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WOMEN AND JUSTICE

ARE WE MAKING PROGRESS?

Linda de Caestecker, (pictured on left) together with fellow commissioners Eilish Angiolini and Sheriff Danny Scullion, contributed to the *Commission on Women Offenders* (2012). Linda is Director of Public Health for NHS Greater Glasgow and Clyde having had a year of extended leave to work for an international charity during 2016/2017.

Speaking here with **Anne Pinkman**, she looks back on progress made since its publication.

FIVE YEARS ON

AP: It has now been five years since the publication of the Women's Commission report. Are you aware of the progress that has been made since then, and if so what are your impressions?

LdC: I do think there has been some good progress and I think the decisions about a new women's prison and community developments are positive. We require a smaller women's prison with a different philosophy and ethos with more women being managed and cared for in the community.

One of the areas I was most enthusiastic about within the Commission report was the development of community justice centres. Being part of the early development of Tomorrows Women, the Community Justice Centre in Glasgow was for me, inspirational. I was impressed by the workers' ability to engage with women in the most difficult circumstances, work with women where they were but also support them to move on. They achieved very promising results. I think this model is a wonderful example of how we need to work with women who are in the justice system. It's very encouraging that the centre is now in a stable footing in Glasgow with sustainable funding. However the vision in the Commission's report was for a network of such centres around the country. So if we are serious about this, we need concrete plans to make this happen. I am not currently aware of any plans or resources to expand the model.

AP: You're right, following the Commission there were additional funds provided via the Community Justice Authorities (CJA's) to increase community provision for women, and there were 16 women's projects developed. There was a positive evaluation done on these projects which is referred to in the new Strategy for Justice. That said, I did ask the government recently if there was ongoing monitoring of those centres and projects but there is not. Some of the projects have not continued. The challenge has been the sustainability which is a real disappointment. So the vision of the Commission about seeing a number of centres being developed has only partly been achieved.

LdC: The recommendation was that it wouldn't be substantial extra money but rather a better use of existing services and reallocation of resource. The centres co-locate a range of services but they also work differently. There have been major advances in development of trauma informed practise and understanding of the support that staff need to practise in that way. There have been developments in these areas but not as much as I would like to have seen. Many of the new structures may well be positive but I would like to see sustainable development of Community Justice Centres for women as part of their plans.

Obviously one of my big concerns in the Commission was about health services and again, I feel that progress since the report is a mixed picture. I'm involved in the group reviewing standards for health care in prisons and have studied recent reports on prison healthcare with interest. There remain major challenges about access to psychological services and occupational therapy for example. There is great potential to improve prison healthcare and there is at least a greater awareness of the need but there are still the gaps and the challenges. One of the recommendations of the Commission Report was that there should be no barrier to a woman starting a programme of therapy while in prison, even if she is not going to be there long term, because continuity of care with community services should be possible. This remains a challenge from the feedback I'm getting. Even access to medical records can still be challenging. There is still variation around the country. We can hope that there may be improvements with the new structures but it appears that supports available in one local authority area are not necessarily available in another.

So I would say that progress has been slower than I, as a member of the Commission, would have liked to have seen. And it's not just about resources.

AP: I think there is that issue that it's not about additional resources but about using existing resources differently.

LdC: I recognise that's not easy. In the NHS we are excellent at development and medical advances but less good at change. You often need some transitional money to shift to a new model.

AP: I understand that you recently spent some time on secondment abroad promoting women's health issues, particularly women who are living in poverty and may or may not be involved in the criminal justice system. Can you tell us about that?

LdC: I was working for the International Federation of Gynaecology and Obstetrics. We were working in six low/ medium resource countries: Kenya, Tanzania, Nepal, India, Sri Lanka and Bangladesh. Very many of the women in these counties experience absolute poverty and women's position in many of these societies is low with little equality. The project I worked on was to promote contraception and women's choice. By empowering women to make choices about when they had their children and whether to expand their family it allowed them to continue in the education system, get into employment and care for their existing children.

It again emphasised to me that women should be empowered to make choices and education and good employment are key to women's equality. I was working in a very specific topic about women's contraceptive choices but that was important because in many of these countries it would be their husband who would make the choices for them. Many women I met would consent to an effective method of contraception but then come back and say their husband did not approve. There were common themes with many women in our criminal justice system who have been subject to abuse, to trauma and experience poverty with little support. This can lead to poor choices and limited options.

AP: So did you make recommendations?

LdC: The recommendations related to how to bring about change in a health system. So I guess there are parallels with the Commission recommendations in that success involves changing hearts and minds of professionals. Some professionals we worked with abroad believed many myths about what many women needed and wanted and also about different methods of contraception. Our project took a human rights approach i.e. that women's rights were not being respected if they were not being offered the full menu of effective contraception because of the prejudices or misconceptions of professionals. In relation to changing practice, the learning would be no surprise to you - it takes time, you need leaders and champions of change, that an external person coming in and telling staff what to do doesn't work. We also tried to create a movement by the women themselves so they demanded effective methods of contraception,

AP: Is there anything you think we could use in promoting the health care needs if women who are/ were or at risk of becoming involved in the criminal justice system?

LdC: This might sound obvious but it is about understanding women's views. Why are they not accessing certain services? We know that for many women living in difficult circumstances, preventative health care is way down their list of priorities. It is important to acknowledge that health improvement is broader that encouraging a woman to stop smoking or to lose weight, she needs to be less anxious about money, have a good home, feel respected. Our welfare system can often work against the most vulnerable women but if they don't enough money for basic needs, of course they will reoffend. Some of the most effective interventions to improve health are fair welfare systems, good housing, good employment and good childcare. If these are in place women in the criminal justice system can then make healthy choices and will have improved mental health.

AP: That was certainly one of the recommendations that came out of the Commission's report about women being able to access their benefits on release from prison. Unfortunately despite the fact there was a pilot at Corton Vale, that remains an issue. I heard of a case recently a woman waiting for 40 weeks to get her benefit.

LdC: I don't know the circumstances of that case but it sounds totally outrageous.

AP: That was someone with a mentor who was supporting her and she was passed back and forth from one area to another within the welfare system.

LdC: I still cannot understand why the problem of access to benefits immediately on release from prison cannot be solved. Why can it not be planned in advance of a woman, or anyone, being released? All of us on the Commission found it ridiculous that the current system persisted when we were trying to reduce re-offending.

AP: One of the other areas that was acknowledged within the Commission's work was about the poor mental and physical health of the women involved in the criminal justice system. The new justice strategy Justice in Scotland recognises that. For example there is mention in this new strategy of the increased mortality rate for women who have been involved in the criminal justice system and the impact of adverse childhood experiences (ACES). Is there anything you'd like to make comment about in relation to that?

LdC: It is very welcome that the new justice strategy acknowledges the importance of ACES. There is a growing body of research from North America and more recently in the UK that people who have suffered particularly four or more adverse childhood experiences will have poorer health outcomes and will be more likely to be involved in the justice system.

It is also important to note that one of the adverse childhood experiences is having a parent in prison emphasising the need to support the children of prisoners in order that they don't suffer the long term effects of their parents' offending.

I work with NHS Health Scotland in raising awareness about ACEs for example in the education system where teachers in particular understand the effect of ACES. They're seeing children who have suffered these experiences every day and they find it helpful to have ACES recognised and quantified. All community planning partners should be considering how to help children who have gone through these experiences to learn better and have better outcomes including less offending. Even more importantly we need robust plans on preventing ACES including family support and promotion and support for parenting. For many years I have advocated for parenting support and for the effective use of evidence based parenting programmes. Prevention of ACES will also require work to reduce child poverty and close the attainment gap, all part of current national policy but very challenging to make into a reality.