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EXPLORING THE IMPLEMENTATION OF A SMOKE-FREE ENVIRONMENT IN A MENTAL HEALTH SETTING

**Summary**

Smoking is the largest single cause of preventable illness in the UK. Those with mental health problems smoke significantly more and are therefore at greater risk. Although designated smoking rooms are permitted in Scotland there are mental health service providers in Scotland who have implemented a smoke-free environment in order to promote good health. This study examines the factors associated with a smoke-free environment in a secure mental health setting. Semi-structured in-depth interviews were conducted with seven participants across two sites. Two interviews were one-to-one and the third interview was a focus group with five participants. All participants worked in a secure mental health setting which had removed a smoking room. All participants discussed a planned, open and collaborative approach when implementing a smoke-free environment. Participants described challenges including fear and resistance to change and challenges when maintaining a smoke-free environment. As well as challenges there were recognised benefits amongst participants to both staff and patient. A smoke-free environment was welcomed and the removal of a smoking room was viewed as beneficial to people’s health and well-being. This study may provide learning for mental health service providers in Scotland yet to implement a smoke-free environment or for those working to maintain a smoke-free environment.

**Background**

The UK and Scottish Government recognise that there is a responsibility to improve health and reduce health inequalities by encouraging people to stop smoking (Department of Health 2008) (NHS Health Scotland 2011a). Smoking rates are highest amongst the most vulnerable groups in society such as those with mental ill health (Hughes et al 1986) (Lasser et al 2000).

Despite public health policies such as the *Smoke-free mental health services in Scotland Implementation guidance* there are many reported challenges when implementing a smoke-free environment (Ratschen et al 2009) (NHS Health Scotland 2011b). However, studies have shown benefits to the patients and staff when implementing a smoke-free environment in a mental health setting such as a reduction in disruptive behaviour and verbal aggression (Hempal et al 2002).

**Study aim**

The aim of this study was to explore the implementation of a smoke-free environment in a secure mental health environment. NHS HS wanted to conduct the study using in-depth interviews in order to:

* engage with stakeholders
* establish how smoke-free change was implemented
* explore what was needed for change and implementation
* establish how effective the Guidance document was in the process
* explore the barriers, challenges and benefits to the change
* ensure use and share lessons learned

**Recruiting sites and participants**

Key stakeholders were identified through relevant NHS HS networks. Sites were identified that had removed a smoking room in a secure mental health site in Scotland. Within those sites people were identified who were instrumental in the change process and who were affected by the change process. In total two face-to-face interviews were conducted (site A) and one face-to-face focus group (site B).

**Interview questions**

A semi-structured interview process was developed to include questions around the change process, attitudes, possible support drivers, facilitators and challenges. There were four main questions to shape the interview:

* What steps and processes were involved/did you observe when implementing the smoke-free mental health status?
* What resources (i.e. human or financial) were needed for change and implementation?
* Overall, how useful was the *Smoke-free mental health services in Scotland Implementation guidance* document (and other factors) in the change process?
	+ How user-friendly was the Guidance
	+ Is there anything you would change about the Guidance
* What were the barriers, challenges and benefits to the change process?

The questions were designed to identify individual participant experiences in taking part in a change process. The questions were also designed to examine the extent to which participants had experienced change in their work environment. Participants were given a copy of the interview questions via email prior to the interview and it was explained part of the interview would be about the *Smoke-free mental health services in Scotland Implementation guidance*.

**Findings**

*Background and rationale*Site A was a single secure mental health ward within a large hospital site, two members of staff were interviewed. Site B was an entire mental health hospital with multiple wards where NHS HS carried out a focus group with five people. Site A and all wards within site B were described as smoke-free, i.e. there was no authorised smoking in any of the wards and designated smoking rooms had been closed. Both sites provided smoking shelters where patients were permitted to smoke.

Both sites gave similar responses when asked why they had decided to remove smoking rooms within the wards. Site A described a clear, consistent message regarding the patient’s health, the patient’s choice and commented that two-thirds of their patients had indicated that they wanted to stop smoking. Site B built on the ‘health of the patient’ message by also speaking about minimising staff being subject to second-hand smoke and ensuring patients were not subject to violence.

*Steps and processes when implementing a smoke-free environment*

Part of the study aimed to explore the steps and processes involved when implementing a smoke-free environment in a mental health setting. As well as locking and prohibiting smoking in the designated smoking room respondents described a number of different processes.

Participants spoke about the relationship with the local smoking cessation team. Partnership working was carried out due to ward staff recognising that health promotion activity by the smoking cessation team with patients would be beneficial with regard to reducing smoking and stopping smoking. Logistically this meant ward staff had to make patient referrals to smoking cessation.

 *“Your choice and the support is there. We believe people [patients] can stop smoking who have mental health issues.”*

(Participant 01, Site A)

Participants also spoke about the availability of nicotine replacement therapy (NRT). This meant having adequate nicotine support on wards to alleviate patient’s nicotine cravings when patients were not able to go outside and smoke. Nursing staff had access to NRT at all times and felt they had a good relationship with local pharmacy colleagues.

Participants mentioned staff training but did not regard this as something new due to the removal of the smoking room. Participants within the focus group at site B regarded training as ‘well established’ and commented on the usefulness of the real-life scenarios within their local training. Other participants commented that there was not a great uptake on the wards in relation to smoking policy training.

*“We all got [as charge nurses] education, smoking cessation came and spoke to us, she gave us some examples of different hospitals and environments where they had tried it [removal of smoking rooms] and what types of myths were around it [removal of smoking rooms] and what was the reality of the situation and I found that quite useful but I think it was a bit like reading that book [the Guidance], it was really useful but what happened in reality I think seems really different”.*

(Participant 04, Site B)

Both sites described a working group with smoking cessation, clinical nursing, mental health and ward staff who met and continue to meet regularly. Through the group decisions were made regarding removing smoking rooms, ongoing tasks, ongoing issues and maintaining a smoke-free environment.

There was a mass canvassed approach when communicating the new smoking policy at both sites. Site A discussed information appearing in payslips, emails and posters. Information was also relayed at staff meetings. This ensured everyone knew the smoke-free launch date. Site B reiterated the modes of communication and also cut down the hours when the smoking room was open on the lead up to closure.

Participants at both sites did not feel they had completed all the necessary steps when implementing and maintaining a smoke-free environment. Participants recognised that there were ongoing issues to address and tasks to be completed. Participant 01 discussed the need to work with Estates and Facilitates in relation to outdoor lighting. Participants at site B spoke about the need to make certain entrances fire exits to minimise smoking by patients in doorways. Participant 01 also wanted to renovate the smoking room in order to make best use of it and benefit the patients in some way.

Table 1: Steps involved when removing a smoking room

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| --- |
| Multi-disciplinary steering group |
| Shutting the smoking room |
| Providing a smoking shelter |
| Smoking cessation support and NRT |
| Staff training |

*Challenges*

There was anticipation amongst the staff of violence and challenging behaviour from the patients who were no longer allowed access to the smoking room.

 *“I really thought this is going to be a nightmare, people [patients] aren’t going to accept it. There is going to be an increase in challenging behaviour”.*

(Participant 02, Site A)

Participants at site B described breaches of local smoking policy and at times breaches of national legislation. This involved patients smoking outwith the designated smoking shelter, i.e. patients smoking on the patio within the grounds or at hospital entrances. Site B had a further challenge around patients smoking indoors. Participants described incidents of smoking in bedrooms, sitting rooms, bathrooms and toilets. This behaviour was described as secretive but at times patients would openly smoke in such areas causing problems for staff. Participant 01 also mentioned covert smoking in the bathroom at times.

Participants went on to describe their concerns surrounding the risk of fire due to secretive smoking and their concern for other patients namely those who were non-smokers. Participants 04 to 07 spoke about their apprehension when approaching smokers breaching local policy and national legislation. Participants 04 to 07 feared confrontation and disruptive behaviour. There was also a lack of consistency and knowledge about what to do or say when confronting covert smoking.

 *“We [staff] don’t have a comprehensive plan for getting people [patients] to stop smoking [covertly]. How do we ensure the policy? How do we put the procedures in place?”*

(Participant 04, Site B)

Participants at site B discussed the challenge of escorting patients to smoke. Participant 05 commented that nursing did not have the resource to escort patients outside 30 times a day and escorting a patient outside for the sole purpose of smoking was not in the policy.

The planning and preparation phase proved challenging, site A stated the group over-planned at times and there was some resistance within the group about the change. A participant at site B described a lack of preparation right at the start of the process and a lack of ownership when it came to delegating tasks.

 *“People would have talked about it forever rather than do it.”*

(Participant 01, Site A)

Table 2: Challenges

|  |
| --- |
| Staff attitudes and anxieties |
| Breaches of policy |
| Ensuring and maintaining the policy |
| Confrontation when approaching smokers |
| Escorting patients to smoke |
| Planning and preparation |

*Benefits*

Participants commented on the beneficial reduction of smoke in the wards. Wards were described as smelling and feeling better for staff. Participants explained that the reduction of second-hand smoke was also a health benefit to patients.

 *“People [patients] used to sit in that [smoking room] all day, it’s better now that isn’t happening.”*

(Participant 06, Site B)

One participant was pleased they did not have to go into the smoking room anymore due to the smoke. Another participant said the removal of the smoking room meant they were no longer in the position where patients were asking to be let into the smoking room, i.e. at night or when the room was closed.

All participants who were fearful and anxious of the change process discussed how there had not been an increase of challenging behaviour or violence within the wards. Some participants thought there had been a reduction of aggression and violence as a result of closing the room. Participant 01 had received no complaints from patients as a result of the change. The environment was also described as safer for the patients. No participant interviewed during this study would reinstate the designated smoking room.

*“It’s not as bad as a lot of us feared.”*

(Participant 06, Site B)

 *“I am surprised it [incidents of violence] didn’t [happen], I had a perceived idea. I am really surprised. I haven’t experienced it [aggression].”*

(Participant 02, Site A)

 *“There was more violence with unsupervised smoking in the smoking room. It’s a safer environment for the patients.”*

(Participant 05, Site B)

All participants had noticed a reduction in patient smoking. One participant discussed how there was an increase of patients using NRT products and an increase of patients partaking in other activities other than smoking such as going to the gym, taking a walk or being outside for fresh air. One participant discussed the important role of nursing staff when promoting stopping smoking to patients.

*“If someone is coming into hospital because their sleep pattern is terrible, they are isolating themselves, they are living on cigarettes….. we aren’t making any change, we aren’t helping people effect any change in their life by just you know promoting that [smoking] here……..I don’t mean to sound judgemental in any way, I have always felt that…………. if someone comes and they don’t go out, they spend all their time at home smoking we can’t just say that’s okay just do the same [smoke] here.”*

(Participant 02, site A)

Participants believed patients were healthier due to the change. One participant discussed patients’ breathing as improved and a noticeable reduction in the amount of prescribed antibiotics taken by some patients. The same participant also discussed improved sleeping patterns and as a result an improved immune system.

 *“Quite quickly people [patients] got used to it; the major positive impact is people’s [patients’] health has improved. Their health improved, their sleeping pattern changed. This meant a big impact on the mental health of the patients. They slept during the night and were awake and up during the day.”*

(Participant 02, Site A)

Table 3: Benefits

|  |
| --- |
| Less smoke on the wards |
| Protection from second-hand smoke |
| Smoking room is closed |
| No increase of challenging behaviour |
| An increase of NRT use |
| Possible health benefits to patients |

*Use of Guidance*

During the interview NHS HS explored the contribution of the Guidance. Responses were mixed when participants were questioned about the Guidance. All participants were familiar with the document and had received it. Participant 01 described how the Guidance was used at the working group meetings. The group at site A worked their way through the document and from there decided how to put steps in place. To Participant 01 the document was the ward’s policy driver when implementing a smoke-free environment and acted as a guide to check the working group were on the right track.

Although all participants had seen the document the Guidance did not appear to be the main focus of the working group at site B. Participant 03 explained the working group were all in agreement about the removal of the smoking rooms and there was a consensus in relation to the task of the group. Site B had removed all smoking rooms prior to the Guidance being issued therefore it may have proved more useful if it had been available earlier.

**Conclusion**

The findings show that all staff interviewed would not reinstate a smoking room and believe the removal of a smoking room in a mental health setting is a positive change. Staff were encouraged to work in partnership, participate in a multidisciplinary working group and participate in a decision making process. Staff were also encouraged to take ownership of tasks in order to implement and maintain the smoke-free environment. Patients were able to receive NRT to combat nicotine withdrawals and were able to smoke outside in designated areas. Smokers could be supported to stop smoking through the partnership with smoking cessation.

Both sites experienced breaches of local policy and national legislation to varying degrees. One site did not have a long lead-in time before the smoking room was closed therefore may have benefited from more preparation time. Both sites also described perceived difficulties and challenges from staff associated with removing the smoking room. However, these fears and anxieties were not founded and staff perceived a reduction in challenging behaviour and aggressive incidents. This could have been because of the consistent, clear message ensuring patients knew they were in breach of the policy.

The removal of smoking rooms at both sites has displayed a participative approach with communication as a key factor. Staff consultation and open communication demonstrates that there was an attempt to address resistance in a rational way. Although all the steps and processes described were in line with the Guidance document there was not a consensus amongst participants whether this was a contributing factor.

By closing a smoking room the staff interviewed felt they had benefited. Participants discussed that they did not smell of smoke and the atmosphere of the ward had improved. Participants mentioned other health benefits to patients as a result of removing the smoking room including improved physical and mental well-being.

*Limitations and strengths*

Findings from this study are mixed and may be due to the small sample size. Although common themes are identifiable from the results this study could benefit from a larger sample size. NHS HS also used a mixed methodology when carrying out recorded interviews, i.e. using two one-to-one interviews and using one focus group with five participants. Although the same questions were used to shape the interviews and focus group it was difficult to truly compare both sites due to the mixed methodology. In order to gather some additional information a follow-up telephone interview was carried out for site B. NHS HS spoke to a smoking cessation professional who was involved in the removal of the smoking rooms.

Questions asked during all interviews and the focus group enabled NHS HS to gather rich qualitative data but may be perceived as having elements of bias. The researcher asked participants about challenges and benefits pre-empting the idea that there were challenges and benefits. Again bias may be perceived as NHS HS only spoke to members of NHS staff. The researcher made the decision to only speak to NHS staff as part of the interview explored the Guidance document, a practitioner’s resource. Gaining ethical approval to interview inpatients in a secure mental health unit may have been time consuming so this was another factor when deciding who to interview.

The last limitation of this study was the differences between the two chosen sites. Site A was a single ward within a large hospital site whereas site B was an entire large hospital site with multiple wards. Site A removed their smoking room after the dissemination of the Guidance document whereas site B made the change prior to the Guidance being issued.

**Recommendations**

The findings from this study suggest that mental health service providers who wish to remove a designated smoking room do so by putting a planned approach in place. Services may benefit from a multidisciplinary working group, linking with key stakeholders, provided smoking cessation support and effective communication. The steps and processes involved in successful implementation are detailed in the Guidance, this or locally devised procedures may be helpful when removing a smoking room. If service providers have already removed a smoking room and wish to ensure compliance these steps and processes may also prove helpful.

Participants observed an increase in patients reducing their smoking and attempting to give up. Therefore patients should be encouraged to give up smoking in a mental health setting. In order to fully understand the health benefits to staff and patients further qualitative and quantitative research should also be carried out. Qualitative research could include patients as well as staff groups.

This research study has successfully explored the process and factors associated with removing a smoking room in a mental health setting. The findings from this study and similar studies could act as a reassurance to service providers in relation to fear and anxiety and how such resistance usually subsides and challenging behaviour does not worsen. However, this study was small therefore future studies should be carried out using comparable sites, i.e. numerous wards or numerous hospitals who have removed a smoking room at the same time.

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