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THE IMPACT OF DH FUNDED PROVISION OF NRT IN HM PRISONS

Revised Findings

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1.0 INTRODUCTION AND STUDY OBJECTIVES

Smoking is the biggest cause of health inequalities. It is estimated that around 80% of the country's prison population smoke (Singleton 1999) and there is an urgent need to tackle smoking in this setting. In addition, the lower socio-economic strata tend to be over-represented in prisons (e.g. Goos 1996) and the prison setting represents an opportunity to access an audience that is normally hard to reach.

The partnership between Prison Health and the Tobacco Policy Team at the Department of Health (DH) established smoking cessation Pilot Projects in prisons (MacAskill and Eadie 2002) and through Acquitted and a programme of regional seminars, the lessons learned were disseminated nationally (Braham 2003). The fundamental rationale is to provide a service based on current good practice and at an equivalent level to that accessible in the local community. NRT doubles the chances of successful quitting by reducing the effects of cravings and is most successful in the context of skilled advice and support (Raw et al 2000). The Pilot Projects demonstrated demand in the prison context, and that provision outside existing pharmacy budgets was seen as a key stimulus to action and success. These results contributed to the decision to fund NRT in prisons NRT is currently accessible free of charge in the community to those on low incomes who do not pay for medication and provision in prisons contributes to equitable provision of care.

The Department of Health has provided £500,000 of ring-fenced funding for provision of Nicotine Replacement Therapy (NRT) in Prisons in England, for each of three financial years (2003-2006). NRT provision is in accordance with NICE Guidelines. The costs for staff to deliver smoking cessation initiatives were met within the existing staff levels in prisons and their local PCTs and stop smoking services.

Local returns to the DH do not provide a separate picture of the uptake of NRT in prisons and the impact on cessation activities. Research was therefore needed to gain understanding of the uptake of funded NRT and outcomes from provision of free NRT in prisons. It would also be useful to obtain information on the process relating to the administration of NRT.

Study Aims and Objectives

The aim of the study was to provide understanding of the uptake and outcomes from provision of funded NRT in prisons during 2004-05. In addition the study intended to provide insight into the processes relating to the administration of NRT in the context of cessation interventions. The study also aimed to contribute to increased understanding of activity within prisons to deal with smoking and with second-hand smoke.

In more detail, the study objectives were to:

- Establish models of interventions and NRT usage.
- Explore issues in relation to distribution of NRT and record keeping.
- Devise mechanisms for obtaining quantitative information and distribute forms.
- Collect and collate quarterly returns to provide measures of quit rates.
- Provide qualitative insight into the uptake and impact of NRT provision over the study period.

2.0 METHOD AND SAMPLE

A case study approach focussed on one region, the North West of England, which incorporated 16 prisons representing a range of prison categories and PCTs (Appendix 1). Since NRT funding was introduced during 2003, the study covered a one-year period, April 2004-March 2005, which allowed follow-up of NRT provision and cessation initiatives once the system might be expected to be embedded.

A mix of methods was incorporated:

- Data gathered was primarily quantitative in nature. Figures collected at three monthly intervals as with the Department of Health returns enabled assessment of quit rates. Forms were devised to facilitate this process and to allow monitoring of NRT distribution and use and give some insight into issues affecting the interventions.

- Qualitative information was also collected to allow exploration of broader issues affecting the distribution of NRT in the context of cessation. Interviews were one-to-one or paired, and conducted face-to-face or by telephone. In addition, the researcher participated in regional network meetings and study days, which facilitated identification of issues and enabled interim evaluation feedback.

- Observation of cessation work and prison settings contributed to insight into issues affecting delivery.

It should be noted that data reported are based on returns compiled by either prison or PCT staff. As noted in the findings below, it was apparent that compiling the figures was not always straightforward, and discussions with staff suggest that there may be some inaccuracies, although these seem likely to result in under- rather than over-reporting.

Sample

A range of respondents were consulted through qualitative interviews, covering all 16 prisons, in addition to the quantitative data returns. Respondents (overall n=34) were drawn from PCTs and stop smoking specialist services (17), prison staff involved in delivery of cessation services and prison pharmacy staff (16), together with a pharmaceutical company representative supplying NRT (1). Some respondents were interviewed more than once over the study period and some were involved with more than one prison. In addition, relevant regional prison and tobacco leads were consulted. Finally, members of network meetings and study days contributed to identification of issues and discussion of findings.

Prisons have been anonymised for this report, and denoted by letter only: see Appendices 2 and 3.

3.0 QUANTITATIVE FINDINGS AND QUIT RATES

This section draws largely on the quarterly returns submitted by individual prisons. It addresses the range of prisons and prisoners involved and achieved quit rates, and discusses local and national contexts.

How Many Prisons Were Involved?

There are 16 prisons in North West region with a range of offender characteristics. Based on the main prisoner category, these incorporated Local/Remand prisons (4), Category B (2), Category C (4), Category D (1), Young Offenders (3), and Female (2) (Appendix 1).

Within the region, an increasing number of prisons reported smoking cessation activities during the study period 2004-05. By Quarter 4, 15 of the 16 prisons had stop smoking interventions, including some which had already been well established prior to the study period. Overall, twelve prisons reported cessation delivery in the first two quarters, with 14 active in Quarter 3 and 15 in Quarter 4. However, one prison had not established a prisoner stop smoking service by the end of the study period, apart from ad hoc prescribing of NRT by the medical officer, although this service was about to start.

This represents a substantial increase in delivery compared with the position reported in 2002 (Fullard and Howell 2002). At that time, only seven prisons reported service delivery in conjunction with specialist support and usually at a low level, with two further prisons reporting NRT prescribing and advice from the medical officer only. However, the remaining prisons were reported to be developing plans and training with the intention of introducing structured services at that time.

How Many Prisoners Participated by Setting a Quit Date?

In the study region, **1,581 prisoners were recorded as setting a quit date** in 2004-05. It is likely that more attended information sessions but decided not to continue. Numbers participating increased over the study period, ranging from 336 at Quarter 1 to 479 at Quarter 4.

Importantly, however, the level and consistency of cessation activity varied across the prisons. For example, six of the fifteen prisons accounted for two-thirds of the prisoners setting a quit date (1,052 prisoners) and some prisons had only achieved quite small numbers of participants over the year.

Characteristics of participating prisoners identify them as key targets for smoking cessation. Prisoners in general tend to come from disadvantaged backgrounds (e.g. Goos 1996) and as such are important health inequality target groups. In addition, the service tended to reach a relatively young population. In most of the adult prisons, between half and three quarters of participants were prisoners aged 18-34 years, in addition to services being delivered in young offender and juvenile units. This contrasts with national figures as a whole, where clients aged 34 years and under are in the minority and represent 30% of those participating in services (DH 2004).

Quit Rates: How Many Remained Quit at Four Weeks?

Among those who had started a course and set a quit date, **642 prisoners were reported as remaining quit at four weeks**. Overall this is **41% of those who set a quit date**. It should be noted that prisons used CO monitors in all interventions and so quit levels were consistently validated by this means.

However, 324 prisoners were lost to four week follow-up (20% of those participating). If one reassesses the quit rate as those remaining quit divided by all those who could be followed up, this gives an overall quit rate of 50%. Loss to follow-up varied across the prisons, and tended to be higher in local prisons and in YOIs, although Prison L[1] was a notable exception.

Quit rates and delivery models in individual prisons are summarised in Appendices 2 and 3. The highest overall four week quit rate in one prison for the year was 64%, with the same prison achieving a quit rate of 78% in Quarter 4 (Prison A). Whilst there was a range of quit rates achieved, seven prisons in all were above the overall prison quit rate for the region of 41%. This includes two prisons which were higher than the 2003-04 national population quit rate of 57% (Prison A 64% and Prison I 59%: DH 2004).

Quarterly quit levels in individual prisons tended to improve over the year, especially where services were well established. This suggests that with increased experience among individual workers and across services, together with ongoing organisational and financial support, overall quit rates are likely to improve.

Did Interest Continue Among Prisoners?

Demand for cessation support among prisoners continued and increased over the study period. Interest levels recorded were 324, 313, 474 and 420 prisoners in Q1, Q2, Q3 and Q4 respectively. There tended to be higher numbers recorded at local prisons (but not all locals) and where one-to-one support was offered. Prisons with better established services and higher throughput also tended to observe continued demand. Not all prisons quantified prisoner interest registered in their returns (9/16), although this would be a useful needs assessment exercise.

How Does this Fit with the Local and National Context?

How do the quit rates compare?

The national quit rate through smoking cessation services was 57% based on self report in 2003-04 (DH 2004). Thus the results (41% overall quit rate) recorded in prisons in the North West are lower than overall national outcomes. However, several factors suggest that prison population characteristics may explain these differences, over and above service delivery issues. Firstly, prisoners largely come from disadvantaged communities, and nationally quit rates are lower among these groups making the prison quit levels more similar (e.g. quit rates across Health Action Zones were 52% in 2003-04; DH 2004). Secondly, prisoner participants tend to be in younger age groups and stop smoking interventions nationally are less

[1] Prisons have been anonymised for this report, and denoted by letter only: see Appendix 2

successful with younger smokers (four week follow-up successful quits ranged from 38% of those aged under 18 years, and 51% of those aged 18-34 years, to 67% of those aged 60 and over; DH 2004).

In addition, recorded quits in the prisons were validated by CO monitoring which suggests enhanced accuracy. In comparison, national statistics are based on self-report with CO monitor validation applied to 35% of those who set a quit date (62% of those self-reporting as having successfully quit after four weeks; DH 2004).

More locally in the North West, across the PCTs covering the 16 prisons, the average quit rate was 50% successfully quit at four weeks (DH 2004), which represents a smaller difference in comparison to the 41% quit rate achieved in the prisons.

Indeed, quit rates in some prisons were higher than or similar to those obtained in the community, especially in local prisons where comparison with the community population is most valid and tended to incorporate more disadvantaged areas. For example, in one large local prison the overall quit rate was 45% and the overall rate for the PCT in 2003-04 was 34%.

What proportion of the North West prison population was reached?

The total offender accommodation in the North West is 11,617. Prisoner turnover means that numbers over a year are higher and total prisoner population is generally taken as double the accommodation levels. Based on this and the assumptions below (Table 1), one can judge what proportion of prisoners who smoke and are likely to attempt to quit have been reached by stop smoking support services in 2004-05 and have been successful in quitting.

Table 1: Impact on smoking in North West Prisons in 2004-05

Offender accommodation in North West	11,617 prisoners at one time 23,234 total population in a year (assumed double)
Assume 80% of these smoke	18,587 prisoners are smokers
Assume 30% of the population will make a quit attempt	5,576 smokers are likely to make a quit attempt in NW prisons
Quit dates were set by **1,581** prisoners in 2004-05	**28%** of those likely to make a quit attempt were supported by stop smoking services (9% of smokers overall)
642 prisoners were successful in quitting (41% of attempted quitters)	12% of those likely to attempt to quit were recorded as successful (**3.45%** of smokers in the prison population recorded as successful quitters)

As shown in Table 1, the assumptions suggest that more than quarter of the prisoners (28%) likely to attempt to quit were supported in doing so. This is 9% of the prison population of smokers. Even if prisoners did not quit at that time this represents a move towards successful quitting.

It is also suggests that 3.45% of smokers overall in the prison population were successful in quitting and remaining quit at four weeks through service support.

What is the potential impact on the total prison population?

Similar assumptions are outlined below in relation to the total prison population in England and Wales (Table 2). From this it is likely that 4,140 prisoners would be successful in quitting in one year across the total prison population (Table 2). As already suggested, it is probable that quit rates would increase as experience is gained in this work and organisational support is enhanced within prisons. The contribution to the national targets over three years would therefore be at least 12,420 quitters at four weeks.

Table 2: Impact on Smoking in the Total Prison Population in One Year

Offender accommodation	75,000 prisoners 150,000 total population in a year (assumed double)
Assume 80% of these smoke	120,000 prisoners are smokers
Assume 30% of the population will make a quit attempt	36,000 smokers are likely to make a quit attempt
Assume **28%** of those likely to make a quit attempt were supported by stop smoking services	Quit dates would be set by **10,080** prisoners
Assume **3.45%** of smokers in the prison population would be successful in quitting	**4,140** prisoners would be successful in quitting in one year (12,420 in three years)

Cessation support through prisons also represents a relatively intensive and effective route to reach a target population group. The potential reach of 2,760 successful quitters per 100,000 prisoners annually compares favourably with the 2003-04 national figures of 512 people per 100,000 population aged 16 and over having successfully quit at four week follow-up (DH 2004).

4.0 SERVICE DELIVERY THROUGH PRISONS AND PCTs

This section outlines the range of delivery approaches used and identifies factors which supported success and aspects holding back progress. It should be noted that many of the issues raised here are also covered in the Acquitted document (Braham 2003) and in the mapping exercise undertaken in 2003 (MacAskill and Eadie 2003).

What Delivery Models Were Used?

A range of approaches were used across the prisons, as summarised in Table 3 below, with additional details provided in Appendix 2 and Case Studies in Appendix 3.

The majority of prisons used **group quit support** programmes (11), but of these many also offered **enhanced one-to-one support in parallel** (eight) with only three prisons reporting **group work only**. The numbers receiving one-to-one support tended to be less or occasionally similar to those involved in group programmes, with this support sometimes offered by a different member of staff to those running the group (e.g. Prison B). Individual support would be offered instead of group work for a variety of reasons, largely reflecting prisoner characteristics: for example, for Vulnerable Prisoners or those who were reluctant to participate or unable to cope with a group setting. Choice of one-to-one support also reflected organisational issues, such as the often long waiting times before a new group could be set up. For example, a prisoner with an urgent medical need to quit could be more quickly accommodated through one-to-one support, or prisoners already on a programme who were 'transferred in' from another prison could continue their programme.

Three prisons offered **enhanced one-to-one support only**. This largely reflected organisational needs initially, where it was difficult to ring fence a set time every week for a group, and individual contacts could be more flexible and arranged at short notice. However, this approach was also seen to have other important benefits as above, especially where prisoners were perceived to be reluctant to be frank in a group setting where they might be vulnerable to outside pressures, or to be unruly in groups as with young offenders.

In one prison, a **combined support approach** incorporated an initial short group meeting and two or three other meetings in the course of the NRT programme, with individual weekly contacts in the remaining weeks (Prison O). This was seen to enable greater throughput as well as responding to shorter attention spans among many inmates and the need for privacy.

Table 3: Approaches used in prisons (additional details in Appendix 2)

Main approach	Number of prisons	Delivery of cessation support work	Quit rate @ 4 weeks
Group work with enhanced one-to-one support in parallel for some individuals	8 prisons	4 led by internal staff 3 mix of internal and external staff 1 external specialist lead with internal support	8%-64%
Group work only	3 prisons	1 external specialist lead with internal support 1 mix of external and internal staff 1 internal staff	31%-59%
One-to-one only	3 prisons	2 led by internal staff 1 mix of internal and external staff	37%-45%
Combination of group and one-to-one in programme	1 prison	internal staff	43%

Timing

Most group courses tended to last six to seven weeks with continued weekly distribution of patches until the end of the course. Some workers, however, described running support group programmes of 10 to 12 weeks which were felt to contribute to success, although longer term quit rates were not assessed. Group sessions tended to last around an hour, although group contacts in Prison O tended to be shorter. In addition, brief ad hoc support was available in between sessions where prisoners could access internal staff for advice and staff could 'check up' on their progress. One-to-one interventions also covered the ten week NRT course but latter weeks tended to involve patch exchange rather than specific appointment times. Main appointment sessions tended to last around 15-20 minutes and so could be described as 'enhanced' brief intervention. For example, in Prison L the staff member saw prisoners at Weeks One, Two and Four and otherwise as requested.

Service delivery sources: PCT stop smoking specialists and prison staff

Cessation support was delivered by external smoking cessation specialists, as part of the PCTs, and / or by internal prison staff. The quality of this interface is crucial, in terms of effective prisoner contact as discussed here, and in more strategic interactions in developing the service and wider tobacco control within the prison setting, as outlined in section 5.0.

External stop smoking specialists delivered service support in seven of the 15 participating prisons. They were more likely to be involved in group sessions, rather than more flexible one-to-one work, because it was easier for them to come at set times. However, some also participated in one-to-one 'clinics' supporting staff cessation which could be organised to link with the same visit to the prison. External support had also been important to facilitate initial groups to give prison based staff experience of the group approach, which they could then take forward themselves. In some cases external support continued for long periods and remained a central part of delivery. Whether or not advisors went into the prisons, the support of the stop smoking services was important, especially where they gave encouragement and technical advice to prison staff working alone, as well as in terms of practicalities such as funding budgets for NRT and collating quarterly DH returns. PCTs have also been given responsibility to commission health care services in the prison, so have an impact on staffing levels and the priority given in terms of staff time and recognition of smoking cessation as an issue, as well as funding external specialist participation. In two prisons, specialist support was commissioned from 'Fag Ends' (The Roy Castle Lung Cancer Foundation).

In some prisons, quit support was provided entirely by internal prison staff, usually from Health Care and Pharmacy Departments, but also from Physical Education and Wing Officers. In most cases, smoking cessation was not allocated administrative support and many prison based staff reported updating paperwork in their own time. Involvement of prison based staff was essential even if external staff continued to visit the prison. Thus many additional activities had to be undertaken by internal staff, whether or not the actual programme was delivered by an external advisor, such as; arrange meeting venues, manage waiting lists, 'call-up' prisoners and arrange for movement around the prison, organise prescriptions and other paperwork, oversee distribution of patches, and provide on-going *ad hoc* support of quitters and 'checks' on fidelity to the quit attempt. In addition, security issues

had to be addressed, with members of prison staff needed to escort and 'chaperone' any external advisors.

NRT support

Nearly all prisoners requested NRT to support cessation, although in a few isolated cases individuals preferred to quit with only the group support. Some forms of pharmacological support were unavailable because of security considerations, such as gum, and Zyban was not used as it would be contraindicated for many prisoners and needs more intensive monitoring. With accumulated experience, most prisons moved to offering 24 hour patches rather than 16 hour, finding them more effective, although a minority offered a choice. By the end of the study period, nearly all prisons were using NiQuitin patches, which are also 'clear' giving an additional security benefit. NRT was mostly dispensed on a weekly basis, although at least one prison undertook daily exchange and collection (Prison L). All were dispensed patch-for-patch, with prisoners returning used patches before receiving new ones, and staff felt this was essential to minimise 'trading' in the prison. All prisons distributed patches to continuing participants over the recommended prescribing period, usually ten weeks, irrespective of the length of the planned support programme. The impact of NRT funding is discussed below (5.0).

Care pathways for prisoner transfers and release

Within the prison regime, prisoners are often likely to be transferred to other prisons and even released at short notice, especially in local prisons. Thus a programme of cessation support could be interrupted, even though staff tried to ensure that participants were expected to be in the prison for at least 3 months. This was a major factor in the 'loss to follow-up' figures reported (Section 3) and prisoners themselves voiced concerns about the issue when starting a programme of support.

Respondents reported approaches that helped address this issue. The ideal seemed to be that prisoners would have an up-to-date record of their participation which could be transferred out when they moved (including NRT levels prescribed, sessions attended, and CO readings) and that they should also have an initial supply of patches to take with them to cover delays in prescribing at the next prison. Staff themselves tried to supply records and NRT if given enough notice, but also reminded prisoners to highlight these needs if they could not alert appropriate prison staff in time. A common approach was to ensure that records are kept up to date in the Inmate Medical Record (IMR) and 'treatment pad' which is nearly always transferred at the same time as the prisoner. Previously, some had recorded participation details separately and only written them up in the medical records sporadically, which risked the information not being transferred with the prisoner. Simplifying prescribing procedures also meant clearer records for a new prison to utilise. Occasionally staff were able to obtain a 'medical hold' to enable prisoners to remain for the duration of their course, but this often proved unrealistic because of pressures on accommodation and security priorities.

Similarly, when prisoners were transferred in to a prison, reception staff were reported to be increasingly responsive to prisoners who requested to continue a cessation programme, although if there was no documentation steps had to be taken to confirm prisoners' claims to be on a programme which could be time-consuming. In addition, where more flexible one-to-

one support was available in the receiving prison it meant that quit support and NRT could be offered with less delay, rather than waiting for a group programme to start. However, respondents commented that coping with prisoner transfers was becoming easier as the extent of service provision and stop smoking networks improved across prisons.

Where prisoners were released unexpectedly, some respondents reported giving them NRT supplies to cover for a week or two and encouraged them to seek out support from their local GP or community services. However, direct referral links had not been established, and there was some concern that this client group may not be confident in seeking help of this kind. There is scope for further work in this area.

Training and professional support

Training for prison staff offering cessation support was provided by local specialist stop smoking services, usually to intermediate level. In some prisons, additional staff were offered brief intervention training, which was felt to give them useful insight into key issues and enable them to support prisoners participating in the intervention, for example by more proactively facilitating attendance at advice sessions and ‘checking’ compliance, as well as actively encouraging enrolment. Training needs were on-going, reflecting staff changes and pressures relating to the work.

It was also seen to be important to offer on-going support of those who were trained and providing support. This could be provided directly if specialist staff were continuing to go into the prison, or indirectly through telephone contact. Personal support and encouragement in what is a difficult area of work was important together with access to technical advice for a specific problem. Some prison staff attended network meetings and this was valued, such as the Regional networks for prison smoking cessation or general health promotion, or local networks for all those involved in stop smoking support in a PCT area.

Some staff reported having limited personal motivation initially to work in smoking cessation, describing being assigned to training in that area from a range of ‘clinics’ with which they might have become involved – *“just dropped in it”*. This potential lack of initial personal motivation, although often overcome, may contribute to drop-out of staff from what is a challenging area of work, and needs to be recognised.

What Worked Best?

Group support?

The highest quit rates were obtained in prisons where there was wholly group support programmes or where group work was a major component (Table 3 and Appendix 3). Thus five prisons taking this approach achieved levels higher than the overall rate for North West (Prisons A, B, C - group support and one-to-one; and Prisons I, J - group support). Prisons A and B in particular achieved high quit levels in the context of a relatively high throughput (each around 150 prisoners). Other characteristics that appear to have contributed to success included: lower levels of loss to follow-up; accumulated staff experience both within the prison and in specialist services; organisational support especially for time slots to deliver the service and for administration; and individual prisoner characteristics and the prison regime.

However, not all prisons adopting a group approach achieved such high levels, indicating the need to carefully consider which approach is appropriate to the prison situation as a whole. Explanations for relatively lower quit levels among group programmes could include higher loss to follow-up, aspects of prisoner characteristics including youngest age groups, and lack of sustained programmes and hence limited experience among staff. In addition, in two prisons which ran ten week support programmes rather than six weeks, the returns initially related to numbers quit at the end of the course rather than at four weeks, and probably under represent four week quit achievements.

One-to-one support?

Some prisons achieved good quit rates with one-to-one interventions or primarily one-to-one interventions. Two prisons achieved levels above 41% overall level together with high throughput (Prisons L, 45%, 141 prisoners and Prison O, 43%, 309 prisoners), although the latter incorporated some group sessions (Appendix 3). Significantly Prison L especially illustrates the potential for success in a large local prison, and Prison O also includes 'local' prisoners as well as young offenders. Key characteristics include prison staff who had run cessation support for a number of years, although largely alone, and operational support in terms of time to run sessions, although not always with consistent time slots. In the third prison to offer one-to-one support only, the prisoner characteristics (young offenders) probably reduced the potential for success.

Mixed flexible approaches?

As indicated above, it would seem that a relatively flexible mix of service delivery enhances success and throughput of prisoners, whether the main emphasis is on group or one-to-one support, *"I think there is a place for them both"* (Prison staff). Quarterly returns did not distinguish between group and one-to-one delivery in individual prisons and it is not possible to compare relative results of the two approaches when utilised within individual prisons. In any case, the characteristics of prisoners choosing each route are likely to be different, which would affect results and make direct comparison difficult.

In addition, some staff reported developing greater flexibility within a programme in comparison with traditional recommendations, such as giving prisoners greater autonomy in choosing their own quit date, rather than all participants quitting at the same time, or encouraging a repeat attempt within a ten week programme if there had been a minor lapse. This reflects more flexible responsive approaches which are being reported in community settings, especially in relation to reaching more disadvantaged groups.

Overview of 'successful' approaches

Overall therefore, the 'success' of an intervention reflected a number of interacting factors in addition to the approach used, such as: staff experience; time available and organisational support for the prison staff involved; the nature of individual prisoners and the prison regime; and numbers lost to follow-up, especially through transfers and releases. It is therefore difficult to say what works 'best' and to some extent, a more flexible 'horses for courses'

approach is appropriate, reflecting the prison characteristics and the stage of development of the service.

In addition, whilst it is important to maintain standards of delivery, delaying offering a service until a perceived ideal model could be put into place, such as group work supported by effective no smoking policies, could be seen as unrealistic. Some respondents described how establishing a foothold with a limited service had led to the evolution of more appropriate services (e.g. Prison C). On the other hand, without core and senior support in place in principle at least, such an initial approach could risk unsustainable one-off interventions (e.g. Prison F).

What Factors Facilitate Initiatives Overall?

It is important to recognise that a range of factors facilitate interventions, and that they will have an interacting effect on the success of an initiative.

- Choice and development of cessation approaches. Group work is often seen as the optimum approach and did work well, especially in prisons with relatively stable populations, experienced staff and good organisational support for the service. However, as discussed above, one-to-one support could also achieve good results and allowed greater flexibility if service time was limited or less structured. It had additional benefits for particular prisoners: many were reluctant to talk in front of others in a pressured prison community environment, or perhaps had mental health problems which made interaction difficult, or had an urgent health condition which required avoiding delay in quitting. It also enabled continuing support of those transferring in to a prison who had already started a programme in their previous prison. In many prisons a mix of support approaches proved successful.

- Ring fenced time for prison staff, ideally at routine periods in a week, to allow regular courses to be held, and time to prepare for sessions, distribution of NRT and to keep paperwork up to date.

- Build up of staff experience, with the same staff involved for a considerable period, contributed to growth in expertise as well as ‘normalising’ the clinics. Staff being moved to different posts, on sick leave, or even on changing shift patterns could make the service more vulnerable.

- Personal commitment by individual staff continues to be important, together with organisational support. Many commented on the satisfaction derived from this work, although time constraints added additional pressures and some described completing administrative tasks in their spare time.

- A mix of staff across the prison was felt to be helpful, but this was not always achieved or sustained. All prison initiatives tended to include health care staff, but a few managed to involve other staff, for example from Pharmacy, PE and Education, and also some Wing Officers. This mix both stimulates and reflects greater integration from the whole prison perspective.

- However, it is important to maintain a key person who both ‘champions’ and co-ordinates the intervention, organises data internally and liaises with the PCT. The latter element becomes more important when a number of staff are running clinics and records need to be co-ordinated.

- Where external stop smoking specialist workers were involved in delivery, input from prison staff remained important to running the initiative and enhancing sustainability. They had a key role in organising the sessions and NRT distribution, and supporting the specialist in delivery, including ‘chaperoning’, as well as being accessible to prisoners for ad hoc support in between sessions.

- Staff felt quit rates were improved when they were able to recruit more than one prisoner from a wing at the same time, to enable mutual support (and checking-up) on an everyday basis. In some prisons, improved high group quit rates were largely attributed to starting to conduct groups entirely made up of prisoners in individual wings, especially where Wing Officers were also offering support (e.g. Prison A).

- Consistent ordering and supply systems for NRT would enhance efficiency and value for money. Fruitful links were built up with NRT suppliers, primarily NiQuitin, which contributed to movement towards more economical ordering and structured systems (see below). Whilst funding of NRT has overcome an important barrier to service development (see below), other aspects, such as limitations in staffing numbers, can continue to provide a barrier to delivery.

- Use of CO monitors is common and is seen to focus the prisoners in their quit attempts by setting a challenge and confirming progress, as well as enabling identification of non-compliance. It also means that all returns are validated by CO monitor, more so than in the community.

- Recognition of the level of successful four week quits seemed to surprise some respondents, but was a rewarding exercise. Few PCTs or prison staff appeared to review quit rates achieved, over and above collating numbers, and this would be worth continuing, as well as feeding back to other interested stakeholders and departments.

- Reimbursement by a PCT for completed, validated returns as in the community was undertaken in some prisons. This appeared to enhance focus as well as maintaining the standard of record keeping in an environment where monitoring and audit were not embedded.

- Many respondents reported accessing appropriate visual aids and devising approaches which recognised lower literacy rates and often limited attention spans. Existing leaflets for example, were seen to be inappropriate, even those designed for use in prisons. One prison had developed a new ‘magazine’ with the aid of prisoners (Prison B).

- Care pathways, incorporating NRT supplies, could help support prisoners moved to another prison or released during a quit smoking course (see above). Staff were increasingly developing approaches to ensure records and NRT initial supplies were transferred along with prisoners and also developing strategies to accommodate those transferred into the prison.

- Integration of the service in a whole prison context, through development of no smoking policies and Prison Health Promotion Groups, was seen to enhance the cessation service. However, prison staff delivering the stop smoking service were not always involved in developments in these areas.

- Participating in regular networking groups was seen to be useful, to gain information and support from others, since workers can feel isolated. These could include prison focussed groups similar to the regional network linked to this study, or local update groups for those undertaking cessation work in a variety of settings.

Partnership working between the PCTs and individual prisons is crucial to success. Funding for health care provision in prisons now rests with the PCTs which also commission stop smoking services. However, development of cessation support mechanisms and other tobacco control interventions in prisons depends on effective relationships across the organisational structures well beyond the boundaries of Health Care departments.

What Aspects Limited Developments?

The development of stop smoking support in prisons required considerable perseverance, often on the part of one or two individuals. Progress in relation to all the above factors is required to develop a service and absence or weakness in any aspect could delay initiation or result in sporadic input and limited momentum in development. However, in those prisons where the initiation of services was delayed or they were run at very low levels, the main reasons cited related to staff shortages in the prison, especially in Health Care. As noted above, internal staff time and interest was important to initiate and sustain a service, but in some cases departments were seen to have been running a *"skeleton service"* with little time available to commit to cessation or other health improvement programmes. The current changeover in Health Care management from the Prison Service to the PCT tends to be seen as increasing the priority given to smoking cessation along with other health improvement activities, as well as increasing staff levels to facilitate these developments.

5.0 ADDITIONAL INFLUENCES ON SERVICE DELIVERY AND EFFECTIVENESS

This section looks at additional influences on service delivery and effectiveness, including impact of NRT funding, monitoring issues, national policy developments, and the interaction between PCTs and prisons organisations, concluding with a sense of prisoner and professional rewards in this area of work.

Impact of NRT Funding

Virtually all cessation attempts were supported by NRT, and so provision of NRT was clearly important to the success of any initiative (see descriptions of models above in Section 4.0). Annual provision in the North West Region was £79,000. Proportional allocation to relevant PCTs was based on initial bids submitted by PCTs and prisons in partnership, reflecting factors such as overall prisoner numbers, anticipated interest in cessation and likely support provision, including anticipated cost of NRT. Allocations varied, with the maximum being £16,000 to one PCT covering two prisons and the minimum being £1,000 for one prison that had not started to develop their service (Appendix 1).

Many respondents from both the PCT and the prison service felt that their work would have been unlikely to have developed without funding for the NRT. It was felt to have removed a major barrier to taking this work forward and acted as a kick start, tipping the balance towards action, especially at the stage when it was first introduced, *"at last we had something to offer the prisons"* (PCT). The initiative also triggered specialist services to review the support offered in prisons, stimulating development, *"a bit of a Trojan horse"* (Specialist Service). In addition, it contributed to the momentum of a service, making it more difficult to abandon once established, *"It would be wrong to stop a service, once it had started"* (Prison Health Care).

However, as noted above and in earlier reports (MacAskill and Eadie 2002 and 2003), there were often additional barriers to service provision, and these were not necessarily ameliorated by the NRT funding. In particular, staff shortages in Health Care contributed to delays in developing a service as well as continuing sustainability, although this is seen to be likely to improve with the change of health care management to the PCTs and often increased staffing levels. It should therefore be noted that funding NRT does not cover the costs of providing cessation support, which also requires ring-fenced staff time for direct prisoner contact and related administration.

There was a complex mix of NRT purchasing patterns across individual PCTs and prisons, including purchase from the local chemist's shop. This reflected differing ordering and invoicing strategies and supply routes, and in some cases the first year's allocation had been 'lost' if key cessation staff had not been informed early enough to incorporate it in the relevant budget. Another result was a range of prices, where some had negotiated purchase prices reflecting economies of scale and some were paying retail costs. Over the allocation period staff representing NiQuitin had worked with prisons and PCTs to try to introduce some consistency in pricing, to enhance value for money, but even with rationalisation, there are still up to four different supply routes. In addition, some prisons benefited from patches as part of the Department of Health Rebate Scheme to PCTs, although this was not recorded in

the returns. It is probable this mixed picture of purchasing patterns is reflected across the country and will have greater implications as the ring fenced allocation comes to an end.

Monitoring Issues

The study process revealed a number of issues in relation to monitoring stop smoking interventions in prisons.

It was apparent that keeping track of participants and outcomes was difficult for staff. This reflects a number of factors, not least the priority for wider security issues on staff time and activities, but also the marked lack of audit culture, the limited time available for prisoner contacts, never mind paperwork, and the range of different people who might be involved. For example, in prisons where a number of prison staff were delivering programmes, there might not be a single person co-ordinating the overall participant details, meaning that some might be missed in the return to the PCT (e.g. Prisons A and C). Even where external stop smoking specialist advisors delivered support in prisons, their community-based experience could be of submitting individual returns relating to individual participants, rather than collating them on a single proforma, and so the monitoring process for this study was also difficult for them. Thus the figures presented here should be seen as the best available and likely to represent under- rather than over-reporting.

There was often an already high level of paperwork required to support an intervention, in addition to completing summary monitoring forms for the study. During an initial session in a group support programme observed by the researcher, completion of prisoner documentation took up a considerable part of the session, even with two members of staff involved, markedly reducing the time to discuss cessation issues themselves. Forms included prisoner agreement ‘compacts’, individual PCT based monitoring forms including CO readings, prescription forms after the NRT support mechanism had been chosen, and forms for medical records. Further paperwork was completed in Healthcare to trigger dispensing of NRT. In addition, where more flexible support patterns had evolved (see above) it could be harder to clarify individual quit dates and hence four week quit levels. It is important that data collection requirements should not override professional judgements in delivery approaches – the tail should not wag the dog – but efforts should be made to make the collection of accurate records as straightforward as possible.

Keeping track of the returns from prison interventions is a valuable and useful exercise, enabling positive feedback to staff undertaking the work and other interested departments and stakeholders, as well as identifying areas for development. Providing returns to the DH as evidence of meeting targets is also important for PCTs. Many of the PCTs would not have monitored separately without this study, tending to incorporate figures into general returns to the DH. Thus few respondents were aware of the quit rates they had achieved and indeed PCT and prison staff were pleasantly surprised when they realised the quit rates achieved in the prison setting. It was also recognised by PCT respondents that it would be relatively easy to keep track by adding an additional identifying column in their database, which would also be useful to identify quit rates in the increasing variety of other settings in which support was being offered. It therefore seemed that in most cases, neither prisons nor PCTs reviewed the success of their work over a set period, for example by comparing quarterly quit rates in addition to merely submitting numbers. However, in one PCT at least, returns were reported to the Prison Health Promotion Group but not to those delivering the service. In one prison,

absence of feed-back meant that prison staff had not realised that there had been under-reporting of their work through limited co-ordination of data from a number of workers providing quit programmes.

Similarly, recording interest in participating expressed by prisoners would be a useful needs assessment exercise, in order to demonstrate demand and plan services, as well as an internal administrative tool for setting up support courses. However, only nine of the 15 active prisons were able to report waiting list figures.

Finally, it had been intended to gain insight into the NRT spend as part of the study (allocation outlined in Appendix 1). In practice this proved more complex than anticipated. Different PCTs had different budgeting practices and the funds appeared to have been allocated in a variety of different ways, which meant that tracking the spend was beyond the resources of this study. Already into the third year of funding, and especially among larger well established programmes, the sums involved tended to be seen as fairly limited, although important in the early stages. Often those using it claimed to spend more than allocated, while supplementing from other sources such as the general prison pharmacy budget or from other PCT budgets. However, the financial allocation still had an impact and was still eagerly awaited. Importantly when considering other initiatives, the delay in finally circulating the first round of funds too late in the financial year had caused considerable confusion and delays in setting up or expanding services, with some PCTs reported to have missed out on utilising the first round of funding altogether, because appropriate staff had not been informed in time. In addition, some had allocated the extra NRT patches ‘paid back’ to PCTs to the prison services, making it harder to keep track of funding.

National Policies and Initiatives

Within PCTs and the NHS

The findings and quit levels reported suggest this is an increasingly rewarding setting for stop smoking services (and hence PCTs) to offer support in the context of continuing cessation targets. Health inequalities targets are set nationally, including smoking levels and successful quit attempts. Respondents from PCTs identified particular benefits in relation to these targets, because quit rate levels achieved in prisons compare favorably with their work in other disadvantaged and hard to reach communities. This route also enables engaging younger men, also a difficult to reach group.

> *“So in terms of meeting the smoking cessation targets, the Health Inequality targets, and the targets outlined within the Cancer Plan, it's been crucial. The prisons work itself is crucial and the fact that the NRT allocation has been there has helped that work to go ahead. … The actual success rates in terms of the work have been much higher than in our general work in the community. That was somewhat of a surprise to us, but I think that proves that prisoners are just as likely to want to give up smoking.”*
>
> (Stop Smoking Service)

Improving the health of prisoners through stop smoking support also offers potential wider health benefits when they return to their families and communities. It also represents

opportunities for partnership working and building productive working relationships across organisations in this and other health improvement work.

The transfer of responsibility to commission health care services in prisons to local PCTs was well underway during the study period. This is due to be complete by April 2006, with the aim of improving health services in broad line with NHS standards, tackling health issues and improving through care between prisons and the wider NHS. Respondents often identified an increase in health care staffing levels linked to these developments which, together with increased prioritisation of health promotion elements, had contributed to a more positive environment for developing sustainable stop smoking services.

More recently, the health priority to reduce smoking levels was reinforced in the Public Health White Paper ‘Choosing Health: making Healthier Choices Easier’ (DH 2004) which also encompasses messages regarding the need for the choice to be in smoke free environments, to inform people about the impact of smoking and second-hand smoke, and to address the commercial and cultural influences that influence smoking behaviour. Since the study period, a new Health Bill (HofC 2005) addresses the issue of smoke-free premises. Whilst the Bill is not yet finalised and prisons are currently exempt in this context, the debate and final outcome is likely to influence perceptions about smoke-free environments with prisons being both a prisoner’s ‘home’ and also a place of work.

Within prisons

The Prison Service Order (PSO) 3200 on Health Promotion (HM Prison Service 2003) emphasises the responsibility ‘to ensure that prisoners have access to health services that are broadly equivalent to those the general public receives from the NHS’, including health education, patient education, prevention and other health promotion interventions within a whole prison approach. This builds on approaches outlined in ‘Health Promoting Prisons’ (DH 2002). The PSO can act as a driver for this work, including setting up Health Promotion Action Groups within prisons. However, prison staff interviewed who were involved in actually delivering the stop smoking support to prisoners were often unaware of these initiatives, at least in detail. They were often not involved in health promotion and tobacco control developments at a strategic level within the prison, either because of lack of time to make a contribution or perceived limited status within the prison.

Health and Safety at Work issues also add pressure to increase the extent of smoke free areas in prisons, in addition to the ‘Choosing Health’ White Paper. In parallel to reducing areas where prisoners and staff can smoke, there is a linked need to offer substantial support to staff who wish to quit, especially in an environment where smoking levels are so high.

Support for staff to stop smoking was offered within some prisons. Six prisons reported staff support in Quarter 4, with increasing numbers of staff involved over the study period. Approaches tended to involve making literature available, and signposting staff to their GPs, perhaps accompanied by a prescription request letter. However, in some prisons the visiting cessation specialist or the internal advisor would hold lunchtime sessions, offering personalised advice. Reponses suggest this area of activity is increasing, with some funding of NRT from prison budgets, e.g. Prison L. Delivery of staff support might come under a different remit in comparison to prisoner support, for example, Occupational Health

departments within a prison, or Health in the Workplace strands in the PCT or Stop Smoking Services.

The PCT and Prison Interface

The quality of the PCT/Prison interface is crucial. The development of smoking cessation services is a good illustration of the developing role of the PCT in relation in general health care provision and wider health promotion activities in the prison setting. The varying input in direct delivery of stop smoking advice to prisoners is outlined in Section 4.0. From a wider perspective, the PCT are commissioners both for specialist stop smoking cessation services and for staff and health care provision. The PCT is also likely to have overall responsibility for NRT budgets and ordering systems through pharmacies, together with internal dispensing mechanisms. Prison based staff have key roles in service delivery, and usually at least one member of health care staff is involved. The PCT therefore has a role in ensuring sufficient ring-fenced staff time is provided for the full range of related activities, in addition to direct prisoner contact. In turn, the PCT benefits from successful quit attempts as a contribution to meeting specific national targets, as well as the health gains for a key population group. It also has a role in facilitating monitoring and record keeping and collating returns, together with feed-back to all stakeholders.

On the other hand, within the prison organisation, a range of staff and departments will also have an impact on effectiveness of smoking cessation interventions and wider tobacco control. Support of the Governor and senior management is crucial for progress. Other staff members beyond health care are likely to be involved, either in contributing to direct service delivery as advisors, and more generally in supporting prisoner attendance and on-going quitting. Additional quit support approaches might include extra PE sessions, healthy food options and more positive Canteen ordering strategies, all of which will come under the Prison remit. In addition all staff will be affected by moves to restrict smoking areas and to have more rigorous no smoking policies, which in turn will be more effective if there has been wide involvement in planning and ownership of the changes. Linked with this, staff may also expect support to quit smoking, currently more likely to be offered in the community.

Both PCTs and prisons therefore need to relate effectively to each other, well beyond the boundaries of health care and at different organisational levels. However they are both large organisations with different departments that need to interact in different ways for different elements of the same goal. Whilst there is scope for tension, this process needs to be proactively managed to move forward.

Personal and Professional Rewards

Staff involved in this area of work felt prisoners obtained a great sense of personal achievement when they quit, as well as recognising substantial health and financial benefits. Staff themselves find the work very rewarding and can see benefits for professional development, in spite of the considerable challenges in developing and sustaining the service.

> *"But a lot of them seem to want to achieve something while they are in here and that is a big achievement to them.… Oh yeah I loved it. I'm hoping, even*

when I start my other role, I'm hoping to have a slot for my clinic to carry it on. There is an awful big demand in here for it. It would be a shame not to."

(Health Care, Prison O)

"Also I feel some sort of achievement as well. You have some lad come up to you and say, 'I've never smoked in so many months', and you think, 'Yeah, good on you'. And they're that pleased with themselves."

(Pharmacy, Prison A)

6.0 SUMMARY AND CONCLUSIONS

The study focused on the North West Region of England, which incorporated 16 prisons representing a range of prison categories and PCTs, and was undertaken over a one-year period, April 2004-March 2005. A mix of methods incorporated: quarterly quantitative returns; qualitative interviews with those involved with service delivery in prisons and in PCTs; and observation.

Summary

Substantial quit rates were achieved in the North West Region during the study period. Quit dates were set by 1,581 prisoners with 642 remaining quit four weeks after (41%). This is less than the national overall rate, but similar to levels achieved by local services in the community and in some cases better, especially in comparison with work in disadvantaged areas.

Extrapolating these findings to the prison population of England and Wales as a whole suggests that at least 4,140 prisoners would be successful in quitting in one year (at least 12,420 over the three year target period).

There was considerable variation in quit rates achieved however, with variation from 64% to 8% in different prisons.

Similarly prisons varied in the extent of reach achieved, with numbers participating over the year varying from 309 to 16.

A range of stop smoking models were adopted across prisons, which reflected differing prisoner characteristics as well as additional organisational factors. The majority of prisons used group quit support programmes (11), but of these many also offered enhanced one-to-one support in parallel (eight) with only three prisons reporting group work only. Three prisons offered enhanced one-to-one support only and in one prison, a combined support approach incorporated an initial short group meeting and two-three other meetings in the course of the NRT programme, with individual weekly contacts on the remaining weeks.

High quit rates were observed across each of these models, but not in all cases. The ‘success’ of an intervention, therefore, reflected a number of interacting factors in addition to the approach used, such as: accumulation of staff experience and personal commitment and enthusiasm; time available and organisational support for the prison staff involved; the nature of individual prisoners and the prison regime; and numbers lost to follow-up, especially through transfers and releases. It is therefore difficult to say what works ‘best’ and to some extent, a flexible ‘horses for courses’ approach is appropriate, reflecting the prison characteristics and the stage of development of the service. Quit rates tended to increase with experience among individual workers and services, highlighting the need for ongoing support.

NRT is used in nearly all quit attempts and the funding of NRT was seen as overcoming important barriers in service provision. It triggered initiatives by reducing an obvious cost barrier and contributing to PCTs re-assessing their involvement. Indeed, some respondents

commented that the service would not have developed without this funding. It also reinforced existing attempts to provide a service, enhancing sustainability.

There was considerable variation in ordering and invoicing strategies for NRT, with differing sources, supply routes and budgeting headings were identified. This had a linked effect on cost and access issues. However, developing service providers' links with pharmaceutical company representatives and prison pharmacies were resulting in greater consistency.

A range of additional issues still tend to limit service provision, and these were not necessarily ameliorated by the NRT funding. Staff shortages in Health Care in particular contributed to delays in developing a service as well as continuing sustainability. This is seen to be likely to improve with the change of health care management to the PCTs and often increased staffing levels. Additionally, there is increased emphasis on health promotion activities in prison settings.

Prisoners participating in stop smoking courses could be transferred at short notice between prisons or released and this remains a challenge. This was addressed by staff trying to keep medical records up-to-date, as these were generally transferred with prisoners, and also tried to provide a short supply of NRT to allow time for prescribing to be renewed. Some developed specific Care Pathway forms. Transfers are likely to be better accommodated as more prisons offer support, with one-to-one approaches enabling prompt continuation of a course.

The study revealed several limitations on effective monitoring and auditing within prisons, including pressures on staff time and extensive and complex paperwork. This means that it was difficult to achieve immediate understanding of progress and achievements and limited feedback to the staff delivering the service as well as to other stakeholders within the prisons and the PCTs. It was suggested that PCTs could include an additional area on their data files which could enable identification of work in this and indeed other more innovative settings. In addition staff delivering stop smoking services were often not involved in strategic tobacco control interventions within the prisons.

Finally, it should be noted that research into prison health issues presents particular challenges. For example, making contact with busy staff who are rarely desk based takes time. Security issues add time to personal visits to prisons and staff need to be provided to accompany visiting researchers around the prison and during any prisoner interviews. Access to prisoners requires further negotiation depending on prisoner category and confidentiality issues.

Conclusions

The findings showed that substantial quit rates can be achieved in prison settings with considerable prisoner interest in participation. There is therefore considerable scope for developing these services.

Extrapolating these findings to the prison population of England and Wales as a whole suggests that at least 4,140 prisoners would be successful in quitting over a one year (at least 12,420 over the three year target period).

There was considerable variation in numbers of prisoners reached across the prisons. However, considerable and increasing demand was noted and lower participation rates tend to reflect limited support opportunities rather than lack of interest.

A range of support models was observed, including group and one-to-one support separately and in combination. Relatively high quit rates were achieved using each approach, although not in all cases, and 'success' reflected additional factors in relation to individual prisons and staffing situations as well as the approach used. It would appear that to some extent, a flexible mix of approaches - 'horses for courses'- is appropriate, reflecting the prison characteristics and the stage of development of the service.

A range of staff could be involved in service delivery, but at least one member of health care staff was usually included, even where groups were led by external stop smoking specialists. Consistent experience allowed build-up of expertise and 'normalised' the cessation intervention in the clinic setting. Individual staff commitment was very important, together with sufficient numbers of trained staff to sustain the service, as was having a key 'champion' for the service.

The provision of NRT remains an important part of stop smoking support services in the prisons and the funding of NRT was seen as overcoming important barriers in service provision. However, there is scope for greater consistency and efficiency in ordering and supply mechanisms. These issues will become more important when the NRT budget is no longer ring fenced.

A range of additional issues still tends to limit service provision, and these were not necessarily ameliorated by the NRT funding. Change of healthcare administration to PCTs is seen to be increasing staffing levels, and to enable and support greater prioritisation of smoking and other health promotion activities.

There is scope for considerable improvement in monitoring and auditing approaches and support for data collection, in order to review services and facilitate feedback to staff and other stakeholders.

The findings and quit levels reported suggest that this is an increasingly rewarding setting for stop smoking services and PCTs in the context of continuing cessation and health inequality targets. Quit rates increased with on-going build-up of experience among staff and services, highlighting the need for on-going support.

Importantly, staff found this to be a rewarding area of work in spite of the considerable demands and felt that prisoners greatly appreciated their achievements.

There is increasing organisational support and pressure within prison settings to develop smoking cessation as well as other health promotion interventions and approaches, and this needs to be sustained. This includes extension of smoke-free areas and more rigorous no-smoking policies, which in turn involves support for staff wishing to quit.

Finally, effective partnership between the PCTs and individual prisons is crucial to success. Funding for health care provision now rests with the PCTs which also provide stop smoking services. However, development of cessation support mechanisms and other tobacco control

interventions in prisons depends on effective relationships across the organisational structures well beyond the boundaries of Health Care departments.

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APPENDIX 1

Prisons and Stop Smoking Services in North West Region

HM Prisons in North West Region

HMP Altcourse	Male local
HMP Buckley Hall	Closed female training-cat C
HMP Forest Bank	Cat B, male local & young offenders
HMP Garth	Closed training cat B
HMP Haverigg	Closed training cat C
HMP Hindly	RC and closed YOI
HMP Kirkham	Open training cat D
HMP Lancaster Castle	Closed training cat C
HMP Lancaster Farms	Remand /closed YOI plus juvenile
HMP Liverpool	Male local
HMP Manchester	Male local
HMP Preston	Male local
HMP Risley	Closed training cat C
HMP Thorn Cross	Open YOI and Juvenile
HMP Wymott	Closed training cat C
HMP Styall	Female

PCTs / Stop Smoking Specialist Services with Prisons in their Area and Annual NRT allocation

PCT	Prisons	NRT allocation
Ashton, Leigh & Wigan	HMP YOI Hindley	£5,000
Chorley & South Ribble	HMP Garth, HMP Wymott	£12,000
East Cheshire	HMP YOI Styall	£1,000
Fylde	HMP Kirkham	£3,000
Morecombe Bay	HMP Lancaster Castle, HMP YOI Lancaster Farms	£4,000
North Cumbria	HMP Haverigg	£5,000
North Liverpool / 'Fag Ends' (The Roy Castle Lung Cancer Foundation).	HMP Altcourse, HMP Liverpool	£16,000
North Manchester	HMP Manchester	£8,000
Preston	HMP Preston	£4,000
Rochdale	HMP Buckley Hall	£4,000
Salford & Trafford	HMP YOI Forest Bank	£5,000
Warrington	HMP Risley, HYOI Thorn Cross	£12,000

APPENDIX 2

Summary of Models and Quit Rates 2004-05

Grouped by intervention approach and then ranked by quit rate at four weeks

	Prison category	Prisoner accommodation	Delivery of stop smoking support	Quit rate @ 4 weeks	Prisoners setting quit date	Loss to follow-up
Group approach with some one-to-one support for individual prisoners						
A	Cat B	667	Internal staff	64%	149+	3%
B	Cat C	232	Mix	47%	149	7%
C	Cat C	1046	Internal staff	44%	16+	6%
D	Local	1100	External staff with internal support	39%**	145	37%**
E	RC / YOI	192	Mix	35%	159	25%
F	Cat D	628	External staff	29%	17*	59%*
G	Female Cat C	326	Internal staff	28%	87	5%
H	Local	480	Internal staff	8%	49	-
Group programme						
I	Cat C	564	Internal staff	59%	32	6%
J	YOI / Juvenile	316	Mix	52%	23+	-
K	Local	1476	External staff with internal support	31%**	101	47%**
One-to-one only						
L	Local	1269	Internal staff	45%	141	7%
M	YOI / Juvenile	527	Internal staff	38%	58	24%
N	Cat C	1073	Mix	37%	105	0
Group and One-to-one in the same programme						
O	Cat B / Local / YOI	1040	Internal	43%	309	28%
No prisoner support monitored						
P	Female	455				

* 41+ patients seen singly by GP prior to stop smoking with course, no monitoring recorded (loss to follow-up refers to the 17 starting the course) + qualitative follow-up suggests considerable under-reporting but records could not be adjusted.

** Qualitative follow-up suggests quit rates and loss to follow-up figures were initially based on quit rates and loss at the end of a 10 week course, rather than at 4 week post quit date.

APPENDIX 3

Case Studies from Different Prison Types and Delivery Models

Prison A
Category B, accommodation for 667 offenders

Overall 4 week quit rate 64% (67% if compare quitters with those available at follow-up).
Highest quarterly quit rate 78%.
Based on 149 prisoners setting a quit date:

- Mostly group work, about 12 prisoners per group (6 week group course and open access to support).
- Small numbers of one-to-one work offered, e.g. prisoners on segregation wing.
- Two key staff members (health care and pharmacy) supported by two wing officers.
- Key staff trained two years ago and continued experience.
- Low turnover of prisoners (only 3% not available to 4 week follow-up).
- Started to run groups one wing at a time which enhances mutual support (also on the therapeutic community wing).
- Weekly distribution of patches.

Prison O
Male local, accommodation for 1040 offenders

Overall 4 week quit rate 43% (59% if compare quitters with those available at follow-up).
Highest quarterly rate 52% (69% if compare quitters with those available at follow-up).
Based on 309 prisoners setting a quit date:

- Short group sessions with up to 10-12 prisoners and one-to-one follow-up – typically four group sessions over 10 week course of NRT (weeks 1,2,7&10), with one-to-one weekly contact in between.
- High throughput achieved.
- Cessation support provided by designated member of health care team with allocated time within role (Respiratory Nurse), supported by at least one other member of staff.
- History of cessation specialist support in prison and continuing on-going links.
- High prisoner turnover (28% loss to 4 week follow-up).
- Weekly distribution of patches.

<u>Prison E</u>
Closed YOI, accommodation for 455 offenders

Overall 4 week quit rate 35% (47% if compare quitters with those available at follow-up).
Highest quarterly rate 55% (100% if compare quitters with those available at follow-up).
Based on 159 prisoners setting a quit date:

- Group work, 10-12 week support, with some flexibility of attendance
- Cessation support provided by designated member of health care who works part time and does this work exclusively.
- Supported by weekly visits from cessation specialist for group sessions.
- Two staff needed because of behaviour problems.
- Well established over two plus years
- Prison staff trained in brief intervention to enhance understanding of issues and approach
- Care pathway for transfer to other prisons.
- High levels of visual aids and videos for this younger and less literate client group.
- High turnover (25% loss to 4 week follow-up).
- Weekly distribution of patches.

<u>Prison L</u>
Male local, accommodation for 1269 offenders

Overall 4 week quit rate 45% (50% if compare quitters with those available at follow-up).
Highest quarterly rate 46% (50% if compare quitters with those available at follow-up).
Based on 141 prisoners setting a quit date:

- One-to-one support, prisoners routinely seen Weeks 1, 2 and 4, with NRT continuing through prescribed programme.
- Opportunities for unscheduled contacts as requested.
- Daily distribution of patches during general treatment sessions; ‘new for old’ exchange.
- Delivered by one health care staff member, with some administrative support.
- Staff member has 3+ years experience of stop smoking support.
- Clinic sessions set aside for stop smoking work when possible (up to 3 sessions), but pattern varies each week.
- Six more staff to be trained in Autumn 2005.
- PCT reimbursement for completed monitoring forms.
- Stop smoking support for staff being initiated through occupational health.

<u>Prison B</u>
Cat C, accommodation for 232 offenders

Overall 4 week quit rate 47% (50% if compare quitters with those available at follow-up). Highest quarterly rate 61% (67% if compare quitters with those available at follow-up). Based on 149 prisoners setting a quit date:

- Group work programme and one-to-one support/small groups in parallel.
- Opportunities for unscheduled contacts as requested.
- Group work delivered by experienced external smoking cessation advisor, supported by prison officer in PE department (trained intermediate advisor) – 6 week programme and continuing NRT.
- One-to-one/small group support by a health care staff member, accommodating more flexible start needs, but with shorter and less programmed contacts.
- NRT dispensed weekly.
- Group work at regular time during week, one-to-one more flexible.
- Have overspent allocated NRT budget but support from prison and PCT prescribing budget.
- Stop smoking support for staff on a drop-in basis, with NRT prescription from GP.
- Developed 'magazine' with information with appropriate literacy levels, in conjunction with prisoners and education department.
- On-going demand from prisoners for support, with almost continuous group programme and one-to-one/small group flexible support in parallel.