mental health smoking partnership

Rethink Mental Illness.

ash. action on smoking and health

Smokefree trusts: Making it work for service users

November 2019

Background

ASH and Rethink hosted an experts by experience focus group on 26 February 2019, on behalf of the Mental Health and Smoking Partnership. The purpose of the focus group was to discuss views on smokefree policy implementation in inpatient mental health services and the support that is available to service users, carers and families. Funding for the research was provided by Cancer Research UK.

Eleven experts by experience contributed to the focus group. Among the participants, they had experiences:
- Of inpatient mental health services
- As family members of someone in an inpatient service
- As a service user inspector of inpatient services
- As smokers, non-smokers and ex-smokers
- As a current e-cigarette user

In January 2019, ASH and the Mental Health and Smoking Partnership published 'A Change in the Air: results of a study of smokefree policy and practice in mental health trusts in England'.[1] This report surveyed smokefree leads working in mental health trusts on the implementation of National Institute of Health and Care Excellence (NICE) Guidance PH48.[2] ASH published a follow-up report, 'Progress towards smokefree mental health services', in November 2019 (funded by Public Health England).[3]

The focus group was structured around the key themes and findings of 'A Change in the Air', to consider similarities and differences between staff and expert by experience views on smokefree policies and their implementation.

Areas discussed during the focus group were:
- Smokefree policy design and implementation
- Support available for smokers in smokefree inpatient services
- E-cigarette use
- Support for smokers in the community
- Communication around smoking and smokefree policies
- Outcomes from smokefree policy implementation

Several members of the group stated that they did not support the policy of making inpatient services smokefree. However, all agreed that the implementation of policies could be better managed and delivered; engaging with patients to support them to take ownership of improving their health.

This report includes detail of the issues raised during the focus group, and ASH's recommendations for action to improve the delivery of smokefree mental health services.

Summary

Four key themes emerged from the workshop discussion:

A person-centred approach

- Participants expressed a clear desire for the implementation of policies to be more person-centred. Participants highlighted the need for service users to be involved in the development and implementation of smokefree policies. This was to ensure co-production and prevent implementation of smokefree policies becoming something that is 'done to' service users.

Greater provision of support to be smokefree

- From their experiences, none of the participants felt that the current support offered to inpatients is enough, in relation to both pharmacotherapy and behavioural support.
- There was an emphasis on peer support both in inpatient services and the community as a route to improving successful quitting.

Improving communication

- Improving the communication with inpatients, their families and care networks about *why* mental health trusts are going smokefree was consistently identified as a key opportunity for greater engagement with smokefree policies.
- This was linked to a desire to change the language around smokefree, making it more positive and moving away from language including 'bans', 'searches' and 'restrictions'.

Consistent policies and approaches

- Inconsistent policies between trusts and in the application of smokefree policies within trusts was identified as a significant barrier to service users' engagement with smokefree policies.

WHAT IS A PERSON-CENTRED APPROACH?

Person-centred care is commonly understood as care that actively involves service users, their families and support networks in their own medical treatment, in close cooperation with healthcare professionals.

There was substantial discussion within the group regarding engagement with service users around the development of smokefree policies and the implementation process. Many felt that the voices of service users, families and carers were being lost as trusts focused on going smokefree due to it being a requirement, rather than because they were brought into the process. Participants highlighted that the best results can come when service users are involved and *feel* involved in choices around their own care. One participant cited the motivation of:

> *"Feeling that you are making that choice — not because it's the law and you have to — but because we're trying to improve our health."*

It was highlighted that common concerns around policy implementation, such as damage to therapeutic relationships, could be addressed through involving service users in the design of policies. Another suggestion was taking time to understand why smoking is important to a service user, as part of that therapeutic relationship and the support being provided. Another participant suggested that:

> *"Where there have been changes made is through 'co-production', which means sitting down the patients, and creating that policy with them, and saying 'Okay — what is it that you would find useful for your situations?' and doing [it] together rather than imposing, because then there's a win-win for everyone, really."*

The theme of making smokefree implementation more person-centred was common throughout the workshop and is raised in subsequent sections.

Greater provision of support

SUPPORT FOR SERVICE USERS TO BE SMOKEFREE

There was consensus through the group's experiences that the current available support for smokers is insufficient. Participants felt that support around smoking was often seen as a 'tick box' exercise: a requirement that trusts were not brought into and which staff did not treat as part of patient care. One participant shared:

> *"Handing someone a card with a number should not, in my opinion, count as actively giving someone smoking cessation support — that's what I've had. But they can say they've given you some support; the fact that you couldn't use the phone at the time doesn't seem relevant."*

National programmes — such as the Preventing Ill Health CQUIN,[4] and moving forward the roll-out of a comprehensive pathway of support under the NHS Long Term Plan by 2024[5] — are seeking to address this. However, these service users' experiences are too common. Ensuring that appropriate support is provided on admission to smokefree services means not only engaging service users, but also staff and service managers.

Further participants expressed a desire for a greater range of support to be on offer for service users, depending on their smoking behaviour, nicotine cravings and how behavioural support fits with other care. One participant shared:

> *"More could be done with the patches, gum, Nicorette … but like inhalers, also like vaping… one-to-ones with staff when craving or feeling anxious."*

'Progress towards smokefree mental health services' found that all trusts offered Nicotine Replacement Therapy (NRT) to their patients, but only 47% offered the most effective smoking treatments of either combination NRT (e.g. dual use of a nicotine patch and nicotine gum), or varenicline.[3]

This is in spite of research showing that varenicline is more effective than NRT and that there is 'little evidence' that varenicline is associated with worse mental health outcomes.[6]

This was further emphasised by examples of incidents caused by nicotine withdrawal, with participants noting that nicotine management within services can be poor. One participant recalled:

> *"I had someone start on me because of cigarettes — nothing to do with me — I was just walking past, and he was smoking in his room … he was there suffering from psychosis, and the lack of nicotine was just making him even more wound-up."*

Research has shown that well-implemented smokefree policies can decrease incidence of violence and aggression on hospital wards.[8] However, tension caused by reduced access to nicotine, thereby increasing incidents on wards, was a consistent topic of discussion. This highlights that while some areas have successfully managed nicotine withdrawal as part of going smokefree, in other trusts there is still work to do to ensure that nicotine withdrawal is not aggravating other stressors.

RECOMMENDATIONS

All NHS mental health trusts should:

- In line with recommendations from the Royal College of Psychiatrists, ensure that varenicline is on their formularies and that psychiatrists are encouraged to consider prescribing varenicline[7]
- Offer combination NRT and varenicline to service users
- Ensure that all staff are trained to deliver Very Brief Advice (VBA) on smoking
- Monitor uptake of VBA training — for example, that which is provided free through the National Centre for Smoking Cessation and Training (NCSCT) or Health Education England — amongst community mental health nurses and psychiatrists
- Ensure key staff members are trained to deliver support for service users to quit — for example, through the NCSCT mental health speciality module

Person-centred support

The need for service users to be involved in the development and implementation of policies was emphasised in ensuring appropriate support was available for all service users while in smokefree services.

Participants emphasised that dealing with the physiological side of smoking and smoking cessation was just one part of going smokefree. Associations with smoking, socialising, and smoking as a coping mechanism are an integral part of smoking within inpatient services. These also need to be considered in the development of smokefree policies. Involving service users in this discussion could help ensure that policy design, not just implementation, takes these factors into account. One participant said:

> *"Sometimes, as we've said, smoking is also about socialising or dealing with deep thoughts and all of that. So that's why 'person-centred' is important, because then you can actually go into things a bit deeper — so okay, 'V suffers from this, so we can help with that.'"*

Engaging with service users to understand what smoking means to them, as well as enabling people to cope with nicotine withdrawal and other physiological effects of going smokefree, was highlighted as key to this approach. It is widely-accepted that smoking is a social activity, including evidence that some service users have taken up smoking when admitted to inpatient services due to the opportunities presented to socialise and to go outside for a break.[9] Participants felt that there were simple steps trusts could take to help address this. One participant said:

> *"You're smoking because you're bored and you're isolated, so let's get a group — we can go for a walk, and you can address a few of those concerns all together."*

Participants were clear that going smokefree effectively would require involving service users in discussions around replacing the positive associations with smoking in inpatient services.

Examples of where this is working effectively as part of a comprehensive smokefree strategy include South London and Maudsley NHS Foundation Trust (SLaM) which has used a range of 'boredom busters' to help with the implementation of their policy on wards.

Service users also highlighted the importance of techniques like routine carbon monoxide measuring as methods of capturing progress, with recognition and/or rewards for those who had succeeded in staying smokefree:

> *"[It] should be rewarding — it shouldn't just be 'You've quit, hurrah!' But also, you've cut down, 'well done!' and other positive steps."*

Adopting an approach that involved service users was also seen as a better way to engage staff in the policy. ‘A Change in the Air’ highlighted that smokefree leads within trusts identified the attitudes of other staff members as one of the main barriers to implementation of smokefree policies. The report presented a range of staff concerns around smokefree policies, including the effect that it could have on therapeutic relationships. However, participants highlighted that making support more personalised and involving service users could reduce these concerns. One participant said:

> *“The point about relationships and if [a smokefree policy] was implemented in a more supportive, person-centred way — that would hopefully address some, or most, of that.”*

This point reinforces the idea that implementation of smokefree policies should not be seen as part of an ‘us and them, patients vs staff’ narrative but rather something that trusts are doing to create environments where all service users, staff and visitors are able to take positive steps to improve their health.

RECOMMENDATIONS

Mental health professionals who have received training in smoking cessation are more likely to engage with service users around smoking.[1]

All NHS mental health trusts should:

- Examine innovative ways to make their approaches to delivering smokefree wards more person-centred

E-cigarettes

The group agreed that e-cigarettes have a role to play in supporting people to be smokefree within inpatient services.

Several participants noted that first generation ‘cig-a-like’ e-cigarettes had been offered to them as service users but that they, along with others, had not found these products satisfying. The group agreed that, with appropriate risk assessments, service users should be able to use their own devices and access different types of e-cigarettes while in inpatient services.

However, participants also agreed that there needed to be consideration of non-vapers within services. While participants felt that use within trust grounds and, in some cases, single occupancy bedrooms should be allowed, it was also felt that prohibiting use indoors, within communal areas, should be considered.

Discussion about the relative harms of e-cigarettes compared to tobacco highlighted that there is continued uncertainty around the efficacy of e-cigarettes for smoking cessation and the level of reduced-risk. One participant highlighted that it could be useful to have a single product or type of product that could be recommended giving both staff and service users confidence in the device:

> *“I think they should make a standardised vape, that under a general consensus you can say works — so ‘Here, you can have this one.’”*

The NHS Long Term Plan’s commitment to smoking and mental health highlights that, on advice from Public Health England, support to quit in hospital should include the provision of e-cigarettes. The Medicines and Health Care Products Regulatory Agency (MHRA) has set out a route for medicinal licensing of e-cigarettes and a licensed product would fulfil the desire for greater clarity around the efficacy and safety of e-cigarettes in inpatient mental health services.

RECOMMENDATIONS

All NHS trusts should:

- Make e-cigarettes available as a quitting method to service users

FURTHER INFORMATION

For further information and the latest evidence on e-cigarettes see:

- Public Health England's E-cigarettes and heated tobacco products: evidence review
- Mental Health and Smoking Partnership's E-cigarettes position statement

Peer support

Research suggests that peer support can be an effective way to support smoking cessation among people with mental health conditions.[10] In gathering evidence from five mental health care providers regarding different approaches to smoking cessation, Rethink's Innovation Network found that there is added value in training peer support workers to deliver advice around nicotine replacement therapy (NRT) and sign-posting to stop-smoking support, especially within inpatient settings.[11]

The group felt that there was real potential for peer support approaches to be used in relation to smoking cessation. There was discussion of other areas where peer support approaches have been used, including Alcoholics Anonymous (AA). The group felt that there was a clear opportunity to learn from these other networks in developing peer support approaches for smoking cessation. One participant said:

> *"You know, like AA; they have a mental health group. It's quite a structured programme, they have people to support them, and it's between people who know the problem, so there isn't that feeling of 'them' and 'us'."*

Participants highlighted that peer support removes the power imbalance that can exist between service users and staff with access to cigarettes, which has sometimes been used as a control mechanism within inpatient services. One participant said:

> *"That peer-support element… combats that power dynamic between clinician and patient; it's someone else saying 'I've been there, done it, this is what helped me and maybe it could help you too.'"*

While there was enthusiasm for peer support approaches, and existing evidence that peer support can be effective in relation to smoking cessation, the group were not aware of this approach being used within trusts.

RECOMMENDATIONS

The Government's Prevention Green Paper commits to further activity to tackle smoking-related inequalities with the aim of achieving a smokefree England by 2030.[12] Further consideration should be given to peer support approaches, especially in population groups where smoking rates remain high.

Support in the community

These principles around peer support and engaging with smokers to understand what smoking means to them were also seen as key to ensuring community mental health teams were delivering appropriate support around smoking.

Discussion was focused on the support that should be provided upon discharge from a smokefree service. It was noted that where smokers had been undertaking a quit attempt, or reducing their smoking within a

service, this support needed to continue upon discharge.

Service users felt that ensuring continuity of support, as they move between inpatient and community services, would improve their experience of the process — whether that support is provided by mental health teams, or through referrals onto other community services.

Community mental health nurses (CMHNs) were seen as a key professional group for engaging with people around their smoking and sign-posting to support services. One participant said:

> *"Community mental health nurses visit people in their own homes, and they see how that person is managing. Smoking's expensive — about £10 a packet, probably more — and if it's the difference between paying your electricity bill and buying a packet of fags… If this person is struggling, the community mental health nurse is in a good position to advise and act as a sign-post, to sign-post people to where they need to go, and link with GP services and the local chemists that offer smoking cessation in the area."*

Smokers with mental health conditions are estimated to spend between £1,200 and £2,200 a year on tobacco.[13] CMHNs have a good relationship and opportunity to raise the impact of smoking on different areas of life. However, staff are more likely to raise the topic of smoking with clients once they have had training in smoking cessation.

RECOMMENDATIONS

A recent survey from ASH found that over half of mental health nurses working in the community who responded to the survey had not had any training in smoking cessation.[14]

All NHS mental health trusts should:

- Ensure that mental health professionals know how and where to refer service users for stop smoking support

Improving communication

Poor communication around policies was identified as a barrier to consistent implementation and engagement of service users. Discussion of communication was broadly divided between discussion of how policies were communicated to service users, carers and families and the language used around smokefree policy.

COMMUNICATING SMOKEFREE POLICIES

Informing service users about smokefree policies, what they mean and why they are being implemented was highlighted as an area for improvement.

Where possible, with voluntary or planned admissions, it was highlighted that service users should be told about the policy and what it would mean for them in advance. These conversations could help service users to prepare, with the intention of making the inpatient admission less stressful. In practice, several trusts already do this, including Solent NHS Trust.

However, for service users where admission is unplanned, communication at the point of admission needs improvement. Participants recalled incidents of tobacco being taken off service users on admission without explanation, either about the policy or why the policy was being implemented. While admission to inpatient services is often stressful, it is also crucial to get the communication right at this point, in addition to promptly supplying nicotine replacement to prevent withdrawal symptoms. One participant suggested:

> *“Explaining to people as soon as they come in, or as soon is appropriate: ‘Look, we’re not doing this to be mean, but we’re doing it because of this, and we’re trying, and we can offer you this. Have you thought about NRT and other options?’”*

There was emphatic agreement on explaining why: why tobacco isn’t allowed and why smokefree policies are being implemented. It was agreed that this would be a positive step towards involving service users and transforming them into active participants. One participant said:

> *“I didn’t realise about the policies, and nothing was said to the patients about why they couldn’t have them [cigarettes]. There were people coming in after me and they just took their cigarettes off them, saying ‘No you can’t’, and they never explained why.”*

Service users also felt that being engaged in a conversation about smokefree policies, rather than simply being told there was a ban on smoking, would be preferable. One participant said:

> *“Not all the same support will work for everyone, and then it’s very important how we ask questions – so ‘Are you interested in this?’, or ‘How can we help you stop smoking’? This approach is very important because it opens, but if you tell me: ‘Oh, you are smoking, okay, here there is no smoking,’ you just close the conversation and dialogue. But if you put it in a different, more open way, then the response will definitely be different.”*

Explanation of why smokefree policies are implemented was also linked to other public health challenges. For example, several participants highlighted that unhealthy or takeaway food on wards was almost encouraged, with no concerns raised about maintaining a healthy weight. The difference in attitudes towards smoking compared to healthy weight or eating habits was highlighted as something that was confusing and, without explanation, meant service users could sense that the smokefree policy was not solely about health. Clearer communication about the impacts of smoking, on both mental and physical health, and on some antipsychotic medications, alongside positive messages about the benefits of being smokefree, could help to address this.

Communicating the reasons for policies with carers, families and visitors was also seen as important for improving implementation. Simple steps, such as publishing FAQ pages on websites and issuing leaflets setting out the policy and available support for smokers, can be a straightforward way of getting these messages out.

RECOMMENDATIONS

All trusts should consider the best way to communicate their smokefree policies to service users, and work to build a collaborative stop smoking relationship with them. Examples of good practice to consider are included below.

GOOD PRACTICE COMMUNICATIONS

For example, Tees Esk and Wear Valleys NHS Foundation Trust has a clear set of FAQs available online; while Leicester Partnership Trust produced a short video setting out what their smokefree policy means and the support available, including the Trust’s policy on e-cigarettes.

For a comprehensive communications campaign around going smokefree, lessons can be learned from Northumbria Healthcare NHS Foundation Trust (NHCT).

NHCT established a smokefree working group approximately 18 months before their smokefree date. This enabled time for engagement with senior management, staff and service users across the trust. This ensured that when the smokefree implementation date arrived, different teams had been able to highlight their concerns about implementation and work through challenges in advance.

It also allowed a comprehensive communications campaign, *Change is in the Air*, to be rolled out across the organisation, including on screens at entrances, on bedside TVs, in waiting areas and on the website. This meant that all service users and visitors were informed about the campaign and aware of the support available to them.

The successful implementation of NHCT's smokefree policy highlights the importance of allowing time in advance of implementation for communication, training and stakeholder engagement.

Smokefree language

The other element of communication that was discussed was the language used. The framing of smokefree policies in the language of 'bans', 'searches' and 'restrictions' was identified as a barrier to engagement with service users and visitors.

Reframing smokefree from a 'ban on smoking' to a positive opportunity for service users to improve their health, save money and potentially reduce some medication dosages, was seen as a way to improve engagement and understanding with policies and encourage service users to take ownership of their care. One participant said:

> *"That's how you could frame it rather than 'No, this is why, and this is how […] we do it with you, not to you,' so you're not punishing and criminalising people."*

This was also discussed regarding visitors. The way that policies were communicated to visitors, especially in relation to searching visitors for tobacco, was seen as creating a negative culture around smokefree policies.

> *"It's been hard going into hospital; not as a patient, but as a relative and a visitor and feeling criminalised myself — because when you arrive, you're not really told about this. And then you turn up, and this is all happening, and they want to know what's in your handbag and 'Have you got cigarettes?' and 'Oh, you can't have that and you can't have that,' and you get taken into that as well — it's not a nice experience for the relatives."*

Both the lack and manner of communication is creating additional stress around the implementation of smokefree policies, resulting in a negative atmosphere where both service users and their visitors feel criminalised rather than supported.

Reframing communication around policies to focus on the positive impact of being smokefree and promote service users' ownership of their care is a good opportunity to improve implementation and help reduce staff stress and exhaustion, which are currently perceived as negative outcomes of smokefree implementation.

Consistent policies

Inconsistent implementation of smokefree policies was highlighted as a source of stress for service users. One participant said:

> *"The first three hospitals I went into had regular smoking breaks, and I thought that was a thing that you were supposed to do, and it was only in my last hospitals that they [cigarettes] weren't allowed at all. I don't understand why you can't have a cigarette if, you know, if down the road you can."*

RECOMMENDATIONS

NICE Guidance PH48[2] sets out clear guidance around smokefree policies in inpatient mental health services and the elements that should be included in a comprehensive policy. With support from Public Health England and NHS England, trusts are working to improve their implementation of PH48. However, one in five mental health trusts still do not have a comprehensive smokefree policy in place, despite the Government deadline for implementation being last year.[3]

All trusts which do not have a comprehensive smokefree policy in place should implement one as a priority.

INCONSISTENCY WITHIN TRUSTS

Inconsistent application of policies within trusts was also seen as an obstacle, particularly when approaches have been inconsistent between staff members.

> *"Sometimes I'd go out with a member of staff and I'd think that this one would probably let me smoke, so I'd ask and they'd say no, and I'd say 'But everyone else lets me!' and they'd get all defensive […] but other staff did let me."*

Participants noted that occasionally being allowed to smoke made it much harder to adapt to being smokefree. Inconsistent policy application led to situations where service users anticipated being allowed to smoke, for example on escorted leave, but were then not allowed, creating more stress and disappointment than a consistently applied policy.

This inconsistency also applied to staff smoking on site. One participant said:

> *"Staff sometimes go out and smoke, and then come back and smell of it, but say 'No, you can't.'"*

This emphasised the perceived unfairness of smokefree policies and the sense that service users were being denied a 'right to smoke' because they were inpatients. Staff smoking on site was also seen as undermining the rationale for policies.

Smokefree leads responding to the survey for 'A Change in the Air' highlighted that the attitudes of other staff members were one of the largest barriers to smokefree implementation, and this is something that NHS and trust leadership must address. Undermining smokefree policies needs to be taken more seriously from a management perspective if it is to be implemented in a consistent manner that best supports inpatients.

Conclusion

While the participants did not all support implementation of smokefree policies in inpatient services, the expert by experience group was clear that implementation needed to improve and that better communication and engagement with service users, their families and support networks was the way to make that change.

Personalising the care available and engaging with smokers to understand their associations with smoking and how these could be managed within smokefree services was a clear ask from the experts by experience.

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