Public Health England

Protecting and improving the nation's health

Smokefree mental health services in England

Implementation document for providers of mental health services

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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1. Executive summary

1. Smoking is the largest single preventable cause of morbidity, mortality and inequalities in health in Britain and accounts for about half of the difference in life expectancy between the lowest and the highest income groups.

2. People with mental health problems smoke significantly more and are more dependent on nicotine than the population as a whole, with levels about three times those observed in the general population.

3. Urgent and effective action is required to close the gap in smoking rates between the general population, and those with mental health problems.

4. The NHS England Taskforce report has recommended that PHE continues to support all in-patient units to be smoke free by 2018.

5. Stopping smoking results in improved mental health with an impact on anxiety and depressive symptoms that is at least as large as antidepressants.

6. Smokers with mental health problems are as motivated to stop as smokers without. As only a minority of smokers with mental health problems receive any help, it is important that health care staff ensure they receive evidence based smoking cessation interventions.

7. It is vital to ensure coordinated provision of smoking cessation interventions to effectively address the damage cause by tobacco smoking and its impacts on both mental and physical health.

8. NICE guidance PH48 recommends that all NHS funded secondary care sites should become completely smokefree. Smokefree policy in inpatient units must be complemented by community based smoking cessation programmes.

9. Nicotine vapourisers (e-cigarettes) have become the most popular quitting aid among smokers in England. Whilst not risk free, their use carries a fraction of the risk of smoking and there is no evidence of harm to bystanders from exposure to e-cigarette vapour. Smokefree policies should include a clear evidence based statement designed to maximise the potential benefits while managing the risks.

10. This guidance, which compliments the PHE document, ‘Smoking cessation in secure mental health settings: guidance for commissioners’ highlights a number of key steps which will support mental health trusts in successfully implementing comprehensive smoke free policies.

2. What is smokefree?

Definition of smokefree

The guidance for local authorities[1] defines smoking as 'smoking tobacco or anything which contains tobacco, or smoking any other substance, and includes being in possession of lit tobacco or of anything lit which contains tobacco, or being in possession of any other lit substance in a form in which it could be smoked. This includes smoking cigarettes, cigars, herbal cigarettes and pipes (including water pipes, shisha and hookah)'.

In this guidance smokefree is defined as the absence of smoking as described above.

The Health Act 2006[2] banned smoking in all substantially enclosed public spaces from July 2007 with an extension for psychiatric care settings until July 2008. In PH48, NICE recommend that hospital smokefree policies are extended to cover both indoor spaces and grounds.[3] The guidance makes this clear that it is not though simply enough to ban smoking both indoors and outdoors; rather that the extension presents patients, staff, visitors and carers with an opportunity to reduce or stop their smoking. This guidance has been produced to support providers of mental health services in delivering smokefree environments for their commissioners, service users and staff.

An audit conducted by PHE in 2010 which explored the implementation of indoor smokefree policies across England, found that 96% of unit managers believed that their policy had achieved positive outcomes for staff, patients, services and standards of care. The importance of greater consultation, and collaboration, as well as focusing on on-going staff education, was highlighted as being key to successful implementation.[4,5] As well as presenting the fundamentals of the NICE recommendations, this guidance draws on case-studies and examples from trusts where entirely smokefree environments have been delivered.

Ethical and legal considerations

Provision of care in an entirely smokefree environment is not an infringement of a service user's human rights. This argument has been legally tested and was upheld by the Court of Appeal in 2008 after Rampton Hospital in Nottinghamshire became smokefree. It ruled that a hospital is not the same as a home environment and is instead a place that should support the promotion of health and wellbeing. The judgement said: "There is, in our view, powerful evidence that, in the interests of public health, strict limitations upon smoking, and a complete ban in appropriate circumstances, are justified."[6]

Use of nicotine vapourisers (e-cigarettes)

The use of nicotine vapourisers, commonly known as e-cigarettes, is not covered by smokefree legislation. E-cigarettes work by heating and creating a vapour from a solution that typically contains nicotine, propylene glycol and/or glycerine, and flavourings. As there is no burning involved, there is no smoke and none of the harmful products of combustion including tar and carbon monoxide.

In his report to Public Health England published in May 2014, Professor John Britton said: "Electronic cigarettes do not produce smoke so the well-documented effects of passive exposure of others to cigarette smoke are clearly not relevant. Exposure of non-smokers to electronic cigarettes poses a concern, though laboratory work suggests that electronic cigarette use in enclosed space exposes others to nicotine at levels about one tenth generated by a cigarette, but little else. The health risks of passive exposure to electronic cigarette vapour are therefore likely to be extremely low."[7]

A systematic review of e-cigarettes as tobacco substitutes concluded: "Although evaluating the effects of passive vaping requires further work, based on the existing evidence from environmental exposure and chemical analyses of vapour, it is safe to conclude that the effects of EC [e-cigarette] use on bystanders are minimal compared with conventional cigarettes."[8]

A systematic review of the chemistry of contaminants in nicotine vapourisers in the context of occupational safety standards concluded: "Analysis of the current state of knowledge about the chemistry of contaminants in liquids and aerosols associated with electronic cigarettes indicates that there is no evidence that vaping produces inhalable exposures to these contaminants at a level that would prompt measures to reduce exposure by the standards that are used to ensure safety of workplaces." And on exposure to second-hand vapour: "Exposures of bystanders are likely to be orders of magnitude less, and thus pose no apparent concern."[9]

3. Benefits of smokefree environments

The benefits of stopping smoking to the individual are well known, and indeed there are many research articles and papers dedicated to the subject. What is less commonly understood are the benefits of smokefree environments to the person and also to the organisations who implement them.

For the person

- Improved physical health and life expectancy
- Improvements in mental health and reductions of symptoms of anxiety and depression at least as great as from antidepressants[10]
- Protects from the harm of second-hand smoke
- Money saved by not smoking can be put to more productive use
- Presents the opportunity to engage in cessation or harm reduction activities
- Time that was spent facilitating smoking can be used for therapeutic activities
- Cessation or a reduction in smoking can lead to reduced doses of some medicines used for treatment of mental health problems by up to 50% within a month of stopping
- Increased of other health life choices including uptake in exercise, healthy eating, reduction in alcohol consumption and uptake of health screening programmes [11,12,13,14,15]

  Address stigma and provide equality of treatment between mental health service users and others

For the organisation

- Consistent with their position as a health-promoting organisation
- Provides a cleaner work environment
- Includes savings in medication costs*
- Time that was spent facilitating smoking can be used for completion of other tasks
- Supports staff to stop smoking, promotes staff health and results in less absenteeism, presenteeism and associated illness
- Reduction in costs associated with transport and care for service users who require admission to other health care centres for treatment of conditions exacerbated by smoking

* RCPsych/RCP reported smoking increases psychotropic drug costs in the UK by up to £40 million a year.

4. Relation between smoking and mental health

Smoking, morbidity and mortality

Every year in England approximately 78,200 people die from smoking related diseases.[16] Smoking is one of the most significant modifiable risk factors for both premature mortality and chronic disease. Having a mental health condition increases the risk of physical ill health and increases the likelihood of smoking. People who live with severe mental illness die between ten to twenty years younger than their peers,[17] and they have two to three times the mortality and morbidity from chronic health conditions such as cardiac and respiratory disease.[18]

Smoking is the single largest cause of reduced life expectancy for every other mental disorder including depression (11 years for men, 7 years for women)[19], personality disorder (18 years for both sexes)[20], alcohol use disorders (17.1 years for men, 10.8 for women) and opioid use disorders (9.0 years for men, 17.3 for women).[21]

Smoking increases the risk of developing a mental health condition. A clear relationship has been identified between the amount of tobacco smoked and the number of depressive and anxiety symptoms, in people with existing mental illness and those without mental health conditions.[22,23]

People with mental health conditions smoke significantly more on average and have higher levels of nicotine dependence than the population as a whole. Despite this only a minority receive the advice and support they need to stop smoking.[24] A third of people with mental health conditions and more than two thirds of people in psychiatric units smoke tobacco.[25] A recent study showed that 42% of all tobacco is consumed by adults with mental disorders.[26]

Smoking behaviour

There is now clear evidence, that patients admitted to inpatient wards tend to change their smoking behaviour by decreasing, increasing or even starting to smoke;[27,28] possibly as a consequence of adapting to inpatient routines and smoking breaks. Staff attitudes may also be a factor, as there is evidence of staff accepting or at times encouraging people to smoke in mental health settings.[29] A variety of reasons have been suggested for this which include; a reward or incentive for appropriate behaviour; to help build relationships or to avoid confrontation; as part of a shared smoking culture between staff and people in their care; and for relief of boredom.[30]

Stopping smoking

Stopping smoking has a positive impact on mental health. The evidence shows that successfully stopping smoking leads to improved mood and quality of life as well as reduced symptoms of anxiety and depression.[31] The impact of smoking cessation on anxiety and depressive symptoms is at least as large as antidepressants.[32] This is important for agencies focusing on the treatment of anxiety and depressive disorders such as Improving Access to Psychological Therapies (IAPT) services.

Admission to a mental health unit is an opportunity to address smoking and offer support, as studies have shown that people with mental health condition are generally just as likely to want to stop and when offered evidence based support are as able to stop as the general population. People with mental health conditions usually smoke more heavily and are more dependent, therefore they may require support that includes higher doses of combined NRT and prolonged treatment, just as other more dependent smokers would.[33]

5. Preparing for the implementation of your smokefree policy

Use others' experience as a starting point rather than a recipe

In preparation to implement a smokefree policy, it is useful to acknowledge the experience of others and to use the lessons they offer as, a starting point which can be innovatively adapted to meet the needs of the local environment and circumstances rather than being applied as a 'standard recipe'.[34,35]

A review of the implementation guidance delivered in Scotland[36] in light of learning from English trusts who have gone smokefree, including South London Maudsley NHS Foundation Trust (SLaM) and Cheshire and Wirral Partnership NHS Foundation Trust (CWP), highlights ten important considerations for the preparation and implementation of your smokefree policy.

1. Establish leadership and a project planning and implementation group
2. Define your implementation plan
3. Develop your policy
4. Listen to views through adequate consultation with a range of stakeholders
5. Establish new protocols
6. Provide smoking cessation support for staff and patients
7. On-going staff training and education
8. Communicate your policy
9. Consider estate and enforcement issues
10. Evaluation

Each of these steps will be described in greater detail in the following chapters, to support the development and implementation of a comprehensive, evidence-based smokefree policy.

Step 1: Establish leadership

Identify an appropriate leader

Strong, clear and accessible leadership and management support are vital to the successful implementation of smokefree policies. You should choose a leader with sufficient seniority to affect and manage decisions at board meetings and who can champion the policy, promoting positive communications and the importance of teamwork to success. The leader will provide a steer the implementation group, who must be capable of addressing emerging challenges and developing the clear process which will engage stakeholders. The leader requires good understanding of the impacts of smoking and cessation, effective interventions and how to address barriers to implementation. They should also be comfortable with the coordination of smoking cessation work in community secondary mental health services, primary care, NHS stop smoking services and public health.

The leader will need to ensure that there is a robust project management approach to the transition.

> "Establish a trust wide group chaired by the Director who is accountable at Board level and ensure that you have the right representatives at the trust wide meeting"
> **Senior manager, Cheshire and Wirral Partnership NHS Foundation Trust**

Establish a smokefree policy development and implementation group

When establishing the goal of the group it is useful to ask members what they can bring to the process, to determine which members will be responsible for undertaking different tasks. Service users who have quit smoking and champions who have benefitted from the service can create momentum and help others understand the process, both in terms of planning and implementation.

You may wish to invite guest speakers to share their experiences of planning for and implementing a smokefree policy within mental health settings. Please see Annex B under resources.

The implementation group should meet regularly with dates agreed in advance. Initially these meetings may be set monthly with an increase in frequency as the implementation date approaches. The meeting schedule should include post-implementation dates to address enquiries, provide an opportunity for feedback and consider any policy modification if such is required. When input from all implementation

group members is not required, task orientated subgroups can be useful in moving forward with specific items.

The implementation group presents the opportunity to engage a wide range of stakeholders in an orderly and structured fashion. The group should include broad representation across various professional and service user groups, allowing both supporters and detractors to engage. Including some of the following stakeholders in the implementation group may be useful in helping identify and address challenges, and communicating important messages;

Project manager	Commissioners
Medical staff	Local public health team
Nursing staff	Service users
Allied health professional staff	Service user advocacy groups
Pharmacy staff	Families and carers of service users
Occupational health	Trade unions
Stop smoking service managers	Risk management officials
Building/estates personnel	Local/area partnership forum members
Human resources representatives	Health and safety officials
Occupational therapists	Fire officer
Project evaluator	Local primary care representatives

Identify internal and external champions

Key attributes are enthusiasm and commitment to the policy. Internal champions may be those who hold influence and are likely to impact on the acceptance and success of the policy. Champions may emerge during planning for the implementation, as people show interest and energy for the policy, and may include managers, staff and service users. Often, those who have benefited from smoking cessation support make excellent champions.

Medical, nursing and service user champions will ensure that concerns about the policy can be addressed at an appropriate level and reduce the likelihood of the policy being seen as ‘top-down’.

External champions are also useful. Supportive journalists, voluntary organisations and GPs can all provide positive messages and supportive statements. In order to maximise this opportunity you should define a role for your champions. This may include;

- spreading the word about the policy and the timescale for implementation
- reinforcing the benefits of the policy following its implementation
- continuing to listen to people ‘on-the-ground’ as the policy beds in

Step 2: Define your implementation plan

Establish your implementation plan

As with all projects of this scale and importance, a well-defined and tested project management approach is crucial. Realistic timescales, identification of key milestones, communication, monitoring and evaluation are all crucial to ensure that, “Smokefree policy implementation is a process not an event” [35]

Your project plan should as a minimum include:

- identification and invitation of key stakeholders
- risk register to monitor and report and rapidly escalate issues if necessary
- agreement on the dataset required for monitoring
- change management strategy

Effective implementation

Broad actions might include:

- leadership and management support
- assessment of current stop smoking service delivery
    - access meets current need
    - access meets planed need
    - interventions delivering expected outcomes
    - staff trained to the appropriate level and in suitable numbers
- staff and service user smoking
- assessment of on-going staff training and education needs
- action to address staff smoking
- consultation with stakeholders
- audit of resources and action required to address training and intervention gaps
- assessment of boundaries and signage
- communication strategy sign off
- configuration of clinical recording systems to include recording of smoking status, referrals and outcome of behaviour intervention
- establishing the monitoring and evaluation framework

Assess the monitoring information you require

As well as the data that is required to be collected for national, and local reporting there will be other aspects of implementation that are of use. Progress can be celebrated so

it is important to capture the starting position and identify successes since then. Monitoring data should be analysed at agreed intervals, and findings fed back to staff and service users who can be involved in suggesting improvements where the data suggests that aspects of the policy need attention.

Make sure that the monitoring data you decide to collect is useful to you. Think about your end aims (short, mid and longer term) and work backwards from these, deciding what data you will need to collect, to show how far you have got in achieving your aims. Advice from one smoking cessation practitioner is to avoid relying on too blunt a measure, which may not provide you with all of the information you require.

"I think we should measure patients' reduction in smoking and not just their successful quits. We are not really collecting hard measures for that. I would like to measure that middle ground – the softer stuff. I want to measure the number of people I support, and for how long I support them. That tells me more than one quit measure." **Senior nurse manager, West London Mental Health Trust**

Collecting and analysing monitoring data should be assigned to ward managers, in addition to those with overall responsibility for the policy.

This might also provide an opportunity to link with local targets and CQUIN (Commissioning for Quality and Innovation) programmes to improve the physical health of people affected by mental illness.

Identify any required changes to your estate

Review your estate, assess whether changes need to be made to facilitate the operation of your smokefree policy and build in time and budgeting accordingly.[30]

- removal of smoking shelters and bins for cigarette ends
- ensure hospital boundaries are clear to indicate smoke free areas
- staff, patients and visitors should not be smoking on-site
- working with other organisation who sharing same grounds and premises

In particular, you will need to address:

- who will be responsible for addressing smoking on the grounds?
- how to work with service users and carers to protect staff from tobacco smoke when they are visiting the homes of people using secondary care services?
- how to support staff to encourage compliance with the smoke free policy?
- how to work with services users, carers, staff and visitors to overcome any problems that may result from smoking restrictions?

"It is everyone's responsibility to address smoking on the grounds. Sometimes staff do not feel confident to tell service users or visitors not to smoke on the grounds. It is important to discuss this and include examples of scenarios or role playing to up skill staff's confident to address smoking on the grounds. We have included this as part of our level 1 smoking cessation training" **Jimmy Noak, Deputy director of nursing, West London Mental Health Trust**

Set the timetable for every part of the plan

A timetable for every part of the plan should be established, including a start date that allows for any lead-in time required. Depending on the extent to which you have already developed your policy and implementation plan, the lead-in may be between 6 and 18 months. Your implementation date may also depend on the completion of new build facilities; in which case it will be wise to establish a realistic timetable, taking on board the progress of the new build and up-to-date advice on the timetable for its completion.

A visual countdown to that date, for example, using posters and calendars, will be helpful to aid adjustment to the policy extension and improve compliance with changes. Evidence to date suggests that policies implemented in one step i.e. trust wide, are more successful that those phased in over a period of time.

Create the greatest chance of success by avoiding a start date that is on a public holiday or weekend, when there may already be disruption to familiar routines and reduced availability of therapeutic activities. Policies implemented in the spring or summer have the advantage of fairer weather allowing a great range of therapeutic activities to take place. Staff, service users and families should be reminded of key dates and provision made for extra staffing at times where this is required to deliver any extra activities or interventions.

Consider timetabling a period post-implementation during which time unforeseen teething problems can be addressed promptly. You may wish to allow a clearly defined 'grace period', where any staff who are not compliant with the policy are not formally disciplined, rather they are interviewed by their line manager and referred for further advice as appropriate. Once this grace period ends, disciplinary procedures should be invoked for staff as defined in the policy.

Step 3: Develop your policy

"A smokefree policy will provide a much needed opportunity to help reduce the divide between the health of residents of mental healthcare institutions and that of the general population".[25]

Confirm your smokefree policy

Addressing key policy decisions before planning the implementation of your smokefree policy will aid implementation.

The following are useful considerations when developing your policy;

1. The policy is framed positively
2. It highlights the use of pharmacotherapy and other effective interventions
3. It facilitates coordination with community mental health services, primary care, NHS stop smoking services and other providers
4. It includes a clear statement about the use of nicotine vapourisers (e-cigarettes)
5. It highlights the opportunities for staff education and training
6. It addresses staff smoking
7. It addresses staff assisted smoking
8. It addresses breaches of policy
9. It is clear about storage of tobacco and paraphernalia
10. It addresses capacity to consent

"An all-round, consistent and positive approach is required in order to maintain progressive change" **Stop smoking facilitator, KICK IT Stop Smoking Service**

1. Frame your policy positively

You should frame your policy in positive terms, emphasising the benefits you expect to accrue to service users and staff.

These could include:

- recognition that the policy is about support for the safe management of nicotine addiction, rather than management of cigarette consumption
- clear consistent messages on the health benefits of stopping smoking which includes dispelling the myth that smoking improves mental health
- positive messages about the health benefits of a smokefree environment

- acknowledging employers' duty of care to provide a safe and healthy environment for staff, patients and visitors
- acknowledging employees' duty of care to support service users in achieving good mental and physical wellbeing
- referencing the legal position if necessary (please see page 5 for more information)

Example of smokefree policy provided as Annex B.

"Avoid a paternalistic approach that is often associated with 'Smoke Free Policies' take an approach that shows clinical concern rather than be anti-smoking" **Senior manager, Chester and Wirral Partnership NHS Trust**

2. Highlight the use of pharmacotherapy and other effective interventions

There are a range of pharmacotherapies and behavioural interventions that are effective in supporting the management of nicotine addiction. NICE has identified these in successive guidance, most notably PH10, PH28, PH45 and PH48. These, and other commonly delivered interventions, are described and the evidence for them is rated in the NCSCT local stop smoking service and delivery guidance 2014. Your policy should identify those interventions and pharmacotherapies that are available, the route by which they can be accessed and the effectiveness of these interventions in supporting the smokefree policy.

E-cigarettes have become the most popular quitting aid among smokers in England and there is evidence that they are helping people to quit, especially when combined with support from stop smoking services. They can also be a valuable tool in supporting smokers who are unable or unwilling to stop in one step to reduce the harm from smoking. While e-cigarettes are not risk free, based on current evidence they carry a fraction of the risk of cigarettes. Public Health England's independent review of the latest evidence, published in August 2015, found that e-cigarette use ('vaping') is around 95% safer than smoking.[37]

From May 2016, e-cigarettes will either be licensed as medicines by the Medicines and Healthcare Products Regulatory Agency (MHRA) or, if unlicensed, will be subject to new regulations including stricter quality and safety standards under the revised EU Tobacco Products Directive.

Once medicinally licensed products become available on the market, e-cigarettes will be able to be provided by stop smoking services and prescribed by the NHS. In the meantime, Public Health England's recommendation is that stop smoking services and healthcare professionals should engage with, and provide support to, people who want to use e-cigarettes to help them quit smoking.

3. Facilitate coordination with community mental health services, primary care, NHS stop smoking services and other providers

Since most people in contact with secondary mental health services care are seen in community settings, steps must be taken to ensure that the policy also benefits people in these settings. Appropriate coverage of interventions and good coordination between different providers greatly improves smoking cessation rates and reduces relapse. Poor or non-existent links with the local stop smoking services increases the likelihood that people will start smoking once discharged. This is both a waste of public money and a wasted opportunity for the individual. An electronic referral system is considered the gold standard for referral from secondary care, however where this is not available a well promoted simple to use and effective referral paper-based system should be implemented and regularly audited. Whilst there is a role for the on-site stop smoking service providers, this should not be purely their responsibility and the policy should establish the pathway for handover of care as part of planning for discharge.

In moving towards a smokefree estate, consistency of care is important. Extending the policy to cover all trust sites ensures that all staff, service users and visitors realise the benefits of the change in policy. Where property is shared with other providers, or is owned by a landlord, then these should be involved at an early stage in the planning process to insure against people being permitted to smoke in grounds shared with people for whom smoking is not permitted.

4. Develop a clear policy on the use of nicotine vapourisers (e-cigarettes)

Public Health England's publication 'E-cigarettes: a new foundation for evidence-based policy and practice' includes the advice that: "There is an opportunity for e-cigarettes to help tackle the high smoking rates among people with mental health problems, particularly in the context of creating smokefree mental health units."[38]

Policies on the use of e-cigarettes in mental health settings should be based on the evidence and designed to maximise this potential opportunity while managing the risks.

As indicated above, the evidence indicates that e-cigarettes can help smokers to quit smoking. They can also help people who are unable or unwilling to stop in one step to reduce the harm from smoking, via the approaches set out in NICE tobacco harm reduction guidance PH45. These include cutting down to quit, reducing the amount smoked and temporary abstinence from smoking, with or without using licensed nicotine-containing products. According to NICE its recommendations "are particularly relevant to people who are highly dependent on nicotine and groups where smoking prevalence is higher than average".

There is no evidence of harm to bystanders from exposure to e-cigarette vapour and available evidence indicates that any risk of harm is extremely low, especially when compared with tobacco smoke (see page 6). There may be other reasons to prohibit or restrict the use of e-cigarettes in indoor/outdoor areas of mental health estates. These should be considered in the context of supporting clients/patients and staff to quit and stay smokefree and supporting compliance with the smokefree policy while avoiding unintended consequences. Guidance on the sorts of things to consider is available from the CIEH/ASH briefing "Will you permit or prohibit electronic cigarette use on your premises? Five questions to ask before you decide".[39]

The evidence base on e-cigarettes continues to evolve, as does the regulatory environment. Public Health England is committed to on-going close monitoring to inform its approach, and local policies and practice will need to be kept under regular review. In spring 2016 Public Health England will publish framework advice to inform the development of evidence-based policies on the use of e-cigarettes in public places and workplaces. This will set out some guiding principles for an approach that accords with our current knowledge and protects against the unintended consequences of being either too permissive or too prohibitive.

A consistent approach to policy in mental health services may be desirable to reduce variation and any unintended consequences. PHE will support NHS England in advising on the latest evidence base and recommendations for secure services.

SLaM developed an EC policy alongside the smokefree policy which allows EC to be used in private spaces or grounds, although EC are not to be offered as first line treatment or replace tobacco cigarette smoking and can only be used as part of a care treatment pathway. Currently, the use of disposable products or rechargeable models with cartridges is allowed (the latter only under supervision).[40]

5. Highlight the opportunities for staff education and training

Training and education are an effective methods to address smoking culture in mental health,[11] are one of the important steps for successful implementation and should include;

- the delivery of very brief advice and referral into stop smoking services
- the effective use of licensed stop smoking medicines, e-cigarettes and behavioural interventions to manage nicotine withdrawal
- the opportunities presented by harm reduction approaches to tobacco cessation
- the safe management of medicines affected by tobacco cessation
- effectively supporting the implementation and delivery of policy
- dealing with breaches of policy

Trusts may consider including very brief advice as part of the mandatory training schedule for all employees. A free training module is available online through the NCSCT web portal http://elearning.ncsct.co.uk/vba-launch.

Where there is a desire for staff to deliver interventions, then these should be trained, mentored and signed off as competent to practice by an appropriate agency. This may be the locally commissioned stop smoking service, an independent specialist provider, such as the NCSCT. Training plans should highlight the role of refresher training to support the smokefree policy post-implementation. More information is provided in step 7.

6. Address staff smoking

Staff who smoke, are in general less likely to encourage patients who smoke to stop. NICE public health guidance PH48 says simply that NHS staff should not smoke if they are identifiable as NHS staff. Another important consideration is that staff also have personal and professional conduct in relation to promoting health and this also includes not smoking in front of clients/patients, not smoking in uniform or with trust identifiable ID and not facilitating others to smoke whilst at work.

In order to promote a smokefree environment your policy may state that staff will not be permitted to smoke, whilst on duty, in uniform or when undertaking trust business.

7. Address staff assisted smoking

In order to prevent patients moving in an out of the nicotine withdrawal associated with intermittent smoking, it is very important that staff do not facilitate smoking. Fully smokefree sites with no designated smoking areas, no staff-supervised or staff-facilitated smoking breaks for service users and access to support including pharmacotherapies are the start of this. There must also be clarity on the policy for escorting patients to smoke outside of hospital grounds. As intermittent smoking can increase symptoms of withdrawal, it is recommended that patients being escorted outside the hospital grounds do not smoke. In some mental health trusts, such as South London and Maudsley (SLaM) and Chester and Wirral Partnership (CWP), staff do not facilitate patients to smoke during escorted off-site leave.

8. Addressing breaches of policy

Guidance and training in addressing breaches of policy must be provided to staff. SLaM's smokefree policy states that, "if staff don't feel confident to engage in difficult or overly challenging situations they should not approach individuals (whether staff or patients) to ask them to stop smoking". Their smokefree policy aims to promote and develop a culture between staff, service users and visitors, in which smoking is seen as unacceptable and everyone respects this. Shifts in culture and behaviours can take time and will not be achieved simply by

releasing policies and guidance. The required culture change will be achieved if everybody commits to smokefree becoming a reality and responds to situations when this does not happen as a breach, using it as an opportunity to engage, rather than a failure of the project.[40]

9. Clarity on storage of tobacco and smoking paraphernalia

The policy must provide clarity on the rules around storage of cigarettes, tobacco and associated paraphernalia. If there is a vague system the whole policy can unravel and be quickly undermined. It may be that the policy states that patients arriving to hospital with cigarettes will have these taken away and they will be returned at the point of discharge. If this is the case then this must be clearly communicated to staff and service users. Establishing advance directives with smokers about their nicotine management, in advance of admission, will ensure patients understand the policy and are comfortable on admission.

Following case study highlights how CWP and SLAM manage the storage of cigarettes:

Patients are informed that they should not bring tobacco, cigarettes, lighters or matches to the hospital. If patients are found to be in possession of these contraband items, they will be asked to return the items to their home with family or friends if this is feasible. In SLAM the items will be stored and returned to the patients at the point of discharge whereas CWP destroy any contraband items immediately rather than storing them.

10. Capacity to consent

Your policy should be very clear that there must be no exceptions made to the smokefree policy. If challenges arise, a best interest meeting with the required representation should be convened. When considering tobacco dependence, there are no circumstances where it is in the patient's best interest to smoke. Patients should be offered cognitive behavioural interventions and combination NRT, which is use of a patch and a second fast acting product. Changes to care should be agreed in the best interest meeting and implemented immediately.

Step 4: Listen to views

‘Mental health practitioners care a great deal about offering the best interventions to help individuals regain and maintain their mental health. Practitioners have shown real commitment and innovation to also help improve the physical health of people living with mental health problems by supporting people in stopping smoking. People living with mental health problems have also shown great drive and commitment to stop smoking, with all the benefits this brings’ **Seamus Watson, National programme manager PHE**

Listen to the views of key stakeholders

There are several key stakeholders with whom consultation will play an important part in successful implementation of the policy. The four most notable groups are;

1. Managers and senior leaders
2. Medical, nursing, pharmacists, allied and support staff
3. Public health commissioners and providers of stop smoking services in both primary and secondary care
4. Service users, their families, carers and representatives

When consultation takes place it is important to manage expectations from the outset. The terms of the consultation should make it clear that it is not the outcome (becoming smokefree) that is under consultation, rather it is the ‘how to get there’ for which opinion is being sought.

Engagement with staff at all levels

Successful smokefree policies are delivered by managers and staff who understand and are engaged in planning, implementation and delivery. If staff lack knowledge and confidence this may lead to ambivalence which can present a significant barrier to effective implementation. This can be addressed by;

- including the key health and equality rationales for going smokefree in routine communications to managers and staff
- consider providing a range of feedback options such as twitter, email, staff comment boxes, formal routes such as team meetings or trust wide events
- encouraging and providing support for all staff to stop smoking
- inviting staff to attend implementation briefing meetings
- setting aside time for formal and informal discussions with staff to identify;
    - communication needs
    - on-going education and training needs

  - resources needed to address intervention gaps
  - smoking cessation interventions appropriate to different settings
  - any other barriers to implementation
- ensuring that the plans are presented at various multi-disciplinary meetings and one-off high profile events giving time for discussion
- publication of any revisions to your policy arising as a result of consultation
- circulating your policy and implementation plan widely, asking for comments, in particular for solutions to issues which staff see as being barriers to implementation

Listening to opinions – that was the most important thing. Be brave and stick to the change, not giving up even when it is very difficult. Get your strong staff on board early on, the motivational go-getters, who will keep everyone else motivated and on track."
Jimmy Noke, Deputy director of nursing, West London Mental Health Trust

"Smoking is emotive; allow staff opportunities to deal with these feelings and concerns constructively. Challenge any misconceptions and stigmatising views. We held trust wide and locality based conferences to provide opportunities for this and there was a palpable shift in attitudes when staff began to see that it was in fact a clinical issue and an issue of stigma and social and health inequalities. Whilst we didn't reach every member of staff we reached sufficient to be confident that the change in approach would be sustained."
Avril Devaney, Director of nursing, therapies and patient partnership, Cheshire and Wirral Partnership NHS Foundation Trust

Engagement with service users, their families, carers and representatives

Consult service users on matters such as:

- what they would like to see in place of smoking shelters
- the activities they would like to be available to displace smoking
- the therapeutic activities which will help them in abstaining from smoking
- what will make it easier for them to remain smokefree on discharge
- what are their main concerns about going smokefree and how can these be addressed
- what preparation will help them in the build-up to going smokefree or prior to admission to hospital
- how best to manage emergency or unplanned admissions into smokefree areas

You may want to invite service users who have already experienced the implementation of smokefree policies to speak to those involved in the process, as learning and sharing information in this way can prove very helpful in realising possibilities, benefits and improvements to quality of life.

Encourage service user representatives to attend formal planning meetings, to raise any concerns and to respond to any consultation on the policy and its implementation.

Opportunities should be taken to discuss the policy such as:

- ward induction meetings
- service user forums
- service user advocate group meetings

”It’s really important not to be seen to be taking something away from patients. Patients need to know they are getting something in return for removing smoking breaks. So get them involved in saying what it will be used for – give back ownership.” **Smoking cessation specialist, Smokefree Ealing**

“Staff were taking patients on so called ‘fresh air breaks’ which were essentially escorted walks off trust premises to facilitate smoking. The practice on most wards was typically 8 or more staff escorted ‘smoke breaks’ per day. This is confusing for patients as it gives a double messages about health promotion. Stigmatising views are a prominent feature in some staff who think that ‘Mental health patients should be allowed to smoke as they have nothing else that is enjoyable and they are unable to succeed anyway’. Opportunities for intervening with positive ambitions to promote health and wellbeing are being missed” **Mary Yates, Nurse consultant, South London and Maudsley NHS Trust**

Step 5: Establish new protocols

Identify and address the need for amending or introducing new protocols

You may need to amend or introduce new protocols in relation to:

- including smoking status and behaviour on admission records and in any recovery/treatment/discharge care plans (see step10)
- smoking care pathway and care plans
- managing nicotine dependency and withdrawal in new admissions
- reminder system to assess smokers' readiness to quit that trigger conversations at least three times a year (see step 5)
- monitoring changes in service users' tobacco use (see step 10)
- keeping information about stop smoking resources up-to-date (see step 5)
- monitoring of plasma levels when service users reduce or stop smoking (see step 7)
- authorisation and provision of NRT on a symptomatic relief basis (see step 5)
- referrals to smoking cessation services (see step 5)
- managing of complaints relating to the smokefree policy

"Test your policies before implementation. At CWP our lived experience representatives attended the wards prior to implementation to ensure that the rotas for having trained staff available worked. This was very effective in checking systems worked, that NRT and support was available prior to the go live date" **Senior manager, Chester and Wirral Partnership NHS Trust**

As policy infringements will undermine the effectiveness of your smokefree policy, you should establish a robust protocol for its enforcement. This should be based upon two principles:

1. Enforcement should be the responsibility of all staff
2. Where possible, enforcement should be educational and supportive.

Address the impact of smoking, stopping and reduction of cigarette intake on plasma levels of medication

The toxic products (tar and not nicotine) of tobacco combustion increase the metabolism of some psychotropic medication by inducing the cytochrome P450 (CYP1A2) enzyme system, which is responsible for the metabolism of some medications. Smoking can therefore lower the plasma levels of certain medications by as much as 50%, resulting in smokers needing higher doses of antipsychotic drugs.[34]

Stopping or reducing smoking is an opportunity to reduce doses of some antipsychotics, antidepressants and benzodiazepines within days of cessation (as reduced metabolism decreases dose requirements).

Following smoking cessation, or a reduction in smoking, doses of these medications need to be reduced to prevent toxicity.[41]

- clozapine and olanzapine: 25% dose reduction during first week of cessation and then further blood levels taken on a weekly basis until levels have stabilised
- fluphenazine and some benzodiazepines: 25% dose reduction in first week
- tricyclic antidepressants: 10-25% dose reduction in first week Further dose reductions may be required with continued cessation although original doses need to be reinstated if smoking is resumed

The recording of incidents of breaches of the policy should be simple and efficient

Staff who feel well informed of the policy and who are confident in approaching individuals will be more likely to challenge breaches than those who are not. Should staff feel unable to support the policy in this way they could benefit from training in protocol for enforcement of the policy and managing dispute and de-escalation techniques. De-bunking misguided beliefs on likely increased levels of aggression amongst service users can also prove effective.

“We should all be recording breach incidents largely due to fire risks. Smoking staff seem to be more lenient towards breaches. This leads to more disruption due to the inconsistencies. Inconsistencies are disruptive. We need to set boundaries so that lines are not blurred. It’s important to state things clearly (in terms of enforcement protocol).” Staff nurse in a Scottish psychiatric hospital

Previous experience has highlighted the most challenging areas of enforcement are:

- toilets
- private rooms
- areas of the grounds where signage is not apparent
- entrances to buildings and sites

“We now include tobacco use as part of our integrated care pathway. On admission, the smoking status of the patient must be recorded. We ask if they want to be referred to the smoking cessation service. This had not been done until recently. The admission form did not include tobacco status until this year.” **Nurse and smoking cessation coordinator, Camdon and Islington NHS Foundation Trust**

Comparison of enforcement by smoking and non-smoking staff

A review of smokefree policy in mental health settings in Australia revealed that compared with non-smoking staff, staff who smoked were more likely to be inconsistent in, or resistant to, enforcing smokefree policy and less likely to provide service users with health promotion support and cessation interventions. Consistent staff enforcement of smokefree policy was associated with successful implementation and level of staff education and training.[42]

Remind staff that they must deliver the smokefree policy, irrespective of their own smoking habits and own personal views and that non-compliance with the policy by staff is subject to disciplinary procedures in the same way as non-compliance with other hospital policies.

"…consistent and on-going enforcement [of the smokefree policy] is paramount to its long- term success; without such enforcement staff morale and anxiety levels may suffer".[43]

Step 6: Provide support to stop or reduce smoking

Ensure the referral process is simple, efficient and responsive to demand

NICE guidance PH48 recommends that a robust system is put in place, to ensure continuity of care for people moving in and out of secondary care. The system needs to link mental health services, local stop smoking service and primary care providers. It must ensure that doctors, nurses, stop smoking advisers, health and social care practitioners are trained to provide very brief advice, refer to and where appropriate, deliver intensive stop smoking support.[3]

Systems that consistently and accurately record smoking status, highlighting those people who are not receiving treatment can help staff identify where interventions are required. Pharmacotherapy and behavioural support should be available on the ward. Carbon Monoxide (CO) monitors should be available every time an intensive stop smoking intervention is delivered and practice must comply with recommendations for monitoring CO levels effectively.

Train all staff in the delivery of very brief advice

Very brief advice is a short, conversational method for engaging people with the idea of stopping smoking. It involves the three steps of;

ASK	if the person smokes
ADVISE	that the best thing they can do is stop and that help is available
ASSIST	by making an appointment for those who are interested in support

It does not involve a long conversation about smoking, as this is best saved for the consultation. It is also not an opportunity to tell the person how bad smoking is for them, as it is likely that the person understands this and taking this track is likely to undermine any offer of support.

Trusts may consider including very brief advice as part of the mandatory training schedule for all employees. A free training module is available online through the NCSCT web portal http://elearning.ncsct.co.uk/vba-launch

Ensure that service users have ready access to specialist help to stop smoking

The use of NRT in conjunction with behavioural therapy from a suitably trained stop smoking service provider is in line with national guidelines for smoking cessation for service users in hospitals.[3**Error! Bookmark not defined.**,44]

Delivery of stop smoking support must be prioritised, with smoking cessation provision advertised through:

- pre-admission information to address smoke free policy and types of intervention provided for service users
- admission information pack containing a summary of treatment options
- posters and other communications in prominent places
- encouragement to attend treatment from nursing and other staff

It is recommended that service users entering smokefree trusts should have access to NRT in a timely manner. NICE guidance PH48 recommends that if NRT is accepted then it should be provided immediately. They also recommend that people should be provided immediate [stop smoking] support if necessary, and otherwise within 24 hours of admission.

The advisor should assess nicotine dependence, provide support on the opportunities to cut down and quit whilst in hospital, agree pharmacotherapy and schedule follow-up appointments. This support should continue throughout their stay and be handed over to the appropriate body on discharge.

Some people may not wish, or be in a position to accept support immediately, so staff should persist with the offer of stop smoking medication in the same way that they will persist with the offer of anti-psychotic medications. It is not simply sufficient to offer a product once and then take refusal as a reason not to offer this again.

A clearly-communicated protocol must be put in place which promotes consistency of approach to use, as well as persistence and proactivity in offering NRT to service users over time. The standard treatment protocols should include a regular reminder system to assess motivation to quit. Smoking cessation medicine should be offered systematically, rather than selectively based on staff perceptions of when service users are ready to quit.

All staff should be responsible for providing reassurance to those considering stopping or reducing smoking that NRT is safe and effective.

The RCP/RC Psych report states that; “It is important to understand that service users may find it more difficult to stop smoking and more likely to need multiple attempts to be successful”.[45]

“Giving up smoking was not easy, most of the other lads on my ward smoke, but I didn’t want to still be smoking when the ban came in. The support really helped me, especially seeing my CO readings staying low each time I came to the clinic”. **Dennis, Service user**

Provide harm reduction options to those who do not wish to stop smoking abruptly

NICE guidance PH45 identifies the opportunities presented by taking a harm reduction approach to tobacco smoking. They recognise four approaches to harm reduction that can be taken and these are;

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

South London and Maudsley recognise these options in their smokefree policy and provide the following directions for staff;

Making an attempt to permanently stop smoking is an opportunity not an obligation. During an inpatient admission a smoker has three options

OPTION 1: to temporarily abstain from smoking whilst in buildings and in the grounds, with pharmacological and/or psychological support
OPTION 2: to temporarily abstain from smoking whilst in buildings and in the grounds, without pharmacological and/or psychological support
OPTION 3: to use the opportunity to make a sustained quit attempt, with pharmacological and/or psychological support”

The policy goes on to stipulate that;

“Regardless of which option the patient chooses, every smoker should be offered NRT to manage their tobacco dependence within 30 minutes of arrival to an inpatient unit.

This should be followed up by the offer of tobacco dependence treatment support from a ward tobacco dependence treatment advisor".

Ensure smoking cessation medications are widely available and accessible

Ensure that different forms of NRT are readily available and accessible (on every ward) for service users to support attempts to stop smoking, reduce the harm of smoking and in the general context of managing nicotine withdrawal. Service users should be offered combination NRT and may require support that continues beyond the recommended 8-12 weeks.[3**Error! Bookmark not defined.**,46]

Hospital pharmacies should stock the full range of stop smoking medicines, including fast acting and slow release NRT products as well as varenicline (Champix) and bupropion (Zyban). Given that smoking cessation treatment will be more accessible, the demand for medication may be greater.

It is important to acknowledge that service users are typically more nicotine dependent, the amount of NRT required is likely to be higher than the general population and it is recommended to offer combination products (transdermal patches with a fast acting product) rather than a single product.

Implement NICE recommendation for NRT, bupropion and varenicline

It is important that those providing stop smoking services, and those responsible for prescribing medication, understand that the same treatments that are effective in the general population are effective in the population who live with mental disorders. Where previously there was considerable reticence to prescribe either bupropion or varenicline, research now shows that, providing care is taken to observe no deterioration in mental state, that both of these can prove effective in the management of nicotine withdrawal and have good outcomes for total cessation.

NICE has identified NRT, bupropion and varenicline as both cost and clinically effective, when delivered as part of an intensive intervention for smokers who wish to stop smoking. NRT in particular can be supplied to smokers who do not wish to stop, to help them cope with their nicotine withdrawal symptoms whilst receiving care in an entirely smokefree environment.[47] Varenicline is more effective than bupropion or single forms of NRT and varenicline is equally as effective as combination NRT.[48]

Varenicline is not contraindicated for use in those with mental disorders. Depression, suicidal thoughts, suicide attempts and completed suicides have been reported in people taking varenicline who have no pre-existing psychiatric conditions.[49] However, it should be noted that there is no evidence that varenicline is associated with an increased risk of depression or suicidal thoughts. The MHRA cautiously advises

particular care in patients with a previous history of psychiatric illness, and states that patients, family members and caregivers should be advised accordingly.[50]

Make full use of non-pharmacological intervention for smoking cessation

Non-pharmacological intervention is as important as pharmacotherapy and the following interventions are likely to be effective for people with mental disorders; (RCP/RCPsych, 2013);

- simple advice from doctors
- smoking cessation advice given by nurses
- multi-sessional intensive behavioural support
    - more effective in groups than individual
    - more effective than self-help or other less intensive interventions
- telephone support and multiple call-back counselling improves cessation rates
- some internet based interventions

A discussion of the merits of these interventions and rating of the evidence that supports them can be found in the local stop smoking services, service and delivery guidance 2014 published by the NCSCT and available here http://www.ncsct.co.uk/usr/pub/LSSS_service_delivery_guidance.pdf

Review service user therapeutic activities

Relief of boredom is a common reason given for the high levels of smoking observed in mental health service users in hospital. Research has shown that patients experience significant boredom due to lack of structured activities[51] and that they became more engaged in ward activities when there was a smokefree policy.[52]

Considerations to be made are:

- working with service users on an individual basis to find out what activities are important to them and best fit their needs and interests
- replacing staff and service users' smoking breaks with fresh-air breaks
- providing more physical activity recreation outlets for staff and service users
- recognising staff for promoting healthy therapeutic activities with service users
- providing motivational tools for staff and service users such as pedometers to measure the number of steps taken during a break
- use this as an opportunity to encourage healthy lifestyles
- increase the range of activities available

Moving towards entirely smokefree sites offers the opportunity to increase the engagement of patients and staff in a range of activities to support physical health.

Mental health services may not have specialist expertise in weight management and may need to work in collaboration with other local services specialising in local obesity pathway and services.

Actions could include:

- ensuring key staff are aware of the NICE clinical guidance relating to obesity in adults and children[53]
- taking a wider health and wellbeing approach to the smokefree transition including providing and promoting healthy options and activities to replace smoking breaks
- converting areas previously associated with smoking to areas that promote physical activities

Continuity of care

It is important to ensure continuity of support and medication both on admission and discharge. Where a person is recieving support to stop smoking on admission, this support must be continued. Where this is not provided as part of the complete package of care from the trust, the local stop smoking service should be informed and invited to deliver support. Where this is provided as part of the whole care package care must be handed over to the appropriate community service on discharge. Primary care should be kept informed following discharge to monitor medication levels.

On discharge following a period of care, the discharge plan should include details of any cessation activity undertaken whilst in the hospital. Staff should ensure that any cessation care is handed over to a suitable community provider in a timely manner and make suitable provision for the supply of stop smoking medications; at least enough to last until the next appointment.

Outcomes of stop smoking service interventions assessed according to the Russell Standard[†], can be reported through the Local Authority commissioner to the Health and Social Care Information Centre (HSCIC). The HSCIC provides quarterly and annual reports on stop smoking service activity. Where services are provided outside of local authority commissioning structures, local arrangements should be made to ensure that this data is reported consistently and accurately. Any enquiries that are not resolved through conversation with the local authority stop smoking service commissioner should be addressed to the HSCIC directly.

Provide support for staff and visitors who wish to stop smoking

[†] The Russell Standard is a specific set of definitions that when adhered to ensure that each quit attempt is measured and reported in the same way and is therefore comparable across treatment settings

Higher rates of smoking are evident among mental health staff than in the general population. Mental health staff who do not smoke tend to show more support for smokefree policies and are more consistent in enforcing such policies. Hospitals have a responsibility towards their staff, those who smoke and those who don't.[25]

As highlighted earlier, providing support for staff to stop smoking is an important key contributor to successful implementation of smokefree policy.[35,42,54]

- Non-smoker managers were more likely to adopt complete bans than smoker unit managers
- Unit managers knowledge, attitude and practice also varied by their smoking status

From previous research it is important to understand that providing support for staff should be a continuous process.[35] Staff who smoke should be offered cessation support on site even if this is support for temporary abstinence while they are at work. They should be allowed to negotiate time to attend support sessions.[35]

Staff should also be signposted to their local stop smoking service if preferred. This will promote the message that staff are valued and that the hospital is committed to a smokefree policy. High profile events such as No Smoking Day or Stoptober can provide a catalyst for staff wishing to stop smoking.

It is also important to advise staff who do not want or are not ready to quit to use licensed nicotine-containing products to help them abstain during working hours. Mental health services providers should ensure that stop smoking medication is available for sale for staff.

Smokefree policy should also be applied to visitors as well. If required, visitors should be able to buy stop smoking medication on mental health sites to support their temporary abstinence while they are on NHS sites.

12 week community stop smoking session with Brent stop smoking service

Abdul is a 36 year old man of Asian ethnicity he was initially referred by his GP and has been living in the UK for a year. Abdul suffers with extreme depression a lot of the time due to having undergone severe trauma during a kidnapping about a year ago. He attends a mental health clinic once a week where he gets counselling. For the first few weeks Abdul would arrive in a depressed mood, he needed me to listen first, as at times he felt frightened and alone. Once we arrived at his Quit date which was on week five it was evident that Abdul wasn't quite ready to take that final step to completely quit. However he had greatly reduced his smoking. The following week during his 6th week of the programme he got a Carbon Monoxide reading of 1 and he had quit

smoking. At the end of the 12 week, he had successfully completed the programme and he felt confident that he wouldn't smoke.

"However for many clients who suffer with mental health conditions such as depression, Schizophrenia, Bipolar, Anxiety disorders amongst others - 12 weeks might not be enough time" **Caroline Evans, Mental health lead, Brent Stop Smoking Services**

Case study: Smoking cessation at a medium secure facility

When St Andrew's Healthcare opened William Wake House – a medium secure facility – in Northampton in 2010, they made it a non-smoking environment in order to improve the physical and mental health of service users. Two established units, Hawkins and Robinson, moved from existing accommodation to new smokefree facilities. Hawkins' service users with a learning disability and detained under the Mental Health Act were offered more intensive support. They were offered a 12-week smoking reduction programme prior to the move, which included information about the link between smoking and poor physical health, NRT and psychological support via the nursing staff and primary care practice nurse. However, only three of the thirteen smokers on the ward took up the programme and they quickly reverted to smoking again. Subsequently, a six week programme of reduced smoking was implemented. Each week the number of allocated smoking times was reduced. Prior to the move, Hawkins' service users were only smoking up to three cigarettes a day, which made the transition to the smokefree facility easier, especially as it was a 'whole-ward' approach. Service users on the Robinson ward were offered nicotine replacement and psychological support at the time of the move. Those without access to escorted leave within the grounds had to give up smoking completely, while those with the right to leave the building with an escort were encouraged to reduce the number or cigarettes they smoked, or quit. On each ward, a health promotion link nurse and a service user representative coordinated healthier living activities, including an increase in physical activity and healthier eating. The facility reports no rise in incidents of aggression and has not had any formal complaints since implementing the policy.

Case Study on Community based abstinence-maintenance support

"A need has been identified for individuals leaving mental health inpatient units, who may have quit smoking during their stay. There is a danger that a return to the community may become an opportunity for relapse should support, advice and medication not be available. Therefore MIND Croydon advisers will provide continuity of care through on-going appointments for appropriate individuals to prevent relapse and maintain abstinence. This will involve the usual provision or motivational interviewing, practical advice, carbon monoxide monitoring and access to medication." **Jimmy Burke, Senior programme manager, Public Health Croydon**

Case Study: Specialist Smoking Cessation Service in Camden, London.

ASCOT is a specialist smoking cessation service for people with psychotic disorders and bipolar disorder. It has been commissioned by Public Health Camden with funding provided by Camden Clinical Commissioning Group (CCG) to Camden & Islington Foundation Trust (C&I) to run a pilot from 2013-2015. ASCOT seeks to provide true 'parity of esteem' of the physical and mental health needs of our service users, by providing a programme of interventions tailored to the cognitive difficulties, high level of social exclusion, social incentives to smoke, and high levels of nicotine dependence often experienced by people with psychotic illnesses. All service users receive a full physical health and Chronic Obstructive Pulmonary Disease (COPD) screening on assessment, and are supported to access appropriate care when needs are identified. The service works with service users for a 6 month period, usually seeing people up to once a week. This allows time to engage in pre-quit therapeutic work to build the resilience and self-efficacy required to make a quit attempt, and to sustain their identity as a non-smoker. The service has achieved an average engagement rate of 80% since inception. Service users are offered at least three opportunities to engage with the service, and if engagement is unsuccessful they are re-offered the service after 6 months.

Step 7: Staff training and education

All frontline staff should be trained to deliver advice on stopping smoking and referral to intensive support, in line with PH48 recommendations:

- ensuring relevant curricula for frontline staff include the range of interventions and practice to help people stop smoking
- ensuring that all frontline staff are trained to deliver advice around stopping smoking and referral to intensive support, in line with recommendations 1 and 2. They should know what local and hospital-based stop smoking services offer and how to refer people to them
- review online training to ensure that it is compliant with bet practice and can be completed and updated annually as part of NHS mandatory training (for example, training provided by the NCSCT)
- ensuring all frontline staff are trained to talk to people in a sensitive manner about the risks of smoking and benefits of stopping
- ensuring all staff who deliver intensive stop smoking support are trained to the respective minimum standard described by the NCSCT (or its equivalent), with additional training that is relevant to their clinical specialism
- ensuring all staff are provided with information about smokefree policies and instructions on maintaining a smokefree work environment

Identify staff training needs

Mental health staff may require training on general or more specific aspects of smoking and mental health, in order to equip them with the confidence and knowledge to be consistent and fair in their enforcement of your smokefree policy.

Topics on which your staff may need more training fall into four broad groups:

- general context
- smokefree policy
- smoking and medication
- smoking cessation and reduction

General context topics include:

- understanding the relationship between smoking and mental health
- understanding the reasons why people with mental health problems smoke more
- interaction between mental health medication and smoking
- understanding common myths surrounding smoking and mental health
- wider contexts of health promotion and health equality

Smokefree policy topics include:

- understanding the evidence base for smokefree policy in mental health settings
- understanding the hospital's smokefree policy, including enforcement
- knowledge of successful smokefree policies elsewhere
- challenging smoking on the grounds
- staff roles and responsibilities in maintaining a smoke free work environment
- knowledge of hospital protocols relating to the smokefree policy
- use of existing skills to manage aggressive smoking-related incidents, both verbal and physical and what action to take in the event of negative responses to smoking restrictions

Smoking and medication topics include:

- understanding how NRT works and how to use it effectively
- policy on systematic prescribing of NRT
- recognising signs of nicotine withdrawal symptoms and contraindications of other pharmacotherapy used in smoking cessation
- difference between nicotine withdrawal symptoms and behaviour associated with mental health problems
- clinical relationship between smoking and medication prescribed to mental health service users
- monitoring and adjusting medication appropriately during quit attempts

Patient Group Direction (PGD) for NRT

NRT is also a very safe treatment and can therefore be administer by other health professionals in addition to physicians.[45] This will ensure it is as widely accessible to patients on the ward and during admission. All smoking cessation advisors should be PGD trained. However PGDs may not always be the best way to supply NRT because the PGD has to be followed precisely and there is little room for professional discretion.[50] Mental health trust could develop a local protocol to manage NRT in the hospital.

"Providing NRT promptly and in sufficient quantity to a smoker who is admitted to a smoke free environment is essential. We have 3 ways of achieving this; one of the best option is by using the 'homely remedy' policy. This authorises all registered nurses to administer NRT for up to 24 hours following admission. Patients who start on NRT straight away on admission are more likely to continue using it and are more comfortable through their admission" **Mary Yates, Nurse consultant, South London and Maudsley NHS Foundation Trust**

Ensure training is available to address these needs

You will need to put effort into raising the profile and priority attached to training staff, ensuring that training resources (in-house and external) are identified and tapped-into and that staff time is allocated to training. Courses may be accredited and can form part of an employee's personal development plan. A challenge identified by some stakeholders is the time away from work required for staff to train.

Ways of addressing this could be:

- ensure that any bespoke training is as efficient and focused as possible, for example brief intervention training can be undertaken in one half-day
- examine possibilities of local training programmes being run by local stop smoking service
- consider training selected staff, for example your champions, to a more detailed level, so that they in turn can educate others in a 'cascade' model of training

Case Study: Smoking cessation training at Murray Royal Hospital

At Murray Royal Hospital, NHS Tayside, one member of staff on each ward has received special training in smoking cessation in order to be on hand to support and encourage service users wanting to quit. Murray Royal is currently developing an action plan to train other staff in delivering brief interventions.

- make sure that the training needs of dealing with aggressive verbal and physical incidents related to smoking are mainstreamed into generic mental health training
- make use of the staff intranet for highlighting issues such as signs to be aware of in relation to nicotine withdrawal and the relationship between smoking cessation and Clozapine

Case study from Berkshire Healthcare NHS Foundation Trust

"There is a misconception that smokers living with mental health problems are unlikely to give up smoking. However, evidence shows that they can quit successfully given the right support. YooQuit Care is useful as it gives professionals working in mental health settings the confidence to raise the issue of smoking and help kick start successful quit attempts." **Dr. Lisa McNally, Public health consultant, Bracknell Forest Council**

Solutions 4 Health introduced YooQuit Care, an online interactive learning system. YooQuit Care allows professionals to gain the knowledge and skills required for effective brief intervention. It contains a whole host of tips for how to approach the issue of smoking in a non-judgmental and supportive way, and if appropriate, referral on to the Smokefreelife Berkshire stops smoking service. Following completion of the

online training in the Berkshire Healthcare NHS Foundation Trust, the online learning system has been proven to significantly increase the confidence levels of staff, with 93% of the 1500 users feeling more comfortable in brief intervention and 86% feeling assured that they can successfully help smokers to quit. For more information regarding the online learning, contact Solutions 4 Health info@solutions4health.co.uk

Case study: Smoking cessation success in South West London

In 2010, South West London and St George's Mental Health NHS Trust established a smoking cessation project to support delivery of its commissioning for quality and innovation (CQUIN) targets. The targets aimed to improve access to smoking cessation information, advice and support for mental health service users, and recorded smoking status; the number of referrals to the smoking cessation service; the number of smokers referred who set a 'quit date'; and a service feedback after 12 weeks.

The project has seen smoking cessation training introduced into the trust's mandatory induction programme. So far, 90 per cent of all relevant clinicians have received smoking cessation brief intervention training, enabling them to deliver brief interventions for identified smokers. Smoking status is noted at initial assessment and recorded on RiO (an electronic patient records system), with 85 per cent of the trust's current caseload registered. If service users indicate they would like to change their smoking habits, a referral is made to the largely community-based cessation clinics. Support to inpatient units is also offered. Service users can also self-refer for support. The smoking cessation clinics offer a 12-week programme of weekly sessions (individual or group), regular carbon monoxide monitoring, pharmacological therapy advice and behavioural change therapy sessions. Close liaison with medical teams ensures medication dosage is monitored.

A dedicated project board team brings together senior staff, clinicians, technicians and specialists from key areas of the trust and drives the programme throughout the organisation. The programme content is tailored to the specific needs of mental health service users and is run by a dedicated team of NHS-accredited smoking cessation practitioners with a range of therapeutic skills and qualifications, including cognitive behavioural therapy, counselling and health promotion interventions. Having additional mental health experience and skills enables smoking advisers to deal with the complex issues they may come across. Over 700 smokers have been referred to the smoking cessation clinics, and more than 30 per cent have either quit or significantly reduced their cigarette intake. While some smokers have been unable to stop completely, their smoking reduction offers immediate health benefits and may give them the confidence to give up at a later date.

For more information, email mark.clenaghan@swlstg-tr.nhs.uk

Step 8: Communicate your policy

Emphasise the positives for service users

- mental and physical health improvement
- reduction in stress level
- reduction in symptoms of anxiety and depression at least as large as the effects of antidepressants
- increased sense of self-esteem
- saves money
- better environment for their carers/families to visit
- increased control over their lives
- reduction in some medications by up to 50% within a month of stopping smoking

"A lot of service users hate taking medication and the smoke free policy could be attractive to them if their levels of medication reduce as a result of quitting." **Mary Yates, Nurse consultant, South London and Maudsley Mental Health Trust**

Communicate in positive language:

All communications should emphasise the positives of stopping smoking and this should start with the policy. All policies should draw on the understanding that they are in place to protect smokers and non-smokers from the harmful effects of smoking, rather than they are in place to "ban" smoking, or castigate smokers. Thinking and speaking in terms of the hospital recognising, that helping people to stop smoking plays an important part of caring for them as a whole person, rather than treating their mental health as a separate issue to their physical health, will help to set the scene for a positive change happening.

Identify and acknowledge challenges and involve stakeholders in identifying solutions/compromises

Both the current literature and the interviews conducted as part of this guidance review, suggest that similar staff concerns emerge repeatedly across mental health settings. For example, general concerns about smokefree policies in mental health settings raised in a survey of staff in psychiatric units in England[25] were:

- service users may abscond
- service users may refuse to be admitted
- service users' stress and anxiety levels will increase

- service users will become more aggressive
- service users need to smoke as there is nothing else for them to do
- smoking helps service users with social contact
- nothing can be done as smoking is so prevalent amongst service users
- human right to smoke will be infringed
- smoking ban will seem like a punishment for being mentally ill

Whilst acknowledging such anxieties, it's important to reminding staff of the health and equality rationales for going smokefree and enlist the help of concerned staff in addressing their own anxieties with constructive solutions. It is also notable that in those areas where extended smokefree policies have been enacted, that these concerns have not emerged as actual issues. Suggestions for a question and answer session on common challenges to smokefree policy are provided in Annex A.

Identify and advertise a firm date for implementing your policy

You may wish to choose an implementation date that avoids holiday periods, where normal ward routine is interrupted or staffing levels are low. An exception would be New Year's Day, which can be a positive day for focusing on stopping smoking. National No Smoking Day in March and Stoptober in October could be used as the start date for your policy as many people will use these as an opportunity to stop.

Set the start date to allow for ample lead-in, with time allocated to each step in the preparation for implementation.

Once the date is set, countdown signs advertising this should be placed in prominent positions such as hospital entrances so that service users, visitors, staff and contractors are all reminded frequently of the forthcoming policy implementation.

Develop and put in place a pre-implementation communication policy

In addition to a visual countdown, consider the following ways to communicate the policy:

- ensure that there are clear signage of smokefree in every ward, corridor and stairwell (Yorkshire and Humber region advice is for signs that are, 'not too small to appear insignificant or too large to come across as shouting')
- provide clear and consistent messages about the need to keep buildings and grounds smokefree
- produce and distribute leaflets that explain the policy rules in easy and straightforward language and tailor these to the needs of service users with learning difficulties (RCPsych has a, 'help at hand' leaflet on smoking)

- display posters in prominent places providing information about the policy and what support will be available for staff and service users
- all job advertisements, job descriptions, contracts and so on should mention the smokefree policy and its implementation date
- advertise in the local press if the policy affects the public for example if the grounds are open to the public
- alert service users to the date as part of the admission procedure
- advertise details of in-house and community smoking cessation services in poster and leaflet form
- board members and key members of the implementation group should make the time to talk to staff and service users personally to reaffirm that the policy is supported at the highest level
- consider alternative ways of communicating the date, such as printed t-shirts for staff, organisation intranet and information in payslips
- use your champions to remind staff and service users informally about the forthcoming implementation date
- include details of the countdown and implementation date in all correspondence with the service users and their families
- celebrate success stories and reductions in smoking rates in the lead up to the implementation date
- including updates on the policy in the staff newsletter, with pieces on, for example, debunking myths about mental illness and smoking
- encouraging networking at relevant seminars and conferences, which provide the opportunity for staff to exchange experiences with others dealing with smoking amongst mental health service users
- making presentations at regular staff meetings
- communicate with GPs, primary care and CCG regarding smoke free policy
- communicate policy with community mental health teams so that they can advise new service users of the policy prior to admission and regarding home visits
- emphasise staff responsibility includes not smoking at any time during working hours or when recognisable as an employee, contractor or volunteer
- inform ancillary services regarding smoke free policy
- take action in line with recommendations 11 and 12 in NICE guidance PH48; developing and communicating the smokefree policy

"Ensure effective communication with people who use services and their families. At CWP we included information about the new policy on all clinic letters. We tasked care coordinators with discussing the new policy with every patient and produced leaflets and posters. We also provided opportunities for people to raise concerns either with staff or with lived experience representatives who visited wards to talk with patients about the new approach" **Avril Devaney, Director of nursing, therapies and patient partnership, Cheshire & Wirral Partnership NHS Foundation Trust**

Step 9: Implementing your policy

"Firm pathways from inpatients to outpatients and outpatients to inpatients need to be established in order to ensure smokers are prepared for a forced change to their smoking on entering the hospital as well maintaining any changes in the community at discharge" **Mary Yates, Nurse consultant, South London and Maudsley Mental Health Trust**

At implementation of your smokefree policy your main emphasis should be on:

1. Reinforcing positive messages
2. Education and training
3. Ensuring availability of interventions is matched to need
4. Supporting staff in the management of smoking
5. Consistency in approach and enforcement including to breaches
6. Support and co-ordination of care following discharge

1. Reinforcing positive messages

- provide visible support for the policy from administrative and clinical leaders, advocacy, carers and champions of the policy
- continue to communicate the policy via different media, both internal to the hospital and externally, for example, features in the media
- continue to locate the policy within wider health contexts of improving quality of service user care, physical and mental health promotion, equality of healthcare
- identify success stories for service users, staff and the organisation and celebrate them

2. Education and training

- maintain your programme of staff training to ensure staff have access to training and continuing professional development as appropriate, and any new staff are equipped to work effectively within the smokefree policy.
- include very brief advice (VBA) as part of mandatory training requirement
- provide smoking cessation resources such as carbon monoxide monitoring device and other smokefree resources.
- staff appraisals and personal development plans reflect the needs to deliver smoking cessation programme.
- attend annual refresher training

"It was important to support staff and remind them that they use motivational skills every single day. Staff training to level 2 was critical in boosting confidence for staff and patients. Our message is that 'If you need to come into any of our wards we will have someone with you who is trained to assess your nicotine dependency and prescribe for you within 3 minutes of your arrival" **Inpatient manager, Cheshire & Wirral Partnership NHS Foundation Trust**

3. Ensuring availability of interventions is matched to need

Training should equip staff to support service users who want to gradually quit smoking, reduce their cigarette consumtion or temporarily abstain from smoking. Regardless of which option the service user chooses, every smoker should be offered stop smoking medication during admission and through their stay in hospital.

NRT should be provided to service users who smoke within 30 minutes of arrival where this is required to support them in managing their nicotine addiction. This should be followed up by the offer of tobacco dependence treatment support from a suitably trained advisor. The combination of medication and intensive behavioural support is the most effective method of managing tobacco withdrawal symptoms during a period of temporary abstinence. A combination of two products, such as a patch and an oral product may be be more effective in helping the user to manage their nictoine addiction than a single product.

4. Supporting staff in the management of smoking

- Provide smoking cessation service for all staff to access
- Occupational health staff should make all new employees aware of the smoking cessation support within the Trust
- Onsite NRT available for staff to manage nicotine withdrawals
- Local arrangement within Trust for staff to attend smoking cessation clinic during working hours.

5. Consistency in approach and enforcement including to breaches

- Define and communicate your enforcement policy and address any breaches. Refer to Step 3 and Step 5.

6. Support and co-ordination of care following discharge

For service users who leave hospital and return to live in their community or another mental health setting, it is important to give them as much support as possible to:

- continue with the behaviour intervention, whether this be quitting smoking, or a reduction in level of smoking
- continue with other healthy choices they may have made in hospital e.g. in relation to regular exercise and diet.

There are several ways in which you could provide this support.

- Include the service user's management plan and any healthy lifestyle choices within their discharge/ continuing care plan.
- Liaise with primary care colleagues, relevant follow-up agencies and local stop smoking services to ensure continuity of support for the service user on discharge, including adequate and available supply of pharmacotherapy/ non-pharmacotherapeutic interventions
- Follow-up agencies may include, outpatient programmes, mental health case managers, voluntary organisations with a focus on mental health, other mental health hospitals/settings and GPs
- Ensure that discharge smoking status and the clinical impact of changes to this status are communicated to receiving partners, given the implications that changes to this status have for Clozapine and Olanzapine metabolism.
- Liaise with families and/or carers of the service user to educate them on how they can support the service user with smoking cessation or reduction on their return to the community.
- Provide the service user with information in which you list contact details for relevant smoking cessation services and other organisations, such as telephone helplines which can provide on-going support for their smoking reduction/quit attempts.

"The Stop Smoking Service, the Mental Health Trust-including IAPT and GP's all have a part to play in the success of continued patient support" **Stop smoking facilitator, Kick IT Stop Smoking Service**

Step 10: Evaluation

Part of becoming a smokefree service involves using robust evaluation to assess the effectiveness and efficiency of the policy. Consider what longitudinal monitoring information (if any) you collect at present and decide what else needs to be recorded for monitoring and evaluation purposes. For example, you may currently record the number of incidents, but may need to set up a record of the number of smoking-related incidents. Consider both objective and subjective measures:

- staff opinions (perhaps gathered in surveys or discussion groups).
- service user opinions (surveys and discussion groups with service users and/or their advocates could produce information on views)
- recording of smoking status
- referral to the on-site stop smoking clinic
- levels of smoking (staff and service users)
- levels of medication
- use of NRT
- smoking-related incidents (frequency and type) and breaches to the policy
- use of *pro re nata* (PRN) medication
- number of service users/staff making quit attempts
- percentage of service users/staff with quit

Set up a monitoring and evaluation framework including baseline data if possible

It is important to set a date for a formal review of the policy. This could be planned for six months initially and annually thereafter. It may be useful for the implementation group to meet quarterly in the first year of operation of the policy to identify and address any teething problems. Monitoring and outcome data should be presented to the trust board annually and the policy modified accordingly.

There may be opportunities to benchmark your data against data emerging from other mental health settings or national data, and to network with others collecting monitoring and evaluation information across England.

Other issues

- liaise with public health to highlight level of unmet need so that this can feed into the local joint strategic needs assessment
- identify and address problem areas to emerge from analysis of the monitoring and evaluation data
- assess whether further estate changes and implementation plan should be made to support the policy more effectively

Annex A: Common challenges to policy

Service users will become aggressive if they are told they cannot smoke

This is a common concern prior to going to smokefree. Reviews of smokefree policy in mental health and addiction settings indicate that comprehensive or partial smokefree policies have no major untoward effects on behaviour of the frequency of aggression.[55] This includes one maximum secure setting, where total disruptive behaviour and verbal aggression was reported as reducing significantly following implementation.[4,56] This was further confirmed by the experiences of Broadmoor and the pilot for South London and Maudsley. Any risk of violence or aggression towards staff should be identified and local procedures for the management of this risk should be applied.

Service users' stress and anxiety levels will increase

While many people believe that smoking helps relieve stress and anxiety, the opposite is true. A recent study showed that those succeeding at stopping smoking (with support) experienced a reduction in anxiety symptoms compared with baseline, rather than an increase which many may expect.[57] The impact of stopping smoking on mood and anxiety disorders has been shown to be at least as large as an antidepressant[32] and when used correctly, pharmacotherapy can minimise nicotine withdrawal symptoms, which may be relatively short lived.[58]

Service users need to smoke as there is nothing else for them to do

An important part of smoke free transition should be to provide alternative therapeutic activities for service users. Given that staff will not need to facilitate smoking breaks there should be more time available for them to do so. This was successfully implemented with the South London and Maudsley pilot, which found that there was also better engagement in their therapy programme, with service users attending more sessions and staying for all the sessions.

A secure unit represents the in-patients 'home'; therefore they should be able to smoke

A ruling by the Court of Appeal (July 2009) concluded that Rampton high secure hospital in Nottinghamshire (and similar establishments) could not be considered to be a private home within the context of Article 8 of the Human Rights Act 1998, as it was a public institution, a public place and not a private place.[59]

Doesn't this breach service user's human rights?

The Human Rights Act 1998 allows an individual choice only if that does not endanger others. The human rights argument is not applied to other forms of substance use, and people are not allowed to drink alcohol or use illegal drugs in mental health units.

There will be problems with service users putting on weight

Concerns around weight gain, as with other concerns, should be addressed and actions to mitigate risks should be implemented. Staff are encouraged to support action through application of other relevant NICE guidance such as that around obesity and minimising weight gain.[53]

Many staff smoke and may not agree with, or may be reluctant to implement smokefree policies

Hospitals have a responsibility towards their staff, both smokers and non-smokers and staff should be supported to stop In line with NICE public health guidance (PH5) to promote smoking cessation in the workplace.[60] If they choose to continue to smoke it is still important that they comply with this policy. It is important to take time to consult extensively with staff in the run up to becoming smokefree, to listen to their concerns, and to communicate the policy and the expected positive outcomes.

There is a general lack of understanding by staff and service users about the interaction between smoking cessation and antipsychotic medication

This is true and it is therefore important to make sure that staff and service users are aware of the potential to reduce medication. Providing clear and consistent information as part of the journey to smokefree will help service users and staff become aware of the potential to reduce drug doses and the associated reduction in side effects. Staff should receive training about the need to monitor medication during smokefree transition.

An inpatient isn't the right time to make a quit attempt

Studies have shown that people with mental health problems are just as likely to want to stop as the general population and are able to stop when offered evidence based support.[26,61] Furthermore, there is clear evidence that admission to inpatient wards is an opportunity to change smoking behaviour. [28,62]

There will be safety problems such as smoking in bedrooms and other unauthorised areas and individuals using wire and battery to light cigarettes in their room

Consultations with staff in the lead up to smokefree should establish a clear policy for any breaches of security and this should be communicated consistently and clearly to service users. A survey of mental health trusts,[4] which looked at difficulties and challenges associated with smokefree policy implementation, found that anxieties related to incidences proved unfounded. However it is important not to minimise this concerns. Smoking in bedrooms are will inevitably occur and happens whether Trusts implement a comprehensive policy or not. If it occurs, it should not be seen as a failure of the policy but an opportunity to review the patients care plan to ensure they are receiving the correct pharmacological and behavioural support to manage temporary abstinence. It is also important to review Trust searching, security and fire policies as there might be cases where patients using contraband items or alternative means of lighting cigarettes on the ward. Recognition of this risk on the appropriate environmental risk with mitigating actions will be useful in planning, implementation and management.

This will be too expensive to implement

Providing smoking cessation support for people with mental health problems is one of the most cost effective lifesaving public health or medical interventions available through the NHS.[63] As well as the wider benefit to the NHS, there is the potential to free up valuable staff resources on the unit. South London and Maudsley NHS Foundation Trust, estimated that in going smokefree they release 90 minutes per shift, lost by facilitating smoking breaks in their forensic unit. In addition the potential to reduce the bill for certain medications may be financially attractive.

Annex B: Smokefree policies and resources

Smokefree policy

South London and Maudsley NHS Foundation Trust

http://www.slam.nhs.uk/media/347567/Smoke%20Free%20Policy%20v5%20-%20%20March%202015.pdf

Cheshire and Wirral Partnership NHS Foundation Trust

http://www.cwp.nhs.uk/policies/2691-cp28-nicotine-management-policy

Resources

PH 48 self-assessment tool for mental health breaks down the NICE guidance into four areas;

- The system required to implement the guidance
- Communication required
- Training for staff
- Treatments to support staff and service users

You can start using the model by completing the FREE self-assessment questionnaire available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/404726/Introducing_the_self-assessment_tool_for_mental_health_NICE_PH48_.pdf

Suite of videos that explains all the four areas is availble at https://www.gov.uk/government/publications/smoking-cessation-in-secondary-care-mental-health-settings

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Prof. Ann McNeill, Professor of Tobacco Addiction, Kings College London
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Katy Harker, Registrar in Public Health, Action on Smoking and Health

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