Smoking in Prisons in England and Wales: An examination of the case for public health policy change

February 2014

Title: *Smoking in Prisons in England and Wales: Considerations for Policy Change*

First published: *February 2014*

Published to OHRN website, in electronic PDF format only
http://www.ohrn.nhs.uk

Authors

Report prepared by

Ms Suzanne Jakeman, University of Manchester
Dr Naomi Humber, University of Manchester
Professor Jenny Shaw, University of Manchester
Dr Jane Senior, University of Manchester

Address for correspondence

Offender Health Research Network
Jean McFarlane Building
University of Manchester
Oxford Road
Manchester
M13 9PL

E-mail: jane.senior@manchester.ac.uk

Acknowledgements

We would like to thank Ms Sanaz Zolghadriha and Dr William Shaw who contributed to earlier work which informed the preparation of this report. We also sincerely thank everyone who gave their time and expertise to this report by being interviewed and sharing their experiences and learning in this area.

Executive summary

The Smoke-Free Legislation Health Act was introduced in 2006, prohibiting smoking in all enclosed work and public places; by 2007 it had been implemented across the whole of the United Kingdom. Prisons were given a partial exemption on the basis that prison cells were considered 'home' for the prisoners housed within them. Consequently, smoking is currently permitted within cells, when not shared with a non-smoker, but prohibited in all other areas of a prison.

Due to the negative health implications of smoking and, in particular, the effects of second-hand smoke exposure upon non-smoking prisoners and prison staff, there is increasing pressure for prisons to become completely smoke-free. Prisons are, however, considered to be a particularly challenging environment in which to implement such policy change.

To inform this debate, the OHRN has completed this report by reviewing the existing literature and then further examining the experiences of a number of prison and correctional services internationally and secure healthcare establishments in England which have already implemented partial or total smoking bans.

We conclude that total smoking bans appear to be more effective than partial bans in terms of the benefits they have for both prisoner and staff health, whilst partial bans also appear to be more difficult to manage and enforce. The successful implementation of a total smoking ban appears to be associated with several factors including thorough planning; clear communication between staff and prisoners; effective staff training and support; comprehensive support and advice for prisoners; and the availability of effective smoking cessation programmes.

Contents

1 Background

"Prisoners should expect to experience a measurable improvement in their health and wellbeing, particularly in respect of recovery from substance misuse addiction, mental health problems, management of long-term conditions and access to public health interventions to prevent disease and illness."

(NOMS, NHS England & Public Health England, 2013)

The Smoke-Free Legislation Health Act was introduced in 2006 within the United Kingdom (UK), prohibiting smoking inside all enclosed work and public places (Great Britain, 2006). This legislation was introduced to protect workers and the general public from the immediate and long-term harmful effects of second-hand smoke inhalation (Cancer Research UK, 2012). By July 2007, the legislation had been implemented across the whole of the UK.

Prison establishments are currently exempted from having to implement a total ban, with smoking in "designated rooms" allowed to continue. Thus, smoking within all indoor prison areas is prohibited, with the exception of prison cells, although this is not permitted if a cell is shared with a non-smoking prisoner (HMPS, 2007).

The arguments around making prisons completely smoke free are complex and more wide-ranging than merely the well-known health considerations. At the time of the implementation of the legislation, and to date, concerns have been expressed that a total ban on smoking in prisons would result in violent incidents and behavioural disorder. For example, in 2005, Mr Phil Wheatley, then Director General of Her Majesty's Prison Service (HMPS), stated that, if there were a total ban on smoking on prison

'[he] would expect to find…an increase in incidents of assaults on staff…and an increased risk of disorder'

(BBC News, 2005).

Historically, Her Majesty's Prison Service (HMPS) was solely responsible for the delivery of all healthcare interventions across the England and Wales prison estate. However, there has since 1999 been a formal partnership with the National Health Service (NHS) to provide care for prisoners equivalent in quality and scope as services provided to the wider population (Joint Prison Service and NHS Executive Working Group, 1999; HMPS, 2006). Since the commissioning of healthcare services in prisons became the responsibility of the NHS, emphasis has been placed upon the importance of promoting healthier lifestyles for prisoners and the provision of preventative services. This is of particular significance, given that people in contact with the criminal justice system (CJS) are acknowledged not to typically access routine healthcare services whilst in the community. Coupled with elevated rates of substance abuse and physical and mental illness this lack of

engagement results in a significant range of health inequalities for this group (DH, 2004; 2007; HMPS, 2003).

A significantly larger proportion of the prison population are smokers, compared to the general population (85% vs. 21%; NHS Information Centre, 2011; Plugge et al., 2009), thus there is the potential to achieve a range of health gains in this population. In 2003, the document Acquitted: Best Practice Guidance for Developing Smoking Cessation Services in Prisons (DH, 2003) was published, with guidelines for effective smoking cessation support. More recently, the 2010 Department of Health report A Smoke-free Future: A Comprehensive Tobacco Control Strategy for England advocated the need to address smoking in prisons and endorsed the provision of smoking cessation support. Previously, financial support had been targeted to facilitate the provision of nicotine replacement therapy (NRT) specifically for prisoners, with £500,000 being provided each year between 2003 and 2006 (MacAskill & Hayton, 2007). If money can be targeted appropriately to help people quit smoking, the pay-off to society as a whole could be substantial; in 2011, the Department of Health report Healthy Lives, Healthy People: A Tobacco Control Plan for England estimated that the NHS currently spends £2.7 billion a year on smoking related illnesses, but less that £150 million on smoking cessation initiatives. The overall economic burden of tobacco use to society is currently estimated at £13.74 billion per year (ibid).

Similarly, pressures for prisons to become completely smoke-free relate not only to the negative health implications for the individual who smokes, but also to the known damaging effects of second-hand smoke inhalation and the impact this may have upon non-smoking prisoners, visitors and prison staff (Butler et al., 2007). In the United States, for example, more prisoners die as a result of second hand smoke exposure each year than are legally executed and, in 1993, the United States Supreme Court ruled that subjecting prisoners to second-hand tobacco smoke was a 'cruel and unusual punishment' (Wilcox, 2007; United States Supreme Court, cited by Butler et al., 2007). The issue of exposure to second hand smoke also brings with it the threat of legal action by non-smoking prisoners and prison staff; in the UK the Prison Officers' Association (2011) stated that, if changes are not made to current smoking policy, they would

'support litigation against the Prison Service on behalf of any member who suffers illness as a result of environmental tobacco smoke exposure during the course of their prison employment'.

1.1 Existing research evidence

Prisons represent a 'particularly distinctive and challenging environment' in which to implement a smoking ban as, although they are the working place of prison staff, they are home for the prisoners housed within them (New Zealand Drug Foundation, 2010). Smoking is seen as an embedded and integral part of prison life, with one English prisoner describing it as 'everybody's lifeline in here' (Gautam

et al., 2011; De Viggiani, 2008; MacLeod et al., 2010). Introducing smoke-free policy within prisons is therefore considered to be particularly challenging.

Cropsey & Kristeller (2005) studied a prison in the United States of America which banned smoking and reported that, of the 188 prisoners surveyed, 76% continued to smoke following the ban's implementation, suggesting that banning smoking does not always result in abstinence. They suggested that low adherence levels were the result of a lack of employee support for the ban and a consequential lack of enforcement. However, there is evidence to suggest that, when successfully restricted, lack of access to tobacco does lead to a reduction in smoking (Plugge et al., 2009). Such restrictions have been linked to significantly improved air quality in prisons; Proescholdbell et al. (2008) found a 77% reduction of PM2.5 exposure levels [average PM2.5 exposure levels are an established measure of second hand smoke concentrations], following the introduction of a prison smoking ban in North Carolina, USA.

There have been concerns in the media and professional literature that smoking bans in prisons could result in an increase in violent disorder (e.g. BBC News, 2005; O'Dowd, 2005). In actuality, there have been only limited reports of any significant violent incidents where bans have been implemented and, where violence has been reported, there has been little to suggest that it was the result of smoking related policy change alone (Action on Smoking and Health, 2010). Kippling et al. (2005) reported the case of Ashfield Young Offender Institution (YOI) and stated that, although threats of disorder were made, no actual disruption occurred as a result of the smoking ban. However, it was noted that 'minor altercations' increased in the month after the introduction of the smoking ban and these were attributed to nicotine withdrawal.

Similarly Lincoln et al. (2005) reported that, whilst most American prisons experienced discontent among prisoners and staff during the transition period of a smoking ban's introduction, no major disorder occurred. However, Awofeso (2005) suggested that the restriction of tobacco in American prisons resulted in greater tensions among staff and prisoners, the development of a tobacco black market and tobacco related violence. Kauffman et al. (2008) further stated that the development of a black market had implications for the success of smoke free policy, safety and security. Consequently, both Awofeso (2005) and Kauffman et al. (2008) suggested that effective smoking cessation/health promotion initiatives, which are largely absent in the American penal system, have the potential to reduce such issues.

Current, albeit limited, evidence of the efficacy of prison smoking bans in promoting long-term cessation is not encouraging. One US study reported that 97% of prisoners are reported to return to tobacco use within six months of release (Lincoln et al. 2005), thus being made to stop smoking whilst in prison does not necessarily equate to quitting completely, in line with much of the evidence around rates of return to drug and alcohol misuse following custody. However, an expressed desire to quit smoking has been established in a range of incarcerated populations; in surveys, 97% of patients in an adult forensic hospital and 58% of smokers in Scottish prisons expressed a desire to quit and a third study found that,

among UK prisoners who stated that they would like to achieve something whilst in prison, many viewed that stopping smoking would be a big achievement (Dickens et al. 2005; Scottish Prison Service, 2010; MacAskill & Hayton, 2006).

MacAskill & Hayton (2007) investigated the impact of nicotine replacement therapy (NRT) and found that, after a four week period, quit rates were between 41-64%, suggesting that individuals in prison can quit smoking with support. Furthermore, appropriate smoking cessation support was highlighted as contributing to the successful implementation of a smoking ban in Wetherby YOI (Thomson & Wilson, 2007). Richmond et al. (2006) conducted a study investigating the impact of holistic smoking cessation support in a maximum security prison in Australia, reporting an abstinence rate of 26% after a six month period, with relapse often related to prison-specific issues, such as being transferred without notice and boredom. In general, the available literature concurs that the success of smoking cessation initiatives appears to depend largely on a wide number of factors including staff experience, enthusiasm and commitment; organisational support; and the nature of prisoners (MacAskill & Hayton, 2006).

1.2 Summary

Time in prison represents a potential opportunity to improve the health of a population that is usually hard to reach but has significantly increased rates of morbidity and mortality in comparison to the general population. By targeting this health-disadvantaged population in prison, there is an opportunity to reduce both these health inequalities and the related national economic burden of smoking.

It is widely accepted that implementing a prison-based smoking ban of any description is likely to be a complex and potentially costly procedure. However, not implementing a ban also has wide ranging implications in terms of health and financial outcomes.

It was considered useful to review the first-hand perspectives and experiences of those working within prison and high security hospitals that have already faced this challenge. This report will therefore now outline the perspectives and experiences of a range of institutions that have already implemented both partial and total smoking bans.

2 Aims and Objectives

This report will now describe the experiences of several jurisdictions internationally and two high secure mental health hospitals in the UK which have implemented a smoking ban, either partial or total, and then summarise the identified key areas for consideration in relation to successfully implementing policy change.
The specific objectives of this report are to:

- Describe the experiences of a small case series of prisons and high security hospitals which have already implemented a smoking ban, including considerations of policy content; practical implementation; ongoing management and enforcement; and evaluation or outcome of ban; and

- Summarise identified areas of best practice and learning which can assist others voluntarily considering, or legislated to, implement a smoking ban in a prison establishment.

3 Method of data collection and research approach

The report contains a small case series obtained via purposive and snowballing sampling between July and November 2012. Where not specifically referenced, the content obtained for each case study was collected via personal correspondence with a senior member of medical/clinical/healthcare or discipline/correctional/ security staff from the institution.

A qualitative research approach was used to determine the perspectives and experiences of individuals working in prisons and high security hospitals which have implemented smoking bans. The authors decided to include institutions that had implemented both partial and total smoking bans for the purpose of comparison and for sharing best practice knowledge to inform policy change.

3.1 Informed Consent

All individuals who contributed to the case series described in this report gave their informed consent to be interviewed and agreed for the information they provided to be published, maintaining their individual anonymity, for the purpose of knowledge sharing and experiential learning.

4 Partial smoking bans in prisons

Similar to the current situation within HM Prison Service, England and Wales, some prisons internationally have opted to introduce smoking policies which place limitations and restrictions upon smoking by prisoners and staff, as opposed to introducing a total ban. Examples of the operation of partial bans are given below.

4.1 Victoria, Australia

4.1.1 Policy outline and introduction

Across Victoria, there are 13 prisons and a small (25 bed) minimum security "transition centre" which provide a range of correctional services from maximum security imprisonment to reparation and treatment programmes. Two of the prisons are for women prisoners only (Corrections Victoria, 2014). As of June 30th, 2013, there were 5,340 people imprisoned in Victoria (Australian Bureau of Statistics, 2013).

Following concerns surrounding the exposure of prisoners and staff to second hand smoke, and in common with other Australian states such as New South Wales and Western Australia, a smoke-free work environment policy was introduced in Victoria in April 2004. The new policy permitted staff and prisoners to smoke in designated outdoor areas only; however, in 'exceptional circumstances', permission could be granted by the Prison General Manager to allow a prisoner to smoke in their cell. Exceptional circumstances may include, for example, prisoners with acute mental illness for whom nicotine withdrawal may be considered a threat to treatment and 'protracted emergency situations where the prison regime only permits restricted time out of cell' (Corrections Victoria, 2012).

4.1.2 Management and enforcement

The policy obliges all prisons within the state of Victoria to ensure that all prisoners and staff are informed about the rules of the smoke-free policy and provided with information regarding disciplinary action that may be taken if rules are not adhered to. Both staff and prisoners can be subject to disciplinary procedures, should they be found to be smoking indoors. Prisoners may be charged with a prison offence and fined, unless there were 'exceptional circumstances'. Further offences can be met with greater penalties, dependant on individual circumstances and prisoners who are repeatedly found to smoke can be placed in accommodation 'with the best possible ventilation or air extraction infrastructure' (ibid).

All visitors to Victoria state prisons are informed about the smoke-free policy and those found to be non-compliant can be sanctioned, for example by having visits terminated and/or being refused entry in to the prison. Furthermore, Victoria's

Corrections Department acknowledged the likelihood that some prisoners may breach the smoke-free policy by giving all new prisoners the opportunity to be placed in rooms with other non-smokers.

As well as enforcement activities, all prisons are required to promote the benefits of a smoke-free environment to both staff and prisoners, including 'the provision of appropriate and relevant information and support'. During the orientation of a new prisoner, they are given information about 'Quit Programmes' which they may apply to participate in, although they may be placed on a waiting list if groups are at capacity. Prisoners wishing to stop smoking are given a medical assessment and may be provided with Nicotine Replacement Therapy with suitable monitoring.

4.1.3 Evaluation and outcome

There is little available information regarding the success of the Victoria prisons partial smoke-free policy, but smoking related breaches are reported as not being amongst the highest recorded disciplinary infractions. Furthermore, Corrections Victoria is currently considering implementing a total smoking ban similar to that of New Zealand (Personal Correspondence, 23rd August, 2012).

4.2 Quebec, Canada

4.2.1 Policy outline and introduction

The province of Quebec, Canada, is host to 12 correctional establishments, including one for women offenders. In addition, a Regional Mental Health Centre deals

> "specifically (with) inmates suffering from mental disorders, personality disorders, inmates who need continuing care, and inmates with comorbid problems"
>
> (Correctional Service Canada, 2014).

In Canada, the administration of adult correctional services is a shared responsibility between the federal and provincial/territorial governments. In 2010/11, the average daily number of people in custody in Quebec was 4,589 (Statistics Canada, 2012).

The Quebec Department of Public Security introduced a total tobacco ban within its prison buildings and grounds on the 5th February 2008. However, the ban was amended three days later, allowing prisoners to smoke in prison courtyards. The partial smoking ban retained prohibition on all smoking within prison buildings, with prisoners only permitted to smoke during their one hour daily exercise period outside. Prisoners were permitted to purchase a limited amount of tobacco from the prison canteen, with the intention that it will be smoked outside; however,

prisoners were allowed to keep their purchased tobacco on them at all times (Institut National De Santé Publique Du Québec, 2010).

The Quebec Department of Public Security stated that the revision was made so to 'facilitate the application of the smoking ban for tobacco users'. However, several news reports suggested that the amendments were made because of a riot which broke out in one of the province's prisons; this has never been substantiated by an official source (Lasnier et al., 2011; CTV News, 2008; Action on Smoking and Health, 2010).

4.2.2 Management and enforcement

According to Lasnier et al. (2011), upon introduction of the ban, all members of correctional facilities staff were instructed to enforce it, but were given little instruction as to how this should be done. Many staff were reportedly disappointed about the changes made to the original total smoking ban and therefore did not enforce the partial ban. Other members of staff were reported to be sympathetic to the needs of smoking prisoners and consequently overlooked illicit indoor smoking practices. Although smoking was permitted in outdoor courtyards for an hour per day, Lasnier et al. (2011) reported that staff were unable to prevent prisoners from returning to their cells with tobacco in possession, nor were they able to prevent them from smoking for the next 23 hours. In the existing literature, there were no indications of any punishments meted out for illicit smoking practices.

4.2.3 Evaluation and outcome

The Institut National De Santé Publique Du Québec (2010) reported that prisoners had little respect for the indoor smoking ban, with 93% of prisoners stating that they continued to smoke inside. Eighty five percent of prisoners and 76% of staff reported that the partial ban increased prisoner-staff tensions (Lasnier et al., 2011). There was no evidence that the partial ban resulted in reduced second hand smoke exposure, although 89% of prisoners reporting at least a reduction in their own tobacco use (Institut National De Santé Publique Du Québec, 2010; Lasnier et al., 2011). As the smoking ban was initially introduced in Quebec's correctional facilities to improve the health of both prisoners and staff, Lasnier et al. (2011) concluded that the 'ban has not yet produced the intended results'.

5 Total smoking bans in prisons

Perhaps to reduce the complexities of managing the rules around partial smoking bans, some jurisdictions have instead opted to implement total prohibition.

5.1 Isle of Man

5.1.1 Policy outline and introduction

The Isle of Man Prison Service runs one prison which has certified normal accommodation for 138 prisoners. The prison moved from a Victorian establishment to its current, newly built site in 2008 and has separate wings providing single cell accommodation for adult men, male young offenders and female adult and young prisoners (Isle of Man Government, 2014).

The Isle of Man government adopted smoke-free legislation in March 2008, which immediately encompassed the island's prison establishment. Although smoking in open air venues was not outlawed generally in the Isle of Man, the Prison Service decided upon a total smoking ban, with neither prisoners nor staff permitted to smoke on any part of the prison premises. It was agreed that smoking should not be permitted in outside areas because it would be difficult to police and make the smoking ban less effective overall. It was thought that allowing outdoor smoking, whilst prohibiting prisoners from keeping tobacco in their cells, would result in difficulties issuing and retrieving tobacco. It was also thought that a partial smoking ban could potentially result in conflict on a daily basis, and that 'allowing prisoners access to tobacco…which they could potentially secrete, would exacerbate the problem and become a serious control issue'. It was also reported that 'issuing tobacco for a one hour period a day only, would be more detrimental for the prisoner than a total ban; this would compromise the detox programs and severely hamper their withdrawal' (Personal Correspondence, 24th July, 2012).

In the lead up to the prison ban, additional health care staff were made available to assist with questions posed by prisoners and a response team was placed on stand-by should any indiscipline arise as a result of the imminent ban.

5.1.2 Management and enforcement

Approximately a fortnight before the ban was introduced prisoners were given their last opportunity to purchase tobacco from the canteen. Prisoners were also given an opportunity to surrender tobacco and smoking paraphernalia during this time. All prisoners and members of staff were warned that, once the smoking ban was introduced, anyone found to be smoking or in possession of smoking paraphernalia would be subject to prison disciplinary procedures. When the ban was introduced searches were conducted and residual smoking paraphernalia removed. Visitors

were also advised that it was a requirement that all smoking materials be surrendered at the site's gate, subject to a maximum fine of £5,000 for those caught trying to smuggle tobacco into the grounds.

To support prisoners in becoming smoke free, prison officers and healthcare staff were given training, support and advice from a smoking cessation specialist. Drop-in sessions with the specialist were provided for prisoners. In the weeks leading up to the ban, extra healthcare staff were made available and this increased level of support continued as the ban came into force.

All prisoners received a newsletter detailing the support that would be on offer to assist the process of nicotine withdrawal. The newsletter informed prisoners that everyone who requested support would be assessed and an individual care plan developed. Nicotine Replacement Therapy was made available in the form of a 14 week withdrawal plan, with nicotine patches/inhaler cartridges exchanged 'new for old'. It was hoped that a 14 week programme would reduce the likelihood of a prisoner being maintained on nicotine, therefore enabling them to stop smoking completely, whilst exchanging new patches/inhaler cartridges for old would reduce the likelihood of NRT items becoming currency within the prison. Several prisoners reported smoking items such as 'pepper and tea leaves' in lieu of tobacco and consequently prisoners were educated by health care staff about the dangers of such practices (Personal Correspondence, 24th July, 2012).

During the initial period of the smoking ban, the prison relocated site. The new site provided more modern, improved facilities and heightened security measures which reportedly further limited the opportunity for smoking paraphernalia to be smuggled in. If a prisoner was found smoking, they were subject to disciplinary procedures. Five prisoners reportedly staged a hunger strike in protest against the smoking ban, but this was noted to end quickly. An incident in which a group of prisoners refused to return to their cells in protest was also reportedly resolved without force within a few hours (BBC News, 2012).

5.1.3 Evaluation and outcome

In 2011, Her Majesty's Inspectorate of Prisons (HMIP) made an announced visit to the Isle of Man prison and the subsequent inspection report stated that

> 'the ban on smoking tobacco had resulted in a number of negative outcomes, including bullying for patches, numerous alternative substances being smoked (with unknown health risks) and dangerous practices to ignite these home-made cigarettes. We observed some officers colluding with illicit smoking activities. There was insufficient smoking support available'.
>
> (HMIP, 2011)

With specific reference to NRT administration, the report stated that 'the protocols for the administration of nicotine replacement therapy (NRT) were lax", with prisoners reportedly able to obtain NRT on numerous occasions without fulfilling

the requirement of returning previously issued items, resulting in some prisoners having 7 or 8 patches in their possession at any one time. Documentation was also reportedly found detailing an occasion where 50 patches were found in the cell of one prisoner. Prisoners were also noted to render the nicotine from their NRT patches, using the extracted nicotine in addition to alternative smoking materials such as tumble drier lint and pubic hair, wrapped in pages from bibles and dictionaries (ibid). More recently, an appeal by a prisoner to be allowed to use e-cigarettes was rejected by the Manx government (BBC News, 2013).

HMIP suggested that both the level of control to prevent breaches of the ban, and the healthcare support available to support those giving up, needed to be improved and that the prison should consider changes in policy, such as allowing smoking outside in the exercise yard. However, the following year, commenting on a similar smoking ban implemented in the prison on the Channel Island of Guernsey, Nigel Fisher, deputy governor of the Isle of Man prison reported that the total smoking ban was "the best decision the facility had ever made" (Guernsey Press, 2012). When interviewed for the current report, our respondent at the prison reported that, although there had been disciplinary 'incidents', they were dealt with successfully and had lessened over time. They reported that those who were found to be smoking or in possession of smoking materials were subject to disciplinary procedures which were enforced vigorously. Furthermore, many prisoners have reportedly stated that the smoking ban gave them the incentive they needed to quit. There has reportedly also been a reduction in the use of other illicit drugs, especially those that are often used in conjunction with tobacco, such as cannabis (Personal Correspondence, 24th July, 2012).

In order to assess the impact of the smoking ban, the Tobacco Control Collaborating Centre (unpublished) measured second hand smoke levels in the Manx prison prior to the ban being enforced and the again three months later. Members of staff were asked to wear personal monitors for the duration of their shift which measured airborne particulate matter. The average measure of second hand smoke concentrations (PM2.5) was largely reduced (75%), although concentrations varied, depending on location within the prison. Saliva samples were also taken from staff before and after the ban, to measure levels of salivary continine, a breakdown product of nicotine. There was no difference reported in average salivary continine levels before and after the ban; however, saliva samples were taken from different members of staff before and after, which may explain the lack of difference noted. Interestingly, an increase in salivary continine was reported during shifts before the ban, but not after. The Tobacco Control Collaborative concluded that allowing smoking to continue in prisons exposed staff and prisoners to unhealthy levels of particulate contamination and that this contamination had a cumulative effect, demonstrated by the rising continine levels identified during pre-ban working shifts.

5.2 New Zealand

5.2.1 Policy outline and introduction

The New Zealand Corrections Department currently operates 18 prisons, including 3 for women. As of 30 September 2012, there were 8,618 prisoners, comprising 8,091 males and 527 females (NZ Dept. of Corrections and Statistics, 2012).

On the 1st July 2011, New Zealand became the first country to introduce a comprehensive national smoke-free policy in prisons. The ban on smoking applied to all prisoners, staff, and visitors within prison buildings and outside areas (Collinson et al., 2012). The New Zealand Government has an objective of creating a completely smoke-free nation by 2025 and banning smoking in prisons provided an opportunity to investigate the implications of reducing the supply of tobacco at both individual and community level (Gautam et al., 2011). In 2005, 67% of the New Zealand prison population smoked (NZ Department of Corrections, 2010). Furthermore, in 2010, Māori prisoners, an ethnic group with high smoking prevalence made up almost half (45.1%) the prison population (NZ Dept. of Corrections and Statistics, 2012; NZ Ministry of Health, 2009). Consequently, the smoking ban provided an ideal opportunity for the New Zealand government to not only reduce the health risks of smoking for prisoners and prison officers, but also to address health inequalities between the Māori ethnic group and the rest of the population (Collinson et al., 2012). Further reasons for the introduction of a total smoking ban in prison included reducing the risk of fire and other safety concerns associated with matches and lighters; reducing the risk of litigation from prison staff and non-smoking prisoners; and to reduce the violence and bullying associated with tobacco used as currency.

Prior to the introduction of the ban, the Department of Corrections commissioned a small independent evaluation of their proposed plans; approached senior prison staff in the UK to provide a review of readiness; and sourced information from two sites in the US which had already been though a similar process (Martin Jenkins, 2011). In mid-2010, a detailed communications strategy was put in place which involved both internal (e.g. prison staff and prisoners) and external stakeholders (e.g. the Ministry of Health, the media, the public, police stations, and stop smoking service The Quit Group). The strategy was designed to increase awareness of the planned changes and of the cessation support available to prisoners and staff (Martin Jenkins, 2011; Collinson, 2012).

In the year leading up to the smoking ban, prisoners were provided with educational material about the dangers of smoking, as well as smoking cessation advice. Psychological and pharmacological support, including Nicotine Replacement Therapy, was offered to both prisoners and staff (Collinson, 2012). A 'Quitline' was heavily promoted, accessible to both prisoners and prison staff, with prisoners able to call from their prison wings. Staff who wanted to give up smoking were also provided with support/advice, including NRT when requested. Furthermore, staff were given the opportunity to train as 'workplace champions', to promote smoking

cessation and provide advice/support to both prisoners and other colleagues (Martin Jenkins, 2011).

The NZ Department of Corrections recognised that banning smoking would have a significant impact upon the daily routine of prisoners and prisons were advised to increase the level of activities on offer. As a result, many prisons organised group activities (e.g. art classes and sport) and purchased more recreational equipment, such as board games and gym equipment. To compensate for potential weight gain by prisoners, prisons increased the range of healthy foods available to prisoners in the canteen (NZ Department of Corrections, 2011; Martin Jenkins, 2011).

Prisoners were able to purchase tobacco from the prison canteen until two months prior to the ban and were allowed to possess and use tobacco and smoking paraphernalia until the day before the ban was introduced. Once the ban was implemented, prisoners and staff were not permitted to smoke within the secure perimeter. Prisoners who were part of return-to-work schemes and left the secure perimeter were also prohibited from smoking outside of the perimeter whilst staff who continued to smoke were only permitted to do so in designated areas outside any prison's secure perimeter.

5.2.2 Management and enforcement

Prior to the implementation of the smoking ban, the New Zealand Department of Corrections completed comprehensive planning in relation to potential security issues and any possible consequences associated with prisoner nicotine withdrawal, including non-compliance and unrest (Martin Jenkins, 2011). Following the ban, there were no major prisoner incidents related to the ban and this has been largely attributed to the extensive planning and preparation undertaken (NZ Department of Corrections, 2011). However, Colin Ropiha, Manager of the Otago Corrections Facility Unit, acknowledged that 'there have been some niggles from remand prisoners who haven't had the benefit of the 12 month lead-in period' (ibid).

During searches completed by prison staff in the first ten months of the smoking ban, 2,031 tobacco and smoking paraphernalia items were reportedly seized nationally. In most cases items were discovered on visitors and prisoners prior to entering the prison itself (New Zealand Herald, 2012). Collinson et al. (2012) suggested that contraband tobacco rose within the first two months following the ban's implementation, with black market tobacco prices doubling. However, prisons have reportedly improved their methods of preventing tobacco products entering the prison and no further issues have been reported. It has also been suggested that, in the initial period following the ban, prisoners were seen smoking nicotine patches and tea leaves (The Age, 2011).

5.2.3 Evaluation and outcome

Dr Simon Thornley, Auckland University, stated that New Zealand's smoke-free prison legislation has been 'the most comprehensive prison ban we've seen [worldwide]'. He attributed its success to the long period of preparation; good

communication with prisoners; and the provision of a comprehensive level of smoking cessation support. There have been no reported violent incidents related to the ban; a reduction in contraband smoking products; and a significant improvement in the air quality of prisons. Thornley and colleagues asked prison officers to wear personal monitors which measured airborne particulate matter for 15 days prior to the ban and 15 days afterwards. The average exposure level of SHS concentrations (PM2.5), were found to reduce by 63% post-ban, and therefore it was concluded that a 'significant health hazard has been reduced for staff and prisoners alike' (Thornley et al., 2012).

In addition, the number of fires and arson-related incidents reduced significantly after the ban, with only 4 incidents during the first month and one during the second month. In the month prior to the ban, 18 fire-related incidents had been reported (Scoop, 2011). Colin Ropiha, Manager of the Otago Corrections Facility, stated that there have been reports of prisoners thanking staff for the introduction of the ban and that prisoners were now more concerned about the potential of smoking relapse following release. Mr Ropiha stated that communities and the families of prisoners are being educated so that they can provide continued support upon release (NZ Department of Corrections, 2011).

5.3 California, United States of America

5.3.1 Policy outline and introduction

The California Department of Corrections and Rehabilitation (CDCR) oversees 34 adult state prisons, including three for women, and a further 3 youth establishments, holding approximately 134,000 prisoners (CDCR, 2014). There are a further number of federal institutions in the state. The California State prison system is currently subject to a U. S. Supreme Court mandate to reduce overcrowding which has been accepted as a cause for unconstitutionally poor health care delivery (Grattet & Hayes, 2013).

In 1998, the state of California introduced legislation prohibiting smoking within prison buildings. However, covert smoking reportedly continued and a number of staff and prisoners filed litigation suits on the basis of exposure to second-hand smoke. Consequently, on the 1st July 2005, a total smoking ban was introduced within all Californian prison sites.

Three years before the state-wide ban, a pilot was introduced in three Californian prisons which prohibited smoking by prisoners only. The pilot was successful, but it was regarded as necessary to also prohibit members of prison staff from smoking when the ban was implemented across the state. Prisoners and staff were informed of the ban's introduction approximately six months prior to implementation and educational information was provided to both. However, although prisoners and staff were educated about the dangers of smoking and the benefits of cessation, NRT was not provided. It was considered that a 'cold turkey' approach was most appropriate as it was stated that 'NRT is contraindicated in [prison settings]' and

was unnecessary, as the nicotine withdrawal period is short. Furthermore, it was stated that NRT provision would be expensive; result in misuse; and prolong the problems of nicotine withdrawal. Psychological support was also deemed unnecessary because all prisoners would be going through the process of withdrawal together.

5.3.2 Management and enforcement

Three months prior to the ban's implementation, the sale of all tobacco products ceased (Hansen, 2013). On the day of the policy's implementation, Californian prisons did not place extra staff on duty, nor complete any extra searches. After the ban, the few people who were found smoking were reportedly subject to disciplinary procedures. Members of staff found to be smuggling tobacco into prisons were dismissed. There were reportedly no incidents or rioting behaviour occurring as a result of the ban.

5.3.3 Evaluation and outcome

There have reportedly been virtually no problems with the California prison smoking ban's implementation. Many prisoners have reported that their ability to stop smoking has empowered them to believe they may be able to make other changes in their lives. Furthermore, a number of prisoners were reportedly seen to give up smoking prior to the ban, as many did not want to give up on a date which had been dictated to them. There has reportedly been less inmate aggression since the ban, improved health outcomes (e.g. 40% reduction in cardiology visits) and reduced associated costs (Hansen, 2013). The success of the ban has been reportedly attributed to a strong 'top down' approach to its implementation (Personal Correspondence, 5th September, 2012).

6 Smoking bans in high security psychiatric hospitals

When smoke-free legislation was introduced across the UK between 2006 and 2007, hospitals were given an extra year before being required to adopt the policy. As many parallels can be drawn between high secure hospital sites and prisons in terms of security; length of stay; their operation as "total institutions" (Goffman, 1961); and the risk characteristics of those they hold, it is useful to consider the implementation of a smoking ban in these settings.

There are three high secure hospitals in England (Ashworth, Broadmoor and Rampton), one in Scotland (Carstairs) and none in Wales. At present, there are approximately 880 high secure places in England, including 50 high secure beds for women at Rampton hospital, and 140 places in Scotland. This is a significant reduction from a record high secure population of 3,937 patients in December 2008 (Centre for Mental Health, 2011).

6.1 Broadmoor Hospital

6.1.1 Policy outline and introduction

In July 2008, a year after the smoke-free policy in English public places was introduced, the policy was adopted comprehensively by the NHS Trust responsible for Broadmoor. The policy banned patients and staff from smoking in the buildings and grounds surrounding the hospital.

There was reportedly a long lead-in period before the ban was introduced to the high secure site, so that both staff and patients could adjust to the planned changes. Information was provided and smoking cessation organisations were invited into the hospital before the ban to encourage both staff and patients to quit smoking. Visitors to the hospital were also informed of the new smoking policy. In the months leading up to the smoking ban, staff were asked not to smoke in the hospital or to bring tobacco or smoking paraphernalia on site. A smoking shelter was constructed outside the hospital gates for staff members who wished to smoke and this continues to be used. Prior to the ban, all patient rooms were searched, the hospital's smoking rooms were decommissioned and extra sports and leisure activities were made available. Post-ban, smoking cessation support and NRT remained available to both staff and patients, with NRT delivered under supervision; patients were only given new NRT patches once an old one had been returned. Staff members were also provided with smoking cessation training to support patients.

6.1.2 Management and enforcement

Due to the secure nature of the hospital it was possible to prevent tobacco and smoking paraphernalia from entering the hospital grounds. However, there were reportedly a couple of occasions when staff members, who had developed an 'unhealthy empathy' with patients' inability to obtain tobacco, were suspected of smuggling it in (Personal Correspondence, 30th August, 2012). Furthermore, it was reported that some patients were found to have hidden a stockpile of smoking material in the recreational grounds of the hospital, but this was reportedly dealt with as soon as suspicions were aroused. In the initial period following the ban, some patients were also seen to be smoking inappropriate items such as tea leaves, or abusing NRT inhalers. Consequently, patients were informed of the dangers of such actions and NRT inhalers withdrawn. Unlike prisons, high secure hospitals do not operate disciplinary procedures but they did inform patients that serious breaches of the smoking ban could be reported to the police as a criminal offence, which reportedly acted as an effective deterrent for most patients.

6.1.3 Evaluation and outcome

In the lead up to the ban there were reportedly a few issues, such as some patients smoking excessive amounts of cigarettes. Furthermore, once the ban had been implemented, patients were reportedly buying extra food and therefore gained weight. As a result, the food made available for purchase at the hospital was reportedly changed, along with a limit placed on the amount a patient could buy.

During the period following the ban's implementation, there was a reported increase in covert smoking, particularly in patient bedrooms and toilets; however, this reduced over time and it has been suggested that, once hidden tobacco supplies ran out, patients were forced to stop smoking. Between 2009 and 2012, smoking related incidents reportedly reduced by approximately 82%, although it should be noted that patient numbers had also reduced by around a third within this period. Nevertheless, the ban's implementation was described as being a 'non-event', with no increase in incidents or major disorder (Personal Correspondence, 30th August, 2012). As tobacco is now much less readily available, it is reported that other associated drug use (e.g. cannabis) has also reduced. Our interviewee related the ban's success to the comprehensive planning which had been undertaken prior to implementation and that 'every problem imaginable' had been considered beforehand (Personal Correspondence, 30th August, 2012). Furthermore, the transition was reportedly relatively smooth because there was good communication between management, staff and patients. Staff were also reportedly well briefed and understood the process, as they had been through it themselves prior to the ban affecting the patient population.

6.2 Rampton

6.2.1 Policy outline and introduction

The NHS Trust responsible for Rampton Hospital adopted the national smoke-free policy in all its mental health units in March 2007. The inclusion of Rampton in the smoke-free policy meant that it was the first high secure hospital in the UK to go smoke-free (Cormac et al., 2010). In 2005, Cormac et al. reported that 70% of patients smoked, with most smoking heavily. The smoking ban implemented included all hospital buildings and surrounding grounds.

Three months before implementation patients were informed about the ban and offered support to quit. Discussion was also welcomed in a variety of forums, with both staff and patients encouraged to offer ideas for successful implementation. The smoke-free policy prohibited all patients, visitors and staff from possessing tobacco and smoking paraphernalia within the hospital site and was rigorously enforced by staff when the ban was introduced. On the weekend the ban came into force, the hospital ensured that all wards were fully staffed and additional activities were provided for patients as a means of distraction (Cormac et al., 2010).

Smoking cessation support was reportedly offered to both patients and staff three months before implementation, with plans developed for all patients wishing to stop smoking so that the ban would be less traumatic. Post-ban psychological and pharmaceutical support continued and smoking cessation training became mandatory for hospital staff, so that current and future patients could be provided with on-going support. Care-planning for all new patients specifically considers smoking cessation during the pre-admission process to ensure that patients do not come into the hospital unprepared.

6.2.2 Management and enforcement

All tobacco and smoking related items were removed from the hospital on the day of implementation and the hospital's already rigorous search schedule continued, with dedicated searches being conducted upon suspicion of tobacco contraband. The hospital prepared for problems following the ban's implementation but, reportedly, only a small number of minor issues arose. Some patients reportedly attempted to smoke alternative items found within the hospital and use alternative forms of ignition (e.g. toasters and hand-dryers), but hospital staff remained vigilant and were able to manage this issue. In addition, vigilance to visitors reportedly attempted to smuggle contraband in for patients was also required.

Although a smoke pod is available for staff outside the hospital's secure area, some members of staff have reportedly found the introduction of the ban difficult and disciplinary procedures are in place for those who have been non-compliant. The staff smoking ban has reportedly helped patients and other staff members to quit, as the smell of tobacco is no longer on the ward.

6.2.3 Evaluation and outcome

Within the four month period following implementation of the smoking ban, no major incidents were reported. Furthermore, no fire incidents related to covert smoking occurred between December 2006 and July 2007 (Cormac et al., 2010). On several occasions after the ban tobacco and smoking paraphernalia were found by security staff; however, it was reported that specific searches of patients were not conducted when the ban was introduced, rather patients were merely asked to surrender their tobacco/smoking related items, which may explain the reported finds (ibid).

Before the introduction of the smoke-free policy at Rampton there were concerns that the ban would result in increased levels of self-harm and behavioural disturbances, as well as an increased level of psychotropic medication use. Cormac et al. (2010) reported that the only statistically significant result related to medication was a reduction in the mean dose of regular anti-psychotic medication in smokers from March to April 2007 (ban was implemented in 31st March 2007). With regard to untoward incidents, defined as self-harm, verbal abuse, physical aggression or damage to property, the only significant finding was an increase in incidents for pre-ban smokers in July 2007, compared to December 2006. No significant difference in rates of seclusion were found, for either pre-ban smokers or non-smokers following implementation.

6.2.4 Human rights legal case

In May 2008, a number of patients brought High Court Judicial Review proceedings against the NHS Trust responsible for Rampton Hospital and the Secretary of State for Health as a result of the smoking ban. It was argued that the smoke-free policy breached the fundamental human rights of patients under Article 8 of the European Convention on Human Rights which stipulates that people should have the right of respect for private and family life. It was argued that the hospital was, essentially, a patient's home and to stop them smoking when they have nowhere else to go encroached on their right to do what they wanted within their own home, as long as it causes no harm to others (Guardian, 2007). It was further argued that psychiatric patients were being discriminated against as smoking within prisons was still permitted (Mills & Reeve, 2008).

The High Court judged that patients of Rampton Hospital had no 'legal right to smoke' under article 8 of the European Convention of Human Rights, stating that

'the law may place restrictions on a person's freedom of action without necessarily interfering with the right to respect required by article 8…preventing a person smoking does not…generally involve such adverse effect upon the person's physical or moral integrity'.

(R (G) v Nottinghamshire Healthcare NHS Trust (2008))

It was noted that it was not practical for patients to be allowed to go outside whenever they wanted for a cigarette, on the grounds of health and safety and risk management. The court also judged that the smoke-free legislation imposed at Rampton was rational, on the basis that it reduced levels of second-hand smoke within a place of work (ibid).

The case was heard again at the Court of Appeal in July 2009, where it was again judged that the patients had no 'legal right to smoke' under the European Convention on Human Rights. Here it was stated that

'it may be necessary to take long-term decisions for the benefit of patients and staff even though to do so would cause short-term problems, provided that careful management was employed in its implementation'.

(R (N) v SSH; R (E) v Nottinghamshire Healthcare NHS Trust (2009))

The court noted that, in some instances, smoking was used by patients as form of self-harm and it was reasonable for the NHS Trust to take action to preserve the health of patients. Furthermore, it was noted that 'all reasonable precautions' should be taken to protect staff from the risk of second-hand smoke. With regard to the hospital being the patients' home, the court stated that

'a person may do as he pleases in his own home, but no one can expect the same freedoms when detained in a hospital…we do not think that there is any real difference between banning alcohol and banning smoking…there is no basis for distinguishing the loss to choose what one eats or drinks in such institutions and the ban on smoking'

(ibid).

The court concluded that 'there is strong evidence of the dangers of smoking both to smokers and those subject to SHS and powerful evidence that in the interests of public health a complete ban was justified in appropriate circumstances. As to SHS, there has emerged powerful evidence of its dangers which supports the Trust's case of justification' (ibid, cited in Mills & Reeve, 2009).

As it was thus judged that there is no absolute human right to smoke, NHS Trusts are under no legal obligation to provide smoking facilities for patients. It also means that NHS trusts may introduce measures that may be judged unpopular and disadvantageous in the short term, if there is evidence that there will be long-term gains and that measures are introduced and managed carefully. Furthermore, although the judgement only applied to patients detained in psychiatric hospitals, it is likely to have implications for other secure settings where individuals argue that they have a right to smoke (ibid).

7 Ban implementation: areas for consideration and recommendations

This report has summarised the existing literature in this area, and conducted further investigations into state and national jurisdictions which have implemented a smoking ban, either partial or total. In addition, we have investigated the implementation of smoking bans in high secure NHS mental health services. Some areas for consideration have been identified and recommendations in relation to ban implementation and policy change are outlined below.

7.1 Policy choice

A total smoking ban should be considered as partial bans appear to be less effective in terms of reducing the harmful effects of second hand smoke exposure and are much harder to manage at frontline service-level.

7.2 Introducing the policy

Successful introduction of a smoking ban policy is associated with

- comprehensive levels of planning;
- a long lead in period;
- clear communication and consultation with both staff and prisoners;
- clear instruction and guidance from management;
- holistic cessation support for staff and prisoners;
- the provision of alternative activities; and
- comprehensive staff training and support.

7.3 Litigation and legislation

A legal precedent has been set within a UK high secure environment which states that a smoking ban does not infringe a person's rights under Article 8 of the European Convention on Human Rights. This should inform the decision making process were any future case(s) levelled against HM Prison Service if a total smoking ban was implemented. Similarly, a total smoking ban would prevent future litigation against HM Prison Service for staff-prisoner exposure to second hand smoke.

7.4 Management and enforcement

There is no evidence nationally, or internationally, to support the view that smoking bans create significantly increased or sustained conduct issues and/or disorder.

7.5 Resource and demand

The prevalence of smoking in the prison population is high and consequently demand will likely be high for help with quitting, including nicotine replacement therapies, support help lines, educational material and professional cessation support. A range of services should be provided for both prisoners and staff.

7.6 Staff-prisoner relationships

During ban enforcement, good staff-prisoner relationships are facilitated by adequate communication and support, inviting prisoners to contribute to the development of policies and plans for implementation, all supported by comprehensive levels of training and support for staff.

7.7 Daily routine and procedure

There may be some initial disruption to the daily routine of establishments in terms of activities to support enforcement, including more frequent searches in the period immediately following implementation.

8 Conclusions

Cigarette smoking is the greatest single cause of illness and premature death in the UK. Around 100,000 people in the UK die each year due to smoking, with deaths mainly due to cancers, chronic obstructive pulmonary disease and heart disease. About half of all smokers die from smoking-related diseases. Smoking is much more prevalent in prison populations than in the wider community, where rates have dropped significantly over time.

Legislation banning smoking in public places, including NHS hospitals, has been in place in the United Kingdom since 2007. At present, prisons across England and Wales have implemented partial smoking bans which limit smoking to cells, where these are not shared by a non-smoker.

Since 1999, it has been the policy of the NHS and HM Prison Service to commission and provide healthcare services for prisoners which are equivalent in scope and quality to those provided to the wider community (Joint Prison Service and NHS Executive Working Group, 1999). In modern-day NHS parlance, this is the comparable to the current policy of 'parity of esteem' which values mental health equally with physical health (HM Government, 2011).

The applied logic behind the concept of parity of esteem is directly applicable when considering the introduction of total smoking bans in prison establishments. Anti-smoking legislation was introduced specifically to reduce the harms resultant from tobacco use. Prisoners are entitled to this protection as much as anyone else in our society.

9 References

Action on Smoking and Health (2010). *Smoke-free prisons.* London: Action on Smoking and Health.

Australian Bureau of Statistics (2013). *Prisoners in Australia, 2013.* http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2013~Main%20Features~Contents~1 [Accessed: 3 February 2014].

Awofeso, N. (2005). Why fund smoking cessation programmes in prison? *British Medical Journal, 330, 852.*

BBC News (2005, 17 November). *Prison chief's smoke ban warning.* http://news.bbc.co.uk/1/hi/uk_politics/4445252.stm [Accessed: 3 February 2014].

BBC News (2012, 26 April). *Isle of Man prison protest ends 'peacefully'.* http://www.bbc.co.uk/news/world-europe-isle-of-man-17841035 [Accessed: 3 February 2014].

BBC News (2013, 2 November) *Isle of Man prisoner's e-cigarette appeal rejected* http://www.bbc.co.uk/news/world-europe-isle-of-man-24773907 [Accessed: 3 February 2014].

Butler, T., Richmond, R., Belcher, J. & Wodak, A. (2007). Should smoking be banned in prisons? *Tobacco Control, 16, 291-293.*

California Department of Corrections and Rehabilitation (2014). http://www.cdcr.ca.gov/Prisons/index.html [Accessed: 3 February 2014].

Cancer Research UK. *Cancer Research UK Policy Statement on Smokefree legislation.* http://www.cancerresearchuk.org/prod_consump/groups/cr_common//@nre/@pol/documents/generalcontent/014310.pdf [Accessed: 3 February 2014].

Centre for Mental Health (2011). Pathways to unlocking secure mental health care. http://www.centreformentalhealth.org.uk/pdfs/Pathways_to_unlocking_secure_mental_health_care.pdf [Accessed: 7 February 2014].

Collinson, L., Wilson, N., Edwards, R., Thomson, G. & Thornley, S. (2012). New Zealand's smokefree prison policy appears to be working well: one year on. *The New Zealand Medical Journal, 125 (1357), 164-168.*

Cormac, I., Ferriter, M., Benning, R. & Saul, C. (2005). Physical health and health risk factors in a population of long-stay psychiatric patients. *The Psychiatrist, 29, 18-20.*

Cormac, I., Creasey, S., McNeill, A., Ferriter, M., Huckstep, B. & D'Silva, K. (2010). Impact of a total smoking ban in a high secure hospital. *The Psychiatrist, 34, 413-417.*

Correctional Service Canada (2014) http://www.csc-scc.gc.ca/institutions/001002-2000-eng.shtml [Accessed: 3 February 2014].

Corrections Victoria (2012). *Commissioner's Requirement*. Victoria: Corrections Victoria.

Corrections Victoria (2014). http://www.corrections.vic.gov.au/home/prison/ [Accessed: 3 February 2014].

Cropsey, K. & Kristeller, J. (2005). The effects of prison smoking ban on smoking behaviour and withdrawal symptoms. *Addictive Behaviors, 30, 589-594.*

CTV News (2008, 18 February). *Quebec Reverses No Smoking Ban After Riot*. http://netk.net.au/Prisons/Prison55.asp [Accessed: 3 February 2014].

Department of Health (2003). *Acquitted: Best Practice Guidance for Developing Smoking Cessation Services in Prisons.* London: Department of Health.

Department of Health (2004). *Choosing Health: Making Healthy Choices Easier.* London: Department of Health.

Department of Health (2007). *Improving Health, Supporting Justice.* London: Department of Health.

Department of Health (2010). *A Smoke-free Future: A Comprehensive Tobacco Control Strategy for England.* London: Department of Health.

Department of Health (2011). *Healthy Lives, Healthy People: a Tobacco Control Plan for England.* London: Department of Health.

De Viggiani, N. (2008). Unhealthy prisons: exploring structural determinants of prison health. *Sociology of Health & Illness, 29, 115-135.*

Dickens, G., Stubbs, J., Popham, R. & Haw, C. (2005). Smoking in a forensic psychiatric service: A survey of inpatients' views. *Journal of Psychiatric and Mental Health Nursing*, *12, 672-678.*

Gautam, J., Glover, M., Scott, A. & Welch, D. (2011). Smoke-free prisons in New Zealand: maximising the health gain. *The New Zealand Medical Journal, 124, 100-106.*

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates.* New York: Anchor Books.

Grattet, R. & Hayes, J. (2013). *Just the Facts: California's Changing Prison Population.* Public Policy Institute of California (online). http://www.ppic.org/main/publication_show.asp?i=702 [Accessed: 7 February 2014].

Great Britain. Health Act 2006: Elizabeth II. Chapter 28. (2006) [Online]. Available at: http://www.legislation.gov.uk/ukpga/2006/28/pdfs/ukpga_20060028_en.pdf [Accessed: 7 February 2014].

Guardian (2007, 28 May). *Rampton patient fights smoking ban at high security hospital.* http://www.guardian.co.uk/uk/2007/may/28/smoking.health [Accessed: 7 February 2014].

Guernsey Press (2012, 23 March). *Smoking Ban Was Our Best Decision.* http://guernseypress.com/news/2012/03/23/smoking-ban-was-our-best-decision/ [Accessed: 7 February 2014].

Hansen, S. L. (2013). *Totally smoke-free prisons – outcomes and insights.* http://healthedcouncil.org/docs/i%20Totally%20Tobacco-Free%20Prisons_Outcomes%20and%20Insigh.pdf [Accessed: 7 February 2014].

H.M. Inspectorate of Prisons (2011). *Report on an announced inspection of Isle of Man Prison.* London: Her Majesty's Inspectorate of Prisons.

H.M. Government (2011). *No health without mental health.* London: Department of Health

H.M. Prison Service (2003). *Prison Service Order 3200 : Health Promotion.* London : HM Prison Service.

H.M. Prison Service (2006). *Prison Service Order 3050 : Continuity of Healthcare for Prisoners*. London: HM Prison Service.

H.M. Prison Service (2007). *Prison Service Instruction 09/2007: Smoke Free Legislation: Prison Service Application*. London: HM Prison Service.

Institut National De Santé Publique Du Québec (2010). *L'interdiction de fumer en établissement de detention québécois.* Québec: Gouvernement du Québec.

Isle of Man Government (2014) http://www.gov.im/about-the-government/departments/home-affairs/isle-of-man-prison-and-probation-service/ [Accessed: 3 February 2014].

Joint Prison Service and NHS Executive Working Group (1999) *The Future Organisation of Prison Healthcare*. London: Department of Health.

Kauffman, R., Ferketich, A. & Wewers, M. (2008). Tobacco Policy in American Prisons, 2007. *Tobacco Control 17, 357-360.*

Kippling, R., Martin, J. & Barnes, L. (2005) UK experience of smoke-free young offender institute. *British Medical Journal, 332, 120.*

Lasnier, B., Cantinotti, M., Guyon, L., Royer, A., Brochu, S. & Chayer, L. (2011). Implementing an indoor smoking ban in prison: Enforcement issues and effects on tobacco use, exposure to second-hand smoke and health of inmates. *Canadian Journal of Public Health, 102, 249-253.*

Lincoln, T., Chavez, R. & Langmore-Avila, E. (2005). US experience of smoke-free prisons. *British Medical Journal, 331, 1473.*

MacAskill, S., & Hayton, P. (2006). *Stop Smoking Support in HM Prisons: The Impact of Nicotine Replacement Therapy. Executive Summary and Best Practice Checklist.* Stirling: Institute for Social Marketing: University of Stirling & the Open University.

MacAskill, S., & Hayton, P. (2007). *Stop Smoking Support in HM Prisons: The Impact of Nicotine Replacement Therapy*. London: Department of Health.

MacLeod, L., MacAskill, S. & Eadie, D. (2010). *Rapid literature review of smoking cessation an tobacco control issues across criminal justice system settings*. Stirling: University of Sterling.

Martin Jenkins (2011). Early-stage process evaluation of the no smoking in prisons policy. New Zealand: Martin Jenkins.

Mills & Reeve (2008). *Challenge to smoke free policy at Rampton Hospital fails.* http://www.mills-reeve.com/files/Publication/919a7597-cfec-4340-9326-420a8ba9ceb5/Presentation/PublicationAttachment/583a8149-7f40-47e1-bfaa-4c2914b20d78/2354.pdf [Accessed: 3 February 2014].

Mills & Reeve (2009). *Second challenge to smoke free policy at Rampton Hospital fails.* http://www.mills-reeve.com/files/Publication/b3a2b834-e612-4387-a728-3602a20c3a03/Presentation/PublicationAttachment/7dc47f93-2d03-4ec8-b4c5-3e49f2e523a0/2569.pdf [Accessed: 3 February 2014].

National Offender Management Service, NHS England & Public Health England (2013) *National Partnership Agreement between: The National Offender Management Service, NHS England and Public Health England for the co-commissioning and delivery of healthcare services in prisons in England.* London: NHS England.

New Zealand Drug Foundation (2010). *Smoking bans in prisons – do they work?* http://www.drugfoundation.org.nz/matters-of-substance/smoking-bans-in-prison [Accessed: 3 February 2014].

New Zealand Department of Corrections (2010). *Corrections News Jul-Aug 2010*. http://www.corrections.govt.nz/resources/latest_news2/corrections_news17.html [Accessed: 3 February 2014].

New Zealand Department of Corrections (2011). *Corrections News Sept-Oct 2011.* http://www.corrections.govt.nz/resources/latest_news2/corrections_news10.html [Accessed: 3 February 2014].

New Zealand Department of Corrections and Statistics (2012). *Prison Facts and Statistics June 2012.* http://www.corrections.govt.nz/resources/facts_and_statistics/quarterly_prison_statistics/ps-July-2012.html [Accessed: 3 February 2014].

New Zealand Herald (2012, 2 August). *Smoking breaches down as prisoners get message.* http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10823870 [Accessed: 3 February 2014].

New Zealand Ministry of Health (2009). *Tobacco trends 2008: A brief update of tobacco use in New Zealand.* Wellington: Ministry of Health. http://www.health.govt.nz/system/files/documents/publications/tobacco-trends-2008.pdf [Accessed: 3 February 2014].

NHS Information Centre (2011). *Statistics on smoking: England, 2011.* London: The NHS Information Centre.

O'Dowd, A. (2005). Smoking ban in prisons would lead to more assaults on staff. *British Medical Journal, 331, 1228.*

Plugge, E. H., Foster, C. E., Yudkin, P. L. & Douglas, N. (2009). Cardiovascular disease risk factors and women prisoners in the UK: the impact of imprisonment. *Health Promotion International*, *24, 334-343.*

Proescholdbell, S., Foley, K., Johnson, J. & Malek, S. (2008). Indoor air quality in prisons before and after implementation of a smoking ban law. *Tobacco Control, 17, 123-127.*

Prison Officers' Association (2011). *A smoke free prison estate.* http://www.poauk.org.uk/index.php?circulars&newsdetail=20111114-185_health-safety-smoke-free-prison-estate [Accessed: 3 February 2014].

R (G) v Nottinghamshire Healthcare NHS Trust (2008). Mental Health Law Online. http://www.mentalhealthlaw.co.uk/R_(G)_v_Nottinghamshire_Healthcare_NHS_Trust_(2008)_EWHC_1096_(Admin) [Accessed: 3 February 2014].

R (N) v SSH; R (E) v Nottinghamshire Healthcare NHS Trust (2009). Mental Health Law Online. http://www.mentalhealthlaw.co.uk/R_(N)_v_SSH;_R_(E)_v_Nottinghamshire_Healthcare_NHS_Trust_(2009)_EWCA_Civ_795 [Accessed: 3 February 2014].

Richmond, R., Butler, T., Belcher, J., Wodak, A., Wilhem, K. & Baxter, E. (2006). Promoting smoking cessation among prisoners: feasibility of multi-component interventions. *Australian and New Zealand Journal of Public Health, 30, 474-478.*

Scoop (2011, 17 August). *Corrections hailed for smoking ban success*. http://www.scoop.co.nz/stories/PA1108/S00348/corrections-hailed-for-smoking-ban-success.htm [Accessed: 3 February 2014].

Scottish Prison Service (2010). *Prisoner Survey 2009*. http://www.sps.gov.uk/Publications/Publication79.aspx [Accessed: 3 February 2014].

Statistics Canada (2012). *Adult correctional statistics in Canada, 2010/2011.* http://www.statcan.gc.ca/pub/85-002-x/2012001/article/11715-eng.pdf [Accessed: 3 February 2014].

The Age (2011, 30 June). *Cigs banned, so prisoners smoke their patches.* http://www.theage.com.au/world/cigs-banned-so-prisoners-smoke-their-patches-20110630-1grr3.html [Accessed: 3 February 2014].

Thomson, H. & Wilson, T. (2007). Giving Up The Habit: HMYOI Wetherby, a No Smoking Establishment. *Prison Service Journal, 172, 29-31.*

Thornley, S., Dirks, K., Edwards, R., Woodward, A. & Marshall, R. (2012). Indoor air pollution levels were halved as a result of a national tobacco ban in a New Zealand prison. *Nicotine Tobacco Research, 15 (2), 343-7.*

Tobacco Control Collaborating Centre *Smoking Policies in Custodial Settings*. Unpublished Manuscript.

Wilcox, S. (2007). Second-hand Smoke Signals from Prison. *Michigan Law Review*, *105, 2081-2103.*

Offender Health Research Network

Jean McFarlane Building (2nd Floor)
University of Manchester
Oxford Road
Manchester
M13 9PL

Website: www.ohrn.nhs.uk