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Working together to promote cessation of smoking in children & young people

A briefing for commissioners of Tier 4 Children & Adolescents Mental Health Services (CAMHS)

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Acknowledgements to Louise Dougherty and Emma Fletcher for carrying out the CAMHS survey and to Dr Margaret Murphy, Clinical Chair NHSE Programme of Care.

Supported by Smoking cessation in Child and Adolescent Mental Health services (CAMHS) working group.

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Published: December 2016.
PHE publications gateway number: 2016495.

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Executive summary

Smoking is the largest single preventable cause of morbidity, mortality and inequalities in health in Britain and accounts for about half of the difference in life expectancy between the lowest and the highest income groups.[1]

There is well-established evidence that adults experiencing mental health conditions smoke significantly more compared to the general population, and there are extensive resources and guidance available to support smoking cessation and smokefree services amongst this cohort.[2] However, this briefing aims to clarify what we know about the relationship between mental health and smoking prevalence amongst children and young people, what Children and Adolescents Mental Health Services (CAMHS) are doing to support children and young people with smoke free advice and support, and what actions commissioners and the public health system might take to reduce levels of smoking and the harms that arise from it.[3]

Key findings

1. Those who start smoking in their teens are more likely to continue smoking as adults and become heavy smokers, with two thirds of adult smokers in the UK starting before their teens.

2. People who start smoking at a young age are more susceptible to the long term harms of tobacco. Compared to those who start to smoke as adults, those who start smoking at a younger age are more likely to develop future long term conditions associated with tobacco use.

3. Many young people who take up smoking during adolescence experience difficulties engaging with standard cessation services and generally exhibit greater ambivalence about their tobacco use than adults.

4. There is limited evidence concerning smoking among children who access CAMHS. However, results from small published studies suggest that children and young people accessing CAMHS demonstrated a high awareness of the harms of smoking, but lacked confidence and motivation to quit.[4] [5] There was also some evidence that children and young people did not feel that their mental health condition impacted negatively on their ability to attempt to quit.

5. The few studies available show variable smoking rates amongst children and young people experiencing a range of mental health conditions.

6. Routine engagement with Children and Adolescent Mental Health Services offers the opportunity to reduce smoking in this important population group.

Prevalence

1. For the population who access CAMHS Tier 4 services commissioned by NHS England, a national survey of units found that smoking prevalence is estimated at 13%. This is comparably higher than the general population prevalence of regular smokers at 15 years of age in England which was 8% in 2014 as reported in the NatCen survey.[6]

2. Prevalence for a range of mental health conditions including eating disorders, depression, conduct disorders, and anxiety were all higher than the 8% prevalence rate of regular smokers in the general population. However, there was wide variation in rates of smoking between the conditions in the reported literature. Evidence from published studies is presented in chapter 3 of this report (table 1) showing the available rates reported by type of mental health condition.

3. There is evidence of variation in age-specific prevalence rates for children and young people with mental health conditions, with one study identified in this review conducted between two CAMHS in-patient units in England reporting age specific prevalence highest amongst 15-18 year olds, with 35% of this age group identified as regular smokers.[7]

Smokefree services

1. A joint report by RCP and RCPsy highlight the importance of focusing attention to targeted populations, such as children who access CAMHS.[3]

2. Younger people may be harder to engage and be more ambivalent about their tobacco use. Piloting within CAMHS units provides an opportunity to trial and evaluate innovative ways to reach young people to both prevent uptake of smoking and interventions to support cessation. NICE guidance notes that in-patient care in specialist units such as these may represent a unique opportunity to intervene.[26]

3. In the context of implementing NICE guidance, many mental health trusts are currently engaged in efforts of making inpatient units smokefree. A PHE and NHS England survey of mental health units has highlighted that 77% of units of NHS England commissioned low and medium secure units were already smokefree, with a further 21% highlighting smokefree policies across site buildings.

4. In conclusion, although there is less evidence on what works for smoking cessation for those under the care of CAMHS, there is clear evidence of harm and long term

impact. The survey clearly indicates variation in smokefree and smoking cessation support in current practice.

Recommendations for commissioning in CAMHS

Based on the findings of this review, the following recommendations for commissioners are proposed. These align and develop those previously published in our aforementioned guidance on smoking in secure mental health services, recognising overall that the strength and scale of evidence in relation to children and young people with mental health conditions requires further research. The recommendations cover action in the following key areas:

1 – Contracting levers	Commissioners should maximise the use of contracting levers to support services in achieving smokefree status, and provide support to staff and services users in reducing smoking and managing nicotine withdrawal.
2 – Guidance	Commissioners should be aware of the guidance documents available to support services in delivering smoking cessation interventions and provision of smokefree treatment areas that apply within the context of units, and ensure that these standards are built in to service delivery.
3 – Legal and ethical duties	Commissioners should take account of the relevant legislation that supports smokefree environments in mental health settings and ensure providers take account of the key legislation.
4 – Robust project management	Commissioners should encourage providers to take a project management approach to the transition to smokefree sites, to include monitoring and evaluation and the development of a minimum dataset.
5 – Trusts undertake self-assessment against NICE PH48 recommendations	Commissioners should ensure all Trusts complete the PHE self-assessment for implementation of NICE guidance PH48, and use this to formulate action plans and review as required.
7 – Care pathways	Commissioners should ensure that contracts with providers have clear pathways to support smoking cessation in mental health settings and that these are in line with published NICE guidance.
8 – Medication use	Information regarding the impact of stopping smoking on psychotropic medication should be highlighted within commissioning arrangements, in terms of potential positive

	impacts on the individual and financial implications for providers and trusts.
9 – Training	Commissioners should ensure that providers train all staff within the unit to be aware of the issues, evidence base and support available to help people to stop smoking or manage their own nicotine use. Regular updates should be provided.
10 – Staff culture	Commissioners and providers should support their staff to stop smoking. This provides benefits for their own health and also helps them in challenging the culture that it is normal for people in mental health settings to smoke.
11 – Weight management	Commissioners should encourage providers to monitor the weight of all service users and put in place interventions to prevent or address this issue as part of wider health and wellbeing strategies. Moving towards completely smokefree sites (including grounds) offers the opportunity to increase the engagement of service users and staff in a range of activities to support physical health. Mental health service providers may not have specialist expertise in weight management and may need to work in collaboration with other local services specialising in local obesity pathways and services.
12- Best practice	Commissioners should work with local providers to highlight and disseminate good practice, innovation, and local progress towards smokefree units. Acknowledging the progress which has been made but recognising in some units ‘smokefree’ environments has not resulted in a ‘whole person’ approach to care.
13 – Further research	This review highlights that there is a need for further research evidence on provision and/or effect of tobacco dependence treatment in CAMHS settings, and on tailored interventions on ‘what works’ within children and young people with mental health conditions in England.

1. Introduction

This briefing is for Tier 4 Child and Adolescent Mental Health Services (CAMHS). CAMHS Tier 4 deliver specialist in-patient and day-patient care to children who are suffering from severe and/or complex mental health conditions that cannot be adequately treated by community CAMHS and deliver tertiary level care and treatment to young people with severe and/or complex mental health conditions. Services are provided for young people between 13th and 18th birthdays with a range of mental health conditions associated with significant impairment and risk to themselves or others such that their needs cannot be safely and adequately met by community Tier 3 CAMHS. These include depression, psychoses, eating disorders, severe anxiety disorders and emerging personality disorders and include young people with mild learning disability and Autism Spectrum Disorders who do not require Tier 4 CAMHS Learning Disability Services. [8]

NICE guidance PH48 and Royal College of Physicians and the Royal College of Psychiatrists (2013) recommends that all NHS funded secondary care sites should become completely smokefree and aligned with smokefree policy in inpatient units that embed support for service users who smoke. PHE's Smoking cessation in secure mental health settings: Guidance for commissioners, published in March 2015, provided a set of 11 recommendations for how to develop, implement and maintain smokefree environments in specialised services. [2]

Based on these key reports and the independent Mental Health Taskforce's Five Year Forward View, published in February 2016, we recognise that systematic implementation of current evidence on provision of safe and effective tobacco dependence treatment in settings such as CAMHS is necessary. [9] The Five Year Forward View reported that people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. This is one of the greatest health inequalities in England.

Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. We know that the impact of smoking upon children and adolescents results in long term health impacts. However, there has been weak and limited evidence reviewing the scale of the impact and effects in the population which access CAMHS. Most of the available published evidence focuses primarily on smoking and mental health amongst adult mental health populations.

Through this we know the problem emerges early on and there are few supportive mechanisms in place in CAMHS for young people who smoke. The limited evidence base relating to smoking cessation in CAMHS has been cited in NICE guidance (PH48) and the joint report by the Royal College of Physicians and the Royal College of

Psychiatrists (2013) on smoking and mental health.[3] Working together to normalise non-smoking and deliver systematic and effective prevention and support to children & young people who smoke is vital if we are to protect them from the diseases and early death that will ensue should such action not be taken.

2. Policy landscape and legislation

Since 1 October 2007, it has been illegal to sell tobacco products to anyone under the age of 18. On 1 October 2015, it has also become illegal for an adult to purchase tobacco or e-cigarettes for under 18s.

There is a legal obligation and duty on health inequalities in the Equality Act (2010) and Health & Social Care Act (2012) to reduce inequalities and to ensure that people with mental illness have the same levels of access to services and outcomes as the general population.

In 2011, the government outlined its mental health strategy: No health without mental health,[9] to ensure more people with mental health conditions have good physical health; and that fewer people with mental health conditions die prematurely.

This is further underlined in the following key government documents:

- Mental health implementation framework (2012) [11]
- Living well for longer (2014) [12]
- Closing the gap - Priorities for essential change in mental health (2014) [13]
- PHE's strategy 'Reducing smoking and stopping children starting' (2014) [14]
- Future in mind (2015) [15]
- Sustainability and transformation plans(2016) [16]
- Mental Health Taskforce Five year Forward View– Recommendation 20 (2016) [9]

3. Children & young people with mental health conditions smoking: the evidence

Smoking prevalence amongst young people

Smoking has been identified as the primary reason for the gap in life expectancy between rich and poor and is responsible for more than half the difference in the risk of premature death between social classes.[1 17] We know that people start smoking in their teens with two thirds of adult current or regular smokers in England started smoking before they were 18.[18] Furthermore, those from disadvantaged backgrounds are more likely to start younger, become more heavily addicted, and this is compounded in smokers with mental health conditions who tend to have higher levels of dependency than the general population and as such face more barriers to quitting.[17]

The Action on Smoking and Health (ASH) report, Stolen Years (2016), recognises the need for robust evidence into the most effective ways to reduce smoking rates among children and young people with mental health conditions.[25] There is significant variation in rates of smoking prevalence amongst young people with mental health conditions. Table 1 highlights this variation. All reported rates are above the reported prevalence rate of 8% classified as regular smokers at the age of 15, as reported in the NatCen survey.[6] For some conditions the difference is stark. For example, the rate of smoking among young people with conduct disorder is around nine times higher than that of children the same age in the general population. There is also evidence of variation in age-specific prevalence rates for children and young people with mental health conditions who are accessing services, with one study identified in this review conducted between two CAMHS in-patient units in England reporting age specific prevalence highest amongst 15-18 year olds, with 35% of this age group identified as regular smokers.[7] Although limited to a few studies there is, therefore, some indication of the relationship between mental health and smoking rates in children.[19 20]

Health risks for children and young people who smoke across the lifecourse

Young smokers may be disproportionately affected by the health risks for several reasons including:

- those who begin smoking in their teens are very likely to continue smoking as adults. They are more likely than others to become heavy smokers with two thirds of adult smokers in the UK starting in their teens [6]

- young smokers are most susceptible to the harms of tobacco and are significantly more likely to die from smoking-related illnesses as adults compared to those who started smoking later in life [21]
- smokers who start at a young age are more likely to develop lung cancer than those who start to smoke as adults even after controlling for the amount and length of tobacco exposure [22]
- children and young people who smoke are also two to six times more susceptible to coughs, increased phlegm, and wheezing than their non-smoking peers [5]
- smoking can impair the growth of their lungs and is also a cause of asthma-related symptoms in childhood and adolescence [6]
- passive smoking is also a major threat to child health.[23] Passive smoking cases generate annually over 300,000 GP consultations, 9,500 hospital admissions, and costs the NHS approximately £23.3 million (RCP 2010). The health damage attributable to passive smoking for children each year cause: 20,000 cases of lower respiratory tract infection, 120,000 cases of middle ear disease, 22,000 new cases of wheeze and asthma, 200 cases of bacterial meningitis, and 40 sudden infant deaths – which is one in five of all SIDs [3]

Children and young people with mental health conditions who smoke

Several studies have found that young people reported using smoking as a coping strategy and that relapse to smoking after quitting was sometimes attributed to difficult emotional and social problems, life events and transitions. Table 1 demonstrates the variation in smoking prevalence among young people with mental conditions.

Table 1: Children and young people with mental health conditions who smoke

Condition	Young people who smoke	Source/ Evidence
Depression	46%	Lawrence et al. 2010; Glass and Flory 2010; Sandford 2008; Dudas et al 2005
Anxiety	12%; 50%	Huddlestone et al. 2014; Dudas et al. 2005
ADHD	38%	Lawrence et al. 2010; Glass and Flory 2010
Emotional disorder	19%	Green et al. 2005; Fuller 2007
Hyper-kinetic disorder	15 %; 53%;	Green et al. 2005; Huddlestone et al. 2014
Conduct disorder	30%; 72%	Green et al. 2005; Lawrence et al. 2010
Eating Disorder	12 %	Huddlestone et al. 2014; Cawley et al. 2004

[See Appendix A for a summary on each of the listed percentages].

Grana et al (2012) study showed 50% were interested in quitting smoking but only 11% were preparing to quit in the next 30 days.[5] Psychosocial factors related to adolescent smoking such as stress and distress or depression are associated with smoking

initiation and maintenance. [24] Despite the lack of research, it is clear that integration of treatment for tobacco dependence into existing CAMHS services is required. The feasibility and effectiveness of interventions targeted at addressing smoking among young people with mental conditions are also required.

4. Current practice

A survey was undertaken in partnership with NHS England to understand the current reach of smokefree policies, stop smoking provision, and key issues in CAMHS services. NHS England surveyed all 93 of its contracted Tier 4 services between August 2015 and January 2016.

Survey Results descriptive analysis

55 units responded (response rate 59%). The data highlights significant progress towards smokefree units, with 77% of units specifying that they are completely smokefree. 21% of units noted that they had smokefree buildings and mainly smokefree gardens.

Survey results clinical information

The 55 units clinical data responses indicated that estimated prevalence is higher in staff than in patients, at 16% and 13% respectively. The survey collected data on policy relating to nicotine vaporisers (e-cigarettes - EC). 76% of units prohibit use, 7% do not prohibit use, and 11% have no policy in place at the time of asking.

This demonstrates the disparity in recording of smoking status between admission and discharge, with 92% of units recording smoking status on admission, but only 29% recording on discharge. This disparity may impact continuity of care in relation to supporting smoking cessation activities. 47% of units recorded smoking status as a routine piece of clinical information integral to the care and support provided to that individual.

80% of units offer smoking cessation support in line with NICE Guidance PH 48 and just over half of units (56%) record the support provided. Approximately half of all units (47%) reported using additional means of smoking cessation support.

Table 2. Clinical indicators and results from 55 sites who responded to the NHS England questionnaire

Prevalence	**%**	**Number**
% Patient Smokers	13%	*
% Staff Smokers	16%	*
E-cigarettes		
% of CAMHS Sites who *prohibit* nicotine vaporisation	76%	42
% of CAMHS Sites who **do not** *prohibit* nicotine vaporisation	7%	4
% of CAMHS Sites who do not have a nicotine vaporisation policy	11%	6

Clinical data recording		
% of CAMHS Sites who record smoking status on admission	92%	51
% of CAMHS Sites who record smoking status on discharge	29%	16
% of CAMHS Sites who record smoking status routinely	47%	26
Adherence to NICE guidance		
% of CAMHS Sites who offer smoking cessation [NICE Guidance]	80%	44
% of CAMHS Sites who record smoking cessation support	56%	31
Number of CAMHS Sites who use additional/other means of smoking cessation support	47%	26

** Units asked in survey to provide percentage estimate only*

Survey data conclusions

The data summarised in chapter 4 highlights that Tier 4 (T4) CAMHS are progressing towards becoming completely smokefree, through updates of policy and provision of smoking cessation support to those who require it. These results highlight progress for both the NHS led and independent provider units.

Prevalence is reported to be higher in staff than patients (16% compared to 13%) which is one indication that any progress towards smokefree units should also incorporate and advocate approaches towards a 'smokefree' culture. This finding is also supported by data from the ASH report. [25]

Although 51 sites record patient smoking status on admission, only 16 sites record status on discharge. This missing data prevents comparison and analysis and so may impact on the understanding of the effectiveness of smoking cessation support provided across the care pathway. To improve understanding, a suggested minimum data set to collect is:

- percentage of patients who are screened for smoking status and whose results are recorded
- percentage of patients who smoke and are offered very brief advice
- percentage of patients who are indicated as a smoker and are offered evidence based smoking cessation support and offered Nicotine Replacement Therapy

The survey data also highlights the approach to the majority prohibiting ECs. This may reflect legislation where from the 1 October 2015, it is illegal for any person under 18 years of age to purchase ECs from UK retailers. The survey did not consider EC use in staff but, given higher prevalence and the impact of staff smoking noted in the ASH survey findings, this may be an important area to target cessation support and methods.

5. Stakeholder engagement

In April 2016 PHE and NHS England convened a half-day workshop with stakeholders from across the system to present the survey results, review evidence and develop recommendations. The workshop included representatives from a wide range of stakeholders including:

- NHS England Clinical Reference Group and Programme of Care Board representatives
- Public Health England
- Care Quality Commission
- National Offender Management Service (NOMS)
- NHS Provider organisations frontline clinicians
- Carer representatives
- The Royal College of Psychiatrists
- Action on Smoking and Health (ASH)

A full list of attendees can be found in Appendix D. Their contribution plus review of NICE guidance, ASH report and RCP guidance are incorporated in this report.

Stakeholder feedback

Stakeholders were presented the latest evidence and survey results. Key themes arising in roundtable discussion included:

1. A number of examples were cited by participants where smokefree building and grounds had displaced smokers to outside of perimeter gates or entrances/exits to units. Delegates highlighted these examples of where a progression to smokefree services had yet to result in a 'smokefree culture'. In some cases, these practices may be putting staff and patients at increased risk in relation to both health and safety factors and in terms of breaching professional standards.
2. Supporting staff in their efforts to stop smoking should have a higher priority attached, specifically where staff who smoke may influence patients in CAMHS units inadvertently or enable smoking practices.
3. A greater emphasis on integrating smoking cessation approaches and interventions across the care pathway is required to effectively support cessation for children and young people accessing these services.
4. Data collection and reporting were highlighted as significant gaps by stakeholders, particularly relating to information on discharge and how this is passed on throughout the care pathway. It was also noted that greater integration and use of data could support improved training for staff in relation to maximising the

opportunities to improve physical health and wellbeing using data from health checks and other routine assessments.

6. Recommendations for commissioning in CAMHS

Although there is less evidence on what works for smoking cessation under the care of CAMHS, there is a clear need to denormalise smoking, normalise quitting and protect them from passive smoking. The evidence on the effectiveness of stop smoking services is well understood, however take-up can be low.

NICE public health guidance PH48 recommends that all NHS funded secondary care sites should become completely smokefree. [26] They should provide cessation in line with NICE guidance and as routine component of the service. Services should continue to ascertain smoking status on entry and discharge to ensure continuity of support for smoking cessation in the community.

Recommendations for commissioners to support young people with mental health conditions and smoking:

1. Contracting levers
2. Guidance
3. Legal and ethical duties
4. Robust project management
5. Trusts undertake self-assessment
6. Reinforcing the public health messages
7. Care pathways
8. Medication use
9. Training
10. Staff culture
11. Weight management
12. Best practice
13. Further research

Recommendation 1 – contracting levers

Commissioners should maximise the use of contracting levers to support Tier 4 services in achieving smokefree status, and provide support to staff and services users in reducing smoking and managing nicotine withdrawal.

This may include:

- mandating smokefree site status in policies and the regular review and update of policies
- highlighting the relevant CQUINs to encourage providers to move to smokefree status, taking account of variation that exists due to environmental factors relating to different sites and buildings
- consideration of the recommendations made in this guidance when negotiating contracts and KPIs with providers
- highlighting the relevant indicators in the public health and NHS outcome frameworks
- monitoring compliance, ensuring good quality data is collected and that evidence on implementation continues to be gathered (see recommendation 10)

Recommendation 2 – guidance

Commissioners should be aware of the guidance documents available to support services in delivering smoking cessation interventions and provision of smokefree treatment areas that apply within the context of units, and ensure that these standards are built in to service delivery.

These include:

- NICE PH 1 brief interventions and referral for smoking cessation
- NICE PH 5 workplace interventions to promote smoking cessation
- NICE PH 10 smoking cessation services
- NICE PH 45 tobacco: harm-reduction approaches to smoking
- NICE PH 48 smoking cessation in secondary care: acute, maternity and mental health services
- NCSCT LSSS: service and delivery guidance 2014
- NCSCT training standards
- The PHE smokefree mental health resources [27]
- ensuring access to implementation guidance for frontline staff, especially where it exists in different places and is produced by different organisations

Recommendation 3 – legal and ethical duties

Commissioners should take account of the relevant legislation that supports smokefree environments in mental health settings and ensure providers take account of the key legislation.

These include the:

- Health and Safety at Work Act 1974
- Health Act 2006
- case of R (N) v SSH; R (E) v Nottinghamshire Healthcare NHS Trust (2009) EWCA Civ 795
- Health and Social Care Act 2012
- Support CAMHS, and local authority foster care and smoking policies to explicitly protect children from passive smoke, and promote smoke-free foster homes
- support a broad programme of health promotion aimed at preventing initiation of smoking as well as smoking cessation

Recommendation 4 – robust project management

Commissioners should encourage providers to take a project management approach to the transition to smokefree sites, to include monitoring and evaluation and the development of a minimum dataset.

This should include:

- a risk register with plans for monitoring and reporting and a system for rapid escalation where necessary
- mapping of key stakeholders for consultation
- development of a minimum dataset

It is recommended that the minimum dataset should include:

- percentage of patients who are screened for smoking status and whose results are recorded
- percentage of patients who smoke and are offered very brief advice
- percentage of patients who are indicated as a smoker and are offered evidence based smoking cessation support and offered Nicotine Replacement Therapy

Outcomes of stop smoking service interventions delivered according to the Russell Standard, can be reported through the local authority commissioner to NHS Digital (formally HSCIC). The NHS Digital team provides quarterly and annual reports on stop smoking service activity. Where services are provided outside of local authority commissioning structures, local arrangements should be made to ensure that this data is reported consistently and accurately. Any enquiries that are not resolved with the

local authority stop smoking service commissioner should be addressed to NHS Digital directly: enquiries@nhsdigital.nhs.uk

Recommendations for additional information to be collected for purposes of monitoring and review of the smokefree policy and status should include:

- **pre 'smoke free' date:** perceptions of service users and staff
- **pre and post 'smoke free' date:** incidents (including security); rapid tranquilisation use; urine drug screens; staff and service user smoking rates
- **post 'smoke free' date:** service user and staff feedback; breaches of policy of incidents; impact on medication costs; changes in weight and uptake of alternative activities to smoking

Continued implementation within CAMHS provide an opportunity to trial and evaluate innovative ways to improve practice. NICE guidance notes that In-patient care in specialist units such as these may represent a unique opportunity to intervene. Results should be published to ensure translation of knowledge, experience, and learning.

Recommendation 5 – trusts undertake self-assessment against NICE PH48 recommendations

All Trusts should complete the PHE self-assessment for implementation of NICE guidance PH48, and use this to formulate action plans and review as required.

PHE has developed a self-assessment model that provides a framework to help NHS trusts to develop local action to reduce smoking prevalence and tobacco use within secondary care settings. The self-assessment model offers a:

- free-to-access model for self-assessment that can assist in evaluating the effectiveness of action to address harm from tobacco
- suite of videos that set the scene and explain the benefits of action
- replicable workshop format that can be delivered at a local level to support local action to reduce the harm of tobacco

The self-assessment tool breaks down the NICE guidance into four areas:

- systems required to implement the guidance
- communication required
- training that will enable staff to successfully implement the recommendations
- treatments that should be available to support staff and service users

The self-assessment will enable trusts to:

- evaluate their local action on smoking in mental health
- ensure that local activity follows the latest evidence-based practice

- identify priority areas for development
- the self-assessment can also be used to monitor improvements to services over time

Trusts can start using:

- the model by completing the FREE self-assessment questionnaire available at www.gov.uk/government/publications/smoking-cessation-in-secondary-care-mental-health-settings. For more information call 020 368 20521 or email CLeaRTobaccoTeam@phe.gov.uk
- PHE Local Tobacco control Toolkit https://publichealthmatters.blog.gov.uk/2015/09/15/health-matters-your-local-tobacco-control-toolkit/

Recommendation 6 – reinforcing the public health messages

Commissioners should take action to highlight and reinforce the key health benefits to prevent smoking uptake and reduce smoking in mental health settings. With reminders of the need to reduce the variation in smoking prevalence between those with mental health conditions and the general population, and between units.

This could include:

- positive messages about the health benefits of a smokefree environment to reinforce prevention
- clear consistent messages on the health benefits of stopping smoking which includes dispelling the myth that smoking improves mental health
- acknowledging employers' duty of care to provide a safe and healthy environment for staff, service users and visitors
- acknowledging employees' duty of care to support service users in achieving good mental and physical wellbeing

Reinforcing the public health message, including RCPsych's recommendation 'in settings where young people are most vulnerable, such as adolescent inpatient units, there should be a broad programme of health promotion aimed at preventing initiation of smoking as well as smoking cessation.'

Recommendation 7 – care pathways

Commissioners should ensure that contracts with providers have clear pathways to support smoking cessation in mental health settings and that these are in line with published NICE guidance.

This should include:

- an assessment of smoking status on entry to the service and provision of timely access to medication and support for service users who wish to stop smoking or temporarily abstain from smoking while in the unit or on-site
- arranging for continued provision of support with harm reduction and smoking cessation interventions prior to discharge
- support for work across the care pathway and non-specialised children's and young people’s services to denormalise smoking, normalise quitting and prevent uptake
- a whole system approach to denormalise smoking, normalise quitting and prevent uptake
- a greater emphasis on integrating smoking cessation approaches and interventions across the care pathway is required to effectively support cessation for children and young people accessing these services
- information provided on discharge and details of how this is passed on throughout the care pathway

Recommendation 8 – medication use

That information regarding the impact of stopping smoking on psychotropic medication is highlighted within commissioning arrangements, in terms of potential positive impacts on the individual and financial implications for providers and trusts.

This should include:

- clear consistent messaging for service users on the benefits of stopping smoking including potential reductions in medication and their associated side effects
- ensuring service users receive appropriate support in managing any changes in their medication if they change their smoking attitude
- ensuring that staff are aware of the impact of smoking and smoking reduction or cessation on psychotropic medications, and that there are appropriate clinical systems in place to monitor the level of certain drugs when an individual stops smoking
- where possible to include reduction in medication in the evaluation and monitoring processes to record the cost saving

Recommendation 9 – training

Commissioners should ensure that providers train all staff within the unit to be aware of the issues, evidence base and support available to help people to stop smoking or manage their own nicotine use. Regular updates should be provided.

This should include (in line with NICE public health guidance PH48):

- relevant curricula for frontline staff include the range of interventions and practice to help people stop smoking
- all frontline staff are trained to deliver advice around stopping smoking and referral to intensive support, in line with recommendations 1 and 2 of NICE PH48
- staff know what local and hospital-based stop smoking services offer, and how to refer people to them
- online training can be completed and updated annually as part of NHS mandatory training (for example the training provided by the NCSCT)
- all frontline staff are trained to talk to people in a sensitive manner about the risks of smoking and benefits of stopping
- all staff who deliver intensive stop smoking support are trained to the minimum standard described by the NCSCT (or its equivalent) with additional training that is relevant to their clinical specialism
- all staff are informed about smokefree policies, their roles and responsibilities in maintaining a smokefree work environment and what action to take in the event of negative responses to smoking restrictions

Commissioners should ensure that all staff in provider organisations have undertaken training to support provision of very brief advice, and those who are responsible for delivery of care are trained in the use of cessation medications and delivery of effective psychoactive interventions.

Greater integration and use of data could support improved training for staff in relation to maximising the opportunities to improve physical health and wellbeing using data from health checks and other routine assessments.

Recommendation 10 – staff culture

Commissioners and providers should support their staff to stop smoking. This provides benefits for their own health and also helps them in challenging the culture that it is normal for people in mental health settings to smoke.

This should include (in line with NICE public health guidance PH48):

- taking action in line with NICE guidance on workplace interventions to promote smoking cessation (PH5)
- advising all staff who smoke to stop
- offering staff in-house stop smoking support
- providing contact details for community support if preferred
- allowing staff to attend stop smoking services during working hours without loss of pay

- advising staff who do not want, or are not ready or able to stop completely, to use licensed nicotine-containing products to help them abstain during working hours, including advice on where to obtain them
- offering and providing intensive behavioural support to maintain abstinence from smoking during working hours and where appropriate follow recommendation 8 in NICE guidance on tobacco harm reduction (PH45)
- engage staff in smoking cessation which supports a smokefree culture

Support to staff in their efforts to stop smoking should have a high priority attached, specifically where staff who smoke may influence patients in CAMHS units inadvertently or enable smoking practices.

Recommendation 11 – weight management

Commissioners should encourage providers to monitor the weight of all service users and put in place interventions to prevent or address this issue as part of wider health and wellbeing strategies. Moving towards completely smokefree sites (including grounds) offers the opportunity to increase the engagement of service users and staff in a range of activities to support physical health. Mental health service providers may not have specialist expertise in weight management and may need to work in collaboration with other local services specialising in local obesity pathways and services.

Actions could include:

- ensuring key staff are aware of the NICE clinical guidance relating to obesity in adults and children (CG43)
- taking a wider health and wellbeing approach to the smokefree transition, including providing healthy options and activities to replace smoking ‘breaks’
- converting areas previously associated with smoking to areas that promote physical activity
- monitoring body mass index pre and post implementation of completely smokefree sites

Recommendation 12 – best practice

- support progress of smokefree units and move towards creating a ‘smokefree’ culture, acknowledging the progress which has been made but recognising in some units ‘smokefree’ environments has not resulted in a ‘whole person’ approach to care
- ensure a coordinated approach to ensuring resources and good practice guidance is in one place, and that their implementation is a core part of contracting by commissioners
- CAMHS should ascertain smoking status and provide cessation support as a routine component of their service

Recommendation 13 – further research

- there is a need for evidence on provision and/or effect of tobacco dependence treatment in CAMHS settings in the UK. More research is needed to better understand smoking behaviour in adolescents and young people, what works to prevent uptake, and effective methods for delivering tobacco treatment [28]
- data collection and further research in this area should be prioritised to understand what works, how to stop starting, and how we can impact on long term outcomes

Appendix A: Summary of Table 1 - Children and young people with mental health conditions who smoke

1. According to the child and adolescent mental health survey of Great Britain (2004), young people aged 11–16 years with an emotional, hyper-kinetic or conduct disorder were much more likely to be smokers (19%, 15% and 30% respectively) than other young people (6%).[29]

2. Kulkarni et al 2014 study with ten specialist CAMHS teams found 53% of smokers had a diagnosis of hyper-kinetic disorder (+/- conduct disorder), 12% of an anxiety disorder and 12% of an eating disorder.[4]

3. Evidence from European and Australian studies showing links between anxiety and depression in teenagers and smoking behaviour and likely nicotine dependence. Cross-sectional data indicate that, in Australia, 72% of young people with a conduct disorder had smoked within the past 30 days, as had 46% of those with depression and 38% of those with ADHD, compared with 21% of those with no mental health diagnosis.[30 31]

4. Depression in adolescence has been associated with smoking in adulthood, whereas young people who smoke appear more likely to become depressed.[32]

5. Adolescents with ADHD are more likely to smoke than their peers, to have started smoking younger, and to have more severe nicotine dependence. [33 34]

6. Smoking is also more common among young people with eating disorders. The American National Longitudinal Study of Youth found that adolescent girls with a high body mass index, who reported that they were trying to lose weight, were more likely to initiate smoking than other females. [35 36]

7. Reported that half of 14-17 year olds with anxiety symptoms and two thirds of those with depressive symptoms used tobacco. [37]

Appendix B: Smoking in Child and Adolescent Mental Health Services Service Questionnaire

1. Introduction
The Mental Health Programme of Care for Specialised Mental Health Services and Public Health England (PHE) are seeking to understand prevalence of smoking and availability of stop smoking support within Child and Adolescent Mental Health Services contracted by NHS England. This questionnaire is to establish the current position.

2. Definition of 'Smokefree'
The Guidance for council regulatory officers (second edition) defines smoking as smoking tobacco or anything which contains tobacco, or smoking any other substance, and includes being in possession of lit tobacco or of anything lit which contains tobacco, or being in possession of any other lit substance in a form in which it could be smoked. This includes smoking cigarettes, cigars, herbal cigarettes and pipes (including water pipes, shisha and hookah).
Smokefree is therefore defined as the absence of smoking as described above.

Please note that we will be asking services to define their smokefree status within the four definitions below:

Type 1 – Entirely smokefree buildings and grounds
Type 2 – Smokefree buildings and secure gardens with smoking allowed within open spaces outside of the secure perimeter – such as hospital grounds (whether sheltered or not)
Type 3 – Smokefree buildings with smoking allowed in secure gardens and outside of the secure perimeter – such as hospital grounds (whether sheltered or not)
Type 4 – Smoking allowed within buildings (defined rooms or not) and open spaces, such as secure gardens or hospital grounds (whether sheltered or not)

3. Vapour and electronic cigarettes
For security and safety reasons Vapour/electronic cigarettes maybe an issue beyond any harm reduction/health benefits and, as such, services may have chosen to prohibit the use of these products as a security and safety matter. Therefore, this questionnaire also asks services to confirm use or prohibition of these products

Public Health England has recently published a comprehensive report on electronic cigarettes which includes the latest available evidence available here.

4. Action for host area team commissioners and services

Host area team commissioners responsible for Child and Adolescent Mental Health Services will distribute this information and questionnaire form to hosted services, requesting services to complete and return to them by **31 July.** The form has been kept to a minimum and we hope the above information provides enough explanation for services to fully complete and return to their host area team. Can services also confirm contact details for any further queries from PHE.

Smoking Cessation in Child and Adolescent Mental Health Services. Please complete all sections.

Service Information

Service Name	
Number of wards in unit	
Number of beds/wards	
Estimated % of patients who are smokers within whole service	
Estimated % of staff who are smokers within whole service	

Smoke Free

Status Type	Please indicate (X) the services "Smokefree" status as set against **one** of the following four types
Type 1 – Entirely smokefree buildings and grounds	
Type 2 – Smokefree buildings and secure gardens with smoking allowed within open spaces outside of the secure perimeter – such as hospital grounds (whether sheltered or not)	
Type 3 – Smokefree buildings with smoking allowed in secure gardens and outside of the secure perimeter – such as hospital grounds (whether sheltered or not)	
Type 4 – Smoking allowed within buildings (defined rooms or not) and open spaces, such as secure gardens or hospital grounds (whether sheltered or not)	

Vapour/Electronic Cigarettes

Service position on these products	Please indicate (X) which option reflects the service position on these products
The products are prohibited within the secure perimeter	
These products are allowed as part of a harm reduction plan (with or without special security measures)	
No position or prohibition on these products	

Do you record smoking status	On admission?	
	On discharge?	
	As routine during treatment?	

Do you offer smoking cessation support in line with NICE Guidance?	
If yes, do you record uptake?	
What other methods of smoking cessation support are available?	

Service Contact details – so we may contact you for further information

Name of person completing form	
Role	
Email	
Telephone	

Appendix C: Smokefree CAMHS Units

Name of Trust*	NHS Region or Hub
Berkshire Healthcare NHS Foundation Trust	South East
Bradford District NHS Foundation Trust	Yorkshire and the Humber
Camden and Islington NHS Foundation Trust	London
Cheshire and Wirral Partnership NHS Foundation Trust	North West
Coventry and Warwickshire Partnership NHS Foundation Trust	West Midlands
Greater Manchester West Mental Health NHS Foundation Trust	North West
Hertfordshire Partnership University NHS Foundation Trust	East of England
Kent and Medway NHS and Social Care Partnership Trust	South East
Lancashire Care NHS Foundation Trust	North West
North East London NHS Foundation Trust	London
Oxford Health NHS Foundation Trust	South East
South Essex Partnership University NHS Foundation Trust	East of England
South London and Maudsley NHS Foundation Trust	London
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	West Midlands
South West Yorkshire Partnership NHS Foundation Trust	Yorkshire and the Humber
Tavistock and Portman NHS Foundation Trust	London

*This list was collated up to April 2016. There may be other CAMHS units that have since gone smoke-free or have set smoke-free dates.

Appendix D: Working Group members & CAMHS Workshop participants - April 2016

Surname	Forename	Title	Organisation
Andrew	Lisa	Regional Director CAMHS	Partnerships in Care
Banfor	David	Stop Smoking Advisor	NE London Foundation Trust
Chand	Neesha	Improvement & Development Manager – Substance Misuse	Turning Point (SE & London)
Cheeseman	Hazel	Director of Policy	Action on Smoking & Health
Choudhri	Tasneem	Health & Wellbeing Manager	Public Health England NW
Coles	Tammy	Children & Young People lead	Public Health England
Day	Matt	Consultant in Public Health	Public Health England
Doughty	Louise	Head of Mental Health & Programme of Care Lead (Secure CAMHS)	NHS England (South) Wessex
Eccles	Richard	Senior Programme of Care Manager for Mental Health	NHS England
Fletcher	Emma	Public Mental Health and Wellbeing Support Manager	Public Health England
Garnham	Helen	Public Health Manager – Mental Health	Public Health England
Harker	Katy	Registrar in Public Health	Action on Smoking & Health
Hill	Paul	Clinical Manager/Modern Matron	The St Aubyn Centre Colchester
Jones	Dave	Tobacco Control Manager	Public Health England
McGaw-Cesaire	Jacy	Public Mental Health & Health Equity Implementation	Public Health England
Murphy	Margaret	Clinical Chair	NHS England Mental Health Programme of Care Board
Ratschen	Elena	Senior Lecturer in Health Services Research	University of York
Risdale	Gary	Inspection Manager	Care Quality Commission
Rubyni	Krishnan	Stop Smoking Facilitator/Specialist for Mental Health	Smokefree Ealing, West London Mental Health NHS Trust
Scaife	Deborah	Education Lead	NOMS YPE CT
Smith	Annemarie	Carer Representative	Hertfordshire Partnership UFT
Tanhara	Robson	Interim Operational Manager	T4 CAMHS, Deaf CAMHS. Perinatal, Neuropsychiatry and PTSD, Springfield University Hospital, London
Thompson	Peter	Senior Programme Manager	Royal College of Psychiatrists, London
Wadsworth	Lee	Acting Modern Matron (CAMHS)	South London and Maudsley NHS Foundation Trust
Yates	Mary	Nurse Consultant	South London and Maudsley NHS Foundation Trust

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