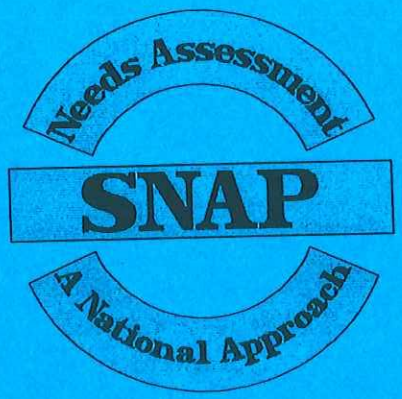
Scottish Needs Assessment Programme



Health Promotion in Prisons

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FOREWORD

This SNAP report casts a welcome spotlight on a group of people with whom there is great potential to work towards improving their health.

While prisons constitute a physical barrier restricting freedom for 6,000 Scottish prisoners at any one time, those institutions and the people within them reflect our wider community and society. Prisoners are entitled to the same health and health care opportunities as everyone else. Indeed, a prison term can be the start of a rehabilitative process where the pursuit of better health is both the means and the objective.

This report comes at the right time for several reasons. Together with the White Paper "Towards a Healthier Scotland", the report proposes ways of tackling public health challenges that face this country. The prisoner population is an important sector of our society and a telling example of health inequality in Scotland. The Scottish Prison Service is responding to this challenge with renewed commitment to the health of prisoners and their staff.

Within the text there are challenges to prison management, health care staff, and importantly, a range of agencies where partnerships could form common approaches and integrated services for the benefit of prisoners. Continuing work is needed to match health needs with the expressed wishes of prisoners and the necessary constraints of custody. This report marks a positive approach to determining how best we continue to address the health needs of prisoners.

DR ANDREW FRASER
DEPUTY CHIEF MEDICAL OFFICER

Show me your prisons and I'll show you what kind of government you have.

WINSTON CHURCHILL
COUNCIL OF EUROPE 45

A European Network for Promoting Health in Prison

It is important both for the rights of the prisoners and for the public health of all countries that time in custody is used positively for the prevention of disease and promotion of health, and that negative effects of custody on health are reduced to a minimum. The target audience is not only prisoners, but also staff, prisoners' families and local communities. Equally, health promotion and disease prevention are not just the responsibility of the clinical professionals in the prison but can, and to be effective should, be built into every branch of prison management to create a whole climate for improving health.

WORLD HEALTH ORGANISATION
HEALTH IN PRISONS PROJECT

Scottish Needs Assessment Programme

Health Promotion Network

Health Promotion in Prisons

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- Hazel Henderson.
- Kathleen Houston.
- The SNAP secretariat.

Further copies of this report and those listed below are available from Mrs Jackie Willis, SNAP, 1 Lilybank Gardens, Glasgow G12 8RZ, tel: 0141 330 5607.

SNAP Reports currently available

Total Elective Hip and Knee Replacement - a comparative assessment
Cataract Surgery
Congenital Dislocation of the Hip
Global Needs Assessment - a screening tool for determining priorities
Increasing Choice in Maternity Care in Scotland - Issues for Purchasers and Providers
Breastfeeding in Scotland
Improving Gynaecological Services Within Existing Resources - A Programme Budgeting and Marginal Analysis Approach
Cancer Care in Glasgow - A Model for Regional Cancer Care in Scotland
Inpatient Resources for Communicable Disease in Scotland
Dental Caries in Children
Addictions - Overview and Summary
- Alcohol Misuse
- Tobacco
- Problem Drug Use

Acute Stroke
Mental Health - Overview and Programme
Teenage Pregnancy
Home Accidents in Scotland
Road Traffic Accidents in Scotland
School Accidents in Scotland
Water and Leisure Accidents in Scotland
Work Accidents in Scotland
Oral Cancer
Paediatric Cochlear Implantation
Hernia Repair
Adult Heart/Lung and Lung Transplantation in Scotland
Health Promotion in Primary Care
Health Related Physical Activity
Health Needs and Health Promotion in Deprived Areas in Scotland
Care of Elderly People
Obstructive Sleep Apnoea and Allied Disorders
Osteoporosis
STI Services in Scotland
Adult Oral Health
Hip Fracture
Domestic Violence
The Burden of Mental Health Problems
Public Health and Mental Health Gain
Dementia
Suicidal Behaviour among Young Adults
Mental Health in the Workplace
Mental Health: Effects of the Changing Patterns of Service Provision and their Health, Social and Economic Implications
The Involvement of Service Users in Assessing the Need for, Commissioning and Monitoring Mental Health Services
Needs Assessment in Primary Care: a Rough Guide
Orthodontic Care
Coronary Heart Disease
Breast Cancer in Women in Scotland
Cleft Lip and Palate
Cancer Services in Scotland

CONTENTS

EXECUTIVE SUMMARY

This report focuses on promoting the health of male prisoners in Scottish prisons.

The main recommendation is that a settings approach to health promotion in prisons be adopted, adequately resourced and sustained over a long period of time.

This assessment has attempted to seek the activities and views of all those involved in Scottish prisons, including prisoners themselves, to decide on the needs, issues and recommendations.

The male prison population in Scotland averages close to 6,000 prisoners per day with up to 40,000 passing through prisons each year. The health costs individually, to families, to communities and to the public health is considerable.

Scottish prisons provide a range of different health promoting actions but no one site could be considered as offering all the elements required. All Scottish prisons do have the potential to become health promoting establishments not only for prisoners but also for staff and relatives.

The method consisted of four pieces of related work - a survey of Health Board health promotion and public health departments, a survey of medical officers based in prison health centres, focus group discussions with prisoners in one long term and two short term prisons and a seminar *Promoting Health in Scottish Prisons*.

Surprisingly the major finding was that HIV/AIDS and drugs were not the over-riding issues for medical officers and prisoners and that basic health issues such as oral/dental health, mental health and relationships were the major concerns.

There is a lack of concerted and coherent action from the services charged with promoting and protecting the public's health to working in the prison setting. This is primarily due to limitations on resources, poor communication networks and the different responsibility remits for this client group and setting.

RECOMMENDATIONS

National

- Links with the World Health Organisation healthy prison network should be strengthened to include representation from Health Promotion. A settings approach to health promotion in prisons should be adopted by Health Promotion Departments and the Scottish Prison Service and should be adequately resourced and sustained over a long period of time.

- A national health promotion group should review the training and resources for health promotion in prisons. Co-ordination of this process should be established at a national level by a health promotion specialist.

- Health Promotion in prisons need a public health champion at the highest level within the Scottish Office.

- A Weighting Model for re-distribution of finances should be applied to prison health related work to reflect the geographical distribution of prison establishments across Scotland.

- National guidelines should be reviewed for throughcare and pre-release provision of prisoners with respect to increasing health promotion's role.

- Scottish Prison Service Headquarters should take a lead in staff health and participate in Scotland's Health at Work. Scottish Prison Service support for those establishments already participating in SHAW should be reinforced.

Local

- Health Boards should identify a Board individual with a specific remit for prison health.

- A model that fits with Health Board structures should be established to coordinate planned programmes of work in prisons and in particular to advise those prisons on preventative and educative work in relation to blood borne viruses and other priorities identified in this report.

- Secondments of prison staff to health promotion and health promotion staff to prisons should be considered to further understanding and commitment to a settings approach to health promotion.

- Piloting of innovative peer led approaches* should be considered within a settings approach.

- Resources should be made available to develop research and evaluation of health promotion programmes in prisons. Support should be sought from the Chief Scientist Office for funding.

- Health promotion advisors should be part of the review process of the Standards for the Health Care of Prisoners.

- Training in principles and practice of health promotion should be offered to prison staff in health centres and to prison officers.

- Prison health centre staff should identify a key individual with a role in health promotion.

* such as the Comeeta health project in Spain

PREFACE

The Scottish Needs Assessment Programme (SNAP) has been set up across all Scottish Health Boards to assist managers in carrying out their required task of health needs assessment. The aim of SNAP is to ensure that needs assessment makes a measurable impact on health outcomes and a key aim is to raise awareness of health needs which the public or even Health Boards might not have recognised and provide evidence as to why they are important issues. It is hoped that this will provide an opportunity to work on improving health status and building health alliances, in addition to informing the planning process for health services. This SNAP sub-group was established to review the health needs and opportunities for health improvement for men in prison. Health promotion in prisons was identified by the Health Promotion Managers in Scotland as an issue for review by SNAP.

This report is the result of a twelve month process of review in relation to the needs of prisoners in Scotland. The recommendations are based on identified gaps in service provision.

BACKGROUND

In Scotland in 1997 the average daily prison population was 6,000. These individuals are held in 23 prisons throughout Scotland. There are approximately 30,000 admissions each year to prison in Scotland. The population for whom there is an opportunity of health promotion therefore is considerably in excess of the daily population.

Prisons cannot be considered entirely separately from the community. As the figures indicate, large numbers of individuals are admitted and discharged from prison each year. Prisons must be seen as a part of the community and the health care that is delivered must reflect the medical services provided for the rest of the community. It must also be recognised that there are special needs of those in prison and the service must reflect these special needs.

Many individuals admitted to prison have not made appropriate use of health resources while in the community for a variety of reasons. While prisons do predominantly hold a skewed and younger percentage of the population there is a significant morbidity as has been shown by the OPCS survey in England and Wales (OPCS, 1991).

Prisons must therefore not only provide core medical services but acknowledge the unique responsibility for delivery of health care to this disadvantaged group of the population. Opportunities for health promotion include improved dental health, a regular diet, exercise, improved mental health and emotional well-being and general health education. Prisons offer a significant opportunity to have a positive effect on the health of prisoners with even a short period spent in prison.

The prison population in Scotland is predominantly male. This report focuses on the opportunities to improve health among male prisoners in Scottish prisons. This does not preclude the need to consider other groups and issues, some of the more important of which are:

- promoting the health of women in prison
- throughcare of prisoners
- the built environment
- young offenders
- staff health
- families of prisoners

These issues should be the subject of further needs assessment.

1 INTRODUCTION

The origins of the healthy prison concept are in the 1986 Ottawa Charter for Health Promotion (WHO, 1986) which supports the concept of promoting health from a settings based approach. The rationale for a healthy settings approach lies with the means to improve health where people live, work, play and interact. It may ensure effective and lasting change for positive health and offers a recognised framework for the development of healthy policy. The Government Health of the Nation Strategy (Department of Health, 1992) identified prisons as such a setting but unlike the health promoting school, hospital and workplace the prison community has not attracted much interest as a focus for activity.

Five main factors have been identified which affect the health of prisoners (McCallum 1995). These are:-

- The social demography of the prison population.
- The built environment of the establishment.
- The organisational culture in the prison.
- Relationships between prisoners, and with the external world.
- Specific medical issues facing the prison population.

Individually and collectively they present a challenging and necessary consideration from the public health sector of the impact these factors have on individual prisoners, which then cascade out on to their families and the communities in Scotland. For example, the prison population are at increased risk of a variety of diseases, but particularly HIV, tuberculosis, Hepatitis B and C. Systematic strategies in order to protect the health of prisoners and their families have to be developed and implemented for the good of the public health.

The health status of prisoners coming into the prison system is often poor, coming as many do from a life of poverty and social exclusion. Their access to and use of health care 'services' has often been low and prison populations show high incidence of problem alcohol and drug use (SPS, 1998). The prison population also has a high incidence of mental health problems (Liebling, 1995). The over representation of prisoners coming from low socio-economic status inevitably generates prison populations at the bottom end of the health inequalities gradient.

It could be argued that promoting health and imprisonment are incompatible. In addition the prison may not appear to lend itself to the promotion of positive health because of the lack of privacy, stress, reduced opportunities for social contact or support and the further pressures of a densely populated community within a highly controlled environment. It is recognised that many people have unhealthy lifestyles before they come into prison with a high prevalence of smoking, drug and alcohol misuse, poor diet and lack of physical exercise. Unhealthy lifestyles can continue despite security and supervision and in themselves may bring further hazards from, for example, shared injecting equipment. The incidence of mental health problems can be very high among the prison population either from existing mental health problems or as a result of stress that the prison environment brings.

How then can these issues be positively addressed within the prison setting? It has been suggested that the structured nature of the prison system may in fact be a positive feature through which to promote health and that the regimes within the prison offer an opportunity to promote the health of those who live and work within the carceral community. Prison can bring improvement to physical health as many prisoners will experience an improvement in their diet, exercise routines and access to health services. It is the belief that there are opportunities for positive promotion of health within the prison environment which has prompted this SNAP report.

The aims of this report are:

1. To explore the potential for health gain for male prisoners within Scottish prisons and to identify a programme of activity.

2. To outline the main health promotion needs of prisons in Scotland.

3. To outline the major public health issues in relation to medical services in prisons.

4. To provide information on current health promotion interventions and their effectiveness within prisons.

5. To make recommendations for change to a range of agencies.

2 PROFILE OF THE PRISON POPULATION IN SCOTLAND

The Scottish Prison Service exists to keep in secure custody those for whom the courts consider a custodial sentence appropriate. There are 20 prison sites in Scotland ranging in size from Barlinnie with over 900 places to Friarton with 90 places. There are two units for prisoners who present particular management problems and a National Induction Centre for prisoners beginning long sentences of 10 years or more.

Most establishments accommodate adult male prisoners. One is solely for young offenders under 21 years of age, while three others have young offenders institutions within the prison. One establishment, Longriggend, is principally for remand prisoners. There are three open prisons and Cornton Vale is the sole establishment for women prisoners but female prisoners are held in custody in prisons elsewhere n Scotland.

There were on average around 6,000 prisoners per day in prison during 1997-98, of which fewer than 200 were women. That is equal to slightly more than one in every 1,000 people living in Scotland. Four to five times that number pass through the prisons each year. The average daily population in the various categories during 1997-98 were remand 927, adult sentenced 4,359, young offender sentenced 773. The projected average daily prison population for the next three years is:

1998 - 1999	6350
1999 - 2000	6550
2000 - 2001	6650

The sentences being served by prisoners in Scottish prisons range from seven days for minor offences up to and including life sentences for crimes of violence or murder. Prisoners are allocated categories within prison. These are Category A to D and relate to the level of dangerousness of the individual prisoner to the public. Category A is the highest security category.

The Scottish Prison Service is obliged to accommodate everyone sent by the courts, whether on remand or convicted. It operates under the Prisons (Scotland) Act 1989 (as amended) and the Prisons and Young Offenders Institutions (Scotland) Rules 1994 (SI 1994/31) (as amended by SI 1996/32, 1997/2007 & 1998/1589).

3 PRISON HEALTH SERVICES

Prison removes the freedom of the individual convicted, but not their right to health care or the duty of the prison managers and health care professionals to ensure that access to health care, and the quality and range of services offered is similar to that enjoyed by the rest of the population (Levy, 1997).

Prison health centres provide primary health care services to the prisoner population. Each prison governor has the responsibility for purchasing these services at the local level, with budgets agreed on an annual basis. A few specialist services, such as chiropody, dentistry and forensic psychiatry are brought in. However for the majority of other services the prisoners are usually escorted to local acute hospitals or specialist provision outside the prison.

All medical staff are trained in general practice medicine and some may have additional medical qualifications; most nursing staff are trained first level nurses. Nursing staff no longer have the dual role as prison officer and nurse.

On admission to the prison all prisoners are assessed by nursing staff, and seen by a medical officer within 24 hours. Prisoners' medical files are held on a revised manual health care records system. If they are transferred to other prisons their records should accompany them. When a prisoner is released from prison a letter is sent to the general practitioner detailing the treatment received whilst in prison.

Standards for the health care of prisoners have been set following a needs assessment carried out in 1993 for the Scottish Prisons Service (SPS, 1993). They include standards for clinical services, as well as standards related to promoting health. These standards were reviewed in May 1999.

There are currently few full time pharmacists based within prisons, although this is under review. All medication is prescribed by the medical officer and dispensed by the nursing staff. The drugs budget is allocated centrally on a yearly basis and held by each prison establishment.

4 METHODOLOGY AND RESULTS

The health needs assessment consisted of four main related pieces of work to explore the range and extent of what health promotion action and programmes have occurred, or could be feasible, in meeting the needs of male prisoners in Scottish prisons.

1. All health promotion departments and public health departments of the fifteen health boards in Scotland received a questionnaire with the aim of assessing health promotion work carried out within a two year period.

2. A survey was conducted with medical officers based in prison health centres in Scotland utilising computer assisted telephone interviewing technique on health promotion programmes carried out in their establishments.

3. Prisoners' own perspectives on health and health related issues were accessed using focus group discussions which were conducted in one long term and two short term prison establishments.

4. A seminar, Promoting Health in Scottish Prisons, was held in Stirling in December 1997 for representatives of prison governors, prison medical staff, other prison staff, the Scottish Prisons Service headquarters staff, health promotion and public health specialists and the voluntary sector (SACRO).

Full results and discussions from these are given in the appendix, and briefly discussed below.

1 The Health Board Survey

The survey from the health boards show that the majority of health promotion work carried out with male prisoners was in relation to HIV/AIDS, and drug issues. This appears to reflect the remit of the health promotion specialists involved in prison work and of the requests from prisons themselves. While this work is necessary, it does not reflect the wider opportunity or possibilities which could occur given the range of issues and topics with which health promotion departments actually work. A full listing is given in the report in Appendix 1. This situation may reflect the ringfenced budgets available in the areas of HIV/AIDS and drugs and the priority placed on these topics both politically and by prison establishments.

The key contacts for health promotion specialist in prisons were prison officers, but there was little indication that the health promotion inputs had the agreement of prison management. This resulted in little universal support for work to be developed in a strategic and sustainable way.

There are few examples of specific resources being developed for work in prisons, with a reliance on using existing resources. A more detailed audit of the needs and availability of useful resources for work in this arena would be very useful. Literacy is an issue for many individuals in custody and the type of general materials may be of little use to this client group. There is evidence of effective use of theatre/drama workshops for health awareness and the use of comic book style information formats which may be of benefit to this client group (The Cage 1996).

Few of the programmes for health promotion in prisons have been evaluated, particularly due to the lack of a dedicated budget for health promotion or evaluations. It would appear from this survey that issues of continuity and consistency in approach would also militate against evaluation criteria. Health promotion work appears to be seen as a low priority for prisons in a climate that has many competing priorities for scarce resources.

Two major barriers to effective health promotion work were identified. The first was the high number of staff changes within prison establishments. The second was that health promotion is not seen as a high priority by the management in prisons, yet opportunities do exist to identify a large potential pool of 'health promoters'. These include staff from catering, physical education and personnel services, as well as the more obvious professions working in prisons.

2 Medical Officers Survey

The medical officers based in prison health centres gave willing and informative responses to the telephone interviews. The priorities they identified differed from those offered by health promotion specialists. Issues for staff were in the main identified by the needs of the prisoners themselves.

Medical staff were certainly involved in all aspects of health promotion work but the priorities they identified were the topics of oral/dental health; relationships; and hepatitis B and C; and the activities of both counselling, testing and vaccination. Other topics covered included asthma care and dermatology, in contrast to the more often stated issues of HIV/AIDS and drugs.

Difficulties they noted were similar to those from the health promotion department and included lack of resources, staff turnover and staff time constraints as barriers to sustaining health promotion in their work.

As a group they tended to work mainly with prison officers and social work staff on health promotion issues and there was little contact on a regular basis with either health promotion or public health staff.

"Only if there is an outbreak or something"

and

"It's bad news if I have to see them"

were common responses to networking with public health.

To medical staff in prisons health promotion work seemed to be idiosyncratic, ad hoc, unstructured and with very little clear rationale behind the work. This could indicate a lack of awareness for social models of health, but more likely suggests a need for improved training and communication across the professions.

Despite the above, there was much optimism voiced insofar as they recognised that there is plenty of scope for health education in prisons, and that a remarkable level of ignorance of health related issues was the norm in the prison population. There

was also some pessimism that, given the nature of the clientele, it may have no effect anyway.

3 Prisoner Focus Groups

The prisoner focus groups were carried out in three prisons - one high security, long term prison, one medium security short term prison and one low security, short term prison. These sessions produced a clear contrast between the needs of long term prisoners and those detained on short sentences, and these are fully discussed in the appendix.

All of the prisoners involved in the focus groups had good knowledge of health promotion issues. Nutrition, exercise and relationships were priorities for both groups.

Long Term Prison

Long term prisoners were very keen to develop skills in relation to nutrition and cooking and to have a gradual and progressive approach to exercise. Smoking was a big issue for those serving long sentences and they felt strongly that they should be offered the support and opportunities to change their smoking behaviour. The timing of help and type of information was crucial to the long term prisoners, particularly for alcohol. They did not feel that leaflets were an answer, but what was required was the use of long term structured programmes that could have a lasting and positive benefit on their health status.

Short Term Prison

Within short term prisons there were mixed views about health status: some men felt that their health had been improved, others felt that their health was worse since coming into prison. Those who had put on weight declared their health to be worse. These same respondents felt that they ate too much through boredom. All prisoners from short term prisons wanted to have more fresh fruit and milk in their diets.

There was recognition of the improved facilities for exercise. Despite this there was almost unanimous agreement that a return to regular exercise for the majority had to be gradual and that each man had to have an exercise programme that best suited his individual needs.

Access to information was not perceived to be a problem. There was however an inconsistency using the information; no-one was absolutely clear on what services were available or how they could access these services should they need to. There was general support for smoking cessation programmes to be made available for prisoners. In discussing stress and the perceptions of stress there was tension experienced between the problems faced outside prison and the stressors identified inside. The key to handling a sentence was the emotional and social support provided by friends and family. There was a lot of discussion on visits and the quality of the visits and the visits area especially on the provision for children. Bullying was not seen as a problem in the short term prison.

All prisoners were aware of Hepatitis B and Hepatitis C, but they had no real understanding of the transmission of the virus, they had no access to information and they had no idea at all on prevention.

Comments on "changed times" were made by all in the short term focus group that they recognised that at one time the main problem for men held in this prison would have been alcohol. Now it was almost entirely custodial sentences relating to drug offences.

4 The seminar *'Promoting Health in Scottish Prisons'*

The seminar was opened by Dr Neil Squires from North West Region in England. Dr Squires outlined the settings approach to promoting health in prisons and gave an overview of the prison services commitment to the WHO European Network which aims to develop the promotion of health in the prison setting. The speakers gave a comprehensive review of the work ongoing in prisons in Scotland from policy level to description of programmes of work in prisons. Speakers covered issues ranging from research to policy to bullying, the final speaker gave an insight into the promotion and needs of staff health.

The discussion groups revealed a wide range of issues (outlined in appendix 4).

The evaluation was positive and highlighted the need for further opportunities for health professionals working in prison to share information on policy and practice.

5 PUBLIC HEALTH AND HEALTH PROMOTION

Public health provision, consideration and thinking within a prison context is not highly developed, with few specialists working in that environment. This is inevitably a consequence of the separation of the responsibility for the health needs of prisoners being with the Scottish Prisons Service and not with local health boards. However, with the growing importance attached to working with health inequalities and in promoting social inclusion, the climate to change may be more supportive in the future.

Specialists in health promotion have been working with the prison population, but this is often at a basic level and is rarely part of a sustained and strategic response. However, prisons do, paradoxically, provide an ideal opportunity to promote health due to the organisational structure of an establishment with a 'captive audience'.

Health promotion with its access to a wide knowledge base can complement and support public health to develop and implement a healthy settings approach in prisons, where the prison community is viewed as a whole, and not as discrete parts. This would include the health needs of staff, prisoners and their families. Both prisoners and staff do leave prisons and return to the communities and families to which they belong. Health issues cannot be restrained by walls and security.

A focus on needs led health education utilising tailored packages suitable for delivery by education staff, prison staff and health workers in partnership with health promotion specialists should form the basis of any developing strategic focus.

This focus should build on the existing quality standards set out in the Scottish Prisons Service standards for the health care of prisoners (SPS). Sustaining this activity requires both co-ordination and clear communication between health boards, the Scottish Prisons Service and individual prison establishments, to ensure proper and sufficient resourcing. Identifying health promotion activity as part of the prisons overall operational planning, and ensuring health boards consider the health needs of prisoners is essential for success in this area.

The needs assessment that has been done in prisons is too often carried out in an ad hoc and unplanned way with inevitable poor use of resources, and little evaluation if any, utilised to work in a more systematic and sustainable fashion. Needs assessment done over time with a prisoner led focus and with the opportunity for all staff in the establishments to consider and delineate their potential health promotional roles are required.

At the seminar 'Promoting Health in Scottish Prisons' one governor made the plea that basic health education be a fundamental element of prison education, and this certainly could be the starting point. As the third prison survey (OPCS, 1991) noted often what is required is to meet the basic needs of prisoners in relation to diet and exercise, and in particular the quality of their family visits. This report echoes these points, where despite the relevance of HIV/AIDS and drugs the major issues highlighted for improving the health of prisoners reported by medical staff were oral and dental health, mental health and maintaining and sustaining relationships.

6 SUMMARY

In summary, this SNAP needs assessment shows that health promotion activity throughout the prison establishment is in general under-resourced and poorly understood. The delivery is far too often ad hoc, unstructured and not negotiated at the most effective levels to enable its worth or value to be understood or evaluated.

There is however, a wealth of opportunity for health promotion with the prison population, allied to the responsibility of offering this client group the opportunities to improve their health as for the rest of the community.

It should also be noted that prison establishments are not equally distributed across health board areas and there is a danger of a disproportionate amount of work falling on some health boards and health promotion departments. However with 40,000 admissions each year into prisons, the public health issues of a sizeable proportion of Scotland's population are at stake.

This SNAP document does not address staff health per se, nor is any consideration focused on the specific needs of either women prisoners, or young offenders. These will have to be fully considered in separate SNAP reports due to the varied and different issues each offer. However, it should be noted that taking forward a settings approach for health improvement in prisons would include promoting the health of the staff.

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APPENDIX 1

HEALTH PROMOTION IN PRISONS
SURVEY OF HEALTH BOARD DEPARTMENTS
OF PUBLIC HEALTH AND HEALTH PROMOTION

Introduction

The questionnaire was sent out to all health promotion departments and public health departments in the summer of 1997 with a requested response date by September in order to assist the SNAP group in considering the range and extent of health promotion activity which had occurred/was occurring in Scottish Prisons from January 1996 onwards.

A copy of the questionnaire is appended for reference. The response rate was reasonable, with replies from twelve different health board areas. Only nine health boards have prisons or institutions within their area.

Results

The results are summarised under each of the questions asked and were collated manually due to the small number of questionnaires for analysis.

Responses

Twelve out of fifteen Health Promotion Departments responded. These come from the following areas, with the actual number of projects noted (n) in brackets after each.

Argyll & Clyde Health Board	(1)
Ayr & Arran Health Board	(2)
Borders Health Board	(1)
Dumfries & Galloway	(2)
Fife Health Board	(2)
Forth Valley Health Board	(1)
Grampian Health Board	(1)
Greater Glasgow Health Board	(1)
Highland Health Board	(1)
Lanarkshire Health Board	(2)
Lothian Health Board	(1)
Tayside Health Board	(1)

In addition responses were also received from the public health departments, of Lanarkshire and Shetland, as well as one from SCIEH.

Therefore in total, responses were received from thirteen out of the fifteen health boards.

The actual number of prisons or institutions in which health promotion work was noted was twelve, with one response each, noting that the project was with; 'all prisons'; 'the criminal justice system'; and 'alternatives to custody' respectively.

The prisons noted were as follows;

Barlinnie
Dumfries & Galloway Prison
Dungavel
Gateside Greenock
Glenochil Prison & Young Offenders Institute
Longrigend
Perth
Peterhead
Polmont Young Offenders
Porterfield
Saughton
Shotts Prison

Clients

The client characteristics of the projects were described as follows;

Male/men	(6)
Male/Female Prisoners	(1)
All (Prisoners & Staff)	(3)
Young Offenders	(3)
Mostly men 17-23 yrs	(1)
90% male	(1)

Topics and Issues

A wide range of these were given both drugs, and HIV/AIDS being the most noted. The full list with the number of times (n) the topic was part of a programme is as follows;

HIV/AIDS	(7)
Drugs	(6)
Health information, resources and access to these	(3)
Resource development	(3)
Alcohol	(2)
Hepatitis	(2)
Pre and post test counselling	(2)
Research	(2)
Tobacco/Smoking	(2)

with one mention each for;

Condoms
Dental health
Diet/nutrition
Drug treatment
HIV testing
Stress Awareness
Tobacco/smoking

Four responses were more generic and wide ranging, being variously called 'health education', 'healthy living', 'social education' and 'healthy prison work' where stress, mental health, diet and nutrition were included alongside drugs, alcohol, HIV/AIDS and tobacco.

The two research projects were 'viral related' insofar as one focused on HIV within one prison and the other was focused on Hepatitis C in prisons in general.

The resource development programmes were involved in production of materials on drugs services, dental health and drug use hygiene respectively.

Time of Projects

Most of the projects occurred (were still running) for more than a year (eight projects), two lasted less than a month and one consisted only of a single input. Two of these had a fixed project length whereas the majority of eight were still ongoing at the time of the questionnaire.

Type of Projects

The size and structure of the projects varied with most consisting of a group either open or closed (7) and of these three were multi-disciplinary. Two groups offered generic support and two offered individual or one to one support work.

Other Staff

Health promotion by its nature tends to be collaborative and a large number of other staff and agencies were involved with health promotion specialists. These included (n) the number of times different staff in the projects were noted;

Prison Officers	(5)
Other health staff	(5)
Social Work Services	(4)
Prison Health Staff/Medical Unit	(3)
Multi-agency	(3)

and one mention each of the following staff services.

Education staff
SACRO
Apex training
Prison management
Local Authority
Criminal Justice Service
Scottish Prison Service Staff
University/Public Health Staff
SCIEH

Resources used and produced

The projects noted a wide range of resources used including teaching packs, videos, slides, displays, leaflets and worksheets either off the shelf or adapted to meet the specifics of the individual programme.

A number of resources were developed specifically for or by the project for their specific work. These included fitness record and target setting cards, workshops on stress and its management, healthy eating, dental health and healthy mouth leaflets as well as a drug services guide (not specific only for the prison project).

Monitoring and Evaluation

A variable response was given to this area where few projects had little specific evaluation other than general feedback (3), participant questionnaires (3) or the following noted once each;

Ongoing monitoring
Pre-testing of resources
Project tracking
Prison evaluation effectiveness
Use of evaluated modules

and as previously noted, two projects were specifically on research.

Costs

Again little attention appeared to have been paid to attempting to cost the work where only one project had specifically costed the work. In addition three projects noted staff time as costs and one further project used an approximate costing. The others (6) either did not note costs or stated it had to be determined.

Preliminary triggers, developments and barriers

Most of the projects originated from needs or gap analysis (5) and from staff requests (2) with one mention each for the need for alternatives; the incidence of HIV per se; and the prompt from the WHO to develop work in prisons.

A number of developments occurred resulting from the initial intervention or projects including one mention each of the following.

Information campaign
Theatre project
In-service training
Increased funding
Resource development
Supporting staff to do health promotion

Three projects optimistically noted that developments would occur but had not yet done so.

The main barriers to development identified the priority taken by prison management and the problems of staff changes or time allowed for staff (6) with one project noting the difficulty of identifying potential health promoters. Two projects noted no, or none, barriers to work.

The next section of the questionnaire was concerned about the organisation (i.e. the health promotion department or unit) which was involved in the projects.

The only additional topics noted in this section not disclosed were alternative therapies and sexual health which each received one mention.

The priority for the work as a whole was at best, was voted medium with five replies, with four low scores and one not sure. The following topics were rated as priority issues as follows;

Topic	Number of Votes by Priority			
	1st	2nd	3rd	other
Drugs	6	5		
HIV/AIDS	5	2		
Alcohol	3	1	1	1
Stress/Mental Health	2		3	1
Diet/Nutrition		2	2	1
Relationships	1		1	2
Smoking	2	1	1	1
Oral/Dental Health			2	1
Physical Fitness		1	1	1
Healthy Settings		2		1
Hepatitis				1
Research				1

Two respondents gave no votes.

Future Involvement

Nine of the respondents noted that work would continue in the future and a further three thought it was probable. Only one respondent stated no future intention as there were no prisons in their area.

The proposed future work was identified as;

Drugs	(5)
HIV/AIDS	(5)
Healthy Setting work	(4)
Hepatitis	(2)
Information and Resources	(2)

With one vote each for alcohol , smoking, and mental health.

An equal number (6) had produced or not produced reports of the projects.

APPENDIX 2

HEALTH PROMOTION IN PRISONS
SURVEY OF PRISON HEALTH CENTRES

Introduction

This questionnaire was sent out to all medical officers in fifteen prison establishments in Scotland and was completed using a computerised assisted telephone interview (CATI) technique in July 1998.

The response rate was admirable with thirteen completing it with the CATI, one in writing due to holiday commitments, and only one non-completion. The survey tool was structured to assess what health promotion had been done in the past with prisoners; what priority was given to various health related issues, and what work was likely to be addressed in the future. Work undertaken in conjunction with other agencies was also elicited. The mean time taken to complete each interview was eighteen minutes with a range of twelve to forty-seven minutes.

Results

All interviewees stated that they had undertaken some health promotion work in the past. These are summarised under each of the questions.

All fourteen establishments reported conducting health promotion work with prisoners and the number covering the following topics were:-

	Yes	No	Don't Know
Smoking	14	-	-
Alcohol	13	1	-
Drugs	13	1	-
Stress/Mental Health	12	2	-
Eating/Diet	11	2	1
Physical Fitness	9	5	-
Oral and Dental Health	6	5	3
HIV/AIDS	13	-	1
Relationships	4	8	2

No medical centre was involved in all the topics asked, however they show a good range of work throughout the prisons. Some additional comments included details that this work was of an individual nature and invariably done at the prisoner's request. Other topics covered by the centres again reflected the individual nature of the requests and ranged from three responses for HIV clinics, counselling, and testing, and two responses for diabetic clinics, the following were all mentioned once.

Asthma
Cholesterol
Drugs Counsellor
First Aid
Hepatitis testing
High blood pressure
Relaxation
Skin care (warts, eczema etc)
Smoking Counsellor
Suicide prevention
Well man

The priority each health centre gave to health promotion/education work with prisoners added up to the following:-

High	-	Five
Medium	-	Seven
Low	-	Two

There was no link between the type of establishment and the priority given to health promotion per se, however for the ten topics given to rate for priority, the total number of 'votes' for each rating was as follows:-

Topic	1	2	3	4	5	6	7	8	9	10
	Highest ←									→ Lowest
Smoking	1	-	2	-	5	1	1	2	-	2
Alcohol	1	-	1	-	4	2	2	1	1	2
Drugs	1	-	-	-	1	-	1	2	2	7
Stress	-	-	-	1	-	2	3	4	2	2
Diet	-	-	4	3	3	1	-	2	-	1
Fitness	-	1	2	2	5	-	2	1	-	1
Relationships	2	-	4	3	-	1	1	-	1	2
Dental/oral	4	1	1	2	3	1	-	-	-	2
HIV/AIDS	1	-	1	-	-	-	3	4	3	2
Healthy Settings	1	3	1	-	-	1	1	1	2	4

Taking a summative score for the first and last three values presents a picture quite different from what is usually discussed or noted as key health issues in prisons, where HIV/AIDS and drugs both feature in the bottom three of the list.

	First three ranks score	Last three ranks score
Oral Dental Health	6	2
Relationships	6	3
Healthy Settings	5	6
Diet	4	3
Fitness	3	2
Smoking	3	4
Alcohol	2	4
HIV/AIDS	2	9
Drugs	1	11
Stress	0	8

It may be initially surprising to see oral health and relationships at the top, however it probably reflects the number of prisoners who have problems in these areas and therefore seek advice and support, compared to agency given priorities such as drugs and HIV/AIDS.

It is positive to see the holistic healthy settings approach being given support, however that is tempered by the counter balancing score given for the least rated area.

Other topics advanced as priorities and not specified in the given list were very similar to other answers for question 2 and included the following answers which they wished rated,

Hepatitis B vaccination, Hepatitis B & C testing, Counselling	Three responses
Asthma	Two responses

and one response each for drug misuse amongst the young, harm reduction, first aid, suicide prevention, hypertension, diabetes and well men work.

One response stated that all work was a priority.

All fourteen establishments noted that they were likely to be doing health promotion work in the future with prisoners, however timescales were vague with the answers invariably in the categories of 'not sure at this stage', 'tends to be part and parcel of the work', 'it's ongoing', 'it's opportunistic', 'lack of time and resources are a problem', 'hoping to expand', 'nothing new'.

Likely topic work units will be doing in the future are as follows:-

	Yes	No	Don't Know
Smoking	12	2	-
Alcohol	13	1	-
Drugs	14	-	-
Stress/Mental Health	14	-	-
Eating/Diet	11	3	-
Physical Fitness	11	2	1
Relationships	10	3	1
Oral/Dental Health	6	5	3
HIV/AIDS	13	1	-
Healthy Settings	6	6	2

Despite the high priority noted for oral health in Question 3 it is a little surprising to see only six of the fourteen considered it likely that future work will be in this area, whereas, for example, the bottom three topics from Question 3 of HIV/AIDS, drugs and stress have 13, 14 and 14 units respectively, stating their likelihood of work in the future. Other likely work not on the given list, again followed the pattern obtained in the earlier questions with most comments focussing on,

Mental Health	Five responses
Viral (especially Hepatitis) and drug issues	Four responses

and one response each for blood pressure checks, relaxation and a sleep clinic.

Work with other staff or agencies was wide and extensive particularly in the voluntary sector. It was also fairly idiosyncratic with usually only one organisation noted for most prison units.

The overall responses for working with other staff were as follows:-

	Yes	No	Don't Know
Prison Officers	12	2	0
Social Work Services	12	2	0
Criminal Justice Service	6	7	1
Psychological Services	8	6	0
Public Health Departments	9	5	0
Health Promotion Departments	9	5	0

APPENDIX 3

Introduction

As part of the Scottish Needs Assessment Programme, focus groups were conducted in two Scottish prisons. The first focus group was conducted in a low security prison, and 9 prisoners participated. The second focus group was in a high security prison, with a group of 8 prisoners. The focus groups covered a number of health-related topics. The topics covered were healthy eating, exercise, drugs, HIV and AIDS, mental health, smoking, stress, hepatitis, access to general health information, bullying, children's welfare, and alcohol. Following each focus group, prisoners were given a sheet for any additional comments they wished to add. Some of these comments have been included in the following report.

Results from prisoner focus groups in a medium security prison, undertaken as part of a Healthy Prisons Initiative in the north of Scotland, are also included.

The issues raised by prisoners during the focus groups will now be discussed, starting with the high security prison.

A High Security Prison

HEALTH: What springs to mind when you hear the word 'health'?

The following responses were given;

"Good food, good exercise."
"Fitness"
"Regular, positive thing"
"Do you mean outside or inside jail? You need to keep yourself healthy in here."

Is your health better or worse since coming into prison?

Most participants reported that their health was worse since coming into prison.

"Health in here is worse."
"I'm fitter but my diet is worse"

Some prisoners felt that the medical treatment in prison was inadequate,

"I'm not happy with my medical treatment in here. They are just trying to shut me up. I'm not getting the right treatment."
"Paracetamol is the answer to everything."
"I think that for the prison it's a self-imposed burden not to give out the right medication: they have a fear that it will be used for something else...I've paid my taxes and I'm entitled to treatment. Men get fobbed off with placebos."
One prisoner disagreed, stating that,
"..overall, medical attention is very good"

HEALTHY EATING

Some participants felt that both the quantity and the quality of the prison diet was inadequate. Most prisoners agreed that the prison diet was inadequate for those who are physically active.

"The SPS would say that you don't need to go to the gym. The nutritional content is okay if you sat around all day, but not for the gym or work. They make us work, and if you work, you need three meals a day. Boys need to work hard. The portions are minute, you would need three or four times the amount for the work that's done. I weigh 13 stone, but a guy that weighs 9 would just get the same as me."

Some participants commented on the lack of cooking facilities in the halls, and the overpriced canteen.

"If you don't smoke or buy phone cards, then you could but tuna or something, but you still can't cook it."
"How come they don't do cooking in Scotland?"
"The only place that you see it is training for release."
"I can spend money out of my own PPC for food, but there's nothing to buy."
"Pricey canteen."
"They really know how to charge."
On the other hand, one prisoner claimed that the canteen stock and prices are currently under review.

Some prisoners commented on the poor quality of prison meals.

""Too much rubbish. In England, if they can feed their prisoners salad every day, then so can Scotland."
"Fibre is extremely important. Appropriate cereal with fibre, or fibre in the meal."
"See how they've done it, they've brought people in to see how little and basic they need."

Some participants mentioned the lack of a complaints system to the cookhouse.

"They should just send it back (food). They are being paid an honest days work to produce this."
"There is a food complaints system. If you use it, they frown upon you as if you are a pain in the arse."
"I only ever made one complaint, the meal was disgusting."
"There is a new menu system. The names have changed, but the food hasn't"

What changes do you feel could be made to the prison diet?

Some prisoners felt that meals could be timed better,

"I'm fed up getting my dinner cold. Dinner is ready at 10am, the Governor samples it, and then its into the hot plates. It gets greasy and sits there until 12.30 from 10.30 in the morning."
"On a weekend its 16 hours without a meal from 4pm on Saturday, and 16 hours on a Sunday, and then you're lucky if you get a slice of bread and a boiled egg."
"Right enough, during the week its better, its only 15 hours."

Participants suggested that the prison spend less money on packaging, and more on food.

"Money is wasted, tens of thousands of pounds, on tins and paper bags for chips. Put it back into the food."
Other changes suggested were larger portions, better quality meals, feedback to the cookhouse, and better budgeting.

EXERCISE: How has being in prison affected your physical activity level?

The answers given to this question were mixed,

"If you went to the gym on the outside then it might harm you, but if you didn't, then it can help you."
"I was fit, but I eat less and put on weight. I'm not fit now. I do more because I go to the geriatric day, the over 35s. I feel the benefit, but its too long between sessions. Once a week is not enough."
"Not enough outside activities. The least wee drizzle and its called off."
"No outside sports, unless you're in the football team."
"They are all self-centred. If they promote a health promotion programme, then it benefits the medics. But they all work for themselves. The people that are in here, they don't have their own mind, they are ignorant of the benefits to health. An officer could say 'I never see you outside, why don't you go?' but there is no encouragement. Some of the guys here have self-motivation, but not everyone has."

What do you think of the PE Unit in the prison?

Responses suggested that the PE service could be improved, and was inferior to English prisons.

"It could be bigger."
"Only 30 are allowed in the gym, for a jail of 500 men. The football pitch is excellent. The gym has 5 permanent PTIs and 6 part-time, yet there is almost one PO for each prisoner. If you pushed the alarm, there would be so many POs would turn up, but there is not enough staff to cover the gym of an evening."
"They are scared to have too many people moving about here...This is Scotland's top security prison, and its a joke. It's as if the Governor doesn't want movement."

DRUGS: If you used drugs before coming into prison, what help have you had since entering prison?

"There was nothing at first, but there is help if you want it. Me, personally, I can't get anymore. It's all been given."
"I feel a harder line, not soft options, is required. Drugs are openly abused."

Who do you think should provide these drug services? (eg. prison officers or health professionals)

"Counsellors in here never took a drug in their life, they know less than me."
"I've got a counsellor and she's okay."
"I'd never seen smack till I came in here. It's all over the place"
At one time in the eighties lots of guys smoked hash, and I never saw any trouble like I see now. Because of this testing they're using harder drugs, and it's purely and simply to avoid detection. I don't ask for legalising, just to apply some common sense. It's the main reason that boys have become addicted to harder drugs. They'll never see another riot because they've all got their kit, or whatever they call it."
"Whose going to go on the roof if the drugs are coming in?"

Some participants suggested that drugs help to cope with being in prison, and that some users do not wish to stop,
"Guys don't want to come off it. It's the only thing they have."
"90% take drugs."
"But the jail would say less."
"They go for help but they're ostracised for taking drugs."
"They take drugs because of the boredom. Escapism"
"Most of them (prisoners) are kidding themselves on about a habit. It's not a habit..."
"They take drugs in here and then they go out and overdose."

HIV AND AIDS: Do you have access to information on HIV and AIDS in the prison?

"Yes, there's information all over the place."
"There's a course run in here on HIV and AIDS."
"Outside, you can go for a test, for hepatitis and AIDS. Once you're off drugs, they say come back in a year and we'll tell you how your liver is."
"If you want an AIDS test then you can go through a test. If you're not a jagger then you won't get one."

MENTAL HEALTH: What do you understand by 'mental health'?

Some participants commented on the long waiting list to see the prison psychologist. One prisoner joked that it's easy to get an intial appointment for a mental health problem; even the prison cat can get one. However,
"..after selling your soul, they say there are only two psychologists. Half of those in jail have a psychological problem."
The problem of confidentiality was also mentioned,
"...if you wanted to see one (psychologist) in here, the whole jail would know. There's no confidentiality."
"The door has a big window, and the Prison Officer has to stand in with the doctor."

STRESS: How does stress affect people in prison?

"When I was into drugs, I never got stressed but now I get wound-up really easy."
"It's stressful sitting overnight and having no resolution the next day, irrespective of what caused the stress in the first place. If you deal with it you get put on report. Instead of a Prison Officer trying to understand you, you get put on report."

One prisoner spoke about the importance of having someone to talk to, and the fact that some prisoners may feel isolated, with no-one to talk to.

"I have a good personal officer and he's good to me, giving me help. I feel I could talk to him anytime. I'm unique, another lifer...he's been in for six months and no-one's talking to him."
"Some officers create stress in a con, even if they don't realise it. They wind cons up."

How do you cope with the stress of being in prison?

"Tai Chi."
"Most of the people know you, and know when I'm stressed, and they just leave you...I am a pain in the arse in the morning, and people just get out of my way."
"Take drugs."
"Take drugs, it takes you out of this because you're wound-up. There's no alternative."
"Yoga. Drug boys get it but we don't, so we need it."

Is there a difference between the type of stress experienced in and out of prison?

Some participants said that the type of stress experienced is due to frustration.

"Frustration leads to anger, and anger leads to violence."

BULLYING: How does bullying affect the lives of the bully and the victim?

"I don't know any bullies."
"It's ironic, but the guys that are supposed to be looking after you produce the problem in the first place. It only takes one person, a minority that spoils it for others. You think all screws are bastards but they're not. Intimidation is bullying."
"I've felt that prisoners are more genuine and care about each other. I've never seen it (bullying)."
"Instead of picking on a softie...he just gets left. Someone will take him under his wing."

CHILDREN'S WELFARE

Most respondents had strong opinions on the effect of prison on children's welfare.

"Everything about children's welfare concerns me. My wife is not bringing my boy back here. I'm going to see the governor, and I want out to see my boy."
"I should be in semi-open. My wee boy is suffering."
"They don't care about us, so they won't care about our kids."
"The irony is that this jail has the best facilities."
"A full day visit here is not possible. I don't know my wee boy. When I get out he will be five."
"The visit room is sometimes only two thirds full, but you still only get your hour. Even though you know that no-one would take your space, you still have to go back (to your cell)."
"There's heavy tension at visits."

SMOKING: How common is smoking in prison?

All participants agreed that smoking was extremely common in prison.

"Common, a high percentage of prisoners smoke."

Do you know if there are any no-smoking areas in the prison?

Participants reported that there were no non-smoking areas in the prison.

"Many would like to stop, but there are no facilities...gum or patches should be available"
"Boredom is the main reason for smoking."
"There's no ventilation in the TV room. Non-smoking areas wouldn't work."

HEALTH INFORMATION: Do you feel that prison provides enough general health information?

The participants agreed that there was not enough health information available.

"All leaflets just end up in the bin."

ALCOHOL: Are alcohol treatment services adequate in the prison?

"There's an alcohol reduction course on a Saturday night."
"Stats on the NIC say that it is working well with cognitive skills and so on. Guys just starting a life sentence when they know that they have twelve years, they need this at the end of their sentence. I don't want anyone to tell me about my alcohol problem when I've just come from getting handed a life sentence. You're still in shock."
"You need help with through-care at the end, not at the beginning."
"Nobody asks the prisoners about the benefit of the NIC. Not one felt that it came at the right time."
"We're not saying that it doesn't help, but the majority go because they have to."

A Low Security Prison

HEALTH: What springs to mind when you hear the word 'health'?

The following responses were given to the above question,

"Exercise"
"Good food"

Is your health better or worse since coming into prison?

Some participants felt that their health was better,

"It's a lot better"

Whereas others felt that their health was worse,

"Not good. Better eating, better exercise outside"
"Worse, I've got a belly"

HEALTHY EATING: How have your eating habits changed since being in prison?

Some participants felt that they ate too much,

"Eat too much. Regular meals three times a day."
"Boredom makes you eat more. You eat a Mars Bar."

One participant thought that 3 meals a day was a good thing,

"It's a good thing. The majority of people only eat a roll on chips on the outside."

What changes do you feel could be made to the prison diet?

"Less steamed food. I've put on loads of weight."
"Times that you get fed at the weekends: 8.30am breakfast, and then at 11am you get your cooked lunch, and then at 4pm it's tea-time."
"Don't get enough fruit. Diabetics get plenty and vegetarians are catered for...if they gave you less steamed fruit and more fruit...more milk would be good."

EXERCISE: How has being in prison affected your physical activity level?

The majority said that they were less active.

What do you think of the PE unit in the prison?

Generally, the PE facilities were considered to be very good. One criticism was that PT didn't cater for different levels of fitness,

"I know I'm unfit. I feel pressure when they give you circuits right away. They need to have exercise designed to individual needs."
"I'm not fit enough for it."
"You need to build up gradually, but there's no chance."
"They say (PTIs) that if you need to take it easy, then take it easy."
"It's all down to peer pressure."

What improvements could be made to the PE service?

"There's a new gym...lots of good changes from 5 or 6 years ago."

DRUGS: If you used drugs before coming into prison, what help have you had since entering prison?

"I've had a bit of help...Drug free billets were not possible a while ago, they've done well."
"Alba House Rehab Centre"
"Depends on your sentence. I think it's 12 weeks before you get help."
"If you want off (drugs) you can get off. It's down to the individual."

Who do you think should provide help (with drug problems)?

"Ex-addicts should give you help, that's the way I see it."

Should officers help?

"They've never had a habit, so they don't know."

What other help could the prison give?

"Withdrawals - some people need to get help."
"..methadone programme. If they (prisoners) get it prescribed, the GP should contact the prison and get the programme inside..."
"It's not just down to the doctors. Prisoners abuse it."
"An officer could shout you down and watch you while you're taking it."

HIV AND AIDS: Do you have access to information on HIV and AIDS in the prison?

"There's posters in and around reception."
"you can get a sample for Hepatitis"
"Can get tested for HIV"

MENTAL HEALTH: How do you think prison affects mental health?

"Depends what it's like on the outside. Coming in can make it worse."
"At the end of the day, this is short-term, and not the same as being locked up.
"Not a problem in Low Moss."

SMOKING: How common is smoking in prison?

"99% of inmates smoke...are heavy smokers."
"I don't smoke on the outside."
"I don't smoke at all, but the smoking doesn't bother me."

Do you know of any non-smoking areas in the prison?

"Corridors are supposed tom be."
"Dining Hall"
"There should be, for other guys who don't smoke."
"There should be a choice for people."

STRESS MANAGEMENT: How does stress affect people in prison?

"You get stressed out easily. The least wee thing can trigger you off."
"You just say to yourself that there are better days ahead."

How do you cope with the stress of being in prison?

"Write a letter"
"PT"
"Go to bed"
"This is my first time, so I just talk."
"I think if you get a conversation going, get a laugh."
"..if you're worried, an officer will let you have a chat..."

Is there a difference between the type of stress experienced in and out of prison?

"Big difference"
"Canny get away (inside)"
Some thought that being on the outside could be more stressful,
"I think there is less stress in here. Outside, you have bills to pay, and you have to put 3 meals a day on the table."
"Where I'm from, there's a lot of stress outside."

Where does the stress come from in prison?

"looking out of the window at the fence. Women are on the outside, and that's stressful...if you've got someone that will stand by you, that makes a difference."

HEPATITIS: Do you have access to information on Hepatitis?

Although information was available, prisoners didn't know much about Hepatitis,

"Down at the surgery"
"Not a thing"
"What causes it, how do you get it?"

HEALTH INFORMATION: Do you feel that the prison provides enough general health information?

There were no complaints about the health information provided by the prison

BULLYING: How does bullying affect the lives of the bully and the victim?

Bullying didn't seem to be a problem, compared to 5 years ago,

"I saw it 5 years ago. It was bad, they used to take you out the back door."
"It's changed now."
"There are posters saying ``Stamp out bullying' "
"It only takes 1 or 2 decent guys in a dorm and it's stamped out. I wouldn't stand by and watch it happen to a first timer."

CHILDREN'S WELFARE: What could be done to improve the relationship between prisoners and their children?

Some participants felt that the visiting facilities could be improved,

"The visits area is not very nice."
"..they could have an open day for families, say once a month. A place separate from the prison, like a cabin area in the car park."

Prisoners then started talking about the condition of the old visit room,

"That visits room was awful"
"There's a big improvement, dramatically, but at the end of the day there's nothing for the weans."
"My wee lassie is going berserk"

ALCOHOL: What alcohol treatment services are available?

"AA services, once a week."
"!For DTs, you get lithium or something to help."

Are there any other services you think should be available?

"No, the services are there if you need them."

Summary: A comparison of two prisons

The results of these focus groups highlighted important health needs in short-term and long-term prisoners. The key issues raised by each prison group will now be compared and contrasted.

Health: Most of the participants from the high security prison felt that their general health was a lot worse since entering prison. Some of the participants from the low security prison felt that their health was worse, whereas some reported that their health had improved since being in prison. Common reasons for poorer health were lack of exercise, poor diet, and inadequate medical treatment.

Healthy eating: With regards to healthy eating, the high security prisoners felt that they did not get enough food, whereas the low security prisoners felt that they got too much. Both groups agreed that the quality of the prison diet could be improved

PE service: Attitudes towards the PE services were very different: the PE services inn the high security prison were felt to be inadequate, whereas the PE services in the low security prison were thought to be very good.

Drugs: In general, both groups felt that you can get help with drugs if you want it. The low security group felt that methadone should be provided for heroin users.

HIV and AIDS: Both groups agreed that information on HIV and AIDS is available if you want it, although the high security group complained that only drug users (injectors) are allowed an AIDS test.

Mental health: Responses to the question on mental health services in prison were very different for both prisons. The high security group felt that the mental health services were inadequate, whereas the other group felt that mental health was not a problem in a low security prison.

Stress: Both groups agreed that being imprisoned is extremely stressful, and that this can be exacerbated by having no support within the prison.

Bullying: Bullying between prisoners did not appear to be a major problem in either prison, although some prisoners in the high security prison felt that intimidation could be a problem.

Children's welfare: Both groups agreed that the visiting facilities could be improved.

Smoking: Smoking was very common in both prisons, and the high security prisoners suggested that they get more help with quitting. The low security group suggested that more non-smoking areas be provided.

Health information: With regards to general health information, the high security group felt that this service was inadequate. This contrasts with the low security group, who felt that the information was adequate.

Alcohol: Both groups reported that the prison had services for those with alcohol problems. The high security group felt that these services were more appropriate at the end of the sentence, rather than at the beginning.

MEDIUM/LOW SECURITY PRISON HEALTH NEEDS ASSESSMENT SUMMARY

LIFESTYLE

There was a general acknowledgement that for the majority of inmates, their lifestyle was probably worse or more health damaging in the community than in prison.

Smoking

Non-smoking areas in prisons now exist. This was seen as welcome by non-smokers as they could opt for a non-smoking partner when sharing a cell.

Drugs

A range of views were given on this issue, some specific to the prison and others to institutions elsewhere. For example, they just "look at the problem for a while", or "there aren't any drugs here". Difficulties were outlined as to when people with drug misuse problems leave prison and the decisions and choices they have to make to get back to every day life, particularly if they are returning to familiar environments.

Alcohol

The 'in and out' nature of those serving shorter sentences for alcohol related offences was clear within the groups. It was however pointed out that there was, "a story behind every tale" and that "alcohol takes over lives."

Food

It was felt that there could be more green vegetables and better access to fruit. There were concerns over access to milk, particularly for women. Another issue was the limited cash available to offenders and that opportunity cost issues meant they probably spend their money on cigarettes and phonecards rather than fruit.

More generally it was noted that often people eat more than they usually do whilst in prison. For some this was a good thing, particularly if they were having a poor diet outside, or if they were misusing alcohol and drugs. For others this was clearly not good, as they tended to put on weight whilst serving sentences.

Exercise

A range of views were offered here depending which Wing offenders were in. Some found they had very limited access to the gym, others had greater access than they would have in the community. Access to shower facilities were felt to be limited.

There was a clear link between emotional well-being and psychological well-being and exercise. Some found they were a lot less active whilst in prison than they were in the community. Concerns were expressed that those who had used the gym while in prison wouldn't be able to access the gym on leaving, either because of access to a gym, and or the related costs.

EMOTIONAL/PSYCHOLOGICAL WELL-BEING

The Prison Environment

Issues around this area concerned the very fact of "being there", the boredom and monotony, and the difficulty of filling time. This provided a lot of thinking time. For some this was seen as positive as it gave them a chance to consider what they were doing and why they were doing it, for others it was negative as they tended to dwell on their problems.

Lack of space, access to open air and the fresh air were also seen as problems as also was the 'greyness of life'. There is very little that is green in the prison other than the plants in the education department.

Stress

The closed nature of the prison environment meant that many people had a heightened sense of awareness of their environment and were aware of the smallest things. There was a consequent pressure on many to manage their emotional well-being.

For some, the prison environment led to a reduction in fitness and appetite which also impacted on well-being.

Relationships with staff were generally felt to be good and have certainly improved over the years. Some inmates spoke particularly positively about their experiences with staff.

The day to day routine when the lights go on and off at various hours was found to be difficult for some people.

Other issues concerned visiting times and the difficulties for individuals with problems with families which existed before people went into prison were unlikely to be dealt with whilst serving a sentence. It was very difficult to resolve these within the visiting system.

Time was felt to pass very slowly. This was a particular pressure for those serving longer sentences.

There were gender specific issues picked up around stress as well. Women in particular found themselves suffering a lot of distress with separation from families and in particular children. Bullying was seen as a problem, probably not in this prison, but in the bigger prisons in the central belt of Scotland. Men identified concerns over relationships with their partners as a particular cause of anxiety and stress.

Release

Issues relating to work, housing and family were identified.

Clothes

The limited nature of the laundry services in the prison which was reflected in the sharing of laundered underwear at certain times, was seen as undermining for a number of those in the groups.

HEALTH SERVICES

GPs

Access is not considered to be particularly good although there was a recognition from a number of groups of the difficulty of the GP role, particularly when it came to people with drug and alcohol problems.

Issues raised included why prison GPs could not link into prisoners own GPs. Often prisoners who had been on medication for a long time when in prison, found their medication being changed. This was not felt to be a good thing, particularly for those on stronger drugs. There was also difficulty experienced in convincing of the need for medication.

Dentist/Chiropody

Access was felt to be poor.

Detoxification

Opportunities to improve to drug and alcohol counselling was identified as an issue. In particularly it was felt there were poor links to outside support services on release.

RELEASE

It was felt that links from within the prison to the outside community were poor and that more could be done inside to prepare for release by establishing links and contacts at the pre-release stage. It was felt that a familiar face and contact on the outside would improve support and morale. It was felt that those who had a family to go to were probably better off.

VISITING

Many prisoners experienced difficulties when visiting time was over. It was also felt that there was a lack of flexibility for people who had to travel long distances to visit. Difficulties with travel, travel arrangements could affect the quality of the visit itself and the way prisoners felt when the visit was over.

APPENDIX 4

Key Issues

- Major problem in prisons is drug misuse. This needs to be addressed before anything else.
- Differentiate between what services are currently provided and what ought to be provided.
- Media influences on prisons, often a knee jerk reaction to media pressure.
- Alternatives to custody needs to redirect resources.

"People working in prisons feel frustrated that the root cause of why people offend are not being addressed. They feel strongly that society has produced the type of person who ends up in prison and they cannot solve all society" ills. There was also a strong feeling that prison is not the right place for many of the people who are sent there and that the money that is spent holding these people in custody could be put to much better use".

Discussion Group 4
Staff Health Promotion

It was suggested that staff have to take ownership and explore the opportunities for staff health initiatives.

Sustainability, some initiatives may be viewed as tokenistic.

Negative atmospheres are debilitating particularly in prison. This has to be recognised when thinking about staff health issues/initiatives.

"You must go sick before you become sick".

Stress was raised as an issue. Staff don't have confidence in going to managers because managers are not supportive of stress related illness.

Support

- Change attitudes
- Training and feedback show that staff are valued
- Positively support all the roles of all the prison officers
- Debriefing mechanism
- Health Policies
- More local research on issues related to staff health
- Good practice e.g. physical exercise, Polmont
- An enabling framework for supportive staff health policies, SPS led

Discussion Group 5
What do we understand by health gain?

- Self-harm/suicide
- Lifeskills mental health
- Lifestyles
- Drugs – how we comprehend and analyse the issues?
- Solvents low use
- Cannabis

Dr. David Jolliffe, Medical Adviser to the Scottish Prison Service, presented on the needs assessment carried out in Greenock Prison in 1996 into the prevalence of drug and alcohol use. David focused his presentation on the use of alcohol. The aim of this study was to establish the alcohol history of prisoners the nature and extent of alcohol use in the community and in the prison and the needs of prisoners in relation to support services available in the prison and in the community. The research revealed that many of the prisoners had their first alcoholic drink at a very young age between the ages of 5-11.

The study shows a strong link between alcohol and crime. These findings have implications for the way that health education is delivered and the opportunities for health promotion in the prison setting in relation to alcohol education.

Barriers and opportunities to promoting health in prison health centres were given by Dr. David Blair and Dr. Frank Shapiro. Key issues in this areas includes establishing access to a variety of health promotion interventions e.g. Asthma Clinics, Well-Man Clinics. Resource implications often impede the continuity of services established, over and above the basic services offered by the medical services in prison establishments.

Afternoon Session

The afternoon programme had two presentations before the discussion groups took place. The first presentation from Alan McPherson, Senior Social Worker at Longriggend Prison, looked at the issue of bullying in prisons.

Diana Sievewright, a freelance consultant, ended the presentations by looking at staff health. Diana began with the premise that the quality of the product or service is dependent upon the health of the organisation. Diana addressed the issue of absenteeism in relation to stress. Pointing to the report from Craiginches prison in Aberdeen which concluded that the causes of stress are multi-factorial and that to address stress within any organisation there must be a systematic approach.

The changing role of the prison officer was examined and the effect of role strain and overload. Diana explored the change in social support networks in the prison community and its consequences for the modern prison officer.

A comprehensive summary of her experience of working in the National Induction Centre HM Prison Shotts was given. Diana concluded with a plea to ensure that support mechanisms be put in place for officers and summed up with 'To keep em, love em, cause you can't do without them'.

Discussion Groups

There were five discussion groups covering health education, staff health, health needs assessment, understanding health gain and the final group looked at challenges and opportunities of working with health boards and trusts.

Key issues arising from the discussion groups included:

Ms Sally Amor, Health Promotion Strategy Adviser
Highland Health Board

Mr David Barrie, Prison Health Worker
Fife Community Drug Team

Dr David Blair, Medical Officer
HM Prison Gateside, Greenock

Jack Bonnar, Clinical Supervisor
HM Prison Peterhead

Mr John Boswell, Health Promotion Manager
Lanarkshire Health Board

Ms Sue Brookes, Head of Planning
Scottish Prison Service

Ms A Bryce, Health Promotion Officer
Argyll & Clyde Health Board

Kevin Bye, Clinical Supervisor in Charge
HM Prison Low Moss

Mrs Edith Chapman, Deputy Governor
HM Prison Peterhead

Mr Grahame Cronkshaw, Programme Manager
Health Promotion – Grampian Health Board

Ms K Farrow, Senior Health Promotion Officer
Greater Glasgow Health Board

Dr Kay Forrest, Deputy Medical Officer
HM Prison Noranside

Dr Andrew Fraser, Deputy Chief Medical Officer
Scottish Office

Mr E A Gordon, Governor
HM Prison Friarton

Ms Norma Greenwood, Senior Health Promotion Officer
Greater Glasgow Health Board

Mr D E Gunn, Governor
HM Young Offenders Institution Polmont

Mr Vince Gunn, Physical Education Supervisor
HM Young Offenders Institution Polmont

Ms S Hands, Health Centre Manager

HM Young Offenders Institution Polmont

Dr David Jolliffe, Medical Adviser to the Scottish Prison Service
Scottish Office

Ms Janette Kidd, Workplace Health Promotion Officer
Forth Valley Health Board

Ms Irene Linton, Health Centre Manager
HM Institution Cornton Vale

Mr Alastair MacDonald, Governor
HM Prison, Noranside

Mr A MacVicar, Governor
HM Unit Shotts

Ms Annita McAuley, Education Co-ordinator
HM Prison Dungavel

Mr John McCaig, Deputy Governor
HM Prison Greenock

Mrs Dorothy McCorkindale, Head of Education
HM Prison Greenock

Mr Kenneth McGeachie, Health Centre Manager
HM Prison Glenochil

Mr Tony McGowan, Senior Health Promotion Officer
Lanarkshire Health Board

Mr Alan McGregor, Health Centre
HM Prison Dungavel

Dr Jim McGregor, Prison GP
HM Prison Glenochil

Dr Joan McKenzie, Education Unit
HM Prison Barlinnie

Mr Tony McNulty, Social Work Adviser
Scottish Prison Service

Mr Alan McPherson, Senior Social Worker
Longriggend Remand Institution

Mr Colin McShannon, Deputy Governor
HM Prison Penninghame

Mr W Middleton, Governor
HM Prison Low Moss

Mr Bill Miller, Depute Director of Custody
Scottish Prison Service

Mr Gordon Morrice, Contract, Finance & Services Manager
HM Prison Low Moss

Dr David Morrison, Specialist Registrar in Public Health Medicine
Greater Glasgow Health Board

Mr J Muller, Physical Education
HM Prison Castle Huntly

Mr K Neil, Support Services Manager
HM Prison Castle Huntly

Mr N Nisbett, Practitioner Nurse
HM Prison Barlinnie

Mr Gerry O'Brien, SACRO

Ms M Palmer

Ms Frances Pennie, Development Officer – Volunteers
SACRO

Mr D A Pirie, Deputy Governor
HM Prison Friarton

Dr M Priestley, Medical Officer
HM Prison Friarton

Erica Robb, Chartered Clinical Psychologist
HM Prison Perth

Dr Kennedy Roberts, Medical Officer
HM Institution Cornton Vale

Mr Hamish Ross, Governor
HM Prison Dungavel

Mr Trevor Short, Regimes Manager
HM Institution Cornton Vale

Ms Diana Sievewright, Training Consultant

Dr Helen Smith, Consultant in Public Health
Argyll & Clyde Health Board

Mr James Smith, Physical Education Teacher
HM Prison Peterhead

Dr Neil Squires, Consultant in Public Health Medicine
NHS Executive North West

Mr John Taylor, Assistant Health Promotion Manager
Fife Healthcare NHS Trust

Mr Jeremy Voaden, Senior Health Promotion Officer – NHS
Ayrshire & Arran Community Healthcare Trust

Dr Hester Ward, HIV/AIDS Co-ordinator
Lothian Health Board

Mr Jim Wilson, Unit Manager
HM Prison Dungavel

Ms K Wilson, Education Head
HM Prison Castle Huntly

Ms Mary Wilson, Health Promotion Officer
Forth Valley Health Board

Mr William Wilson, Project Manager
SACRO