Public Health England

Protecting and improving the nation's health

KING'S College LONDON

Reducing Smoking in Prisons

Management of tobacco use and nicotine withdrawal

About Public Health England

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Published March 2015
PHE publications gateway number: 2014588

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Executive summary

Key points

1. Approximately four times as many people in prisons smoke than in the general population, with similarly high levels of smoking found among those in police custody and probation.
2. These extraordinarily high rates of smoking damage health, and, when compared with the general population, cause marked health inequalities for offenders.
3. Given the high rates of smoking, exposure to second-hand smoke is extensive across the CJS and damaging to health of smoking and non-smoking offenders, visitors and staff.
4. Comprehensive smoke-free policies can protect staff and prisoners from second-hand smoke, provide an environment conducive to non-smoking and should be promoted. However, many smokers will need support with nicotine withdrawal when placed in such settings.
5. Stop smoking service provision is variable across the whole of the prison estate and is not joined-up between criminal justice system (CJS) settings or between the CJS and the community.
6. Due to the often complex needs of prisoners and the security issues required to maintain the custodial environment, there are some specific considerations when supporting smoking cessation in these settings. However, in the main these interventions are the same as those delivered to the general population.
7. Reducing smoking should be given the highest priority across the CJS and comprehensive nicotine dependence treatment (cessation and/or harm reduction) should be delivered to all smokers in the CJS.
8. The national government is supportive of action in this area.

1. Introduction to tobacco use in prisons

1.1 Smoking prevalence among offenders

Nationally around 80% of prisoners smoke compared with around 20% in the general population.[1-4] The last national survey (England and Wales) of offenders was carried out in 1997 and found 85% of male remand, 78% of male sentenced, 83% of female remand and 81% of female sentenced prisoners were current smokers compared with 28% in the population at that time.[1] More recently, a 2014 survey of smoking in six prisons across Kent, Surry and Sussex reported smoking rates of between 62% and 81%.[4]

Similar high rates of smoking have also been observed across the criminal justice system (CJS).[5-7] For example, a 2007 survey of offenders on probation in Nottinghamshire and Derbyshire found 83% to be smokers, compared with a national average at the time of 22%.[6] In another survey that year, 63% of detainees in police custody in London reported dependence on cigarettes.[5]

Smoking is reported to be an integral part of life in prison and other CJS settings.[7] This quote from a male prisoner in an English prison encapsulates the views of many smokers in the CJS:

"*[Tobacco is] everybody's lifeline in here*" [8]

As discussed in Section 2, the offender population has a high prevalence of poor mental health and other substance misuse and is predominantly from disadvantaged backgrounds,[9-12] all of which are associated with elevated smoking prevalence.

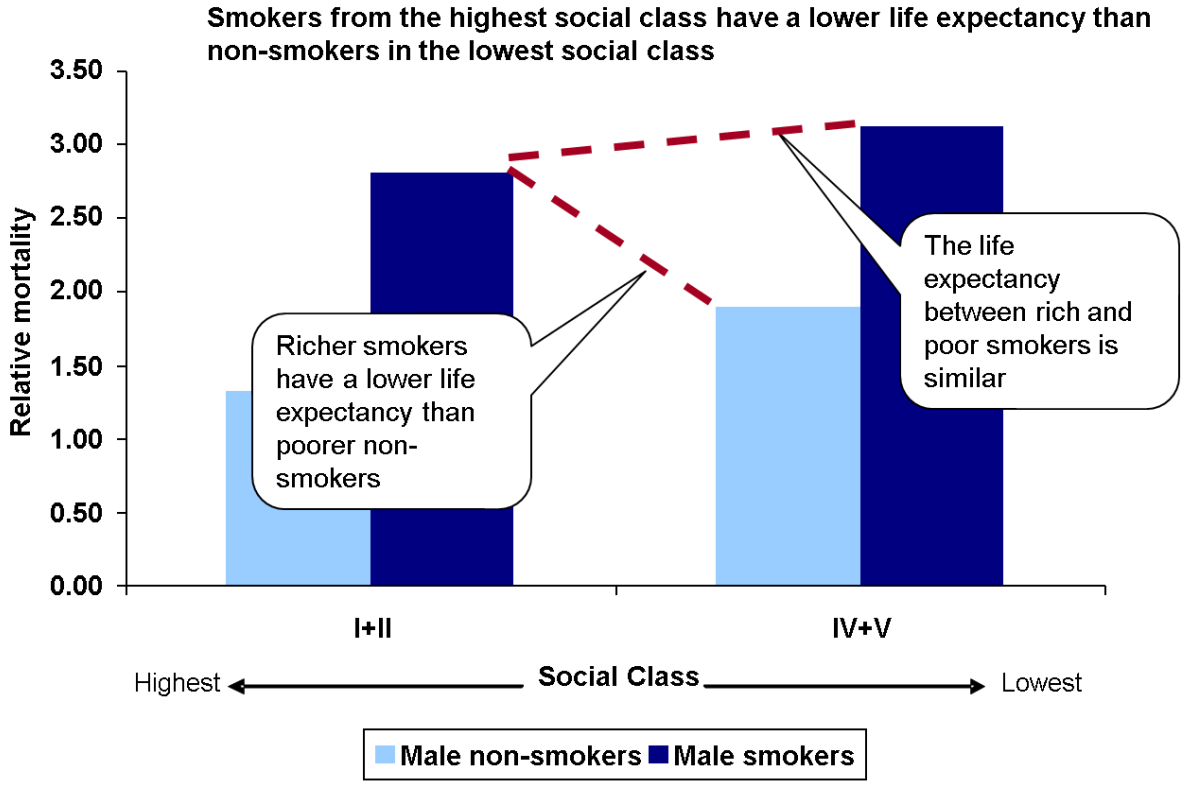
Over the last 50 years, smoking has decreased significantly in the UK,[13] though far less quickly among the more disadvantaged groups in society. A recent study that scored people in England according to the number of personal indicators of low socio-economic status (SES) found that 15% of those with no indicators of low SES smoked, compared with 61% of those with the most (6 to 7) indicators of low SES.[14] Smokers from more deprived groups also have higher levels of cigarette consumption and are less likely to be successful when trying to quit.[15]

As shown above, smoking rates among offenders appear to have changed relatively little over the last few decades.

1.2 Smoking and health inequalitiess

Smoking kills one out of every two regular persistent smokers[16] and in the UK smoking is responsible for just under one fifth of all deaths.[13] Second-hand smoke also kills and is estimated to be responsible for 11,000 deaths annually in the UK.[17]

The high rates of smoking among offenders also cause them to suffer marked health inequalities compared with the general population, both through active smoking and breathing in other people's smoke. Indeed richer smokers have lower life-expectancy than poorer non-smokers, with over half of the difference in mortality between the



poorest and richest groups caused by smoking-related diseases.[18,19]

Stopping smoking is therefore the single most important thing most smokers can do to improve their health.

1.3 Impact of engagement with the CJS on smoking behaviour

Recent reviews have identified the various ways prison influences smoking behaviour.[7,20] Limited access to tobacco can reduce the volume or frequency of smoking and the cost of tobacco can also be an inhibiting factor. However, smoking is reported to be a coping strategy to manage stressful situations such as imprisonment, transfers, court appearances, sanctions and prison visits, and helps to alleviate boredom. Given the high prevalence of smoking, it is thought that prisoners also smoke

for social reasons, as being a non-smoker in such a high prevalence population could be socially isolating. Smoking and tobacco are also used as currency among offenders.

The majority of prisoners who smoked in the 1997 survey reported smoking prior to prison; some increased their smoking in prison (Table 1).

Table 1. Change in smoking behaviour after entry to prison from 1997 survey[1]

	Male %		Female %	
	Remand	Sentenced	Remand	Sentenced
Smokes more	38	35	36	41
Smokes about the same	22	21	22	21
Smokes less	40	44	42	38
Base N*	994	658	146	386

*Base: current smokers in prison < 2 years and who had smoked prior to prison entry

This is similar to other countries. For example, a review of the 2012 Australian National Prisoner Health Data Collection[21] focusing on smoking and smoking cessation behaviour of prisoners showed that overall, "*80% of dischargees reported being smokers on entry and the same proportion were current smokers as they were approaching being released (80%). Nevertheless, some changes were observed. While about 1 in 5 dischargees (20%) were ex- or non-smokers, 21 (5%) who were non-smokers on entry to prison reported that they started smoking while in prison*."

The highest rates of smoking in the general population are among people aged 20-24, a group that currently dominates the offender population. However, whereas in the general population smoking peaks at age 24 and then steadily declines with age, evidence suggests that smoking tends to be sustained lifelong among offenders and remains high across all age groups.[22]

2. Why is smoking so prevalent in offender and prisoner populations?

2.1 The exemption of prisons from smokefree legislation

In 2007 a comprehensive national smoke-free policy was introduced in England. Adult prisons were the only setting exempted (mental health settings were given an extra year to introduce smoke-free policies). The exemption for the prison estate only allowed prisoners to smoke in their own cells and nowhere else in the prison. Secure establishments/places of detention accommodating children and young people under the age of 18 years were not exempted, to bring them in line with national policy as the age of sale of cigarettes was raised from 16 to 18 years old.

Smoking presents a risk not only to the smoker, it also exposes other prisoners, prison staff and visitors to second hand smoke. Given the high smoking rates among prisoners described above this exposure is likely to be significant. There is an urgent need to ensure the same protection for offenders, staff and visitors as afforded to the general population.

2.2 Offender population characteristics

Between June 1993 and June 2012 the prison population in England and Wales increased by 41,800 prisoners to over 86,000.[23] By March 2014 the prison population was estimated to be 85,265 [24] of whom 11,800 were on remand. The vast majority were adults: 45% were less than 30 years of age with 762 being aged 15-17 years. Only a small minority overall, 3,888 (4.5%), were female and approximately 28% were from black or minority ethnic groups (almost one in three of the latter being foreign nationals).

Offenders are over-represented among deprived and socially excluded communities. For example, around half of prisoners have no educational qualifications, nearly half have experienced exclusion from school and over two-thirds are unemployed prior to entering prison. Offenders are also more likely to have experienced poverty and unemployment than those in the general population. Adverse family and social experience prior to entering prison is common: for example, 24% reported having spent time in local authority care as a child, levels of domestic violence and sexual abuse are high among female prisoners, and homelessness is prevalent.[25]

The 2013 inquiry into the illicit trade in tobacco products by the All Party Parliamentary Group on Smoking and Health summarised that "*Illicit tobacco causes harm by: increasing the availability of tobacco to the most deprived socioeconomic groups*

leading to widening health inequalities; increasing the availability of tobacco to children; and developing links with organised criminal activity in communities."[26] Given the majority of the prison population comes from more deprived groups, smokers may be drawn towards cheaper illicit tobacco, resulting in developing links to the criminal fraternity and provide a potential route to re-offending. The links between smoking, stopping smoking and re-offending therefore warrant research.

2.3 Offending, deprivation and smoking

Given the strong relationship between high smoking prevalence and low socio-economic status described above, it is perhaps not surprising, given the similarly strong association between offending and deprivation, that smoking is more common among offenders. However, smoking prevalence is much higher among prisoners than among lower socio-economic groups as a whole.

In the 1997 survey[1] over half of prisoners were moderate or heavy smokers (Table 2) and this appeared to be a much more common behaviour than among lower socio-economic groups in the general population at that time. Only 4% of male remands, 8% male sentenced and 3% of female remand and sentenced reported being ex-regular smokers, compared to 22% in the general population at that time. This quit ratio, the percentage of those who report being ex-smokers, has improved in more recent studies, but the greater dependence of smokers in the offender population implies that more intensive stop smoking support is more likely to be effective (see below).

Table 2. Smoking in the 1997 national survey of offenders[1]

	Male %		**Female %**	
	Remand	**Sentenced**	**Remand**	**Sentenced**
Heavy smoker (20+/day)	31	24	41	34
Moderate (10-19/day)	36	34	31	32
Light smoker (<10/day)	18	19	11	15
All smokers	85	78	83	81
Non-smoker	10	14	15	15
Ex-smoker	4	8	3	3
N	**1235**	**1109**	**185**	**581**

2.4 Other substance use

In the general population, people who use other substances or misuse alcohol tend to smoke more. There is a strong association between offending and use of substances, which may also help to explain the preponderance of smoking in offenders.The national study in England and Wales in 1997 indicated that a majority of prisoners reported

having used illegal drugs prior to custody and some initiated drug use in prison.[1,27] Furthermore, moderate or severe drug use prior to custody were reported by just under half of offenders (Table 3). In 2007, a further study found that just over half (52%) of arrestees reported illegal drug use in the month prior to arrest and 30% a dependency on heroin or crack cocaine, with cannabis was the most frequently reported drug used across all populations surveyed (71%), followed by cocaine (45%) and crack cocaine (43%); just under one-third (30%) of these reported having injected drugs and 27% reported that they had overdosed.[28] The high use of cannabis and the fact that tobacco is frequently used to take cannabis might affect attempts to stop smoking.[29]

Less is known about alcohol use in offender populations. The 1997 survey[1] indicated high levels of hazardous drinking in the 12 months prior to coming into prison: 63% of male sentenced, 58% of male remands, 39% of female sentenced and 36% of female remands (Table 3). More recent data suggests that alcohol use is still a problem. Using the prison based offender assessment system (OASys) data from 2009/10, 19% of prisoners were reported to have needs in relation to alcohol misuse (19% of male and 17% of female prisoners) and 36% were reported to have exhibited violent behaviour related to their alcohol use (37% of male prisoners and 27% of female prisoners).[30]

Table 3. Smoking, drinking and drug use among sentenced prisoners from the 1997 survey[1,10]

Characteristic	Male	Female
Smokers	78%	81%
Admitting to hazardous drinking which carries the risk of physical or mental harm in year prior to prison	63%	39%
Admitting to hazardous drinking which indicates severe alcohol problems in year prior to prison	30%	19%
Reported moderate drug dependence in year prior to prison	11%	8%
Reported severe drug dependence in year prior to prison	32%	34%
Reported 2 or more out of smoking, hazardous drinking or drug dependence in year prior to prison	68%	55%

2.5 Mental health problems

Smoking is also more prevalent among those with mental health problems in the general population (about twice as high on average and there is a dose response rate between the heaviness of smoking and the severity of the mental disorder).[31] There is a very strong relationship between offending and having mental health problems which may again help explain the higher smoking prevalence in this population (Table 4). A recent review, identified that 80% of prisoners have mental health problems and 72% of sentenced male and 70% of sentenced female prisoners suffer from two or more mental disorders, compared with 5% and 2% (respectively) in the general population. [32 33]

Table 4. Mental health problems among prisoners

Characteristic	Total	Male	Female
Prisoners having mental health problems	80%		
Sentenced prisoners having two or more mental disorders (defined as drug or alcohol dependence, personality disorder, psychosis and/or affective disorder)		72%	70%
Sentenced prisoners having four or more mental disorders		14%	18%
Sentenced prisoners having a neurotic disorder		40%	63%
Sentenced prisoners having a psychotic disorder		7%	14%
Sentenced prisoners previously having been admitted to a psychiatric hospital		8%	15%
Offenders have learning difficulties or learning disabilities which interfere with their ability to cope with the criminal justice system	20-30%		
Young prisoners aged 15-21 have a mental disorder	95%		
Young prisoners aged 15-21 have at least two mental disorders	80%		

Sources: (10,31)

In conclusion, offenders are more likely to be from a background of deprivation, display problematic drugs and alcohol use, and be diagnosed with a mental health problem. All these factors are associated with increased use of tobacco and decreased likeliness of attempts at cessation. There is also a history of tobacco being used as a currency in prisons and reports from prisoners that tobacco is an integral part of the prison routine. These are all contributing factors to the high rates of smoking observed in this population.

3. Existing interventions to support stopping smoking across the criminal justice system

3.1 Government support for reducing smoking in prisons

A strong case for addressing smoking among offenders is endorsed in '*Improving health, supporting justice*',[34] which recognised high levels of health needs among offenders, whether in police custody or under community supervision and included key objectives such as working in partnership, equity of access to services, improving pathways and continuity of care.

A basic principle underpinning health provision within prisons is that services are based upon need and offered to an equivalent standard to those available in the wider community. Recent tobacco control policy documents for England and Wales also emphasised the importance of smoking cessation support across the CJS.[35,36]

3.2 Successful stop smoking interventions in prisons

Pilot work in four prisons of different categories[37] resulted in the development of the 'Acquitted toolkit'[20] for service delivery, which provided guidance for prisons and for external providers. This mapping exercise found that nearly 80% of prisons reported that they provided smoking cessation support for prisoners in the previous year. Stop smoking service data for April 2013 to March 2014[38] showed that 10,833 prisoners set a quit date and 54% of these were successful quitters at four weeks. This success rate is higher than for other settings (which averaged 51%) and this is especially striking when considering the client group and environment. A range of models were observed, typically offering individual and/or group support together with pharmacotherapy although individual support is sometimes required for reasons of security or through choice. Rolling groups were also useful in reducing waiting time for support. Prisons differed over the use of trained prison service staff, or specialists from stop smoking services, to deliver support and there is no conclusive evidence on the relative effectiveness of these approaches.[20] A best practice checklist is also included in the current national stop smoking service delivery and monitoring guidance.[39]

In April 2013 NHS England became responsible for commissioning public health services for people in prison, and local authorities began commissioning services for people in the community. There is a concern that the provision of smoking cessation services in prisons has been disrupted during this transfer process. In some prisons access to stop smoking services are efficient and timely whereas in others they are unable to meet the current need. As the responsible commissioning authority, NHS

England is now in a position to optimise service delivery so that across the board current need is met. This also presents an excellent opportunity to ensure that services are set up to meet future needs and any requirement for extended capacity. Doing this will require consideration of the different ways in which stop smoking services can be effectively delivered across the estate and may mean that healthcare is not the only point of access to pharmacotherapy or support.

3.3 Strengthening the care pathway in line with the offender pathway

Prisoners may be a ‘captive audience’ but they are also very mobile and smoking cessation support is less accessible across all criminal justice settings than in prisons, with care often not joined-up through the offender pathway. This pathway incorporates police custody, court appearances, movement from prison to prison, and within the probation services as well as other social care agencies. Many prisoners have short sentences, which provide little time to initiate cessation support. In addition, smoke-free policies vary across the offender pathway and where smoke-free policies are in place, offenders are often not given appropriate support to mitigate nicotine withdrawal symptoms.

It is therefore important that understanding of the opportunities presented for promoting and supporting stopping smoking is reinforced across the CJS and that consistent messages and a smoke-free environment are available throughout. There are many opportunities for joined-up working across the CJS, to raise the issue of smoking and encourage access to specialist support where appropriate. One example is the developing role of offender health trainers in probation settings, which includes raising awareness of and referring prisoners to health improvement oportunities such as stop smoking services.[40] Helping prisoners to stop smoking may also have a positive impact for the families of offenders and the wider communities in which they live.

A recent pilot study assessed the barriers and facilitators to implementing smoking cessation support across the CJS in England.[41] This also identified that the availability of a regional coordinator could enhance and provide better coordination and consistency of support.

3.4 Monitoring and reporting outcomes of the care pathway

The pilot study [41] also identified a knowledge gap regarding how best to monitor quitting behaviour and outcomes in the CJS. The optimum standard used is the Russell Standard.[42] Using this standard a ‘treated smoker’ is one who sets a quit date and has at least one treatment session on or before the quit date. A ‘self-reported four-week quitter’ is a treated smoker who is assessed (either face to face, by postal questionnaire or by telephone) around four weeks after the designated quit date (minus three days or plus 14 days) and declares that he/she has not smoked even a single puff of a cigarette

within the past two weeks. A ‘carbon-monoxide (CO)-verified four-week quitter’ is a self-reported four-week quitter who also had his/her expired-air CO assessed at four weeks and the reading was less than 10ppm. These definitions are covered in greater detail in the stop smoking service delivery guidance 2014-15.[39]

Outcomes from stop smoking service interventions, delivered according to the Russell Standard, can be reported through the local authority commissioner to the Health and Social Care Information Centre (HSCIC). HSCIC provides quarterly and annual reports on stop smoking service activity.[38] Where services are provided outside local authority commissioning structures, local arrangements should be made to ensure that this data are reported consistently and accurately. Any enquiries that are not resolved through conversation with the local authority commissioner of stop smoking services should be addressed to HSCIC directly.

Prisons use SystmOne, but at present this is a closed system. A shared electronic system across the CJS for recording smoking and regular updating of attempts to stop smoking, nicotine treatment and referral mechanisms is recommended wherever possible. This would enable smoking to be recorded at every new contact, and regular updates on smoking cessation efforts and treatment can be made. Medical records need to be accessible across the CJS or be transferred with patients. Such systems should ensure continuity of care when prisoners are released or transferred to other prisons. This could include automatic referrals to the stop smoking service near where they live on release. In such cases the local stop smoking service should be given the contact numbers of the ex-offender. Release into the community can be a stressful time and relapse is likely during this time. In a US study, only 18% of prisoners released from a tobacco-free correctional facility remained abstinent by the end of the first week of release.[43] NHS England’s ambition is to build into the secure estate the second generation Information Technology (IT) system that will be available from 2016 when the SystmOne contract ends. The premise of the new IT system is that it will talk to other secure environments, and connect secure and community environments.

4. Treatment for nicotine dependence

4.1 Smoking as nicotine dependence

Most people smoke to ingest nicotine and smoking is now recognised as a drug dependence disorder. In 2001 the RCP stated that *"it is now well established that users of tobacco tend to regulate or titrate their nicotine intake to maintain body levels within a certain range."* [44]

When smokers go without nicotine, withdrawal onset can be as short as 30 minutes.[45] Some of the characteristic symptoms of nicotine withdrawal include impaired concentration, irritability, tension, disturbed sleep or drowsiness, intense longing or craving for a cigarette, and headaches. These symptoms mean that people frequently relapse back to smoking. In addition, people who experience any of these symptoms are less likely to perform well in cognitive tasks.[46,47]

A variety of measures can be taken to reduce withdrawal and support people in stopping smoking which are discussed in later sections.

4.2 Benefits of stopping smoking

The health benefits of stopping smoking are well established and include immediate improvements in certain diseases as well as long-term health benefits such as years of healthy life gained.[48] Emphasising immediate benefits may be better than emphasising far-reaching benefits of stopping smoking which might have limited relevance for the prison population due to the day-by-day nature of prison living.[49]

Between April 2011 and March 2012, 26.5% of offenders reoffended within a year.[50] Stopping smoking may help break links with the criminal world for those offenders who would use illicit tobacco on release. Should the offender also manage to stop using other substances, then this may also help to limit or break contact with criminal fraternity in the community on release.

4.3 Motivation to stop smoking

Some evidence suggests that a significant majority of offenders who smoke are motivated to stop. For example, a study of smokers in a prison in Cardiff revealed 79% wished to stop.[2] Studies of offenders in contact with other CJS settings have also revealed an interest in support to stop smoking.[51] The prison setting, in particular, presents a valuable opportunity to engage marginalised groups with very high smoking prevalence in cessation initiatives. Prisoners themselves have described imprisonment

as an opportunity to access cessation services,[52] an opportunity that is viewed by some as a means of achieving something positive while in prison.[51]

4.4 Interventions to support stopping smoking

Smokers are more likely to succeed in stopping if they receive support to do so. Support comes in many forms: behavioural support, such as in groups or individuals face-to-face, telephone or text messaging support, internet programmes, and pharmacological support, such as proven effective nicotine replacement therapies, bupropion and varenicline. The best support, which increases the chances of successful stopping by up to four times when compared with no support, is a combination of behavioural and pharmacological support as delivered by the national network of stop smoking services.[53] Smoking cessation interventions have been identified as the most cost-effective healthcare intervention.[54] A brief summary of the evidence base for the main treatments follows.

4.4.1 Behavioural support

Receiving brief advice from a healthcare professional has been shown to trigger attempts to quit. Part of the brief advice should include the offer of a referral for stop smoking behavioural support.

Behavioural support consists of advice-giving, discussion and exercises, delivered on a weekly basis for at least six weeks, to provide evidence based support for stopping smoking. Though not all of these methods may be used in every custodial setting, support can be delivered face-to-face on an individual or group basis, and through channels such as the telephone, text messages, social media or the websites. Behavioural support can be effective when delivered through all these avenues and there is evidence to suggest that group support is more effective than individual support. The most important factors in success are that the behavioural support is delivered by a trained advisor and follows a clear evidence-based structure.[39] An example of this is the National Centre for Smoking Cessation and Training standard treatment programme.[55] Though we know that these methods in general have successful outcomes, research is ongoing to identify what the key components are for maximising this in the CJS setting.

4.4.2 Pharmacological support

There are several different medications which are currently licensed for smoking cessation, these are NRT, bupropion and varenicline. This section provides an overview of their place in smoking cessation and clinicians are advised to access national clinical guidance[39] including the manufacturer's summary of product characteristics and latest British National Formulary for further information. A recent Cochrane Review concluded that "*NRT, bupropion [and] varenicline… have been shown to improve the chances of*

quitting. Combination NRT and varenicline are equally effective as quitting aids." [56] However, the medications have differing side effect profiles and contraindications and the most up to date evidence can be found on the Medicines and Healthcare Regulatory Products Authority (MHRA) website.[57] The best decision of which medication to use, is made by a combination of health professional advice, client preference and consideration of any side-effects, contraindications (eg, pregnancy or breast-feeding) or cautions. The use of NRT is supported for children and young people from the age of 12, however varenicline and bupropion are licensed only for those aged 18 or over.

NRT consists of nicotine-containing products, generally regarded as safe, which are designed to deliver nicotine to the body in a form that does not involve smoking and hence taking in all the other smoke constituents, many of which are proven carcinogens or other toxins. There are several different forms including:

- 16-hour or 24-hour transdermal patches
- 2mg or 4mg chewing gum
- 1mg, 1.5mg, 2mg or 4mg nicotine lozenges
- 2mg sublingual tablet
- nasal spray
- inhalator
- oral film
- mouth spray

There is not enough evidence to conclude that one form of NRT is more effective than another, but overall evidence suggests that higher dose forms might be more effective than lower dose forms.[56] Combining a patch with a more rapid delivery form (such as the gum) has been shown to be more effective over using just one form. NRT can be purchased over-the-counter or is available on medical prescription.

Bupropion (trade name Zyban) is an atypical antidepressant: a typical course is 300mg per day for 7-8 weeks, beginning a week prior to the designated quit date. Bupropion is accessed via a medical prescription. Bupropion is not suitable for everyone, for example it should not be given to people with seizures. [57]

Varenicline (trade name Champix) is also a prescription-only medication. It is a partial agonist which binds to nicotine receptors in the brain and reduces the enjoyment of smoking as well as some symptoms of nicotine withdrawal such as craving. A typical course of treatment is 1mg per day beginning one week before the designated quit date, then 11 weeks at 2mg per day. The MHRA suggests that people with psychiatric problems should consult a doctor before using varenicline and that "people who are taking varenicline who develop suicidal thoughts, agitation, depressed mood, or display any changes in behaviour or thinking that are of concern for the doctor, patient, family, or caregiver should stop varenicline and contact their doctor immediately."[57] However, a

recent study has shown that varenicline can be used in those with mental health disorders without problems and observed no increase in psychiatric problems when used.[58]

4.5 Interventions for harm reduction

More recently, the importance of offering support to smokers who cannot, or do not want to stop smoking, has been identified and in 2013 NICE published public health guidance (PH45) tobacco harm reduction.[59] Such support is aimed at reducing the harmfulness of on-going smoking and there are several different ways to do this:

- stopping smoking: using one or more licensed nicotine-containing products as long as needed to prevent relapse
- cutting down prior to stopping smoking (cutting down to quit): with the help of one or more licensed nicotine-containing products (the products may be used as long as needed to prevent relapse) or without using licensed nicotine-containing products
- smoking reduction: with the help of one or more licensed nicotine-containing products (the products may be used as long as needed to prevent relapse) or without using licensed nicotine containing products
- temporary abstinence from smoking: with the help of one or more licensed nicotine-containing products or without using licensed nicotine-containing products

Traditionally, all smokers have been encouraged to stop abruptly, though recent evidence suggests that cutting down the number of cigarettes smoked may help smokers to control their smoking and result in complete cessation. This may be especially important for those smokers who are unable to stop completely and in one step, such as those in the prison population. In addition, the use of replacements or substitutes for nicotine (such as NRT) is recommended for times where temporary abstinence is desired (see below).

The provision of NRT to support people who are continuing to smoke is an important part of a harm reduction strategy. Where people attempt to reduce the numbers of cigarettes they smoke without replacing the nicotine that they are losing they tend to over-compensate by taking longer, deeper drags on each cigarette. This results in little or no actual reduction in quantity of smoke inhaled. Conversely, use of NRT decreases the need for compensatory smoking, allowing the user to more effectively reduce the amount of nicotine required, and hence smoke obtained from each cigarette. Smokers may also wish to use these nicotine substitutes on a long-term basis as a means of reducing the harmfulness of their smoking.

4.5.1 Accessibility of nicotine replacement therapy (NRT) for managing nicotine withdrawal

NRT is available in some prison settings to help patients with nicotine withdrawal and this practice should be extended across the whole estate.

There are several points within the CJS whereby a prisoner or person within the CJS will not be permitted to smoke, such as police stations, court cells and while being transferred between settings. Given the impact of nicotine withdrawal on performance and mental state, it is appropriate to give smokers a replacement for the nicotine in cigarettes to combat withdrawal. These measures were implemented recently, when significant pressure on the prison estate necessitated the occupancy of court cells by sentenced prisoners.

Where evidence exists that NRT is being used as currency by prisoners in a similar way to cigarettes solutions, such as introducing exchange schemes where new patches are only provided on return of used ones, can be implemented. Most prisons use transparent nicotine patches so that prisoners cannot conceal illicit substances beneath them. Also most prisons prohibit chewing gum, and some foil wrappings or plastic containers. Nevertheless given there are currently several forms of NRT available, there is still the opportunity to offer offenders one or more NRT products. From the range of products currently available, the clear patches, mini-lozenges and oral film seem the most suitable.

A short supply of pharmacotherapy should also be supplied for those about to transfer in order to tide the offender over until prescribing can be renewed in the new setting. [60] Staff who smoke should be allowed to use such medications if appropriate and these may be available from their GPs or local stop smoking service.

4.6 Electronic cigarettes or nicotine vapourisers

The recent popularity of electronic cigarettes (e-cigarettes) has demonstrated that many smokers are interested in trying and using less harmful sources of nicotine. E-cigarettes are nicotine delivery devices that heat nicotine and do not involve combustion. Two recent reports for Public Health England provide a useful source of information on e-cigarettes.[61,62] One of these commented in relation to electronic cigarettes that: "*the hazards associated with use of products currently on the market is likely to be extremely low, and certainly much lower than smoking*".[62]

This review also concluded that e-cigarettes can help smokers to stop smoking. More recently, a Cochrane review on electronic cigarettes based on evidence from two trials concluded that electronic cigarettes help smokers to stop smoking long-term compared with placebo electronic cigarettes.[63]

Additonally, the health risks of passive exposure to electronic cigarette vapour were reported as '*likely to be extremely low*'.[61] This is consistent with another review which concluded that the effects of e-cigarette use on bystanders are minimal compared with conventional cigarettes.[64]

Public Health England, Action on Smoking and Health, the NCSCT, NICE and the three regional offices of tobacco control, have co-produced supporting material based on feedback from six regional workshops to support commissioners and practitioners in implementing this guidance, which is available on the Smokfree Action on website.[65]

4.7 Supporting people with co-morbidities

There is a traditionally held belief that people with a mental health disorder, those with co-morbidities and those who are polysubstance users are generally incapable of stopping smoking until they have sorted out their other problems. There is no evidence for this.

Smokers presenting with comorbidities can have complex needs and are highly likely to require greater support than those without. For those with mental illness, evidence indicates that smoking cessation treatments used with general population smokers are as effective with those with mental health problems.[31,66] As specific cautions and contra-indications exist with certain smoking cessation pharmacotherapies, closer supervision is required. In addition, tobacco smoking increases the metabolism of some medicines by stimulating the hepatic enzyme CYP1A2. When people reduce or stop smoking, the dose of these medicines, in particular theophylline, cinacalcet, ropinirole, and some antipsychotics (including clozapine, olanzapine, chlorpromazine and haloperidol), may need to be reduced. Regular monitoring for adverse effects is advised.[67] The NHS care programme approach (CPA) team and other relevant professionals should be kept informed of cessation/reduction attempts. Further guidance on treating smokers with mental health problems is available.[67]

A frequently expressed concern is that mental health may deteriorate on stopping smoking. A recent review of research identified in general, that "*smoking cessation is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke. The effect size seems as large for those with psychiatric disorders as those without. The effect sizes are equal or larger than those of antidepressant treatment for mood and anxiety disorders.*" [68]

Stopping smoking does not appear to impact negatively on the success of stopping the use of other substances. A body of evidence suggests continued nicotine dependence may be a risk factor for relapse in other substance use although the evidence is not always consistent. [69-71] However, best current practice would be to support the user to

stop smoking when trying to stop other substance misuse. Guidance for treating the use of other substances in prisons is available from the Department of Health.[72]

4.8 Supporting young smokers

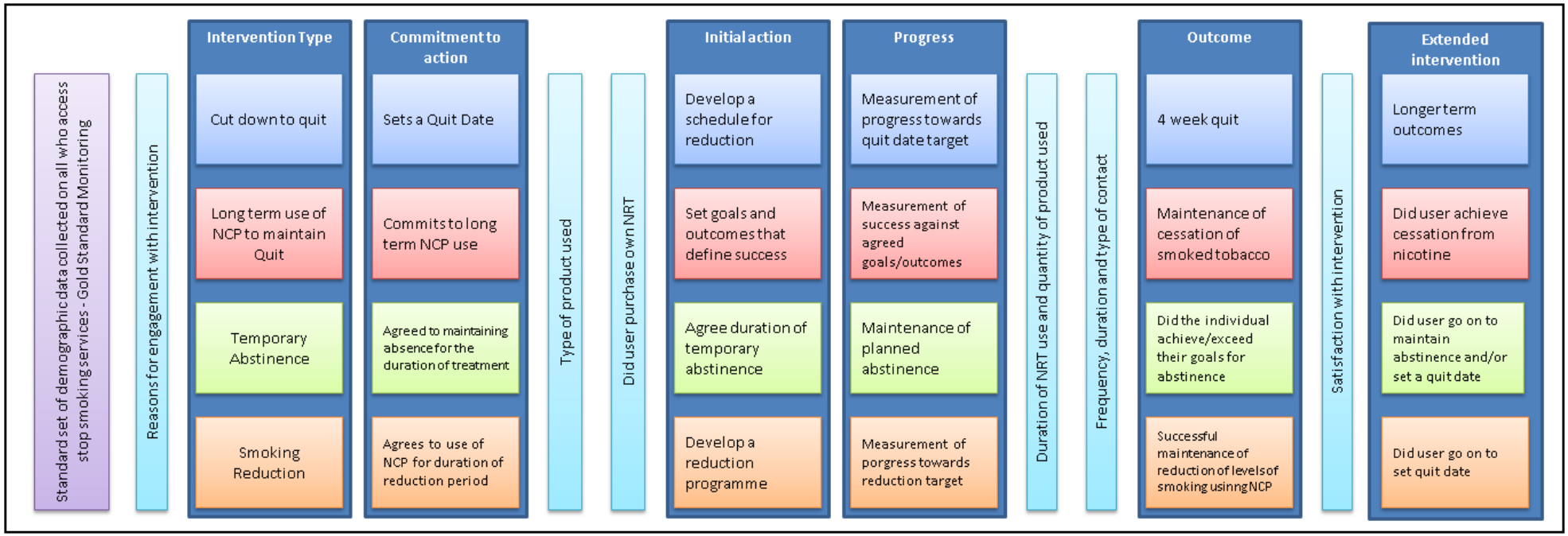
In line with national policy and the age of sale of cigarettes being raised to 18, secure establishments/places of detention accommodating children and young people under 18 were not exempted from the smokefree legislation. Currently there is no single mechanism for collecting data on the number of young people smoking, with some parts of the estate using SystmOne and others collecting and inputting information on local systems only. This means that admission, treatment and discharge information is not currently available.

To date there have been variable levels of support, either pharmacological or behavioural provided to this group. An attitude that young people 'should not be smoking because they are too young' and therefore do not require any treatment is not helpful in these settings. In actuality, young people are as likely to experience withdrawal as older people and are as likely to experience the frustration and anxiety that it may bring.

A 2014 audit of healthcare standards for children and young people in secure settings in England reported that *"some establishments did not appear to have smoking cessation services in place and argued that this was because smoking cessation treatment was not available for under 18s, that NHS smoking cessation services were not 'secure setting focused' or were targeted at adults*." [73] In addition, NRT was seldom provided to aid withdrawal. NICE Public Health Guidance on smoking cessation states that "*professional judgement should be used to decide whether or not to offer NRT to young people over 12 years who show clear evidence of nicotine dependence. If NRT is prescribed, offer it as part of a supervised regime.*" [74] Young people who smoke must be treated with an understanding that they will often have a longstanding addiction to nicotine and must be provided with the same level of care as their peers in the community.

4.5.1 Monitoring harm reduction approaches

Currently harm reduction activity is not recorded nationally. However, suggested outcomes that could be captured locally are in the table below. NCP refers to any nicotine containing product.
The light blue vertical text boxes indicate the suggested minimum set information that shold be recorded, in addition to the gold standard at each point.



5. Establishing a care pathway throughout the CJS

5.1 Achieving multiple aims

Establishing an effective care pathway throughout the CJS for smokers will achieve multiple aims:

- help people to change a health damaging behaviour, smoking
- help people to avoid the problems of nicotine withdrawal
- reduce health inequalities
- give people control over an aspect of their lives which might increase confidence and self-respect
- improve mental health of offenders
- potentially break the links between smoking and other substance abuse
- potentially reduce re-offending
- provide a smoke-free environment to protect people from tobacco smoke pollution and also help to prepare individuals to adopt ways, rules and norms of greater society

In addition to providing treatment, increased activities to alleviate boredom and/or loneliness, employment, and education may be important support mechanisms.[75]

Extended periods of abstinence from smoking increase the likelihood of complete cessation. In cases where complete cessation occurs there are additional benefits to be realised by the families of offenders and the wider communities within which they live.

5.2 Strengthening the smoke-free pathway in line with the offender pathway

Embedding smoking cessation support across the CJS requires a wide range of stakeholders, providers and target groups to work together to:

- raise the profile and priority of addressing smoking to ensure all professionals working in the CJS are aware of the importance of cessation
- work with offenders to understand their needs, promoting access to services delivered by trained advisors and in line with NICE guidance
- commit to ongoing staff training and ensure all prison staff are appropriately trained (see below)
- ensure nicotine medications are available in settings where offenders are kept for short periods to help them manage any nicotine withdrawal (see below)

- ensure that all licensed stop smoking medications that are considered safe for use within the custodial environment are available on appropriate formularies
- ensure, where clinically appropriate, that children and young people have access to NRT and support when they are required to stay in smokefree environments
- ensure all nicotine dependence treatment is delivered according to NICE standards
- use existing electronic services and referral mechanisms to support the nicotine dependence treatment care pathway across the CJS to ensure continuity of care pathway on release or transfer to other prisons
- as many offenders misuse other substances and/or have mental health disorders, smoking dependence treatment should be integrated with treatment programmes for these conditions

5.3 What does the care pathway involve?

The type of treatment provided might vary depending on the setting. In some CJS settings, for example, stop smoking services provide support primarily to advisors (mainly through tailored training) and these advisors then support offenders who smoke directly. In other settings, the services provide support of offenders directly.

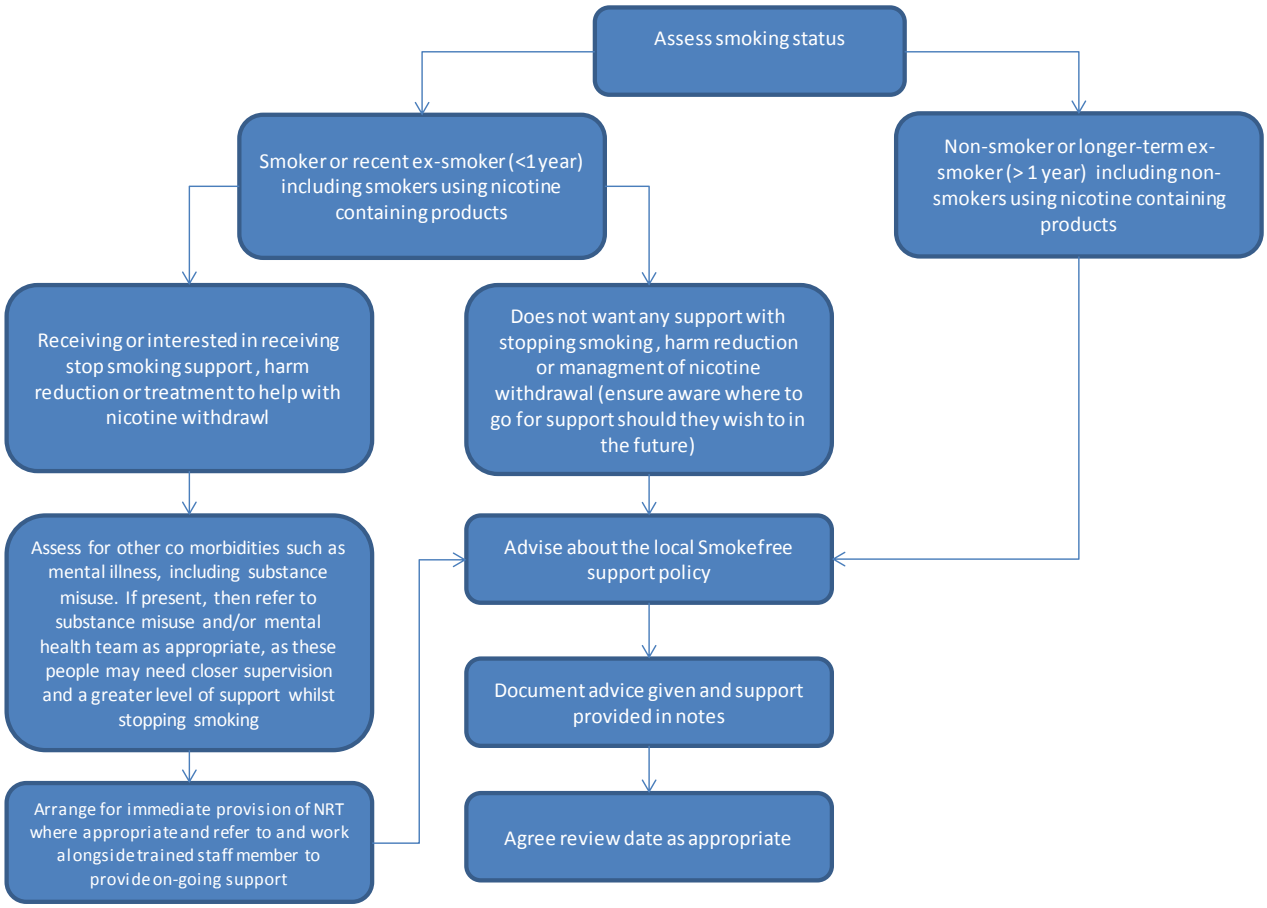
Implementing a comprehensive nicotine dependence care pathway across the CJS will require a wide range of stakeholders, providers and target groups to work together to ensure the following are in place:

5.3.1 A simple decision support tree

Assessment of smoking status is undertaken during the screening process every time a person moves through the system. The simple decision tree (detailed overleaf) can be applied in each case and will ensure that smoking status is recorded and appropriate action taken to address need.

5.3.2 Awareness raising activities

Raising the profile and priority of addressing smoking will ensure that all professionals working in the CJS are aware of its importance. Smoking cessation support materials which are suitable for low literacy levels should be available throughout the CJS. The use of prison champions from healthcare and from custody staff will facilitate this process and numbers required should be guided by local need.



5.3.3 Training

All front line staff (prisons officers, healthcare and recovery staff) within the CJS should be trained to give very brief advice (VBA)[76] on smoking, identify relevant support, and in how to access medication or specialist support for stopping smoking or managing nicotine withdrawal. This very basic training should also cover the prevalence of smoking in the general population compared with the offender population, the benefits of stopping and the inequalities caused by the higher smoking prevalence in the offender population. Training could also identify support for staff to reduce the harmfulness of their smoking.

Additionally, all prisons should have access to a specialist stop smoking service or advisors trained to give specialist support (offering the best treatment available, so maximising a smoker's chance of stopping for good).

It's good practice for a range of staff and peers to complete relevant NCSCT training programmes[77] to help support others to stop smoking. The numbers of staff and peers

who require training will vary between locations and should be based on a local needs assessment so that smokers can be supported as soon as possible.

Staff time should be protected to support the nicotine dependence delivery pathway.

5.3.4 Accessibility of pharmacotherapies and behavioural support

NRT products should be available in all settings, including those where offenders are kept for short periods, and those areas where non-smoking is enforced, such as across the children and young people's secure estate, so that offenders can manage their nicotine withdrawal. The currently available products that seem most suitable are clear patches, mini-lozenges and oral film. In addition, varenicline and bupropion should be accessible across the CJS. This will require the medication to be on formularies and in stock.

Evidence does not suggest that NRT, bupropion and varenicline held 'in-possession' in residential custodial settings to be problematic, unless the risk assessment outcome for an individual patient suggests otherwise. Some prisons have introduced checking processes to minimise over-supply and prevent misuse.[78]

Clear information should be included highlighting the cautions and contra-indications, and involving multidisciplinary partnerships in prescribing and monitoring these medications for patients with mental health co-morbidities. A short supply of pharmacotherapy should be supplied for those about to transfer, as outlined above, until prescribed medications can be renewed.

Staff who wish to stop smoking or manage their smoking while at work should be referred to their local NHS stop smoking service for support. Where local policies are in place staff may be supported with pharmacotherapy and behavioural support through the service provided in the prison, though of course there will be cost implications for this service.

Intensive behavioural and pharmacological support is likely to be necessary for many smokers in the CJS because of the greater nicotine dependency. In addition, each prison will have access to a specialist service or advisor providing behavioural and pharmacological support and in some cases, harm reduction advice and support. This can be provided by the local stop smoking service or by trained prison staff with dedicated protected time.

Where there is an identified need for support, this must be delivered in a timely fashion, to the standards set out in the most recent version of the local stop smoking service delivery and monitoring guidance and in every case, all nicotine dependence treatment

should be delivered by staff who are certified by NCSCT and according to NICE guidance.

5.3.5 Treatment for other substance misuse

Nicotine dependence treatment should form part of any other substance misuse treatment being offered. Those offering substance misuse treatment should be trained to give brief advice on smoking and signpost and refer further support. Smoking with prisoners should not be allowed under any circumstances.

5.3.6 Alternative recreational activities

In agreement with the prison establishment, alternative recreational activities should be provided as they will help alleviate prisoner's boredom, one of the key reasons given for smoking. They also provide opportunites to improve mental health and increase socialisation.

5.4 Smokefree policies

Prisons have a legal duty to ensure that the working environment for staff, prisoners, contractors and visitors are safe and without risk to health. The smokefree legislation (Health Act 2006) took effect from 1 July 2007 and included an exemption to allow smoking in cells (a 'place of residence' in law) under certain circumstances, as laid out in PSI 09/2007.[79] However, smoke-free policies across the CJS will protect workers in offender settings and will also provide offenders with the most conducive atmosphere for reducing and ultimately stopping smoking. In any case policies should at the least:

- guarantee a healthy working environment and protect the current and future health of employees, contractors, visitors and prisoners
- guarantee the right of non-smokers to breathe in air free from tobacco smoke
- comply with health and safety legislation and employment law
- raise awareness of the dangers associated with exposure to tobacco smoke
- take account of the needs of those who smoke and support those who wish to stop

6. Conclusions

The extraordinarily high smoking prevalence found among offenders is of great concern. Smoking damages the health of offenders and those around them, exacerbates existing health inequalities for offenders compared with the general population and is likely to contribute to feelings of marginalisation. Stopping smoking will therefore result in many benefits for offenders. It may also reduce contact with the criminal fraternity given the attraction of illicit tobacco to those on reduced incomes, and it may also reduce the likelihood of re-offending.

There are many reasons for the high levels of smoking in prisons, including the relationship between smoking and other substance use, and smoking and mental health problems, and the lack of comprehensive smoke-free policies in prisons. Nevertheless, smoke-free policies are now being introduced and effective treatments exist to help offenders reduce or stop smoking, including those with co-morbidities, so the time is right to tackle this situation. Government documents have also highlighted the importance of tackling smoking in the offender population and across the CJS.

In recent years accessibility to effective stop smoking support in some prisons has improved markedly. However, the recent transfer of responsibility for commissioning public health services for prisoners to NHS England and for people in the community to local authorities has raised concerns that the provision of smoking cessation services in prisons might have been disrupted during this transfer process. Support is patchy elsewhere across the CJS and is not joined-up between CJS settings or between the CJS and the community. Addressing smoking and delivering a joined up approach to its management across the CJS will therefore maximise opportunities to reduce relapse, reinforce non-smoking and may have a knock-on effect on smoking among the families of offenders.

Reducing smoking should be afforded the highest priority across the CJS and there is a strong case for delivering comprehensive nicotine dependence treatment to all smokers in the CJS. This guidance has outlined a joined-up care pathway to do this.

7. Acknowledgements

PHE would like to acknowledge Professor Ann McNeill, Professor of Tobacco Addiction King’s College London, for her contribution to this guidance.

We also are grateful to colleagues from the National Offender Management Service, NHS England Health and Justice and those govenors and staff who provided valuable feedback into the process.

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