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Rapid Literature Review of Smoking Cessation and Tobacco Control Issues Across Criminal Justice System Settings

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Introduction

This review was undertaken to inform the development of the Regional Criminal Justice Coordinator role in the North West Region. It was conducted by the Institute for Social Marketing at the University of Stirling and involved a rapid review of literature on smoking cessation and tobacco control issues across criminal justice system (CJS) settings, namely prisons, probation services, police and courts.

Both academic and grey literature searches were carried out to identify relevant English language literature published between 2005 and 2010. The following academic databases were searched: Cinahl, IBSS, PsychINFO, and PubMed. Detailed and comprehensive search terms were used to search databases. Search results were screened for relevance and potentially relevant resources were obtained in full text. A range of sources were searched for relevant grey literature, including but not restricted to: the Offender Health Research Network, Google advanced search, Cochrane Collaboration, National Institute for Clinical Excellence (NICE), HM Prison Service website and Action on Smoking and Health (ASH) website. Literature was synthesised to form a narrative review.

The review describes the nature of smoking cessation initiatives implemented internationally and in the UK. The focus is largely on initiatives implemented in prisons, as the published literature suggests that most initiatives in the CJS have been implemented in this setting, however effort has been made to include initiatives from other CJS settings. The review also includes initiatives that target or include the families of CJS clients and CJS staff. Barriers and facilitators to the success of smoking cessation initiatives are then identified from experiences described in the literature. Finally, the implications of the evidence-base for the development of smoking cessation initiatives in the UK criminal justice context are considered.

Smoking Prevalence and Potential for Smoking Cessation Initiatives

Smoking is an established and integral part of the culture and a social norm in prisons and other criminal justice settings (Butler *et al* 2007; Richmond *et al* 2009; Long & Jones 2005). A male prisoner in a category-C prison in England described tobacco as "everybody's lifeline in here" (de Viggiani 2008).

Investigations in a variety of countries and prison settings have consistently reported prison inmate smoking prevalence rates of greater than 60%, and in many cases greater than 80% (Hartwig *et al* 2008; Plugge *et al*, 2009; Holmwood *et al* 2008; Papadodima *et al* 2010; Sieminska *et al* 2006; Nijhawan *et al* 2010; Belcher *et al* 2006; Cropsey *et al* 2005a; Cropsey *et al* 2005b; Cropsey *et al* 2010; Scottish Prison Service 2010a). A trend for high smoking prevalence rates among prisoners has been shown among female prisoners as well as male prisoners (Holmwood *et al* 2008; Nijhawan *et al* 2010; Plugge *et al* 2009; Belcher *et al* 2006; Scottish Prison Service 2010b). For example, in a 2004/2005 study conducted in two large women's' remand prisons in England, 85% of prisoners reported being smokers (Plugge *et al* 2009). Given that the average smoking prevalence of the general adult population in Britain is around 21% (Office for National Statistics 2009); this represents a significant health inequality.

It is important to consider that smoking in prison presents a risk to the health of other prisoners, prison staff and prison visitors through second hand smoke, as well as the risk to the health of smokers themselves. Given the trend for high smoking prevalence described in prisons, the health risks associated with second hand smoke can be significant. Indeed, it has been reported that more prisoners in the US die from exposure to second hand smoke every year than the number who are legally executed (Wilcox 2007). Concern around second hand smoke in prisons has led to a move towards smoke free policies.

Although less research has been conducted than in prisons, there is some evidence to support the supposition that smoking prevalence is also high in other areas of the criminal justice system (CJS). For example, a 2007 survey of offenders on probation caseloads in Nottinghamshire and Derbyshire revealed that 83% of probationers were smokers compared to only 22% of the general population in that area (Brooker *et al* 2008). Sixty-three percent of detainees in police custody in London reported dependence on cigarettes in a 2007 survey (Payne-James *et al* 2010). There is also some evidence to suggest that smoking prevalence may also be higher among CJS staff than among the general population. A 2002 survey conducted at HMP Bowhouse in Scotland revealed a smoking prevalence of 75% among staff (Knox *et al* 2006).

Smoking habits can change in prison, both positively and negatively. A lack of access to tobacco and other factors can be associated with a reduction in the amount of tobacco smoked and/or frequency of smoking (Plugge *et al* 2009; Papadodima *et al* 2009). However, imprisonment can lead to an increase in smoking behaviour. For example, a US study conducted in a female prison found increases in smoking behaviour among inmates, with 14% of prisoners having started smoking for the first time and more than 50% having increased their smoking since entering prison (Cropsey *et al* 2008). Although the authors do not explore the reasons for these changes in detail, other studies have shown that factors such as boredom and coping with stress are reasons frequently given by prisoners to explain why they feel a stronger need to smoke while in prison (Richmond *et al* 2006; Sieminska *et al* 2006). No published literature was identified addressing changes in smoking habits related to involvement in CJS settings other than prison.

Despite the fact that involvement in the CJS can result in increased 'need' to smoke, studies across different CJS settings have revealed desire among offenders[1] to quit smoking, and an interest among offenders in receiving smoking cessation assistance (Nijhawan *et al* 2010; Proescholdbell *et al* 2008; Stuart *et al* 2006a; Stuart *et al* 2006b; Sieminska *et al* 2005; Dickens *et al* 2005; Belcher *et al* 2006; Scottish Prison Service 2010). In a UK context, the authors of a 2004 study reported that 97% of patients in an adult forensic psychiatric service had previously considered stopping smoking, and would consider quitting at some time in the future (Dickens *et al* 2005), and 58% of smokers in Scottish prisons expressed a desire to quit smoking in a 2009 survey (Scottish Prison Service 2010a). A survey of Polish prisoners revealed that concern about health was the main reason given by prisoners for wanting to quit, and 25% of inmates cited saving money as a motivator (Sieminska *et al* 2005). In addition, qualitative research conducted in UK prisons has revealed that many inmates want to achieve something while in prison and view quitting smoking as a big achievement (MacAskill and Hayton, 2006). Prisoners have described imprisonment as an opportunity access smoking cessation courses and nicotine replacement therapy (Condon *et al* 2008).

[1] For the purposes of this review, the term "offenders" has been used to refer to prisoners, prisoners on remand, detainees in police custody and probationers.

Given the high smoking prevalence rates and associated health risks, the scope for making positive changes to smoking behaviour and the level of motivation to quit, there is huge potential for smoking cessation initiatives to improve health and reduce health inequalities across the criminal justice system. The prison setting, in particular, offers a valuable opportunity to implement smoking cessation initiatives in marginalised groups with very high smoking prevalence rates (Baker 2006).

Smoke Free Policy

Prisons have, to varying extents, been exempt from bans on smoking in public buildings that exist in many countries. This is due to the fact that while prisons are a workplace for staff, they are also a home for prisoners (Butler *et al 2007*). However, more countries are moving towards stronger restrictions on smoking and total bans on smoking in prisons to protect the health of smokers and non-smokers alike (Butler *et al 2007;* Hartwig *et al* 2008).

The Netherlands, Belgium, Finland and Scotland were the first EU countries to introduce smoking restrictions in all prisons in 2006. The majority of EU countries have since followed their example (Hartwig *et al* 2008). While some EU countries have imposed total smoking bans in prisons, others have imposed only partial smoking bans that restrict smoking to designated smoking areas (Hartwig *et al* 2008).

Smoke free legislation in prisons was introduced in England in 2007. The Prison Service Instruction (PSI) 09/2007 requires that all indoor areas of prisons in England must be smoke free with the exception of cells occupied solely by smokers aged 18 and over, and establishments holding persons under 18 years old must have an entirely smoke free environment within their buildings (HM Prison Service 2007).

HMYOI Wetherby implemented a smoke free policy in 2005, in advance of English smoke free legislation. In the six months prior to implementation of the policy, specialist training was provided to qualify 14 smoking cessation advisors for the establishment whose role was to provide smoking cessation support for both staff and offenders (Thomson and Wilson 2007). The development and successful implementation of the policy led to recognition as an example of best practice and a number of awards. The importance of smoking cessation initiatives to complement smoke free policies/legislation was highlighted in an evaluation of the HMYOI Wetherby initiative (Thomson and Wilson 2007).

It has been noted that, the move towards smoke free policies in prisons in the USA has been accompanied by a diversion of resources away from smoking cessation initiatives (Eldridge & Copsey 2009). By 2007, 60% of the 52 correctional departments had implemented total bans on tobacco on prison grounds. However, only 39% continued to provide smoking cessation programmes after the initial transition period (Kauffman *et al* 2007). In contrast, the inclusion of the criminal justice system in the Department of Health Inequalities pilots reflects the fact that smoking cessation initiatives in prisons continue to remain high on the agenda in England, as a means of supporting smoke free legislation. Cessation support for prisoners is endorsed in the recent Department of Health tobacco control policy document "A Smokefree Future" (Department of Health 2010).

Range of Smoking Cessation Initiatives

A range of delivery models have been used in smoking cessation initiatives implemented in the criminal justice arena both internationally and in the UK. Initiatives frequently combine more than one method. It is common for initiatives to combine individual counselling and/or group therapy with pharmacotherapy (Knox *et al* 2006; Long and Jones 2005; Jones *et al* 2007; Platt *et al* 2009; Cropsey *et al* 2008). Individual behavioural counselling involves scheduled face-to-face meetings between a smoker and a counsellor trained in smoking cessation, while group behaviour therapy normally consists of scheduled meetings where groups of smokers receive information, advice and encouragement to help them quit smoking and some form of behavioural intervention for example, cognitive behavioural therapy. Pharmacotherapy involves the use of nicotine replacement therapy (NRT), varenidine or bupropion as an aid to help smokers quit.

For example, an initiative to tackle smoking among prisoners and staff in HMP Bowhouse Kilmarnock, a prison in Scotland accommodating male adult prisoners (remand, short-term and long-term) and male young offenders on remand, combined these three methods. The initiative consisted of provision of NRT to prisoners (prison insurance did not cover the prison doctor to prescribe NRT to prison staff) along with 10-week group smoking cessation sessions and individual sessions. A Smoking Cessation Advisor was based inside the prison and prison staff were trained in smoking cessation (Knox *et al* 2006).

A 2002 pilot smoking cessation initiative (the "EQuip Programme") in HMYOI Polmont also combined group therapy, individual therapy and pharmacotherapy. The initiative consisted of 12-week supported smoking cessation advice with NRT if requested /suitable and individual or group support through a self-referral system. Peer support was a feature of the initiative, and two participants from the first course were involved in promoting subsequent courses. Group participants took ownership of the programme by deciding on the order of delivery of the 12 sessions (Platt *et al* 2009).

The pilot initiative at HMYOI Polmont also included brief interventions delivered to offenders at entry to and exit from the YOI (Platt *et al* 2009). Brief interventions for smoking cessation usually take the form of opportunistic advice, discussion, negotiation and encouragement and referral to more intensive treatment where appropriate. Such interventions are typically delivered by CJS staff such as prison doctors, and are very short in duration.

Cropsey *et al* reported on a trial of a smoking cessation initiative in a state prison housing female offenders in south-eastern USA. The initiative consisted of 10-weekly group behavioural smoking cessation sessions based on mood management training, combined with the provision of NRT. Participants made their quit attempt between the third and fourth week of the 10-week course (Cropsey *et al* 2008).

Smoking cessation initiatives combining group or individual therapy and pharmacotherapy have been implemented in CJS settings other than prisons, for example forensic psychiatric establishments (Long & Jones 2005; Jones *et al* 2007). Long and Jones reported on an initiative in four medium secure wards of St. Andrew's Hospital, Northampton. Patients participating in the initiative were provided with NRT in conjunction with 12 weekly group smoking cessation sessions run by a smoking cessation trained psychologist and two assistant psychologists (Long & Jones 2005).

A smoking cessation initiative in a maximum-security male prison in Australia combined two brief cognitive behavioural therapy sessions with pharmacotherapy (NRT and bupropion) and the provision of self-help resources for participants (Richmond *et al* 2006). Self-help resources include any manual or structured programme in printed or electronic format that can be used by individuals in a quit attempt without the help of or in conjunction with support from health professionals, counsellors or group support.

Effectiveness of Smoking Cessation Interventions

It is difficult to make general statements about which approaches to smoking cessation work best in the criminal justice setting. Evaluations report on a variety of delivery models and use a variety of different measures of "success". Measures used in terms of smoking cessation outcomes include: proportion of participants setting a quit date; self-reported quit rates (4-week, 6-month etc); and biochemically validated quit rates. Measures of "success" such as the rate of participation in smoking cessation programmes and the satisfaction of participants have also been used. It is also important to consider that the "success" of a programme is dependent on a number of factors other than the model of delivery.

MacAskill and Hayton evaluated 2004/2005 NRT-based smoking cessation initiatives across 15 prisons in the North West Region of England (MacAskill and Hayton 2006). Department of Health funded NRT was provided in all of the prisons, while resources for delivery of initiatives were met within existing prison and local Primary Care Trust budgets and staffing levels. Different approaches were used across the prisons: nine prisons offered group support and one-to-one support in addition to NRT; three prisons offered only group support in addition to NRT; and three prisons offered NRT with only one-to-one support sessions. The average quit rate at four weeks across the prisons was 41%; similar to rates achieved by community based services in the Region. However, high quit rates were not demonstrated in all cases. The authors concluded that it was not possible to say which approach worked best, as success was dependent on factors such as: personal commitment and enthusiasm among staff delivering the service; accumulation of staff experience; time available and organisational support from prison staff involved; the nature of individual prisoners and the prison regime; and numbers lost to follow-up, especially through transfers and releases. They recommend a flexible approach, reflecting prison characteristics and the stage of development of the service (MacAskill and Hayton 2006).

Barriers and Facilitators to Smoking Cessation Initiatives

A variety of barriers to the success of smoking cessation initiatives in the CJS have been reported. Most are from experiences in prison settings, again reflecting the fact that the majority of published literature on smoking cessation initiatives in the criminal justice arena is concerned with this setting. Barriers can occur either at the organisational/structural level, or at the individual level. Where barriers are identified, effort has been made to include examples of how such barriers have been/could be overcome in practice to improve the success of initiatives. While much of the published literature focuses on barriers to success, facilitators to success were also identified in the literature. These are described.

(i) Other Health and Social Problems

Offenders often have other issues in addition to smoking, such as addictions to other substances and social and interpersonal difficulties that can affect their motivation and ability to quit smoking (Knox *et al* 2006). In terms of substance addictions for example, in a 2007 survey of detainees in police custody in London, 63% reported being smokers, 34% reported being dependent on heroin, 34% reported being dependent on crack cocaine and 25% reported being dependent on alcohol (Payne-James *et al* 2010). Mental health problems such as depression, anxiety and psychosis are known to be more common among offender s in the CJS than in the general population (Brooker et al 2008; Plugge *et al* 2006). Although the higher prevalence of such issues in the CJS can make smoking cessation initiatives more challenging than in community settings, successes can be rewarding when achieved. Knox *et al* share their experience of a prisoner with multiple substance addictions who successfully quit smoking with the support of prison smoking cessation services. As a result of his success, the prisoner gained the confidence and self-belief to address his other addictions (Knox *et al* 2006). Addressing other health and social problems as well as smoking may improve the chances of success of smoking cessation initiatives while also contributing to reducing wider health inequalities.

(ii) Smoking as a Coping Mechanism

Smoking has been described by prisoners as a way of coping with prison life (Condon *et al* 2008; MacAskill & Hayton 2006; Richmond *et al* 2009; Douglas & Plugge 2006), and prisoners have reported feeling a stronger need to smoke while imprisoned (Sieminska *et al* 2006). Smoking can be seen by prisoners as a way of helping to manage stressful situations such as prison transfers, court appearances and prison visits (Richmond *et al* 2009). Forty-four percent of Polish prisoners in a survey said that the boredom associated with being in prison encouraged smoking (Sieminska *et al* 2006). Boredom, prolonged periods locked in cells and stress have also been given as reasons for relapse by prisoners who have made quit attempts while in prison (Richmond *et al* 2006).

Resistance and negative attitudes to smoking cessation in prisons can be based on the belief that quitting smoking, especially if this is enforced through smoking restrictions, would place an intolerable burden of stress on prisoners at an already stressful time (Douglas & Plugge 2006). Strategies to mitigate stress and boredom among prisoners should be considered as part of smoking cessation initiatives. Improved access to gym facilities or sporting activities, for example, might be helpful to quitters as physical exercise has been described by prisoners as a substitute for smoking (Richmond *et al* 2009). In addition, it may be appropriate to target smoking cessation programmes at prisoners during the less stressful periods of their life in prison to improve the chances of success.

(iii) Family Support

Lack of family support and missing friends and family have been identified as reasons why prisoners feel a need to smoke while in prison (Sieminska *et al* 2006). Prisoners in an Australian study felt that encouragement from family members helped their quit attempts while in prison (Richmond *et al* 2009). Involving families of CJS clients in smoking cessation interventions may have the potential to improve their success. A US initiative to

tackle substance abuse in serious juvenile offenders demonstrated significant reduction in cigarette use among participants when treatment included family involvement, but limited reduction when it did not (Chassin *et al* 2009). It has been recommended that prison smoking cessation programmes should link to dedicated community programmes offering cessation support to prisoners' families (Knox *et al* 2006).

(iv) Transfer and Release

The transience of offenders within the CJS can be a barrier to accessing smoking cessation services and a barrier to their success (Cancer Institute NSW 2008; MacAskill &Hayton 2006). For example, participants in a smoking cessation programme in an Australian prison reported transferral to another prison without notice as a reason for relapse. As well as being stressful for prisoners, transfers caused difficulties in maintaining access to pharmacotherapy (Richmond *et al* 2006). The continuation of cessation support and counselling for prisoners can also be a challenge in the face of transfers (MacAskill & Hayton 2006).

Smoking cessation initiatives should take the likelihood of transfers into account (Richmond *et al* 2006). Problems associated with transfers can be mitigated by ensuring that up to date medical records are transferred with prisoners and a short supply of NRT is provided to allow prescribing to be renewed at the new location (MacAskill & Hayton 2006). Prompt continuation of courses for individuals moving between facilities will become easier as more offer smoking cessation support services (MacAskill & Hayton 2006).

Although no CJS smoking cessation initiatives were identified in the literature that involved the use of telephone counselling or quitlines, they are a potentially useful resource. Telephone counselling or quitlines provide encouragement and support over the telephone to smokers who want to quit or who have recently quit. It has been suggested that free access for prisoners to these services could help to overcome the disruption to cessation service access associated with transfers (Cancer Institute NSW 2008; Richmond *et al* 2009).

As well as transfers within the criminal justice system, release from prison can present a barrier to the continuation of smoking cessation support. Combined with the fact that the post-release period can be a challenging time of re-adjustment, relapse is likely to be common among those who have quit smoking while in prison. No studies were identified investigating post-release relapse rates among prisoners who had voluntarily quit smoking while in prison. However, a US study of prisoners released from a tobacco free correctional facility (i.e. enforced abstinence) found that only 18% remained abstinent at the end of the first week post-release (Lincoln *et al* 2009). Community smoking cessation programmes that are linked to prison programmes can offer support to prisoners after release and reduce relapse rates (Knox *et al* 2006; Richmond *et al* 2009).

(v) Staffing Issues

Negative staff attitudes to smoking cessation initiatives can be a barrier to their success (MacAskill & Hayton 2006). Evaluation of an initiative in the State Hospital, Carstairs, a high-security forensic psychiatric facility in Scotland, revealed that some staff viewed smoking cessation as taking away an opportunity to manage patient behaviour. In the facility, cigarettes had been used by some staff as a reward for appropriate behaviour and withheld as

punishment for inappropriate behaviour (Jones *et al* 2007). An evaluation of NRT-based smoking cessation programmes in English prisons revealed that prisoners found prison staff to be critical rather than supportive of quit attempts. However, prisoners appreciated the supportive attitude of external smoking cessation advisors, and felt that this encouraged them to quit (MacAskill *et al* 2008). Staff engagement is important, and smoking cessation initiatives should be implemented in a supportive atmosphere (Cancer Institute NSW 2008; MacAskill & Hayton 2006).

The smoking behaviour of CJS staff can represent a barrier to client smoking cessation. In a survey conducted in a UK forensic psychiatric hospital, 56% of patients said they felt that seeing staff members smoking would make it difficult for them to stop smoking (Dickens *et al* 2005). This underlines the importance of engaging staff in smoking cessation initiatives, not only for their own benefit, but also in order to improve the chances of success with clients. A smoking cessation initiative in HMP Bowhouse offered smoking cessation support to staff as well as prisoners. Although there was demand for the service, group sessions were not well attended. This was attributed to a lack of flexibility in staff working schedules. Authors of an evaluation of the initiative recommend that if cessation support groups for staff within prisons are to be viable, staff should be allowed time off to attend. However, they recognise that this may not always be possible due to the operational demands of the prison service, and therefore recommend that informal support and support in the community and in pharmacy settings may be more appropriate for staff (Knox *et al* 2006).

Delivery of smoking cessation initiatives in the CJS can be seen as a burden on staff time (MacAskill & Hayton 2006; MacAskill *et al* 2008). For example in a smoking cessation initiative in prisons in North West England, even where programmes were delivered by external advisors, internal prison staff often had to undertake many activities related to the programme in addition to their normal duties, such as: managing waiting lists; organisation of prescriptions and other paperwork; distribution of nicotine patches; and provision of on-going *ad hoc* support to quitters (MacAskill & Hayton 2006). Experience has shown that it can be difficult to maintain services in the face of staff shortages, differing shift patterns and staff transfers (MacAskill & Hayton 2006). It is important to secure protected staff time to provide a sustainable service (MacAskill & Hayton 2006).

(vi) Peer Attitudes and Behaviour

The attitudes and behaviour of peers are also important to the success of smoking cessation initiatives in the CJS. For example, 79% of forensic psychiatric patients said in a survey that seeing other patients smoking would make it more difficult for them to stop smoking (Dickens *et al* 2005). However, smokers can be inspired by the shared experiences of other service users who have successfully quit (Knox *et al* 2006; MacAskill *et al* 2008). Fostering a supportive atmosphere that involves sharing experiences and understanding each other's difficulties is beneficial for programme participants. It may even be beneficial to encourage healthy competition among quitters (MacAskill *et al* 2008).

(vii) Waiting Lists

Long waiting lists can be a barrier to accessing smoking cessation services in the CJS arena. Prisoners in a number of English prisons described long waiting lists for smoking cessation

programmes (Condon *et al* 2008). In 2005, prisoners at HMP Bowhouse faced a waiting time of up to five months to access services. After the appointment of a specialist smoking cessation advisor and the introduction of restrictions on smoking in the prison, demand for the service increased. To tackle the expanding waiting list, "rolling" groups were introduced. Adoption of this system meant that by the end of 2006 there were no longer waiting lists for smoking cessation services in the prison (Knox *et al* 2006).

(viii) Misuse of NRT

Cigarettes are often used as "currency" in prisons, used by prisoners in exchange for goods and used to pay debts for gambling (Richmond *et al* 2009; Lawrence & Welfare 2008). It has been reported that in some initiatives where NRT has been used, nicotine patches have replaced or supplemented cigarettes as currency (Lawrence & Welfare 2008; MacAskill & Hayton 2006; MacAskill *et al* 2008). MacAskill *et al* report on prison staff experience of prisoners gaining access to a smoking cessation programme in order to sell nicotine patches to other prisoners, whilst continuing to smoke (MacAskill *et al* 2008). Such misuse of nicotine patches as currency is a barrier to the success of smoking cessation initiatives. In order to mitigate the problem, prisons have dispensed nicotine patches to quitters in exchange for used patches (MacAskill & Hayton 2006).

(ix) Suitability of Support Materials

It is important to ensure that smoking cessation counselling and materials in the CJS are suitable for the mental health and intellectual status of quitters and that they are culturally appropriate (Cancer Institute NSW 2008). As a result of an evaluation of an ongoing initiative at HMP Bowhouse, a DVD was produced for prisoners with information about smoking cessation support services available to them. The DVD was produced in addition to other sources of information about support services, such as leaflets and posters, in recognition of the fact that printed materials alone were not appropriate due to the low literacy level among prisoners in the facility (Knox *et al* 2006).

Social Marketing Approach

A major barrier to smoking cessation is the extent to which smoking is a social norm in prisons and other CJS settings (Butler *et al* 2007; Richmond *et al* 2009). It is acknowledged that changing established cultural norms or behaviour is difficult, a problem compounded in the case of smoking by the addictive nature of tobacco (MacAskill *et al* 2008). Social marketing has been used as a framework to bring about smoking behaviour change, denormalise smoking and challenge the "inevitability" of smoking in prisons (MacAskill *et al* 2008; Awofeso *et al* 2008).

MacAskill *et al* described a smoking cessation pilot initiative implemented in four prisons in England (MacAskill *et al* 2008). As with many other initiatives in the CJS, the initiative combined group smoking cessation therapy with pharmacotherapy, but it differed from other initiatives in that it took a social marketing approach. Social marketing has been defined as "the application of commercial marketing technologies to the analysis, planning, execution

and evaluation of programmes designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of society" (Andreasen 1995).

The first phase of the initiative described by MacAskill *et al* involved research, including market research with the target audience, in order to propose a suitable marketing mix and identifying channels for delivery. In the second phase, development of the marketing mix and testing of messages to be communicated to participants took place. The "4 P's" of marketing were considered and defined for the initiative: Product – successful smoking cessation; Place –prison; Promotion –end users advocating the benefits of the initiative rather than a dedicated promotional campaign; Price – consumer benefit versus cost e.g. improved health or money saved versus pleasure gained from smoking. A fifth P was also considered: Partners – supportive people around the smoking cessation initiative. The third phase of the initiative was the implementation and evaluation phase. At this stage, focus was on how the programme was delivered, how it was perceived and whether it achieved its aim of successful smoking cession among prisoners (MacAskill *et al* 2007).

Conclusion

There is significant scope for smoking cessation initiatives to address the health inequalities associated with the high smoking prevalence among offenders in the criminal justice system. Such initiatives are an important compliment to smoke free policies.

A range of delivery models have been used in smoking cessation initiatives across the criminal justice system. Most common are programmes that combine individual counselling, group therapy and pharmacotherapy. However, no "best" approach has been identified and "success" is dependent on a number of factors including personal commitment, staff experience and organisational support.

Experience of implementing smoking cessation initiatives in criminal justice settings has identified a number of barriers and facilitators to success. Such experiences can be used constructively to inform the development of smoking cessation initiatives for the criminal justice system.

Implications for the Development of UK CJS Smoking Cessation Initiatives

A number of implications for the development of smoking cessation initiatives in the UK criminal justice system can be drawn from the evidence base:

- It is important to ensure that the importance of smoking cessation in the criminal justice system is recognised and that it receives the attention it deserves. There is huge potential for smoking cessation initiatives to reduce health inequalities across the CJS.
- Smoking cessation initiatives are an important complement to smoke free policy.
- There is no "best" approach to smoking cessation: a range of delivery models that suit the needs of individual clients/facilities or client groups should be offered.
- Addressing offenders' other health and social problems may help to increase the success of smoking cessation initiatives, and will contribute to reducing health inequalities.
- Cessation initiatives should include strategies to mitigate stress and boredom, as such feelings can increase "need" to smoke and contribute to relapse after quit attempts. It may also be appropriate to target initiatives at offenders during less stressful periods of their lives.
- Family support can improve the chances of offenders successfully quitting. Involvement of offenders' families in smoking cessation initiatives should be encouraged, and family members who smoke should be offered the opportunity to participate in community cessation programmes linked to CJS programmes.
- Smoking cessation programmes should be available across the criminal justice system, to widen access and limit the disruption to access associated with transfers.
- Up-to-date medical records should be transferred with offenders, and a short supply of NRT should be provided to transferred offenders for use until prescribing is renewed at the new location.
- Access to telephone counselling and quitlines could help to help to overcome the disruption to accessing cessation services associated with transfers.
- The post-release period can be a high-risk time for relapse. Community smoking cessation programmes, linked to prison programmes, should be available to support prisoners after release.
- Staff attitude is an important determinant of the success of smoking cessation initiatives. Ensuring that staff are engaged and supportive will improve success rates.
- Initiatives that include smoking cessation support for staff are likely to be more successful than those that do not. Informal or community support may be appropriate where operational demands do not permit staff to take time off to attend in-house cessation services.
- It is important to ensure there is protected staff time for the delivery of smoking cessation programmes.
- Waiting lists for access to smoking cessation services should be kept short.
- There is potential for misuse of nicotine patches in prisons. Measures should be put in place to prevent misuse.
- It is important to ensure that smoking cessation initiatives and materials are suitable for the target audience. A social marketing approach should be considered.

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