

A CHANGE IN THE AIR

Results of a study of smokefree
policy and practice in mental
health trusts in England



Contents

Key findings	3
1. Introduction	6
2. Methods and sample	7
3. Smokefree policies of mental health trusts in England	8
Progress in implementing smokefree policy	8
Enabling progress	9
Challenges and current obstacles	9
Winning hearts and minds	10
Different client groups within acute services	11
4. Where do patients on adult mental health wards smoke?	12
Where patients and staff are permitted to smoke	12
Where patients actually smoke	13
Escorted leave to smoke	14
Boundary problems	15
5. Temporary abstinence, harm reduction and quitting	16
Patient experience on admission	16
Training and specialist support	16
NRT and other pharmacotherapy	19
Vaping and e-cigarettes	19
Stop smoking support for staff	21
Everyday challenges for frontline staff	22
6. Support in the community	23
The role of community services	23
Local authority and mental health trust community services	24
7. Impacts and benefits of going smokefree	26
Changes for better or worse	26
The best things about going smokefree	27
8. Discussion	29

Key findings

Highlights

- » 79% of mental health trusts surveyed had implemented comprehensive smokefree policies prohibiting smoking in all interior and exterior spaces including hospital grounds.
- » 87% of mental health trusts surveyed supported vaping by some or all of their patients but policies varied in where vaping was permitted.
- » Reported benefits of smokefree policies included more patients and staff quitting smoking, cleaner wards, better air quality, less staff time spent on smoking breaks, and improvements in patients' physical health and wellbeing.

The **aim** of this study was to describe the progress made by mental health trusts in England in implementing NICE guidance PH48.

The **methods** combined an online survey of smokefree leads in mental health trusts in England with face-to-face interviews with 14 professionals involved in developing or implementing smokefree policy within these trusts. Survey responses were received from 39 out of 54 trusts contacted, a response rate of 72 per cent.

The great majority of the mental health trusts surveyed had implemented a **smokefree policy** at the time of the survey (n=34, 87%). Of the remaining five trusts in the sample, four were still developing their policies and one had suspended its policy.

Thirty-one of the mental health trusts surveyed (79%) had implemented **comprehensive** smokefree policies prohibiting smoking in all interior and exterior spaces within their NHS boundaries.

The **recommendations of NICE PH48** had been widely addressed within the smokefree policies of the mental health trusts surveyed.

Senior management leadership was most often cited as an **enabler** of smokefree policy delivery. The biggest **challenge** to the implementation of smokefree policies was identified as resistance from frontline staff.

In acute services, **non-compliance** with smokefree restrictions was universal: all mental health trusts surveyed reported some patient smoking in areas where smoking was not permitted. There was great variation in the frequency of non-compliance between trusts and within trusts: in the best practice wards of the trusts that had made the most progress, patient smoking was reported to be rare both inside and outside.

Section 17 leave was widely used to enable patients within acute mental health services to smoke.

Most of the mental health trusts surveyed (87%) reported problems on their **site boundaries**. These included cigarette littering, complaints from local residents and conflicts with neighbouring NHS premises that permit smoking.

Across the mental health trusts surveyed, there were significant variations between trusts and within trusts in how patients who smoke are advised and treated **on admission**. Patients are not always asked about their smoking status, nor are smokers always offered NRT. However, most trusts (84%) reported that these interventions always happen on their best practice wards.

There were big variations in the investment in staff training between mental health trusts, with the proportion of staff trained in **very brief advice** ranging from zero to all staff.

In 38% of the mental health trusts surveyed, patients on adult mental health wards were able to access **specialist** tobacco dependence clinics or specialist staff. Most trusts invested in training frontline staff to provide this support.

Almost all of the mental health trusts surveyed (92%) offered patients on adult mental health wards **combination NRT** but only 37% offered varenicline (**Champix**).

Most of the mental health trusts surveyed (87%) supported the use of e-cigarettes (**vaping**) by some or all of their patients. Those that did not were trialling the use of e-cigarettes or reviewing their policies.

Policies on **where vaping is permitted** were diverse. Two in five of the mental health trusts surveyed (39%) permitted vaping in private rooms.

Three-fifths of the mental health trusts surveyed (61%) were able to refer all their patients to a community stop smoking service on **discharge**. Elsewhere, some or all patients were not able to access such a service due to decommissioning or service restrictions.

Over half of the mental health trusts surveyed (57%) provided some stop smoking support of their own in the **community**. Although some trusts had invested in their own clinics or specialist staff, the most common approach was to train existing staff within community mental health teams.

Perceived **positive outcomes** of smokefree policy included successful quits by patients and staff, cleaner ward environments, better air quality, less staff time spent on smoking breaks, and improvements in patients' physical health and wellbeing.

Perceived **negative outcomes** of smokefree policy included staff exhaustion with the burden of enforcement, an increase in verbal abuse, a reduction in physical activity, and a deterioration in some patient relationships due to differences in access to tobacco.

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For more information about the work of the Mental Health and Smoking Partnership visit www.smokefreeaction.org.uk/smokefree-nhs/smoking-and-mental-health/

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1. Introduction

This report presents the findings of a study of smokefree policy and practice in mental health trusts in England. The findings are principally drawn from a survey of mental health trusts conducted in the summer of 2018. This was the first survey examining smokefree policy in mental health trusts since a similar study was conducted in 2007¹.

In the intervening decade there have been significant legislative and policy changes, beginning with the 2008 smokefree legislation that required all public indoor spaces to be smokefree. A key intervention came in 2013 with the publications of NICE guidance PH48, *Smoking: acute, maternity and mental health services*. This set out a clear framework for action which balanced a requirement for completely smokefree premises with recommendations for the treatment of tobacco dependence.

In 2016, the *NHS Five Year Forward View for Mental Health* recommended that NHS England and Public Health England should support all mental health inpatient units to be smoke-free by 2018². Public Health England subsequently published guidance for mental health services on implementing smokefree policies³ and the Care Quality Commission published a guide to smokefree policies in inpatient mental health services⁴. In 2017 the government made clear its position on smokefree mental health services in its Tobacco Control Plan⁵: *We are committed to implementing comprehensive smokefree policies, including integrated tobacco dependence treatment pathways, in all mental health services by 2018*.

The wider public health community has also pressed for change, notably in *The Stolen Years: the mental health and smoking action report*⁶ which led to the formation of the Mental Health and Smoking Partnership. One of the ambitions of the report, and the partnership, is that: *All inpatient and community mental health sites are smokefree by 2018, through full implementation of NICE PH48 guidance and embedding support for service users who smoke*.

The aim of this study is to describe the progress made by mental health trusts in England in implementing NICE guidance PH48. This scope of the study included the content of smokefree policies; current practice, especially within acute services; perceived outcomes of smokefree policies; and the factors that have obstructed and enabled the implementation of PH48. As well as providing insight into current policy and practice in mental health trusts, the authors of this report hope that it may provide a baseline for ongoing assessment of progress towards smokefree mental health services.

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- 1 Ratschen E, Britton J and McNeill A. Implementation of smoke-free policies in mental health in-patient settings in England. *Br J Psych* 2009; 194: 547-551
 - 2 The Five Year Forward Review for Mental Health, Mental Health Taskforce to the NHS in England, 2016
 - 3 Public Health England: Smokefree mental health services in England: Implementation document for providers of mental health services, 2016
 - 4 Care Quality Commission: Brief guide: Smokefree policies in mental health inpatient services, CQC 2017.
 - 5 Department of Health: Towards a Smokefree Generation. A Tobacco Control Plan for England, 2017.
 - 6 Harker K and Cheeseman H: The Stolen Years: the mental health and smoking action report, Action on Smoking and Health, 2016.

2. Methods and sample

The study combined an online survey of smokefree leads in mental health trusts in England with face-to-face interviews with a range of professionals involved in developing or implementing smokefree policy within these trusts.

The survey was conducted online using Survey Monkey. Professional contacts in 54 mental health trusts in England were contacted by email and asked to complete the survey, which was open from August 1st to October 5th 2018. Non-respondents were followed up by telephone and encouraged to complete the survey. There were 45 responses, of which six were substantially incomplete and had to be rejected. The final sample size of 39 represents a response rate of 72 per cent.

Data were analysed using SPSS version 23. Responses to open, free-text questions were subject to content analysis and quantified where appropriate.

Of the 39 survey participants, 38 reported their job title and described their role within the trust in relation to smokefree policy. Thirty-six respondents either had a lead role in implementing smokefree policy within their trust (n=32) or a supportive role within the smokefree project team (n=4). Of the remaining two respondents, one was an Infection Prevention and Control Lead and one was a Smoking and Mental Health Advisor.

The face-to-face interviews were designed both to inform the content of the survey questionnaire and to frame, illustrate and elucidate findings from the survey. Fourteen interviews were conducted with staff in seven mental health trusts: three in London, two in the East Midlands, one in the West Midlands and one in the Northeast. Nine interviews were conducted prior to the survey going live; the remaining five were conducted while the survey was live.

Of the 14 interviewees, five were trust smokefree leads, three were service managers, three were nurses, one was a trust medical director, one was a unit smokefree lead and one was a ward manager. All interviews were conducted face-to-face except one telephone interview. The five trust smokefree leads who were interviewed also completed the online survey.

Interviews were recorded and transcribed. Thematic analysis was conducted: themes were identified and relevant text collated across the interviews. These were explored for internal conflict and consistency as well as being tested against the findings of the survey.

3. Smokefree policies of mental health trusts in England

Preparation was the key, really. We spent a lot of time talking to people. We didn't shirk from challenge, so when the challenge was coming, even an irrational challenge, we were hitting that head on and dealing with it and working with people.

Progress in implementing smokefree policy

The great majority of the mental health trusts surveyed had implemented a smokefree policy at the time of the survey (n=34, 87%). This includes four trusts where policies were under review. Of the remaining five trusts in the sample, four were still developing their policies and one had suspended its policy.

Thirty-one of the trusts surveyed (79%) had implemented comprehensive smokefree policies prohibiting smoking in all interior and exterior spaces within their NHS boundaries (see page 12).

Survey participants were asked when their smokefree policies had been implemented. The time that smokefree policies had been active for ranged from one to 10 years. Of the 34 trusts that had active smokefree policies, five had implemented them prior to the publication of NICE guidance PH48 in November 2013, including two in 2008. Subsequently, six went live in 2015, ten in 2016, seven in 2017 and three in 2018 (three start dates were missing).

The recommendations of PH48 have been widely addressed within trust smokefree policies. Table 1.1 identifies, for each pre-defined policy topic drawn from PH48, the number of trusts that addressed the topic in their smokefree policies, as reported by survey respondents. All trusts were able to report on the content of their policies whether these were active, suspended or in development. Most of the topics are covered by all, or nearly all, smokefree policies. The only three topics to be omitted by more than 10 per cent of respondents concern stakeholders beyond the inpatient environment: professionals who refer or provide support on discharge, and family and friends.

Table 1.1. Number of trusts including PH48 recommendations in their smokefree policies (n=39)

Policy topic	Included in policy (number, n=39)
Informing patients about the smokefree policy prior to admission	35
Identifying and recording smoking status on admission	39
Providing pharmacotherapy for tobacco dependence on admission	38
Providing advice and support to smokers while they are inpatients to help them abstain from or stop smoking	38
Adjusting drug doses for people who stop or cut down on smoking	37
Referral of smokers to community stop smoking services on discharge	34
Informing carers and family members about smokefree policy	34
Communicating the smokefree policy to all site visitors	39
Communicating the smokefree policy to all staff	39
Supporting staff to stop smoking	39
Training staff in the management of tobacco dependence	38

Enabling progress

Survey participants were asked to identify who or what had enabled them to make progress towards being smokefree (an open free-text question). Thirty-six answered the question.

The most common response, cited by half of those who answered (n=18) was senior management leadership. Other important stakeholders identified as enabling the journey to smokefree were staff in general including ward champions (n=8), and patients including patient advocates (n=5). Smokefree leads were also identified though not as often as they probably deserved as the survey participants were themselves smokefree leads. Three respondents specifically mentioned the importance of teamwork, as in the following response:

Listening to patients' and staff real concerns about the change was fundamental for the implementation. It was never a case of whether or not a policy should be implemented but how best we could work together to implement a public health requirement. It was a great team effort which involved staff from all areas and levels, service users using community or inpatient services, their carers/families and colleagues from the Stop Smoking Service. (survey respondent)

Ten respondents identified advice and support from external stakeholders as having been valuable. These included Public Health England, local public health departments and stop smoking services, and other mental health trusts.

Other enablers identified by survey respondents were investment by the trust, e-cigarettes, signage, pharmacy support, union support, and 'determination, resilience and commitment.'

Challenges and current obstacles

Survey participants were asked what they felt had been the biggest challenges of going smokefree (an open free-text question). All 39 survey participants answered the question. The most common issue cited, by half (n=20) of respondents, was staff resistance and the cultural shift required to effectively implement smokefree policy. These respondents volunteered a variety of reasons why staff were unwilling to sign up to smokefree policy: they opposed the policy because the task seemed too difficult, given the busy and challenging environment; because they felt patients had a right to smoke, or that smoking is a choice rather than an addiction; because they lacked confidence in the nicotine alternatives; because of anxieties about violence and aggression from patients; or because the policy was perceived to impinge on their therapeutic relationship with patients.

Resistance from patients was cited less often, by six respondents, though a further five respondents highlighted the everyday problems of enforcing smokefree policy and two identified an increase in violence or challenging behaviour from patients. Three respondents mentioned an increase in covert smoking and the smuggling of smoking paraphernalia onto wards, with related safety issues.

Seven respondents drew attention to the challenge of implementing smokefree policy in a consistent fashion. As staff so often have different views about the appropriateness and practicality of smokefree policy in acute mental health units, practice can diverge between different wards or different sites. In addition, there may be conflicts between trusts: two respondents highlighted the difficulty of trying to deliver a smokefree policy within a mental health unit when the host acute trust has a much laxer approach.

Other challenges identified included insufficient staff resource, competing policy agendas, high turnover of patients on adult mental health wards, the issues raised by introducing e-cigarettes onto wards, the frustration of frontline staff who have to enforce the policy every day, and the lack of training in tobacco dependence of clinical staff.

Survey participants were also asked to describe the biggest obstacles they currently faced in going smokefree (an open free-text question). Thirty-six respondents answered this question. Unlike answers to the retrospective question about the challenges they had encountered so far, which were dominated by the issue of staff resistance to smokefree policy, this question elicited a more diverse set of answers.

Eleven respondents identified the challenge of maintaining momentum and fully embedding smokefree practice within the inpatient service. Specific threats to this were also identified, including a lack of resources or staff (n=8), ongoing staff resistance to the policy (n=5), unmet training needs (n=5) and inconsistencies in local policy and practice (n=4).

Six respondents highlighted issues relating to community stop smoking support for people with mental health conditions, including loss of local stop smoking services, the difficulty of engaging community mental health teams, and the lack of awareness in some community services of smoking as a cause of physical and mental ill health. This is explored further in chapter 6.

Winning hearts and minds

The interviewees described the process of going smokefree in detail. A key theme from the interviews was the process of winning hearts and minds, not only of staff and patients but also of the wider community.

All mental health trusts have had to communicate their smokefree policies to staff but tackling the resistance expressed by some staff has involved a larger process of engagement and training. The following detailed account describes the range of staff attitudes encountered by champions of smokefree policy:

Our senior clinical director, our heads of services, our director of ops: it was taken very positively and they all felt this was something we needed to do to support. But once you got to matron, ward manager level, staff on the ground level, it became obvious that there were quite a lot of people that were quite resistant, really, to the change. For a lot of different reasons, there were things mooted such as people's right to smoke, their human right to smoke, that we're taking away choice. There were lots of concerns about violence and aggression, and the increase that it would potentially cause. What our fire risks would be. Also we have a lot of staff who smoke, who work on the ground, who very strongly felt that we didn't have the right to stop other people from smoking. So, right at the start there were very mixed feelings from it. (interviewee: service manager)

Most trusts have put significant resources into training their staff in the management and treatment of tobacco dependence. This has been important not only in delivering appropriate support for patients but also in changing the attitudes of staff themselves:

I also look after the health and wellbeing strategy for the staff with the HR Director and we have acknowledged that if we want to make our staff healthier, the best way to do that in relation to smoking is to train them at Level 2. It changes their mindsets, and that's a stronger thing than just trying to do stuff for them, and it works for the patients – it's a win-win. (interviewee: medical director)

A similar point was made by another interviewee, a service manager, who said that even training in Very Brief Advice “opened lots of people’s eyes”. She felt that many staff overestimated how much they knew about smoking and the harms of tobacco.

Champions at ward level have also been critical to implementation of smokefree policy. Resistance at this level can seem intractable:

The most important champions are actually some of the ward managers because they're really at the front line. Organisationally, the board are completely behind it. (interviewee: medical director)

If you've got a matron who's really positive, and you've got a manager that's really positive, then the staff have to follow what the matron and the manager say. And in some areas we've had matrons and managers who smoke, who disagree and still are disagreeing. (interviewee: trust smokefree lead)

Staff attitudes may also change over time as individuals see the effects of smokefree policy. These effects maybe negative as well as positive but, if the balance of outcomes is positive, support for the policy builds:

I suppose the main point of contact for us are the healthcare support workers because they are the staff with the patients 90% of the time. I think there are still a few there who are saying “I don't agree with it” but, obviously, it's policy so they will go along with it. But, most of them have been won round and I think they do see the advantages of people not smoking and they can use the garden for other purposes - now it's used for group activities, especially in the summer in the nice weather. So, you're not exposed to secondhand smoke as much as you used to when people were smoking in there. So, they can see the advantages of people not smoking, but they've also seen the disadvantages – the aggression and the abuse we get from people who want to smoke but can't. (interviewee: nurse)

Preparing patients for change was also a major undertaking. One interviewee had spent a lot of time prior to policy implementation working with community teams and local community groups to prepare for the change, not least because so many acute patients are re-admissions with prior experience and expectations of an environment where they can smoke. The experience was challenging:

[I went to] community groups, like local Mind, the local day centre and each time it was like walking into a war zone, I did find a lot of hostility, but by the end people would start to see it differently, sometimes by the end of the meeting, but certainly in the process I found people did change their attitudes and they have. It's not what it was two years ago. (interviewee: unit smokefree lead)

Another interviewee described a similar process of engagement on the wards themselves:

So, I attended each ward's community meeting to talk to them about going smokefree, to give them reasons why we were doing it, what the guidance was, how we were going to get there, what things we'd already considered. But a lot of that was about the patients being able to tell me what it was they felt they needed, what would be the most beneficial, and to be able to ask me questions about how to get from A to B. So, throughout that process, we've identified lots of issues around boredom, lack of structure to the day, access to activities, and coping strategies around smoking – because obviously some patients use that as a coping strategy, all linked to that feel-good factor for that short period of time. (interviewee: service manager)

All interviewees who discussed these processes of change described them as ongoing. Some attitudes take a long time to shift and staff and patient turnover continually renew the need for communication and training.

Different client groups within acute services

This survey focused on the issues faced by staff and patients on adult mental health wards. In the context of acute services, these wards have presented the greatest problems for smokefree policy and practice. This is partly because many patients on adult mental health wards can leave the wards and the hospital site to smoke and to buy tobacco and smoking paraphernalia. These problems are much easier to manage on secure (forensic) wards:

The fact that we're a secure service and we can control what comes in and out definitely helps, because other areas didn't have that luxury, so if people were bringing smoking paraphernalia in they couldn't do anything about it. We can because it's a contraband item, we're a secure service and we keep track of what's coming in and out. (interviewee: service manager)

In mental health services, smoking prevalence in the adult patient population is also exceptionally high. Interviewees noted that prevalence was lower among younger patients, older patients and people with learning disabilities.

Most of the older people in these wards have got challenging behaviour associated with dementia and, actually, very few of them smoke – so again, it tends not to be a problem. The big problem is with ambulatory patients who have retained some of their insight and who are free to leave the premises. (interviewee: medical director)

Nonetheless, the challenges for other client groups and settings are still considerable. This study cannot describe these challenges in any detail, given its focus on adult mental health wards, but the following points were raised in the interviews and in the responses to an open question in the survey which invited participants to identify issues for other client groups:

- » A smokefree environment may be easier to achieve in the closed environment of forensic services but forensic patients who are given leave may quickly restart smoking and subsequently present challenging behaviour when they return to the ward;
- » Older adults with dementia who smoke may be aggressive if denied cigarettes; they may be entitled to leave the ward but be too frail to do so without help;
- » Communicating smokefree policy to patients with learning disabilities can be difficult;
- » Long-stay patients on rehab units may be unwilling to abstain from smoking, not least because the unit is perceived as their 'home', resulting in high rates of covert smoking or reliance on Section 17 leave.

4. Where do patients on adult mental health wards smoke?

I've been there today and sat in the courtyard and stopped three people smoking. And one of their brothers came in and sat whilst I was talking and he's just a visitor, and I'm like "I'm sorry it's a no smoking area, you can't smoke in here".

Where patients and staff are permitted to smoke

Survey participants were asked to identify where patients are currently permitted to smoke. Figure 4.1 illustrates the results for all the mental health trusts surveyed, identifying the closest environment to the inpatient ward where patients are permitted to smoke. More than one in five of the trusts that participated in the survey (21%, n=8) still permit smoking within NHS boundaries, either in secure courtyards or in hospital grounds (all but one of the trusts surveyed had secure courtyards integrated into their wards).

There is, however, a big difference between trusts with active smokefree policies and the minority of trusts that are still developing their policies. In all four of the trusts where policies are still in development, and in the one trust where policy has been suspended, patients are permitted to smoke in secure gardens attached to mental health wards, as well as within the wider hospital grounds. This accounts for the majority of the smoking within NHS boundaries illustrated in Figure 4.1 (5 out of 8 cases).

Across the 34 trusts where smokefree policy has been implemented, two trusts permitted smoking in secure gardens and one permitted smoking in hospital grounds including smoking shelters (9% of these trusts). Hence 31 trusts (79%) had comprehensive policies where smoking was not permitted anywhere on site.

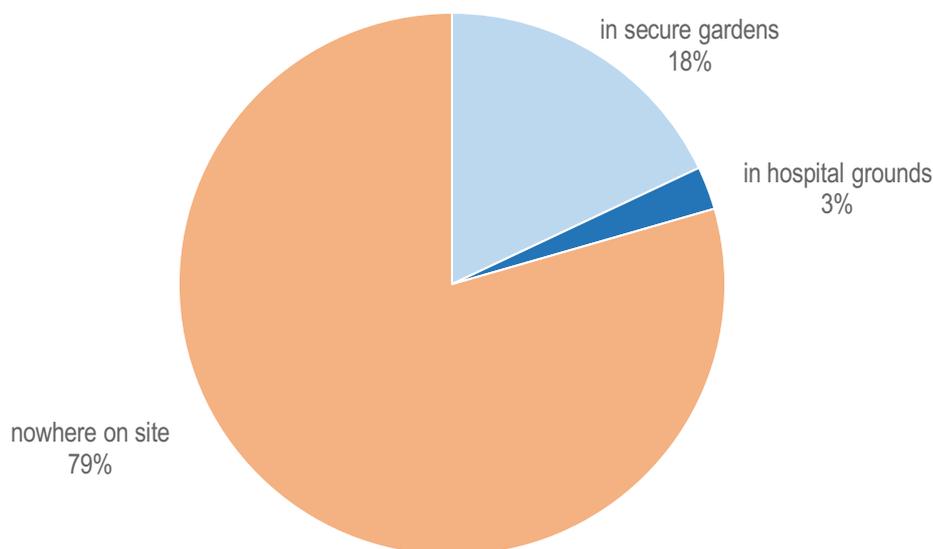


Figure 4.1. The closest environment to the ward where patients on mental health wards in England are permitted to smoke.

With one exception, staff were not permitted to smoke within NHS boundaries in any of the trusts participating in the survey. The exception was a trust where staff were still permitted to smoke within hospital grounds, including in smoking shelters. This trust was one of the four which were still developing a smokefree policy.

In the great majority of trusts (n=34, 87%), staff were permitted to smoke off-site. Only five prohibited smoking around, as well as within, hospital grounds. However, off-site permission to smoke may be constrained: staff may be prohibited from smoking off-site in uniform, or in line of sight of NHS premises, or they may have to take unpaid breaks to smoke.

Where patients actually smoke

Survey participants were asked to identify, to the best of their knowledge, how often patients on their trust's adult mental health wards are found smoking in their rooms or bathrooms, in communal rooms, in secure gardens or courtyards, and in the wider hospital grounds beyond the inpatient wards. They were asked to distinguish, if possible, between the incidence of smoking on typical wards and on 'best practice' wards.

Figure 4.2 shows the results for typical adult mental health wards in trusts which have an active smokefree policy. All respondents reported patients smoking within hospital grounds and in private rooms and bathrooms, and all but one reported patients smoking in secure gardens. Over half of respondents answering this question reported that patients were found smoking in hospital grounds every day.

Figure 4.3 shows the results for 'best practice' adult mental health wards in trusts which have an active smokefree policy. Overall, incidence is lower than in typical wards, with the daily incidence of smoking on hospital grounds falling by half. Frequency of 'never smoking' in indoor environments also increases markedly.

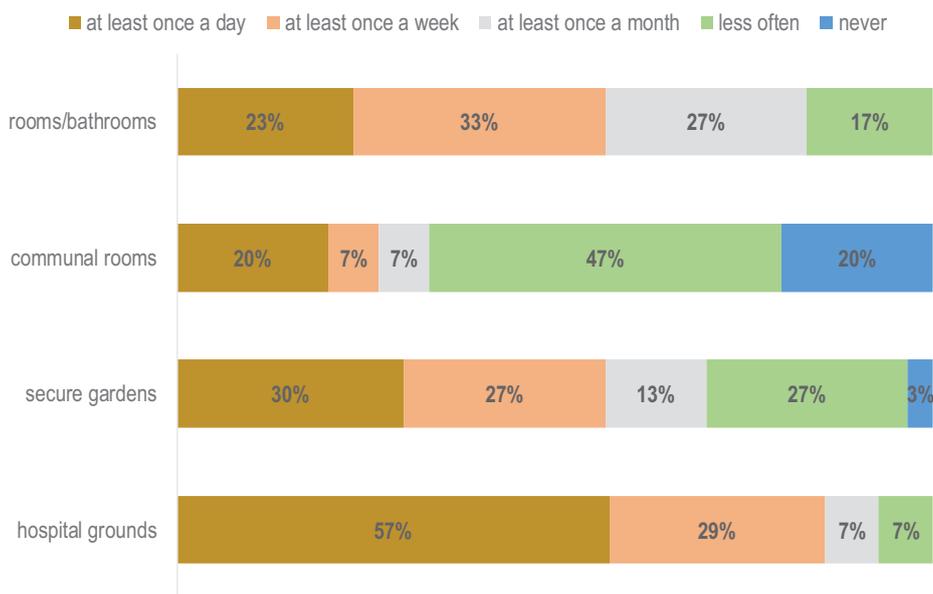


Figure 4.2. Frequency of patient smoking on TYPICAL adult mental health wards (% trusts with active smokefree policies). Denominator excludes 'don't know' responses

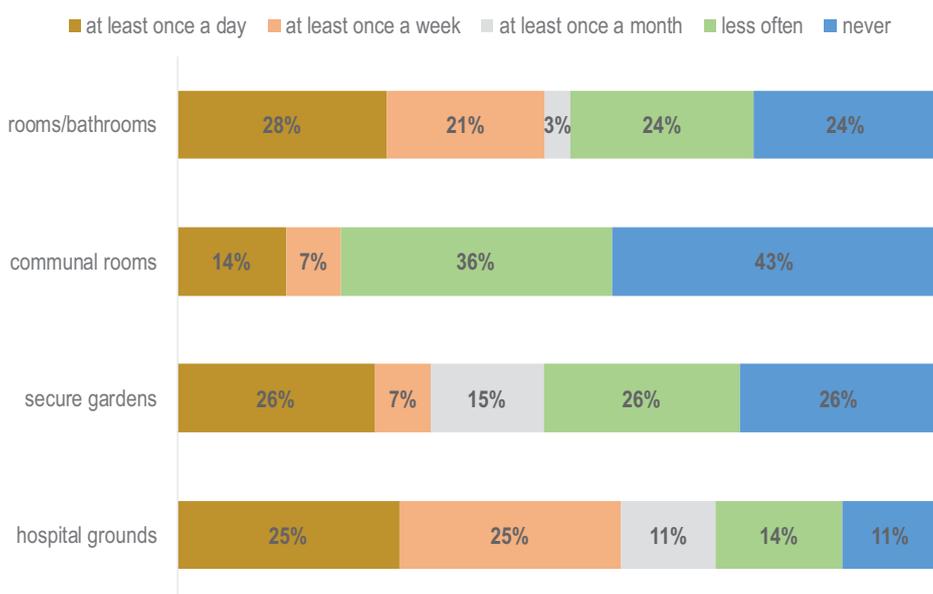


Figure 4.3. Frequency of patient smoking on BEST PRACTICE adult mental health wards (% trusts with active smokefree policies). Denominator excludes 'don't know' responses.

As these questions focused on how often patients are *found* smoking, these results may under-represent actual incidence of smoking. Furthermore, ward-based systems for recording smoking incidents may not be reliable, especially if smoking is a common occurrence. The interviewees described some of the problems with reporting systems and their efforts to improve them:

We've had huge problems with just the mechanics, we seem to have under-reporting data quality issues. I've had lots of meetings with IT people and actually capturing the data can be quite difficult, even simple things. (interviewee: trust smokefree lead)

Most of the time we don't record smoking related instances. Technically every instance of smoking on site should be datix, but if we were to do that we would be doing datix every half an hour. The message from HQ was that we should be doing one every time somebody smokes so we get a clear picture of how the policy is working, so they probably think that it's working better than it is, because we haven't reported nearly as much as we should have done, but we're busy recording other things. I will record a smoking related incident if it's resulted in aggression or destruction of the property or whatever, but if it's just somebody lighting a cigarette and us taking it off them, we probably wouldn't record that. (interviewee: nurse)

We've got different levels of report: so there's incidents where it's been a fire risk because they've been smoking in a place where they shouldn't be smoking; and we've got a separate log on the incident form for incidents where the patient has become violent or aggressive; and then another where people have just been refusing to hand in lighters and things like that. So, we're trying to monitor the impact of the policy. (interviewee: service manager)

Escorted leave to smoke

Survey participants were asked how often detained patients on adult mental health wards are granted escorted leave to smoke by health professionals. Again, they were asked to distinguish between typical and 'best practice' wards. However, as the number of survey participants who were able to answer this question was relatively low, results are presented here for typical wards only.

Among the survey participants in trusts that had smokefree policies in place, 24 answered this question. Of these, 11 (46%) reported that leave to smoke was granted every week or every day and 13 (54%) said that leave was granted less often than every month or never.

Leave to smoke may be enabled by Section 17 leave. Although Section 17 of the Mental Health Act (1983) allows a Responsible Clinician to grant a detained patient leave of absence from hospital, it was not designed to facilitate smoking breaks. Consequently data on escorted leave to smoke may be under-reported, as the following survey respondent acknowledged:

Data not robust here. Staff will tacitly support smoking on breaks, but no documentary evidence in notes (as it contravenes policy). Has reduced since e-cigarettes offered in January 2018. (survey respondent)

Interviewees acknowledged that Section 17 leave was used to enable smoking. They had mixed views about whether this was justified or not: although it remains an important tool for many professionals in acute mental health units, this was often complemented by an intention (either individual or corporate) to relinquish it. Two of the following interviewees mention the staffing implications of permitting escorted leave to smoke, from contrary perspectives of using and prohibiting Section 17 leave:

They're just using section 17 leave as smoke breaks, which completely undermines the policy. But because we've got locums, we can't stop them from doing it. So, there's all sorts of practical dilemmas in doing what we know is best, and we have to be pragmatic. (interviewee: medical director)

It [Section 17 leave] has an immediate de-escalating effect, because the ward is like a boiler room sometimes obviously and if somebody's just screaming asking to be let out for a cigarette that can be the difference between them being calm or doing something, retaliating or whatever... I mean there is this push to try and go all the way, which would free up time if you didn't have to take people out and do all that stuff, but that's only going to happen I guess if you feel really confident you can manage it without taking people out. (interviewee: nurse)

We got together and said “these are the key messages: we don’t want escorted leave to smoke.” If somebody chooses to go out shopping on a Section 17 leave or whatever, and then decides to light up at that point, then that’s different. But, what I don’t want is going back all those years. Because we’ve got issues with staffing, we’re the same as everybody else, so we don’t want the staff to be used as a resource to advocate smoking. (interviewee: trust smokefree lead)

Consultant psychiatrists are writing in their care plans: ‘fresh air break’. I mean, complete bollocks really – on the record, whatever. But without having an e-cigarette safety valve, I think we couldn’t really enforce the ban. (interviewee: trust smokefree lead)

These four examples are from four different trusts. Differences in attitudes and practice within trusts, and within individual mental health units, also exist. This is a particular issue with the use of Section 17 leave, not least because of its visibility: interviewees expressed frustration that practice could vary between wards in the same unit, leading to confusion about both policy and practice.

Boundary problems

Problems related to patients smoking on site boundaries are common. Of the 39 survey participants, 34 (87%) said they faced such problems on some (51%) or all (36%) sites. Of the five respondents who did not report problems at boundaries, three were from trusts where smoking in secure gardens is still permitted.

Survey participants were asked to describe the nature of these problems (an open question). Littering was the most common problem identified. Seven respondents reported complaints from neighbours about littering and people smoking outside their homes. In one case, this had been escalated to a more serious complaint, leading to a change in policy:

More of a problem in our site which sits in a residential area as we have had to restore a smoking shelter to contain the problem after complaints from neighbours and local MP. (survey respondent)

The following respondent described a more positive experience of managing smokers and the litter they generate at a hospital boundary:

This was initially problematic but is now better managed - the presence of smokers has reduced considerably, the system for cleaning the area at the hospital boundaries has improved and smokers are better engaged with the treatment offered and are more considerate to non-smokers sharing this space. (survey respondent)

As one respondent highlighted, it is not just patients who head to site boundaries to smoke. The problem created on the edge of well-defined smokefree premises is a wider one:

People smoking on or around the site aren’t always patients, it can be public, and staff from other hospital services on the site, visitors and bus drivers. (survey respondent)

A different type of boundary problem identified by five survey respondents is conflict with neighbouring health service providers. If a mental health trust is located on a site run by another trust which does not share the smokefree policy, a consistent approach is hard to achieve:

Three sites are shared with the local acute provider who has not yet gone Smoke Free. This creates a challenging set of circumstances for patients, carers, visitors and staff. (survey respondent)

5. Temporary abstinence, harm reduction and quitting

They get NRT and e-cigs immediately on admission, as soon as they're identified they get them straight out of the cupboard and hand them over. So patients get something immediately when they walk through the doors. It's about embracing it and taking it on board.

Patient experience on admission

The point of admission to a smokefree ward is a critical, and often difficult, moment for patients and staff alike. It is therefore vital that professionals identify the need for nicotine replacement and respond quickly.

Survey participants were asked to describe, to the best of their knowledge, current practice on adult mental health wards when patients are admitted. As with the questions on smoking non-compliance, they were asked to distinguish, where possible, between practice on typical wards and on 'best practice' wards. They were asked:

- » When patients are admitted to an adult mental health ward, are they asked about their smoking status?
- » When patients are admitted to an adult mental health wards, and are identified as smokers, are they given advice about how they can abstain from smoking?
- » When patients are admitted to an adult mental health wards, and are identified as smokers, are they given access to nicotine replacement therapy?
- » When patients are admitted to an adult mental health wards, and are identified as smokers, are they given access to e-cigarettes?

Figure 5.1 illustrates the results for typical adult mental health wards within each trust. Figure 5.2 illustrates the results for 'best practice' wards. If we focus on best practice, we find that in almost all trusts patients are always asked about their smoking status when being admitted to adult mental health wards; likewise the great majority of trusts always offer advice and NRT on admission to patients who are smokers. However, in many of these trusts, typical practice falls short. On typical wards, only half of trusts always ask about smoking status. When smokers are identified only a third always give advice about abstaining from smoking, and just over half always offer NRT.

Table 5.1 describes the differences in typical practice on admission by the duration of trusts' policies, distinguishing between trusts that implemented smokefree policies prior to 2015 (n=5), trusts that implemented policies in 2015 or 2016 (n=16), and trusts that implemented policies in 2017 or 2018 (n=10). Responses to the questions on frequency of practice were coded from 1 (always) to 4 (never). There is some evidence of a difference in the provision of access to e-cigarettes: the trusts with the most established policies were least likely to give access to e-cigarettes whereas the trusts with the most recently launched policies were the most likely to give access to e-cigarettes on admission.

Training and specialist support

The treatment of tobacco dependence within inpatient services for adults with mental health conditions has a range of goals including enabling patients to abstain from smoking during their stay on the ward, engaging patients in ways to reduce their ongoing harm from tobacco, and supporting patients to quit smoking altogether. Every mental health trust in England has developed its own approach to addressing these needs, investing in a combination of staff training and, in some cases, specialist support.

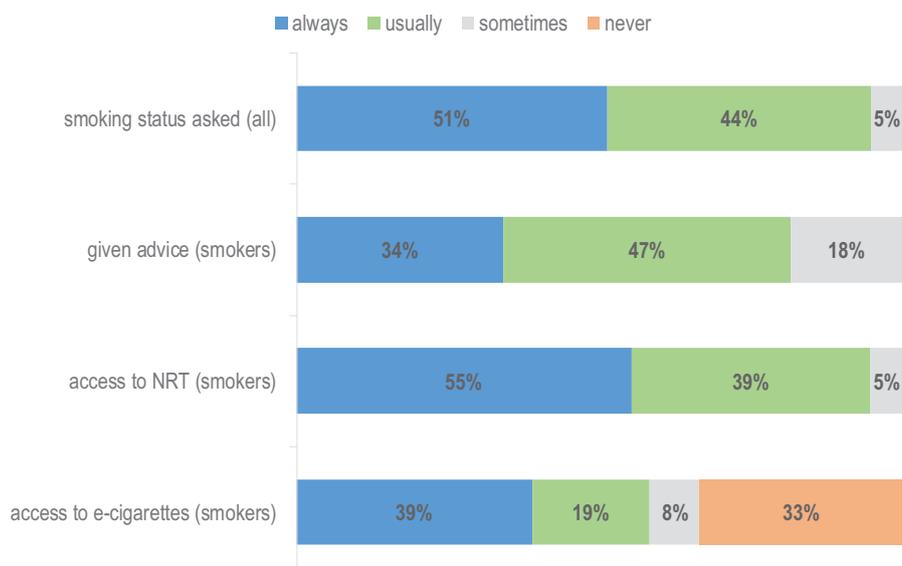


Figure 5.1. Current TYPICAL practice when admitting patients to adult mental health wards (% all trusts). Denominator excludes 'don't know' responses.

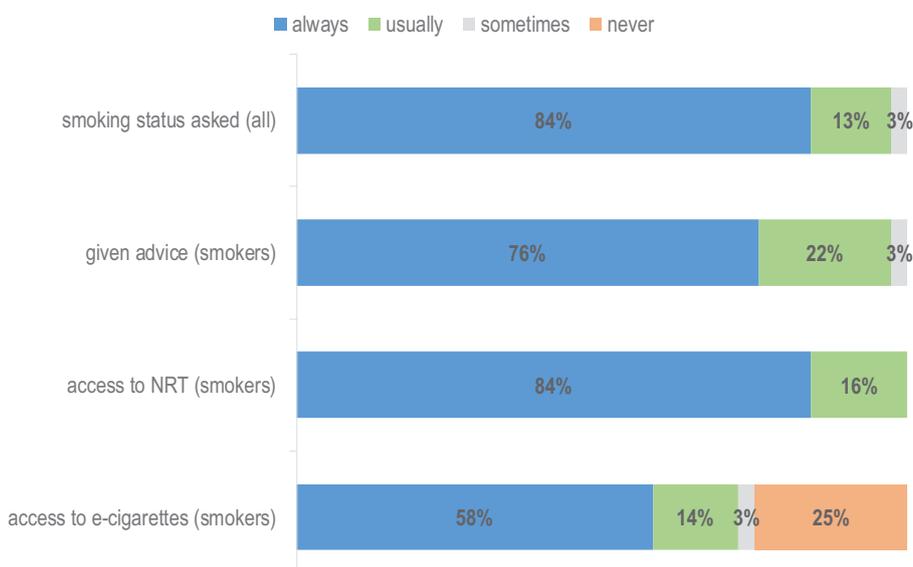


Figure 5.2. Current BEST PRACTICE when admitting patients to adult mental health wards (% all trusts), Denominator excludes 'don't know' responses.

Table 5.1 Typical practice when admitting patients to adult mental health wards by duration of policy

Trust smokefree policy launch date	Mean frequency of practice score (1='always', 2='usually', 3='sometimes', 4='never')			
	asked about smoking status (all patients)	given advice (smokers)	given access to NRT (smokers)	given access to e-cigarettes (smokers)
2017 or 2018	1.4	1.6	1.4	1.7
2015 or 2016	1.7	2.1	1.6	2.2
prior to 2015	1.2	1.6	1.4	3.2

Survey participants were asked if their trust had an on-site specialist service, or any specialist staff, who support patients to stop smoking or abstain from smoking. Twenty-three respondents (59%) said that they did. In their descriptions of this specialist support, however, only 15 respondents (38%) described specific specialist services (n=5, 13%) or specialist staff (n=10, 26%). Others described staff who had received extra training, a component of support that was explored more fully in a subsequent question on staff training (see below). The following examples illustrate these different approaches:

Local stop smoking service offers onsite clinics on both main sites. Physical health clinics also offer stop smoking services. (survey respondent)

We have 2 smoking cessation advisors - who are so important to us and the success of this work as they deliver the day to day support to staff on the wards, and support the community teams to integrate stop smoking within their physical health clinics. (survey respondent)

We have trained around 100 staff as Level 2 smoking cessation practitioners to support patients to reduce or quit smoking. We need to do further work to top up this training and support staff to fully use the training. (survey respondent)

Where specific specialist services are offered, they tend to be scheduled clinics. On-site specialist staff are likely to provide more continuous support, especially for patients who want to quit. The emphasis on training existing staff reflects the ubiquitous, ongoing need within mental health units to manage the tobacco dependence of smokers in a smokefree environment.

Specialist services and staff were consistently valued by survey respondents and by interviewees, not least because of the support they provided to frontline staff. One of the interviewees expressed regret at the loss of a specialist worker, who played a crucial role in supporting patients and staff alike:

We had a specialist band 5 worker who had a caseload of 70 patients who provided support directly to the patients but also for their key workers to help them; and did a bit of work preparing them for discharge, linking them to the community services as was. But then, two things happened at the same time. One was that that post was put at risk; and secondly, we knew that the community services were going to be shrunk, and were shrunk, then subsequently decommissioned. And those two things scuppered it for us. It made the position of the ward nurse, who was keyworking somebody who'd just come in and was smoking 40 a day, almost untenable. (interviewee: medical director)

The everyday demands on frontline staff mean that staff training is vital to the delivery of smokefree inpatient mental health services. Survey participants were asked what proportion of trust staff working on adult mental health wards on a daily basis are trained in Very Brief Advice. Their answers ranged from none of them (one respondent) to all of them (six respondents). Figure 5.3 illustrates the full range of responses.

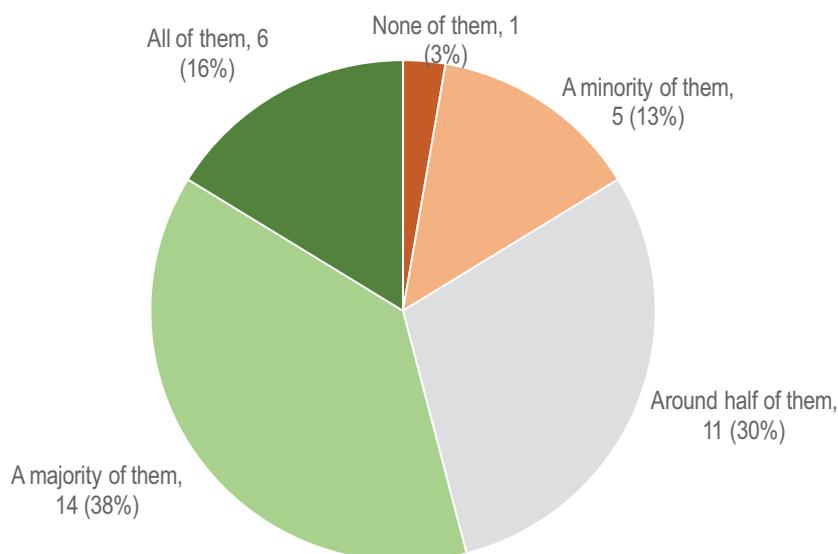


Figure 5.3. Proportion of staff who work on adult mental health wards on a daily basis who are trained in very brief advice (all 39 trusts)

Beyond Very Brief Advice, trusts have taken a variety of approaches to training staff in the management of tobacco dependence and stop smoking support. Most (33 out of 39 trusts, 85%) have delivered some form of face-to-face training, often drawing on existing expertise and resources from the NCSCT, other trusts (notably South London and the Maudsley), local stop smoking services or public health teams, and other local smoking cessation professionals.

The content and coverage of such training is diverse, as can be seen in the following examples:

We have commissioned bespoke 2 day face to face training from the NCSCT and other mental health smoking cessation experts, purchased online level 1 training from SLAM, run workshops facilitated by a health behaviour change expert, run training that we have developed in house. (survey respondent)

Mental Health Smoking Cessation lead from LA Stop Smoking Service provides face to face training for qualified mental health staff across the inpatient wards. This includes the PGD training for dispensing NRT products. (survey respondent)

Aim for all frontline staff to be trained in NCSCT VBA Level 1. A number of staff on each ward to train in NCSCT Level 2 and then followed up with a Trust 2 hour face to face session to embed learning. Also provide Brief Intervention training (2 hours) to staff wishing to receive more knowledge than VBA but less than Level 2 training. 3116 staff trained in the Trust to date. (survey respondent)

One outcome of the promotion of smokefree policy within mental health trusts is that staff within acute mental health services are now far better informed about tobacco dependence and its treatment. As described in Chapter 3, this has in turn been important in changing attitudes to the policy and its enforcement. However, the resources required to develop and sustain this training are significant. The following comment from a survey respondent is salient:

Despite that fact that smoking is the leading cause of preventable disease and premature mortality, all health care professionals continue to successfully graduate without completing any formal training in tobacco dependence. This complete blind spot is crazy, it means we have to train every new recruit from scratch. What a waste of resources. (survey respondent)

NRT and other pharmacotherapy

Survey participants were asked to identify what pharmacotherapy was available to patients who wanted to quit smoking. Nicotine replacement therapy (NRT) was universally available and the great majority of trusts (n=35, 92%) offered combination NRT. Three respondents indicated that only single form NRT was available (one did not know).

In contrast, only 14 trusts (37%) offered varenicline (Champix), of whom five who also offered bupropion. One of the interviewees described the difficulties in trying to persuade doctors to prescribe Champix:

I just think they're unfamiliar with it, they're so unfamiliar with it. I just want to keep pushing it really, and it's right across the trust, people say "Oh what's that?" I think they're also worried about interactions with other medications, and they don't want to add another medication into the mix, into somebody who's acutely ill and maybe not fully compliant with the medication they're taking. Because I really tried to get one patient onto it, who wanted it, and the consultant said "I'm not going to introduce something new to this patient". I can understand that in an acute [setting], but hopefully that would be a definite option for rehab, when somebody's around longer, and they're more settled and certain it should be happening via the GP, in community settings. (interviewee: unit smokefree lead)

Vaping and e-cigarettes

The great majority of the survey participants reported that their trusts supported the use of e-cigarettes (vaping) by adult patients on mental health wards (n=33, 87%). Of the five respondents (13%) in trusts where they are not currently supported, one was currently developing a pathway for their use, one described an ongoing trial in rehab and secure services, and the remaining three all said their policies were under review. Among the trusts that currently support the use of e-cigarettes, three currently do not permit their use in

forensic services. Several respondents also pointed out that the sale of e-cigarettes is not legally permitted to young people aged under 18.

The trusts that currently support vaping had diverse policies about where it is allowed (Figure 5.4). Vaping was rarely permitted in communal rooms but 15 trusts allowed patients to vape in their own rooms (39% of all trusts, 45% of trusts that permit vaping). Patients were allowed to vape in communal gardens in 58% of trusts and in hospital grounds in 66% of trusts.

Several trusts described a willingness to allow vaping inside but a wariness of problems that might arise. Two reported problems with fire alarms, though in other trusts this problem has been overcome. Acceptance by the whole patient population is also an issue:

Work is underway to ensure that each ward has a confirmed designated vaping area. Vaping can be undertaken in the ward gardens. We are testing a vaping project on two wards to ascertain whether vaping within bedrooms or internal ward spaces can be supported by both other patients and the fire risk assessment. (survey respondent)

As e-cigarettes are not prescribed medications, trusts that support their use have had to work out how best to give patients access to them. Of the 33 trusts that permit the use of e-cigarettes, a third currently provide them free, though sometimes only at the beginning of the patient stay. Nine trusts (27% of trusts where e-cigarettes are permitted) sell them on wards, including five that use vending machines, and ten (30%) sell them in hospital shops. The remaining nine trusts that use none of these methods rely on patients buying them off-site or obtaining them from friends or family.

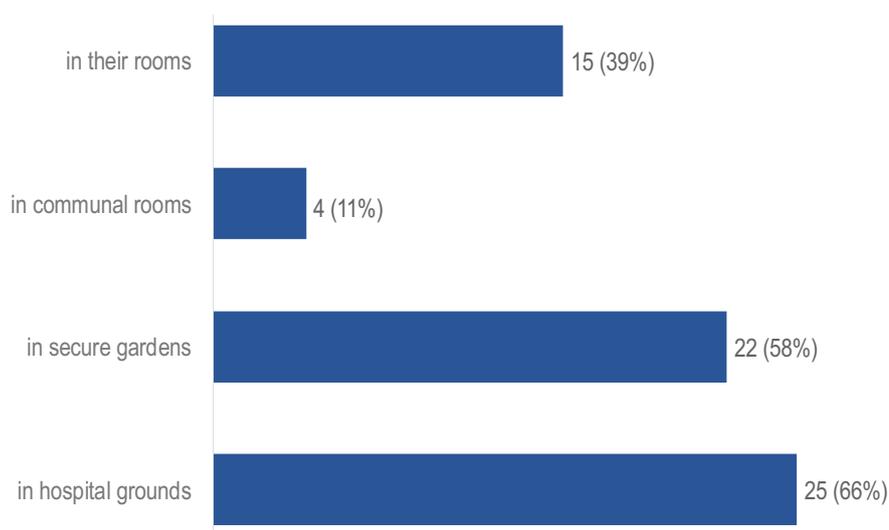


Figure 5.4. Where adult mental health inpatients are permitted to vape (% all trusts providing data, n=38)

The idiosyncratic character of local policy and practice in relation to e-cigarettes reflects the complex range of issues that trusts have had to grapple with in deciding if, and how, they should be deployed. Some of the study interviewees described the difficulties they had faced in getting trust boards to approve their use, centring on questions of their toxicity and safety. One of the interviewees had still not gained her trust's support for their use, principally due to an exceptionally slow decision-making process rather than serious resistance.

Where vaping was permitted, interviewees reported a consistently positive reception from patients:

You have to see it from the other point of view, from people who are trying to stop smoking and people who have stopped. At last meeting on site, I detected a shift from the service users. There were a few complaints about the human rights issues and the deprivation not to smoke. And it was countered, not by me, but by another service user who said "The e-cigarettes have been amazing, I think they're a really good way to go. At least you're giving us e-cigarettes instead of just telling us not to smoke". (interviewee: trust smokefree lead)

I think it has a really effective short-term impact on them. There is the occasional patient who is very on top of their NRT anyway and they'll have a regimen that they follow, and they'll want the patch, and some lozenges and things like that. Most the time now I get requests for e-cigarettes and nothing else. (interviewee: nurse)

It is, however, possible to achieve a smokefree service without e-cigarettes, at least in a secure setting: one of the interviewees had achieved this for a forensic service where vaping had not been permitted due to fire and weaponising risks. She reported a range of benefits from being free of e-cigarettes as well as tobacco:

It's meant that we've not got staff having to charge e-cigarettes; we no longer have to facilitate smoke breaks, that frees up time to care; we've not got that ongoing nicotine withdrawal that happens when people are smoking or using e-cigs that only last you for so long then you need the next one and the next one and the next one. (interviewee: service manager)

Elsewhere, interviewees described how some of these risks had been minimised, for example by the use of E-Burn vapes which are designed for secure settings. One interviewee expressed concern about the addictive nature of e-cigarettes, not least because they were offered free by his trust. Yet this interviewee had fought hard to permit the use of E-Burns and acknowledged that the addictive nature of the product was intrinsic to its effectiveness as a safer analogue for tobacco (where the addiction begins).

Some trusts have fully embraced vaping as a response to the tobacco dependence of the smokers among their patients. One interviewee described a novel initiative within her trust led by a local vape shop: the owner of the shop undertook regular drop-in sessions on the adult mental health wards, introducing both patients and staff to vaping products. The success of the project had a lot to do with the willingness of the owner to engage directly with people with serious mental health conditions:

He understands how when you're really unwell smoking is part of that picture. He's an ex-smoker and he's got a real affinity with our patients, which is why he's now employing some of our ex-service users. And I think, for us, that's really lovely because some of them just don't have that. That's a real opportunity for them, to be in paid employment. And he sits in the involvement centre and he's just got a really lovely way about him, and he isn't scared. He's not afraid to go on the wards, sit with very difficult people, very challenging people. He doesn't know why they're in, he doesn't need to know but he's willing to have that conversation with them. (interviewee: trust smokefree lead)

Stop smoking support for staff

Survey participants were asked to describe the support available to staff who want to stop smoking or abstain from smoking while at work (an open question). Thirty-five respondents answered the question. The range of responses was notable, from nothing to comprehensive support in work time:

None, intentionally. It is in our policy that we would not take responsibility for staff quitting as if they are actually motivated they can easily get advice via their own GPs or pharmacies, and we have no on site OH services which could do it. (survey respondent)

Individually tailored one to one or group support during working hours and accessible to the staff, with full pharmacotherapy costs covered. (survey respondent)

Twenty respondents (57%) described some form of on-site stop smoking support including Level 2 advisors and clinics run by the local stop smoking service. Five said that staff were referred to the trust Occupational Health service. Seven described sign-posting to the community stop smoking service only. Nine respondents stated, unprompted, that staff could access these services within work time, for some or all of the support they needed.

As smokefree policies become established, the needs of staff may change, requiring different types or levels of intervention:

Support through Occupational Health and local Specialist services coming on site. This was offered during the initial stages and was withdrawn at the point there was no further interest/requirement. They can access Local Stop Smoking Services directly within their Borough and are advised of GP and Pharmacy support. Plus there is the offer of one to one behavioural support from the Smokefree Lead. (survey respondent)

Everyday challenges for frontline staff

Professionals who work every day on mental health wards bear the primary burden of enforcing smokefree policy and supporting tobacco-dependent patients to abstain. The interviewees described the range of challenges these staff face including the moments of acute crisis when patients react badly to being refused tobacco, the constant need to enforce the smokefree environment by reminding patients not to smoke and removing their lighters, and the therapeutic obligation to support patients to maintain abstinence and keep them occupied during the times when they would normally smoke.

Challenging smoking behaviour can be exceptionally difficult when a patient is experiencing acute mental illness. But this does not mean that alternatives to smoking have to be set aside. The following incident, recounted by a nurse, illustrates the tension between the quick solution – allowing smoking – and the harder task of engaging patients in alternatives:

I was working on one of the wards the other day and there was a new admission, and she was quite unwell. She'd just been admitted and she wouldn't accept NRT and she was quite abusive towards me about not being able to have a cigarette. We did actually take her off the ward with a member of staff. She went off the grounds and she did go out for a cigarette. But it was talking about the use of NRT: sitting down and talking with the patient, instead of them saying "no, I don't want NRT" and you just accepting that. Actually sitting down and saying "what actually puts you off about NRT?" So, she was saying that she's had side effects with Champix, and that she used a throat spray and it made her cough. So, we were explaining to her about different NRT: rather than having throat spray or Champix, maybe you could use lozenges or patches. At that time, she was more accepting of that. She didn't actually want to have it, but she was thinking about it. (interviewee: nurse)

Such events can be contrasted with the ever-present, ongoing challenge of maintaining a smokefree environment. Interviewees expressed concern that the requirement to continuously and repeatedly challenge smokers and remove their lighters was leading to exhaustion among some frontline staff. One way to counter this was to maintain a focus on the potential for change:

Some of [the patients] are almost more flippant about it. It's kind of like they think you're joking, because you've probably spoken to them a lot of times about smoking in the courtyard. They say "oh come on, you know what I'm like! It's not for me – not smoking is just not for me. You know, I want to smoke." But, I think you still should re-approach it because there is that one time that they will turn around and say "yes". And actually, if you captured one out of every ten that would do that, then you're achieving something aren't you? (interviewee: ward manager)

I think, to be fair, staff are struggling with it. It's another stress for the staff and another task for them to do, and it can be confrontational... So, what we've decided is that over time it does get better; over time people get used to it; over time people do stop smoking and some people reduce, some will vape, and some will try NRT. So, over time the number of people who smoke will decrease and it will get easier. (interviewee: trust smokefree lead)

This focus on outcomes is integral to the wider physical health agenda that many mental health trusts are seeking to advance. The challenge of filling the time left by smoking with other activities is an opportunity to encourage patients to engage in physical activity and think about their wellbeing.

We've tried to increase the activities on the ward because a lot of the activities used to be the patients going out in the garden and smoking together. Before they went to bed, for example, first thing in the morning after breakfast. (interviewee: trust smokefree lead)

We're doing lots of work around engaging families and carers and trying to have that conversation with them about the support that they can offer. So, "don't bring in a takeaway, don't bring in 20 Malboros. You know, come and have a meal on the ward". Finding alternatives rather than just a need of cigarettes, so we've got therapy liaison workers on all of the wards now who are providing daily activity – it might be Wii club, it might be gardening. So, we try to find things for people to do rather than go for a cigarette. Having that initial conversation with them about recovery in its really broader sense and how they can manage their own recovery (interviewee: trust smokefree lead)

6. Support in the community

It's something else for the community teams to do on top of what they're already doing. But it should be part of physical health care, shouldn't it? It's the same as any other physical health advice that you give to patients, whether they're drinking alcohol or taking drugs or anything else, you try and build their care plan around whatever needs they've got. Stopping smoking should be part of that, really.

The role of community services

Even from the perspective of acute services, community services are vital in addressing the tobacco dependence of people with mental health conditions. Firstly, community mental health services play an important role in preparing people for admission to the smokefree acute environment. Secondly, acute providers need a community service to meet the ongoing tobacco dependence needs of their patients after discharge. Community stop smoking services funded by local authorities are (or have been) the primary point of referral. Thirdly, professionals within acute mental health services are keen to see smoking prevalence within their patient population fall. Their own contribution to this goal is important but relatively minor compared to what can be achieved in the community by stop smoking services, community mental health services and wider public health interventions.

Interviewees drew attention to each of these functions. Engagement with patients prior to admission was described as an opportunity not only to inform patients about the smokefree environment but also to inform acute services about the choices and expectations of patients:

They're now very much pushing that we train all the community psychiatric nurses to engage with it well in advance. So, we've developed a lovely intervention plan where they can sit with the patient and see how many they smoke; what you've tried before; if you come into hospital as an emergency admission, what would you like us to do as soon as you walk through the door; do you want an e-cig, do you want a patch? And then staff can have a look and see "oh, they want this". It hasn't yet come into place because we haven't had enough time with the community staff. (interviewee: trust smokefree lead)

Discharge planning for tobacco dependence relies heavily on referral to community stop smoking services. However, since the transfer of the commissioning of these services to local government in 2013, some have been decommissioned or cut back. This has created a serious problem for mental health trusts, not least because they typically cover more than one local authority area:

With [the city], they've got a very good stop smoking service for everybody, basically – so they will be seen by the team. It's changing to another provider, but they'll still be seen. Whereas, for [the county], they've only got a service for over 50s in certain areas, the more deprived areas. So, that's the issue we're finding at the minute: we're referring patients into smoking cessation service but they might not actually be seen by an actual service, they might be signposted to pharmacy, the internet, which isn't ideal but that's the best that's been commissioned at the minute. (interviewee: nurse)

The importance of long-term community action to reduce smoking prevalence within the population of people with mental health conditions was acknowledged by interviewees. For as well as reaching many more people than acute services, community services engage with patients when they are not acutely ill, and not being forced to stop smoking. Interviewees described the inherent difficulty of asking patients to stop smoking at precisely the point (acute admission) where they are least likely to be receptive to this request.

To have a community that was smokefree that then comes into a hospital [that is] smokefree is probably an easier way of doing it. Because, actually, what you have got is smokers that come in, that are then made to do something, and probably not many people like to be made to do things – and it just becomes another battle against the system for some of them. (interviewee: ward manager)

One interviewee expressed regret at the loss of community stop smoking services precisely because the achievement of this long-term goal of declining prevalence had been undermined:

The stop smoking service has been decommissioned within the last couple of months. So, we told all those ward staff who were having to ask patients not to smoke (when it was the most inappropriate time you could choose): "in a year or two, don't worry, we'll have gotten to all of them in an upstream way, and at least they will be warned whilst they're in a slightly greater state of cognition." And that hasn't happened and it never will happen, not in the foreseeable future. And so we have had to – and we are in the process of – relaxing our smokefree policy. (interviewee: medical director)

Given the importance of community services to these related goals, mental health trusts are beginning to take their own contribution to meeting tobacco dependence needs in the community more seriously. However, this work is at an early stage. Most policies still take a relatively narrow view:

We're doing a lot of work around patient stay in hospital, but their care is much broader than that. And actually, the time they're spending in the community pre-admission/post-discharge, we didn't seem to have that connection. When you read the policy, it's very much around place: you know, you're on our ward, you come off the public road, you come into the hospital and it's very much a round space. (interviewee: trust smokefree lead)

One of the limitations of the smokefree policy which I've picked up on is that it doesn't really engage the broader client population who are accessing community services – of which there are about maybe 10,000 in the community compared to 1000 in the inpatient service, so that's where the big numbers are. (interviewee: trust smokefree lead)

Local authority and mental health trust community services

As discussed above, local authority stop smoking services and community mental health services both have a role to play in meeting the tobacco dependence needs of people with mental health conditions in the community. The current support offered by these services was explored in the survey.

Survey participants were asked whether their patients had access to a local authority-funded stop smoking service in some or all areas. Of the 36 respondents who were able to answer the question, 22 (61%) said that all their patients had access to such a service, 13 (36%) said that patients only had access to a stop smoking service in some areas, and one said that none of their patients had access to a local service. Where patients no longer have access to a service this may be because the service has been decommissioned altogether, or because it targets a range of smokers that excludes many people with mental health conditions, or because the service is so limited as to be of no practical use, as in the following example:

[The city service] can assess a smoker but can't issue NRT so we have set up our own dedicated clinic to support people in this area. Many services now only offer one NRT product so may not be enough for some of the heavier smokers. (survey respondent)

Over half of trusts surveyed (57%, n=21) provided some stop smoking support of their own in the community. Although this may be linked to the loss or diminution of community stop smoking services, as in the example above, there are many other factors in play. Overall, trusts were no more likely to report providing such support in areas where local authority provision had gone than in areas where all patients still had access to local stop smoking services.

The nature of this 'stop smoking support' varied in a similar way to the inpatient stop smoking support described in Chapter 5: some respondents described specific clinics or groups, others described specialist staff, and others described tobacco dependence training given to professionals within community mental health teams. The last of these was much the most common approach cited.

Specific clinics or groups were mentioned by three respondents. All three indicated that they had been successful, as in the following example:

In one borough, we have an established Mental Health Smokefree group facilitated by trained mental health community staff. This has been developed with the initial input of the local stop smoking service. Due to the success of this work we are currently trying to roll this out across other boroughs within the Trust. (survey respondent)

A further three respondents described specialist staff, all of whom were employed by the mental health trusts but were based in local stop smoking services. Thirteen respondents described the support offered by community mental health staff. This ranged from Very Brief Advice and referral to stop smoking services to more substantive stop smoking support within community mental health teams:

Community practitioners are trained in VBA and will support facilitation to local stop smoking services if requested by the patient. (survey respondent)

We have level two trained smoking cessation practitioners among our mental health staff in the community - who can provide stop smoking support - but have no budget for NRT. (survey respondent)

We don't yet have a full complement of Stop Smoking Practitioners in each CMHT, but where they are in place we are keen to offer this service in-house. (survey respondent)

Most mental health trusts are at an early stage in developing appropriate stop smoking/tobacco dependence support through their existing community providers. The task may be as great, if not greater, than the challenge that is still being addressed in the acute context. One interviewee, who had made some first initial steps in this direction, described her anxiety about what she might encounter:

I think we'll go through the whole process again about human rights, and "how dare you?!", and "what do you think you're doing?!" (interviewee: trust smokefree lead)

However, the scope is considerable, given the range of community services mental health trusts support. For example, many mental health trusts run small residential services in the community, such as hostels, for rehabilitation. These have not been a focus of smokefree policy, as prohibition of smoking is not practical other than in secure units but, as elsewhere in the community, they offer opportunities for supporting quitting and harm reduction:

There's not much point banning it in the garden and having patients smoking on the pavements, someone will get run over. That's a difficult one. I think what it is, it's going to be a harm reduction approach, an incentive approach. So thinking of social incentives, maybe even financial prizes, this sort of thing, trying to change the culture, sit down with every single person and work out a plan, and have something every single week, I don't know, a quiz and chips night, and people get a clap if they made a step, you know, so you sort of have a journey for people. (interviewee: unit smokefree lead)

Many opportunities for mental health trusts exist in all their everyday community contacts with people with mental health conditions. However a question remains over what role trusts should play in providing stop smoking support directly in these contexts, rather than referring to community stop smoking services. One of the study interviewees noted that the stop smoking services funded by her local authority were appropriate for 'the vast majority' of people with mental health conditions, especially people with depression or anxiety, but that people with psychosis, schizophrenia or personality disorders typically needed more specialist help.

7. Impacts and benefits of going smokefree

It's a culture change for years to come. We've already done well. The more staff who quit, the more patients who quit year on year, the less smokers will come in, and then you'll end up with more people who believe in it than don't. Staff who were totally against it have turned around. So now we're understanding, actually, patients are quitting.

Changes for better or worse

Survey participants were asked if they could identify any changes that had followed the introduction of smokefree policy, including outcomes evidenced by formal evaluation and their own personal views of the impact of the policy (two open questions).

Only three respondents reported the results of formal evaluation, as follows:

Overall reduction in actual violence by 39%. Improvements in environmental cleanliness scores [and in] staff and patient quit rates. (survey respondent)

Pre-audit 2015 identified 43% of patients were smokers. New audit 2017 showed 21% patients as smokers (nearly a 50% reduction) mainly from forensic services but reductions seen across all groups year on year since 2015. Staff smoking rates have reduced from 10% in 2015 to 7% in 2017. (survey respondent)

We have recorded at least 75 successful quit attempts in two years (April 2016-March 2018). There are no baseline data for previous years but this looks like the result of a concerted effort. (survey respondent)

Many more respondents (n=30) reported their own observations of change. These were mostly positive and included:

- » staff and patients abstaining or quitting smoking; an increase in the uptake of NRT and e-cigarettes; and an increase in patients trying out approaches to harm reduction and quitting;
- » improvements in the environment, including cleaner wards and better air quality; one respondent noted that the gardens were now more attractive to non-smokers;
- » greater acceptance of smokefree policy by staff and patients alike, and an increase in the engagement of staff;
- » improvements in patients' physical health and wellbeing, and in the money they had to spend on other things;
- » improvements in staff and patients' understanding of the impact of smoking on physical health;
- » reductions in the use of prescribed medications such as clozapine.

The following two responses illustrate the range of issues identified through informal evidence:

The feedback I have got from staff and patients has been positive, such as, "I am glad I don't have to smell smoke anymore while I am in hospital", "I feel healthier in myself", "I feel more energized", "the money I saved, helped me buy myself a car", "I can taste things". (survey respondent)

[There has been] a significant change in staff attitude and culture across the organisation as we now move towards the 2 year mark since implementing smokefree... There is a far better understanding and 'buy-in' for smokefree and staff report the hospital environment is a much healthier and safer place to work. Reports from staff that some patients have continued their smokefree journey after discharge. (survey respondent)

When the interviewees were asked about the changes they had witnessed, a similar range of positive outcomes was described for patients, staff and the environment. In addition to those identified above:

- » No longer having to take patients for smoking breaks;
- » Improvements in patients' sleep;
- » More patients staying at home rather than being admitted to hospital (in order to avoid the smokefree environment).

The only negative change identified by survey respondents was an increase in the incidence of covert smoking, which one respondent linked to an increased fire risk.

The lack of data here may reflect a bias in the question towards positive outcomes. The interviewees were more forthcoming about the negative changes that they had seen. Again, these are personal views reported by interviewees, *not* the results of formal evaluation. As well as the increase in covert smoking indoors, the following changes were described:

- » Staff exhaustion with the enforcement of smokefree, constantly telling people not to smoke;
- » An increase in verbal abuse at times of confrontation with patients who want to smoke;
- » A reduction in physical activity in the morning, and increased weight, because patients stay in bed longer;
- » A deterioration in patient relationships between detained and non-detained patients because of differences in access to tobacco;
- » A deterioration in professional-patient relationships where patients are determined to smoke.

It is worth reporting that the interviewee who identified weight gain as a problem also described a local response to this:

One of our female wards, for example, it's a medium secure ward and it does have some issues with motivation and getting up, and their weights increasing. So they agreed as a community, as a ward, that after tea on an evening they would have a community walk. So they walk the perimeter – it's actually quite big with the gates open – so they do a couple of laps around the perimeter to build them up to a half an hour community walk. And they do that as a ward group with the staff, and that's something that they came up with as a ward about improving their active day. (interviewee: service manager)

One of the interviewees, a nurse, described a case study that illustrates the last of the negative outcomes listed above. She stressed that the case was unusual. Nonetheless, it is someone's life:

We've got one lady who's a chronic lady, and so she doesn't know anything else. The only thing she's got in her life is cigarettes: she's got no family, she's got no friends, she's got an enduring mental illness, she's probably never going to be able to go back to her own home. The only thing she's ever done is smoke 60 cigarettes a day. And so she comes in and one little inhalator and a patch will do nothing – she's not interested. On numerous occasions she's been found saying "I would rather commit suicide than stop smoking". So, I'm really conflicted about that patient's quality of life because she's got absolutely zero, nothing else. We've always had a good relationship with her; she hates us now. We've got no rapport there. I mean, obviously with our medication we have to rely a lot on rapport to get her to take anything. There's no positive rapport there whatsoever. (interviewee: nurse)

The best things about going smokefree

At the end of the survey, participants were asked a more subjective question: 'What have been the best things about going smokefree'? As this open question was answered by more respondents, and in greater detail, than the question on outcomes, basic quantification of the answers was possible.

Of the 34 respondents who answered the question, 21 cited improvements, or potential improvements, in health and wellbeing outcomes for patients and staff. Such improvements may be the result of quitting, abstaining, or otherwise reducing the harm of smoking; or less exposure to secondhand smoke; or having more time for therapeutic activities; or having more money to spend on essentials; or from the broader outcomes of engaging patients in discussions about their physical health and lifestyle choices.

Fourteen respondents mentioned improvements to the hospital environment including a cleaner physical fabric, cleaner air and the absence of the smell of tobacco smoke.

Seven respondents identified the value of the changing culture within mental health units, with professional attitudes shifting away from an acceptance of smoking in this environment and in this population.

The following response encompasses all three of these benefits of going smokefree:

Addressing the issue of smoking with mental health patients, which have historically been neglected from this perspective. Raising awareness of the harmful effects of smoking and second-hand smoking on individuals and the environment. Promoting a healthily environment for patients, staff and visitors. Offering patients the chance to make a quit attempt and receive support during their hospital stay. (survey respondent)

8. Discussion

This study provides a snapshot of current smokefree policy and practice within mental health trusts in England. The design of the survey focused on acute services, as this is where the prohibition of smoking has presented the greatest challenges. Findings in relation to community stop smoking support for people with mental health conditions are limited. Furthermore, within acute services, the survey focused on adult mental health wards. Findings for other wards, such as forensic wards and older people's wards, are also limited.

All results are based on the self-report of survey participants or interviewees. Almost all survey participants had a strategic view across their trusts. Nonetheless their answers are necessarily constrained by their specific professional roles and by the limitations of the data available to them. Many mental health trusts are large institutions with many sites. Although the survey was designed to capture something of the differences in practice within trusts as well as between trusts, the findings necessarily simplify this complexity.

In 2018, five years after the publication of NICE guidance PH48, the recommendations of the guidance have been widely addressed within the smokefree policies of mental trusts in England. Some trusts have yet to implement their policies but 87% have active policies and 79% have active *comprehensive* policies, i.e. policies which prohibit smoking in all indoor and outdoor areas within NHS premises.

The key issues faced by mental health trusts today relate to the implementation, enforcement and maintenance of policy. Some policy differences between trusts remain, especially in relation to the use of e-cigarettes. There is an emerging consensus supporting the use of e-cigarettes in mental health units but trusts differ in where and when they permit their use.

In all five trusts in which smokefree policy had not yet been implemented or had been suspended, smoking was still permitted in secure courtyards within adult mental health wards. In contrast, only two of the 34 trusts that had active policies permitted smoking in secure courtyards; one further trust permitted smoking in hospital grounds. Policy is driving change: the shift to comprehensive prohibition of smoking within acute mental health units is well underway.

In practice, however, patients are still lighting up within NHS boundaries in all trusts: in 30% of trusts with active smokefree policies, patients were found smoking within the secure courtyards of typical wards every day. In two thirds of trusts, patients were found smoking in hospital grounds every day. None of the survey participants reported 100% compliance with smokefree policy.

Total compliance with smokefree policy on adult mental health wards may be an unreasonable expectation, given that patients can routinely leave the premises and purchase tobacco. Consequently, patients who are determined to smoke can find ways to do so, within NHS premises as well as outside them. Nonetheless there is considerable scope for improvement: the differences between trusts, and within trusts, show how far many trusts have progressed and what good practice can deliver. For example, in contrast to the trusts reporting daily smoking in courtyards, 30% of trusts reported infrequent smoking (less than once a week) in the courtyards of typical wards. On best practice wards, rather than typical wards, this finding rises to 52% of trusts including 26% where smoking was never found within secure courtyards.

Differences between typical and best practice were also significant in reports of what happens to patients on admission to adult mental health wards. In 84% of trusts surveyed patients are *always* asked about their smoking status on their best practice wards. But this only happens in half (51%) of trusts on typical wards. Likewise, on best practice wards, 84% of trusts *always* give identified smokers access to NRT on admission, but this falls to 55% on typical wards, though a further 39% are *usually* given access to NRT on admission.

Intelligence from the interviews offers some insight into the causes of these differences within and between trusts. Differences within trusts often reflect differences in the attitudes and commitment of ward managers or matrons. These differences can be pronounced: interviewees described wards where matrons and ward managers were completely committed to the smokefree agenda and others where they resisted the policy

and were happy to allow patients to smoke. Research elsewhere has identified consistency of practice in inpatient units as a factor associated with successful smokefree policy implementation⁷.

Differences *between* trusts may also reflect differences in attitudes and commitment to the smokefree agenda, starting at the top: leadership from the board was cited by half of survey respondents as being important in enabling smokefree policy and practice. Ward champions and patient champions were also identified as enabling progress. On the flip side, half of survey respondents cited staff resistance as a key obstacle to delivering smokefree policy.

Many prior studies have drawn attention to the opposition of staff in mental health units to smokefree policy⁸ and the importance of education, training and communication in changing attitudes^{9,10}. This study describes something of the complexity of this task: addressing fears and anxieties among all stakeholders; training professionals to increase awareness and skills, not least in relation to the interactions with other medications; and communicating effectively and consistently. However, frontline staff may still struggle to adhere to smokefree policy if they do not have the necessary support to enable patients to abstain from smoking. As in the case of one of the nurses interviewed for the study, they may support the policy in principle but work around it on a daily basis (for example by using Section 17 leave) if they feel unable to adequately address their patients' tobacco dependence.

This study describes significant variations in the treatment and support for tobacco dependence offered to patients in mental health units. Specialist stop smoking/tobacco dependence workers appear to be particularly valued in supporting patients and taking some of the burden off frontline staff. However, most trusts rely on training their own staff to provide the necessary support. Although this training is important, and helps to change attitudes as well as improve skills, a lack of specialist support may contribute to the frontline 'burnout' in enforcing smokefree policy reported by some interviewees. Specialist stop smoking/tobacco dependence support may be more sustainable if it is integrated into wider physical health programmes, an approach which some trusts are already pursuing.

There is also increasing diversity in the treatment offer to patients in the community, primarily because of the ongoing changes to local Stop Smoking Services, some of which have been decommissioned altogether or replaced with integrated 'lifestyle' services¹¹. Such changes make it difficult for mental health trusts to meet PH48 recommendation 9, and the related CQUIN requirement, to 'put referral systems in place for people who smoke.' Mental health trusts are, however, beginning to consider the potential rewards of investing in stop smoking support in the community themselves, both through dedicated services and through training professionals in community mental health teams. Given the much bigger population engaged with by community services, such moves are worthy of further research. One study of an integrated model of tobacco dependence treatment spanning acute, rehabilitation and community services reported clear demand from patients for the service, and successful outcomes, but also multiple institutional and professional barriers¹².

In its scope and methods, this study is similar to the last survey of smokefree policy and practice in acute mental health services in England, conducted in 2007¹³. The current policy environment is different but similar, once again requiring a shift of everyday patient smoking out of an accepted environment. In 2007 the shift was out of indoor smoking rooms into outdoor spaces; now the shift is out of courtyards and hospital grounds altogether.

There are similarities in the studies' findings. For example, the earlier study reported that infringements of policy occurred on a daily basis in more than a third of trusts. This is almost identical to this study's non-compliance finding repeated in the discussion above. On a more positive note, the earlier study's reports of perceived beneficial outcomes are comparable to those reported by survey participants and interviewees in this study: cleaner air and reduced exposure to secondhand smoke, increased motivation among patients

7 Lawn S, Campion J: Factors associated with success of smoke-free initiatives in Australian psychiatric inpatient units. *Psych. Serv.* 2010; 61:300-305.

8 McNally L, Oyefeso A, Annan J et al. (2006) A survey of staff attitudes to smoking-related policy and intervention in psychiatric and general healthcare settings. *Journal of Public Health* 28: 192-6

9 Jochelson K, Majrowski B: Clearing the air: debating smoke-free policies in psychiatric units, King's Fund, 2006

10 Ratschen E, Britton J, McNeill A. The smoking culture in psychiatry: time for change. *Br J Psychiatry.* 2011 Jan;198(1):6-7.

11 Cancer Research UK and Action on Smoking and Health: Feeling the Heat: The decline of stop smoking services in England, 2017

12 Parker C, McNeill A, Ratschen E. Tailored tobacco dependence support for mental health patients: a model for inpatient and community services. *Addiction.* 2012 Dec;107 Suppl 2:18-25

13 Ratschen E, Britton J and McNeill A. Implementation of smoke-free policies in mental health in-patient settings in England. *Br J Psych* 2009; 194: 547-551

to stop smoking, reduced smoking prevalence among staff and the liberation of spaces previously used for smoking for other recreational activities, with knock-on effects for patient well-being.

The additional benefit identified in this study of freeing staff time from overseeing smoking breaks – a burden created by the earlier shift from indoor to outdoor smoking – is significant: a 2015 study of a mental health trust where outdoor smoking was permitted estimated that the annual staff cost of these breaks was over £130,000¹⁴. Such costs may not, however, be saved if Section 17 leave is still used to sustain smoking behaviour, or if trusts only permit vaping outside.

The 2007 survey of mental health trusts noted that ‘it will be important to acknowledge the difficulties faced by staff in everyday practice’. This study has sought to do this, while also recognising the considerable progress that trusts have made in the last decade. Many trusts are already reaping the benefits of comprehensive smokefree policies but the scale of the ongoing challenge, both strategically and at the frontline, should not be understated.

14 Sohal H, Huddleston L, Ratschen E: Preparing for Completely Smoke-Free Mental Health Settings: Findings on Patient Smoking, Resources Spent Facilitating Smoking Breaks, and the Role of Smoking in Reported Incidents from a Large Mental Health Trust in England. *International Journal of Environmental Research and Public Health* 2016



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