**Smokefree mental health inpatient settings – a matter of debate?**

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Abstract

Im Vergleich zur Allgemeinbevoelkerung sind Tabakrauchpraevalenz und Tabakabhaengigkeit in der Bevoelkerung mit psychiatrischen Erkrankungen stark erhoeht – so stark, dass Rauchen den groessten Beitrag zu gesundheitlichen Ungleichheiten in dieser Bevoelkerung darstellt. Das Rauchen von (und mit) Patienten ist in der systemischen Kultur der Psychiatrie historisch tief verwurzelt und bis heute international vielerortens weitgehend noch immer als Norm akzeptiert. In England allerdings sind psychiatrische Einrichtungen derzeit im Begriff, neue Richtlinien, die ein komplettes Verbot des Rauchens waehrend der stationaeren psychiatrischen Behandlung bei gleichzeitig umfassender evidenzbasierter behandlung der Tabakabhaengigkeit vorsehen, zu implementieren. Dieser Beitrag praesentiert einen Ueberblick ueber die wissenschaftliche und praxisorientierte Debatte zum Thema ‘rauchfreie Psychiatrie’ mit Fokus auf Erfahrungen aus England, und bietet kritische Reflektion in Bezug auf die hiermit in Zusammenhang stehenden Herausforderungen, Moeglichkeiten und Konsequenzen.

Introduction

The prevalence of tobacco smoking among people with severe mental illness (SMI) substantially exceeds smoking rates in the general population and has been identified as the largest contributor to health inequalities in this group. Historically deeply embedded in the culture of mental health treatment environments, smoking until very recently was the norm in inpatient settings and still prevails in many settings internationally. In England, mental health Trusts are currently implementing recent national guidance, according to which mental health settings will become entirely smokefree, with no exemptions, providing comprehensive evidence-based support to patients for smoking cessation and smoking abstinence during the inpatient stay. The aim of this article is to summarise the rationale for and the debate surrounding smokefree mental health inpatient settings, and to review and discuss the evidence on challenges, opportunities and impact of smokefree policy implementation in these settings, with a focus on the English debate and experience to date.

Smoking and severe mental illness – a tight link

Tobacco smoking remains one of the leading preventable causes of death and disease worldwide(World Health Organization 2009). In England, smoking prevalence of the general population has steadily declined over the last decades, now standing at an all-time low of ~16%, but little change in smoking rates has so far been observed for people with mental illness(Royal College of Physicians and Royal College of Psychiatrists 2013). With average smoking prevalence figures of 40%, people with mental illness are more than twice as likely to be smokers as the general population (Royal College of Physicians and Royal College of Psychiatrists 2013), although smoking rates reach figures of 70% and above in certain subgroups, such as hospitalised patients with severe mental illness (SMI) (Meltzer et al. 2003; Royal College of Physicians and Royal College of Psychiatrists 2013). The reasons for the high prevalence, which is also found in the German psychiatric population(Batra 2000),are complex and include neurobiological, genetic and psychosocial mechanisms, not all of which are fully understood (Ziedonis et al. 2008). Notably from a clinical perspective, metabolic interactions between hydrocarbon agents in tobacco smoke and many psychotropic medications (including Clozapine for schizophrenia) mean that smokers require up to twice the amount of medication compared to non-smokers. Upon quitting, metabolism decelerates, requiring medication dosages to be decreased by up to 50% and monitored. Smokers with SMI are typically more highly dependent on tobacco than smokers from the general population, which results in heavy cigarette consumption(Williams and Ziedonis 2004) and in substantially increased risks of premature smoking-related morbidity and mortality due to respiratory and cardiovascular disease and cancers (Royal College of Physicians and Royal College of Psychiatrists 2013). People with SMI die on average 20 years earlier than the general population, largely from smoking-related causes, especially cardiovascular and respiratory diseases, and cancer (Action on Smoking and Health (ASH) 2016).

Although people with SMI are similarly motivated to quit smoking to those without(Siru, Hulse, and Tait 2009) and indeed can successfully do so if supported comprehensively using evidence-based behavioural and pharmacological support including Nicotine Replacement Therapy, varenicline and bupropion(Peckham et al. 2017), addressing tobacco smoking among patients with SMI has not always been a priority in mental health settings internationally. Common misconceptions that can also be found in Germany(Batra 2000) include the belief that smoking is an effective form of self-medication for people with SMI, constitutes the ‘only pleasure’ in patients’ lives, and could not be given up without negative consequences on patients’ mental health. These, including conscious efforts by the tobacco industry to promote smoking among people with schizophrenia(Prochaska, Hall, and Bero 2008), have contributed to what has been identified as the ‘smoking culture in psychiatry’ (Lawn 2004; Ratschen, Britton, and McNeill 2011; Royal College of Physicians and Royal College of Psychiatrists 2013; Lawn et al. 2015). Historically, this smoking culture entailed mental health staff and patients ‘bonding’ in the context of smoking together, cigarettes being used as ‘currencies’ on mental health wards, and a general acceptance or even expectation that patients would smoke during their hospital stay – to the point that it was recognised patients would sometimes be ‘admitted as non-smokers but leave as smokers’ (King's Fund 2006).

Addressing the ‘smoking culture’ in mental health: policy efforts

With the widening tobacco-related health gap between the general population and people with SMI increasingly recognised (Royal College of Physicians and Royal College of Psychiatrists 2013; The Mental Health Taskforce 2016), and with strong evidence that quitting smoking improves rather than exacerbates symptoms of mental illness emerging (Taylor et al. 2014), the urgent need to address the smoking culture in mental health is clearly recognised (Royal College of Physicians and Royal College of Psychiatrists 2013). In England, guidance from the National Institute for Health and Care Excellence (NICE)(National Institute for Health and Care Excellence 2013) recommends that all mental health settings be entirely smokefree without exemption, with no facilitated smoking breaks, and evidence-based tobacco dependence treatment for smoking cessation, harm reduction and support for temporary abstinence available to all patients who smoke (National Institute for Health and Care Excellence 2013). The guidance extends and supersedes the *Health Act 2006*, following which mental health Trusts in England became smokefree indoors to avoid harmful exposure of patients, staff and visitors to secondhand tobacco smoke. The expectation that all mental health Trusts fully implement the recent NICE guidance is written into the recent *Tobacco Control Plan for England(Department of Health 2017)* by the British government. Mental health Trusts across the country are currently in the process of implementing the guidance, with first evaluations underway.

Smokefree mental health in England – a matter beyond debate

Of course, both the decision to advocate strictly smokefree mental health settings and the development of guidance for mental health Trusts to help with implementation did not take place in a vacuum but were framed within a very lively and longstanding debate. Although the urgency of tackling the ever increasing tobacco-related inequalities was widely recognised and supported, anxieties related to the anticipated challenges of implementing complete smokefree policies were not uncommon. As comprehensively documented in two seminal reviews of smokefree implementation in mental health settings (Lawn and Pols 2005; El-Guebaly et al. 2002), some mental health staff in particular anticipated that the implementation of smokefree mental health inpatient settings would result in an increase of disruptive behaviours and violent incidents, and be on the whole unenforceable. Notably, however, evidence from these international reviews demonstrated that these fears and negative expectations proved on the whole unjustified, and that smokefree policies could be implemented successfully, with support from patients – especially when clear and comprehensive frameworks of regulations were developed that transcended partial enforcement and regular granting of exemptions to the non-smoking rule (El-Guebaly et al. 2002).

Another line of argument in the debate arose in the context of discussing patients’ ‘freedom of choice’ (to smoke) during a mental health inpatient stay. Notably, after smokefree policies had first been introduced in English mental health settings (albeit partially, with lower expectations), some patients filed a legal appeal against a high security forensic hospital in 2008, arguing that preventing them from smoking constituted a breach of the Human Rights Act. The case went to the European Court of Justice and was decided in favour of the mental health Trust (Ratschen et al. 2008). In brief, the judge rejected both the notion of an absolute right to smoke wherever one is living and the argument that those responsible for the care of detained people are obliged to make arrangements to enable them to smoke. They concluded that in the interests of public health, strict restrictions on smoking and a complete ban in appropriate circumstances are justiﬁed. The Court further noted that the various disturbing consequences of a smoke-free policy that had been anticipated by the claimants, such as an increase in the prescription of sedative drugs, had not actually materialised.

In view of the international evidence base, pertinent legal judgements and growing concerns over tobacco-related inequalities, the debate of completely smokefree mental health settings is now resolved in favour of those who viewed it as an avenue for health promotion in a highly disadvantaged population with vast unmet tobacco-related intervention need. There is a perception that, while the practicalities of implementation remain ‘debatable’, the principal decision of including people with SMI in all efforts related to addressing tobacco in the most comprehensive way is not.

Smokefree mental health in action – opportunities and challenges

The publication of national guidance and the endorsement of smokefree mental health as a matter of priority in the *Tobacco Control Plan for England* were hallmarks of efforts and commitment that centrally recognise the value of equality and the need to support those most vulnerable in society. However, the challenges of implementing smokefree mental health settings successfully and sustainably, both in view of the historic smoking culture and of the fact that mental health inpatients are often highly tobacco dependent have been recognised (National Institute for Health and Care Excellence 2013; Lawn and Campion 2013). Even if smokefree policies contain comprehensive provisions, enforcement of strictly smokefree Trust premises (indoors and on often extensive outdoor premises) can prove difficult in reality (Ratschen et al. 2009; Ratschen, Britton, and McNeill 2009). A particular challenge lies in the fact that in England, acute adult mental health inpatient wards are often ‘mixed’ in terms of voluntary and involuntary admissions. Voluntarily admitted patients are usually free to leave the ward and Trust premises ad libitum, for example to purchase cigarettes in a shop and smoke them outside the boundaries of the Trust premises. This means that in reality, patients do not always quit or consistently abstain from smoking during an inpatient stay. Inconsistencies in smoking behaviour can make the effective management of tobacco dependence, including the treatment of withdrawal symptoms, difficult and render the experience of smokefree policies frustrating for some. Special consideration in this regard needs to be given to the adjustment and monitoring of antipsychotic medications, as described above. Practical challenges relating to managing possession and use of tobacco and paraphernalia (e.g. lighters) also need to be considered.

Larger evaluation studies of complete smokefree policy implementation have not yet been concluded, and clearly, targeted research on how to best support patients staff and visitors in the context of implementing complete smokefree policies is still needed. However, preliminary evidence from smaller research projects following complete smokefree policy implementation in English mental health Trustshighlights both challenges and opportunities. A structured interview study (Ratschen 2017) showed that of 25 mental health inpatients who had been smokers on admission, four were completely abstinent at the time of interview, 18 smoked ‘less than usual’, and three were smoking as much as before. No participants had started smoking since admission. In terms of intentions to quit smoking, four stated they ‘really wanted to stop but did not know when’, three they ‘wanted to stop and hoped to soon’, two they ‘really wanted to stop and intended to in the next 3 months’, and two that they ‘had stopped whilst on the ward and did not intend to start smoking again’. These findings are in line with a recent systematic review on the impact of smokefree psychiatric hospitalisation on patients’ smoking behaviour, which showed that the evidence base is scarce, but that positive impacts on smoking behaviour, motivation and beliefs are observed during an inpatient stay (Stockings et al. 2014). Notably, between 76% and 89% of patients relapse to smoking within five days of discharge (Stockings et al. 2014), although reduction in cigarette consumption at 14 days and 3 months indicate the potential for sustained behaviour change after the hospital stay. The review highlights likely links between post-discharge smoking behaviour change and (variations in) smoking abstinence/cessation support received during the inpatient stay and adherence to smokefree policies.

Results from a time series analysis (Robson et al. 2017) of violent incidents on mental health inpatient wards before and after complete smokefree policy implementation in the largest English mental health Trust are also reassuring. They demonstrate that, contrary to what has often been assumed, the number of incidents of physical violence actually decreased as a result of smokefree policy implementation. In conclusion, smokefree policies are identified as potentially important part of wider violence reduction strategies in mental health settings (Robson et al. 2017). These findings echo results from a recent mixed-methods evaluation (Huddlestone 2018) of smokefree policy implementation in a mental health Trust in Northern England, where a qualitative content analysis of incident reports demonstrated a decrease in challenging behaviour during the post-implementation period (6% compared to 23%). In line with previous findings, patients also reported encouraging changes in smoking behaviour following admission. Notably, the importance of electronic cigarettes to help manage tobacco abstinence or reduction of consumption, was highlighted, resonating with findings from research in substance abuse settings in the US(Gubner et al. 2016). Clearly, the need for further research in this context, both in terms of cessation and harm reduction, should be recognised.

Amidst positive messages, it is important to take note also of preliminary findings that indicate potential challenges. The above mentioned interview study (Ratschen 2017) with mental health inpatients, for example, revealed most smokers interviewed reported ‘strong’ to ‘extremely strong’ consistent urges to smoke a lot since the time of admission, suggesting that patients were not accessing or using sufficient nicotine replacement products. When prompted to indicate, on an ascending scale from 1 to 10, how well they felt staff had supported them to be smokefree during the day, the average rating was 5.25. Although most participants named positive effects of the smokefree policy (e.g. a ‘fresher’ smokefree environment, a ‘feeling of being healthy’), many also indicated difficulties. Several participants reported that seeing others smoke in the context of a policy that was inconsistently adhered to, had undermined their initial efforts to remain abstinent. These findings chime with insights from the evaluation project(Huddlestone 2018), where issues that challenged full policy implementation included covert facilitation of smoking by staff and difficulties in collecting relevant and complete data for comprehensive evaluation and monitoring purposes. The authors conclude that the implementation of complete smokefree policies in mental health settings may currently be undermined by complex unintended psychosocial dynamics, and suggest that strategies to enhance support and suitable data collection to monitor progress should be developed (Huddlestone 2018).

Discussion

When policy makers and other stakeholders in England decided to put smokefree mental health high up on the agenda for public health and tobacco control, nobody said that pursuing the new goal would be easy. Given the history of smoking in mental health settings, it was quite clear that it wouldn’t be (Lawn and Campion 2013; Ratschen et al. 2009; Ratschen, Britton, and McNeill 2009). The fact that implementation has proven to be challenging in parts, therefore, must not detract from the substantial progress that has been made, and from the success stories that can be told. Mental health inpatient settings in England are not generally 100% smokefree (yet), and not all patients quit smoking or abstain consistently following admission to a mental health inpatient stay. There are all manner of challenges, some deeply intertwined with more complex psychosocial dynamics involving staff and the staff-patient relationship, policies are sometimes breached, and emerging questions, such as whether and how to incorporate electronic cigarette use into policies, need to be addressed. Some mental health Trusts are doing very well with their smokefree policy implementation, others not so much; some find it easier than others.

Does this mean smokefree mental health has failed? Hardly. Not much more than ten years ago, addressing smoking in people with SMI was nowhere on any public agenda in England. Mental health inpatient wards were still pervaded by clouds of tobacco smoke emanating from each wards’ smoking room, where most patients would spend much of their time, day and night. That patients were smokers and would smoke more or less permanently during their inpatient stay (and beyond) was considered a given. Those patients who entered non-smokers would exit smokers. Nobody questioned this. Under the influence of an irrational perception of wanting to ‘protect’ inpatients with SMI from the challenges of abstaining from tobacco, and from ‘preserving’ the ‘choice to smoke’ as one of the last bastions of choice patients had in their lives (when smoking, of course, is typically driven by a serious addiction), the smoking culture still thrived in most places, and the tobacco-related burden of excess death and disease among people with SMI went unchallenged.

Looking at where we are now represents nothing less than a victory. We still have a long way to go but we have made an excellent start. So much has already changed for the better, in the interest of those who need it most. Creating smokefree mental health settings is worthwhile – for every single patient who manages to quit tobacco, as a direct or long-term result, and for all the benefits that follow. We should embrace both the opportunities and the challenges, learning as much as we can along the way from progress monitoring and in open and honest debate with all involved, and keep going - step by step. In the context of an evolving tobacco control research and policy landscape in Germany, where the concept of ‘smokefree psychiatry’ (‘rauchfreie Psychiatrie’) has been subject of long-standing debate(Friederike D. Wernz 2009; Ruther et al. 2014), perhaps it is time for thecountry to to make a decision on the direction it wants to walk in when it comes to smoking and mental health soon.

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