

# Minimum Offer for Stop Smoking Services and Support in Custody



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## Minimum Offer for Stop Smoking Services and Support in Custody

This document defines the minimum service offer for smoking cessation services to be offered in all adult establishments in support of the HMPPS smokefree prisons policy. All prisons are expected to meet this minimum service offer.

It supports the work programme to reduce levels of smoking in prisons and is aimed at standardising the approach and quality of smoking cessation services delivered in prisons.

This document defines standards for training, interventions and pharmacological support for smoking cessation to be adhered to by stop smoking services in all prisons. It recognises the need for a whole prison approach to smoking cessation and continuity of care as part of a wider healthy living model and is based on learning from the early adopter smokefree prisons.

The minimum service offer has been agreed by NHS England, Public Health England and Her Majesty’s Prison and Probation Service (HMPPS). It is based on existing specifications and complies with NICE and PHE guidance. It has been developed to support the implementation of the national programme for smokefree prisons and has taken into account specific learning and experience from the early adopter prison sites.

## Service Specification

The national NHS England smoking cessation specification sets out what healthcare providers are expected to deliver within the wider healthcare contract.

Some healthcare services were procured prior to the release of the national service specifications and consideration may need to be given to aligning existing (pre-smoke free) services with the national specification.

This specification acknowledges two fundamental models of care, one for those requiring full cessation interventions and one for those people who require a harm reduction intervention. The distinction between these interventions and when they should be delivered is set out below.

## National stop smoking service specification for a full cessation intervention

This intervention is suitable when an individual wishes to stop smoking completely and is intending for this to become a permanent cessation. For those people who for whatever reason are unwilling or unable to stop completely then a harm reduction intervention should be offered.

The healthcare provider will ensure that;

- a. Smoking status is reviewed at each contact with healthcare, and SystemOne is updated as required. For the definition of a Smoking Status, please see page 21.
- b. All prisoners who smoke are opportunistically advised to quit and those motivated to do so are referred to the stop smoking service.
- c. Motivated smokers seeking support are offered an evidence based intervention delivered over 8 weeks with their smoking status recorded 25-42 days after their set quit date. For those prisoners whose tenure falls short of the 25-42 days from their quit date, who have been engaged in evidence based interventions and for whom an outcome is not known, then the outcome should be recorded as not known
- d. Interventions offered must include:
  - brief intervention (Ask Advise Act)
  - individual behavioural counselling and/or group behaviour therapy

- pharmacotherapies either as a single or a combination of products
- Interventions may also include enhanced access to further behaviour change promoting activities, such as psychosocial interventions, addiction management, increased gym or education provision and enhanced levels of peer support
- e. The particular level of intervention that is suitable for each person is identified, to ensure appropriate onward referral and treatment. This will depend on several factors, including:
    - the individual's willingness to quit
    - how acceptable they find the intervention on offer
    - the previous ways they have tried to quit
  - f. Proactive follow up of patients during the treatment period reduces lost to follow up and increases quit rates.
  - g. At each appointment, including when NRT is collected, CO monitoring is used to motivate continuation with the programme, outcomes are recorded and a reading of <10ppm at 4 weeks is used to indicate CO validated success has been achieved. CO monitoring is not expected to be used as a punitive measure to stop access to services.
  - h. Fully completed (electronic) cessation activity reports are submitted (HJIPs), according to a calendar of monthly deadlines issued at the start of the year.
  - i. Achieve a quit rate above 35% at 4 weeks and work to keep lost to follow up rates  $\leq 15\%$ , subject to exception for Reception prisons as identified in point C. above.
  - j. Staff delivering stop smoking support and/or supplying NRT must be NCSCT certified or equivalent and signed off as competent.

### National stop smoking service specification for harm reduction approaches

Harm reduction interventions are instigated for one of four reasons;<sup>1</sup>

1. Stopping smoking: using one or more licensed nicotine-containing products as long as needed to prevent relapse.
2. Cutting down prior to stopping smoking (cutting down to quit): with the help of one or more licensed nicotine-containing products (the products may be used as long as needed to prevent relapse) or without using licensed nicotine-containing products.
3. Smoking reduction: with the help of one or more licensed nicotine-containing products (the products may be used as long as needed to prevent relapse) or without using licensed nicotine containing products.

4. Temporary abstinence from smoking: with the help of one or more licensed nicotine-containing products or without using licensed nicotine-containing products.

Traditionally, all smokers have been encouraged to stop abruptly, though recent evidence suggests that cutting down the number of cigarettes smoked may help smokers to control their smoking and result in complete cessation.<sup>1</sup> This may be especially important for those smokers who are unable to stop completely and in one step, such as those in the prison population. In addition, the use of replacements or substitutes for nicotine (such as NRT) is recommended for times where temporary abstinence is desired (see below).

The provision of NRT to support people who are continuing to smoke is an important part of a harm reduction strategy. People who attempt to reduce the numbers of cigarettes they smoke without replacing the nicotine that they are losing tend to over-compensate by taking longer, deeper drags on each cigarette. This will result in little or no actual reduction in quantity of smoke inhaled. Conversely, use of NRT decreases the need for compensatory smoking, allowing the user to more effectively reduce the amount of nicotine required, and hence smoke obtained, from each cigarette. Smokers may also wish to use these nicotine substitutes on a long-term basis as a means of reducing the harmfulness of their smoking.

Where a prisoner has engaged with harm reduction approach, is not smoking, and wishes to reduce their dependence upon nicotine, then behavioural / psychosocial support should be provided, and a nicotine reduction plan put in to place. It is not expected that monies identified for cessation will be used to provide nicotine at this time.

There are several points within the CJS whereby a prisoner or person within the CJS will not be permitted to smoke, such as within prisons where smokefree has been enacted, police stations, court cells and while being transferred between settings. Given the impact of nicotine withdrawal on performance and mental state, it is appropriate to give smokers a replacement for the nicotine in cigarettes to combat withdrawal, in line with existing healthcare discharge to court processes.

Where evidence exists that NRT is being used as currency by prisoners in a similar way to cigarettes, solutions such as introducing exchange schemes where new patches are only provided on return of used ones can be implemented. Most prisons use transparent nicotine patches so that patients cannot conceal illicit substances beneath them. Also most prisons prohibit chewing gum, and some foil wrappings or plastic

containers. Nevertheless given there are currently several forms of NRT available, there is still the opportunity to offer offenders one or more NRT products. From the range of products currently available, the clear patches, mini-lozenges and oral film seem the most suitable.

A short supply of pharmacotherapy should also be supplied for those about to transfer in order to tide the offender over until prescribing can be renewed in the new setting.<sup>2</sup>

The recent popularity of electronic cigarettes (e-cigarettes) has demonstrated that many smokers are interested in trying and using less harmful sources of nicotine. E-cigarettes are nicotine delivery devices that heat nicotine and do not involve combustion. Two recent reports for Public Health England provide a useful source of information on e-cigarettes.<sup>3,4</sup> One of these commented in relation to electronic cigarettes that: “*the hazards associated with use of products currently on the market is likely to be extremely low, and certainly much lower than smoking*”.

This review also concluded that e-cigarettes can help smokers to stop smoking. More recently, a Cochrane review on electronic cigarettes based on evidence from two trials concluded that electronic cigarettes help smokers to stop smoking long-term compared with placebo electronic cigarettes.<sup>5</sup> Additionally, the health risks of passive exposure to electronic cigarette vapour were reported as ‘*likely to be extremely low*’.<sup>3</sup>

Public Health England, Action on Smoking and Health, the NCSCT, NICE and the three regional offices of tobacco control, have co-produced supporting material based on feedback from six regional workshops to support commissioners and practitioners in implementing this guidance, which is available on the Smokefree Action on website.<sup>6</sup>

A harm reduction option may be more suitable than a programme of cessation for patients transferring into smokefree accommodation, who intend to return to smoking on transfer or release. All prisoners who are on sentences of less than 8 weeks should initially be offered a harm reduction intervention, to help them manage their addiction whilst in prison. Those prisoners in a reception or local prison should be offered harm reduction interventions as a first line treatment, with full cessation being offered at the point of sentence or on transfer to another prison, whether that is to another place of detention, or to the community. All prisoners should be offered a first session with a trained advisor to discuss these options, with those who choose cessation being offered further appointments and those who choose harm reduction provided with access to nicotine replacement therapies and e-cigarettes from the canteen and behavioural support from appropriately trained individuals. Where people are signposted to canteen purchases as management of harm reduction, Healthcare must be assured that the person has sufficient funds in place to purchase NRT. Where a person doesn't have sufficient funds, a care plan should be put in place between

Healthcare and the prison. Interventions for this group of individuals are included as part of the funding formula for the cohort within the establishment.

Where there are concerns about the abuse of NRT, these should be discussed with the prison leads; there are a range of responses available to tackle prisoner behaviour associated with finding ways to continue to smoke; similar behaviour was seen in other jurisdictions implementing smokefree policies. Whilst the behaviour might be anticipated, it does not mean that it should be tolerated and there are a number of approaches that can be used to challenge prisoner behaviour. Responses include:

- Responding to harms associated with the new behaviour
- Controlling NRT Products
- Managing prisoner behaviour, including tackling the psychological aspects of smoking behaviour
- Health & Safety responses
- Use of IEP and Adjudications

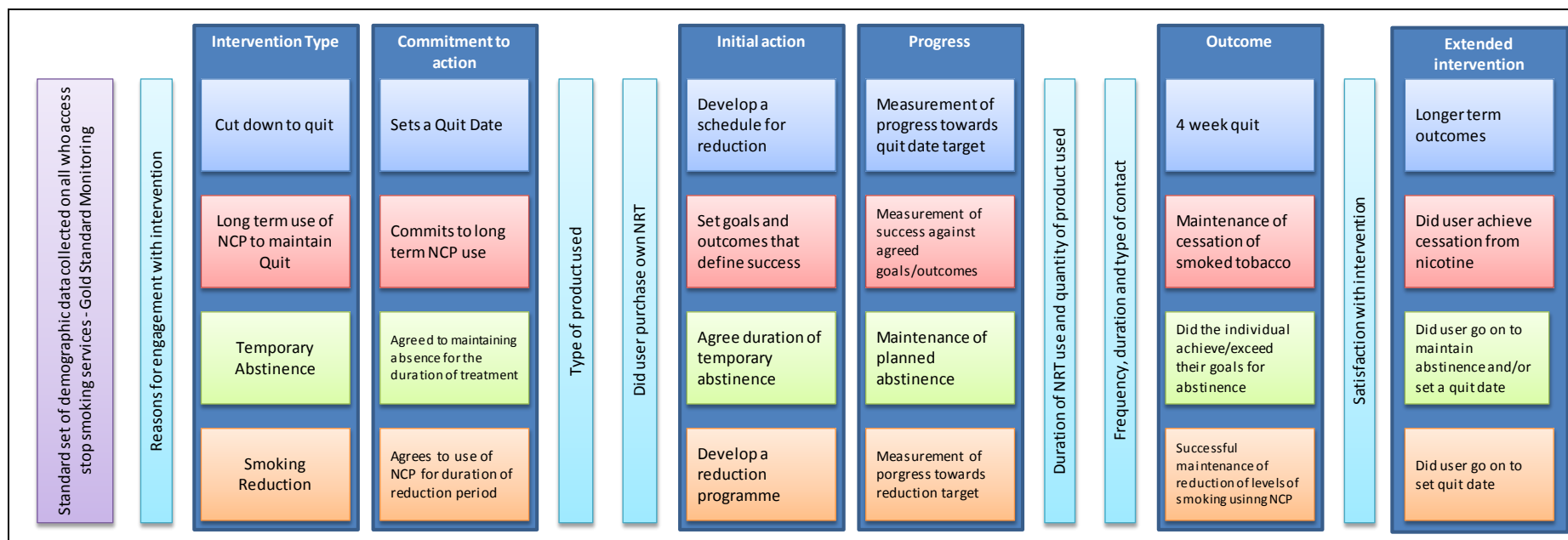
In all cases of suspected misuse use or challenging prisoner behaviour, healthcare staff are required to submit an intelligence report on the Mercury system, (if you require further advice about how to submit an intelligence report, please contact the Security Department for more information).

The decision to withdraw any treatment approach at an establishment level should only be taken following a full and thorough review and in consultation with the national smokefree prisons board.

Currently harm reduction activity is not recorded nationally. However, suggested outcomes that could be captured locally are in the table below.<sup>7</sup> NCP refers to any nicotine containing product. The light blue vertical text boxes indicate the suggested minimum set information that may be recorded, in addition to the gold standard at each point.

If a harm reduction approach is adopted, then the following information should be recorded in that person's notes to ensure continuity of care.





In addition, healthcare providers are required to provide health education and promotion in partnership with the other healthcare service providers for nutrition advice, promotion of self-care, exercise and medicines management.

All health services in prison are required to work alongside custodial staff and include programmes that specifically address, amongst other things, smoking cessation/reduction and include:

- Current smoking status is checked at each routine appointment and at other appointments where this is appropriate to care, and their healthcare record updated (SystemOne and NOMIS)
- Stop smoking services are clearly identified and Very Brief Advice<sup>8</sup> provided to all identified as smokers
- Work in collaboration with the prison and all health services to achieve a good standard of service, including prison staff, SMS and MH teams, PEI's and other groups providing services to patients and tobacco services in the LA
- Working with the prison around the use of e-cigarettes to work with individuals who choose this route and encourage all people who are using e-cigarettes and smoking to stop smoking by switching over to only using e-cigarettes, NRT or a combination of both

- Dentistry participation in national events such as Smile Month, National No Smoking Day, Stoptober and provides training for healthcare staff in oral health promotion messages including the links associated with poor oral health such as sugar consumption, smoking and substance misuse

Other areas of health and wellbeing provision that require partnership working with custodial staff and provide support to the smokefree policy include:

- Healthy eating and nutrition, to include BMI assessment
- The training of people in prison as peer educators - health trainers
- Supporting access to a range of physical exercise programmes appropriate to age and needs
- Supporting access to a range of wellbeing programmes and activities appropriate to age and needs, such as yoga, mindfulness techniques
- Those with mental health conditions, those at risk of self-harm and those patients whose medicines may require adjustment if they commence or stop smoking

Maternity Services are required to provide advice and interventions to pregnant and breastfeeding mothers in prison in line with NICE Guidelines for smoking in pregnancy PH 26<sup>9</sup>.

### Peer approaches

Healthcare will need to work collaboratively with the prison to offer a stop smoking peer support scheme and/or consider how other health peer schemes can be enhanced to include stop smoking support, such as health trainers. In establishments where this has happened, it has had the multiple benefit of:

- Enhancing provision for patients.
- Increasing the skills of prisoners.
- Providing a degree of 'out of hours' support, when healthcare are unavailable or engaged in other activities.
- Increasing the capacity of the service to respond.

- Building a further feedback and service improvement link, between the patient, supporter and healthcare to assist in the planning and effective delivery of services.
- Provide the talking help – when people need it - that many patients have identified as a gap in their cessation journey.

### Substance Misuse Services

The substance misuse service should assist staff and patients with awareness raising activities and support with group and one-to-one psychosocial elements of smoking cessation – such as managing withdrawal, relapse prevention, managing cravings and maintaining behaviour change. There should also be specific support to individuals already on the Substance Misuse Service caseload to help them to manage their addictions holistically, as well as support to those who misuse NRT and enabling (with colleagues) the development and maintenance of peer support schemes.

### Procurement and continuity of medicines used for smoking cessation

Providers are required to source and purchase NRT stock cost effectively either directly from manufacturers or via suppliers that have a MHRA Wholesale Dealers Licence (WDL). NRT stock management arrangements and prescribing and supply of prescription only medicines should ensure continuity of medicines access especially on release or transfer to another establishment.

### NRT Pharmacotherapies

In accordance with NICE guidance<sup>10</sup> the Provider must:

- a. Offer HMPPS approved NRT products and varenicline or bupropion, as appropriate, to people who are planning to stop smoking.
- b. Offer advice, encouragement and support to help people in their attempt to quit.

- c. NRT, varenicline or bupropion should normally be supplied as part of an abstinent contingent treatment, in which the smoker makes a commitment to stop smoking on or before a particular date (target stop date), or when that smoker is undertaking a planned period of smoking reduction, leading to abstinent contingent treatment being initiated.
- d. The supply of NRT, varenicline or bupropion should be sufficient to last only until 2 weeks after the target stop date. Normally, this will be after 2 weeks of NRT therapy, and 3–4 weeks for varenicline and bupropion, to allow for the different methods of administration and mode of action.
- e. Subsequent supplies should be given only to people who have demonstrated, on re-assessment that their quit attempt, or smoking reduction is continuing as planned, (see Relapse section below). However CO monitoring alone should not be used to make decisions about the continuation of treatment given that environment, shared cells etc. can affect the reading; cases / progress should be assessed based on a fuller exploration of an individual's progress, support needs and motivation to continue with a quit attempt.
- f. Explain the risks and benefits of using NRT to young people aged from 12 to 17, pregnant or breastfeeding women, and people who have unstable cardiovascular disorders.
- g. To maximise the benefits of NRT, people in these groups should also be strongly encouraged to use behavioural support in their quit attempt.
- h. Neither varenicline nor bupropion should be offered to young people under 18 nor to pregnant or breastfeeding women.
- i. Varenicline or bupropion may be offered to people with unstable cardiovascular disorders, subject to clinical judgement.
- j. If a smoker's attempt to quit is unsuccessful using NRT, varenicline or bupropion, then providing they remain sufficiently motivated to quit, they should be encouraged to try again, increasing the level of support provided, with those who are not receiving behavioural support, required to attend these sessions, (see Relapse section below)
- k. Do not offer NRT and varenicline, NRT and bupropion, or varenicline and bupropion concurrently during any intervention, other than when managing withdrawal during the initiation period of bupropion or varenicline in people who have technically already stopped smoking(usually 7-14 days)
- l. Consider offering a combination of nicotine patches and another form of HMPPS approved NRT to people who show a high level of dependence on nicotine or who have found single forms of NRT inadequate in the past.
- m. Do not favour one medication over another; the clinician and patient should choose the one that is safest for them and seems most likely to succeed.
- n. When deciding which therapies to use and in which order, discuss the options with the client and take into account:
  - whether a first offer of referral for behavioural support has been made

- contra-indications and the potential for adverse effects
  - the client's personal preferences
  - the availability of appropriate counselling or support
  - the likelihood that the client will follow the course of treatment
  - their previous experience of smoking cessation aids
- o. Support the prison in the risk management of clients, including identification of those requiring medication reviews and/or closer supervision as a result of stopping smoking or receiving smoking cessation medicines.
- p. Bupropion and varenicline must be provided via a prescription from a prescriber (medical or non-medical prescriber). Information from the smoking cessation appointments will be used to inform the prescribing decision, including whether repeat templates are needed and how many.
- q. NRT can be supplied by NCSCT certified (or equivalent) practitioner which can include healthcare or prison staff. Protocols should be used for the supply of NRT to ensure appropriate referral where potential clinical cautions or risks are identified. Every supply of NRT should be recorded on SystemOne/HJIS within 24 hours of the supply being given. Whilst prisoners can be trained to deliver stop smoking support, (NCSCT certification), they cannot issue NRT.

### Offender Personality Disorder Services

Prisoners in Offender Personality Disorder services are likely to have significant psychological, emotional and social problems; in addition coping with change can be difficult and threatening.

The OPD cohort are very likely to have smoking and other substance use problems as part of their overall pathology, and are likely to have used substances to help them cope, as a distraction from psychological and emotional turmoil, and for 'self-soothing'. It is likely that OPD cohorts will require longer and more intensive stop smoking service provision than other prisoners and you may wish to consider engaging with this group of prisoners in advance of full mobilisation of smokefree activity.

The joint HMPPS and NHS England Offender Personality Disorder team have identified a number of key points that you will need to action for this group when introducing a smoke free environment in your prison:

- Brief the OPD clinical and operational leads as soon as possible regarding plans and timescales
- Ensure there is a plan for early and transparent discussion with prisoners, informed and agreed with OPD leads
- Include OPD leads in establishment smokefree project boards
- Listen to feedback and adjust plans if necessary – show you are listening; but be clear that not going smoke free is not an option
- OPD clinical and operational leads can work with service users on managing the implications to the OPD service, and preparing the whole service in accordance with the establishment timetable
- OPD clinical leads to think about and plan for impact on the mental health of their service users, and the impact on staff OPD leads to work with healthcare and stop smoking service advisers with regard to the delivery of stop smoking services, including issuing NRT products, to the OPD cohort and ensure clear dialogue and where necessary protocols are in place
- OPD clinical and operational leads to provide advice and support to stop smoking service staff to ensure they are aware of the specific needs and risks when working with OPD cohorts
- Consider appointing an OPD prisoner lead to be a liaison between service users and staff

## Information Sharing

Healthcare providers are required to agree and operate information sharing agreements with their host prisons; under these agreements healthcare providers are able to share information about individual patients engaged in stop smoking services, such as those at increased risk who require additional monitoring and supervision and those people suspected of abusing nicotine products.

Prisons are required to agree and share information with healthcare providers about individual prisoner purchases from canteen, such as those purchasing NRT or e-cigarettes, and those people suspected of abusing nicotine products, to ensure risks associated with self-managing a quit attempt are mitigated.

## Risk Management

All individuals who smoke are required to be assessed for nicotine dependence and to identify how they intend to manage the transition to a smokefree prison. A risk assessment is undertaken for all those who have specific challenges around co-morbidity and risk, such as substance misuse, learning difficulties, self-harm, mental health, long-term significant tobacco use or prescribed specified medications to ensure nicotine withdrawal is appropriately managed and medication adjustments are made. Prison staff should be involved in these activities and individual management plans shared with prison staff.

Providers should work in collaboration with prison teams to develop mechanisms to:

- Implement and promote education and training provision to prisoners for the safe and effective use of stop smoking products, (NRT and e-cigarettes).
- Receive and act on reports of abuse/misuse of NRT and prescribed medicines.
- Encourage the use of treatment compacts that explain the risks of misusing NRT and prescribed medicines.
- Appropriately record, report and share information about any events, where that misuse or behaviour is associated with access to services or nicotine replacement therapies, such instances should be shared with prison staff, using the Mercury system.
- Use prison systems, such as IEP or adjudications, to sanction inappropriate or challenging behaviours, as appropriate
- Where misuse/diversion is identified, an exchange programme for NRT may be implemented whereby patients exchange a used NRT product when receiving a new supply.
- Review the quantity supplied to all or individual patients to reduce the risk of misuse or diversion.
- Support and manage the behaviour of patients that continue to seek to smoke where the prison is smoke free.

To ensure continuity of care and safe management of patients, information about high risk behaviours and individuals should be recorded on the appropriate systems (SystemOne and NOMIS).

## Training

All staff delivering stop smoking services must be trained to NCSCT certified practitioner (or equivalent)<sup>11</sup> level and signed off as competent by an experienced adviser. This training is often, but not always, accessed through the local authority stop smoking services; where there are difficulties accessing this training, please contact your Health & Justice Commissioner.

Healthcare providers must specify what proportion of healthcare staff will be trained to NCSCT Very Brief Advice (VBA) in preparation for the smokefree policy. For those working with pregnant patients an NCSCT Very Brief Advice for Pregnant Smokers online module<sup>12</sup> is now available and should be used.

Prison and healthcare management are required to work together to ensure sufficient staff are trained to offer VBA interventions at all times, that refresher training is available as and when required and this information is regularly shared. Embedding this in workforce development for both very brief advice and level 2 training is advisable, to ensure capacity and experience is maintained beyond initial implementation. Training staff to deliver evidence based training and share best practice is recommended to support this.

Pharmacists and pharmacy technicians can access NCSCT training free here: <https://www.cppe.ac.uk/programme-listings/a-to-z>

## Delivery Models

Healthcare providers (including Stop Smoking Services) must define the preferred delivery model to be offered and then agree this with the prison team and other healthcare providers, taking into account local requirements, such as centralised or wing based delivery, one to one, group sessions or both and the involvement of prison staff and prisoners in the delivery of interventions. However the service model must deliver across the minimum programme duration set out below.



The minimum service delivery for a supported smoking quit attempt within the prison setting is an 8 week programme. The 8 week programme must follow the standard treatment programme as set out by the NCSCT in the Local stop smoking services: service and delivery guidance.<sup>7</sup>

Behavioural support must be provided up to the 8 week period as a minimum, with NRT provision and/or behavioural support continuing beyond this where it is deemed clinically appropriate. Feedback from early adopter sites suggest the provision of behavioural support beyond 8 weeks is likely to be beneficial in supporting patients to maintain their smokefree status and may reduce post implementation incidences of NRT tampering and smoking-related behaviours.

In addition, healthcare providers are required to provide support to those people who face specific challenges around co-morbidity and risk such as substance misuse, learning difficulties, self-harm, mental health, long-term significant tobacco use or prescribed specified medications - to ensure nicotine withdrawal and:

- who wish to receive NRT without formal behavioural support.
- who wish to stop smoking without medication or behavioural support.
- who wish to stop smoking with behavioural support alone.
- who wish to temporarily abstain from smoking whilst located in a smokefree prison, (harm minimisation).

Prisoners who face these challenges and choose these routes should be considered for a medication review and if there are challenges around co-morbidity or interactions between medicines that these are addressed through multi-disciplinary teams (which include relevant prison staff) and an appropriate care plan put into place. People choosing these routes should be CO monitored and offered behavioural support and supply of NRT at each appointment. If cessation is not achieved by these routes then the uptake of behavioural support may be made compulsory for the continuation of medication provision.

Initial non-acceptance of treatment should not be a barrier to receiving that treatment in the future.

Having an integrated healthcare team working with the prison regime is important so all aspects of delivery are considered. An integrated healthcare approach, for individuals with specific challenges around co-morbidity, must ensure that a risk assessment is carried out and any challenges are managed in a timely and effective way.

## Treatment Episode

At the point of attending one session of a planned multi-session intervention, consenting to treatment and setting a quit date with a stop smoking practitioner, a client becomes a treated smoker and the treatment episode begins. Error! Bookmark not defined. The outcome of care is recorded between day 25 and day 42 of treatment; this is known as the four week quit period. The three possible outcomes recorded are quit, not quit and lost to follow-up, with any outcome not achieved by day 42 being marked as lost to follow-up, even if the result of care is subsequently found. A small amount of smoking is accepted within the first two weeks of the quit; however any smoking after this must result in the outcome being recorded as not quit.

A quit can be CO validated or self-reported and results from the client not smoking even a single drag from day 14 to the point of recording the quit outcome between days 25 and 42. Practitioners should aim to ensure that at least 85% of all reported quits are CO validated. CO validation is achieved if the client blows a score of <10ppm on a calibrated CO monitor. Good practice dictates that if the client wishes to continue treatment after a lapse, treatment should be continued if it seems appropriate, but the quit date should be reset and the outcome of that session recorded as not quit.

## Relapse

Where a patient engaged in any form of stop smoking service reports smoking has taken place or records a CO reading of >10ppm which indicates that they have smoked, attempts must be made to establish whether the person remains committed to the quit or whether it is a pattern of non-compliant behaviour. Where commitment to quit remains, it is expected that the individual continues with their supported quit attempt through a process of treatment review, motivational support and treatment optimisation; where there is no commitment to quit, the patient should be signposted to e-cigarettes or NRT purchased from canteen and additional supportive activities as appropriate.

Such patients may require ongoing monitoring and supervision to ensure risks continue to be managed, (see Risk Management above), for example checks to ensure they hold sufficient funds to enable them to purchase such products; access to psycho/social behavioural support; peer support; additional safeguards for those managed under the ACCT process. SystmOne and NOMIS must be updated. Where a patient chooses to disengage with a service or is removed from a stop smoking service for non-compliance, attempts must continue to be made to re-engage them in services. No patient should be excluded from receiving stop smoking services and support.

## Time between Treatment Episodes

*(See also Treatment episode, above)*

When a client has not managed to stop smoking, there is no definitive period of time required between the end of a treatment episode and the start of another. The stop smoking practitioner should use discretion and professional judgement when considering whether a client is ready to receive support to immediately attempt to stop again. If this is the case, the client must start a new treatment episode, i.e. attend one session of a structured, multi-session intervention, consent to treatment and set a quit date with a stop smoking practitioner in order to be counted as a new data entry on the quarterly return.

Providers must offer relapse prevention support to those leaving smokefree accommodation and promote the availability of voluntary smokefree accommodation to support prisoners to maintain their smoke free status.

## Equality Impact Assessment

Providers must monitor access to and take up of service offers to ensure services are open to all, including those groups less likely to seek support. This information must be shared with the prison's single point of contact (SPOC) for the smokefree programme.

## E-Cigarettes

The use of e-cigarettes as a stop smoking and harm reduction technique will be promoted in all prisons.<sup>13,14</sup> Though Healthcare providers will not have access to e-cigarettes, or be issuing them, they may assist with protocols whereby prison staff can be supported to provide access to e-cigarettes for craving management and where an individual's withdrawal symptoms are impacting (or have the potential to impact) on wellbeing and behaviour. Such protocols should include recognition of withdrawal symptoms and indicators for escalation and systems for

prison staff to access e-cigarettes. Information must be shared with healthcare to ensure any contra-indications or medication interactions are reviewed.

## Reception

All prisoners must have their smoking status reviewed and recorded on arrival to prison and provided with advice and information about the smokefree project and the availability of voluntary smokefree accommodation.

On arrival at a smokefree prison, a smoker must be assessed as part of the first night health screen and sufficient NRT or e-cigarettes provided via HMPPS first night packs until they are seen by a stop smoking adviser. Prisoners should be advised that on average an e-cig tends to last about a day and so taking enough supplies to last until they are seen. Smokers must be seen by a stop smoking adviser within 48 hours of arrival into custody. Where smokers are not seen within this timeframe, providers must make arrangements to ensure sufficient NRT is provided until they can be seen by a stop smoking adviser. The individual may prefer to purchase e-cigarettes during this period as an alternative – though it should be acknowledged that they may have limited resources to make numerous purchases. In either event, as a part of mitigating risk of harm the provider must ensure that the individual's smoking addiction is adequately managed and controlled.

Prisoners transferring from a smokefree prison must be identified in reception and encouraged to maintain their smokefree status e.g. locating in voluntary smokefree accommodation, continuation of stop smoking support.

## Continuity of Care

Healthcare providers are required to support continuity of care for people entering or leaving a non-smoking environment. Where individuals are part way through a quit attempt, providers must link them to the local stop smoking service in the area they are released to. This information can be passed to the offender manager and local CRC to be included in the resettlement plan. For those who have remained smokefree in custody and may be released to a smoking environment, providers must offer relapse prevention support and information about local stop smoking services in their release area.

Prisons where smoking is allowed are required to adequately prepare prisoners for transfer to a smokefree prison. This could include promotional material about the smokefree project, details of the smokefree prisons and the services available at those prisons, prioritising prisoners into services prior to transfer and offering effective voluntary smokefree areas. Healthcare providers should work with prison leads to prepare prisoners for transfer.

Short term access to a suitable nicotine replacement product should be provided to those who smoke and are required to undertake a period of temporary abstinence, such as a court appearance or prison transfer. This includes those people who manage their nicotine withdrawal symptoms using e-cigarettes as their use is not permitted in court buildings, prison vehicles or hospitals.

A 7-day supply of NRT or prescribed medicines should be provided to those already on a structured programme who are transferring or released to allow ongoing treatment until prescribing can be renewed in the receiving prison setting or in the community.

## Reporting Requirements

The full care-pathway, including medication and details of behavioural support, should be recorded as part of the patient record on SystemOne and outcomes included as part of the Health and Justice Indicators of Performance. Information relevant to the risk management of individuals should also be recorded in NOMIS.

Where a local authority provider supports the prison in providing services, they will provide quarterly reports, detailing quit attempts and outcomes, to the NHS Digital, formerly Health and Social Care Information Centre (HSCIC). Providers can request copies of this information to ensure all stop smoking activity is captured.

The NHS Digital local stop smoking service report<sup>15</sup> is a national collection and accepts reports of any activity that is in line with a defined standard, known as the 'Russell Standard'.<sup>16</sup> As such it must be emphasised that once a prison environment becomes entirely smokefree and activity is driven by policy, rather than by the request of a client, then the activity will fall outside of the definitions of the 'Russell Standard' and should no longer be reported to NHS Digital.

Where establishments are not supported by a local authority stop smoking service there is no requirement to report to NHS Digital.

During the lifetime of the smokefree project establishments are required to complete the capacity dashboard and submit it to their Regional Smokefree Board on a monthly basis. This allows the establishment and regional board to monitor activity, target resources and evidence readiness and the ongoing provision of services.

During the implementation phase of the smokefree project establishments are required to complete readiness assessments and provide evidence in support of their assessments.

Patients who successfully complete a stop smoking intervention should have their NOMIS and SystemOne records updated to reflect the new smoking status. Patients who are being managed under a harm reduction intervention utilising e-cigarettes or NRT should be recorded as Vape/NRT. Prisoners who are choosing to self-manage without support retain their status as smokers.

For those prisons with a high turnover (reception prisons), it is expected that the majority of prisoners will not achieve a quit date within the 25-42 days standard due to discharge and inability to follow up. These will then be recorded with an outcome of lost to follow up. For commissioning arrangements within these prisons, we recommend that commissioners count success rates as “quits” divided by “quits + non quits”, as opposed to “quits” divided by “quits + non-quits + lost to follow-up”, as this will provide a fairer representation of successful activity. This will provide success rates for people only whose treatment outcomes are known.

## Post implementation

Once a prison is fully smokefree there will continue to be a need for ongoing stop smoking support and relapse prevention. This is likely to be at a different level to pre-implementation, and providers and commissioners will need to monitor need on a regular and structured basis to ensure that adequate capacity is available. Learning from the early adopters is that ‘go live’ is a part of a longer process and not the end of a short one. “Business as usual” post implementation is not simply a return to previous activity; it is an acceptance of the new ways of working, which includes the enhanced provision of stop smoking.

This level of ongoing need will also be dependent on prisoner movement and turnover within the establishment, whether prisoners are received from smoking or smokefree establishments and consideration should be given to what is required in a reception prison with comparatively high turnover as compared to a training prison with a more stable population.

## Governance

Healthcare providers are expected to take a full and active part in the establishment planning processes, including nominating a SPOC to work with the prison SPOC on preparations, implementation planning, delivery and post implementation of a smokefree prison and attending local project boards.

Evidence from early adopter sites demonstrates the need for partners to continue to meet to monitor and respond to the ongoing management of prisoners in the non-smoking environment beyond the go live date, and to effectively manage any unintended consequences of implementation.

## Definitions Error! Bookmark not defined.

### Quit

For reporting purposes within a prison where smoking is still permitted, a Quit is defined as a treated smoker who reports not smoking for at least days 15–28 of a quit attempt and whose CO reading is assessed 28 days from their quit date (-3 or +14 days) and is less than 10 ppm. The -3 or +14 day rule allows for cases where it is impossible to carry out a face-to-face follow-up at the normal four-week point (although in most cases it is expected that follow-up will be carried out at four weeks from the quit date). This means that follow-up must occur 25 to 42 days from the quit date (Russell Standard).

Where a person is smoke free, smoking status is recorded as perception of self as a smoker. This will allow us to understand those people who intend to return to smoking once released from prison. Please refer to page 3 for application of this definition.

### Lost to follow-up (LTFU)

If follow up cannot be established between days 25-42 from the quit date then the activity is recorded as lost to follow up.

### Self-reported four-week quitter

A treated smoker who reports not smoking for at least days 15–28 of a quit attempt and is followed up 28 days from their quit date (-3 or +14 days). The -3 or +14 day rule allows for cases where it is impossible to carry out a face-to-face follow-up at the normal four-week point (although in most cases it is expected that follow-up will be carried out at four weeks from the quit date). This means that follow-up must occur 25 to 42 days from the quit date (Russell Standard). CO verification should be conducted face to face and carried out in at least 85% of self-reported four-week quitters.

### Treated smoker

A smoker who has received at least one session of a structured, multi-session intervention (delivered by a stop smoking practitioner) on or prior to the quit date, who consents to treatment and sets a quit date with a stop smoking practitioner. Smokers who attend a first session but do not consent to treatment or set a quit date should not be counted.

### NCSCT Vert Brief Advice on Smoking (VBA) online training module

A less than 30 minute training module on how to deliver Very Brief Advice on Smoking offered by the National Centre for Smoking Cessation and Training.



### NCSCT certified

An online training and assessment programme built around evidence-based behaviour change techniques and for which we have evidence that it improves quit rates, through effective delivery of face-to-face individual smoking cessation interventions, including the 16 key competences that are most important in increasing smokers' chances of quitting.

### CO Monitoring

Provides a simple screening test to establish smoking status; it is also an important motivational tool and evidence based behaviour change technique.

## Annex A. Nicotine replacement therapy (NRT) products approved for use in prisons<sup>1</sup>

Table 1

This summary is informed by <i>BNF Online</i> as accessed from <a href="https://www.evidence.nhs.uk/formulary/bnf/current/">https://www.evidence.nhs.uk/formulary/bnf/current/</a> on 11/04/2016. It is the prescribers' responsibility to ensure that prescribed medicines are safe and appropriate for their patients. Prescribers' should <b>always</b> refer to the current BNF and the manufacturer's information leaflet for further guidance and information on drug contra-indication, and interactions.							
Product	Level of nicotine dependency		Generic product		How it is used / prescribing guide	Who would it not suit	Some side effects specific to product
Nicotine Transdermal patch	Smoking within 10 minutes of waking use (24 hour patch)	<b>High Dependency</b> More than 10 cigarettes a day start with High strength patches and step down	High strength	Nicotine transdermal patches 21 mg/24 hours patch	<b>Use</b> <ul style="list-style-type: none"> <li>• Apply on a dry, non-greasy, non-hairy area and not near to the heart, (clients with skin conditions i.e. eczema can place patch on sole of foot)</li> <li>• Hold in position for 10–20 seconds to ensure adhesion</li> <li>• Rotate site daily</li> </ul>	Pregnant or breastfeeding women using the 24 hour patch must remove it before going to sleep and in any case should not wear a patch for more than 16 hours in any 24 hour period.	<ul style="list-style-type: none"> <li>• Skin irritation</li> <li>• Dry mouth</li> <li>• Abnormal dreams - removal of the patch before sleeping at night may help</li> <li>• Sweating</li> <li>• Myalgia</li> <li>• Arthralgia.</li> </ul> <p>For full list of cautions and contraindications, <b>always</b> refer to manufacturer's information leaflet.</p>
		<b>Lower Dependency</b> Less than 10 cigarettes a day Start with medium strength and step down (step up if required)	Medium strength	Nicotine transdermal patches 14 mg/24 hours patch			
			Low strength	Nicotine transdermal patches 7 mg/24 hours patch			
	Does not	<b>High</b>	High	Nicotine			

<sup>1</sup> BNF Online as accessed from <https://www.evidence.nhs.uk/formulary/bnf/current/> on 11/04/2016.

	smoke within 10 minutes of waking use (16 hour patch)	<p><b>Dependency</b> More than 10 cigarettes a day start with High strength patches and step down</p> <p><b>Lower Dependency</b> Less than 10 cigarettes a day Start with medium strength and step down (step up if required)</p>	<p>strength</p> <p>Medium strength</p> <p>Low strength</p>	<p>transdermal patches 25 mg/16 hours patch</p> <p>Nicotine transdermal patches 15 mg/16hours patch</p> <p>Nicotine transdermal patches 10 mg/16 hours patch</p>	<p><b>Dosage</b></p> <ul style="list-style-type: none"> <li>• One patch a day</li> <li>• 1 week's supply = 1 box of 7 patches</li> </ul> <p><b>Duration</b></p> <ul style="list-style-type: none"> <li>• Up to 12 weeks</li> </ul>		
Product	Level of nicotine dependency	Generic product	How it is used / prescribing guide	Who would it not suit	Some side effects specific to product		
Nicotine Inhalator	All levels of dependency	Plastic holder containing cartridge impregnated with nicotine available in 10mg & 15mg versions.	<p><b>Use</b></p> <ul style="list-style-type: none"> <li>• Requires special puffing technique. Once used up cartridge needs to be changed</li> </ul> <p><b>Dosage</b></p> <ul style="list-style-type: none"> <li>• Maximum daily dose= 12 x 10mg cartridges <u>OR</u> 6 x 15mg</li> </ul>	<ul style="list-style-type: none"> <li>• Clients with dexterity problems</li> <li>• Care should be taken patients with obstructive lung disease, chronic throat disease, or broncho-spastic disease.</li> </ul>	<ul style="list-style-type: none"> <li>• Throat irritation</li> <li>• Cough</li> <li>• Rhinitis</li> <li>• Pharyngitis</li> <li>• Dry mouth</li> </ul> <p>For full list of cautions and contraindications, <b>always</b> refer to manufacturer's information leaflet.</p>		

				cartridges • 1 week's supply= 84 x 10mg cartridges 42 x 15mg cartridges		
Nicotine Lozenge	Patients smoking more than 20 cigarettes daily:	Prescribe 4mg Lozenge	Sugar-free nicotine containing compressed tablet in 4mg and 2mg versions	<b>Use</b> • Lozenges should not be chewed or swallowed whole. For larger lozenges, use the suck and park technique. For mini lozenges suck or place under tongue. • Users should not eat or drink while a lozenge is in the mouth • Acidic beverages, such as coffee or fruit juice should be avoided for 15 minutes before use.  <b>Dosage</b> • One lozenge every 1 - 2 hours. Maximum daily	<b>Some lozenges should not be used by those with hypersensitivity to peanut or soya. Please always refer to manufacturer's information leaflet.</b>  Should only be used under medical supervision after 6 months of pregnancy	<ul style="list-style-type: none"> <li>• Throat irritation</li> <li>• Dry mouth</li> <li>• Hiccups</li> <li>• Nausea</li> <li>• Vomiting</li> <li>• Indigestion</li> <li>• Ulcerative stomatitis</li> <li>• Increased salivation</li> <li>• Diarrhoea</li> <li>• Constipation</li> <li>• Dysphagia</li> <li>• Oesophagitis</li> <li>• Gastritis</li> <li>• Mouth ulcers</li> <li>• Bloating</li> <li>• Flatulence</li> <li>• Rash</li> <li>• Hot flushes.</li> </ul>
	Patients smoking less than 20 cigarettes daily	Prescribe 2mg Lozenge				

				<p>dose= usually 8 – 12 up to a maximum of 15 lozenges</p> <ul style="list-style-type: none"> <li>• 1 weeks supply = Varies depending on brand/ product. Refer to manufacturer's information leaflet</li> </ul> <p><b>Duration</b></p> <ul style="list-style-type: none"> <li>• Up to 12 weeks</li> <li>• Uses for 6 weeks, then gradually reduce lozenge use over 3 months. Stop when 1 - 2 lozenges used daily.</li> </ul>		
Product	Level of nicotine dependency		Generic product	How it is used / prescribing guide	Who would it not suit	Some side effects specific to product
Nicotine Microtabs	Do not exceed the maximum dose of 40 tablets per day	Initial dose based on dependence; continue use for duration of treatment, reducing towards the	Sublingual 2mg microtab	<ul style="list-style-type: none"> <li>• Acidic beverages, such as coffee or fruit juice should be avoided for 15 minutes before use.</li> </ul>	Microtabs do not give patients nearly as much nicotine as they get from their cigarettes, they will be used in combination with	<ul style="list-style-type: none"> <li>• Throat irritation</li> <li>• Dry mouth</li> <li>• Hiccups</li> <li>• Nausea</li> <li>• Vomiting</li> <li>• Indigestion</li> <li>• Ulcerative</li> </ul>

		end of treatment, with use eventually stopping entirely.			the nicotine patch for many patients and you will probably want to discuss this with all patients wanting to use the nicotine microtab	stomatitis • Increased salivation
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### Prescription Only Medication

Bupropion and varenicline are licensed for use as prescription only smoking cessation aids. These medications carry some risks associated with other treatments or medical conditions, and these cautions/contra-indications must be carefully considered before the medicine is prescribed. Patients who are prescribed either of these medicines will need to be carefully monitored and encouraged to report any adverse side effects.

The combination of nicotine replacement therapy with varenicline or bupropion is not permitted, unless a patient requires NRT for the varenicline initiation period (first 2 weeks) because they are not permitted to smoke; further details follow the table below.

**Table 2. Varenicline and bupropion**

This summary is taken from the BNF online as accessed from <a href="https://www.evidence.nhs.uk/formulary/bnf/current/">https://www.evidence.nhs.uk/formulary/bnf/current/</a> at 08/04/2016. It is the prescribers' responsibility to ensure that prescribed medicines are safe and appropriate for their patients. Prescribers' should <u>always</u> refer to the current BNF and the manufacturer's information leaflet for further guidance and information on drug contra-indication, and interactions.					
Product	Level of nicotine dependency	Generic product	How it is used / prescribing guide	Who would it not suit	More common side effects and MHRA advice (where applicable)
Varenicline (Champix) tablets	All dependency levels	Varenicline (as tartrate) • 500mcg 56-	Dosage For adults over 18 years; • Champix is taken 1 to 2 weeks before the quit	• Avoid with pregnant or breastfeeding	• Gastro-intestinal disturbances • Appetite changes

		<p>tab pack</p> <ul style="list-style-type: none"> <li>• 1 mg 28-tab pack / 56-tab pack</li> <li>• Starter pack of 11 x 500mcg tabs with 14 x 1mg</li> </ul>	<p>date, (up to max. 5 weeks before target stop date)</p> <ul style="list-style-type: none"> <li>• Days 1-3: one 0.5mg tablet once a day</li> <li>• Days 4-7: one 0.5mg tablet twice a day, once in the morning and once at night</li> <li>• Day 8 (often the quit date) to the end of treatment: one 1mg tablet twice a day, once in the morning and once at night</li> </ul> <p>Duration</p> <ul style="list-style-type: none"> <li>• Normally prescribed for 12 weeks, although a further 12 weeks is available if patient is still struggling with their quit attempt.</li> </ul>	<p>women</p> <p>May not be suitable for people with;</p> <ul style="list-style-type: none"> <li>• history of psychiatric illness (may exacerbate underlying illness including depression)</li> <li>• predisposition to seizures, including conditions that may lower seizure threshold; history of cardiovascular disease</li> </ul>	<ul style="list-style-type: none"> <li>• Dry mouth</li> <li>• Taste disturbance</li> <li>• Headache</li> <li>• Drowsiness</li> <li>• Dizziness</li> <li>• Sleep disorders</li> <li>• Abnormal dreams</li> </ul> <p><u>MHRA/CHM advice - Suicidal behaviour</u> Patients should be advised to discontinue treatment and seek prompt medical advice if they develop agitation, depressed mood, or suicidal thoughts. Patients with a history of psychiatric illness should be monitored closely while taking varenicline.</p>
<b>Product</b>	<b>Level of nicotine dependency</b>	<b>Generic product</b>	<b>How it is used / prescribing guide</b>	<b>Who would it not suit</b>	<b>More common side effects and MHRA advice (where applicable)</b>

<p>Bupropion (Zyban) tablets</p>	<p>All levels of dependency</p>	<p>Bupropion hydrochloride 150mg 60-tab pack</p>	<p><b>Dosage</b> For adults over 18 years;</p> <ul style="list-style-type: none"> <li>• Zyban is taken 1 to 2 weeks before the quit date, (up to max. 5 weeks before target stop date)</li> <li>• Days 1-6: one 150mg tablet twice a day</li> <li>• Days 7 to the end of treatment: one 150mg tablet twice a day, (max. single dose 150 mg, max. daily dose 300 mg; minimum 8 hours between doses)</li> </ul> <ul style="list-style-type: none"> <li>• Max. 150 mg daily for elderly patients, patients with hepatic or renal impairment</li> <li>• Consider max. 150 mg daily in patients with risk factors for seizures</li> </ul> <p><b>Duration</b></p> <ul style="list-style-type: none"> <li>• 7–9 weeks. Discontinue if abstinence not achieved at 7 weeks</li> </ul>	<p><b>Contra-indicated for;</b></p> <ul style="list-style-type: none"> <li>• acute alcohol or benzodiazepine withdrawal</li> <li>• severe hepatic cirrhosis</li> <li>• CNS tumour</li> <li>• history of seizures, eating disorders, or bipolar disorder</li> </ul> <p><b>Avoid with;</b></p> <ul style="list-style-type: none"> <li>• pregnant or breastfeeding women</li> <li>• severe hepatic cirrhosis</li> </ul> <p><b>Caution for elderly;</b> predisposition to seizures (prescribe only if benefit clearly outweighs risk) including concomitant use of drugs that lower seizure threshold, alcohol abuse, history of head trauma, and diabetes;</p>	<ul style="list-style-type: none"> <li>• Dry mouth, gastro-intestinal disturbances</li> <li>• Taste disturbance</li> <li>• Agitation</li> <li>• Anxiety</li> <li>• Dizziness</li> <li>• Depression</li> <li>• Headache</li> <li>• Impaired concentration</li> <li>• Insomnia (reduced by avoiding dose at bedtime)</li> <li>• Tremor</li> <li>• Fever</li> <li>• Pruritus</li> <li>• Rash</li> <li>• Sweating</li> </ul>
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				measure blood pressure before and during treatment	
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As a lesson learnt from initial smoke free prisons the following issue was raised:

**Query:** What happens if prisoners stop smoking on the day they start taking varenicline / Champix, or have already stopped smoking, instead of smoking for an additional 1-2 weeks after starting the drug, as mentioned in the Summary of Product Characteristics<sup>2</sup>. Is there was any evidence or safety to support the use of NRT in this interval.

**Answer:** NHS England sought advice from the Medicines Information Division of the NHS England Specialist Pharmacy Service ([www.sps.nhs.uk](http://www.sps.nhs.uk)).

The best advice for H&J clinicians is that:

- Prescribers should be aware of the interactions and cautions associated with the use of varenicline as shown in the British National Formulary ([www.bnf.org](http://www.bnf.org)) and the SPC<sup>3</sup>.
- Prescribers can initiate varenicline in line with local clinical protocols and national guidelines (i.e. after NRT has failed)- it is ok to initiate it even if a person has stopped smoking
- Be aware that the beneficial effects of varenicline may take at least 4 days at a continuous dose to be realised- thus cravings and withdrawal symptoms from nicotine may arise, as smoking has ceased and/or NRT stopped
- If patients experience these withdrawal symptoms, then a short 7-14 days of NRT may be advisable to manage these
- If a person is initiated on varenicline and they have not yet ceased NRT, but varenicline is needed (as NRT hasn't been working effectively), then consider continuing NRT for 7-14 days whilst the dose of varenicline is titrated and reaches a steady state. Then the NRT can be stopped as per guidance.

If a person is using e-cigarettes and is initiated on varenicline, the continuing the e-cigarette for 7-14 days may be desirable.

<sup>2</sup> Summary of Products Characteristics: Champix (Pfizer Ltd)- accessed at [www.medicines.org.uk](http://www.medicines.org.uk)

<sup>3</sup> Summary of Products Characteristics: Champix (Pfizer Ltd)- accessed at [www.medicines.org.uk](http://www.medicines.org.uk)

## Additional Resources

NCSCT website and guidance - [www.ncsct.co.uk/](http://www.ncsct.co.uk/)

PHE Reducing Smoking in Prison guidance - <https://www.gov.uk/government/publications/smoking-in-prisons-management-of-tobacco-use-and-nicotine-withdrawal>

All Wales guide: Pharmacotherapy for Smoking Cessation - [www.awmsg.org/docs/awmsg/medman/All%20Wales%20Guide%20-%20Pharmacotherapy%20for%20Smoking%20Cessation.pdf](http://www.awmsg.org/docs/awmsg/medman/All%20Wales%20Guide%20-%20Pharmacotherapy%20for%20Smoking%20Cessation.pdf)

UKMI 2007, Smoking and Drug Interactions

NHS One You [www.nhs.uk/oneyou/smoking](http://www.nhs.uk/oneyou/smoking)

Action on Smoking and Health [www.ash.org.uk](http://www.ash.org.uk)

Second hand smoke in prisons - [www.gov.uk/government/publications/air-quality-reports](http://www.gov.uk/government/publications/air-quality-reports)

Delivering Better Oral Health

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/367563/DBOHv32014OCTMainDocument\\_3.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/367563/DBOHv32014OCTMainDocument_3.pdf)

## References

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- <sup>2</sup> PHE and Kings College London (2015) Smoking in prisons: management of tobacco use and nicotine withdrawal. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/412567/Reducing\\_smoking\\_in\\_prisons.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/412567/Reducing_smoking_in_prisons.pdf)
- <sup>3</sup> McNeill A, Brose LS, Calder R, Hitchman SC, Hajek P, McRobbie H (2015) E-cigarettes: an evidence update. A report commissioned by Public Health England. <https://www.gov.uk/government/publications/e-cigarettes-an-evidence-update>
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- <sup>6</sup> <http://www.smokefreeaction.org.uk/harmreduct.html>
- <sup>7</sup> NCSCT (2014) Local Stop Smoking Service: Service and Delivery Guidance [http://www.ncsct.co.uk/publication\\_service\\_and\\_delivery\\_guidance\\_2014.php](http://www.ncsct.co.uk/publication_service_and_delivery_guidance_2014.php)
- <sup>8</sup> NCSCT Very Brief Advice [http://www.ncsct.co.uk/publication\\_very-brief-advice.php](http://www.ncsct.co.uk/publication_very-brief-advice.php)
- <sup>9</sup> NICE PH26 (2010) Smoking: stopping in pregnancy and after childbirth <http://www.nice.org.uk/guidance/ph26>
- <sup>10</sup> NICE PH10 Stop smoking services <https://www.nice.org.uk/guidance/ph10>
- <sup>11</sup> NCSCT Training and Assessment programme [http://www.ncsct.co.uk/publication\\_training-and-assessment-programme.php](http://www.ncsct.co.uk/publication_training-and-assessment-programme.php)
- <sup>12</sup> NCSCT Pregnancy and the postpartum period [http://www.ncsct.co.uk/publication\\_pregnancy\\_and\\_the\\_post\\_partum\\_period.php](http://www.ncsct.co.uk/publication_pregnancy_and_the_post_partum_period.php)
- <sup>13</sup> RCP London Press Release <https://www.rcplondon.ac.uk/news/promote-e-cigarettes-widely-substitute-smoking-says-new-rcp-report>
- <sup>14</sup> NICE PH45 Smoking Harm Reduction (2013) <https://www.nice.org.uk/guidance/ph45/chapter/1-recommendations#recommendation-9-people-in-closed-institutions>
- <sup>15</sup> NHS Digital Lifestyles reports <http://content.digital.nhs.uk/lifestyles>
- <sup>16</sup> West R (2005) Assessing smoking cessation performance in NHS Stop Smoking Services: The Russell Standard (Clinical) <http://www.ncsct.co.uk/usr/pub/assessing-smoking-cessation-performance-in-nhs-stop-smoking-services-the-russell-standard-clinical.pdf>