Ministry of JUSTICE
National Offender Management Service

Reasonable adjustments for disabled prisoners: meeting our duties under the Disability Discrimination Act

Introduction

What is a reasonable adjustment?

A reasonable adjustment is an adaptation put in place to help a person who has a disability or medical condition to access services as if they were not disabled. In prison, a reasonable adjustment should enable the prisoner to take a full part in the normal life of the establishment.

How do we decide what is reasonable?

The Disability Discrimination Act doesn't specify what factors you should take into account when considering what is ' reasonable'. In the event of any legal action, reasonableness is determined by the courts on an individual basis.

The Code of Practice states that what is reasonable will vary according to:

- the type of service being provided
- the nature of the service provider, and its size and resources
- how the person's disability affects them in that context.

The Code also says that you might need to take some of these factors into account when considering what is reasonable:

- how effective any steps would be in overcoming the difficulty
- how practicable it would be for the service provider to take these steps
- how disruptive taking the steps would be
- the financial and other costs of making the adjustment
- the extent of the service provider's financial and other resources
- the amount of any resources already spent on making adjustments
- the availability of financial or other assistance.

What level of cost should we bear?

The courts consider the Prison Service to be a single entity, similar to a large organisation like a supermarket chain. Compare what would be reasonable at a small corner shop and what could be expected from a large supermarket. The supermarket, as part of a chain, will be expected to bear a higher level of cost than a small independent retailer. The same applies to us.

Because we are part of a large organisation, we cannot use the cost of an adaptation as reason not to provide it, unless it is significant and out of proportion to the benefit the individual will receive. The courts will look at the

funds available across the entire organisation, rather than the budget for the establishment in question.

Provision of a lift

It would be reasonable for us to specify a lift in a new build, as part of the overall cost, but not to install one in an existing old building at significant cost, to help a single prisoner. In this situation, providing an alternative location for the facilities would be acceptable. However, when specifying the requirements of a new build, we must ensure it is DDA-compliant, as failing to consider access at that point would not be reasonable.

The advantage of being a single entity is that we do not have to make every prison fully DDA-compliant; instead we must be able to accommodate a disabled prisoner appropriately somewhere in the prison estate.

‘ Appropriately’ means in accommodation suitable for his/her disability, in the right category, with access to the required interventions, work and education, and other regime activities.

Location and access

Where should we locate the prisoner?

It is not normally appropriate to locate a prisoner with a disability in healthcare unless he/she needs that level of medical care. Placing a prisoner on healthcare does not allow them to take a full part in the regime of the establishment, and blocks a bed that may be needed by a prisoner who is actually ill.

Prisoners with disabilities should have reasonable adjustments made to enable them to live in normal accommodation.

Please read PSI 31/2008 Allocation of Prisoners with Disabilities.

Ensuring access for all prisoners

Access surveys will help you identify those areas which cause physical access problems. However, don’t just think about physical access. Access to courses and activities may be restricted for prisoners with learning difficulties or sensory problems.

For example, if you have to apply for the gym by completing a form, and you have learning difficulties or are blind, you may not be able to complete the form. If fire alarms are all audible, a deaf prisoner may be unaware that he/she should evacuate.

Some of these issues may become apparent from complaints, but many prisoners will not complain. You must, therefore, make sure that prisoners are aware that they can either get help or use alternative methods to access facilities.

Who can provide advice?

There is a range of organisations and people to whom you can go for help with reasonable adjustments.

Talk to the prisoner Always discuss what support is needed with the prisoner, as each individual will have different ways of managing their disability.

Specialist organisations In the case of an individual reasonable adjustment for a specific prisoner, the best source of information will be organisations that deal with the particular disability. General reasonable adjustments are designed to make prison life accessible to the largest number of prisoners possible. You can get advice on ways to make the prison, facilities, information and activities more accessible from the specialist organisations.

Charities Charities and other third sector organisations which specialise in supporting people with particular disabilities can often supply aids and adaptive technology or recommend suppliers.

The prison service Talk to your DLO; other establishments may have made adjustments to deal with similar situations, therefore Disability Liaison Officers (DLOs) and Regions can share solutions that have been shown to work. We also offer suggestions and examples in this guide.

Healthcare can advise on the suitability of some aids and may even be able to source things like hearing aids, walking supports etc. through the PCT

You may need to talk to the **works department** if an adaptation requires physical alterations.

Occupational therapists For individuals entering custody who need aids and adaptations it is important to consider a referral to a local specialist, such as an occupational therapist, for an assessment of activities of daily living (ADL). This will determine that they are able to manage in the prison setting. Prisoners who develop a disability in prison should also be referred for advice on personal aids and adaptations. It is not always in their best interest to be provided with ‘ off the shelf’ aids and adaptations.

Types of disability and examples of reasonable adjustments

Sensory problems

Hearing difficulties and profound deafness

Reasonable adjustments include:

- provision of hearing aids - provided by NHS if newly diagnosed. *Ask clinical team to refer for assessment*.
- British Sign Language (BSL) translators
- staff learning BSL
- other prisoners being offered courses in BSL
- Teletext on TVs
- visual alarms, i.e. a flashing light to supplement audible fire alarms
- vibrating alarm clocks
- text phones
- hearing loops in reception, visits, interview & adjudication rooms (can use mobile hearing loops).

Useful contact: see **RNID Royal National Institute for the Deaf** on page 38.

British Sign Language

British Sign Language is classed as a language in its own right. Like other languages, BSL has dialects and someone who speaks BSL from the north may not understand everything that someone from the south may sign. BSL interpreters are often used in courts and police stations. If the prison does not have details of an interpreter, the local police or court will have lists of approved interpreters. Alternatively, the RNID should be able to put you in contact with qualified interpreters in your area.

BSL courses are available from some local colleges and organisations such as the RNID.

A basic finger-signing alphabet is illustrated in ***ANNEX A: Communicating with people who have hearing difficulties*** on page 34.

Other sign languages

There are also sign languages from other countries (for example Irish Sign Language), and Makaton, which was developed to help people with learning/ speech difficulties.

It may be more difficult to find interpreters for Makaton (www.makaton.org) and sign languages from other countries. The embassy of the appropriate country may be able to help in the latter case.

Text phones

A text phone is telephone device that has a keyboard and a display screen. You type what you want to say rather than speaking into it, so it's useful if you are deaf or if you have problems with your speech.

If you're using a text phone to call a voice phone user, you will not be able to connect to them directly.When they pick up the telephone, they will simply hear a pre-recorded message such as ' Hearing impaired caller, please use a text phone' or they will just get silence. You need to call them using a ' relay service'.

Typetalk is the BT-funded national relay service run by RNID. It links text phone and voicephone users. If you want to talk to someone who uses a voice phone you ' call' a Typetalk operator who will read out your messages and type replies from the person you are talking to. Calls made to you from a voice phone are relayed in the same way.

Dial 0906 680 6666 for an automated 24hr service. Calls cost 25p a minute and are added to your phone bill.

Limited vision and complete or substantial blindness

This includes conditions such as glaucoma and cataracts.

Reasonable adjustments for sight problems include:

- large print
- Braille
- speaking books
- audio clocks
- audio versions of documents
- audiotapes instead of letters
- assistance in completing forms, applications and VOs
- assistance in reading documentation and letters
- clear markings on steps, with yellow banding and/or textures to indicate the lip of each step
- clear distinction between door frames and walls,e.g.painting the door frame black
- voice-recognition software such as Dragon Naturally Speaking for the PC. There is a range of packages available.

Useful contact: see ***Royal National Institute of The Blind*** on page 39.

In individual cases, ask the healthcare team to consider referral to an ophthalmologist for advice on management, low vision aids and, if appropriate, registering the person blind/partially blind

See also **Limited vision and complete or substantial blindness** on page 16.

Communication problems

Reasonable adjustments to support prisoners with speech difficulties include:

- patience – give the prisoner extra time and do not pressure them to communicate quickly
- referral for therapy assessment (through healthcare)
- speech therapy (through healthcare)
- support for official proceedings and interviews
- Typetalk (see ‘ Text phones’ above)
- text phones (see ‘ Text phones’ above)
- alternative media such as written or sign language
- letters to replace phone calls or extra visits

See also **Communication problems** on page 17

Mobility and flexibility problems

Wheelchair use

There are many reasons why a prisoner may need to use a wheelchair either permanently or for certain activities. Many progressive conditions affect mobility, for example, arthritis and Multiple Sclerosis. Older prisoners and others whose mobility is restricted may need to use a wheelchair to travel any distance.

Some adaptations may be appropriate for someone who has to use a wheelchair temporarily, such as during recovery from an injury.

New builds should always consider wheelchair access, ramps, lifts and adapted cells.

Reasonable adjustments for wheelchair use include:

- adapted cell – space to enter the cell, room to move around
- bed height appropriate to move from chair to bed
- shower chair
- shower rails and toilet rails
- raised seat for toilet
- ramps instead of steps
- lowered counters, posters
- lowered phones
- raised tables to enable the chair to slip under
- gloves for self-propelled wheelchair users
- alternative venues for activities if classrooms etc are not accessible
- alternative routes to access services
- lowered call bells and light switches
- plans made regarding who will push the wheelchair, especially for outside

appointments
- assistance with carrying trays.

In individual cases consider referral to NHS through healthcare for an occupational therapy assessment.

Walking difficulties

Prisoners who do not use a wheelchair may have mobility problems such as needing to walk with one or more sticks, a frame or simply have difficulties with walking long distances or climbing stairs. Reasonable adjustments for those who have problems walking include:

- locating them in accommodation on the ground or most accessible floor
- ramps rather than steps
- shower seats
- higher chair seats to make standing and sitting easier
- alternative locations for activities, for example moving classes from the first to ground floor
- alternative routes avoiding stairs
- help with carrying trays and opening doors
- use of a wheelchair for long journeys
- patience; allowing extra time for prisoners to move between locations.

Problems sitting, standing or lying down

Other prisoners may be mobile, but have problems sitting, standing or lying for long periods. This could be because of back, hip or neck problems, or conditions like arthritis.

Reasonable adjustments for these conditions include:

- orthopaedic mattress or firm bed
- upright chair
- planning involvement in activities to avoid extensive standing
- chairs in the exercise yard
- cushions for support in bed or while sitting.

Problems with flexibility and movement

People with arthritis and some other conditions can have problems with raising their arms above a certain level, or with bending.

Reasonable adjustments include:

- lowered call bells, shelves and light switches
- clothes with front openings rather than going over the head
- aids for picking things up, pulling up socks and zips
- raised surfaces to reduce bending.

If an individual develops or has recently developed a disability, or ability is deteriorating, ask the healthcare team to consider assessment and possible referral to specialist.

Manual dexterity problems

This covers any mobility impairment that reduces the ability to use the hands. These difficulties can manifest themselves in a number of ways, for example: being unable to carry objects such as trays, having difficulty with handles, doors, taps etc, or limited fine motor skills.

Reasonable adjustments include:

- assistance with meals, for example arranging for some else to collect meals, open packaging etc
- ‘ lever’ style door handles; when being replaced the DDA-compliant style should be used whenever possible
- ‘ lever’ style taps
- jar- and tin-opening aids
- cutlery which is easy to hold; converters for existing cutlery, pens etc.
- choose computer equipment with larger keypads
- trackball mouse rather than traditional mice
- velcro instead of buttons or zips for clothing.

Many major charities and companies supply adapted technology and living aids. Shop around for the best deal. The works department should be able to assist with the more permanent changes such as door handles

See also **Manual dexterity problems** on page 17.

Medication

Healthcare staff should always be involved in discussions over reasonable adjustments and the prisoner’s requirements.

Pain control

A number of conditions and illnesses result in significant levels of pain, either regularly or during flare-ups. Although the healthcare team will prescribe painkillers, wing staff may need to consider how to manage access to medication, especially where there is concern that other prisoners will try to obtain the medication.

Reasonable adjustments include:

- fitting a secure safe in cell
- holding medication in the wing office
- allowing limited medication in possession
- considering with healthcare alternative non-medication pain control, such as a Tens machine, for when medication cannot be held in possession.

Access to other medication

Some medication needs to be available to the prisoner either to use as required, such as inhalers, or because the medication must be taken or used at regular but unsociable hours.

Reasonable adjustments would be similar to those suggested for pain control, but in some cases medication may, as in the case of certain eye drops used to treat glaucoma, require temperature-controlled storage. In these cases the reasonable adjustment is to fit a small fridge either in the wing office or the cell.

Medical conditions

Healthcare staff should always be involved in discussions over reasonable adjustments and the prisoner's requirements.

Breathing difficulties

This can be an effect of conditions like lung cancer, Chronic Obstructive Pulmonary Disease (COPD), which includes chronic bronchitis and emphysema, and chronic asthma.

Any condition which affects breathing will impact on stamina and tolerance of exercise. It may make walking any distance difficult.

Reasonable adjustments include:

- extra pillows or cushion to enable them to sleep sitting upright
- access to an inhaler or oxygen
- a wheelchair to travel longer distances
- extra blankets etc in cold weather
- immediate access to inhalers
- location on the most accessible floor to reduce use of stairs.

Lung cancer often is progressive, with death occurring within months. The healthcare team and relevant specialists should see the patient regularly to ensure that their condition is being managed in the best way. Consider compassionate release as an option.

See also **Chronic asthma** on page 18, **COPD** on page 18 and **Lung cancer** on page 23.

Dementia/ Alzheimer's

Dementia sufferers may manifest a number of symptoms which can affect life and those around them, including a lack of impulse control and inappropriate behaviour. There are a number of reasonable adjustments that can help manage memory problems, confusion and changes in behaviour:

Memory problems

- a calendar or diary clearly stating when the prisoner needs to attend

appointments, interviews etc
- a card reminding the prisoner of when he/she needs to take medication
- a structured day
- regular reminders of what he/she should be doing from staff who have awareness of the condition
- encourage prisoners to put labels on items in their cells to remind themselves. For example, who people are in a photograph, or what their pills are for and when they should be taken
- tolerance and patience in dealing with individuals who may be unable to organise themselves or remember things that appear obvious.

Confusion
- emphasis on routine
- activities to encourage mental activity
- buddying with another prisoner to provide support
- not challenging the prisoner when he/she has hallucinations or imagines things. *For example, challenging them when they say they've been speaking to a dead relative will cause confusion and may result in aggressive behaviour. Non-confrontational agreement will avoid a flare-up and reduce distress.*

Changes in behaviour
- regular risk assessment; a prisoner with dementia may be physically less dangerous, but represent a greater risk to other prisoners or staff due to lack of impulse control
- enhanced supervision.

Consider compassionate release in advanced cases. The individual may be able to be cared for in a residential or nursing home; secure mental health facilities should be unnecessary.The individual should be referred for a Single Assessment Process (SAP) through the healthcare team and local Social Services.

Diabetes

The healthcare team will determine the necessary treatment, but wing staff will need to observe diabetic prisoners and be aware of symptoms.

Reasonable adjustments include:
- access to food at regular intervals
- access to medication in possession or in wing office.

You may also need to consider adjustments for related mobility problems, such as difficulties walking due to numbness in the feet or obesity.

See also **Diabetes** on page 19.

Epilepsy

The healthcare team will provide any treatment the prisoner needs and will advise on what to do if the prisoner has an attack, but wing staff will need to:

- be aware of triggers, e.g. flashing lights
- know about emergency procedures
- consider access to medication in possession or wing office.

If individual continues to have frequent fits, ask the healthcare team to consider assessment and possible referral to specialist.

Two booklets produced by Epilepsy Action specifically for prisoners and prison staff are available on the REAG intranet site. See also **Epilepsy** on page 19

Heart disease

Reasonable adjustments for a prisoner with heart problems will depend on the symptoms and severity of the condition.The healthcare team will advise, but generally the prisoner should avoid strenuous activity.

See also **Heart problems** on page 20

HIV/Aids

The healthcare team will manage the treatment of any prisoners with HIV. Practices which protect against the transmission of blood-borne and sexually-transmitted diseases such as HIV and Hepatitis C should be normal practice in any case, as it will not always be possible to identify which individuals present a risk.

The reasonable adjustments appropriate will depend on the progress of the disease and the symptoms that each individual is suffering.

It is important to respect the confidentiality of information about a prisoner's disability and this is particularly important with conditions like HIV.

See also **HIV/AIDS** on page 21

Multiple Sclerosis (MS)

Reasonable adjustments will have to be specific to the individual and will depend upon the stage of the illness, the symptoms and what support the individual needs. They may include:

- aids to mobility and balance such as a stick or frame
- adjustments because the individual is easily tired, like regular breaks
- pain management.

Useful contact: The MS Society, www.mssociety.org.uk. Free helpline 0808 800 8000

See also **Multiple Sclerosis** on page 23.

Stroke

Reasonable adjustments will depend on the type and severity of symptoms.Every prisoner who has suffered a stroke will need a healthcare assessment and specialist assessment.

The healthcare team will advise you, and the individual will be able to indicate what level of support they need.

See also **Stroke** on page 24.

Urinary incontinence

Reasonable adjustments include:

- access to in-cell sanitation
- incontinence pads
- increased access to laundry and cell cleaning materials

Unless there are medical reasons, incontinence would not normally exclude a prisoner from providing samples for VDT or MDT when required.

The healthcare team should refer all individuals with urinary incontinence to the local NHS community continence specialist. The condition often improves following specialist assessment and management.

See also **Age-related conditions** on page 30.

Learning difficulties

Dyslexia

There are a number of adaptations that can help, although not all will work in every case:

- consider printing on yellow paper
- coloured lenses in glasses can help when reading computer screens
- use name badges and signs; names and places have to be put in long term rather than short term memory
- ‘ speaking’ software can help when drafting text, by reading back what is written
- ‘ mindmap’ software creates mind maps, which are useful for decision-making
- diaries and reminders can help with memory problems

Education may be able to offer support in improving reading and writing, and suggest other reasonable improvements.

See also **Dyslexia** on page 28.

Autism, Autistic Spectrum Disorders and Asperger's Syndrome

Seek specialist advice. It may also may help to:

- offer a structured regime which offers limited variation, so that the prisoner knows what to expect
- allow the prisoner to remain on basic if he/she feels more comfortable, or only offer those elements of standard or enhanced that the prisoner asks for
- give instructions clearly, without euphemism
- ensure the prisoner understands what is happening and any instructions you have given them
- allow hobbies about which the prisoner may appear obsessive
- do not assume empathy or understanding; many autistic people cannot relate to other people's emotions
- ensure questions are clear. *For example, don't ask ' Have you showered?' as the response may be ' No' if they took a bath. It is better to ask ' Have you washed?' People with these conditions can be overly precise in their understanding*.

See also **Autism/Autistic spectrum disorders** on page 28.

Attention deficit hyperactivity disorder (ADHD) and attention deficit disorder (ADD)

Prisoners with ADHD would benefit from:

- a properly structured routine
- boundaries which are clearly explained, such as standards of acceptable behaviour.

ADHD is a consideration at adjudication, but does not excuse disruptive behaviour. Where a diagnosis of ADHD has been made by professionals, this might affect the punishment awarded at adjudication, but individuals with ADHD need to have clear boundaries and understand that there is a consequence for overstepping them.

See also **ADHD** on page 29.

Intellectual disability

Once a prisoner has been identified as having an intellectual disability, it is important to:

- explain any information clearly and ensure they have understood
- identify an ' Appropriate Adult', especially if going through court proceedings
- give orders clearly and simply
- provide help with accessing activities and courses
- ask the education team for appropriate provision; personal achievement can be particularly important for prisoners who have never gained qualifications before
- give advice and support, especially when decisions need to be made
- consider alternative provision of offending behaviour courses.

Other reasonable adjustments include:

- using EasyRead for documents
- including pictures on canteen lists, induction handouts etc.
- including pictures on signs
- ensuring that there are audio or video versions of information on induction
- making sure that prisoners with learning disabilities have a personal officer who understands how to talk to them.

See also **Intellectual disability** on page 29.

Mental health

Appropriate reasonable adjustments for prisoners with mental health problems will need to be suggested by the healthcare team, taking into account individual circumstances.

Not all prisoners with mental health problems will require medication or treatment. Refer to guidance on safer custody procedures for how to manage prisoners in these circumstances.

See also **Mental health** on page 25.

More about the most frequently-encountered disabilities and conditions

Detailed information about the disabilities and conditions you may come across.

Sensory difficulties

Hearing difficulties and profound deafness

Deafness can be mild, moderate, severe or profound. People with mild deafness have some difficulty following speech, mainly in noisy situations. Those with moderate deafness have difficulty following speech without a hearing aid.

People who are severely deaf may rely extensively on lip-reading, even with a hearing aid; profoundly deaf people often understand speech by lip-reading. For both severely and profoundly deaf people, British Sign Language (BSL) may be their first or preferred language. Although many people are born with some degree of deafness, the commonest cause of hearing loss is ageing, and three-quarters of people who are deaf are aged over 60.

Limited vision and complete or substantial blindness

People can have limited vision for a number of reasons. Normal long or shortsightedness which is corrected by glasses or contact lenses is not considered to be a disability under the DDA. However, sight that is so poor as to be impossible to correct with glasses or lenses would be covered by the DDA. Other conditions which can affect sight and are covered by the DDA are:

Glaucoma

Glaucoma covers a range of conditions in which the pressure inside the eye becomes too high. This results in damage to the optic nerve at the back of the eye, which can lead to loss of vision if left untreated. Glaucoma is one of the most common causes of blindness worldwide. There are two main kinds:

Primary open angle glaucoma The build up in pressure in this condition is very slow. Loss of vision is gradual and patients often do not notice any problem until there is evidence of severe visual impairment. Peripheral vision is affected first, so the eyesight is not obviously affected. Peripheral visual field loss spreads until eventually central vision is damaged, leading to blindness.

Primary angle closure glaucoma In this condition the pressure inside the eye rises rapidly and the eye becomes very painful and often reddened. Vision becomes blurred. The patient may notice halos around lights. There is often significant headache; occasionally the patient feels very unwell and may even

vomit. This condition is very rare in patients under the age of 50 and is more common in people who are long-sighted.

Cataracts

Cataracts are cloudy areas in the lens inside your eye. They can develop in one or both eyes and one eye can often be more affected than the other. A normal healthy lens is clear. It allows light to pass through to the back of your eye, helping you to see sharp images. If parts of the lens become cloudy (opaque), light cannot pass through the cloudy patches. Over time, these patches usually become bigger, and more of them develop. As less light is able to pass through the lens, your vision may become blurry or cloudy. The cloudier the lens becomes, the more your sight will be affected. Cataracts are most commonly found in older people. These are called age-related cataracts.

Communication problems

In some people there may be a medical condition which affects normal development of speech, language and communication. *For example, neurological damage, hearing impairment, cleft palate*.

Manual dexterity problems

This covers any mobility impairment the result of which is a reduction in the ability to use the hands. Restricted manual dexterity may be temporary (in which case it is not covered by the DDA), recurring or permanent. It may be caused by a wide range of conditions, from repetitive strain injury (RSI), carpal tunnel, or injury, to arthritis, a tremor-inducing condition such as Parkinson's disease, or cerebral palsy.

A small number of people have problems due to **dyspraxia**, which involves difficulties with purposeful movement and organisation and secondary language difficulties associated with reading (dyslexia).

These difficulties can manifest themselves in a number of ways. *For example, being unable to carry objects such as trays, having difficulty with handles, doors, taps etc, or limited fine motor skills*.

Specific medical conditions

Cerebral palsy

Cerebral palsy is not a single condition. It is an umbrella term used to describe a group of conditions that cause movement problems. The condition is caused by damage or faulty development in a part of the brain that sends messages to muscles to control movement and co-ordination. The damage or faulty development in the brain usually occurs as the baby is developing in the womb, during birth, or shortly after birth.

If someone has cerebral palsy it means that they are not able to control some of the muscles in their body in the normal way. So, for example, depending on the type of cerebral palsy and the area of brain affected, the person may not be able to walk, move, talk, or eat in the same ways as other people.

Cerebral palsy is classified into four main types and can range from mild to severe. The type depends on the exact part of the brain that is affected and each has different symptoms.

For example, a person with **mild spastic haemiplegia** (this means that the leg and arm of one side of the body are affected) is likely to be fully mobile, active, and independent but have a slightly abnormal gait. At the other extreme, someone may be in a wheelchair and need help with daily living tasks. Every case is different, and reasonable adjustments will be personal to the individual. An individual with cerebral palsy may already have aids and adaptations. However, it is important that the patient's ability is reassessed in prison to ensure the individual is as independent as possible in this new setting.

Chronic asthma

Asthma is a condition that affects the small tubes that carry air in and out of the lungs. When a person with asthma comes into contact with something that irritates their airways (an asthma trigger), the muscles around the walls of the airways tighten so that the airways become narrower and their lining becomes inflamed and starts to swell. Sometimes sticky mucus or phlegm builds up which can further narrow the airways. All these reactions cause the airways to become narrower and irritated – making it difficult to breathe and leading to symptoms of asthma.

Asthma is often worse at night or in the early morning.

COPD

Chronic Obstructive Pulmonary Disease (COPD) is an 'umbrella' term for people with chronic bronchitis, emphysema, or both. COPD restricts/obstructs the airflow to the lungs. It is usually caused by smoking.

Emphysema is a progressive lung condition which leaves sufferers struggling for breath.

Chronic bronchitis is an inflammatory condition in the lungs that causes the respiratory passages to be swollen and irritated, increases mucus production, and may damage the lungs.The symptoms are coughing and breathlessness, which will worsen over the years.

Cystic fibrosis

Cystic fibrosis a condition which mainly affects the lungs and pancreas, but can affect other parts of the body including the liver, nose and sinuses, reproductive organs and sweat glands. Normally, cells in these parts of the body make mucus and other secretions. In people with cystic fibrosis, these cells do not function correctly and make mucus and secretions which are

thicker than normal. This can result in breathing difficulties, coughing, wheezing, chest infections, malnutrition, bloating, constipation, sinus infections, infertility, cirrhosis of the liver, diabetes, and osteoporosis, amongst other symptoms.

The healthcare team can advise on what reasonable adjustments would be appropriate.

Diabetes

Diabetes mellitusis is a condition where the amount of glucose in the blood is too high because the body cannot use it properly. Glucose comes from the digestion of food and drinks containing carbohydrate, and is also produced by the liver.

Insulin is a vital hormone produced by the pancreas which helps glucose to enter the cells, where it is used as energy so we can work, play and generally live our lives.

There are two main types of diabetes:

Type 1 diabetes develops if the body is unable to produce any insulin.This type of diabetes usually appears before the age of 40.

Type 2 diabetes develops when the body can still make some insulin, but not enough, or when the insulin that is produced does not work properly (known as insulin resistance). In most cases this is linked with being overweight. This type of diabetes usually appears in people over the age of 40, though in South Asian and African-Caribbean people it often appears after the age of 25.

Epilepsy

People with epilepsy have recurrent seizures. There are about 40 different types; common ones include:

- Generalised tonic-clonic (previously called grand mal) – loss of consciousness; person falls down; body stiffens; starts to jerk uncontrollably
- Generalised absence (previously called petit mal) – brief loss of consciousness; doesn't fall down; usually no abnormal movements; person appears as if they're daydreaming
- Simple partial – person fully aware; abnormal twitching movement of part of the body, for example, head, eyes, hand or arm, or tingling sensation; person may sense odd smells, sounds or tastes
- Complex partial – person experiences odd tastes or smells or déjà-vu; dream-like state follows; during an attack, lipsmacking, grimacing or fidgeting may occur; can be followed by generalised seizure.

Heart problems

Coronary heart disease (CHD)

In CHD, the arteries that supply the heart with oxygen and nutrients become narrowed. This restricts the supply of blood and oxygen to the heart, particularly during exertion when there are more demands on the heart muscle.

The main symptom is **angina**, caused by insufficient oxygen reaching the heart muscle because of reduced blood flow. Angina is a feeling of heaviness, tightness or pain in the middle of your chest that may extend to, or just affect your arms (especially the left), neck, jaw, face, back or abdomen.

It is most often experienced during exertion, if you run for a bus, for example, or climb stairs. It may also occur in cold weather, after a heavy meal, or when you're feeling stressed. It can subside once you stop what you're doing and rest, or take medication.

The following symptoms are by no means restricted to CHD, and could be harmless or caused by other medical conditions:

- unusual breathlessness when doing light activity or at rest, or breathlessness that comes on suddenly.
- palpitations – awareness of your heart beat or a feeling of having a rapid and unusually forceful heart beat, especially if this feeling lasts for several hours or recurs over several days and/or it causes chest pain, breathlessness or dizziness.
- fainting – although not always a serious symptom, fainting is due to insufficient oxygen reaching the brain.
- fluid retention (oedema) or puffiness in the tissues of the ankles, legs, lungs or abdomen. Although a mild degree of ankle oedema maybe quite normal – for example, on a hot day – it can be a sign that the heart isn't pumping as well as it should. This is known as heart failure.Fluid retention in the lungs, or pulmonary oedema, can cause intense shortness of breath, and may be life-threatening.
- bluish-tinged fingernails or lips can be the result of too little oxygen in the blood.
- fatigue is a common symptom of heart disease, but has numerous causes, including depression.

Chest pain is a symptom that must be taken seriously as it may indicate the onset of angina or a heart attack.Staff should immediately ask healthcare staff for advice and assessment.The individual may be referred to a hospital specialist.

Heart attack

Unfortunately, for many people the first indication that something's wrong is a heart attack. This happens when the blood supply to a part of the heart muscle is completely interrupted or stops, usually when a blood clot forms in a diseased coronary artery that's already become narrowed by **atherosclerosis** (when the walls of your arteries are thickened by cholesterol deposits).The pain

of a heart attack is often severe, and is frequently described as a central, crushing type of pain, like a tight band around the chest. Unlike angina, the pain doesn't subside when you rest.

Sometimes the pain can be mild, and is mistaken for indigestion. Some people have a heart attack without experiencing pain. Other heart attack symptoms include sweating, light-headedness, nausea or breathlessness which, again, aren't alleviated by rest.

Other heart diseases

Other diseases that affect the heart include:

- Infection. Bacterial infections are relatively rare, but can damage the valves of the heart as well as other tissues. Viral infections can damage the heart muscle leading to heart failure, or cause abnormal heart rhythms.
- Congenital heart disease.
- Cardiomyopathy. This is disease of the heart muscle and may occur for many different reasons, including CHD, high blood pressure, viral infection, high alcohol intake and thyroid disease.

For many people with heart disease, it is the combination of several factors that causes problems. For example, CHD (most adults have some degree of atherosclerosis, especially if they smoke) and high blood pressure are often found together.

HIV/AIDS

The Human Immunodeficiency Virus (HIV) is a sexually transmitted virus that attacks the body's immune system. A healthy immune system provides a natural defence against disease and infection.

Acquired Immune Deficiency Syndrome (AIDS) is a term used to describe the latter stages of HIV, when the immune system has stopped working and the person develops a life-threatening condition, such as pneumonia (infection of the lungs). The term AIDS is no longer widely used, because it is too general to describe the many different conditions that can affect somebody with HIV.

Primary HIV infection

The initial stage of HIV is known as primary HIV infection. The early symptoms are often very mild, so it is easy to mistake them for another condition, such as a cold or glandular fever.They can include:

- fever
- sore throat
- tiredness
- joint pain
- muscle pain
- swollen glands (nodes)
- a blotchy rash on the chest.

After the initial symptoms listed above, HIV will often not cause any further symptoms for many years. This is known as asymptomatic HIV infection.

During this time, the virus is still reproducing and damaging the immune system.

Late-stage HIV infection

Left untreated, HIV will cause the immune system to stop working. It normally takes 10 years for the virus to damage the immune system in this way. A damaged immune system will inevitably result in a serious infection. Possible symptoms of a serious infection caused by a damaged immune system include:

- persistent tiredness,
- night sweats,
- unexplained weight loss,
- persistent diarrhoea,
- blurred vision,
- white spots on the tongue or mouth,
- dry cough,
- shortness of breath,
- a fever of above 37C (100F) that lasts a number of weeks
- swollen glands that last for more than three months.

AIDS-related illnesses, such as TB, pneumonia and some cancers, may appear.

Kidney disease

The most common form of kidney disease is chronic (long-term) kidney disease (CKD). CKD develops over time, when the kidneys cannot remove toxins, waste products and fluids from the body. Anyone can get chronic kidney disease, but it is more likely to develop after the age of 55.

It is also possible to get acute kidney disease. This starts quickly, lasts for a short time and often needs emergency treatment.

CKD often gets worse over time and the damage to the kidneys is permanent. It usually happens slowly, and most people do not develop kidney failure (also called established kidney or renal failure). It is important to diagnose and treat kidney disease early, before people need dialysis or a transplant, because it is often possible to stop kidney damage getting worse.

Having kidney disease also means you are more likely to get heart disease or have a stroke.

Signs and symptoms of moderate or severe kidney disease may include:

- weakness and tiredness or fatigue.
- urinating frequently at night.
- itchiness of the skin that may slowly get worse.
- pale skin that bruises easily.
- muscular twitches, cramps and pain (restless legs syndrome).
- pins and needles in the hands and feet.
- feeling sick (nausea) and loss of appetite.
- swelling of the face, arms, legs and abdomen.

For individuals who have been on kidney dialysis (haemo or peritoneal) in the community, it may be important to consider if dialysis can be undertaken in prison.

Lung cancer

There are two main types of lung cancer: about a quarter are rapidly spreading small-cell lung cancers (SCLC); the remainder are relatively slow-growing non-small-cell lung cancers (NSCLC).

Symptoms may include:

- a persistent cough, or change in the nature of a longstanding cough
- shortness of breath
- coughing up blood-stained phlegm (sputum). Blood is a warning sign that always needs urgent investigation
- chest discomfort–a dull ache or sharp pain when you cough or take a deep breath
- loss of appetite and weight.

Note that these symptoms occur in many other conditions and do not necessarily indicate cancer.

Multiple Sclerosis

Multiple Sclerosis (MS) is the most common neurological condition among young adults in the UK. It is possible for MS to occur at any age, but in most cases symptoms are first seen between the ages of 20 and 40. Women are almost twice as likely to develop MS as men.

MS is a condition of the central nervous system (the brain and spinal cord), which controls the body's actions and activities, such as movement and balance. Each nerve fibre in the central nervous system is surrounded by a substance called myelin. Myelin helps the messages from the brain travel quickly and smoothly to the rest of the body. In MS, the myelin becomes damaged, disrupting the transfer of these messages.

The symptoms of the condition are numerous and unpredictable, and they affect each person differently. Some of the most common conditions include

problems with mobility and balance, pain, muscle spasms and muscle tightness.

MS is a life-long condition. It progresses at different rates in different individuals, though progression often occurs quite dramatically. Individuals may suddenly become more incapacitated over a period of days.

Healthcare assessments will help determine the management of individual cases. Reasonable adjustments will have to be specific to the individual and will depend on the stage of the illness, the symptoms and what support the individual needs.

Stroke

The symptoms of a stroke and a transient ischaemic attack (TIA) are the same. A TIA is also known as a ' mini-stroke'.

Symptoms include:

- sudden weakness, numbness or paralysis often down one side of the body, affecting the face, arm, leg or whole side
- problems communicating, being unable to talk or understand what others are saying, or an alteration in speech, such as slurring words
- sudden blurring, loss or disturbance of vision, especially in one eye
- swallowing difficulties
- dizziness, loss of balance or coordination
- sudden severe headache.

Other less obvious symptoms include difficulties in perception or thinking, mood swings and personality change.

Effects of stroke

The physical damage stroke causes to the brain can have a wide range of effects. These will depend on the type of stroke and its severity, the part of the brain affected, the extent of brain damage and how quickly other brain cells take over the function of the damaged and dead ones. Around a third of strokes are fatal.

Effects may include:

- weakness or paralysis, leading to difficulties with walking, movement or coordination. This often affects only one side of the body
- lack of feeling or loss of awareness of objects on one side of the body
- swallowing difficulties, causing trouble with eating or drinking. If this isn't carefully managed, and food or liquid passes into the windpipe and lungs, it can result in chest infections such as pneumonia. Dehydration or constipation may also result
- speech or language difficulties, including difficulties in understanding, speaking (dysphasia, aphasia), reading, writing and calculation
- problems of perception, including trouble recognising or being able to use everyday objects, difficulties telling the time and problems interpreting what

the eyes see, even when vision isn't affected
- cognitive difficulties, including problems caused by damage to areas of the brain controlling mental processes such as thinking clearly and logically, learning, paying attention, memory, decision making and forward planning
- behaviour changes, which may include being slower to react than before the stroke, excessive caution, disorganisation, difficulties adjusting to change and becoming confused or irritated
- difficulties with bowel or bladder control (urinary or faecal incontinence)
- fatigue
- mood changes, including mood swings, irritability and laughing or crying, even when you don't feel particularly happy or sad
- depression, with symptoms such as loss of appetite, insomnia, crying, low self-esteem and anxiety
- post-stroke pain. A small number of people develop a burning, shooting, throbbing pain that won't respond to painkillers
- epilepsy, which affects around 7–20 percent of people who have strokes.

Short-term effects disappear with time, as any swelling in the brain goes down and the damaged cells surrounding the dead brain cells are repaired.

Long-term effects are caused by the death of brain tissue. They won't go away, but they can often be modified with rehabilitation.

Mental health

Seek advice from the healthcare team for all mental health issues.This section provides brief descriptions of the most common conditions.

Bipolar disorder

Bipolar disorder, previously called manic depression, is a condition that affects your moods, which can swing from one extreme to another. If you have bipolar disorder, you will have periods or episodes of:
- **depression** where you feel very low.
- **mania** where you feel very high. If your symptoms are slightly less severe, it is known as hypomania.

Both extremes of bipolar disorder have other symptoms associated with them. Unlike simple mood swings, each extreme episode can last for several weeks or longer. The high and low phases of the illness can be so extreme that they interfere with daily life.

Depression

Depression affects one in five people at some point in their lives. Anyone can get low at times, but with depression, the feelings don’t go away quickly or

become so bad they interfere with everyday life. Symptoms of depression include:

- losing interest in life
- finding it harder to make decisions
- not coping with things that used to be manageable
- exhaustion
- feeling restless and agitated
- loss of appetite and weight
- difficulties getting to sleep.

Often people don't realise how depressed they are, because the depression has come on gradually.They may try to struggle on and cope by keeping busy. This can make them even more stressed and exhausted. This can cause physical pain, such as constant headaches, or sleeplessness.

Eating disorders

Anorexia nervosa

Anorexia nervosa is an eating disorder and a mental health condition.People who have anorexia nervosa have problems with eating. They are obsessed with food, eating and calories. They are very anxious about their weight and keep it as low as possible by strictly controlling and limiting what they eat, and sometimes by making themselves vomit.

Anorexia means 'loss of appetite'. People can lose their appetite because of other conditions, such as cancer. Doctors may use the medical term anorexia to describe this. However, it is not the same as the condition anorexia nervosa. People with anorexia nervosa do not usually lose their appetite; their disease encourages them to avoid eating.

This can be a serious condition.Starving yourself affects every part of your body and can lead to health problems. If anorexia nervosa is not treated, these problems can become severe and even life-threatening.

Bulimia

Bulimia nervosa (usually referred to just as bulimia) is an eating disorder. People with bulimia tend to alternate between eating excessive amounts of food (bingeing), and making themselves sick or using laxatives (purging), in order to maintain a chosen weight. This is usually done in secret. People with bulimia purge themselves because they feel guilty about the binge eating, but the bingeing is a compulsive act that they feel they cannot control.

Obsessive Compulsive disorder

Obsessive compulsive disorder (OCD) is a chronic mental health condition that is usually associated with both obsessive thoughts and compulsive behaviour. OCD is one of the most common mental health conditions.

The symptoms of OCD can range from mild to severe. For example, some people with OCD may spend around one hour a day engaged in obsessive compulsive thinking and behaviour, while for others, the symptoms completely dominate their life. A form of psychotherapy, known as cognitive behavioural therapy (CBT), can be very successful in helping many people with OCD.

Psychosis

Psychosis is a term used to describe a mental condition where somebody is unable to distinguish between reality and their imagination. People who are experiencing psychosis are referred to as **psychotic**. People with psychosis often experience:

- hallucinations, when you hear or see things that are not there, and
- delusions, when you believe things that are untrue.

Psychosis is not a condition in itself. It is a symptom of other conditions. The most common cause of psychosis is a mental health condition such as schizophrenia or bipolar disorder (manic depression). Psychosis can also be triggered by physical conditions, such as Parkinson's disease, or as a result of drug or alcohol abuse.

Do not confuse the term ‘ psychosis’ with the term ‘ psychopath’. The two conditions are very different.

Someone with psychosis has an acute condition. Psychosis may occur due to schizophrenia or sometimes it may be organic, secondary to substance misuse. The latter may be reversible. A psychopath is someone who has an incurable anti-social personality disorder, which means that they lack the capacity for empathy, are manipulative and often have a total disregard for the consequences of their actions.

Unlike people with psychosis, people with anti-social personality disorders can appear to act in a rational manner.

Schizophrenia

Schizophrenia is a chronic mental health condition that causes a range of different psychological symptoms. These include:

- hallucinations – hearing or seeing things that don't exist
- delusions – believing in things that are untrue.

Hallucinations and delusions are often referred to as psychotic symptoms or symptoms of psychosis. Psychosis is when somebody is unable to distinguish between reality and their imagination.

Schizophrenia is often a poorly-understood condition and many people hold misconceptions about it.

One misconception is that people with schizophrenia have a split or dual personality, behaving perfectly normally one minute and then irrationally or bizarrely the next. It would be more accurate to say that people with

schizophrenia have a mind that can experience episodes of dysfunction and disorder.

Another misconception is that people with schizophrenia are violent. Acts of violence committed by people with schizophrenia get a great deal of high-profile media coverage, and this can give the impression that such acts happen frequently, when they are in fact very rare.

People with schizophrenia may have moderate or even severe difficulties with the activities of daily living, so an occupational therapy assessment maybe useful. If an individual has difficulties with washing and dressing they may need considerable help. Staff should not think that the individual is being un-cooperative or willful; they may actually be incapable of satisfactory self-care.

Learning difficulties

Dyslexia

Dyslexia is a specific learning difficulty which mainly affects the development of literacy and language-related skills. It is likely to be present at birth and to be lifelong in its effects. It is characterised by problems with phonological processing (associating sounds with written words), rapid naming, working memory, processing speed, and the automatic development of skills. These things may not match up to an individual's other cognitive abilities.

Modern teaching techniques can help people with dyslexia to learn to read, write and handle numbers. There are coping strategies that help them to organise and remember things. Large numbers of people with dyslexia actually have high IQs, but might have spent most of their lives being labelled as stupid.

Autism/Autistic spectrum disorders

Autism is a lifelong developmental disability that affects the way a person communicates and relates to people around them. People with autism have difficulties with everyday social interaction.

Autistic prisoners may

- find it difficult to interact with other prisoners and staff
- deliberately seek a rigid routine as change and choice confuse them
- demonstrate obsessive behaviour and a need to do things in a particular order
- take statements very literally, and answer questions in a very literal way.

The condition does not affect IQ levels, but the intelligence may be very focused into a particular aptitude, ability or skill. There is some scientific evidence that the genes that predispose an individual to an autistic spectrum disorder are linked to ability in maths and the sciences. Certainly the ability to

focus narrowly on a subject may lead to individuals becoming expert in their chosen subject or field.

People with autistic spectrum disorders are commonly divided into **low functioning**, where ASD is combined with a learning disability, and **high functioning**, where IQ is normal.

Asperger syndrome

Asperger syndrome is a form of autism.It is a condition that affects the way a person communicates with and relates to others. People with Asperger syndrome may find difficulty in social relationships and in communicating, and limitations in social imagination and creative play.

Like those with autism, people with Asperger syndrome may need routine and may find it difficult to interact with others. There are different degrees of Aspergers; some people may simply be a bit withdrawn, while others may find people and social situations very difficult.

ADHD

Attention deficit hyperactivity disorder (ADHD) and attention deficit disorder (ADD), refer to a range of problem behaviours associated with poor attention span. These may include impulsiveness, restlessness and hyperactivity, as well as in attentiveness, and often prevent children and young people from learning and socialising well. ADHD is sometimes referred to as hyperkinetic disorder.

Intellectual disability

Someone who has a learning disability will have certain limitations on their ability to think (known as an impairment of intellectual ability). This limitation might be hardly noticeable or very severe, and anywhere in between.

The most important issue with prisoners who might have an intellectual disability is ensuring understanding. They may also be easily influenced or bullied by other prisoners, may get into debt, may find it difficult to express themselves, have anger issues, or not understand the boundaries of acceptable behaviour.

Down’s syndrome

Down's syndrome is a genetic abnormality that causes physical and intellectual impairments. People with Down's syndrome tend to look different; they typically have a flat facial profile and eyes that slant upwards. People with the syndrome also tend to be shorter than average with poor muscle tone and have short, broad hands with a single crease across the palm.

Almost half of people affected have heart defects, some of which can be treated. Many also have gut problems, which can make eating difficult and increases the risk of problems such as constipation and disorders of the thyroid gland. Other physical problems include cataracts, hearing and sight problems, and a susceptibility to infections. Later in life there is also an increased risk of leukaemia and Alzheimer's disease.

People with Down's syndrome have varying degrees of learning disability, which may range from moderate to severe. Autistic spectrum disorders are also more common.

Physiotherapy, speech therapy and special educational programmes have an important role to play, while specific medical conditions associated with the syndrome need to be treated as appropriate.

Age-related conditions

These conditions can affect younger people, but are mostly associated with old age.

Arthritis

The most common type is **osteoarthritis** (or degenerative arthritis), where the cartilage that protects the joints gets worn away. This makes joints stiff, painful and creaky. It is often caused by normal wear and tear of the joints, so usually occurs as people get older. But younger people can also get it, often because of an accident or sports injury where a joint has been placed under unnatural strain.

Rheumatoid or **inflammatory arthritis** is a more severe but less common condition. The body's immune system attacks and destroys the joint lining, making joints painful, unstable and deformed. This type of arthritis tends to affect younger people and is more common in women than in men. The disease can progress very rapidly (the speed of progression varies widely between individuals), causing swelling and damaging cartilage and bone around the joints. Any joint may be affected but it is commonly the hands, feet and wrists.

Other common types of arthritis include:

- Ankylosing spondylitis
- Cervical spondylosis
- Gout.

Individuals with arthritis may have general or limited disability. Aids and adaptations may be required according to the level and type of disability.

Dementia/ Alzheimer's

Dementia causes the (usually gradual) loss of mental abilities such as thinking, remembering and reasoning. It is not a disease, but a group of symptoms that may accompany some diseases or conditions affecting the brain.

The most common symptoms include loss of memory, confusion, and changes in personality, mood and behaviour. Alzheimer's disease is the most common cause of dementia. During the course of the disease, the chemistry and structure of the brain changes, leading to the death of brain cells.

Mental activity, hobbies and social interaction are all shown to help protect from developing dementia, and can help to mitigate against the effects. A healthy diet is also believed to help sufferers.

Osteoporosis

Loss of bone density is a natural part of ageing.Osteoporosis is diagnosed when bones are so weak that they may fracture after only a minor fall. If osteoporosis affects your spine, the vertebrae can collapse and cause severe pain and immobility.

Parkinsonism

The main symptoms of Parkinson's disease (shaking, stiffness and slowness of movement) are also the main symptoms of Parkinsonism, a collective group of conditions, of which Parkinson's disease is the most common. The less common forms of Parkinsonism include:

- multiple system atrophy (MSA) – a neurodegenerative disorder that affects your motor system (the deterioration of brain signals to the muscles and limbs responsible for movement)
- progressive supra nuclear palsy (PSP)– a degenerative disorder that affects a person's vision and movement.

Both of these disorders have similar symptoms and effects as Parkinson's disease.

Parkinson's disease

Parkinson's disease is a chronic (persistent) neurological condition that affects the way the brain coordinates body movements, including walking, talking and writing.

Parkinson's disease affects both sexes, although, statistically, men are slightly more likely to develop the condition than women. When the symptoms of Parkinson's disease occur in a person between 21 and 40 years of age, it is known as young-onset Parkinson's disease. If a person is diagnosed with Parkinson's disease before the age of 18 it is known as juvenile Parkinson's disease, but this is extremely rare.

The symptoms of Parkinson's disease usually begin slowly develop gradually, in no particular order. Parkinson's disease affects each individual differently and each person with the condition will have a different collection of symptoms and respond differently to treatment. The severity of symptoms also differs between individuals.

There are three main symptoms of Parkinson's disease:

- **Bradykinesia** (slowness of movement) – initiating movement, such as starting to get out of a chair, can become difficult and it can take longer to perform tasks. The person may also lack coordination in their movements. People often put this slowness of movement down to old age, and many do

not have Parkinson's disease diagnosed until other symptoms occur.

- **Tremor** (shaking) –usually begins in one hand or arm. It is more likely to occur when that part of that body is at rest, and usually decreases when the person uses it. Shaking may become more noticeable when the person is stressed or anxious. However,the presence of tremor does not necessarily indicate Parkinson's disease, as it is also a symptom of other conditions, including over-active thyroid (hyperthyroidism), multiple sclerosis, brain inflammation (encephalitis) and alcoholism. Although most people associate Parkinson's disease with tremor, up to 30% of people with the condition will not have this symptom.
- **Stiffness of muscles** (rigidity) – muscles may feel tense and due to the stiffness, the person may have trouble performing simple everyday tasks or to turn around, get out of a chair and roll over in bed. Fine finger movements, facial expressions and body language may also become difficult.

Other symptoms associated with Parkinson's disease include:

- tiredness
- constipation and bladder weakness
- depression
- problems with handwriting, speech and balance
- difficulty swallowing.

Urinary incontinence

There are various types of urinary incontinence, but the two main types are stress incontinence and urge incontinence. Incontinence can be due to age, pregnancy, menopause, hysterectomy, obesity, urine infections, conditions that affect the nervous system like Parkinson's Disease, enlarged prostrate gland, urinary stones, spinal injury, smoking and birth defect.

Short term incontinence is not covered by the DDA. Permanent and long term conditions are.

Stress incontinence occurs when the pelvic floor muscles are too weak to prevent urination. Stress incontinence is not related to feeling stressed, but occurs when your bladder is put under an extra amount of sudden pressure.

If you have stress incontinence, you may find that urine leaks out during physical activities such as:

- coughing
- sneezing
- laughing
- heavy lifting
- exercise.

The amount of urine that is passed is usually small, but stress incontinence can also cause you to pass larger amounts, particularly if your bladder is very full.

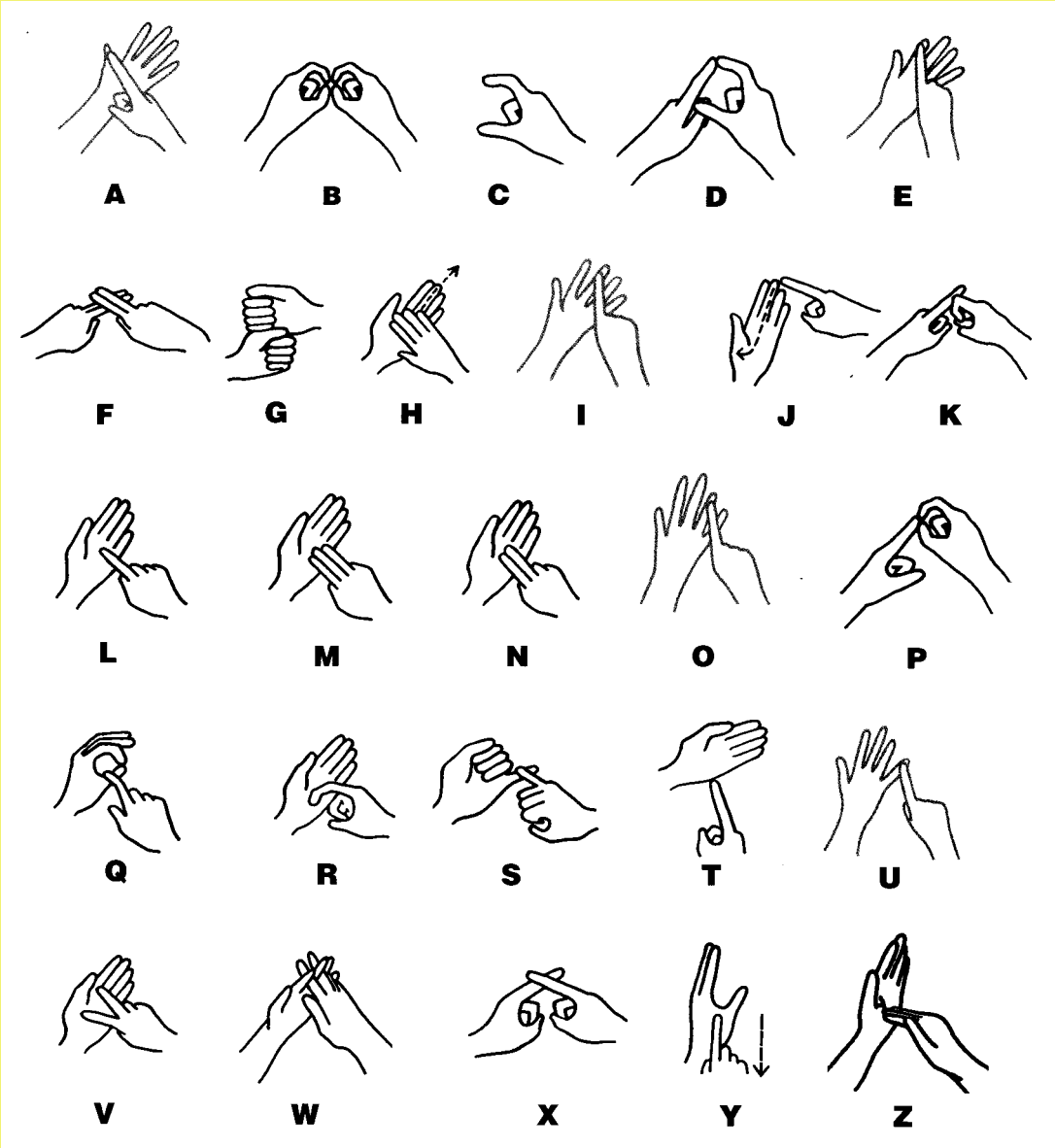
Urge incontinence is thought to be a result of incorrect signals being sent between the brain and the bladder. It is a sudden and very intense need to pass urine before quickly releasing large amounts of urine. There is often only a few seconds between the need to urinate and the release of urine. The need to pass urine may be triggered by a sudden change of position, or even by the sound of running water.The person may need to pass urine very frequently and get up several times during the night.

Overflow incontinence is a type of urinary incontinence that is common in men who have an enlarged prostate gland, which can obstruct the bladder. The person may pass small trickles of urine very often.They may also feel the bladder is never fully empty, and cannot empty it even when they try.

Urinary incontinence that is severe and continuous is sometimes known as **total incontinence**. It usually occurs as a result of a congenital (present from birth) bladder disorder, after surgery, or following an injury.Total incontinence may cause the person to constantly pass large amounts of urine, even at night. Alternatively, they may pass large amounts of urine every so often and leak small amounts in between.

ANNEX A: Communicating with people who have hearing difficulties

Standard manual alphabet



Tips for helping people who lip-read

Points to remember when speaking to deaf or hard of hearing people

- make sure the light is on YOUR face
- make sure you face the deaf person
- make sure the subject is clear
- get to the point and keep it simple
- speak a little more slowly
- be prepared to repeat, rephrase and/or write it down

- it's easier to lip-read a whole sentence than a single word
- never say ‘ Oh, it doesn't matter’, because it does.

Not all deaf and hard of hearing people can lip-read so be patient and understanding.

ANNEX B: Useful contacts and organisations

General

Equality & Human Rights Commission

Replaces the CRE, DRC etc amalgamated into a single equality body, and has four main offices in Manchester, London, Cardiff & Glasgow.

Manchester: Arndale House, The Arndale Centre, Manchester, M4 3AQ Telephone 0161 829 8100 (non helpline calls only) Fax 01925 884 000

London: 3 More London, Riverside Tooley Street, London, SE1 2RG Telephone 020 3117 0235 (non helpline calls only) Fax 0207 407 7557

Cardiff: 3rd floor, 3 Callaghan Square, Cardiff, CF10 5BT Telephone 02920 447710 (non helpline calls only) Textphone 029 20447713 Fax 02920 447712

0845 604 6610 - England main helpline number 0845 604 8810 - Wales main helpline number

http://www.equalityhumanrights.com

info@equalityhumanrights.com

wales@equalityhumanrights.com

Directgov – Disabled People index

Government resource site for Disabled People http://www.direct.gov.uk/en/DisabledPeople/index.htm

NHS Choices -NHS Trusts in England

Search site for NHS facilities http://www.nhs.uk/servicedirectories/Pages/ServiceSearch.aspx

Nacro

Crime reduction charity http://www.nacro.org.uk

The Prison Reform Trust

Information on prison reform. Of particular interest are the No One Knows and Doing Time briefing papers. http://www.prisonreformtrust.org.uk/nok

National Appropriate Adult Network

The National Appropriate Adult Network (NAAN) brings together those involved in managing schemes of volunteers or paid workers. NAAN gives advice, guidance and support, provides information on training and standards, and works with Government and others on policy and practice issues. http://www.appropriateadult.org.uk

Legislation

Disability Discrimination Act

http://www.opsi.gov.uk/ACTS/acts1995/ukpga_19950050_en_1

http://www.opsi.gov.uk/acts/acts2005/pdf/ukpga_20050013_en.pdf

EHRC Website - guidance

http://www.equalityhumanrights.com/your-rights/disability/

Transfer of Prisoners to Secure Hospitals

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4123628

Support organisations

Support for professionals

British Psychological Society

Support for professionals and provides free advice leaflets to the public. www.bps.org.uk

College of Occupational Therapists

Support for professionals and public forum. http:// www.cot.co.uk

Royal College of Speech and Language Therapists

http://www.rcslt.org

Royal College of Nursing

http://www.rcn.org.uk

Royal College of Psychiatrists

http://www.rcpsych.ac.uk

Directory of expert witnesses

Criminal Justice related website.

http://www.bps.org.uk/e-services/find-a-psychologist/expertwitness.cfm

National Network for Learning Disability Nurses

http://www.nnldn.org.uk

General

RADAR – The Royal Association for Disability and Rehabilitation

Phone: 020 7250 3222

http://www.radar.org.uk

Communication

Know What I Mean

Booklets (will accept commissions to write accessible booklets about any subject)

http://www.knowwhatimean.co.uk/

Makaton

Uses signs and symbols to teach communication, language and literacy skills to people with communication and learning difficulties.

http://www.makaton.org/index.htm

Photosymbols

Photosymbols are a collection of pictures for making easy read information.

http://www.photosymbols.com/index

Signalong

A sign-supporting system based on British Sign Language. http://www.signalong.org.uk

Inspired Services Publishing Ltd

EasyRead and other accessible information, any format, any language.

http://www.inspiredservices.org.uk/Sales.htm

Housing

Housing Options

Housing and homelessness; advice for people with learning disabilities

http://www.housingoptions.org.uk/

Housing Net

Housing and homelessness; search for housing providers across the country

http://www.housingnet.co.uk/

Homeless UK

Accommodation services for the homeless and advice

http://homelessuk.org/details.asp?id=LP124&ds=1

Shelter

Advice on housing and homelessness

http://england.shelter.org.uk/home/index.cfm

Impaired hearing and sight

British Institute for The Deaf

Phone: 0121 246 6100

http://www.bid.org.uk

The Royal Association For Deaf People

http://www.royaldeaf.org.uk

RNID Royal National Institute for the Deaf

19-23 Featherstone Street, London EC1Y 8SL

Freephone information line

Phone: 0808 808 0123

Textphone: 0808 808 9000

informationline@rnid.org.uk

Royal National Institute of The Blind

105 Judd Street, London, WC1H 9NE

Tel: 020 7388 1266

Fax: 020 7388 2034

http://www.rnib.org.uk

Learning disability

Association for Real Change

A membership organisation, which supports providers of services to people with a learning disability to promote real change.

http://www.arcuk.org.uk

Books Beyond Words

Books Beyond Words (BBW) is a series of picture books that has been developed to make communicating easier, and to enable discussion about difficult topics. Supporting text and guidelines are also provided for carers, supporters and professionals. The series is particularly useful for people with learning difficulties.

http://www.rcpsych.ac.uk/publications/booksbeyondwords.aspx

The British Dyslexia Association

http://www.bdadyslexia.org.uk

British Institute of Learning Disabilities

Source of information, particularly around challenging behaviour

http://www.bild.org.uk/index.html

CHANGE

National rights organisation led by disabled people. Campaigns for equal rights for all people with learning disabilities and raises awareness of the issues.

http://www.changepeople.co.uk

Foundation for People with Learning Disabilities

Support for People with learning disabilities

http://www.learningdisabilities.org.uk

Intellectual Disability

Learning about intellectual disabilities and health.

http://www.intellectualdisability.info

Learning disabled offenders website

The care and treatment of offenders with a learning disability.

http://www.ldoffenders.co.uk

Mencap

Campaigning and support organisation for people with learning disabilities

http://www.mencap.org.uk

The National Autistic Society

The society runs a course about autism for CJS professionals

http://www.nas.org.uk/

People First

People with learning difficulties speaking up for themselves.

Central England People First Limited, Eskdaill House, Eskdaill Street,Kettering, Northants, NN16 8RA

Phone: 01536 515548http://www.peoplefirst.org.uk

Respond

Supporting people with learning disabilities, their families, carers and professionals affected by trauma and abuse

http://www.respond.org.uk

Voice UK

Supports people with learning disabilities and other vulnerable people who have experienced crime or abuse

Voice UK, Rooms 100-106, Kelvin House, RTC Business Centre, London Road, DERBY DE24 8UP

Phone: 01332 291042

Fax: 01332 207567

http:// www.voiceuk.org.uk

Mental health

Bristol Crisis Service for Women

Help with self-harming behaviour; lots of information may be relevant to men too.

PO Box 654, Bristol BS99 1XH

Helpline: 0117 925 1119

Office/Admin: 0117 927 9600

http://www.users.zetnet.co.uk/bcsw/leaflets/resources.htm

National Advocacy Network (UKAN)

User controlled national federation of advocacy projects, patients' councils, user forums and self-help and support groups working in the field of mental health.

http://www.u-kan.co.uk

Mind

Mental health charity http://www.mind.org.uk

Revolving Doors Agency

Revolving Doors Agency is the UK's only charity dedicated to improving the lives of people who are caught up in a damaging cycle of crisis, crime and mental illness.

http://www.revolving-doors.co.uk

Older people

Age UK

Age UK is the new force combining Age Concern and Help the Aged. The merger is happening in Spring 2010. It will take some time for websites and offices to merge.

http://www.ageuk.org

Age Concern (National)

http://www.ageconcern.org.uk

Age Concern Regional Support Services (South West)

http://www.acoop.org.uk

The Alzheimers Society

Phone: 0207 423 3500

http://www.alzheimers.org.uk

Better Government for Older People

http://www.bgop.org.uk

Help The Aged

http://www.helptheaged.com

RESTORE 50plus

Peer-led support services for older people in prison

Footprints House, 3 North Square, Dorchester, Dorset DT1 1HY

Phone: 01300 342062

Mobile: 07742 377744

stuartware@btinternet.com

Social care

Social Care Online

Extensive free database of social care information and learning disability, with everything from research briefings, to reports, government documents, journal articles, and websites.

http://www.scie-socialcareonline.org.uk

Care Improvement Partnership West Midlands

Social care in prisons for disabled and older prisoners, and access to information about mental health and older people.

http://www.westmidlands.csip.org.uk/health-and-social-care-in-criminal-justice/social-care.htmlCSIP

Valuing People Support Team

Lots of information about what's happening in the sector, plus resources

http://valuingpeople.gov.uk/index.jsp

Annex C: Examples from around the country

Here are some practical examples of reasonable adjustments made at prisons around the country. Please contact the DLO at the establishment for further details.

The Verne

- has installed hearing loops in the visits hall
- keeps portable hearing loops for legal visits.
- set up a hearing Loop system on their PIN Phones
- provides Type Talk Telephones for profoundly deaf prisoners.
- pays prisoner helpers to assist other visually impaired and very unwell prisoners,
- provides a mobility scooter to severely restricted prisoners
- installed a Stannah stairlift on a wing that had been designated for older prisoners.

Birmingham

The prison has installed Dragon Naturally Speaking; this is software that speaks back as you type, can read documents, and type from spoken word onto computers for both staff and prisoners with dyslexia.

Littlehey

Provides alternative PE provision for older prisoners; yoga, carpet bowls.

Wakefield

Holds memory groups for older prisoners to share reminiscences. They also have cards or hangers on cells to indicate those prisoners who might need help in an evacuation. The cards distinguish between the degrees of assistance needed by individuals.

HM YOI Glen Parva

On receiving their first prisoner who was in a wheel chair, they:

- made sure that the prisoner's wheelchair would fit through all doorways. The

prisoner had a special chair which is slightly wider that the average wheel chair
- installed grab rails in his cell and toilet/wash sink area to allow him some freedom to move around his cell
- provided a slip chair for him to get him on and off the toilet pan and allow him to use the sink to wash himself
- provided a specialist plastic chair in the shower area to allow him to shower himself and maintain his dignity
- lowered all shelving/work tops to allow ease of access to his personal belongings. Light switches were also lowered
- set up a Personal Emergency Evacuation Plan (PEEP) in case of emergencies
- provided a wireless remote alarm in case of medical emergencies (a simple household wireless door bell system)
- arranged accommodation on ground floor. All activities he attended were also on the ground floor i.e. education classes, chapel, gym etc.

Standford Hill

- arranged for a free standing shower chair to be chained to the inside of the shower instead of having the whole shower area changed
- provide trays to take meals from the servery to their cells if prisoners can't manage them
- arrange mentors for reading/writing difficulties.

Stocken

Stocken had a prisoner who was going blind. They bought a ‘ teach yourself Braille’ kit with tapes which proved very useful. The prisoner learned Braille and left the course in the library when he left.

Braille kit details: MegaDots Command Summary, Version 2.0, July 1999, by David Holladay, Aaron Leventhal and Caryn Navy.

Available from: Duxbury Systems Inc., 270 Littleton Road unit 6,Westford, MA01886, USA

http:// www.duxburysystems.com

Isle of Wight

The prisons on the Isle of Wight have:
- arranged for the DLO to visits offenders whilst in hospital to establish if they have any disability needs, and also to liaise with other professionals i.e. OT

or specialist nurses for advice and guidance, with offenders' permission.
- established an older offenders group who both organise and run the activity afternoons themselves with minimal supervision.
- developed a menu of activities to enable choice for individuals, including bowls and light exercise.
- invited guest speakers in to discuss different topics with older prisoners.

Lindholme

Has purchased mobile mini-coms for prisoners who have a hearing impairment so that they can keep in touch with family.

Maidstone

- use the Universal Language System. These are picture cards to aid communication, see http://www.forestbooks.com. The product is PocketComms: Universal Language System. This is also very useful for Foreign National Prisoners.
- provide digi-boxes to profoundly deaf prisoners so they can access subtitles
- provide headphones for the TV so that the sound can be turned right up without disturbing other prisoners
- provided equipment to enable a prisoner with severe burns to one of his hands to complete the bricklaying course. This prisoner had specialist gloves were provided to protect his hands and his tools adapted. The tools were provided by the education trust and the prisoner was able to keep them on his release from prison.
- use Widgit – software which produces documents in an alternative format, i.e. pictures
- provided a typewriter for a prisoner with Parkinsons to enable him to complete the OBP.

Manchester

Prisoners with hearing difficulties have been offered a Bellman Audio Neckloop, which gives them a higher quality of hearing through their hearing aids.

Whitemoor

Has arranged for special postal learning materials to be made available through the Library Manager, for a prisoner who suffers from severe

neurological head pain when trying to read normal print. Until this was arranged he had been excluded from all education classes.

Styal

Has provided a lady who had lost 80% of her eyesight an A4 piece of equipment that has elastic lines on it, which she uses for writing letters.

Bullingdon

Has a fire buddy scheme which ensures that everyone is evacuated smoothly in the event of an emergency.

Woodhill

Has training sessions from MIND on mental health awareness for prisoners, especially those employed as carers. Carers are also trained in wheelchair management, nutrition, and exercise.