Includem takes an individual-in-the-community approach, as opposed to putting people together in care. I am probably speaking from the edge of my knowledge here, but such an approach might be of benefit.

The Convener: The Justice Committee encounters such huge and complex issues all the time. What you are talking about probably merits a separate inquiry.

Do you want to comment on the evidence that we heard earlier about the transfer of healthcare delivery from the SPS to the NHS?

Brigadier Monro: It was an interesting session. I thought that Frank Gibbons's comment about it being early days was intriguing. Before the transfer, he was one of my healthcare inspectors—I now use an inspector from Healthcare Improvement Scotland—so I know him well. He has a deep knowledge and understanding of prison healthcare, so his view that these are still early days is relevant.

Frank Gibbons's comment was certainly relevant to me. I have inspected only four prisons since the NHS took over and I cannot give much more than a general picture of where we are. It is certainly true to say that the process of transfer went well, although each prison and the health board that it was dealing with might have done things differently. The complications are compounded by the fact that some prisons are national prisons, some are local prisons and some are both, but we have got through the process of transfer perfectly well.

The important point to take away is that now that the transfer has taken place there is a good opportunity for improvement. The important point is that throughcare can improve greatly and is beginning to do so.

I still have two major areas of concern, which I have raised before. The first involves addictions. In my previous annual report, I said that not enough is done to encourage and support prisoners to come off methadone or reduce their use of it. Methadone is a perfectly sensible medical mechanism, but I too often see prisoners either maintaining their dosage or even increasing it. I would like more thought to be put into how we deliver that treatment. I am not trying to make a clinical point—that is not my business—but I think that we need to consider whether there is enough mentoring, leadership and persuasion involved in how we deal with the complex underlying issues.

Connected to the issue of addiction is a concern that not enough is done about alcoholism. I do not think that there is sufficient access to alcohol treatment programmes. Much more of an effort is made on drugs.

The final point that I would make on addiction is that I do not think that there is sufficient measurement of trends—again, I have mentioned this in reports. What drugs are we talking about? How are we dealing with them? Is the use of heroin going up or down in prison? Why are we not measuring the trends in the prison population? Is the number of people who test positive for drugs when they enter prison going up or down? The measurement is poorly done.

I also do not think that we have a proper, comprehensive drug-testing regime. If we had one, we would have a much better clue about the smuggling of drugs into prison. Is it still an issue? If so, what can we do about it?

The second major area of concern relates to mental health, which has been discussed quite a lot this morning. I have a particular concern about mental health training, not just for the experts but for the whole prison.

There has been an interesting discussion, but I think that there is still a lot of work to do.

The Convener: As you heard us say, we will probably return to the questions in six months' time to see whether we are getting the same or similar answers or whether there has been progress.

You have had a long morning, waiting to speak and answering questions. I thank you for your attendance.

Subordinate Legislation

Criminal Legal Aid (Scotland) (Fees) Amendment Regulations 2012 (SSI 2012/276)

12:43

The Convener: This negative instrument makes new provisions relating to fees payable to senior and junior counsel for criminal legal aid work and to conditions of payment.

Members will see from the clerk's paper that the Subordinate Legislation Committee has identified that, in the table of fees that is listed in the regulations, the reference to the Road Traffic Act 1998 should have been to the Road Traffic Act 1988. No doubt somebody has had their fingers rapped for that.

The Scottish Government has accepted that there is an error and has already laid a second negative instrument to correct the mistake—I suppose that it deletes one digit and puts in another. The committee will consider the amending instrument in due course.

Do members have any comments?

Roderick Campbell: I refer members to my declaration in the register of members' interests.

The Convener: Yes, you are a member of the Faculty of Advocates.

Are we content to make no recommendation on the instrument?

Members *indicated agreement.*

The Convener: The next meeting is on 27 November, when we will take evidence—

Graeme Pearson: Before we finish, I recall that we have a panel of witnesses booked for next week. Do we have confirmation that all the witnesses are attending?

The Convener: I am about to come to that—if you bear with me, I will make you smile.

The next meeting is on 27 November, when we will take evidence on issues related to police reform from Her Majesty's inspectorate of constabulary for Scotland, the chair of the Scottish Police Authority, and Chief Constable House. Was your question about that, Graeme?

Graeme Pearson: Yes.

The Convener: It is now answered. That concludes the meeting.

Meeting closed at 12:45.

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