TOBACCO USE IN PRISONS

World Health Organization
REGIONAL OFFICE FOR Europe

SMOKING-RELATED DISEASES, SUCH AS CANCER AND CARDIOVASCULAR DISEASE, ARE LEADING CAUSES OF DISEASE AND DEATH IN PRISONS IN MANY COUNTRIES *(1)*.

TOBACCO IS THE PSYCHOACTIVE SUBSTANCE **MOST WIDELY USED** BY PEOPLE LIVING IN PRISON *(1)*

TOBACCO-SMOKING IN PRISONS IS THE **LEAST ADDRESSED** OF THE HEALTH RISKS POSED BY ABUSE OF ALL SUBSTANCES *(1)*

SMOKING IN PRISON POPULATIONS IS VERY HIGH

MALES

France	**90.0%** *(2)*
Germany	**88.0%** *(3)*
Greece	**80–91.8%** *(4,5)*
Italy	**77.0%** *(6)*
Lithuania	**85.5%** *(7)*
Poland	**81.0%** *(8)*
Switzerland	**83.0%** *(9)*

Source: data from Ritter et al. *(10)*, except for Italy and Switzerland.

FEMALES

France	**63%** *(11)*
Lithuania	**82.1%** *(7)*
United Kingdom	**85.0%** *(12)*

Source: data from Ritter et al. *(10)*.

There is enormous difficulty in obtaining reliable data on smoking habits in prison at country level. Most estimates presented therefore result from ad hoc research studies, which presents limitations. The most recent data from the Health in Prisons European Database suggest that while smoking status is assessed on prison admission by roughly 80% of Member States (29 of 36 reporting on this for all prisons and four for most prisons), poor documentation is likely to be a determinant of the inability to indicate the proportion of individuals who smoke (a variable reported by only seven countries) (WHO Regional Office for Europe, unpublished data, 2022).

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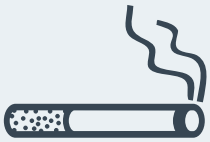
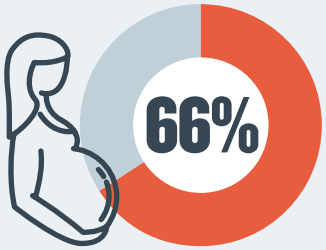


2–4
TIMES HIGHER

Smoking prevalence rates are 2–4 times higher in prison populations than in general populations *(13)*.

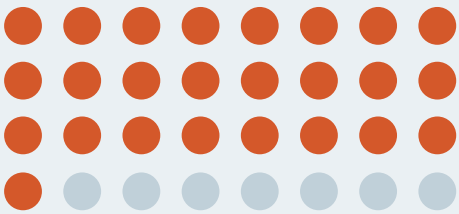


Studies in some countries have indicated that a large proportion of pregnant women living in prisons (66.0%) are also likely to smoke *(14)*.

Smoking among prison staff is largely unexplored. In some countries, smoking rates among prison staff are higher than in the general population *(15)*. While a striking decline in smoking prevalence rates has been observed in the general population of countries in which tobacco-control policies are being implemented, no comparable changes have been seen in prison settings over recent decades *(10,15)*.

HIGH EXPOSURE TO SECOND-HAND SMOKE IN PRISONS

People in prisons face high exposure to second-hand smoke due to smoking among people living in prisons and staff and the fact that most of their time is spent indoors.

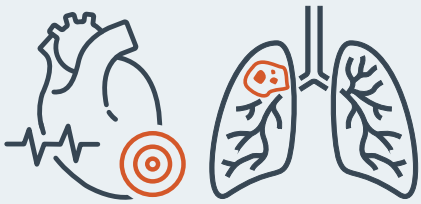


25 COUNTRIES HAVE SMOKE-FREE CELLS AVAILABLE IN SOME PRISONS

Of 32 countries of the WHO European Region reporting data, 78% had smoke-free cells available in some prisons. Of these, 88% had smoke-free cells available in all prisons *(16)*.

Data on how many Member States have an entirely smoke-free prison estate are not available *(17)*.

Data are limited on the supports in place to assist smoking cessation in prison populations in the Region *(17)*.



SECOND-HAND SMOKE is known to have health-damaging effects, including an increased risk of heart disease (by 25–30%) and lung cancer (by 20–30%) in non-smokers *(18)*.

In the absence of a comprehensive smoke-free prison, smoke-free cells do not adequately protect from the harms of second-hand smoke *(18)*.

GUIDANCE FOR ACTION

THE PRISON ADMINISTRATION HAS A DUTY OF CARE FOR THOSE LIVING IN PRISONS. THIS INCLUDES:

Protecting people living and working in prison, as well as visitors, from the harmful impact of second-hand smoke exposure.

Promoting and supporting cessation for smokers.

Safeguarding non-smokers from starting tobacco use.

Member States can be guided by the WHO Framework Convention on Tobacco Control (WHO FCTC) (Box 1) and the United Nations Minimum Standard Rules for the Treatment of Prisoners (Nelson Mandela Rules) (Box 2), which provides an outline of the agreed minimum standards for the treatment of people in prisons *(19)*.

BOX 1. KEY HIGHLIGHTS OF THE WHO FCTC FOR ADDRESSING TOBACCO USE IN PRISONS

WHO FCTC

ARTICLE 8. PROMOTE SMOKE-FREE ENVIRONMENTS

- Duty to protect all people. The effective way to protect everyone's right to breathe clean air inside public places and at workplaces is to adopt and enact complete smoke-free policies.

ARTICLE 12. PROVIDE EDUCATION, COMMUNICATION, TRAINING AND PUBLIC AWARENESS

- With consideration of key differences among population groups and special regard to frequently neglected groups
- Include prenatal tobacco prevention and cessation interventions

ARTICLE 14. PROMOTE SUSTAINABILITY IN TOBACCO CESSATION AND PROVIDE ADEQUATE TREATMENT FOR TOBACCO DEPENDENCE

- With inclusivity and tailoring for needs of population groups
- Ensure tobacco use status is included in all relevant notes

ARTICLE 20. STRENGTHEN SURVEILLANCE AND EVIDENCE

BOX 2. KEY HIGHLIGHTS OF THE NELSON MANDELA RULES FOR ADDRESSING TOBACCO USE IN PRISONS

NELSON MANDELA RULES

RULE 5. MINIMIZE DIFFERENCES BETWEEN PRISON LIFE AND LIFE IN LIBERTY

RULES 6 and 10. INDIVIDUAL FILE MANAGEMENT SYSTEM THAT CAN ALSO BE USED TO GENERATE DATA AND CREATE A BASIS FOR EVIDENCE-BASED DECISION-MAKING

RULE 13. ACCOMODATION IN PRISON SHOULD MEET HEALTH REQUIREMENTS AND CONSIDER AIR QUANTITY AND QUALITY

RULE 24. "EQUIVALENCE OF CARE" – HEALTH CARE IN PRISONS SHOULD MEET THE SAME STANDARDS AND QUALITY TO THAT IN THE COMMUNITY AND ENSURE ACCESS TO NECESSARY CARE

RULE 26. MEDICAL FILES ARE UPDATED AND TRANSFERRED WITH INDIVIDUAL TO SUPPORT THE CONTINUITY OF CARE AND PREVENT TREATMENT DISCONTINUATION

RULE 28. SPECIAL ACCOMODATION IN PRISONS FOR ALL PRENATAL AND POSTNATAL CARE

RULE 87. BEFORE COMPLETION OF THE SENTENCE, ENSURE FOR THE INDIVIDUAL A GRADUAL RETURN TO LIFE IN SOCIETY

OPPORTUNITIES FOR ACTION

People living in prisons often want to achieve something while in prison and can perceive smoking cessation as a big achievement *(15)*.

Marginalized individuals may have an opportunity to access cessation services and pharmacotherapy only during incarceration *(20)*.

Prisons can have the potential to promote health and help address the extensive inequalities in health experienced by the prison population *(20)*.

CHALLENGES AND CALL FOR ACTIONS

THE CHALLENGES ARE:

- fear that quitting smoking could place an intolerable burden of stress on people living in prisons and staff *(15)*;
- belief that smoking cessation will increase boredom in prison *(15)*;
- perception that people in prison are not provided with an individual choice to be healthy – by, for instance, not smoking – in cases of a complete smoke-free prison estate *(21)*;
- absence of interventions addressing smoking and cessation among people living in prisons *(4,22)*;
- scarcity of data that capture the prevalence of smoking among female and young people living in prison and staff *(10)*;

CALL FOR ACTIONS

Smoking cessation programmes in prison should be tailored to the unique stresses and circumstances of the prison environment.

Smoking-cessation initiatives should include activities to alleviate stress and boredom among people in prisons.

This can include the promotion of physical activity as a substitute for smoking. Creating facilitated access to gym facilities or varied sport activities is likely to improve programme adherence, decrease stress levels and improve overall quality of life.

Staff should be involved in developing tobacco-control policies in prisons and their own attempts to stop should be supported.

People in prisons should be facilitated and empowered to embrace a healthy life and sustain healthy behaviours after release. Education and training activities should raise awareness and contribute to developing skills in engaging with health promotion.

Nonspecific actions to be taken to facilitate healthy choices in prison should be included in the public health agenda.

Prisons should be included in national tobacco-control strategies.

Data and evidence need to be strengthened.

Prevalence data are required for different population groups in prison, including staff, females and young people living in prison. Investment should be made in documentation and efficient information systems.

Best practices on smoking cessation among people living in prisons should be collected.

Steps should be taken to avoid confusion between the health department and custodial authorities over ownership of measures to address tobacco in prisons. Collaborative agreements should be in place and synergies should be fostered.

• prisons concentrate people who frequently use tobacco, alongside those who have lower socioeconomic status and/or lower educational attainment *(23)*;	**Interventions that are tailored to the specific population group should be ensured.** Health information materials should translate easily into the prison setting, and cultural, language and health literacy needs should be taken into account in preparing materials.
• prisons are condensed environments with people who frequently use tobacco and other substances (including alcohol and drugs) or who are experiencing mental health disorders *(24)*;	**Periodic assessments should be made to ensure nicotine withdrawal is appropriately managed, particularly for high-risk individuals.** High-risk individuals include people with substance-use disorders, learning difficulties, histories of self-harm, mental health disorders, long-term significant tobacco use or who have been prescribed specific medications. **Smoking-cessation interventions should be integrated with mental health and/or substance-abuse services.** **Use of transparent nicotine patches to prevent the concealment of illicit substances should be considered.** **A whole-prison approach should be adopted through a multi-disciplinary team approach.**
• cigarettes and tobacco are frequently used as currency by people living in prisons, as can medicinal nicotine; • people living in prisons may enter cessation programmes to secure pharmacotherapy to sell to others living in the prison while they continue to smoke *(20,24)*;	**Various models can be used to address possible misuse of pharmacotherapy.** Examples include the introduction of pharmacotherapy exchange schemes (exchange of used products when receiving a new supply) and reviews of the quantity supplied to reduce the risk of misuse or diversion.
• people living in prisons are often transient, creating an additional layer of challenge in maintaining engagement and contact with smoking-cessation services and continuation of support and counselling *(23,24)*; and	**Plans should be in place to adequately prepare people living in prisons for the likelihood of transfers.** In moments of transition, medical records should be updated and transferred with individuals released, together with a short supply of pharmacotherapy (sufficient to last until prescribing can be renewed at the new location). Those transferring from a smoke-free prison should be identified to encourage them to maintain their smoke-free status by, for instance, electing voluntary smoke-free accommodation and continuing with cessation support. People living in prisons where smoking is allowed who are to be transferred to a smoke-free prison should be adequately prepared.
• the post-release period from prisons is particularly challenging and presents a stressful time of readjustment *(23,24)*.	**Extra post-release support should be offered to avoid relapse.** Transitioning from a smoke-free prison to life outside prison, with possibly fewer smoke-free environments, adds complexity to the transition. People may need extra post-release support to avoid relapse, which can include linking of prison programmes with community smoking-cessation services.

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1 All weblinks accessed on 7 March 2022.

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