PERSONAL VIEW

Why fund smoking cessation programmes in prisons?

Over the past decade, most prison authorities in Western countries have responded to the public health, litigation, and security problems posed by high prevalence of tobacco use among prisoners, primarily through prohibition and severely restrictive policies. Although Britain recently funded nicotine replacement pharmacotherapy and smoking cessation programmes to assist prisoners willing to quit, such programmes to complement restrictive policies are rare in American and Australian prisons. The main argument against the funding of these complementary smoking cessation programmes by custodial authorities is cost. I would argue that, for a number of reasons, the benefits of funding smoking cessation programmes for inmates willing to quit surpass the costs of implementation.

Funding of smoking cessation programmes for inmates that require such services is by itself a strong counterargument to the allegedly punitive nature of tobacco control policies in prison settings, such as prohibition. The provision of funded programmes for smoker inmates willing to quit should act as a disincentive to inmates and staff who traffic tobacco ostensibly to “help” smoker prisoners cope with their addiction.

Prohibition of tobacco in most prisons has generally resulted in more black market activity, greater tension between prisoners and staff, an increase in tobacco related violence, and a higher cost of tobacco trafficking surveillance. In the United States in the mid-1990s, in state prisons in Georgia and Vermont, total prohibitionist policies were relaxed after only a few months of operation because of such problems. At Woodford prison, Queensland, also in the mid-1990s, inmates rioted and caused major damage to prison property because of severe tobacco restriction and inadequate welfare services. Funded and structured smoking cessation programmes have the potential to reduce the likelihood and severity of these sorts of problems.

Tobacco prohibition or restrictions do not necessarily lead to smoking cessation, especially when smokers view such policies primarily as punitive. The goal of helping smokers to quit in the long term should be accorded a higher priority than just keeping prisoners smoke free. Integrating smoking cessation programmes into tobacco control activities makes it more likely that both priorities are achieved.

Although the cost of smoking cessation programmes is substantial (typically $US350 (£190; €270) per smoking inmate over 12 weeks), this is not an excessively high cost when you realise that prisoners’ basic healthcare bills in the United States, Britain, and Australia are on average about $10 a day, or $540 over 12 weeks. In terms of cost per year of life gained, smoking cessation interventions compare favourably with other common preventive strategies currently offered for free to prisoners, such as treatment of moderate hypertension. The benefits of such a programme—including a decrease in the cost of tobacco related health care for participating inmates and people who otherwise would have been exposed to their smoke, increased custodial harmony, and less need for tobacco trafficking—may also be neutralised by the cost of helping inmates willing to quit with funded smoking cessation programmes.

Interventions that help inmates to quit smoking, rather than those that merely prevent them from smoking while incarcerated, are likely to make significant positive contributions to inmates’ long term economic rehabilitation. A recent study showed that each adult year of regular smoking is associated with a decreased net worth of around $400 (Tobacco Control 2004;13:370-4).

Surveys of prisoners on smoking issues indicate that their demand for smoking cessation programmes is strong. Although such demand does not necessarily indicate willingness to quit smoking, they at least suggest that funded quit programmes would be well received by inmates. Such responsive approaches to prisoners’ health needs that make allowance for prisoners’ self care and personal responsibility for health issues are useful starting points for reducing pressure on prisons’ health service budgets.

It is difficult to implement effective tobacco prohibition among illicit drug users and psychiatric inmates, as they seem to use tobacco partly as self treatment and partly to increase the desired effects of licit and illicit drug use. These groups constitute the majority of prisoners in Western societies. Mentally ill prisoners who are prohibited from smoking and who are not provided with nicotine pharmacotherapy have been known to be particularly violent and uncontrollable. Such episodes of aggressive and violent behaviour have led some staff to use tobacco to manage patients and to minimise the risk of violence. Making exceptions for some inmates on account of psychiatric illness is likely to weaken the credibility and effectiveness of severely restrictive smoking policies and outright prohibition.

Although the issue of tobacco use in prison settings needs to be addressed urgently, prisons should adopt approaches that are sustainable, humane, and cost effective. Policies such as prohibition and severe restriction of tobacco use are more likely to be cost effective and sustainable in settings where inmates’ basic health and welfare needs are addressed in a humane manner and where inmates have opportunities to access voluntary smoking cessation programmes.

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