16. Tobacco use in prison settings: a need for policy implementation

Michelle Baybutt, Catherine Ritter, Heino Stöver

Key points

- Tobacco is the psychoactive substance most widely used by prisoners, with prevalence rates ranging from 64% to more than 90%, depending on the country and the setting.
- Tobacco use is completely entangled in prison life where it helps to cope with boredom, deprivation or stress, relieve anxiety and tension and function as a source of pleasure or monetary value in an environment without currency.
- Few measures other than the implementation of bans have been taken so far to reduce exposure to second-hand smoke (SHS), indicating the low priority attached to this factor in health promotion in prisons.
- There is limited available evidence for best practice regarding smoking cessation in prison populations. More cessation programmes need to be implemented. Smoking by staff should be addressed systematically in tobacco control policies in prisons. Since the broader public health system should systematically include incarcerated people, national and local tobacco strategies and plans should include prisons.

Introduction

Tobacco is the psychoactive substance most widely used by prisoners, with prevalence rates ranging from 64% to more than 90%, depending on the country and the setting. The rates regarding female prisoners are either comparable or higher *(1)*. Whereas a remarkable decline in smoking prevalence rates has been observed in the general population where tobacco control policies are being implemented *(2)*, no comparable changes have occurred in prisons over the last decades. Smoking prevalence rates in prison populations remain two to four times higher than in the general population.

Prisoners face an elevated probability of being exposed to SHS due to the high prevalence of smokers and the fact that they are often forced to spend most of their time indoors where ventilation is usually poor. This creates a need for effective interventions to reduce involuntary health risks to both detainees and staff.

Main issues: prevalence and exposure to SHS in prison settings

The reported prevalence rates of exposure to SHS in the literature vary according to the setting (prison, jail, remand custody), the country and the study population. One common trend, however, shows higher prevalence inside prisons (two to four times) or proportions that tally with the proportion of non-smokers outside prison (for example, 75% of smokers inside and 25% outside) *(3)*.

In the United States, it has been reported that 82.5% of male prisoners smoke *(4,5)*. In Australia, values reach 90% or even 97% *(6,7)*. In Europe, high prevalences are reported in: Greece 91.8% *(8)* or 80% *(9)*, France 90% *(10)*, Germany 88% *(11)*, Lithuania 85.5% *(12)*, Switzerland 83% *(13)*, Poland 81% *(14)*, United Kingdom 78% in London *(15)* or 89% *(16)* and Italy 77% *(17)*.

Fewer data are available for women. In the United States, prevalence varies from 42% to 91% *(18,19)*. In Australia, 88% has been reported *(20)*. Values are similarly high in Europe, with 85.3% in Lithuania *(21)*, and 85% in the United Kingdom *(22)*. Smoking is also reported during pregnancy in 66% of women *(23)*.

Almost no data are available for younger prisoners. In the United States, 46.6% smoke daily *(24)*. In Australia, 58% smoke despite a total ban *(25)*.

The situation among staff is also largely unexplored and few data are available. In some countries, the prevalence rates among staff in detention facilities are higher than or comparable to those of the general population. In Canada they are 2.5 times higher in prison *(26)*. In Switzerland, prevalences of smoking among staff ranging from 26% to 55% have been reported *(17)*.

Related to the high prevalence of tobacco-smoking, exposure to SHS is frequent when prisoners spend a lot of their time indoors and in compounds with poor ventilation systems. SHS is known to have health-damaging effects, including an increased risk of heart disease and lung cancer (by 25% to 30%) in non-smokers *(27)*. There is no threshold below which exposure is risk-free, and measures such as separating smokers from non-smokers and improving ventilation are either inadequate or impracticable in most situations and do not provide full protection from SHS *(2,28–31)*.

The introduction of total bans, where the entire compound should be completely smoke-free, and partial bans, where smoking is allowed in cells or designated places indoors or outdoors, have shown improvements in air quality. These are still insufficient, however, as the detected thresholds of dust particles or nicotine concentrations remain above those detected outdoors or in completely smoke-free areas *(28,32,33)*. Such isolated measures can bring an improvement that remains partial. A more comprehensive approach is needed to reduce SHS further, by helping tobacco-users to change their behaviour and not just regulating the places where they are allowed to smoke or not.

WHO Framework Convention on Tobacco Control (WHO FCTC)

In 2003, the Fifty-sixth World Health Assembly developed the WHO Framework Convention on Tobacco Control (WHO FCTC) *(34)*. This declares that all persons need to be protected from exposure to environmental tobacco smoke (Articles 4 and 8), which in practice includes prisoners and prison staff, as specified in the Guidelines regarding the implementation of Article 8: "Careful consideration should be given to workplaces that are also individuals' homes or dwelling places, for example, prisons, mental health institutions or nursing homes. These places also constitute workplaces for others, who should be protected from exposure to tobacco smoke" *(31)*. A further specific document considers the application of Article 8 in prisons *(35)*.

Reasons for the high prevalence of tobacco use in prisons

Prisons concentrate people who frequently use tobacco and show an important degree of dependence. They often have a lower socioeconomic status, use multiple drugs (including alcohol) and suffer from mental health problems. They are also recognized as the groups resistant to smoking cessation strategies outside *(7,9,15,25,36–38)*.

Another main reason for the high prevalence rates of smoking in prisons is the absence of interventions addressing this issue, specifically among prisoners. Prisons have rarely been included in national tobacco strategies *(9,39)* and there is still a lack of evidence for best practice regarding smoking cessation among inmates *(7)*.

As with the great majority of all smokers, incarcerated men and women are interested in stopping their tobacco use *(40,41)*. As spontaneous cessation is rare, however, there is a need for a policy to address the characteristics of closed settings and the complex needs of the individuals living and working there.

Even if prisons are considered as places where there are opportunities to equilibrate access to health care services *(15,42)*, effective prevention messages and smoking cessation programmes have not maximized the potential reach to the incarcerated population *(5)*. In most places, quitting remains a lone and environmentally unsupported decision and process.

Smoking cessation programmes are given a lower priority than other health care issues or other substance abuse programmes. It is not uncommon to find, along with highly developed access to health care, inclusive harm reduction and OST for intravenous drug users, an absence of concern or programme addressing tobacco use and a lack of health staff specifically trained to address tobacco cessation support. Tobacco-smoking seems to be the health risk addressed the least compared to abuse of other substances, which are massively overrepresented in prisons *(43)*.

Furthermore, even when they are available, prisoners seem to make little use of treatment programmes for smoking cessation *(40,44)*.

Significance of tobacco use in prison

Smoking is an established and integral part of the culture and a social norm in prisons and other criminal justice settings *(7,38,45)*. Prisons have entrenched cultures that shape the ways in which social relations between prisoners, and between prisoners and staff, are conducted *(46,47)*. A male prisoner in a category C prison in England described the significance of tobacco as "everybody's lifeline in here" *(48)*.

Smoking habits can change in prison, either positively or negatively. For example, a lack of access to tobacco and other factors can be associated with a reduction in the amount of tobacco smoked and/or frequency of smoking *(12,22)*. Conversely, being imprisoned can lead to an increase in smoking behaviour. Factors such as boredom and coping with stress are frequently given by prisoners to explain why they feel a stronger need to smoke while in prison – 40% of Polish prisoners in a survey said that the boredom associated with being in prison encouraged smoking *(9,49)*. Smoking can be seen by prisoners as a way of helping to manage stressful situations such as prison transfers, court appearances and prison visits *(49)*. Lack of family support and missing friends and family have been identified as further reasons why prisoners may feel a need to smoke while in prison *(9)*.

Further, boredom, prolonged periods locked in cells, bullying and stress have also been given as reasons for relapse by prisoners who tried to stop while in prison *(49)*. Cigarettes and tobacco are frequently used by prisoners as currency *(38,50)* and there are reports that this may apply to medicinal nicotine as well *(15,50,51)*. In some instances, it has been reported that prisoners have gone on to stop smoking programmes in order to obtain nicotine replacement therapy to sell to other prisoners while they themselves continue to smoke *(15)*. Nicotine patch exchange schemes have been introduced into some prisons in response to this problem *(51)*. Some prisons insist on the use of transparent patches to prevent the concealment of illicit substances.

Offenders often show other challenging issues in addition to smoking, including addiction to other substances. Social and interpersonal difficulties can also affect their motivation and ability to stop smoking *(22,52,53)*.

Learning difficulties and high rates of low educational attainment among prisoners *(54)* can have an impact on their ability to access services through the application process, in addition to coping with complex health information materials *(55)* which frequently do not translate easily to the prison setting.

The transient lives of prisoners can provide additional challenges in terms of engaging them and keeping them in contact with smoking cessation services as well as the continuation of support and counselling *(51,56)*. The post-release period is particularly challenging and a stressful time of readjustment. Smoking cessation services should, therefore, plan for the likelihood of transfers *(49)* by ensuring that medical records are transferred with prisoners together with a short supply of pharmacotherapy to last until prescribing can be renewed at the new location *(51)*. Linking community smoking cessation services with prison programmes could offer post-release support and thus reduce rates of relapse *(44,52)*.

On the other hand, qualitative research conducted in United Kingdom prisons has revealed that many prisoners want to achieve something while in prison and view stopping smoking as a big achievement *(51)*. Prisoners have described being in prison as an opportunity to access stop smoking services and nicotine replacement therapy *(57)*.

Resistance and negative attitudes to smoking cessation in prisons can be based on the belief that stopping smoking, especially if this is enforced through smoking restrictions, would place an intolerable burden of stress on prisoners at an already stressful time *(58)*. Mitigating stress and boredom among prisoners should be considered as part of stop smoking initiatives. Since physical exercise has been described by prisoners as a substitute for smoking, these could include improved access to gym facilities or sporting activities, for example, as part of a joint response across the prison setting *(49)*.

While not primarily concerned with the health of the prison population, prisons have a duty of care for those they hold in detention. In relation to smoking, this should include the promotion and support of cessation for those smokers wishing to stop, protecting non-smokers from starting to smoke and protecting prisoners, staff and visitors from exposure to passive smoke. Tackling smoking is difficult in an environment where it is an established and integral part of the culture and social norms, widely used in social rituals to relieve boredom and stress, and in which tobacco is often used as currency *(7,38,45)*.

Addressing smoking among the offender population should not be limited to prisons, as smokers awaiting trial or on probation after serving a sentence may also need help and support. It is well recognized that addressing inequality issues through an engagement with stop smoking initiatives with offenders will have improved health outcomes for their families and the wider communities in which they live. A current study in the north-west of England addresses these issues by looking at the organizational and systems perspectives across a series of criminal justice settings in relation to tobacco control and stop smoking support and treatment (Box 3).

Tobacco use by prison staff

Tobacco is particular in the sense that it is the only psychoactive substance visibly used by prison staff. The regulations regarding their use of tobacco while at work vary greatly between countries, ranging from total prohibition to smoking being allowed in designated areas, even indoors (Germany, for example) *(37)*. The United Kingdom is an example of how support for smoking cessation is sometimes available and included as a health promotion target for staff *(59)*. It is particularly important to gain a better acceptance of regulations. Staff have been shown to be resistant to changes in smoking policy *(60)*, with non-smokers being more supportive of a ban *(61)*. As part of a whole-prison approach, staff should systematically be included in tobacco control policies in prisons and supported in their attempts to stop *(62)*.

Addressing the smoking issue in prisons

Prison administrators should address the tobacco issue in cooperation with prison health staff and tobacco cessation specialists from the regional network, to ensure the inclusion of the various components of an efficient policy and, in particular the regional regulations prevailing outside prison, cessation support, training of medical and prison staff, and education of prisoners about tobacco and the consequences of its use *(63,64)*. Confusion over ownership of the smoking problem between the health department and custodial authorities has to be avoided. The importance of a whole-prison approach managed through a multidisciplinary team is also underlined *(65)*.

A study completed in 2011 in prisons in Germany included the design of a tobacco control policy in prisons *(66)*. It is intentionally addressed to prison administrators, to guide their reflections on and implementation of comprehensive tobacco control policies in their institutions.

Box 3. Case study: local action for tobacco control: criminal justice setting, United Kingdom (England and Wales)

Background

In England and Wales, over 80% of men and women in prison are smokers, compared to general population levels of around 21% *(20,22,36,37)*. Similar levels are apparent in police custody and probation, although there is less information available. A strong case for addressing tobacco control issues in prisons and the wider criminal justice setting is increasingly being recognized *(67,68)*, with positive effects on public health as individuals move in, through and out of criminal justice settings.

Prisoners' health has been a responsibility of the National Health Service since 1995. The aim is to give prisoners access to the same range and quality of health care services as the public receives in the community *(69,70)*. Support to stop smoking is commissioned by primary care trusts and provided in a variety of ways, typically by specialists going into prisons or by prison health care staff being trained and supported by community stop smoking services. Cessation work with other categories of offender, such as those in custody or on probation, is minimal. Common areas in prisons are smoke-free but prisoners may smoke in their cells in adult prisons, with issues recognized in relation to shared cells and staff exposure on entering cells.

Achievements

With the innovative appointment of a tobacco control coordinator for the North West Region, the project (2010–2011) has focused on organizational systems in prisons, probation and police custody and the relevant health commissioners and providers in relation to tobacco control and stop smoking services and treatment. This project is part of the Health Inequalities Programme funded by the Department of Health and led by the United Kingdom Centre for Tobacco Control Studies (a United Kingdom public health research centre of excellence and a strategic partnership of nine universities involved in tobacco research in the United Kingdom) *(71)*.

A wide range of activities have encompassed: (i) a rapid review of literature *(72)*; (ii) initial mapping of cessation activity across 16 prisons in the north-west of England, which highlighted a wide variety of models for the provision of stop smoking services – all establishments have smoking policies in place as required in Prison Service Order 3200, Health Promotion *(73)*; and (iii) five in-depth case studies, which provide a focus on the key issues of tobacco in varied criminal justice settings.

Key project outputs have included the development of a Stop Smoking Training Framework for Prisons, a service delivery framework for stop smoking services in prison, a nicotine replacement therapy protocol for prisons to provide consistency and a data collection reminder paper.

The tobacco control coordinator was an active participant in various regional meetings and tobacco control local alliances. This made it easier to raise awareness of tobacco control issues in criminal justice settings for health care commissioners and providers and to help establish tobacco control issues on the broader criminal justice agenda.

Conclusion

This project is evidently unique and, with its emphasis on the role of a project coordinator, many strengths have been identified which are clarified in its evaluation, including acting as a conduit for information-sharing and knowledge transfer, supporting the development of services and networking. The coordinator has provided a proactive and consistent voice in a range of health and criminal justice settings. It is vital that these strengths are disseminated directly to a variety of audiences including the criminal justice system, agencies providing smoking cessation support and relevant geographical alliances, whether or not additional funding for a separate role can be identified. More information on the project can be found on the web site *(72)*.

Source: Baybutt M, MacAskill S, Woods S. Report of North West Case Studies of Best Practice and Innovation, 2011. Prepared as part of the Tobacco Control in Prisons and Criminal Justice Settings: Regional Coordination Pilot Project (unpublished document).

Outline of a tobacco control policy in German prisons

***Introduction*[13]**

In 2011, a study was undertaken in German prisons, supported by the Federal Ministry of Health, with the aim of proposing a sustainable tobacco control policy in German prisons.

The objectives of the policy are to improve the living and working conditions of prisoners and staff by creating a better health-promoting environment, in particular to reduce their exposure to SHS, to support smoking reduction and cessation attempts, and to optimize cooperation between health services and prison administrators.

Some of the elements presented here might not be adaptable to the exact situations prevailing in other countries, where different degrees of protection against exposure to SHS might already have been implemented.

The policy is aimed at prisoners and staff. It consists of six modules: (i) general principles of the policy; (ii) regulations; (iii) health education and training; (iv) individual support to reduce or stop smoking; (v) networking with tobacco prevention experts; and (vi) a checklist.

General principles of the policy

The concept is based on the following principles.

According to the regional laws protecting against SHS (Germany counts 16 regions and laws) smoking is only allowed in designated areas. The cell is considered a private area. Smoking is prohibited when numerous people, including non-smokers, are together in the same area *(74)*.

Isolated measures are insufficient. Examples are: the availability of therapeutic services with no account taken of the environment; or the implementation of smoke-free regulations alone, when they should be supplemented by therapeutic and counselling services, efficient networking and staff training.

Regulations for protection against SHS or for smoke-free areas should be as comparable as possible with those prevailing outside prisons (in the corresponding area). This allows for greater acceptance by everyone involved and prepares prisoners for their return to life outside prison, since they are familiar with the same rules. In this respect, efforts to accept measures for protection against SHS are part of social reintegration.

A health promotion officer should be designated in the prison and trained to implement the tobacco control policy and develop advice, reduction and cessation programmes for both prisoners and staff.

Tobacco use and protection against exposure to SHS should be tackled as part of health promotion in the workplace. It is a crossover issue and requires concerted work with clearly defined responsibilities for the health services, prison staff representatives, prison administration and representatives of prisoners.

Tobacco is often used together with other substances. Tobacco control should, therefore, be included in the implementation of comprehensive addiction strategies at institutional, regional and national levels.

Campaigns that are organized outside prison can also be implemented inside prison, in particular activities during the World No Tobacco Day on 31 May *(75)* or, for example, during a one-week campaign before or after that date, when prisons can focus on tobacco issues.

Smoke-free regulations

Prison regulations should be checked for their inclusion of rules governing exposure to SHS. Non-smokers should not share cells with smokers. Smoke-free floors should be established, with specific smoke-free cells available for prisoners on the first day of their arrival in the prison. The smoke-free regulations covering the working areas should be implemented and endorsed uniformly, especially regarding breaks. Working areas and toilets should be smoke-free, in line with the law prevailing outside prison.

Health education and training

Information should be available about the consequences of tobacco use and reducing or stopping it. Each region should provide education and training for staff. Unfortunately, the tobacco use issue is still rarely systematically included in training programmes, meaning that interested prison and health staff have to find out by themselves where such training is available.

Individual support to reduce or stop smoking

Support in reducing or stopping smoking should be available to individual prisoners and staff members, as follows.

Prisoners should actively and regularly (at all stages of detention) be approached about their smoking behaviour.

Support should be available for prisoners seeking to reduce or stop their use of tobacco. Such support should be

[13] This policy was prepared by Catherine Ritter and Heino Stöver in 2012 as part of a research project on tobacco prevention in prisons.

developed according to the uses and resources available in each setting (for example, access to medication either free of charge or with shared costs).

Staff should be told about the smoke-free regulations applying to them when they start work in the detention setting. These regulations should be one of the main principles in each setting.

As a general rule, staff should not smoke with prisoners, especially not in their cells. This is to avoid giving a false impression of solidarity, to respect prisoner' private space and to avoid hiding when smoking has been banned indoors.

Conversations between prisoners and staff should take place in rooms other than cells occupied by smokers *(74)*.

Cells should be intensively aired before they are searched and prisoners should be asked to refrain from smoking when staff are present.

The motivation for staff to reduce or stop using tobacco should be regularly tested. Smoke-free workplaces promote smoke-free homes, which further protect families and strengthen smoking cessation attempts in general.

To avoid the promotion of smoking while at work, there should be no indoor smoking areas and tobacco use should be limited to designated places outdoor and during breaks (even where it is legally permitted to smoke indoors, as in Germany *(76,77)*).

A qualified professional should be available to provide support for individuals trying to reduce or stop their smoking.

Rewards (or contingency management) could be introduced as part of the support for people trying to stop smoking, such as a half-day off for non-smokers.

Networking with tobacco prevention experts

Cooperation with competent and qualified experts in tobacco use, reduction and cessation should be sought and developed at local or national level. This is important and useful for the provision of training materials (in particular for vulnerable groups, such as young people) and in certain facilities such as prison hospitals.

Checklist

A checklist is useful in reviewing the situation regarding exposure to SHS and efforts to reduce it. It clarifies which points in this policy have been achieved and which need closer attention (Fig. 6).

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Fig. 6. Suggested checklist for reviewing exposure to SHS

If you answer one or more questions with "No", you are recommended to look up those particular aspects with the help of specialized literature or local experts in tobacco-related issues.

Prisoners

Smoke-free regulation

Is protection for prisoners against exposure to SHS discussed with the medical unit?	☐ Yes	☐ No
Is protection for prisoners against exposure to SHS discussed with their representatives?	☐ Yes	☐ No
Has a person been nominated to be in charge of protection against exposure to SHS or of health promotion among the prisoners?	☐ Yes	☐ No
Are experts in protection against exposure to SHS involved, for example in a local network?	☐ Yes	☐ No
Are there smoke-free regulations?	☐ Yes	☐ No
Are the regulations endorsed?	☐ Yes	☐ No
Do non-smoking prisoners have systematic and straightforward access to smoke-free cells?	☐ Yes	☐ No
Are the work areas smoke-free?	☐ Yes	☐ No
Are the toilets smoke-free?	☐ Yes	☐ No
Are the indoor break rooms smoke-free?	☐ Yes	☐ No

Health education

Are the sources of information on tobacco use (consequences, cessation) known?	☐ Yes	☐ No
Is information on tobacco use (consequences, cessation) regularly and proactively distributed?	☐ Yes	☐ No
Are prisoners involved in the transmission of information to other prisoners?	☐ Yes	☐ No

Training

Are the staff (health, social or prison) trained in health education regarding tobacco use?	☐ Yes	☐ No
Are the health staff trained to support prisoners trying to reduce or stop their tobacco use?	☐ Yes	☐ No
Is the nominated person in charge of prisoners' protection against exposure to SHS trained in this issue?	☐ Yes	☐ No

Individual support to reduce or quit smoking

Is it easy for prisoners to get access to help in reducing or stopping tobacco smoking?	☐ Yes	☐ No
Are prisoners regularly approached to reduce or stop their tobacco smoking?	☐ Yes	☐ No

Staff

Smoke-free regulations

Is protection for staff against exposure to SHS discussed with the medical unit?	☐ Yes	☐ No
Is protection for staff against exposure to SHS discussed with their union or representatives?	☐ Yes	☐ No
Has a person been nominated to be in charge of protection against exposure to SHS or of health promotion among the staff?	☐ Yes	☐ No
Are experts in protection against exposure to SHS involved, for example in a local network?	☐ Yes	☐ No
Are there smoke-free regulations?	☐ Yes	☐ No
Are the regulations endorsed?	☐ Yes	☐ No
Are staff protected against exposure to SHS outside the cells?	☐ Yes	☐ No
Is the purchase of tobacco impossible at work?	☐ Yes	☐ No
Are staff restricted to smoking in their breaks in designated areas outdoors?	☐ Yes	☐ No
Are staff restricted to smoking in their breaks?	☐ Yes	☐ No

Health education

Are the sources of information on tobacco use (consequences, cessation) known?	☐ Yes	☐ No
Is information on tobacco use (consequences, cessation) regularly and proactively distributed?	☐ Yes	☐ No

Training

Is the tobacco issue addressed in staff training?	☐ Yes	☐ No
Is the nominated person in charge of staff protection against exposure to SHS trained in this issue?	☐ Yes	☐ No

Individual support to reduce or quit smoking

Is it easy for staff to get access to help in reducing or stopping tobacco smoking?	☐ Yes	☐ No
Are staff regularly approached to reduce or stop their tobacco smoking?	☐ Yes	☐ No

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Further reading

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Vulnerable groups