November 2021: NICE guidelines PH45 (June 2013) PH48 (November 2013) have been updated and replaced by NG209.
The recommendations labelled [2013] or [2013, amended 2021] in the updated guideline were based on these evidence reviews.
See www.nice.org.uk/guidance/NG209 for all the current recommendations and evidence reviews.

Smokefree Mental Health Review

Expert testimony to the NICE PDG on tobacco harm reduction

Expert paper 5:
'Smokefree mental health review', by Ian Gray, Chartered Institute of Environmental Health and Hilary Wareing, Co-Director, Tobacco Control Collaborating Centre

Introduction

The following draft abstract of a research report (not yet published) relates to six months work carried out in early 2010 by Hilary Wareing, a Clinician and Co-Director of the Tobacco Control Collaborating Centre and Ian Gray, Principal Policy Officer of the Chartered Institute of Environmental Health (CIEH) and responsible for leading the CIEH training of Compliance Officers in preparation for implementation of the Smokefree Legislation in 2007.

It appraises the way in which the smokefree legislation, as it applies to Mental Health Service in the English NHS, has been implemented. It was undertaken following concern regarding the appropriateness of the general smokefree legislation applying to enclosed public places and workplaces being used in the field of mental health. It was argued that service users' human rights were breached by applying the policy to situations which often provided a long term residence for mental health patients and that the risk to staff in ensuring compliance with such legislation upon sometimes stressed individuals was disproportionate to the benefit to staff of securing a safe smokefree environment. Others pointed to the entrenched 'smoking culture' of mental health services with up to 70% of service users being smokers (Jochelson and Majrowski 2006) and the inherent difficulties of addressing such a situation.

However, as 'New Horizons – a shared vision for mental health' (December 2009) points out: 'People with mental illness have significantly higher rates of mortality and morbidity from physical illnesses such as cardio-vascular disease, diabetes, and obesity … some behaviours that increase the risk of physical illness, such as smoking, drug and alcohol abuse are higher among those with mental illness, however, they often miss out on … smoking cessation interventions' (p52).

In fact life expectancy rates for people with a mental illness diagnosis are dramatically poorer than for the general population and smoking behaviours are not merely more common (up to four

times the rate in the general population) but such smoking is far heavier with over half of such smokers consuming 20 or more cigarettes a day.

Furthermore the principle of ‘normalisation’ is increasingly difficult to adopt with a Mental Health Service which would have been out of alignment with smoking practice in the rest of society.

It is against this background that this study was undertaken.

Abstract

Objective

To investigate the application of smokefree legislation to mental health settings after two years of implementation.

Method

An observational survey supported by a self administered questionnaire undertaken in a broad range of mental health facilities across England. The two hundred and twenty units addressed were selected to ensure geographical setting, level and type of service. Eighteen per cent of the sample was from the independent sector as it is a significant provider of mental health services to NHS patients.

A questionnaire asked about compliance with and attitudes towards the smokefree legislation. In addition it asked for information about the prevalence of smoking amongst staff and patients, the management of smoking and the availability of cessation support.

Visits were made to twenty eight of the selected units. They were identified from a cross section of respondents whose returns appeared to report exceptionally good in their practice, those who reported problems and some who had simply not replied to the questionnaire.

The initial key questions set for this investigation were:

a) Are mental health facilities complying with the smokefree legislation?

and

b) What has happened to smoking?

A scoring system was developed and notes were made during the visits pertaining to the areas to be scored. The visits included observation and discussion regarding:

- Compliance with legislation
- Policy - Staff
- Policy - Patients/Visitors
- Signage
- Knowledge/attitude of staff
- Provision for smokers - physical and organisational
- Treatment - range/availability
- Behavioural support
- Problem solving
- Availability of activities

Results

From the replies to the questionnaire there appeared to be significant satisfaction by respondents with the implementation of the smokefree legislation in mental health settings. Ninety three per cent of respondents described the implementation of the legislation as having been successful.

From the observational visits it was established that mental health facilities in England were complying with the smokefree legislation. Only one unit was found to be operating in outright defiance of the law.

Elsewhere the problems lay less with a deliberate disregard for the legislation and rather reflected inadequate responses to incidents by management and staff.

Difficulties in implementation were reported and observed, particularly the amount of staff and patient time spent managing and engaging in smoking breaks.

However, in general, respondents perceived smoking to have diminished when compared with the experience before 1 July 2008.

Despite the finding that compliance with legislation was good it was clear that the concept of 'smokefree' as used in the units we visited was generally very ambiguous, confusing or simply resulted in 'mixed messages'.

The most common place where smoking by patients appeared to be allowed was in 'designated areas' in the grounds where this formed part of a unit's smokefree policy.

The most difficult area, which defeated most service providers, was managing smoking in their grounds.

In general there was reported poor use of the 'NHS Stop Smoking Services Service and Monitoring Guidance 2010/11' with very few reporting full compliance with or even the knowledge of the guidelines.

This may be attributed to a lack of knowledge about the effect of smoking and appreciation of its interaction with mental health conditions as well as the attitude to the physical wellbeing of their patients.

Smoking policies affecting staff were also seen to be difficult to manage. Several units reported that staff who smoked continued to be allowed extra cigarette breaks. It was the comparisons between units that raised interesting issues for further investigation.

There appeared to be little correlation between what was observed on the ground in the units which were visited and the responses received through completion of the questionnaire. Therefore the value of this research was in the observational visits.

Conclusions

Overwhelmingly tobacco use was being treated as different from other addictions and in some ways less serious or life threatening.

If the status quo were to continue this would mean many service users would continue to fail to benefit from the very significant changes in legislation, behaviour and attitude affecting smoking in our society in general. Many staff and patients have got use to 'rubbing along' with the constraints on smoking whilst leaving staff exposed to secondhand smoke, producing significant costs to the organisation in health and maintenance and to individual service users in terms of life expectancy and physical dependence. Failure to address these issues will maintain a situation where service users with mental health problems also demonstrate very severe physical health deficiencies.

Options which should be considered are:

greater management of smoking to reduce tobacco consumption with clear guidance for organisations, staff and patients,

or

the removal of tobacco use from mental health settings.

Introduction

Methods

During 2010 the Chartered Institute of Environmental Health (CIEH) and the Tobacco Control Collaborating Centre (TCCC) examined the implementation of smokefree legislation as applied to mental health facilities in England. The work was undertaken by Hilary Wareing a clinician and Co-Director of the TCCC and Ian Gray, a Principal Officer of CIEH and responsible for leading the CIEH training of Compliance Officers in preparation for implementation of the smokefree legislation in 2007.

Two hundred and twenty units were selected from NHS and Independent providers of mental health facilities. The units were selected to ensure a full range of geographical setting, level and type of service were appropriately represented in the survey. See Table 1.

Table 1

	Totals	Rehabilitation		Day Care		Acute Inpatient		Low Secure		Medium Secure		High Secure		PICU		Detox		Other	
		NHS	IND	NHS	IND	NHS	IND	NHS	IND	NHS	IND	NHS	IND	NHS	IND	NHS	IND	NHS	IND
East Midlands	26	3	2	1		6		4	2	2	2	1		2			1		
East	26	4	2	1		6		5		2				2		2		1	1
London	21	3		2		4	1	1	1	3				3			2		1
North East	12	3	1	1		4				1					1		1		
North West	30	5	2	2		5		4	1	2	1	1		5	1		1		
South East	32	6	2	5	1	8		3	1	1	2	1		1		1			
South West	27	5	1	2		6		3	1	2				2	1	2	1	1	
West Midlands	22	4	2	2	1	5		1		4				2		1			
Yorkshire & Humber	24	5		2		5		3	1	2	1			3		1	1		
		38	12	18	2	49	1	24	7	19	6	3	0	20	3	7	7	2	2
		50		20		50		31		25		3		23		14		4	
Questionnaires Received		23	11	9	1	42	2	16	5	13	3	3	0	13	0	0	5	1	0

Total sent	220
NHS	180
Independent	40

Total returned	147
NHS	120
Independent	27

The questionnaire was based on work undertaken by [1]Dr Sharon Lawn (Flinders University, Adelaide) and was adapted, developed and coupled to observational visits in order to fulfil the research objectives.

The questionnaire asked about compliance with and attitudes towards smokefree legislation. In addition it asked for information about the prevalence of smoking amongst staff and patients, the management of smoking and the availability of cessation support.

It is important to recognise two significant caveats:

> The respondents' responses remain just that – our visits did not consistently demonstrate congruence between our observations and the questionnaire return already received in many instances.
>
> The views demonstrated in the responses were sometimes inconsistent, even in a single return. For example, returns claiming satisfactory implementation might also report breaches, secret smoking or challenges from service users which jeopardised staff safety.

In addition to the detailed analysis of the different service providers' responses we undertook visits to twenty eight units. These were drawn from a cross section of respondents which on the face of the questionnaire returns appeared to be exceptionally good in their practice, those who had reported problems and some who had simply not replied to the questionnaire. It seemed to us likely that we would find a difference in practice as a result of these differences in response. All units approached agreed to be visited.

The selection of sites for visiting was determined against the following criteria:

- Type of facility – to represent the range
- Geographically by region
- NHS/Independent
- Critique of the questionnaires i.e. indication of
    - exceptional practice
    - likely non-compliance
    - non return.

[1] ***Ref:*** *Lawn S, Campion J (2008) Smoke-free initiatives in psychiatric inpatient units: A national survey of Australian sites. Flinders University, Adelaide, Australia. ISBN 1 920966 16 1*

The primary areas of observational investigation were:

a) Compliance with the smokefree legislation

and

b) What has happened to smoking?

The investigators started each visit with a recording sheet covering selected areas which had been identified as the key issues to be observed/discussed. However, it quickly became clear that the tool was too cumbersome. A scoring system was developed in order to be able to compare and contrast.

Scores were allocated independently by each investigator over ten areas, with a maximum of five points in each, which affected both the compliance with the legislation and management of smoking in each of the units as shown in the table in the Results section. The maximum score that could be achieved was 50.

The visits were made after consideration of the information given in the questionnaire and background information about the nature of the facility.

The investigators were accompanied by members of staff and were given access to all facilities and were able to interview members of staff and patients without unreasonable restriction. Records were made and photographs taken. Also, advice was often sought and given both in the course of the visit and subsequent to the visit.

Results

Overall there appears to be significant satisfaction with the implementation of the smokefree legislation in mental health settings. Ninety three per cent of respondents described the implementation of the legislation as having been successful, ranging from 100% in high secure settings to 80% in day care centres.

Difficulties in implementation were reported in medium secure and day care units and to a lesser degree in acute inpatient units. The most common place where smoking by patients appears to be allowed is in 'designated areas' in the grounds.

The number of patients reported as being smokers varied significantly between respondents. Sixty two per cent of respondents in medium secure units reported over 60% of patients to be smokers; 86% in low secure units; 92% in Psychiatric Intensive Care Units (PICU); 67% in residential rehabilitation, 43% in acute, 66% in high secure and only 20% in day care units.

In general it is the case, though not for example in PICUs, that respondents perceive smoking to have diminished significantly when compared with the experience before 1 July 2008.

It is clearly desirable that the smoking status of patients is known and recorded on admission. This does seem to happen currently in most cases. Between 90%–100% of units reported that in-patients were asked whether they smoked, however in medium secure only 81% were asked and in day care only 60%.

In general there is reported to be poor use of the 'NHS Stop Smoking Services Service and Monitoring Guidance 2010/11' with very few reporting full compliance with the guidelines and many actually saying that they had not 'got around' to applying the guidance at all.

The issue of being a smokefree site is however discussed with a very large proportion of patients at their admission. Leaving aside day care units, such discussion on admission was taking place in well over 90% of all such admissions. In general pre-admission procedures did provide information to the service user regarding each unit's smokefree status.

Below is an overview of comparative responses to some key questions taken from the questionnaire. See Table 2.

Table 2

Issues	High Secure	Acute	PICU	Medium Secure	Low Secure	Residential Rehab	Day Care	Detox
Successful implementation (Q4)	100%	91%	100%	94%	95%	94%	80%	100%
Smokefree site (Q5)	100%	14%	8%	19%	14%	3%	40%	0%
Smokefree site with exceptions (Q5)	0%	77%	54%	44%	29%	59%	60%	100%
Smokefree discussed on admission (Q9)	100%	89%	100%	94%	90%	85%	60%	100%
Staff very supportive (Q11)	100%	52%	85%	25%	43%	65%	60%	100%
Daily infringements of legislation (Q13)	0%	23%	8%	12%	10%	18%	10%	0%
Secret smoking (Q27)	0%	55%	38%	44%	57%	62%	20%	60%
Smoking related fires (Q28)	0%	18%	31%	25%	5%	9%	0%	0%
Medication reassessed on quit (Q29)	100%	80%	77%	87%	90%	85%	20%	60%
Quit aggravates mental illness (Q30)	67%	55%	38%	62%	48%	35%	50%	80%
Legislation damages relationship (Q31)	0%	27%	15%	25%	38%	24%	20%	40%
Staff smoking >40% (Q36)	0%	14%	38%	25%	29%	32%	0%	0%
Staff attempting quit as result of legislation (Q37)	100%	77%	62%	75%	71%	65%	60%	80%
Stop Smoking Lead (Q42)	33%	55%	62%	56%	71%	42%	50%	0%
Require further training(Q43)	67%	50%	38%	56%	43%	53%	60%	80%
Very beneficial (Q57)	33%	34%	54%	19%	19%	38%	50%	40%
Overall beneficial (4 & 5) (Q57)	67%	61%	77%	56%	52%	56%	70%	80%

The investigators presumed there would be observed correlations which could be extracted to demonstrate the reliability of the information given in the questionnaires (e.g. very supportive staff with high levels of compliance) and give indications of what needs to be in place to ensure the unit is smokefree. However, this was not found to be the case and no consistent correlations could be found. Furthermore, much of what was observed or revealed during the visits was often contrary to claims made in the questionnaires.

We can clearly determine from the visits that mental health facilities in England are complying with the smokefree legislation. We found only one unit where there was outright defiance of the law and three units where on a five point scale for compliance a score of only two was achieved. On two occasions tobacco was seen to be offered for sale on the premises as part of a commercial undertaking, contrary to NHS direction. In those which were non compliant or significantly weak we found one unit which retained two smoking rooms despite being in an excellent and proactive region with significant levels of smokefree activity taking place throughout the region. There was another unit where we believe that smoking was allowed and another that had over four hundred incidents in a three-month period. Elsewhere the problems lay less with a deliberate disregard for the legislation and rather reflected inadequate responses to incidents by the manager and staff.

Despite the finding that compliance with legislation was good it was clear that the concept of 'smokefree' as used in the units we visited was generally very ambiguous, confusing or simply resulted in 'mixed messages'. Phrases such as 'this hospital is smokefree' without indicating whether such a requirement applied to the building alone or together with the grounds, 'smoking is only allowed in designated areas' when it was unclear where designated areas might be and 'thank you for not smoking' without any indication as to where this might apply or what benefits might be derived from adherence to such an injunction contributed to a very uncertain, and therefore difficult to regulate, environment.

Smoking policies affecting staff were particularly difficult to manage and varied from open invitations to smoke, with staff and patients doing so together, staff being allowed smoking breaks at whim through to rigorous measures requiring a change of uniform, a move off site and time limited official breaks, measures so constraining that in one case all but four clinicians had completely quit.

The most difficult area, which defeated most service providers, was managing smoking in their grounds. It was this issue that led to long discussions around human rights and the extent to which both staff and service users were entitled to expect the right to smoke to be observed by

service providers. In addition there was rarely acknowledgement of the damage which tobacco did to the physical health and wellbeing of service users. We certainly did come across units which saw the physical health and wellbeing of patients as central to their concern, but this was not demonstrated on numerous visits.

Whatever the signs said and whether the message given was ambiguous or not on almost all of the sites visited cigarette butts were seen in abundance and often cigarette bins were placed well within areas which were supposedly smokefree.

In addition we observed a correlation between ambiguity in signage and ambiguity in practice in the units we visited. A lack of clarity in policy or inconsistency in application seems to inevitably weaken consistency in practice.

In particular, we were surprised by the apparent lack of knowledge about the effect of smoking. There was limited appreciation of its interaction with mental health conditions and the attitude of the staff to the physical wellbeing of their patients sometimes disregarded those aspects of normal clinical care which would be expected to permeate the whole of the NHS culture. In some units patients were allowed to acquire and smoke as many cigarettes as they were able to accommodate in their secure lockers.

Even where some service providers were addressing aspects of wellbeing including exercise, appropriate foods and caffeine management they still sought to exercise little or no control over the use of tobacco. The converse however was also true, that where smoking was being tackled firmly then in our experience other aspects of physical wellbeing were also valued and supported.

We visited several units, mainly on upper floors, which had no reasonable access to any outside space, either for smoking, fresh air or exercise. For patients on these units their main opportunity to get outside on a regular basis was when groups of patients were escorted for cigarette breaks.

It is difficult to overstate the challenge which a failure to manage tobacco use imposes on other aspects of the therapeutic environment offered by mental health providers. In one Trust the Occupational Therapists complained that the offer to patients of a ten minute smoking break every hour, on the hour, with the inevitable preparatory period and the settling down period following such breaks meant that it was impossible to get any serious and long term OT programmes underway.

In some secure units the impact of smoking regimes in prisons had a particular effect with prisoners being admitted from prison environments where smoking was allowed. Also these patients were discomforted by the very substantial gap in income between themselves and their

neighbours in receipt of benefits and able to exercise their choice of cigarettes and indeed other personal purchases which staff told us could lead to conflict.

In general, units were under-prepared for handling the consequences of smoking. Only one unit was found with high dose patches (25mg) available for use with service users coming from a high level of cigarette use. Few units assessed the level of nicotine dependency of patients coming onto the unit or had the expertise to prescribe appropriate pharmacotherapy to adequately alleviate cravings and withdrawal.

Overwhelmingly tobacco use is treated as being different from other addictions and in some ways less serious or life threatening. Indeed on a few units we found cigarettes used as part of a conditioning process, and in one unit the threat of withdrawal of cigarettes was used as a negative incentive to good behaviour.

The difference in practice varied, largely as a result of the extent of 'management grip' exercised not at the Chief Executive level in an organisation but much closer to the front line than we originally expected. Different managers of the same unit at different times of the day could produce dramatically different patterns of behaviour.

In other units smoking appeared to be impedance to therapeutic activity due to the time taken in preparing for and supervising patients smoking.

On the units visited it was exceptional to find staff who had been trained as specialist stop smoking advisors.

Many of the units reported little and in fact diminished contact with the Stop Smoking Services, most only contacted the units on request.

This resulted in it being difficult for staff to not only support patients who wanted to quit, but to be able to offer appropriate temporary abstinence using Nicotine Replacement Therapy.

Not withstanding any of the above there were a small number of units, of various types, who managed tobacco use as a key contributor to their wellbeing agenda for patients and staff. By careful examination of the leadership, motivation and process of the staff involved the researchers were able to identify key success criteria, which is reported as:

"What made the difference?"

- The policy for patients, staff and visitors was unambiguous and easily understood by all.
- The approach used by service managers was consistent and there were no exceptions to that practice.

- When problems arose they were not merely logged but resolved.
- Activities for patients were varied and given high status.
- Staff training in managing nicotine addiction was widespread and supported by the availability of a broad range of pharmacotherapy with an understanding that NRT could be used not merely to help quit attempts but also to minimise harm and encourage a reduction in use and temporary abstinence.
- In units demonstrating success in managing cigarette use there was a much clearer understanding of the interaction between physical and mental health and wellbeing.
- The physical environment was pleasant, clean and ordered with a sense of the importance of such characteristics in the mental health of service users.
- Support from the NHS Stop Smoking Service.

Conversely the researchers were also able to identify the characteristics of poor practice which is reported as: *"What went wrong?"*

The characteristics of poor practice were even more visible and are easily understood:

- Patients standing in littered and untidy courtyards with large numbers of cigarette butts around and with no attempt to clean up the environment.
- Patients with obvious and severe chronic obstructive pulmonary disease (COPD) being allowed to continue behaviours that exacerbated their condition and indeed threatened their health.
- The use of cigarettes as either positive or negative incentives to comply with desired behaviours.
- The selling of cigarettes on the hospital site thus institutionalising and legitimating such behaviours.
- The evidence of smoking within buildings, ie cigarette burns to floors and bedding which were not remedied.

- The main activities observed were not therapeutic but consisted of watching television and smoking. In such settings therapy was sometimes arranged around smoking breaks.
- Few or no staff trained to offer brief interventions or specialist support which would have enabled staff to raise the issue and support patients and staff who want to stop smoking.
- Lack of interest on the part of staff in physical wellbeing as part of their professional remit was a good predictor of a failure to utilise the smokefree initiative in a way that could improve the overall wellbeing of service users
- Lack of support from the NHS Stop Smoking Service. It is unclear in many cases as to whether this had been offered and not taken up or just not offered.

The researchers investigated the likely scale and cost of the common arrangements for facilitating smoking.

The units visited assessed, on average, that facilitating restricted and observed smoking took the time of one whole time equivalent (wte) member of staff for each day. This is equivalent to approximately 1.66wte per ward per year. If, as is shown in the table below, there are approximately 739 such wards across the country that would need this level of management, this would cost £31 million at a mid Band Four level. See Table 3.

Table 3

Unit	Beds	Wards (approx)
PICU	937	94
Medium Secure (local and national)	1,679	112
Low Secure	1,551	103
Acute	6,450	430
739 wards x 1wte at mid Band Four for 365 days per year ie 1.66wte = £31,005,907.00		