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

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Background

People with mental health issues die disproportionately earlier than the general population due, in part, to higher smoking rates (DHSC, 2017; Williams et al., 2015). In response, the National Institute for Health and Care Excellence introduced Public Health Guidance 48: *Smoking: acute, maternity and mental health services* (NICE, 2013).

(U.S. Air Force Graphic)

Aim

To explore the implementation process of NICE (2013) and identify opportunities and challenges to normalising the changes to mental health service users' smoking behaviour.

Findings

Coherence – meaning and sense-making

Mixed responses, made sense to some participants not others.

Many staff found themselves in receipt of mixed messages and felt conflicted about how they should act.

Cognitive Participation - commitment and engagement

Some excellent, creative preparation work increased engagement. An enabling discourse was important.

Buy-in increased with consistent, senior support and prioritisation, and clear communication lines. However, non evidence-based beliefs persisted among many participants.

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Collective Action - work to make the intervention function

Required strong buy-in from all staff.

Ongoing challenge with regard to enforcement.

Staff felt caught between risks of compliance/ non-compliance with NM policies.

Provision of Nicotine Replacement Therapy within polices uncertain regarding access and administration.

Highlighted importance of continuing support.

Reflexive Monitoring - reflect on /appraise the intervention

Lead champion crucial to success.

Patients enthusiastically reported successful quits; some felt increasing pressure to comply but unable to do so.

Remained a struggle to create shift in culture.

Sustained effort still required.

Partnership between agencies supporting patients in quit attempts, on transition between hospital and community, not generally apparent.

Limitations

Recruitment of participants, especially service users, in terms of numbers and experience did not meet the intended targets. The context varied widely in terms of service provision and settings; not all contexts were considered.

Discussion and Conclusion

Context—deeply entrenched, smoking culture; inroads made to change culture.

Three fundamental disconnects, which undermined coherence and cognitive participation:

1 NM and quitting seen as contradictory; 2 Smokefree policies seen as unenforceable; 3 NM cuts across the patient choice agenda. To counter these undermining influences and take collective action successfully it requires organisational structures to address these issues through system design, review, amendment and communication of NM policies. Many of the activities outlined in the logic model had been initiated but more work was required before the outputs were embedded, new practices normalised, and outcomes and impact fully realised.

Methods

Process evaluation of attitudes towards nicotine management (NM) policies and experiences of implementation

- Logic model created.
- Data collection tools and analysis based on Normalization Process Theory (NPT) (May & Finch, 2009).
- Data collection conducted (November 2016-April 2017), using semi-structured interviews with a purposive sample of staff (n=51), members of partnering organisations (n=5), service users (n=5) and carers (n=2).
- Framework approach using the four concepts of NPT: coherence, cognitive participation, collective action and reflexive monitoring (May & Finch, 2009; Ritchie & Spencer, 1994).

Recommendations

Key requirements to facilitate this culture change:

1. Preparation — in-depth, long-term, host a stakeholder event, share success stories
2. Senior support — prioritised, active, at every management level
3. Communication — clear, focused, continuous, ongoing, open and supportive dialogue
4. Training — mandatory, all frontline staff, address non evidence-based beliefs
5. Community support — develop a seamless transition between primary and secondary care stop smoking services
6. Consider requirements of service users and carers — involve them in decision-making
7. Ensure that staff who smoke are supported to avoid smoking on-site and to quit
8. Create a cycle to reflect, appraise, review and amend the NM policies
9. Enforce NM policies consistently.

For more details search online for the report:

Evaluation of the introduction of smokefree policies in two North East NHS Foundation Trusts Northumberland, Tyne & Wear NHS FT and Tees, Esk & Wear Valleys NHS FT

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Public Health England

NHS Tees, Esk and Wear Valleys NHS Foundation Trust