Specification for national prison smoking cessation service in Scotland
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1. Introduction

This section outlines the reason for, and the importance of, having a national service specification for the smoking cessation service in Scottish prisons.

1.1 Background and context
1.2 Policy drivers
1.3 Purpose and aim of specification
1.4 Who is this specification for?
1.1 Background and context

Scotland is seen as a world leader in legislating and implementing effective tobacco control policies. In particular, these policies include smoke-free legislation in 2006; increasing the age of sale of tobacco to the age of 18; new laws on the sale and display of tobacco products and the first tobacco retail register in the UK. Scotland is one of the few countries in the world with a network of comprehensive smoking cessation services offering a programme of behavioural support and pharmacotherapies free of charge.

These policies have made an impact on the number of people smoking in Scotland, with rates dropping from over 30.7% in 1999 to around 23% (25% of men, 22% of women) in recent years.¹ However, smoking rates are linked to health inequalities; adults in the 15% most deprived areas of Scotland were considerably more likely than the rest of Scotland to say that they are current smokers (40% and 20%, respectively).¹ In Scotland, tobacco use is estimated to be linked to over 13,000 (around a quarter) of all deaths and 56,000 hospital admissions every year.² The annual cost to NHSScotland of treating smoking-related diseases is estimated to be more than £323 million and may be higher than £500m.²

Rates of smoking in prisons are extremely high, with three-quarters of prisoners reporting that they are smokers. This has been consistently reported in the Scottish Prison Service (SPS) biannual surveys, with the 2013 survey reporting that 74% of prisoners smoked.³ The more times an offender appears in custody, the more likely they are to smoke: 60% smoke who have never previously appeared in custody; 74% 1–5 times; 86% 6–10 times; 89% >10 times.³ However, it reported that three in five male smokers surveyed expressed a desire to give up smoking (60%).³

The prison setting offers the opportunity to engage with hard-to-reach smokers and presents a location and time for smokers to access smoking cessation support. This can result in a sense of positive achievement of a goal, and improved health outcomes for the prisoner, their families and the wider community.⁴
1.2 Policy drivers

The Scottish Government’s policy *Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland* (2013) outlines the importance of reducing health inequalities and how reducing smoking rates in the most deprived communities can contribute to this. This is reflected in the Scottish Government’s recent Health Improvement (HEAT) targets for smoking cessation services, which focused on quit outcomes made by smokers living in the most deprived areas. The 2015–16 LDP Standard performance target (replacing the HEAT target) now includes all quits from prisoners who smoke. The inclusion of prisoners’ quit rates emphasises the increased priority of this group, which is also highlighted in the recent *Review of NHS smoking cessation services* (2014). The review recommends increasing reach and success with priority groups such as pregnant women, young people, people with mental health problems, prisoners, and those living in disadvantaged areas.

This priority and ensuring consistent access and quality of health services for all the population was initially outlined in the national strategy on health inequalities, *Equally Well* (2008), which identified offenders and ex-offenders as a vulnerable group and underlined the principle that prisoners ‘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.’ This was re-emphasised in the framework *Better health, better lives for prisoners: A framework for improving the health of Scotland’s prisoners* (June 2012). This framework builds on NHSScotland’s Quality Strategy (May 2010) that states the need to develop person-centred services, ‘which respect individual needs and values and which demonstrate compassion, continuity, clear communications and shared decision-making.’

The dangers of second-hand smoke (SHS) are widely recognised. The importance, therefore, of smoke-free environments, particularly in the workplace, is acknowledged as essential to the health and welfare of the staff and prisoners. This is core to the Healthy Working Lives (HWL) Award scheme and is set out in the Scottish Government’s tobacco control strategy which contains ambitious aspirations for a smoke-free Scotland stating that:

‘In line with developments across Scotland, creating a smoke-free prison service should be seen as a key step on our journey to creating a smoke-free Scotland.’

In order to achieve this, the strategy identifies an action to have plans in place by 2015 that set out how indoor smoke-free prison facilities will be delivered. Having a high-quality and consistent national smoking cessation service on offer to prisoners is fundamental to progressing with these plans.

There is a duty of care to promote cessation, protect non-smokers from starting, or smokers who have previously quit from relapsing, and to protect other prisoners, staff and visitors from second-hand smoke exposure.

The Ministerial Working Group on Tobacco Control receives an annual update on the progress of the tobacco control strategy, which includes the above action. The specific action for a national prison smoking cessation service specification was supported and prioritised by the Substance Misuse Workstream and National Prisoner Healthcare Network.
1.3 Purpose and aim of specification

Prisoners tend to have poor health, both physically and mentally. Many have low education and literacy levels, and/or often have a lower socio-economic status resulting in low levels of employment. In 2012–13, the average daily prison population was 8,014 people – of these 18% were on remand. The breakdown of the prison population is 94% male and 6% female.\textsuperscript{10}

This specification reinforces the need for an equitable, consistent and person-centred smoking cessation service to be delivered to all prisoners who want to stop smoking. While taking the prison setting and culture into consideration, the prisoners’ experience of this service and all throughcare should be as consistent as possible with local community services.

The purpose of this document is to ensure:

\begin{itemize}
\item that all prisoners are promptly offered and receive a consistent and equitable smoking cessation service, irrespective of location across the prison system and Health Board area
\item that this high-quality, specialist smoking cessation service meets the needs of the service user, including intensive behavioural support and choice of suitable pharmacotherapy\textsuperscript{11}
\item the quality standards required for an effective service are achieved, including monitoring and recording smoking status, quit attempts and successful outcomes as recorded in local and national databases, such as the smoking cessation database managed by Information Services Division (ISD)
\item seamless transfer between prisons and to community smoking cessation services on liberation
\item a robust foundation for the development of smoke-free prison plans.
\end{itemize}

The term ‘all prisoners’ includes remand/short-term prisoners and prisoners in custody, and also young offenders and pregnant women prisoners who smoke.
1.4 Who is this specification for?

All Health Boards are responsible for the delivery of this smoking cessation service in line with national evidence-based smoking cessation guidelines\(^1\) and to the quality standards outlined above. 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. Other partners include the third sector. Health Boards that do not have a prison in their geographical area still need to provide throughcare to prisoners after liberation.
2. Providing and delivering the smoking cessation service

This section details all the key information for providing and delivering the smoking cessation service in Scottish prisons, including performance measures.

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2.1 Service delivery recommendations

This prison smoking cessation service should be consistent with the specialist smoking cessation service delivered in the community, ensuring that it is person-centred and adheres to the evidence-based guidance in *A guide to smoking cessation in Scotland 2010* and the *Addendum on tobacco harm reduction* (2014). The guidance recommends that a specialist smoking cessation service is ‘a combination of multi-session intensive behavioural support together with pharmacotherapy.’

Health Boards should lead on the planning and delivery of this service specification. This includes:

- appropriate planning and management of resources (staff and budget) for delivery, including pharmacotherapy
- effective partnership working and collaboration with SPS and third sector
- providing training and support for staff
- promoting the service to ensure a high level of awareness with staff and prisoners
- reviewing and communicating local protocols to ensure effective delivery and throughcare on transfer or liberation
- regular review of service to ensure quality and effectiveness in line with performance measures on the next page.

In **Appendix 1** there is a checklist to record evidence of planning and delivering the smoking cessation service. The interactive version for you to use is available at [www.healthscotland.com/documents/25618.aspx](http://www.healthscotland.com/documents/25618.aspx)
2.2 Key performance measures

The following performance measures are recommended for a prison smoking cessation service:

- prisoners’ awareness of smoking cessation service (measured through the biannual SPS survey)
- prompt access to smoking cessation service (measured by waiting times)
- uptake of smoking cessation service (measured by quit attempts)
- success of smoking cessation service (measured by percentage of carbon monoxide (CO) validated quits at 4 and 12 weeks)
- demonstration of innovative practice; e.g. tests of change, partnership working, harm reduction pilots.
2.3 Person-centred services

In order for the service to be person-centred, it is important that service deliverers understand the prisoners’ barriers to quitting, including the culture within the prison. This will allow them to ensure that the intensive support offered is appropriate to the setting: that it covers not only how the prisoner can maintain motivation with the quit while in prison, but also how to overcome boredom and stress. Examples of providing a person-centred service are:

- ensuring the prisoners’ needs and commitment to quit are assessed
- minimum waiting time/quick referral
- appropriate pharmacotherapy including combination NRT and/or access to varenicline or bupropion
- CO monitoring to give positive feedback on the quit progress
- small tests of change that demonstrate innovative, person-centred practice such as cutting down to quit
- providing intensive behavioural support that takes into account the issues and barriers of quitting in a prison setting
- when improving and delivering the service, taking into account issues pertinent to the prison setting, such as boredom, stress, transfers to other prisons, court appearances, and isolation from family and friends
- providing peer support within prison, which may help to reduce the prisoners’ feelings of being isolated
- the option to request a smoke-free cell
- affirming a successful quit by using resources such as certificates.

think about...
how you can deliver person-centred services
2.4 Referral

The prison setting provides an opportunity to reach smokers and offer them a referral into smoking cessation services. A UK qualitative study revealed that many prisoners want to achieve something while in prison and view stopping smoking as a big achievement. The World Health Organization (WHO) has also highlighted this opportunity, as prisoners describe it as a time that they can access smoking cessation services and pharmacotherapy.

The prisoner’s smoking status should be established and recorded electronically. Smokers should be flagged up on the system with a requirement for a follow-up.

When appropriate, a follow-up brief intervention should be delivered by staff. This should cover:

- whether the prisoner wishes to stop smoking
- if they do, brief assessment of the prisoner’s readiness and commitment to quit
- an explanation of the benefits of using the smoking cessation services, outlining pharmacotherapy options and the behaviour support
- either referral to the smoking cessation service in the prison, or details of how to access the service
- the dangers of second-hand smoke and how to request a smoke-free cell.
Case study: Using the induction programme (NHS Ayrshire & Arran)

Prison establishments have an induction process for all new prisoners. The purpose of the induction is to inform prisoners about prison life, the regime and their responsibilities and privileges. The programme will also include local information provided by agencies working within the prison, and an outline of all services available to prisoners.

The induction programme is an ideal opportunity:

• to ensure that the prisoners are aware of the prison smoking cessation service
• for smoking cessation service advisers to engage with prisoners
• to deliver brief advice on stopping smoking.

For some, this may be the first time they have thought about their smoking behaviour and learned about the smoking cessation services available to them within the prison and in the community.

Smoking cessation service information materials that promote and inform the prisoners how to access this service should be available. It is also beneficial for some successful quitters, who have already used the prison smoking cessation service, to attend.

Depending on the amount of time available, participatory methods such as CO monitoring could be used.

Referrals for the smoking cessation service should be taken at this time, as interest in the service and motivation to quit tends to increase after such interventions.
Self-referral/staff referral

Good marketing is required to ensure that prisoners are aware of the smoking cessation service on offer in the prison and encouraged to take it up. Examples of where the service could be marketed include:

- admission/transfer process
- induction
- recreation areas
- health centre
- links centre
- family centre
- library
- by using technology; e.g. TV screens within prisons and kiosks
- through new routes; e.g. the prisoners’ canteen purchasing sheet, by the tobacco products

It should be simple for prisoners to self-refer to the smoking cessation service.

Prison staff and other healthcare professionals should be trained in brief intervention and referral pathways. Multi-agency paperwork should include a smoking cessation referral box and the information passed directly to the smoking cessation service team. Any referrals highlighted as urgent should be prioritised.

It is good practice on receiving referrals to contact the prisoners, informing them that the service has acknowledged their request for support, and of the expected waiting time for their first appointment.

A visual care pathway covering referral for the smoking cessation service is included at Appendix 2.
2.5 Throughcare

Transfer of prisoners to other establishments
Prisoners may be transferred to other establishments while on a smoking cessation programme. It is very important that the receiving smoking cessation service is contacted to:

- make them aware of the prisoner’s progress and to ensure their ongoing quit attempt is supported
- confirm the prisoner’s pharmacotherapy support or shared medical information via the electronic system
- provide a short supply of pharmacotherapy until renewal of prescription at the new location is made available.12

Please also refer to the ISD protocol for transferring client records to another Health Board.

Referral into community services
Liberation can be a difficult adjustment period, and it is important that prisoners attending the prison smoking cessation service continue to be offered support from community smoking cessation services. It is the responsibility of the prison smoking cessation service to make contact with the receiving service. There is a variety of ways of referring such as:

- electronically, for example SCI gateway or Vision
- phoning the local community smoking cessation service
- using the Integrated Care Management process if the prisoner is undertaking cessation, or the Community Integration Plans (CIPS)
- contacting Throughcare Addiction Services (TAS)
- working with other third sector organisations, e.g. The WISE Group – Positive Routes.

Prisoners should be made aware of the options available to them; e.g. community pharmacy service, local NHS service and Smokeline.

Smokeline is a useful source of support. It can be offered in addition to, or while waiting for, smoking cessation support. It is staffed by trained advisers who can give expert advice as well as details of local smoking cessation services. This can be accessed every day from 8.00 am to 10.00 pm by:

- phoning the Smokeline telephone number: 0800 84 84 84
- texting CALL to Smokeline on 83434 and an adviser will ring back
- a live webchat with an adviser on www.canstopsmoking.com

In Appendix 3, there is a protocol to aid seamless transfer of prisoners and consistent throughcare.
2.6 Intensive smoking cessation behavioural support

Tobacco use has been described as: ‘completely entangled in prison life where it helps to cope with boredom, deprivation or stress’.\textsuperscript{4} Therefore, it is important that the smoking cessation support offered to prisoners takes into account boredom and stress relief.\textsuperscript{12,14}

Examples of incentives and diversionary activities could be:

- more group activities
- additional gym sessions
- sport activities
- family involvement in smoking cessation groups, as this could effectively provide prisoners with extra family time
- art classes
- access to recreational activities, such as board games
- issuing quit packs that contain puzzles, etc.

Think about...

Engaging activities you could offer prisoners

Intensive behavioural support is usually provided face to face in either a group or one-to-one format. This helps the service user to:

- plan for, and set, a quit date
- receive encouragement, advice and motivation to quit and stay quit
- cope with cravings and withdrawal symptoms
- optimise their pharmacotherapy
- develop a supportive relationship with the smoking cessation adviser
- identify triggers to prevent relapse.

The benefits of running group sessions are that more people can attend, which may help manage waiting times, and that prisoners can support each other during their quit.

The case study on the next page outlines how using closed groups can manage waiting lists.
Case study: Using closed groups to manage waiting lists (NHS Lanarkshire)

To manage their waiting lists, NHS Lanarkshire run two closed group sessions simultaneously (mainstream and protected prisoners). They run these two group sessions weekly, for a ten-week period. During this period, they collect names for the next two closed group sessions. Some lead time is required to allow for checks on prisoners’ compatibility with each other in the group sessions. As these group sessions end one week, the next new group sessions start the following week. All one-to-one sessions are organised to run after the group sessions to avoid any waiting times. NHS Lanarkshire advises a six-month period in between quit attempts, as this is the practice in their community groups.

Groups can be closed, open/rolling, or drop-in. There is more robust evidence for the effectiveness of closed groups rather than open/rolling groups, and some evidence that open/rolling groups are significantly less effective than one to one in prison settings. Normally there is a minimum of seven closed group sessions. In the prison setting, there is likely to be a requirement for one-to-one support for an individual. This is usually over an agreed time period; normally a minimum of four sessions. There may be differences between Health Boards and the number of sessions can be extended to maximise the possibility of a positive outcome; for example, cutting down to quit or managing relapse.

In preparation for running these intensive smoking cessation behavioural support sessions, some of the key aspects to consider, and examples of what to do are in Appendix 4. There is insufficient evidence to support any particular model or specific approach. However, there is also some information included in Appendix 5 on health behaviour change techniques, such as the addiction triangle, motivational interviewing techniques, and MAP (Motivation, Actions and Prompts).
2.7 Effective delivery

As well as a mechanism that helps give feedback, CO monitoring is an essential part of the smoking cessation service delivery. It allows progress to be regularly validated and recorded, and is an ideal opportunity to provide feedback and motivation to the prisoner.\textsuperscript{12,13} CO monitoring is therefore a mandatory requirement for the smoking cessation service.\textsuperscript{16} This should be delivered in line with the Russell Standard (Clinical).\textsuperscript{17}

Prisoners need to be motivated to quit and attend the sessions regularly. Their readiness to quit can be covered in the initial assessment before attending the sessions. A balance is needed between giving the prisoner sufficient time to prepare for the quit attempt (particularly if a harm-reduction approach, e.g. cutting down to quit, is being taken) while being clear that this is not an open-ended commitment. If they have attended for several weeks and failed to set a quit date, their motivation and commitment to smoking cessation should be reassessed.

It is important that both the prisoner and SPS staff know when the prisoners are due to attend their smoking cessation session. The use of appointment cards and sharing of information is good practice that can help with regular attendance. If a prisoner fails to attend their smoking cessation session, it is advisable to understand the reason for their non-attendance before taking remedial action.

It is advisable to have six months between quit attempts. However, discretion can be used where there are exceptional circumstances.
2.8 Pharmacotherapy

This should be consistent with *A guide to smoking cessation in Scotland 2010 and the Addendum on tobacco harm reduction (2014)* with an appropriate application to the prison setting, as some pharmacotherapies are unsuitable for prescribing due to security issues.

<table>
<thead>
<tr>
<th>Suitable for prison setting</th>
<th>Not suitable for prison setting</th>
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<tbody>
<tr>
<td>Patches and oral strips</td>
<td>Gum</td>
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<tr>
<td>Lozenges</td>
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<tr>
<td>Sublingual tablets</td>
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<tr>
<td>Varenicline (requires local protocol/patient group direction (PGD))</td>
<td></td>
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<tr>
<td>Bupropion</td>
<td></td>
</tr>
<tr>
<td>Oral spray</td>
<td></td>
</tr>
<tr>
<td>Nasal spray</td>
<td></td>
</tr>
<tr>
<td>Inhalator*</td>
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*Please note: inhalator is only suitable when supplied by NHS as part of the smoking cessation service*

To ensure the best chance of a successful quit, the provision of pharmacotherapy should be prioritised by using the most effective pharmacotherapies. Prescribing varenicline or using combination NRT may help to achieve this.6

The local prison medicines management group should oversee the development and updating of the protocols, informed by specialist expertise as appropriate.

For prisoners on a course of varenicline, GP details will need to be confirmed and a request for continuation completed by prison or local services, dependent on agreed referral pathways and protocols. The national protocol is outlined in the Public Health Service (PHS) *Smoking Cessation Service Revised Service Specification (2014)* in ‘Appendix B – Varenicline Service Procedure’ and should be adhered to.18

The use of pharmacotherapy can be open to abuse. Careful management of this is required with systems put in place to monitor and manage.
2.9 Services designed for specific groups

2.9.1 For pregnant women who smoke

While second-hand smoke adversely affects all people, it is particularly harmful for pregnant women. Pregnant women should avoid being exposed to second-hand smoke. This is particularly important in terms of cell-sharing.

Smoking while pregnant is an established cause of harm to both mother and baby. Smoking affects smokers by causing cancers, coronary vascular diseases, respiratory illnesses, infections and a wide range of other conditions. Smoking during pregnancy also affects the placenta, the source of the baby's food and oxygen, and lowers the amount of oxygen available to both mother and baby. Smoking causes an increase in the following risks:

- premature birth
- the baby being born with low birthweight
- the baby having reduced lung function
- the chance of stillbirth
- cleft lip or palate, and
- sudden infant death syndrome (SIDS)

Due to the pregnancy-specific harm caused by smoking and second-hand smoke, the importance of quitting should be emphasised at the brief intervention/referral stage. Pregnant women should receive an urgent referral for intensive support and be made aware of the option to quit using nicotine replacement therapy (NRT). The content of intensive, behavioural support at services should be similar to that offered to other smokers.

In terms of pharmacotherapy, it is important to note that varenicline and bupropion are not licensed for prescription for pregnant women. The smoking cessation adviser, clinician or prescriber should discuss the use of NRT with pregnant women as, ideally, pregnant or breastfeeding women should stop smoking without its use, but if this isn’t possible, then some NRT products may be used. A risk–benefit assessment should be undertaken, taking into account that NRT contains only nicotine, in lower quantities than that in cigarettes, and without the other chemicals from tobacco smoke.

Harm-reduction options are currently not advocated for pregnant women as these options and the use of NRT in this way have not been tested with this group. Also, importantly, the fact that ‘cutting down’ confers little or no benefit to health, due to the ongoing ingestion of CO and tar, and the tendency to inhale more and more deeply to ‘compensatory smoke’, are all the more pertinent among pregnant women.
2.9.2 For young offenders – providing a youth-friendly service

There is a lack of available data and well-designed studies on sustained quitting, which means it is difficult to recommend widespread implementation of any particular model. However, interventions which do show promise for helping young people to quit are complex ones, incorporating aspects sensitive to stage of change and using motivational enhancement and cognitive behavioural therapy. Note that varenicline and bupropion are not licensed for prescription for under-18s, but NRT can be prescribed for under-18s.

In a national programme of eight pilot studies in Scotland involving a range of target groups, settings and approaches to identify potentially acceptable and effective approaches to help young people to quit, conclusions were that services should:

- be flexible but structured, based on one-to-one or group support (i.e. in line with users’ needs and so that projects can adapt to their users and within their context) and addressing broader aspects of mental health and wellbeing
- be more intensive than brief interventions, which are unlikely to meet needs
- include an understanding of the role of smoking in their lives (e.g. position in peer group)
- be delivered by a known and trusted service provider rather than by strangers.

Additionally, a supportive wider environment such as smoke-free legislation/policies is needed to enhance motivation to quit. Services should also include the following values:

- client-centred
- responding to need timeously
- empowerment
- a holistic, whole-person approach
- non-judgemental
- holistic approaches, e.g. considering the relationship between cannabis and tobacco, and tobacco and alcohol consumption.
3. Monitoring and recording of data

This section highlights the importance of monitoring and recording of data, as well as some of the practical details.
Key performance measures outlined earlier in 2.2 require the smoking cessation service in prisons to report on the effectiveness of the service and its contribution to national smoking cessation statistics. It is therefore crucial that data is collected, monitored and recorded promptly on the national smoking cessation database, which is managed by ISD. It is Health Boards’ responsibility to ensure that this is done. This includes inputting of the Minimum Data Set (MDS), recording of quit attempts, follow-up of the quit outcome at 4 weeks and 12 weeks, and all prison transfer details. All quit outcomes should be CO-validated and recorded as such, where possible.

Staff should be aware of the importance of ensuring accurate data collection and timely entry. Protected staff time for training on data collection and recording must be planned for and training carried out. Training on the database is available from ISD.

In terms of good practice, a quality audit of a percentage of the data collection should be carried out regularly by the local Health Board to ensure prompt and accurate data recording.

**Recording the resetting of quit dates**

Complete existing MDS form and record at 4 weeks as ‘smoker’.

Complete a new MDS form, input to ISD and issue new ISD number.

**Prisoner transfer**

Within the ISD database, designated staff will have access to refer/transfer current client records from their respective Health Board to an alternative Health Board. All records designated for referral/transfer should have a cover note attached explaining the circumstances for the referral/transfer. Health Board staff should access their own respective transfer batch daily to monitor any record activity and process accordingly.

**Follow-up**

It is essential that follow-up of the prisoner is completed at 4 weeks and 12 weeks post-quit-date and with outcomes recorded. To ensure that this information can be collected at 12 weeks and possibly one year, it is important to understand the length of time that the prisoner will be based in the prison, and also that suitable contact details are recorded in the national smoking cessation database. It is anticipated that the one-year follow-up for all specialist smoking services will be piloted by NHS 24 in 2015 (date still to be established). This will take place on a national basis, with a representative sample from the smoking cessation database managed by ISD to derive a Scottish figure.

It is important for information governance that consent forms obtain consent for NHS Scotland rather than the local Health Board. This then enables follow-up by any Health Board if the prisoner transfers to another service, including long-term follow-up of data by NHS 24 on behalf of the Scottish Government.
4. Training

This section focuses on the importance of training of everyone involved, and developing these opportunities.

4.1 Responsibility of prison management

4.2 Staff: brief intervention training

4.3 Smoking cessation advisers: training for workers delivering the intensive support within a prison setting

4.4 Opportunities to use prisoners as health trainers or peer support
4.1 Responsibility of prison management

SPS should consider working collaboratively with Health Boards to provide training to prison staff. Every opportunity should be taken to improve awareness of the service and encourage prisoners to access it. The most effective way of achieving this is through ‘brief intervention’ training on health behaviour change and information on tobacco/tobacco control. Ideally, all staff who have contact with prisoners should be trained. This includes operational prison staff and regime activity staff; examples are healthcare professionals, physical education instructors, exercise referral scheme staff, education and skills department staff, counsellors, and prison officers. Creating enthusiastic ‘champions’ to help promote the service can aid referrals. They can also help to coordinate activities and can liaise across the prison, resulting in a more effective service.

4.2 Staff: brief intervention training

Ideally this ‘brief intervention’ training should fulfil the criteria outlined in ‘Standard A: Training for basic brief advice’ which suggests a minimum of three hours training. If three hours is not achievable, as many of the learning outcomes should be covered as possible within the timeframe given and adaptations made to suit the audience.

Part of the training should include the process for referring to smoking cessation services within the prison setting.

Second-hand smoke awareness training should also be incorporated into the ‘brief intervention’ training described above.
4.3 Smoking cessation advisers: training for workers delivering the intensive support within a prison setting

Anyone delivering intensive smoking cessation support within the prison setting should have fulfilled the training criteria outlined in ‘Standard C: training for specialist stop smoking support’. Ideally, after training they should be supported by someone experienced in delivering intensive smoking cessation support.

They should also have completed the eLearning modules Level 1 and 2 of NHS Health Scotland’s Health Behaviour Change (HBC) courses. HBC Level 1 is aimed at informed workers – those who will ‘raise the issue’ of health behaviours and then refer on. HBC Level 2 is aimed at skilled workers – those who will actually perform the brief intervention. The eLearning modules can work as stand-alone resources to increase knowledge. However, it is recommended that they are used as part of a blended programme and delivered in conjunction with the face-to-face training to improve skills and address attitudes. The eLearning modules can be accessed using the following link: [http://elearning.healthscotland.com/course/index.php?categoryid=108](http://elearning.healthscotland.com/course/index.php?categoryid=108)

It is fundamental that these staff receive adequate training to allow them to collect and record data on the national smoking cessation database managed by ISD.

In addition to the above, staff delivering smoking cessation support within a prison setting will be required to undergo prison-specific training. This will vary between prisons but essentially needs to include:

- prison induction: this will cover local prison policy and protocol, fire safety, etc.
- personal protection training (annual revision required)
- violence and aggression training.

It is also important that staff maintain their knowledge and skills by ensuring their continued professional development within the field of tobacco and smoking cessation service delivery.
4.4 Opportunities to use prisoners as health trainers or peer support

Training prisoners as health coaches develops their skills and allows them to become peer mentors. An example of this has been developed and is supported by an SQA module, supervised by a SPS psychologist and run by Fife College, for prisons in the east of Scotland. Taking this type of approach allows the opportunity for:

- peer mentors to develop additional life and vocational skills
- providing a positive role model for those making a quit attempt
- increased awareness of the service with prisoners
- additional support as well as the smoking cessation sessions.

NHS Health Scotland’s current eLearning Health Behaviour Change modules 1 and 2 training could be included in, or supplement, the SQA module.
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References


22. Fagerström Test for Nicotine Dependence (FTND). Available at: www.ncsct.co.uk/publication_dependence-on-smoking.php

## Appendix 1: Checklist for delivery of the smoking cessation service

<table>
<thead>
<tr>
<th>Task</th>
<th>Action</th>
<th>Planned (details: how, who and when)</th>
<th>In place/ completed (date completed)</th>
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<tbody>
<tr>
<td>Establish leadership</td>
<td>Identify a leader and pull together a working group to lead the implementation of this service specification.</td>
<td></td>
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</tr>
<tr>
<td>Define your action plan</td>
<td>Working group develops an action plan and prioritises actions required.</td>
<td></td>
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</tr>
<tr>
<td>Review service processes and protocols</td>
<td>Review prison care pathway and adapt if required (including referral and throughcare). Review pharmacotherapy protocol in prison against specification, and revise accordingly if applicable. Communication of service processes and protocols.</td>
<td></td>
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</tr>
<tr>
<td>Marketing of service</td>
<td>Develop and implement a plan to market the service in the prison.</td>
<td></td>
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<tr>
<td>Managing demand for service</td>
<td>Process in place for recording and regularly reviewing waiting times/referral lead times for service.</td>
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<tr>
<td>Demonstrating innovation, pilots, tests of change</td>
<td>Consider additional activities or benefits for prisoners who are on the quit programme.</td>
<td></td>
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<tr>
<td>Understanding the user experience</td>
<td>Gathering feedback from service users and using this to inform service developments.</td>
<td></td>
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<tr>
<td>Training</td>
<td>Identify key staff for brief intervention training and begin a training programme.</td>
<td></td>
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<tr>
<td>Monitoring and evaluation</td>
<td>System to regularly monitor and review performance measures.</td>
<td></td>
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</tbody>
</table>

Download the interactive version of this form from [www.healthscotland.com/documents/25618.aspx](http://www.healthscotland.com/documents/25618.aspx)
Appendix 2: Integrated care pathway for identification and management of smoking cessation in prison

Smoking cessation information for all admissions to prison from custody/community/care

Prisoner’s smoking status established and recorded at reception

Smoker – follow-up by health centre staff

Is the prisoner a smoker already in treatment (i.e. undertaking a quit attempt)?

Yes

Referral prioritised: continue and/or complete treatment

No

Follow up with brief invention: a smoker who wants to stop?

Yes

Assessment of the prisoner’s readiness and commitment to quit and prisoner’s referral prioritised (Protocol 3.1)

No

No – offer of service declined: prisoner details recorded for follow-up at a later date

Follow-up or self-referral

Smoking cessation service

Prescribe pharmacotherapy as per national Prison Smoking Cessation Service Specification and intensive behavioural support

Integrated pre-release health planning

e.g. referral to smoking cessation services, GP registration, health and social care needs, throughcare (statutory or voluntary provision), peer support and mentorship.

Transfer:

- To another prison
- To hospital
- Liberated to community – support from gate and beyond; throughcare officers (TCOs) if provided, peer mentorship, Throughcare Addiction Services (TAS), The WISE Group, Positive Routes, Smokeline (Protocol 3.2)

N.B. At any point in a prisoner’s stay, if they feel they want to quit smoking, they can enter or re-enter at assessment level.

All local protocols must be consistent with national guidelines; NICE, SIGN, DoH.
Appendix 3: Protocols

3.1 Assessing the prisoner’s commitment to quit

- **Check that they still want to quit.**
- **Prioritise by the following:**
  - Referral due to health reasons.
  - Least amount of time in prison; e.g. if a remand prisoner and therefore a short timespan, checking liberation dates or court dates with prisoner.
- **Assessment of nicotine/cigarette dependence (this can be done using questions 1 and 4 of the Fagerstrom test:22)**
  - How soon after you wake up do you smoke your first cigarette?
  - How many cigarettes per day do you usually smoke?
- **Quit history; e.g. quit before, within the last year, longest period of quit**
- **Detail what the service can offer and what to expect**
  - Benefits of the service: NRT, intensive support, any additional incentives; i.e. the best and most effective way to stop smoking (evidence-based).
  - Benefits of stopping smoking; i.e. health and making use of their time while in prison.
- **Detail what’s expected from them as a service user**
  - 100% attendance (two non-attendances is likely to result in discharge)
  - Setting of quit date including defining what ‘quit’ means, i.e. no puffs and the process of validation by using CO testing
  - No abuse of NRT
- **Check whether prisoner needs any additional support; i.e. any learning difficulties, translator**
- **Issue any resources**
3.2 Guidance on managing throughcare: including transfer of prisoner to another prison’s service and transfer to community services

Staff delivering the smoking cessation service need to organise a system for them to check the transfer list weekly.

The transfer of prisoners is communicated to health centre.

Transfer to another prison

If a prisoner is using SCS, email SCS contact in new prison detailing the name of the prisoner and how long they have quit for

New prison contacts the transferred prisoner and offers to continue support in smoking cessation

Transfer to acute services or mental health unit

If a prisoner is using SCS, email SCS contact in acute services or mental health unit detailing the name of the prisoner and how long they have quit for

On return to prison, SCS contact at acute services or mental health unit to update SCS contact at prison on prisoner’s progress with quit

Transfer to community

Smokeline wallet cards in induction packs and pre-liberation packs to ensure offender knows how to seek support

If applicable, make links with:
- SPS prison throughcare officers
- Throughcare Addiction Services (TAS)
- Other third sector organisations, e.g. The WISE Group – Positive Routes
Appendix 4: Delivering intensive smoking cessation behavioural support

In preparation for running these intensive smoking cessation behavioural support sessions, the lists below highlight some of the key aspects to consider and examples of what to do at each session using either a group or one-to-one format.

For a group format

Session 1: Introduction, paperwork, information and discussions

Introduction should consist of the following:

- Meet and greet – give a warm welcome to the service.
- Agree and set the ground rules.
- Give resources to each prisoner, if applicable.

Paperwork

- Check prisoners expected against register.
- Each prisoner should complete a questionnaire for minimum data set (MDS) information (it may be relevant to check timings of release and hence explain the importance of contact details for follow-up).

Information and discussions

- Outline the purpose of the smoking cessation service/group structure in terms of support.
- Explain what can be expected of the service.
- Explain what is expected of quitters.
- Discuss previous quitting history, reasons for smoking, reasons why wanting to stop.
- May wish to describe and use the addiction triangle (see page 38) to help discuss the reasons for smoking.
- Discuss the health and wider benefits of stopping smoking.
- Emphasise the importance of getting off to a good start and complete abstinence.
- Focus on the importance of changing routines, and the need to plan and think of solutions that will help them cope with stopping smoking; e.g. solutions to cope with boredom or stress.
- Explain planning and preparation is the key to success.
- Time-dependent: discuss and identify solutions to these situations and available support within the prison setting.
- Suggest getting rid of all cigarettes, ash trays, lighters prior to quitting.
- Make the prisoner aware of their option for a referral to a smoke-free cell.
- Reinforce the importance of setting a quit date, and their reasons for quitting.
• Provide information on/demonstrate NRT products, varenicline and bupropion to allow prisoner to make an informed choice.
• Assess nicotine dependence and offer appropriate feedback.
• On providing a prescription, a quit date must be agreed and entered on prisoner record.
• Take a CO reading and feedback to prisoner. Explain the relevance of readings to the client. Record CO level by entering on client’s record.
• Re-emphasise that the better prepared the prisoner is, the easier it will be to identify the danger signals when they may be tempted to smoke, so the more likely they are to remain quit.
• Confirm future group sessions outlining rules for non-attendance.

For every session, remember to:
• Confirm no changes in prisoner’s medical condition.
• Maintain group register.
• Take a CO reading and feed back to prisoner.
• Record CO level by entering reading on prisoner’s record.
• Dispense pharmacotherapy in line with local policy.
• Remind clients how to use chosen product(s).
• Explain and discuss any withdrawal symptoms.
• Promote the positive aspects of the cessation service.
• Encourage the group to discuss feelings experienced by smokers when they quit smoking in prison.
• Encourage prisoners to develop and share coping strategies.
• Encourage group cohesion and respect for each other’s views.
• Remind prisoners that abstinence is the key to success: not even a single puff.
• Remind them that additional support is available if required.
• Praise them on progress and achievement to date.

Session 2
• Reiterate the importance of setting/maintaining quit date and getting off to a good start.
• Record quit date.
• Emphasise that this is the start of a serious quit attempt.

Session 3–5
• Monitor compliance with, and dispense, pharmacotherapies.
• Encourage the group and increase motivation levels to remain abstinent.
• Offer practical advice and help in dealing with boredom, withdrawal symptoms/cravings.
• Group discussions: lifestyle issues; e.g. stress management, healthy weight, physical activity, oral health and the options available within the prison.
Session 6

- Congratulate them on their achievements, and possibly issue certificates.
- Get the group to discuss and review the past few weeks – what have been the best bits and the worst bits?
- Get the group to discuss coping strategies.
- Get the group to give feedback on the stop smoking service.
- Encourage prisoners to complete their course of pharmacotherapy.
- Monitor compliance with, and dispense, pharmacotherapy.

Final/7th session

For sessions beyond week 6, address provision of pharmacotherapy, the future, and relapse prevention:

- Final CO reading, feed back to prisoner and record.
- Update/complete all relevant database requirements.
- If relevant, discuss ongoing coping mechanisms to ensure that the prisoner remains quit and how to get additional support if required.
- Offer longer-term support, if seen to be beneficial.
- Remind the prisoner when they will be contacted again for follow-up, i.e. at 12 weeks and possibly one year post-quit-date. It may be relevant to check timings of release and therefore contact details. Emphasise the importance of collecting this information, to allow the NHS to report on the effectiveness of the service.
- Request feedback from the prisoner on the stop smoking service.

Using a one-to-one format

Session 1

The smoking cessation adviser goes through the type of service that is offered, along with an outline of behavioural support and pharmacotherapy support, to ensure that the prisoner has an informed expectation regarding the structure and process. They then carry out the following:

- Complete MDS information (it may be relevant to check timings of release and therefore explain the importance of contact details for follow-up).
- Discuss previous quitting history, reasons for smoking, reasons why they are wanting to stop.
- Assess nicotine dependence and offer appropriate feedback.
- Go through the range and use of products as stop smoking aid(s).
- Reinforce the motivation to quit and set a quit date.
- Emphasise the importance of abstinence when prescribing.
- Explain the use of the CO monitor.
- Plan future appointments.
• Explain timings and reasons for follow-up.
• Provide information about altering or cancelling attendance times.
• Emphasise the importance of changing routines, and the need to plan and think of solutions that will help them cope with stopping smoking, e.g. solutions to cope with boredom or stress, and withdrawal symptoms/cravings.
• Emphasise health and wider benefits.
• Make the prisoner aware of the option for a referral to a smoke-free cell.

Subsequent sessions (a minimum of two)
• Establish smoking status.
• Emphasise benefits of stopping smoking.
• Address any concerns; check whether solutions planned to help them cope are working. If not, discuss new solutions.
• Check prescription is being followed and is still being effective.
• Take a CO reading, give feedback on progress and record.
• Use recommended service resources for specific information.
• Check the next appointment time.
• If required, offer additional support.

Final session
• Final CO reading and record.
• If relevant, discuss ongoing coping mechanisms to ensure that the prisoner remains quit and how to get support.
• Complete all relevant database requirements, including one-month follow-up details.
• Longer-term support offered if seen to be beneficial.
• Remind the prisoner of when they will be contacted again for follow-up; i.e. at 12 weeks and possibly one year post-quit-date. It may be relevant to check timings of release and therefore contact details. Emphasise the importance of collecting this information to allow the NHS to report on the effectiveness of the service.
• Request feedback from the prisoner on the stop smoking service.
Appendix 5: Health behaviour change techniques

The addiction triangle can be used to help the smoker:

- explore all the reasons why they smoke
- build a list of alternatives to smoking, which they can then break down into small meaningful activities
- tackle emotional, habitual and the raw drug addiction to nicotine.

The triangle is used in relation to the information supplied by the client regarding their smoking history (Ferry 1999).

What is motivational interviewing (MI)?

MI:

- is a way of working with people's ambivalence to trigger change
- is about guiding people in their decision-making
- is about expressing empathy, sharing in the quitters’ experiences
- is not about ‘advising’, controlling or forcing people to do things they don’t want to do!
- uses key communication skills.

Use the principle of ‘developing discrepancy (working with people’s ambivalence) to guide motivation’ (Rollnick and Miller, 1995).

Using MAP

Practical behaviour change techniques as identified in the Health Behaviour Change Competency Framework (HBCC). All of these techniques can be used as routes to change. The framework distinguishes between techniques to:

- develop motivation (M)
- support specific actions (A)
- prompt specific behaviours (P)

More information is available on the eLearning module Level 2 of NHS Health Scotland’s Health Behaviour Change (HBC) course.

Appendix 6: Membership of the national Smoking Cessation Prisons subgroup

This specification has been produced by members of the national Smoking Cessation Prisons subgroup, including:

Celia Gardiner (Chair), Health Improvement Programme Manager (Tobacco), NHS Health Scotland
Kate Barlow, Senior Health Improvement Programme Officer (Tobacco), NHS Health Scotland
Fiona Moore, Public Health Adviser, NHS Health Scotland
Valerie Logan, Fresh Air-shire Lead, NHS Ayrshire & Arran
Trish Grierson, Tobacco Control Lead/Service Manager, NHS Dumfries & Galloway
Kat Jarvie, Senior Stop Smoking Specialist, NHS Forth Valley
Fiona Gordon, Service Manager, NHS Forth Valley
Joanne O’Suilleabhain, Stop Smoking Coordinator, NHS Forth Valley
Doris Williamson, Health Improvement Lead (Prisons), NHS Greater Glasgow & Clyde
Rebecca Campbell, Health Improvement Lead (Tobacco), NHS Greater Glasgow & Clyde
Derek Petrie, Tobacco Control Coordinator, NHS Grampian
Kate McGhee, Stop Smoking Nurse Specialist, NHS Lanarkshire
Diana Martin, Stop Smoking Coordinator – Prisons, NHS Lothian
Helena Connelly, Smoking Cessation Coordinator, NHS Lothian
Fiona Currie, Stop Smoking Facilitator, NHS Lothian
Susan Birse, Senior Health Promotion Specialist, NHS Highland
Margaret Winton, Senior Health Promotion Officer, NHS Tayside
Adrian Hyndman, Data Manager, NHS National Services Scotland
Tom Byrne, National Prisons Pharmacy Adviser, NHS Healthcare Improvement Scotland
Ruth Parker, Head of Health & Wellbeing, Scottish Prison Service