Equality and Human Rights Impact Assessment Publication Document

This template summarises the key decisions/actions taken in the EHRIA, and has been separated from the full EHRIA document for publication on the SPS external website in compliance with statutory requirements.

Background

Title of the Policy	Embedded smoke free culture in prisons.
EHRIA Lead (role)	Health and Wellbeing Policy Manager
Date EHRIA completed	25.07.17
Review date and frequency	Change in prison rules or legislation
Is this a new or revised policy/practice?	New ☒ Revised ☐

Scoping

What are the aims of this policy/practice?

The aim of this project is to implement a smoke-free policy in all Scottish prisons by March 2021 while maintaining a safe and orderly environment.

The policy contributes to Scottish Government:

- National outcomes “We live longer, healthier lives” and “We have tackled the significant inequalities in Scottish society”;
- Purpose targets “Increase Healthy Life Expectancy”; and
- National Indicators “Improve self-assessed general health”, “Reduce premature mortality” and “Reduce the percentage of adults who smoke”.

WHO did you consult with?

Representatives from Scottish Government and NHS Health Scotland were involved in developing the EHRIA. We consulted with the National Offender Management Service in Wales, which has impact assessed and implemented a smoke-free policy in all 4 prisons in Wales.

Staff and prisoner surveys, interviews and focus groups are taking place as part of TIPS, an independent research study into smoking in Scottish prisons. The findings from these will be considered as part of the impact assessment process.

WHAT did you learn?

Evidence gathering and discussion was a key role of the National Tobacco Strategy Work stream in the preparation of the options paper “Continuing Scotland’s Journey towards smoke-free prisons”. Partner agency representatives from the work stream also contributed to the EHRIA.

Learning is set out in detail below.

Going forward, the findings of the independent research study will inform development of policy, practise and implementation.

HOW will this shape your policy/practice?

The evidence considered by the National Tobacco Strategy Workstream informed the options that were recommended to and accepted by the Cabinet Secretary for Justice (i.e. a comprehensive policy, implemented within a timescale of up to 5 years).

The findings of the independent research study will inform development of policy, practise and implementation.

What quantitative and/or qualitative evidence as well as case law relating to equality and human rights have you considered when deciding to develop new or revise current policy/practice?

The work of the Embedding a Smoke-free Culture in Prisons workstream is informed by the options paper developed by the Tobacco strategy Workstream.[i]

A literature review was carried out to support the strategy workstream: Sweeting H & Hunt K (2015). Evidence on smoking and smoking restrictions in prisons. A scoping review for the Scottish Prison Service's Tobacco Strategy Group. MRC/CSO Social & Public Health Sciences Unit, University of Glasgow, occasional paper No. 25. "Continuing Scotland's Journey Towards Smoke Free Prisons" also considered case law on the topic and referred to the results of the 2015 Prisoners' Survey for data.

In this section, the positive and negative effects for all are discussed. The way that these relate to specific groups of people is explored in the relevant sections. Negative and positive impacts are discussed together. The impacts are the consequences of stopping smoking tobacco. Due to the nature of addiction to a substance hazardous to health, the negative and positive impacts are inextricably linked.

Everyone who spends time in prisons will experience significant positive effects resulting from a comprehensive smoke-free policy. Some people who spend time in prisons will experience some negative effects as a result of the policy. These positive and negative effects are broadly consistent across protected characteristics. The negative effects will be experienced more intensely by heavily addicted smokers, however, the positive effects are likely to be greater for this group.

Creating a smoke-free prison service is seen by Scottish Government as an important step on the journey to reducing health inequalities, particularly amongst the prison population.

The Ministerial Group on Offender Reintegration noted that "*prison presents an opportunity to address the health and wellbeing of a particularly marginalised group of people*", that "*those with criminal convictions are often those with the fewest personal assets on which to draw in order to move towards healthier lifestyles*" which in turn "*increases the challenges associated with supporting people to make the sorts of improvements to their health which would reduce their likelihood of reoffending*." *(Scottish Government 2015)*

Smoking is very common in Scottish prisons. Those in custody have over three times the smoking rate in the general population. The high level of active smoking amongst those in custody has a significant impact on the health of smokers and contributes to the poor health profile in this population. In the SPS survey, 56% of smokers in custody expressed a desire to give up smoking.

The high level of smoking and resultant second-hand smoke (SHS) in prisons poses a serious health risk to prison staff, those in custody and staff from partner agencies. Prisons are one of the few remaining workplaces where employees are exposed to SHS during their working day.

The high levels of smoking seen in prisons can be attributed to both the risk factors for smoking, which those in custody have previously been exposed to in the community, and characteristics of the prison setting itself:

Risk factors in the community
Smoking is common in groups that are over-represented in the prison population. Smoking is much higher in people from lower socio economic groups, people with mental illness, people with substance use disorders, in those with lower levels of education, and the homeless.[ii]

The prison setting
Whilst smoking is more common among people coming into prison, entry into prison is also associated with an increase in smoking prevalence. This is the result of both relapse of ex-smokers back to smoking as well as non-smokers taking up smoking. In addition, prison entrants tend to smoke more frequently and consume more tobacco whilst in prison than when in the community.[iii]

Some aspects of the prison environment are suggested as being associated with the likelihood that those in custody will smoke. These include: stress, high rates of smoking in prison, smoking providing a sense of group membership, a lack of social support, boredom, and lengthy periods locked in cells and isolation from family and friends.

Tobacco smoking is a major risk factor for coronary heart disease, stroke, and peripheral vascular disease, a range of cancers and other diseases and conditions and is the single highest cause of preventable ill health and premature death. One in two long term smokers will die prematurely as a result of their smoking and in Scotland, smoking is responsible for a fifth of all deaths.[iv] Likewise, the health impact of SHS is well documented and includes causing lung cancer and ischaemic heart disease in non-smoking adults and is the basis for the existing smoking restriction in public places in Scotland.

Evidence suggests that higher rates of all-cause cancer among prisoners in comparison to the general population could be accounted for by smoking status,[v] and that the mortality risk from smoking-related cancers is higher among prisoners than among the general population.[vi]

Time in prison represents a potential opportunity to improve the health of a population that is often difficult to provide services for 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 these health inequalities.

In addition to physical health benefits, there is good evidence that despite of short term difficulties, people with mental health problems experience an improvement in their mental health when they stop smoking. Studies have shown a reduction in the need for medication for mental health problems in mental health settings where smoke free policies have been introduced, e.g. the State Hospital, Carstairs.[vii]

In terms of negative effects, addicted smokers will experience withdrawal symptoms including cravings, irritability, poor concentration, depression and disrupted sleep patterns. These symptoms are usually temporary. There are health benefits within days of stopping smoking, but it may take a month for the worst cravings to subside. Some tobacco addicted prisoners may find stopping smoking, and even the anticipation of tobacco no longer being available, distressing. Some heavily addicted prisoners may have mental health problems such as anxiety or depression, which may mean that an enforced smoking quit is experienced by them as more challenging. For some individuals in custody, especially those with mental health problems or with experience of adverse childhood experiences, smoking is a maladaptive coping mechanism. Implementation work will need to take account of this.

There is a risk that when tobacco is no longer available prisoners use other psychoactive substances as substitutes for tobacco. In other jurisdictions that have implemented smoke-free policies, some of those in custody attempted to smoke inappropriate materials such as tea bags, banana skins, nicotine patches or even AstroTurf. This practise is harmful to health.

Weight gain has been observed in settings where smoke free policies have been implemented (e.g. Broadmoor and the State Hospital, Carstairs), however this was found to even out over time.

The work of the National Tobacco Strategy Workstream has had a strong focus on developing implementation proposals that take account of the challenges faced by smokers and mitigate the negative impacts. For example, the options paper developed by the Workstream outlined issues that require further consideration including timescales, appropriate cessation provision, communications and the provision of purposeful activity, and highlighted the need for sufficient smoking cessation provision being available to prisoners prior to implementation.

Impact

Will the impact and outcomes of the new/revised policy/practice:

Contribute to eliminating discrimination, harassment and victimisation? E.g. • Raise awareness of our SPS vision and values for equality and diversity • Challenge appropriately any behaviours or procedures which do not value diversity and advance equality of opportunity	**POSITIVE:** It will contribute to eliminating discrimination, harassment, victimisation ☐
	NO EFFECT: It will have no effect on discrimination, harassment and victimisation ☒
	NEGATIVE: It will make discrimination, harassment and victimisation worse ☐
Advance equality of opportunity between those who share a protected characteristic and those who do not? E.g. • Remove or minimise disadvantage • Meet the needs of equality groups that are different from the needs of others participation in public life	**POSITIVE:** It will advance equality of opportunity ☒
	NO EFFECT: It will have no effect on equality of opportunity ☐
	NEGATIVE: It will reduce equality of opportunity ☐
Foster good relations between those who share a protected characteristic and those who do not? E.g. • Tackle prejudice • Promote understanding	**POSITIVE:** It will foster good relations ☐
	NO EFFECT: It will have no effect on good relations ☒
	NEGATIVE: It will cause good relations to deteriorate ☐

Impact

Will the impact and outcomes of the new/revised policy/practice:

Ensure Human Rights Compliance?	It will uphold human rights articles. ☒
	It will breach human rights articles. ☐

Please summarise the results of the Equality & Human Rights Impact Assessment, including the likely impact of the proposed policy/practice advancing equality and human rights.

Positive Impacts

Protected characteristics affected:
The new policy supports equality of opportunity:

Smoking is common in groups that are over-represented in the prison population. Smoking is much higher in people from lower socio economic groups, people with mental illness, people with substance use disorders, in those with lower levels of education, and the homeless.[viii]

Time in prison represents a potential opportunity to improve the health of a population that is often difficult to provide services for 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 these health inequalities.

The new policy upholds Article 2, the right to life. Prison currently exacerbates smoking habits and exposure to SHS amongst groups already likely to experience health inequalities and higher prevalence of smoking. Tobacco smoking is a major risk factor for coronary heart disease, stroke, and peripheral vascular disease, a range of cancers and other diseases and conditions and is the single highest cause of preventable ill health and premature death. One in two long term smokers will die prematurely as a result of their smoking and in Scotland, smoking is responsible for a fifth of all deaths.[ix] Likewise, the health impact of SHS is well documented and includes causing lung cancer and ischaemic heart disease in non-smoking adults and is the basis for the existing smoking restriction in public places in Scotland.

Evidence suggests that higher rates of all-cause cancer among prisoners in comparison to the general population could be accounted for by smoking status,[x] and that the mortality risk from smoking-related cancers is higher among prisoners than among the general population[xi].

Negative Impacts

Protected characteristics affected:

Impact	Mitigation
☒ **Age** *(e.g. older people or younger people):*	There were clear differences in cigarette smoking status by age in 2015, as noted in previous Scottish Health Survey reports. Self-reported current smoking prevalence in 2015 was highest among those aged 25-54 (24-26%), lower among those aged 16-24 (21%) and those aged 55-74 (15-21%) and

Negative Impacts Protected characteristics affected:	
	lowest among those aged 75 and over (8%).[xii] Despite the negative effects noted on pp 9-10, the positive effects are likely to be considerable for this age group. Action on Smoking and Health (ASH) state that stopping smoking before the age of 40 enables individuals to avoid 90% of the associated risks of dying caused by smoking, while stopping by the age of 40 allow people to avoid 97% of the risk.[xiii]
☒ **Race** *(e.g. people from black or any minority ethnic groups):*	The 2012 report on Equality Groups from Scottish Health Survey[xiv] found that *"respondents from Pakistani and Asian Other ethnic groups were significantly less likely to smoke than the national average (prevalence of 13% and 9% respectively)"* And that "*White British smokers smoked an average of 14.4 cigarettes a day, significantly more than those from Other White ethnic groups."* Strategy and implementation work will be based on an understanding that the prison population are significantly more likely to be dependent smokers than the UK average.
☒ **Gender** *(e.g. women or men):*	The Scottish Health Survey has consistently found that men are slightly more likely to be smokers than women. *"For both men and women aged 16 and over in 2014/2015, just over a fifth (22%) self-reported as current cigarette smokers. When adjusted for cotinine levels, prevalence rose to 25% for all adults (26% for men and 24% for women)."*[xv] However, the smoking prevalence at Cornton Vale (the only dedicated women's prison in Scotland) in the 2015 Prisoner Survey was 75%, slightly higher than the Scottish prisons average of 72%. High levels of substance misuse, mental health problems and history of adverse childhood experiences is likely to add to the challenge experienced by women in custody in stopping smoking. In the 2015 survey, 40%

Negative Impacts Protected characteristics affected:	
	of women at Cornton Vale wanted to stop smoking. Research has shown that the health risks associated with smoking are greater for women than for men.[xvi] [xvii] Therefore, while many individuals in this group will experience policy implementation as very difficult, the long term gains for this group are also significant. Pre-implementation will include a workstream to consider how to identify support the most heavily dependent smokers.
☒ **Disability** *(e.g. people with visible or non-visible disabilities, physical impairments):*	Nationally, those with a reported disability have been found to be significantly more likely to smoke than those who do not. 34% of those with a limiting long-term condition smoked compared with only 23% and 22% of those with a non-limiting condition or with no condition.[xviii] Smoking is around twice as common among people with mental health disorders. Smokers with mental disorders are just as likely to want to quit as those without, but are more likely to be heavily addicted to smoking and are less likely to successfully stop.[xix] These groups will benefit from the reduced health inequalities associated with stopping smoking but are likely to find the negative effects challenging. Implementation work will need to consider the specific needs of these groups.
☒ **Gender Identity** *(e.g. changed/changing gender from that assigned at birth):*	Those who have or are planning to undergo Gender Reassignment are more likely to smoke and are therefore likely to experience both the negative and positive effects of the policy.[xx] Pre-implementation will include a workstream to consider how to identify support the most heavily dependent smokers and those who will be most in need of alternative coping mechanisms.

Negative Impacts Protected characteristics affected:	
☒ **Religion or Belief** *(e.g. belonging to a particular religion/belief or no affiliation):*	Nationally, Roman Catholics and those of no religion are more likely to smoke.[xxi] These groups make up a significant proportion of the prison population in Scotland, however, there is no evidence to suggest that these groups will find stopping smoking any more challenging than other groups. Those in custody who burn incense in accordance with their faith needs will require provision for an ignition source to enable them to do so, as lighters will no longer be readily available. Pre-implementation work will need to take this into account.
☒ **Sexual orientation** *(e.g. lesbian, gay, bisexual or heterosexual):*	The 2012 report on Equality Groups from Scottish Health Survey[xxii] found that *"Self-identified bisexual (27%) and gay and lesbian respondents (28%) had a slightly higher smoking prevalence than heterosexuals, but the difference was not significant. Those who self-identified as having an 'other' sexual orientation were significantly more likely to smoke than heterosexual respondents (36% compared to 24%)."* Bisexual, gay and lesbian prisoners are more likely to experience both the negative and positive impacts of an embedded smoke free culture in prisons. Pre-implementation will include a workstream to consider how to identify support the most heavily dependent smokers and those who will be most in need of alternative coping mechanisms.
☒ **Maternity and Pregnancy** *(e.g. pregnant/on maternity leave/breastfeeding):*	Pregnant women in prisons are currently exposed to SHS. Women are not usually transferred to the Mother and Baby Unit, which is smoke-free, until they have given birth and only if assessed as suitable. Smoke-free accommodation is available on other units within HMP & YOI Cornton Vale. Exposure of mothers to SHS during pregnancy reduces birth weight and may also effect risk of prematurity and being small for gestational age.[xxiii] The new

Negative Impacts Protected characteristics affected:	
	policy will have a positive impact on unborn children.
☒ **Marriage and civil partnership:**	Unmarried people are almost twice as likely to be smokers as individuals who are married.[xxiv] The marital status of the overwhelming majority of prisoners is single (78%)[xxv]. Strategy and implementation work will be based on an understanding that the prison population are significantly more likely to be dependent smokers than the UK average.
☒ **Socio-economic groups:**	Across Scotland, smoking is lowest within the most affluent communities and incrementally increases with increasing levels of deprivation; from 35% in the most deprived quintile by the Scottish Index of Multiple Deprivation (SIMD1), to 11% in the least deprived (SIMD5).[xxvi] Strategy and implementation work will be based on an understanding that the prison population are significantly more likely to be dependent smokers than the UK average.
☒ **Human rights compliance** *(e.g. civil, political, economic, social, and cultural rights):*	As discussed in answer to the question "What are the positive impacts?" the new policy promotes Article 2, the right to life. Rampton Secure Hospital implemented a comprehensive smoke-free policy which was tested in the High Court in 2008, and the Court of Appeal in 2009 by 2 patients from Rampton Special Hospital. Both the High Court and the Appeal Court found that there was no human right to smoke.

Recommended course of action	
Outcome 1: Proceed – no potential for unlawful discrimination or adverse impact or breach of human rights articles has been identified.	☐
Outcome 2: Proceed with adjustments to remove barriers identified for discrimination, advancement of equality of opportunity and fostering good relations or breach of human rights articles.	☒

Recommended course of action	
Outcome 3: Continue despite having identified some potential for adverse impact or missed opportunity to advance equality and human rights (justification to be clearly set out).	☐
Outcome 4: Stop and rethink as actual or potential unlawful discrimination or breach of human rights articles has been identified.	☐

Summary of Outcome decision and Recommendations

The outcome is that the policy of embedding a smoke-free culture in Scottish prisons will proceed. Development of policy and practise will be informed by consideration of the needs of specific groups and will seek to mitigate the negative impact.

Next steps

Development of policy and practise will continue to be informed by the findings of the TIPS research study. This includes staff and prisoner surveys, focus groups with staff and interviews with prisoners. University of Glasgow

Pre-implementation will include a work stream to consider how to identify support the most heavily dependent smokers and those who will be most in need of alternative coping mechanisms. Head of Health & Wellbeing

Pre-implementation work will take into account those with faith needs that involve burning incense. Head of Health & Wellbeing

If you require this document in an alternative format, please contact **SPSEqualityandDiversityTeam@sps.pnn.gov.uk**

[i] Ibid.
[ii] ASH Scotland (2014). Smoking in Scotland where are we now? Key facts, figures and trends http://www.ashscotland.org.uk/media/5980/Smoking_in_Scotland_Jan2014.pdf
[iii] Sweeting H & Hunt K (2015). Evidence on smoking and smoking restrictions in prisons. A scoping review for the Scottish Prison Service's Tobacco Strategy Group. MRC/CSO Social & Public Health Sciences Unit, University of Glasgow, occasional paper No. 25
[iv] Salomi Barkat et al., (2015). ScotPHO Tobacco Profiles Second release http://www.scotpho.org.uk/opt/Reports/scotpho-tobacco-profiles-secondrelease2015-overview-report.pdf
[v] Binswanger, I., P. M. Krueger and J. F. Steiner (2009). "Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population." Journal of Epidemiology & Community Health **63**: 912-919
[vi] Kariminia, A., T. Butler and S. Corben (2007). "Extreme cause-specific mortality in a cohort of adult prisoners - 1988 to 2002: a data-linkage study." International Journal of Epidemiology **36**: 310-316
[vii] NHS Scotland (2012): Working towards a smokefree environment: An account of the journey undertaken at the state hospital http://www.tsh.scot.nhs.uk/Official%20Visitors/Docs/ASH%20Scotland%20-%2022%20Feb%2012%20-%20final.pdf
[viii] ASH UK (2014), *Smokefree Prisons*, ASH Action on Smoking and Health UK, Editor http://ash.org.uk/files/documents/ASH_740.pdf
[ix] Salomi Barkat et al., (2015)
[x] Binswanger, I., P. M. Krueger and J. F. Steiner (2009).
[xi] Kariminia, A., T. Butler and S. Corben (2007)
[xii] The Scottish Health Survey 2015: Volume 1, http://www.gov.scot/Publications/2016/09/2764
[xiii] Action on Smoking and Health. Stopping Smoking: The Benefits and Aids to Quitting. September 2014. http://ash.org.uk/stopping-smoking/stopping-smoking-the-benefits-and-aids-to-quitting/
[xiv] Scottish Health Survey, Equality Group, 2012, http://www.gov.scot/Resource/0040/00406749.pdf
[xv] The Scottish Health Survey 2015: Volume 1, http://www.gov.scot/Publications/2016/09/2764
[xvi] Dr Rachel R. Huxley and Mark Woodward, "Cigarette Smoking as a Risk Factor for Coronary Heart Disease in Women Compared with Men: A Systematic Review and Meta-Analysis of Prospective Cohort Studies," The Lancet, Volume 378 (October 2011) Issue 9799: 1297-1305
[xvii] Sanne A.E. Peters, Rachel Huxley, and Michael Woodward, "Do Smoking Habits Differ Between Men and Women in Contemporary Western Populations? Evidence from Half a Million People in the UK Biobank Study," BMJ Open. December 2014 http://bmjopen.bmj.com/content/4/12/e005663.long#ref-7. Accessed July 2015
[xviii] Scottish Health Survey, Equality Group (2012), http://www.gov.scot/Resource/0040/00406749.pdf
[xix] ASH Scotland, Tobacco Use and people with mental health problems (2011)
[xx] NHS Health Scotland Equality issues
[xxi] Ibid
[xxii] Scottish Health Survey, Equality Group, 2012, http://www.gov.scot/Resource/0040/00406749.pdf
[xxiii] Jayes L, et al., (2015). Second-hand smoke in four English prisons: an air quality monitoring study. UK Centre for Tobacco and Alcohol Studies.
[xxiv] Office for National Statistics. Adult Smoking Habits in Great Britain, 2013, https://www.gov.uk/government/statistics/adult-smoking-habits-in-great-britain-2013
[xxv] Prisoner Equality Monitoring December 2016
[xxvi] http://www.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey/Publications/Supplementary2015