STOP SMOKING SUPPORT IN HM PRISONS: THE IMPACT OF NICOTINE REPLACEMENT THERAPY

Includes Best Practice Checklist

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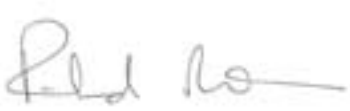
Foreword

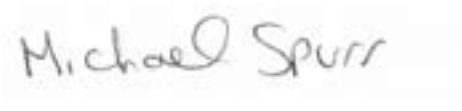
Nowadays promoting the health of prisoners is, of course, a mainstream activity for the NHS. This publication represents an important milestone in tackling smoking, which is the largest cause of premature death in the UK today. With around 80% of prisoners smoking, and prison presenting a challenging environment for health promotion, it is a great pleasure for us to note:

- many prisoners who smoke want to give up, and in this they mirror the smoking population elsewhere.
- PCTs and their Smoking Cessation Services are having considerable success in meeting prisoners' needs, and have achieved very encouraging quit rates to date.
- There is a growing body of evidence of 'what works' in this area – and this publication sets out to share that evidence more widely.

We should note that an initiative such as this is also core business for the prison service, and involvement of prison staff and managerial support are key to success. Improving the health of prisoners can form an important part of their rehabilitation and resettlement. This may seem more obvious when tackling illegal drug use, and addictions associated with them. However, to those individual prisoners who discover they can give up smoking, the evidence is that this can create a tremendous sense of personal achievement. The personal health and economic benefits to a prisoner are of course obvious, but we would like to make the case that helping prisoners who smoke to quit is one way that they begin to take more control, in a very positive way, of their lives. Against a backdrop where smoking in society is less tolerated and less socially accepted, this type of initiative can be recognised as part of the wider issues of tackling health inequalities and social exclusion.

Legislation which comes into effect in England in July 2007 to control smoking in all enclosed public places, means that in future adult prisoners will only be able to smoke in their cells or in the open, and staff will not be able smoke anywhere within prison buildings. We see this as an opportunity to improve conditions within prisons for all who work or live there. But it remains most important to encourage and help those wishing to quit smoking to do so. We commend this publication as an important step in assisting the growing numbers of prisoners who want to quit smoking, and who subsequently will have an opportunity to return to society as non-smokers.





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Introduction

Smoking is the principal cause of avoidable premature death in the UK. It is estimated that around 80% of the UK's prison population smoke (Singleton et al 1999). These are much higher levels than among the general population (around 25%) where smoking levels have been falling over the years. There is considerable evidence of a wish to quit and demand for support among inmate smokers. As in the general public, at least two thirds of smokers express a desire to quit and three quarters indicate that they would accept support to quit if it was available (e.g. Lester et al. 2003, SPS 2005).

Reducing smoking levels in general has been prominent in UK health improvement strategies. The prison setting therefore represents an opportunity to access key smoking cessation target groups that are normally hard to reach in terms of stop smoking support, for example disadvantaged populations and younger men. It follows that prisons can make a significant contribution to a PCT's achievement of its DH smoking cessation targets, in addition to the benefits for the prisons and inmates themselves.

At the time of writing this report the 2006 Health Act has been passed and will bring in new regulations concerning smoking in England and Wales. From July 2007 smoking in enclosed public places and work places in England will be banned. The impact on prisons will be communicated in a Prison Service Instruction to be published in the near future.

The Prison Service Instruction is likely to state that:

- Adult prisoners over 18 will still be able to smoke, but only within their own cells or outside of buildings.
- Non-smoking prisoners will not be made to share a cell with someone who smokes.
- Juvenile establishments (for those aged 17 and under) will be totally smoke free.
- Prison staff will not be able to smoke anywhere within prison buildings.

It follows that:

- Adult smoking prisoners who wish to give up will still require smoking cessation support.
- Juveniles, experiencing immediate withdrawal from tobacco upon entering establishments, will need support. For these young prisoners much can be learnt from the 'trailblazers' who have already gone smoke free successfully. Thereafter, the main effort with juveniles must be to encourage them to stay stopped on release.

Study Aim and Objectives

The Department of Health 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.

The aim of this study was to gather evidence and insight into the impact of this specially funded NRT, and to inform policy and implementation of best practice across the whole prison estate and all PCTs hosting prisons. The North West prisons were chosen for in-depth study because of the existence of an unusually supportive regional infrastructure to facilitate the research, as well as a good mix of types among the 16 prisons there. The regional infrastructure consisted of a Regional Tobacco Control Lead at the Government Office of the North West, who took a lead with the relevant PCT smoking cessation services, and a Regional Healthy Prisons Co-ordinator, based within the University of Central Lancashire, whose remit was to support the same prisons in the delivery of Prison Service Order (PSO) 3200 on Health Promotion, which includes smoking cessation. It must be emphasised that the report is of national significance and offers evidence to inform all prisons and their PCTs across England and Wales concerning smoking cessation.

The study objectives were to:

- Identify and assess various intervention models;
- Examine NRT usage and distribution;
- Collect and collate quarterly returns to provide quit rates among prisoners;
- Provide qualitative insight into the uptake and impact of NRT provision over the study period.

Key findings are summarised and a 'best practice checklist' is provided for all involved in the delivery of prison based smoking cessation. A full report is also available at **http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/PrisonHealth/**

Please note the 'Best Practice Checklist: Learning to Maximise Success with Quitters in Prison Settings' is attached to the end of this report.

Headline Findings

- Substantial quit rates can be achieved in prison settings with considerable prisoner interest in participation. There is therefore considerable scope for developing these services.

- The quit rates achieved are remarkably encouraging. The average quit rate achieved was 41% at four weeks (validated by carbon monoxide monitoring) across prisons in the North West Region over the one year period, with the highest rate being 64% in one prison. While the average was less than the national rate for the general public (which stood at 57%), these are similar to levels achieved by many community based services in the Region, and the increased validity given by CO monitoring adds strength to these figures. Also in some cases the quit rates were better than those normally achieved by their PCTs with the general public, especially in comparison with their work in disadvantaged areas.

- Extrapolating the 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 as a conservative estimate (at least 12,420 over the three-year target period).

- Across the prisons there was considerable variation in numbers of prisoners reached (ranging from 309 to 16 participants). However, ongoing and increasing demand was noted and where lower participation rates were apparent they tend to reflect limited support opportunities rather than lack of interest on the part of prisoners. The prison population for the North West for 2004/05 was 11,351 and throughput was in the region of twice the population. Numbers involved overall in the study (1,581 prisoners setting quit dates with 642 remaining quit after four weeks) are figures of which any PCT would be extremely proud - representing around four times the numbers of attenders, as a rate, than the general population. Of course this does not mean there is no scope for improvement and further work.

- A range of support methods were observed including group and enhanced one-to-one support offered separately and in combination. Relatively high quit rates were achieved using each method, but levels did vary reflecting additional factors in relation to individual prisons as well as the cessation approach used. These included staff commitment and experience, time allocation and organisational support, and prisoner characteristics. It would appear that to some extent, a flexible mix of approaches - 'horses for courses' - is appropriate, reflecting the prison and prisoner characteristics and the stage of development of the service.

- The funding of NRT was seen as overcoming important barriers in service provision and triggering more structured activity. The provision of NRT remains an important part of stop smoking support services in the prisons. Consideration should be given to continuance of funding that is ring-fenced within the PCTs, with guidance on future allocations to assist planning, as this would provide maximum encouragement to address this population's needs. Scope for greater consistency and efficiency in ordering and supply mechanisms for providing NRT in Prisons was a finding of the research.

- A range of additional issues still tends to limit service provision, and these were not necessarily ameliorated by the NRT funding, especially staff shortages and competing work load demands, together with prisoner movements across prisons. Thus there is a continuing need for organisational support.

- The transfer of healthcare commissioning to PCTs was seen to contribute to increasing staffing levels and to enable and support greater prioritisation of smoking cessation and other health promotion activities within each prison.

- Evidence showed that a wide range of staff could be involved in service delivery, with external stop smoking specialists delivering group support in 7 of the 15 active prisons, and internal prison staff (including health care staff, pharmacy assistants, a physical education instructor and wing officers) also offering support, independently or in parallel to external specialists. At least one member of health care staff was included, and would undertake continuing administrative and dispensing activities as well as on-going contact with prisoners, even where groups were led by external stop smoking specialists. PCT stop smoking specialist services also offered training and on-going support to prison staff.

- In some prisons the encouragement of experienced staff and a gathering momentum from continuous service input enabled a build-up of expertise, and 'normalised' the cessation intervention. 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 either within the prison or PCT or both. Ring-fenced staff time and organisational support was also key to a consistent service.

- There is scope for considerable improvement in monitoring and auditing approaches, with greater support for data collection and record keeping, in order to review service delivery and facilitate feedback to staff and other stakeholders. Identifiers for prisons (and other key settings) could be usefully included in PCT returns and databases to enable feedback on progress and review of provision.

- Staff delivering the service largely worked in isolation, with little interaction on this issue with the rest of the prison or the PCT. Staff could usefully be kept more informed about progress and achievements from interventions. They could also make a more active contribution to wider tobacco control strategic developments in the prison, although often constrained by other workload demands.

- As well as benefits to the PCTs, individual staff found this to be a rewarding area in spite of the often demanding nature of the work and felt that prisoners who had quit greatly appreciated their achievements.

- There is increasing organisational support and positive guidance within prison settings to develop smoking cessation as well as other health promotion interventions and approaches, including support for staff in quitting, and this needs to be sustained across the prison service as a whole. Legislation on smoking in the workplace and public places will also have an important impact in prisons.

The quit levels reported and overall findings suggest that this is an increasingly rewarding setting for Stop Smoking Services and PCTs in the context of continuing cessation and health inequality targets. Interventions bring benefits to the prison in relation to meeting the PSO 3200 health promotion requirements, addressing health at work issues and increasing pressure for smoke-free areas, as well as benefits to prisoner health and well-being, and staff rewards. Quit rates increased with build-up of experience among individual staff and services, highlighting the need for on-going support.

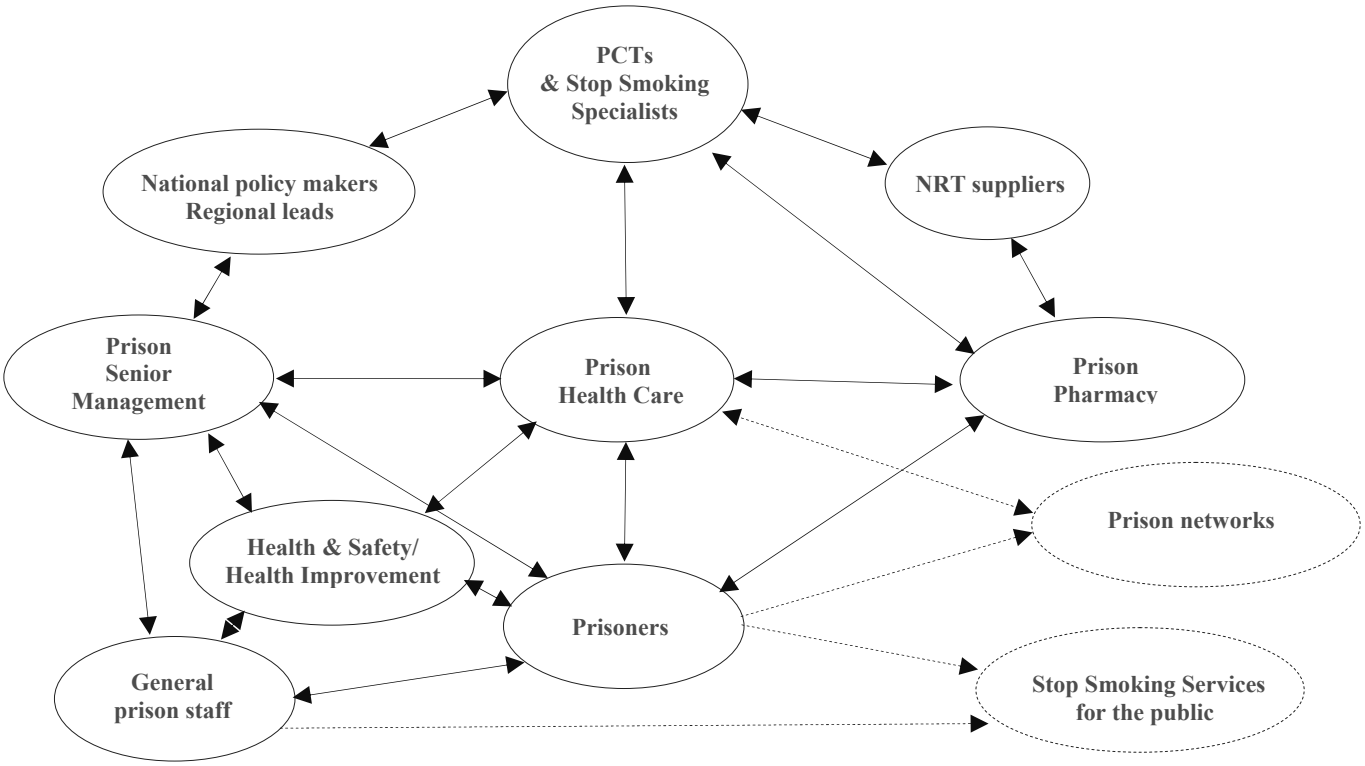
"So in terms of meeting the smoking cessation targets, the Health Inequality targets, and the targets outlined within the Cancer Plan, it's been crucial. The prisons work itself is crucial and the fact that the NRT allocation has been there has helped that work to go ahead. ... The actual success rates 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)

"But a lot of them seem to want to achieve something while they are in here and that is a big achievement to them."
(Prison Health Care)

"No more bad chest, feel fitter, more money to spend on myself. I feel good about this achievement."
(Prisoner)

Partnership between the PCTs and individual prisons has proved crucial to success. PCTs have responsibility to commission prison health care services, so have an impact on staffing levels and the priority given in terms of internal staff time to smoking cessation, as well as funding external specialist participation and NRT. The quality of prison / PCT interface is crucial, in terms of effective prisoner contact, and also in more strategic interactions in developing the service and wider tobacco control within the prison setting. Thus 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 prison Health Care departments. Key stakeholders are outlined in Figure 1.

Figure 1: Who are the Key Stakeholders?



Background and Methods

Smoking is a major cause of health inequalities as well as the principal cause of avoidable premature death in the UK. It is estimated that around 80% of the country's prison population smoke (Singleton et al 1999), much higher levels than among the general population (around 25%). The prison setting also represents an opportunity to access socially excluded audiences that are normally hard to reach in terms of stop smoking support. The partnership between Prison Health and the Tobacco Programme Team at the Department of Health (DH) established smoking cessation Pilot Projects in prisons (MacAskill and Eadie 2002) and the lessons learned were disseminated nationally through the publication 'Acquitted' (Braham 2003) and regional seminars.

The fundamental rationale of smoking cessation support is to provide a service based on current good practice and at an equivalent level to that accessible in the local community. Nicotine Replacement Therapy (NRT) doubles the chances of successful quitting and is currently accessible free of charge in the community to those on low incomes who do not pay for medication. The results of the Pilot Projects contributed to the decision to fund NRT in prisons from 2003 onwards. However, local returns to the DH do not provide a separate picture of the uptake of NRT in prisons and the impact on stop smoking activities and further research was needed. More recently, the health priority to reduce smoking levels nationally and the need for increased smoke-free environments was reinforced in the Public Health White Paper 'Choosing Health: Making Healthier Choices Easier' (DH 2004) and the 2006 Health Act.

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 based in prisons, PCTs and a pharmaceutical company; and observation. Relevant regional prison and tobacco leads were consulted, and participants in network meetings and study days contributed to the identification and discussion of key issues.

Quantitative Findings

Substantial quit rates were achieved in prisons in the North West Region during the study period. Quit dates were set by 1,581 prisoners with 642 remaining quit after four weeks (41%). This is less than the national overall rate (57%; DH 2004), but similar to levels achieved by community based services in the Region and in some cases better, especially in comparison with work in disadvantaged areas. The highest level achieved was 64% quit at four weeks in one prison. This can be set in the context of a prison population for the North West of 11,351 in for 2004/05 with throughput in the region of twice the population.

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 as a conservative estimate).

Levels of engagement and success varied across prisons, however. Quit rates ranged 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. Overall activity increased over the study period, however, both in terms of prisoner participation and in prisons involved. By Quarter Four, 15 of the 16 prisons had stop smoking interventions running, which in turn represented an increase from the seven active prisons reported in 2002 (Fullard and Howell 2002).

Service Delivery

A range of stop smoking approaches was adopted across prisons, which reflected differing prisoner characteristics and 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 or 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: personal commitment and enthusiasm among staff delivering the service; accumulation of 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 flexible 'horses for courses' approach is appropriate, reflecting the prison characteristics and the stage of development of the service. Appropriate visual aids and support literature were needed reflecting literacy levels and the prison setting, and one prison developed its own publication.

NRT is used in nearly all quit attempts and the funding of NRT was seen as overcoming important barriers in service provision. It triggered new initiatives by reducing an obvious cost barrier and contributed to PCTs re-assessing their involvement in this setting. Indeed, some respondents commented that the service would not have developed without this funding. It also reinforced existing attempts to provide a service and enhanced sustainability.

There was considerable variation in ordering and invoicing strategies for NRT, and differing sources, supply routes and budget headings were identified. This had a linked effect on cost and access issues. However, enhanced development of links between service providers, prison pharmacies and pharmaceutical company representatives resulted in greater consistency and often financial savings. Most prisons successfully dispensed NRT on a weekly basis in exchange for used patches in order to address misuse as currency.

A range of additional issues still tend to limit service provision, as identified in earlier research (MacAskill and Eadie 2002, 2003), 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. Respondents felt that there had been improvements with the transfer of health care commissioning to the PCTs, often resulting in increased staffing levels and increased emphasis on health promotion activities in prison settings. Staff training by specialist smoking cessation services is important, together with on-going support as experience develops.

Delivery of cessation support was by external smoking cessation specialists, commissioned by PCTs, and / or by internal prison staff. External stop smoking specialists delivered service support in seven of the 15 participating prisons and were more likely to be involved in group based programmes. They were also involved in initial and on-going training and support of prison staff at intermediate and brief intervention levels. In many prisons, quit support was provided by internal prison staff, alone or in parallel to specialist advisors. These were usually from Health Care and Pharmacy Departments, and hence part of services commissioned by the PCT, but also included Physical Education staff and Wing Officers. Many additional activities had to be undertaken by internal prison staff, whether or not the actual programme was delivered by an external advisor, such as; managing waiting lists, 'calling up' prisoners, organising prescriptions and other paperwork, overseeing distribution of patches, and providing on-going ad hoc support of quitters.

Build-up of individual experience and consistent delivery enhanced success as well as 'normalising' the intervention. Personal commitment among staff was important, together with sufficient trained staff, to sustain the service in the face of staff shortages, differing shift patterns and staff transfers. However, having a key 'champion' within the prison was important, to maintain the profile of smoking cessation, co-ordinate the intervention and monitoring data, and liaise with the PCT.

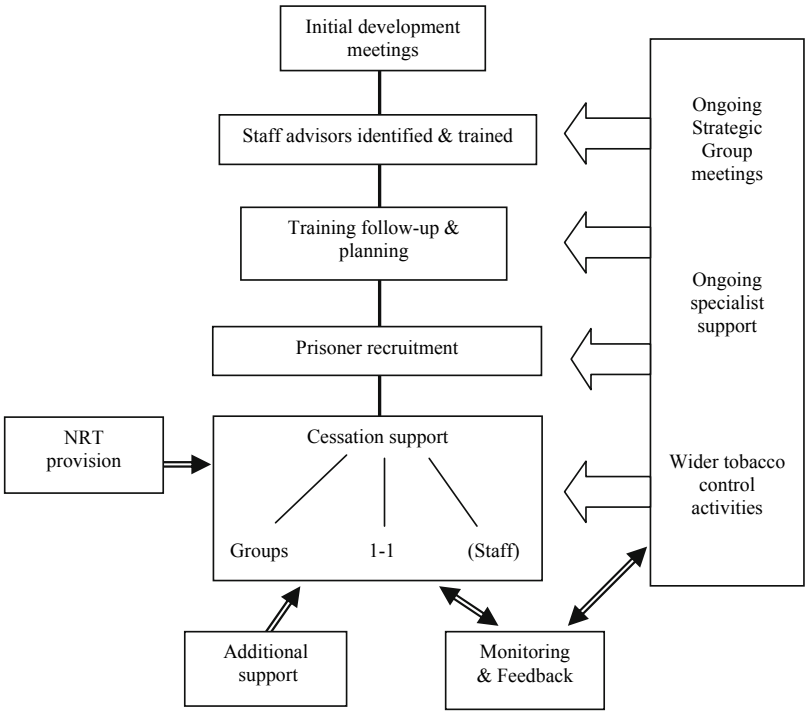
Prisoners participating in stop smoking courses were often transferred at short notice between prisons or released and this remains a challenge to continuing a course of NRT and cessation support. Staff addressed this by trying to keep medical records up-to-date, as these were generally transferred with prisoners, and also tried to provide a short supply of NRT to allow time for prescribing to be renewed in the new location. Some had developed specific Care Pathway forms. Transfers are likely to be better accommodated as more prisons offer stop smoking support, with more flexible 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, complex paperwork during a programme. This means that it was difficult to achieve immediate understanding of progress and achievements from an intervention, and there was limited feedback to the staff delivering the service as well as to other stakeholders within the prisons and the PCTs. Indeed, respondents were often surprised at the level of quit rates achieved. Reimbursement by PCTs for validated returns enhanced standards of record keeping. It was suggested that PCTs could include an additional area on their data files which could enable identification of work in the prisons and indeed other more innovative settings.

It was apparent that many of the staff delivering Stop Smoking Services were not involved in wider tobacco control activities at a strategic level within the prisons. Their input would be valuable in development of smoking plans and wider approaches to support quitting.

Responses indicated a number of stages in developing a stop smoking service (Figure 2). All stages needed to be addressed across the relevant organisational structures and stakeholders (Figure 1) and the process could take up to a year. On-going review and development is also important.

Figure 2: What are the Key Planning Stages and On-going Support Structures?



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Best Practice Checklist: Key Learning to Maximise Success with Quitters in Prison Settings

✓ **Effective partnership** development between the PCT and the prison is an underpinning essential - both in health care and the wider prison organisational structures - building relationships through on-going planning and feedback mechanisms for cessation and wider tobacco control issues.

✓ **A range of cessation delivery models**, both group and one-to-one support, should be available offering flexible support to meet individual needs. Services can be offered through a range of prison staff, i.e. not just health care staff but others such as physical education instructors or Prison Officers. Stop smoking external specialists may run group sessions and staff quit support, but involvement of internal prison staff remains vital.

✓ **Protected staff time and role development** for those delivering the service needs to be secured, not just for core interaction with quitters, but for administration and record keeping activities which may be more demanding than in community settings. This is important for both prison staff and stop smoking specialists and will also enable advance planning of programme sessions. Sufficient staff should be recruited and supported to provide a sustainable service. An enthusiastic 'champion' who promotes the service, co-ordinates activities and liaises across organisations is extremely valuable and should be supported, making cessation part of core work.

✓ **Clear record keeping** will enable promotion of the service – telling people what is happening and 'selling' the successes. This is important for providing rewarding feedback to those delivering the service and making a case for future developments.

✓ **Assessing and exploiting the expressed desire to quit** among prisoners, as well as interest from staff, will contribute to building the service. Needs assessments and keeping track of waiting lists will help.

✓ **Ring-fenced or clearly identified NRT budgets for prisoners and on-going funding commitment** continue to be needed. Efficient and economical ordering procedures and effective supply mechanisms should be developed across localities, in conjunction with prison pharmacies and pharmaceutical companies.

✓ **Straightforward NRT prescribing and dispensing** should be developed within the context of safety issues. Experience shows that weekly dispensing of NRT with return of used patches achieves a balance between empowering prisoners and minimising misuse of NRT as currency. Consistent guidance is needed, for example in use of alternative forms such as lozenges.

✓ **Staff training and on-going support** by stop smoking specialist services will contribute to high standards and increase confidence among those delivering the service. Network meetings are valuable.

✓ **Additional support approaches** should be explored and developed, such as peer support, previous quitters joining a session, and access to exercise and healthier food options. Wider involvement of prison staff will contribute to a supportive environment, for example, through Brief Intervention training. Recruitment of prisoners from one wing at a time facilitates mutual support, or at least involving a few quitters at a time from each wing to minimise isolation. Appropriate visual aids and support literature are needed.

✓ **Care Pathways** should be developed with mechanisms to cope with prisoners being transferred from one prison to another or released during a course of treatment (PSO 3050).

✓ **Wider tobacco control interventions**, which are being addressed nationally by the Prison Service, should be on the agenda in each prison, considering for example smoke-free cells for non-smokers and quitters and making all 'public areas' outside of cells smoke free. This will support cessation attempts and contribute to de-normalising smoking. Staff cessation support should be considered, within the prison or through links to community settings.

✓ **Awareness and anticipation of relevant legislation and guidance** in relation to prisoner health promotion and workplace issues will enable and support planning and preparation and increase effectiveness – be ahead of the game. This includes the 2006 Health Act and the forthcoming PSO, current PSO 3200 and the requirement for Local Delivery Plans.

Remember, ***for PCTs and Stop Smoking Services***, effective stop smoking support in prison settings can make an important contribution to achieving DH cessation targets, in particular with disadvantaged populations, as well as providing clear benefits to prisoner health. ***For prisons***, stop smoking interventions help meet PSO 3200 requirements, and address health in the workplace issues, as well as offering rewarding work for staff. A range of stakeholders from the prison and the PCT should be brought on board with on-going development and planning to enhance success.

At the time of writing this report the 2006 Health Act has been passed and will bring in new regulations concerning smoking in England and Wales. The impact on prisons will be communicated in a Prison Service Instruction to be published in the near future. Adult smoking prisoners who wish to give up will still require smoking cessation support, and juveniles, experiencing immediate withdrawal from tobacco upon entering establishments, will also need support.

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Many people contributed to developing this report and the time and thought given to the issues are much appreciated. Informants included prison staff, members of stop smoking specialist services and PCTs, regional prison and tobacco leads and participants in network meetings and study days.