**Staff attitudes to completely smoke-free policies and smoking cessation practices in a mental health setting.**

A Ratier-Cruz\*1, JG Smith2, M Firn1 and M Rinaldi1

A. Ratier-Cruz, Smoke-free Clinical Lead

JG Smith, Senior Research Fellow

M. Firn, Deputy Director of Nursing

M. Rinaldi, Head of Recovery and Social Inclusion

1 South West London and St George’s NHS Mental Health Trust, Springfield University Hospital, 61 Glenburnie Road, Tooting, London SW17 7DJ, England, United Kingdom.

2 Population Health Research Institute, St George’s, University of London, Cranmer Terrace, Tooting, London, SW17 0RE, England, United Kingdom.

\*Corresponding author (please address proofs and reprints to): Adriana Ratier-Cruz aratiercruz@gmail.com

**Abstract**

**Background**

Mental health trusts across England were expected to become completely smoke-free and embed smoking cessation practices by 2018. Such policies are fraught with concerns and have received mixed support from mental health staff. Understanding staff attitudes to these practices prior to enforcement of the policy could help design an effective implementation strategy.

**Methods**

A cross-sectional survey was conducted with clinical and non-clinical staff in a Mental Health Trust to understand smoking cessation practices and attitudes to the implementation of a completely smoke-free policy.

**Results**

There were 631 responses. Most participants disagreed with the policy on wards (59.6%) and throughout all mental health settings (57.4%). Clinicians expressed significantly lower organisational policy support *(P =* 0.001) than non-clinicians (*P* = 0.001). Psychiatrists were more supportive of the organisational items than nurses and allied health professionals. Clinicians’ attitudes towards smoking cessation practices were less positive for those who were current smokers (*P* < 0.001) but more positive for clinicians who had received or were interested in attending smoking cessation training (*P* < 0.001).

**Conclusions**

Partial or completely smoke-free policies remain unsupported by staff in mental health settings. Smoking cessation training appears to reinforce rather than alter attitudes towards smoking cessation.

**Keywords**: smoke-free policy, mental health, NICE PH48, smoking cessation, smoking cessation training, staff survey, tobacco.

**Introduction**

In England 40.5% of people with severe mental illness registered with a GP smoke tobacco1 and for those hospitalised in psychiatric wards these rates can be as high as 70%.2 Deaths attributed to tobacco smoking disproportionally affect people with mental illness and smoking is a leading cause of the premature mortality observed in this population.3-4 In 2013, the National Institute for Health and Care Excellence (NICE) published the guidance (PH48) advising secondary care settings in Britain including mental health services to become completely smoke-free by 2018. They recommended extending smoke-free policies to hospital grounds, removing designated smoking areas, banning tobacco products from wards and ensuring there were no staff-facilitated smoking breaks for patients. NICE also recommended that front-line staff are trained to provide smoking cessation advice and support for inpatients and outpatients.5 This initiative is central to the recent Tobacco Control Plan for England to become a smoke-free generation by reducing the general population smoking prevalence rate from 14.4% to 5% or below by the end of 2030.6 In line with national guidance,5-6 all 56 mental health trusts in England were expected to become completely smoke-free by the end of 2018. However, a recent national survey found one in five mental health trusts still have open-air smoking areas within their hospital grounds.7 Completely smoke-free policies in psychiatric services incite a range of ethical, safety and clinical concerns among mental health staff specifically regarding patients’ rights to smoke,7-9 deterioration of patients’ mental health10-13 and increased patient aggression and violence.10,14-15 Furthermore, staff attitudes to smokefree policies and smoking cessation practices vary across different groups. These variations are likely to reflect a range of personal and social factors including their own smoking status,12,16-18 professional group,12,15-16,18 smoking cessation specific knowledge and skills,9,11 and misperceptions about the impact of smoking and of smokefree measures.12,16-17,19 Despite international acknowledgement of these factors, there remains a gap between evidence-based recommendations for smokefree policies and practices, and the implementation within mental health settings. Understanding these factors prior to policy enforcement can be important to the development and implementation of successful smoke-free policies and practices. This paper reports on the differences in levels of support among clinical and non-clinical staff for a completely smoke-free policy and smoking cessation practices prior to implementation across a large mental health trust in south west London. The impact of smoking cessation training, job role and smoking status on staff attitudinal responses was explored.

**Methods**

**Setting**

A cross-sectional survey was conducted with all clinical and non-clinical staff at South West London and St George’s NHS Mental Health Trust (SWLSTG). The Trust is the leading provider of mental health services across south west London serving a population of 1.1 million people in the London boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth. The Trust provides community mental health services across the five boroughs and mental health inpatient care at three hospital sites. At the time of the survey, the organisation had a partial smoke-free policy which had been in place for the previous ten years that enabled smoking in courtyards and designated smoking areas adjacent to inpatient wards.

**Completely Smoke-free Policy and Smoking Cessation Practices Questionnaire**

The questionnaire included demographic, job characteristics, smoking status, smoking cessation training, and incorporated an adaptation of questionnaires used in previous studies15,18 after obtaining permission from the principal authors. The questionnaire consisted of seven items (each response was recorded on five-point Likert-type scale ranging from ‘strongly agree’ to ‘strongly disagree’) concerning completely smoke-free policies, smoking cessation training for ward staff, smoking ban across all mental health services including inpatient wards, smoking cessation intervention during hospitalisation and smoking cessation advice routinely offered by all clinical staff. The questionnaire was piloted and the final version was approved by the Trust’s audit department.

**Sample**

The survey was conducted between July and October 2015 and was sent to all staff at SWLSTG (*n* = 2145) via a Survey Monkey weblink. Informed consent was sought through an initial page before their survey started, which contained a brief summary of the project. Consent was indicated when participants clicked the ‘Go to Survey’ button from this page. The survey was open for 12 weeks where three methods of distribution were utilised: 1) internal email, 2) announcements on the staff intranet and 3) organisational e-newsletter weekly distributed to staff by the Trust’s Communications Department. The latter method acted as prompts to complete the questionnaire. Participants were given the option to enter a random prize draw for one of four restaurant vouchers as participation incentives.

**Statistical Analysis**

Cronbach alphas were calculated across the whole sample to test internal consistency of the questionnaire. Subsequently, in order to examine the underlying structure of the questionnaire items and extract linear composites of questionnaire items, principal component analyses (PCA) was administered with a subsequent Varimax rotation (with Kaiser normalisation). The criterion for extraction was an eigenvalue associated with each linear component (factor) of >1. Means (M) and 95% confidence intervals (CI) were calculated for component scores. To establish factors relevant to attitudinal responses, bivariate analyses (one-way analysis of variance; ANOVA) considering associations between component scores and age, gender, job role (clinical, non-clinical), number of weekly contact hours, smoking status, and whether or not staff had received smoking cessation training (dichotomised by collapsing those who indicated they had not received training and those who stated it was not applicable to their role into a single group) were administered. Only variables at least moderately associated (i.e., *P* < 0.10) with component scores in bivariate analyses were subsequently included as independent variables in Generalized Linear Modelling (GLM) models. Planned post-hoc comparisons of percentage in agreement with specific policy items were administered for significant job-related variables in GLM models using binary logistic regression. Associations were given in the form of odds ratios with 95% CI. Finally, GLM and binary logistic regression were employed to compare component scores among subgroups for variables of interest, including clinical staff with different roles and the level of (or interest in developing) skills in providing smoking cessation training. Across analyses, where continuous variables did not meet requirements for univariate normality using skewness and kurtosis estimates (acceptable range between -1 and +1 and -1.5 and +1.5, respectively);20 bias corrected and accelerated (BCA) bootstrapping using 2000 replications was employed.21 All statistical analyses were completed with the SPSS (IBM, Version 22.0) with a criterion for statistical significance set at *P* < 0.05.

**Results**

***Sample Characteristics***

The survey was distributed to all 2145 staff (1625 clinical and 510 non-clinical) working across five boroughs of the Trust. The majority of clinical staff (63%) was working in community services and 595 clinicians were working on wards. Participants were eligible for the survey if they were aged 18 years or older and had permanent, locum or volunteering contracts with the Trust. A total of 663 staff consented and participated in the online survey resulting in a response rate of 30.9%. Thirty-two did not provide their job role and/or complete the policy and practice questionnaire and were excluded from the analysis. The total sample size for analysis was therefore 631. A total of 388 (61%) entered the prize draw. The sociodemographic and employment details of the 631 participants are displayed in Table 1.

[Insert Table 1 about here]

***Completely Smokefree Policy and Smoking Cessation Practices***

The Completely Smokefree Policy questionnaire showed adequate internal consistency in the sample (α = 0.801). Two factors were extracted, one broadly falling under ‘Organisational’ (anti-smoking) orientation and the other related to matters of (good) ‘Staff Practice’ (Table 2). The two factors were significantly correlated (*r* = 0.38, *P* < 0.001), indicating shared variance, although the small-to-moderate magnitude suggests the factors were distinct. The mean score on the Organisational factor was 3.35 (95% confidence interval (CI) = 3.27-3.43), indicating an overall (average) response somewhere between ‘undecided’ and ‘agree’. There was a high level of agreement for items relating to Staff Practice (M = 4.06, CI = 4.01-4.10). Overall, there were high rates of agreement with smokefree policy items concerning awareness of existing policies in the Trust and that ward/clinical staff can be trained to deliver and provide smoking cessation advice and support (Table 2). There was much less support for the total ban of smoking in all areas of inpatient wards and throughout areas of mental health services, with less than half in favour for both and more than 40% (40.6% and 40.7%, respectively) in disagreement (Table 2).

[Insert Table 2 about here]

[Insert Table 3 about here]

***Factors Associated with Organisational and Staff Practice Attitudinal Responses***

The mean (95% CI) values, bivariate comparisons and GLM models for the Organisational and Staff Practice scores considering relevant sociodemographic, job role and smoking-related variables are presented in Table 3. Smoking status had a significant effect on both factors, reflected by mean agreement levels that were markedly higher in non-smokers than current smokers for Organisational and Staff Practice factors and higher than ex-smokers for the Organisational factor. Type of job role also influenced attitudes on the Organisational factor; clinical staff scores were significantly lower than non-clinical staff scores (Table 3). Post-hoc analyses comparing the proportion of clinical and non-clinical participants in agreement on specific Organisational items revealed that (after controlling for those sociodemographic, job role and smoking-related variables at least moderately associated with corresponding factor scores in bivariate comparisons) clinical staff significantly less often agreed that smoking should be totally banned in all areas of inpatient wards, that hospitalisation is a good opportunity for smoking cessation intervention, and that patients who smoke should be encouraged to quit smoking while hospitalised, with odds ratios ranging from 0.67 to 0.55 (Table 4).

[Insert Table 4 about here]

Notably, for participants with clinical roles, there were no differences in Organisational and Staff Practice factor scores between those who worked in inpatient wards and those who worked in the community only (*P* > 0.135; Table S1). However, medical doctors (majority psychiatrists) evidenced significantly higher agreement levels on Organisational and Staff Practice items than nurses and on Organisational items compared with allied health professionals (Figure 1), effects which were maintained after controlling for those sociodemographic, job role and smoking-related variables at least moderately associated with corresponding factor scores in bivariate comparisons (for both adjusted comparisons, *P* < 0.006; see Table S1). Only smoking status and being trained to deliver smoking cessation advice were significantly associated with Staff Practice scores in clinical staff.

[Insert Figure 1 about here]

Attitudes towards Staff Practice were significantly affected by whether or not participants had received smoking cessation training (Table 3), with higher overall agreement levels in those receiving smoking cessation training compared with those who had not or were unsure. Post-hoc analyses that controlled for those sociodemographic, job role and smoking-related variables at least moderately associated with corresponding factor scores in bivariate comparisons (detailed in Table 3) indicated that, compared with staff not trained, higher proportions of staff trained in the delivery of smoking cessation services were in agreement with all Staff Practice items (Table 4). The odds of agreement for specific policy item statements that ward staff should be trained to offer advice and support on smoking cessation and that all clinical staff should offer smoking cessation advice routinely were more than double in those who had received training to deliver smoking cessation advice than those who had not. Those clinical staff who indicated that they were unsure about or did not want to receive smoking cessation training evidenced lower Staff Practice factor agreement levels (M = 3.84, CI = 3.71-3.97) than staff who had not received any training but were interested in doing so (M = 4.14, CI = 3.95-4.30; comparison adjusted for variables previously considered in GLM, *P* = 0.004). Interestingly, the latter group held similar attitudes to those staff members trained to deliver one-to-one smoking cessation interventions (M = 4.21, CI = 4.00-4.40) and to staff members trained to deliver brief advice (M = 4.16, CI = 4.08-4.24). Bivariate analyses revealed that those clinical staff with interest in receiving training to deliver smoking cessation advice were more likely than those without any interest (or unsure) to be female and work with inpatients, with trends in the same direction for younger staff and those who had greater weekly patient contact; the effects of gender and working with inpatients remained significant in multivariate analyses (Table S2).

**Discussion**

**Main finding of this study**

The majority of clinical and non-clinical staff support smoking cessation practices and training in mental health settings however, their attitudes to a completely smoke-free policy were generally unsupportive. Less than half of participants (40%) agreed with a completely smoke-free policy in all areas of inpatient wards and throughout areas of mental health services. Non-smokers and medical doctors (mainly psychiatrists) were more likely to support a completely smoke-free policy whereas non-clinical staff were mostly agreeable to a partial smoke-free policy. For smoking cessation practices and training the majority of staff agreed that all clinical staff should routinely offer smoking cessation advice and that inpatient staff should be trained to offer this advice and support to patients on the wards. Two-thirds of participants agreed that hospitalisation is a good opportunity for smoking cessation and patients who smoke should be encouraged to quit. However, smoking cessation practices and training in mental health settings were more likely to be supported by non-smokers and by those who had received smoking cessation training or were interested in receiving training.

**What is already known on this topic**

Our results are consistent with international evidence that staff attitudes to partial smoke-free policies12,18,22 and completely smoke-free policies8,15-16 in mental health settings are generally unsupportive, particularly the views of those in clinical roles.15 The evidence suggests mental health staff believe that mental health settings should be exempted from smoke-free legislation,13 that banning smoking can worsen patients’ behaviours16 and some prefer partial to completely smoke-free policies.23 Clinical staff anticipate significant barriers to the success of smoke-free policies which non-clinical staff may not appreciate: fear of increased patient aggression and violence, concerns regarding clinicians’ time, capacity, role and the organisational support for the policy.10-11,15,24 However, the anticipatory concerns about increased patient aggression and violence do not appear to be substantiated after implementing smoke-free policies in mental health settings.15,24-26

The current findings also support previous evidence that medical doctors appear to be more supportive of smoke-free policies than nurses and allied health professionals.12,15,18,20-21 However, whilst psychiatrists acknowledge the potential benefit of smoke-free policies, they have concerns about the inhibition of the rights and capacity of patients to engage in this practice.9 Whereas, other mental health professionals particularly nurses, tend to perceive smoking as a therapeutic tool11,13 and see the benefit of staff being allowed to smoke with patients.27 The persistence of the debates around patient choice, harm avoidance and the health services’ moral imperative to promote well-being appear to lead to wide variations in the application of completely smoke-free policies across mental health services.8 Our results show that staff who smoke (14%) had significantly lower levels of agreement with both the policy and practices compared to non-smokers. This finding is consistent with the literature where staff who smoke tend to be less supportive of smoke-free policies in mental health services than ex-smokers and non-smokers.12,15-16,27 Previous evidence suggested that clinicians who smoke are usually less likely to encourage patients to quit than ex-smokers or never smokers.28 This highlights the need for support for staff who smoke as part of the implementation of smoke-free policies.27

**What this study adds**

Despite previous evidence reporting differences in mental health staff attitudes to partial smoke-free policy implementation and smoking cessation in psychiatric settings, in Britain limited evidence has been published prior to the implementation of NICE PH48 guidance and the requirement for a completely smoke-free policy. Previous studies have examined differences in levels of support for smoke-free policies between mental health staff and other healthcare professionals;18 however, this present study is believed to be the first in Britain to investigate these attitudinal factors in both clinical and non-clinical staff working in inpatient or community mental health settings within the context of a completely smoke-free policy.

An interesting finding from this study relates to smoking cessation training. Evidence indicates that smoking cessation training of mental health professionals is important for the success of smoke-free policy implementation.15,18,29 An interpretation of our findings suggests that smoking cessation training has influenced clinical mental health staff ‘ views on smoking cessation practices. This is based on the observed positive association between smoking cessation training and attitudes towards staff practice. However, this is to some extent diluted by the finding that those with an interest in smoking cessation training shared similar attitudes towards staff practice as those who had participated in the training, which perhaps suggests that smoking cessation training reinforces rather than alters attitudes.

The relationship between attitudes, intentions and behaviour is well established30 and this survey highlights the potential for such attitudes to present as barriers to successful implementation. Implementation of a completely smoke-free policy and smoking cessation practices across an organisation which has more than twenty inpatient wards across three hospital sites will result in varying levels of compliance. The embedding of the policy in routine day-to-day clinical practice will be the product of action, not necessarily attitudes or intentions. To understand how a completely smoke-free policy has been embedded will require looking at what staff actually do and how they work.

**Limitations of this study**

A limitation of this survey is the response rate (30.9%), which raises issues of sample representativeness and the potential to produce false-positive results or overestimate the magnitude of an association in relation to attitudes on organisational items or staff practice factors. However, whilst the response rate was less than a third, it equated to 631 responses. Suggestions of response bias are to some extent mitigated by the fact that several important group differences were observed after accounting for responders’ age, gender and smoking status. Additionally, the study was conducted in one Mental Health NHS Trust in an urban centre in England and caution must be exercised over the generalisability of the results to other organisations or countries.

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