Brief guide: Smokefree policies in mental health inpatient services

Context

Mental health care providers have a duty of care to protect the health of, and promote healthy behaviour among, people who use, or work in, their services. This includes providing effective support to stop smoking or to temporarily abstain from smoking while using or working in secondary care inpatient services[1]. Services are increasingly mandated by their commissioning authorities to implement comprehensive smoke-free policies, where smoking is banned within the whole hospital estate and tobacco dependence treatment pathways are integral to service provision. Smokefree policies might be perceived as contentious, particularly in services where there is a lack of support to effectively manage nicotine withdrawal and provide a range of alternative activities. However, in response to legal challenges, the Court of Appeal has ruled that smokefree policies do not infringe human rights.

CQC inspections should not challenge smokefree policies, including bans on tobacco smoking in mental health inpatient services (for example, by raising such policies as a unwarranted 'blanket restriction'). Instead, focus should be paid on whether such a ban is mitigated by adequate advice and support for smokers to stop or temporarily abstain from smoking with the assistance of behavioural support, and a range of stop smoking medicines and/or e-cigarettes. Inspections should also consider whether alternative activities are in place and promoted, including regular access to outside areas.

Evidence required

An evidence gathering tool is included at **appendix 1** to this guide.

Reporting

- The fact that a service is smokefree should not itself be raised as a concern about 'blanket restrictions'. Blanket bans on e-cigarettes that have no cogent justification could, however, be raised as blanket restrictions.
- Where services have implemented smokefree policies without tobacco dependence training for staff, access to smoking cessation support (i.e.nicotine replacement therapy (NRT), varenicline and/or e-cigarettes), this should be discussed under the 'effective' section of the report.
- Appropriate medication reviews and monitoring should be completed to ensure that medicines doses are altered when necessary, as smoking status changes. This should be discussed under the 'safe' section of the report.

[1] National Centre for Smoking Cessation and Training (2014) *Smoking Cessation and Mental Health: A briefing for front-line staff*

Policy

NICE recommends that all NHS-funded secondary care sites should become completely smokefree and offer tobacco dependence treatment[2]. NHS England recommends that all mental health inpatient units and facilities be smoke-free by 2018.[3]

The Court of Appeal has ruled that smoking bans do not engage human rights principles[4]

PHE has published guidance, evidence and practice to support mental health services to implement smokefree policies and support patients stop or reduce harm from smoking. It advises commissioners to use contracting levers (including CQUIN payments) to require secure services to achieve smokefree status[5].

DH, NHS England and PHE recommend mental health staff routinely ASK is the patient a smoker, ex-smoker or a non-smoker? ADVISE that best way of stopping smoking is with a combination of medication and specialist support. ACT by building confidence, giving information about and enabling access to evidence based stop smoking support, stop smoking medicines and/or e-cigarettes.[6] An independent review of e-cigarettes commissioned by PHE states that it is not appropriate to prohibit e-cigarette use in health services as part of smokefree policies unless there is a strong rationale to do so[7].

Link to regulations

Whilst smokefree policies are not themselves to be considered as unwarranted blanket restrictions, it is possible that measures associated with their implementation, such as any restrictions on movement, searching practices, etc, could be so considered, or could raise concerns as to whether least restrictive alternatives are being used.

CQC seeks to be consistent in its application of the regulations, so please refer to **appendix 2** for a breakdown of how they should be applied if unjustifiable blanket restrictions are in place.

[2] NICE public guidance PH48 *Smoking: acute, maternity and mental health services*
[3] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[4] *R (N) v SSH; R (E) v Nottinghamshire Healthcare NHS Trust* (2009) EWCA Civ.
[5] Public Health England (2015) *Smoking cessation in secure mental health settings: Guidance for commissioners*
[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/532253/JRA_Physical_Health_revised.pdf
[7] McNeill A, Brose LS, Calder R, Hitchman SC, Hajek P, McRobbie H (2016) *E-cigarettes: an evidence update. A report commissioned by Public Health England*

Appendix 1

Evidence required: what to consider when inspecting services

General comments

The fact that a service is smokefree should not itself be raised as a concern about 'blanket restrictions'.

Where services allow smoking, avoid referring to blanket restrictions in relation to smoking breaks. Refer to outside breaks rather than smoking breaks, and focus on access to fresh air for all patients

Bans on the use e-cigarettes may be raised in terms of blanket restrictions, but services may offer a cogent rationale for such a ban.

Evidence table

The following is designed as an aide rather than a checklist. It will not always be possible to explore every issue on every inspection.

	POLICY
1	Was the smokefree policy, developed in collaboration with staff and people who use secondary care services, or their representatives?
2	Are all staff aware of the smokefree policy and do they comply with it?
3	Are all staff provided with information about the smokefree policy and instructions about their roles and responsibilities in maintaining a smokefree work environment?
4	Does the organisation provide everyone with verbal and written information and advice about the smokefree policy before their appointment, procedure or hospital stay?
	TRAINING
5	Is there a requirement that all staff are trained to deliver advice on stopping smoking and to make a referral to intensive support?
6	Are all frontline staff trained to deliver advice around stopping smoking and referral to intensive support? They should know what local and hospital-based stop smoking services offer and how to refer people to them.
7	Are all frontline staff trained to talk to people in a sensitive manner about the risks of smoking and benefits of stopping?
8	Are all staff who deliver intensive stop smoking support trained to the minimum standard described by the NCSCT, with additional training that is relevant to their clinical specialism?
	SUPPORTING SERVICE USERS
9	During the first face-to-face contact, do staff ask everyone if they smoke or have recently stopped smoking and record smoking status and the date they stopped, if applicable, in the person's records (preferably computer-based) and any hand-held notes?
10	Before a planned or likely admission, do staff work with the person to include the management of smoking on admission or entry to the secondary care setting in their personal care plan?
11	Does the trust encourage everyone who smokes to stop smoking completely and if necessary

	provide immediate access to NRT or other pharmacotherapies when appropriate?
12	Do staff offer and, if the person agrees, arrange for them to receive intensive behavioural support, either during their current outpatient visit or during their inpatient stay?
13	Do staff encourage the use of NRT for anyone who does not want, is not ready or is unable to stop completely?
14	Do staff ensure that people who use drugs that are affected by smoking (or stopping smoking) are monitored, and the dosage adjusted if appropriate? • Stopping smoking can reduce metabolism of several psychotropic medicines resulting in higher, sometimes toxic blood levels over a few days. This applies in particular to clozapine and olanzapine, two commonly used antipsychotic medications Clinical guidelines recommend reducing doses of these drugs and monitoring blood levels before and at weekly intervals after stopping smoking until levels have stabilised. • Services should be mindful of potential consequences to medication plasma-levels should patients resume smoking upon discharge, or smoke heavily when given off-site leave.
15	When people are discharged from hospital, do staff ensure they have sufficient stop smoking pharmacotherapy to last at least 1 week or until their next contact with a stop smoking service?
	SUPPORTING STAFF
16	Does the service advise all staff who smoke to stop? Offer staff in-house stop smoking support? Provide contact details for community support if preferred? Allow staff to attend stop smoking services during working hours without loss of pay?
17	Does the service support staff who do not want, or are not ready or able to stop completely to use licensed nicotine-containing products to help them abstain during working hours?
18	Does the service offer and provide intensive behavioural support to maintain abstinence from smoking during working hours?
	ENVIRONMENT
19	Are all stop smoking pharmacotherapies included in secondary care formularies?
20	Does the hospital pharmacy stock varenicline, bupropion and a full range of NRT (including transdermal patches and a range of fast-acting products) for patients and staff?
21	Do all hospitals have an on-site stop smoking service?
22	Is a range of NRT available for sale in hospital to visitors and staff?
23	Is use of e-cigarettes included as a component of a strategy to help people quit or cut down? If not, why not, and does the policy reflect NCSCT guidance on e-cigarettes (http://www.ncsct.co.uk/usr/pdf/Electronic%20cigarettes.%20A%20briefing%20for%20stop%20smoking%20services.pdf)? • E-cigarettes should not routinely be treated in the same way as smoking. It is not appropriate to prohibit e-cigarette use in health services as part of smokefree policies (see policy position in above brief guide). • Some e-cigarette devices contain heating elements and batteries that may pose risks on mental health wards, CQC will expect services to explore individual risk assessment and the use of alternative models of e-cigarette to mitigate these, rather than a blanket ban on the use of e-cigarettes. There is, for example, an e-cigarette model approved for use in prisons. • There is increasing flexibility in the ways in which some services are responding to e-cigarette

	technologies as a way of managing smokefree services. For example, some mental health services have allowed that patients may use electronic cigarettes in certain indoor spaces (such as patients' own bedrooms).
	SYSTEMS
24	Are discussions and decisions related to stop smoking advice, referrals or interventions recorded in the person's records (preferably computer-based)?
25	Are systems in place to alert the person's healthcare providers and prescribers to changes in smoking behaviour because other drug doses may need adjusting?
26	Is a robust system in place (preferably electronic) to ensure continuity of care between secondary care and local stop smoking services for people moving in and out of secondary care?
	RISKS AND MITIGATION OF RISKS
27	What risks have been identified in relation to the smokefree policy, and how have these been mitigated? • Especially in acute services, are patients informed of the policy before admission, and do staff consider whether this is having any effect on patients' willingness to be admitted? • For all services, are the rules associated with the smokefree status fully explained to patients, including the ward policy in relation to the retention (or destruction) of smoking materials that patients might have on them on admission, or on return from leave (see 28 below). • Check whether the smokefree policy (or any safety issue arising from surreptitious smoking) is being enforced by searches, and if so how the service is ensuring proportionality in such security measures. In general terms, searching people on a health promotion premise is unlikely to be appropriate, but searching may be a proportionate response to risks associated with cigarette lighters etc. • Likely problems in the implementation of the smokefree policy include fire-risks through surreptitious smoking, or the risk of exploitation of vulnerable patients as a result of illicit markets in smoking materials. • Services should have identified any patient at risk of exploitation and sought to counter this. Services that provide access to NRT or e-cigarettes may be less likely to experience illicit markets in smoking materials.
28	How do services manage patients who return from leave with cigarettes in their possession? The smokefree policy should clearly state how staff should respond when patients bring smoking materials into a smokefree environment. These arrangements should be clearly communicated to people who use services. Services are likely to require patients to hand over any smoking materials. Some services will return these when that patient is next leaving the hospital site. Others only return confiscated smoking materials upon eventual discharge,which could be challenged under the MHA Code of Practice principle of least restriction. Other services have reported destroying any confiscated smoking products, which may also raise questions of legal authority to do so.
29	In acute services, do staff report any changes in admission patterns that may be linked to the smoking ban – for example, do patients refuse informal admission?

Appendix 2

Deciding which regulation applies

Whilst smokefree policies are not themselves to be considered as unwarranted blanket restrictions, it is possible that measures associated with their implementation, such as any restrictions on movement, searching practices, etc, could be so considered, or could raise concerns as to whether least restrictive alternatives are being used.

Regulation 9 person centred care

This regulation may be breached when a blanket restriction is not accompanied by:

- individual risk assessments
  or
- involvement of service users[8] in relation to the restriction.

Regulation 10 dignity and respect

This regulation requires service users to be treated with dignity and respect and requires a provider to ensure the privacy of the service user and to support the services user's autonomy, independence and involvement in the community.

Regulation 12 safe care and treatment

This regulation may be relevant where the impact of the blanket restrictive practice raises issues relating to the safety of services users.

Regulation 13 safeguarding from abuse and improper treatment

This regulation may be breached when a blanket restriction includes an act which is:

- intended to control or restrain the service user
  and
- is not necessary to prevent, nor a proportionate response to, the risk of harm to the service user or another individual.

[8] Service user is the term used in the regulations.