PH48 Smoking cessation in secondary care: podcast for staff working within mental health trusts

An interview with Mary Yates, a Modern Matron from South London and Maudsley Foundation Trust (SLAM), who led on the introduction of a smoking cessation service for patients within her trust. Mary also provided expert testimony during development of the NICE guidance PH48.

The podcast runs for 12 minutes 57 seconds and covers:

• Why providing access to smoking cessation within mental health services is important;

• Approaches that can help the delivery of smoking cessation support in a person-centred way;

• An overview of the work at SLAM, including how it was introduced and delivered, and the outcomes that have been generated so far for patients.

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Podcast transcript

PH48: Smoking cessation in secondary care settings, podcast for staff working within mental health trusts

Interviewer: Hello and welcome to this implementation podcast from NICE which supports the public health guidance on smoking cessation in secondary care, acute maternity and mental health services.

In this discussion we will focus on smoking cessation within mental health services. I'm Mandy Harling, the implementation advisor for the NICE guidance and with me is Mary Yates, a Modern Matron from South London and Maudsley NHS Foundation Trust. Mary was one of the expert advisors to the development group for the NICE guidance. "

Interviewer: Mary, why is it important to raise smoking cessation with patients or clients of mental health services?

MY: Well, smoking is now widely accepted as the single most important contributory factor to premature mortality for patients with mental health problems. I believe therefore that healthcare professionals engaging with this patient group have a moral and ethical responsibility to do everything they can to support, cut-down and quit attempts. To ignore this issue is like ignoring the elephant in the room.

It's estimated that 42 per cent of all the tobacco consumed in the UK is by those with mental health problems so it's not an issue we can ignore. Discussing smoking cessation is the right thing to do. It's the first step towards addressing this health inequality.

It's clinically and cost effective and so it's very worthwhile at all levels. It seems to me a missed opportunity if smoking cessation is not incorporated into the routine work we do as mental health professionals. In supporting patients' recovery we need to look at the whole person and deliver evidenced based interventions to address the problems that patients present with, and this includes smoking.

People with mental health problems have a right to access smoking cessation interventions. They have a right to be informed about the harmful effects of smoking in a way that they understand. And they have a right to access smoking cessation interventions. Having

regular discussions with healthcare professionals about their smoking status can provide a platform for accessing specialist smoking cessation advice.

Interviewer: What particular challenges may there be for people with mental health problems when considering quitting smoking?

MY: Clearly quitting smoking is an enormously difficult thing for anyone to do but especially for those with the added burden of a mental health problem. There are the obvious problems of poor self-esteem and low confidence that can make it hard to even contemplate quitting. People often experience negative symptoms that are manifested as lack of activity, boredom and loneliness. There has been a lack of interest in developing bespoke interventions for supporting our patients to quit and the result has been that this big issue is not high on our agenda.

Addiction to nicotine means that smokers may suffer cravings when the nicotine level reduces. The urge to smoke is compelling and when relieved can provide a sense of relaxation. Smokers often confuse craving with feelings of stress and anxiety, which can be quite similar.

But I think a big challenge is the lack of confidence amongst the staff to tackle the issue. I would like to see staff with a positive attitude to promoting smoke-free environments, particularly for young patients entering our services.

There has been a widely accepted culture of smoking in mental health institutions and that needs to change so that people using our services are not starting to smoke when they're admitted as a way of integrating into our environments. Staff need to have confidence that the patients who arrive in their services can quit. They must have ambition for their patients. They must instil hope in them and inspire them to make smoking cessation a reality. Patients have enormous capacity. They are resilient and they are very much able to quit if they have the right support to do so.

Interviewer: Thinking about the challenges you've mentioned, Mary, how can staff within mental health services help clients or patients to overcome some of these challenges?

MY: I think that staff working in mental health services need to make smoking cessation a routine part of their daily work. As a minimum they must ask their patients about their smoking status, assess their readiness to quit and refer them to smoking cessation specialists as required. This requires a shift in practice so that smoking is placed on everyone's agenda. But it also demands that a care pathway is available for patients who indicate that they are contemplating quitting. Staff need to be informed about the impact of smoking on health and the particular concerns for those with mental illness. They should be able to share this knowledge with patients in a format that they understand. They need to know how to support their patients to access local smoking cessation support and they are well placed to provide ongoing support for people who are cutting down and quitting.

Some important interventions will be ensuring that patients have access to adequate nicotine replacement therapy and being aware that smoking cessation may impact on other forms of therapy such as prescribed psychotropic medication. Nicotine replacement combinations must be provided as regular and on a need to have basis so that withdrawal can be carefully managed."

Interviewer: What can help smoking cessation interventions to be delivered in a person-centred way?

MY: Staff can begin by listening to and seeking to fully understand the patient's experience in relation to smoking. Any smoking cessation intervention must support the patient to make autonomous decisions. Patients can make informed choices when they've been given information that's relevant and understandable. The patients I've worked with do not enjoy being dependent on their cigarettes. They very much want to be free and back in control of their life. They want to be able to spend money on food, clothes and other household essentials. They are motivated towards health. But they need healthcare professionals, support staff and their family and friends to support them.

Interviewer: Are there particular approaches that you found successful at South London and Maudsley Trust that have enabled clients to consider and engage in a quit attempt?

MY: Since July 2008 all of our mental health services have been smoke-free indoors but we recognised that this had not impacted on the prevalence of smoking and the subsequent chronic diseases that our patients suffered. So we decided to review the situation by engaging with patients to determine the extent of the problem. The first step was a listening exercise to explore the problem. We examined the prevalence of smoking amongst our patient group but also amongst our staff group and we observed the impact of smoking on our services. We learnt that 92 per cent of our forensic inpatients were smokers. 11 per cent of our staff were smokers. 70 per cent of our staff wanted the trust to be smoke-free. Our nurses were spending 90 minutes per shift facilitating smoking. Some patients were smoke-free in other care settings for many years but had begun to smoke in our wards because of the culture in our ward environments.

We used the information we'd gathered and fed it back to the patients and the staff and we were able to develop a smoke-free strategy and agree revisions to our smoke-free policy. This formed the basis for driving the required changes in practice to tackle the issue.

The interventions included staff training programmes, patient focus groups and incorporated in assessment of smoking status, a standard for all our new patients. And we now provide access to smoking cessation support both on an individual and a group basis. Some patients were supported to cut-down their smoking in preparation for quitting. In addition we have ensured that all the patients who require it have access to nicotine replacement therapy."

Interviewer: What outcomes have there been from your work at the South London and Maudsley Trust?

MY: The most obvious change is the environment. It's so much cleaner. Prior to our smoke-free period the areas around the entrances to our wards were littered with cigarettes, matches and rubbish. And all of our ward gardens were used for smoking but now the gardens are cleaner and more inviting spaces. The patients have regular fresh-air breaks throughout the day and there's no longer the smell of smoke lingering in the air after the door has been open.

We have a more informed workforce. Smoking cessation training at level one is now mandatory for all clinical staff. We also have level two trained smoking cessation advisors working across the organisation and these are well placed to deliver individual and group

support for those who are contemplating a quit attempt. In some instances we link our patients up with local smoking cessation services so that they can access the interventions close to their own home. We now have 10 of our ward environments completely smoke-free and we are looking at extending this through the rest of the trust.
For individuals who have managed to quit there's been real joy at being liberated from their addiction. The patients have enjoyed the benefits of more money. They are spending this money on themselves and have focused on new hairstyles, new clothes and even teeth cleaning. Some patients who have quit have been able to reduce their prescribed Clozapine medication and this has also been very exciting to experience the lesser side effects. Patients tell me that they can walk further. They have less problems with asthma and fewer chest infections.
Within the ward environments the staff tell me they have released more time to care since they are no longer shopping for patients' cigarettes, facilitating smoking breaks to the garden and resolving as many disputes about smoking.
Patients attending therapy sessions have been noticeably more engaged in their treatments. Previously they were preoccupied by the smoking breaks, demanding to know when the session would allow the break and concerned about missing an opportunity to get their next cigarette. This is no longer an issue that gets in the way of the therapy sessions provided.
We've been monitoring carbon monoxide levels and we have seen these dramatically fall to normal levels.
And finally, I would like to say that we have not noticed any increase in incidents of violence or aggression. This was a real concern for many staff before our smoking-free period began. So it's quite pleasing to be reassured that smoke-free policy does not contribute to increased violence and aggression. I would also add that there has been no deterioration in mental state associated with our smoke-free periods.
Interviewer: Thank you very much Mary.
Interviewer: You've been listening to an interview with Mary Yates, Modern Matron from South London and Maudsley NHS Foundation Trust. We hope you find the information in this podcast useful in helping you to put the NICE guidance into practice. For more information about the NICE public health guidance on smoking cessation in secondary care, including the NICE implementation tools, please visit our website atwww.nice.org.uk/PH48
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