



## **SMOKING, MENTAL HEALTH AND WELL-BEING** ***'Be happy, don't worry and stop smoking'***

**A report of a story dialogue event held at the Teacher Building, Glasgow, on  
December the 1<sup>st</sup> 2006**

**March 2007**

## **Preface**

The UK Public Health Association Scotland, Scottish Tobacco Control Alliance and Community Health Exchange came together in summer 2006 to collaborate on sharing good practice that helps people with mental health problems to stop smoking and to highlight this good practice to the wider public health work force.

Tobacco use is a significant indicator of health inequalities, with a high prevalence in smokers experiencing mental health problems. Several theories have been put forward to explain this; for example that smoking is a coping mechanism or a form of self medication.

The partnership's mutual interest in improving health and wellbeing through smoking cessation prompted the creation of an opportunity whereby their respective networks could share their different perspectives, expertise and approaches. The partnership also wanted to place the work firmly within the context of tackling health inequalities, working in different health settings, and the benefits of listening and acting on individual smoker's experience.

Consequent to the desire to spotlight cessation benefits and opportunities for people with mental health problems a *Story Dialogue Event* was organised for December 2006. The event not only enabled individual smokers and practitioners to tell their story, but was structured in a way that insights and practical lessons were gained for the wider public health workforce. This report draws on these lessons, cites implications for practice development and highlights key messages for both practitioners and policy makers.

## **Acknowledgements**

The organisers of this story dialogue event give their sincere thanks to all the story-tellers and practitioners who took part and made it such a stimulating and thought-provoking event. We would also like to thank the Scottish Executive for funding the event and all the staff of the partner organisations who assisted with arrangements. The event was greatly enhanced through professional facilitation by Áine Kennedy who has a particular regard and flair for story dialogue.

## **Note**

The stories told and the insights shared at the event do not represent the policy of any of the partners who organised it.

## Contents

<b>SUMMARY</b> .....	4
<b>1. INTRODUCTION</b> .....	5
<b>2. THE STORY DIALOGUE TECHNIQUE</b> .....	5
<b>Ann’s story – ‘It takes as long as it takes – one-to-one support for a long term smoker with a psychiatric history’</b> .....	6
<b>Insights from Ann’s story</b> .....	7
<i>Theme 1: NRT</i> .....	7
<i>Theme 2: Confidence</i> .....	7
<i>Theme 3: Tailoring services</i> .....	7
<i>Theme 4: Stress</i> .....	7
<i>Theme 5: The smoking ban</i> .....	8
<b>Beth’s story – ‘Not a proper smoker – smoking and complexity’</b> .....	8
<b>Insights from Beth’s story</b> .....	9
<i>Theme 1: No single approach works</i> .....	9
<i>Theme 2: Reviewing the aims of smoking cessation</i> .....	9
<i>Theme 3: Be willing to change the aim and methodology</i> .....	9
<i>Theme 4: Recognising the barriers to achieving the aims</i> .....	9
<b>Calum’s story – ‘From fags to Prozac, one day at a time’</b> .....	9
<b>Insights from Calum’s story</b> .....	10
<i>Theme 1: Addressing the reasons why people smoke</i> .....	10
<i>Theme 2: Addressing the difficulties of quitting</i> .....	10
<i>Theme 3: Readiness to quit and the responsiveness of services</i> .....	11
<i>Theme 4: Tailoring smoking cessation services to individuals</i> .....	11
<i>Theme 5: A range of types of support are needed</i> .....	11
<b>Dee’s story – ‘A counsellor’s perspective on smoking cessation in a healthy living centre’</b> .....	11
<b>Insights from Dee’s story</b> .....	12
<i>Theme 1: The importance of a wider support network</i> .....	12
<i>Theme 2: Issues of group size</i> .....	12
<i>Theme 3: Dealing with emotions</i> .....	12
<i>Theme 4: Approach and methodology of facilitator</i> .....	12
<i>Theme 5: Tension between policy and practice</i> .....	13
<b>Eve’s story – ‘A work in progress’</b> .....	13
<b>Insights from Eve’s story</b> .....	14
<i>Theme 1: Consultation</i> .....	14
<i>Theme 2: Working with success</i> .....	14
<i>Theme 3: Joined-up services and communication</i> .....	14
<i>Theme 4: Methods for smoking cessation support</i> .....	14
<b>4. CONCLUSIONS</b> .....	15
<b>Evaluation of the event</b> .....	15
<b>Main messages from the event</b> .....	15
<i>Understanding why people smoke</i> .....	15
<i>Improving smoking cessation services</i> .....	15
<i>Developing tobacco policies and services</i> .....	16
<b>5. FURTHER DIALOGUE</b> .....	16
<i>Partnership contact details</i> .....	17

## SUMMARY

The UK Public Health Association (Scotland) (UKPHA (Scotland)), the Scottish Tobacco Control Alliance (STCA) and Community Health Exchange (CHEX), in partnership, organised a story-dialogue event on smoking, mental health and well-being in December 2006. The event was funded by the Scottish Executive. The story-dialogue technique is structured to enable participants to learn and discuss insights from people's stories about their experiences of mental health and smoking.

The storytellers<sup>1</sup> were:

- Ann, a heavy smoker with physical and mental health problems, who has been supported in giving up smoking for 8 months;
- Beth, an occasional smoker, who realised that her smoking had become a habit she didn't like;
- Calum, a long term smoker, who had finally managed to give up smoking after his GP prescribed Prozac for depression;
- Dee, a counsellor and smoking cessation practitioner, who developed an alternative approach to providing smoking cessation support;
- Eve, who had overcome major obstacles in her attempt to introduce smoking cessation services in a psychiatric hospital.

After listening to the stories, participants discussed what they had learned from the stories that could be applied in practice. The learning points are summarised below.

1. It is important to understand why people smoke, so that smoking cessation support services can be tailored to individual needs.
2. Standard approaches to smoking cessation do not work for everyone, particularly for people with mental health problems. Support services need to be flexible in terms of group size, type of support offered and length of time for which support is offered. Services should be responsive to people when they reach the point of being ready and motivated to quit.
3. Smoking cessation services should also offer confidence-building and stress management techniques and help people prepare for the perseverance and determination that is needed for a quit attempt.
4. Smoking cessation practitioners should be able to direct people to other services that might help them, for example money advice.
5. In developing tobacco policies, proper time should be given to consultation and involvement of all stakeholders to build support for and commitment to the policy. Consistent application of a policy across services is important.
6. Joint working, communication and information sharing will improve the effectiveness of policy implementation.

The partner organisations give their responses to these learning points at the end of the report.

---

<sup>1</sup> Fictitious names are used.

## 1. INTRODUCTION

The UKPHA (Scotland), the STCA and CHEX, in partnership, organised an event on smoking, mental health and well-being in December 2006. The event was funded by the Scottish Executive.

The event employed a structured 'story dialogue technique'. This allowed those with experience of either giving up smoking, or supporting others to give up smoking, to relate their experiences, and all participants to consider what insights arose from those experiences.

The objectives of the event were to:

- raise awareness of the effects of smoking on mental health and well-being
- share ideas, information and practice in improving mental health and well-being affected by smoking
- facilitate dialogue between service users, community volunteers and health practitioners
- produce a report of personal stories and insights from the event.

The event was attended by approximately 60 practitioners, story-tellers, researchers and volunteers from across Scotland.

The partner organisations give their responses to the issues arising from the event at the end of this report.

## 2. THE STORY DIALOGUE TECHNIQUE

The story-dialogue technique was devised by Ron Labonte and Joan Feather, Canadian health promotion experts<sup>2</sup>, to bridge the gap between theory, research and practice in health promotion. It is a structured, participatory research method which takes place in small groups and involves the following stages:

1. Establishing a 'generative theme' for the event, which captures key tensions and issues for the target audience
2. Agreeing the ground rules (confidentiality, etc.)
3. Listening to the story, told by the storyteller, who has been briefed beforehand
4. Reflection circle, when other group participants say in one sentence how they feel about the story
5. Structured dialogue when four types of questions are asked: what? (descriptive), why/how? (explanatory), so what? (synthesis) and now what? (implications)
6. Creating insight cards – distilling the key lessons from the story and structured dialogue
7. Creating categories – grouping the insights into common themes.

This event on smoking, mental health and well-being was facilitated by Aine Kennedy, a health promotion practitioner who has considerable experience of using the story-dialogue technique and training others in the use of the method.

---

<sup>2</sup> 'Handbook on using stories in health promotion practice', Labonte and Feather, 1996.

### 3. STORIES AND INSIGHTS

The purpose of the story-dialogue technique in this event was to help practitioners gain insights for improving or changing practice in smoking cessation, which arose directly from the experiences of the storytellers.

There were five story groups at the event, each with one main story-teller (in some cases supported by another person). The stories, and the insights that arose from the story-dialogue sessions, are detailed below.

#### **Ann's story – 'It takes as long as it takes – one-to-one support for a long term smoker with a psychiatric history'**

Ann had a long term mental health problem. She wanted to quit smoking and has required a long time to stop (8 months with the current quit attempt). The focus has been on breaking the link between smoking and stress and providing support when there is a need to be calm.

Ann is in her early 60s and was diagnosed with schizophrenia in her 20s. She also suffers from diabetes and heart disease. Her physical health problems, including major heart surgery, prompted her to quit several years ago but she found it very difficult to do so.

Ann was a heavy smoker, 60 a day. When one cigarette was over she would light another if the situation allowed. All her family and many friends smoke and therefore there was little support in those quarters for her to remain tobacco-free.

Support from a cessation service and regular phone calls for reassurance and encouragement, along with continued use of NRT gum and inhalators, has allowed her to remain abstinent for 8 months, her longest quit period.

At the beginning of her quit attempt Ann rated her confidence in being able to succeed as 0 out of 10 and has found that her belief in her ability to quit has increased simply by doing it.

In the past when Ann has lapsed she would leave the house to smoke without the family being aware that she had started smoking again; she was afraid to admit her failure. She feels that the smoke-free public places law has definitely helped to reduce her exposure to other people's smoking and hence to the pressure to resume smoking.

Although Ann has been using an inhalator, she often sucks on the plastic mouth piece when there is no NRT left; it gives a degree of comfort. She has been on NRT for a considerable length of time but feels the benefits outweigh any possible disadvantages and believes that she will eventually quit using this support. She feels proud of her achievement and has been saving a considerable amount of money that has been used to buy clothes and trips away.

In the absence of smoking Ann has recognised that smoking contributed a lot to her anxiety. Now she realises that anxious moments are not because she needs a cigarette, or, that it would help to have one, but that the way she feels happens

sometimes and she can use other ways to calm herself, for example, seeking support from her counsellor and friends.

### **Insights from Ann's story**

#### *Theme 1: NRT*

This group of insights focused on the benefits of NRT. It was felt that NRT should be provided for as long as it is needed. Even when nicotine has dried up, an inhalator can sometimes provide a good “prop” or substitute for a cigarette in the mouth. One participant sounded a note of caution, however, about the risk of dependency on nicotine through NRT. Another raised the issue of prescribing of NRT (as in Eve's story, below) and questioned whether this could be done by smoking cessation advisors rather than GPs.

#### *Theme 2: Confidence*

These insights related to the importance of self-confidence in giving up smoking and the impact of smoking on levels of self-confidence and anxiety. Ann's story illustrated that she felt very little self-confidence initially, but her confidence had grown the longer she abstained from smoking. Participants felt that it was important to help people to develop self-confidence and that smoking cessation workers should be taught skills to support and build people's confidence.

It was also recognised, from Ann's story, that persistence was important in giving up smoking, as some people need long-term support to maintain abstinence. It was felt that people who are attempting to give up should be helped to understand how difficult it can be and that perseverance and determination are needed. It is also useful to try to learn from relapses, so that support can be tailored in future.

#### *Theme 3: Tailoring services*

Three main groups of insights fell under the overall theme of tailoring services to individuals. One group of insights was about the support that is offered to people trying to give up smoking. It was felt that a range of types of support were needed. Group support had not worked for Ann and she had found the one-to-one support most useful. For her, it was lonely trying to quit, and the regular support via phone calls helped enormously. Participants felt that individualised support was an important option, particularly for people with multiple problems.

The second group of insights was about the need to listen to the clients' stories, value their experiences and tailor services directly to their needs. It was felt that the standard model of smoking cessation programmes was unlikely to work with people with mental health problems and that the service should be driven by the smoker's needs.

The third groups of insights related to the need to provide support for as long as it is needed. In Ann's case, the standard seven-week smoking cessation support programme was insufficient. It was felt that timescales for support should be tailored to the individual's needs as “it takes as long as it takes” to give up smoking.

#### *Theme 4: Stress*

This group of insights arising from Ann's story related to stress. Ann said that, for her, it became apparent that smoking was actually causing her stress, rather than

relieving it. This was an important step for her in the process of giving up. Participants therefore felt that it is important to support and educate people, particularly those with mental health problems, to manage their stress using techniques other than smoking.

*Theme 5: The smoking ban*

The final insight from Ann's story was that the smoking ban had helped her to give up smoking.

**Beth's story – 'Not a proper smoker – smoking and complexity'**

Beth is a health promotion practitioner and always felt that the smoking issue was over-simplified. She felt uncomfortable with the evangelising, 'expert knows best', 'give up what's bad for you' approach to health promotion. It did not fit with her growing commitment to an empowering way of working and the 'social model of health', which starts with the health issues people themselves identify as important and takes a wider perspective on the determinants of health, beyond what the individual is free to change.

Beth had also been an occasional "social smoker" herself, for many years. She had started smoking because her husband and work colleagues all smoked and her workplace was quite stressful. At the time she did not consider smoking to be a problem. She had changed the frequency of her smoking depending on what was happening in her life at the time. Over time, however, her smoking habit became heavier due to family tragedy and work stress. She realised she had become a "proper smoker" when she bought her own cigarettes and when she noticed she was always putting off the moment when she would stop.

It had become a habit she was enjoying; her self-image was shifting to accommodate it; it appealed to the rebel adolescent in her to say that she had taken up smoking since the ban just to be perverse. There was more than a grain of truth in that. But Beth was also ambivalent about it. One woman said to her, "you don't look like a smoker" and Beth was glad as, "when I looked around at the other smokers in the smoking cage at the back of the Stranraer- Belfast boat, I didn't want to be part of that illustrious company".

It was vanity rather than health that finally motivated Beth to give up. She didn't like the stains on her teeth and the way her clothes, car and breath smelled. The prospect of ageing faster and the potential for a visible impact on her skin and gums were all extremely off-putting. Beth still reserves the right to have the occasional fag and bitterly resents people who take the liberty of lecturing her about it, but on the whole she's glad that public tolerance of smoking is lower than it was 10 years ago and that she had the willpower to ensure that she controlled her smoking rather than it controlling her. As she says "There's not much autonomy or empowerment in addiction".

## **Insights from Beth's story**

### *Theme 1: No single approach works*

Insights under this theme reflect the complexity of Beth's story and emphasise the need for smoking cessation services to respond to each individual's needs and motivations, rather than having a "one size fits all" approach. It was recognised that people who continue to smoke may have more complex needs than those who have successfully given up and that a greater range and variety of information and services is required, including working with other services and adopting an empowering approach.

### *Theme 2: Reviewing the aims of smoking cessation*

Beth's story raised questions for participants about the aims of smoking cessation services and the need for clarity of purpose. For example, was the ultimate aim to ban smoking from the British Isles altogether, or to stop certain groups, e.g. pregnant women, from smoking? Should only those who are motivated to stop be able to access smoking cessation services? Should the cultural shift in attitudes about smoking be exploited to work towards banning smoking altogether?

### *Theme 3: Be willing to change the aim and methodology*

These insights focused on the methods used in smoking cessation services. It was felt there was a need to understand that a smoker's situation may be a "journey", rather than a static position, and to conduct smoking cessation work accordingly. Smoking cessation practitioners should reflect on the methods they are using and not necessarily be "bunkered" by past approaches.

### *Theme 4: Recognising the barriers to achieving the aims*

Some of the barriers to giving up smoking illustrated by Beth's story were that:

- smokers sometimes want to stop and at other times they like smoking
- some people choose to smoke knowing all the risks
- sometimes anti-smoking messages have the reverse effect, e.g. if people "want to die young"
- smokers may be alienated if they feel patronised or judged.

The barriers emphasise that smoking cessation services need to be flexible and responsive to people's individual circumstances and motivations.

It was recognised, as also illustrated by Calum's story (below), that physical factors can be one of the triggers to stop smoking.

## **Calum's story – 'From fags to Prozac, one day at a time'**

Calum had been a smoker since he was a boy. He was now retired. He described himself as a confident, extrovert person, but he had not always been so in the past. He had been shy and withdrawn when younger and sometimes "edgy" in social situations. He started smoking because he wanted to "be a man". In his youth, smoking was what men did and it was a symbol of growing up. In those days, the health risks of smoking were not well known.

Calum became a heavy smoker whilst in the merchant navy and smoked 50 cigarettes a day. He described cigarettes as his "emotional crutch" and nicotine as

his "friend". His job was quite boring and cigarettes helped to pass the time. Later, he changed career and became a community worker, but he still continued to smoke heavily.

Calum tried to give up smoking on a number of occasions, but described these early attempts as "half-hearted". He experienced a number of episodes of depression and developed a "terrible cough" and diabetes. He knew that cigarettes were harming his health, but still could not give up. He also saw his mother die of lung cancer but this did not prompt him to give up at the time. His self esteem suffered through failed attempts to quit.

Eventually, during an episode of depression, Calum was put on Prozac by a GP. This same GP suggested that he should try to quit whilst on Prozac, as it might help him with the withdrawal symptoms. Calum did not give up immediately; however, one subsequent New Year's Day, he woke up and had a severe coughing fit, resulting in him "blacking out". He had smoked about 100 cigarettes the day before. He describes the experience of blacking-out as a moment of revelation. He decided to stop smoking that day and to "throw everything" at the quit attempt. He put on a nicotine patch from a pack he had in a cupboard. Two days later he still had not smoked a cigarette and went to the chemist to buy more patches. He has not smoked since.

Calum thinks that the following things helped him to give up smoking:

- He reached a "critical mass" point of "everything coming together" to "change his mindset"
- His daughter, who had children, would not allow him to smoke at her house or when with his grandchildren, which made it difficult for him to see them
- His mother dying of lung cancer a few years earlier
- The blackout and cough
- The cumulative effect of the Prozac and patches (though he stopped using the patches before the 3 month course was up and is no longer on Prozac). The Prozac helped to stop him "being crabbit" during withdrawal.
- The financial benefits – he bought a computer with the money he saved
- Telling himself "I'm not going to smoke today" rather than "I don't smoke any more".

### **Insights from Calum's story**

#### *Theme 1: Addressing the reasons why people smoke*

A small number of the insights generated by Calum's story related to identifying and addressing the underlying reasons why people smoke. For Calum smoking was a symbol of adulthood and helped him to alleviate boredom in his job. It is important, therefore, to address any underlying issues which lead people to smoke, both in the provision of smoking cessation services and in social marketing aimed at discouraging smoking.

#### *Theme 2: Addressing the difficulties of quitting*

The insights grouped under this theme related to the overwhelmingly difficult task it can be to stop smoking. Calum had described nicotine as "his friend" and that stopping smoking was like losing a friend. Smokers may be psychologically dependent on cigarettes and fear can be a big issue when trying to quit. Participants

had various suggestions for addressing these difficulties, including: taking one day at a time or stopping smoking in small chunks of time, rather than thinking that you are quitting forever. Another suggested that smokers needed to “unlearn” smoking and “learn” how to be a non-smoker. It was also important to help people maintain their self-esteem if their quit attempts failed.

*Theme 3: Readiness to quit and the responsiveness of services*

These insights were about recognising that people may take quite a long time to build themselves up to being ready to quit. A number of factors may lead smokers to a “critical mass” point when they are motivated to make a serious quit attempt. It was felt that support and cessation services should be able to respond quickly at this point, because motivation may be lost if potential quitters have to wait for help. There was also a recognition that people can only quit when they are ready and the time is right for them. This raises the question of how can service providers tell when someone is ready and whether a “readiness indicator” can be developed?

*Theme 4: Tailoring smoking cessation services to individuals*

This theme was about recognising differences between individuals in terms of their reasons for smoking, patterns of smoking and needs for support. Some smoking cessation services follow a highly structured programme, consistently applied to all groups of aspiring non-smokers. Two people commented, however, that “one size doesn’t fit all” and others said there was a need for a more flexible, tailored and personalised approach to smoking cessation services. Another said there should be an “open door” policy for those who relapse.

*Theme 5: A range of types of support are needed*

In addition to the need for tailoring smoking cessation services to people’s individual needs, it was felt that there should be additional forms of intervention and support available. It was also felt that a wider range of support workers, for example youth workers, should be trained in smoking cessation techniques.

**Dee’s story – ‘A counsellor’s perspective on smoking cessation in a healthy living centre’**

Dee is a trained counsellor who provides smoking cessation support in a healthy living centre. She underwent Maudsley (smoking cessation) training two years ago and had also previously worked for Smokeline. Dee, influenced by her counselling background, was interested in working with smaller groups of people undergoing smoking cessation than is typical with Maudsley approaches. She set up a group of seven people who wanted to quit and had self-referred to the service after attending No Smoking Day stalls. She also had the help of a co-facilitator who dealt with administration etc.

The small group allowed for more intimacy and the development of supportive ‘buddy-type’ relationships. It also allowed people to spend time telling their stories about why they smoked and other areas of their life, not necessarily related to smoking. Dee and her co-facilitator kept in touch with group members by text, phone or post to give them support and encouragement between meetings and to ensure they felt included.

One client went “cold turkey” without the use of NRT and this was supported and accepted by the facilitators. Others quit at week 3 with NRT prescribed by a ‘Smoking Concerns’ representative and their CO<sub>2</sub> levels were monitored. Five out of six group members had stopped smoking by the end of 7 weeks. One member had cut down on their smoking, but this was regarded as a positive outcome, not a failure. In general, the approach to success was that it was a personal measure. Through support from the group, one member also got signposted to mental and physical health services.

Dee used different counselling techniques throughout the seven weeks, to raise self-awareness, and enable ownership and responsibility. Dee felt that the small size of the group and the sense of responsibility between group members helped to retain people in the group. The experience for Dee was different in that she felt “part of the group as a human being, not an expert”.

### **Insights from Dee’s story**

#### *Theme 1: The importance of a wider support network*

This group of insights recognised how important it was that Dee was able to offer signposting or access to other services which could support people with other problems in their lives, for example, debt or mental health issues. It was felt that smoking cessation groups can act as a trigger for people to tackle other problems in their lives. It is important, therefore, that smoking cessation workers are aware of other relevant services and, in turn, that other services, for example debt advisers, are aware of smoking cessation support options.

#### *Theme 2: Issues of group size*

Dee’s story gave rise to a debate about the size of smoking cessation support groups. Upper limits for group sizes range from between 12 and 20 in Glasgow to, for example, 8 in Grampian and possibly smaller groups in rural areas. Participants felt that it was important to be flexible about group size as smaller groups can help to create greater intimacy and allow supportive relationships to develop more easily. There is, however, a balance to be struck between quantity and quality, as smaller groups would mean fewer people could be offered support.

#### *Theme 3: Dealing with emotions*

A small number of insights were grouped into this category. They related to the ability of the support worker to be confident about dealing with people’s emotions, and to offer a holistic approach which encompassed both physical and mental well-being. It was recognised that this could be quite an intense process and required striking a difficult balance between offering empathic understanding and wearing an “expert’s hat”.

#### *Theme 4: Approach and methodology of facilitator*

It was recognised from Dee’s story that the role of the smoking adviser may be changing into more of a counselling role, and that advisers would need to develop counselling skills. Attention was drawn to the importance of adopting a non-judgemental and non-directive approach which was service user-led rather than service-led. One participant, however, felt that “stoppers need to be taught how to quit”. Another had found it useful to hear about Dee’s approach to contacting non-attenders.

### *Theme 5: Tension between policy and practice*

This group of insights focused on the need for flexibility in providing smoking cessation services, for joint working across teams and for working outside of service level agreements. It was also felt that measures of success should include smoking reduction rather than complete cessation. As with other groups, participants felt that a “one size fits all” approach was not appropriate.

#### **Eve’s story – ‘A work in progress’**

Eve is a health care worker who had introduced smoking cessation services in a psychiatric hospital. The hospital still had smoking rooms (except in one area) and there was no special provision for smoking cessation services for mental health patients. If patients wanted support for giving up smoking they had to access smoking cessation services in the community.

Eve wanted to introduce better services for patients in the context of the national smoking ban, which was due to be implemented in the near future. The health board was in the process of developing a tobacco policy. It was proposed to employ a smoking cessation worker on a pilot basis, however, difficulties in getting authorisation to recruit the post meant that some of early funding was lost due to financial policy within the NHS (monies not used by 31st March cannot be carried forward).

One of the staff nurses in the area which was becoming smoke free on 26th March took on the role of smoking cessation worker for that area. She later became the smoking cessation worker for the pilot, once the go-ahead to recruit was finally given. However, problems were caused by the need for GPs to prescribe nicotine replacement therapy (NRT) after the patient was discharged, because of difficulties in accessing community-based smoking cessation services part way through a quit attempt. Some services were very helpful, but others not. There were some concerns by both GPs and hospital pharmacy service about the funding for NRT.

Eve says that she “naively” expected support from colleagues, but was surprised and shocked at the level of hostility from them in her attempts to introduce smoking cessation. Two acute wards had agreed to be a part of the project but then staff consistently did not come to meetings - there was a sense that they hadn't expected to be required to put much effort in and that the smoking cessation worker would deliver all of the service. Support and interest came from an unexpected quarter - patients in long term rehabilitation wards - and it was agreed to drop one of the acute wards in the pilot and include a rehabilitation ward instead.

Another problem was caused by delays in finalising the health board tobacco policy, from which the hospital policy would come. Although there had been wide consultation at the draft stage, there were a number of significant changes to the policy and it was not finalised until February 2006, which meant that there was not much time to get staff on board, or give them the opportunity to air their concerns and, in some cases, anger about the policy.

A further problem was that success is currently measured by a successful quit, not attempts at giving up, or a reduction in tobacco use. The project aimed to look at harm reduction, improvement in health and social benefits as part of developing smoking cessation services in mental health.

## **Insights from Eve's story**

### *Theme 1: Consultation*

Insights grouped under this theme centred on the need for all stakeholders, including patients and staff at all levels, to be involved in decision-making about changes. This requires adequate and significant time for proper consultation and involvement.

### *Theme 2: Working with success*

Leading on from the theme of consultation, this group of insights focused on the respective role of patients and staff and how to bring them together to seek solutions. Many of the insights were about the need to get staff on board through understanding their perspective and supporting them in working on health improvement. It was felt that all change, whether local policy or national legislation, needs staff compliance and support to make it a success.

Other insights under this heading related to the need to learn from the experiences of people with mental health problems who have tried or been successful in giving up smoking. Such information can be used to spell out, to both staff and patients, the benefits of stopping smoking amongst this client group. There may also be a need to review measures of smoking cessation success among people with mental health problems, to reflect a harm reduction approach, for example, a reduction in nicotine intake (through long term NRT) would be considered a success, in addition to complete cessation. Overall, in order to work towards success, it was felt that staff and patients need to jointly seek solutions, possibly on a ward by ward basis.

### *Theme 3: Joined-up services and communication*

A number of services played a role in Eve's story: the health board, primary and community-based services and hospital services. It was felt that a greater degree of information-sharing and communication between hospital staff, hospital departments, the health board and primary/community services, as well as better communication with patients, was necessary to make such significant change a success. However, one participant thought that it was better tackled gradually, by working with each component of a service to achieve a gradual change to the whole service.

It was felt that good practice could be more widely shared by, for example, looking at smoking cessation policy and practice in other hospitals and settings, such as prisons. One participant suggested creating a database of smoking cessation work throughout mental health and another suggested creating a network of smoke-free initiatives.

In terms of developing policy, it was recognised that, in Eve's story, the tobacco policy was finalised too late to get people on board. It was suggested that, in future, there should be proper forward planning of policies, allowing enough time for staff support and involvement followed by funding secured for implementation. There should also be a consistent approach within any hospital to smoking cessation service provision (including NRT), smoking rooms and rules etc.

### *Theme 4: Methods for smoking cessation support*

Insights grouped under this theme focused on the need for more flexible, needs-based approaches to smoking cessation with people with mental health problems. A number of methods were suggested, including narrative therapy, group work,

motivational interviewing and training people with mental health problems to provide peer support to others. Another suggestion was to offer additional social activities as an incentive to stop smoking. One participant also felt that staff in mental health services should also be offered smoking cessation support within the hospital.

## **4. CONCLUSIONS**

### **Evaluation of the event**

Evaluation of this story-dialogue event showed that participants had found the story groups insightful, relevant and informative. People also commented that the story-dialogue method was dynamic, inclusive and thought-provoking. Of those completing an evaluation form, 98% thought that the event had been excellent or good and 95% had found it useful to their work or their appreciation of smoking issues.

### **Main messages from the event**

#### *Understanding why people smoke*

Understanding people's motivations for smoking is important, both for social marketing to prevent smoking and in providing smoking cessation services tailored to individual needs. Ann's, Beth's and Calum's stories illustrated the very different reasons why people start and continue to smoke and find it hard to give up.

An understanding of the factors which lead people to decide to give up smoking and how their mental health can impact on that decision is also an important part of supporting people to quit. Some of these factors were explored in the dialogue sessions and include issues common to everyone such as levels of self-confidence and self-esteem and the degree to which people have separated their smoking behaviour from other behaviours.

It is also important to learn from people's experiences of smoking and relapse in order to improve or modify the support available for the next quit attempt.

#### *Improving smoking cessation services*

Participants in all five story-dialogue groups suggested ways to improve and develop smoking cessation services, based on the stories they had heard. Smoking cessation services tend to follow a standard, structured approach, although this may vary slightly across Scotland. However, all the groups found that a "one-size fits all" approach was not always appropriate and that smoking cessation services need to be flexible enough to offer a more individualised approach, particularly when dealing with people with mental health problems. It was also felt that measures of success should include a reduction in smoking, as well as a complete quit.

In dealing with individual smokers who were attempting to quit, it was felt that it was important to recognise the huge difficulties they face trying to quit and be able to offer a great deal of support, for "as long as it takes". Aspiring quitters need to know that it takes perseverance and determination to succeed. Confidence-building and stress management techniques could be taught to strengthen people's ability to persevere with and manage the quit attempt. The stories illustrated that sometimes people reach a "critical mass point" when they are ready to quit, and that developing ways of recognising this point and being able to provide services at that time, were important.

In terms of improving the range and variety of smoking cessation services for people with mental health problems, Dee's story showed that there should be more flexibility about the size of support groups, as smaller groups may work better for some people. However, others may not find group work helpful and individual support may be necessary. Different types of support might include motivational interviewing, counselling, peer support, telephone support. Longer term support may also be required, including longer term NRT.

It is important for the smoking cessation practitioner to be able to refer or direct people to other relevant services, for example money advice, and for other services, in turn, to be able to refer to smoking cessation.

#### *Developing tobacco policies and services*

Eve's story showed that, in developing policy, it is important to allow time to consult with and involve all stakeholders, including service users. This will help to build crucial support for implementation of the policy. It is also important to apply policy consistently within a service.

Communication and joint working with other departments and services, such as those based in the community, are essential to the effective development and implementation of tobacco policies. Sharing information between similar services across Scotland can help in learning from others and developing good practice.

The story dialogue method was used to good effect to give those with an interest in supporting smoking cessation an insight into how people feel and act when they are quitting, or helping to support a cessation intervention. It may be useful to help those in other settings to identify with the people they are attempting to support. Each story-teller provided a unique picture of their experience and care should be exercised in extrapolating and generalising.

Further such studies in community mental health projects and in specialist cessation services would help to build a better understanding of how cessation can best be supported in mental health settings.

## **5. FURTHER DIALOGUE**

The event partnership group submitted this report to the STCA Tobacco Control Issues Group on March the 1st 2007 at which a meeting was held to discuss the formation of a Smoking and Mental Health Forum.

The partnership hopes that this report will provide a useful catalyst for further discussion and for proposals for policy and service development in this important area of health improvement.

## PARTNERSHIP CONTACT DETAILS

### CHEX

CHEX, based in the Scottish Community Development Centre, is a resource to support community development approaches to health improvement. The staff team also support a Network of Community Health Projects and Healthy Living Centres to share information, ideas and practice on community development.

Community Health Exchange (CHEX)  
Suite 305  
Baltic Chambers  
50 Wellington Street  
Glasgow G2 6HJ.  
Tel: 0141 248 1990  
Website: [www.chex.org.uk](http://www.chex.org.uk)

### Scottish Tobacco Control Alliance

The STCA is a multi-disciplinary, multi-sectoral body of over 120 organisations concerned with the impact of tobacco on Scotland and its people. STCA provides a forum for information exchange and a voice for those working in the tobacco field to influence policy development. Management support for the STCA is provided through ASH Scotland.

STCA  
Alliances Manager  
ASH Scotland  
8 Frederick Street  
Edinburgh, EH2 2HB

Tel: 0131 220 9467  
Website: [www.ashscotland.org.uk](http://www.ashscotland.org.uk)

### UK Public Health Association in Scotland

UKPHA brings together individuals and organisations from all sectors who share a common commitment to promoting the public's health. UKPHA seeks to promote the development of healthy public policy at all levels of government and across all sectors. We act as an information platform and aim to support those working in public health both professionally or in a voluntary capacity.

Nathalie Holmerin Bartfay at: [nathalie@ukpha.org.uk](mailto:nathalie@ukpha.org.uk)  
Website: [www.ukpha.org.uk](http://www.ukpha.org.uk)

Event facilitated by: **Áine Kennedy**

[aine.kennedy@ntlworld.com](mailto:aine.kennedy@ntlworld.com)

Report compiled by: **Clare Lardner**

Clarity  
20 Galachlawside  
Edinburgh  
EH10 7JG  
Tel: 0131 445 5842  
Mob: 07808 930652  
Fax: 08717 33 55 62

e-mail [clare@clarity-scotland.co.uk](mailto:clare@clarity-scotland.co.uk)  
Website [www.clarity-scotland.co.uk](http://www.clarity-scotland.co.uk)