Space to breathe

Findings from a survey of smokefree policies and tobacco dependence treatment services in NHS mental health trusts in England, 2024

March 2025

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Contents

Summary

This report presents the findings of an ASH survey of NHS mental health trusts in England, conducted between October and December 2024.

A similar survey was conducted in 2019. Since then, the context has changed significantly. While NICE guidance on the treatment of smoking and the creation of smokefree hospital settings remains the same, significant investment has been made in tobacco dependency treatment services in inpatient mental health settings. Trusts are also preparing for the forthcoming ban on disposable vapes and vending machines and the Government has announced plans to legally require hospital sites to be smokefree.

Findings are from 40 of the 50 NHS trusts that provide inpatient mental health care to adults in England, a response rate of 80%.

Tobacco dependence treatment

- In 70% of trusts, tobacco dependence treatment services were fully implemented.
- However, only 42% of trusts were able to offer tobacco dependence treatment to all their patients who smoked.
- 82% of trusts employed dedicated practitioners to provide tobacco dependence treatment (compared to 44% in 2019).
- In 33% of trusts, patients were always asked about their smoking status on admission.
- In 39% of trusts, patients were offered ongoing support from the in-house tobacco dependency treatment service on discharge.
- All surveyed trusts offered smokers nicotine replacement therapy. However, only a minority offered generic varenicline (15%), Cytisine (13%) or Bupropion (8%).
- In 46% of trusts, staff were offered some form of stop smoking support within the trust.
- Implementation of tobacco dependence treatment services had been inhibited by staff attitudes and beliefs, lack of capacity and resources, lack of leadership, and inadequate or poorly enforced policy.
- Implementation of tobacco dependence treatment services had been enabled by clear leadership, funding, strong smokefree policy, the commitment and engagement of tobacco dependence advisers, vapes, and ICB support.

Smokefree policies

- 85% of the surveyed NHS trusts had comprehensive smokefree policies.
- In 6 trusts (15%) smoking was still permitted in outside areas (this is likely to become illegal under new regulations in the Tobacco and Vapes Bill).
- In 72% of trusts, patients' tobacco products were stored until they were granted leave or discharged.
- The proportion of trusts with comprehensive smokefree policies has changed little since the last survey in 2019 (85% vs. 82% in 2019).

How often patients smoke in practice

- In 48% of trusts, on an average ward, patients were found smoking in hospital grounds every day.
- In 35% of trusts, on an average ward, patients were found smoking in secure courtyards/gardens every day.
- In 37% of trusts, on an average ward, patients were found smoking in their bedrooms every week.
- In 50% of trusts, on an average ward, staff escorted patients on breaks to enable smoking every day.
- In 33% of trusts, on an average ward, most or all of these smoking breaks were facilitated by Section 17 leave.
- Smoking was more common on acute wards and male wards.
- There has been a decline in smoking in indoor communal areas and an increase in smoking in outdoor areas since 2019.

Vaping

- All surveyed trusts permitted adult mental health inpatients to use vapes.
- 65% of trusts permitted vaping inside as well as outside but mostly only in private bedrooms.
- 78% of trusts provided vapes free but this was often only for a limited period.
- Disposable vapes were the product used most often on mental health wards.
- The ban on disposable vapes presents challenges in relation to the safety, accessibility and cost of reusable vaping products for this patient group.

Patient involvement

- In 67% of trusts, patients had been involved in the development of smokefree policy and/or tobacco dependence treatment services.
- Approaches included patient representation on committees, consultation with user groups, and ward surveys and discussions.

Current challenges

The key challenges for the future faced by smokefree and tobacco dependence leads in mental health trusts were:

- Changing attitudes and culture,
- Ensuring consistency of practice across wards,
- Securing long-term funding and increasing capacity.

Recommendations

	Recommendation	Who is responsible for delivery?
1	Maintain and improve funding for tobacco dependence treatment services in mental health trusts to ensure that all service users and staff who smoke have access to tobacco dependence treatment. This should include both inpatient and community mental health services.	DHSC, NHS England, ICBs
2	Ensure that healthcare settings are prepared for any changes in the law, for example regarding smokefree policies, the single-use vapes ban and the ban on vape vending machines. This should be accompanied by national guidance and support on issues where there is significant variation in service delivery and outcomes.	DHSC, NHS England
3	Ensure that comprehensive implementation of tobacco dependence treatment services and smokefree policies is a priority for all staff.	ICBs, leaders in mental health trusts
4	Expand access to the stop smoking medications varenicline and cytisine, which are under-prescribed to people with mental health conditions, alongside consistent access to vapes and NRT.	ICBs, leaders in mental health trusts
5	Provide mandatory training to all staff working in mental health trusts to address widely-held misconceptions about the impact of smoking on mental health and equip them to support inpatients who smoke to be smokefree. This should cover providing evidence-based advice on stop smoking medications and vaping.	NHS England, ICBs, leaders in mental health trusts

Introduction

This report presents findings from a survey of NHS mental health trusts in England. The survey explored smokefree policy and practice in adult inpatient mental health units and the implementation of tobacco dependence treatment services within these units.

Over the past decade a series of policy announcements has sought to promote smokefree mental health services. NICE first recommended that hospital sites should be smokefree in 2013[1]. In 2016, the Five Year Forward View for Mental Health[2] recommended that all inpatient mental health services should be smokefree by 2018, a goal that was reiterated in the government's Tobacco Control Plan[3] the following year. The rationale for this goal is to create healthier environments for people to recover in, to support smoking cessation, and to limit the burden on staff from facilitating smoking. NICE guidance has always recommended smokefree sites in the context of adequately provided alternatives to smoking and support to quit.

The NHS Long Term Plan, published in 2019, committed the NHS to providing tobacco treatment services to all hospital inpatients, including inpatients of mental health units, by 2023/24. In 2022, NHS England and the Royal College of Psychiatrists Launched QuITT (Quality Improvement for Tobacco Treatment), a collaborative programme to increase the proportion of patients on mental health wards who engage in tobacco treatment. In 2024, the Care Quality Commission published guidance to ensure that its inspections consistently supported the efforts of trusts to go smokefree[4] and the Government announced a ban on disposable vapes from June 2025.

What has been the impact of all these policies? In 2019, ASH conducted a survey of mental health trusts and found that progress in delivering smokefree services was mixed[5]. Despite most trusts having smokefree policies in place, mental health inpatients still routinely smoked on site, often with the support of staff. Treatment for tobacco dependence was patchy.

This new study considers how much has changed since 2019. The big shift in the last five years has been the roll-out of NHS tobacco dependence treatment services. This has had a major impact, but many obstacles remain in the path of delivering genuinely smokefree environments for mental health inpatients and staff, above all the entrenched culture of smoking on many mental health wards. Respondents to this survey expressed their determination to overcome these obstacles but were realistic about the resources and time that it would take to do so.

[1] National Institute for Health and Care Excellence: Smoking: acute, maternity and mental health services. Public health guideline PH48, 2013.
[2] Mental Health Taskforce to the NHS: Five Year Forward View for Mental Health, 2016.
[3] Department of Health and Social Care: Towards a Smokefree Generation. A Tobacco Control Plan for England, 2017.
[4] Care Quality Commission. Brief guide: Smokefree policies in mental health inpatient services, 2024.
[5] Progress towards smokefree mental health services. Findings from a survey of mental health trusts in England. ASH, 2019

Methods

The survey was conducted online using Survey Monkey. Smokefree leads, tobacco dependence leads, and other contacts in NHS mental health trusts were emailed and asked to complete the survey. Non-respondents were followed up and encouraged to complete the survey. The survey was open online from October to December 2024.

The questionnaire was based on the instrument used for an earlier survey of mental health trusts conducted in 2019. Key questions on policy and practice were repeated and new questions on tobacco dependence treatment services were introduced.

Forty valid responses were received from the 50 NHS trusts that provide inpatient mental health care to adults in England, a response rate of 80%.

Of the 40 respondents, three quarters described themselves as either the tobacco dependency lead for the trust (n=21) or the smokefree lead (n=9). In addition, there were three tobacco dependency treatment advisers, two health improvement programme managers, and five respondents with other clinical or managerial roles.

Smokefree policies in adult mental health units

Smokefree policy and practice

Smoking was not permitted anywhere on trust premises in 34 of the 40 surveyed NHS trusts (85%). However, 18 of these trusts permitted patients to go off-site to smoke.

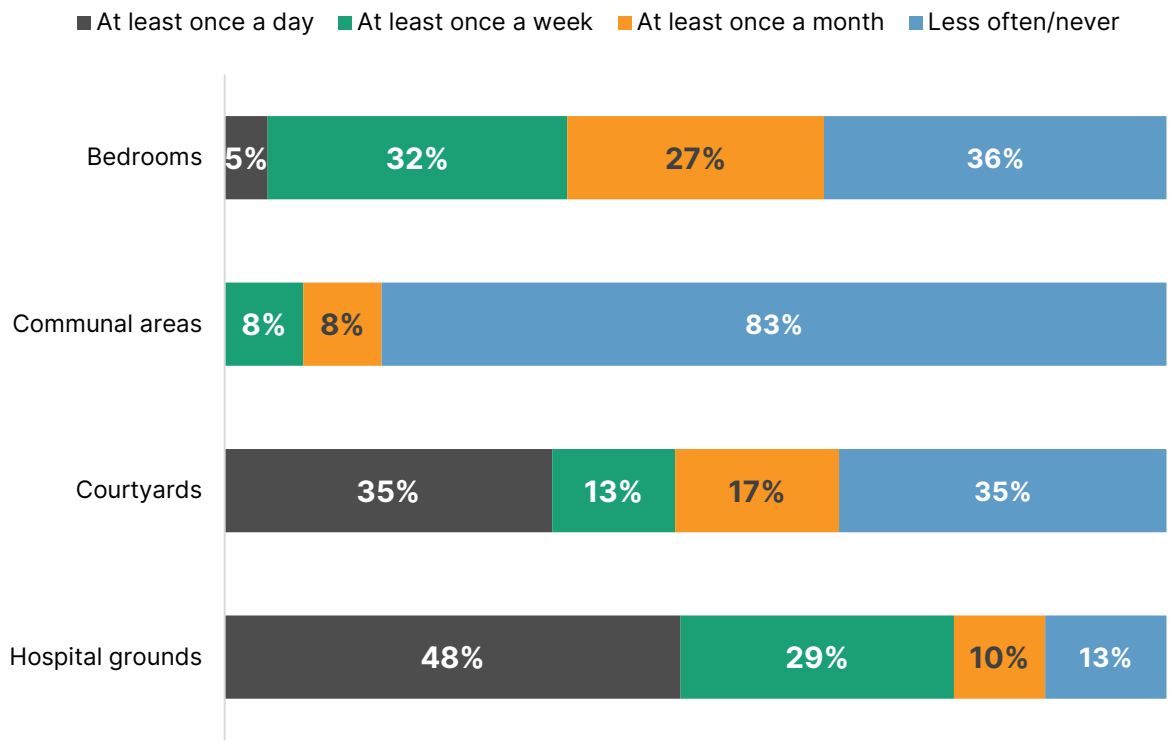
In the six trusts (15%) where smoking was permitted:

- 5 trusts permitted smoking in secure courtyards or gardens (of which 2 also permitted smoking in the grounds of the hospital)
- one trust permitted smoking only in the grounds of the hospital

To assess current practice, survey respondents were asked how often patients on an average adult mental health ward were found smoking (Figure 1). Smoking was rare in indoor communal areas but in 37% of trusts, on an average ward, patients were found smoking in their bedrooms at least every week. Smoking outside was more common:

- In over a third of trusts (35%), on an average ward, patients were found smoking in secure courtyards/gardens every day.
- In nearly half of trusts (48%), on an average ward, patients were found smoking in hospital grounds every day.

Figure 1. Frequency of smoking on an average inpatient mental health ward, reported by trust, 2024



Respondents were also asked how often, on an average adult mental health ward, staff accompanied service users on breaks where they used the opportunity to smoke. Such escorted breaks happened every day, on an average ward, in half (50%) of trusts and at least once a week in 28% of trusts. Most or all of these smoking breaks were facilitated by Section 17 of the Mental Health Act in a third (33%) of trusts.

Respondents had mixed views about whether smoking was more common on some wards than others. Acute wards and male wards were most often identified as having higher smoking prevalence (each by six respondents). Some respondents drew attention to the factors that contributed to higher smoking rates on some wards.

> "Acute wards tend to have more unwell patients who are less compliant."

> "It tends to be indicated by smoking prevalence and security type. Acute wards have highest prevalence (55% admissions identified as people who smoke). CAMHS units almost non-existent."

> "Male wards seem harder for staff to manage smoking due to concerns of violence and aggression should staff challenge men smoking."

> "Wards where they are constantly short staffed, more bank staff work, poor team dynamics. It impacts patient care."

> "Much more common on wards at sites where they do not have Tobacco Treatment Teams in place."

> "This seems to depend on leadership for the wards and senior managers."

Handling of service users' tobacco

Trusts had diverse approaches to dealing with service users' tobacco products at the point of admission (Table 1). The most common approach was for the products to be removed and stored until service users were either granted leave (42%) or discharged (30%). The three trusts that let service users retain their tobacco products during their stay all permitted smoking in courtyards and gardens.

Four respondents noted that practice can vary depending on patient classification, for example:

> "Those with unescorted leave can retrieve their products when going off site, whereas those on escorted, ground or no leave cannot access the products until leave status changes or final discharge."

> "Products are removed and sent home with carers, or they are saved in some cases and destroyed in others. Despite what policies state it depends on the availability of storage and patients' personal circumstances."

Table 1. Trust policy on handling services users' tobacco products on admission.

Policy	Trusts (n=40)
Products are removed and securely stored until service users ask for/are granted leave	17 (42%)
Products are removed and securely stored until final discharge	12 (30%)
Products are sent home with friends/family or by post	4 (10%)
Service users retain products during stay	3 (8%)
Products are removed and destroyed	2 (5%)
Trust has no policy	2 (5%)

Changes in policy and practice since 2019

Since the last survey was conducted in 2019, there has been little change in the proportion of trusts with comprehensive smokefree policies in place (Table 2). In terms of practice, there has been a decline in smoking in indoor communal areas and an increase in smoking in outdoor communal areas.

In 2019, 82% of surveyed trusts (37/45) did not permit smoking anywhere on trust premises compared to 85% (34/40) in 2024. With one exception, however, the trusts that did not have comprehensive smokefree policies in 2024 were different from the trusts that were not smokefree in 2019. Of the six trusts that were not smokefree in 2024:

- 3 had comprehensive smokefree policies in 2019 but now permitted smoking
- 1 had consistently permitted smoking
- 2 did not respond to the earlier survey

Of the 8 trusts that permitted smoking in 2019, 5 had put in place comprehensive smokefree policies by 2024, one still permitted smoking, and 2 did not respond to the 2024 survey.

Table 2. Policy and practice on adult mental health wards, 2024 and 2019

	Trusts, 2024 (n=40)	Trusts, 2019 (n=45)
Trust has comprehensive smokefree policy in place	85%	82%
Practice on average mental health ward:		
Patients found smoking in bedrooms every week	37%	48%
Patients found smoking in indoor communal areas every week	8%	41%
Patients found smoking in secure courtyards/gardens every day	35%	22%
Patients found smoking in hospital grounds every day	48%	53%
Escorted breaks with smoking at least once a day	50%	57%

Tobacco dependence treatment

Patient experience on admission

Respondents were asked to estimate how often their service users were asked about their smoking status on admission. In four fifths of trusts (82%), this happened 'always' (33%) or 'usually' (49%). Service users were asked about their smoking 'sometimes' in 13% of trusts and 'rarely' in 5%.

The proportion of trusts where patients were always asked about the smoking status on admission declined from 45% in 2019 to 33% in 2024.

Implementation of tobacco dependence treatment services

Tobacco dependence treatment services were supposed to be fully implemented in mental health trusts by April 2024. In fact, when the survey was conducted at the end of 2024, treatment services were fully implemented in 28 (70%) of the surveyed trusts. They were in place for some but not all mental health inpatients in 10 trusts (25%). There were two trusts (5%) where the service was still only in development with no progress made on implementation.

Where the service was in place for some but not all mental health inpatients, this was mainly due to the constraints of the programme of implementation and the challenges presented by different wards.

A fully implemented service did not guarantee that all patients would be offered a service. Respondents were asked what proportion of smokers admitted to mental health wards were offered tobacco dependence treatment during their hospital stay. Table 3 describes the results, broken down by whether the service was fully implemented or not.

- Two fifths of surveyed trusts (42%) offered tobacco dependence treatment to all their patients who smoked.
- Among trusts with fully implemented tobacco dependence treatment services, 54% offered this service to all patients who smoked.

Trusts that still permitted smoking were more likely to be behind in the implementation of tobacco dependence treatment services: 50% had fully implemented services, compared to 74% of the trusts that did not permit smoking, and 33% offered a service to all patients compared to 44% of trusts that did not permit smoking.

Table 3. Proportion of smokers offered tobacco dependence treatment during hospital stay

Proportion of smokers offered TDTS	All trusts (n=40)	TDTS fully implemented (n=28)	TDTS not fully implemented (n=12)
All of them	17 (42%)	15 (54%)	2 (17%)
A majority of them	16 (40%)	10 (36%)	6 (50%)
Around half of them	2 (5%)	2 (7%)	0
A minority of them	3 (8%)	1 (4%)	2 (17%)

None of them	1 (2%)	0	1 (8%)
Don't know	1 (2%)	0	1 (8%)

Survey respondents were asked to describe in their own words the factors that had inhibited and supported the implementation of tobacco dependence treatment services on adult mental health wards. The factors that had inhibited implementation were:

- Staff attitudes and beliefs
- Lack of capacity, insufficient funding, and uncertainty about future funding
- Lack of leadership
- Inadequate or poorly enforced smokefree policy
- Lack of training, and lack of time or willingness of staff to undertake training
- Inconsistent practice across wards
- Storing tobacco on site

The resistance of staff to smokefree policy was presented as a complex issue, rooted in a long-established culture of smoking and sustained by a combination of genuine worries, personal tobacco dependence, lack of training, and persistent misinformation. Respondents cited examples of challenging views held by staff including the belief that smoking is a human right, that banning smoking is cruel, that now isn't the right time to make people stop, that smoking serves a therapeutic purpose and taking it away will increase aggressive/violent behaviour.

> "Attitudes of patients and some staff towards being smoke free can be challenging. Some staff find it difficult to challenge smoking on site due to fear of confrontation and/or aggression from patients."

> "Staff views, culture, own smoking habits, staff not implementing the policy. Need to improve ownership and adherence of the policy within clinical teams."

> "Opinions and personal perceptions of smoke free in mental health. We are often told it is unfair or makes mental health worse which we know is not the case. Also individuals with these perceptions will (knowingly or unknowingly) resist or sabotage efforts to implement the service."

> "Negative attitudes of some staff towards smoke free premises policy. Misinformation regarding use of treatment aids (specifically vapes) has been unhelpful. Lots of myth busting needed."

> "Some challenges are cyclic: there is still a constant need to remind staff about why this work is needed, and the work is not over. New staff are employed all the time. People transfer from other trusts and poor practice creeps in, training for nurses/medics pre-qualification is poor or

> non-existent, social media messages and documentaries push out poor messages that contradict evidence base for treatment options."

Given the scale of this challenge, capacity has been a major issue for some tobacco dependence treatment services:

> "Resources: we have 40+ mental health inpatient wards. The allocated funds have not been sufficient for all the work that has been needed to implement across the Trust."

> "Severe staff shortages are a significant barrier. For example, there are only two members of the tobacco dependence treatment team working across three sites looking after over 23 wards. The capacity to provide adequate tobacco dependence treatment or sufficient training to staff is highly constrained."

Lack of security about future funding was also identified as an inhibiting factor, not least where progress was being made:

> "Initially staff were the biggest barrier to accessing wards and supporting patients but since staff clinics were established this has 'opened the door' for the advisors to visit and support patients and staff in the ward environment. Those patients who are extremely unwell always pose a challenge to enabling discussion re smoking but the new QuITT initiatives developed by the Trust are showing promise in improving such engagement. Funding for 2025 onwards is a significant barrier as staff have already left due to the uncertainty of their jobs."

The factors that had enabled implementation of tobacco dependence treatment services were principally:

- Institutional support including leadership, funding, strong smokefree policy, governance, and consistent messaging
- The commitment and presence of dedicated tobacco dependence treatment advisers
- Engagement with wards and staff, provision of information and resources, staff training, and nurse/adviser prescribing of NRT
- Provision of vapes
- Staff and patient involvement in policy development
- Support and funding from ICBs and partnerships with local authorities, academics and NGOs
- Networking among mental health trusts

Dedication from tobacco dependence teams and engagement with staff are common features of the following examples:

> "Leadership and ongoing corporate support. Dedication and passion amongst the small team of tobacco dependency treatment advisors. Tobacco dependency treatment advisors investing in forming relations with ward teams."

> "Visible presence of service and building rapport with all. Training for staff and drop-in 'chill and chat' sessions for service users and staff. Rewritten policy, policy on a page, and resource packs for the wards. Advisers can prescribe NRT, free vapes, all treatments available. Quit kits, resources displays, posters, leaflets. Dedicated long term plan funding. Knowledge of working with the different service users groups and variance in illness & stage of admission. Good working relationship with vape provider."

> "1. A unified voice from all clinical staff has been instrumental in promoting the importance of tobacco dependence treatment. This has allowed the patients to receive cohesive support. 2. Engaging staff in the process has been pivotal. Their involvement has fostered ownership and has facilitated treatment protocols such as nicotine replacement therapy, to effectively integrate into patient care. 3. My team has provided comprehensive training on NRT, emphasising the importance of initiating treatment at the earliest opportunity, ideally at the point of admission. This has also enhanced staff confidence. 4. Vaping has played a significant role in supporting patients to transition away from smoking. This has made it possible for patients to have a fall- back option while we maintain a focus on harm reduction."

As this last example demonstrates, successful implementation was most likely when all the key enabling factors were in place: leadership, staff engagement, capacity in the tobacco dependence team, and readily available alternatives to smoking.

> "Financial support in place for our smokefree programme to operate. Support from senior leads and management in acknowledging the importance of a smokefree support programme. Full-time smokefree advisors in position dedicated to tackling smoking. Approved PDG and policy paper in place."

> "Service user engagement and feedback. Staff involvement in the implementation via a mobilisation group. Having a full established team of Tobacco Dependence Advisers. Clear leadership and process, training, and co-monitoring. Introduction of vapes as an additional treatment offer to NRT."

Ten respondents specifically mentioned the importance of funding and support from their ICB.

> "Without the support of our local ICB regional lead, none of this would have been possible."

> "Excellent support from our ICB with project management. Good engagement from operational and quality leads including service managers and Matrons. Collaboration with the RCP QuITT collaborative has also been helpful, including networking opportunities with other Trusts."

Provision of support, advice and pharmacotherapy

More than four in five trusts (82%) employed dedicated practitioners to provide tobacco dependence treatment to smokers in mental health wards. Frontline staff also played an important role (Table 4). The number of trusts employing dedicated practitioners has almost doubled since 2019, when 44% of trusts utilised dedicated smoking cessation workers.

All but two trusts relied on trained staff to provide support, a combination of dedicated advisers, frontline staff and/or pharmacy technicians. The two remaining trusts fell back on frontline staff who had no specific training in smoking cessation. These were the two trusts where the service was still in development and had not been implemented. One respondent noted the limitations of training frontline staff and the value of dedicated staff:

> "Previously trained ward staff to deliver support. This approach was very inconsistent and added to staff workload. Not successful. New approach with dedicated TTD team much more successful - consistent approach, over 30 x successful 4-week quits after 6 months."

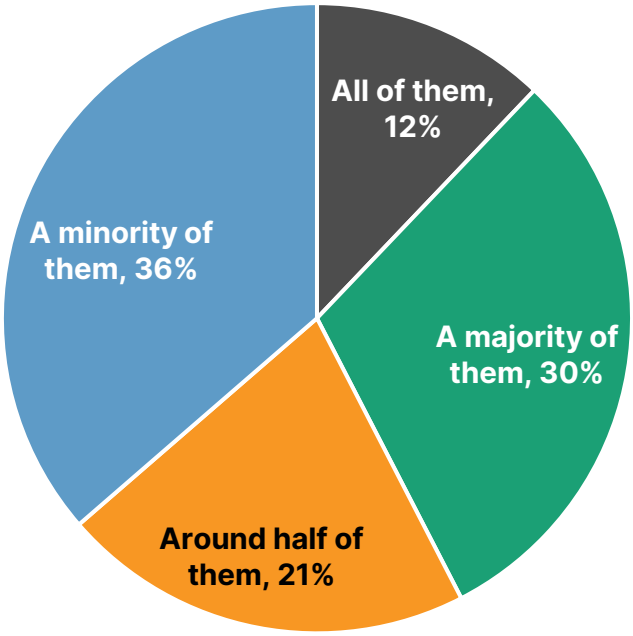
Figure 2 describes the extent to which frontline staff working with mental health inpatients were trained in providing Very Brief Advice on smoking cessation. Overall, 42% of trusts had trained over half of their staff in providing VBA.

All surveyed trusts offered smokers nicotine replacement therapy. However, only a minority offered generic varenicline (15%), Cytisine (13%) or Bupropion (8%). Generic varenicline was removed from the market in October 2021 and reintroduced in August 2024. This period off the market has clearly affected its availability: in 2019, 49% of trusts offered varenicline compared to 15% in 2024.

Table 4. Providers of tobacco dependence support to patients on mental health wards

Type of advisor	Trusts
Dedicated tobacco dependence/smoking cessation practitioners/ advisers	33 (82%)
Frontline staff who are trained to support service users through a quit attempt or period of abstinence	12 (30%)
Frontline staff who are not specifically trained in smoking cessation support	12 (30%)
Pharmacy technicians	4 (10%)

Figure 2. Proportion of frontline staff working with mental health inpatients who are trained in providing Very Brief Advice on Smoking Cessation ('don't know' responses excluded)



Stop smoking support for staff

In less than half of the surveyed trusts (46%), staff were able to access some form of stop smoking support within the trust. Elsewhere, staff were referred to the local community stop smoking service or Smokefree App.

> "Anyone based at our hospital can access 12 weeks support including free NRT or up to 1 month of free vapes alongside support."

> "Trust tobacco dependence treatment team provides support to staff - interventions, NRT and/or Swap to Stop vapes. NRT also available for temporary abstinence."

> "Commenced trust-wide staff clinic support 2 years ago. In 2023/24 over 400 staff have accessed for support to quit. Only e-cigarettes are available not NRT."

> "Swap to stop open to staff. Resources on our intranet."

Vaping

Policy on the use of vapes

All surveyed trusts permitted their adult mental health inpatients to use vapes. They were permitted for all adult patients, subject to risk assessment, except in one trust where their use was restricted to rehab patients.

> "The only time these are restricted is when they are misused and this is based on individual risk assessment."

Policy on where vapes could be used varied:

- 14 trusts (35%) restricted vaping to outside areas
- 26 trusts (65%) also allowed vaping inside, but this was usually restricted to private bedrooms
- Only 3 trusts (8%) permitted vaping in communal areas

Three respondents commented that, in practice, it was difficult to prevent patients from vaping in indoor communal areas. Vapes brought other challenges too:

> "This requires constant review and attention as different challenges present: THC Vapes, illegal NR vapes, plus the fire risk, vaping in non-designated areas, and different staff opinions."

Provision of vapes

Over three quarters of trusts (78%) provided vapes free on adult mental health wards but this was often for a limited period.

> "Service users are provided with 14 single use vapes on admission."

> "Given one free vape on admission."

> "Provided free for 3 days then patients continue to buy their own unless they set a quit date. If they do, the tobacco treatment advisers can provide 1 month of vapes free of charge."

Patients' other sources of vapes were:

- friends and family (68%)
- buying from shops off-site (65%)
- buying online with delivery to the ward (50%)
- buying from wards, vending machines, and hospital shops (50%)

The two main brands of vapes that were available free or to buy on adult mental health wards were E-burn and Dinner Lady.

Most of the surveyed mental health trusts (83%) purchased vapes directly from the relevant companies or from a local supplier. Four (13%) used the Crown Commercial Services procurement platform (OTG or Unite). One trust relied on the ICB for provision of vapes. A third of trusts (33%) had also obtained vapes through the national Swap to Stop scheme.

Types of vapes permitted

Disposable vapes were the leading technology used on adult inpatient mental health wards, permitted by all but one of the surveyed trusts (97%). The exception was a trust that had already shifted to other types of vapes in advance of the June 2025 ban on disposables.

Table 5 describes which types of vapes were permitted among surveyed trusts. Overall, 18 trusts (46%) allowed patients to use all the types listed in Table 5, though their use was constrained by individual risk assessments and other practical considerations:

> "All types are permitted though personal devices are assessed before being allowed (individual care-plan restrictions will apply). Tobacco dependence advisers support ward staff to assess suitability. In some areas, such as the forensic setting, only certain types, such as pods, are allowed."

> "E-cigarette policy allows all vapes, including tank and refillable types, however there is no process that allows rechargeable vapes on the wards so we only have disposables."

Table 5. Types of vapes permitted on adult mental health wards

Type of vape	Trusts (n=39)
Disposable vapes (non-rechargeable)	38 (97%)
Vaping devices that use a replaceable prefilled cartridge or pod (rechargeable)	26 (67%)
Vaping devices with a tank that is refilled with liquids (refillable)	19 (49%)

The potential impact of the ban on disposable vapes

Over two thirds of respondents (69%) said that the June 2025 ban on disposable vapes would affect their service for mental health patients. However, around half of these respondents indicated that their trust was making plans for the change.

Disposable vapes were perceived to be an effective option for this client group, especially for adults who were newly admitted or acutely unwell. They also presented fewer potential safety hazards than more complex products.

> "Disposable vapes are helpful for initial use when patients are first admitted. Some patients struggle with pod systems and some are not suitable due to risk assessment."

> “Disposable vapes really help our service users reduce their smoking. We are working with the company to support us on what devices we can use after the ban of disposable vapes.”

There were cost implications of the change for both patients and wards, alongside practical issues of how the new devices would be made available.

> “Patients who can only afford single vapes will not be able to afford the rechargeable ones.”

> “The main problem is how patients will be able to access pre-filled vapes on site and at a reduced price. The vending machines on our sites only dispense E-burn which have kept prices low since 2017. The Swap to Stop scheme should be extended to psychiatric wards, considering the needs of patients who are acutely unwell and not ready to abruptly quit smoking. Some have no leave, no money or access to their money, others have no family to bring them their vapes.”

> “Removal of a vending machine providing vapes. Unsure of the right type vapes to offer to patients. Risk issues are raised from other forms of vapes such as refillables or pod systems that could be swallowed. Other issues of charging, and lack funding available.”

There was also some concern that the change could make the transition from tobacco products harder for patients.

> “We have already procured a rechargeable device to roll out. However, in regards to preferences within this population, we are anticipating that this will affect their willingness to use vapes as an alternative to tobacco use.”

Stop smoking support after discharge

On discharge, 83% of surveyed trusts offered patients referral to local community stop smoking services. Community pharmacy, GPs and the Smokefree app were also identified as options. However, two fifths of trusts (39%) offered ongoing support from the in-house tobacco dependency treatment service, often as an alternative to referral to the community service. Respondents noted the benefits of maintaining support from a dedicated mental health team.

> "Referral pathways are available but very seldom do smokers request referral to community services. Following the success of our recent QuITT improvement work a number of patients have requested support from the team of advisors and therefore we are able to offer telephone support and a pilot for home visit support is taking place."

> "We offer a transition service for up to 12 weeks by the tobacco dependence advisers that have been working with inpatients. If the discharged person would rather work with a local authority service, then they are referred."

> "We are a pilot site for a community tobacco dependency service. Which has been amazing. So many of our patients have tried the local services but they are not suitable for them. Our community tobacco dependency service has been a lifeline for some as our tobacco dependency advisers visit their homes to conduct the interventions."

Three fifths of surveyed trusts (61%) provided some form of support to community mental health services to help their users quit smoking (Table 6).

Table 6. Support offered to community mental health services to help their users quit smoking

Form of support offered	Trusts (n=39)
Trains practitioners in community mental health teams in smoking cessation	14 (36%)
Supplies stop smoking medication	11 (28%)
Supplies vapes	11 (28%)
Runs its own community stop smoking clinics	9 (23%)
Funds worker/s within local stop smoking service	1 (3%)

Patient involvement

In two thirds of the surveyed trusts (67%), patients had been involved in the development of smokefree policy and/or tobacco dependence treatment services. A further 13% of trusts were planning patient involvement.

Several respondents described approaches that relied on user representation on steering groups.

> "Service users currently sit on the Reduced Harm from Smoking steering group and were part of the tobacco dependence treatment service implementation group. We plan to further include them in all aspects going forward."

> "A representative of the local Mental Health Forum is member of Treating Tobacco Dependence development group. Consults with peer group on policy and other aspects of tobacco dependence treatment."

> "We have used people with lived experience at many points of this work, including patient representative on our smoke free committee."

Alternatively, patient groups or representatives were consulted at key moments in policy development:

> "Before the policy was ratified, we sought feedback from Experts by Experience."

> "At service user groups, community meetings, we have included feedback from service users on the suitable vapes required inpatient settings."

Respondents also described ward-based discussions and surveys, and direct feedback through daily patient contact.

> "Through Experts by Experience groups, patient council meetings, peer support workers and patient surveys, we have managed to gather patients' thoughts and concerns while designing the service and the policy."

> "Smokefree advisors are able to discuss and record information made by patients regarding all aspects."

The ambition and range of patient involvement varied greatly between trusts. In the following example, involvement of patients was linked to wider involvement with staff and the wider community:

> "We have involved inpatients, outpatients, staff at all levels, carers and families, local GPs and hospitals. We have involved and consulted even with the local community and neighbours of the trust."

Current challenges

At the end of the survey respondents were asked to describe the current challenges they faced. Their responses reiterated and expanded upon the issues identified earlier in this report, especially hostile staff attitudes and inadequate funding.

> “Staff attitudes, beliefs and values - culture! We can have the best service in the world and deliver all the training going, but whilst staff still believe that ‘it is the patient's right to smoke, and it's not the right time to make them stop’ we are fighting an uphill battle. We know it takes years to shift culture, but it is very disheartening.”

> “Lack of engagement by inpatient clinical teams. Smoking is seen as lowest of all competing priorities. Staff often don’t screen smoking status (left for tobacco dependency team to do). Escorted/facilitated smoking in a culture where ‘banning’ smoking is seen as cruel, unkind, or a restrictive measure. Section 17 leave for numerous ‘fresh air’ breaks when everyone knows that the real purpose is to allow smokers out to smoke. There is a commitment at senior and Exec level to being smokefree, but this does not easily translate to clinical implementation.”

Negative staff attitudes at all levels of the organisation inhibited the work of promoting smokefree environments:

> “Staff culture: staff believe smoking is the patient's human right therefore we cannot take it away from them. Consultants think it is better for patients to smoke therefore do not support the work we do. Funding is limited. Training is not mandatory, there are no consequences for not following the Tobacco Free policy. Huge resistance from other teams such as health and safety, fire safety, estates. Within the Tobacco Free Steering group, it is expected that the tobacco dependency lead does all the work. Very few staff turn up to the steering group, hard to communicate messages and have consistency across the trust.”

The lack of consistency of commitment and practice across the organisation was identified as a challenge by other respondents:

> “Consistency is really difficult to maintain, and we struggle with middle managers who have personal opinions and perceptions against the smoke free policy. If the managers are not on board, then we struggle significantly with the staff on the ward.”

Funding was also a prominent concern in respondents’ descriptions of their current challenges:

> “Funding has been the main issue. There is a growing recognition that things need to change, but resource is too tight.”

> “Funding allocations to trusts to deliver tobacco dependency treatment services do not allow for all elements of the NHS Long Term Plan ambition to be achieved. This includes the ambition for all patients who smoke to be seen and offered support within 24 hours of admission. The funding allocation does not allow for a 7-day service in our experience.”

> "Funding is the most significant barrier. Should the ICB stop funding (which we believe they will in April 2025) we will only have approximately £105K national funding but the costs of the service for staffing and treatment is £300K. The advisors work really hard to provide quality improvements for patients and staff who smoke but are concerned that if funding is reduced next year they will be redeployed back to jobs as HCAs onwards. We are currently working as a team with 2 vacancies as no staff are willing to apply for a position with the team due to the fixed term nature of the posts."

Two respondents identified the importance of funding in addressing the inequalities experienced by this client group.

> "To meet the aims of the NHS Long Term Plan for mental health inpatients, more funding needs to be invested. The prevalence, comorbidities, and inequalities need to be addressed."

> "The funding for this service needs to continue in order to reduce the health inequalities of our patient population."

Several respondents made specific recommendations for the system as a whole:

> "More resources and a national policy framework would significantly help."

> "There needs to be more mandatory elements to smoke free across mental health trusts. For example, there should be some CQC targets or expectations that can be measured on inspection. This would make Trusts take it more seriously. There also needs to be more work in changing perceptions that smoking helps with mental health and education for HCA/NA level staff."

> "I hope the results from this survey can promote positive changes to smokefree policies in mental health settings. But I also think this exercise should be follow-up with a proper consultation with patients and staff who are directly affected by the unintended consequences of such policies. I feel that we can still get the practices around this policy right before it becomes a mandate."

> "Smoking cessation funding should be extended to community mental health services/charities as discharged patients are likely to access support through services which are familiar to them and less anxiety

> provoking. Also, for patients with learning disabilities, hearing disabilities, etc., the sessions need to be tailored to their needs (e.g. easy reading materials, sign language or interpreters). Local stop smoking services are not equipped with adequate skills and resources."

Discussion

Both the quantitative and the qualitative findings presented in this report describe a diversity of experience in the efforts of NHS mental health trusts to implement smokefree policies. At one extreme, there are two trusts that have barely begun: they do not have working smokefree policies in place, patients are permitted to smoke in outdoor spaces, and tobacco dependence treatment services are non-existent. In contrast, there are many more trusts that have comprehensive smokefree policies in place, do their best to prevent smoking in all indoor and outdoor spaces, and offer tobacco dependence treatment to all adult mental health inpatients.

Every trust has faced enormous challenges in trying to radically change a culture where, for decades, smoking was accepted. Although there is now clear evidence that smoking exacerbates rather than relieves mental ill health[6], the task of communicating this evidence to frontline staff and changing practice has been onerous. Nonetheless, progress has been made, especially in those trusts that have enjoyed strong leadership, effective engagement with staff, sufficient resources and capacity, and a range of alternatives to smoking including e-cigarettes. The most optimistic responses to the survey were from respondents who had not only witnessed a shift in attitudes among staff but also significant numbers of patients quitting smoking. Although the survey did not ask specifically about the Royal College of Psychiatrists' QuITT programme, several respondents drew attention to the benefits that this programme had brought.

If change can happen, why has it been so difficult to achieve in some trusts? There is nothing new in the answer to this question: lack of leadership, lack of resources and capacity, and resistance from staff at all levels of the organisation. These were also the barriers to implementing smokefree policies identified in the 2019 survey of mental health trusts in England[7].

Progress since 2019 has been mixed. There has been little change in the number of mental health trusts with comprehensive smokefree policies in place, patients on mental health wards are still regularly found smoking inside and outside, and staff continue to accompany patients on smoking breaks. Section 17 leave is routinely used to facilitate smoking breaks offsite, despite CQC guidance stating that doing so undermines the 'principles of the duty of care to protect health'.[8] Smoking in communal areas has, however, shifted outdoors.

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[6] Wootton R, Sallis H, Munfo M. Is there a causal effect of smoking on mental health? A summary of the evidence. University of Bristol 2022.
[7] Progress towards smokefree mental health services. Findings from a survey of mental health trusts in England. ASH, 2019
[8] CQC. **Brief guide: Smokefree policies in mental health inpatient services**. 2023

The main positive change since 2019 has been the roll-out of tobacco dependence treatment services in adult mental health units. All but two of the surveyed trusts had fully (70%) or partially (25%) implemented tobacco dependence treatment services and four fifths of trusts had dedicated tobacco dependence treatment advisers working on the wards. These advisers have played an important role not only in supporting patients with tobacco dependence but also in engaging with staff and enabling smokefree policies.

However, even among trusts that had fully implemented tobacco treatment services, over half could not provide services to all patients with tobacco dependency. This lack of full coverage may in part be explained by a lack of funding for tobacco treatment services in mental health settings, compared to other healthcare settings. FOIs submitted by ASH found that in the funding year 2023/24, funding for tobacco treatment services in mental health settings fell by 17%. This compares to a 55% increase in maternity settings and no change in funding for acute settings.[9] Mental health wards will struggle to offer comprehensive stop smoking support to patients if funding for these services is continuously deprioritised.

The June 2025 ban on disposable vapes presents another challenge to mental health trusts. Many of the surveyed trusts were planning for the change and one trust had already made the transition and had removed disposables from the wards. This is encouraging, given how important vapes have been to enabling abstinence from tobacco in mental health wards. However, many trusts had not begun planning for the change despite the upcoming ban. Further guidance is urgently needed from NHSE, DHSC and DEFRA to support trusts to transition from disposable vapes without disrupting smokefree policies.

The increase in tobacco dependence treatment capacity in mental health inpatient settings has not been matched in community settings, meaning that many patients are at risk of losing access to support at the point of discharge. Although most trusts offered patients referral to community stop smoking services, two fifths also offered ongoing support from their tobacco dependence treatment advisers, who were seen as offering a more appropriate service to this patient group. The capacity of tobacco dependence treatment teams to take on this role may however be limited, given the size of their task for the inpatient population.

In summary, the ASH survey found that some trusts have been proactive, determined, and innovative, whereas others have struggled to even begin the process of change. This has created an inequality which may increase without sustained investment in tobacco dependence treatment in NHS mental health trusts. The expectation that hospital sites will become smokefree by law in the years following the enactment of the Tobacco and Vapes Bill makes this even more urgent. Investment should be backed up by a national strategy to reduce the disproportionately high smoking rates among people with mental health conditions.

[9] ASH and Cancer Research UK. **Integrated Care Boards and tobacco control: making good progress. Findings from a survey of Integrated Care Boards, an analysis of Joint Forward Plans, and data from tobacco dependence treatment funding services**. August 2024