fusebrief

Fuse - Centre for Translational Research in Public Health

- A partnership of public health researchers across the five universities in North East England
- Working with policy makers and practice partners to improve health and wellbeing and tackle inequalities
- A founding member of the NIHR School for Public Health Research (SPHR)

Introducing smokefree policies into hospital mental health services

Implementing smokefree policies in mental health services is recommended in national guidance to improve physical and mental health among people with psychiatric problems. However, changing an entrenched smoking culture is challenging. Fuse researchers identified active ingredients for successfully supporting mental health service users to stop smoking.

Life expectancy is 10-20 years lower among people with a severe mental health disorder. Most early deaths are due to chronic conditions, including cardiovascular (conditions affecting the heart or blood vessels) and respiratory diseases. Smoking is a major risk factor for these conditions and introducing smokefree policies has been recommended to mental health service providers in England by the National Institute for Health and Care Excellence (NICE). However, implementing these guidelines is not straightforward because smoking has become an integral part of the hospital culture for socialising and managing patient behaviour.

Fuse researchers evaluated the implementation of smokefree policies in two mental health trusts in North East England. Interviews were carried out with staff, members of partnering organisations, service users and carers between November 2016 and April 2017. Normalisation Process Theory (NPT) was used to design data collection and analysis, using the four concepts: coherence, cognitive participation, collective action and reflexive monitoring (see 'What is NPT?' for details).

The results demonstrate that there was varied acceptance and implementation of the NICE guidance within the region. For the policy to be *coherent,* perspectives and beliefs were required to change, and work needed to be ably led by senior staff, prioritised, and resourced, with training and workable solutions provided.

There are specific barriers for people with psychiatric problems, notably their high dependency, interactions between nicotine and medication, the way that smoking has been used by patients to manage their condition(s) and how the environment reinforces smoking behaviour. This reduced their *cognitive participation* with the smokefree agenda.

For *collective action* to take place, we found that staff and patients needed the change to be coherent and to 'buy-in' to the idea. Some wards became smokefree, especially among the long stay patients.

Stories of others' successes were a powerful tool to convince doubters, and gathering numerical data to reflect on the implementation, highlighted the importance of monitoring changes to reinforce success.

Nevertheless, *reflexive monitoring* revealed that continued efforts were required by those heading the implementation, to carry the organisation beyond the initial enthusiasm and persuade staff and patients to change their beliefs, then behaviours, before a widespread, smokefree environment in mental health hospitals could be maintained.

What is Normalisation Process Theory?

A sociological toolkit used to understand the dynamics of implementing, embedding and integrating a complex intervention.

The four concepts:

1. **Coherence** is the **sense-making work** that people do individually and collectively when they are faced with the problem of operationalising a set of practices.
2. **Cognitive Participation*** is the **relational work** that people do to build and sustain a community of practice around a complex intervention.
3. **Collective Action** is the **operational work** that people do to enact a set of practices.
4. **Reflexive Monitoring** is the **appraisal work** that people do to assess and understand the ways that a new set of practices affects them and others.

*This can be thought of as 'buy-in' to the change.

Key Findings

- Inroads have been made in changing an entrenched, smoking culture into one that is smokefree on Trust sites. However, there remain variations across specialties and challenges to full implementation.
- Once there is sufficient 'buy-in' to a non-smoking culture it is anticipated that the issues relating to enforcement and perceived risk will diminish.
- Long-term perseverance is required to establish smokefree sites in participating mental health trusts, supported by robust, routine, data collection.
- Normalisation Process Theory (see 'What is NPT?') and logic modelling are helpful in increasing understanding of the dynamic implementation process.

Policy relevance and implications

- Careful use of language is needed to encourage smokefree policies to be seen positively.
- When interpretation of the term 'patient leave' was left open for leave to be used for smoking, it led to inconsistent practice.
- Consistency of enforcement is key to success.
- There were many details that needed to be worked out following the introduction of the policies; suggesting a requirement for ongoing review and response in a timely manner.

"I smelt them smoking, that's when it started again. Now that the ban's in its perfect; saves money as well." Inpatient, Trust B

BRIEF DESCRIPTION OF THE RESEARCH

Implementing smokefree policies into mental health hospitals remains challenging. Going smokefree has been embraced on some wards but smoking remains an entrenched norm in others. Ongoing effort is needed to create smokefree spaces that follow the evidence on the physical and mental benefits of quitting.

Two mental health trusts in North East England went smokefree in 2016. AskFuse, the responsive research and evaluation service run by Fuse, was approached by a partnership between the two trusts, Public Health England (PHE) and the North East England Strategic Clinical Network to evaluate the implementation of their smokefree policies. Fuse researchers at Teesside University conducted the process and impact evaluation in collaboration with the PHE North East Local Knowledge & Intelligence Service.

Peer reviewed paper: Jones, Susan; Mulrine, Stephanie; Clements, Heather; Hamilton, Sharon (2020) *Supporting mental health service users to stop smoking: findings from a process evaluation of the implementation of nicotine management policies into two mental health trusts*. BMC Public Health, 20: 1619. Web: doi.org/10.1186/s12889-020-09673-7

Final report: https://bit.ly/3cnCJmN

FURTHER INFORMATION

Dr Susan Jones, Teesside University
Email: Susan.Jones@tees.ac.uk
Twitter: @Susan_E_Jones

Fuse, the Centre for Translational Research in Public Health, is a collaboration of the five North East Universities of Durham, Newcastle, Northumbria, Sunderland & Teesside.

Website: fuse.ac.uk/research/briefs
Blog: fuseopenscienceblog.blogspot.co.uk
Twitter: @fuse_online

All Fuse briefs produced by Mark Welford, Fuse Communications Manager, in conjunction with the academics involved in the research. Email: m.welford@tees.ac.uk or Tel: 01642 342987 for details.