Annex A

Continuing Scotland's journey towards smoke-free prisons

SECTION 1: Executive Summary

1.1 Purpose

This paper seeks agreement for the introduction of a new smoking policy in Scottish prisons.

1.2 Summary

Reducing smoking prevalence and addressing inequalities in health are priorities for the Scottish Government.

Smoking rates are very high amongst those in custody, compared to the general population. 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. There is a risk of litigation for failing to provide a safe workplace for staff and a safe environment for those in custody.

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.

There have been policy changes over the last decade to restrict smoking in Scottish prisons. Under current Prison Rules, those in custody are only permitted to smoke in their own cells and during outdoor recreation. Staff, visitors and contractors are not permitted to smoke anywhere on SPS property. A small number of prisons in Scotland have designated a proportion of their residential areas as smoke-free. Despite these types of restrictions in place, staff and those in custody are still potentially exposed to significant levels of SHS, Prisons are one of the few remaining workplaces where employees are exposed to SHS during their working day.

Smoking cessation services, provided by the NHS, are available to those in custody who wish to stop smoking, however uptake of these services is currently low.

There are two options available to reduce the risks associated with the current arrangements: to restrict smoking to designated outdoor areas; or implement a comprehensive smoke-free policy, whereby no person would be permitted to smoke anywhere in any Scottish prison or grounds. The latter option would be supported by a prohibition on tobacco, smokers' materials, lighters and matches on all prison property.

Each option has associated risks and benefits and there are examples of each being implemented in other jurisdictions. Risks, benefits and recommendations are discussed in detail in the full report (see Section 3). Both options would require changes to the Prison Rules.

Based on the evidence available and set out in this paper, a comprehensive smoke-free policy is considered the most effective option to address the negative health impacts associated with exposure to SHS to those in custody and those working in or visiting prisons.

The key risks associated with the implementation of a comprehensive smoke-free policy are prison unrest and prisoner non-compliance. However, with careful implementation and an appropriate preparation period these risks can be mitigated. The experiences of other jurisdictions which already have a comprehensive smoke-free policy in place can be used to support effective implementation.

A key element to successful implementation of a comprehensive smoke-free policy is the provision of effective smoking cessation support capable of meeting demand. This will require implementation of the existing National Smoking Cessation Specification for Prisons, provision of appropriate pharmacotherapy and suitable training for NHS and prison staff.

E-cigarettes have a potential role in supporting those in custody to comply with a comprehensive smoke-free policy. These are relatively new products. There is an on-going debate about the long-term impacts of these products but there is general consensus that they are much less harmful than tobacco. Specific to prison settings, there are also safety and security concerns about how these products may be used. This paper discusses some of the risks and possible benefits associated with introducing e-cigarettes in Scottish prisons but concludes that this needs further in depth consideration. This paper recommends that should the Scottish Prison Service (SPS) wish to explore this further, a specialist group should be convened to consider this specific issue and make recommendations.

In terms of timescales, it is proposed that an appropriate preparation period is up to 5 years from the point of decision on which option to implement. There are financial implications associated with the introduction of a new smoke-free policy, in terms of increasing the level of smoking cessation support, implementation and enforcement of the policy which would need to be addressed.

The Trade Union Side (TUS) position is that a comprehensive smoke-free policy covering buildings and grounds is the only viable outcome to alleviate the risks to members posed by SHS. The TUS consider a **2 year** timescale for implementation to be realistic and achievable, and consistent with the evidence drawn from other countries. **The TUS would like to see a smoke-free implementation date of 2018.**

If the proposal is approved, SPS would lead implementation, with support from relevant colleagues to prepare the operational details of the policy, ensure its successful implementation, and keep track of its progress.

An application has been submitted by an academic research team to the National Institute for Health Research for funding to support a large scale research project to measure SHS levels, the current prevalence of smoking among those in custody and staff, and investigate the impact and meaning of smoking and restrictions from multiple stakeholder perspectives within Scottish prisons. Findings from the research would help to inform the implementation of a new smoke-free policy.

SECTION 2: Background context and rationale for change

2.1 Introduction

The Scottish Government's current Tobacco Control Strategy, *Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland* (2013), articulates the Scottish Government's vision for a tobacco-free Scotland by 2034. This is defined as a smoking prevalence of 5% or lower across the adult population.

Creating a smoke-free prison service is seen as an important step on the journey to achieving both the tobacco-free aim and reducing health inequalities, particularly amongst the prison population. *Creating a Tobacco-Free Generation* contains a commitment for Scottish Government (SG) to work in partnership with the Scottish Prison Service (SPS) and local NHS Boards to "have plans in place by 2015 that set out how indoor smoke-free prison facilities will be delivered".

In response to this, a multi-disciplinary National Tobacco Strategy Workstream was convened by the SPS to provide strategic leadership in the development of a joint action plan. Membership comprised of SPS, NHS Scotland, SG Tobacco Control Team, academia, the Trade Union Side (TUS) and the Third Sector.

This paper is the output of this group and seeks agreement for the introduction of a new smoking policy in prisons. It outlines the rationale for a new policy, the evidence base, the policy options available, potential resource implications and steps required to implement the new policy.

This paper supports the priorities identified in *Equally Well, the Report of the Ministerial Task Force on Health Inequalities* (2008). These include: improving the health and well-being of offenders, ensuring appropriate access of offenders and ex-offenders to quality health services, preventing young people from starting to smoke and supporting those that want to quit.

Additionally, this paper is informed by themes identified by the Ministerial Group on Offender Reintegration, e.g. 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)*

2.2 Background

Prisons are one of the few remaining workplaces where employees are exposed to second-hand smoke (SHS) during their working day. The Smoking, Health and Social Care (Scotland) Act 2005 prohibited smoking inside enclosed public places, as defined by the Act, from March 2006. This legislation was introduced to protect workers and the general public from the immediate and long-term harmful effects of SHS inhalation.

While prison establishments do not fall within the scope of the Act (prisons are not a public place nor a place which has the key purpose of providing healthcare), Prison

Rules were changed in 2006 to support the principles of the Act. This restricted smoking to cells and during outdoor recreation. However, these restrictions mean that staff and those in custody remain exposed to SHS indoors.

2.2.1 The high smoking prevalence amongst those in custody

Smoking is very common in Scottish prisons, with those in custody having over three times the smoking rate in the general population. This has been consistently reported in the SPS biennial surveys, with the 2015 survey reporting that 72% of those in custody smoked, compared to 20% in the general population (*Scottish Household Survey, 2014*). To put this in context, the Scottish prison population is typically over 7,600 at any one time, with approximately 20,000 prisoners coming into custody over the course of the year. Similarly high levels of smoking are found among those in police custody and probation.

The prison survey shows that the more times an offender appears in custody, the more likely they are to smoke:

- 60% of those who have never previously appeared in custody smoke
- 74% of those who have appeared 1 – 5 times smoke
- 86% of those who have appeared 6-10 times smoke
- 89% of those who have appeared more than 10 times smoke

Smoking rates among those in custody appear to have changed relatively little over the last few decades (*ASH Scotland, 2014*), despite smoking rates decreasing in the general population in Scotland over that time. However, more positively, in the SPS survey, 56% of smokers also expressed a desire to give up smoking.

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 *(ASH Scotland, 2014).*

- **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 *(Sweeting and Hunt 2015).*

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 is also used as currency in the prisons - for barter, in gambling, or as protection from violence, bullying or trouble with others in custody. *(Sweeting and Hunt, 2015)*

Finally, prisons are a challenging setting for smoking cessation programmes, which have tended to be given low priority over other health issues or other substance abuse programmes. Some of those in custody have low motivation to quit and / or lack of access to relevant support and health education. In addition, the often transient (and at times unpredictable) nature of prison stays as well as the daily routine in prison reduces the opportunity for consistent cessation support. (*Sweeting and Hunt, 2015*)

2.2.2 Exposure to second-hand smoke (SHS)

Despite restricting those in custody to smoking only in their cells, rooms or open air, the high rates of smoking in Scottish prisons are likely to result in exposure to SHS and in damage to the health of smokers and non-smokers in custody, prison staff and staff from partner agencies working in prisons.

Exposure of pregnant women to SHS in prisons is also a potential problem. 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 (*Jayes et al 2015*).

A recent report for the National Offender Management Service (NOMS) based on data from six prisons in England and Wales provides new evidence in relation to the level of SHS experienced by prison staff *(Semple et al., 2015).* It shows that peaks in SHS in cells where smoking takes place can be considerable. Prison staff self-reported that about half of their working day involves exposure to SHS. Objective measurement of personal exposure indicated that staff spent about one-sixth of their work shift in areas where fine particulate matter ($PM_{2.5}$) – an excellent indicator of SHS concentrations- exceeded health-based guidance from the World Health Organisation (WHO). Some of the personal exposure measurements reported in this study indicated that prison staff were exposed, albeit for short periods, to concentrations of SHS similar to those measured in Scottish bars prior to smoke-free legislation in 2006. A study of air quality in Scottish prisons is proposed to support policy implementation but, given the similarities between Scottish and English prisons environments, the level of SHS exposure is likely to be of a similar magnitude.

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. As such, there is increasing concern about the health, safety and litigation risks associated with the current smoking arrangements (see section 2.2.4 for further discussion), leading to pressure for prisons to go completely smoke-free, particularly from TUS and Public Health partners. Public Health England re-emphasised the urgent need to provide the same level of protection from SHS in prisons as afforded to the general population (*Public Health England, 2015)*

2.2.3 Inequalities in health

The *Better Health, Better Lives for Prisoners* report (2012) observes that the burden of physical and mental illness in the prison population is disproportionately high when compared to the general population. This can be attributed to a number of socio-economic, lifestyle and behavioural factors – one of which is 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 (*ScotPHO, 2015*).

Given these facts, the very high rate of smoking in prisons compared with the general population is a major contributor to health inequalities for those in custody.

Evidence suggests that higher rates of all-cause cancer among prisoners in comparison to the general population could be accounted for by smoking status (*Binswanger et al, 2009*), and that the mortality risk from smoking-related cancers is higher among prisoners than among the general population (*Kariminia et al, 2007*).

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.

2.2.4 Current legal challenges relating to SHS exposure

A non-smoking long stay offender raised judicial review proceedings challenging his detention in conditions in which he is exposed indoors to SHS. The case was heard at the Court of Session by Lord Armstrong on 23 October 2015. The individual sought to rely on the various statements made by Scottish Ministers about the dangers of SHS and in particular the statements made that no amount of SHS is safe. His complaint is that having taken this consistent position about the dangers of SHS, it is unreasonable and thus unlawful for Scottish Ministers to detain him in conditions in which he is exposed indoors to SHS.

Scottish Ministers' response to these matters was that a comprehensive smoke-free prisons policy was something which could only be done in a carefully planned and managed way (currently underway in pursuance of the commitment in the Tobacco Control Strategy). They also noted that there were operational reasons, in particular relating to managing the location of those in custody, which meant it was not possible to have non-smoking areas within prisons such as HMP Shotts at this time.

Lord Armstrong's judgement was issued on the 16th December where he refused the offender's petition. He considered the issues put forward by the SPS and also noted the policy objective to achieve smoke-free prisons. Lord Armstrong was accordingly persuaded that the approach which SPS are taking is within the range of reasonable responses to the situation of dealing with smoking in prisons. SPS have received confirmation that this decision will not be appealed.

2.2.5 Secondary issues arising from smoking

Allowing the use of tobacco and smokers' materials in prisons presents a number of wider security issues. A substantial number of incidents in prisons involve those in custody using lighters or matches to start fires, trigger smoke detectors, smoke illicit drugs and potentially make weapons.

From April 2014 to March 2015 there were 77 fire incidents recorded in Scottish prisons, of which 64 (83%) were recorded as wilful fire-raising. Of the wilful fire raising incidents the source of ignition for 62 (97%) was found to be lighters or matches. Of the 11 accidental fire incidents, careless disposal of smokers' materials within cells accounted for 2 (18%) of the incidents.

A revised smokefree policy could help to address these issues.

2.3 Policy context

WHO Framework Convention on Tobacco Control
In 2003, the 56th World Health Assembly developed the WHO Framework Convention on Tobacco Control, to which the UK (and Scotland) is a signatory. This declares that all persons need to be protected from exposure to environmental tobacco smoke (Articles 4 and 8), which in practice includes those in custody and prison staff.

Smoking, Health and Social Care Act (Scotland) 2005
Scotland introduced a smoke-free law in March 2006. This defined 'no smoking places' in which it was made an offence to smoke. Prisons do not fall with the scope of a "no smoking place" as defined by the Act, however, Scottish Ministers gave a commitment that prisons would conform to its principles.

Prison Rules
The smoking policy regarding those in custody is set out in Rule 36 of the Prisons and Young Offenders Institutions (Scotland) Rules 2011 and associated Direction, the Scottish Prison Rules (smoking) Direction 2014. Those in custody are only permitted to smoke:

- In a cell or room in which a single individual is accommodated
- in a cell in which two are or more individuals are accommodated that has not been designated as non-smoking
- During outdoor recreation

National Tobacco Control Strategy for Scotland 2013
As described in the introduction, the national Tobacco Control Strategy, *Creating a Tobacco-Free Generation,* contains an action for the SPS to have plans in place by 2015 that set out how indoor smoke-free prison facilities will be delivered. The strategy also outlines the importance of reducing health inequalities and the role that reducing smoking rates in the most deprived communities, such as prisons, can play in this**.**

Trade Union Side (TUS)
The TUS are calling for a comprehensive smoke-free policy (buildings and grounds) to be introduced in Scottish prisons, to protect staff from SHS exposure. The TUS would like a Government announcement in early 2016 which

confirms that the SPS are to prohibit smoking within Scottish Prisons, with an implementation date of 2018.

Equally Well
The national strategy on health inequalities *Equally Well (2008),* identified those in custody and those formerly in custody as a vulnerable group and underlined the principle that those in custody "should have access to the health and other public services they need, and benefit from the same quality of service as the rest of the population."

Better health, better lives for prisoners
The principle outlined above was re-emphasised in the National Prison Health Improvement Framework: *Better health, better lives for prisoners: A framework for improving the health of Scotland's prisoners (2012).*

The Better Health Better Lives framework takes an asset based approach, recognising the positive health improvement potential of those in custody, including peer supporters, staff and the internal and external prison environment. The aim is to deliver innovative action that meets consistent standards, includes meaningful involvement with those in custody, is underpinned by workforce development and links into services and support out in the community. A National Prison Health and Wellbeing Group provides strategic support and direction to health improvement and is chaired by a Governor in Charge with membership from key stakeholders including the Scottish Government, NHS Health Scotland and local NHS Boards and SPS staff including the SPS College and a Trade Union representative.

The National Prison Health and Wellbeing Group has previously focussed on specific health topics and issues within the framework advising local prison health improvement groups on implementation and sharing best practice.

Ministerial Group on Offender Re-integration
The report of the Ministerial Group on Offender Re-integration includes recommendations to improve the provision of healthcare to those in custody. It recognised that custody presents an opportunity to deliver smoking cessation interventions to address high smoking prevalence. The report committed NHS Scotland and SPS to work together to develop and implement a national specification for a smoking cessation service to be delivered in all prisons. The national specification was published by NHS Health Scotland at the end of June 2015 and is currently being implemented across Scottish prisons *(NHS Health Scotland 2015).*

National Prisoner Healthcare Network Advisory Board (NPHNAB)
NPHNAB supports the delivery of high quality, safe, effective and consistent health and healthcare services in Scottish prisons. The group identified substance misuse as a priority and a Substance Misuse Workstream was set up in 2013. The workstream is close to publishing a report outlining issues associated with substance misuse in prisons, reviewing current service delivery and best practice and making recommendations on approaches likely to result in assisting recovery and reducing reoffending. The report will include a section on tobacco.

Implementation of smoke-free prisons in England and Wales

Following 5 years of preparation, it was announced in October 2015 that a comprehensive smoke-free policy (buildings and grounds) will be implemented in all Welsh prisons from January 2016 and at 4 early adopter sites in England (HMPs Exeter, Channings Wood, Dartmoor and Erlestoke) from March 2016. As in Scotland, English prisons policy currently allows those in custody to smoke in their cells but not in communal areas. The same policy had applied to prisons in Wales, although regulations made by the Welsh Government, the Smoke-free Premises etc. (Wales) Regulations 2007, did not identify prisons as being exempt.

Preceding the implementation of their policy, those in custody are being encouraged and supported to stop smoking using pharmacotherapy such as Nicotine Replacement Therapy and behavioural support. E-cigarettes suitable for use in prisons are also now available in every prison shop in England and Wales.

From the end of 2015, those in custody in open prisons in England and Wales will not be able to smoke indoors and will only be able to smoke in designated outdoor areas. Plans are also underway to provide voluntary smoke-free areas in all prisons from early 2016.

The proposal is to use the experience of the first prisons going smoke-free to inform the speed at which the remaining prisons in England move to smoke-free.

2.6 Current position in Scottish Prisons

2.6.1 The history of smoking restrictions in prisons

The Scottish Prison Service has had rules in place relating to smoking in prisons since 1950 when The Borstal (Scotland) Rules 1950 were introduced. Over time, smoking has become increasingly restricted for both staff and those in custody. This reflects the growth in evidence on the harms associated with both active smoking and SHS exposure and mirrors restrictions in place in the wider community. In addition, smoking cessation support has increased in prominence.

2.6.2 Current smoking arrangements

The Scottish Prison Rules, when amended in 2006, restricted the places where an individual in custody could smoke. Smoking is only permitted within an individual's cell or room (in a cell in which a single person is accommodated; or in a cell in which two are or more individuals are accommodated that has not been designated as non-smoking) or during outdoor recreation. The 2006 Rules also introduced a new disciplinary offence of smoking in an area of a prison where smoking was not permitted.

Every effort is made by those responsible for cell allocation to ensure that smoking and non-smoking individuals are not required to share a cell (Advice notice 30A/04). The Scottish Prison Rules (Smoking) Direction 2012 provides that regular reviews need to take place where those in custody have expressed a specific preference to be allocated to either a smoking or a non-smoking cell and that preference has not been met.

The SPS smoking policy requires members of staff to consider ventilating a cell in which an individual has smoked before they carry out a routine search of the cell.

Since March 2008, the SPS has not permitted anyone who is working in or visiting a prison to smoke within its boundary.

Since 2010, the SPS has not required any members of its escorting staff to take those in custody into any enclosed space where other people are smoking and has forbidden those in custody from smoking when members of its escorting staff are present.

2.6.3 Effectiveness of current arrangements

Whilst smoking is restricted to cells, those in custody are allowed to smoke with the cell doors open – a requirement that those in custody must close the doors would be difficult to enforce effectively. In addition, the cell doors in prisons are designed so that even when closed they do not form a complete seal. Therefore smoke circulates, entering the common non-smoking areas of the prison

It is unlikely that natural ventilation of a cell prior to a routine search will make a difference to the SHS exposure of a prison officer entering that environment. A recent Scottish study found that SHS can remain at considerable levels in homes for several hours after smoking has ceased; over one-quarter of measurements made showed $PM_{2.5}$ concentrations above WHO guidance levels for more than 5 hours after smoking took place *(Semple and Latif, 2014)*.

In addition, there are issues with those in custody smoking in non-smoking areas. In 2014 there was a total of 299 guilty findings for those in custody found to be smoking in an area of a prison where smoking is not permitted. There may be instances of smoking in areas where it is not currently permitted that are dealt with informally by staff, leading to an under reporting of individuals smoking in non-smoking areas.

Despite the efforts of staff to ensure that smoking and non-smoking individuals are not required to share a cell, it is not always possible. A snapshot report at the time of writing this paper showed that 12 non-smoking individuals were sharing cells with smoking individuals due to operational need.

In terms of SPS staff there is evidence of very limited numbers smoking on prison property.

2.6.4 Provision of smoke-free Units

HMP & YOI Cornton Vale, HMYOI Polmont and HMP Castle Huntly have designated specific units within the prison as non-smoking. These three prisons are unique settings within the SPS estate and are not necessarily representative of the rest of the estate.

Whilst providing smoke-free units is desirable, in the majority of prisons it is difficult to implement for operational reasons. These include the need to house those in custody according to the segmentation of the population (e.g. women, young offenders, short term, long term, sex offenders and those with high care needs), the separation of those in custody who are “enemies” and the housing of those individuals on protection.

- **HMP & YOI Cornton Vale**
  Cornton Vale women's prison is made up of a series of small units designed to hold a relatively small number of those in custody compared to other prisons. This design has enabled the establishment of no smoking units across the residential areas of the prison, with a current capacity of twenty four spaces.

  In addition to these No Smoking Units, the Mother and Baby Unit is also a designated No Smoking area alongside the Mother and Baby Independent Living Unit. The Tobacco Strategy Group are working towards the expansion of designated No Smoking residential areas within Cornton Vale, in particular, making Skye House for Young People a no smoking area by June 2016. Skye House accommodates 16 to 21 year olds and it is illegal to sell tobacco to persons under 18 years old.

  Within the No Smoking Units, individuals receive a range of incentives and support, including a different Canteen/Shop Sheet (with the absence of smoking and tobacco products), bed linen is laundered separately, and additional fresh fruit is provided.

  There has been relatively low demand from women for places within the smoke-free units, as women prefer to remain in friendship groups, irrespective of smoking status. Recently, eight women who were smokers and attended the smoking cessation group were housed in a smoke free unit. However, there is only one woman remaining as all others relapsed back to smoking.

- **HMYOI Polmont**
  Accommodation for young offenders under the age of 18 at HMYOI Polmont is smoke-free. This is because it is illegal to sell tobacco to persons under 18 years old. Young offenders detained in Blair House are not entitled to keep cigarettes or tobacco in their cells as detailed in Scottish Prison Rules (Storage of Property) Direction 2011. 16 and 17 year olds are accommodated in a living area that is totally separate from those over 18. However, during the course of the day, 16 and 17 year olds come in to contact with the over 18 population as they attend education and other activities. This provides them with access to a source of tobacco. Enforcement in this environment is challenging.

- **HMP Castle Huntly**
  HMP Castle Huntly is Scotland's only open prison. It currently has smoke-free areas in the accommodation blocks: - Wallace Wing has 40 smoke-free rooms (40 spaces) and Murray House B Wing has 28 smoke-free rooms (56 spaces). These areas are designated no smoking but are not necessarily fully enclosed so there may be smoke drift from other rooms. The amount of space set aside as smoke-free has been driven by demand. According to a snapshot of the PR2 (the prison records database) the population of Castle Huntly is unusual in that it consists of 55% non-smokers.

2.6.4 Smoking cessation provision

In 2005, Enhanced Addiction Casework Services (EACS) were introduced across Scottish Prisons. This service included the delivery of Smoking Cessation interventions to those in custody who were motivated to reduce or cease smoking.

The EACS was in place until November 2011 when the responsibility for healthcare in prisons was transferred to NHS Scotland. Since then NHS Health Boards have been responsible for the delivery of smoking cessation support within the prison setting in Scotland.

Whilst smoking cessation support is available in all prisons in Scotland there is inconsistency in the approach to service delivery across prisons and local NHS Health Boards. This includes: variation in terms of the types of Nicotine Replacement Therapy available to those in custody; access to varenicline; capacity of the service to cope with demand, the space available within prisons in which to deliver this intervention; the types of behavioural support on offer; and the level of priority given to providing prison cessation services, from both the SPS and NHS. To help address this and in response to a recommendation by the Ministerial Group on Offender Re-integration, NHS Health Scotland developed a "National Smoking Cessation Specification" for prisons which was published in June 2015.

The specification reinforces the need for an equitable, consistent and person-centred smoking cessation service to be delivered to all those in custody who want to stop smoking, in line with community cessation services. The specification aims to ensure:

- All those in custody are promptly offered and receive a consistent and equitable smoking cessation service, irrespective of location across the prison system and NHS Board area.
- That this high quality, specialist smoking cessation service meets the needs of the service user and includes intensive behavioural support and choice of suitable pharmacotherapy.
- That quality standards required for an effective service are achieved, including monitoring and recording smoking status, quit attempts and successful outcomes.
- Seamless transfer between prisons, and to community smoking cessation services on liberation.
- A robust foundation for the development of smoke-free prison plans.

Despite the fact a national specification is in place, at present, there are only a small number of recorded quit attempts taking place in Scottish prisons. In 2014, the total for Scotland was 1,043.

Challenges to implementation of the smoking cessation specification that have been reported include competing priorities impacting on action planning, availability of suitable accommodation and a lack of consistency around which pharmacotherapy is approved for use due to security concerns.

2.7 Learning from other areas which have gone smoke-free

In developing this paper, the group considered the learning of other jurisdictions which have already successfully implemented a smoke-free policy across their prison estate.

In Canada, federal prisons adopted a smoke-free policy in indoor areas in 2006. All Canadian provinces now have comprehensive smoke-free policies (apply to both indoor and outdoor areas). In New Zealand, prisons have had comprehensive smoke-free policies since July 2011. In Australia, most states have now implemented

comprehensive smoke-free policies, with the Northern Territory the first to implement such a policy in July 2013. In the USA, all 105 federal prisons are now smoke-free in indoor areas and, as at April 2014, 20 out of 50 states have implemented comprehensive smoke-free policies in their correctional facilities.

In the UK, comprehensive smoke-free policies were adopted by Broadmoor Secure Hospital in 2007 and by the State Hospital in Scotland in 2011.

Lessons from the experiences of other jurisdictions have been used to inform this paper. Annex A provides more detail on the learning from other areas, key elements of which are summarised in Table 1.

Table 1: *Experiences from other jurisdictions of implementing smoke-free policies in the prison setting*

Organisation/ Jurisdiction,	**Key learning:**
Mental Health	**The State Hospital, Carstairs, Scotland** *(from: NHS Scotland 2012)* • A partial smoke-free policy (indoors) from August 2011, resulted in patients tending to "power smoke" when they could, with patients' daily schedules revolving around smoke breaks. SHS continued to be raised by staff as a concern. • In August 2011, significant operational and potential security risks came to light resulting in a decision to implement a comprehensive smoke-free environment as of December 2011. • Despite initial challenges and concerns, there were no significant problems in respect of implementation. • The first six months showed an above average weight gain which levelled out over twelve months. Patients' spending on confectionery and soft drinks increased. Rates of aggressive behaviour reduced, physical activity remained the same. Positive attitudes of patients and staff towards a comprehensive smoke-free environment increased. • Around 90% of patients required a reduction in their clozapine (a sedative used to treat schizophrenia) dose after they stopped smoking. • Factors crucial to success included appropriate leadership, funding and resources, effective planning and preparation, involvement of key stakeholders and consistent enforcement • A patient at the State Hospital is challenging the comprehensive smoke-free policy. The case is still under appeal at the Supreme Court **Broadmoor Special Hospital** • Adopted a comprehensive smoke-free policy in 2007. With adequate notice period and support the transition had virtually no impact on the level of adverse/ significant incidents. • There was a subsequent increase in other health issues such as increased weight. Broadmoor made provision for healthy living through diet advice and exercise. • The hospital no longer required a regular cardiologist to see patients as health improvements were significant. • Policy provision was made to allow smoking in exceptional circumstances; for example, if someone came in with a limited life expectancy. This was later withdrawn as it was not used. **Rampton** • The comprehensive smoke-free policy 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

Organisation/ Jurisdiction,	Key learning:
	smoke and that they were in an institution whose primary role was to promote good health. **Butler Clinic** • The Butler Clinic, a medium secure mental health unit that caters for a similar population as HMP Exeter, adopted a comprehensive smoke-free policy in 2014. • They had calculated the cost of nicotine replacement based on 80% of the population being smokers and needing 8 weeks supply. In reality they used approximately 10% of the budgeted amount. • They attributed this to an adequate lead in time and good communication with patients. This enabled patients to quit smoking in advance of the go live date.
Canada	• In Canada, federal prisons adopted an indoor smoke-free policy in 2006. All Canadian provinces now have comprehensive smoke-free policies. • The 2006 partial restriction on smoking adversely affected the regime as the focus of those in custody turned to getting outside in order to smoke. As a result work and education suffered and activity sessions were shortened. • Staff found it difficult to make sure that smoking did not take place indoors and searching those in custody on entry to buildings took a significant amount of time. • Subsequently, they moved to a completely smoke-free environment. There were no reports of incidents as a result.
New Zealand	• New Zealand introduced a comprehensive smoke-free policy in prisons (both indoors and outdoors), country-wide, in July 2011 • Critical factors to the successful implementation have been cited as the 12 month lead in time, preparation of a detailed communications strategy to increase awareness of changes, provision of cessation support and planning in relation to potential security issues. • In the year prior to the comprehensive smoke-free policy, those in custody were provided with educational material about the dangers of smoking as well as smoking cessation advice. Psychological and pharmacological support, including NRT, were offered to those in custody and staff, as was a “Quitline”, with those in custody able to call from their prison wings. • Many prisons increased the availability of group activities, recreational equipment and healthy food options. • No major incidents were reported following the implementation of the comprehensive smoke-smoke-free policy • SHS concentrations (PM2.5) reduced by 63% compared with pre-implementation levels, and both fires and arson-related incidents decreased. Evaluation conducted a year post-implementation noted: staff understood its purpose and were committed to its success; tension between those in custody and staff had reduced; staff-reported improved working conditions; some staff had reduced or quit smoking; and there were fewer smoking-related illnesses.
Australia	• In Australia most states have now implemented comprehensive smoke-free. The Northern Territory was the first to implement a comprehensive smoke-free policy in July 2013, Queensland followed in May 2014 and the states of New South Wales, South Australia, Tasmania and Victoria implemented comprehensive smoke-free policies during 2015. • As part of the policy “Quit Programmes” are offered to those in custody, which may include NRT. • Key learning taken has been the importance of having a strong communications and engagement strategy, making sure the health funding is in place to support those in custody through the transition and keeping staff engaged. • It is important to note that both Victoria and New South Wales said that a long lead in time made stakeholder engagement more challenging.

Organisation/ Jurisdiction,	Key learning:
Isle of Man	• Introduced a comprehensive smoke-free policy in 2008 on the grounds that it would be easier enforce. There is one prison in the Isle of Man; there were 118 individuals in custody when the Inspectorate of Prisons visited in March 2011. • Possessing smoking paraphernalia is subject to disciplinary procedures and potential heavy fine for visitors caught smuggling tobacco into the prison. • Cessation support included a 14-week withdrawal plan with nicotine patches or inhaler, extra healthcare staff support, cessation specialist drop-in sessions and cessation support from prison staff • Adverse incidents following implementation included those in custody smoking alternative items, a small hunger strike (the hunger strike began approximately one month after restrictions were introduced. The number involved varied but peaked at 9; the total period was 12 days; after 8 days only 1 person was refusing meals and at no point was there concern for the health of any individual involved *(IOM Today 2008)*) and an incident when those in custody refused to return to their cells. Both the latter were reported to have been quickly and fairly easily resolved. • An Inspectorate of Prisons visit in 2011 noted bullying for patches, non-adherence to the NRT policy, smoking of alternative substances, dangerous ignition practices, and collusion with some staff over illicit smoking and insufficient cessation/withdrawal support. • Despite this, an unpublished study found a 75% reduction in second-hand smoke concentrations (PM2.5) and in 2012, prison management reported improvements over time, with strict enforcement
The example below does not relate to smoke-free policy, but the lessons learned are relevant and are therefore included.	
Methadone	In 2000 the SPS changed their policy and allowed methadone maintenance treatment (MMT) to be started in prison establishments as well as continuity of prescribed methadone on admission from the community. Lessons learned from this policy implementation are transferable to proposed changes in smoking policy. • The change in SPS policy to allow MMT in prisons was brought in haphazardly with no training for staff on methadone. • The presence of ever-increasing numbers of those in custody on MMT had a huge impact on prison life. • Many staff were ignorant of the “treatment aims” of methadone and, as a result, were resentful at what they saw as those in custody abusing help. Education and training of staff about methadone and managing its presence in the prison constructively would have helped to lessen resentment. • Training of all new officers in training college about methadone may aid understanding and stop misconceptions developing.

In summary, in order to ensure any change in smoking policy is effective, supported and enforceable, the following key themes have emerged during the analysis of available evidence:

- Ensuring a sufficiently long lead in time prior to the implementation of the policy;
- A robust stakeholder engagement and communication strategy which engages those in custody, staff and key partners;
- Good data and an understanding of the issues in each prison;
- attitudes of staff and those in custody;
- Clear instruction and guidance from management;
- Funding for nicotine replacement therapy, behavioural and psychological support being in place ahead of the implementation of the policy;
- The provision of purposeful activities;

- Comprehensive staff training and support;
- Prisons go completely smoke-free, even in outside areas, to make the policy operationally manageable.

2.8 The use of e-cigarettes as a cessation aid in Scottish prisons

2.8.1 E-cigarette evidence

E-cigarettes have developed relatively recently. They are consumer products which offer an alternative to tobacco products. There is on-going debate about the safety of e-cigarettes and their potential role as an aid for quitting tobacco. The general consensus, as recently reflected in a review of evidence commissioned by Public Health England *(McNeil et al., 2015)* and position statements by NHS Health Scotland and the Scottish Directors of Public Health, is that:

- these products are much less harmful than tobacco but are not risk-free;
- they should not be used by non-smokers, particularly young people;
- e-cigarettes may have benefits for current smokers if they use them as a full replacement for tobacco;
- more evidence is needed on the long term benefits and risks of e-cigarettes and their role as an aid for quitting tobacco.

2.8.2 Current status of e-cigarette regulation

Under the revised EU Tobacco Products Directive (TPD) which is due to come into force in May 2016, e-cigarettes will be regulated as consumer products unless the manufacturer chooses to seek a medicinal licence. The EU regulations will ensure that e-cigarettes which are sold as consumer products, will be subject to various criteria regarding maximum nicotine strength, size of nicotine-liquid containers and such containers being tamper-proof, packaging labelling, and advertising and promotional restrictions. The TPD e-cigarette provisions are currently subject to legal challenge.

2.8.3 E-Cigarettes licensing

Medicines licensing is a reserved matter, which is the responsibility of the UK Medicines and Healthcare Regulatory Authority (MHRA). Within the last year, the MHRA has granted medicines licenses to two e-cigarette type products, which allows them to be marketed as a medicine on general sale (i.e. over the counter medicine) rather than a prescription only medicine. In practice, this means it would be for individual NHS Health Boards to decide whether to make these products available on prescription.

Both of these products are produced by Nicoventures (a subsidiary of British American Tobacco). While licenses have been granted, to date the manufacturer has not yet launched these products in the UK or made available any pricing structures. Until such times as more information becomes available, the SG and NHS Health Boards cannot consider the cost-benefits compared to those NRTs already available.

2.8.4 Scottish Government legislation

The Scottish Parliament is currently considering the Scottish Government's (Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill). This will make it an offence to sell an e-cigarette to someone under the age of 18. It also includes a range of other measures to regulate the sale and domestic marketing of these products. The intention is to build on the EU TPD to achieve a comprehensive ban on all advertising of e-cigarettes with the exception of most point of sale advertising.

2.8.5 E-cigarettes in Scottish Prisons

The use of e-cigarettes by both staff and those in custody is currently prohibited in Scottish Prisons because of the on-going debate in terms of safety and efficacy, and, more specifically, concerns about the potential security risks presented by e-cigarette products. There is a diverse range of products on the market and there is real concern about how these might be tampered with in a prison setting.

2.8.6 England and Wales

As part of the move to smoke-free prisons in 2016, all prison sites in England and Wales introduced a specific, prison approved e-cigarette in August 2015. This followed a successful trial of a range of products. E-cigarettes are considered an important element of their move to smoke-free prisons and have proved extremely popular with those in custody. Purchasing rates of both e-cigarettes and tobacco goods are being monitored to help to inform decisions on the number and range of products needed to support a move to smoke-free status.

2.8.7 TUS Position

The TUS have expressed concerns regarding the safety of e-cigarettes and have asked for assurances that e-cigarettes will not pose any threat to the operational environment.

2.8.8 Issues for consideration by the SPS

The use of e-cigarettes in Scottish Prisons requires further detailed consideration in light of emerging evidence on effectiveness and safety, information from England and Wales on the use of e-cigarettes in prisons and the development of e-cigarettes suitable for use within the prison setting. This should be considered in depth as part of the implementation plan.

There are clear advantages to introducing e-cigarettes, such as making a smoke-free prisons policy more acceptable for those in custody. However, little is known about the impact of the vapour that would result from heavy e-cigarette use in an enclosed prison environment. In addition, there are ethical concerns amongst some in the public health and justice communities about potentially maintaining addiction to nicotine, and acceptability of a behavior that mimics smoking through the introduction of e-cigarettes within prisons. There are also concerns that allowing e-cigarettes within prisons would indirectly continue to support the tobacco industry (they produce some e-cigarettes) which has historically denied the health risks of smoking, and contributed to the health inequalities this strategy seeks to address.

The Workstream concluded that there is a need for a specialist group to be convened to consider the concerns, risks and benefits of introducing e-cigarettes to Scottish prisons and make recommendations.

SECTION 3: PROPOSALS

3.1 Policy Objective

The objectives of the smoking policy are:

- To ensure an environment that is free from the risk of second- hand smoke for those in custody, prison staff and staff from partner agencies.
- To improve the health of those in custody who smoke, contributing to reducing inequalities experienced by an especially marginalised group, for whom it is often difficult to provide services.

An effective smoking policy is one that manages the following risks:

- Health risks to those in custody associated with active smoking in prisons.
- Health risks to those in custody, prison and other staff associated with exposure to SHS.
- Safety risks to staff and those in custody associated with those in custody misusing tobacco, lighters and matches.
- Litigation risk from staff and those in custody being exposed to SHS.
- Economic risks associated with managing poor health outcomes, safety issues.

3.2 Option for smoking policy in Scottish prisons

3.2.1 Option 1 – No change to the current smoking policy in Scottish prisons

Under this option those in custody would continue to be permitted to smoke within their cell and in designated outdoor areas. Current challenges in relation to the effective enforcement of Prison Rules would continue.

Benefits

Maintaining the status quo reduces the risk of prison disorder and litigation from prisoners that may arise as a result of increased restriction, or a comprehensive smoke-free policy in prisons.

Risks

This option would result in on-going exposure to SHS by both those in custody and staff and would fail to protect staff or those in custody from the harm associated with SHS. It leaves SPS open to continued litigation for failing to protect staff and those in custody from SHS as outlined in section 2.2.2. This option fails to recognise the concerns of the TUS (see below). It is also not in line with Action 31 of the Tobacco Control Strategy for Scotland, which was agreed with the Scottish Prison Service and approved by Scottish Ministers.

TUS Position

Maintaining the “Status Quo” **is not acceptable** to the TUS. This report recognises that staff, prisoners and all other parties will continue to suffer the effects of SHS. This report outlines that Scottish Prisons are one of a few remaining workplaces where staff are exposed to SHS during their working day. Exposure can be evidenced in the report on SHS exposure in prisons recently published by NOMS in England and Wales. The evidence that SHS is a risk to health has been recognised by SG since in 2006 when

smoking was prohibited within all enclosed public places in order to protect workers and the general public.

3.2.2 Option 2 – Smoking restricted to designated outdoor areas

Under this option those in custody would be prohibited from smoking in all indoor areas and some outdoor areas, but would still be allowed to smoke during the limited time they spend in designated outdoor recreational areas.

Benefits
This would be in line with the requirements of Action 31 of the Tobacco Control Strategy for Scotland in implementing *indoor* smoke-free prison facilities and would address the concerns of the Ministerial Group on Offender Reintegration in relation to health inequalities. This option also has the potential to reduce exposure to SHS, as SHS can disperse more easily outdoors. This would potentially mitigate against the risk of litigation, both from those opposed to further restrictions on smoking and those supporting them.

Risks
Evidence from other jurisdictions where partial restrictions have been implemented (e.g. Australia and Canada) shows that this option is difficult to manage and enforce. For example in Quebec, despite the indoor smoking restriction, a study found that 93% of those in custody who smoked still reported using tobacco products inside the prison. It also found this option had limited impact on tobacco use with 48% of those in custody who smoke reporting no reduction in their tobacco use (*ASH smokefree prisons paper*).

The risk of litigation from those exposed to SHS persists due to the difficulty of enforcement, and there is a still a risk of litigation from those opposed to any restrictions.

Those in custody who smoke remain nicotine dependent. This means they will continue to suffer withdrawal symptoms during the rest of the day when they are indoors and unable to smoke. Prison Rules state that those in custody must be given the opportunity, where the weather permits, to spend time in the open air for not less than one hour every day i.e. most would be unable to smoke for 23 hours each day and might suffer withdrawal symptoms for extended periods. One of the downsides noted from the implementation of a partial smoke-free policy at the State Hospital was that patients tended to smoke more when they could, and patients' daily schedules revolved around opportunities to smoke. A partial restriction therefore creates an environment where it is difficult to quit smoking.

Furthermore, restricting smoking to designated outdoor areas does not address secondary issues associated with smoking in prisons, including the misuse of tobacco as a currency by those in custody, and fires caused by smoking related materials (see section 2.2.5 for further details).

TUS Position
Introducing a partial ban where outdoor smoking is permitted is not a realistic approach for the TUS. Facilitating outdoor smoking will pose operational difficulties for SPS staff. In addition this approach does not support the Scottish Government's smoke-free agenda.

3.2.3 Option 3 – A comprehensive smoke-free policy in Scottish Prisons covering both indoor and outdoor areas

This option would mean no person would be permitted to smoke anywhere on any Scottish prison property (indoors and outdoors). This would be supported by a prohibition on tobacco, smokers' materials, lighters and matches on all prison property. This option would be in line with the aspirations of the Tobacco Control Strategy and the principles of the Equally Well strategy on health inequalities.

Benefits
The available evidence shows that a comprehensive smoke-free prisons policy is likely to be the most successful in terms of eliminating SHS exposure. A comprehensive policy would protect staff, those in custody and partner agencies from the health risks associated with SHS. It would protect SPS from litigation related to exposure to SHS, and would recognise the concerns of the TUS (see below). A comprehensive policy would be enforced more easily as non–compliance would be more difficult without legitimate access to tobacco.

Risks
To achieve the benefits above there is an increased risk of prison disturbance. However, based on evidence from English mental health and young offender institutions, an Action on Smoking and Health (ASH) review on smoking in prisons (2015) concluded that concerns that total smoke–free policies would result in disorder were unfounded. Most other reviews present similar conclusions based on evidence from other countries and including studies in secure hospitals (*Sweeting and Hunt, 2015).*

A small number report more mixed findings, including riots in a Queensland (Australia) prison in 1997 and a hunger strike in an Ontario (Canada) prison in 2000. Despite the challenges encountered, restrictions are now in place. Evidence shows that this risk is mitigated by well managed preparation and sufficient availability of smoking cessation support.

There is a risk of litigation by those opposed to a comprehensive smoke-free policy.

TUS Position
A comprehensive smoke-free policy is the only viable outcome for the TUS as this will alleviate the risks to members from the effects of SHS. The TUS fully understands the difficulties the SPS will have in achieving a smoke-free prison environment and will support a careful and considered phased approach in reaching a smoke-free environment. It will be TUS members who will be instrumental in the project's success.

The TUS also recognises that the NHS and SPS will need time to work in partnership to deliver a comprehensive smoking cessation service prior to the smoke-free implementation date. It is essential that in achieving such a complex task the organisation will require a well-defined communication strategy.

3.3 Discussion

The Tobacco Strategy Workstream concluded that Option 3, a comprehensive smoke-free policy, is the most effective response to Action 31 of the Tobacco Control Strategy. This approach is the most effective option in terms of achieving the policy objective to

manage the health risks to those in custody and staff associated with exposure to SHS, the safety risks associated with those in custody misusing tobacco, lighters and matches, and the litigation risk from staff and those in custody being exposed to SHS.

While it is noted that international experience shows that prison riots and disorder have occasionally been linked to smoking restrictions, these disturbances occur in the minority of cases and are usually exacerbated by poor implementation practices, when those in custody and staff are unprepared and/or unsupported during the period leading up to, and during the imposition of restrictions. Risks associated with a move to non-smoking prisons can be mitigated through careful implementation and through the provision of smoking cessation support to both those in custody and staff, discussed further in Section 4 below.

Evidence from other jurisdictions shows that Option 2, smoking restricted to designated outdoor areas, is challenging to enforce and unlikely to protect those in custody, staff and partner agencies from SHS. Option 1, no change to current smoking policy, is least likely to offer adequate protection from SHS.

SECTION 4: IMPLEMENTATION

An Implementation Group would be required to consider and develop an implementation plan for moving to a comprehensive smoke-free prisons policy. This would require detailed consideration of timescales, resources, handling and a range of operational matters. The following section outlines possible approaches to implementing a comprehensive smoke-free prisons policy as well as some of the issues that require further consideration including timescales, appropriate cessation provision, communications, financial considerations and the provision of purposeful activity.

4.1 Approaches to implementing a comprehensive smoke-free prisons policy

4.1.1 Comprehensive smoke-free prisons policy – phased approach

A phased approach can take place at establishment level and / or national level. It is worth noting that a phased approach is being progressed in English and Welsh prisons at both establishment and national level (see section 2.3 for detail).

Establishment level
At establishment level, a phased approach could be adopted by introducing smoke-free residential areas within the prison, with areas defined by individual establishments, before implementing a comprehensive smoke-free prison policy throughout the prison. In this context a smoke-free area is one in which smoking is not permitted at all in a defined area; tobacco or smoking material are not allowed on the person or in cell and tobacco/smoking items are not allowed to be purchased from the canteen list. The smoke-free area is voluntary in the sense that it is populated by individuals who have chosen to live in a smoke-free area. For implementation purposes, prisons would be expected to establish smoke-free areas unless there were compelling operational reasons why this is not possible.

National level
At a national level, a phased approach could be adopted by identifying early adopter sites, which would implement a comprehensive smoke-free policy first. This would allow for evaluation and monitoring of the introduction of the policy, which would support wider roll-out across the remainder of the estate. Sites could be selected for early adoption based on features likely to support success (e.g. existing voluntary smoke-free residential areas, well established smoking cessation service, more compliant population, and slow turnover of prison population).

Risks and benefits of a phased approach
A structured phased approach will allow the experiences from initial sites to inform the speed and approach to subsequent implementation across Scotland.

At establishment level, the benefits of introducing smoke-free residential areas include the early provision of smoke-free environments for some of those in custody.

Evidence suggests that with a well-planned and managed implementation plan, unrest is unlikely *(Sweeting and Hunt, 2015).* In the unlikely event that unrest does occur, a nationally phased approach enables a targeted response. This is likely to promote staff confidence.

However, a phased approach may result in some difficulties with prison transfers, e.g. individuals who smoke refusing to transfer to non-smoking prisons, and vice versa. This approach would also need to take into consideration implications for NHS Health Boards' management of continuity of treatment and waiting lists transfers when individuals are transferred. This approach also potentially leaves significant numbers of staff and those in custody exposed to SHS and therefore there is a risk of litigation as a result.

Introduction of smoke-free residential areas is likely to be challenging in Scottish prisons as many hold a diverse population that already require separate residential areas (e.g. men/women, convicted/remand, short term/long term, those who have committed sexual offences/are under protection) making it difficult to manage residential areas for another specific purpose.

4.1.2 Comprehensive smoke-free prisons policy – simultaneous approach

The alternative to a phased approach is a simultaneous approach where all prisons implement the smoke-free policy at the same time.

With a simultaneous approach there is no opportunity to learn lessons from early adopter sites to inform implementation at establishments that may present a challenge. In the unlikely event of unrest, implementing a comprehensive smoke-free prisons policy across all establishments simultaneously has the potential to result in limited resources having to respond to multiple simultaneous incidents. However, a simultaneous approach negates the difficulties of transferring individuals who smoke between prisons where smoking is permitted to prisons where smoking is not permitted, provides consistency across the prison estate, and protects all staff and those in custody from the health impacts of SHS.

4.1.3 Discussion

The Tobacco Strategy Workstream recommend a phased approach at establishment level as far as operationally manageable within the accommodation available as well as at a national level, beginning with test sites that are judged to be less challenging, to inform implementation plans for the rest of the prison estate. This approach allows sharing of learning and good practice from early adopter sites, which will help to ensure successful implementation of a total smoke-free prison policy

4.2 Timescales for implementation

Irrespective of the approach adopted for implementation, ensuring appropriate timescales are in place will be critical to its success, as emphasised in the findings of those jurisdictions that have implemented restrictions on smoking in prisons. Successful implementation is dependent on the completion of key phases, illustrated in the diagram below.

Diagram 1: *Key phases for policy implementation*

- Plan implementation of tobacco restrictions. - Identify stakeholders - Prepare communication plan. - Objective measurement of second hand smoke. - Impact assessments.	- Ensure necessary funding is in place for NHS delivery. - Change to Prison Rules. - Development of establishment implementation plans. - Communication with stakeholders, including staff and those in custody. - Decision on e-cigarettes.	- Build smoking cessation capacity. - Where possible introduce or expand voluntary smoke-free residential areas. - Site implementation begins.	- Smoking amnesty period. - Cease selling tobacco products through canteen. - Intensive communication with staff and those in custody and promotion of smoking cessation support available.	- Implementation potentially phased across the estate.

- **Shorter timescale option (under 1 year)** – Given the constraints cited above and the evidence from other jurisdictions, the Tobacco Strategy Workstream concluded that a timescale of less than 1 year from decision to implementation of smoke-free prisons would be challenging. There would be an increased risk of NHS services being unable to meet demand, and those in custody perceiving lack of communication and consultation. These factors would increase the risk of disorder.

- **Medium timescale option (up to 5 years) –** Based on the evidence available and taking into account the concerns of the TUS and risk of litigation, the Workstream concluded that the optimum timescale for delivery was up to 5 years.

  This period allows for funding to be secured for appropriate smoking cessation services and for NHS Health Boards and SPS to jointly identify and develop the necessary arrangements to deliver the service. This period would also allow for development of a national strategic action plan to support the development of local implementation plans, together with enhancement of regime activities in line with the SPS Organisational Review and Purposeful Activity Programme. Purposeful activity, in-cell and out-of-cell, will alleviate boredom for those in custody and address one of the reasons cited for the high prevalence of smoking in prison. A timescale of up to 5 years would be consistent with the planning that took place within NOMS prior to announcing implementation of smoke-free policies at a number of pilot sites.

  During the intervening period SPS propose increasing smoke-free residential areas and working with the Five Nations (a UK collaboration with representation from Scotland, England, Wales, Northern Ireland and Republic of Ireland providing a forum to share best practice and mutual learning between health and justice partners) to learn lessons with regard to planning, development and implementation of smoke-free prison policies in other jurisdictions and to focus on the common objectives of addressing the prevalence of smoking in prisons.

However, a timescale of up to 5 years for implementation is not supported by the TUS who are calling for a shorter timeframe of 1-2 years for implementation, as outlined below under "TUS Position".

- **Longer timescale option (over 5 years)** – Based on the evidence considered, the Workstream concluded that a timescale of any longer than 5 years between the initial decision and implementation was unnecessarily long. This timescale would expose staff, those in custody and partner agencies to continued risks associated with exposure to SHS for longer than absolutely necessary, would be out-with the expectation set by TUS and probably lead to litigation. There is a risk that rather than agencies using the additional time available to enable better detailed planning, more pressing concerns would be prioritised and action would not be taken to address funding for and capacity of smoking cessation services until two to three years prior to implementation.

TUS Position
The TUS would like to see a Government announcement in **early 2016** which confirms that the SPS are to prohibit smoking within Scottish Prisons.

The timescales in delivering such a plan are not yet agreed though early indications are that it would be up to 5 years. **The TUS believes that a timescale of up to 5 years is too extensive and the strategy may not be fully considered by some prisons until later within the 5 year timeframe**. The TUS view is that the implementing a full smokefree policy should not take longer than **2 years**. This would be consistent with the evidence drawn from other countries and appears to be realistic and achievable. **The TUS would like to see a smoke-free implementation date of 2018.**

4.3 Enhanced smoking cessation provision to support implementation

4.3.1 England and Wales

Planning for the smoke-free policy in the 8 pilot establishments in England and Wales is based on an expectation that once the policy is in place the majority of those in custody affected will opt out of smoking cessation services and use e-cigarettes, NRT alone (purchased through the prison canteen) or willpower alone. It is possible that uptake of smoking cessation support might be much lower than expected. The Butler Clinic, a medium secure mental health unit that went smoke-free in 2014, budgeted for 80% of the population needing 8 weeks supply of nicotine replacement and used only 10% of the budgeted amount. However, sufficient provision of NRT is also regarded as key to successful implementation.

4.3.2 Key considerations/steps

Implementation of the prison specification across all prisons
NHS Health Scotland, in collaboration with the SPS, published a specification for a National Prison Smoking Cessation Service in June 2015 (see section 4.2.6), to ensure an equitable, consistent and person-centered service is available for all those

in custody who wish to stop smoking.

Whilst the specification is published, it has not yet been fully implemented in any area. Health Boards are responsible for the delivery of the service itself. However, there is a responsibility for SPS to support the delivery of the specification by working in collaboration with Health Boards and offering operational support. An example of this would be providing suitable accommodation for the group sessions, and supporting prisoners to attend timeously.

The number of recorded quit attempts in prisons is low (in 2014 the total for Scotland was 1,043). In one prison there have been no recorded quit attempts. Prior to implementation of a smoke-free prisons policy, cessation services need to be in place which are in line with the specification. Implementing the specification and increasing the capacity of services beyond current provision will incur additional costs. NHS costs would likely include additional staff time and prescribing. There would also be costs for SPS which would be required to support the delivery of any cessation service. Costs to SPS could include:

- providing suitable accommodation for group support;
- ensuring those in custody are released from other duties and able to attend group sessions;
- supporting quit attempts by providing suitable and meaningful alternative activities;
- supporting prison smoking cessation by enabling the use of the full range of pharmacotherapies approved in the above specification;
- generally prioritising smoking cessation through leadership and planning from senior management within the prison.

Managing withdrawal – Provision of pharmacotherapy on prescription

Prescribing varenicline or using combination NRT for a defined period of time will almost certainly be required immediately after implementation of a smoke-free prisons policy. Further consideration will be required of how long pharmacotherapy should be appropriately continued for – both for those already in custody and those newly admitted. This would have an impact on the costs of the service required.

Managing withdrawal - Provision of NRT for purchase

As discussed above, England and Wales are expecting that the majority of those in custody will opt out of NHS cessation services and may choose to purchase their own NRT from the prison canteen. Information from HMP Shotts highlights that those in custody spent **£251,942** on tobacco from the prison shop between March 2014 and August 2015). A comprehensive smoke-free prisons policy will mean that those in custody who smoke will have more disposable income, some of which could be spent on NRT.

Training

To achieve a successful transition to smoke-free, a significant culture change will be required within each prison. NHS staff will have a supportive role as key partners in changing the culture, but leadership will be required by SPS staff at all levels in the prison setting. Training for SPS staff on how to carry out brief interventions and appropriately raise the issue of smoking cessation, can be provided by NHS smoking cessation staff. Ideally all staff should receive brief intervention training. This will ensure clear and consistent messages are communicated to those in custody by all

staff. However, the length of training and the requirement to release staff to attend this training will need to be negotiated locally. Some justice areas already use local "champions" to advocate smoking cessation and this model may prove helpful in working to establish a supporting culture for those in custody to stop smoking.

Transfer of individuals

Those in custody may be transferred to other establishments while on a smoking cessation programme. Consideration will need to be given to how best to ensure continuity of care. This would be especially important if a smoke-free prisons policy is implemented on a phased approach across different sites. Guidance is already included within the existing specification but requires a joined up approach between agencies to ensure that this practice is followed.

Release from prison

On release from prison, it is important that those attending the NHS smoking cessation service are offered on-going support from community smoking cessation services. It is the responsibility of the NHS smoking cessation service to make contact with the receiving service. Those in custody should be made aware of the options available to them e.g. community pharmacy service, local NHS services and Smokeline.

Peer support

There are also opportunities to make the most of the achievement of those in custody who do give up smoking through encouraging them to offer support to their peers who are also trying to quit or to take on more formal training in mentoring or health behaviour change which would benefit them on release.

Staff support

With regard to support for SPS staff who wish to give up smoking, while NHS smoking cessation staff may be willing to provide on-site support in some prisons, community smoking cessation services are usually preferred due to shift patterns and, for some individuals, a preference for anonymity.

E-cigarettes to support policy implementation

The current position in relation to e-cigarettes in terms of legislation, safety and effectiveness is outlined in section 2.6.5. The Workstream concluded that there is a need for a specialist group to be convened to consider the risks and benefits of introducing e-cigarettes to Scottish prisons and make recommendations.

Ensuring adequate Purposeful Activity

Smoking is described by those in custody as a way of dealing with boredom, lengthy periods locked in cells without purposeful – or indeed any – activity, and isolation from family and friends (see section 2.2.2). Research shows that offering access to alternative activities and/or facilities to reduce stress or boredom is a factor in the success of prison smoking cessation interventions and successful introduction of smoking restrictions in prisons. There is an existing Purposeful Activity Programme within SPS, which includes a Health Improvement workstream. Plans for increasing provision of purposeful activity are out of scope of this document. However, in view of the key role that alternative activities will have in successful achievement of smoke-free prisons, next steps will include liaison with the Purposeful Activity Programme.

4.4 Stakeholder engagement Plan

A stakeholder engagement plan would need to be developed as part of the implementation plan. This would need to include consideration of:

- Key messages addressing stakeholders' concerns about implementation and promoting the benefits;
- Engagement with those in custody, both smokers and non-smokers;
- Engagement with staff and those in custody smoking cessation champions;
- Engagement with NHS Health Boards, prison healthcare including smoking cessation services;
- SPS and private prisons;
- Canteen service providers, how we implement Better Health Better Lives;
- TUS;
- Scottish Government;
- Families and friends;
- Media handling strategy
- Others (wider community, through-care, commercial, third sector, champions).

4.5 Financial implications

4.5.1 Costs to SPS

Costs to SPS associated with implementation will include appointing a senior manager with responsibility for providing leadership and coordinating work stream activity in collaboration with NHS and other partner agencies; hosting and attending meetings in relation to planning and implementation activity and promotional materials such as posters and leaflets. Early work will involve a scoping exercise to identify resource implications required to enable effective implementation. Enforcement of smoking restriction is likely to be operationally demanding in the initial stages of implementation and may be disruptive to the regime.

An increase in activities available to those in custody, especially opportunities to spend time out of cell, is associated with successful outcomes in implementing smoking restrictions. Increasing activity provision will be an important consideration in preparations for implementation. Costs associated with increasing provision are out of scope of this paper and will be considered as part of the Purposeful Activity Programme. The Purposeful Activity Programme will also consider maximising use of the existing purposeful activity provision.

There will be an impact on revenue that is currently generated from tobacco sales by the prison shop service. Prison shop profits are divided between contributing to the costs incurred in running the service and the establishment's Common Good Fund, which exists for the benefit of the prisoners in custody. It would be realistic to anticipate a proportion of prison shop spend to move to other products, however a reduction in spending by those in custody overall could be anticipated. This could be mitigated through the introduction of NRT products and / or a prison approved e-cigarette.

4.5.2 NHS costs

Due to the range of options considered by the Workstream, it was not possible to develop a detailed analysis of NHS costs within the time available. Once a preferred approach for implementation has been identified, a detailed modelling exercise will be carried out as part of the development of an implementation plan.

4.5.3 Potential cost savings

Fire
In 2014-15 the source of ignition for 83% of fires in Scottish prisons was smokers' materials, however it is not possible to identify the exact cost represented by remedial work due to fire incidents in Scottish prisons. Effective fire safety measures limit the impact and therefore the cost of fire incidents.

Individuals in custody
Those in custody who currently smoke will save the money they would currently spend on tobacco and associated items. It is likely a proportion of the potential saving may be spent on alternative prison shop items, especially confectionary and sugary drinks. Health promotion approaches should be incorporated within plans to attempt to reduce the impact of any such behavioural change.

Health
Smoking remains the leading preventable cause of early death and ill health in Scotland. As experience of deprivation increases, so too do smoking rates, hence smoking is a significant contributor to Scotland's on-going health inequalities. Smoking costs the NHS as much as £300 million to £500 million each year. The impact of a comprehensive smoke-free policy in reducing both tobacco use amongst 72% of the prison population who smoke and the high level of SHS exposure to those in custody and prison staff, will undoubtedly contribute to savings in healthcare costs in the short, medium and long-term. With the significant movement of people between our prisons and communities, these health benefits have the potential to spread beyond the prison walls and into Scottish communities experiencing high levels of deprivation.

4.6 Governance/enforcement

Progress towards implementation of restrictions will be monitored centrally to ensure safety of staff, those in custody and partner agencies is maintained, balanced with the need to deliver within agreed timescales so that staff, those in custody and partner agencies are not exposed to SHS for any longer than necessary. Establishments' readiness for implementation will be based on evaluation of stakeholder communications and engagement strategy, sufficient availability of smoking cessation support (pharmacotherapy, behavioural and psychological support), capacity to enable individuals' attendance at smoking cessation and operational resilience, including robust contingency plans for the initial period.

Enforcement of smoking restriction in the initial stages of implementation is likely to be challenging and may be disruptive to the regime. Next steps will include consideration of SPS responses to breaches of restrictions e.g. whether to promote a punitive

approach or a supportive approach, similar to that adopted in relation to the misuse of drugs, working in collaboration with NHS addiction services.

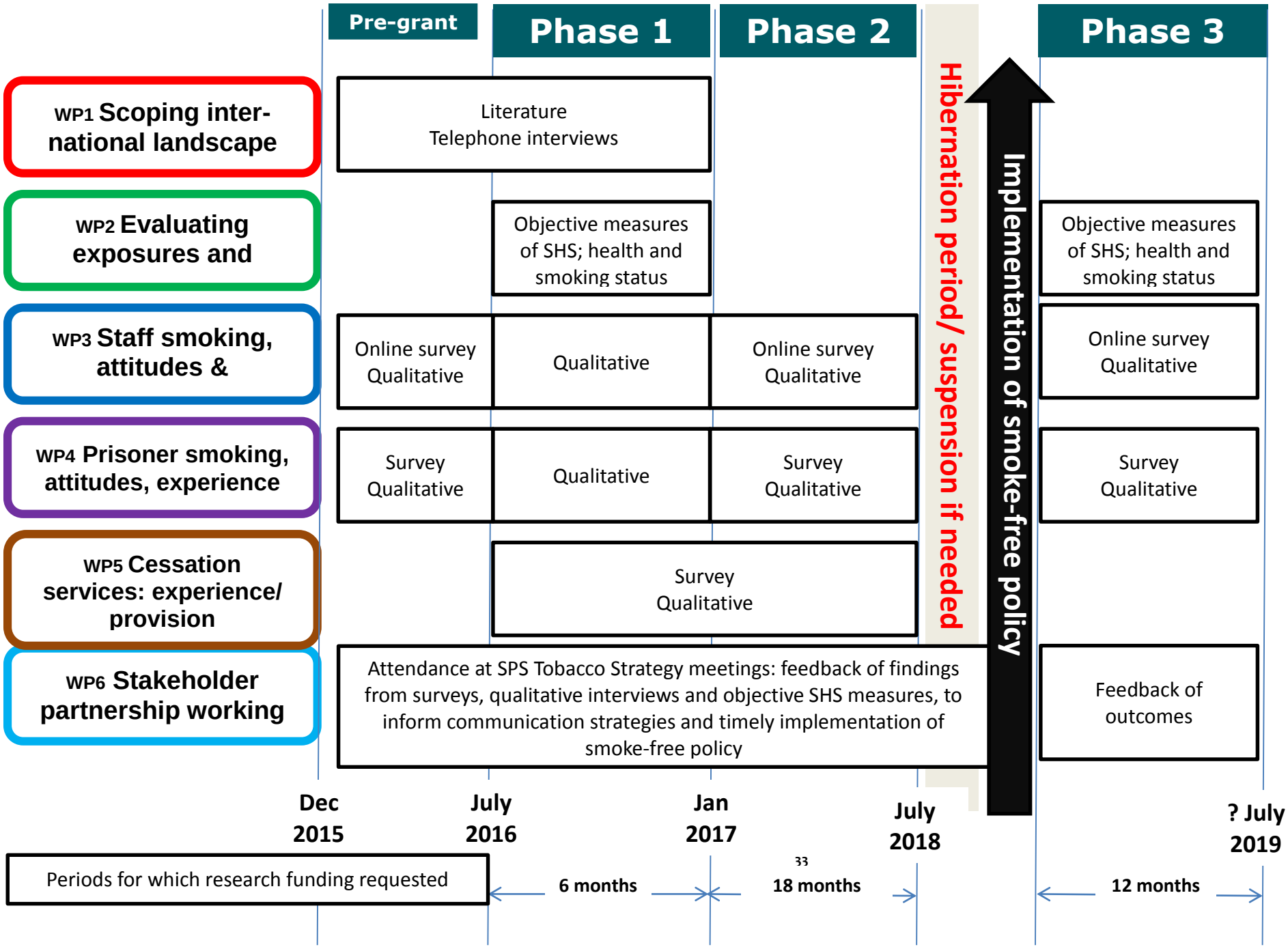
Consideration should be given to governing this project through the SPS Change Portfolio Board as part of the Strategy and Innovation Directorate programme of work.

4.7 Monitoring, evaluation and research

An application has been submitted to the National Institute for Health Research for funding to support a large scale research project to measure SHS levels and the current prevalence of smoking among those in custody and staff, and investigate the impact and meaning of smoking and restrictions from multiple stakeholder perspectives within Scottish prisons.

The research aims to provide evidence obtained through multiple methods, feedback into effective communication, planning and implementation of increased restrictions, and collect data to allow evaluation of smoke-free policies when they are introduced.

The diagram below illustrates the range of work packages (WP) that make up the proposed research. The application was successful at the outline stage and a decision on the full proposal is expected in Spring 2016. The research team, led by Professor Kate Hunt, University of Glasgow, intend to make their findings available internationally to support successful implementation of smoking restrictions in other jurisdictions.


Pre-grant
Phase 1
Phase 2
Phase 3
WP1 Scoping inter-national landscape
WP2 Evaluating exposures and
WP3 Staff smoking, attitudes &
WP4 Prisoner smoking, attitudes, experience
WP5 Cessation services: experience/ provision
WP6 Stakeholder partnership working
Literature
Telephone interviews
Objective measures of SHS; health and smoking status
Online survey
Qualitative
Survey
Qualitative
Attendance at SPS Tobacco Strategy meetings: feedback of findings from surveys, qualitative interviews and objective SHS measures, to inform communication strategies and timely implementation of smoke-free policy
Hibernation period/ suspension if needed
Implementation of smoke-free policy
Feedback of outcomes
Dec 2015
July 2016
Jan 2017
July 2018
? July 2019
Periods for which research funding requested
6 months
18 months
12 months

SECTION 5: Next steps

If the proposal is approved, SPS would lead the implementation, with support from partner agencies to prepare the operational details of the policy, ensure its successful implementation and keep track of its progress.

A number of key steps towards implementation are identified below, illustrating the extent of the task and the need for a measured approach to give assurance of successful implementation of restrictions.

- Necessary legislative change to Prison Rules.
- Undertake an objective measurement of levels of SHS exposure
- SPS to appoint a senior manager with responsibility for providing leadership and coordinating work stream activity in collaboration with NHS and other partner agencies.
- Form an Implementation Group, to consider and develop an implementation plan for moving to comprehensive smoke-free facilities, including detailed consideration of timescales, resources, handling and a range of operational matters.
- Undertake a scoping exercise to identify resource implications required to enable effective implementation.
- Identify appropriate test sites for early implementation.
- Develop a robust stakeholder engagement and communication strategy which engages those in custody, staff and key partners.
- Secure funding for sufficient pharmacotherapy, behavioural and psychological support.
- Partnership working between NHS Health Boards and SPS to build capacity of smoking cessation provision.
- Implementation Group to liaise with SPS Purposeful Activity Programme in relation to enhanced regime activity provision.
- Implementation Group to support development of establishment implementation plans.
- Put in place governance arrangements to monitor establishments' progress towards implementation of restrictions and support assessment of establishments' readiness for implementation.

- Introduce or expand voluntary smoke-free residential areas, where this is operationally manageable.

- Roll out comprehensive staff training and support.

- Ensure arrangement are in place to monitor and evaluate the implementation process and the impact of changes.

Annex A - Analysis on options for smoking policy in Scottish prisons

	Status Quo – smoking permitted in cell and designated outdoor areas	**Smoking restricted to designated outdoor areas**	**Completely smoke-free prisons**
Health Outcomes	**Risks:** Those in custody, staff and partner agencies continue to be exposed to SHS. No improvement in health outcomes for staff, partner agencies and those in custody. Exposure to others' smoke creates a difficult environment to quit smoking.	**Risks:** Risk of exposure to SHS is reduced though some drift from outdoor areas to indoor areas would remain an issue. **Benefits:** Likely healthier indoor environment for those in custody, staff and partner agencies, improved health outcomes for non-smoking people in custody, staff and partner agencies. Risk of "power smoking" during limited opportunities to smoke and experiencing withdrawal for extended periods. Enforcement will be problematic and may be unachievable, undermining potential benefits.	**Benefits:** Optimal option for reducing risk of exposure to second hand smoke. Healthier environment for those in custody, staff and partner agencies. Improved health outcomes for non-smoking people in custody, staff and partner agencies. Those in custody who smoke will be tobacco free for the duration of the custodial period. Supportive environment for those who wish to quit smoking.
Risk of disorder	**Benefits:** Unchanged risk of disorder as the environment is what is currently expected.	**Risks:** Potentially increased risk of disorder, particularly if rules/implementation are perceived as unfair; risk mitigated by good communication and planning. Increased risk of disorder amongst those in custody with less access to time outdoors, these are likely to be the most volatile individuals. Smoking restriction challenging to enforce effectively. Risk of those in custody pressurising staff to unlock them to access smoking area.	**Risk:** Potentially increased risk of disorder if staff and those in custody are unprepared for smoke-free policy, and/or perceive the policy as unfair and unnecessarily restrictive. Risk mitigated by good communication and planning.

Risk of litigation	**Risks:** Staff, those in custody or partner agencies could claim for being exposed to an unsafe environment resulting from harmful levels of second hand smoke.	**Risks:** Very low risk if restriction is effectively enforced. However, there were still be exposure outdoors, smoke drift from outdoors in and risk of non-compliance indoors remains high; therefore there remains a moderate risk of litigation due to staff or those in custody being exposed to SHS.	**Risks:** Litigation from those opposed to restriction in other jurisdictions, claiming a right to smoke, have been unsuccessful. **Benefits:** No risk of litigation in relation to exposure to second hand smoke. Low risk of litigation from those opposed to restriction. Internationally, the risk has been mitigated by provision of smoking cessation support.
Cost of option	No new implementation costs but there is the continued health cost of smoking and SHS. Also potential litigation from staff and those in custody exposed to SHS. Ongoing costs associated with fires caused by smokers' materials (see 2.2.5). Exact cost not known, and limited by existing effective fire safety measures. However in 2014-15 the source of ignition for 83% of fires in Scottish prisons was smokers' materials.	Cost of communications for those in custody, staff, partner agencies and visitors. Cost of providing support for those in custody to abstain from tobacco while indoors depending on duration of NRT supply. (Cost of pharmacotherapy, healthcare staff resource and prison staff to escort individuals). Ongoing costs associated with fires caused by smokers' materials (see 2.2.5). Exact cost not known, and limited by existing effective fire safety measures. However in 2014-15 the source of ignition for 83% of fires in Scottish prisons was smokers' materials. Enhanced regime activity should be considered to alleviate boredom; the costs associated with this are out of scope of this documents and in scope for the Purposeful Activity Programme.	Cost of communications for those in custody, staff, partner agencies and visitors. Cost of smoking cessation service, initially for all those in custody who smoke and request the service; long term for those newly admitted to custody (cost of pharmacotherapy, healthcare staff resource and prison staff to escort those in custody). These costs will be offset by significant long term reductions in smoking-related costs to the state sector. Enhanced regime activity should be considered to alleviate boredom; the costs associated with this are out of scope of this documents and in scope for the Purposeful Activity Programme.

Operational impact	None over and above the ongoing challenges of enforcing existing prison rules and the identifying and allocating smokefree spaces for non-smoking individuals.	Increased need for facilities to deliver smoking cessation support and operational support to facilitate attendance by those in custody. Time and resource required to enforce smoking restrictions indoors and manage related misconduct.	Initially for all those in custody who smoke who request the service; long term for those newly admitted to custody: • Impact on NHS services and pharmacy to meet demand. • Impact on SPS through increased need for facilities to deliver smoking cessation support and operational support to facilitate attendance by those in custody. Increase in managing smoking related misconduct e.g. smoking, possession of tobacco or associated paraphernalia. Tobacco less commonly used as currency for illicit trading. Potential reduction in fires/arson incidents.
Unintended negative consequences	Ongoing risk that those in custody are still able to start fires. Ongoing risk that those in custody use tobacco as currency for illicit trading, leading to debts and associated violence and intimidation. Ongoing risk of use of illicit substances, e.g. NPS.	Ongoing risk that those in custody use tobacco as currency for illicit trading, leading to debts and associated violence and intimidation. New unintended consequence that canteen spend on unhealthy items (carbonated drinks, confectionary) likely to increase, likely to lead to weight gain. Ongoing risk of use of illicit substances, e.g. NPS, is increased.	New unintended consequence that tobacco, lighters, associated smoking requisites may become highly valuable contraband (though less common than they currently are). New unintended consequence of potential increase in canteen spend on unhealthy items (carbonated drinks, confectionary), likely to lead to weight gain. Ongoing risk of use of illicit substances, e.g. NPS, is increased. New unintended consequence of potential for those in custody to attempt to smoke inappropriate alternative

			substances (e.g. tea leaves, nicotine patches) using dangerous ignition practices. New unintended consequence of pressure on staff and visitors to traffic tobacco into prison.

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