



# **Report on the mapping of existing smoke-free provisions within residential mental health services in Scotland: A snapshot of current policies and practice**

March 2010

## **Disclaimer**

Every effort has been made as part of the Tobacco and Inequalities work to conduct a comprehensive mapping of existing smoke-free policies and current practice in terms of stop-smoking provisions across all residential psychiatric services in Scotland. This was a rapid mapping exercise and therefore it is possible that we may have missed out a small number of residential psychiatric units or hospitals in our search.

Tobacco policy in health boards is an area undergoing current development, as the report will highlight, and therefore some of the information contained within may have altered since the mapping took place.

If you spot any inaccuracies in the listing of residential psychiatric hospitals or units please do not hesitate to get in touch so that we can amend the information which we hold.

This work was carried out as part of the 2009/2011 work plan for Partnership Action on Tobacco and health (PATH) and Tobacco and Inequalities.

Further information about PATH and Tobacco and Inequalities can be found at the ASH Scotland website at [www.ashscotland.org.uk/ash/3801.html](http://www.ashscotland.org.uk/ash/3801.html).

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## Key findings

- 13 boards (regional or special) across Scotland were identified as providing residential psychiatric service; these include 16 psychiatric hospitals and 29 psychiatric wards or units within a general hospital
- variations were found in tobacco policies implemented within the psychiatric services
- the majority of boards still make use of the current smoke-free exemptions within psychiatric hospitals and units
- few boards have extended their smoke-free policies to cover grounds
- compliance with the policies (and the law) on the whole was considered good although isolated cases amongst staff, patients and visitors are reported
- stop-smoking support was found to vary: with particular variations in the practitioner delivering support; when support is accessible; and the behavioural and pharmacological aids provided
- whilst negative attitudes and perceptions toward tobacco policies, smoking and stopping smoking still exist amongst the general public, psychiatric and mental health services interviewed are starting to see a shift in attitudes; influenced by an increased awareness of tobacco, the benefits of stopping smoking and the purpose of the tobacco policies
- the majority of the 13 boards are reviewing their existing tobacco policy which is an encouraging sign for future developments of tobacco policies within residential psychiatric mental health services.

**Recommendation 1:** Scottish Government should encourage good practice in the development and implementation of tobacco policies relating to smoke-free buildings and grounds, taking into consideration local needs and facilities available to ensure expectations for equality and standards are met for services users and staff.

**Recommendation 2:** The Scottish Government, NHS Health Scotland and ASH Scotland should continue to raise awareness of tobacco and the benefits of stopping to health, to challenge and address negative attitudes and perceptions towards smoking and stopping smoking within mental health settings (community and inpatient) through training and by raising awareness.

**Recommendation 3:** Stop-smoking services should regularly review staffing capacity and resources for the delivery of specialist stop-smoking services to support mental health service users and staff in residential psychiatric services who wish to stop smoking.

**Recommendation 4:** PATH and Tobacco and Inequalities to follow up boards that had indicated that they were undertaking a review of their tobacco policies and determine the extent, outcome and implementation plans. The Scottish Government should also provide clear guidance and timescales for any moves or changes towards the provision of smoke-free mental health services following the recent consultation.

# 1. Introduction

Compared to the general population people living with a mental health problem are twice as likely to smoke<sup>1</sup>; tend to smoke more heavily and be more dependent than smokers without mental health problems<sup>2</sup>. According to the mental health charity Mind, 70% of people in mental health inpatient units smoke<sup>3</sup>. Despite these high rates they are far less likely to be offered advice about lifestyle changes such as giving up smoking<sup>4</sup>. People with mental health problems have a higher risk of cardiovascular disease, coronary heart disease and respiratory disease<sup>5</sup>.

Despite the huge inequalities described above, people with a mental health problem can successfully give up smoking and can experience positive health benefits. When provided with stop-smoking medication and advice from healthcare professionals, the abstinence rates in people with mental health problems can be as high as those for general populations.

To address the inequalities, whether in health amongst people living with a mental health problem who smoke living within the community or in a mental health setting, the 2004 Smoking Cessation Guidelines for Scotland<sup>6</sup> states that as part of best practice

- smokers should be offered advice to stop smoking by health professionals who are in regular contact with them
- support is delivered by specialist service staff working closely with mental health staff
- Nicotine Replacement Therapy (NRT) is considered for patients with a high level of dependence
- support for smokers wanting to stop should be available and accessible when implementing smoke-free policies.

The *Guide to smoking cessation in Scotland*, jointly published by Health Scotland and ASH Scotland will be published in spring 2010 to replace the 2004 guidelines.

## 2. Recent developments

Over a number of years Partnership Action on Tobacco and Health and the Tobacco and Inequalities Project (both managed by ASH Scotland) have led a number of developments to address some of the issues described including:

- the mapping of existing services, resources and experiences of smoking amongst people with a mental health problem and stopping smoking – exploring the challenges and solutions
- the funding of several tobacco demonstration pilots targeting mental health services, service users and staff to identify innovative approaches to engaging with mental health services users who smoke
- the support and facilitation of discussions and debates on tobacco and mental health related issues; sharing experiences, expertise on service and policy developments implemented across mental health services

through two Scottish symposiums; and the creation of the Smoking and Mental Health Working Group (SMHWG) coordinated by PATH and ASH Scotland

- developed tailored tobacco training for mental health practitioners on raising the issue of smoking with mental health service users.

Through these pieces of work we have helped gather useful insights into some of the challenges and solutions to addressing tobacco use and smoking amongst people with a mental health problem. Our work has also helped to identify challenges that remain within mental health services and the opportunities there are for further reducing smoking rates amongst their service users.

Whilst we have built up our knowledge of tobacco policy and service delivery developments within the membership of our Smoking and Mental Health Working Group we knew little about what was happening in other local areas. In particular, what services were available, and what moves mental health services had made to implement smoke-free policies. For example whether services had removed designated rooms on wards and units for smoking since the 2006 legislation came into force, which ended smoking in all enclosed public places in Scotland.

Exemptions currently exist for psychiatric hospitals and psychiatric units, along with a number of other establishments, where they are considered a place of residence for long stay service users. Such establishments can therefore permit smoking, by residents only, within a designated room in a building, which meets certain criteria. While these exemptions exist, psychiatric hospitals and units are not obliged to provide a designated smoking room. Boards also have the power to remove the exemptions and extend the smoke-free policies to cover the grounds of premises.

The current exemptions mean that staff and service users within a psychiatric setting are still at some risk of exposure to second-hand smoke.

The Scottish Government at the time of this mapping being carried out launched the consultation '*Achieving smoke-free mental health services in Scotland*'<sup>7</sup> to look at the current exemptions in the smoking in public places legislation which permit smoking in designated rooms in residential psychiatric units and hospitals. This proved timely for the mapping exercise.

### **Aim of mapping exercise**

The aim of the mapping exercise was to gain a clearer national picture of existing tobacco policies and available support implemented across mental health services in Scotland - looking specifically at residential psychiatric hospitals and units within general hospitals.

To achieve this a simple mapping exercise was conducted to understand current policy and practice regarding smoking and exposure to smoke such as the implementation of smoke-free policies for buildings and grounds; the provision of stop-smoking support (pharmacological aids and behavioural

therapy) for service users and practitioners; and brief advice or specialist training in stop-smoking support for staff.

### **3. Method**

Fourteen regional NHS boards exist in Scotland. Amongst their many roles they are responsible for the provision and management of the whole range of health services in their area such as hospitals and general practice. Such provisions include the implementation of tobacco policies like smoke-free services and the provision of stop-smoking support. In total 12 of the regional health board areas currently provide residential psychiatric care (see Appendix 1, Table 1). In addition there are also eight special health boards in Scotland. Only one, The State Hospital Board, provides psychiatric services through the State Hospital (see Appendix 1, Table 2).

All of the relevant 13 boards with a remit for delivering residential psychiatric services were targeted by the mapping exercise, which covered a total of 44 hospitals (psychiatric hospitals and general hospitals with psychiatric wards/units).

To gather the required information the mapping exercise included the use of an online questionnaire and a semi-structured telephone interview questionnaire.

Information was gathered between January and February 2009 from individuals with a lead responsibility for the mental health or tobacco policies at board or local level. The two themes we wanted to look at as part of the mapping exercise were the current policy and practice on: smoking and exposure to smoke; and provision of information and support to smokers.

The following areas were explored:

- the extent of the current tobacco policy for service users and staff within the premises (e.g. for grounds and/or buildings only)
- how long the policies have been in place
- whether the policies are adhered to in practice and how they are monitored
- the type of support offered to smokers (e.g. one-to-one support, group counselling or pharmacological aids)
- whether stop-smoking support is provided with the aim of complete abstinence or cutting down the amount smoked
- who delivers stop-smoking support (e.g. in-house or external staff)
- key 'enablers' which have helped services successfully deliver their tobacco policy e.g. where a policy might involve implementation of a smoke-free policy or delivering stop-smoking support
- barriers encountered by services implementing their tobacco policy.

#### **Online questionnaire**

Using an online survey tool [*Survey Monkey*] a questionnaire (see Appendix 2) was generated and distributed by e-mail to identified staff at residential

psychiatric hospitals and units in Scotland with a lead role in either smoking cessation or mental health.

### **Semi-structured telephone questionnaire**

For the semi-structured telephone interviews a questionnaire was developed based on the questions presented in the online survey (see appendix 3). The questions were however, expanded to allow the interviewer an opportunity to explore the response further and provided prompts to stimulate discussion.

### **Data analysis**

Anonymous responses to the online questionnaire were automatically directed to a database where they were compiled for analysis. The telephone interview questionnaires were recorded on the pro-forma sheets and responses collated. For the purpose of reporting our findings the results have been made anonymous.

## **4. Results**

### **4.1 Response rate**

#### **4.1.1 Online questionnaire**

Seven of the 13 identified board areas responded to the online questionnaire. More than half of those submitted incomplete.

#### **4.1.2 Semi-structured telephone interview questionnaire**

Through the telephone interviews we were able to gather data from all of the 13 relevant boards that provide residential psychiatric services.

As mentioned above the semi-structured interviews asked similar questions to the online questionnaire and as a result we were able to complete the questionnaire survey in full for all of the 13 board areas. The semi-structured interviews also allowed the interviewer to explore responses further and clarify areas covered therefore eliciting more detailed responses.

Therefore the report will focus on the analysis of data gathered through this method.

### **4.2. Buildings and grounds tobacco policy**

#### **4.2.1 Current smoking policy for staff and service users: within residential psychiatric buildings**

Out of the 13 relevant health boards, ten provided a designated room where patients are permitted to smoke within the buildings.

As we would expect, in line with the Smoking, Health and Social Care (Scotland) Act 2005, no staff member was found to be permitted to smoke in the buildings across all of the boards surveyed.

Encouraging results from the interviews showed that three boards had at the time already gone completely smoke-free within buildings. Whilst discussing pending and planned reviews of their tobacco policies, unprompted, several other areas suggested that they were waiting for the Scottish Government to provide a clearer steer on the position that mental health services should take with regards to smoke-free services and the removal of current exemptions.

A hospital in one of the boards interviewed was at the time of the mapping exercise piloting a smoke-free policy within two wards by removing the designated room from those areas. They also planned a wider roll-out across the Board, depending on the outcome of the evaluation.

Measures that were recorded that were found to help staff to implement the smoking policies within buildings for patients included the removal of all lighters and tobacco-related products from patients on admission; staff supplying patients with restricted/limited access to a lighter; cigarette machines removed from sites; access to rooms restricted to one person at a time, and opening times applied for the designated rooms.

#### **4.2.2 Current smoking policy for staff and service users: within the grounds of residential psychiatric services**

In four of the boards interviewed members of staff were required to use a specified outdoor area where smoking is permitted on the grounds. Within one health board area it was reported that one hospital had no restrictions on where staff and patients are allowed to smoke on the grounds. The rationale given for permitting staff to smoke on the grounds in these situations related to the location, layout and size of the hospital grounds. This in itself was felt to present risks to the safety of staff and patients, and in particular for staff working night shifts who wish to take their break to smoke a cigarette.

Measures that helped staff to implement the tobacco policies on the grounds included the introduction of 'zones' where smoking was permitted (e.g. beyond a certain distance from buildings) and the provision of shelters for smoking.

#### **4.2.3 Current smoking policy for staff and service users: within the grounds and buildings of residential psychiatric services**

No board had, at the time of carrying out the survey, introduced smoke-free policies which covered both buildings and grounds of the premises.

Seven hospitals (across seven boards interviewed) were found to have a complete indoor and outdoor ban on staff smoking.

The tobacco policies implemented for the majority of boards which we discussed had been in place since 2006. Additional information gathered through the interviews found that eight of the boards were in the process, or about to commence, a review of their tobacco policies, which was an encouraging sign. New building developments, relocation of services, extensive refurbishments and a board-wide review of all their services and policies were reasons given by four boards for their current policy review.

## 4.3 Compliance monitoring and implementation

### 4.3.1 Compliance

Monitoring adherence to the tobacco policy varied but tended to be the responsibility of local level staff such as the ward manager (Table 1).

**Table 1:** Responsibility for monitoring compliance (n=13)

Lead	Number
Tobacco Policy Group	1
Acute Mental Health Manager	1
Ward Manager (local manager)	7
Facilities Manager	1
Unspecified	3

In one board the hospital receptionist or management were reported to proactively challenge smoking behaviour of individuals where the policy is being breached or, to direct smokers to areas where smoking is permitted. The same members of staff tended to highlight the parameters of the tobacco policy, which suggested that there was not yet full acceptance from all staff within that board of their role in ensuring compliance. In one other board area a hospital employed security staff to patrol the grounds and deter smokers in non-designated areas, but this was not reported as common practice in any other board. Effectiveness of this particular approach was not explored.

The majority of boards reported that the smoking restrictions within their policies were adhered to in practice 'always' and 'generally' (Table 2).

**Table 2:** Compliance to restrictions in practice (n=13)

Adherence to restrictions	Number
Always	6
Generally	6
Sometimes	1
Never	0

However further exploration revealed that in ten boards there were examples where adherence to the restrictions was not always followed by staff, patients or visitors (Table 3).

**Table 3.** Number of health board areas reporting examples where the tobacco policy had not been adhered to (n=12)

<b>Examples of non-compliance</b>	<b>Number</b>
Patients and visitors smoking in non-permitted areas of the grounds (e.g. building entrances)	3
Patients smoking outside the designated room (e.g. toilet and private room)	2
Staff smoking in buildings having a break	1
Staff permit patient smoking in non-designated room	3
During staff handover	2
Continued smoking when leaving designated room	1

Whilst these were reported as rare occurrences, reasons provided (anecdotally) for the nursing staff in two boards found smoking within the building, were that they were unable to leave the ward and premises for their break as there were not enough fully-trained (mental health) staff on the wards, or the wards were too busy and they felt unable to leave for a break.

There were three boards that gave examples where in exceptional circumstances staff permitted a patient to smoke on the ward. In those cases staff saw patient care as being paramount and would permit smoking in special circumstances where:

- psychiatric care would be seen by staff to be compromised
- when managing admissions e.g. emergency admissions
- where a clinical situation arose such as a patient becoming agitated and requesting a cigarette, but staff are unable to move the patient to a designated room
- in acute cases of chronic schizophrenia or mania.

In those cases it was emphasised that this was not normal practice, and that once the patient was more stable staff would go through the policy outlining where the designated rooms for this are located. We did not explore through our questions what measures were put in place to protect or minimise staff and patient exposure to second-hand smoke in those special circumstances.

Incident reporting procedures and audits were mentioned by six out of the 13 boards as a means to log reports of non-compliance of the restrictions and policy. Audits were also reported to be carried out at a board-wide level not just at a local level, of policies that have been implemented and monitored. Additional approaches to ensure adherence to the tobacco policies included

good signage which was felt to be important in highlighting to patients, visitors and staff the areas where smoking was permitted.

#### **4.3.2 Enablers and barriers to implementing the tobacco policies**

Whilst the tobacco policies were in place we wanted to explore the enablers and barriers experienced by services during their implementation within the residential psychiatric hospital and units of boards identified. This covers the implementation of revised policies or adapted policies where smoke-free buildings and or grounds have been introduced.

A list of enablers and barriers to implementing, in particular the 'smoke-free' element of the tobacco policies, are collated by theme and highlighted in Table 4 below, covered:

- attitude and perception
- information
- capacity building, support and training
- policy guidance.

The attitude and perception amongst staff and service users about smoking and the suggested rights of an individual to smoke acted both as a barrier and enabler in the implementation of tobacco policies.

Information that helped to raise the profile of tobacco; engage staff or patients in the development and review of their tobacco policies; increase knowledge and skills of staff through capacity building and training, were identified as positive contributors to the success of their tobacco policy. However in a small number of relevant boards a lack of information provided at entrances to buildings and poor communications to staff and patients relating to the tobacco policies did not aid its success.

Some responses from the boards interviewed highlighted that there were certain challenges in monitoring the policy to ensure adherence, particularly where there were smoke-free grounds or buildings. Barriers highlighted included the opening times of the smoking rooms, maintaining smoking in one place and the issues around capacity for staff to chaperone patients to designated smoking areas.

A consequence of the existence of exemptions and their impact is the exposure of staff and patients to smoke where a person must undergo special observations<sup>i</sup> as part of the admissions or monitoring processes.

A positive result of the implementation of smoke-free policies within those boards interviewed was the absence of increased aggression amongst patients. This had been raised in other reports and discussions as a potential concern for staff but was not experienced by boards in this study.

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<sup>i</sup> Carried out where a risk assessment for an individual is required to monitor behaviour, medication prescriptions and compliance to medication.

**Table 4.** Enablers and barriers to implementation of tobacco policies where smoke-free buildings or grounds have been enforced, by theme

<b>Theme</b>	<b>Enablers</b>	<b>Barriers</b>
<i>Attitude and perception</i>	<ul style="list-style-type: none"> <li>• pre-existing change in culture around smoking amongst patients and staff within mental health settings</li> <li>• acknowledgement of the needs of non-smokers</li> </ul>	<ul style="list-style-type: none"> <li>• staff attitudes regarding smokers rights</li> <li>• belief that smoking rooms should be available and patients should be allowed to smoke freely</li> <li>• covert smoking</li> </ul>
<i>Information</i>	<ul style="list-style-type: none"> <li>• engagement with staff and patients on the tobacco policies and reviews</li> </ul>	<ul style="list-style-type: none"> <li>• lack of tobacco policy signage at entrances</li> <li>• poor communication of policy to service users and staff</li> </ul>
<i>Capacity building, support and training</i>	<ul style="list-style-type: none"> <li>• support and involvement of nursing and medical staff</li> <li>• support from patient and carer groups</li> <li>• stop-smoking training has had a positive impact on staff engagement with the tobacco policies</li> </ul>	<ul style="list-style-type: none"> <li>• increased workload for staff delivering support and monitoring compliance</li> <li>• capacity to chaperone patients outdoors when short staffed</li> <li>• senior staff failing to fully implement policy</li> </ul>
<i>Policy guidance</i>	<ul style="list-style-type: none"> <li>• cordoned-off area for smoking provided</li> <li>• policy change has not prevented those who wish to access areas for smoking</li> <li>• most of the hospital is already smoke-free</li> <li>• profile of tobacco has changed within the mental health setting</li> </ul>	<ul style="list-style-type: none"> <li>• length of time required to implement the tobacco policy</li> <li>• lack of agreement about what is practically possible during development of tobacco policies</li> <li>• lack of safe and secure outdoor spaces</li> </ul>

## **4.4 Provisions for stop-smoking support**

### **4.4.1 Behavioural support**

Stop-smoking services were found to be provided by every board interviewed and were offered automatically on admission. The practice of delivery and support did however vary slightly from board to board. For example, two boards mentioned that they provide support for staff who smoke. As this was not a standard question asked of all interviewees, we speculate that this figure may be higher.

All 13 boards during the interviews indicated that they offer individual (one-to-one) support, whilst nine of those boards also offered group support to service users.

Whilst all services indicated that they provided stop-smoking support which assists an individual to stop smoking completely; six out of the 13 boards interviewed emphasised that complete abstinence might not be realistic or achievable for everyone. In those circumstances they would support a patient who wished to reduce the amount that they smoked. Whichever approach was taken it was clear from reports from the boards that patients would be involved any decision to reduce smoking or stop smoking completely.

Overall stop-smoking support was available for a minimum of 12 weeks although most respondents (12 out of 13) reported that patients could access support on a daily basis and for as long as required.

#### **4.4.2 Pharmacological aids**

The next set of questions posed explored the type of pharmacological aids used to help assist a quit attempt. As expected all 13 boards interviewed offered pharmacological aids as part of the provision for stop-smoking support.

The majority (eight out of 13) of boards were found to offer the full spectrum of NRT products. This was with the exception of some wards that provided forensic services or secure wards where products such as inhalators and gum are not used for security reasons. Bupropion and Varenicline were less widely used (four and five boards respectively) and then only with caution and close monitoring.

#### **4.4.3 Delivery of stop-smoking support**

Of the relevant boards 12 out of the 13 indicated that they had internal staff or teams (i.e. psychiatric nurses generally trained to deliver stop-smoking support but also included stop-smoking advisors specialising in mental health) to deliver stop-smoking support to patients (see Table 5).

Three boards had staff delivering stop-smoking support who had not received formal training to do so, whilst five made use of external experts such as a local NHS stop-smoking service to deliver specialist support where needed. In one hospital there was only one nursing staff member trained to deliver stop-smoking support and they worked a permanent night shift, which suggested accessibility issues for those wishing to receive timely support relating to stopping smoking.

**Table 5.** Support offered by specialist and non-specialist trained staff (Boards were allowed to select more than one option where applicable)

<b>Staff delivered stop-smoking support</b>	<b>Number</b>
Internal staff – not trained to deliver stop-smoking support	3
Internal staff trained to deliver stop-smoking support*	1
Stop-smoking specialist in mental health or mental health specialist trained to deliver stop-smoking support	12
External specialist trained to deliver stop-smoking support to mental health service users	5

\*option not included in semi-structured interview but additional response provided

#### **4.4.4 Enablers and barriers to the provision of stop-smoking support**

Themes similar to those identified as ‘enablers’ and ‘barriers’ when exploring implementation of the tobacco policies were experienced by boards in the provision of stop-smoking support within the residential psychiatric services.

The themes identified were similar to those regarding the implementation of the tobacco policies with some minor differences:

- attitudes and perceptions
- smoking behaviour
- capacity building, support and training
- service delivery

Where training was provided in the delivery of brief and specialist stop-smoking support it was suggested that mental health staff felt more confident in supporting patients in their quit attempt. This might be because the mental health staff felt better equipped to understand the tobacco policies, the health impacts of smoking, the role of stop-smoking services and the range of support available that they could talk about.

The availability and presence of a dedicated stop-smoking advisor on wards was reported as an important factor for a few boards interviewed in ensuring the success of stop-smoking support. This enabled:

- relationships between the stop-smoking and mental health service staff to develop
- an increase in referrals to stop-smoking services from wards as mental health service staff know who and where to refer patients to
- patients to see when, where and who they could readily access support from, and
- patients to respond positively to the stop-smoking advisors who took an interest in their care.

In the absence of enablers such as those described above, the provision of stop-smoking support was found to be challenging. This was found where there was an interruption in the continuity of stop-smoking services for a minority of boards responding e.g. where dedicated support was no longer available due to an advisor being off on sick-leave and cover not available.

**Table 6.** Enablers and barriers to the provision of stop-smoking support by theme

Theme	Enablers	Barriers
Attitudes and perception	<ul style="list-style-type: none"> <li>management of units more supportive of stopping smoking</li> <li>patients' mental health recovery programme not affected by stopping smoking</li> </ul>	<ul style="list-style-type: none"> <li>working with a difficult patient group</li> <li>small number of patients will not quit smoking</li> </ul>
Smoking behaviour	<ul style="list-style-type: none"> <li>increased awareness of smoking and health impact among staff and patients</li> </ul>	<ul style="list-style-type: none"> <li>limited options for what patients do once they stop smoking</li> <li>patients and visitors who do smoke are visible to stoppers</li> <li>patient health/behaviour can be unpredictable</li> </ul>
Capacity building, support and training	<ul style="list-style-type: none"> <li>training to deliver stop-smoking support has had a positive impact on staff confidence and understanding of stop-smoking support and interventions</li> <li>improved communications between key staff</li> </ul>	<ul style="list-style-type: none"> <li>not enough staff trained to deliver specialist stop-smoking support</li> <li>no replacement for stop-smoking advisor if on long-term sick leave and hence loss of valuable support for patients</li> </ul>
Service delivery	<ul style="list-style-type: none"> <li>availability and presence of a dedicated specialist advisor to provide regular or daily support and support staff on wards</li> <li>pharmacy support for staff and patients who wish to receive support on stopping smoking</li> <li>increased referrals to stop-smoking advisors</li> </ul>	<ul style="list-style-type: none"> <li>patients are sometimes too ill to maintain quit attempt or continue receiving stop-smoking support</li> <li>some units cannot offer support quickly enough</li> </ul>

Additional positive outcomes recorded during the interviews on the provision of the stop-smoking services and the introduction of the smoke-free policies related to improvements in the environment, smoking behaviour and future policy developments:

- long term/long stay patients who services thought would never engage with stop-smoking services are attempting to stop smoking for the first time

- members of staff are now accessing stop-smoking services
- greater protection from second-hand smoke (for staff and patients)
- services making a move to consider the removal of designated areas for smoking within buildings
- hospital and social environment has improved e.g. patients able to enjoy the use of the facilities
- cleaner and better atmosphere
- new building developments will see further smoke-free policies being introduced
- over-exposure to cigarette smoke in the designated areas has influenced quit attempts and reduced consumption amongst patients that smoke.

#### **4.5 Partnership working to support the tobacco policy**

A variety of partners were mentioned as playing an important role in supporting the tobacco policies, particularly in relation to smoke-free provisions. These include:

- specialist stop-smoking service
- pharmacy staff
- senior management
- Tobacco Action Teams (set up to review existing tobacco policies)
- service user-led organisations
- advocacy service
- carer and patient groups
- services providing accommodated services for people with mental health problems (e.g. Penumbra)
- nursing staff
- alcohol service.

## **5. Conclusions**

The mapping exercise helped us to see how services have developed their tobacco policies to support the health and well-being of psychiatric services in residential settings.

Variations in tobacco policies exist between the 13 residential psychiatric services relating to smoke-free provisions within the buildings and grounds. The majority of boards still make use of the current exemptions within the legislation to allow smoking in designated rooms within psychiatric hospitals and units. In practice few boards had at the time of conducting the mapping exercise extended the smoke-free provisions within their tobacco policy to cover the grounds of residential psychiatric hospitals and units.

Evidence from this mapping and earlier research commissioned by NHS Health Scotland<sup>8</sup> indicates that boards are able to implement policies to remove smoking in buildings and or grounds without further changes to

legislation where appropriate steps and measures have been taken to involve patients and staff.

In practice the delivery of specialist stop-smoking support was also found to vary across the 13 boards.

Whilst negative attitudes and perceptions toward tobacco policies, smoking and stopping smoking still exist they are slowly changing amongst mental health service staff, which is enabling services to effectively implement their tobacco policies and stop-smoking support to improve health of staff and service users. Several factors may be responsible for influencing the change in behaviour including the smoking in public places legislation; access to training; increased awareness and availability of stop-smoking services and support.

Evidence of plans to review existing tobacco policies at board level were found but the extent of the review and measures that would be implemented were not at the time discussed or agreed.

## 6. Recommendations

The following are recommendations for future action to support the provision of stop-smoking support, develop tobacco policies and support implementation within residential NHS psychiatric settings.

**Recommendation 1:** Scottish Government should encourage good practice in the development and implementation of tobacco policies relating to smoke-free buildings and grounds, taking into consideration local needs and facilities available to ensure expectations for equality and standards are met for services users and staff.

**Recommendation 2:** The Scottish Government, NHS Health Scotland and ASH Scotland should continue to raise awareness of tobacco and the benefits of stopping to health, to challenge and address negative attitudes and perceptions towards smoking and stopping smoking within mental health settings (community and inpatient) through training and by raising awareness

**Recommendation 3:** Stop-smoking services should regularly review staffing capacity and resources for the delivery of specialist stop-smoking services to support mental health service users and staff in residential psychiatric services who wish to stop smoking.

One possible barrier to services not extending their tobacco policies to remove designated rooms and shelters for patients is potentially the 'exemption' itself. Whilst the mapping exercise did not ask questions specifically that looked at the opportunities and challenges presented by the exemption there were suggestions that boards were 'waiting' for further guidance from the Scottish Government before making a move towards complete smoke-free services (which would bring their policies in line with general hospitals) and that a case for smoke-free mental health settings is required.

**Recommendation 4:** PATH and Tobacco and Inequalities to follow up boards that had indicated that they were undertaking a review of their tobacco policies and determine the extent, outcome and implementation plans. The Scottish Government should also provide clear guidance and timescales for any moves or changes towards the provision of smoke-free mental health services following the recent consultation.

## 7. References

- <sup>1</sup> McNeill, A. (2004). Smoking and patients with mental health problems. [online] Health Department Agency. Available from: [www.nice.org.uk/aboutnice/howweare/aboutthehda/hdapublications/hda\\_publications.jsp?o=559](http://www.nice.org.uk/aboutnice/howweare/aboutthehda/hdapublications/hda_publications.jsp?o=559) [accessed 08.01.10]
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- <sup>5</sup> Joukamaa M, Heliovaara M, et al. (2001). Mental disorders and cause-specific mortality. *British Journal of Psychiatry* [online] 179: pp.498-502. Available from: <http://bjp.rcpsych.org/cgi/content/abstract/179/6/498> [accessed 08.01.10]
- <sup>6</sup> Health Scotland and ASH Scotland. (2004). Smoking Cessation Guidelines for Scotland 2004 Update. Edinburgh: Health Scotland and ASH Scotland
- <sup>7</sup> Scottish Government. (2009). Achieving smoke-free mental health services in Scotland: a consultation. Scottish Government [online] Available from: [www.scotland.gov.uk/publications/2008/12/22094350/0](http://www.scotland.gov.uk/publications/2008/12/22094350/0) [accessed 24.03.09]
- <sup>8</sup> NHS Health Scotland. (2008). Moving towards smoke-free mental health services in Scotland. McNeill A, Bauld L, Ferguson J. NHS Health Scotland [online] Available from: [www.healthscotland.com/documents/2387.aspx](http://www.healthscotland.com/documents/2387.aspx) [accessed 24.03.09]

## Appendix 1: Regional and special health boards providing mental health services

Table 1 and 2 showing regional and special health boards that provide residential mental health services

**Table 1:** Regional health boards with residential psychiatric provisions

Health Board Area	Providers	Psychiatric hospital	General hospital with psychiatric ward/unit
Ayrshire and Arran	Yes	1	3
Borders	Yes	1	0
Dumfries and Galloway	Yes	1	0
Fife	Yes	2	2
Forth Valley	Yes	1	5
Grampian	Yes	1	2
Greater Glasgow and Clyde	Yes	5	6
Highland	Yes	1	0
Lothian	Yes	0	6
Lanarkshire	Yes	1	3
Orkney	No	0	0
Shetland	No	0	0
Tayside	Yes	2	1
Western Isles	Yes	0	1

**Table 2:** Special health board providing residential psychiatric services

Special health board	Provision of residential psychiatric services
NHS 24	No
NHS Education for Scotland	No
NHS health Scotland	No
NHS Quality Improvement Scotland	No
Scottish Ambulance Service	No
State Hospitals Board for Scotland	Yes
The National Waiting Times Centre Board	No
National Support Organisations	No

## **Appendix 2 Tobacco and Mental Health Policy and Practice Survey**

[Online survey: [www.surveymonkey.com](http://www.surveymonkey.com)]

### **Introduction**

This survey is a mapping exercise to gather data on the CURRENT policy and practice around tobacco and smoking within Scotland's RESIDENTIAL psychiatric hospitals and psychiatric wards within a general hospital. The survey will take between 5 and 15 minutes to complete depending on your responses, and is anonymous.

There are two areas of investigation:

- 1) The current policy and practice regarding smoking and exposure to smoke for service-users and staff in your mental health unit.
- 2) The current policy and practice on the provision of information, behavioural support, and pharmacological aids to smokers.

For all responses, please think about your current residential psychiatric service.

The results will be used to inform further development of policy and practice around smoking in the mental health sector by providing a picture of services' current experiences.

**The deadline for submitting your response is 09 January 2009.**

Many thanks for taking part in this work.

## Section 1: About your service

1. Is your current mental health unit a...

- Psychiatric hospital
- Psychiatric ward within a general hospital
- Other (please specify)

2. In which health board area is your current mental health unit located?

- Ayrshire & Arran
- Borders
- Dumfries & Galloway
- Fife
- Forth Valley
- Grampian
- Greater Glasgow & Clyde
- Highland
- Lothian
- Lanarkshire
- Orkney
- Shetland
- Tayside
- Western Isles

## Section 2: Current policy and practice on smoking and exposure to smoke

3. Does your current mental health unit have any kind of restrictions on where service users or staff can smoke?

- Yes
- No

4. What is the current smoking policy in your mental health unit for service users?

- Complete indoor ban
- Smoking permitted indoors in all private rooms
- Smoking permitted indoors in one designated room
- Smoking permitted anywhere outside
- Smoking permitted in designated area(s) outside
- Complete indoor and outdoor ban
- Other (please specify)

5. What is the current smoking policy in your mental health unit for staff?

- Complete indoor ban
- Smoking permitted indoors in all private rooms
- Smoking permitted indoors in one designated room
- Smoking permitted anywhere outside
- Smoking permitted in designated area(s) outside
- Complete indoor and outdoor ban
- Other (please specify)

6. Approximately how long have the most comprehensive restrictions on where service users can smoke been in place?

- Less than 6 months
- Between 6 months and 1 year
- Between 1 year and 2 years
- Between 2 to 5 years
- More than 5 years

7. Are there any exemptions to the restrictions?

- No
- Yes (please specify below)

8. Are the restrictions set out in policy adhered to in practice?

- Always
- Generally
- Sometimes

9. Have the restrictions been altered since first implementation?

- No
- Yes (please specify below)

#### Section 4: Current policy and practice on provision of information and support to smokers

10. Does your current mental health unit have any policies to provide support to service users who are smokers?

- No
- Yes

11. What is the nature of the support you offer to smokers? (Select as many as apply)

- Individual Counselling
- Group Therapy
- Pharmacological Aids

12. Who is the support offered by? (Select as many as apply)

- Internal untrained staff
- Internal trained staff
- External specialists
- Smoking Cessation Specialist
- Other (please specify)

13. Does your unit offer any of the following pharmacological aids? (Select as many as apply)

- We don't offer pharmacological aids
- Lozenge
- Microtabs
- Chewing gum
- Patches
- Inhalators
- Nasal sprays
- Bupropion (Zyban)

14. How long is a typical course of pharmacological treatment? (If this does not apply, leave blank)

15. Is the support offered part of a...

Quit dependant treatment (Abstinence model)?

Cutting down/harm-reduction model?

16. Please describe below any partners you work with to provide support to service users about their smoking.

17. Please describe ONE key success of your support policy below.

18. Please describe THE MOST SIGNIFICANT challenge you have encountered in providing your support below.

### Section 5: Survey complete

19. Please use this box if you would like to provide any further information or comments.

Many thanks for the time you have taken to complete this mapping exercise. The results will be used to inform further development of policy and practice around smoking in the mental health sector by providing a picture of services' current experiences. For more information regarding this survey, or the issues surrounding smoking and mental health, please contact: [john.sim@ashscotland.org.uk](mailto:john.sim@ashscotland.org.uk) phone: 0131 220 9463

## **Appendix 3: Semi-structured telephone interview questionnaire**

### **Mapping of existing smoke-free policies in residential psychiatric hospital's, units and services in Scotland**

#### **INTRODUCTION [Instruction for interviewer]**

*Introduce self:*

*Purpose of call:*

We are following up with telephone interviews a recent online survey circulated by ASH Scotland in December 2008 to Psychiatric hospitals and psychiatric wards within general hospitals '**Tobacco and Mental Health Policy and Practice Survey**'

Did you recently complete an online survey circulated by ASH Scotland in December 2008 **Tobacco and Mental Health Policy and Practice Survey**?

IF YES – We have selected a number of those we circulated the survey to explore some of the questions in more detail.

If NO - ASH Scotland's Inequalities team are undertaking a mapping exercise to understand current policy and practices regarding smoking and exposure to smoke, and the provision of support in stopping smoking within residential mental health hospital and units in Scotland. The information gathered will be used to help identify development and support needs relating to training, awareness raising, smoking cessation service provision, and policy development. It will also be used to inform our work around tobacco, mental health, and broader inequality issues.

Respondent answers used will be anonymous and name or roles will not appear in any written report, though the institution may be identified.

The interview will last approximately 20-30 minutes and will explore:

1. The current policy and practice is regarding smoking and exposure to smoke for service-users and staff in your residential psychiatric hospital/unit or service?
2. The current policy and practice on the provision of information, behavioural support, and pharmacological aids to smokers?

Interviewer:

Date of interview:

Psychiatric Hospital/Unit/Service Details

Respondent's name	
Respondent's role/job title	
Telephone	
Email	
Name of organisation	
Psychiatric Service Provision	Psychiatric hospital <input type="checkbox"/> Psychiatric ward (within hospital) <input type="checkbox"/> Psychiatric unit (within hospital) <input type="checkbox"/> Psychiatric/mental health service within a hospital <input type="checkbox"/> Psychiatric/mental health service within community <input type="checkbox"/>
Specialism (e.g. elderly adults, young people, mother and baby, elderly adult, e.g. forensic, intensive palliative care etc)	

**TOPIC 1: What is the current policy and practice regarding smoking and exposure to smoke for service-users and staff in your mental health unit?**

Q1: What is the current smoking policy within the respondent's unit for both service users and staff?

Prompts:

- Complete indoor ban
- Smoking permitted indoors in all private rooms
- Smoking permitted indoors in one designated room
- Smoking permitted anywhere outside
- Smoking permitted in designated area(s) outside
- Complete indoor and outdoor ban
- Other (please specify)

[If 1(d) is ticked **SKIP TO Q3**]

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If there are limits or restrictions on where smoking is permitted for service users:

Q2.1. How long have the restrictions been in place?

*[Prompt: Less than 6 months; between 6 months and 1 yr; 1 and 2 yrs, 2 and 5 yrs, more than 5 yrs]*

Q2.2 Are there any exemptions to the restrictions? If 'Yes' what are they?

Q2.3 Has the policy been altered or modified? If yes what changes were made?

Altered?  Modified?  No changes or modifications

Description of changes made:

---

Q2.4 How is adherence to the policy monitored and how is does your organisation ensure that the policy is complied with?

Q2.5 Are the restrictions set out in the unit's policy actually adhered to in practice?

*[Prompt: Always; generally; sometimes; never]*

Q2.6 If the restrictions are not adhered to, in what ways, and why?

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Q2.7 What have been the difficulties (if any) in implementing the restrictions?

[SKIP Q3 and GO TO Q4]

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Q3 If there are no limits or restriction in where smoking is permitted are there any informal rules of practice that mean smoking is usually confined to particular areas?

Yes  No

If answer is 'Yes' what are they?

---

**TOPIC 2: What is the current policy and current practice on the provision of information, behavioural support, and pharmacological aids to smokers?**

Q4: Are there policies to offer support to service users who are smokers?

Yes  No

[If answer to Q4 is 'No' **SKIP TO Q5**]

---

Q4.1 What is the nature of the support you offer? (Tick all that apply)

- (a) Individual therapy
  - (b) Group therapy
  - (c) Pharmacological aids
- 

Q4.2 Who is the support offered by? (Tick all that apply)

- (a) Internal untrained staff
  - (b) Trained staff
  - (c) External specialists
- 

Q4.3 How frequently is this support offered?

---

Q4.4 Does your hospital/unit offer any of the following NRT or pharmacological aids? (Tick all that apply)

- (a) Lozenge
  - (b) Microtabs
  - (c) Chewing gum
  - (d) Patches
  - (e) Inhalators
  - (f) Nasal sprays
  - (g) Bupropion (Zyban)
  - (h) Varenicline (Champix)
-

Q4.5 How long is a typical course of pharmaceutical treatment provided?

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Q4.6 Is this part of a:

Quit dependant treatment (Abstinence model)?

Cutting down/harm-reduction model?

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Q4.7 How has the policy worked in practical implementation?

Key success	Difficulties

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Q4.8 Can you describe any partners you work with to provide support to service users regarding their smoking? Who are they?  
*[Prompt: Training, specialist information provision etc.]*

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**YOU HAVE NOW COMPLETED THE QUESTIONNAIRE**

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**WRAP UP TELEPHONE INTERVIEW**

- **Thank respondent for time**
  - **Give opportunity for any questions**
  - **Detail timescale for how the information they have provided will be used, and what format it may appear in (e.g. report, presentation)**
  - **Take email details if they wish to receive a copy of any written report based on their input**
- 
- 

Q5            Are there any activities in practice that currently provide support to smokers (even though they may not be part of the unit's official policy)?

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**YOU HAVE NOW COMPLETED THE QUESTIONNAIRE**

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**WRAP UP TELEPHONE INTERVIEW**

- **Thank respondent for time**
  - **Give opportunity for any questions**
  - **Detail timescale for how the information they have provided will be used, and what format it may appear in (e.g. report, presentation)**
  - **Take email details if they wish to receive a copy of any written report based on their input**
- 
-



**PATH is a joint initiative between ASH Scotland, NHS Health Scotland and the Scottish Government to reduce the prevalence of tobacco use in Scotland**



Action on Smoking & Health (Scotland) (ASH Scotland) is a registered Scottish charity (SC 010412) and a company limited by guarantee (Scottish company no 141711).

