Tobacco use in prison settings: A need for policy implementation

Michelle Baybutt, Catherine Ritter, Heino Stöver

Key points

- Tobacco use is the most widely used psycho-active substances by prisoners, with prevalence rates ranging from 64 to over 90 percent, depending on the country and the setting.
- Tobacco use is completely entangled in prison life where it occupies various functions, for instance as ways of coping with boredom, deprivation, stress, as self-help for relieving anxiety and tension; 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) - pointing to the low priority attached to this factor in health promotion within prisons.
- Prisons have implemented either partial or total bans, but those regulations cannot be considered as proper tobacco control policies. They are only part of a more comprehensive approach that should include tobacco cessation support, training health staff, and alternative ways to reduce inactivity and/or cope with stress, and education.
- There is lack of evidence for best practice regarding smoking cessation within the prison population. More cessation programs need to be implemented to gain abetter understanding of what is comparable to the general population in the wider community community and to equilibrate health services in prisons according to the epidemiology of substance use and the offer addressing other substances' use.
- Interventions targeting tobacco issues need to take into account the complexity of interrelated dynamics influencing its use among incarcerated people, in order to avoid perpetuation and aggravation of these specific health inequality factors.
- Staff's smoking should systematically be addressed in tobacco control policies in prisons. This concern is part of a wider health promoting workplace approach.
- Based on the fact that broader public health should systematically include incarcerated people, national and state tobacco strategies/plans should include prisons.

Introduction

Tobacco is the most widely used psycho-active substance by prisoners, with prevalence rates ranging from 64 to over 90 percent, depending on the country and the setting. The rates regarding female prisoners are either comparable or higher (Ritter, Stöver, Levy, Etter, & Elger, 2011). Whereas a remarkable decline in smoking prevalence rates have been observed in the general population where tobacco control policies are being implemented (WHO, 2007a), no comparable changes occurred within prisons over the last decades. Smoking prevalence rates in the prison population remain between two to four times higher than in the general population.

Within prison grounds, due to the high prevalence of smokers, the fact that prisoners are often forced to spend most of their time indoors and ventilation

usually is poor, the probability of being exposed to second-hand smoke (SHS) is high. This creates a need for effective interventions to reduce involuntary health risks to both detainees and staff.

Main Issues: Prevalence and SHS exposure in prison settings

Reported prevalence rates in the literature vary according to the setting (prison, jail, remand custody), the country and the study population. One common trend shows however higher prevalence inside prisons (two-four times) or proportions that tallies with the proportion of non-smokers outside prison (e.g. 75% of smokers inside, 25% outside) (Patrick & Marsh, 2001). 82.5% of smokers among male prisoners have been reported in the US ((Lincoln, et al., 2009) (Kauffman, Ferketich, Murray, Bellair, & Wewers, 2010). In Australia, values reach 90% or even 97% ((N. Awofeso, R. Testaz, S. Wyper and S. Morris 2000; Butler, Richmond, Belcher, Wilhelm, & Wodak, 2007). In Europe also, high prevalence are reported in France 90% (Sannier, et al., 2009), Poland 81% (Sieminska, Jassem, & Konopa, 2006), Lithuania 85.5% (Narkauskaitè, Juozulynas, Mackiewicz, Surkiene, & Prapiestis, 2007), Greece 91.8% (Lekka, Lee, Argyriou, Beratis, & Parks, 2007) or 80% (Papadodima, et al., 2010), Italy 77% (Rezza, et al., 2005), UK 78% in London (Heidari, 2007) or 89% (MacAskill, 2008), and Germany 88% (Tielking, Becker, & Stöver, 2003).

For women, less data is available. In the US, prevalence varies from 42% to 91% (Eldridge & Cropsey, 2009) (Durrah, 2005). In Australia, 88% (Holmwood, Marriott, & Humeniuk, 2008) have been reported. Values are similarly high in Europe, with 85.3% in Lithuania (Narkauskaite, Juozulynas, Mackiewicz, Venalis, & Utkuviene, 2010), and 85% in UK (Plugge, Foster, Yudkin, & Douglas, 2009). Smoking is also reported during pregnancy in 66% of women (Knight & Plugge, 2005).

Almost no data is available for younger prisoners. In the US 46.6% are daily smokers (Cropsey, Linker, & Waite, 2008). In Australia 58% smoke under a total ban (Belcher, Butler, Richmond, Wodak, & Wilhelm, 2006).

The situation among staff is also largely unexplored and few data are available. In some countries the prevalence rates of staff in detention facilities are higher than (in Canada it is 2.5 times higher in prison (Guyon, et al., 2010)) or comparable to those of the general population.

Related to the high tobacco smoking prevalence, where prisoners spend a lot of their time indoors and in compounds with poor ventilation systems, SHS exposure is frequent. SHS is known to having various health-damaging effects, and among them an increase risk of heart disease and lung cancer (by 25% to 30%) in non smokers' (US Department of Health, 2006). There is no threshold below which exposure is risk-free, and measures such as separating smokers from non-smokers and ventilation are either insufficient or impractical in most situations (Proescholdbell, Foley, Johnson, & Malek, 2008; US Department of Health, 2010; WHO, 2007a, 2007b, 2009).

Introduction of total (the compound should be completely smoke-free) and

partial ban (smoking remains allowed in cells or designated places indoors or outdoors) have shown significant improvements in air quality, but which are still insufficient, as the detected thresholds of dust particles or nicotine concentration remain above the ones detected outdoors or in completely smoke-free areas (Hammond & Emmons, 2005; Proescholdbell, et al., 2008; Ritter, Huynh, Etter, & Elger, 2011). Such isolated measures can bring an improvement that remains partial. A more comprehensive approach is needed to further reduce SHS, by sustaining tobacco users to change their behaviour, not only regulating the places were there are allowed to smoke or not.

WHO Framework Convention on Tobacco Control (WHO FCTC)

The WHO developed the Framework Convention on Tobacco Control (WHO FCTC). It declares that all persons need to be protected from exposure to environmental tobacco smoke (Art 4 & 8) (WHO, 2003), which in practice includes prisoners and prison staff, as specified in the Guidelines regarding the FCTC implementation of Article 8: "*Careful consideration should be given to workplaces that are also individuals home 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*" (WHO, 2009). A further specific document considers the application of Article 8 in prisons (Global Smokefree Partnership, 2009).

Reasons for high prevalence of tobacco use in prisons

Prisons concentrate people who frequently use tobacco and show an important degree of dependence. They originate from lower socio-economical classes, use multiple drugs (inclusive alcohol) and suffer from mental health problems. They are the also recognised as the groups "resistant" to smoking cessation strategies outside (MacAskill, 2008; Richmond, et al., 2009) (Butler, et al., 2007) (Belcher, et al., 2006) (Sieminska, et al., 2006) (Cropsey, Jones-Whaley, Jackson, & Hale, 2010; Hartwig, Stöver, & Weilandt, 2008).

Another main reason for the high prevalence rates is the absence of interventions addressing this issue specifically among prisoners. As a matter of fact, prisons have rarely been areas for state tobacco strategies (N. Awofeso, 2002; Sieminska, et al., 2006) and there still is lack of evidence for best practice regarding smoking cessation within inmates (Butler, et al., 2007).

Surprisingly and for various reasons (health, economic), incarcerated men and women are interested in quitting tobacco use (Kauffman, Ferketich, Murray, Bellair, & Wewers, 2011) (K. Cropsey, et al., 2008). However, as spontaneous stop is rare, a policy addressing the characteristics of closed settings and the complex needs of individuals' living and working there have to be developed.

Even if prisons are considered as places with an opportunity to equilibrate access to health care services (MacAskill, 2008; Thibodeau, Jorenby, Seal, Kim, & Sosman, 2010), effective prevention messages and smoking cessation programs have not maximised the potential reach to the incarcerated population (Kauffman, et al., 2010). In most places, quitting remains a lone and environmentally unsupported decision and process.

Smoking cessation programmes are given less priority than other healthcare issues, or other substance abuse. It is not uncommon to find, alongside with highly developed access of healthcare, inclusive harm reduction and opioid substitution treatment for intravenous drug users, an absence of concern or program addressing tobacco use, and of capacitated health staff in tobacco cessation support. Tobacco smoking seems to be the less health risk compared to other substance use, which are massively overrepresented in prisons (Fazel et al. 2006).
Furthermore, even when available, prisoners seem to make little use of treatment programmes for smoking cessation. When they attempt to quit, most of the time they use the “cold turkey” method (Kauffman, et al., 2011) (Hofstetter, Rohner, & Müller-Isbener, 2010).

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 (Butler et al 2007; Richmond et al, 2009; Long & Jones 2005). Prisons have entrenched cultures which shape the ways in which social relations between prisoners, and between prisoners and staff, are conducted (Sykes, 1958; Liebling, 1999). A male prisoner in a category C prison in England described the significance of tobacco as ‘everybody’s lifeline in here’ (de Viggiani, 2008).

There is the potential for smoking habits to 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 amount of tobacco smoked and/or frequency of smoking (Plugge et al, 2009; Papadodima et al, 2009). Conversley,, being imprisoned can lead to an increase in smoking behaviour.Factors such as boredom and coping with stress are reasons frequently given by prisoners to explain why they feel a stronger need to smoke while in prison - forty per cent of Polish prisoners in a survey said that the boredom associated with being in prison encouraged smoking (Richmond et al, 2006; Sieminska et al, 2006). Smoking can be seen by prisoners as a way of helping to manage stressful situations such as prison transfers, court appearances and prison visits (Richmond et al, 2009). 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 (Sieminska et al, 2006).

Further, boredom, prolonged periods locked in cells, bullying and stress have also been given as reasons for relapse by prisoners who made quit attempts while in prison (Richmond et al, 2006). Cigarettes and tobacco are frequently used by prisoners as currency (Richmond et al, 2009; Lawrence and Welfare, 2008) and there are reports that this may apply to medicinal nicotine (Lawrence and Welfare, 2008); MacAskill and Hayton, 2007; MacAskill, 2008). In some instances, it has been reported that prisoners have accessed stop smoking programmes in order to obtain nicotine replacement therapy to sell to other prisoners whilst they themselves continue to smoke (MacAskill, 2008). Nicotine patch exchange schemes have been introduced into some prisons in response to this problem (MacAskill & Hayton, 2007) whilst 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, and social and interpersonal difficulties that can affect motivation and ability to quit smoking (Brooker et al, 2008; Plugge et al, 2009; Knox et al, 2006).

Learning difficulties and high levels of low educational attainment among prisoners (Prison Reform Trust, 2011) can have an impact on an individuals ability to access to services through the application process in addition to coping with complex health information materials (Clark and Dugdale, 2008) which frequently does not translate easily to the prison setting.

The transient nature of prisoners can provide additional challenges in terms of engaging and sustaining contact with stop smoking servicesas well as the continuation of support and counselling (Cancer Institute NSW, 2008; MacAskill & Hayton, 2007). The post-release period is particularly challenging and a stressful time of readjustment. Therefore stop smoking services should plan for the likelihood of transfers (Richmond et al, 2006) by ensuring that medical records are transferred with prisoners along with a short supply of pharmacotherapy until prescribing can be renewed at the new location (MacAskill & Hayton, 2007).Linking community stop smoking services into prison programmes could offer post release support and thus reduce rates of relapse (Knox et al, 2006; Richmond et al, 2009).

Alternatively, qualitative research conducted in UK prisons has revealed that many prisoners want to achieve something while in prison and view quitting smoking as a big achievement (MacAskill & Hayton, 2006). Prisoners have described being in prison as an opportunity to access stop smoking services and nicotine replacement therapy (Condon et al, 2008).

Resistance and negative attitudes to smoking cessation in prisons can be based on the belief that quitting smoking, especially if this is enforced through smoking restrictions, would place an intolerable burden of stress on prisoners at an already stressful time (Douglas & Plugge, 2006). Mitigating stress and boredom among prisoners should be considered as part of stop smoking initiatives By improving access to gym facilities or sporting activities for example (as part of a joined up response across the prison setting), as physical exercise has been described by prisoners as a substitute for smoking (Richmond et al, 2006).

Whilst not primarily concerned with the health of the prison population, prisons have a duty of care for those it holds in its detention. In relation to smoking this will include the promotion and support of cessation for those smokers wishing to quit; protecting non-smokers from uptake of smoking; and, protecting prisoners, staff and visitors from passive smoke exposure. It is recognised that tackling smoking is difficult in an environment where smoking is an established and integral part of the culture and social norm, widely used in social rituals to relieve boredom and stress, and in which tobacco is often

used as currency (Butler et al, 2007; Richmond et al, 2009; Long and Jones, 2005).

Addressing smoking among the offender population should not be limited to prisons as smokers awaiting trial or those on probation after serving a sentence may also need help and support. It is well recognised that addressing inequality issues through engagement with stop smoking initiatives with those who offend 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 through looking towards the organisational and systems perspectives across a suite of criminal justice settings in relation to tobacco control and stop smoking support and treatment.

Case Study:

Local Action for Tobacco Control: Criminal Justice Setting England &Wales[1]

Background

Country context: In England and Wales over 80% men and women in prison are smokers, compared to general population levels of around 21% (Hartwig *et al* 2008; Plugge *et al*, 2009; Holmwood *et al* 2008; Cropsey *et al* 2010). Similar levels are apparent across the prisoner journey in police custody and probation, although there is less information available. A strong case for addressing tobacco control issues in prisons and wider criminal justice setting is increasingly recognised (DH 2011, 2009), with positive effects on public health as individuals move in, through and out of criminal justice settings.

Overview: Prisoner health has been an NHS responsibility since 1995, aiming to give prisoners access to the same range and quality of health care services as the public receives in the community (DH, 1999). Stop smoking support is commissioned by Primary Care Trusts and provided through varied routes typically, by specialists going into the prison or by prison health care staff trained and supported by community stop smoking services. Cessation work with other offender categories such as custody and probation is minimal. Common areas in prisons are smoke free but prisoners may smoke in their cells in adult prisons, with issues recognised in relation to shared cells and staff exposure on entering cells.

Achievement
The innovative appointment of a Tobacco Control coordinator for the North West Region, the project (2010-2011) has focussed on the organisational

[1] **Michelle Baybutt, Stephen Woods, Susan MacAskill, Douglas Eadie, Jennifer McKell: North West Demonstration Project in England & Wales – Tobacco Control in Prisons and Criminal Justice Settings**

systems across 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 a portfolio in the Health Inequalities Programme funded by the Department of Health and led by the UK Centre for Tobacco Control Studies (UKCTCS www.ukctcs.org): a UK Public Health Research Centre of Excellence and a strategic partnership of nine universities involved in tobacco research in the UK.

A wide range of activity has encompassed:
Rapid Review of Literature
(http://www.uclan.ac.uk/schools/school_of_health/research_projects/hsu/files/cjs_litreview.pdf);
Initial mapping of cessation activity across 16 North West prisons 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);
Five **in depth case studies** 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 NRT Protocol for Prisons to provide consistency
- Data Collection Reminder paper

The Tobacco Control Coordinator was an active member of a variety of regional meetings and tobacco control local alliances, which has facilitated raising awareness of tobacco control issues in criminal justice settings for health care commissioners and providers and helping to establish tobacco control issues on the broader criminal justice agenda.

Conclusion[2]
This project is evidently unique and with an emphasis on the role of a project coordinator there have been many strengths identified which are clarified in its evaluation: acting as a conduit for information sharing and knowledge transfer, supporting service developments and networking. The coordinator role has provided a proactive and consistent 'voice' in a range of health and criminal justice settings. It is vital these strengths are disseminated directly to a variety of audiences incorporating 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.

Tobacco use by prison staff

[2] More information on the project can be found on the Website http://www.uclan.ac.uk/schools/school_of_health/research_projects/hsu/tobacco_in_prisons.php)

Tobacco is particular in the sense that it is the only psycho-active substance visibly used by prison staff. The regulations regarding their use while at work vary greatly among the countries, ranging from total prohibition to smoking being allowed in designated areas, even indoors (Germany for example (Hartwig, et al., 2008). Support to smoking cessation is sometimes available and included as a health promotion target for staff, in UK for example (Department of Health South West Regional, 2007). It is particularly important to gain better acceptance of regulations. Staff have been shown to be resistant to change smoking policy (Carpenter, Hughes, Solomon, & Powell, 2001), with non-smokers being more supportive of a ban (Foley, Proescholdbell, Malek, & Johnson, 2010). As part of a whole prison approach staff should systematically be included in tobacco control policies in prisons and supported to quit (Butler & Stevens, 2010).

How to address the smoking issue in prison?

We recommend that prison administrators address the tobacco issue in cooperation with prison health staff and tobacco cessation specialists from the regional network, in order to address the various components of an efficient policy and in particular the regional regulation prevailing outside prison, cessation support, training of medical and prison staff, education of prisoners on tobacco and the consequences of its use. 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 by Hayton (World Health Organization & Europe, 2007).

A recently completed study (2011) in prisons in Germany included the design of a tobacco control policy in prisons. It is intentionally addressed to the prison administrators, in order to guide their reflection and implementation of a comprehensive and efficient tobacco control policy in their prison institution. Its objectives are to improve the living and working conditions of prisoners and staff respectively, by implementing a better health-promoting environment. In particular:

- To reduce second-hand smoke (SHS) exposure;
- To support smoking reduction and cessation attempts; and,
- To optimise the cooperation between health services and prison administrators.

The tobacco control policy emerges from the results of a study in German prisons (conducted in 2011 supported by the Federal Ministry of Health (BMG), the international framework against SHS exposure (WHO and FCTC), and special characteristics of the prisoners and their environment (raised in the literature and through the research).

Comprehensive Tobacco control policy in prisons[3]

[3] This policy has been prepared by Catherine Ritter and Heino Stöver (2012) within a research project on tobacco prevention in prisons.

Objectives
The objectives of this policy are to improve the living and working conditions of prisoners and staff respectively, by implementing an improved health-promoting environment, and in particular:

- To reduce second-hand smoke (SHS) exposure
- To support smoking reduction and cessation attempts among prisoners and staff
- To optimise the cooperation between health services and prison administrators.

Introduction
This present tobacco control policy emerged from the results of a study in German prisons (conducted in 2011 with the support by the Federal Ministry of Health (BMG)), the international framework regarding SHS exposure (WHO and FCTC), and characteristics of prisoners and their environment (raised in the literature and through the research). A draft of this policy was reviewed with health and administrative stakeholders in prison settings.

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

The policy is aimed at prisoners and staff. It consists of 6 modules:
1. General principles of the policy
2. Regulations
3. Health education and training
4. Individual support to reduce or stop smoking
5. Networking with tobacco prevention experts
6. Checklist

1. 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 as private area. Smoking is prohibited when numerous people gather together in the same area, and non smokers figure among them (Breitkopf Helmut & Stollmann Frank, 2010).

- Isolated measures are insufficient. For example: therapeutic services are available, without taking into account the environment; or smokefree regulations alone are implemented, when they have to be completed by therapeutic and counselling services, efficient networking, and staff training.

- Effective SHS protection includes a larger range of measures, in order to create an environment with efficient protection on one side, but where

smoking still remains possible in some areas, hence avoiding discrimination against smokers or stricter rules than in the general society.

- SHS protection or smoke free regulations should be as comparable as possible with the ones prevailing outside prisons (in the corresponding area). This allows a greater acceptance by the various actors involved and prepares prisoners for their return to life in freedom, since they were already confronted with the same rules. In this respect, efforts to accept SHS protection measures are also part of social reintegration.

- One person in the prison is nominated as a "Health promotion officer". He/she should have the opportunity to be properly train, in order to implement the tobacco control policy and develop advice, reduction and cessation programmes to both prisoners and staff.

- Tobacco use and protection against SHS exposure has to be tackled as part of health promotion on the working place. It is a crossover issue and requires concerted work with clearly defined responsibilities between health services, prison staff representatives, prison administration, and prisoner representatives.

- Tobacco is often used along with other substances. Tobacco control should therefore be included in the more comprehensive institutionally/regionally/nationally implemented addiction strategy.

- Campaigns that are organized in the general society can also be implemented in prisons, in particular actions to the World No Tobacco Day (31 May, see http://www.who.int/tobacco/en/), as such or as a hint to a one-week campaign before or after that date, where prisons can their focus to tobacco issues for example.

2. Smoke-free regulations

- Prisons regulations have to be checked for their inclusion of SHS exposure rules.

- Non-smokers should not share cells with smokers. Smoke free floors have to be established, with specific smoke free cells available as from the first day of arrival to the prison.

- The smoke-free regulations prevailing in the working areas should be implemented and endorsed uniformly, especially regarding the breaks. Working areas and toilets should be smoke-free, in line with the law prevailing in the general society.

3. Health education and Training

- Information on the consequences of tobacco use, reduction and cessation should be available.

- Each region is providing education and training for staff. Unfortunately, the tobacco use issue is still rarely systematically included in training programs, with the consequence that interested prison and health staff need to find where such trainings are implemented in an isolated way.

4. Individual support to reduce or stop smoking

Prisoners:

- Prisoners should actively and regularly (at all stages of detention) be approached with regards to their smoking behaviour.

- Supports to reduce or stop tobacco use should be available. More details regarding the support should developed accordingly to the uses and resources available in each setting (e.g., free of cost access to medication, or on the contrary shared costs with the prisoner).

Staff:

- The smoke-free regulation applying to staff has to be communicated to staff, at the time of commitment. It has to figure in the leading principles of the setting.

- As a general rule staff should not smoke together with prisoners - especially not in the cells (false solidarity, respect of prisoners private space, dodging after the dissolution of designated smoking areas indoors).

- Regarding the cells:
    - Other rooms than cells occupied by smokers should be used for conversations between prisoners and staff (Breitkopf & Stollmann, 2010).
    - The cells should be intensively aired before their searching, and prisoners should be asked to refrain from smoking when staff is present (see example in Ireland; NIPS, 2007).

- Staff's motivation to reduce or stop tobacco use should be regularly proofed. Smoke-free working places promote smoke-free homes, which will then further protect the family, and strengthens the smoking cessation attempts in general.
  To avoid the promotion of smoking while at work, no smoking areas indoors should exist, and tobacco use should only be limited to outdoors designated places and during breaks (even where it remains legally permitted to smoke indoors, as it is the case in Germany (Bundeszentrale für gesundheitliche Aufklärung, 2008).
- Smoking reduction or cessation supports should be available and provided by a qualified professional.
- Rewarding (or contingency management) could be developed, to increase smoking cessation attempts (for example half-day off for non-smokers).

5. Networking with tobacco prevention experts

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

6. Checklist

This checklist is a help to review the current situation regarding SHS exposure and efforts to reduce it. It brings up clarity on the points of the above-mentioned policy that were already achieved or on the contrary that would need a closer attention.

If you answered one or more questions with "No", we recommended you to look up those particular aspects with the help of the literature at the end of the policy.

a. Questions regarding the prisoners

<u>Smoke-free regulation</u>

Do we discuss protection against SHS exposure of prisoners with the medical unit
☐ Yes ☐ No

Do we discuss protection against SHS exposure of prisoners with their representatives ☐ Yes ☐ No

Is there a nominated person who is in charge of the protection against SHS exposure or of health promotion among prisoners ☐ Yes ☐ No

Are we working together with experts in the protection against SHS exposure, for example in the local network ☐ Yes ☐ No

Do we have a smoke-free regulation ☐ Yes ☐ No

Is our regulation endorsed ☐ Yes ☐ No

Do non-smoking prisoners have a systematic and straightforward access to a smoke-free cell ☐ Yes ☐ No

Are the working areas smoke-free ☐ Yes ☐ No

Are the toilets smoke-free ☐ Yes ☐ No

Are the break rooms indoors smoke-free ☐ Yes ☐ No

Health education

Do we know where to get information on tobacco use (consequences, cessation)

☐ 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

Is staff (health, social or prison) trained in health education regarding tobacco use

☐ Yes ☐ No

Is health staff trained to support prisoners attempts in tobacco smoking reduction or cessation ☐ Yes ☐ No

Is the nominated person in charge of prisoners' protection against SHS exposure trained in this issue ☐ Yes ☐ No

Individual support to reduce or quit smoking

Is the access to reduce or quit tobacco smoking easy ☐ Yes ☐ No

Are prisoners regularly approached to reduce or quit tobacco smoking

☐ Yes ☐ No

b. Questions regarding staff

Smoke-free regulation

Do we discuss protection against SHS exposure of staff with the medical unit

☐ Yes ☐ No

Do we discuss protection against SHS exposure of staff with staffs' union or representatives ☐ Yes ☐ No

Is there a nominated person who is in charge of the protection against SHS exposure or of health promotion among staff ☐ Yes ☐ No

Are we working together with experts in the protection against SHS exposure, for example in the local network ☐ Yes ☐ No

Do we have a smoke-free regulation ☐ Yes ☐ No

Is our regulation endorsed ☐ Yes ☐ No

Is staff protected against SHS exposure outside the cells? ☐ Yes ☐ No

Is the purchase of tobacco impossible at work ☐ Yes ☐ No

Is staff's smoking restricted to breaks in designated areas outdoors only
☐ Yes ☐ No

Is staff's smoking restricted to breaks only ☐ Yes ☐ No

Health education

Do we know where to get information materials on tobacco use (consequences, cessation) ☐ Yes ☐ No

Is information on tobacco use (consequences, cessation) regularly and proactively distributed ☐ Yes ☐ No

Training

Is the tobacco issue addressed in staff's training ☐ Yes ☐ No

Is the nominated person in charge of staff's protection against SHS exposure trained in this issue ☐ Yes ☐ No

Individual support to reduce or quit smoking

Is the access to support staffs' attempts to reduce or quit tobacco smoking easy
☐ Yes ☐ No

Is staff regularly approached to reduce or quit tobacco smoking
☐ Yes ☐ No

Conclusion

A few recent changes in tobacco control policies in closed settings have been implemented in some countries. Their long term effect has to be explored further. Research on smoking prevalence in prison has been conducted over the last three decades with insufficient data to show an evolution towards reduction in prevalence of smokers, unlike the situation in the general community.

It will be particularly interesting to demonstrate if and how the implementation of total versus partial bans will have influenced the smokers' prevalence.

Regulation regarding tobacco use in prison should be comparable to the one prevailing outside. It is one component of a more comprehensive and multiple activities, that includes tobacco cessation support, training health staff, and alternative ways to reduce inactivity and/or cope with stress, and education. Those are absolute imperatives for a global public health strategy to reduce SHS in prison.

Key documents for further reading

Further details of prevalence data can be found in:

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Global Smokefree Partnership. (2009). FCTC Article 8-plus Series Reducing Tobacco Smoke Exposure in Prisons.

Department of Health and HM Prison Service. (2007). Department of Health and HM Prison Service, Acquitted - Best practice guidance for developing smoking cessation services in prisons. London. Retrieved 23. April 2010 from
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