Smoking cessation in secure mental health settings

Guidance for commissioners

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. It is recognised that admission to a secure mental health unit can be an opportunity to intervene to reduce smoking and that interventions are welcomed and effective.

4. Supporting individuals to stop smoking while receiving NHS care represents a significant opportunity to close the gap in morbidity and mortality, between those people experiencing mental health conditions, and the general population.

5. NICE public health guidance PH48 recommends that all NHS funded secondary care sites should become completely smokefree.

6. A survey of all NHS England commissioned low and medium secure mental health units revealed that though the majority of units (83%) were smokefree within buildings, but allowed within secure gardens, only 9% of units had also implemented smokefree grounds.

7. An emerging evidence base on e-cigarettes and their potential as a part of harm reduction strategies has resulted in a varied approach to e-cigarette policy. Further research as to their safety and efficacy as cessation and harm reduction aids is warranted.

8. PHE has developed a self-assessment tool for NHS trusts to assess against NICE guidance PH48, identify gaps and develop action plans. Further details are provided within this guidance.

9. NHS England and PHE will continue to work in partnership to support the ambitions set out in this guidance.

2. Recommendations

1. All medium and low secure units should progress towards providing care in completely smokefree buildings and grounds.

2. Support for smokers to achieve complete cessation or manage their nicotine use, should be provided in accordance with NICE guidance.

3. NHS England should use available contracting levers, such as the 'smoking cessation in secure settings' Commissioning for Clinical Quality and Innovation indicator (CQUIN) to incentivise providers to align fully with NICE guidance.

4. NHS England and PHE can ensure providers are aware of best practice guidance and support with developing smokefree units, ensuring that this best practice is built into service specifications and delivery indicators.

5. The impact of stopping smoking on psychotropic medication should be highlighted in commissioning arrangements; alongside benefits relating to reduced side effects from medication, there may also be financial benefits relating to reduced dosage and prescribing costs.

6. Adopting a whole system approach to support cessation and long-term abstinence from smoking is necessary. It is important, therefore, that there are clear care pathways that provide continuity of care between secure units, and between primary care and community providers following discharge.

7. Commissioners should ensure that all staff in provider organisations have undertaken training to support provision of very brief advice, and those who are responsible for delivery of care are trained in the use of cessation medications and delivery of effective psychosocial interventions.

8. All trusts should complete the PHE self-assessment for implementation of NICE guidance PH48, use this to formulate action plans and review as required.

9. Finally, commissioners should encourage services to monitor and evaluate the impact of smokefree policies. Some examples of good practice have been included in this guidance.

3. Background

Secure mental health services are commissioned for the population of England by NHS England as a specialised service, as outlined in the 'Prescribed Services Manual' (NHS England, 2012). The manual defines the three levels of security as follows:

High secure providers: service users in high secure services present a grave danger to the public and require a significant period of treatment, on average seven to eight years.

Medium secure providers: service users in medium secure services typically have a history of serious offending and some will have been transferred from prison, or from court, to receive inpatient treatment. Typically, service users remain in treatment between two and five years.

Low secure providers: service users in low secure services present a level of risk or challenge that cannot be treated in open mental health settings. Service users may have been transferred from prison or courts to receive inpatient treatment. Typically, service users remain in treatment between one and five years.

Medium and low secure services also provide non-admitted care, transition and outpatient services for those service users who are considered to remain 'high risk'.

NHS England currently commissions approximately 7,700 inpatient beds in secure mental health services. There are approximately; 795 beds in high secure (commissioned for England and Wales); 3,192 beds in medium secure; and 3,732 beds in low secure units. At any time there will be more than 7,000 service users in secure care, with over 200 separate services commissioned across a range of providers including the NHS and the independent sector.

NHS England, through its mental health programme of care board, and PHE, through its specialised services and mental health and wellbeing teams, have developed this guidance to support commissioners and providers of secure mental health services to develop, implement and maintain smokefree environments.

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)'.

Smokefree can therefore be described as the absence of smoke as defined above.

4. Smoking and mental health, the evidence

Smoking is the largest single preventable cause of death and long-term health conditions in England. It is also the largest single cause of inequalities in health, accounting for about half of the difference in life expectancy between the lowest and the highest income groups[2] and most of the reduction in life expectancy among people with serious mental illness is attributable to smoking.[3]

People with mental health problems smoke significantly more on average and have higher levels of nicotine dependence than the population as a whole. A third (33%) of people with mental health problems[4] and more than two thirds (70%) of people in psychiatric units smoke tobacco.[5] While the last 20 years have seen large reductions in smoking rates in the general population, the same cannot be said for those people with mental disorders.

Clear evidence shows that service users admitted to inpatient wards tend to adapt their smoking behaviour to inpatient routines and smoking breaks by decreasing, increasing or even starting to smoke.[6,7] Staff attitudes may also be an encouraging factor, as evidence shows that staff accept or at times encourage smoking in mental health settings. A variety of reasons have been reported for this including as 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 to relieve boredom.[8]

Admission to a secure unit is an opportunity to reduce smoking[9] and offer support. 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.[4,10]

4.1 Population health impact

Every year in England approximately 79,100 people die from smoking related diseases.[11] It caused an estimated 43,000 cancer deaths in the UK in 2010 which is more than a quarter (27%) of all cancer deaths.[12] Smoking is one of the most significant modifiable risk factors for premature mortality and chronic disease.

People with mental health problems are more likely to smoke and it is the single largest contributor to their ten to 20-year reduced life expectancy.[13,14,15,16] A recent UK study highlighted that men and women living with schizophrenia in the community have a 20.5 and 16.4-year reduced life expectancy respectively.[13]

4.2 Benefits of stopping smoking

Evidence shows that there is improved respiratory, vascular, reproductive, gastrointestinal and general health even within a few months of stopping smoking.[17,18,19,20,21,22,23,24,25,26] These benefits can be even greater for people with mental health problems. There can also be dosage reductions of some medications, with associated reductions in side effects – further information on this is provided below.

New research published by PHE also indicates that smoking plays a role in the progressive decline of musculoskeletal systems, cognitive function, oral health and vision.[27] The benefits of stopping smoking are therefore much wider than those associated with the respiratory and cardiovascular systems.

Stopping smoking appears to be associated with other healthy life choices including increases in exercise, healthy dieting, reduction in alcohol consumption and uptake of health screening programmes.[28,29,30,31,32] There is also a substantial financial gain to be considered, as people with serious mental illness may spend up to 40% of their income on cigarettes and tobacco.[33]

Furthermore, while many people believe that smoking helps relieve stress and anxiety, the opposite is true. A recent study of 491 NHS Stop Smoking service users showed that those succeeding at stopping experienced a marked reduction in anxiety symptoms compared with baseline, thus contradicting the common assumption that smoking is a stress reliever.[34] The impact of stopping smoking has been shown to be at least as large as an antidepressant on improving mood and anxiety disorders.[35]

The symptoms of nicotine withdrawal, which are relatively short-lived, can be reduced through provision of stop smoking medicines such as nicotine replacement therapy.

Reasons for smoking are multifactorial, so attempts to reduce smoking in the secure care population need to address what happens within, on leave and on discharge from the unit. This will include access to stop smoking medicines on discharge and appropriate support in the community and primary care settings. This is vital for sustaining positive decisions about health and lifestyle, and for achieving positive health benefits in the longer term.

4.3 Legislation

The Health Act 2006[36] made virtually all 'enclosed' and 'substantially enclosed' public places and workplaces smokefree from 1 July 2007. Mental health units were given a temporary exemption until 1 July 2008. Prison cells, which could be considered a person's home, when not shared with a non-smoker received a full exemption.

Section 2 (2) of the Health and Safety at Work etc Act 1974[37] places a duty on employers to 'provide and maintain a safe working environment which is, as far as reasonably practicable, safe without risk to health and adequate as regards facility and arrangements for their welfare at work'.

Although significant progress has been made in England in prohibiting smoking in buildings, our analysis, detailed in chapter five, highlights the inequality that service users experience in secure healthcare, with some services allowing smoking in secure gardens while others have stopped access to smoking entirely.

4.4 The policy landscape

The Health and Social Care Act 2012, which promotes parity between mental and physical health, as well as a clear duty to have regard to reducing inequalities suggests that a moral duty exists to ensure that people with mental illness have the same levels of access to services and outcomes as the general population.

In 2011 the government outlined its mental health strategy: No health without mental health,[38] which sets out plans to:

- ensure more people with mental health problems will have good physical health
- ensure fewer people with mental health problems will die prematurely

This is further underlined in the following government documents:

- Mental health implementation framework[39]
- Living well for longer: a call to action to reduce avoidable premature mortality[40]
- Closing the gap: priorities for essential change in mental health[41]
- Living well for longer – national support for local action to reduce premature avoidable mortality[42]

4.5 Ethical and legal considerations

These need to be acknowledged, especially for secure services. When Rampton hospital in Nottingham, went completely smokefree it was challenged in the High Court by service users who argued that they had a fundamental right to smoke and this constituted a breach of their human rights under Article 8 of the Human Rights Act. The High Court found that there was no breach of human rights and that it was not unlawful for smoking to be prohibited in these circumstances. When this ruling was appealed, the Court of Appeal agreed with the High Court that service users had no 'legal right to smoke'.[43] It also went further and noted that the trust owed a duty of care to staff and that when it identified a risk to its staff from second hand smoke, it followed that it had a duty to take 'all reasonable precautions' to protect staff from this risk. Furthermore,

recent research[44] into ethical issues concludes that people with mental health problems are as important and deserving of intervention to aid cessation in anyone else and that supportive policies and interventions are just as important in mental health settings as elsewhere in the NHS. There is a need see health and not mental health (or order, discipline and safety) as a key institutional goal.

4.6 The economic case

Treating smoking-related illnesses cost the NHS an estimated £2.7bn in 2006[45] including £720m a year in hospital admissions, GP consultations and prescriptions[46] and a potential £40m per year in increased NHS drug costs, for people receiving psychotropic medication,[5] due to a more rapid drug metabolism caused by smoking. The financial burden of all smoking to society has been estimated at £13.74bn each year.[47]

Providing smoking cessation support for this group is one of the most cost effective life-saving public health or medical interventions in the NHS.[48] When only comparing the costs of an intervention with no intervention, the estimated incremental cost per quality-adjusted life year (QALY) gained varies from around £221 to around £9,515. Even by assuming that the effectiveness of smoking cessation interventions for this group is only half that observed in the general population, treatment is still highly cost-effective when compared to the NICE willingness-to-pay threshold of £20,000 to £30,000 per QALY.[5]

4.7 Effects of stopping smoking on medication

Metabolism of several psychotropic drugs and antidepressants is increased in cigarette smokers. As a result, service users who smoke are likely to require higher doses of these drugs to achieve similar blood levels to non-smokers. It is important to recognise that these interactions are not caused by nicotine and that nicotine replacement therapy does not contribute to these drug interactions.[49] Considerations include:

- for service users: doses of affected drugs can be lowered, sometimes by as much as 50%, which may also result in reduced side effects[50]
- for staff: awareness of, and training in the management of drugs affected by stopping smoking are needed – a survey of clinical staff in one NHS mental health trust found that 41% of doctors were unaware that smoking can decrease blood levels of antipsychotic drugs, and 36% were unaware that stopping smoking could reduce the dose needed[51]
- for finance: drug costs are increased by smoking, and there are substantial savings to be made in terms of medication

5. Evidence from early adopters/successful implementers

5.1 Evidence to support smokefree policies

NICE public guidance PH48: 'Smoking cessation in secondary care: acute, maternity and mental health services' recommends that all NHS-funded secondary care sites should become completely health smokefree.[52] The following are case studies are from trusts that have been pioneering in this area.

5.2 South London and Maudsley (SLaM) smokefree pilot

On 13 March 2013, the behavioural and developmental psychiatry clinical academic group (B&DP CAG) began a smokefree pilot in their inpatient forensic, learning disability and neurodevelopmental disorders services. This involved approximately 500 staff, 11 wards and 162 beds.

5.2.1 Methods

An audit was undertaken involving staff and service users to set a baseline, explore support for a smokefree policy and identify issues that required work streams. The preparations were focussed on service user and staff engagement at all levels. Board approval was secured and a project leader was appointed. The pilot sites went smokefree on 13 March 2013.

5.2.2 Results

One year later smoking prevalence had decreased for service users. They also had more confidence in using nicotine replacement products to stop or reduce smoking. Illicit substance use (smoking cannabis) also declined significantly. No escalation in smoking-related incidents and rapid tranquilisation use was observed (this being one of the biggest concerns among staff before going smokefree). There was more time available for staff to facilitate therapeutic activities and service users were better engaged in the therapy programme, attending and completing more sessions. Ward environments were improved with gardens being used to grow flowers, herbs and vegetables.

5.3 West London Mental Health Trust

In 2008, Broadmoor hospital and the two other associated high secure forensic hospitals became smokefree. Broadmoor hospital is part of West London Mental Health Trust and includes large medium secure forensic services at a site in Ealing.

At present service users at the medium secure service are allowed to smoke off premises and when on leave. Physical health care services are provided by the same clinicians using the same model of care on both sites.

This allowed a comparison between Ealing and Broadmoor to assess the differences that could be attributable to smoking, and smoking related illnesses.

5.3.1 Results

Among the 200 service users at Broadmoor, one required an acute hospital admission for treatment of a respiratory related condition in two years. Among the 300 service users at Ealing, there has been about one admission a month to a local acute hospital over a similar period.

Cardiovascular risk was assessed using the QRISK2 (cardiovascular disease risk calculator) score:

- the proportion who have a QRISK score above 20% at Broadmoor is 2% of the population
- the equivalent figure for Ealing is 5.5%
- the equivalent figure for percentage of people with serious mental illness in the general population is 7%

(It is noted that the advice as to the cut off level for 'high risk' cardiovascular risk has recently been reduced to 10%).

5.3.2 Remaining smokefree

A small survey followed up service users cared for in Broadmoor's entirely smokefree environment 12 months after discharge to see if they remained smokefree. The survey showed that 40% of the 50 service users who had left Broadmoor were still not smoking. Considering only 20% of service users enter Broadmoor as non-smokers, this is a good indication that care in a smokefree environment can significantly increase the likelihood of people remaining smokefree on discharge.

While there are many positive examples of smokefree transition, the process can be challenging. Staff need to address concerns around weight gain and other matters, and

take action to mitigate risks. Staff are encouraged to support action by applying other relevant NICE guidance, such as that around obesity and minimising weight gain.[53,54] An example is the investigation of local obesity pathways and services to understand how they can be delivered in hospital settings. Providers should also ensure there are healthy alternatives to replace smoking breaks, recognising that this as an opportunity to develop an holistic approach to health and wellbeing: for example, by encouraging physical activity and providing healthy meals/snacks. Advice can be directly provided to service users on how to stop smoking without putting on weight. An example of this is on the NHS Choices webpage: www.nhs.uk/Livewell/smoking/Pages/weightgain.aspx[55]

Some providers have cited security issues as a reason to roll back smokefree policies. Although the evidence is mixed and there are examples of a reduction in incidents, and this should be acknowledged. As with other organisational changes a risk manager should be appointed and a risk register maintained. In the initial stages there should be frequent monitoring and reporting and a system for rapid escalation where necessary.

Appendix A sets out more concerns that providers might raise and provides suggestions for addressing and overcoming these. Following the recommendations set out below will also support implementation of smokefree policy.

6. Current practice

To understand the current reach of smokefree policies and stop smoking provision in medium and low secure services, NHS England surveyed all (n=105) of its contracted services. As well as being asked to estimate the percentage of smokers within the whole service they were required to define their smokefree status using one of the following four definitions:

- type 1 – total smoking prohibition across all hospital grounds and buildings
- type 2 – smoking prohibited within buildings and secure gardens but allowed within open spaces outside of the secure perimeter – such as hospital grounds (use of shelters or not)
- type 3 – smoking prohibited within buildings but allowed within secure gardens and outside of the secure perimeter – such as hospital grounds (use of shelters or not)
- type 4 – smoking allowed within buildings (defined rooms or not) and open spaces, such as secure gardens or hospital grounds (use of shelters or not)

Finally, they were asked for their position on electronic cigarettes:

- these products are prohibited within the secure perimeter
- these products are allowed as part of a harm reduction plan (with or without special security measures
- no position or prohibition on these products

6.1 Results

Every secure unit completed the survey, corresponding with a response rate of 100%. Though this represents a 'snapshot' of a specific time (July 2014) it provides a rich source of data.

The average estimate of smoking prevalence across all low and medium secure mental health units at this time was 64%. This is consistent with the evidence that two thirds (70%) of people in psychiatric units smoke tobacco – more than three times that observed in the general population (18.4%).[56]

Of all units, nine (9%) reported being 'type 1', that is, entirely smokefree buildings and grounds and all of these were NHS providers.

Figure 1. Smoking prevalence in low and medium secure mental health units, by region

% of service users who are smokers
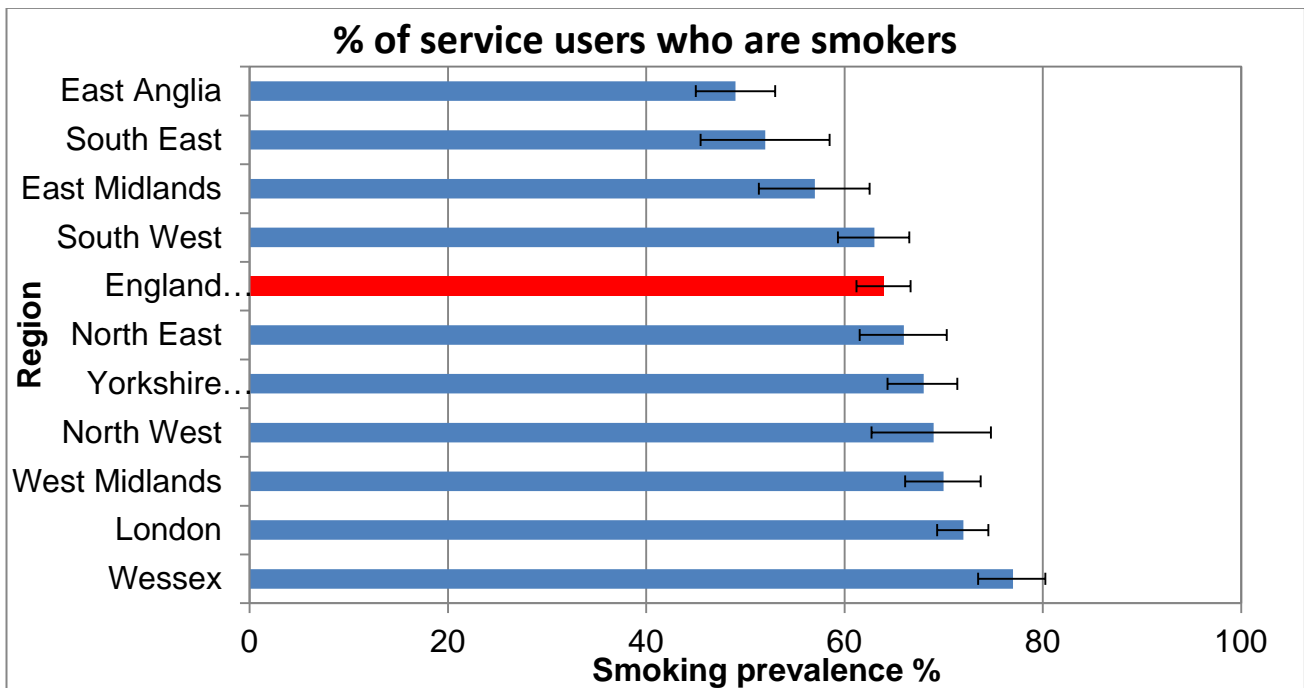
A sliding scale of smoking prevalence was observed, rising according to type, with type 1 having the lowest average estimated smoking prevalence and type 4 the highest. It should be noted however, that when clarified, the unit that self-identified as type 4 was actually type 3.

Table 1. Estimated smoking prevalence in low and medium secure mental health units, by type

Type	Percentage
Type 1	31%
Type 2	48%
Type 3	71%
Type 4	87%

Table 2. Breakdown of number of units by type

Type	Number	Percentage
Type 1	9	9%
Type 2	6	6%
Type 3	87	83%
Type 4	1	1%
Blank	2	2%

Eighty-seven units (83%) were classified as 'type 3', (where smoking is prohibited within buildings but allowed within secure gardens and outside of the secure perimeter, such as hospital grounds). This predominance means it is hard to draw any further conclusions around whether security, region or service provider has an effect on smoking prevalence. The high proportion of units at this level indicates that there is great potential to in supporting these units to change to type 1, in accordance with the NICE guidelines and the recommendations made in chapter 7.

6.2 E-cigarettes (nicotine vaporisers)

Of those that recorded their position (n=103), 65 (63%) units prohibit e-cigarettes, 26 (25%) allow them as part of their harm reduction strategy and 12 (11%) have no position or prohibition. Thirty four (63%) of low security units prohibit e-cigarettes, compared to 21 (68%) of medium/low and ten (54%) of medium secure units. Two units did not provide this information.

The recent popularity of nicotine vapourisers suggests that many smokers are interested in using less harmful sources of nicotine. The MHRA's paper on nicotine-containing products summarises that, 'The UK wants to ensure that nicotine containing products, including electronic cigarettes, are available that meet appropriate standards of safety, quality and efficacy to help reduce the harms from smoking'.[57] A recent report for PHE recognised that the health risks of passive exposure to electronic cigarette vapour 'are likely to be extremely low'[58] and a systematic review of nicotine vapourisers as tobacco substitutes concluded, 'although evaluating the effects of passive vaping requires further work … it is safe to conclude that the effects of EC [e-cigarette] use on bystanders are minimal compared with conventional cigarettes'.[59]

The evidence base on nicotine vapourisers is rapidly evolving. A consistent approach to policy in secure units may be desirable to reduce variation and any unintended inequalities. PHE will support NHS England in advising on the latest evidence base and recommendations for secure services.

6.3 Contracting levers/incentives

These are relevant indicators in the clinical commissioning group indicators set:

- reducing premature death in people with severe mental illness: smoking rates
- enhancing quality of life for people with mental illness: health-related quality of life for people with a long-term mental health condition
- NHS and public health outcomes framework: excess under 75 mortality rate in adults with a serious mental illness

6.4 CQUINs

There are now two CQUINs available for commissioners to negotiate inclusion in contracts and service specifications:

- supporting service users in secure services to stop smoking
- improving physical healthcare to reduce premature mortality in people with severe mental illness

7. Recommendations for commissioning in secure mental health settings

Recommendation 1 – contracting levers

That commissioners maximise the use of contracting levers to support secure services in achieving type 1 smokefree status, and provide support to staff and services users in reducing smoking and managing nicotine withdrawal.

This may include:

- mandating type 1 smokefree status in policies and the regular review and update of policies
- highlighting the relevant CQUINs to encourage providers to move to type 1, taking account of variation that exists due to environmental factors relating to different sites and buildings
- consideration of the recommendations made in this guidance when negotiating contracts and KPIs with providers
- highlighting the relevant indicators in the public health and NHS outcome frameworks
- monitoring compliance, ensuring good quality data is collected and that evidence on implementation continues to be gathered (see recommendation 10)

Recommendation 2 – guidance

Commissioners should be aware of the guidance documents available to support services in delivering smoking cessation interventions and provision of smokefree treatment areas that apply within the context of secure units, and ensure that these standards are built in to service delivery.

These include:

- NICE PH 1 brief interventions and referral for smoking cessation[60]
- NICE PH 5 workplace interventions to promote smoking cessation[61]
- NICE PH 10 smoking cessation services[62]
- NICE PH 45 tobacco: harm-reduction approaches to smoking[63]
- NICE PH 48 smoking cessation in secondary care: acute, maternity and mental health services[51]
- NCSCT LSSS: service and delivery guidance 2014[64]
- NCSCT training standards[65]

Recommendation 3 – legal and ethical duties

Commissioners should take account of the relevant legislation that supports smokefree environments in secure mental health settings and ensure providers take account of the key legislation.

These include the:

- Health and Safety at Work Act 1974
- Health Act 2006
- case of R (N) v SSH; R (E) v Nottinghamshire Healthcare NHS Trust (2009) EWCA Civ 795)
- Health and Social Care Act 2012

Recommendation 4 – robust project management

Commissioners should encourage providers to take a project management approach to the transition, to include monitoring and evaluation and the development of a minimum dataset.

This should include:

- a risk register with plans for monitoring and reporting and a system for rapid escalation where necessary
- mapping of key stakeholders for consultation
- development of a minimum dataset

It is recommended that the minimum dataset should include:

- smoking status on entry (including those people using non smoked nicotine products such as electronic cigarettes as non-smokers)
- smoking status on discharge
- offer of support
- uptake of support

Outcomes of stop smoking service interventions delivered according to the Russell Standard,[66] 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 a conversation with the local authority stop smoking service commissioner should be addressed to the HSCIC directly.

Recommendations for additional information to be collected for purposes of monitoring and review of the smokefree policy and status should include:

- **pre 'smoke free' date:** perceptions of service users and staff
- **pre and post 'smoke free' date:** incidents (including security); rapid tranquilisation use; urine drug screens; staff and service user smoking rates
- **post 'smoke free' date:** service user and staff feedback; breaches of policy of incidents; impact on medication costs; changes in weight and uptake of alternative activities to smoking

Recommendation 5 – trusts undertake self-assessment

PHE has developed a self-assessment model that provides a framework to help NHS trusts to develop local action to reduce smoking prevalence and tobacco use within secondary care settings. The self-assessment model offers a:

- free-to-access model for self-assessment that can assist in evaluating the effectiveness of action to address harm from tobacco
- suite of videos that set the scene and explain the benefits of action
- replicable workshop format that can be delivered at a local level to support local action to reduce the harm of tobacco

The self-assessment tool breaks down the NICE guidance into four areas:

- systems required to implement the guidance
- communication required
- training that will enable staff to successfully implement the recommendations
- treatments that should be available to support staff and service users

The self-assessment will enable trusts to:

- evaluate their local action on smoking in mental health
- ensure that local activity follows the latest evidence-based practice
- identify priority areas for development

The questionnaire can also be used to monitor improvements to services over time.

Trusts can start using the model by completing the FREE self-assessment questionnaire available at www.gov.uk/government/publications/smoking-cessation-in-secondary-care-mental-health-settings

For more information call 020 368 20521 or email CLeaRTobaccoTeam@phe.gov.uk

Recommendation 6 – reinforcing the public health messages

Commissioners should take action to highlight and reinforce the key health benefits of reducing smoking in secure mental health settings, as outlined in chapter 4, with reminders of the need to reduce the variation in smoking prevalence between those with mental health problems and the general population, and between secure units.

This could include:

- 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, service users and visitors
- acknowledging employees' duty of care to support service users in achieving good mental and physical wellbeing

Recommendation 7 – care pathways

Commissioners should ensure that contracts with providers have clear pathways to support smoking cessation in secure mental health settings and that these are in line with published NICE guidance and should include:

- assessment of smoking status on entry to the service and provision of timely access to medication and support for service users who wish to stop smoking or temporarily abstain from smoking while in the unit or on-site
- arranging continued provision of support with harm reduction and smoking cessation interventions prior to discharge

Recommendation 8 – medication use

That information regarding the impact of stopping smoking on psychotropic medication is highlighted within commissioning arrangements, in terms of potential positive impacts on the individual and financial implications for providers and trusts.

This should include:

- clear consistent messaging for service users on the benefits of stopping smoking including potential reductions in medication and their associated side effects
- ensuring service users receive appropriate support in managing any changes in their medication if they change their smoking behaviour

- ensuring that staff are aware of the impact of smoking and smoking reduction or cessation on psychotropic medications and that there are appropriate clinical systems in place to monitor the level of certain drugs when an individual stops smoking
- where possible to include reduction in medication in the evaluation and monitoring processes to record the cost saving (see recommendation 4)

Recommendation 9 – training

Commissioners should ensure that providers train all staff within the secure unit to be aware of the issues, evidence base and support available to help people to stop smoking or manage their own nicotine use. Regular updates should be provided.

NICE public health guidance NICE PH48 recommends that this includes ensuring that:

- relevant curricula for frontline staff include the range of interventions and practice to help people stop smoking
- all frontline staff are trained to deliver advice around stopping smoking and referral to intensive support, in line with recommendations 1 and 2 of NICE PH48
- staff know what local and hospital-based stop smoking services offer, and how to refer people to them
- online training can be completed and updated annually as part of NHS mandatory training (for example the training provided by the NCSCT)
- all frontline staff are trained to talk to people in a sensitive manner about the risks of smoking and benefits of stopping
- all staff who deliver intensive stop smoking support are trained to the minimum standard described by the NCSCT (or its equivalent) with additional training that is relevant to their clinical specialism
- all staff are informed about smokefree policies, their roles and responsibilities in maintaining a smokefree work environment and what action to take in the event of negative responses to smoking restrictions

Recommendation 10 – staff culture

Commissioners and providers should support their staff to stop smoking. This provides benefits for their own health and also helps them in challenging the culture that it is normal for people in mental health settings to smoke.

This should include (in line with NICE public health guidance PH48):

- taking action in line with NICE guidance on workplace interventions to promote smoking cessation (PH5)

- advising all staff who smoke to stop
- offering staff in-house stop smoking support
- providing contact details for community support if preferred
- allowing staff to attend stop smoking services during working hours without loss of pay
- advising staff who do not want, or are not ready or able to stop completely to use licensed nicotine-containing products to help them abstain during working hours, including advice on where to obtain them
- offering and providing intensive behavioural support to maintain abstinence from smoking during working hours and where appropriate follow recommendation 8 in NICE guidance on tobacco harm reduction (PH45)

Recommendation 11 – weight management

Commissioners should encourage providers to monitor the weight of all service users and put in place interventions to prevent or address this issue as part of wider health and wellbeing strategies.

Moving towards completely smokefree sites (including grounds) offers the opportunity to increase the engagement of service users and staff in a range of activities to support physical health. Mental health service providers may not have specialist expertise in weight management and may need to work in collaboration with other local services specialising in local obesity pathways and services.

Actions could include:

- ensuring key staff are aware of the NICE clinical guidance relating to obesity in adults and children (CG43)[52,53]
- taking a wider health and wellbeing approach to the smokefree transition, including providing healthy options and activities to replace smoking 'breaks'
- converting areas previously associated with smoking to areas that promote physical activity
- monitoring body mass index pre and post implementation of completely smokefree sites

Appendix A. Common challenges to smokefree policy

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

This is a common concern before going smokefree. Reviews of smokefree policies in mental health and addiction settings indicate that comprehensive or partial policies have no major untoward effects on behaviour of the frequency of aggression. This includes one maximum secure setting where it was reported that total disruptive behaviour and verbal aggression reduced significantly following implementation.[67] This was further confirmed by the experiences of Broadmoor and the pilot for South London and Maudsley. However, this should be recorded in a risk register with plans for monitoring and reporting, and a system for rapid escalation where necessary.

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 who successfully stop smoking experience a marked reduction in anxiety symptoms compared with the baseline rather than an increase, which many may expect.[32] The impact of stopping smoking on mood and anxiety disorders has been shown to be at least as large as antidepressants.[33] When used correctly, pharmacotherapy can minimise nicotine withdrawal symptoms, which may be relatively short lived.

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

An important part of smokefree 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 offer alternatives. This was successfully implemented with the South London and Maudsley pilot, which also experienced better engagement in its therapy programme, with service users attending more sessions and staying for all the sessions.

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.

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.

There will be problems with service users putting on weight

Staff need to address service users' concerns around weight gain and other matters, and take action to mitigate risks. Staff are encouraged to support action by applying other relevant NICE guidance, such as that around obesity and minimising weight gain.

Many staff smoke and may not agree with smokefree policies and might be reluctant to implement them

Hospitals have a responsibility towards their staff, whether smokers or non-smokers, and staff should be supported to stop In line with NICE public health guidance (PH5) to promote smoking cessation in the workplace.[50] If staff 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.

Staff and service users have a general lack of understanding 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 becoming 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 the smokefree transition.

Nothing can be done because smoking is so prevalent among service users

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.[4,10] Furthermore, there is clear evidence that admission to inpatient wards is an opportunity to change smoking behaviour.[6,7]

There will be security problems such as smoking in bedrooms and other unauthorised areas, and people using wire and battery to light cigarettes in their rooms

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,[68] which looked at difficulties and challenges associated with smokefree policy implementation, found that anxieties related to incidences proved unfounded. Recognition of this risk on the appropriate risk registers 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 life-saving public health or medical interventions available on the NHS.[4] 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 it released 90 minutes per nurse, per shift, lost by facilitating smoking breaks. In addition the potential to reduce the bill for certain medications may be financially attractive. There are also now two CQUINs that provide a financial incentive to take action in this area.

Appendix B. Members of the smoking cessation in secure mental health services committee

Matt Day (Chair)	Consultant in public health specialised commissioning, Public Health England. Public health lead NHS England programme of care board, mental health
Patrick Neville	Portfolio director (mental health), NHS England
Seamus Watson	National programme manager – wellbeing and mental health, Public Health England
Anne-Marie Smith	Carer representative for acute and secure clinical reference group, NHS England. Associate lecturer at the University of Hertfordshire. Recovery and wellbeing committee for Hertfordshire partnership university foundation trust
Louise Davies	Mental health and programme of care lead - Yorkshire and Humber, NHS England
Ian Callaghan	National service user lead, recovery and outcomes, and service user representative high/medium and low secure clinical reference group
Dr Jeremy Kenney-Herbert	Clinical director, secure care, specialities and offender health and chair of the high and medium secure mental health clinical reference group Birmingham and Solihull mental health NHS foundation trust
Dr Josanne Holloway	Consultant forensic psychiatrist and clinical director, Greater Manchester West mental health NHS foundation trust

Nikki Churchley	Head of mental health and programme of care lead, NHS England
	Bristol, North Somerset, Somerset and South Gloucestershire (South West) area team
Jimmy Noaks	Deputy director of nursing – high secure services, West London mental health NHS trust
Michelle Parker	Representing secure mental health clinical reference group on behalf of the royal college of nursing, partnerships in care
Jo Locker	Tobacco control manager, Public Health England
Dave Jones	Tobacco control manager, Public Health England
Helen Garnham	Public mental health and wellbeing manager, Public Health England

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