

# Death of the smoking den

The initial impact of no smoking legislation  
in psychiatric units in England in 2008

June 2009

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The rest of the NHS is going smokefree. What message would an exemption for mental health wards send out about the importance of the lives of mental health patients? People with mental illness have high rates of smoking-related disease. How could we justify doing less for those at greater risk? The 'smoking den' culture that has afflicted mental health wards for decades is over. The benefits will be felt by patients and staff, both smokers and non-smokers.

**Louis Appleby, National Director for Mental Health**  
**The Guardian, 14 February 2007**

Smoking has a significant impact on the health of people with mental health problems, with higher levels of smoking responsible for a large proportion of the excess mortality of people with mental illness. Smoking cessation strategies aimed at people with mental health problems can significantly reduce health inequalities for this vulnerable group of people. As well as improving the physical health of individuals, reducing smoking in mental health service users will also significantly improve health and wellbeing in wider populations that experience disproportionate levels of ill-health. As of 1 July 2008, all enclosed areas of mental health premises in England became smokefree, protecting people receiving treatment and those working in these settings from the damaging health effects of secondhand smoke.

**Faculty of Public Health**  
**Mental Health and Smoking – A position statement, July 2008**

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**Simon Lawton Smith, Head of Policy  
Mental Health Foundation**

## Executive summary

After the passing of the Health Act 2006, which prohibited smoking in public places, smoking restrictions in psychiatric units in England and Wales came into effect on 1 July 2008. Smoking is no longer permitted in enclosed areas (such as in a ward, bedroom or corridor), although it may be permitted in outside areas (such as in a courtyard or garden). Some units had already imposed smoking restrictions before the legislation came into force.

In autumn 2008 the Mental Health Foundation circulated a questionnaire to a range of psychiatric units to assess how effectively the prohibition on smoking had been implemented (in terms of no smoking in enclosed spaces as required by law), the factors that had led to greater or lesser success and what extra support might be required for full effective implementation.

120 responses from psychiatric units within the UK, and one from Canada, were received, indicating whether the smoking prohibition had been wholly effective, partially effective or not effective at all. Of these, 109 responses (100 from NHS units based within 40 mental health trusts and nine from independent sector units) came from within England, and the responses from these English units form the basis of this report.

### Limitations

Respondents were self-selecting, contacted via the circulation of a questionnaire through the good offices of the National Acute Steering Group and the National Association of Psychiatric Intensive Care Units (NAPICU). No attempt was made to receive responses from all psychiatric units in England, or from a unit within every Mental Health Trust. Information was not sought on the type, size or layout of unit that was responding. Respondents were not asked to state their job title or responsibilities; neither were they asked to state whether they were themselves smokers or not, which may have been influential in determining their replies. A number of respondents indicated that their comments were given in a personal capacity rather than an organisational one.

The findings therefore represent a snapshot as at the end of November 2008, some five months after the smoking prohibition had come into effect.

### Main findings

The table below sets out a breakdown of the 109 NHS and independent sector responses from England, and respondents' overall assessment of how effectively they thought the smoking prohibition had been implemented some four or five months after new law came into effect (ie as at November 2008).

Type of unit	Wholly effective	Partially effective	Not effective at all
Non-PICU	10	41	7
PICU	7	38	6
Total	17 (15.6%)	79 (72.5%)	13 (11.9%)

## Factors contributing to a wholly effective prohibition

Respondents who reported that the prohibition had been wholly effective described a range of factors that had supported this.

The smoking prohibition had been planned and implemented within the context of a wider public health discussion. It was presented as part of the wider public health drive to improve the physical health of both patients and staff, and not just as an isolated measure that some might see as merely punitive. There had been early and widespread consultation and a wide range of information and support was made available to patients and discussed well before the prohibition came into effect. Smoking cessation support, such as Nicotine Replacement Therapy (NRT) and alternative activities that patients could get involved in were also essential. Rules were clear and applied consistently.

Successful units had easy access to an outside space such as a courtyard or garden with an effective shelter against poor weather. They also indicated that they had adequate staffing levels to monitor the implementation of the smoking policy, to escort patients where necessary to outside areas and to provide guidance to patients on smoking cessation. The active backing of senior management in support of frontline staff implementing the policy and strong and consistent monitoring arrangements were also required.

## Factors in partially effective or ineffective prohibition of smoking

Respondents who reported only partial effectiveness in implementing the smoking prohibition, or no effectiveness at all, not surprisingly focused on problems in implementing the policy in broadly the same areas as outlined above.

Some said the prohibition had been applied inconsistently. Partly the problem appears to be that some staff are themselves unclear as to the rules and how they should be applied. Some responses suggested that there was a shortfall in smoking cessation support and guidance for patients. This could be either a shortage of staff trained to offer support or a shortage of actual materials, such as NRT patches and gum. Many patients were simply not interested in taking up the opportunity of smoking cessation support.

A number of respondents reported patient aggression or violence as a result of the prohibition. The flashpoint appears often to be triggered by patients not being able to go outside to smoke due to a lack of staff to escort them, or simply being told they could not smoke on the ward. Without safe outside smoking facilities (which many units clearly did not have) it was very difficult to implement the prohibition effectively. Even if a unit did have such facilities, it did not always mean things went smoothly. Some patients preferred to smoke indoors regardless.

Some staff were uncomfortable with the smoking prohibition on human rights grounds. It made staff feel more like policemen than nurses. This had an adverse impact of their attempts to build good, trusting therapeutic relationships with patients.

## Executive summary

Many patients do stick to the rules prohibiting smoking indoors. But others are extremely reluctant to comply. At a time when some patients might in fact be very unwell – including upon admission under the Mental Health Act – denying them a cigarette could be neither sensible nor practical. There are circumstances where staff ‘turn a blind eye’ to the rules.

Pressure on staff time was a major factor in not being able to implement the smoking prohibition effectively. Monitoring the smoking prohibition rigorously demanded more staff resources than many units had.

The smoking room or ‘smoking den’ in psychiatric units in England is now a thing of the past. However it appears to have been replaced in many units by an increase in ‘secret smoking’. A number of respondents submitted evidence of patients ignoring the ban and smoking secretly in private areas such as bedrooms and bathrooms. A repeated concern with the rise in ‘secret smoking’ was the accompanying increased fire risk, although no serious incidents were reported.

## Conclusions

In reaching conclusions from the survey findings, it should be remembered the data was collected for the first four or five months after the prohibition was implemented. This report reflects an informal snapshot of the position as at November 2008. Since then, the situation in units may have changed as the policy becomes more embedded in ward routine.

It is clear that many Trusts have made significant efforts to try to ensure the smoking ban is effectively implemented. This has involved information for patients, training for staff, the provision of alternatives in terms both of nicotine replacement therapy and other activities, and changes to the physical environment of units to facilitate the ban.

A minority of respondents (15%) did state that the smoking prohibition had by and large been accepted by patients and staff, and implemented effectively. Some respondents also noted an overall reduction in smoking among patients.

However there remains strong opposition to the prohibition in psychiatric units among many patients and some staff, and as at November 2008 the ban had been implemented only partially effectively, or not at all effectively, in 85% of respondents’ units. These respondents’ comments paint a picture of hundreds of hard-pressed staff in psychiatric units having to take decisions every day about how much time they can devote to accompanying patients outside to smoke and monitoring patients on wards to try to reduce the risk of ‘secret smoking’, and whether or not to ‘turn a blind eye’ when a patient is caught smoking, or to allow exemptions in certain circumstances.

The rationale for the prohibition on smoking was primarily a public health one – to improve the health of both patients and staff, both smokers and non-smokers. Yet there appears to be no formal data currently being collected on the effect of the smoking prohibition in this respect.

Additionally, the survey raises the question of both patients and staff potentially breaking the law – the former by knowingly smoking in an enclosed space, the latter by knowingly allowing this to happen. Both offences may be liable to a fine up to a limit set out in regulations.

The lack of total success in implementing the smoking prohibition in enclosed spaces in psychiatric units need not be read as a criticism of the policy or the legislation. But it does highlight the need for more effective practice within units if the law is to have its intended effect.

## Recommendations

There are a number of lessons to be learnt from the findings of this informal survey, which reflect the views of staff facing significant practical problems in implementing the smoking prohibition on a daily basis in a variety of psychiatric units across England, while striving to provide a safe, caring and therapeutic environment for patients.

However, the survey confirms previous findings set out in the existing literature on smoking in psychiatric units. Accordingly, we do not make any recommendations around actual practice. The existing literature and guidance already sets out the best evidence.

We do, however, make three recommendations focusing on where further work might be considered.

1. Units that are experiencing difficulties in implementing the no smoking policy could usefully learn from the first-hand experience of those that say they have. A number of respondents asked for more guidance and benchmarking. We recommend that the National Mental Health Development Unit takes the lead in gathering good practice from successful units and establishing a series of learning events across the country. This might be undertaken in collaboration with Strategic Health Authorities and mental health trusts, and the current Star Wards programme.

Learning events might particularly look at:

- (a) best ways of supporting training for staff regarding smoking cessation;
  - (b) managing smoking situations where patients are detained in locked wards or are very ill;
  - (c) managing 'secret smoking' and the associated fire risk
  - (d) effective coordination with community services, and how to ensure smoking cessation support is offered prior to an admission, and continues after discharge;
  - (e) the legal position with regard to staff potentially breaking the law by allowing smoking in enclosed spaces under certain circumstances.
2. Given the implementation problems outlined in this report, and that the main rationale for the no smoking prohibition was to improve both patients' and staff's health, we recommend that the Department of Health commissions a formal review of the impact of the smoke free legislation in psychiatric units in England one year after its introduction (ie as at July 2009), both in relation to the effectiveness of its implementation and the benefits that have resulted for patients and staff, both smokers and non-smokers.
  3. Given the problems it appears many staff are encountering in implementing the smoking prohibition at present, we recommend that the Care Quality Commission should monitor the effectiveness of implementation as part of its ongoing programme of regulation and performance assessment, and consider making the issue the subject of a special review.

# 1. Background

On 1 July 2008, prohibitions on smoking were introduced in mental health premises in England. The power came in via the Health Act 2006 and the Smokefree (Exemptions and Vehicles) Regulations 2007. In effect, all enclosed areas of psychiatric units had to be smoke-free, although smoking could still take place in unenclosed areas (such as gardens).

Details of the new arrangements were sent to Chief Executives of mental health trusts, Strategic Health Authorities and independent mental health hospitals by the National Director for Mental Health in a Department of Health letter dated 1 February 2007 (Appendix A). This stated that:

*“From 1 July 2008, smoking will be against the law in any enclosed or substantially enclosed part of any mental health establishment. This will include smoking by patients, visitors or members of staff, and will include all residential mental health units, regardless of whether they provide acute or long-term services” (Appleby, 2007).*

The provision to prohibit smoking in psychiatric units in England came into effect some twelve months later than for the general public (although some units had in fact already implemented smoke free strategies well before the legislation came into being). Much of the reasoning behind this lay in the anticipated difficulties of enforcing a prohibition in psychiatric units, and the wish to prepare both staff and patients adequately before the prohibition came into effect.

During the passage of the Health Bill, the issue of prohibiting smoking in psychiatric units had been contentious. Studies of psychiatric patients in hospitals show that up to 70 per cent smoke, and around 50 per cent are heavy smokers (references in Jochelson and Majrowski, 2006). Some argued for psychiatric units to be exempt from the legislation on the grounds of increased risk of aggression from patients and that a ban would infringe patients’ rights, not least because for some long-stay patients the unit was effectively their home. Against this, there was a counter-argument based on the rights of non-smokers (whether patients or staff) not to experience passive smoking, and a general desire, as part of a push towards greater public health, to try to improve the physical health of the many patients with mental health problems who smoked.

The issues facing staff on the ground were encapsulated in a report from a Trust that implemented a smoking ban in January 2007 (earlier than the legislation required), copied to the Foundation as part of its evidence for this survey. Clearly the no smoking issue remained a highly charged debate:

*“It has implications on a mental health unit unlike anywhere else as many of our patients have not chosen to be on a ward having been detained under the Mental Health Act. To a lot of people it felt like one restriction too many and there was much discussion re human rights, practicality of ban and feasibility of making or being forced to make difficult lifestyle changes at an inevitable time of distress. There was a real fear this may increase risk re frustrations / confrontation, fire hazards and even increase in use of the Mental Health Act, as well as fear of withdrawal interacting with prescribed medication”.*

The links between smoking and mental health, and the benefits of smoking cessation among people with mental health problems are well documented (Faculty of Public Health, 2008; Forum for Mental Health in Primary Care, 2008). An overview of smoking by people with mental illness and benefits of smoke-free mental health services has recently been published in the journal *Advances In Psychiatric Treatment* (Campion et al, 2008a). This includes a summary of the evidence on the factors that can lead to the successful implementation of a no-smoking policy in psychiatric units. However it also refers to a trial of a smoke-free policy in an acute mental health unit of a regional hospital in Australia that was abandoned after six weeks due to perceived increases in aggression by patients towards staff working in the high dependency unit, although subsequent review revealed that there had been no such increase in aggression (Campion et al, 2008b).

Evidence from other studies suggests that there is nothing impossible about implementing a smoking ban effectively (Jochelson and Majrowski, 2006), with minimum adverse impact in terms of increased patient aggression and benefits in terms of a healthier living and working environment, an overall reduction in the volume of cigarettes smoked and increased alternative options for other activities:

*“Far from being ‘impossible’ to implement smoke-free regulations, these units experienced relatively few problems. Certainly there were complaints from patients, and some tried smoking in their rooms, but staff reported that patients ‘conformed’ to the policy once they understood the reasons for it. Furthermore, there was no increase in aggressive incidents, as patients still had the opportunity to smoke outside. Staff believed that closing smoking rooms and removing cigarettes as a bargaining tool or reward helped prevent and resolve difficult situations and forced them to develop new ways of interacting with patients. The former smoking rooms were used for clinical activities or as patient lounges. One respondent commented that before the new regulations ‘patients were staying up in the night smoking and were unable to get up in the morning to attend to daily living skills, activities or therapeutic interventions.’ Now the smoking room was used for activities that ‘stopped them being so bored’ and patients were more engaged in ward activities.”*

In 2007 the Foundation published a report that looked at the mental health implications of anti-smoking legislation (Mental Health Foundation, 2007). Its ten recommendations included:

- patients in both in-patient and community services must be offered help with smoking cessation as part of their care package
- information should be made widely available to staff, service users and visitors to mental health services about how their environment will change as a result of the smoking ban, and of any help that is available with smoking cessation
- in-patient units need to ensure that there is a sheltered outdoor space that smokers can access, and where necessary, regular escorted visits to these spaces should be offered as a priority
- any aggression or violence towards patients and staff in in-patient settings that are believed to be linked to the smoking ban should be monitored and reported to senior managers in Mental Health Trusts.

Most recently, a study of the challenges associated with smoke-free policy implementation in English NHS mental health settings (Ratschen et al, 2009) cited high smoking prevalence among patients, related safety risks, adverse effects on the clinician-patient relationship and potential interactions with antipsychotic medication. Despite these challenges, the smoke-free policy was regarded as beneficial.

This present survey sought to clarify whether the Foundation’s recommendations have been followed, how effectively the prohibition on smoking in psychiatric units in England has been implemented, the factors that have led to greater or lesser success and what extra support might be required.

## 2. Methodology

A short questionnaire (Appendix B) was given to members of the National Acute Steering Group, with an invitation to circulate it more widely to psychiatric units (the Steering Group is a sub-group of the National Acute Inpatient Mental Health Project Board, whose core aim is to provide a collective focus between national and local stakeholders on acute inpatient care in England). Through the good offices of the National Association of Psychiatric Intensive Care Units (NAPICU) a copy was also circulated to the PICU membership. Questionnaires were circulated in the last week of October 2008 and responses invited by 27 November 2008.

The questionnaire indicated that all responses made publicly available would be anonymised.

Responses were analysed thematically, with conclusions and recommendations drawn from the findings.

Over and above the returned questionnaires, the Foundation also received a small number of email responses commenting on the issue of smoking in psychiatric units.

### Limitations

No attempt was made to receive responses from all psychiatric units in England, or from a unit within every NHS mental health trust (of 75 NHS mental health trusts in England, response were received from units within 40 of them). The questionnaire relied on its circulation by members of the National Acute Steering Group and NAPICU, and contained no obligation to respond. The findings therefore represent a snapshot as at the end of November 2008, some five months after the smoking prohibition had come into effect.

Other than some of the questionnaires being sent specifically to PICUs, information was not sought on the type, size or layout of unit that was responding. It is likely that the nature of different units (for example, the level of illness of patients in different units, length of patient stay in a unit, level of security, and physical layout of the unit) will impact on how effective the ban has been, but no analysis of this was possible.

No record was kept of which units received a copy of the questionnaire nor which member of staff. Respondents were not asked to state their job title or responsibilities. Some did, however, suggesting that the majority of responses were completed by ward staff and ward managers with a few completed by consultant psychiatrists or hospital or Trust managers. Nor were respondents asked to state whether they were themselves smokers or not, which may have been influential in determining their replies.

What was and what wasn't considered "effective" may have been interpreted differently by different respondents – indeed, two respondents specifically queried what "effective" meant. Overall, however, responses suggest that the vast majority of respondents interpreted "effective" to mean that it had been possible to stop all patients and staff smoking in enclosed spaces within units as required by law.

A number of respondents indicated that their comments were given in a personal capacity rather than an organisational one.

### 3. Responses received

A total of 121 responses were received, 59 through the National Acute Steering Group route and 62 through the NAPICU route. Of these, 109 came from units in England, 58 through the National Acute Steering Group route and 51 through the NAPICU route. Of these 109, 100 were received from NHS units (including three anonymous responses that we have assumed are from NHS units) and nine from independent sector units. The responses from these English units form the basis of this report.

Questionnaires asked respondents to name the trust that their unit was in, but not the name of their unit. Setting aside the three anonymous responses, the 97 responses from NHS units that indicated their trust area were based within 40 geographically diverse mental health trusts, and distributed as below:

- 16 trusts: 1 response
- 11 trusts: 2 responses
- 3 trusts: 3 responses
- 5 trusts: 4 responses
- 2 trusts: 5 responses
- 2 trusts: 6 responses
- 1 trust: 8 responses

It is possible that a small number of the 100 responses from NHS units in England are from different staff in the same unit, ie responses came from fewer than 100 NHS units.

Table 1 below sets out a breakdown of the 109 NHS and independent sector responses from England, and respondents' overall assessment of how effectively they thought the smoking probation had been implemented some four or five months after the change in the law (ie as at November 2008).

**Table 1: England (109 responses)**

Type of unit	Wholly effective	Partially effective	Not effective at all
Non-PICU	10	41	7
PICU	7	38	6
<b>Total</b>	<b>17 (15.6%)</b>	<b>79 (72.5%)</b>	<b>13 (11.9%)</b>

This report looks in detail at the data received from units in England. There were, however, a total of 12 responses (11 from PICUs) from units in other countries, as set out in Table 2. Of these, eight came from Scotland, two from Northern Ireland, one from Wales and one from Canada.

**Table 2: other countries (12 responses)**

Type of unit	Wholly effective	Partially effective	Not effective at all	Not applicable (ie prohibition does not apply)
Non-PICU	0	1	0	0
PICU	2	7	0	2
<b>Total</b>	<b>2</b>	<b>8</b>	<b>0</b>	<b>2</b>

## Responses received

A summary of the responses from other countries is at Appendix C.

### **Differences between PICU and non-PICU units, and NHS and independent sector units**

As can be seen from Table 1 above, there appear to be no significant variations in responses between PICUs or non-PICU units in terms of views on effectiveness of implementation.

Of the nine independent sector responses from England, three (33%) indicated they had implemented the smoking prohibition wholly effectively, while six (67%) thought they had been partially effective. However the sample numbers are too small to reach any firm conclusion about whether the independent sector has been more successful than the NHS in implementing the no smoking prohibition.

Overall, there appear to be no significant differences in the data on stated effectiveness between PICU and non-PICU units, or NHS and independent sector units. Accordingly no distinction between units has been made in the following analysis of responses.

## 4. Findings

In Section 4.1 below, the thematic analysis is based on respondents' views on the factors behind whether the prohibition had been wholly effective, partially effective or not effective at all.

Section 4.2 sets out respondents' views on what extra support staff and patients would need to ensure the no smoking legislation is implemented effectively.

### 4.1 Factors behind the effectiveness of implementation of the smoking prohibition

#### 4.1.1 Factors contributing to a wholly effective prohibition

17 respondents (out of 109) reported that the prohibition had been wholly effective. The most common reported factors behind this are set out below.

- (a) The smoking prohibition had been planned and implemented within the context of a wider public health discussion. It was presented as part of the wider public health drive to improve the physical health of both patients and staff, and not just as an isolated measure that some might see as merely punitive. To help counter this latter impression, one Trust provided information to patients making clear that the prohibition had come from the government as opposed to the Trust. Another indicated that the prohibition had formed part of its overall commissioning strategy for health inequality reduction.
- (b) there had been early and widespread consultation with all stakeholders before the prohibition came into effect, including, importantly, estates. Communicating the implications of the legislation to patients in good time had been essential.

*"The regional public health lead was very helpful in creating a framework for the Trust to implement a smoke free environment. This included wide stakeholder involvement i.e. staff, staff side, service user representatives, public health leads, smoking cessation services, pharmacy support, estates and capital."*

- (c) a wide range of information and support was made available to patients and discussed at patient and staff meetings and clinical discussion forums well before the prohibition came into effect. This meant staff and patients were aware of the new rules, including where and when smoking was still permitted. It was as important for staff to be clear of the rules as it was for patients. Smoking cessation support, such as Nicotine Replacement Therapy (NRT) and alternative activities that patients could get involved in, such as computer games or music, were also essential. Effective approaches included training staff in smoking cessation interventions.

*"Training in brief interventions (level 1) and intermediate training (level 2) have been rolled out across all Directorates."*

*"PCT leads in the different localities have provided support and training arrangements for designated smoking areas and shelters for patients have been agreed, the majority have been put in place."*

*"Plans to have brief intervention training included in all local inductions."*

- (d) rules were clear and applied consistently. There was clear no smoking signage. A number of responses referred to ward restrictions reducing the opportunities to smoke, such as allowing patients to smoke outside only on an hourly basis. Again, these rules were clearly and visibly set out.

## Findings

- (e) almost all responses cited the closure of smoking rooms, and easy access to an outside space such as a courtyard or garden (where the legislation does allow smoking), with an effective shelter against poor weather, as a key factor in stopping smoking inside buildings.

*"We are a low secure hospital and have not implemented a total ban for the site. We canvassed service users for a lengthy period prior to the ban coming into force and provide on-site outdoor smoking facilities. For the ground floor ward this is a smoking hut in their specific garden. For the 2 first floor wards – they have access to a specific garden area with a smoking hut and a balcony which can be used."*

- (f) units reported adequate staffing levels to monitor the implementation of the smoking policy, to escort patients where necessary to outside areas and to provide guidance to patients on smoking cessation (two responses cited 70% and 90% of staff trained in smoking cessation respectively). Specialist 'smoking nurses' or 'smoking cessation champions' played a key role. A positive multidisciplinary staff attitude was also necessary for effective implementation of the no smoking policy, and the active backing of senior management in support of frontline staff implementing the policy.
- (g) strong and consistent monitoring arrangements were required. This involved high levels of observation of patients known to smoke, and confiscation of any cigarettes and lighters found on them both on admission and during their time on the ward. This could only be achieved if staff took their monitoring role seriously.

*"Strict policing of smoking on the wards. Patients having to leave smoking materials in the office. Confiscation of "contraband" smoking products with same only being returned on discharge. Smoking cessation groups being offered by staff."*

### One Trust that claimed that the ban has been wholly effective in its units cited the following factors:

Clear leadership of a very active and robust acute care forum, system both in every borough and at trust wide coordinating level with phased timetabled project based approach from estates, L & D, audit, HR etc

User consultation re the alternative use of the 'smoking rooms' and use of computers, games etc

Staff support to stop smoking as the research evidence suggest that if staff can be supported to stop, they are more expert at and more likely to support service users

Excellent estates leadership which means we were able to get shelters up in time and on 1st floor acute units

Concomitant commitment to healthy lifestyles initiatives ie every ward has stretch and movement to start the day, a gym, and staff trained to diploma level in physical healthcare

A PowerPoint training presentation which went to every ward and team to be shown in their team meetings

Multiple audits led by junior frontline medical and nursing staff to engage and undertake benchmarking

Innovative posters, and leaflets written and publicised by the same great frontline staff

Informative, expert posters specifically designed by our pharmacy staff to indicate the dangers of medication interactions with smoking, so this really engaged medics and nurses and users and carers

Partnership conferences with PCT and health promotion units

Education posters

Easily accessible smoking cessation leaflets on our newly redesigned intranet which offers user / carer information in multimedia accessible formats

Mapping on to the accessible intranet the names of all smoking cessation champions so that staff who wanted support knew who to contact for advice

#### 4.1.2 Factors in the ban being only partially effective or not effective at all

Nearly three-quarters of respondents (79 out of 109) felt that their units had only been partially successful in implementing the no smoking legislation effectively. Respondents from a further 13 units actually felt the prohibition had not been implemented effectively at all.

Not surprisingly, the factors given focused on problems in implementing the policy in broadly the same areas as outlined above. With regard to these factors, there was considerable overlap between the views of respondents who cited partial effectiveness and those who cited no effectiveness (although the latter tended to put their views in more forceful language). Accordingly, the factors set out below bring together the views from both groups of respondents.

## Findings

A wide range of factors was cited. These are itemised below under the headings: inconsistency; lack of access to smoking cessation support; increased levels of aggression / violence; lack of access to outside space or lack of section 17 leave; human rights, choice and therapeutic relationships; patient compliance; patient illness; staffing levels; problems with monitoring; and a lack of alternatives to smoking.

### Inconsistency

A small number of respondents cited problems caused by inconsistency in the application of the ban. This was not only within wards (where some patients might be allowed to smoke in certain circumstances), but between different wards in the same site (where access to an outside area might vary) and between different units in a Trust. Partly the problem appears to be that some staff are themselves unclear as to the rules and how they should be applied.

*"Lack of consistency within teams about how to respond to smoking in the grounds/on the ward. The fact that patients from adjoining trust ([X] General Hospital) are smoking openly in the grounds."*

*"We have exemptions which cause conflict and are difficult to manage."*

### Lack of access to smoking cessation support

Some responses suggested that there was a shortfall in smoking cessation support and guidance for patients. This could be either a shortage of staff trained to offer support or a shortage of actual materials, such as NRT patches and gum. One response indicated that staff lacked guidance on smoking and seclusion, finding it challenging to enforce the no smoking policy with patients who are secluded.

On top of this, though, it was pointed out that many patients were simply not interested in taking up the opportunity of smoking cessation support, and that there was little belief among either staff or patients in smoking cessation interventions. A common theme was that there was little or no evidence that patients were being offered smoking cessation support while in the community, or informed by community mental health staff that when they were admitted to a ward they would not be allowed to smoke. This made effective smoking cessation much harder for staff on wards to plan and implement.

### Increased levels of aggression / violence

Prior to the passing of the no smoking regulations there was a perception among many commentators and staff that enforcing a no smoking policy in psychiatric units could lead to increased levels of patient aggression or even violence.

The academic literature suggests that smoking prohibitions do not necessarily lead to increased levels of aggression, and even where they do, this will reduce over time as patients become used to the no smoking rules (Jochelson and Majrowski, 2006, Lawn and Pols, 2005). However many respondents to this survey did report higher levels of patient aggression as a result of the prohibition. This was a major cause of concern, as well as being a reason why respondents believed the prohibition was not being implemented consistently. The flashpoint for aggression appeared often to be triggered by patients not being able to go outside to smoke as there were not enough staff to escort them, or simply being told they could not smoke on the ward.

*"We do not have the staff to take patients out to the gardens when required. This has caused several verbal and physical outbursts leading to incidents. We are prevented from collating specific incidents relating to the smoking ban by the trust reporting system."*

*"Our PICU has no outside smoking area so some individuals have had to wait longer times when they have been most acute leading to frustration, agitation and the use of PRN medication."*

*"Increased discord amongst patients at times due to access to smoking area. There are times that patients become distressed and agitated about the partial ban."*

*"The inability to smoke was used by patients as a trigger to aggression and violence, including self injury, harm to others and property damage."*

*"Whilst there has been an overall reduction in smoking, there has been an increase in secret smoking and verbal and physical threats against staff when they intervene to stop patients smoking."*

*"There have been incidents where not being able to smoke on wards has resulted in violent incidents as staff resources cannot always provide service users at high level of risk to leave wards on their own to smoke."*

*"Many incidents (i.e.) verbal abuse, challenging, hostile attitude towards nursing; patients become increasingly agitated; put more pressure of nursing in dealing with difficult issues."*

*"We have not gone for a total ban on smoking, and patients have designated smoking areas external to the ward. These have smoking shelters in them. This has caused difficulties in some wards i.e. staffing needs in escorting patients off the ward, and has been a contributory factor in at least one incident of aggression directed at staff."*

*"Threats of violence to staff who cannot comply with smoking demands - staff do not feel safe confronting the issue."*

Linked to the increase in aggression, a small number of respondents cited a lack of determination to prosecute a patient in such circumstances, either by hospital managers or the police.

*"Patients' threats of violence to staff if not allowed to smoke. Police disinterest in prosecution."*

### **Lack of access to outside space or lack of section 17 leave**

A key factor in stopping smoking indoors is access to an outdoor space, ideally with a shelter in case of poor weather. Responses demonstrated that without such facilities (which many units clearly did not have) then it was very difficult to implement any prohibition effectively. A small number of units cited a lack of funding to create an acceptable and safe outside space, or a suitable shelter.

Even if a unit did have such facilities, it did not always mean things went smoothly. Some patients preferred to smoke indoors regardless, "could not be bothered" to go outside, or clustered around the entrance to the building. In other cases, respondents cited risk issues that meant they could not always let patients go outside at particular times even if they were allowed to, largely in terms of having too few staff to accompany them. If patients were not able to be granted leave from hospital under section 17 of the Mental Health Act 1983, then that also acted as a barrier.

*"Long stay patients do not have designated smoking areas."*

*"[We have] no provision for smoking at all in the outside areas."*

*"We are reliant upon the generosity of our acute trust allowing our service users to smoke in their grounds, if this permission was removed we would have serious problems."*

*"Risk issues with the patients in PICU preclude / make it difficult to facilitate smoking outside the premises of the unit."*

## Findings

*"Ward garden is outside of the ward and downstairs so patients need escorted leave to the garden area and have to be assessed as safe for this. If risks are too high leave may have to be suspended."*

*"Our particular unit was designed with communal outside space for nearly 100 patients. There are no balconies or other ways of accessing a smoking area directly from an individual ward. We have problems with absconding and also supervision in the courtyard with patients from several wards mixing together in a way that was not possible or necessary before. Some female patients have said that they feel unsafe in the courtyard with male patients that they do not know."*

*"Just moved hale of smoke from contained smoking rooms on wards to doorways at exits to units. This causes access problems to buildings as there are always groups of patients standing smoking and means having to walk through smoke when entering or exiting the units. Patients are generally taking cups of hot drinks down the stairs and this is causing an extra hazard due to spills."*

*"Locked unit and some clients not given leave because of poor mental health."*

*"Some clients may be in seclusion and no opportunity to leave."*

*"Lack of leave for clients to go outside to smoke or no leave at all."*

The weather conditions make a difference, regardless of whether there is a shelter or not.

*"Poor weather significantly contributes to patient reluctance to go outside for a cigarette, even if there is a covered shelter."*

*"Patients find it difficult to smoke in outside space when the weather is cold."*

*"Patients smoking in non designated areas, some altercation during inclement weather."*

*"When it is raining it becomes a big problem for those who want to smoke."*

A small number of respondents reported that it was harder to enforce the no smoking rules in open wards than in secure wards.

*"As was generally predicted, 'no smoking' rules have been easier to implement in higher secure wards than in the admission wards. Staff in areas that have large numbers of patients coming and going have difficulties getting the message over to a rapidly changing inpatient group. Also there are greater instances of clandestine smoking in the more open wards"*

*"It has been easier on acute wards and PICUS as new patients accept the rules and staff can reinforce boundaries"*

## Human rights, choice and therapeutic relationship

Some staff were uncomfortable with the smoking prohibition on human rights grounds. Firstly, they felt that they could be denying patients a basic human right in telling them that they could not smoke indoors, given that smoking is not an illegal activity in itself; one respondent thought smoking was a patient's "sole comfort". Secondly, it could make staff feel more like policemen than nurses. This had an adverse impact on their attempts to build good, trusting therapeutic relationships with patients. Instances were cited where staff did not enforce the rules in order to maintain a good therapeutic relationship.

*"Need to recognise people's human rights to smoke if they wish and choose to (even when given all the information and offers of support)."*

*"Impact on therapeutic relationship – staff seen as enforcers."*

*"Lack of acknowledgement that some psychiatric patients 'live' on units – having stays of 10+ years in some cases."*

*"Policing this area undermines staff attempts to build therapeutic relationships with some types of patient."*

*"A problem here may be one of time because until the ban is owned by the majority of inpatient service users it will be up to staff to police the ban, and policing is, by definition, something that can involve staff appear controlling and coercive."*

*"How do nurses become policemen in a way not to impact on engagement / therapeutic relationship?"*

*"Clients perceive themselves as being penalised for being a smoker in hospital."*

*"I think it is very difficult to stop smoking on wards with longer stay patients on the wards for a long time. They feel the ward is their home."*

### **Patient compliance**

Overall, respondents made it clear that many patients do comply with the no smoking rules, whatever their personal preferences, and that anticipated problems have not always been realised.

*"The ban presented very few problems and was supported by patients, contrary to what staff perceived would be a difficult period leading to a rise in incidents of violence"*

*"On the whole inpatient staff have found the ban less problematic than they had imagined on the wards."*

However there was also a good deal of evidence that some patients are extremely reluctant to comply.

*"In our Trust we have been very successful in implementing the legislation of No Smoking inside enclosed spaces. i.e., inside the building. On occasions some patients need verbal reminders to go outside the building into the outdoor shelters provided and in the main are compliant with such a request. However it is difficult to be absolute as some patients do breach the rules either as a consequence of their condition and poor understanding of the rule or the over-riding preoccupation of their thinking processes and symptoms of mental illness. As we move into the winter period staff will be asked to increase their vigilance especially in inclement weather."*

Responses suggested that non-compliance could be for a variety of reasons, such as patients felt that they were being treated unfairly, or were unable to resist a cigarette at a time when no outside access was available, or poor weather, or a lack of interest in alternatives such as NRT. Often patients simply had no interest or intention of stopping smoking, inside or outside the ward environment. (It was also pointed out in two responses that staff who themselves smoked had no interest in giving up.) Given that patient choice is, as far as possible, meant to be a central tenet of the care given to people with mental health needs, then denying patients the choice can be uncomfortable for staff, as noted above.

## Findings

*"The main problem we have is patients smoking as an anti-establishment thing. We regularly raise non-smoking at the ward community meetings and then issue offenders with a warning, sometimes we just are not able to get them outside when they want to."*

*"Often when working with this client group it would very much depend on the individual's wellbeing at the time but most of the service users feel that the choice has been taken away from them to smoke in what they see as their own homes and continue to do so causing risks to themselves and others."*

*"The main problem has been in persuading patients that smoking is not appropriate and bad for their health, coupled with a general dislike on the part of patients to replace their cigarettes with nicotine replacement therapies."*

*"Difficult to deprive patients of some activity if they choose to like it while they are otherwise detained in hospital."*

*"There is a high proportion of patients who smoke and who do not wish to give up whatever strategies have been put in place."*

*"Patients still smoking in non-designated areas due to non-compliance with the ban. Reluctance to go outside due to weather conditions."*

*"The main factors in this ban not being wholly effective is that the service users continue to want to smoke and despite any attempts at health promotion or safety aspects they are not fully aware of the effects of smoking."*

*"The majority of our client group have smoked for all of their adult life. They have all been offered help to quit and this is revisited regularly but so far only one has given up smoking. Their desire to keep smoking and inability to understand the new legislation means that we have an ongoing problem of people lighting up indoors. This is worse when the weather is inclement."*

## Patient illness

One issue raised in debate before the prohibition became law was that at a time when some patients might in fact be very unwell – including on admission under the Mental Health Act – denying them a cigarette would be neither sensible nor practical. Responses suggested that this was indeed a problem facing staff on a daily basis, and despite it being technically illegal, seriously ill patients were being allowed to smoke in certain circumstances within a ward environment. As one respondent put it, "Psychotic patients do not understand the smoking ban".

*"[A factor is] the mental health condition of a minority of patients who are not able to understand the rules or if they do understand are not able to comply i.e. patients who are psychotic and preoccupied with their symptoms, patients who are severely depressed and although may understand are not able to comply and patients who have substance misuse issues or personality disorders, who do understand but will not comply."*

*"The vast majority of patients within psychiatric units smoke and many have substance misuse issues. To prohibit smoking entirely, from the point of admission, often causes a patient's mental state and conduct to deteriorate as it can be one of the few things that helps to calm them down."*

*"It is utterly unreasonable to expect formally detained patients to cease smoking at a time of significant distress. Sectioned patients neither chose to be admitted nor to stop smoking. Any successful addiction work must as a prerequisite be based on the service user's willingness to change their behaviour."*

*"There have been particular problems with patients with marked negative symptoms in accepting the smoking ban."*

*"Most patients have been co-operative and concordant with ban/boundaries and do smoke in designated area (i.e. garden). However some will continue to smoke in bedrooms until observed by staff and on rare occasions smoking within building has been permitted [on account of] acutely disturbed behaviour."*

*"Most of our service users are acutely unwell and going through a very stressful period where nicotine may be the only thing they derive any pleasure from."*

### Staffing levels

A great many responses cited pressure on staff time as a factor in not being able to implement the smoking prohibition effectively. We have noted above that staff shortages leading to delays in escorting patients off wards to have a cigarette have contributed in some units to higher levels of aggression and violence. Escorting patients to go outside to smoke was "a drain on staffing resources each shift". It was also noted that the time taken to resolve patient incidents and complaints resulting from the smoking prohibition made further inroads into staff resources.

*"We have implemented this policy and have completely banned smoking and bringing in lighters and matches on to our wards. We have real problems in that our wards are on a unit that has 3 floors. We therefore have to escort patients downstairs out to the courtyard/garden area to smoke and this can be risky if the patient is someone who may abscond or become aggressive. Also, we don't always have the staffing levels to escort patients to go out when they want so this can increase agitation and aggression. We often have patients who require close observation – that means they must be escorted to smoke. I also think the passive smoking for our staff has not improved – in fact I think it is worse as staff have to sit or stand close to the patient while they smoke!"*

*"Having staff accompanying patients to the courtyard and standing in the corridor is a backwards step. It is not a good use of their time as they are not engaged in a therapeutic activity but often leave the actual ward short of cover."*

*"Currently our unit is escorting service users into the garden for cigarette breaks, resulting in an increase in incidents related to aggression and absconding. This activity is preventing nurses from carrying out other important core duties."*

*"Our problem is that our adult ward is on the first floor so we have no direct access to an external smoking area. This has caused problems escorting patients to the smoking shelter (staff resources)."*

*"Not high enough staffing levels for service users on section or observation that want to go outside to smoke."*

## Findings

### Problems with monitoring

One factor put forward by a Trust stating that it had implemented the smoking prohibition effectively was that its staff were rigorously monitoring known smokers and being vigilant about confiscating cigarettes and lighters. However this appears to be a luxury for most of the units that responded to our survey. On top of difficulties in finding the time to monitor patients, some staff also pointed out that visitors on wards could also be a problem in that they secretly brought in cigarettes and lighters for patients. A lack of effective sanction against anyone found with cigarettes or lighters was also considered to hamper effective monitoring.

*"Inadequate resources to monitor patients smoking on the patio area."*

*"Inability of teams to police smoking ban."*

*"Inability to control outside areas."*

*"Patients smuggle tobacco back onto the ward in their private parts."*

*"The long stay patients on continuing care/rehabilitation wards (open wards) do not agree that they cannot smoke. They will go out and buy cigarettes and matches, bring them back to the ward without informing staff."*

*"It is difficult to enforce smoking ban without resorting to highly restrictive measures that the majority of staff are unwilling to implement."*

*"The use of nicotine patches and inhalation needs to be more closely monitored (patients just take their patch off when go out on leave)."*

*"Hard to search visitors / other patients bringing lighters in – no legal powers"*

*"Lack of legal enforcement anywhere (not just hospitals) which makes smokers know they will not be fined by an enforcement officer from the local councils. Enforcement is a civil matter (environmental health) and is of no interest to the police (hence many people think it is a joke)."*

### Lack of alternatives to smoking

There is considerable research evidence to suggest that boredom lies behind much of the high prevalence of smoking on psychiatric wards, and that alternatives to smoking are required if reduced levels of smoking are to be achieved.

*"Fifty-six percent of participants were smokers before admission, rising to 70% afterwards. Of the smokers, 17% smoked less after admission, and 63% smoked more. The average number of cigarettes smoked per person per day increased from five to thirteen. The main reasons for smoking more were boredom, stress and the wish to socialise. . . . Our study participants wanted to socialise, speak freely with other inpatients, and achieve some stress reduction; the challenge is to provide a smoke-free setting where these activities can flourish." (Ker and Owens, 2008).*

*"In the King's Fund survey, staff commented that patients smoked to relieve boredom and stress, and to relax or ease social contact, and that staff used cigarettes to create a rapport with patients, to offer comfort and support, or to manage threatening behaviour." (Jochelson and Majrowski, 2006)*

A number of responses referred to the alternative use that smoking rooms were being put to. In one unit, the smoking rooms were converted into a gym, an IT room and a quiet room / faith room. Interestingly,

however, only a handful of respondents cited a lack of alternative activities as a problem in terms of the smoking prohibition not being effective. One specifically referred to a lack of alternatives for patients detained under section without leave. This relative lack of focus on providing alternative activities suggests either that it has generally been possible to provide alternatives to smoking, or that other solutions, such as extra staff resources, more accessible outside spaces and better training for staff, were considered a greater priority in tackling problems in implementing the smoking prohibition.

## 4.2 Extra support needed

In an attempt not only to highlight where problems lay, but also what solutions might be available, the questionnaire asked "What extra support do you think patients and staff need to ensure a wholly effective ban on smoking in psychiatric units?".

A common thread that ran through responses from the 17 units that stated they had effectively implemented the smoking prohibition was that they had adequate support to do so. One response suggested that

*"We have all support necessary and have not required any extra. Patients have adapted well with the use of smoking aids available."*

This was, however, a minority view. 85% of respondents indicated that more support was needed. The two most commonly cited requests were for extra staffing capacity and improved access to safe outside areas for patients to smoke. These were clearly requests based directly on the widespread practical difficulties experienced by staff in many units on a daily basis.

Other suggestions fell broadly under the headings below.

### Better co-ordination with community services

Respondents wanted to see better co-operation and liaison with community services in two areas: firstly in preparing patients for the smoking prohibition prior to arriving in hospital; and secondly in providing smoking cessation services in the community, and continuing any smoking cessation support when a patient was discharged.

*"Community staff should take more responsibility for promoting change in need and behaviour in preparation for the demands of admission re smoking."*

*"Better publicity prior to admission about the positive effects / consequences of non smoking environment may have on them in hospital."*

*"Information from community staff / care co-ordinators re ban to prepare them prior need for hospital admission."*

*"Understanding of staff in community and open acute wards of the intensity of an admission to a PICU and how the practical difficulties of nursing smokers in an area with no facilities for long periods of time cause extra stress to the patient so they need to give clear, accurate info in preparation of an admission."*

*"People are being asked to stop smoking when they are in an acute episode of their illness. More emphasis should be put on assisting people to stop smoking in the community not when they are admitted to a PICU unit."*

*"Time to engage in therapy (smoking cessation) in community."*

## Findings

### More smoking cessation support on wards

As well as calls for smoking cessation services in the community, a number of respondents wanted more support available on wards. This was not just a question of having enough NRT patches or information leaflets and posters, but also involved extra training for staff both so that they could advise patients with fluctuating degrees of capacity, and provide smoking cessation treatment themselves. One respondent pointed out that some staff wanted support to stop smoking as well.

*"Staff do feel that as a health promotion smoking cessation support is an excellent initiative and all staff will continue to advocate its principles - however we are living in a 'capacity' driven culture and being asked to check relentlessly if decisions embody capacity thinking is exhausting. Service users are assumed, more often than not, to have capacity to decide to refrain from smoking, that they will rationalise and accept policy in preference to personal choice and addiction - clearly this is not the case."*

### Extra guidance and benchmarking

Reflecting the findings that in certain circumstances (generally involving acutely unwell or aggressive patients, or detained patients who could not be allowed into outside areas) a blind eye was being turned on smoking in wards, a number of respondents called for guidance on how to deal with such circumstances. Linked to this was a request for services to be benchmarked so that those struggling to implement the smoking prohibition effectively could learn from other units that had had more success.

*"An awareness of the difficulties posed by smokers especially when they are acutely unwell and not in a position to consider abstinence."*

*"Recommendations for management of detained patients waiting to smoke that may not have leave."*

### Prosecution of patients

It has been noted that some respondents felt that there were no adequate sanctions against patients who broke the law by smoking indoors, or became aggressive and violent when told they could not smoke. There were calls for a tougher regime of sanctions and police prosecution in these circumstances.

*"I would like to see service users and visitors prosecuted when they are aggressive and abusive to staff who politely enforce policy."*

*"More support to staff - why should they get assaulted in trying to implement a law with no police support? Can you envisage the Crown Prosecution Service wanting to prosecute a mentally ill person?"*

### Consistency – and a total ban?

As noted above, an inconsistent application of no smoking rules can cause problems, and some respondents called in broad terms for more consistency. Perhaps surprisingly, given that many staff are uncomfortable with imposing even the partial smoking prohibition as it stands, a number of respondents called for a total ban to be implemented across units, in both internal and external areas. Their arguments generally referred to the need to address current inconsistencies and enable easier management of units, rather than public health grounds.

*"Government to instigate a total ban in mental health units and stop "sitting on the fence."*

*"I personally would recommend a total ban on smoking in psychiatric units as this would be easier to manage."*

*"I personally would love to be managing a totally cigarette free area, safely and with clear guidelines to keep it that way - and enough staff to do so."*

*"Complete ban on hospital site for all patients."*

*"A total blanket ban by the hospital would have ensured a more effective smoking ban on PICU."*

*"The reasons that I feel have influenced the smoking ban are that we have a partial no smoking ban within the hospital. The Adolescent Service operates as a no smoking service which has been very successful in supporting the patients with stopping smoking support groups and the use of NRT, however the patients can still purchase tobacco products on site and have access to smoking within the hospital grounds. It is of my opinion that in order to have a successful smoking ban than it needs to be a complete ban and not just a partial one."*

The evidence in the responses from the small number of units where a total ban was cited as already in place was mixed. One hospital that had already implemented a total ban on smoking anywhere, including in the grounds, said the ban had been wholly effective:

*"The total ban on smoking for all staff, visitors, contractors etc anywhere on the site including grounds has raised sufficient awareness to ensure that staff are vigilant."*

However other respondents cited a less optimistic example of a unit that had banned smoking both in buildings and "on campus":

*"This is unmanageable in some areas where off campus is 10 minute walk away, ward is full of 75% smokers mostly under the Mental Health Act and only 4/5 staff on duty to escort. A blind eye is turned and smoking in an open but controlled space is the norm."*

*"We tried to introduce a total ban grounds and all and it has been problematic. Often reports around compliance do not reflect the reality on the ground. Staff have different views and these tend to be polarised – total ban v total disagreement with the legal position – prevalence of smoking amongst mental health staff is an issue here."*

*"Our trust decided to place a ban on smoking anywhere in the grounds! This has left staff trying to force patients to 'give up smoking'. It has been particularly difficult on PICU where patients transferred from prison expect to be able to continue smoking as they have done in prison."*

The apparent strength of feeling among some staff that a total ban should be introduced, despite acknowledged issues around patient rights and choice, and potential practical difficulties, suggests that it may in time be an option worth considering on public health grounds. Any debate on this issue would be influenced by future legal rulings on people's right to smoke under human rights legislation.

## 5. Secret smoking

The smoking room or 'smoking den' in psychiatric units in England may have become a thing of the past. However, in the majority of units, it has clearly not been replaced by a wholly smokefree environment.

A large number of respondents submitted evidence of patients ignoring the no smoking prohibition, and smoking secretly in private areas such as bedrooms and bathrooms.

*"Whilst there has been an overall reduction in smoking, there has been an increase in secret smoking."*

*"There is definite evidence of surreptitious smoking particularly in the ensuite of individual bedrooms with nicotine stained ceilings, burn marks on flooring and sinks blocked with butts."*

*"Patients use toilets and bathrooms as we are an acute ward on the 1st floor and we do not always have the staff to take patients into the shared garden. We are now enforcers of the smoking ban as well as everything else."*

*"Increased smoking in bedroom areas and toilet areas."*

*"People do not comply with the law and smoke in toilets/bed areas secretly."*

*"Some patients have been found to be smoking within bathrooms or bedrooms. This is more risky than before the ban, and the Trust can offer no solution to dealing with this."*

*"Patients' total disrespect for the rules set out and continue to ignore despite attempts to ban lighters in bedrooms."*

We have seen that strict monitoring of patients who smoke and confiscation of cigarettes and lighters have helped some units implement the smoking prohibition effectively. However attempts to prevent illicit smoking often met with failure. Staff control of lighters or matches could be circumvented, for instance, by visitors bringing replacements or patients buying them – one respondent referred to "a black market in lighters".

*"Service users are continuing to smoke in the buildings especially in their bedrooms. If cigarettes and lighters are removed from service users and kept in the office service users will go to the shops and buy some more and hide them in their rooms/on their person. There is little we can do to stop people smoking in the buildings other than reminding them of the policy and asking them to go outside with their cigs."*

A lack of an effective sanction was cited by some respondents, though others made it clear that confiscation of smoking material was itself considered the sanction.

### Increased fire risk

Email correspondence received in response to our survey gave anecdotal evidence of some fire-related incidents as a result of patients continuing to smoke on wards, in bedrooms and in bathrooms (including one report of a patient burning themselves badly). This appears to corroborate other examples of increased fire risk, such as that cited by a consultant psychiatrist who has noted that "the frequency of fires has quadrupled since the start of the ban, from about one fire every two months to two fires a month" (Dent, 2008).

No respondent provided examples of serious fires resulting from secret smoking, although many referred to the increased risk.

*"We have seen an increase in clients smoking in their bedrooms and inappropriate areas. We have provided a smoking shelter but clients do not use it especially in bad weather, early mornings and at night. Cigarettes are being sneaked into rooms and we do not have the resources or the right in cases of informal clients to search rooms. We have had a marked increase in the fire alarms being activated sometime resulting in Fire Brigade having to attend. As Fire Officer I feel it will only be a matter of time before a serious incident could happen."*

*"Some wards have an increased risk of patients now smoking in their rooms illicitly, increasing the risk of fire."*

*"Some patients manage to smoke on the unit covertly and this causes concern and risk of fire. We have become the smoking police."*

*"I spent a morning on a rehab unit at [X] recently. The service users all have their own rooms and of course are not allowed to smoke in them. I went into one room first thing and it was like a fog. The nurse did not challenge the service user because she could be a 'difficult' patient, however another service user was caught smoking in his room on the same day and he chucked the cigarette under his bed in an effort to hide it. How dangerous is that?"*

*"Patient been caught smoking in their bedroom posed significant fire risk to staff and others patients on the ward."*

*"Although most service users are prepared to smoke outside some are not. This has led some of them to smoke in inappropriate areas, in particular their bedrooms, which is a greater fire and health hazard than having a designated area."*

Balancing these comments, we were pointed to a paper submitted to the Trustees of one mental health Trust in October 2008 stating that, despite "15 smoking related incidents reported since the smoke free policy implementation on 1st July 2008... for the first time in recent memory, there have been no fire related incidents in the last three months across the Trust", suggesting that in this trust at least the ban had led to a reduction in fire risk, rather than an increase.

## 6. Conclusions

In reaching conclusions from the survey findings, it should be remembered the data was collected for the first four or five months after the no smoking prohibition was implemented. This report reflects a snapshot of the position as at November 2008, since when the situation in units may have changed as the prohibition becomes more embedded in ward routine.

The acknowledged methodological limitations of our survey, and in particular the self-selecting nature of respondents, as outlined in Section 2, also need to be borne in mind. Nevertheless the number of responses that we received from within a geographically diverse range of trusts, and the many consistencies in respondents' views, allow us to be confident in reaching a number of conclusions.

### Some good news

It is clear that many Trusts have made significant efforts to try to ensure the smoking prohibition in enclosed spaces is effectively implemented. This has involved providing information for patients, training for staff, the provision of alternatives in terms both of nicotine replacement therapy and other activities, and changes to the physical environment of units to facilitate the ban.

A minority of respondents (15%) did state that the smoking prohibition had by and large been accepted by patients and staff, and implemented effectively.

*"Our trust allows patients to smoke in designated outdoor areas within the unit; the ban could be viewed as wholly effective as we do have a totally smokefree indoors environment."*

Some respondents also noted an overall reduction in smoking among patients.

*"Within the unit I manage, which is a Rehab unit specifically for service users with enduring psychotic illness, we have found that due to the service users having to have cigarettes outside they have cut down quite considerably, a small number have stopped smoking them altogether. Due to the smoking ban the staff have had to take more control over the distribution and observation of service users smoking."*

*"Patients probably do generally smoke less as there is more effort involved."*

*"Very stressful and time consuming for nurses, but on the positive side it also says something very positive and normal i.e., you can no longer smoke in pubs – it makes perfect sense that you cannot smoke in a hospital, plus the positive message it gives to non smokers re smoke free environment."*

### Some less good news

While the 'smoking den' culture referred to by the National Director for Mental Health has ended, this has not led to the complete cessation of smoking in enclosed spaces in psychiatric units.

There remains strong opposition to the prohibition in psychiatric units among many patients and some staff. As at November 2008, in many units across England the ban had only been implemented only partially effectively. Respondents' comments paint a picture of hundreds of hard-pressed staff in psychiatric units having to take decisions every day about how much time they can devote to accompanying patients outside to smoke and monitoring patients on wards to try to reduce the risk of secret smoking, and whether or not to 'turn a blind eye' when a patient is caught smoking, or to allow exemptions in certain circumstances.

The lack of total success in implementing the smoking prohibition in enclosed spaces in psychiatric units need not be read as a criticism of the policy or the legislation. But it does highlight the need for more effective practice within units if the law is to have its intended effect.

The following paragraphs set out our conclusions in key practice areas concerning awareness and information; staffing issues; smoking cessation training and support; secret smoking; the physical environment; patient compliance and levels of aggression; perceived benefits; and whether the law is being broken.

### **Awareness and information**

Good patient and staff awareness of the smoking prohibition was a factor in implementing it effectively. Making inpatients aware of the ban well before its imposition had eased the transition, allowing concerns to be discussed and addressed. Clear and informative posters and leaflets helped the process. Equally, work by community staff to make patients aware of the prohibition prior to admission to hospital was also helpful, though appeared not to be widespread.

It was always best to 'sell' the smoking prohibition on public health grounds, so that it was not perceived as a form of punishment or control of individual patients. As one respondent put it, what was required was "a real emphasis on health promotion, eg this is about having a fun, healthy lifestyle, not just the negative of smoking cessation".

### **Staffing issues**

The smoking prohibition had led to extra pressures on already hard-pressed staff. There were widespread concerns over the amount of time staff were spending escorting service users to outside smoking areas and supervising them once there. This could at times lead to other core duties being neglected. Staff time to accompany patients and provide supervision while they are smoking needs to be built into ward staffing levels.

Many staff had personal misgivings about implementing the prohibition, including doubting the ethics of stopping people smoking in what was, for many, effectively their home. Some felt it was turning them into policemen rather than nurses, which impacted adversely on the development of a good therapeutic relationship with patients; they were too busy, or helpless, to monitor the prohibition effectively in any case. A number felt inadequately trained or briefed in how to manage a situation with aggressive or very ill patients who wanted to smoke where and when they were not allowed to.

### **Smoking cessation training and support**

The need for adequate smoking cessation support in units was mentioned frequently in the responses. Access to both NRT and staff trained in advising on and implementing smoking cessation practices were key factors in the smoking prohibition being effective. Although one respondent indicated that 90% of staff were trained, a number of other responses suggested staff training was inadequate. This needs to be addressed.

Successful smoking cessation took time. It was easier to achieve with longer-stay patients than with short-stay patients. The relatively short time many patients spent in PICUs made success with individual patients relatively difficult to achieve. Units need to offer a range of socially engaging activities for patients to participate in as an alternative to smoking.

A significant help would be for patients to receive smoking cessation support both before they were admitted, and following discharge. However this was clearly not common, suggesting a need for community and hospital smoking cessation services to co-operate more effectively. One respondent reported that the smoking prohibition "has deterred patients from coming in until acutely ill and sectioned". This might provide a further argument for ensuring closer co-ordination of community and hospital smoking cessation support.

## Conclusions

### Secret smoking

While the death of the 'smoking den' can be welcomed, there is a good deal of evidence that this has not in itself led to smokefree environments in enclosed spaces in psychiatric units. Secret smoking, especially in patients' bedrooms and in bathrooms and toilets, is clearly a major problem for many units. One of the most worrying features of this is the perceived increased fire risk as patients attempt to avoid being spotted smoking. An audit of the frequency of fire-related incidents before and after the no smoking prohibition came into effect would be helpful to clarify whether the prohibition has actually increased or decreased risk, or had a zero effect.

Some units indicated that it is possible to create a wholly smoke free environment indoors, with, among other things, good access to outside space, a strict monitoring system and adequate staffing levels. The effective practice within those units needs to be disseminated to units that have had less success.

### Physical environment

The provision of safe, accessible outdoor smoking facilities was a key factor in the prohibition being effectively implemented. For most effective use, the outside space needed have a covered facility in case of poor weather, though some patients were reluctant to leave wards even if there was a shelter. Funding needs to be made available for good weatherproof shelters where there are none.

### Patient compliance and levels of aggression

Many patients are compliant with the new smoking prohibition. However many others are not. Some may not be well enough to appreciate that there is a prohibition; others may simply not care, feeling that they have a basic right to smoke where they want. Some staff empathise with this, reflecting that the ward can be, in effect, a person's home if they are a long stay patient, and that it is not always possible to accompany a patient outside due to other pressures or risk issues.

The academic research suggests that an increase in aggression and violence is not inevitable following a smoking ban (Jochelson and Majrowski, 2006, Lawn and Pols, 2005). A 2008 audit of an indoors smoking ban in a psychiatric hospital in Staffordshire found that incidents of patient violence almost halved in the first year of operation, from 1,294 to 738 (The Sentinel, 2008).

Despite this evidence, the responses to our survey clearly indicate that some staff have faced aggression and violence as a direct result of imposing the no smoking rules. While the expectation might be that such incidents die down over time as patients become reconciled to the no smoking rules, units should continue to do all they can to pre-empt such incidents through good information, training and practice.

### Perceived benefits

When the smoking legislation was being passed there was a strong emphasis on the public health benefits to both patients and staff of reducing smoking in psychiatric units, and this was used as the rationale for introducing the smoking prohibition.

While there were units where an overall reduction in smoking was reported, it is clear that many patients had no interest in stopping smoking, and what smoking cessation support was offered was not always taken up. It is encouraging that a recent study (Ratschen et al, 2009) has pointed to the positive effects of introducing smoke-free policies. However we suggest it requires a much longer timescale than four or five months to assess the success of the smoking prohibition in terms of patients' (and staff's) improved physical and mental health. Units should collect data on smoking cessation and smoking reduction rates, and the health of patients and staff, to enable a clearer picture to develop during 2009/2010.

### Breaking the law?

Some units have allowed patients to smoke in enclosed spaces in certain circumstances. Technically, it therefore appears that both patients and staff may be breaking the law.

The Health Act 2006 (part 1, chapter 1, sections 7 and 8) states that a person who smokes in a smoke-free place commits an offence. There is also an offence of failing to prevent smoking in smoke-free place, summarised below:

It is the duty of any person who controls or is concerned in the management of smoke-free premises to cause a person smoking there to stop smoking.

A person who fails to comply with the duty in subsection (1), or any corresponding duty in regulations under subsection (3), commits an offence.

It is a defence for a person charged with an offence under subsection (4) to show —

- (a) that he took reasonable steps to cause the person in question to stop smoking, or
- (b) that he did not know, and could not reasonably have been expected to know, that the person in question was smoking, or
- (c) that on other grounds it was reasonable for him not to comply with the duty.

A person guilty of an offence under this section is liable on summary conviction to a fine not exceeding a level on the standard scale specified in regulations made by the Secretary of State.

Respondents gave no evidence of any threat of prosecution of either patients or staff simply for smoking in an enclosed space, or for allowing smoking in an enclosed space. However since it appears the law may be being broken (a defence could be made that it was reasonable to allow smoking in enclosed areas in certain circumstances), this is an issue where it would be helpful for the Department of Health to issue clear guidance as to a hospital's and staff's position.

## 7. Recommendations

There are a number of lessons to be learnt from the findings of this survey. However, it confirms previous findings set out in the existing literature on smoking in psychiatric units. Accordingly, we do not make any recommendations around actual practice. The existing literature and guidance already sets out the best evidence. As far back as 2001 a literature review reported that the success of no smoking policies depended on educating staff and service users, having adequate staff resources and effectively managing the implementation and roll-out of policy (McNeill, 2001). More recently, an Australian study (Campion et al, 2008b) concluded that:

*“Salient factors appear to be preparation of staff and patients, appropriate training, avoidance of exceptions and inconsistency, considering alternatives to smoking to fill the gap created by the policy and a culture of critical evaluation in practice”.*

All these factors feature in responses to our survey, and it is helpful to have them confirmed by over 100 staff who are facing the practical problems of implementing the smoking prohibition on a daily basis in a variety of psychiatric units, while striving to provide a safe, caring and therapeutic environment for patients.

We do, however, make three recommendations focusing on where further work might be considered.

### 1. Disseminating the learning

Units that are experiencing difficulties in implementing the no smoking policy could usefully learn from the first-hand experience of those that say they have. A number of respondents asked for more guidance and benchmarking. We recommend that the National Mental Health Development Unit takes the lead in gathering good practice from successful units and establishing a series of learning events across the country. This might be undertaken in collaboration with Strategic Health Authorities and mental health trusts, and the current Star Wards programme.

Learning events might particularly look at

- (a) best ways of supporting training for staff regarding smoking cessation;
- (b) managing smoking situations where patients are detained in locked wards or are very ill;
- (c) managing ‘secret smoking’ and the associated fire risk;
- (d) effective coordination with community services, and how to ensure smoking cessation support is offered prior to an admission, and continues after discharge;
- (e) the legal position with regard to staff potentially breaking the law by allowing smoking in enclosed spaces under certain circumstances.

### 2. Measuring the benefits

On 3 July 2008 Tim Loughton MP received an answer to his written Parliamentary Question asking “what plans the Government have to measure the effect of the forthcoming smoking ban in in-patient psychiatric units on (a) the physical health and (b) the mental health of smokers being treated”. Government Minister Dawn Primarolo responded “The Government are not planning to do any specific research on the impact of the smoke free legislation on the physical and mental health of mental health service users, but is committed to review the impact of the smoke free law in its entirety within three years of implementation.”

Given the implementation problems outlined in this report, and that the main rationale for the no smoking prohibition was to improve both patients’ and staff’s health, we recommend that the Department of Health commissions a formal review of the impact of the smoke free legislation in psychiatric units in England one year after its introduction (ie as at July 2009), both in relation to the effectiveness of its implementation and the benefits that have resulted for patients and staff, both smokers and non-smokers.

We understand that an evaluation of the impact of smoke-free legislation on mental health settings is currently being planned by the Department of Health. We would hope that this takes into account the scope of our recommendation. Such an evaluation should allow definitive guidance and advice to be drawn up tailored to different types of unit and different patient groups (for example, formal and informal patients, and patients in seclusion).

### 3. Monitoring progress

Given the problems it appears many staff are encountering in implementing the smoking prohibition at present, we recommend that the Care Quality Commission should monitor the effectiveness of implementation as part of its ongoing programme of regulation and performance assessment, and consider making the issue the subject of a special review.

# Appendix A

Gateway No: 7783

1 February 2007

**Chief Executives of Mental Health Trusts**

**Chief Executives of Strategic Health Authorities**

**Chief Executives of Independent Mental Health Hospitals**

Dear colleague

I wanted to take the opportunity to update you on the Government's plans for how smokefree legislation will affect mental health units.

The Government yesterday afternoon laid the Smokefree (Exemptions and Vehicles) Regulations before Parliament. While the regulations will be subject to Parliament's approval, the laid regulations represent the Government's finalised position on exemptions from smokefree legislation.

In July 2006, the Department of Health published a consultation on the smokefree regulations to be made under the Health Act 2006, including proposals for residential mental health settings. The question of whether smoking should be permitted within enclosed parts of residential mental health units proved to be controversial, with opinion between consultation respondents somewhat divided. Nevertheless, the majority view from respondents to the consultation was that there should either not be any exemption to permit smoking within residential mental health units, or that any exemption should be time-limited. This view was shared by stakeholders including the Royal College of Psychiatrists, Cancer Research UK, the Royal College of Physicians, the British Medical Association and many NHS organisations that responded to the consultation.

Smokefree legislation represents a landmark in public health, and will afford protection in a wide range of settings from the harmful effects of secondhand smoke. Secondhand smoke is known to cause a range of serious medical conditions including lung cancer and heart disease, and can trigger asthma attacks. The Department of Health wants to ensure that the benefits and protection of smokefree legislation will also extend to mental health settings.

For this reason, the regulations the Government laid before Parliament yesterday provide a time-limited exemption from smokefree legislation for 12-months only. From 1 July 2008, smoking will be against the law in any enclosed or substantially enclosed part of any mental health establishment. This will include smoking by patients, visitors or members of staff, and will include all residential mental health units, regardless of whether they provide acute or long-term services.

Between 1 July 2007 and 31 June 2008, mental health units† that provide residential accommodation would be able to have "designated rooms" where smoking is permitted. These designated rooms could either be bedrooms or rooms used only for smoking, and must meet specific conditions. Rooms designated for smoking must:

- be designated in writing by the person in charge of the mental health unit as being a room in which smoking is permitted;
- have a ceiling and, except for doors and windows, be completely enclosed on all sides by solid, floor-to-ceiling walls;
- not have a ventilation system that ventilates into any other part of the premises (except any other designated smoking room);
- be clearly marked as a room in which smoking is permitted; and
- not have any door that opens on to smoke-free premises that is not mechanically closed immediately after use.

Importantly, like other enclosed public places and workplaces, it will be against the law for anyone to smoke in enclosed parts of mental health establishments that do not provide residential accommodation (for example, day units) from 1 July 2007.

A range of support exists to assist mental health units to become smokefree:

- In 2005, the Health Development Agency published Guidance for Smokefree Hospital Trusts (available to download at [www.nice.org.uk/page.aspx?o=502903](http://www.nice.org.uk/page.aspx?o=502903)).
- In October 2006, Smokefree London in collaboration with Wandsworth Teaching PCT published Smokefree Policy and Interventions in Mental Health Settings: A toolkit (available to download at [www.smokefreelondon.org/article.php?id=106](http://www.smokefreelondon.org/article.php?id=106)).
- The Tobacco Control Centre (TCC) has also developed resources, including a Support Pack for Smokefree Mental Health Services (available by contacting the TCC by email at [tcc@tobaccocontrolcentre.org.uk](mailto:tcc@tobaccocontrolcentre.org.uk) or by telephone on 01926 490190).

Smokefree mental health is an extremely important development, and I am committed to making it a success. Of course, smokefree mental health will require planning and hard work, but the evidence shows that mental health units can successfully and safely become smokefree. The Department of Health will continue to communicate with Mental Health Trusts in the lead-up to the implementation of smokefree legislation.

Smokefree mental health will help to ensure that mental health patients receive treatment in a healthier environment that is equal with other patients in the NHS, as well as tackling the institutional use of tobacco and the clear health inequality that mental health patients suffer because of smoking.

Yours sincerely,

Louis Appleby

National Clinical Director for Mental Health

† For smokefree regulations, “mental health unit” means any establishment (or part of an establishment) maintained wholly or mainly for the reception and treatment of persons suffering from any form of mental disorder as defined in section 1(2) of the Mental Health Act 1983.

# Appendix B

## The questionnaire

### Implementation of smoking ban in psychiatric units: MHF survey

The Mental Health Foundation would be most grateful if you could take a few minutes to complete and return this form. Many thanks for your help.

**Any information provided that is used publicly by the MHF will be anonymised.**

Please return to [slawton-smith@mhf.org.uk](mailto:slawton-smith@mhf.org.uk) by 20 November 2008, or post to Simon Lawton-Smith, Mental Health Foundation, Sea Containers House, 20 Upper Ground, London SE1 9QB

From:	Date:
Trust:	

1. Do you believe the smoking ban in psychiatric units has been
  - (a) wholly effective
  - (b) partially effective
  - (c) not effective at all
2. If (a) above, what have been the main factors in achieving this?
3. If (b) or (c) above, what have been the main factors in the ban not being wholly effective?
4. What extra support do you think patients and staff need to ensure a wholly effective ban on smoking in psychiatric units?

# Appendix C

## Summary of responses from Scotland, Northern Ireland, Wales and Canada

12 responses were received from countries outside England - eight from Scotland, two from Northern Ireland, one from Wales and one from Canada. 11 of the responses were received from PICUs.

The evidence set out in these responses broadly echoes that in the responses from England.

### Positive comments

*"I do believe this approach has had a significantly positive impact on the working environment and has greatly improved the living area for both smokers and non smokers."*

*"Not sure what 'effective' means in real terms. Our clients have a reduced cigarette intake of approximately 40-50% (anecdotal evidence) Though none so far have committed to cessation we have an enclosed garden therefore the transition has been made easier."*

### Factors cited for successful implementation of no smoking policy

- Good support from management
- Multidisciplinary team approach with education for staff and patients
- Information boards on how to get help to stop smoking
- Patient groups for support, weight management etc
- Appropriate areas to smoke off the ward
- Follow up including counselling / smoking cessation as part of care plan
- Continued visits from smoking cessation providing education etc.

### Problems

*"Within a low secure are the enclosed garden is utilised far greater now than before therefore increasing our "real" floor space considerably. This stretches your ability to offer a range of activities given that staff are frequently drawn to meet people's request for cigarettes."*

*"I'm not sure this is a realistic goal. Possibly a clear directive that smoking would not be tolerated under any circumstances – at present the ban is only partially enforced."*

*"It remains one of our biggest power struggles and is often a factor in increasing agitation; rather than having a designated smoking area, patients' family often try to hide cigarettes and lighters, and smoke them on the sly. This is a fire hazard and trust issue."*

*"Some clients try to smoke indoors due to bad weather etc. then you also get the cigarette ends dropped anywhere they wish as they don't want to go further than the back door."*

*"Patients continue to smoke despite advice not to."*

*"We facilitate patients being allowed a cigarette at least hourly. No uptake on NRT despite encouragement. Health promotion education is limited when patients are extremely psychotic."*

*"Patio areas and hospital grounds continue to be used for smoking."*

*"In IPCU patients hide lighters in underwear and smoke indoors causing a severe fire hazard."*

## Appendix C

*"While many measures have been introduced that are helpful (nicotine replacement therapy, efforts to ensure all contraband is confiscated by staff etc) as long as there are smokers admitted to hospital, there will be likely to be these."*

*"I guess as long as there is the partial ban, smoking will continue but if there is legislation for a total ban, people will have no choice."*

*"Individuals who do not adhere to a reasonable request to refrain."*

*"Staff, particularly medical and nursing, who do not accept they have a role to influence change of habits."*

*"Inconsistent application of approach."*

*"Focus is on rights to smoke rather than on benefits of reduction or on the positive impact on the internal environment."*

### What would help to implement the no smoking policy

- Terminology - the use of the term 'ban' creates negative connotation
- Practical support - additional external litter clear up
- Review of observation policy, in its present format it has become unwieldy and difficult to manage. More frequent opportunities to meet to discuss challenges, and gain a greater understanding of the positive benefits
- More information on negative aspects of smoking for mental health service users- physical ill health, lifespan, impact on medication, toxicity etc
- Support from other parts of the NHS e.g. CMHT and GP to inform people prior to admission that the facility is smoke free
- A move to make the grounds smoke free within mental health facilities, as this is in accordance with other healthcare facilities
- Consideration of how to manage the internal environment, with hindsight there were obvious problems that had not been considered - e.g. management of patient activity to allow access to external smoking faculty, managing access to and exit from the building
- Longer lean-in time to ensure leaflets, posters, education and awareness was adequately targeted and sufficiently robust to try to ensure the majority of stakeholders had some knowledge
- A specific approach to managing 'secret smoking' e.g. battery operated alarms in areas where this tends to happen
- Greater focus on and more insistent use of nicotine replacement therapy. Neither medical nor nursing staff have really embraced the use of NRT to support nicotine withdrawal. I believe this is a result of ignorance, and not taking withdrawal and its management seriously
- Undertake smoking assessment on admission and automatic prescription of NRT either on its own or as part of a symptomatic relief policy
- More education on addiction element of smoking and nicotine.

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# Mental Health Foundation

Founded in 1949, the Mental Health Foundation is the leading UK charity working in mental health and learning disabilities.

We are unique in the way we work. We bring together teams that undertake research, develop services, design training, influence policy and raise public awareness within one organisation. We are keen to tackle difficult issues and try different approaches, many of them led by service users themselves. We use our findings to promote survival, recovery and prevention. We do this by working with statutory and voluntary organisations, from GP practices to primary schools. We enable them to provide better help for people with mental health problems or learning disabilities, and promote mental well-being.

We also work to influence policy, including Government at the highest levels. We use our knowledge to raise awareness and to help tackle stigma attached to mental illness and learning disabilities. We reach millions of people every year through our media work, information booklets and online services. We can only continue our work with the support of many individuals, charitable trusts and companies. If you would like to make a donation, please call us on 020 7803 1121 .

Visit [www.mentalhealth.org.uk](http://www.mentalhealth.org.uk) for free information on a range of mental health issues for policy, professional and public audiences, and free materials to raise awareness about how people can look after their mental health.

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