NHS Health Scotland

Reducing offending, reducing inequalities

Achieving 'better health, better lives' through community justice

NHS Greater Glasgow and Clyde

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Published by NHS Health Scotland

1 South Gyle Crescent
Edinburgh EH12 9EB

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NHS Health Scotland is a WHO Collaborating Centre for Health Promotion and Public Health Development.

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Acknowledgements

Ruth Parker: Head of Health & Wellbeing, Scottish Prison Service.
Lee Knifton: Mental Health Foundation.

Chapter 1: Introduction and rationale

NHS Boards in Scotland are all-purpose organisations: they plan, commission and deliver NHS services and have a duty and responsibility for the health of their populations. The vision for health and care in Scotland is that:

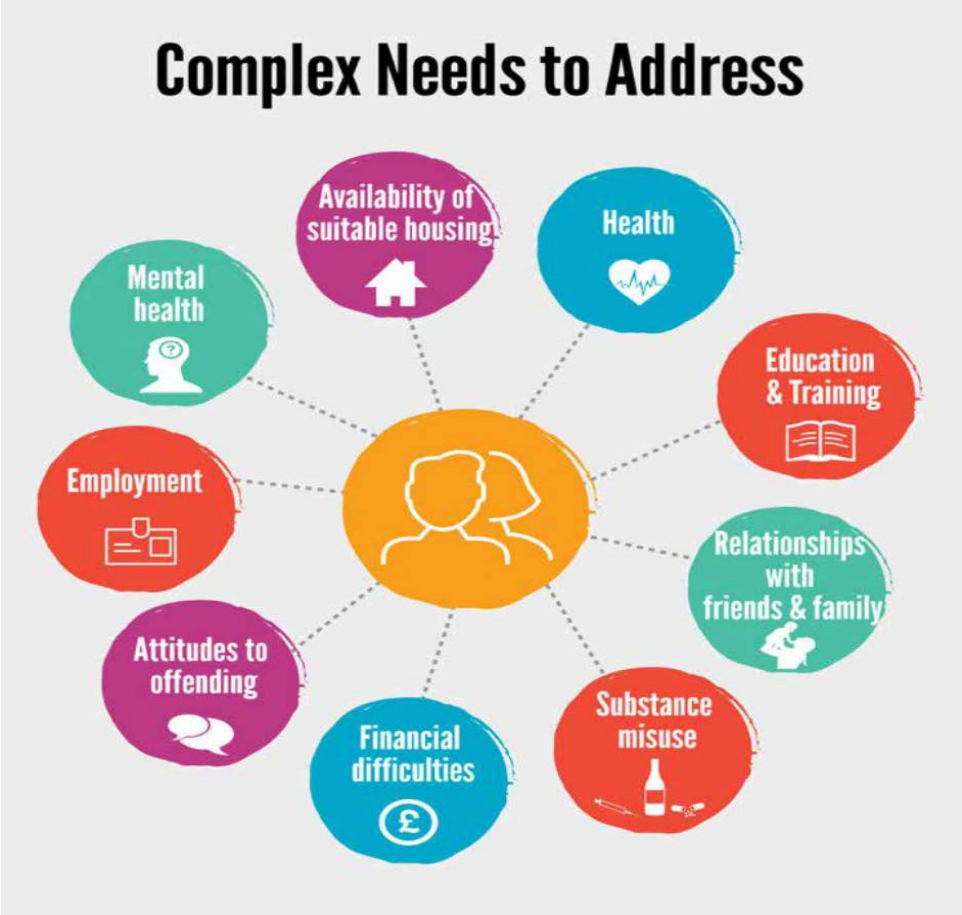
> ‘by 2020 everyone is able to live longer, healthier lives at home, or in a homely setting’.

Underpinning this are core values committed to by NHSScotland. These values are collaboration, co-operation and partnership working across NHSScotland, with staff, patients and with the voluntary sector; continued investment in the public sector rather than the private sector; increased flexibility, provision of local services; and openness and accountability to the public.

NHS Boards work closely with their partners including patients, staff, local authorities and the voluntary sector to deliver effective healthcare services and to safeguard and improve the health of their residents and individuals under their care. This care includes individuals with a number of complex needs (see **Figure 1**), for example: people with histories of trauma and violence; people with substance use and mental health issues (often in tandem); people who are at risk of homelessness or who are homeless; refugees and asylum seekers; and those in contact with justice services. These needs cannot be addressed by health interventions alone.

In considering the drivers and consequences of offending, the social patterns and inequalities behind this challenge provide a common series of drivers and levers which a range of partners both within community justice and beyond in wider universal public services can utilise as a rationale for collective action. This document, while not a systematic review, collates some of the evidence across a range of highly varied determinants related to health and offending to provide a foundation for increased focus on health, justice and inequality. This first section introduces and frames the relationship between offending and inequalities across key domains as our impetus for more collective local action on health and community justice.

Figure 1: Example of complex needs of people in the healthcare system.



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NHS Health Scotland: our approach

NHS Health Scotland is a national Health Board working with and through public, private and third sector organisations to reduce health inequalities and improve health. We are committed to working with others and provide a range of services to support our stakeholders take the action required to reduce health inequalities and improve health. Our vision[1] is a Scotland in which all of our people and communities have a fairer share of the opportunities, resources and confidence to live longer, healthier lives. Our mission is to reduce health inequalities and improve health. To do this we influence policy and practice, informed by evidence, and promote action across public services to deliver greater equality and improved health for all in Scotland.

Health inequalities[2] are the unfair differences in people's health across social groups and between different population groups. They represent thousands of unnecessary premature deaths every year in Scotland, and for men in the most deprived areas nearly 24 fewer years spent in 'good health'. These circumstances disadvantage people and limit their chance to live a longer, healthier life. We believe that health inequalities are unfair and avoidable. To reduce health inequalities we need to act across a range of public policy areas, with policies to tackle economic and social inequalities alongside actions with a specific focus on disadvantaged groups and deprived areas.

Health inequalities do not exist in isolation. The broader pattern of income inequality, the state of the economy, welfare reform and the impact of recession on poverty and health provide an important context for our work. Building on the inherent strengths of communities and individuals must also, therefore, be part of the solution, as well as providing better support for the integration of local services and the involvement of communities, families and individuals in those services. We also need to shift the focus from meeting the cost of dealing with health or social problems after they have developed to prevention and early intervention. At the same time, our population is changing and people are living longer. We need to make sure that longer life means longer, healthy life – adding quality of life to years as well as years to life. We need to make sure that the benefits of investing in prevention and early intervention are understood and acted on.

In order to achieve this, key actions we promote include a drive towards a fairer share of income, power and wealth through policy, legislation, regulation and taxation. We should ensure fair and equitable access to good-quality housing, education, health and other public services. To deliver this we must also ensure all public services are planned and delivered in proportion to need.

This, therefore, makes community justice everyone's business to improve, and NHS Health Scotland in planning current and future work increasingly recognises that forging new links with this policy area and making best use of the new and established frameworks which drive this agenda will be crucial to our success in reducing inequality in Scotland.

The parallels with our approach to reducing inequality and the opportunities the new vision for community justice present are exciting. The experience of individuals in contact with the justice system is all the more acute, compounded or chronic in its negative inequalities impact. The wider impact should also be noted on victims, families and communities. This is borne out in the following section describing some of the social patterns found within individuals who offend.

The social pattern of offending

While a sizable population of those who offend in Scotland are sentenced through non-custodial and community disposals, the health and social care needs of those in prison custody are an indicator of some of the social patterns that health and justice together might impact on. While many of the findings below are recorded at different times and from both Scotland and the wider UK prison population and are constantly being updated, they contribute to a complex picture of rights and needs.

As at April 2017 there were just under 7,500 prisoners (excluding home detention curfew) in prison custody.[3] The average daily prison population for 2014/15, as an example, was 7,731. Just over 1,500 (20%) of those were prisoners on remand – either awaiting trial or sentencing. Just over 6,200 (80%) were prisoners with sentences, of which 55% were serving sentences of less than four years in length. The current prison population projections suggest that the daily prison population in Scotland will remain stable, with an annual average of 7,800.[4] This equates to a rate of around 141 per 100,000 – the second highest in Western Europe after England and Wales.[5]

The risk factors that increase an individual's likelihood of offending and receiving a custodial sentence are defined by wider societal inequalities. The social patterns found within prisoners indicate both inequalities and missed opportunities to intervene and prevent offending. There are, for example, very high correlations between income inequality, low social mobility, teenage births, imprisonment, levels of trust, mental health problems and, as an indicator of poor physical health, high levels of obesity.[6]

Income

Scotland's prison population predominantly reflects our most socially deprived communities. Although less than 1% of all children are in care in Scotland, looked-after children account for more than 25% of all people in prison.[7] At UK level, the families of those imprisoned relatives have stated their debts increase during the period of incarceration. Where families have a poverty of aspiration, the likelihood of generational offending within family groups will be high. The experience of poverty does not directly lead to a prison sentence but rather the interrelationship between poverty, social exclusion and other socially restrictive factors enhances this risk.

In England and Wales, around 50% of all prisoners have a history of debt, with one-third never having had a bank account.[8] In a study of English and Welsh prisoners' experiences of education, 47% of all those sampled had no formal qualifications compared with 15% of the general population.[9] More than 20% of this prison population needed support with reading, writing and basic arithmetic. A total of 41% of men, 30% of women and 52% of young men in the English and Welsh prison system were permanently excluded from school.[10]

When also considering the prison population in relation to the legally protected equalities characteristics of the Equality Act 2010,[11] the relationship between prison and experience of inequality becomes even starker.

Age

As at 30 June 2013 (the latest available publication date) around 59% of prisoners were under the age of 35 and just over one-fifth of prisoners were under the age of 25.[4] There are over 300 older Scottish prisoners (over 65, with the oldest in 2015 aged 87[12]) who are likely to have a physical health status 10 years older than their counterparts in the community[13] and will experience life-reducing health concerns at a younger age.[14] A total of 54% of older prisoners have also been estimated to have a disability.[15] Given people aged 60 and over are the fastest-growing age group in the prison estate,[16] the challenges associated with responding to the needs of older prisoners is likely to become more pressing in the future.

Disability

Around 20% of prisoners have a physical disability.[16] An estimated 20%–30% of all prisoners also have a learning difficulty/disability that interferes with their ability to cope with the criminal justice system[17] (75% of prisoners with a learning disability have difficulty reading prison information[18]). A Scottish Prison Service (SPS) Health and Social Care Needs Assessment has recently been published to determine how best to meet growing need around both age and disability within prison establishments.[19] This is also an area of ongoing research to establish models of care and pathways tailored to these needs.

Race and ethnicity

Scotland has a low rate of black and ethnic minority prisoners compared to the UK; however, 26% of the UK prison population are from a minority ethnic group. As at June 2013, the Scottish prison population was just over 96% white. Prisoners from Asian or black ethnicities accounted for just over 3% of the population. Around 0.5% of prisoners were from mixed or other ethnicities. The Scotland Census 2011[20] suggests that the proportion of prisoners classified as being from a white ethnicity is the same proportion found among the general population. The proportion of people from Asian or black ethnicities within the general population differed from the rate of the prison population. It was found that 2.5% of the population was from an Asian ethnicity, whereas 1.7% of the prison population was classified as Asian. People from black ethnicities accounted for 0.6% of the population, although they accounted for 1.4% of the prison population.

This compares to the UK prison population, where 10% are black and 6% are Asian. This is significantly higher than the 2.8% of the general population they represent. In England and Wales, black prisoners account for the largest number of minority ethnic prisoners (49%). At the end of June 2014, 28% of minority ethnic prisoners were foreign nationals.[21] This led the Equality and Human Rights Commission to conclude that there are greater proportions of black people in UK prisons than in prisons in the United States.[22]

As at 30 June 2013, just over 4,600 prisoners (58% of the prison population) in Scotland indicated that they held religious beliefs. Of these, 93% were Christian (of various denominations). Muslim prisoners accounted for 4.4%. Together Buddhist, Sikh, Jewish, Hindu and other religions accounted for 2.7% of the religious prison population. Just over 3,270 prisoners (42% of the prison population) held no religious beliefs.

Gender

Between 2004/5–2013/14, the average daily Scottish prison population increased by 17%.[23] The number of male prisoners increased by around 16% and female prisoners by 30%. Female prisoners averaged around 5% of the average daily prison population over the period. While men account for the largest percentage of prisoners (95%), the number of women in prison has significantly increased over the last 20 years.[24] Most women entering prison have committed a non-violent offence, with 41% sentenced for theft or handling stolen goods (see table A2.2B in referenced document).[16] Two-thirds of female prisoners report committing offences to get money to buy drugs,[25] with around half of women in prison doing this to support someone else's drug use.[26] Alcohol and drug use, therefore, is a key strand of this document, for both men and women. A small number of transgender individuals are also present in prison custody,[27] which creates both a challenge and an opportunity to improve equality-sensitive practice and care.

Other significant socially driven health and wellbeing issues also appear to be stark within both the prison population and wider populations at risk of offending.

Sexual health, pregnancy and parenting

People who offend often disproportionately have a background of family breakdown, poor nurturing and abuse during childhood. Young people involved in offending are particularly at risk of becoming teenage parents. In 2014, 26 women were pregnant while in prison and 10 women gave birth while serving a sentence in Scotland. In 2015, this reduced to 14 pregnant women and six births.[28] The greater majority are in HMP Cornton Vale, with much smaller numbers in HMP Grampian. A majority of English and Welsh prisoners are parents – 54% have children under 18 when they

enter custody while two-thirds of women prisoners are mothers.[29] More children are impacted by a parent's imprisonment than are affected by divorce. The 200,000 children with a parent in prison in England and Wales is three times the number in care and five times more than are on the Child Protection Register there. Children can consequently suffer a range of problems during their parent's imprisonment such as depression, hyperactivity, aggressive behaviour, withdrawal, clinging behaviours, sleep problems and other associated mental health problems.

The challenges for young men and women associated with being a parent are also exacerbated by involvement in the justice system.[30] Issues such as repeat teenage pregnancy raise issues for partners in education, housing, social work, justice and health, and reinforce the determinants of inequality. Potentially this can also create or further complicate a cycle of poverty, exclusion and offending that young people can find themselves caught within.

Alcohol use

Scotland has a complex relationship with alcohol and drugs misuse. Just under half (45%) of Scottish prisoners in 2013 reported being drunk at the time of their offence.[31] Over half (59%) of victims of violent crime thought that the person who offended was under the influence of alcohol.[32] Over one-third (38%) of the total of 77 persons accused in homicide cases in 2014–15 were reported to have been under the influence of alcohol and/or drugs at the time of the homicide. Of these 77, 11 (14%) were under the influence of alcohol, two (3%) were under the influence of drugs and 16 (21%) were both.[33] Nearly 70% of assaults in A&E are alcohol related. Alcohol, along with drug use, has both an attributable link to violent behaviour and contributes to offending.[34]

Research with young people in prison has suggested that as many as 80% believed that their alcohol use had contributed to their offending.[35] The SPS's regular survey of prisoners suggests that around two-thirds of young people were under the influence of alcohol when they committed their most recent offence.[36] Around eight out of 10 had used drugs in the 12 months prior to entry to prison and half reported being under the influence of drugs at the time of their most recent offence.[37]

Drug use

The links between crime, deprivation, and high alcohol and drug use are strongly related.[38, 39] Because the drug-using population is hidden, prevalence figures can only ever be estimates. The prevalence of drug misuse can be derived from numerous sources, for example: from surveys (among the general adult population, school children and prisoners); drug offences and drug seizures recorded by the police; drug testing in prisons; and drug users coming into contact with healthcare providers because of their drug use or coming forward for treatment.

From late-teens onwards, the progression from experimentation to regular and then problem drug use is strongly linked to socioeconomic disadvantage. Alcohol and drugs may therefore be viewed as both a symptom and cause of the health inequalities within Scottish society. A study of drug-use hospital admissions in 2003–4 showed that the admission rate in the most deprived quintile was 17 times higher than in the least deprived quintile.

Of the 1,026 tests carried out when entering prison (reception) in 2016/17, 79% were positive for drugs (including drugs prescribed as part of a treatment programme) and 76% were positive for illegal drugs (including illicit use of prescribed drugs). Since 2010/11, the percentage testing positive for illegal drugs when entering prison has been relatively stable, ranging between 70% and 77%. The drugs most commonly detected when entering prison in 2016/17 were cannabis (47% of tests (52% in 2015/16)), benzodiazepines (41% of tests (35% in 2015/16)) and opiates (codeine, morphine, dihydrocodeine or heroin) (33% of tests (25% in 2015/16)). Cocaine presence increased from 15% of tests in 2015/16 to 20% in 2016/17. Selected opioids (buprenorphine, methadone and tramadol) were subject to specific tests – of these, the most commonly detected was buprenorphine (10% of tests (7% in 2015/16)).[40]

Mental health

Higher prevalence of mental health conditions and illness is recorded in lower socioeconomic groups, in deprived communities and disadvantaged groups; especially those who have experienced trauma, bullying, social isolation, stigma and

discrimination. Ability to recover and lead a fulfilling life is also affected by these social factors. The stigma associated with having a mental health problem can exacerbate any existing risk factors and create circumstances wherein such problems thrive, while exposure to protective factors and recovery become increasingly challenging.

A high proportion of people in contact with justice services have mental health problems.[41] Low socioeconomic status has a strong correlation with offending behaviour. Around 53% of women and 27% of men in prison report having experienced emotional, physical or sexual abuse. A total of 46% of women report a history of domestic violence.[42] Approximately 50% of female prisoners and 25% of male prisoners also suffer from depression or anxiety,[25] with 25% of women and 15% of men reporting symptoms indicative of psychosis.

It is also well documented that the prevalence of psychiatric morbidity is higher among prisoners than in the general population[43] and increases in prison population numbers means there are more people in prison with such problems,[44] representing a population at significant risk of injury or fatality.[45]

Given the social patterning above relating to those in prison, the task of strengthening social justice (rather than solely mitigating negative impact) is paramount. The second part of this section proposes how action can be taken forward to prevent, mitigate and more effectively manage offending within the context of health inequality. It is intended for use by local community justice partners, in particular those co-ordinators and staff who lead on planning and aim to ensure health planning and service engagement and commitment to collective action. It emphasises the opportunity in the common aims, approaches and common purpose which partnership and integration can contribute to strengthen our response to the community justice challenge.

Reducing offending and reducing inequality

A reduction in social exclusion, inequality and discrimination requires the concerted efforts of a diverse range of stakeholders, not least those people most affected by imprisonment. It is a complex problem that often lies more at a structural, rather than an individual level. There is an imperative for an effective partnership approach, which aims to tackle inequality and achieve common outcomes. It is only through partnership that Scotland has the ability to impact a reduction of offending by tackling the determinants of crime rooted in inequality.

Community justice partners, in particular, can contribute to improvements in health and a reduction in offending through collective action. This document also aims to assist integrated health and social care services acting as justice partners who support local community justice chairs and co-ordinators in prioritising effective and evidence-informed actions to improve health, reduce the likelihood of offending and thereby work together to reduce the inequalities that damage individuals and communities.

Collaborative action is required on the multiple determinants that we know contribute to a likelihood of offending. We have to work together effectively to reduce the negative impact of such behaviours and use the new model for community justice as an opportunity to steer individuals, families and communities towards hope, recovery and resilience. This can be achieved with co-ordinated effort across the pillars in **Box 1**.

A range of evidence and key levers are collated under these pillars to support partners in considering how, by implementing the new vision for community justice, they can collectively address the local determinants of offending and inequality. This document aims to collate both familiar approaches and highlight gaps and opportunities. The key challenge that now presents itself is to optimise, intensify and deliver this effectively in partnership.

Box 1: Pillars to steer individuals, families and communities towards hope, recovery and resilience.

Opportunities for earlier intervention in:

- preventing violence
- reducing alcohol and drug misuse
- improving mental health
- reducing trauma.

Mitigating the negative impact of offending and sentencing by:

- reducing victimisation
- working with families as assets
- opportunities in police custody and liaison
- increasing alternatives to prosecution and diversion
- increased community-based sentencing
- optimising custodial care.

Building resilience and sustaining change through:

- maximising individual resilience
- improving the delivery of custodial services
- strengthening community justice.

Community justice: an opportunity to reduce inequalities

Several policy and legislative drivers[46,47,48,49] reinforce a focus on both health inequality and the links between justice and health improvement. The 2012 Audit Scotland Report on reducing reoffending,[47] highlighted that mutual outcomes for community planning and community justice to reduce offending, for example via Alcohol and Drug Partnerships (ADPs) needed improvement. It was also noted that there was a mismatch between interventions and proven effectiveness to reduce reoffending, as well as missed opportunities for joint, collaborative approaches. Community alternatives and the support individuals need on release from prison have the potential to effectively sustain the interventions offered in prison custody and mitigate against the inequalities which offending and sentencing can create.

The Community Justice (Scotland) Act 2016[50] set out the transition of community justice planning responsibilities from eight national community justice authorities to community justice partners at a local level. The role that partners now have in relation to community justice will maximise opportunities for and integrate local services, programmes and health improvement action within community justice across Scotland. This will also ensure that we align, co-ordinate and collaborate to reduce the inequalities that offending, victimisation and fear of crime bring with them. The Community Justice Outcomes, Performance and Improvement (OPI) Framework[51] sets out seven high-level common outcomes, across four structural and three person-centred domains. These have familiar ambitions to many of our own organisation's aims in improving health and wellbeing and reducing inequality in Scotland.[1] The structural priorities are listed in **Box 2**.

Box 2: Structural priorities.

Structural

1. Improved community understanding and participation: increasing community inclusion while simultaneously reducing the stigma associated with people with convictions.
2. Improved strategic planning and partnership working: ensuring strong leadership and accountability, service and system improvement, and smarter use of local resources.
3. Equal access to services: ensuring they are equitable, needs led, co-ordinated and timed effectively to improve health and wellbeing, prevent offending and boost reintegration.
4. Effective use of evidence-informed interventions: ensuring that these are person centred, proportionate, timely and effective.

Person centred

The person-centred priorities are also framed to demonstrate positive change to individuals in contact with justice services:

5. People's life chances are improved: through needs (including health, finance, housing and safety) being met effectively.
6. People develop positive relationships and more opportunities to participate and contribute through education, employment and leisure activities: to gain more opportunities to participate as citizens.
7. Individuals' resilience and capacity for change and self-management are enhanced: to increase recovery and reintegration.

These will encourage the transformation and resilience required to sustain positive change and move individuals on from offending and victimisation. Improved life chances, positive relationships, participation as a citizen and ultimate self-management, recovery and rehabilitation are also key goals. They also have the potential to support recovery from substance use and reduce mental health problems, as well as a reduction in offending. These also acknowledge a range of wider determinants of wellbeing such as housing, education and employment. The creation of a national non-departmental public body, Community Justice Scotland, will further drive these ambitions.

In response to these wider inequalities challenges, this document proposes a series of potential collaborative actions across the health and justice system to optimise our impact. These will influence the negative impact of being a victim, of being sentenced (in some individuals, the impact of experiencing both) and working together to build positive change in people's lives.

These ambitions align well to our interest in reducing inequality in Scotland, articulated in our policy review for the Scottish Ministerial Task Force on Health Inequalities.[52] The fundamental causes of health inequalities are an unequal distribution of income, power and wealth. This can lead to poverty and the marginalisation of individuals and groups.

To address these, we must '**undo**' the fundamental causes of inequality by addressing poverty, marginalisation and discrimination and '**prevent**' any negative impact by the wider environmental influences such as the availability of good-quality housing, work, education and learning opportunities, as well as access to services and social and cultural opportunities within an area and in society. Together, we can also '**mitigate**' against negative individual experiences in accessing services that provide these opportunities. This is further strengthened by building self-management, recovery and working towards sustained positive change in these individuals. These concepts have informed how we propose to approach the challenge that community justice presents.

Three main health inequalities opportunities are proposed and we must align these with the vision and priorities of the National Strategy for Community Justice[51] to ensure that their actions complement and consolidate each other. These are:

- **increasing the opportunities for earlier intervention**
- **mitigating the impact of offending and sentencing**
- **building resilience and sustaining change.**

NHS Health Scotland consider improved links between health and justice to be a fundamental means of responding to this challenge and essential in addressing health inequality in Scotland. The three key opportunities above frame the main content of this document. We propose these to strengthen both formal and informal collaborative links between health and justice agencies in their contribution to community planning. We will use them to promote smarter, joint outcomes and improvement in services and systems. Throughout, we will work with others to build an evidence-informed, outcome-focused approach that bridges health improvement, community justice and community planning.

Chapter 2: Increasing the opportunities for earlier intervention

Community justice partners, through close alignment with community planning and health and social care integration, are in a strong position to influence and address the determinants that drive both crime and the likelihood of becoming a victim. Current actions driven by community planning, for example on: community safety and policing; alcohol licensing; social housing and homelessness; and social care provision, offer opportunities for many professionals to impact on offending through both primary and secondary prevention.

The requirement to reduce duplication and system costs demands that partnerships operate with greater co-ordination, collective action and effective delivery. Community planning work on early years, children and families in supporting parenting and in offering early intervention (e.g. where there are signs of behavioural difficulties in pre-school) are key features of co-ordinated action to reduce inequality.

Many early-intervention programmes aimed at infancy and early childhood that focus on supporting families to develop secure attachment and competent, confident parenting are known to be significant protective factors in mitigating against poor outcomes by increasing confidence, resilience and adaptability.

The Getting It Right For Every Child (GIRFEC) approach epitomises this in safeguarding and supporting children to achieve their fullest potential. In considering the parallel social patterning above, a similar care and support framework could potentially be applied to the adult population in prison.

GIRFEC provides a strategic approach to primary prevention of offending by seeking to effectively address the needs of children and young people. For example, addressing health and wellbeing needs,[53] including among young people with learning difficulties[54] or mental health problems.[55] By championing these principles, every adult could also achieve resilience. Core to these are:

- improved screening and assessment at key points of contact in the system
- improved staff training to support identification and the right response at the right time
- multiagency responsibility, communication and action.

Underpinning this approach is a foundation of evidence to inform interventions, but the challenge is also to simultaneously address the many underlying factors. This concept is now increasingly being cited as relevant to a number of adult populations, and in view of the underlying determinants and demographics, appears transferable to many within the justice system. Community planning partners, therefore, have a pivotal role and are fundamental to the success of earlier intervention.

Involvement in the justice system can be indicative of and contribute to multiple complex health and wellbeing issues. Driven by inequalities, four priority health and wellbeing risk factors for offending behaviour repeatedly appear throughout the available evidence to consider in how justice services work with individuals.

Earlier interventions by health leads and their partners within community planning can generate the highest potential impact through a focus on:

Preventing violence

The prevalence of violence in Scotland

Internationally, violence is one of the main causes of death for people aged 15–44,[56] and while not the main cause of death, violence is more prevalent in Scotland than in other UK countries. Homicide rates have fallen in recent years,[57] but it was noted in 2012 that Scotland had the 12th highest rate of homicide of the 36 Organisation for Economic Co-operation and Development (OECD) countries.[58] In 2014/15, 27% of crime was violent crime, comprising minor assault with no/negligible injury (17%), minor assault with injury (4%), attempted assault (4%), serious assault (1%) and robbery (1%).[59] A higher proportion of men than women are incarcerated in Scottish prisons for violent crime, mainly serious assault and sexual crimes. Victims of violence in Scotland are disproportionately young, male and from deprived backgrounds.[60]

Linked to the above prevalence, young men have been identified as a high-risk group for facial injuries, most frequently alcohol related.[61] The key determinants for such injuries are age (15–19 years), male sex and deprivation – also key correlatives to involvement in offending. The Violence Reduction Unit is active in injury surveillance and exploring the implications of such facial injuries on young people, including long-term stigma associated with permanent scarring.

The prevalence of domestic violence in Scotland is also high – 17% of women and 10% of men report being a victim of abuse by a partner in their lifetime.[62] Drug and alcohol use, combined with mental health and experiences of trauma, are common determinants of women's experience as both victims and perpetrators of crime.[63]

Inequalities and violence

Violence is associated with poor health and wellbeing, and high social, financial and psychological costs. Being a victim of violence is associated with poor mental and physical health and numerous long-term health conditions. These all create interrelated stigma. High levels of violence are associated with high healthcare costs

and high justice system costs. In Scotland, the estimated economic and social cost is upwards of £2.25 billion per year.[64]

Violence is associated with inequality – it is experienced disproportionately by people in poorer countries, and by the most deprived groups within richer countries.[65] Research and development around a public health approach to violence championed by the World Health Organization (WHO)[66] shows that violence can be prevented and its impact lessened in the same way as other public health issues are tackled, such as infectious diseases.

A report by the Scottish Public Health Network (ScotPHN)[64] describes the global and Scottish evidence and policy context in more detail. It commends the public health approach to violence prevention and summarises a range of local projects around Scotland that have evaluated well or show signs of promising practice.[67]

Violence reduction policy levers

Equally Safe,[68] the Scottish Government and COSLA's joint strategy for preventing and eradicating violence against women and girls, aims to deliver greater gender equality, tackle perpetrators, and intervene early and effectively to prevent violence. This approach, alongside a more person-centred and specialist court response[69] and a specific offence of domestic abuse, has gained consultation support.[70] These will improve the ability of police and prosecutors to tackle domestic abuse.

The Scottish Government defines hate crime[71] as crime committed against a person or property that is motivated by 'malice or ill-will towards an identifiable social group'. In Scotland, the law recognises hate crimes as crimes motivated by prejudice based on race, religion, sexual orientation, transgender identity and disability. The Advisory Group on Tackling Sectarianism in Scotland[72] also recommended that existing equality, human rights and hate crime legislation should be enacted to tackle this cultural dimension where violence manifests in order to support victims.

Health inequalities action that can reduce violence

A comprehensive review of evidence by WHO[73] suggests a focus on interventions in seven key interlinked approaches to preventing interpersonal and self-directed violence:

- developing safe, stable and nurturing relationships between children and their parents and caregivers
- developing life skills in children and adolescents[74]
- reducing the availability and harmful use of alcohol[75,76]
- reducing access to guns, knives and pesticides[77]
- promoting gender equality[78] to prevent violence against women[68,a]
- changing cultural and social norms[79,80,81] that support violence[82,83]
- victim identification, care and support programmes.

Although not systematically, many of these approaches have in part been adopted in Scotland, but often the scale and longevity of programmes mean that proof of impact is limited so more evaluation is required. *(*See **Appendix 1**).

Reducing the impact of alcohol and drug use

The economic impact of alcohol and crime

The consequence of alcohol-related crime affects individuals, their families, as well as the health and emergency services and wider society, with costs of over £3.6 billion annually.[84] Additionally, there is research to show that the average economic and social cost per problem drug user in England and Wales is around £50,000 per year. This includes the costs to the victims of crime, the criminal justice, health and social care systems, and the costs of drug-related deaths. This suggests that the total economic and social costs of problem drug use in Scotland could amount to around £2.6 billion per annum. If earlier interventions are successful there is greater potential to both prevent the harm and cost due to substance misuse but also the associated costs of criminality and involvement in the justice system.

[a] Note also emerging evidence of higher prevalence in LGBT people of intimate partner violence, see also the **Reducing victimisation** section below.

Inequality, alcohol and drug use

Alcohol misuse is a major public health challenge in Scotland and the relationship between alcohol and crime, in particular violent crime, is strong. Not all people in deprived areas will develop a drug problem, but those with the most limited prospects in society appear to be most at risk, and less likely to overcome a drug problem once it has become established. Indeed, studies have shown that: there is a clear link between problem use of heroin and crack cocaine and deprivation;[38] evidence that a drug user in a deprived area is less likely to access treatment and recovery; and that deprived areas with high unemployment levels can foster an environment where drug dealing flourishes as a way of making money.[85] The association between deprivation, drugs and health inequalities is also clear.[86]

In particular, Scotland has highly concentrated pockets of intense deprivation, with multiple social problems.[b] Illicit drug markets have created widespread availability of illegal drugs and a range of barriers to recovery, such as a lack of opportunities for employment or access to essential services.[87] This also operates within a wider series of societal influences and mirrors the complex relationship between the causes and consequences of inequality. Earlier opportunities to intervene or collective action to reduce the barriers to access are required to tackle these challenges.

Policy and delivery levers

In 2008, the Scottish Government published 'The Road to Recovery'[38] in recognition of the need to align the approach to problem drug use towards an evidence-based, recovery-focused model. At the time of its publication, an estimated 59,600 people were problem drug users[88] in Scotland. The national alcohol strategy, Changing Scotland's Relationship with Alcohol: A Framework for Action (2009),[89] outlined the Scottish Government's commitment to work with partners to encourage the development of integrated care pathways for people within justice services and

[b] The 15% most deprived data zones in the Scottish Index of Multiple Deprivation (SIMD) 2006 contain 36% (257,041) of Scotland's income deprived population and 33% (134,347) of Scotland's employment deprived working age population (Scottish Executive, SIMD 2006). See also Scottish Executive (2006) High Level Summary of Statistics: Key Trends for Scotland 2006. Edinburgh: Scottish Executive.

information sharing to ensure they receive continuity of alcohol support and treatment in both custody and the community.

Ensuring a person-centred, outcomes-focused approach to service delivery is one of the core ambitions of the Health Quality Strategy for Scotland (2010).[90] The Quality Alcohol Treatment and Support (QATS) report,[91] published in 2011, details a range of recommendations for improvements in alcohol service delivery and continues to inform access, outcomes and quality. A set of nationally agreed standards and principles for delivery of care and support in alcohol and drug services were also published in 2014[92] and these apply equally to those in custody or in communities.

Local ADPs lead on assessing need and commissioning alcohol and drug services. Through ADP Local Delivery Plans,[93] NHS Boards led the delivery of Alcohol Brief Interventions both within custody and the community. National guidance[94] has also encouraged a focus to broaden delivery in wider settings, including the justice setting to capture 'hardly reached' individuals.

In 2014, NHS Health Scotland published an outcomes framework for problem drug use in Scotland,[95] which aligned to the four pillars (prevention, enforcement, families and recovery) and strategic priorities in The Road to Recovery and building on the ADP Outcomes Toolkit.[96]

The framework includes a specific nested logic model focused on enforcement, although all four nested models are useful in collating best evidence of effectiveness and as planning tools for improved outcome focus and impact. It includes a focus on:

- community engagement and assets-based approaches
- integrated recovery-oriented services
- therapeutic services and diversion from prosecution
- a holistic, whole-systems approach (WSA) for person-centred care and management of people in the justice system
- staff training and development.

Prevention priorities in the framework include: a focus on enhancing life chances for those in the most deprived communities; reducing health inequalities; improved

citizenship; access to credible information; and safer, stronger communities. These overlap with the enforcement priorities alongside approaches that reinforce recovery, reduced crime and drug-related death, continuity of care on entry, during and on release from custody. This work is being fed into a new national drugs policy governance structure to inform delivery and outcome measurement. The Partnership for Action on Drugs in Scotland has been set up to reduce problem drug use and complement the work of the established Road to Recovery strategy.[97] The group will help lead and focus the sector on three priorities:

1. building communities focused on recovery and tackling stigma
2. quality and consistency of service planning and delivery
3. harm reduction and reducing drug-related deaths.

Health inequalities actions that can reduce the impact of alcohol and drug use include the following areas.

Reducing the impact of new psychoactive substances

New psychoactive substances (NPS) are an emerging issue of concern to NHS Boards in delivery of emergency services and harm-reduction approaches, to ADPs within communities and to services within justice and are now routinely considered as part of the National Records of Scotland's publication of drug-related deaths.[98] NPS can cause a range of physical and psychological symptoms, ranging from cardiovascular problems and seizures to psychological disorders such as anxiety, agitation, memory loss, depression and psychosis.

There is limited evidence available on the best means to manage NPS-related health issues within prisons, although some concerns have been voiced by the Prison Ombudsman for England and Wales regarding a potential link to fatal incidents in prison.[99] Following an evidence review by the Scottish Government Safer Communities Analytical Unit published in August 2014,[100] an expert review group was convened to review the powers that are currently available in Scotland to tackle the sale and supply of NPS, making six overarching recommendations.[101] These included developing a specific NPS definition and a system to share data, a national centre of excellence in detection and analysis, information sharing protocols, licensing-restriction powers and a national toolkit and operational guidance for key

agencies and partners to tackle the issue. The Psychoactive Substances Act[102] applies across the UK and makes it an offence to produce, supply, offer to supply, possess with intent to supply, possess on custodial premises, import or export psychoactive substances. National guidance for retailers was published in May 2016[103] and Public Health England published a toolkit in 2015[104] for prison staff on intervening where NPS use occurs.

A balance of enforcement of this legislation and clear pathways for harm reduction, treatment and recovery for the direct impact, and with NPS use on top of existing substance use, will be required at local level. This will be required particularly where its use disrupts individual recovery and increases susceptibility to relapse or causes drug-related death. NPS also remains an area of concern regarding both the evidence gap and its variability, which has created an enormous research challenge.

Promoting recovery

Recovery has been defined as: ‘voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society’.[105] According to Yates and Malloch (2010),[106] while recovery has ‘always been implicated, either centrally or on the periphery, of interventions in the drug and alcohol field, it has only recently been embraced by government as a key policy focus and placed at the forefront of policy documents’.

In relation to recovery and recent policy, the essential care report by the Scottish Advisory Committee on Drugs Misuse (SACDM) Integrated Care Project Group in 2008[107] identified support services that would maximise the opportunity for recovery for those with substance misuse problems and incorporated the principles set out in the national drug strategy, The Road to Recovery.[38] The stronger emphasis on outcomes and recovery, rather than treatment as the end goal, is also centrally relevant to discussions on the goals of alcohol-specific interventions.

Recovery is the process through which an individual is enabled to move on from their problem drug use towards a drug-free life and become an active and contributing member of society.[108] Progressing in recovery can include ceased sharing of injection equipment, reduced use of substances, stability through maintenance

therapies, safer use of drugs, alcohol and tobacco, as well as abstinence. Moving to a recovery-based approach will mean a significant change in both the pattern of services that are commissioned and in the way that practitioners engage with individuals.[109,110] Core to this is the reform of the way that drug services are planned, commissioned and delivered to place a stronger emphasis on outcomes.

In practice, people can best be empowered to recover through the establishment of a recovery-oriented system of care (ROSC). The underlying philosophy of a ROSC is that treatment, review and aftercare are integrated, and priority is given to empowering people to sustain their recovery.

Distinguishing features of a ROSC include:

- being person centred
- being inclusive of family and significant others
- keeping people safe and free from harm
- services that are connected to the community
- services that are trauma informed in the provision of individualised and comprehensive services, such as housing, employability and education.

At its centre it has strength-based assessments, which take account of individuals' recovery capital, and integrated interventions and services that are responsive to a person's needs and beliefs. There is a commitment to peer recovery support services, and most importantly, it is inclusive of the voices and experiences of people, and their families, in recovery.

Numerous community and justice examples exist for peer support, with recovery cafes and networks in place and in development across Scotland. Some of these networks also have accredited training to recognise and enhance the skills of volunteers involved in running peer-support networks. Many of these now operate within prison establishments, support individuals in throughcare and some have become beacons for community recovery capital within communities to explicitly impact on reducing the likelihood of further offending. An example is provided of practice in the Community justice practice spotlight summary 3 HMP Perth – Recovery Workstream.

Improving mental health

Mental health, inequality and justice

Mental health is not experienced equally in Scotland. Individuals who live in deprived communities or in low socioeconomic circumstances are more likely to experience poor mental health. Numerous reports and documents have highlighted the effect of exposure to protective factors and risk factors resulting in unequal distribution of mental health conditions and illness in Scotland.[111,112,113,114,115,116] High rates of mental health problems are evident across the justice system. At all stages (police custody, courts and prison custody) research indicates higher rates of mental health problems compared to the general population.[117,118] Health inequalities actions that can improve mental health include the following areas.

Reducing the fear of crime

Perceived levels of crime and violence create both acute and chronic mental health issues for individuals and their families and impact on levels of fear within communities. As outlined in **Chapter 3**, victimisation has direct impacts on mental wellbeing in both victims and families. However, in many respects, Scotland is becoming a safer place to live. For example, overall crime in Scotland is falling. This spans the various dimensions of community safety. The Scottish Crime and Justice Survey 2014/15[119] reported that the prevalence of being a victim of a crime in Scotland fell from 20.4% in 2008/9 to 14.5% in 2014/15. The reduction in crime is not equally distributed. Between 2008/9 and 2014/15, crime prevalence fell in the most deprived areas from 26.0% to 21.2%, while elsewhere crime fell from 19.4% to 13.4%.

Despite continuing decreases in crime, perceptions of local crime rates have not changed since 2012/13, with the majority of adults reporting that crime rates in their area have remained the same. Fear of crime erodes psychological wellbeing and quality of life, and is heightened among lesbian, gay, bisexual, transgender and intersex (LGBTI) people, disabled people, older people, women and those who have previously been a victim of crime. Social factors (e.g. familiarity and social networks)

appear to be more important to generating fear of crime than physical factors (albeit signs of environmental neglect are important).[120]

Fear of crime can affect how people perceive their local area, and may restrict the activities they participate in.[121] Perceptions of the risk of crime, while falling, often remain significantly overestimated. For example, 9.9% of adults thought that it was likely that their car would be damaged by vandals in the next 12 months; however, the actual likelihood of this was only 3.4%. For some types of crime, the difference was even greater. For example, 8.1% thought that it was likely that their home would be broken into, however, prevalence figures show the probability of this happening to be 0.8%.

In response to the common proxy for perception of safety, when asked 'how safe do you feel walking alone in your local area after dark', the majority of Scottish adults (74%) feel fairly or very safe. However, the proportion of those who felt fairly or very safe was lower in the 15% most deprived areas (62%) and among those who are victims of crime (67%). Females were less likely than males to report feeling fairly or very safe (64% compared with 86%). Stronger engagement with communities to improve on these perceptions, therefore, will be welcome.

Reducing mental health problems and distress

A significant proportion of the focus on mental health in the justice system targets the prediction of violence risk as part of a more downstream approach to diagnosis and treatment of mental health problems.[122] Despite the lack of empirical evidence to suggest that mental health problems are a significant predictor of offending, or particularly of violent crime, there remains intense media attention on the danger of violence posed by people with a diagnosis of mental health problems and positive examples of resources and guidelines which counteract this.[123] Poor reporting can contribute to public fear thereby increasing social exclusion and stigma of those with severe and enduring mental health problems.

People with either identified mental health problems or lower threshold levels of anxiety, stress and distress come in contact with police, ambulance,[124] and accident and emergency services[125] on a regular, or sometimes frequent basis, particularly

outside standard service hours. In relation to domestic abuse and assault, high levels of intoxication and incidents of panic attack, threatened self-harm or attempted suicide appear.

These are opportunities to intervene, both for individuals and their family/children involved in the justice system, as these may also be people who have a higher risk of becoming a victim of crime. Police contact provides an opportunity for not only arrest and place of safety, but also for early access to mental health support and services, and for appropriate treatment where necessary.[126] Through closer working partnerships with health and social care, Police Scotland schemes to divert from arrest, to liaise and arrest-refer and provide in-reach to police custody for substance use, mental health and experiences of trauma are already demonstrating positive results for services and individuals in distress. Examples include:

- a distress liaison service between NHS Greater Glasgow & Clyde and Police Scotland, highlighted in the practice spotlight summary 1 alongside this document
- alcohol brief interventions (ABIs) and drug use assessment in-reach within NHS Lothian
- nurse-led police custody, court and prison liaison for individuals with mental health and substance use issues in NHS Greater Glasgow & Clyde.

New national guidance[127] on police custody and substance use will strengthen best practice and ensure greater impact on the complex needs which professionals aim to meet in delivering health care to those in custody, which includes:

- ‘Guidance for Police Scotland and healthcare professionals‘
- ‘Making it happen: Delivering quality alcohol, drugs and tobacco healthcare services to people in police custody in Scotland’.

Stigma and discrimination also create significant barriers to effective and early intervention within the community, in both identifying individuals and in their help seeking. The ‘See Me’[128] and ‘ChooseLife’[129] campaigns have been successful in challenging social perceptions of mental health and mental health problems through anti-stigma and anti-discrimination campaigning. Locally implemented programmes

contribute to this aim by supporting the anti-stigma messages and building social capital for mental health [e.g. Scotland's Mental Health First Aid,[130] SafeTALK,[131] Applied Suicide Intervention Skills Training (ASIST),[132] and Suicide Safer Communities[133]). Through the efforts of these campaigns and programmes in Scotland's most deprived communities, and by creating stronger links with the justice system, we can normalise mental health issues, support help seeking and create greater acceptance so that positive mental health can flourish.

Better access also to a range of support and services as well as interventions that reduce stigma, discrimination and social isolation, will encourage recovery and protective factors for individuals to thrive. Focusing such efforts on those with the greatest risk factors has the potential to greatly amplify that effect. When this is coupled with appropriate and accessible early intervention on prevention and treatment of mental distress and mental health problems, particularly for those most at risk there is the potential 'to break cycles of poor outcomes'. The previous mental health strategy in Scotland[115] took action in recognition of the evidence and the Mental Health Strategy for Scotland 2012–2015[134] is no exception. The recently published 10-year vision for mental health is expected to build on this approach.[135]

Preventing adverse childhood experiences

Adverse childhood experiences (ACEs)[136] can contribute to a series of life consequences and the ability to make life choices in adolescence and adulthood, and impact across a range of behaviours, including likelihood to offend. Vulnerability to poor outcomes can include school disruption, family dysfunction, mental health problems, social isolation, drug and alcohol problems, loss of employment productivity, as well as contributing to crime and antisocial behaviour.[137] These are highly correlated to the complex interaction of personal, social and environmental factors that occur during infancy and childhood.[138] Children and young people for whom normal developmental behaviours of aggression, non-compliance and emotional distress persist throughout childhood (beyond the pre-school years) have a highly elevated risk of long-term negative personal and social outcomes.

ACEs have been shown to be related to deprivation, with the experience of four or more ACEs being reported by 4.3% in the least deprived quintile and 12.7% in the

most deprived quintile. ACEs, therefore, clearly have a role in inequalities which can overlap with the likelihood of offending. Those with poorer attachment are at higher risk for developing severe mental health problems, and therefore the likelihood of offending.[139]

Conduct disorder in childhood is correlated with risk for experiencing custodial care and for conviction of a crime in young adulthood.[140] A greater focus and timely response to the needs of children experiencing stressors and problems through the implementation of GIRFEC, Named Person legislation and prompt assessment and access to specialist child and adolescent mental health services will help to mitigate the risks of negative outcomes associated with negative childhood experiences.

The effects of all trauma are much more significant for children.[141] Children exposed to type 2 trauma (such as domestic or sexual abuse) are at risk of developing complex trauma, or developmental trauma disorder, which impacts the developing brain. This damage is often caused to the prefrontal cortex, resulting in issues with lack of empathy, social connectedness, and regulation of stress and impulse.[142] These effects can blunt emotional development and socialisation, levels of self-esteem and confidence, and the ability to form relationships with others.

In a recent ScotPHN report, 'Polishing the Diamonds',[143] three key priorities to prevent adverse childhood experiences were identified:

1. **community context:** for example tackling low wages and poverty, mitigating the impact of recession and austerity, and increasing connectedness by reducing isolation
2. **family risk factors:** strengthening of parenting and family support interventions, particularly in those families with multiple risk factors
3. **tackling household adversity:** reducing domestic violence, parental substance use in a co-ordinated way across local services.

Research and consideration of these early experiences are increasingly being cited as opportunities to consider earlier intervention to prevent the likelihood of behavioural consequences that could increase the likelihood of offending.

Reducing trauma

The scale and scope of trauma

All definitions of trauma focus on the way in which an individual immediately experiences negative events. However, trauma can affect individuals differently, particularly in long-lasting effects.

> Trauma is an emotional wound, resulting from a shocking event or multiple and repeated life threatening and/or extremely frightening experiences that may cause lasting negative effects on a person, disrupting the path of healthy physical, emotional, spiritual and intellectual development.
>
> National Child Traumatic Stress Network (NCTSN)[144]

> Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being … In short, trauma is the sum of the event, the experience, and the effect.
>
> Substance Abuse and Mental Health Services Administration (SAMHSA)[145]

Trauma can be generated by a wide range of events: interpersonal or impersonal; immediate and one-off (type 1 trauma); or chronic and ongoing (type 2 or complex trauma). Life events that have the potential to induce trauma include: neglect; assault; bullying; family, school or community violence; war; acts of terrorism; natural disasters; serious accidents or injury; abandonment, separation or loss; and bereavement. These events are traumatic if they overwhelm an individual's capacity to cope and if they elicit emotional responses such as fear, terror, helplessness, lack of control, hopelessness and despair.

How trauma manifests

Traumatic events elicit distress symptoms or changes in behaviour that can be detrimental to the individual's mental health and wellbeing, for example development of new fears, separation anxiety, sleep disturbance, sadness, loss of interest in

normal activities, reduced concentration, anger and irritability. The majority of individuals demonstrate resilience in the aftermath of traumatic experience and distress symptoms decrease over time so that normal functioning can resume. An individual's resilience can be dependent on several factors both internal to the individual (e.g. mental and emotional strengths or weaknesses) and external (e.g. the type of support available from family, community or a significant other).

'Interpersonal traumas' (involving violence or abuse) have a greater correlation with longer-term impacts, the development of post-traumatic stress disorder (PTSD), and their experience increases the risk of further traumatic experiences and revictimisation compared to 'impersonal trauma' (e.g. road accidents or disasters). This is seen particularly when the symptoms persist (e.g. become PTSD) or are compounded by the experience of further traumatic events.

This experience of trauma can generate lasting damage to an individual's health and wellbeing where an accumulation of trauma is also accompanied by risks of victimisation, likelihood of offending and a lack of protective or resilience factors. In short, where individuals have multiple traumatic experiences in their backgrounds, the impact of these may accumulate and reinforce one another and likelihood of offending and involvement with health and justice services can increase. However, trauma also affects an individual's ability to form trusting relationships, which can then extend to how they engage with services that intend to help them. This can manifest in disruptive behaviour, difficulties in keeping appointments and reinforces the inequality created by the 'inverse care law'.[146] Health inequalities actions that can reduce trauma include the following areas.

Reducing trauma in childhood

Trauma in childhood can manifest in longer-term impacts and can be linked to a range of risk behaviours in adolescence and adulthood including: attention difficulties, substance abuse, eating disorders, self-mutilation, emotional avoidance, indiscriminate sexual behaviour, reduced awareness of danger, and offending. These behaviours may serve to reduce the distress symptoms in young people, particularly those who have experience of multiple interpersonal trauma, but this can

also in turn increase the likelihood of further victimisation and therefore perpetuate a cycle of further trauma.

Young people who have experienced a number of incidents and types of maltreatment during childhood are at greater risk of revictimisation in adolescence and adulthood. For example, abuse victims are more likely to have also experienced psychological neglect; children exposed to physical abuse are more likely to experience psychological abuse and brain injury; intrafamilial abuse is associated with extrafamilial abuse; and being sexually abused as a child substantially increases the likelihood of being sexually assaulted in adulthood.[147]

Additionally, there is evidence to suggest a link between complex trauma in childhood, chronic victimisation and subsequent offending or criminal behaviour.[148,149,150,151,152] Young men in prison are also more likely to have suffered bereavement, particularly parental, multiple and traumatic deaths.[153] The need for earlier effective interventions to reduce the likelihood of these longer-term impacts, or indeed of vulnerability to repeated trauma and victimisation is critical. More also needs to be known on the mitigating and protective factors which counteract these risks in some individuals.

Risk factors for traumatic events

Gender is a significant indicator in risk of experiencing trauma. During childhood both men and women are at equal risk of physical and/or sexual abuse from family members or individuals known to the child. In adolescence, however, gender begins to differentiate the risk of men and women to trauma experience. Adolescent gay boys, boys of non-white ethnic origin or those engaged in gang activity are at a higher risk than their female counterparts.[154]

As adolescence progresses, young men are more likely to be harmed by a stranger or someone who has a prejudice or dislike of them (e.g. an enemy). The risk to young women at a similar age is comparatively low, however, risk is greatly increased if they are engaged in a significant relationship. Associated risk for trauma experience in young women is more likely from an intimate partner. This also has to be taken account of in the wider context of the prevalence of violence towards

women and girls, which is exacerbated by factors such as age, homelessness, poverty and financial dependence, disability, insecure immigration status and ethnicity.[68]

In adulthood, trauma risk for men is greatly associated with being in combat, or from being a victim of crime, from an enemy or a stranger. For the adult woman, trauma risk remains greatly associated with her significant relationship. The complex gender relationship with trauma risk may explain the differences in psychological response between men and women but also indicates the need to provide intervention that is both trauma informed and gender responsive.[155] Child abuse and neglect, poverty, sexual molestation and witnessing violence are, among others, the most common risk factors for post-traumatic reactions, aggression and antisocial behaviour.[156,157,158]

Community justice and community planning partners are in a good position to earlier effect change on the risk factors for trauma. Combined action on violence reduction, GIRFEC and child protection, domestic abuse, financial inclusion and employment initiatives, and community empowerment activities can all contribute. However, this alone will not alter these experiences of trauma until universal services act to ensure that they are not inadvertently undoing this work. Only such action in combination with trauma-informed services (often also termed ‘psychologically informed environments[159]) will remedy this.

Increased use of trauma-informed approaches

People with trauma characteristically present to multiple services over long periods of time. Many trauma survivors have not connected their current problems and behaviours with past traumatic experiences – nor indeed have many health or mental health workers. Trauma survivors can experience services as unsafe, disempowering and/or invalidating. Trauma-informed services work to understand that until an individual is safe physically and emotionally from violence and abuse, recovery is not possible.[160] Organisations, programmes and services need to work to understand the vulnerabilities and/or triggers so that trauma survivors experience (and that these can be exacerbated by traditional delivery) recovery and positive outcomes will not be stifled.

People with histories of trauma can be frequent attenders at mainstream and out-of-hours services, often having repeated poor experiences, slipping through referral pathways or integrated care approaches, and this can risk retraumatisation and compounding problems as previous trauma goes unrecognised. Frequently, they withdraw from seeking assistance. Unfortunately, one of the pervasive impacts of trauma can include the way people approach potentially helpful relationships.[161] This includes seeking help from professionals. Responsive crisis management has to be matched by affordable, accessible, ongoing care, delivered in a manner maximising consumer self-determination. Escalation and entrenchment of trauma symptoms can be psychologically, financially and systemically costly.

As current models of care in public and primary healthcare settings mostly focus on diagnosis, many complex trauma survivors carry multiple diagnoses and levels of need. Services that embed trauma-informed care and practice (TICP) principles[162] not only move away from a sole focus on diagnosis but also facilitate holistic care based on lived experience and individual need.

Trauma-informed services, regardless of contexts, are based on principles, policies, and procedures that provide safety, voice and choice. Every part of the service, organisation, management and delivery system should be modified to ensure a basic understanding of how trauma impacts the life of a person seeking services. They must focus first and foremost on an individual's physical and psychological safety, including responding appropriately to suicidality. They must also be flexible, individualised, and culturally competent, promote respect and dignity, hope and optimism and reflect best practice. It is this approach that is likely to prove more effective in both universal and specialist services in achieving positive outcomes for individuals with previous experience of trauma when they have become involved with justice services.

In May 2017, the Scottish Government/National Education for Scotland 'Transforming Psychological Trauma: A Skills and Knowledge Framework for The Scottish Workforce' was launched.[163] The overarching goal is to support the strategic planning and delivery of training for those who have contact with survivors of trauma across all parts of the Scottish Workforce.

Chapter 3: Mitigating the impact of offending and sentencing

When someone is charged and convicted of a crime, the consequences and costs[164,165] for the individual, their family, community and the justice system itself are considerable.[166] In addition, the experience of criminal behaviour as a victim can also have serious and lifelong effects on individuals, families and communities.

Agencies planning and delivering services across community justice have ideal opportunities to mitigate against the potential negative impacts of the processes and decisions they are duty bound to deliver. Community justice partners are perfectly placed to forge stronger links with wider community planning partners and further mitigate the potential to unintentionally widen inequalities gaps that contact with justice services can create.

Reducing victimisation

Inequality and victimisation

The prevalence of crime in Scotland significantly decreased from 20.4% in 2008/9 to 14.5% in 2014/15. However, risk of victimisation remains higher in low socioeconomic areas (21.2%) and for young men (23.6%) who also have the highest risk of violent crime (8.7%). Victimisation represents a unique form of distress to those affected. It is common for victims to suffer health problems as a result of their experience and it substantially increases fear of crime and negatively affects feelings of safety. This is particularly prevalent in women's victim experience.

There were an estimated 186,000 violent crimes committed in Scotland in 2014–15.[167] Between 2008/9 and 2014/15, both Scottish Crime and Justice Survey estimates and recorded crime violent crime figures have shown a decrease (41% and 24%, respectively). Population risk of being a victim of violent crime was 2.6%, with a 2.1% risk of minor assault, a 0.3% risk of attempted assault and a 0.1% risk for both serious assault and robbery. However, age and gender have a significant

role to play in risk for violent crime, with men of all ages having a significantly higher risk than women (3.5% compared with 1.8%, respectively) and the risk for young men being almost twice that of women of the same age group (8.7% compared with 3.2%, respectively).[168]

There is also evidence to suggest that marginalised groups or individuals who experience discrimination or stigma experience greater adverse effects, as lesbian, gay, bisexual and transgender (LGBT) victims demonstrate significantly higher levels of acute stress and general anxiety,[169] and victims with severe mental health problems are more likely to suffer social, psychological and physical adverse effects as a result of the crime than those in the general population.[170]

Gender and victimisation

Gender influences the impact of victimisation experience, with outcomes for women consistently worse than comparative male counterparts. Domestic abuse and the sexual violence experienced by women is of particular concern; 17% of women experience domestic abuse in their adult life,[171] and 4% of women experience at least one form of sexual assault from the age of 16.[172] Women who have experienced repeat victimisation have worse health, trauma and addiction problems, which are compounded if there is a lack of social connection with the community.[173] Studies of sexual violence show elevated rates of depression, anxiety and comorbidity[174] and there is evidence of very severe health impacts associated with trafficking[175] and stalking. Commonly, sexual violence also has negative effects on body image.[176] Furthermore, depression increases when the victim knows their attacker,[177] a significant risk factor for women experiencing trauma.

The UK is signed up to the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (the Bangkok Rules),[178] which outline the requirements needed to meet the distinctive needs of women in the criminal justice system. The rules emphasise the importance of providing physical and psychological safety for women, ‘taking account of the history of victimisation of many women offenders and their caretaking responsibilities’.

The Corston Report[179] highlighted research indicating that women who are persistent offenders are more likely to have been exposed to violence as a child, experienced childhood sexual abuse, had a violent partner, have severe or enduring mental health issues, or alcohol and drug problems. The evidence of victimisation experience being over represented in female offenders led to the conclusion that many women in custody 'can be described as victims as well as offenders'. The majority of women involved in street-level prostitution, for example, have experienced violence and untreated mental health problems as well as physical ill health.[180] Health inequalities actions that can mitigate against victimisation include the following areas.

Effectively supporting victims of violence

Victims of violence are especially vulnerable to negative outcomes as a result of their experience. These can include dissociation, substance abuse, depression and PTSD.[181,182] In some cases, these psychological and behavioural reactions can result in isolation and withdrawal from certain aspects of social life.[183] Moreover, being a victim of violence frequently has significant negative overall impact on intimate relationships, parenting, work functioning and un/employment.[184]

The experience of being a victim can be traumatic.[185] Type 1 trauma can occur in individuals who are victims of a single-event crime (e.g. a robbery or assault), while type 2 or complex trauma can develop in individuals who are exposed to repeated victimisation (e.g. frequent violence, domestic or sexual abuse).[186] Victims of personal assaults have a higher risk of developing PTSD than those who have experienced less personally traumatic events.[187] Crime victims are also more likely to suffer from PTSD, depression, obsessive–compulsive disorder and phobias than non-victims.[188] In the United States, criminal victimisation is the leading cause of acute stress disorder and PTSD,[189] thereby perpetuating experiences of trauma.

Trauma as a result of exposure to chronic periods of prolonged violence is further suggested as a significant risk for the perpetuation of a cycle of violence through 'experiences of violence as victims and later experiences of violence as a perpetrator'.[190,191] A substantial evidence base exists to support the assertion that chronic victimisation along with intergenerational violence is a significant predictor of

subsequent post-traumatic stress, aggression and antisocial behaviour in adolescent men.[192,193,194,195]

Recovery for victims occurs in three stages: (1) establishing safety; (2) remembrance and mourning; and (3) reconnection with ordinary life.[161] Medication along with a variety of psychological treatments have been shown to be effective in treating victims of crime, particularly in relation to depression and PTSD. Examples of this include cognitive–behavioural therapy [such as eye-movement desensitisation and reprocessing[196]], hypnotherapy and psychodynamic therapy.[197] Psychological debriefing[198] and trauma screening for PTSD after violent crime are found to be ineffective.[199] Treatment can be provided through the NHS, private health care or by some third sector organisations. NHS Boards should strengthen treatment access for victims of crime when presenting to health services. Particular focus should be on groups for which the trauma of physical or sexual assault is magnified and recovery inhibited (those with severe mental health problems, those with substance abuse disorders, LGBTI individuals and women involved in street-level prostitution).

However, mental health service utilisation for crime victims is low.[200,201,202,203] There are a number of barriers to seeking help for mental health concern, including long waiting lists for NHS psychological services and exclusions on services provided by third sector organisations (based on gender, geographical area or crime type). Furthermore, stigma has been found to be a significant factor impeding care seeking in this area.[204] Victims often engage with third sector organisations such as Victim Support Scotland, Rape Crisis and Women's Aid instead, as these agencies are often not associated with professional psychological treatment.

Reducing victim susceptibility to problem substance use

There is a clear relationship between trauma and problematic substance use. First, experiencing trauma can increase levels of substance use and likelihood of dependency. Young victims of attempted murder, for example, can have increased drug and alcohol abuse,[205] and female victims of domestic abuse are 15 times more likely to abuse alcohol and nine times more likely to abuse drugs than non-abused women.[206] This also reinforces a need to both prevent and mitigate the negative impact that adverse childhood trauma causes and the corresponding increased risk

of substance use, unplanned pregnancy and likelihood of offending and custodial sentencing.

Previous substance misuse has also been shown to increase the severity of PTSD symptoms and adversely affect recovery from trauma.[207] Women with lifetime alcohol use disorder can have higher intrusive and avoidance symptoms than those who do not, and women who present with alcohol problems can display higher PTSD symptoms.[208] As complex as this dual experience of offending and a life history as a victim with associated trauma can appear, this suggests that if all services were offered in a trauma-informed way, they would both improve health and contribute to reducing the impact of offending and sentencing on these individuals. This would likely also reduce the likelihood of a cycle of further victimisation and of offending.

Working with families as assets

Those most vulnerable in society and individuals living in Scotland's 15% most deprived communities are at greatest risk of crime. It is within these communities that the majority of people with offending behaviour and convictions reside and the risk of childhood and domestic violence and abuse is also highest in these neighbourhoods. These combined risk factors mean that the impact of offending and sentencing is most keenly felt by families living in these neighbourhoods, which are already vulnerable to social and economic deprivation. Health inequalities actions that can mitigate negative impact on families include the following areas.

Building the resilience of families

As most families of those who offend live in our most deprived areas, this creates cumulative disadvantages and inequalities. They can face a process of grief and readjustment throughout the arrest, trial, imprisonment and release of their family member. They often have difficulty getting the information and support they need to help them feel in control during periods of crisis and stress, causing uncertainty and fear.[209] No parent or family should feel isolated or that they lack the information, advice and support they need. Current estimates are that 27,000 children in Scotland every year experience the imprisonment of a parent.[210,211] More children each year are affected by parental imprisonment than by divorce.

Imprisonment can be a traumatic experience for families, and its impact is often significant and long term.[212,213] Families of people who offend experience multiple and often complex issues.[214] These can include:

- potential accommodation issues
- significant health and wellbeing issues including anxiety, distress, isolation, stigma, and rejection and/or victimisation by neighbours and the community
- uncertainty
- financial pressures
- problems in caring for children and the often complex impact on the children who lose a parent to imprisonment each year.

Building the resilience of children and young people

The children of people in the justice system are an overlooked and much neglected group. They are innocent victims who, if not recognised and supported, remain highly vulnerable and at risk. There is commonality with parental substance use research and evidence from criminal justice research which suggests that children of people with convictions are more likely than their peers to experience significant disadvantages. They often come from families with multiple and complex needs,[215] including social exclusion,[216,217] family financial difficulties, family discord and instability of care arrangements,[218,219] stigma,[220] isolation and victimisation,[221] and poor educational attainment.[222]

A health inequalities approach[223] therefore needs to consider children's needs when a parent or sibling is in prison. The amount of love and nurturing that a child receives is integral to their health, mental health and wellbeing,[224] not just in their early years[225] but also through childhood, adolescence and into young adulthood.[226] Those children who experience a secure loving and nurturing home environment are better able to withstand life's challenges and achieve their full potential. Positive parenting helps to develop strong self-control, reduce risks and build resilience to cope with setbacks.[227]

Empirical evidence of the impact on children and young people of parental involvement in the justice system is limited. However, there is a small but growing body of evidence that suggests that parental involvement in the justice system has association in children and young people with a range of emotional difficulties, including feelings of grief, loss and sadness, distress, confusion and anger, suffering depression, becoming withdrawn or secretive, showing regressive or attention-seeking behaviour, having disturbed sleep patterns, eating disorders, and symptoms of PTSD.[218,228,229,230,231,232,233,234]

There are established correlations between children affected by parental imprisonment, behavioural problems (including risk-taking behaviours) and school expulsion.[235] Children who are excluded from school by age 12 are four times as likely as other children to be imprisoned as an adult.[236] Two-thirds of boys with a parent in prison are likely to offend themselves.[237]

A review of risk and resilience in children of prisoners[238] suggests that effective interventions should seek to support children to better manage the experience of having a parent in prison through a 'positive psychology' approach. This increased focus on the improvement in a child's wellbeing can arise from appropriate support to both the child and the family unit or primary care-giver through interaction in both family and community environments.

Children are, however, not a homogenous group and ongoing developmental stages, family environments and wider social factors have influence on the impact of parental imprisonment at different ages and at different stages of the justice process.[239] For example, an infant, whose attachment becomes disorganised, can experience high levels of stress and anxiety without outwardly displaying symptoms.[133,240]

Involvement in the justice system experienced by families with complex vulnerability is often not a single discrete event, but more usually a complex and dynamic process taking place over time, punctuated by engagement in different aspects of the system. Each point in that process presents challenges to the resilience of the child, young person or family unit and has the potential to impact negatively. For example, police

arrests can be traumatic, bewildering and stressful because they are usually unexpected, and can be violent or confrontational, or unexplained to the child.[241,242,243]

In order to effectively mitigate parental involvement in the justice system, consideration must be given to the developmental stage of the child as well as their short-term needs and the potential long-term effects of the justice processes, including arrest procedure and consequent separation, parental absence during imprisonment and of reunion after release.[244] Further consideration and opportunity to mitigate at the point of sentencing will be strengthened by current proposals to integrate family impact assessments into proceedings in the event of parental sentencing to custodial care.

While evaluation evidence on effectiveness and impact varies, a range of services specific to the rights and needs of children and families affected by imprisonment operate good practice in Scotland and are captured in **Appendix 2**.

Opportunities in police custody and liaison

A single force, Police Scotland, was created in April 2013 and the overall responsibility for healthcare provision in police custody transferred to the NHS in 2014. Services are provided through forensic medical examiner services and nurse-led services which: assess the needs and fitness of people with substance use issues and people with mental health problems; attend to injured detainees or police officers; and examine adults and/or children alleging sexual assaults and alleged assailants.

A range of other services through nurse liaison, specialist in-reach and triage have emerged since the transfer of responsibility. Providing care in police custody that is equitable and does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socioeconomic status is central to the ethos of the provision of health care in Scotland.[245]

Although evidence is limited, a degree of caution should be applied to measures open to the police such as arrest referral or fines, and measures such as Community Payback Orders (CPOs) (see **Increasing community-based sentencing***)* which can be highly effective, particularly where social work assessment reports direct suitability, but could have an unintentional unequal impact if they hinge for instance on an ability to pay or ability to complete unpaid work. The caution is that this could unintentionally exacerbate health inequalities that already exist as well as undoing the potential these alternatives have to tackle associated offending behaviour. Diversion to support and if required treatment services, at police discretion, is likely to be more effective and reduce negative impact.

Useful policy levers

The report of the Ministerial Task Force on Health Inequalities (Scottish Government (2008)[246] noted that people in the justice system, including those in police custody, should have access to the health and other public services they need, and benefit from the same quality of service as the rest of the population. This principle applies equally to alleged offenders in police custody. This is reaffirmed by professional bodies such as the British Medical Association (BMA) and the Faculty of Forensic and Legal Medicine (FFLM) who note that 'As a general principle, the standard of care for detainees should be equal to that provided by the NHS'.[247] The BMA and FFLM recognise the challenging environment healthcare professionals find themselves in, noting that forensic physicians 'need to be continually aware of the obligation to respect detainee's human rights and to be sensitive to ways in which those rights can be compromised'.[247]

The Strategy for Justice in Scotland 2012 provided a wider vision of a justice system that contributes positively to a flourishing Scotland, helping to create an inclusive and respectful society in which all people and communities live in safety and security, individual and collective rights are supported, and disputes are resolved fairly and swiftly. Priorities include tackling crime by reducing reoffending and tackling the underlying causes of crime, as well as reducing the damaging impact of drug and alcohol problems. The new **Vision and Priorities for Justice in Scotland, 2017**[248] builds on this approach, as it is framed by the definition of community justice within the new legislation. Police custody provides an opportunity for both secondary

prevention and mitigation of any negative impact of arrest. In particular, health inequalities actions across the following key strands are essential.

Reducing alcohol and drug misuse

Many offences are committed under the influence of alcohol and drugs and increase potential interactions with the justice system. ABIs have recently had an increased focus on alcohol use within justice settings, in particular within prison custody. However, while delivery of ABIs have become a common feature of good practice in NHS and third sector in-reach, there is currently limited evidence on their direct impact on offending through delivery in police custody settings.[249]

Early interaction with the system can provide an opportunity for earlier intervention with a group whose substance use and underlying inequality or health and wellbeing issues are the trigger for contact with the justice system – sometimes at the start of a cycle of offending and justice system involvement.

This can be, for example, through screening and delivery of an ABI or referral to a follow-up drug treatment programme – both of which have been trialled in Scotland through arrest–referral to a nurse liaison service (e.g. NHS Tayside and NHS Greater Glasgow & Clyde) and local third sector in-reach to custody (West Lothian Alcohol and Drug Service, piloted with NHS Lothian).

For those who have a substance use problem, creating various access points to recovery-focused treatment options and services is important in a ROSC. Recovery is the process through which an individual is enabled to move on from their problem drug use towards a drug-free life and become an active and contributing member of society.[108] The underlying philosophy of a ROSC is that treatment, review and aftercare are integrated, and priority is given to empowering people to sustain their recovery.

While custody is not always the right environment for effective recovery-focused treatment, it may be the first time an individual has contact with a ROSC. Therefore, arrest provides an opportunity to engage individuals for referrals to appropriate services while keeping them safe and free from harm during their time in custody. A

suite of national police custody outcomes and indicators expands on this approach, alongside the substance use guidance from the National Coordinating Network for Healthcare and Forensic Medical Services for People in Police Care (2017).[127]

Improving mental health

Unnecessary processing through the justice system, including remand in police custody, is particularly and disproportionately damaging for those with mental health issues.[250,251] Presenting issues including problems communicating and exacerbation by drug and alcohol use can mean that direct or diversionary measures are not used effectively for people experiencing poor mental health. Liaison and rapid referral or follow up by health and social care support are more likely to be more cost-effective and appropriate to these needs. A range of diversionary and community alternatives to custodial sentencing are outlined in Chapter 3.

People with learning difficulties and disabilities can also come in contact with justice services. Online resources[252] and a range of professional practice guidance documents[44,253,254,255] can assist frontline staff in contact with these individuals. There are opportunities through working in partnership at these earlier stages which can also help identify health and wellbeing issues that might drive offending behaviour and provide opportunities to build pathways into appropriate support, for instance by an intervention at the point of arrest or while in police custody. The necessary components of an effective service for police and courts for these individuals would consist of:

- Police obtaining rapid assessments of those taken into custody who they believe to be disordered or impaired. Specifically, provision of appropriate assistance to people with learning disabilities or impairment through brain injury needs to be readily available.[256,257] These schemes require workforce development and will depend on whether or not the police believe accessing these services lightens, or increases, their workload.
- Diversionary schemes to shift, where appropriate, individuals with mental health problems, learning disability and brain injury from the criminal justice system to the best and most appropriate services. Ideally this involves health professionals willing to go to police lock ups and courts to assess and admit

when indicated, and emergency clinics willing to accept as patients for assessment individuals who are brought to them by police.

- Court liaison services to provide onsite assessments and arrange diversions when necessary.[258,259,260] Such services are based on psychiatrists, psychologists and mental health and learning disability nurses who attend court when requested or who are placed permanently in larger courts. This would be preferable as these staff gradually become integral to the court process and more appropriate use is made of their services.
- Often people with mental health problems or learning disability are placed in prison custody because the courts saw no alternative placement. The use of bail hostels have much to offer in reducing the unnecessary imprisonment of distressed and vulnerable individuals.[261]
- People with a learning disability should either not be placed in prison custody or, if they are, they should be provided specific placements and services, the rhetoric of normalisation notwithstanding.[262,263,264] Currently, diversionary programmes for such individuals are poorly developed. The focus appears to be more on assisting them though the justice process than reviewing them at the earliest stage in that process.[265]

Preventing suicide and self-harm

Many people who die by suicide have a history of self-harm, and we also know that the relationship between suicide and self-harm is complex. The first commitment in the Scottish Government's Suicide Prevention Strategy 2013–16[266] was to undertake separate work, in 2014, on supporting people at risk of non-fatal self-harm, including those in distress. Several stakeholder events were held in 2014 and 2015 (Perth, Edinburgh and Glasgow) to consider how to reshape and improve responses to people in distress.

One illustration that spotlights good practice includes work with the British Transport Police (BTP) – the national police force for the railways. They have two joint health and policing suicide prevention and mental health (SPMH) teams, made up of NHS mental health nurses, BTP officers and staff, and their job is to deal with suicide incidents that occur across the rail network. The role of the teams is to provide advice and guidance to officers while they are supporting people on the rail network,

and to follow up all cases. As part of case follow-up, in some cases SPMH teams work with police and health teams to provide additional support in the form of a suicide prevention plan.

In 2014/15, the SPMH teams dealt with 1,156 people on suicide prevention plans across the whole rail network (including the London Underground), with less than 1% of those going on to take their own lives. This clearly demonstrates the tremendous work of the SPMH teams and BTP officers; however, every suicide is a tragedy and BTP continue to work to reduce this figure to zero.

The Scottish Government Suicide Prevention Strategy 2013–16 aims to reduce suicide and focuses on five key themes of work in communities and in services, and made 11 commitments to continue the downward trend in suicides and contribute to the delivery of the National Outcome to enable people to live longer, healthier lives.

The key themes are:

- responding to people in distress
- talking about suicide
- improving the NHS response to suicide
- developing the evidence base
- supporting change and improvement.

National leadership by the Scottish Government on reducing suicide – together with the retention of local ChooseLife co-ordinators – provides support and direction for this national and local work. In 2017, Scottish Government will engage to inform on a new Suicide Prevention Strategy and Action Plan for Scotland.

Increasing alternatives and diversion from prosecution

In some less serious offences, although the procurator fiscal may consider that it is in the public interest to take action, prosecution may not be the most appropriate course of action. In those cases there are a number of direct measures available.

As a direct measure, individuals may be:

- given a warning by the procurator fiscal
- given the option of paying a fine or fixed penalty
- given the option of paying compensation
- offered the chance of referral for specialist support or treatment; otherwise known as diversion.

Through the range of alternatives to prosecution, costs in the justice system can be substantially reduced. Additionally, the accused does not have a criminal conviction recorded against their name, members of the public are spared the inconvenience of attending as witnesses, and courts are freed up to spend time dealing with more serious cases.

Diversion is an alternative to prosecution often applied through social work and third sector individual and group work to meet the needs of those within the justice system. While such interventions can appear costly, the costs of diversion need to be set against the other benefits to the accused, a trauma-informed approach to supporting victims and, if further offending is prevented, there is a benefit to society.

There is some evidence that specific targeting of health and wellbeing issues as part of diversion from prosecution schemes can be effective in terms of both reducing offending and improving health,[267] specifically these include mental health,[268,269] alcohol and drugs but also can help with benefits, budgeting and other skills.[247]

Issues of gender-based violence and abuse, however, do not fit into a diversionary approach, being particularly complex in cases of domestic violence. Use of fines can also, unintentionally, impact negatively on children and families by eroding income and increasing likelihood of offending, or dependence on an abusive partner.

Fiscal Work Orders (FWOs) were introduced by the Criminal Proceedings etc. (Reform) (Scotland) Act 2007[270] and are also available as a form of direct measure – an alternative to prosecution designed to prevent minor offences from tying up court time. FWOs provide the procurators fiscal with the option of offering an alleged

offender a period of community-based reparative work (of between 10 and 50 hours), completion of which discharges the right to prosecute for the related offence. Seven FWO pilots were run in various local authorities across the country. Four initial sites in the Highlands, South Lanarkshire, West Dunbartonshire and West Lothian began operation during the course of 2008, and a further three were set up in Aberdeen, Edinburgh and Dundee in early 2011.[271] FWOs were made available across the whole country in April 2015. Health inequalities actions that can increase alternative sentencing and diversion should focus on the following areas.

Young people, maturation and criminal justice

In Scotland, young people under 21 accounted for 10% (9,182) of all cases of males with a charge proved in Scottish courts in 2013–14, and 8% (1,431) of all female cases. As a result, under 21s received over 1,300 custodial sentences and over 2,960 community sentences (criminal proceedings in Scottish courts 2013–14).[272] The picture is improving – the numbers of young people in Scottish courts has reduced by almost 20% in the last 10 years.

Behind these statistics, it is also accepted that childhood abuse and neglect is underreported. Despite this, estimates suggest that 16% of the UK population of children and young people have experienced some form of abuse or neglect. However, this figure is suggested to rise significantly for those children and young people living in poverty. Prevalence for children and young people involved in the justice system is estimated at somewhere between 33 and 92%, with sexual abuse rates for young women in the justice system being particularly high.[272] With the potential for trauma prevalence to be over 90% of youth and young adult offenders, treatment as offenders rather than as victims may result in retraumatisation and compounding of the mental and emotional effects of their experience, as outlined in chapters above.

The criminal justice system differentiates between adults and youths based entirely on the age of the individual. However, age alone does not determine an individual's maturity and developmental stage. Sociological, psychological and criminological research all indicates that development and maturation continue well into early adulthood. For example, brain development and maturation, in particular higher

executive functions of the brain that control impulse, planning and memory, continues on average until age 25.

Many criminal justice systems in Europe recognise this by making provision in legislation and practice for greater flexibility and personalisation in the justice system and its courts when dealing with young adults. Countries such as Germany and the Netherlands have extended juvenile justice measures to young adults, thus granting the judiciary more flexibility in their dealing with young adults in the justice system. In Scotland, FWOs were introduced in 2007 for first-time or low-tariff individuals aged 16 and above, and while pilots were evaluated in 2011, limited evidence of their effectiveness in reducing reoffending has been captured.

Building on a WSA

Young people aged 16+ who are involved in offending fall into the 'transitions' group, moving from the youth to adult justice systems. Young people may receive an age-specific response, in some cases up until 25, although in practice most people aged 21+ involved in offending will be dealt with under the adult system.[273]

The youth justice system in Scotland is underpinned by the same principles and processes that cover all intervention with children and young people – GIRFEC and the Children's Hearings System. Youth justice has typically focused on 8-to-16-year-olds but links to families and their needs are strong. Several useful resources are available on the Scottish Children's Reporter Administration website online at: **www.scra.gov.uk/resources_articles_category/resources-for-partners**

In 2010, the Scottish Government endorsed a new approach to achieve positive outcomes for vulnerable young people. The whole-system approach (WSA) is a multiagency approach to prevent and reduce offending by children and young people. The WSA aims to support those who offend with early and effective interventions and provide robust solutions for those who present the greatest risk. In order to achieve this aim, the WSA requires efficient use of planning, assessment and decision-making processes for young people who offend to facilitate more effective intervention at the right time. The ethos of the WSA suggests that 'many young people could and should be diverted from statutory measures, prosecution

and custody through early intervention and robust community alternatives'.[274] The components of the WSA are different in different areas but should look to provide some or all of the following activity:

- Early and effective interventions for low-level offences, offering support and advice to young people in order to address need and change behaviour.
- Diversion from prosecution, where the needs and risks of the young person are addressed.
- Robust alternatives to secure care and custody. Locking up young people is not effective in reducing reoffending. By providing the children's panel and courts with robust alternatives to custody young people's risks and needs can be addressed within the community.
- Effective risk management measures, where the risks some young people present are managed by partners through the children's hearings system as opposed to adult courts.
- Supporting young people if they do appear in court, to aid their understanding of the process and advise decision-makers of options available within the community.
- Support offered as part of reintegration and transition back to the community from secure care and custody, including working with families in order to reduce reoffending.
- Encouraging more cases to be dealt with through the children's hearings system rather than adult court.
- Retaining more young people on supervision requirements through the children's hearing system, where there is a need to do so.

Both policy guidance[275] and early research by McVie and McQueen[276] show the approach can be an efficient means of addressing a range of complex needs and effectively achieve positive outcomes. Programmes frequently feature interventions on mental health and wellbeing, and substance misuse. This approach tends to focus on under-18s only, although it has been tested on older age groups in some areas.[277] A national evaluation of the WSA and three local case studies were published in 2015.[278]

There is also potential to apply the principles and ethos of this approach in parallel to how GIRFEC can inform our work, with vulnerable adult individuals held within the justice system.

The youth justice strategy for Scotland, 2015–2020[279] has a strategic focus on advancing the whole-system approach, improving life chances and developing capacity and improvement and will strengthen the partnership working which is critical to any positive impact on young people at risk of involvement in justice services.

Increasing community-based sentencing

Many individuals serving a community sentence are still living in the family unit with their children and are still part of the community. In women and in many young people, there is a higher likelihood of previous experiences of trauma as children or as an adult. This again requires a trauma-informed approach to ensure avoidance of negative impact, poor care and management, and an unintended retraumatising of the individual.

A public consultation on extending the presumption against short sentences was undertaken in 2015. This could present an opportunity to strengthen and increase community sentencing,[280] and community alcohol, drug and mental health treatment access. This could further support justice evidence below on the ineffectiveness and unintended greater likelihood to reoffend which can arise from short sentence decisions and also acknowledges the missed opportunity, through alternatives to custody, to address the social and health determinants of offending.

Individuals with complex histories of substance use, trauma, violence and poor mental health also often struggle to access or engage consistently.[146,163] There are signs of success in prevention, care and recovery through longer-term strategies and a more cohesive and co-ordinated approach between services in the community.[281] The potential negative consequences of persisting with short sentences are high.[282] Fewer short sentences and fewer repeated sentences for individuals would save costs, be more effective in delivering the aims of reducing reoffending[283,284] and

protecting community safety. Community alternatives are often more effective and essential to maintaining individual assets, including family support and positive relationships.

In the 'Healthier People, Safer Communities' framework published in 2013,[285] partnership working, joint outcomes between justice and health, and an assets-based approach are fundamental to community-based approaches to reducing reoffending. The potential unintended impact on families and on children through custodial sentencing decisions, both for men and women, should be a major consideration and in the majority of cases result in a strengthening of diversion and community sentencing. Health inequalities actions that can increase these approaches include the following areas.

Effective use of electronic monitoring

Electronic monitoring[286] has been available in Scotland since the national rollout in 2002[287] and can support agencies working within justice and youth settings. This followed pilots in three Sheriff Courts in 1998 (Aberdeen, Peterhead and Hamilton), initially applied to Restriction of Liberty Orders. As this approach has developed and judicial confidence has increased their use, a number of community sentence approaches are using electronic monitoring as part of the condition of sentencing: Drug Treatment and Testing Orders (DTTOs), Home Detention Curfews, Restriction of Liberty Orders and Movement Restriction Conditions for young people.

In September 2013, the Scottish Government embarked on a period of consultation[288] to examine options for the development of electronic monitoring in Scotland. This consultation sought views on the operation of the current electronic monitoring service as well as options for future development of the service. An expert working group was set up to explore opportunities around the use of electronic monitoring and the effectiveness of GPS and remote alcohol monitoring technologies to ensure they are fit for purpose before any decisions are made about their future use.[289]

This technology is potentially versatile and can be used in a number of different ways as an alternative to custody for those appearing at court, to sustain early liberation

from custody and the transition from custody to the community. It also supports the work of the Parole Board, local arrangements for Multi-Agency Public Protection Arrangement (MAPPA) and offers an option to the Children's Hearing System for both people who have offended and victims of crime through application of 'away from' orders for specified locations. The current use of personal identification devices and home monitoring units can potentially be extended to the use of GPS technology to more specifically track individuals across Scotland and introduce greater flexibility and specificity to monitoring on hours applied, location and ability to promotion of positive choices and behaviours.

The potential exists, therefore, for a reduction in the cost or inappropriate use of prison custody, the applications for conditions of parole as well as opportunities to strengthen transition and accelerate community reintegration. This approach would also enhance opportunities to moderate, incentivise and align actions and behaviours to complement approaches to recovery, treatment, employment, family support, self-management and mutual aid, as well as satisfy the decision and intentions of the imposed sentence.

The success of this approach and increased use of these technologies does not rely solely on justice services. A co-ordinated and collaborative effort across health, social work, benefits and welfare, housing, children's services, mentoring, mutual aid and support agencies will be required to sustain these interventions. It will also be required to align with the mutually beneficial outcomes to reduce the likelihood of further offending, improve wellbeing and strengthen resilience in individuals, reduce victimisation and improve outcomes for children and families affected currently by custodial sentencing.

Increasing use of DTTOs

The primary aims of DTTOs are prescribed by legislation under section 234B of the Criminal Procedure (Scotland) Act 1995.[290]

The function of the DTTO team is to deliver assessment, statutory supervision and holistic treatment services to enable it to offer effective and credible alternatives to the use of custody and traditional court disposals to those with drug use issues to

receive support within the community. The interventions employed by the DTTO team need to break the cyclic pattern of heavy drug misuse, associated offending behaviour and prison.

The principles that govern the service provision are:

- treatment provision must be robust and effective
- commitment to proactively retain drug users in treatment
- reduce the harm caused by illicit drug use and related offending behaviour in terms of individuals, families and communities
- promote the physical, mental and emotional wellbeing of service users
- protect service users and their families from neglect, abuse, exploitation, harassment or discrimination
- ensure service users have choice, dignity and respect
- commitment to the process of multidisciplinary/multiagency working to achieve positive outcomes for both the court and the service user.

Increasing use of community treatment

Drug misuse is a high risk factor and a significant proportion of people in justice services who are assessed as having this particular criminogenic need. A meta-analysis of drug treatment programmes in Europe found that treatment reduces the likelihood of further offending in those with drug problems.[291]

In 2012–13, 15% of those appearing in court in the NHS Greater Glasgow & Clyde area were given a community sentence, just slightly more than those given a custodial sentence (14.8%). The majority of the community sentences imposed were CPOs.[292] These orders have nine requirements associated with the order which can be used singly or multiply at the point of sentencing. Three of these requirements are directly related to a health input and offer potential to reduce offending through access and engagement with a structured health intervention:

- a mental health treatment requirement
- an alcohol treatment requirement
- a drug treatment requirement.

The mental health treatment requirement appears to be rarely used in Scotland. In the main where low use is reported, it was considered to be owing to the following threshold and delivery factors:

- There is a need for a diagnosis before a mental health treatment requirement can be imposed. Several areas highlighted the difficulties in getting a formal diagnosis in time for sentencing.
- Individuals in the justice system who are assessed as having a mental health problem that does not constitute a formal diagnosis have their needs addressed under supervision, other activity or conduct requirements.
- Individuals in the justice system with a formal diagnosis are often already in contact with mental health treatment services.

Where mental health treatment requirements have been imposed, local authorities highlight the importance and positive impact of multiagency working. A number of areas have appointed dedicated mental health officers within criminal justice teams and this has highlighted the improvements made to streamlining access to specialist support and services.

Little evidence is available on the effectiveness of mental health interventions in prison and community justice settings. Researchers have also noted there are gaps in service provision for young people aged 16–18.[293] The use of drug and alcohol treatment requirements is also low. This is particularly pertinent in view of the high number of individuals in the justice system who reportedly misuse alcohol and/or drugs. In the main where low use was reported,[294] it was considered to be caused by a number of similar threshold and delivery factors:

- those with drug or alcohol misuse problems are already in treatment
- addiction support and/or counselling are provided for under a supervision, conduct or other activity requirement
- those with substance misuse problems do not meet the stringent criteria for a drug or alcohol treatment requirement (but, as noted above, are supported to access substance misuse services through a different requirement)

- in the case of drug misuse, it was highlighted in several reports that there appears to be a preference to impose a DTTO over a drug treatment requirement.

Alcohol misuse increases the risk of reoffending, however, there is no evidence as yet to show a direct effect of alcohol treatment on reduced reoffending, although alcohol interventions can reduce alcohol problems more generally.[295] In harmony with the proposals to reduce the use of short sentences, thresholds for alcohol, drug and mental health/distress treatment and recovery support should be lowered and services should be integrated to capture greater opportunity to intervene on these determinants of offending.

Increasing use of other purposeful activity

The ‘other purposeful activity’ component of the unpaid work and other activity requirement places a responsibility on the individual to develop their interpersonal, educational or vocational skills to enable their desistance from offending. Criminal justice social work staff work with them to identify and arrange the type of other activity to be undertaken, if appropriate. Where it is agreed with the individual that other activity should be undertaken, this component of the CPO must not exceed 30% of the specified number of hours in the unpaid work or other activity requirement, or 30 hours, whichever is lower. As with unpaid work, a diverse and considered range of other activities have developed, many of which mirror the widening of purposeful activity offered within the prison service for those in custody.[296] Local authorities report that CPO teams take a creative and person-centred approach to the other activity element of the requirement. Some activities noted that have already been used in this approach include:

There is an opportunity through partnership working to utilise these other activity hours to greater effect, improve health and wellbeing and address any health problems.

Building integrated approaches

For those with substance misuse issues, rapid access pathways to support and intervention can reduce crime, as well as reduce associated mental health problems, therefore boosting recovery from harmful or dependant substance use.[297]

In addition to these issues, a range of other social determinants such as accommodation, employability and literacy are captured in, for example integrated pathways for prison and community interface for working with substance misusing offenders.[298] The scope of these includes opportunities from arrest to reintegration and the arrest referral component introduces earlier opportunity across local authority areas to increase access and engagement with services and ultimately reduce reoffending behaviour.

The Persistent Offender Project run by Glasgow Addiction Services[299] was evaluated in 2008 and was developed in response to the disproportionate amount of acquisitive crime due to drug use and the associated consequences of addiction, poor mental health, poverty, homelessness and imprisonment[300]. On evaluation of the project, a reduction in conviction for offences, a reduction in time spent in custody and, while no formal economic evaluation was carried out, encouraging signs of reduced cost were identified.

The 'problem-solving courts' approach is being implemented by Glasgow Drug Court for offences where drug use has been a factor. Holloway *et al*.'s meta-analysis found that drug courts were effective interventions in reducing drug-related offending.[301] A separate review of the effectiveness of drug courts in reducing reoffending found that the vast majority of studies reported a reduction in offending for drug court participants.[302]

A mental health court model with a set of key principles has also been developed in the USA.[303] These outline eligibility, referral, screening, assessment and links to community-based interventions for mental health problems. Similar models to reduce the harm through gender-based violence, to target young people and to support veterans who offend, are also being developed there to tailor interventions to these complex needs.

Optimising custodial care

A range of policy and strategy levers exist relating to custody and care, and the responsibility for health care and wellbeing in both police and prison custody which lies with the NHS. Co-ordinating and implementing this range of complementary levers remains a challenge. In 2012, 'Better Health, Better Lives'[304] put in place a framework for addressing and improving the health of those people serving a custodial sentence. In his foreword to this, the then Chief Medical Officer stated:

> 'Part of the contribution of prison health services reduces the harm that loss of liberty incurs – harm to the prisoner, the effects on other prisoners, but

particularly harm to children, families and communities they leave behind and, usually and inevitably, to whom they return'.

The wellbeing and provision of health care and access to interventions applies equally to individuals held on remand, although these individuals often receive very basic levels of support. As with content above, for lower tariff offences, diversion, community diversion and community sentencing is preferable to (and more effective than) a short period in prison custody.

In general, prisoners, both before and on liberation from prison, live in the poorest areas of Scotland. The Scottish Public Health Observatory (ScotPHO) Healthy Life Expectancy Report[305] noted that in 2011–12, male life expectancy at birth in Scotland ranged from 71.3 years in the 20% most deprived areas to 81.7 years in the least deprived 20% of areas (a difference of 10.4 years). These health inequalities are further exacerbated by the even higher rates of premature death that people with convictions experience, related to violence, accidents, substance misuse and suicide.[306,307]

Policy levers on prisoner health and wellbeing

The 'Better Health, Better Lives' national prison health improvement framework[304] document was developed through a partnership with the SPS, the Scottish Health Promotion Managers' group and ScotPHN. The framework was launched in 2012. It has been used since as a resource for action planning, focusing on policy development; the creation of healthy working, living and learning environments; and prevention, health education and other health promotion initiatives.

The framework is a practical guide to assist the development and implementation of action that will contribute to improved health outcomes and a reduction in health inequalities. Although based around health 'pillars', in order to reduce the risk of silo working, there are four unifying themes. These attempt to highlight where there is the opportunity for prisoners, prisons and stakeholder partners to be involved and specifically address the prison context for that individual topic area.

The four unifiers are:

- prisoner involvement
- healthy prison policies and environment
- links with community and public sector services
- measureable outputs and outcomes.

Implementation of Better Health, Better Lives is at different stages across the 15 establishments in Scotland, however, the SPS is ensuring local delivery is progressed by providing the support and infrastructure that will deliver a consistent whole-prison approach to health improvement, and ensuring appropriate links are maintained on transition to the community. Further health inequalities actions that build on this approach and can further optimise custodial care include the following areas.

Tobacco control

Rates of smoking in prisons are extremely high and meeting this challenge presents an opportunity for health improvement. This high rate has been consistently reported in the SPS biannual surveys, with the 2015 survey reporting that 72% of prisoners smoked.[308] This contrasts with a prevalence rate of around 23% in the rest of the community, although it is notable that this can vary across Scotland. Prisoners can be a key subpopulation to target with smoking cessation interventions. The more times an individual appears in custody, the more likely they are to smoke: 60% smoke who have never previously appeared in custody; 74% one to five times; 86% 6–10 times; 89% > 10 times. However, three out of five (60%) smokers surveyed expressed a desire to give up smoking.

The justice setting offers the opportunity to engage with hard-to-reach smokers and presents a location and time for smokers to access smoking cessation support. Successfully quitting smoking can result in a sense of positive achievement of a goal, and improved health outcomes for the prisoner, their families and the wider community.[309]

The Scottish Government's recent tobacco control strategy, Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland (2013)[310] outlines the importance of reducing health inequalities and the role and contribution that reducing smoking rates in the most deprived communities can make to this. This is reflected in the Scottish Government's recent health improvement (HEAT) target for smoking cessation services, which since 2011 has had an increasing focus on successful quit outcomes by smokers living in their NHS Board's Scottish Index of Multiple Deprivation (SIMD) 1 and 2 areas (or SIMD 1, 2 and 3 for Island Boards). The Scottish Government's strategy contains ambitious aspirations for a smoke-free Scotland stating that:

> 'In line with developments across Scotland, creating a smoke-free prison service should be seen as a key step on our journey to creating a smoke-free Scotland.'[310]

In order to achieve this, the strategy identified an action for the SPS to have in place by 2015 a plan that sets out how indoor smoke-free prison facilities will be delivered. An SPS-chaired multiagency strategic group is driving this task having both reviewed the literature and commissioned research initiatives to evidence impact. The Scottish Prison Service (SPS) has **now announced** its intention for all prisons in Scotland to be smoke free by the end of 2018. Having a high-quality and consistent national smoking cessation service on offer to all prisoners in Scotland is fundamental to progressing with these plans. NHS Health Scotland published a new prison smoking cessation service specification for use by all NHS Boards in March 2016.[309] This was developed through a subgroup of the NHS Boards' Smoking Cessation Co-ordinators' group.

The 2015–16 Local Delivery Plan (LDP) standard performance target (replacing the HEAT target) will now include all quits from prisoners. The inclusion of prisoners' successful quit outcomes within the target emphasises the increased priority of this group, which is also highlighted in the review of NHS smoking cessation services (2014).[311] Data in relation to smoking cessation quit attempts and outcomes are entered into the national smoking cessation database, managed by ISD, available online via the ScotPHO website.[312]

Reducing the impact of alcohol and drug misuse

Nearly three-quarters (73%) of prisoners have an alcohol use disorder with over one-third (36%) likely alcohol dependent.[313] It should be noted that not all alcohol problems in prisoners are necessarily linked to their offending behaviour. Men who have been imprisoned in Scotland were nearly three times (2.9) more likely to die an alcohol-related death, with figures for women being nearly tenfold (9.3).[314] The justice setting provides an opportunity to detect, intervene and signpost to treatment those who are otherwise 'hardly reached'. Although there is some evidence that prisoners may be unwilling to admit to having an alcohol problem,[315] others are willing, with two in five prisoners saying if they were offered help for their alcohol problem in prison they would take it. Treating alcohol problems for those who offend also has the potential to contribute to tackling health inequalities in prisoners who are predominately from disadvantaged areas[306] and disproportionately suffer from alcohol-related harm.[316]

Most custodial periods are relatively short but the opportunity that involvement in the justice system provides can be used to maintain or initiate treatment which is consistent with community-based approaches.[317] The best available evidence also suggests that treatment in these situations should be through using the appropriate substitute drug and maintaining this for a prolonged period, often at least two years.[318] Therefore, treatment should often continue until and after discharge from custody with no interruption. Buprenorphine should be available as an alternative to methadone where appropriate,[319,320] for example longer custodial periods.[321] Naloxone should also be made available to all those leaving these settings who are at risk of opiate overdose.[322] These consistent and safe approaches have been further strengthened with the publication of the final workstream report on substance use by the National Prison Healthcare Network in 2016,[323] which reinforces both harm-reduction opportunities and alignment with substance use recovery.

Improving mental health and reducing suicide risk

The prevalence of psychiatric morbidity and substance misuse are higher among prisoners than the general population.[324,325,326] Indeed, the growing prison population means that there are now more people in prison with mental health problems than ever before.[44] There is widespread concern that the prison environment, with its rules and regimes, may have a detrimental impact on the mental health of prisoners, and those with mental health problems in particular.[327]

The handover of responsibility of prison health care from the prison service to the NHS has heralded significant developments in prison mental health and substance misuse services.[328,329,330] Indeed, current prison healthcare policy asserts that prisoners are entitled to the same range and standard of care as that received by the general population in community settings.[331]

Delivering quality healthcare services in prisons is a complex undertaking, hampered by not only the high level of need among prisoners, but also the constraints of the prison environment, which is often viewed as anti-therapeutic and counterproductive to the effective provision of care.[332,333,334] Factors such as overcrowding, separation from family and friends, boredom and loss of autonomy have all been identified as being potentially detrimental to mental health.[335,336,337] Research also indicates that some groups of people do experience a decline in mental health in prison. These individuals are more likely to be female, on remand, have a pre-existing severe and enduring mental health problems or some combination of these factors.[338]

Given that, on average, women serve shorter sentences than men, it is plausible that many may have been approaching release. Shorter time in contact with services within prison and more imminent release dates have been suggested as the cause of the gender effect of prison and mental health. Release may bring uncertainty with regard to reforming relationships, arranging housing and regaining access to children, an issue particularly relevant to women prisoners. Given the high proportion of prisoners with histories of trauma and physical and sexual abuse, especially women,[339,340] this is an area that deserves further attention.

However, prison does not have a universally detrimental effect on mental health, with several studies indicating that symptoms can also generally improve over time in prison.[341] Most prisoners, even those with mental health problems, do not experience deterioration in their mental health while in custody. The improvements in symptoms observed may have partly been owing to input from health services while in custody. Indeed, prison may provide an opportunity for offenders who were struggling previously to engage to settle into a more stable routine and engage with services.[118]

Studies have also indicated that symptoms of negative mental health and suicidal ideation were found to decrease in convicted prisoners, but it is notable that no significant decreases were found among remand prisoners using the same measures. Indeed, higher rates of mental disorder have been indicated in remand prisoners than in convicted prisoners.[342] The failure of remand prisoners to 'settle' in line with their convicted counterparts could plausibly be explained by the increased uncertainty, stress and anxiety levels associated with being on remand.

Within prison custody, ACT2Care was the strategic framework for suicide prevention from 1998–2016. ACT2Care was extensively reviewed in 2014 to reflect the change in responsibility for primary health care within prison to the NHS in 2011.[343] From December 2016, it was superseded by the revised strategy, Talk to Me, which incorporates many of the key aims and principles of ACT2Care.[344] It builds on the proven success of this multidisciplinary strategy, adding increased emphasis on individualised care planning and support for those in distress.

The principle of providing individualised care through effective assessment and engagement and working effectively as a team are paramount. The key aims of Talk to Me are:

> 'To assume a shared responsibility for the care of those 'at risk' of suicide; to work together to provide a person centred care pathway based on an individual's needs, strengths and assets and promote a supportive environment where people in our custody can ask for help'.[344]

Talk to Me also intends to encourage:

- improved family involvement, care planning and communication
- less dependence on safer clothing and accommodation
- improved recognition of a ‘supportive environment’
- more use of ‘day care’ and other out-of-cell activities
- improved culture of contact and support.

This is seen as a key measure of prisons moving towards an improved person-centred, asset-based care approach.

Across most prison establishments, in collaboration with Samaritans, volunteer listener schemes operate as peer support services, which aim to reduce suicide and self-harm in prisons. Samaritans volunteers select, train and support prisoners to become listeners. Listeners provide confidential emotional support to their fellow inmates who are struggling to cope. Selected prisoners attend an intensive training course. This is based on the training that Samaritans’ volunteers undertake but is adapted to the prison setting.

On completion of their training, listeners receive a certificate and agree to follow Samaritans’ policies and values. Prisons aim to have enough listeners available round the clock, for anyone who needs them. Support is given in private to allow complete confidentiality. The policy on confidentiality is the same as it is for Samaritans volunteers. Knowing that the service is completely private often gives prisoners the courage to ask for help and talk about what is getting to them. Even after a listener has left prison, their work as a listener must remain completely confidential.

Listeners are not paid and do not receive any form of benefit for their role. However, these schemes have established a strong culture of peer support and mentorship, which is now being applied to wider outcomes of recovery, identity and employability to strengthen reintegration and fit well with established community-based services and organisations. Evidence on peer approaches are also captured below under ‘Building resilience and sustaining change’.

Improving sexual health and wellbeing, and reducing blood-borne viruses

Consideration and discussion of sexual health and wellbeing in the prison context is an issue which can elicit embarrassment, controversy and conflict in opinion. Research on the impact of custodial care on individuals' sexual health and wellbeing were previously small in scale and often limited in the range of issues considered.

In 2012, Howard League for Penal Reform established an independent commission on sex in prison[345] to review the limited British evidence and amass new evidence to facilitate the understanding of consensual and coercive sexual activity within prison, and the sexual development of young people in prison. The commission reported that from both the academic and collected evidence, the majority of prisoners satisfied their sexual desires and needs while in prison through masturbation but that a minority of prisoners did so through active sexual practice with another individual.

The emphasis on maintaining contact and relationships with families and partners being a central element of reducing reoffending programmes also raises the consideration of the health of prisoners' partners. If a prisoner should acquire an STI while in prison they will potentially take that back into the community when they leave, and infect sexual partners. Sexual health in prison needs to be considered as part of wider public health programmes and as WHO has noted 'protecting prisoners' health protects general public health'.[346]

The nature of the prison environment as one that constrains an individual's usual behaviour and choices raises concern that it is difficult to determine whether or not sexual activity in prison can ever be truly consensual.[347] However, the Howard League has also suggested that some prisoners do consider themselves to have consensual sexual activity or relationships within prison. This supports previous research that indicates that the term of sentence can influence the nature of and attitude towards sexual activity or behaviour in prison. A review of culture and punishment found that prisoners' behaviours and attitudes to same-sex acts changed the longer they were held in prison.[348] Prisoners serving longer sentences or held in high-security facilities are more likely to acknowledge a homosexual

identity. Additionally, female prisoners are more likely to be open and overt about their relationships within the prison environment than male prisoners.

In contrast to sexually active male prisoners who feel the need to be ‘discreet’, female prisoners report and are reported to be more overtly affectionate, and more willing to be seen to be emotionally and socially reliant on other women prisoners to ‘cope with’ their imprisonment. The salience of emotional and sexual relationships between women, sometimes comprising platonic ‘make-believe’ or ‘play families’, or romantic and sexual dyadic relationships and ‘marriages’, has been a consistently observed feature of studies of women’s prisons.[349]

WHO have raised concern about the violence and discrimination that individuals can experience as a result of their sexual orientation or sexual activity within prison. Investigations on behalf of WHO suggested that experience and impact of violence, discrimination and stigma in communities may be heightened when an individual is held in prison and as a result could explain significant underreporting and underestimation of male sexual activity in prison, compared to females.[346] Concerns have also been raised over attempts to control or prevent sex in prison through separating prisoners or enforcement of punishment, resulting in increased risk-taking behaviour and the undermining of public health programmes.[350,351] The National Aids Trust (2013)[352] in their submission to the Commission on Sex[341] additionally asserts that threats of violence, discrimination, and stigma or even punishment as well as fear of breaches in confidence inhibit help-seeking or protective behaviour.

While some individuals may engage in consensual sexual activity while in prison, others may experience abuse, rape or coerced sex. Research suggests that 1% of prisoners in England and Wales had been raped and 5.3% were victims of coerced sex.[353] Additionally, data from the ministry of justice for England and Wales indicate a significant rise in sexual assaults in prison since 2013 and is at its highest recorded level since 2005. Additionally, individuals known within the prison environment to be gay or transgender are at greater risk of sexual assault than heterosexual prisoners. However, as is the case in the general public, it is highly likely that these figures are underreported.

Good staff–prisoner relationships are fundamental in preventing such sexual abuse. Staff shortages and overcrowding can undermine professional relationships and put prisoners at risk. Specific issues around sex in prison, such as the provision of condoms, need to be approached pragmatically to protect the health of prisoners, their partners and the wider community.

WHO[354] has stated that prisons are high-risk environments for the transmission of the human immunodeficiency virus (HIV). According to the Department of Health,[355] people in the criminal justice system are more likely to have engaged in higher levels of risk-taking behaviour including injecting drugs, sharing drug paraphernalia, excess alcohol consumption but also unprotected sex. Prisoners are then at greater risk than the general population of acquiring sexually transmitted infections.

Blood-borne virus transmission within the prison setting is viewed historically with some concern. Both UK[356,357] and international evidence and guidance[358] has indicated high levels of prevalence, additional risks regarding injecting practice by prisoners and recognised the strong association between drugs misuse, crime and criminalisation. Increasingly, however, a dual approach of harm reduction education and opiate substitute therapy to initiate recovery from drug use within prisons is demonstrating effectiveness in managing and preventing transmission and reducing incidence. The prison setting is also increasingly facilitating testing/diagnosis, and for many prisoners providing a stable, supportive environment to access, initiate and complete antiretroviral therapy for hepatitis C, which is also becoming more effective in achieving sustained viral response and an effective cure[359]

Caring for young people in custody

Young offender institutions (YOI) are designed to prevent young people in custody from mixing with or being influenced by older prisoners. They also offer a greater focus on interventions, education and training needs at the particular development stages of a young person. A young person serving a custodial sentence in Scotland may, determined by their age and legal status, be detained either within Her Majesty's Young Offender Institution (HMYOI) Polmont (aged 18–20) or the adult custodial estate (aged 21+).

Transition from youth into young adulthood is a key developmental stage in an individual's life. There is evidence to suggest that the developmental processes involved in maturation during this stage can be severely disrupted and delayed by imprisonment, and may interfere with the tendency towards desistance in mid-20s.

Opportunities are extremely restricted in custody for young people and young adults to undertake normative explorations of relationships and to model healthy adult behaviours. The BMA (2014) published a report on the health and human rights of young people in custody and found 'It is manifestly clear … that children and young people seldom thrive in the secure estate'.[360] Research published by the National PREA Resource Center (2014) recognised that 'custody places limits on adolescent development such as inhibiting opportunities to assert independence and take risks, and limits questioning and experimentation'.[361]

Disruption of guidance and supportive relationships with parents, teachers and other sources of normative adult role modelling, therefore, significantly alters a young person or young adult's ability to build prosocial peer or romantic relationships.[362]

Additionally, some young people in custody may have had no positive care-giver experiences or role models in childhood. Understanding of issues such as equality, respect, sexuality, gender identity and sexual consent can be irreparably skewed by a young adult's experiences in custody.

The HM Inspectorate of Prisons (HMIP) report into Feltham under-18 young offenders institution[363] and Youth Justice Board (YJB) response[364] acknowledged that one-third of the boys in prison felt unsafe at some point and one-fifth had been victimised while in prison. The most common form of victimisation was being hit, kicked or assaulted. Estimates suggest that many young people and adults in custody will have been victims of abuse, some will have been involved in gangs[365] and some may have sexually exploited girls,[366] with 5% of the young prison population having been convicted of sexual offences.[367]

Similar to their adult counterparts, young males in custody keep their sexual behaviour secret. However, most individuals reach sexual maturity around the ages of 16–24 years. Development of sexual maturation within a single-sex environment

that discourages sexual expression precludes opportunity to explore, form and maintain appropriate and healthy peer social and romantic relationships.[368] The 2014 Howard League commission on sex in prison[345] also found that punishment for normal sexual behaviour evoked feelings of guilt and shame for young men in prison. Such restrictions and conflict at a time of sexual development and maturation could increase the risk of sexual offending. The 2013 HMIP and YJB annual survey of young people in prison found 3% of young males surveyed had experienced sexual abuse while in prison.[369] The same survey also found that only one-third would tell staff if they were being victimised by other young people or by staff.

In order to improve, prisons must consider how they identify, support and respond to the needs of vulnerable children in custody, including those at greater risk of abuse as a result of their sexual orientation. Data published by the Bureau of Justice Statistics (BJS)[370] in the USA have shown that children who identify as non-heterosexual are more likely to be sexually victimised in prison and seven times more likely than a heterosexual prisoner to be victimised by another child. HMIP also published in 2013[371] that four out of 38 of the boys surveyed at the Keppel Unit in Wetherby prison had been victimised by other children because of their sexual orientation. A series of further inspection and responses by the Howard League have built on these and other findings of young people's experience in this institution.[372]

Young people in prison are often fearful about sex and relationships after release, particularly if they had been abused. Some young people, who had entered custody at a young age and were serving a long-term sentence, had no history of sexual experiences. This causes anxieties for young people approaching release. One young man in the 2013 Howard League[371] commission research, who had spent his entire adolescence in custody, worried about how future partners would respond to his complete lack of romantic and sexual experience at the age of 22.

The Howard League project U R Boss[373] has worked with children in the criminal justice system and supported them on release. Boys in custody talked about wanting to catch up with their peers on release, which might include drinking alcohol and having sex, adolescent experiences that they felt they had missed out on while in prison. Other boys felt that having a relationship and a home after release would demonstrate to others they had matured and put their life on the right track.

There is evidence that some boys in prison had high or unrealistic expectations about relationships following custody. The annual survey by HMIP and YJB (2013)[374] also found that 30% of boys thought having a partner would stop them offending and 18% of boys thought having children would stop them offending. Lanctôt *et al*.[375] found that the imprisonment of adolescents was associated with a number of negative outcomes, including premature transitions into cohabitation and parenthood.

Young people remain a subpopulation of great health and wellbeing concern, therefore, particularly if the preventative, diversionary or community alternatives have failed to intervene effectively. The previous content related to the ineffectiveness of short sentences and the negative impact these have on young people's development, wellbeing and likelihood of further offending also clearly applies.

Chapter 4: Building resilience and sustaining change

Maximising individual resilience

The 2014 ScotPHN throughcare healthcare needs assessment[376] stated that 'there is a clear need to ensure any health gains achieved whilst in prison are not lost on liberation due to a lack of continuity of care'. A range of community interventions, custodial and non-custodial sentencing and recovery opportunities exist and the coalescence of such work can contribute to a reduction in inequality.

Several validated group work programmes of secondary prevention,[377] which bring together the above elements, are also used with those in Scotland convicted of violent offences both in custody and the community. Evaluation of, for example, socially focused programmes looking at alcohol use and parenting is limited and predominantly focused on gender-based violence perpetrated by men.[378,379]

This section will point to a number of wider opportunities that will drive and sustain improved delivery for health improvement and justice. They will ultimately contribute to a reduction in health inequalities through legislation, collaboration and change management for individuals, services and communities. Health inequalities actions that can maximise individual resilience include the following areas.

Building universal trauma-informed services

The transition from prison to community is critical. There are a number of barriers to the appropriate links to community housing, employability, welfare and health services for the prisoner seeking help for, as a key example, mental health concern, including long waiting lists for NHS psychological services and exclusions on services provided by third sector organisations (based on gender, geographical area or crime type).

Furthermore, stigma has been found to be a significant factor impeding care seeking in this area.[203] Victims often engage with third sector organisations such as Victim Support Scotland, Rape Crisis and Women's Aid instead, as these agencies are often not associated with professional psychological treatment. The most effective approaches for supporting recovery from trauma are well-integrated psychological/ therapeutic health services that also reflect the centrality of trauma in the lives and experiences of service users.[380,381]

International evidence clearly identifies benefits of introducing TICP. Outcome studies in the USA provide substantial evidence related to the benefits for service users and workers, as well as the cost-effectiveness of introducing TICP policies and practice.[382] Some studies[383] and pilot programmes[384] utilising a TICP model have shown a decrease in psychiatric symptoms and substance use. Some of these programmes have shown improvement in service users' daily functioning and a decrease in trauma symptoms, substance use and mental health symptoms. Early indications suggest a positive effect on the prevention of homelessness and increasing housing stability, and therefore decreases use of crisis-based services.[385] Findings also suggest that integrating services for traumatic stress, substance use and mental health leads to better outcomes,[386,387] and service users were more satisfied when organisations are trauma informed. Moreover, integrated TICP programmes do not cost more to deliver than standard services.

As stated in Chapter 1, recovery from trauma occurs in three stages: (1) establishing safety; (2) remembrance and mourning; and (3) reconnection with ordinary life.[161] Medication, along with a variety of psychological treatments, have been shown to be effective in treating victims of crime, particularly in relation to depression and PTSD. Examples include cognitive–behavioural therapy, such as eye-movement desensitisation and reprocessing, hypnotherapy and psychodynamic therapy.[388,389] Psychological debriefing[390] and trauma screening for PTSD after violent crime are found to be ineffective.[197] Treatment can be provided through the NHS, private health care, or by some third sector organisations. However, mental health service use by crime victims is also often low.[391,392,393,394]

As an example of how to improve this uptake, a consultation service was established as a pilot to test the usefulness of monthly consultations between Victim Support Scotland and Glasgow Psychological Trauma Service. This resulted in an increase in staff confidence and knowledge when managing difficult cases, providing additional support to those victims suffering from complex trauma and complementing services provided by the NHS. Support agencies are well positioned to screen for mental health issues in victims of crime.

For victims of partner abuse and sexual violence, specialist services are fundamentally important in ensuring integrated care for victims[395] and ensuring services are directed at the needs of this group, such as addressing different body image impact for victims of sexual violence.[396] There is a need for training for health professionals in dealing with victims of sexual assault, owing to the negative impact of inexperience, adherence to stereotypes, disrespectful and inconsiderate treatment.[397] For identification and prevention purposes, the use of routine enquiry has been found to be acceptable in sexual health clinics in Scotland.[398] Studies on the link between PTSD severity and pre-existing substance abuse[399] suggest that early intervention strategies for women who have previous histories of alcohol problems and seek medical attention early post trauma may be indicated.

The presence of social support has been shown to have a positive effect on coping with and recovery from crime. Victims with high levels of perceived social support reported higher levels of wellbeing and suffered less from depression and anxiety.[400] There was also a marked difference in the recovery of rape victims between those who had social support and those who had not.[401] Another study reported that lack of social support post trauma was found to be the strongest risk factor in the development of PTSD,[402] and for victims of domestic abuse, low levels of social support have been linked to higher levels of PTSD and depression.[403] In addition, control studies show that female survivors of interpersonal violence (IPV) improve physical health if they have higher perceived social support, and if they are supported to leave the aggressor, as ongoing psychological IPV prevents recovery.[404]

For example, the Willow Project works with a woman-centred approach which is drawn from the work of Gelsthorpe and Corston[405] and their research into women who offend. These are ground-breaking works in relation to the development of an approach that takes into account the societal power dimensions in which women may engage in on-street sale of sex or commit offences. Women who sell sex or women imprisoned or in the criminal justice system experience a higher incidence of sexual and domestic abuse, coercion, poverty, unemployment, increased levels of addiction problems and lower educational attainment than non-offending women. A woman-centred approach is one that acknowledges women's lower status in society – that women are usually the prime caregiver for children, and that their needs (and desistance from crime and prostitution) are rooted in social, health and welfare needs. In the Willow Project this means:

- providing a women-only environment to foster safety and a sense of community
- fostering women's empowerment to increase their self-motivation and problem-solving ability
- using learning styles that are effective for women
- taking a holistic, practical stance to helping women address social problems, which may be linked to their offending
- facilitating links with mainstream services
- encouraging 'top ups' or continued support
- ensuring women have supportive mentors after completion of the programme
- providing practical help with transport and childcare to encourage involvement with programmes.

Tomorrow's Women Glasgow (TWG) is a further example of TICP. The model of delivery of TWG is 'trauma informed', which underpins the methods of delivery and also the value base that the project adheres to. Trauma-specific therapies are also offered. The approach treats everyone as if they have been exposed to, or are vulnerable to, trauma. This establishes practice that is non-judgemental, compassionate and accepting. A short summary on this project is also available online alongside this document.

Increasing peer and mentoring interventions

Peer-based interventions, where prisoners provide education, support or advice to other prisoners, can contribute to achieving health and social goals within the prison environment and these interventions increasingly have their equivalents beyond the prison gate. Benefits included: the ability of peers to connect with other prisoners and to have social influence with vulnerable populations resistant to professional advice; direct benefits for the peer deliverers themselves; and wider benefits for the prison system including effective use of resources.[406]

Peer support is an established feature of prison life in England and Wales, for example the listeners scheme, developed by the Samaritans and first launched in 1991 at HMP Swansea as part of a suicide prevention strategy, now operates across most prisons in England and Wales. SPS schemes currently operate across the prison estate and have been established since 1995.

Other peer-based interventions in prisons address substance misuse, violence reduction, support for new prisoners, translation services, housing and employment advice, mentoring schemes and, more recently, health trainer schemes. There is an extensive evidence base on peer roles for improving access to healthcare services and removing barriers to health in the general population, but more needs to be known about the effectiveness of these interventions in prison settings, especially given their prominence.[407] Recovery and mutual aid is a particular new and energised opportunity to both encourage peer support and to capture learning on impact on individuals, establishments and ultimately linking this back to communities.

Moving On

The aim of this project – known as ‘Moving On Renfrewshire’ – is to identify gaps within current service provision for imprisoned young people who offend or are at risk of imprisonment. The primary goal is to make a real and lasting difference to those who engage and, as a result, to reduce reoffending. The partnership identifies eligible young people as soon as possible after they enter custody, and then takes a ‘youth work’ approach to supporting them and linking them with services both during and after custody. The three-year evaluation in 2011 showed that:

- Moving On staff achieved effective, post-release, voluntary engagement with 75% of their clients; the engagement rate overall was 95%.
- With the assistance of Moving On, clients have successfully addressed substance misuse, accommodation issues and obtained employment.
- Of those clients already released from custody, 80% have attracted no further custodial sentences.

Shine

The Shine Women's Mentoring Service[408] is a Public Social Partnership, funded from the Reducing Reoffending Change Fund, a fund set up and administered by Scottish Government, SPS and the Robertson Trust. The lead organisation in the Public Social Partnership is Sacro that, along with seven other third sector partners, has co-designed the mentoring service in conjunction with the eight community justice authorities – representing the 32 local authorities in Scotland.

The service operates nationally across Scotland and over 2,500 women have been referred to Shine since it opened in 2013. The service offers women who are leaving prison after short-term sentences of less than four years, or women sentenced to a CPO, a designated mentor who will work with the women for at least six months and often longer.

Mentors support the women, who sign up for Shine voluntarily, to gain confidence to understand that they can make decisions, address their offending behaviour and make positive changes in their lives. The mentors work with the mentees in a non-judgemental relationship to support them in maintaining accommodation, accessing health care and benefits and bring order and structure to their lives. Many women regain access to children taken into care, repair relationships with families and leave behind abusive relationships.

Around 70% of women offenders have mental health issues, often as a result of enduring abuse throughout their lives. Supporting women to access and maintain engagement with mental health services is just one of the practical supports the mentors offer. Many women attending Shine have shown improvements in both their attitudes to offending and their belief that they can change.

Strengthening substance use recovery

Partner agencies, along with prisoners, their families and the recovery community, are working together to reduce not only the consequences of continued drug use but also recidivism, as outlined in the national core indicators for ADPs.[409]

The ADP outcome on community safety (Communities and individuals are safe from alcohol- and drug-related offending and antisocial behaviour) recognises that addressing alcohol problems can contribute to this. There is also a strong commitment to recovery within custody settings which mirrors the emerging recovery capital within local communities, aiming to develop ROSC, the features of which are detailed throughout this document.

At its centre, ROSC has strength-based assessments, which take account of individuals' recovery capital, and integrated interventions and services that are responsive to a person's needs and beliefs. There is a commitment to peer-recovery support services, and most importantly, it is inclusive of the voices and experiences of people, and their families, in recovery. Several examples of community-level ROSC approaches are now developing in Scotland, shifting the focus, increasing the person-centred nature of recovery and the community capital required, including several examples within prison custody (including HMP Greenock, HMP Perth and others).

Improving the delivery of custodial services

Key strategic levers have emerged which provide strong opportunities for services to collaborate across custody and community to work more effectively and improve their potential impact on health inequalities. Among these opportunities are the following.

The SPS organisational review

'Unlocking Potential Transforming Lives'[410] set out a 'new way of working' for the prison service, including increased collaboration with other agencies; transforming management of people within justice services to focus on wellbeing, holistic and asset-based approaches; and building individuals' strengths and potential, empowering people to change their own lives. It recognised the need for a different approach to health and wellbeing in the prison population, formulated around Antonovsky's concept of salutogenesis.[411] This has seen the SPS moving towards an asset-based approach mirroring that which has been championed by those working in public health.

The organisational review supports the use of assets to 'promote purposeful activity and to engage, support and assist prisoners in building new talents and interests that will help sustain them on liberation from prison'.

Boosting employability, skills development and offering learning interventions and pathways into work and training both inside the prison and out substantially reduce the risk factors associated with reoffending, and poor health and wellbeing among young people.[412] Young people involved in offending often have a negative experience of the education system. A number of innovative approaches have been adopted with young people in prison to engage with young people who do not engage well with traditional education and training. For instance:

- Arts-based approaches involving Theatre Nemo, Citizens Theatre and others[413] in HMYOI Polmont and HMP Cornton Vale.
- Paws for Progress Dog Training Rehabilitation Project[414] focused on 'animal therapy', developing relationships and managing behaviours. An evidence-informed approach, developed with University of Stirling and delivered in HMYOI Polmont.
- Employability-focused Glasgow Passport (publication of evaluation pending in 2017 from Reid Howie on behalf of Robertson Trust) which operated in HMYOI Polmont and provides 'through the gate' support for young people involved in justice services returning to Glasgow.

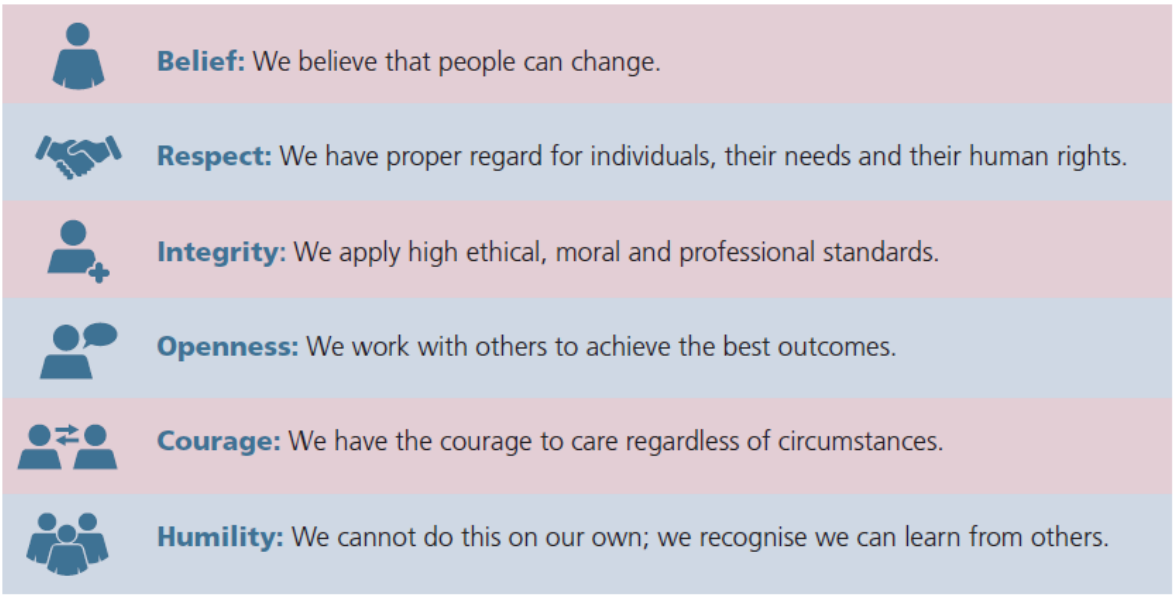
Increasing use of purposeful activity

Following on from the journey from implementation of Unlocking Potential Transforming Lives and in response to the recommendations set by the Justice Committee on purposeful activity in prison[415] and the 2015 SPS review into purposeful activity,[296] the SPS is in the process of researching and redesigning this provision. The SPS recognises purposeful activity, just as it is expressed within communities, is about investing in people as citizens and supporting people within prison custody to take responsibility and agency for transforming their lives, by developing resilience and independence.[416]

'Better Health, Better Lives' incorporated the foundation themes of standards; training; referral to community resources; impact assessment, personal planning and evaluation. This framework also now has the potential to strengthen the building of ROSC for those in prison custody with several establishments demonstrating leadership both for the population under their care and the wider community, who benefit from recovery capital which the prison invests in.

Improving workforce skill and use of case management

Although committed to the concept of the prison as a setting in which to improve health and wellbeing, the SPS advocates for an integrated approach that contributes to improved health and wellbeing for people with both custodial and non-custodial convictions available in the community. The SPS People Strategy (2015)[417] sets out a commitment to harness and develop the talent of prison staff to deliver the recommendations of the organisational review in 2014. Underpinning this are a set of values that staff are committed to:



Building up only capacity within custody without increasing the opportunities through which this can be exercised will not bring about the transformational change that the organisation has committed to. McNeill *et al*.[418] highlight that for change to happen prisoners require both capacity (human capital) along with opportunity within the community (social capital). The Community Justice Act 2016 provides further momentum to the changes required in outcome focus, prison workforce skill and consistency with community approaches. This includes TICS and understanding of ROSC.

The existing case management process mainly focuses on prisoners serving over four years and is not strongly based on desistance theory. The move to a more asset-based approach for all prisoners with close involvement from the personal officer will allow a more holistic approach to personal planning for health and wellbeing, developing strengths and addressing needs in a person-centred way to sustain positive change (and recovery in many) through to community reintegration.

A clear skill set is required to deliver this change. 'Survive and Thrive'[419] for example, is a psychoeducational course that is designed for clients/service users who are experiencing the psychological and emotional difficulties which can result from life events often described as causing complex trauma. This includes all forms of childhood abuse, domestic abuse and other forms of prolonged or repeated

interpersonal trauma. The course delivers normalising information on the range of effects of abuse and trauma and provides an opportunity to learn effective strategies to cope with these.

It has been designed to meet the needs of survivors in phase one of a phased intervention approach to delivering psychological therapy to survivors of complex trauma. This is in line with the best available evidence base as defined in the Matrix.[420] Phase one overall is characterised by a focus on:

- Safety. Clients often are unsafe due to self-harm, ongoing substance misuse, poor self-care and suicidality but also may experience ongoing risk from others owing to the high rates of revictimisation.
- Stabilisation of symptoms that can result from the experience of complex trauma.

The course is based on the most up-to-date evidence in the trauma field which postulates that key challenges facing those survivors affected are difficulties with emotional regulation and interpersonal difficulties. For example, substance misuse and self-harm that are conceptualised as attempts at affect (emotion) regulation. Psychoeducation is also one of the key elements of providing a trauma-informed service as it encourages an empowerment stance which is seen as central to recovery. The training is 2.5 days and includes an observed practice element that must be delivered by a trained Survive and Thrive trainer.

Multidisciplinary training such as this programme[421] is increasingly becoming common to prison officers, and NHS and social sector staff to ensure a common understanding and effective joint delivery.

Strengthening throughcare support

The SPS has evaluated three prison establishments to test awareness and readiness for a ‘community-facing prison’ approach.[422] This identified from the many comments that such a prison would:

- support the concept of a ‘journey’ with continuity of support from the point at which an individual committed an offence, through their sentence and period in custody, to their return to the community, reintegration and desistance

- focus on the ‘normalisation’ of prison
- improve the permeability of prison walls to families, communities, community-based services and prison staff
- work towards building a desistance-supporting community.

Additionally, the following features were felt to embody this approach and align with much of the direction of travel that the organisational review, the People Strategy, the ambitions of ROSC, TICS and the custodial element of the new scope for community justice aim to reinforce:

- a positive overall ethos, culture and relationships
- an appropriate environment, facilities and regime.

Throughcare support officers (TSOs) aim to work collaboratively with short-term prisoners, families, colleagues and partners to develop an asset-based, individualised plan. Short-term prisoners face the highest risk of reoffending immediately after leaving custody – which can be exacerbated by the lack of co-ordinated support and mentoring during this early period post prison.

TSOs can act as advocates on a prisoner’s behalf with partner agencies and encourage prisoner motivation to change through sustained engagement with key services. This approach builds on self-efficacy and plays a pivotal role in the process of utilising individual case management plans to aid transition into the community. This is undertaken through engagement with personal officers, families and partners to support a successful reintegration into the community.

A 2014 review of the HMP Greenock TSO project[423] highlighted:

> ‘positive progress in terms of a replicable project structure, aligned to accurate and robust data collection. Positive external stakeholder engagement is evident alongside high team commitment. Client perception was positive and the impact on individual cases is marked. The link to desistance was however unproven given the longer timescales needed to provide accurate measurement. Risk factors were highlighted under the categories of internal officer engagement, recruitment and review of case practice. The last of these represents the biggest

> opportunity to develop a pedagogy of practice, impacting immediate project success whilst shaping policy at a national level.'

This approach should, however, also facilitate increased partnership working across case management and address issues such as those highlighted in the ScotPHN throughcare report:[376]

> 'The integration of the SPS and NHS prison health care services has been a positive step forward for the health of prisoners, signposting a move toward equitable health care provision for a marginalised group of people. However, the effectiveness of this move could be enhanced by ensuring the NHS is fully integrated into throughcare planning processes to promote and secure greater continuity of care for the whole of the prisoner's journey. The lack of a coherent, single system for the management of throughcare militates against effective continuity of health care, this is worse for short-term and remand prisoners.'

These initiatives will further support the implementation of Better Health, Better Lives through a whole-prison approach and delivery on the agenda which 'Healthier People, Safer Communities'[285] set out for partnership working, joint outcomes between justice and health, and an assets-based approach. These recognise that when aiming to improve the health and wellbeing of people in prison not only individual health status should be targeted but also the risk factors and the determinants of health. These mirror the factors that determine reoffending and, therefore, everyone in prison has a role, not solely those with the responsibility for providing health care.

Strengthening community justice

The challenges and themes in this document all point to the opportunity that the new model for community justice brings to: reducing inequalities; the social determinants of health; timely and early access to interventions; true person-centredness; and seamlessly integrated services, all resulting in both individual and community resilience. Underpinning this, effective joint strategic commissioning will be required to strengthen learning and impact as the legislation drives local improvement for

individuals in the justice setting.[424,425] Health inequalities actions that can strengthen this new vision include the following areas.

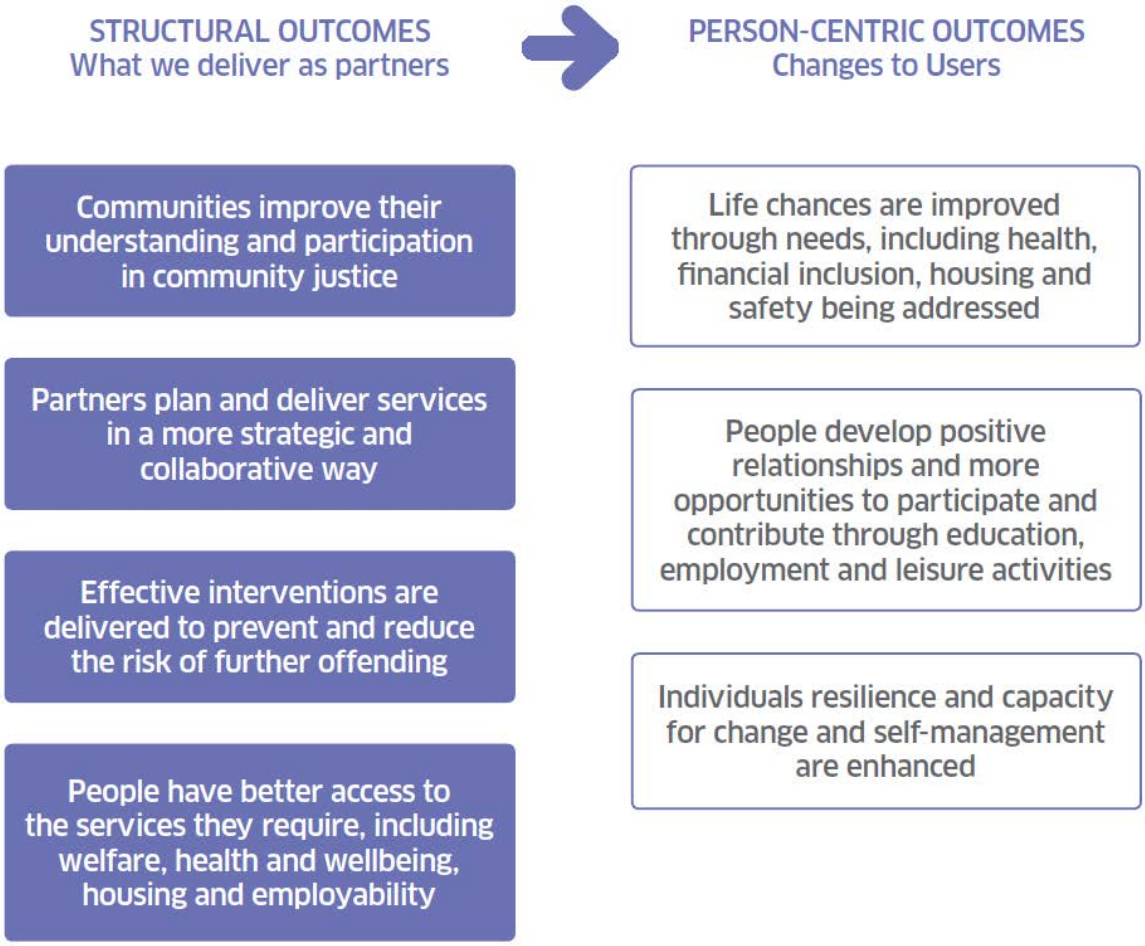
National Strategy for Community Justice

The Strategy for Community Justice in Scotland[426] creates an opportunity to reduce inequality. At its heart are four high-level and structural outcomes alongside three person-centric outcomes which service users should experience in the new approach (see **Figure 2**).

Impact will be a challenge to measure, but a set of local and national outcomes and indicators to assure of change and impact, alongside associated measurable data, have also been produced to drive this forward. The Outcomes, Performance and Improvement Framework[51] which will drive this agenda in the next few years will also provide critical opportunities to improve health and reduce inequalities in communities and a number of approaches will further foster this.

Justice in Scotland: Vision and Priorities[427] updates the Justice Strategy published in 2012. Using the latest evidence it describes recent successes, highlights key challenges and sets out key priorities for the future. These shared priorities are for everyone involved in keeping our communities safe and delivering civil, criminal and administrative justice. They will be achieved by people and organisations working together across the justice system and beyond to deliver improvement and focus on shared outcomes. The accompanying Delivery Plan sets out the key actions that Scottish Government, justice organisations and partners will take in 2017–18. The Scottish Government will review and update this plan annually.

Figure 2: Community justice outcomes.



Reproduced from Scottish Government. Community Justice Outcomes, Performance and Improvement Framework; 2016. **www.gov.scot/Resource/0051/00510517.pdf under Crown copyright 2016.**

Building support for individuals returning to the community

The 2011 report 'What Works to Reduce Reoffending'[428] highlighted evidence that a holistic approach to addressing the needs of people with convictions means that ongoing support should be available as required and that the provision of practical support in prison is unlikely to have a lasting impact on the risk of reoffending unless it continues on release. The updated 2015 summary report[284] also cited the transitioning from prison to the community and that gaps in service provision can then hamper attempts to desist from offending. It stressed the importance of

agencies from different government (and third) sectors working together effectively to assist those transitioning back into the community. It also states that although 'the evidence evaluating strategies of through-care is limited, that which exists suggests that transitions to life outside prison are smoothest when multiple agencies, including third-sector organizations, work together with prisoners before release to plan transition to the community.'

The report, however, also notes 'research suggests that people with convictions who feel a welcomed part of society are less likely to reoffend compared to those who feel stigmatised. It is therefore important that criminal justice professionals work not only with people with convictions but also with their family, friends and the wider community (e.g. employers, community groups, the voluntary sector) to ensure prosocial and positive relationships can be developed and sustained'.

These two findings relate clearly to the ability to deliver on several of the structural outcome measures of the Community Justice Strategy above, relating how both services and communities themselves have solutions to the challenges of moving beyond being a person with convictions.

Building a collaborative approach

In relation to improving the health of people in the justice system, collaborative working is paramount to meeting both the health and justice agenda.[47] The need for a collaborative approach was recognised in the Equally Well Review 2010[429] which recommended that health issues should be addressed in the wider context of all the actions needed to ensure improved community reintegration of people with convictions. The Reducing Re-offending in Scotland report by Audit Scotland[47] also stated: 'Overall, a more coherent approach at national, regional and local level is required, with a shared commitment to reduce re-offending among all the bodies who work with offenders, including criminal justice bodies, councils, the judiciary, the NHS and the third sector'.

As one example, NHS Health Scotland hosted a multiagency Health Improvement and Justice Collaboration Group in 2014/15 which had representation including the NHS, the Scottish Government, the SPS, community justice authorities and the third

sector. It was formed as recommended in response to Healthier People, Safer Communities (2013)[285] as a time-limited group that would promote equity, bring agencies together, add value and strengthen the focus on outcomes. This work will be consolidated by NHS Health Scotland, in part through promotion of this document, as we have identified the need for strategic and operational support to deliver on health improvement outcomes. The collaborative ethos needed and the financial constraints within which both statutory and voluntary organisations requires agencies to work together by:

- promoting a public health approach to reducing reoffending
- supporting co-production and asset-based approaches
- providing operational support and workforce development.

As a final suggestion, throughout this process, adaptive leadership and solution-focused improvement approaches have been implicit to develop this work in an iterative style and navigate a busy and uncoordinated landscape.

As well as the hard power and traditional/technical solutions, many of which are captured in **Figure 3,** and can contribute to a reduction in the impact of crime and therefore the inequalities these create, the Community Justice Strategy 2016 also demands a collaborative and adaptive leadership approach to offending, as it presents a 'wicked' inequality issue to local planners and users of local public services. This requires stronger alliances, deeper consideration, and adaptive and solution-focused responses across the system. Use of collaborative leadership programmes[430,431,432] will be critical to ensure genuine, person-centred partnership in meeting the requirements and ambitions of the new community justice vision and the requirements of the Community Justice Act 2016.

Figure 3: The leadership task.

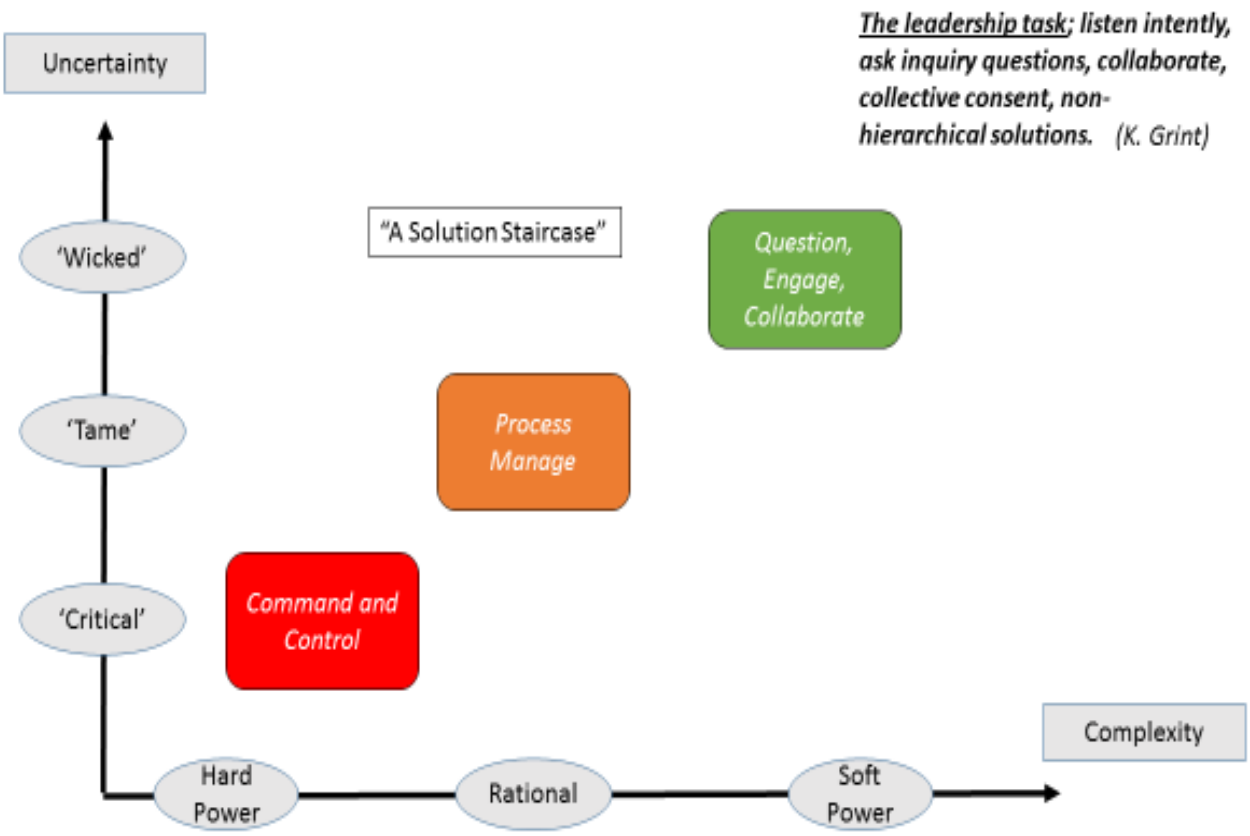


Figure adapted from: Grant K. Wicked problems and clumsy solutions: The role of leadership. URL: **leadershipforchange.org.uk/wp-content/uploads/Keith-Grint-Wicked-Problems-handout.pdf**

Building evidence of what works

A key challenge throughout this document has also been to scope out a wide and variable scale of evidence and literature to inform this agenda. More precise and more integrated research strategies will therefore be required to both optimise use of such resources and learn across a matrix of local, regional and national evaluation to evidence impact. The national guidance issued for local community justice partners by the Scottish Government helpfully includes the 'five-stage model' of evaluation, best current evidence on effective interventions to reduce reoffending[433] and crime,[434] with advice on logic modelling and planning to further capture both impact and learning.

Chapter 5: Proposed opportunities for action

The following high-level opportunities distil the above document and should be considered in local planning processes in using implementation of the new model for community justice to reduce both offending and the health inequalities.

Opportunities for earlier intervention

These will be increased by:

- preventing victimisation; reducing the impact of being a victim, especially among women; and reducing adverse and traumatic events among children
- making better use of current alcohol and drug policy, partnership and recovery capital to reduce crime and its impact
- preventing and reducing the fear, distress and inequality that poor mental health creates
- preventing, mitigating and better managing those who have experienced trauma within specialist services.

Mitigating the negative impact of offending and sentencing

This will occur by:

- strengthening our equalities, gender-based violence and alcohol and drug misuse work to reduce the likelihood of becoming a victim
- strengthening the resilience of children, young people and families involved with the justice system
- intervening in police custody to better manage people with mental health and substance use issues and reduce the risk of self-harm
- providing alternatives to prosecution, diversion and support, especially to develop women and young people to reduce the likelihood of further offending
- increasing use of community sentencing with use of treatment, recovery and purposeful activity, and deliver this in an integrated way

- provide better care for people serving prison sentences, particularly young people, those with mental health problems, substance use issues or at sexual health risk.

Building resilience and sustaining change

This will occur through:

- increasing the ability of both specialist and universal services to respond effectively to people in recovery or with histories of mental health problems or trauma
- improving delivery of interventions in custody and strengthening peer, mentoring, and mutual aid and recovery capital to reduce the likelihood of further offending
- build on the SPS organisational and purposeful activity reviews to increase workforce skill and capacity, including maximising throughcare support
- promoting effective joint commissioning of services and collaborate to devise an effective monitoring strategy to measure success in achieving these actions and results
- strengthening the impact of the Community Justice Strategy through collaboration and a combination of directive and adaptive leadership.

Only by a synthesis of these actions, aligned to the seven structural and person-centric outcomes of the Outcomes, Performance and Improvement framework,[51] will a reduction in offending be achieved and contribute to an overall reduction in inequality across Scotland.

Appendix 1: Scottish examples of evidence-based violence-prevention programmes

Local and Scotland-wide approaches have included:

- The Advice, Support, Safety and Information Services Together (ASSIST) service for victims of domestic violence, which provides multiagency intervention. Originally a west of Scotland-based service, it is now developing nationwide.[435]
- Nationwide media and communications campaigns focusing on changing cultural and social norms around violence and also on promoting gender equality.
- There are school-specific projects such as the Violence Reduction Unit's 'Bystander' project[436] that develop young people's life skills in tandem.
- The Scottish Government's alcohol strategy seeks to reduce availability and harmful use, to synchronise with community justice. ADPs have 'reducing reoffending' as a core outcome.[437]
- As well as 1995 legislation to counter knife crime,[438,439] the Scottish Government published a thematic report in 2011[440] and funds a national awareness and good practice initiative; 'No Knives, Better Lives'.[441]
- Projects to tackle 'gang'-based interpersonal violence such as the Community Initiative to Reduce Violence[442] and the Includem[443] gangs programme have based their approach on established models of violence prevention in the USA, with proactive group intervention aimed at changing norms and values, alongside a policing approach to reduce access to weapons.
- Community-focused initiatives to prevent female genital mutilation, such as Replace 2,[444] have had some success in addressing cultural and social norms around this specific gender-based violence (see also Scottish Refugee Council[445]).

Appendix 2: Scottish agencies and initiatives which build resilience in families, children and young people

Families Outside

Families Outside[446] delivers bespoke training and awareness-raising regarding issues for families affected by imprisonment, who have a relative or friend involved in the criminal justice system, among other things. Training includes input to the Officer Foundation Programme at the SPS College for all new prison staff, as well as continued professional development for teachers, delivered in prisons throughout Scotland, so that teachers can experience what it is like for a child to visit a prison. Families Outside has also taken on the training role of Kids VIP,[447] which for many years worked with supporting and promoting improved contact between children and their imprisoned parents. Specific projects include the following.

Direct family support service

Families Outside provides a national freephone helpline, supporting 1,800 callers each year, currently one-third of which are professionals. Families Outside also provides holistic, solution-focused support work designed to meet the needs of families affected by imprisonment throughout the whole of Scotland. Families Outside currently employs staff throughout Scotland to meet the needs of families affected by imprisonment in the community.

School/prison link project

HMP Low Moss started an initiative to help dads to be more closely involved in their children's education. The school/prison link project means that dads receive reports and updates directly from the school, while Families Outside helps teachers support these families better. Already there have been conversations with school staff and families, and the feedback so far has been very positive. School/prison link work is now available through Families Outside staff for all prisons on a case-by-case basis.

Family Nurse Partnership (FNP)

FNP[448,449] is a preventive programme for vulnerable young first-time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until the child is two. FNP has three aims to improve: (1) pregnancy outcomes; (2) child health and development; (3) and parents' economic self-sufficiency. The methods are based on theories of human ecology, self-efficacy and attachment, with much of the work focused on building strong relationships between the client and family nurse to facilitate behaviour change and tackle the emotional problems that prevent some mothers and fathers caring well for their child.

The programme is currently being delivered in seven NHS Board areas – Lothian, Tayside, Fife, Greater Glasgow & Clyde, Ayrshire & Arran, Highland and Lanarkshire. NHS Forth Valley and Grampian both began implementing the programme during the course of 2014.

Families affected by imprisonment

Circle Scotland[450] delivers this support service for parents at risk of imprisonment or in prison who have children under 16. In the areas the service is provided, Circle Scotland offers direct support in the prison and the community. Otherwise they will signpost to other agencies throughout Scotland. Any professional or agency can refer to Circle. It is also possible to self-refer or speak directly to the family support worker in prison as part of The SHINE public social partnership.
The Robertson Trust, a large grant-making organisation in Scotland are also currently working with Evaluation Support Scotland and a range of organisations

providing support to prisoners' families through a learning set and skills development programme available to view online at: www.evaluationsupportscotland.org.uk/how-can-we-help/shared-learning-programmes/families-affected-imprisonment

Family visitor centres and help hubs

Prison visitors' centres are valuable means of supporting isolated and vulnerable families.[451] People experience a range of deprivations as a direct result of their family member's imprisonment, but the stigma of that experience often prevents them from seeking help. Visitors' centres therefore have the potential to provide a crucial link for families to community-based supports, to the prison, and ultimately to their family members in custody. The SPS has embarked on a journey to develop a visitor help hub at each prison. The visitor centre is an environment that can aid the identification of the potential target group for other support initiatives such as the FNP. Several initiatives are also supported by the SPS across Scotland. For example:

- Action for Children has been awarded a contract to manage the new family visitor centre at HMP Grampian.
- Barnardo's has been funded to run the '5 to Thrive' parenting programme in HMP Perth and has completed an audit on family visiting.*
- Scottish Book Trust is running amended 'bookbug rhyme time' sessions in the home for families affected by imprisonment.
- Dads Rock is piloting a Dads' programme in HMP Addiewell.
- The 'Family Time' parenting project is delivered in collaboration with NHS Lanarkshire in HMP Shotts*.

* These projects were showcased at the National Prison Health Improvement Event in December 2014 and Family Time is also included in a short summary paper online alongside this main document.

Scottish Families Affected by Alcohol and Drugs

This national agency is commissioned by the Scottish Government to support families affected by substance use issues and foster recovery. It works increasingly with families in the prison and justice setting.[452] It is delivered across a network of family support groups, and by sharing information and learning between the groups. Information is also provided to individuals through a helpline, email service and website. They also run an annual conference where family members and service providers can meet up, share stories, attend workshops and learn about best practice in family recovery both nationally and internationally.

Useful policy links

UN Convention on the Rights of the Child (UNCRC)

The UNCRC[453] Article 24 recognises the responsibility to ensure that children enjoy 'the highest attainable standard of health'.

The Scottish Government National Performance Framework[454] sets out clear outcomes for the whole Scottish public sector to work towards, this includes reductions in crime, victimisation, poverty and specific outcomes related to children:[455]

- giving our children the best start in life
- reducing significant inequalities in Scottish society
- improving the life chances of children and young people at risk
- creating strong and resilient communities where people take responsibility for their own actions and how they affect others.

Children and Young People (Scotland) Act 2014

The Children and Young People (Scotland) Act 2014 was passed in the Scottish Parliament on 19 February 2014 and received its Royal Assent on 27 March.[456] The Act covers a variety of areas relating to the wellbeing of children and young people. It will strengthen the role of early years support in children's and families' lives.

The Early Years Framework

The Early Years Framework[457] highlights the importance of all national and local agencies, the third sector and independent sector working together to deliver improved outcomes for children. The framework identifies the 10 key elements of transformational change in the early years. These are:

1. a coherent approach
2. helping children, families and communities to secure outcomes for themselves
3. breaking cycles of poverty, inequality and poor outcomes in and through early years
4. a focus on engagement and empowerment of children, families and communities
5. using the strength of universal services to deliver prevention and early intervention
6. putting quality at the heart of service delivery
7. services that meet the needs of children and families
8. improving outcomes and children's quality of life through play
9. simplifying and streamlining delivery
10. more effective collaboration.

The Early Years Framework is particularly relevant, but not limited to, the delivery of three of the National Outcomes:

1. our children have the best start in life and are ready to succeed
2. we have improved the life chances for children, young people and families at risk

3 our young people are successful learners, confident individuals, effective contributors and responsible citizens.

Early Years Change Fund

No parent or family should feel isolated or that they lack the information, advice and the support they need. The Scottish Government is investing £18 million through the Early Years Change Fund over three years to develop high-quality, accessible family support across our communities. The aim is to increase the wellbeing of children, parents, families and whole communities through improved access to a comprehensive range of activities and services that make the best use of the resources available across all sectors.

The Scottish Government will continue to support third sector organisations working with children, young people and families through a new £20 million fund over the next two years. This fund will aim to improve outcomes through activities focused on prevention and early intervention.

GIRFEC

GIRFEC[458] is a consistent way for people to work with all children and young people. It's the bedrock for all children's services and can also be used by practitioners in adult services who work with parents or carers. The approach helps practitioners focus on what makes a positive difference for children and young people – and how they can act to deliver these improvements. GIRFEC is being threaded through all existing policy, practice, strategy and legislation affecting children, young people and their families.

The National Parenting Strategy: Making a positive difference to children and young people through parenting

The strategy[459] highlights the value and importance of parenting, recognising that parents are the biggest influence on the life chances of our children, the future generation of our society. It makes specific mention of the need for extra support for parents in prison and is for mums and dads, grandparents and the wider family, as well as foster, kinship and adoptive parents – in other words, anyone involved in bringing up children. And it covers parenting of children of all ages – from pre-conception and early childhood, through school years and adolescence to adulthood. The strategy recognises that prevention is better than cure. Effective parenting by building more positive futures for children and their families will have long-term benefits for communities and the country as a whole.

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