HEALTH AND (IN)JUSTICE

Edited by Andrew Fraser and Maggie Mellon

Featuring: Health Inequalities • Older Prisoners Mental Health • Drug Misuse • Neuroscience

ALSO: Current Issues • History • International
We are pleased to publish this, our fourth edition, on the first anniversary of our launch. In that year our readership has grown, SJM articles appear on many desks, and we have had no shortage of volunteers to contribute. Our themes, reform, desistance, and the arts in criminal justice, have reflected some of the most contemporary issues and debates within Scottish criminal justice.

This edition’s special theme is health and (in)justice, an issue of critical importance for criminal justice. Andrew Fraser, director of public health science with NHS Health Scotland, and former director of health and care with SPS and Maggie Mellon, a non-executive director with NHS Health Scotland have brought their particular expertise and insights to their role as guest editors.

Their introduction stresses the strong links between social deprivation, health, crime and criminal justice. We see this most explicitly in the dialogue between Gerry McCartney from the health sector and Fergus McNeill, an expert on desistance. People from the most deprived backgrounds are over-represented in our courts and penal institutions, and many suffer from a range of problems such as poor physical and mental health, disability, drug abuse and alcoholism – well described by Oliver Aldridge in our interview feature (also available on SoundCloud). It can also be added that there are links between victimisation and health with long term sickness, substance abuse and mental illness exacerbating vulnerability to victimisation along with its impact. Some of the issues raised in the contributions pose serious questions for our justice system. We are only just beginning to wake up to the realisation that we cannot begin to to think about the criminal justice system in isolation from matters of health and inequalities, an insight that Scotland’s public health strategy to prevent violence pre-figured. We hope to publish more on this approach in our November issue.

In our other content, McLoskey’s account of working with sex workers, many of whom have health needs and also suffer from stigma, helps to underline this point in relation to prostitution. Our Danish contribution by Karin Sten Madsen confirms the serious health impact of rape for victims along with reporting on a fascinating project involving them in restorative justice. In “Take 5” politicians tell us what their priorities are in relation to tackling inequalities. Sarah Armstrong’s critique of ‘killer’ stats takes on supposed links between poverty and being in prison.

Christine Scullion’s account of the work of the Robertson Trust reveals the connections between funding, evaluation and learning in practice. John Blackie attempts to bring clarity or a third way, to the polarised debate about proposed reforms to the use of corroboration evidence. Our previous theme of arts in prison is taken up in our historical account of the Barlinnie Special Unit and its demise, in which Mike Nellis also points to the dangers of using narrow evaluative measure: an issue also raised by a review of Dornescu and McNeill’s international collection dealing with understanding penal practice. The book review of the recent Child Poverty Action Group’s report on Poverty in Scotland underlines the persistence of deprivation in Scotland.

If you like the SJM, there are ways in which you can support the project to ensure its survival by paying for a hard copy or making a donation from our website.

Mary Munro and Hazel Croall
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THE SPIRIT LEVEL (Wilkinson. R, and Pickett. K, 2009) argued that the less equal a society, the more pernicious are the outcomes. The authors claim that outcomes for each of eleven health and social problems (including physical and mental health, drug abuse, education, imprisonment, obesity, social mobility, trust, and community, violence, teenage pregnancy and child wellbeing) are significantly worse in more unequal rich countries. The recent report Wealth and Assets in Scotland 2006-2010, shows how that plays out in Scotland, where 30% of children live in households that possess only 2% of national wealth. The wealthiest 30% of households have 76% of the national wealth and the wealthiest 10% have 900 times the wealth of the least wealthy (Scottish Government, 2014). Thomas Piketty, in his recent book, argues that 250 years of social and economic progress, where the wealthy accumulate capital faster than economies grow, threatens the democratic order (Picketty, 2014).

Greater inequality increases the need for big government: for more police, more prisons, more health and social services of every kind. These are expensive and only partially effective in mitigating the impact of structural inequalities. There is increasing evidence to support the case for tackling structural inequality in order to really tackle Scotland’s poor health and high mortality, and our high rates of imprisonment, drug deaths, domestic and other violence and victimisation.
Simplistic messages, adopted during the Thatcher years, urged victims of this inequality to just say ‘No’ to drugs, smoking, junk food, crime and violence, and ‘Yes’ to hard work, exercise, healthy eating, self-improvement, still exert a strong influence on policy, and reflect the distance travelled from the philosophy of collective responsibility that underpinned the post-war welfare state.

However there is in Scotland today a growing recognition that, whatever the outcome of the referendum, tackling inequality has to be a top priority.

The articles commissioned for this issue are concerned with both the structural issues underlying crime and ill health in Scotland, but also with the health care needs of those who come into contact with the justice system, and particularly those in the prison population, which has been growing alongside inequality.

Areas with high incidence of crime also suffer from poor health and higher mortality. Imprisonment further multiplies the risk of death from all causes but particularly those associated with alcohol, drugs, violence and self-harm. Lesley Graham and Andrew Fraser consider the evidence on the state of health of people in prison and in police custody: new research exposes high mortality rates on release from prison especially following short sentences.

We brought together Gerry McCartney, an expert on health inequalities in NHS Health Scotland, and Fergus McNeill of Glasgow University, an expert on crime and desistance from crime, to discuss the evidence of overlap between health and justice inequality, and the limits of individual choice in tackling Scotland’s poor health and crime. This discussion demonstrates the benefits of sharing research evidence and insights across current silos of work and policy, and the potential of preventive spend in one area to benefit another. The original recording can be heard on https://soundcloud.com/sjmjournal.

However there is in Scotland today a growing recognition that, whatever the outcome of the referendum, tackling inequality has to be a top priority.

Paul Hayton and colleagues look at international standards and conventions for the wellbeing of detainees, and the new challenge set out by the World Health Organisation for Health Ministries to take on responsibility for prisoners’ health; work that influenced the transfer of health care in Scottish prisons from the SPS to local Health Board management. The population of older and frail prisoners in increasing steadily due to continued high rates of imprisonment, coupled with longer sentences. Options for the future of care for those who struggle with physical ailments within the prison estate are explored by Sarah Coupar, reporting on studies within the Scottish prison system.

Drug use and abuse is a major social and health problem and crime problem. Prohibition has not prevented crime or harm and the harms of illegal drug use are mostly experienced by the poorest communities. Mike McCarron, former chair of Apex Scotland, and board member of Transform Drug Policy Scotland, makes the case for decriminalisation and with it an integrated, evidence based understanding of alcohol, tobacco and other drugs and their comparative benefits and risks, to inform individual choices and government policy that could provide the basis for a new integrated framework of law for all psychoactive substances.

Former police officer, Bridget Mackinnon, uses evidence from her research to argue that mental health first aid should be an essential part of the training for police who are daily faced with the challenge of detaining and caring for people in acute mental distress.

The development of neuroscience, although its application outwith the clinical sphere is still in its infancy, has opened many previous assumptions about behaviour and choice to question: Elizabeth Shaw looks at the implications for justice.

As a former prison governor, Dan Gunn argues passionately for health inequalities to be taken seriously as an aspect of justice policy.

Finally, the need to integrate understanding and responses to trauma, inequalities, and addictions themes are also stressed in the interview with addictions consultant, Oliver Aldridge.

Health and justice systems rely on social inclusion and support to prevent crime and disease. They struggle to afford the escalating burden of dealing with the consequences of inequality and lost opportunity for all but the most fortunate. In Scotland, the gradient of inequality is as steep as any wealthy western society; the spirit level is furthest from achieving a state of greatest fairness in health, and efficient justice. Justice decision-makers and social policy-makers cannot be indifferent to the effects of their actions on health. Carrying on in the direction we have been heading will mean continuing to deal with consequences of inequality and engaging predominantly in downstream activity. Rebalancing the distribution of wealth and power would benefit justice and health, reducing reliably the risk and fear of crime and disease and worse.


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PEOPLE who come to the attention of the criminal justice system in Scotland are drawn predominantly from communities that experience poor physical and mental health, often associated with a lifetime of social exclusion, lack of employment, hope, purpose and their consequences. Challenging, promoting and protecting the health and wellbeing of offenders, and those at risk of offending, can have benefits for individuals, their families and communities as well as wider society. The delivery of healthcare in criminal justice settings offers an opportunity to reach some of those who are hardest to reach in the community and so tackle health inequalities, which remain a major problem in Scotland, and has the potential to reduce crime and re-offending.

As well as having one of the most unequal societies in Western Europe, Scotland has one of the highest imprisonment rates. Overcrowding and constant movement of prisoners, many who are in prison for a very short time, remain issues. This creates huge challenges for detection and assessment of health problems and needs, and delivery of integrated care, both within prison and in the transition between prison and the community. Healthcare also has to be delivered in a setting where custody and good order must be effective at all times.

That applies equally to police custody, where throughput is also high (approximately 200,000 episodes per annum) with detainees often in custody for 24 hours or less (HFSPPCN, 2012). The limited evidence on the healthcare needs of police custody detainees (UK) shows a high prevalence of morbidity, particularly of mental health and addiction problems with many in an acutely distressed or disorientated state.

The health profile of prisoners in Scotland paints an equally bleak picture. The starkest aspect of a prisoner’s profile on reception into prison is the likelihood of having a problem with or dependency on alcohol, drugs and tobacco. Nearly three quarters (73%) of prisoners have an alcohol problem, with almost two in five (36%) of those likely to be alcohol dependent. Nearly half (45%) reported being under the influence of alcohol at the time of their offence. 77% of prisoners tested positive for illegal drugs on reception to prison (33% for opiates) and 39% of prisoners reported being under the influence of drugs at the time of their offence. 74% of prisoners smoke compared with 26% of men and 23% of women in the general population. Nearly one in five of those in prison (19%) are estimated to be Hepatitis C positive.

There are no robust figures for the prevalence of mental health problems in Scottish prisoners though prescribing indicators suggest a considerable burden, in particular for depression and psychosis. 14% of prisoners were reported as having a psychiatric history and 7% a history of self-harm, including attempted suicide. 4.5% prisoners were identified as having a ‘severe or enduring’ mental health problem, rates of which were higher than those in the general population.

Severe dental decay in male prisoners was three times that of the general population (29% compared to 10%) whilst for women prisoners it was 14 times greater (42% compared with 3%). Prevalence of certain long-term conditions was found to be higher than in the general population (such as asthma and epilepsy), whereas others were similar or lower (such as diabetes and coronary heart disease), possibly due to the young age profile but also fewer opportunities before coming to prison to approach services for detection of health problems (Graham, L 2007).
Imprisonment confers a sharply increased risk of death over and above the poor health record of communities from which most prisoners are drawn. A Scottish study on the mortality of those who had been imprisoned in Scotland found that men were over three times more likely to die (3.3) than the general population and women over seven (7.6) times more likely to die, with risks elevated even after accounting for deprivation (2.3 and 5.7 respectively). Relative risks were highest for drug and alcohol related causes, suicide and homicide, and were markedly higher in women than men. The majority of deaths occurred outside prison, with deaths most frequent in the first two weeks after release. Mortality rates were lower in those with longer total duration in prison but higher in those with multiple, short episodes of stay (Graham, L. et al 2010).

The high risk of dying soon after leaving prison calls for joint action both to divert people from crime and imprisonment, especially for short periods, and effective, co-ordinated support from the moment of leaving the prison gate. Health policy has increasingly recognised the health needs of those in criminal justice settings and that addressing their health needs can also help tackle health inequalities. In 2007, the Better Health, Better Care Action Plan stated ‘it … makes sense for NHS Scotland to review its approach to the health and health care of offenders and ex-offenders and to consider what more can be done in prisons and custody settings to ensure continuity of care during the transition between prison and the community’ (Scottish Government 2007). In November 2011, responsibility for delivery of healthcare in Scottish prisons moved from the Scottish Prison Service to the NHS (see Hayton et al, page 9). Better transitions and throughcare were key objectives of the change, underpinned by the guiding principle that health care in prisons should be equivalent to that delivered in the community.

Scotland’s prison healthcare is nurse led, enhanced primary care, with additional services for mental health, addictions and Blood Borne Viruses (BBVs). Nine Health Boards have prisons located in their area although all share responsibility for the healthcare for ex-prisoners on release. The SPS and other agencies also have a role and responsibility in promoting wider health improvement of those in prison, as set out in the framework Better Health, Better Lives (ScotPHN, 2012). It is crucial to ensure continuity of care on release, not only for sustaining the health gains achieved in prison and saving lives immediately thereafter, but also to promote reintegration and prevent re-offending.

The NHS also now delivers all healthcare and forensic services for people in police custody, with Police Scotland retaining statutory responsibility for forensic healthcare services.

In further recognition of the importance of offender health, a new NHS post of Director of Health and Justice has been created, to provide strategic leadership and promote cross sector working.

Recent justice policy in Scotland has highlighted that addressing the health needs of offenders is important in order to reduce re-offending. Prisons have been and are being modernised to be fit for purpose: more prisons are to be ‘community facing’, allowing prisoners to be nearer to families and friends; crucially and reflecting the severe and multiple problems that imprisoned women face, the management of women prisoners is being reformed following the influential Angiolini Commission on Women Offenders (2012).

The SPS review, Unlocking Potential, Transforming Lives, adopts a person-centred, asset based, desistance approach with an emphasis on collaborative working with community partners (SPS 2014). Other reforms that could impact on health and justice include the introduction of Community Payback Orders; a presumption against short-term sentences of less than three months; the redesign of community justice structures, with Community Planning Partnerships taking on responsibility for the local planning and delivery of services to reducing re-offending. Innovations include the ‘whole systems’ approach with young offenders as well as mentoring schemes for prisoners on release.

Offenders are often the most vulnerable, unwell and disadvantaged individuals in our society. The factors underlying offending and poor health for example, early traumatic years and poverty, are often the same. Both desistance and recovery have common solutions, such as addressing wider health and wellbeing and social inclusion (see McNeill and McCartney p. 7). Achieving that requires working in partnership, not just in the health and justice field with important voluntary and social enterprise organisations, but across the whole public sector. ‘Upstream’, fundamental and preventive interventions such as those that sustain more resource and greater hope amongst those who have least, and face the greatest challenges, need to be rebalanced with ‘downstream’ care and support with meaningful outcomes. The challenge ahead is to tackle inequalities that drive and determine future risks of offending and poor health, and to keep focused on that common purpose.


Lesley Graham, associate specialist, public health lead for drugs, alcohol and offender health, ISD, NHS National Services Scotland.

Andrew Fraser, director of public health science, NHS Health Scotland
HEALTH INEQUALITIES AND CRIME: Common Causes and Solutions?

Gerry McCartney, consultant with NHS Health Scotland and head of the Scottish Public Health Observatory, and Fergus McNeill, professor of criminology and social work, University of Glasgow, discuss the relationship between health inequalities, crime, and desistance with guest editor, Maggie Mellon.

M Gerry, you recently led on a major report on health inequalities in Scotland (Beeston C, 2014). What did that tell us?

G Health inequalities are the systematic differences in health outcomes between social groups. In Scotland this means 17 years less life expectancy between the poorest areas in Glasgow compared with the most affluent areas just outside the city. It’s not inevitable. Previously the focus of health improvement work was on health behaviour, diet, smoking, etc. These approaches are insufficient. We need to tackle inequality, not the symptoms. So we need to engage beyond the health service, to engage across boundaries.

F Theories about desistance, why people stop offending, range from rational choice right through to those that stress more structural problems in unjust and unequal societies. Desistance from crime often occurs when new opportunities arise that have been denied or not available. I would be surprised if there was not a similar debate in health?

G To the GP, the individual’s choice to smoke or not is important, but from the public health perspective, the people most likely to take up these messages are the most affluent. Structural change, such as smoking bans, alcohol cost, or even bigger change, such as reducing income inequalities is what is more effective. Health inequalities were wide in the 1920s. Then they reduced. With the introduction of the welfare state, unions were relatively stronger, and wages higher. 1976 was a historic low in health inequalities, and simultaneously recorded the highest happiness ratings. Since then the welfare state has been eroded, there is less universalism, more stigma, and we have focused more on individual choice. But inequalities flow largely from political choices.

F As a discipline, criminology began with a focus on the individual and the reasons for their criminality. With the advent of more sociological perspectives, broadly structural explanations came into play. With respect to desistance, I have been forced by the evidence to push out from the individual to the structural in seeking to understand the process of change and what supports it. There is a case that far too much attention is paid to the individual choices and not enough on the structural issues. We have neglected the social dimensions.
M You suggested mapping health inequalities alongside high rates of prosecution or imprisonment. What advice would you give to Community Planning Partnerships about better approaches, better use of resources?

F There is growing interest in ‘justice reinvestment’. JR developed in part from a group of offenders in an upstate New York prison who had all been born and raised within the same poor neighbourhood in New York; all now incarcerated, at a cost of a million dollars for just one block. They asked: what if the million dollars had been or could be spent in the block instead of the prison? But while there is a lot of interest in this idea of shifting resources upstream where the investment can be more productive, we have not got far with moving money out of penal institutions. Some argue for moving more money into policing to deter crime; on the other side, more radical criminologists argue for investment in community development rather than in deterrence. I am sure that there are parallels with health spend.

G Most of our spend is on treating the problem, on ‘failure demand’: mopping up afterward basically. Preventive spend is something that John Swinney (the Finance Secretary) has been supporting. But is it just about taking the money from one place and spending it somewhere else? Prevention has to go further. Preventive spend won’t tackle income inequality, which is one sure way of remedying the problems.

F The way we direct or misdirect the spend can also be part of a pathologising narrative about ‘failing’ people, that we can ‘fix’. But for me, ultimately the issues are often economic; about the extent to which we are prepared to take difficult and politically unpopular decisions about pooling and using resources and regulating markets.

G Is there not a fundamental problem about this need for punishment: why punish people with prisons? Surely prisons should only be used for minority of cases for public safety rather than just as punishment? We spend millions every year on locking people up in prison, but it does not reduce offending.

F I would not use prison as routine measure. It stores up problems, but I think society does need to redress wrongs and there is a case for accountability. We can’t let wrongs go: we can’t ignore harm and suffering. I would prefer responses based on restitution, conflict resolution, peacemaking and reconciliation. But I accept there is a place for prisons for a small number of people who need to be contained.

M What can be said about assets and coproduction approaches. Are they a welcome move away from the big state?

G If you say people should build on their own assets and solve their own problems, where does that take us? Who has the most assets? The most affluent, those with the money, the social networks, who will get that job, that opportunity. If we rely on that route predominantly, we could exacerbate inequalities.

F I agree that the state’s rejection of its responsibilities can be oppressive. But if you flip that on its head, would we want to have a state with the power to force the community to accept someone? Solidarity and citizenship need to be nurtured not imposed. I am for the big state in the sense of market regulation, and taxation, but I don’t think we can look to the state to dictate solutions.

Crime and punishments are symptoms of inequalities just as are health inequalities

M If the state is to be seen as a facilitator of change at a macro level, what do you say about the case for a citizen’s income now being discussed in mainstream policy discussions?

F In some desistance theories, the question of generativity (making a positive contribution) or stagnation is important. For many of us generativity comes from family, work, civic participation; these are all important. The Arts was a recent feature for Scottish Justice Matters. At the same recent event in Barlinnie I was struck by the dignity that people get from creating things, from making art, and by the individual and collective benefits there are. So what does that mean on the question of minimum income? The connection between work and income has always been a tenuous one for me. I’m not sure we need to think of wages as the only or even the main incentive for production.

G A minimum income would allow people to care for family members, to volunteer, to engage in life long learning. It would just be part of the wage for those with jobs. But the most interesting jobs get paid the most. These great political, economic and social issues underlie the choices we will make in the next few years to tackle inequalities, whether it affects health or crime. It is incumbent on all of us to participate in that debate.

M I’ll vote for that!


Scottish Public Health Observatory http://www.scotpho.org.uk/

The full discussion can be heard on https://soundcloud.com/sjmjournal
HOW SHOULD WE organise health care to best meet the needs of those in contact with the criminal justice system? A recent publication from WHO comes down firmly in support of reforms whereby health care for those in contact with criminal justice passes to the control of the Ministry of Health, as has already occurred in the UK. This paper explores the rationale for this new thinking, and also asks what the main resulting benefits have been so far in England and Scotland.

Models of health care in justice

There are three main models for the organisation and provision of prison health services internationally:

1. By far the most common is direct provision of healthcare as part of prison services, and therefore the responsibility of the government ministry responsible for justice.

2. A mixed model, with primary health care directly supplied by the prison service and secondary care provided by local community hospitals. In this case the Ministry of Justice (or equivalent) remains ‘in charge’ of health within the prison. This was the service configuration in Scotland until November 2011.

3. Healthcare is provided by health authorities from the wider community, as provided for other citizens. The Ministry responsible for national or public health services, normally the Ministry of Health (MoH), commissions health services, and may also directly provide all or some of them. This model is relatively new, but has now been adopted by several European states and entities: Norway, France, two Swiss Cantons, two autonomous regions of Spain, Italy, Kosovo, and the UK, including Scotland since 2011. Several other States of the WHO/European Region have started or are considering a similar prison health reform, but elsewhere this model is still rare.

HEALTH SERVICES IN THE CRIMINAL JUSTICE SYSTEM

modern governance, new approaches, and the way forward in Europe

Paul Hayton, Stefan Enggist, Andrew Fraser

The European Region of the WHO’s Health in Prisons Programme (HIPP), has recently issued a policy brief supporting the MoH led model (UNODC, WHO, 2013).

WHO’s advice draws upon relevant studies on prison health as well as on international law relating to the legal and ethical requirements of prison health. It leads to the following main findings based on the premiss that prison health is public health.

❖ Prisoners share the same right to health as any other person.
❖ Prisoners come predominantly from vulnerable groups, and carry a higher burden of diseases than the general population.
❖ Prisons are settings with high risks of disease presenting a complex challenge for public health, especially with regard to communicable diseases.
❖ States have a special duty of care for prisoners including their health and healthcare.
❖ Prison health services should be at least of equivalent professional, ethical and technical standards to those applying to community public health services.
❖ Prison health services should be provided exclusively to care and must never be involved in the punishment of prisoners.
❖ Prison health services should be fully independent of prison administrations and yet liaise effectively with them at all levels to meet patients’ health needs.
❖ Prison health services should be integrated into national health policies and systems.

WHO recommended that the management and coordination of all relevant agencies and resources contributing to the health and well-being of prisoners, is a whole-of-government responsibility and that health ministries should provide and be accountable for health care services in prisons. Predicted long term benefits include lower health risks and improved health protection in prisons, improved prisoner health, improved public health and better re-integration of prisoners on release.
Perhaps surprisingly, there have not been any comprehensive national evaluations of this type of reform in Europe or elsewhere. There have been collations of informed opinion and indications that such reforms are, on human rights grounds, the ‘right thing to do’, and on public health grounds, the ‘beneficial thing to do’. For example, a 2004 conference report, evaluating reforms in Norway, France, England and Australia, found that in general ‘the gains can be great … the standard of care provided to prisoners has improved in all four countries. National health policy has greater awareness of the specific health needs of prisoners. Recruitment and policy of staffing has improved. Links with health services in the community have been strengthened’ (ICPS, Doh 2004). Nonetheless, limited evidence to support these statements has accumulated in the interim. There is evidence of common deficiencies and poor practices in health provision across Europe. Scotland has sought to comply with international standards and conventions, to uphold rights and meet responsibilities for health and healthcare for people in detention. One compelling reason to institute change in 2011 was the need to comply with international standards as well as criticism from the Prisons Inspectorate (Prison Healthcare Advisory Board, 2007).

Reform in the UK

People in prison in England and Scotland are now NHS patients, and NHS standards prevail, offering broadly equivalent services to those in the community. This has reduced the risk of previous problems occurring among health staff of ‘dual loyalty’ and professional conflicts of interest between patients and prison service management. There has been significant additional investment in English custodial health provision since or as a result of the reforms (Hayton and Boyington, 2006) while stable levels of resource in Scotland reflect higher existing levels of investment at the time of reform. There are now systematic approaches to:

- health needs assessment;
- commissioning services; NHS England now commissions services for all prescribed places of detention and that includes, for example, people in police cells, Immigration Removal Centres, or in contact with probation services. Scotland has instituted a full set of changes for detainees, completed in 2014;
- standards; developed, monitored and implemented in line with the NHS quality and outcomes frameworks (Scottish Government, 2010);
- improving health informatics compatible with community-based systems;
- improvements in clinical drug treatment services for people in prison placing the prison system nearer the centre of initiatives to help those with substance misuse problems;
- and, complaints about health care are now handled within the remit of the health services ombudsman.

In addition, in England, the Prison Service and Ministry of Justice continue to be involved in a dynamic partnership approach in which health is seen as a key element within moves to rehabilitate and reintegrate prisoners.

Such changes have been widely welcomed in principle, local accountability for services to support those in contact with the criminal justice system has developed well, and there have been anecdotal reports of benefits to patient care for people with complex problems. Reforms have straddled sustained reductions in prison suicides, improvements in Hepatitis B vaccination uptake and spread of the disease, and enrolment and outcomes from smoking cessation programmes.

However, in Scotland systematic data collection and supporting systems of analysis to meet expectations of governance are not routinely in place. Key performance issues range across the effectiveness of throughcare, to support for those in transitions, especially those newly released from prison; improvement and risk management of services. Aside from healthcare, new governance demands a sustained focus on health for prisoners as one group with complex needs in the NHS, as well as recognition that prison is a setting that presents opportunities for health protection and improvement. For instance, isolation from family, the quality of food provision, security and availability of illicit drugs, smoking restrictions and a culture of respect between prisoners and staff are all important influences on health, and require a public health approach jointly between criminal justice services and the NHS.

In conclusion, whilst across the UK there is growing consensus that the NHS model is fit for purpose, in terms of human rights and healthcare standards compliance and improved health for all those in contact with the criminal justice system, evidence for assurance and governance is still under development. Progress in Europe towards better governance is likely to be a fairly slow process. More thorough evaluation of progress in those countries that have carried out reform is important to sustain modern governance, demonstrate delivery of each State’s duty of care to detainees, and to allow other countries to benefit from experience when they opt to do so.


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THE NUMBER OF PRISONERS AGED OVER 50 in Scotland increased by 71% from 387 in 2001 to 660 in 2011. Numbers are likely to rise further in future due to the trend for longer sentences, people surviving longer into old age and the older age of some sex offenders when detected and sentenced.

The definition of an ‘older prisoner’ is subject to debate, but age 50 upwards is most frequently used (Loeb, 2006). Prisoners are often in poorer health than the general population and so may become ‘elderly’ before their time (Aday, 1994).

The associated health and social care issues more prevalent in this group mean that the prison regime may be more challenging for them; they may rely on prison staff or other prisoners to assist them with daily activities. Despite improvements in the prison estate, physical facilities may also pose challenges, such as lack of space in cells for wheelchairs and special aids and appliances to support care. However, these problems do not solely affect older people. Many older prisoners remain in relatively good health and younger prisoners, due to poorer general health in the deprived population from where they are predominantly drawn, may also suffer illness or disability. Any assessment of need should, therefore, focus on ability rather than age.

The issue of accommodating older prisoners or prisoners with severe ill health or disability has been raised from time to time. An SPS policy document Intervention and Integration (SPS 2000) published in 2000 reviewed options; an informal consultation took place in 2005, and a needs assessment reported in 2012.

Older and frail prisoners are still accommodated in existing facilities and regimes, albeit with significant modernisation of the prison estate. Cells designated for people with disability are now a feature in newer prisons.

How many people are affected?

Prior to 1st November 2011, the Scottish Prison Service (SPS) had responsibility for providing primary medical services to prisoners in Scotland. Prisons relied on paper records which made routine national monitoring of prisoners’ health, and the quality of health care in prisons, very difficult. We therefore undertook a needs assessment to find out how many prisoners find the regime difficult due to disability, to inform discussion concerning how Scottish prisons can best accommodate them (Couper, unpublished).

Health Centre Managers in each of Scotland’s 15 prisons completed a questionnaire for each prisoner supported by ‘stepped up care’, who had care plans, or who had problems with routine ‘Activities of Daily Living’ (ADLs) in May and June 2012.

All 15 prisons responded, reporting 67 people with long-term health issues. 48 required assistance with at least one ADL: Glenochil (20), Barlinnie (14), Shotts (5), Edinburgh (3), Kilmarnock (3), Greenock (2), Addiewell (1). All but one were male. Eight prisons including the open estate had no prisoners matching the criteria. The 19 people who required no assistance with ADLs are still relevant to this audit as their conditions make it likely that they will require some assistance in the future.

Is the Scottish Prison Service looking after its older and frail prisoners?

Sarah Couper and Andrew Fraser
The age group with the largest number of affected individuals was 50-59, although 43% were under 50. Glenochil had the highest number of prisoners requiring assistance with three or more ADLs.

ADLs most commonly requiring assistance were: climbing stairs; walking and fetching their meals. 27 people were reported to need help walking, being dependent or not being able to walk. 17 prisoners (six in Glenochil), and another 11 in five other prisons used wheelchairs. 19% of prisoners in this audit (13 of 63) were reported as not coping with the prison regime and arrangements were reported not to be optimum in 49% of cases (33) and not satisfactory in 22%.

18 cases, in the respondent’s opinion, would benefit from a prison facility dedicated to meeting care needs (Glenochil 11, Barlinnie 3, and one each in Addiewell, Greenock, Kilmarnock and Shotts). 13 of these were reported as not coping with the prison regime.

In a 2005 qualitative study on growing old in prison in Scotland, there was a strong preference among older prisoners to maintain a mixed age range ‘like normal communities’ and a recognition that functional ability, not age, were key determinants of coping with the prison regime: ‘you are as old as you feel’. Recommendations were that there should be more focus on function and the design and detail of the daily regime, including informal peer support and monitoring, for older and less physically able prisoners. Staff in mixed age and ability prisons commented on making individual adjustments, such as people who are less mobile or have chronic diseases occupying the bottom flat cells, with more flexible daily routines and frequent informal checks for those who stayed in their cells (Fraser, 2005).

**Options for provision of care**

Although a relatively small number of prisoners were frail and in need of daily support for living, some had needs that were complex and required frequent attention. So what are the options for provision of care for people with disabilities in prison who require assistance?

Options detailed in the SPS policy document ‘Intervention and Integration’ were:

1. Maintain the status quo (older prisoners are ‘absorbed into existing regimes and wholly or partly excluded from aspects of those regimes in an ad hoc way’).
2. Provide appropriate facilities across the adult prison estate.
3. Establish, as part of a larger prison, a facility for elderly people (at least for male prisoners) where specialist care services and prison staff expertise could be developed.
4. Develop resources and services in a small number of sites (SPS, 2000).

The number and distribution of prisoners who require significant assistance do not appear to support the need for a national facility. However, there are larger numbers in some prisons (Glenochil, Barlinnie and Shotts), and even a few prisoners with additional support needs for ADLs can place large demands on both the health and prison services. In addition, people with ‘high needs’ can arrive in prison from the courts with very little or no notice. If numbers rise and needs become more complex, a more efficient solution may be a secure facility adjacent to a care institution, rather than a care facility in a secure place such as a prison.

Glenochil had the highest number of people requiring assistance with ADLs, requiring assistance with 3 or more ADLs, using wheelchairs, not coping with the prison regime and for whom current arrangements were reported not to be optimum. If some prisoners were to make special provision for ‘stepped-up care’, this would raise the option of transferring prisoners with high needs to those facilities. However, this might create social and sentence management problems if prisoners were moved farther from home to receive care. Whilst older prisoners expressed a preference for maintaining integration of varying ages of prisoners, the need for alterations in the prison regime for affected individuals has to be a priority.

The physical infrastructure of some prisons creates access problems for some prisoners. Stairs and walking are two of the most common problems. Therefore, changes to physical facilities, such as access to lifts, cells with space to manoeuvre, access to social areas and services are needed to counteract these.

Lines of responsibility for social care are presently unclear between health care and prison staff. Currently, social care assistance is provided from health care staff, prison staff and other prisoners. This varies according to the problem and the prison. Responsibility for pushing wheelchairs is a basic care requirement that needs to be assured. Options for the provision of social care include: peer support (i.e. training prisoners to care for other prisoners) or professional provision. Discussion should take place with prison staff and the local soon-to-be Health and Social Care Partnership as to who will provide social care.

‘End of life’ care was not reported as a current issue in any of the prisons in the 2012 survey. However, palliative care is an important issue. There have been examples of exemplary care for prisoners who remain in prison to die. This matter will become a more frequent problem in the future due to the ageing prison population.

Frail prisoners present a challenge for Scottish prisons. Numbers may be modest but the daily challenge of coping with disability and supporting those who struggle is a matter of growing importance for individuals and prison managers. Options now need to be debated by responsible agencies in order for local arrangements to provide the optimum solution to caring for frail prisoners.

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**References**


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Dan Gunn

I HAVE just retired after nearly four decades working in Scottish prisons, finally as Director of Operations. Undoubtedly one overwhelming change in my time ‘inside’ is the recently enhanced importance of health care. In some prisons it dominates the entire regime and in others is central both in terms of policy development and meeting individual need. But just how well understood is this major change within and without the SPS?

When I joined as an Assistant Governor in Perth, health was a small, self-contained part of the prison. The prison nurses were in prison staff uniform. The Medical Officer was not known for his bedside manner and it was a brave, if not foolhardy Hall Governor, who advocated on behalf of a prisoner. In six years, I remember only one Governor grade reflecting on health care, and that only when he was about to be transferred!

Prisoners were mostly young men: 25 plus was seen to be old, and 36 plus bordering on ancient. Forty years on we have an ageing prisoner population (average in the mid-30s), a good number between 40 and 70 and, incredibly, some in their 80s. Some jurisdictions have an upper age limit on imprisonment. Scotland does not. This raises the issue of which of the generally accepted purposes of imprisonment applies to incarcerating old people suffering from dementia? 2012 saw the imprisonment of an 81 year old lady on remand for making nuisance phone calls to the police and in 2009 the Parole Board found itself unable to release a recalled lifer with no limbs and a short life expectancy. Presumably he was still a risk to the public? In 2013-2014 SPS had a record number of deaths in custody from natural causes and one establishment currently has nine terminally ill prisoners. Are the complexities and importance of health in prisons today fully appreciated?

Historically, the first relevant legislation, the Health of Prisons Act 1774, provided that every jail should have an experienced surgeon or apothecary: by 1840 every prisoner was to be visited weekly by the surgeon. The power of the Medical Officer was notable and a triumvirate consisting of the Governor, the Chaplain and the Medical Officer ran 19th century prisons. The Elgin Report (1900) examined “The provision made in Scottish prisons for the nursing and accommodation of sick prisoners” and argued that “A sick prisoner ought, we think, to receive at least as prompt and satisfactory treatment as he could have obtained had he not been in prison”. This principle, known as equivalence, continues to be at the heart of government policy. For many years I opened the Induction programme for Practitioner Nurses with this quote which most thought was very recent. Sadly reports into prisons during the 20th century did not focus on health and the professionalisation of the Nursing Service and the emergence of a nurse-led health service was the only fundamental change. It arguably led to the SPS becoming a leader in health care, although the nursing staff in Scottish prisons became frustrated that their expertise was not sufficiently recognised by colleagues in the NHS.
From the late 80s a combination of AIDS, drugs (legal and illegal), self-harming, mental health and acceptance of alcohol abuse were evident. During my time as Governor of YOI Polmont (1996 to 2004) we prioritised health care within a changing ethos. A discrete mental health team wore a different uniform and were intended to be visible and accessible, a change seen to benefit good order, personal safety and a sense of wellbeing. Smoking cessation was prioritised. The wider objective was to show change was possible. If a young person could change his behaviour in one additive area then arguably he could do it in another.

The seminal Social Exclusion Unit Report on Reducing Re-offending (2002) stressed the importance of prisoners’ mental and physical health problems, and recognised that “the Prison Service and NHS have made real progress” but also noted that “good practice is still scarce”, identifying issues of adequate assessment and post-release arrangements. The overarching principle remained equivalence. It might however have asked whether provision was sufficient? It also recognised a wider agenda, arguing that “untreated mental and physical health problems could be made worse by imprisonment” thus exacerbating challenges of finding or keeping a home or a job. It pointed out that time in prison can present a valuable opportunity to address some of these issues and called for further work to ensure post release help. Lesley Graham’s report, Prison Health in Scotland: A Healthcare Needs Assessment (2007), specified no less than 13 domains where work was underway, often multi-professional.

Prison health care will always rightly be primarily a response to presenting need but these wider considerations are vital to rehabilitation. Back in 1912 it was argued that “the treatment of a criminal is a matter of public health” (Devon, 1912). Is this recognised today and what implications are there for policy, resource allocation, and the integration of services to support any prisoner on release?

Health promotion opportunities in prison are one aspect of this public health dimension. The first SPS multi-disciplinary group to look at this, which I chaired, focused on smoking, diet and activity. Current Scottish work, implementing Better Health, Better Lives for Prisoners (2012), is arguably too wide-ranging and in reality health promotion or improvement remains merely ‘nice to do’. SPS should provide clear and inspirational goals, not a resource issue but about commitment at practitioner and senior management level. Health promotion activities can be fun and involve mass participation, not to be underestimated in a prison context. The potential remains huge.

A focus on public health also allows analysis of the widely recognised and debated link between health inequalities and offending. But have criminal justice or health practitioners and policy makers have devised action plans? The Management of Offenders Act (2006) specified the first of of nine offender outcomes as “The central belief that better health and wellbeing can contribute to a reduction in the rate of re-offending”. But just how widespread was and is this “central belief”? Health features in the priorities outlined in the Strategy for Justice (Scottish Government, 2012), but are we any closer to establishing exactly what ‘better health and wellbeing’ can contribute to reducing re-offending? Statisticians have not focused on this area, and advocates of desistance have not focused on offender health or the ageing prisoner population. This is not so much unfinished business as business yet to start.

In summary, this article offers four main arguments. First, we should recall the precedent set in 1913 by the appointment of a Prison Medical Officer as a Prison Commissioner. Should the newly created Director of Health and Justice in the Health Department not be a Non-Executive Director on the SPS Board and a member of the Justice Board?

Second, the importance of health care has still to be truly recognised internally and externally. There should be an annual Health and Criminal Justice conference, run jointly by Justice and Health departments and third sector and advocacy organisations, such as SASO and Howard League Scotland, should be encouraged to include health as a matter of course in their programmes.

Third, there needs to be a greater awareness of aspects of prison life which affect health and wellbeing and require a multi-disciplinary approach, reflecting best practice outside, inside. These should include the protected characteristics of the 2010 Equalities Act, bereavement counselling, speech and learning therapy, management of terminal illness and social care.

Finally, we need a new paradigm for the governance of health in prisons and effective support on release, starting with new performance measures in respect for governors and local health managers. The Supporting Prisoners Advice Network is the only body focused on this agenda but has no less than 11 current priorities and 13 emerging issues and no executive or dedicated funding.

The SPS is adopting a new theoretical model placing the prisoner at the heart of all that should happen in a prison, with the objective of unlocking potential and transforming his/her life chances on release. The Strategy for Justice called for ambition and innovation. What is the joint justice and health input to be? Who will be prescribing what to whom and when? The eighteenth century penal reformer John Howard prioritised health: today is the time to go back to the future.

http://www.scotphn.net/projects/previous_projects/health_improvement_in_prisons/

Elgin Report (1900) Report from the Departmental Committee on Scottish Prisons. HMSO.


Supporting Prisoners Advice Network
http://www.sacro.org.uk/services/criminal-justice/supporting-prisoners-advice-network

Dan Gunn is a retired prison governor. He wishes to thank all NHS and SPS colleagues who helped in the writing of this article but the opinions and recommendations are solely his responsibility.
Police in Scotland and Mental Health

TIME FOR CHANGE?

Bridget McKinnon

IT HAS BEEN estimated that up to 15% of all incidents police deal with ‘have some kind of mental health dimension’ (Bather et al., 2008:1), and in 2010 the World Health Organisation found that at least 10% of community police time is spent dealing with incidents concerning those with identified mental illness (as cited by Chappell, 2011). Whereas emergency first aid training for police has been prioritised so that responses to injured casualties are appropriate, this approach is not applied to mental health issues.

In Scotland, training covers legal aspects of emergency protection and detentions relating to mental illness where there are perceived risks of serious harm to self or others. Most officers report that their learning is effectively ‘on the job’. The relatively new Adult Protection reporting measures are designed to prevent people slipping through a net if concerns are raised about welfare, and to encourage multi-agency approaches and appropriate action. These emphasise awareness by police officers of mental health issues, but also concern mental disability, and do not necessarily change immediate responses in mental health crises where police attend as first responders.

Police are often first responders in situations where people with mental illness are presenting as problematic to be managed according to risk

This relative neglect in police training contracts sharply with the amount of interaction police officers tend to have with people with mental illness or mental health service users. These have increased due to cutbacks in funding in mental health specialist services, and reductions in availability of long and short term beds. Pressure on support services can quickly lead to people losing structure, reassurance and practical help to maintain stability: a combination of circumstances that can result in crises where more support might have prevented police involvement. Discourses of danger and risk around mental illness can be fuelled by lack of community care and police approaches may reflect these perceptions. This problematising of people with mental illness could, paradoxically, be a potential driver for better basic training for police in mental health issues.

Police are often first responders in situations where people with mental illness are presenting as problematic to be managed according to risk (Peay, 2011: 109). Assumptions are often made about dangerousness and violence, and police themselves may react to this cultural stereotype, without the benefit of training or experiences which provide alternative images and realities. Research actually reveals that people with mental illness are more likely to be victims than perpetrators of crime (SAMH report 2010: 6). Unfortunately, stereotyping has prevented general and police awareness of this alternative experience and this needs to be addressed in training.

Officers are left to apply ‘common sense’ and tactics based on experience...
to fragile mentally ill people and sometimes inappropriate responses can escalate rather than de-escalate situations. These encounters can quickly spiral into aggressive exchanges driven by fear and mistrust. Obviously officers may also deal very well with these situations, and when the outcome is safe for all, it is less likely to attract attention or comment, or a ‘9 o’clock jury’ of after the event analysis. However, this in itself impedes dissemination of knowledge of good practice. Service users I spoke to in 2013 whilst researching their experiences with police, spoke of feeling criminalised by the way officers dealt with the situation, “as if I’d done something wrong” by being unwell.

Perceptions of people with mental illness as risky and dangerous are promoted by media coverage of incidents and TV soap operas. Police officers are as influenced by cultural media stereotyping as the rest of the community. In the absence of training or personal exposure to alternative images they may adopt risk averse tactics whereby the actual risk of harm is increased, through fear, leading to aggression and lack of empathy. This situation could be improved through training, discussion and reducing the stigma associated with mental illness within the police, and the general population.

For example, a research participant described attending hospital due to feeling suicidal, was arrested for carrying a knife, which was in his pocket and intended solely for self harm, kept in cells over the weekend without seeing a doctor or having any medication, then was named in local papers as a ‘knife man’. The court accepted the psychiatric reports that his behaviour was due to illness at the time: “‘... all I needed was the proper medication, and a wee rest, a wee rest in the psychiatric wards, and get myself sorted out, and get a blether with somebody that you can talk to, without them judging you like, an’ to cap it all, it was in the newspapers.” More and better police awareness could avoid situations developing in this way.

If it is accepted that there is room for improvement in police training in dealing with mental illness, then the new national Scottish police service is surely an opportunity to incorporate fresh approaches, and strive for best practice. In addition, it must not be forgotten that there is inevitably a potential for a slippage in best practice between what is taught, absorbed, or accepted in theoretical terms, and what action is actually taken by officers in real life situations. Responses can vary depending on unanticipated factors such as the effect of adrenaline after a ‘blue light run’, or officers’ personal feelings which result in resistance to the training inputs. Added to the possibilities of people with mental illness in crisis presenting bizarre behaviours, it is always going to be hard to train in consistently appropriate first line responder reactions, but as with physical health first aid there are steps which can strengthen the probability of a good outcome, and lessen risks to all concerned. Tactics to de-escalate encounters, and raising officer awareness of effects of mental illness, and some medications, could be incorporated into initial training, as a compliment to legal powers to detain. For example, common medication for schizophrenia can cause slurred speech which can be interpreted as drunkenness.

Using mental health professionals as team members alongside police, especially if 24 hour availability is possible, can reduce poor outcomes after police encounters with people in crisis or distress, (Ogloff et al., 2013: 66-7) but this is often not a practical or financially viable option. Therefore putting in place ways that officers can be confident in their knowledge and preparation around first response to mental health issues could be very productive. De-escalation and negotiation can increase efficiency through preventing situations becoming so conflictual as to require additional police units to attend. It has been suggested that people with mental illness and mental health service users should be involved in police training so that officers can increase their understanding of how mental illness can affect people, and better empathise. Sometimes it is very simple issues where big differences can result, such as taking time to ‘verbally communicate well’ with people’s supporters and advocates, and ‘provide an accessible written record’ to them for later as those who are ‘very depressed or experiencing breakdown or crisis’ may not absorb information in letters or leaflets (SAMH, 2009:12). Understanding reasons for this type of approach could save police time later lost in communication confusions.

Prioritising a standardised and professionalised approach for police officer initial training which incorporates greater awareness of mental health issues beyond legal powers to detain and relevant legislation is surely overdue, with mental health awareness deserving of at least the level of training that police receive in public order operations (ICMHP report 2013: 41). Police training which encourages engagement with people with mental illness, would enhance police understanding and enhance better responses to a sector of the community that has often only received negative attention after media highlighted violent encounters. This preventative approach whereby officers are encouraged to have more positive images of, and confidence in their own abilities to deal with people with mental illness in crisis with minimal recourse to force, linked to mental health first aid training from the outset, could then provide linkages not breaks between police and community.

Independent Commission for Mental Health and Policing (ICMHP), May 2013
Scottish Association for Mental Health (SAMH), September 2009 Involvement Event – Justice Disability Steering Group
Scottish Association for Mental Health (SAMH) Criminal Justice Research Briefing 2010

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THE 1961 UN SINGLE CONVENTION ON NARCOTIC DRUGS underpins international prohibition of production and supply of specified drugs for non-medical use. In the UK these prohibitions are enforced by the Misuse of Drugs Act 1971. Today, world-wide enforcement of prohibition, estimated at $100 billion annually, has failed to prevent drugs supply and at best only been modestly effective in reducing drugs demand. Criminal networks manage a global illicit drugs market worth an estimated $320 billion. Despite investment in health measures including needle exchange, detox facilities, and supply of opiate substitutes, Scotland’s levels of problematic drug use, drug overdose deaths and drugs crime are among the highest in the world (The Herald, 2.8.10).

Global critique of the UN Drug Treaty

The UN Office on Drugs and Crime acknowledges five unintended harmful consequences of the Single Convention: three concern the growth of the criminal infrastructure and drugs market; fourth, that public health, the primary aim of drug control, has to take a back seat to law enforcement; fifth, the marginalisation of people with drug addictions through their exclusion from the social mainstream, being tainted with moral stigma and unable to find treatment (UN Office on Drugs and Crime, 2008). The issues of social dislocation and human rights are not directly the focus of this paper.

In 2011, the Global Commission on Drug Policy (Global Commission on Drug Policy, 2011) called for public debate and recommended a shift from a criminal justice to a public health approach, flexible policies tailored to national contexts, and evaluated experiments in decriminalisation and regulation.

Over the past 40 years more than 20 countries have decriminalised drugs in various ways (Rosmarin and Eastwood, 2012). Within the last three years, there have been reforms to regulate and tax previously illicit drugs: Uruguay and the USA states of Colorado and Washington legalised marijuana, and Bolivia legalised traditional coca chewing practice. New Zealand has moved to regulate, not prohibit, new synthetic drugs such as ‘legal highs’.

From this brief overview, the conclusion may be drawn that there is a growing movement of critique and experimentation towards fundamentally reforming the UN Drug Treaty.

The Scottish context

As the drugs market has grown, socioeconomic costs of drug harms have soared. It has been estimated that this amounts to around £3.5 billion for Scotland (Scottish Government, 2009). Whilst innovative developments have taken place, such as drug courts, and take-home naloxone to prevent heroin deaths, there has been no significant shift from a criminal justice to a health approach through decriminalisation or consideration of regulated supply. Yet the report of the Christie Commission (2011) called for reform of services that recycle negative outcomes, in order to bring wasted resources into productive use. Despite this, there has been no willingness to examine how many of citizens have been criminalised and recycled through costly community and penal sentences because of their involvement with illicit drugs, and how this has placed public health in the back seat.

For people bearing the burden of harms of the current system and for tax payers, procrastination is hard to justify. The reality is described by Stevens: “the harms that are increased by the combination of psychoactive drugs and inequality include crime, illness and early death. The methods we currently use to control drugs contribute to the continuation and deepening of this inequality” (Stevens, 2011, p147).

One of the choices denied illicit drug users, but available to alcohol and other drug users is to bring heavy drug use under control if possible, especially if it is their substance of choice for relaxation: and when alcohol and tobacco users need to abstain for health reasons, they are not criminalised.
Neither is the world leading scale of Scotland’s drug problems examined strategically. We are therefore unable, or have not chosen, to invest in proportion to other countries with a lower prevalence of drug use, so as to provide a similar range and quality of treatment. The workforce have little time to help with issues of trauma, mental health problems, poor physical health and other everyday effects of inequalities like unemployment, benefit insecurity and sanctions.

Despite vocal support for recovery by policy makers, service providers and community recovery networks, there has been silence about how criminalisation is a major barrier to many people's recovery. An exception was a report to the Scottish Parliament by Scotland’s Futures Forum, which proposed a shift from criminal justice to health interventions, including decriminalisation, anticipated the regulation of marijuana, and offered an innovative framework to address systemically the scale of drug harms (Scotland’s Futures Forum, 2008).

Scotland in many ways has a very humane drugs policy but nevertheless has turned away from developments in other countries marking a shift from criminal justice to public health (see below).

Politicians are undoubtedly in a difficult place as every new move is scrutinised, but the experience of the Transform Drug Policy Foundation Scotland is that the Scottish media and public generally react with openness to the topics it proposes for discussion. This might suggest that civic, academic and professional domains should open up discussion about decriminalisation and drug law reform for health and social benefits, but would politicians welcome and listen to such debates?

Possible ways forward

Evaluation of drugs decriminalisation policies around the world show the doomsday prediction of runaway rising drug use is wrong, albeit that the different approaches have led to mixed quality and outcomes. However, “a decriminalisation approach coupled with investment in harm reduction and treatment services can have a positive impact on both individual drug users and society as a whole” (Rosmarin and Eastwood, 2012, p14).

The following treatment and harm reduction innovations based on practice in other countries might complement drugs decriminalisation to achieve such benefit and also release resources expended in the justice system.

Drug users with complex problems:

- Treatment services, currently prescribing other drugs as substitutes for heroin, should also prescribe heroin. This would increase choice in keeping with a patient-led health service. It would also offer the option of detoxification from heroin without transferring dependence to substitute opiates.
- Drug Consumption Rooms for the provision of heroin to drug users at high risk, particularly isolated or homeless people, who are not seeking intensive treatment but may access low threshold health services and social networks.
- Development of peer led support groups to control, reduce or cease drug use and advocacy organisations such as Copenhagen Drug Users Union and Vancouver Area Network of Drug Users.
- Support for drug users to change from injecting to smoking heroin. This could significantly reduce Scotland’s high levels of drug deaths and Hepatitis C infection.

Recreational drug users:

- Decriminalisation would benefit people arrested for drug offences only, 41,733 in 2006, of whom 93% were recreational users, at a cost to criminal justice of £80 million. Most of this expenditure could be freed up for other uses. Closer examination might find considerable knock-on reductions in the £500 million overall cost to the criminal justice system in dealing with problematic drug users (Scottish Government, 2009).
- Full regulation as in Uruguay and the states of Washington and Colorado would add much more to the public purse through taxation. However, until such time, the following public services could complement decriminalisation.
- A service where the public could send ‘legal highs’ and illicit drugs for quality testing both for their personal safety and to provide better information to the public, as is done in Holland and, more recently, in Wales.
- Licensed cafes or clubs selling specified drugs, tested for quality, adapted from the model of Dutch cannabis cafes and American medical marijuana shops.
- An integrated, evidence based understanding of alcohol, tobacco and other drugs and their comparative benefits and risks, to inform individual choices and government policy. This could provide the basis for a new integrated framework of law for all psychoactive substances.

To make society safer and lives healthier, it is in the interests of both justice and health to decriminalise drug users. Supported by the strengths of Scotland’s legal system and allowing frank discussion with former and current drug users, such a development could add value to international policy and practice and promote a step change in growth of recovery at every level.

Herald, 2.8.10 Scotland among world’s worst for drug abuse http://bit.ly/1pH099y

Mike McCarron has been closely involved throughout the last 30 years with Scotland’s drug policy development, local implementation and impact on drug users.
AS THE development of neuroscience provides new insights into human thought-processes and behaviour, it is likely to have increasing relevance for the criminal justice system. Evidence of brain dysfunction may cast doubt on an accused’s mental capacity and therefore culpability. It is also important to consider if neuroscientific evidence fundamentally challenges some of the assumptions on which retributive punishment is based and its potential application in offender rehabilitation.

**Mental Capacity**

The majority of references to neuroscience in criminal cases in the UK relate to evidence about victims’ injuries. However, neuroscientific evidence is increasingly being used in the United States to shed light on whether the accused’s mental capacities were impaired. 1500 cases were identified (2005 - 2012), where evidence from neuroscience or behavioural genetics was used to support the defence’s claim that the accused could not control himself, or was biologically predisposed to aggression and impulsivity. In most cases, such arguments did not result in acquittals or decreased sentences (Wright 2014).

Neuroscientific evidence may involve neuroimaging. Juxtaposing images of a ‘normal’ and an allegedly ‘abnormal’ brain can be a dramatic form of scientific evidence. However, interpreting neuroimaging data is complex. It is important that neuroscience is not given undue weight. Studies show that irrelevant neuroscientific terminology (“neurobabble”) can give subjects false confidence in evidence. Scotland should therefore follow most other common law jurisdictions and review its framework on expert scientific evidence, to ensure that only reliable, probative evidence is admitted. Judges and lawyers should undertake training in understanding neuroscientific evidence as part of their continuing professional development.

To what extent then should brain abnormalities provide an excuse for criminal behaviour? Consider this: a 40-year-old schoolteacher underwent disturbing personality changes. He accumulated a large collection of child pornography and molested his young stepdaughter despite having had no previous history of paedophilia. After he began to suffer headaches, it was discovered that he had a brain tumour: this was removed and his deviant interests vanished. A year later he re-offended and it was discovered that the tumour had regrown. Again, after the tumour was removed the deviant urges disappeared. His doctors were convinced that the tumour caused his impulses to offend (Burns and Swerdlow 2003).

It is tempting to blame the tumour rather than the man for the offences. Yet, I would argue, that the fact that his impulse to break the law had an unusual cause, by itself, cannot eliminate his responsibility, if his impulse was resistible. The case for excusing *irresistible* impulses is compelling, (and has recently been supported by the Law Commission in England), but would require a change in the law. Currently, mental disorder is only a defence if it undermines understanding rather than control.

The Scottish Law Commission doubted whether it were possible to distinguish between being incapable of resisting an impulse and choosing not to resist (SLC 2004). One way of demonstrating such an incapacity to make a choice is to show that a necessary condition for capacity is absent. For example, if a car lacks an engine then it does not have the capacity to move. For humans, the counterpart of the car’s engine is the neural correlates underlying the relevant capacities. If reliable correlations are found between certain brain structures’ activation and the capacity for self-control, this would strengthen the case for excusing an individual with apparent deficits in the relevant neural circuitry (Brass and Haggard 2007).
Neuroscience, responsibility and punishment

One of the purposes of the penal system is retribution: imposing hardship on wrongdoers because they deserve it. For retribution to be fair the offender must have been responsible for a crime, which in turn assumes the offender had free will. Neuroscience may challenge the assumption that anyone has free will in the sense required for retribution to be appropriate.

For example, according to the theory of epiphenomenalism, our actions are really caused by unconscious rather than conscious (the decisions, intentions and desires of which we are aware) brain processes. We may think that the reason we acted a certain way was because we consciously decided to act that way, but actually our unconscious brain processes had already ‘decided’ what we would do. This approach is influenced by experiments which seem to reveal that brain activity associated with the initiation of action occurs in the brain before subjects consciously decide to perform a simple action such as pressing a button. However, even if unconscious processes cause certain spontaneous actions this does not show that complex courses of conduct performed after much conscious deliberation would happen regardless of that deliberation. Nonetheless, if simple, spontaneous actions can be caused by wholly unconscious processes (for which the person is not blameworthy) this might have implications for legal responsibility in certain cases such as some driving offences.

Neuroscience suggests that we all make the decisions that we do because of the state of our brains

A different kind of challenge to the assumption of free will comes from determinism. While not denying that a person’s conscious decision to act is a necessary step in the causal chain that brings about her action, determinism does imply that all our conscious thought processes are, in turn, caused by factors beyond our control such as our biological constitution and environment. However, neuroscience suggests that we all make the decisions that we do because of the state of our brains. Many philosophers believe that our conscious thought processes simply are certain brain processes. If everyone’s motivations, personality and deliberations were entirely determined by their brains’ development, which in turn was caused to develop in that exact way by genetic and environmental factors beyond their control, can it ever be fair to inflict retributive punishment on anyone?

There are essentially two ways of defending retributivism against this challenge. First, libertarians deny that all our decisions are entirely determined by prior brain states or anything else. These factors may influence us, but do not make the outcome of our deliberations inevitable and it is still possible, up to the moment of choosing, for a free agent to decide differently. Compatibilists, in contrast, believe that capacities such as rationality are all that is required for freedom. If a person is rational, understands the reasons against breaking the law and does not care about them, then she is responsible: that her genes and environment made it inevitable that she would develop into the kind of person who would not care about these reasons, is irrelevant.

Greene and Cohen (2004) argue that most non-philosophers find libertarianism more intuitive than compatibilism, but claim that libertarianism is empirically flawed. They predict that as neuroscience develops, and becomes more widely understood, there will be a tendency towards less retributive and more rehabilitative responses to offending.

Rejecting retributivism does not simply mean reducing the prison population. A non-retributive approach to imprisonment means concentrating on forward-looking aims, such as public protection and enabling offenders to lead useful lives in society.

Neuroscience may help achieve these goals. For example, researchers are developing risk prediction tools involving neuroimaging (Aharoni et al 2013). Although, for the foreseeable future, these techniques seem insufficiently reliable on their own, they may play a helpful role alongside other clinical and actuarial methods. Neuropsychopharmacological treatments such as antidepressants and anti-libidinal medication, are already being used in sex-offender rehabilitation in Scotland. However, there are significant concerns over their safety and effectiveness (Greely 2007). A promising technique without known serious side effects is neurofeedback. Studies demonstrated behavioural improvements in juvenile offenders who viewed real-time visual feedback about their brain activity, and re-trained their brainwave patterns (Smith and Marvin 2006).

Neuroscience provides new insights into mental capacity, may influence our approach to punishment and may offer methods for reducing reoffending. However, an uncritical approach to neuroscience could distort responsibility-assessments and expose offenders to unjustified detention and harmful medication. The relevance, reliability and safety of such evidence and interventions must be carefully assessed.


Wright, J. (2014) My Brain Made Me Pull the Trigger: Neuroscience-Based Defenses are Flooding the Courtroom, Scientific American Mind, 25 (3).

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Taking an evidence-based approach to funding criminal justice projects

Over the last eight years, The Robertson Trust has invested over £7 million in criminal justice projects across Scotland. This article outlines our journey as we have moved towards becoming an evidence-based funder and some of our learning from funding and evaluating these projects.

Christine Scullion

The Robertson Trust

The Robertson Trust is Scotland’s largest independent grant making Trust. Every year it funds a wide range of third sector organisations across the country. It was established in 1961 by the three Robertson sisters, Elspeth, Agnes and Ethel, who donated their shares in their family business, Edrington, to the Trust for charitable purposes. To date, the Trust has given more than £150 million to charities in Scotland, with over £16 million awarded in 2013/2014.

In addition to our main grant scheme, the Trust also works proactively within a small number of development areas, including criminal justice. In these we aim to make a significant investment in programmes and projects over an extended period of time to develop the evidence-base about what works, what doesn’t work and why. We then use this evidence to influence policy and practice at a local and national level.

Our development approach

Through our Development Awards, the Trust tries to focus on hard issues that no-one else is looking at and identify gaps in service provision where our support can make a difference. For example, ten years ago we identified a significant gap in support for offenders serving short-term sentences of less than four years, so began investing in voluntary throughcare services for this group. Today, there is a wide range of voluntary throughcare services operating across Scotland and this is a key area that the Scottish Government is focusing on in Phase 2 of the Reducing Reoffending Programme (RRP2).

The Trust now begins its development work by undertaking research to identify the existing evidence-base within an area, including looking at international research and studies. We then set up an advisory group to consider this research and establish a funding programme to test out some of the approaches that evidence suggests may prove effective.

Partnership working is integral to this: we bring together key stakeholders from the public sector and third sector at the start to agree shared outcomes for this work, co-design the programme and begin to look at how the work can be sustained in the long term. We then identify and fund third sector organisations to deliver specific interventions within local communities across Scotland. Increasingly, we fund these programmes in partnership with other organisations.

The Trust tries to focus on hard issues that no-one else is looking at and identify gaps in service provision where our support can make a difference

While supporting organisations to make a positive difference to their service users’ lives is a key outcome of our Development Awards, it is not the only one. We also aim to use the learning from these programmes to increase knowledge of ‘what works’ within these areas and ultimately to ensure that this knowledge is reflected in future policy and practice in Scotland. Although we would like to see the high quality services we support being mainstreamed, it is more important to us that the learning from their work is sustained and used to improve services so that it benefits as many people as possible.

Becoming an Evidence-Based Funder

Evaluation plays a key role in our development work. All of our development projects are externally evaluated or receive support to undertake self-evaluation, or both. These have two aims: (i) to help organisations understand and demonstrate the impact of their services better and (ii) to identify areas of
good practice within projects and contribute to the evidence-base about ‘what works’. Increasingly, we build ‘learning sets’ into all of our new development programmes where we work with Evaluation Support Scotland (ESS) to improve organisations’ self-evaluation skills. An example of this is the ‘Families Affected by Imprisonment’ Learning Set that we are running with eight organisations over the next two years to empower them with the knowledge, skills and tools they need to measure the impact of their services.

In 2013 we worked with the Scottish Government’s Justice Analytical Services (JAS) to improve our approach to evaluation, as part of the Scottish Government’s Analytical Exchange Programme. When we initially approached JAS, we hoped they would help us to undertake economic evaluations of some of the criminal justice projects we were supporting. However, we quickly learned that before we could even begin to look at economic evaluation, our impact evaluations would need to be more robust. JAS has reviewed all of the evaluations we had commissioned over eight years and provided some very constructive feedback about their strengths and weaknesses. A key question they challenged us to consider, was what we wanted to gain from these evaluations? Did we want to use these evaluations to prove that a project was working or to use it to fully analyse and understand which aspects were working, which weren’t working and why? They also provided us with guidance about what evaluations can and cannot be used to demonstrate and how to make the evidence in them more relevant, useful and persuasive.

We have also benefited from JAS’s ‘Reducing Reoffending Evaluation Resource Pack’ which outlines four steps for designing and evaluating criminal justice interventions:

1. review the existing evidence about ‘what works’ in reducing reoffending;
2. draw a logic model describing how the intervention works and show the links between inputs, outputs and outcomes;
3. identify indicators and collect relevant monitoring data;
4. analyse data to understand if the inputs, outputs and outcomes have taken place as planned (Scottish Government, 2013).

The Trust has found this resource invaluable and it has strongly influenced our current approach to funding and evaluating projects. We are now working alongside JAS, ESS, the Criminal Justice Voluntary Sector Forum and other stakeholders to promote the use of this model amongst service providers, policy makers and commissioners to help the sector move towards a consistent, evidence based approach to designing, funding and evaluating criminal justice services going forward.

Key learning

Through our long-term investment in criminal justice, we have developed a growing evidence base about ‘what works’ to reduce reoffending and the valuable contribution that third sector organisations make to this agenda. In 2012, we published a paper on behalf of the Scottish Third Sector Research Forum which identified the third sector’s responsiveness, flexibility, commitment and ability to form relationships with offenders as being integral to their success (The Robertson Trust, 2012, pp.3-4).

The ‘Breaking the Cycle’ programme, funded in partnership with Serco, is one example of our investment in criminal justice. Launched in 2008, the £1 million programme has supported the development of five demonstration project across Scotland that provide throughcare support to offenders receiving short-term sentences. These include Barnardo’s ‘Plan B’ project, Access to Industry’s ‘Passport’ project, Station House Media Unit’s ‘Adjust’ project and Centrestage’s ‘Catalyst’ project (links below). In summary, we found that:

- Throughcare services are more likely to be effective if they engage with offenders at the point of custody, continue to work with them after release from prison and assign a designated worker who acts as a consistent point of contact;
- It can take a significant amount of time to embed new services in prisons and to develop a shared understanding of the services’ aims and objectives amongst prison staff, delivery agencies and service users;
- It is vital to take a multi-agency approach when developing and delivering services and to ensure services such as housing and health are involved in this process (The Robertson Trust, 2014).

Another significant development over the last two years has been our involvement in the Reducing Reoffending Change Fund (RRCF) in which we have invested £2 million, and have project managed the six RRCF Public Social Partnerships (PSPs) on behalf of all the funders. As part of this work, we have organised two successful networking events that have provided a forum for the PSPs to come together and discuss best practice and challenges around providing mentoring support to offenders. While RRCF has been a challenging process, it has helped to bring together independent funders, third sector practitioners, policy makers, analysts and commissioners across the sector in a more coordinated way. This is an exciting development in criminal justice and one that the Trust hopes to see, and help replicate, in other sectors.

Adjust: http://www.shmu.org.uk/adjust
Centrestage Catalyst: http://bit.ly/1lZZIm4
Evaluation Support Scotland: http://www.evaluationsupportscotland.org.uk/

Christine Scullion is head of development at The Robertson Trust.
The Great Corroboration Debate

John Blackie

The debate about the Scottish Government’s proposal to make a criminal conviction possible without corroborative evidence is unprecedented: the law of evidence typically attracts the attention only of academics, lawyers and judges. A Scottish Law Commission proposal to change the rules excluding evidence of bad character would very possibly have a much greater impact on the criminal process than abolition of the corroboration rule, but there has been almost no media comment.

So, why is corroboration different from reforms about what types of evidence can be used?

Corroboration is one of a small number of rules of criminal evidence, including for instance the ‘beyond reasonable doubt’ standard, that are about something fundamental: how judges and juries are to go about decision-making on the facts. Even if the outcome of the present debate is the abolition of the requirement, the big issue will remain: what is the optimum set of rules and practical measures to promote good decision-making on facts in the criminal process?

The immediate background to the proposal to abolish the requirement of corroboration obscured this question. As a result of the human rights decision in Cadder v HMA (applying article 6 ECHR “fair trial”), the law changed so that a confession to the police became inadmissible evidence if the accused had not been given the right to have a solicitor present. That was not a change to a rule regulating decision-making. It was about a particular type of evidence. The only thing that was unusual was, that it made inadmissible, evidence that had been previously admissible. Changes have usually been to the opposite effect, to make admissible types of evidence that had not previously been so.

This would have been seen as unremarkable by anyone working in criminal justice outside Scotland: whatever the legal arguments, Scotland was in practice non-standard. Of course it did affect police practice, raised questions about resources, including, obviously, how to ensure that there were lawyers available to perform the role, and whether the current police powers of detention needed adjustment. These matters for practical reasons needed to be dealt with relatively quickly. In autumn 2010 the Minister of Justice asked the Lord President to set up a Review to be carried out “expeditiously”. Lord Carloway was appointed with wide terms of reference: “To consider the criminal law of evidence, insofar as there are implications arising from [the new right to have a lawyer present]” and “in particular the requirement for corroboration and the suspect’s right to silence”. The need for speed and the specific mention of corroboration meant it would not have been possible to consider the bigger issue of good decision-making on the facts. So the debate was narrowed unsatisfactorily before it began.

The trouble is that this form of dispute cannot provide the answer as both sides are inevitably right.

The corroboration rule is relatively complex. It is perhaps impossible to conduct a true political debate about a complex idea, so debate simplified it to the easily understood paradigm of a requirement for two witnesses. But that is just one possibility: obviously it can be one witness and a confession.
This was possibly the paradigm the Minister had in mind in specifying it in the terms of reference for the Review. Perhaps there would now be fewer confessions because of the right to have a lawyer? However, corroboration can also be one witness or confession and circumstantial evidence, including scientific evidence; it can be two sources of circumstantial evidence.

There are two further complexities. Corroboration does not apply to every fact, only to identity, and to the facts that constitute the elements of the crime or offence in question. Secondly, the requirement is modified by a number of what one commentator has memorably described as fiddles and fudges. For example, if there is a pattern between two or more offences charged, corroboration is not required of each. The evidence of one or more can corroborate the other(s).

Our current debate has been reduced to simplifications. Abolitionists state that there would be more rightful convictions or wrongful acquittals, as there are cases which are not prosecuted, or fail in court, because of lack of corroboration. Those opposed state that there will be more wrongful convictions. The trouble is that this form of dispute cannot provide the answer as both sides are inevitably right. Attempts have been made at a statistical assessment of the effect of the corroboration rule on the level of wrongful acquittals, including the criticised Crown Office data in the Carloway Review, but it may be impossible to be definitive. Comparisons with systems, such as England and Wales, that do not have the corroboration requirement come up against the problem that lots of relevant variables are different, such as a different approach to the obtaining of confession evidence. Even looking at Scotland, assessing the numerous variables and making predictions may be unreal.

A real problem in Scotland is the lack of research on the impact of the rules of evidence including at the investigatory stage

The one indisputable statistic is the low conviction rate for sexual offences. In the debate the police, the Lord Advocate, and the Solicitor General have concentrated on the problem of getting convictions in these cases. These offences often take place with no one other than the perpetrator and the victim present, and turn often on whether the victim consented (which is not in the nature of things likely to be the subject of circumstantial evidence). The low prosecution and conviction rate is manifestly a serious issue for the justice system and society. However, even here it is not possible to show with any confidence what the effect of the corroboration rule is.

The Minister of Justice has now moved the whole question to a reference group chaired by Lord Bonomy. This gives a real possibility of addressing my earlier question: what is the optimum set of rules and practical measures to promote good decision-making on facts in the criminal process? It is more than just about “safeguards”, if it should recommend removing the corroboration requirement, whether generally or for some types of fact, or possibly, though unlikely, for some types of crime. The Bonomy review provides an opportunity for real consideration of the issue of unreliability of evidence and the promotion of good factual decision making, on both of which topics there is a vast amount of empirical and theoretical research outside Scotland. (None of this was considered in the Carloway Report, and, except in contributions by academics, has not figured in the debate). Lord Bonomy has now recruited expertise from that wider world, going beyond the English speaking jurisdictions, to advise.

A real problem in Scotland is the lack of research on the impact of the rules of evidence including at the investigatory stage. Even on confession evidence, the subject of hundreds of research projects round the world, there are only a couple of studies. Whatever the final outcome of the Bonomy review it is crucial that in the future studies are funded to assess the impact of the new law.

It would not be useful or sensible to predict the outcome of Bonomy but certain specific topics have emerged in the course of the debate. The problem of sexual offences is clearly one. The worry is though, that abolishing the corroboration requirement may raise false hopes of change. Conviction rates may remain the same. In particular juries may not like convicting on one person’s word against another. If so, the psychological impact on the victim of not being believed may be even worse than where the case is not prosecuted, or fails for lack of corroboration. Another question is that of evidence of identity (in all types of cases). Others have appeared off and on in the debate, including the education of judges and juries in the handling of evidence and its pitfalls, whether experts can assist effectively in this, and in jury cases, the roles of judge and jury with respect to evidence.

Any system is going to come up with a compromise. In the 19th century the continental European systems, with predominantly inquisitorial procedure, moved to ‘free proof’. Any type of evidence can be used, but there are limits to ensure the right to fair trial such as that the standard of proof is ‘beyond reasonable doubt’, and the burden of proof is on the prosecutor. Other instances include rules requiring disclosure of prosecution evidence, and that hearsay evidence is not enough for conviction if it is the sole or decisive evidence. Scotland, and the English speaking world generally, with adversarial procedure, have lots of rules, but the abolition of many inadmissibility rules has been in the direction of more free proof. Somewhere in the middle must lie the optimum, but what that is may well reasonably differ from one jurisdiction to another.

Cadder v HM Advocate [2010] UKSC 43

Papers and background to the Carloway Review are available on http://www.scotland.gov.uk/About/Review/CarlowayReview

For more on the Post-corroboration Safeguards Review (Bonomy) see http://www.scotland.gov.uk/About/Review/post-corroboration-safeguards

A useful database of links to the politics of the debate, essential papers and so on is http://www.cjscotland.co.uk - search ‘corroboration’.

John Blackie is a professor emeritus at the University of Strathclyde and has published on the law of evidence in Scotland.
THE ROOTS of the Alternatives to Violence Project (AVP) can be traced back to Green Haven Prison in Stormville, New York. A prisoner there called Roger Namu Whitfield had developed the ‘Think Tank Concept’ in 1972, a programme where he and a group of other prisoner activists worked with young men in custody and gang members in an effort to steer them away from a life of crime (Morris, 1976). Whitfield came to realise that his group lacked some of the skills necessary for such a difficult task, and knowing about the Quaker nonviolence training programme, requested assistance. In March 1975 the Quaker Project on Community Conflict took a team of trainers into the prison where they ran an intensive three day workshop for nine prisoners. In December 1976 seven inmates received their certificates, recognising that they were now qualified as trainers.

From the early days in Green Haven to present day Scotland, much has happened. A programme that was co-created by prisoners and experienced group workers with support from the Quakers is now a distinct movement with no denominational affiliations. AVP now operates in over 50 countries, and in the UK is a charity registered both in England and Wales and in Scotland. Our stated mission is to support people to learn how to handle conflicts constructively, resist violence and build stronger relationships.

The content of early workshops would be familiar to any present day facilitator, but at the same time much has been changed and adapted in line with experience and improvements in understanding. At heart there remains the central belief in the potential of individuals and communities to discover and cultivate their own power to transform situations non-violently, and to live and flourish without violence. Our starting point is not that some people have a problem that needs fixed. Our starting point is that conflict is an inevitable part of life, and we can all get better at dealing with it.

AVP was established in Scotland by a small, dedicated group of volunteers and our first Scottish workshop took place in 1997. Over time the scope and frequency of workshops increased, with some being run in the community in Glasgow and Edinburgh and some, for a time, in HMP Kilmarnock. In 2011, with financial support from the Robertson Trust, The Volant Trust, the Allen Lane Foundation and many other benefactors AVP appointed a development worker in Scotland. We are now associate members of the Health and Social Care Alliance and have an office base at the Alliance Hub in Glasgow.

The learning at workshops comes from sharing, doing and reflecting. A range of techniques are used from games and activities to discussion and role play, all relating to our ‘building blocks’ of self-esteem and affirmation, communication, trust, cooperation, building community, responding to conflict and problem solving.

THE ALTERNATIVES TO VIOLENCE PROJECT IN SCOTLAND

Des Fik
Moreover, there is immense value in the experience of working together in the safe harbour of the ‘community in microcosm’ that forms over the three days. Workshops are offered at an introductory Level 1 and for those who wish to go on to do so, a more in-depth Level 2. At this level the participants choose the topic they wish to focus on, a process that inevitably involves exploring what consensus is and how to achieve it.

After completing three workshops (with at least one having been at level 2) interested and able participants can undergo a process of guided self-assessment then go on to train as facilitators if appropriate. It remains a core principle of our work that all our facilitators are volunteers that have followed this route. After training, volunteers initially operate as ‘apprentices’ and work in teams where they will be supported by experienced colleagues to ensure consistency, high standards and reflective practice. Each team is led by a very experienced facilitator who has received additional training for this role. The apprentice will also be able to access a mentor whom they can turn to for advice and support.

Our starting point is that conflict is an inevitable part of life, and we can all get better at dealing with it

In 2012 and 2013 we ran 27 workshops for 214 participants in Scotland. A number of these were community workshops open to people who either self-referred or were signposted to us by their GP, social-worker or solicitor. We receive no funding from any statutory body and participants have to pay a fee for their place. Although full-price fees are exceptionally good value at £95, and AVP offers concessionary rates, it is recognised that this is still a substantial barrier to many people. Utilising a grant we received from ‘Awards for All’ in 2012, we were able to ensure that 89% of community workshop places were free at point of receipt for people who could not afford a place, and we are currently seeking funding to carry this practice forward.

The remaining workshops were planned and delivered together with partners including HMP Addiewell, Circle Scotland (Families Affected by Imprisonment Project), PositivePrison?PositiveFutures, SAMH, Redhall Gardens (a SAMH project in Edinburgh), GAMH, Jobs and Business Glasgow, Addaction and Parent Network Scotland. Our programme at HMP Addiewell is continuing throughout 2014 and we are delighted to be piloting our first workshops in partnership with HMP Perth this year. We also provide a six week distance-learning resource called Facing Up to Conflict, designed for use in prisons. So far we have only had learners at HMP Addiewell completing this, but we hope to extend availability to other Scottish prisons.

Taking a statistical ‘snapshot’ of participant feedback in Scotland for the period September 2012 to September 2013, we found that:

- 91% reported they could communicate better
- 97% stated that they understood and believed in themselves more, and
- 93% reported that they felt better able to handle conflicts and solve problems.

More widely the statistics tell a similar story. For example a longitudinal study of community workshops in Walker in Newcastle found in a post-workshop follow-up that over 90% of respondents had retained greater understanding of feelings and actions, used more peaceful ways of resolving conflicts, trusted people more and worked better with others (Redpath, 2011). There is value in looking beyond the statistics however. Workshops do more than help people learn new ideas and skills; they enable them to discover and enhance their self-efficacy, to develop positive social ties, to perceive themselves in new and positive ways, and to uncover and develop their capacity for self-determination.

These wider outcomes have benefits that overlap across several different areas. Desistance research tells us that it is asset-based interventions of this kind, which help people to see themselves in new, positive ways, raise social capital and exert personal agency towards change that are the most effective (McNeill and Weaver 2007). If we focus on health, violence and family conflict are known issues that contribute to mental illness (WHO, 2004); while influences such as staying connected, learning new things, mindfulness and helping others (all fostered through participation in workshops) are recognised protective factors that promote mental wellbeing (SAMH).

More than this however, Alternatives to Violence is quietly but unashamedly a social movement that dares to envision a non-violent society. There is more to this than just living in communities free of violent criminal assaults or homicides, highly desirable though this is. When people at workshops discuss the violence inherent in things such as war, poverty, inequality and the abuse of power; they are exploring the idea that a truly non-violent society is one that seeks peaceful solutions and is devoted to social justice. I can’t say for sure, but I think Roger Namu Whitfield and the other pioneers of AVP would approve.

Prison Research Education Project, Syracuse, New York.


longer term impacts upon workshop participants, Newcastle Conflict
Resolution Network.

SAMH (web page accessed 30.4.2014) Five Ways to Better Mental Health
www.samh.org.uk/mental-health-information/five-ways-to-better-
mental-health

interventions and policy options: Summary Report.

The Alternatives to Violence Project Scotland is based
at the Alliance, 349 Bath Street, Glasgow, G24AA.

The dates for our regular community workshops can be
found on our website at www.avpbritain.org.uk.

We welcome enquiries from individuals and from
potential partners by email at scotland@avpbritain.org.uk
or by telephone on 078 6077 0581.

Des Fik is a former police officer and at the time of
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Scottish Justice Matters : June 2014
THE BARLINNIE SPECIAL UNIT never fully came of age. It was terminated by the Scottish Prison Service in its twenty first year, 1994, at which point few in Scotland were aware it still existed. In its first decade it had rarely been out of the news, particularly the tabloids, and the closure announcement briefly rekindled their interest, reminding readers more of past scandals than analysing the pros and cons of shutting it down. Nowadays, to the extent that the Special Unit is remembered at all in Scottish public life, it is still in terms of the media controversy that suffused its early years and in particular the persona of Jimmy Boyle, the convicted murderer who made the most of the Unit’s distinct artistic opportunities and became its most spectacular success.

There is no official or unofficial history of the Unit. Several people who were associated with its inception and early years, psychiatrist Peter Whatmore and prison officer Ken Murray, wrote about it at the time. Art therapist Joyce Laing, who was crucial to the direction the Unit took, wrote of its “evolution through art”. Psychologist-researcher David Cooke provided statistical evidence that confirmed practitioner experience that the Unit’s regime massively reduced its residents’ proclivity for violence and confrontation with authority. The later years of the Unit are only really documented in inspectorate reports, in the evaluation produced by penologists Keith Bottomley, Alison Liebling and Richard Sparks, and the response of the Scottish Prison Service, which made significant use of it, against the authors’ expectations and intentions, to justify closure.

Richard Sparks’s (2002) subsequent exploration of his inadvertent complicity in the closure remains by far the best academic analysis of what the Unit was, and why its original therapeutic ethos, admittedly somewhat diminished in 1992, when he was researching there, deserved to be revitalised. Nonetheless, it underplays the distinctive role that artistic endeavour, particularly sculpture and painting, played in the reform of violent offenders, in media debates about the unacceptable privileges being given to Unit prisoners, and in mobilising an unprecedented degree of support for the Unit among significant players in Scotland’s creative professions.

Sparks plausibly argues that the Unit’s relative longevity was because it served a useful practical purpose in Scotland, keeping seriously disruptive prisoners out of mainstream prisons. The witheringly negative publicity, and the political embarrassment this caused, could easily have induced closure before its first decade was up: sheer need outweighed this. Sparks cites a prison governor who appreciated that the Unit’s existence made his own work easier, and did not care much how it was done. This betrays a certain cynicism towards what was actually done, and towards the people who made it possible. The activities which actually wrought the Unit’s early success with its prisoners should not be written out of the story as if they were epiphenomenal. Sparks recollection that “there was something numinous there – something about sculpture, something about psychiatry” (p563) reflects the hazy
myths and legends that had grown up about the Unit by 2002, but at the time these activities were actually being pursued, in the 1970s, they seemed materially tangible and intellectually intelligible: exciting and novel, yes, but not especially numerous.

I have written elsewhere of the role creative arts played in both the regime and the public image of the Unit’s early years, and hence also the media controversies surrounding it (Nellis 2010). I sought specifically to retrieve the importance of art therapist Joyce Laing, without whose chance arrival and guiding influence, once the prisoners (led by Jimmy Boyle) began to show interest in clay modelling and sculpture, the regime and reputation of the Unit may have been very different. Undoubtedly, a somewhat loose vision of a therapeutic community underpinned the relatively relaxed and informal relationship between prisoners and the specially trained staff, the resolution of difficulties through regular communal meetings and the centrality of “talk” to the milieu that was being created, but unlike purer models of therapeutic communities, no thought had been given to the work around which daily routines could be structured. To a significant extent, creative arts (and the sense of purpose and achievement they gave) came to occupy this place and worked alongside the other therapeutic features of the Unit in bringing about a reduction in violent and confrontational behaviour.

Through Joyce Laing, Scots artist and influential arts impresario Richard Demarco became acquainted with the Unit, resulting in a steady stream of artists, inspired and impressed with the work, becoming regular visitors and sometime teachers there. The Unit acquired a constituency of passionate and mostly respectable supporters that no other penal facility in Scotland, Britain or maybe anywhere, had ever had before. When Jimmy Boyle began going on day release to Demarco’s gallery he was introduced to renowned German artist Joseph Beuys: the two men found some surprising affinities and Beuys played a part in shaping and consolidating Boyle’s growing sense of himself as an artist. Beuys was fascinated by the use of creative arts in the Special Unit: it reinforced his grand belief that artistic talent was universal and that the art being created there, by the kind of men of whom it might never have been expected, could be a catalyst for social and political change. Beuys cared enough to lecture on Jimmy Boyle and, towards the end of Boyle’s imprisonment, when he was transferred from the Unit to a conventional prison, Beuys (and others) took the Scottish Office to court for denying Boyle art materials and cutting him off from fellow artists.

The Boyle-Beuys-Demarco relationship, and this kind of activism, went way beyond what a conventional penal-therapeutic community might have been expected to achieve and was understandably a public talking point. Sparks’s footnoted observation that “the lionizing of some prisoners by the chattering classes of Glasgow and Edinburgh was too much for many prison officers [in the Unit] and indeed no small number of other prisoners to bear” (p579), is too dismissive of the value of middle class, media-savvy support for a contentious penal initiative, which acted as a counterweight to the derision shown the Unit by the tabloids. It was simultaneously embarrassing and useful to the prison authorities to have voices from Scotland’s artistic elite supporting their Unit, however much it had become something different, and a little out of control, from what they had intended. True, some resentment existed among staff and prisoners about Boyle’s celebrity, and towards some of the Unit’s middle class supporters, but that was a rift which, in the longer term interests of creating publics who are supportive of rehabilitative initiatives, needed to be politically bridged rather than accepted in a partisan fashion. Cross-class dialogue of that kind was never going to be easy, the prison authorities were never likely to foster it, but liminal characters like Beuys, Demarco and Boyle himself were the kind of people who could have created it, and indeed, tried to.

The Unit’s later years, after Boyle and Ken Murray left, were somewhat diminished in comparison. The Prison Service re-established control, but lessons had been learned and incidents of violence and confrontation remained negligible. Creative arts teachers continued to be brought in, but the once defining artistic ethos became more subdued and later generations of staff showed less commitment to it. For reasons which are unclear, the arts community’s own interest lessened, and as the Unit became less unorthodox, so did that of the tabloid press. Kirsteen Bunting (1992), an undergraduate from the Glasgow School of Art who did a placement in the Unit in the same year as Sparks did his research, sensed both that the Unit was losing its way, but also that there was a tentative official appetite for rekindling the energies that had made it so transformative for some earlier prisoners.

That, as Sparks so brutally found, was not to be. One lesson to be drawn from this dispiriting experience might be that “evaluation” was conceived too narrowly here, too penologically: that liberal penal reform interests are not always best served by an evaluative model in which academics gather data to discreetly present to a seemingly benign authority. Granted, no one really saw closure coming. If they had, and if the Unit was to have been saved and revitalised at that point, someone somewhere needed to re-mobilise the arts community which had once helped to sustain a serious public debate about what a prison should be, that penology as an academic discipline has never quite managed to do on its own.


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“HOW COULD YOU DO THIS TO ME?” is the question asked by most women who have been raped. We hear it put precisely like that at the Centre for Victims of Sexual Assault, wonderingly, despairingly or angrily; referring to the “you” who committed the assault and hence the only one who knows the answer. Even so, we never imagined that anyone would want to sit down face to face and ask the question directly until a young woman named Anna, asked for our help. She had been raped by a close (and at the time drunk) friend and, like many other women in the same situation, she did not want to involve the police. Anna did not see or hear from the friend again, yet she seemed to see him everywhere, in the street, on the bus, in a shop window and she became increasingly reluctant to leave her home. One day Anna told the psychologist at the centre that she thought the only thing that would help her move on was to talk to the man. She had to ask him why. How could he do it? Would we help her do that?

What, we had to ask ourselves, if a meeting with the perpetrator could help the woman regain power and control over her life?

The Centre for Victims of Sexual Assault is a one-stop centre situated at the University Hospital of Copenhagen. It was established in 2000 by a parliamentary decision, after years of political pressure from women’s organisations, in order to provide a coherent and interdisciplinary service to women and men who had been exposed to rape or attempted rape. A team of physicians, nurses, psychologists and social counsellors provides medico-legal examination, medical treatment in the acute phase followed up by short or long term psychological treatment and social counselling. The centre works independently but in collaboration with the Institute of Forensic Medicine, and the police, when the assault has been reported. By offering professional and skilled medical and psycho-social treatment immediately after the traumatic experience, it is the aim of the centre to help the woman regain power and control over her life and to reduce the risk of further victimisation.

Restorative dialogues that involved contact with the offender were never on the cards but what, we had to ask ourselves, if a meeting with the perpetrator could help the woman regain power and control over her life? What if a facilitated meeting in safe surroundings could help reduce her anxiety and fear? And how could we make sure that such a meeting would not further victimise the woman and jeopardise her safety?
A combination of fortunate circumstances made it possible to reach the decision to help facilitate restorative dialogues if and when a woman requested it. A devoted staff led by a visionary consultant, a counsellor already trained as a victim-offender mediator and access to funding, paved the way for what started out as a cautious experiment to become an integral part of the help available at the centre.

**Why want a restorative dialogue?**

When we started listening to why women like Anna wanted to face the offender we learned, that they had questions to ask, anger to show. They wanted their suffering to be recognised and validated by the one who had caused it. They wanted an apology; they wanted to be justified. They wanted it never to happen to anyone else. They wanted to get on with their lives, to live no longer in ‘his’ shadow. They wanted to feel free and safe again. To sum up, the women wanted exactly what many victims want in the aftermath of a criminal act: to (literally) stand up for themselves, speak their mind, and become visible. They don’t want the story to end here but to add another narrative that restores their dignity.

The request most often comes from women who know or know of the offender and do not report to the police, but it also comes from women whose case has been dropped by the police, but not by them. The Centre being situated in the health sector, outside the criminal justice system, gives certain possibilities and certain limitations. One is that the Centre is not allowed to contact the offender directly. It can only be done by the ‘patient’, the woman herself. Anticipating the vulnerable situation of the woman ‘inviting’ the offender to a dialogue and the possibility of a ‘no answer’ or a rejection is an essential part of the assessment done by the facilitator. In terms of power balance taking this initial step towards a dialogue is however very powerful for the woman, even if the journey, as can happen, ends here. No response from the offender is of course a great disappointment for the woman, but the satisfaction of having done what was in their power to do stays with them. They stood up for themselves. If the offender agrees to meet the woman a lengthy journey of preparations begins. The facilitator meets the woman and the offender separately a number of times assessing the possibility of a face to face meeting and clarifying the motivation, interests and needs of both. Contrary to victim-offender meetings within the criminal justice system where guilt has already been established and confessed to, this is not the case when the restorative meeting takes place outside the criminal justice system. This calls for clarification of the purpose of the restorative meeting. The parties will be prepared for what can be achieved and what may not possible to achieve in a meeting where accounts may differ and the question of guilt be up for negotiation. The role of the facilitator, empathic and impartial, will be made clear as well as the overarching aim of the facilitator: to ensure that no further harm is done.

Sometimes, though seldom, the journey ends here on the wish of one of the parties or the recommendation of the facilitator. It is however our experience, that the women and men who by their own choice engage in the process of facing each other, and agree to undertake lengthy preparation with the facilitator, are motivated to do this, in the words of Howard Zehr ‘to make things right’ or to do the right thing: mostly for themselves. The narratives that are exchanged, the questions asked and answered, the emotional expressions (of all kinds) that surface during the meeting help promote conciliation with what happened, but not reconciliation nor forgiveness.

**Is justice achieved?**

Do women achieve a sense of justice by participating in a restorative process and a face-to-face meeting? In a follow up of 16 women some women express that they feel justice, wholly or partly, has been done. Others are left with a feeling that there has been no reasonable consequences for what they had been through. Meanwhile, the fact that women don’t regret embarking on the restorative dialogue process, coupled with satisfaction expressed with the process, indicates that the option of a restorative dialogue, regardless of the outcome, can give women a good feeling merely by participating in the process. It is however important to recognise that the restorative dialogues are not a way to end or reach closure of a traumatic experience, nor an option for all women, but it is a step that some women find helpful to take in regaining meaning and dignity in their lives after a sexual assault.

“No crime victim should be forced to confront her perpetrator, but neither should she be denied the opportunity if she desires it.” (Koss, 2000)

None of the women I have referred to had imagined before they were raped, that they would elect to sit face-to-face with the man who assaulted them. But, being denied your personal right of choice and rendered powerless, is a changing experience. So it is for those of us, whose job it is to support victimised women in the struggle to regain their dignity, to be open and receptive to whatever the women feel can help them, even when it strikes at the heart of our own deep-rooted fears and prejudices or challenges our professional views.

The restorative dialogues carried out at the Centre for Victims of Sexual Assault have over the years received much attention from professionals from near and far. Only few other institutions though have been able to adapt a similar practice and even at the Centre in Copenhagen keeping up the restorative practice is an ongoing challenge. The wind is not always behind new ideas exceeding normal boundaries. It is however our hope that others will follow our example and create institutional platforms for restorative justice approaches to women (and men) who’ve been raped.

Karin Sten Madsen is a counsellor in sexual and serious violence in Denmark. and is involved in a EU(Daphne) project: ‘Developing integrated responses to sexual violence: An interdisciplinary research project on the potential of restorative justice’.

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RECOVERY POSITION

Nancy Loucks in conversation with Dr Oliver Aldridge

A renowned expert in the field of addiction medicine, Dr Aldridge is the Medical Lead for Edinburgh, Midlothian and East Lothian Drug Treatment and Testing Order (DTTO) Services.

OA: I came to addictions medicine from general practice, and I am seconded as part of a multi-disciplinary team to the Drug Treatment and Testing service covering Edinburgh, Midlothian and East Lothian.

My remit is to be responsible for the overall design of the treatment plan … but I do a lot of direct clinical work as well. I feel it’s a very fortunate place to work because it is a multi-disciplinary team: everyone who goes to the DTTO has their own social worker, resource worker, and a mental health trained nurse as well.

I’m also on the committee of the Howard League and the board of the Scottish Drugs Forum, and I do some work with Circle as part of their advisory panel.

NL: How did you become involved in the addictions field?

I became interested in the psychological side within general practice through exposure to people struggling around issues to do with alcohol, smoking and drugs. For the last 10 years I have been working in addictions medicine.

What got you interested in the justice side of your work?

Initially, I was apprehensive about working in the DTTO: I thought I would be confronted with people who had been forced into treatment. What I discovered was that the DTTO deals with an enormous pool of unmet need: people who are actually very keen to do something different with their lives.

There is sometimes, within health circles, the feeling that drug treatment should be divorced from the criminal justice system. I feel that is impossible and that the two have to work together. That’s partly because drug use and involvement in the criminal justice system are often symptoms of deeper underlying issues in the first place, and those issues have become so intertwined, it is artificial to try to separate them.

You said that there was untapped need: why weren’t these people getting help before?

They seem to experience extraordinary difficulties in engaging with services, coming from backgrounds of very significant deprivation and trauma with fractured relationships, often homeless, in and out of custody creating difficulty sustaining engagement with primary care. Sometimes their experiences of life combine to make what can be quite a challenging presentation.

It’s also difficult, if you are a service that is not engaged with the criminal justice system, to work with people whose priority needs are determined by it. It’s easier to work within it, and there’s evidence for that internationally.

Is there a way of making sure that the justice issue isn’t lost or overtaken by the wider health and social care agenda, which seems to focus more on the elderly?

We can’t simply do more of the same either in terms of the way we work or in how we deal with drugs, and I very much include within that, alcohol. If we don’t change our relationship with alcohol, then all services will be affected: a lot of issues in elderly care, dementia and so on can be traced back to alcohol issues.

Is there more you think can be done in prevention?

By the time I am seeing people, usually in their late 20s, early 30s, you can trace back a history which, in terms of drug misuse, typically begins with alcohol often aged around 11 or 12, then progresses through a variety of drugs until they start using heroin in the late teens. Mixed in amongst that...
is a gradual involvement of the criminal justice system, whether protecting people who are suffering from neglect or getting involved in a more punitive way. Then typically you have failure at school, exclusion and not completing their education.

Then there’s also the issue of young men getting drunk and fighting, and that’s an enormous risk factor in traumatic brain injury: we know that this is of great importance in terms of violent offending and the risk of further offending, yet it’s probably not addressed nearly as much as it ought to be. There isn’t enough resource put in either to detecting it or providing facilities for treatment.

**If you wind the clock further back before the person started to drink, what you find so often is a background of deprivation and trauma from psychological, physical, sexual abuse.**

If you wind the clock further back before the person started to drink, what you find so often is a background of deprivation and trauma from psychological, physical, sexual abuse. Often people are in communities with high rates of imprisonment and from backgrounds where they know of people who have been in prison. They may come from families where they have been the child who has witnessed their mother or father being arrested, who has been to visit that parent in prison. So there is a mix of factors, a web of causation, that is difficult to address with a single intervention.

If you look at sociological theories around addiction, then prevention lies in moving back to something that is more culturally cohesive and where people can be helped to be given a sense of meaning and purpose. Jimmy Reid spoke of “alienation”: we have to address that.

I think a lot more resource can be put into schools to pick up children who are experiencing trauma generally. So - greater awareness, professionals working more closely together. There’s no doubt that the way we treat alcohol could have a significant impact. There’s evidence around minimum pricing tending to reduce consumption, particularly amongst very young people.

**But would pricing really have an influence on people who are heavy drinkers?**

It’s not a panacea. What people often don’t realise is the exponential curve of the relationship between alcohol and harm and that there is a cohort of people who are on the tipping point every day of a fatal outcome from drinking. Even if you could reduce their consumption by a very small amount, you can pull them back from the brink, and Scotland unfortunately leads the world with places like Russia in alcohol-related deaths.

**Are there are other things that health can do to have an impact on re-offending?**

The WHO definition of health emphasises that health is not just the absence of disease. It is not enough to say that “we’re Health, and so social wellbeing is not really down to us”, and hopefully that kind of attitude will be eroded by the integration of Health and Social Care. People need support around work, housing, security including financial security, in order for them to feel healthy.

**Anything else?**

The people that we see have lives characterised by a lack of resilience, and it takes a long time to build resilience into people; there is no quick fix. Sometimes there is a temptation to very much jump at ‘quick fix’ solutions and focus on measurable outcomes: the flip side is that you only do what you can measure and sometimes end up with a service which isn’t ultimately helpful.

There has to be a willingness to engage with people in the longer term. Ideally I would like to see a move away from a welfare system that seems to be predicated on driving people to a place of fear and insecurity in the hope that this would force them into work – that work often being very inadequate and sometimes harmful - to a system emphasising social security.

**Can you say a bit more about trauma?**

One of the things said about people who use drugs is that they are somehow hedonistic pleasure seekers who chose this lifestyle. I think it is an enormous misconception.

When you take a drug on a one-off basis, your body tends to revert back to its baseline in a homeostatic response. But if you take a drug on a regular basis, there is no baseline to return to, and so the body sets a new one. Chronic drug use involves a chronic hyper-activation of the stress response system.

If you take a child whose response system is still developing, and you stress it across multiple different parameters in a toxic way, that also causes a de-regulated stress response system. When they take the drug, it’s like introducing a key into a lock: it’s the first time they find something that balances out the negative experience they’re having, and sometimes it’s the only way in which they can feel normal. This concept allows us to link trauma with drug use at a neurological level.

There’s an element of course that people with trauma welcome the mind-numbing effect of intoxication, and that can be a driver in itself, but that’s a million miles away from someone who’s decided to have a good night out. Mostly these are people who have had experience of enormous trauma: drug and alcohol use becomes a dysfunctional way of dealing with it, but it feels at the time to be the most effective thing they’ve done. So I really don’t buy into the idea that the people we are treating are pleasure seekers who couldn’t care about society.

The full interview can be heard on www.soundcloud.com/sjmjournal
A DAY IN THE LIFE OF … A CRIMINAL JUSTICE WORKER

Nicola McCloskey on a typical day with Sacro’s “Another Way” service for sex workers

MY SHIFT STARTS at 9pm on a Wednesday evening. As a criminal justice worker with Sacro’s Another Way service in Edinburgh, I provide an outreach service for street sex workers, in partnership with NHS Lothian’s Harm Reduction Team. We are based in Leith, where women usually are working on the street, and offer a place of safety for women. Women access our van, where we have tea and coffee facilities and can provide emotional support, condoms, needles and other harm reduction equipment. For me, this service is assertive outreach at its best. We are not at someone’s door screaming through a letter box. We are based where women are working and make our service accessible, while remaining discrete. We work from 9pm - 12am as many women work late and a typical ‘9 to 5’ service isn’t sufficient. We tend to see between one and five women each night. Not bad for a client group known as hidden and hard to reach!

Unfortunately the reality for our client group is that the risk of assault, rape and robbery is exceptionally high

Unfortunately the reality for our client group is that the risk of assault, rape and robbery is exceptionally high. As a result, we take third party reports for women who experience any kind of abuse and can remote report this intelligence to Police. The scheme is aptly named the ‘Ugly Mug’ scheme and we provide the information to other sex workers so that they too can recognise any ‘dodgy punters’. Women use our outreach service to report any attacks and have trust that their anonymity will be secure. Street workers are typically charged by the Police under the Civic Government (Scotland) Act 1982, for loitering in a public place for the purposes of prostitution. This does stop some women from directly reporting offences to the Police and thus, it is important that women report via our service so that important intelligence does get through. Our client group continue to remain stigmatised and women report trust issues and challenges accessing services. This is a constant challenge for workers however we find that persistence pays off and women will engage when they are ready.

Thursday morning involves catching up with paperwork and recording events from the evening shift. I ensure that any required follow ups are completed, either by me or by partner services. As the service works closely with the twoProstitutes Liaison Officers in Edinburgh Police, I call them to catch up about service delivery and discuss any women who are of concern. I see clients throughout the day in and out of the office. There are a number of barriers to women accessing the service, including control from partners or pimps, trust issues and complex drug and alcohol addictions. If appropriate women can be matched with a volunteer mentor who can provide long term support.

I attend a meeting with staff from Police Scotland, NHS Lothian and other third sector organisations that has a focus on best practice, policy developments and partnership working. This has been particularly important over the recent months after the highly publicised sauna raids in Edinburgh and the removal of the Public Entertainment licenses for massage parlours.

It is particularly important for women to link in with health services, as many present with vast unmet health needs. The rates of Post Traumatic Stress Disorder are extensive and a large number of women I work with have experiences of trauma and abuse in their life. On Thursday afternoon and into the evening I am based at the Spittal Street Women’s Clinic, primarily a sexual health clinic for women involved in sex work or using drugs. I meet a number of women at the clinic, either by appointment or drop in. Support tends to focus around addictions, domestic abuse, safety while working and support to exit from prostitution. I work closely with the medical staff to ensure that we share appropriate information regarding individual clients and this holistic approach works extremely well. We have a great team that support one another to offer a ‘one stop shop’ for female sex workers. There is no ‘typical’ sex worker however many of the women I work with do have similar needs and we strive to offer a trauma informed service to all.

I thoroughly enjoy my role and feel lucky to be involved in policy and service development, volunteer coordination and most importantly working directly with service users. At the end of the day a cup of tea is always appreciated! Trust me, there is no ‘typical working day’ for me.

Nicola McCloskey is a criminal justice worker with Another Way, Sacro, Edinburgh.

Scottish Justice Matters : June 2014
ENSURING every Scottish child has the chance to live a life of potential - not of crime - is fundamental to our criminal justice system.

Our ‘whole systems approach’ creates a tailored, speedy response to young people who offend, freeing up resources to focus on more challenging individuals. Since 2010/2011 more than £5 million has been spent on enabling local authorities, police and the third sector to deliver this. Recorded crime stands at a 39 year low while detected crime by children and young people has decreased by 52 per cent between 2008-2009 and 2012-2013. Since 2006/2007 offence referrals to the children’s reporter have also fallen by 78%.

Central to this achievement is providing young people with appealing alternatives. Since 2007, Cashback for Communities has provided 1.25 million activities and opportunities for children and young people. These were all funded from proceeds confiscated from the very criminals who seek to perpetuate the cycle of crime and misery in communities.

Education is also crucial to ensuring children make the right choice. The ‘No Knives Better Lives’ initiative has seen a 60% reduction in the carrying of offensive weapons since 2007. We recognise that drugs and alcohol are all too often catalysts for criminal behaviour. The Scottish Government funded ‘Choices for Life’ initiative and Know The Score website provide drugs and alcohol education for schoolchildren, including about potentially dangerous new ‘legal highs.’ This is contributing to declining drug use among young people.

The Air Weapons and Licensing (Scotland) Bill, recently introduced, contains provisions to give police powers to disrupt illegal drinking dens where adults supply alcohol to young people.

All these measures are keeping young people out of the criminal justice system and giving them better choices and chances, no matter where they come from.

WE KNOW that many of the causes of offending can be traced back to events that occur early in life, even pre-birth. Often offenders were once to some degree a victim, if not of crime then of difficult circumstances.

Growing up in an unstable environment, for example amid poverty, abuse, parental criminality and addiction, substantially increases a child’s vulnerability to a similarly calamitous end.

Inter-generational health and social inequalities are intrinsically linked to poor educational attainment and criminality. Aged seven, children in poverty are already two years behind their peers and may never catch up.

Scottish Liberal Democrats are therefore committed to giving children the best start in life in order to create the fairer society we all want to see.

That is why our top priority during the 2014-2015 budget negotiations was early years education.

Following our campaign, the Scottish Government agreed to extend free childcare provision. 8,400 extra two-year-olds from the poorest backgrounds will now toddle through the doors of nurseries across Scotland in September, increasing to 15,000 (27% of two-year-olds) next year.

Removing impediments to learning through extending free childcare is one of the most effective ways to address the disadvantages some of our most vulnerable children and young people face. Hence we propose to target the 40% of two-year-olds from the poorest backgrounds.

Scotland’s former Chief Medical Officer, Sir Harry Burns, has highlighted how developing parents’ life skills and educating them on how best to support their families is equally important.

And for those who grow up in care, we need action to address the national shame that a quarter of those in prison come from this background, despite their comprising only 2% of the population.

We need an early intervention revolution. Lasting solutions require a spend-to-save approach, targeted where inequalities start.
Graeme Pearson MSP, Scottish Labour

**THIS CHALLENGE** demands a set of responses to be effective. Early intervention to deliver education; breakfast clubs in primary and secondary schools; vocation skills training is essential, leading to the opportunity for employment. Employment for the parents too will have a significant impact on the quality of life and a positive approach to living. Add to this a creative policing plan focused on issues affecting communities such as low level antisocial behaviour, alcohol and drug abuse and bullying, would go a long way to enhancing the personal security of young people particularly.

In that context a substance abuse strategy needs to go beyond reducing risk and supporting harm reduction. The strategy must be aimed at encouraging abstinence by humane policies seeking to address the underlying problems faced by those who abuse alcohol primarily and also drugs. Prisoners should be offered encouragement to access substance abuse courses, whilst the prison authorities should record prisoner success in dealing with their addictions. Reductions in the patients on long term medication such as methadone should be a target.

In addition, I would like to see a prisoner’s previous commitment to positive outcomes become a part of the reports received at court on any subsequent hearing and an absence of such a commitment taken account of at sentencing. Such a process would set a healthy respect for opportunities that are offered.

There will be some who are so embroiled in substance abuse all attempts to deliver abstinence may fail. We would need to accept such outcomes. The problem with the current approaches lies in the sheer cost to the public of maintaining people in their addictions without any apparent improvement at a time when there is insufficient funding for all services. We cannot and should not tolerate such an approach in future given current evidence to show that drugs deaths remain high and Scotland’s experience of alcohol and drug abuse is deplorable in spite of this Government’s strategies.

Margaret Mitchell MSP, Scottish Conservatives

**THIS IS** a complex issue with no easy “one size fits all” solution but rather, as with most inequality issues, it requires a multi-disciplinary approach.

Decision makers responsible for the provision of housing, health, education, policing and social work need to cooperate and engage in “problem solving” type discussions. Adopting this kind of holistic approach has a track record of success.

Despite this, and regardless of the potential preventative spend, the effort required and the upfront expense involved means this approach is not adopted often enough. This represents a wasted opportunity to improve young lives.

Community and school campus police have achieved some remarkable success in building positive relationships with children at risk of offending and can provide a father figure type presence, once trust has been established, where these children can seek guidance and advice.

Sadly under Police Scotland these posts are increasingly under threat with the emphasis moving away from community engagement to achieving targets.

More health visitor provision helps identify problems early to give children the best possible start in life, and educating children generally about the dangers and often horrific consequences of drug and alcohol abuse through the experiences of ex-addicts, is known to be effective.

Finally parental support is a key factor in helping children from whatever background they come from, to realise their potential, to grow into responsible adults and to try to avoid life’s pitfalls. Much more assistance should be available to parents struggling to do the hugely important parental role to the best of their ability. When things do get out of hand, a positive intervention in the form of parenting orders, which require parents to attend counselling or parenting classes, should be used.

Patrick Harvie MSP, Scottish Green Party

**FOR THREE DECADES** after the Second World War the gap between rich and poor was narrowed as a result of deliberate economic policies. Then came neoliberal economics, a wave of privatisation, deregulation, massive cuts to corporate taxes, and an ever bigger share of national wealth was hoarded by the rich minority. The politicians leading this change made empty promises that wealth would “trickle down” and everyone would benefit. It was never true.

Even now, after the catastrophic failure of this economic system, most politicians are trying to get back to business as usual instead of seeking a better way. Many cannot see beyond the ideology that free markets know best, the welfare state is bad for people, and inequality is just a law of nature. When obscenely high salaries keep on rising, the pathetic defence is that employers need to attract “the best people”. Since when did best mean greediest?

The evidence is clearer than ever from around the world that simply growing an economy, generating higher GDP, does not achieve a better society. The wealthiest are able to grab the lion’s share of the economic proceeds of growth, while ensuring that the social and environmental costs of generating it fall on others. Inequality makes us less healthy, less safe, less sustainable and less happy.

There are a host of specific policies which can close the inequality gap, from maximum wage ratios to public and community ownership of assets. We need truly progressive tax on income and wealth, and a welfare state designed to meet people’s needs instead of bullying them into low paid jobs.

But underpinning all of this is the need to measure what matters, knocking GPD growth off its pedestal and making human wellbeing our top economic priority.
ATTACK OF THE KILLER STATS!

HOW SHOCKING NUMBERS BOTH HELP AND HURT

Sarah Armstrong

HAVE YOU HEARD THIS ONE? ‘One in three black men in America is in prison.’ Now forget it, because it’s not true. Some version of this has been floating around for years. Google the words ‘black men prison’ and you will hear one-third of them is, has been or will be in prison. These are examples of the killer fact, ‘those punchy, memorable, headline-grabbing statistics that cut through the technicalities to fire people up about changing the world’ (Green, 2012). Maybe it doesn’t matter that these circulated ‘facts’ are not exactly true. The ‘one in three black men’ family of ‘killer’ stats does at least wake us up to the very real and very alarming connection between race and imprisonment in the U.S which has arguably led to policy concern and change.

However, there’s a danger to these not quite accurate truths. They create an association in our mind between two things: here it is being black and being in prison, and this association is open to a range of interpretations. Maybe it means the criminal justice system is racist, or maybe it means that black people are more criminal than people of other races, a troubling interpretation used by some as evidence for atavistic theories of crime. One need only scroll down to the comments section of an online newspaper to see how statistical evidence on nearly any topic is invoked as proof of diametrically opposed positions.

The power of the killer stat contains also a danger. They lock in certain ideas and associations, telling us something we did not know but then making it difficult to understand the problem in any other terms.

The purveyors of killer stats (and I am one of them) sometimes appear to have too much faith in the neutrality of numbers, in their power to make a self-evident, irrefutable argument. This faith neglects the fact that evidence, statistical and otherwise, is innately emotional and will be read through one’s own life experience, values and belief systems. I am endlessly surprised when a killer stat I use, that shoplifting is one of the most common reasons people go to prison in Scotland, leads some to conclude that Scotland has a particularly nasty breed of criminals, the proof of which being how many shoplifters end up inside. If you believe that Glasgow is the murder capital of Europe (it is not, and what a silly concept), you are likely to be looking for evidence of Glasgow hardness in any crime stats on Scotland.

Scotland, prison and social deprivation: the Houchin Report’s killer stat

A well known killer stat about Scotland distils the relationship of punishment and social exclusion. It comes from a report by former prisoner governor and Glasgow Caledonian University academic Roger Houchin (2005). He wrote:

‘There are 1222 local government election wards in Scotland. The home address of one quarter of the prison population of 6,007 is in just 53 of those wards’ (p. 15). He adds that, ‘A further quarter [of the prison population] come from the next 102 wards.’

These quotes are a likely source for a speech given two years later by Cabinet Secretary for Justice Kenny MacAskill in which he launched the Scottish Prisons Commission:

‘One study indicated that half of our prison population comes from 15 per cent of Scotland’s poorest council wards’ (MacAskill, 2007).

In fact, the concentration looks even worse than this: adding together Houchin’s killer stats shows that half the prison population came from 155 wards out of 1222, or just 13% of local election wards.

However, it is worth noting that a number of these election wards are densely populated so that the 13% of wards where half of prisoners come from account for nearly 900,000 Scottish residents, or almost one fifth of the entire population. What at first looks like extreme concentration of the prison population to a handful of neighbourhoods, is not quite so extreme when set in the context of how many people are living in these neighbourhoods. In other words, half the prison population are coming from places where 20% of the total Scottish population lives. Maybe this tells us as much about population density in deprived communities as it does about prison populations.

It is interesting that in MacAskill’s speech ‘local government election wards’ has been translated as ‘poorest council wards’ (MacAskill, 2007). Houchin’s report does not quite say this; he notes that a small number of areas account for a large portion of prisoners. He does say a bit later that ‘the imprisoned population comes disproportionately from the most deprived communities’ (p.17), and that there is a ‘linear correspondence’ of this theorem: the greater the rate of deprivation of a given area, the higher its rate of imprisonment (p. 17). So MacAskill’s killer fact, like most, has a few technical inaccuracies but gets across the larger, and statistically validated, point that poverty and prison are connected. But what is the connection and what are the possible misinterpretations of these killer data?
Two associations against which we constantly struggle are first that poverty causes crime, and, second, that poor people are more criminal than other people. Unfortunately, Houchin's killer stat is perfectly positioned to be called on to support either of these two views. People in prison often come from deprived neighbourhoods, does it not follow that people with less money are committing more crime (and hence ending up in prison at higher rates)?

Dig a bit deeper into Houchin's analysis and we see that social deprivation does not seem to hold all the answers. 'Social deprivation is not as concentrated in Edinburgh as it is in Glasgow. Neither is imprisonment. Nor is the imprisoned population as concentrated in Edinburgh in the areas of highest deprivation' (p. 43). Patterns of poverty and imprisonment vary by area suggesting that something about cities and neighbourhoods, and equally about the ways in which they are governed, holds a portion of the answer. The longitudinal study being conducted by Edinburgh criminologists has already begun to suggest that crime and punishment levels say much more about criminal justice official activity than about any underlying difference in people’s behaviour (ESYTC).

In place of the poverty=crime or criminality thesis, and the ready appeal of its cause and effect logic, Houchin’s analysis urges a shift in how we understand imprisonment itself, not as the result of individual choices or structural factors but as a feature of social environments. Just as people living in the most deprived areas are required to put up with lower air quality, poorer schools, so do they also face a greater risk of imprisonment. This is truly a killer idea that shakes up the way criminologists, the media and policy makers think about punishment.

The power of the killer stat contains also a danger. They lock in certain ideas and associations, telling us something we did not know but then making it difficult to understand the problem in any other terms. Can Americans hear the word ‘prisoner’ without visualising a black face? Can Scots do so without seeing a ‘poor’ person?

It has been nearly ten years since the Houchin report came out, and it would be an interesting exercise to update its findings. Its killer stat was heavily covered in the media and has had wide influence since then, showing the power of capturing a hidden social reality in a quotable statistical fact. Houchin also found that 269 local council wards, or areas covering a population of over 800,000 people, sent no one to prison. Maybe this is the killer stat we should be publicising and explaining.


Edinburgh Study of Youth Transitions and Crime (ESYTC)
http://www.esytc.ed.ac.uk/
Scottish Justice Matters: June 2014

BOOK REVIEW

Poverty in Scotland 2014. The Independence Referendum and Beyond
John H McKendrick, Gerry Mooney, John Dickie, Gill Scott and Peter Kelly.

POVERTY IN SCOTLAND 2014 takes a closer look at the changing political landscape within Scotland and outlines the evidence in relation to poverty, its main dimensions, dynamics and its uneven social and geographical impacts. Ultimately the book successfully challenges the myths perpetuated about poverty and those who live in poverty. The book is divided into six sections covering the nature of poverty, the evidence, welfare and constitutional questions, principles for a more equitable Scotland and perspectives from Europe and beyond.

In his introduction, Gerry Mooney highlights the regressive austerity measures currently being implemented in the UK. From the first page, Mooney completely undermines the idea that ‘we are all in this together’ and points to the disproportionate impact of current welfare reform on women, children and other groups in the population. He concludes that the problem is ultimately not the amount of resources we have but the distribution of that wealth (p.10).

The first half of the book focuses mainly on statistical measures of poverty. There is a lot of clear evidence both presented and explained. However, there could have been room for more qualitative evidence reflecting the voices of those living in poverty, to give a voice to the numbers as it were. In chapter eight, John McKendrick interweaves quotes from people living on a low income. This is very effective in highlighting the stark reality of life for many people. The book would have benefited from more of a mix of qualitative and quantitative evidence.

As the latest in a series that began in 2002, this edition focuses on the Scottish Independence referendum in September 2014. The authors’ consideration of what this means for Scotland and its potential future is particularly engaging. The arguments for and against are presented directly in section four.

Chapter six contrasts the Scottish Government’s commitment to reduce income inequality by 2017, with the reality of its persistence. What then makes the book refreshing is that it is followed by a full section on key principles to address and reduce poverty, insecurity and inequality. Chapter 16 by Stephen Boyd, stands out: it outlines the salient issues of wages, the labour market and low pay, pointing out that “It is difficult to conceive of an agenda so damaging to the interests of workers and communities while being so irrelevant to the challenges facing the economy” (p.213). Throughout the book gender inequalities are highlighted, and then brought together by Angela O’Hagan (Chapter 19) to show that despite current promises of “jam tomorrow’, the bread is cut pretty thin in 2014” (p.233).

Section five, on principles for a more equitable Scotland, echoes Wilkinson and Pickett’s (2010) argument that everyone benefits from more equal societies and takes this further, as all the authors are passionate about the ability to address the persistence of poverty.

The book also contains some interesting and pertinent explorations of international contexts of poverty and anti-poverty policy. The insight gained from looking at Spain, Belgium, Germany, Ireland, Canada and the Nordic states constitutes a real bonus in section six. It reinforces the idea that the status quo can change and Scotland can learn a lot by looking at the pitfalls and successes of other countries.

For those teaching social policy, social justice or anything related to inequality and poverty this book is recommended. The chapters are ‘bite-size’ and perfect for student reading while not being overwhelming. There are also several tables that will be very useful for teaching undergraduates the factors relating to poverty in a clear and helpful way. While social justice as a concept is not directly dealt with, matters relating to it are interspersed and I would place this as a must read for anyone interested in social justice.

Overall, the book presents more than simple a picture of poverty: it highlights the importance of political decisions and the steps that need to be taken to tackle poverty, which, in the words of Nicola Sturgeon at the book’s launch, is a “badge of shame on everybody”. On this note, Poverty in Scotland 2014 successfully brings attention and a renewed focus to the root causes of poverty in Scotland.

Vikki McCall is lecturer in social policy (housing), School of Applied Social Science, University of Stirling.

Scottish Justice Matters: June 2014
BOOK REVIEW

Understanding Penal Practice.

A BOOK aiming to increase our understanding of penal practice without concentrating primarily upon prisons is to be welcomed. Focusing on community supervision this volume scores a hit from that perspective alone. However, the book has a broader ambition: it seeks to shift the debate from ‘what works?’ to ‘who works?’ by considering where community supervision practitioners are drawn from, how they are trained, and what motivates them. The subsequent question is: how can they be supported to work better? To achieve this shift the editors challenge us to move beyond merely evaluative to more critical and exploratory research, and offer us the work of internationally renowned academics and practitioners.

The book is divided into two sections. The first includes contributions from America, Japan, Canada, Romania, France, Germany, Belgium and the UK. Chapters encompass the ideologies of probation and parole systems, staff training, motivation and organisational pressures, volunteers, the perils of siting probation within prison services, and the importance of relationships to probation. It also addresses quality in probation practice and the role of social work within the criminal justice system.

The second part, concerned with what practitioners need to improve practice, is also geographically diverse, including a Europe-wide perspective deriving from the European Probation Rules. This part focuses on how professionalism is defined and developed, highlighting the crucial link between supervision skills and outcomes, and considering specific tools to aid engagement and effective practice.

This is a volume of many strengths: it is well-structured and keeps its focus on practitioners to enable in depth consideration. Many authors are engaged in ongoing and innovative research, which provides an immediacy consistent with the desire to move practice forward. The down side of reporting current research early (e.g. Durnescu et al, Hermanns et al) is that the evidence may be somewhat tentative, but can nevertheless suggest new ways to understand the core motivation, professional skills and ultimately the effectiveness of probation practitioners.

The book is timely in the Scottish context, when community justice is being closely scrutinised and is about to undergo a major transformation. McNeill’s chapter on criminal justice from a Scottish social work perspective offers an insight into professional cultures and identities which may be especially relevant. Key themes in community based penal practice that apply across jurisdictions emerge very clearly, including the shift towards evidence based practice and the importance of desistance theory. The predominance of the risk-needs-responsivity model (RNR) and the importance of relationships recur in several chapters, providing a contemporary context. There is also a welcome focus by several authors upon the practicalities of helping probationers or parolees to desist from offending. Housing, friends and family, debt advice, the problems of illiteracy and dyslexia are all identified as needs to be met by referrals to appropriate services. This reminds us that no matter how well motivated, trained and supported, penal practitioners cannot do the job alone. Thus, Vogelvang urges the adoption of a ‘support paradigm’ to promote social inclusion, consisting of a series of networks with the offender at the centre.

‘What works?’ is not a foolish question, but taken on its own is limited, and it is instructive to engage with research going beyond evaluation. The various projects described in

Understanding Penal Practice involve a wide range of methodologies: interviewing, observational and mixed methods research along with appreciative inquiry in both the Shapland et al chapter on quality in supervision, and Liebling and Crewe’s chapter on prisons, which reports fascinating results about the nature and quality of relationships between professionals and their clients, and, like other chapters, inspires further reading on the subject.

The book is about professional practice with offenders but the offender is something of a silent partner despite the argument that desistance is co-produced (Weaver). If involved, the offender is simply observed either directly (Phillips, Trotter), in video analysis of interviews (Ugwudike et al), or in a fictional case study used by Chu et al to exemplify the Good Lives Model. This muted voice sits uneasily with emphasising the importance of relationships although, as Weaver acknowledges, it reflects the book’s focus on practitioners.

From the outset the editors were clear about their aims. The project is well-conceived and well executed and has resulted in an important collection that should be read by policymakers and community justice practitioners, in addition to a broad range of academics.

Dinah Aitken is a studying for a PhD at the University of Edinburgh.
HMP and YOI Grampian, the new prison replacing Peterhead and Aberdeen, opened in March: some disturbances have been reported.

The Scottish Crime and Justice Survey 2012-2013 published in March showed a continuation of decreasing trends overall in crimes and the risk of victimisation. 66% respondents agreed that community sentencing is an effective way of dealing with less serious crime and that prisons are effective at protecting the public from crime (68%).

Double jeopardy rule reform: COPFS has applied for permission to re-try those accused of the murder of Surjit Singh Chhokar in 1998 and will proceed against the accused in the ‘World’s End’ murders of Christine Eadie and Helen Scott in 1977.

Opponents of a minimum unit price for alcohol succeeded in obtaining a referral by the Court of Session to the European Court of Justice, thereby further delaying implementation of the Alcohol (Minimum Pricing)(Scotland) Act 2012.

While Police Scotland continued prioritisation of policing domestic abuse by announcing plans to launch a pilot of ‘Clare’s Law’ allowing disclosure of previous abuse on application, long delays for the specialist domestic abuse courts are ‘unacceptable’ according to Scottish Women’s Aid.

Sacro announced the national roll-out of Circles of Support and Accountability following the publication of an evaluation of the pilot project in Fife by SCCJR researchers.

Criminal justice social work statistics show that in 2012-2013 completion rate for social work orders was 69%, up from 59% in 2008-2009.

Disquiet over police stop and search continued (see Kath Murray’s research article in SJM3), resulting in a tightening up of procedures by Police Scotland. A report on the matter by the Scottish Police Authority published as we went to press, found that “if appropriately used, stop and search can play a part in helping detect and prevent criminal and anti-social behaviour. However, there are risks in the way the tactic is applied and how this affects different groups, particularly young people and different communities” and makes a number of recommendations. Read Kath Murray’s comments in her blog on our web site in which she concludes that “the real issue at stake here is police legitimacy and democracy” and that “it now falls upon the Scottish Government to modernise and regulate stop and search practice in Scotland” (http://scottishjusticematters.com/call-police-stop-search-legislation/)

History extra coming in September

As an extension of our health and justice theme, Anna Forrest, former librarian of the Royal College of Physicians and Surgeons of Glasgow, will be writing for Scottish Justice Matters on the mid-19th century “Glasgow System” This was a local approach to the ‘control’ of prostitution and therefore venereal disease, formed by an alliance between the medical authorities and the police. It was a regime of repression, subjecting women to painful, forced examination and then possible admission to the Lock Hospital, the Magdalene Asylum or processing through the courts. Curiously, Anna has found that a substantial number of the ‘special’ officers recruited to enforce this system, were to require treatment themselves.

Keep in touch with SJM through our newsletter (email: Helen Rolph at scccj.info@ntlworld.com) and on Twitter at www.twitter.com/SJMJournal
Current legislation

Air Weapons and Licensing (Scotland) Bill
This Bill was introduced in May to "make provision for the licensing and regulation of air weapons" and other licensing matters relating to alcohol. The regulation of air weapons was an SNP manifesto commitment in 2007 and 2011, and the right to legislate was implemented by the Scotland Act 2012.

Criminal Justice (Scotland) Bill
“A Bill . . . to make provision about criminal justice including as to police powers and rights of suspects and as to criminal evidence, procedure and sentencing" and other matters. Most media attention continues to be directed at the provisions to implement the proposal in the Carloway Review, to reform the Scottish evidential tradition on corroboration.

The Justice Committee’s Stage 1 report published in February supported the general principles of the Bill with the exception of the corroboration proposals. A late announcement, by the Cabinet Secretary, that a reference group under Lord Bonomy was to be set up, to consider what additional safeguards and changes to law and practice may be needed in when the corroboration requirement is abolished, came too late for the report (see John Blackie’s article in this SJM). Although the Bill then cleared Stage 1, a surprise announcement in April, in heated exchanges at Holyrood, postponed Stage 2 and therefore any further progress, until after the Bonomy group reports.

Criminal Verdicts (Scotland) Bill
This Member’s Bill was introduced by Michael McMahon MSP on 27 November 2013 to “make provision for the removal of the not proven verdict as one of the available verdicts in criminal proceedings; and for a guilty verdict to require an increased majority of jurors”.

No other information is available at the time of writing.

Proposed Human Trafficking (Scotland) Bill
Jenny Marra MSP’s proposals for legislation fell in March when the Scottish Government served notice that it was proposing to bring forward its own Bill on these matters.

See the www.cjscotland.co.uk database for regular updates on what is happening in Scottish criminal justice.
Contact sccj.info@ntlworld.com to subscribe.

Events

Experiencing Prison: Past, Present and Future
Keynote Speaker: Jamie Bennett
Jamie Bennett has worked in prisons since 1996 and he is currently Governor of HMP Grendon & Springhill. His lecture takes place in Lecture Theatre 270 at Old College, University of Edinburgh, 5:30pm on 11 June 2014.
For details visit eventbrite.com or email: louise@howardleaguescotland.org.uk.

Crime and Justice: A Vision for Modern Scotland
Apex Scotland Annual Lecture 2014
Prof. Lesley Mc Ara, will deliver the annual Apex lecture on 2 September at Edinburgh’s Signet Library. At this free event, Prof McAra will look at the implications of the Edinburgh Youth Transitions Study and challenge current thinking on justice approaches, especially assumptions around the value of some interventions.

Cross-Party Group on Children & Families Affected by Imprisonment
The next dates and provisional topics for the Cross-Party Group on Children & Families Affected by Imprisonment are as follows:

2014
11 June: NSPCC research into babies with a parent in the criminal justice system
13 August: Women and the Justice System (as people who offend and as families/partners of people who offend); the timing will inform the Scottish Government’s report on the progress of recommendations from the Angiolini Commission
1 October: Q&A with Colin McConnell, Chief Executive of Scottish Prison Service
3 December: Kinship Care (provision speaker: Anne Schwartz, Kinship Care Alliance Scotland)

2015
4 February: AGM, and Relevant aspects of the Children & Young People Act
4 April: (TBC) Q&A with David Strang, HM Chief Inspector of Prisons
3 June: International input and good practice, coinciding with European Prisoners’ Children Week
All meetings take place at Parliament on Wednesdays from 1pm-2pm. Please contact Michelle.Martin@familiesoutside.org.uk so she can circulate relevant papers to you.

Sir Harry Burns:
Sacro Annual Lecture 2014
Former Chief Medical Officer, Sir Harry Burns, will give the annual Sacro Lecture in Edinburgh’s Playfair Library, 21 October. www.sacro.org.uk.

Lord Carloway:
The Howard League Scotland Drummond Hunter Lecture
Lord Carloway, the Lord Justice Clerk will deliver the Drummond Hunter Lecture in Edinburgh’s Playfair Library, 22 October. www.howardleaguescotland.org.uk.

“Crime, Justice and Community”
SASO Annual Conference
Dunblane Hydro is the venue for the Annual Conference of the Scottish Association for the Study of Offending on 14 and 15 November 2014. Chaired by Lady Rae, speakers include: The Rt Hon Henry McLeish, Sir Harry Burns, Lesley Thomson QC, Professor Mike Nellis, Justina Murray, Bridget Campbell, Christine Scullion, Hans Dominicus and Catherine Dyer.
The Annual Conference of the Scottish Association for the Study of Offending (SASO) is Scotland’s leading criminal justice conference and brings together all the leading participants in the Scottish criminal justice system: Judges, Sheriffs, JPs, social workers, police, prisons, the voluntary and statutory sectors, central and local government, academics, fiscals, children's hearings members, as well as interested individuals. The atmosphere is friendly and informal and there are great opportunities for networking across the criminal justice system.

This year the title of the Conference is Crime, Justice and Community and it will look at a wide range of issues on justice in the community.

The Conference attracts outstanding speakers. This year speakers include:

- The Rt Hon Henry M’Leish (formerly First Minister),
- Sir Harry Burns (formerly Chief Medical Officer for Scotland),
- The Solicitor General (Lesley Thomson QC),
- Professor Mike Nellis,
- Justina Murray (SW Scotland Community Justice Authority),
- Bridget Campbell (Director, Justice Directorate, Scottish Government),
- Christine Scullion (The Robertson Trust),
- Hans Dominicus (Belgian Ministry of Justice).
- The Crown Agent, Catherine Dyer will lead an interactive session on the work of the fiscal service.
- The Conference will be chaired by the High Court Judge, Lady Rae.

All those with an interest in the Scottish criminal justice system are very welcome to attend.

Registration forms can be downloaded from the SASO website or obtained from the SASO Administrator by e-mailing info@sastudyoffending.org.uk

**Registration rates:**
- Residential: £365 (Non-Statutory Sector & Individuals £260);
- Non-Residential: £190 (Non-Statutory Sector & Individuals £80); Student £38

www.sastudyoffending.org.uk