Progress towards smokefree mental health services

Findings from a survey of mental health trusts in England

Action on Smoking and Health, October 2019

Commissioned by Public Health England

Contents

Key findings and recommendations

Highlights

The target in the Government's Tobacco Control Plan was for all mental health trusts to implement comprehensive smokefree policies by 2018. By April 2019, 82% of trusts who responded to the survey had a fully comprehensive smokefree policy in operation.

All trusts offered nicotine replacement therapy (NRT) to their patients but only 47% offered the choice of combination NRT or varenicline.

The use of e-cigarettes by some or all patients was permitted in 91% of trusts.

Significant staff time was spent supporting smoking: staff accompanied patients on smoking breaks every day in 57% of surveyed trusts.

Two fifths (42%) of surveyed trusts had experienced conflicts between their own smokefree policy and the policy or practice of neighbouring or host trusts.

Methods

Findings are from an online survey of mental health trusts in England with an 83% response rate (45 out of 54 trusts responded in full).

Smokefree policy implementation

Four fifths (82%) of surveyed trusts had a comprehensive smokefree policy in operation prohibiting smoking on wards and hospital grounds[*].

The remaining fifth (18%) of surveyed trusts still permitted smoking in ward courtyards or in designated areas on the hospital grounds.

The most commonly identified enablers of smokefree policy were leadership, staff support, e-cigarettes and training.

The most commonly identified barriers to smokefree policy implementation were staff resistance, patient resistance, lack of senior management leadership and insufficient resources.

Recommendation

1. Mental health trusts that have yet to implement comprehensive smokefree policies should do so at their earliest opportunity. If additional support is needed, they should seek guidance and support from Public Health England, NHS England and trusts where such policies are established and working well.

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[*] In May 2019 initial findings from this survey were provided to PHE and DHSC to track the Tobacco Control Plan ambition (Survey of smokefree implementation in NHS mental health trusts in England). The results were framed to enable comparison with a similar survey of acute trusts which designated trusts as being 'smokefree or substantially smokefree' if they scored five or more points on a seven-criteria scale. This analysis found 70% of mental health trusts to be 'smokefree or substantially smokefree' compared to 63% of acute trusts. The core finding in the fuller analysis presented here is that 82% of mental health trusts have a comprehensive smokefree policy in operation. This is a single indicator, not a compound measure, and unlike the earlier report does not include survey non-responders in the baseline

Smokefree sites in practice

Noncompliance with smokefree policy was universal: all surveyed trusts reported smoking on site though this was much less frequent in some trusts than in others. In trusts with comprehensive smokefree policies in operation:

- patients were found smoking in their bedrooms or bathrooms at least every week in 48% of trusts
- patients were found smoking in ward courtyards every day in 22% of trusts
- staff accompanied patients on smoking breaks every day in 57% of trusts
- Section 17 leave was used to facilitate smoking breaks in 86% of trusts

Problems arose at trust boundaries:

- all but one of the surveyed trusts reported problems with cigarette littering on their boundaries
- 42% of surveyed trusts had experienced conflicts between their own smokefree policy and the policy or practice of neighbouring or host trusts

Recommendations

2. Mental health trust managers and smokefree leads should work with ward managers and staff to audit and reduce the time spent by staff escorting patients on smoking breaks.

3. Trusts should ensure that Section 17 leave is not improperly used to facilitate smoking.

4. NHS acute trusts that host mental health trusts on their grounds should work with them to ensure that comprehensive smokefree policies are consistently implemented across all NHS premises, including at trust boundaries.

Treatment for tobacco dependence

Most but not all of the surveyed trusts (93%) provided on-site support for tobacco dependence:

- 84% of trusts had trained frontline staff
- 44% of trusts employed dedicated smoking cessation workers
- 29% of trusts had a dedicated smoking cessation service

All trusts offered nicotine replacement therapy (NRT) to their patients but only 47% offered the choice of combination NRT or varenicline.

In 55% of trusts, patients were not always asked their smoking status on admission.

In 51% of trusts, local authority funded community stop smoking services were not available to people with mental health conditions on discharge in some or all of the local authorities covered by the trust.

Three fifths of trusts (62%) have made some investment of their own in community stop smoking support.

Recommendations

5. Smoking status should be routinely and consistently asked and recorded on patients' admission to acute mental health services.

6. Effective treatment and support for tobacco dependence should be made available to inpatients from the point of admission onwards.

7. As a minimum, all trusts should ensure that staff who have had at least two days of face-to-face training in smoking cessation are available to support smokers throughout their stay.

8. Trusts should offer both combination NRT and varenicline to inpatient smokers, with behavioural support, to give them the best possible chance of quitting.

9. Local authorities should work with mental health trusts to ensure that people with mental health conditions in the community can access appropriate specialist support to enable them to quit smoking or successfully abstain when necessary.

E-cigarettes

In 91% of surveyed trusts, some or all inpatients were permitted to use e-cigarettes.

- 47% of surveyed trusts allowed all types of e-cigarettes to be used
- 31% of surveyed trusts only allowed the use of non-rechargeable, disposable devices

All but one trust restricted where e-cigarettes could be used.

- 44% of surveyed trusts allowed the use of e-cigarettes indoors
- three quarters (76%) of surveyed trusts allowed the use of e-cigarettes in ward courtyards

Two fifths (42%) of surveyed trusts provided e-cigarettes free to their patients.

Recommendations

10. Mental health trusts should consider how best to utilise e-cigarettes in acute settings to reduce the harm of smoking.

11. Where e-cigarettes are not available on site, trusts should consider taking steps to make them available.

Introduction

In 2016 the *Five Year Forward View for Mental Health* recommended that all inpatient mental health services should be smokefree by 2018.[1] The following year, the Government's Tobacco Control Plan set out a commitment to implement comprehensive smokefree policies, including integrated tobacco dependence treatment pathways, in all mental health services by 2018.[2] Core guidance for this task includes NICE PH48, *Smoking: acute, maternity and mental health services*[3] and the guidance published by Public Health England.[4]

This report presents the findings of a survey of mental health trusts in England conducted by Action on Smoking and Health (ASH) for Public Health England in the spring of 2019. It offers an assessment of the extent to which the Government's 2017 objective has been achieved. It describes both the extent to which smokefree policies have been adopted and the reality of local practice in delivering these policies.

This study is informed by a 2018 pilot study, funded by Cancer Research UK,[5] which combined an online survey with in-depth interviews. The qualitative insights from this study remain relevant to the current study. Smokefree leads, ward managers and nurses all expressed commitment to smokefree policy and valued the changes they had seen including the improvements in patients' health and wellbeing and the cleaner, healthier working environment. But they also acknowledged that the journey to being fully smokefree was long and beset by obstacles, not least the resistance to change expressed by staff and patients alike. Winning the hearts and minds of staff, patients and families was a common concern.

These journeys are ongoing. Although smokefree policy is now well established in some mental health trusts, others still have much to do to normalise smokefree practice for staff and patients alike. This new study describes how far trusts have come, and how much has been achieved, while also establishing indicators to track further progress in the years ahead.

Methods

The questionnaire was based on the instrument used for the 2018 pilot study but was simplified to reduce completion time and improve the response rate.

The survey was conducted online using Survey Monkey. Smokefree leads and other contacts in 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 January to April 2019.

> *Local experience*
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> *Survey participants were invited to describe examples of good practice in implementing smokefree policy that they would like to share. The free-text responses to this question are included in sidebars throughout this report.*

Forty-five valid responses were received representing 83% of the 54 mental health trusts in England with inpatient services (the Tavistock and Portman NHS Trust was excluded as it has no inpatient services). Data were analysed using SPSS Version 23.

Of the forty-five participants in the survey, 34 (76%) identified themselves as the smokefree lead for their trust. Of the eleven who did not, eight described themselves as supporting local smokefree work in various ways such as co-ordinating a smokefree working group, supporting an executive lead or participating as a member of a working group. One respondent noted that the smokefree lead role no longer existed as smokefree policy was now 'business as usual'.

Smokefree policy implementation

Key findings

Four fifths (82%) of surveyed trusts had a comprehensive smokefree policy in force prohibiting smoking on wards and hospital grounds.

The remaining fifth (18%) of surveyed trusts still permitted smoking in ward courtyards or in designated areas on the hospital grounds.

The most commonly identified enablers of smokefree policy were leadership, staff support, e-cigarettes and training.

The most commonly identified barriers to smokefree policy implementation were staff resistance, patient resistance, lack of senior management leadership and insufficient resources.

Recommendation

Mental health trusts that have yet to implement comprehensive smokefree policies should do so at their earliest opportunity. If additional support is needed, they should seek guidance and support from Public Health England, NHS England and trusts where such policies are established and working well.

Comprehensive smokefree policies

Mental health trusts in England have made significant progress towards achieving the Government's target of implementing comprehensive smokefree policies.

Forty-two of the 45 surveyed mental health trusts had an active smokefree policy at the time of the survey. Two trusts reported that their policies were still in development and one trust had suspended its policy.

Eight trusts, including the three without active policies, permitted smoking on NHS premises. Hence, overall:

- 37 trusts (82%) had comprehensive smokefree policies prohibiting smoking on all NHS premises

Of the 8 trusts that permitted smoking:

- 6 trusts (13%) permitted smoking in ward courtyards, of which two also permitted smoking on hospital grounds beyond the wards
- 2 trusts (4%) permitted smoking in designated areas on hospital grounds beyond the wards

Forty-one trusts (91%) had installed 'no smoking' signs on site. Of the four that had not done so, three were among the eight trusts that permitted smoking in some areas.

Local experience

"The implementation of the policy is most effective where it is enabled by the proactive work of ward managers and staff. Engagement of frontline staff in developing their own approach, within the general guidance of the policy, encourages ownership of the issue (problems and possibilities). When patients are receptive to these changes, staff are more motivated to keep going."

"On the initial stages all the planning was done with a local service user group which really helped to sell the message in a positive way."

Enablers and barriers

Survey participants were asked to describe in their own words what had been the greatest enabler of smokefree policy implementation in their trust, and what had been the greatest barrier.

The most commonly cited enablers were:

- leadership, including senior executive support, dedicated project leads, and dedicated project teams
- staff support, including frontline champions
- allowing e-cigarette use
- training, including Making Every Contact Count, Very Brief Advice, and Level 2 training

Other enablers identified by survey respondents included a consistent approach, good communications, patient consultation, dedicated smoking cessation support, and support from external partners such as the local stop smoking service.

The most commonly cited barriers were:

- staff resistance, including lack of leadership by role models such as consultants and ward managers
- patient resistance
- lack of senior management leadership
- insufficient resources and capacity

Other barriers identified included inconsistent approaches within the organisation, poor access to e-cigarettes, the difficulty of policing compliance, and a lack of smoking cessation support in the community.

Local experience

"Consistent messages and management of policy implementation are critical. It just takes one small group of staff to not support the policy due to their own beliefs for challenges to arise. In these cases assertive leadership is vital. We have had the benefit of joint initiatives between our local authority 'wellbeing service' in providing training, support, literature and consulting on policy development. This has been invaluable."

"Good, positive stories were shared with all clinicians through The Health Promotion Newsletter. Problem-solving event took place last year. Nicotine Management Group Meeting helps with implementation of the smokefree policy. The NRT bite size teaching sessions are available for the staff and doctors and continuously running around all localities."

"Capturing the voice of patients regarding the smokefree policy and working in partnership with patients through their Patient Experience Groups."

Smokefree sites in practice

Key findings

Noncompliance with smokefree policy was universal: all surveyed trusts reported smoking on site though this was much less frequent in some trusts than in others.

- patients were found smoking in their bedrooms or bathrooms at least every week in 48% of trusts
- patients were found smoking in ward courtyards every day in 22% of trusts
- staff accompanied patients on smoking breaks every day in 57% of trusts
- Section 17 leave was used to facilitate smoking breaks in 86% of trusts

Problems arose at trust boundaries:

- All but one of the surveyed trusts reported problems with cigarette littering on their boundaries
- 42% of surveyed trusts had experienced conflicts between their own smokefree policy and the policy or practice of neighbouring or host trusts

Recommendations

Mental health trust managers and smokefree leads should work with ward managers and staff to audit and reduce the time spent by staff escorting patients on smoking breaks.

Trusts should ensure that Section 17 leave is not improperly used to facilitate smoking.

NHS acute trusts that host mental health trusts on their grounds should work with them to ensure that comprehensive smokefree policies are consistently implemented across all NHS premises, including at trust boundaries.
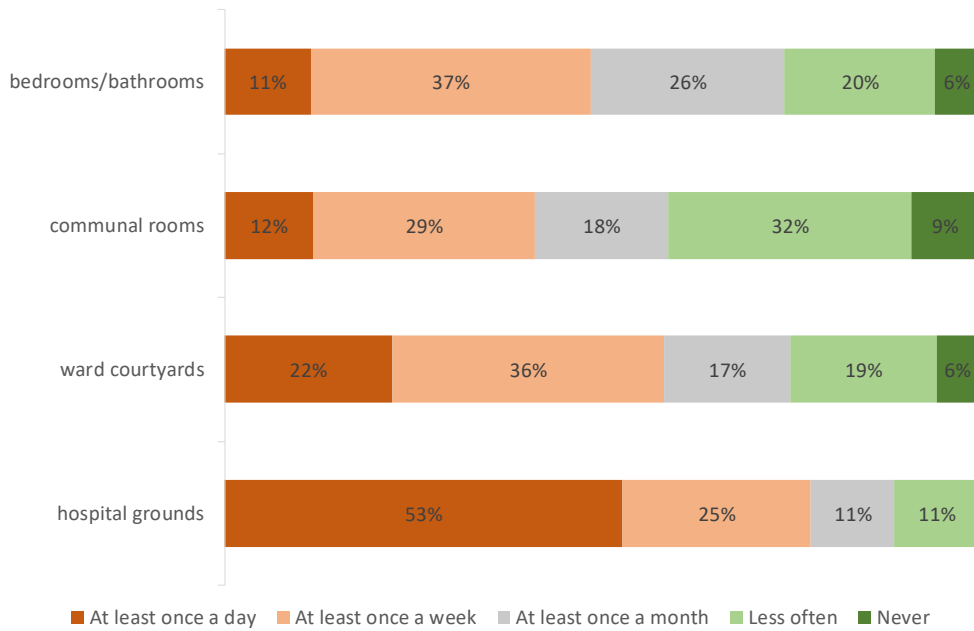
Smoking on mental health trust premises

The surveyed trusts reported diverse experiences of noncompliance with their smokefree policies but, without exception, all reported some smoking on their NHS premises.

Survey participants were asked to estimate how often patients on an 'average' adult mental health ward were found smoking in their bedrooms, in communal rooms, in ward courtyards and in the wider hospital grounds beyond the wards. Figure 1 illustrates the results for trusts with comprehensive smoking bans.

On 'average' adult mental health wards of trusts with comprehensive smoking bans:

- patients were found smoking in their bedrooms or bathrooms at least every week in half (48%) of trusts
- patients were found smoking in ward courtyards every day in a fifth (22%) of trusts
- patients were found smoking on the wider hospital grounds every day in half (52%) of trusts
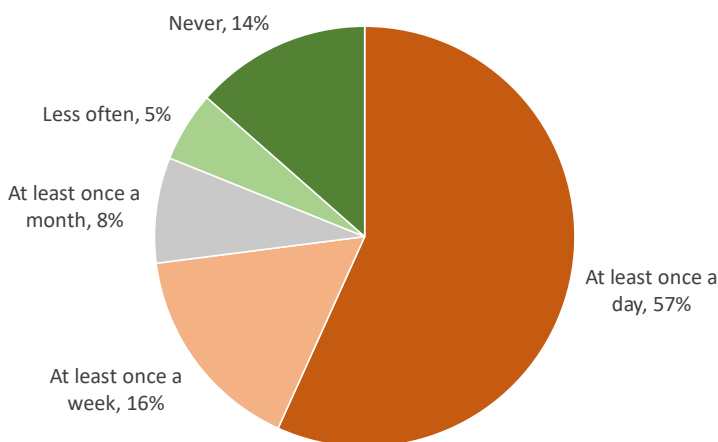
Figure 1. How often patients are found smoking on an average adult mental health wards (trusts with comprehensive smoking bans, 'don't know' responses excluded).

	At least once a day	At least once a week	At least once a month	Less often	Never
bedrooms/bathrooms	11%	37%	26%	20%	6%
communal rooms	12%	29%	18%	32%	9%
ward courtyards	22%	36%	17%	19%	6%
hospital grounds	53%	25%	11%	11%	

It is still common for staff to accompany patients on smoking breaks (Figure 2). Across all surveyed trusts, on 'average' adult mental health wards, staff accompanied patients on smoking breaks every day in 57% of trusts.

In the trusts where smoking breaks were reported (86% of all trusts), some of these accompanied breaks were facilitated by Section 17 leave of the Mental Health Act. In three trusts (7%), Section 17 leave of absence was used to facilitate all accompanied smoking breaks.

Figure 2. How often staff accompany patients on smoking breaks on average adult mental health wards (all surveyed trusts)

Never, 14%
Less often, 5%
At least once a month, 8%
At least once a week, 16%
At least once a day, 57%

Handling patients' tobacco

The surveyed trusts had diverse approaches to handling patients' tobacco. Among the trusts with comprehensive smokefree policies:

- 24 trusts stored patients' tobacco products until their discharge or until leave was granted,
- 4 trusts let patients retain products during their stay,
- 4 trusts destroyed the products on admission.

Boundary problems

Survey participants were asked to identify any problems they had experienced on their trust boundaries. The list of problems in the questionnaire was derived from an open question in the pilot survey. Table 1 describes the results in descending order of frequency.

Cigarette littering was an almost universal problem, identified by all but one of the survey respondents. This may be one of many possible causes for the high rate of complaints from those living next to, or near, the trust premises.

Conflicts with neighbouring or host acute trusts, reported by over a fifth (42%) of respondents, may be triggered by different policy commitments to smokefree sites or different approaches to enforcement.

Table 1. Boundary problems (all trusts)

Problem	trusts
Cigarette littering	44 (98%)
Complaints from neighbours	27 (60%)
Conflict with neighbouring/host NHS trusts which permit smoking on grounds	19 (42%)
Anti-social behaviour	9 (20%)

Local experience

"In developing the smoking cessation policy we emphasised that smoking was best viewed as a co-morbidity or 'dual-diagnosis' issue. Moreover, smoking increased the risk of people developing mental health problems - possibly via complex interactions with neural reward processing, increased cortisol levels and de-valuing of non-smoking related rewards, a common feature of addictive disorders. Stopping smoking is therefore more than a purely physical health matter it is a key to speeding recovery and preventing relapse in mental health contexts."

Specialist smoking cessation training and supervision for ward staff. Weekend recreational and therapeutic activities on the wards facilitated by the smokefree activity champions. Audits, evaluation and a balanced review of smokefree activities based on staff and patient feedback.

Treatment for tobacco dependence

Key findings

Most but not all of the surveyed trusts (93%) provided on-site support for tobacco dependence:

- 84% of trusts had trained frontline staff
- 44% of trusts employed dedicated smoking cessation workers
- 29% of trusts had a dedicated smoking cessation service

All trusts offered nicotine replacement therapy (NRT) to their patients but only 47% offered the choice of combination NRT or varenicline.

In 55% of trusts, patients were not always asked their smoking status on admission.

In 51% of trusts, local authority funded community stop smoking services were not available to people with mental health conditions on discharge in some or all of the local authorities covered by the trust.

Three fifths of trusts (62%) have made some investment of their own in community stop smoking support.

Recommendations

Smoking status should be routinely and consistently asked and recorded on patients' admission to acute mental health services.

Effective treatment and support for tobacco dependence should be made available to inpatients from the point of admission onwards.

As a minimum, all trusts should ensure that staff who have had at least two days of face-to-face training in smoking cessation are available to support smokers throughout their stay.

Trusts should offer both combination NRT and varenicline to inpatient smokers, with behavioural support, to give them the best possible chance of quitting.

Local authorities should work with mental health trusts to ensure that people with mental health conditions in the community can access appropriate specialist support to enable them to quit smoking or successfully abstain when necessary.

Approaches to providing support

The behavioural support offered by mental health trust to their inpatients to help them maintain abstinence during their stay, or quit smoking altogether, may be delivered by frontline staff who have received training in smoking cessation, by dedicated smoking cessation workers, or by a dedicated service. Across the surveyed trusts, investment in these approaches ranged from pursuing all three to providing no support at all.

Table 2 describes the frequency of these approaches across the surveyed trusts. The most common approach was training frontline staff, which 84% of trusts undertook.

- 19 trusts (42%) *only* trained frontline staff
- 9 trusts (20%) had a dedicated service, dedicated workers and trained frontline staff
- 3 trusts (7%) did not provide any behavioural support

Of the three respondents who reported that their trusts did not offer any behavioural support, two had nonetheless stated that they had a policy of doing so.

Table 2. Approaches to treatment and support (all surveyed trusts)

Type of support	trusts
Dedicated smoking cessation service	13 (29%)
Dedicated smoking cessation workers	20 (44%)
Frontline staff who are trained to support patients through a quit attempt or period of abstinence	38 (84%)
None of the above	3 (7%)

The extent to which frontline staff were trained in Very Brief Advice also varied markedly across the surveyed trusts (Figure 3):

- 22 trusts (49%) had trained all or a majority of their staff in Very Brief Advice
- 11 trusts (24%) had trained only a minority of staff trained in Very Brief Advice

Figure 3. Staff trained in Very Brief Advice (all surveyed trusts)
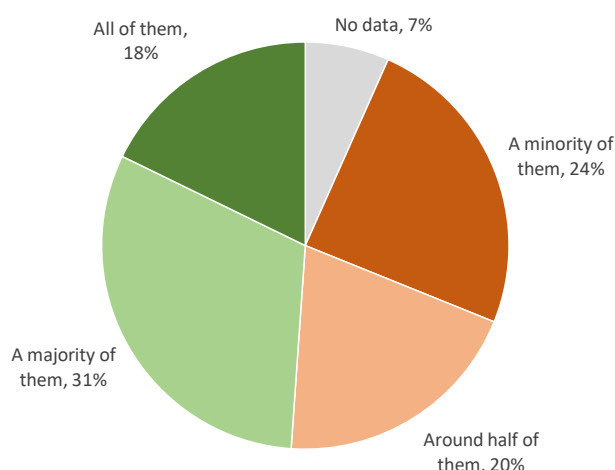
Pharmacotherapy offered

All surveyed trusts offered their patients nicotine replacement therapy (NRT). In addition:

- 37 trusts (82%) offered combination NRT (two or more varieties of NRT)
- 22 trusts (49%) offered varenicline (Champix)

Twenty-one of the surveyed trusts (47%) offered both combination NRT and varenicline.

The offer on admission

All surveyed trusts with active smokefree policies had a policy of 'identifying and recording smoking status on admission'. In practice, 55% of respondents said this did not *always* happen on an 'average' adult mental health ward (Figure 4). Most smokers received advice and NRT on admission most of the time but only in 10 trusts (22%) were they always offered both advice and NRT.

CQUIN No. 9 (*Preventing ill health by risky behaviours – alcohol and tobacco*) had been implemented by at least 38 trusts (84%). Only one respondent reported that it was yet to be implemented but a further six did not know if it had been implemented.

Support on discharge

Half of all surveyed trusts (51%, n=23) reported that they did not have a local authority-funded stop smoking service to refer patients to in some or all the areas they covered. Three trusts (7%) had no local authority services at all to refer to in their area. Respondents' comments suggested that although in some areas services had been decommissioned or restricted to certain client groups, in other areas the local service still existed but was not deemed adequate for people with mental health conditions.

Some community stop smoking support is provided directly by many mental health trusts: 28 of the surveyed trusts (62%) had put some provision of their own in place. All but one of these trusts (60%) had trained community mental health workers in smoking cessation. Seven trusts (16%) ran their own smoking cessation clinics in the community and 3 trusts (7%) had funded specialist workers in the local stop smoking service.

> **Local experience**
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> *"Offer a wide variety of NRT, allow the use of e-cigarettes, have service user/patient representatives on our trust wide smokefree group meeting, engage patients and carers in the community and in a collaboratively-produced smokefree policy."*
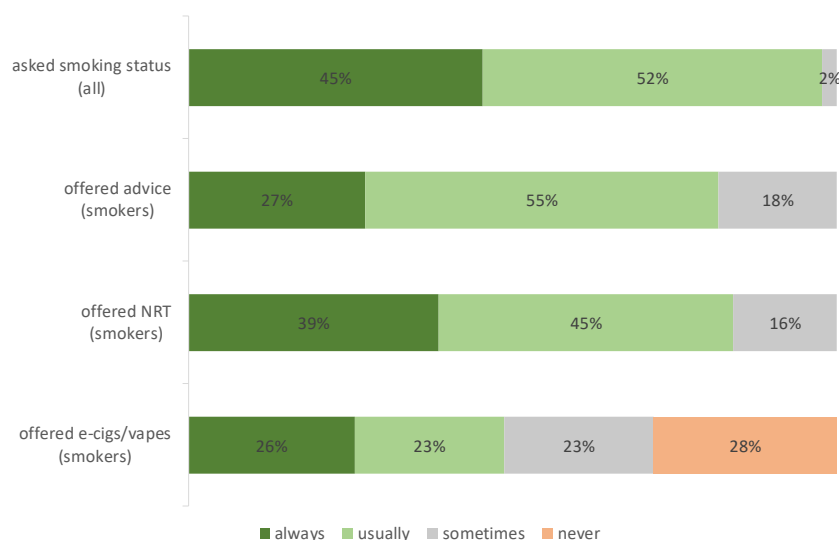>
> *"Smoking cessation advisors linking and working with wards and community teams."*

Figure 4. Experience of patients on admission to average adult mental health ward (all surveyed trusts, 'don't know' responses excluded)

E-cigarettes

Key findings

In 91% of surveyed trusts, some or all inpatients were permitted to use e-cigarettes.

- 47% of surveyed trusts allowed all types of e-cigarettes to be used
- 31% of surveyed trusts only allowed the use of non-rechargeable, disposable devices

All but one trust restricted where e-cigarettes could be used.

44% of surveyed trusts allowed the use of e-cigarettes indoors

- Three quarters (76%) of surveyed trusts allowed the use of e-cigarettes in ward courtyards
- Two fifths (42%) of surveyed trusts provided e-cigarettes free to their patients.

Recommendations

Mental health trusts should consider how best to utilise e-cigarettes in acute settings to reduce the harm of smoking.

Where e-cigarettes are not available on site, trusts should consider taking steps to make them available.

Products permitted

E-cigarettes are now widely used within acute mental health services but their use is restricted in a variety of ways.

In 41 of the surveyed trusts (91%) inpatients were permitted to use e-cigarettes. Of the four trusts where e-cigarettes were not permitted, three were reviewing the policy with a view to allowing their use.

Five of the trusts that permitted the use of e-cigarettes did not allow their use in forensic (secure) services. Conversely, two trusts only allowed their use in forensic wards, one of which also allowed their use in rehabilitation wards.

The trusts that permitted the use of e-cigarettes differed in what types of product they allowed. The following types of product are currently available on the market:

- non-rechargeable, disposable devices (the simplest models)
- rechargeable devices with a replaceable prefilled cartridges or pods
- rechargeable devices with a tank that is refilled with e-liquids
- rechargeable, modular systems with separate devices, batteries, atomisers, etc.

Table 3 illustrates the types of e-cigarettes and vaping devices currently on the market and describes the number of trusts that allowed their use.

> *Local experience*
>
> *"Supporting vaping has been a breakthrough in terms of implementing the smokefree policy. However, we feel that a focus on health promotion can be influential, empowering smokers and enabling them to make their own decisions relating to tobacco use."*
>
> *"I think our vaping policy is good. If anyone is still thinking you need to restrict it to disposable e-cigs I would say let people use what they like."*

Table 3. Types of e-cigarettes and vaping devices allowed (all surveyed trusts)

Type of product	Example	No. trusts allowing use
Non-rechargeable, disposable devices		41 (91%)
Rechargeable devices requiring replaceable prefilled cartridges		24 (53%)
Rechargeable devices with tanks for liquids that can be refilled		23 (51%)
Rechargeable modular systems		21 (47%)

All 41 trusts that permitted the use of e-cigarettes allowed patients to use non-rechargeable, disposable varieties.

- in 14 trusts (31% of all trusts) non-rechargeable, disposable devices were the only models that were allowed
- 21 trusts (47%) allowed all types of e-cigarettes to be used

Where vaping is permitted

Trusts' policies on where vaping is permitted were diverse (Table 4). In particular, there was no consensus about whether vaping should be permitted indoors.

Twenty trusts (44%) allowed the use of e-cigarettes indoors, most often only in private bedrooms. Twenty-seven trusts (60%) had some shared occupancy bedrooms as well as private bedrooms, of which only one allowed e-cigarette use in these rooms.

In contrast, three trusts (7%) only allowed the use of e-cigarettes in the hospital grounds and one only allowed their use off-site but sold them on the ward.

Five trusts (11%) had installed 'it's OK to vape' signs.

Local experience

"Free e-cigarettes is the innovation we think which has shown the biggest impact."

"Adoption of the Tees, Esk and Wear Valley model of providing access to free e-cigarettes and also providing them for sale on site. Using the Zappar augmented reality app on signs, leaflets and posters linking to PHE videos (e.g. vaping information). We are about to begin an intensive and extended communications campaign across the trust with a view to embedding smokefree policy and practice."

Table 4. Where e-cigarette use is allowed (all surveyed trusts)

Location	No. trusts allowing use
All areas	1 (2%)
Private bedrooms	20 (44%)
Shared bedrooms	1 (2%)
Communal areas of wards	6 (13%)
Ward courtyards	34 (76%)
Hospital grounds	33 (73%)
Off-site ONLY	1 (2%)
Not permitted anywhere	4 (9%)

Where e-cigarettes are obtained

There was also a lack of consensus among trusts about where and how e-cigarettes could be accessed (Table 5). Nineteen of the surveyed trusts (42%) provided e-cigarettes free to their patients while 12 trusts (27%) made no provision for the supply of e-cigarettes on their premises.

Table 5. Where patients obtain e-cigarettes (all trusts)

Source of e-cigarettes	trusts
Not permitted	4 (9%)
Provided free by the trust	19 (42%)
Sold on wards	9 (20%)
Vending machines	8 (18%)
Hospital shops	10 (22%)
Not available on-site (bought off-site/provided by friends ONLY)	12 (27%)

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Local experience

"We offer limited free e-cigarettes and have supported a local retailer to stock the approved e-cigarette. We are currently consulting with ward managers, pharmacy and budget holders to extend the offer of free e-cigarettes for the duration of admission."

Discussion

The high response rate for this study (83%) suggests that the findings are a fair representation of the current state of smokefree policy in mental health trusts in England, as reported by key stakeholders within these trusts. Nonetheless there may be a skew in favour of trusts that have taken action to deliver a smokefree environment. Non-respondents were pursued by telephone and trusts that could not identify an individual with an overview of smokefree policy were less likely to complete the survey than those that did have a smokefree lead or similar role.

The target in the Government's Tobacco Control Plan was for all mental health trusts to have implemented comprehensive smokefree policies by 2018. By the beginning of 2019, 82% of the English mental health trusts that responded to the survey had done so. The 18% of trusts that had not achieved this goal either had not implemented their smokefree policies or still permitted smoking in some areas within NHS acute settings.

Delivering smokefree environments remains a challenge in almost all trusts. In practice, no mental health trust in England is entirely smokefree. All trusts reported noncompliance with smokefree policy, to a greater or lesser extent. A majority of trusts with comprehensive smokefree policies reported patients on 'average' adult mental health wards being found smoking in hospital grounds every day (53%) and in secure ward courtyards at least once a week (58%). But in a minority of trusts, such incidents were rare.

These findings are similar to those of the pilot study which described the diversity of practice not only between trusts but also within trusts, investigating experience on both 'typical' wards and 'best practice' wards. For example, the pilot study reported that on typical wards patients were found smoking in hospital grounds every day in 57% of trusts but this only happened in 25% of trusts on 'best practice' wards.

In order to establish meaningful indicators for long-term assessment, the 2019 study focused on current practice in 'average' adult mental health wards only. However, the insight from the pilot study should be borne in mind: every mental health trust is doing better, on some wards, than these results suggest. Just as some trusts have led the way within England, so smokefree leaders and ward champions continue to lead the way within individual trusts.

The examples of local innovation and good practice cited by survey participants and reproduced in the sidebars of this report offer inspiration to all mental health trusts in England but especially to those trusts where smokefree champions are still the minority voices. Even within these examples, however, the diversity of local experience is clear: some trusts inevitably are much further ahead than others.

The findings reported here describe both how much mental health trusts have achieved but also the gaps that remain. Each finding is a potential indicator for ongoing assessment of progress towards successful implementation of smokefree policy, locally as well as nationally. The following measures could all be used locally and nationally for this purpose:

- Universal recording of patients' smoking status on admission to acute mental health services (45% of trusts in 2019)
- The provision of treatment and behavioural support for tobacco dependence to inpatients of acute mental health services (93% of trusts in 2019)
- The offer within acute services of the choice of combination nicotine replacement therapy or varenicline (47% of trusts in 2019)
- Reduction of the frequency of smoking incidents within private bedrooms of adult mental health wards to less than once a week (52% of trusts in 2019)

- Investment in smoking cessation support within community mental health services (62% of trusts in 2019)

These and other measures derived from the findings in this report could be used by local smokefree champions, alongside national guidance from NICE, Public Health England and NHS England, in assessing local progress to date and in defining the path towards fully integrated smokefree policies.

References

[1] Mental Health Taskforce to the NHS: *Five Year Forward View for Mental Health*, 2016.

[2] Department of Health and Social Care: *Towards a Smokefree Generation. A Tobacco Control Plan for England*, 2017.

[3] NICE Guidance PH48: *Smoking: acute, maternity and mental health services*, 2013

[4] Public Health England: *Smokefree mental health services in England, Implementation document for providers of mental health services*, 2016

[5] Cancer Research UK, Mental Health & Smoking Partnership and Action on Smoking and Health: *A Change in the Air: Results of a study of smokefree policy and practice in mental health trusts in England*, 2018.