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FEATURE ARTICLE

Transition to a smoke-free culture within mental health and drug and alcohol services: A survey of key stakeholders

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ABSTRACT: *Tobacco smoking is common among people with mental illnesses, and they carry a higher burden of smoking-related illnesses. Despite this, smoke-free policies and systems for supporting cessation have proved difficult to introduce in mental health and drug and alcohol services (MHDAS). This paper examines the barriers to becoming smoke free within New Zealand services. Key informants, including staff, smoke-free coordinators, and cessation specialists were interviewed. Of the 142 invited informants 61 agreed (42%) to participate in a telephone interview, and 56 provided useable data. Organizations had a permissive or transitioning smoking culture, or were smoke free, defined by smoke-free environments, smoke-free-promoting attitudes and behaviours of management and staff, and cessation support. Most organizations were on a continuum between permissive and transitional cultures. Only eight services had a fully smoke-free culture. MHDAS face many challenges in the transition to a smoke-free culture. They are not helped by exemptions in smoke-free policies for mental health services, staff smoking, negative staff attitudes to becoming smoke free, poor knowledge of nicotine dependence, smoking-related harm and comorbidities, and poor knowledge and skills regarding cessation-support options. Health inequalities will continue across both service and socio-economic divides without a concerted effort to address smoking.*

KEY WORDS: *mental health and drug and alcohol service, smoke free, smoking cessation, tobacco use.*

INTRODUCTION

Tobacco smoking is a major contributor to poor health outcomes and has a significant impact on morbidity and mortality in active smokers and in others exposed to environmental tobacco smoke (Ajwani *et al*. 2003; Blakely & Wilson 2005). In 2012, 18% of New Zealanders were current smokers; 41% of Māori (indigenous New Zealanders) and 26% of Pacific people (Ministry of Health 2012) Smoking is very common among people who use mental health and drug and alcohol services (MHDAS; hereafter referred to as 'service users'). In the UK, smoking prevalence among people with a long-standing mental illness is 37% compared to 20% of the general population (Action on Smoking and Health (UK) 2013), and studies in the USA reveal that smoking prevalence among patients in mental health is as high as 70% (U.S. Centers for Disease

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Control and Prevention 2013). In New Zealand (NZ), smoking prevalence has reached 73% among users of drug and alcohol outpatient clinics (Adamson *et al*. 2006) and 96.1% among those receiving methadone-maintenance treatment (Deering *et al*. 2004). Te Rau Hinengaro, a NZ mental health survey, reported that people with any mental illness had a higher prevalence of cardiovascular disease and respiratory conditions compared to the general population (5.8%) (Oakley Browne *et al*. 2006). Cardiovascular and respiratory diseases are well known to occur at greater rates among smokers than non-smokers (U.S. Department of Health and Human Services 2004; World Health Organization 2002). Smoking is also linked to poverty, and poverty to mental illness. Smoking prevalence is three times higher in the most deprived areas than in the least deprived for both men and women after adjusting for age (Ministry of Health 2010). Users of mental health services (MHS) commonly live in the most deprived areas, and have mortality rates that are at 2.5–4.3 times the rate of the general population (Mental Health Commission 2004).

Nicotine is a highly-addictive substance (Bevins & Caggiula 2008; Casella *et al*. 2010), and the link between higher nicotine dependence and mental illnesses is well known. Approximately 33% of all cigarettes in NZ are consumed by people with mental illnesses that are at least 12 months in duration (males, 27%; females, 39%) (Tobias *et al*. 2008).

The last decade has seen several countries, including NZ, legislating smoke-free workplace and public place policies. However, in NZ, the legislation allowed an exemption, whereby those working in MHDAS were not required to implement smoke-free policies. Currently, 15 of 20 district health boards (DHB) (government-owned regional health funding and provider organizations) have smoke-free policies that include MHS (H. Button, pers. comm., 2013; Canterbury DHB 2009; Hawke's Bay DHB 2011; Wairarapa DHB 2013). Two DHB, which initially included smoke-free policies for MHS, have now rescinded those policies.

Smoke-free environments

There is little legal support for the continued use of tobacco in a supervised treatment setting that is publicly funded. MHS users deserve the same protection from tobacco exposure that benefits the rest of the public (National Institute of Health 2009). In NZ, the Smoke-free Environments Act (SFEA) 1990 and its amendments instigated a progressive move towards smoke-free environments. Despite this, some DHB MHS continue to have designated outside areas where users can smoke (C. Billington, pers. comm., 2011), while institutional smoking bans prevent staff from smoking in or near the buildings. Yet studies indicate that total or partial smoking bans in MHS have had no significant adverse effects on either unrest or adherence (El-Guebaly *et al*. 2002).

Smoking within MHDAS

Smoking within MHS affects both users and staff. Te Rau Hinengaro found a higher prevalence of current smoking in people with any mental illness (32%; non-institutionalized) compared with people without mental illness (21%) (McRobbie *et al*. 2008; Ministry of Health 2006). Among health-care workers, the highest smoking prevalence is among psychiatric nurses (26% male and 30% female nurses), according to the 2006 census, exceeding all other nursing groups, and this is above the general population rate at the time of 23.7% (Edwards *et al*. 2008). According to Lawn and Pols (2005), staff who smoke are more likely to encourage or tolerate smoking by those they care for. Smoking cessation programmes for staff are gradually being recognized as a key component in reaching smoke-free status.

Cessation has been shown to improve mental and physical health in the short and long term (McNeill 2001; West & Hajek 1997), so any intensive cessation interventions providing multisession support and medication would appear to be beneficial to service users. Psychiatric nurses can deliver effective cessation support if supported to do so by their institution (Lawn & Condon 2006). However, service users who smoke typically display a high dependence on tobacco, find it very difficult to quit, and have not often been advised to do so despite significant benefit to their health. Recent work suggests service users can quit if offered effective cessation support (Prochaska 2010; Ratschen *et al*. 2010). Drug and alcohol services are more likely to deal with the perceived primary addiction, neglecting the long-term impact of smoking. This is often deemed a lower priority than other substance misuse, given that mental functioning is not impaired alongside the known sedative qualities of nicotine (Brown 2004).

Key reports on mental health in NZ largely overlook smoking (Ministry of Health 2005). Yet nicotine dependence is an important but neglected addiction among psychiatric patients (Ratschen *et al*. 2010; Sellman 2005), inferring that a specialist workforce might be required given the widespread 'clinical neglect' of nicotine dependence in psychiatry. However, no case has yet been made for specific cessation services for service users (Oakley Browne *et al*. 2006).

The treatment of multiple addictions (including nicotine) involves an understanding of how cessation affects widely-used psychoactive medications and the distinction

between nicotine withdrawal and symptoms of mental illness (Hughes 2006). This complicates diagnosis, medication prescribing, and symptom observation (Mental Health Commission 2004).

Key barriers to the provision of cessation to service users include smoking and socialization, smoking as a stress relief, and cigarettes as currency. Ironically, smoking initiation is associated with contact with MHS (Department of Health 2005/2006; Mental Health Commission 2004).

The present study into the smoke-free status of MHDAS was undertaken by a consortium of cessation experts led by the Clinical Trials Research Unit, University of Auckland (Auckland, NZ), with guidance from a mental health advisory group established by the consortium. The aim was to identify and examine perceived barriers in the transition to smoke-free status in NZ, and to review current staff attitudes to providing support for service users to quit smoking.

METHODS

We surveyed key informants, including managers and workers in mental health and drug and alcohol services and smoke-free coordinators and cessation providers within DHB. A total of 142 potential informants were identified by compiling lists of DHB workers, and were invited by email or telephone to participate in a semi-structured face-to-face or telephone interview. Interviews were conducted during October–December 2006, and took 20 min on average. The interview schedule was developed in consultation with the mental health advisory group to cover demographics, perceived smoking prevalence among staff and users of the MHDAS, protocols for nicotine dependence management and cessation, and the provision of nicotine-replacement therapy (NRT). The interview process and questions were piloted with three smoke-free coordinators and one cessation DHB specialist to ensure validity; that is, that the participants would comprehend the intended meaning of the questions.

Ethics approval was obtained from the University of Auckland Human Participant Ethics Committee in May 2009.

Data analysis

Responses were entered directly into an Excel spreadsheet in an abridged format. The text in each column formed a category provided by the questions. A general inductive approach was used to analyse the data (Pope *et al*. 2000; Thomas 2006) into key themes; this allowed new or unexpected categories to arise from the data. The data were then summarized as text.

RESULTS

Sixty-one (42%) key informants agreed to participate, but data from five respondents were excluded, as they were unable to provide detail on policies, protocols, systems, and cessation treatment in MHDAS, resulting in a final number of 56 participants. Most of the respondents worked for DHB (Table 1) in a variety of services, including smoke-free units. These services involved hospital, residential, rehabilitation, and community-based staff. Some respondents were from non-governmental organizations, including from some specialist Māori and Pacific MHDAS.

We identified three categories of organizations according to their progress towards a smoke-free culture (Fig. 1) based on three indicators: (i) smoke-free environments; (ii) smoke-free-promoting attitudes and behaviours of management and staff; and (iii) cessation support for staff and service users. However, the 56 participating MHDAS could not easily be categorized into these distinct categories, as some fit in different categories for different criteria. Most fell between a permissive and transitional smoking-to-smoke-free culture. Only eight were able to be categorized as having a smoke-free culture. However, there was a sense that the smoke-free coordinators and smoking cessation advisers in the DHB were gaining some momentum in their services. Many of the respondents interviewed were interested in their services moving towards smoke-free status, but could not envisage how that could happen.

Permissive smoking cultures are characterized by a lack of support from management and staff for smoke-free changes or the provision of cessation support to staff and

TABLE 1: *Respondents by category*

Types of respondents	Respondents interviewed (*n*)
Smoke-free co-ordinators	15
Cessation specialists	6 (–2)
Community health workers	2
Managers	15
Team leaders	7
Counsellors	8
Nurses	3
Total	56

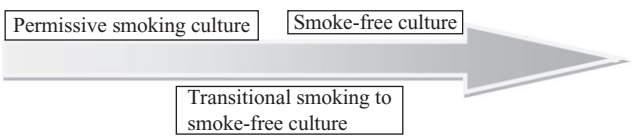

FIG. 1: *Smoke-free progression scale.*

service users, lack of or ambiguous implementation of smoke-free areas, high smoking prevalence among staff or critical leaders and clients, poor acceptance of smoking as problematic, and scepticism about the provision of cessation support for service users. Permissive smoking cultures permit smoking by service users and staff on the premises, if not indoors, with exemption under the SFEA (1990) cited as a reason for having a dedicated smoking room for patients. The majority of inpatient MHDAS allowed smoking in designated areas, such as on external verandas, gazebos, and in semi-enclosed areas. Some have distinct policies for service users and for staff; for example, even where there are designated smoking areas for the users, staff are generally required to smoke offsite. Some respondents stated that service users had 'ready access to a ventilated smoking room' and they 'can still smoke at the detox unit, which doesn't encourage quitting'.

An organization with a transitional smoking-to-smoke-free culture is characterized by there being some support towards a 100% smoke-free policy. They also provide cessation support for service users.

Smoke-free environments

Allowing smoking on the premises and even indoors was seen to discourage cessation, respondents reported that DHB 'still allow smoking (in MHS), so it is not a total ban' and 'it does appear a little inconsistent' when it is not allowed elsewhere. One respondent said that 'patients go in (to MHS) as non-smokers and come out as smokers'.

Psychiatrists were identified as not being helpful in implementing smoke-free policies, with one respondent complaining that the 'psychiatrist says they (service users) cannot be forced to stop', and another that the 'psychiatrist overrode management and allowed an exemption (to the smoke-free policy) in the day rehab area'.

Where an organization had implemented a smoke-free policy, a real challenge was identified as to whether staff could 'look at themselves (as needing to make change)'. Some respondents felt that staff were the 'worst offenders of the lot'. They believed that staff who still smoke inadvertently impeded patients wishing to become non-smokers, and that 'high rates of staff who smoke is modelling' smoking to service users. There was a perception that staff who smoked were more likely to take patients out to smoke more often. One respondent said that staff 'relax their professional role and have a smoke with clients', and they believed that staff were smoking with clients in their homes. The high proportion of staff who smoked and tolerated smoking inside was seen as a barrier to moving towards a smoke-free cessation-promoting service.

Attitudes and behaviours of management and staff

A number of staff beliefs and practices supported a 'culture of smoking', with 'smoking as the norm'. Respondents reported that some staff thought that smoking is a necessary part of treatment; for instance, for relieving stress. Respondents talked about service users using cigarettes to 'self-medicate' and 'soothe themselves'. Another respondent said if 'tobacco use is going up while cannabis use is going down, so be it'. Some respondents believed that smoking enabled positive social experiences, which helped staff develop rapport with service users. As one respondent said, staff were worried that they would not be able to 'go out for a smoke with clients to create dialogue'. In contrast, disallowing smoking onsite was believed to lead to 'difficulty managing MHS users', and some respondents were afraid that people might stop using the service if they could not smoke there. Some respondents thought that smoking was a 'clients' rights issue', especially if they were residents, which meant that the service was their home. Disallowing smoking was then seen as a 'type of discrimination, taking rights off them'. Some respondents backed up their stance against becoming smoke free and cessation by reference to the Mental Health Commission view that cessation treatment should not be offered when the mental illness is very active and acute, and when it is considered unreasonable for inpatient units to provide any form of cessation treatment in the early stages of a person's admission. For example, a respondent perceived that in MHDAS, it was widely believed that service users 'can't quit when acutely ill' and that 'there is passive acceptance (that service users smoke)'.

Far from encouraging cessation, some staff enabled smoking by 'offering cigarettes' with 'nurses who purchase cigarettes (for the service users), even out of their own money at times'. One respondent reported that staff had to light cigarettes for service users, who were not permitted to carry a cigarette lighter. In this case, staff were said to leave doors open to enable them to come inside to light cigarettes. Staff gave 'cigarettes as incentives' or they used 'smoking as a reward' as a way to 'manage' or 'pacify' service users as part of a reward system that 'contained elements of coercion'. Some staff who smoked were reportedly actively resisting changes, such as being unwilling to be trained in cessation.

Leadership

Management attitudes towards cessation were believed to be critical to the success of a transition to a smoke-free culture: 'Attitudes of senior staff can either help or hinder

smoking cessation among consumers and staff. If the manager is not interested, it hinders, if interested it helps'.

Some respondents reported that smoke-free changes and cessation support was being led at a senior management level. Respondents cited as important the support of the financial manager, the board, and the chief executive officer (CEO), who was seen to be able to influence the board: 'We have a good Board who support anything we want to do'.

Some respondents were unsure if their leaders were really committed. They relayed that reservations had been expressed about whether becoming smoke free was the 'right way to go', with staff reported to 'have issues around personal rights and control'. Another respondent could only think of one clinical team leader who had 'some interest' in the issue, but 'time and staff factors may be issues for greater involvement'. Another was unsure about the support she could expect from her CEO, who was 'very averse to publicity' and 'won't say "get rid of smoking rooms" '. She then went on to say that the current policy was 'half- pie' and 'doesn't feel right'. Whether leaders smoked themselves was seen to reduce the level of support they gave for progressing to a smoke-free culture. One respondent cited as a major weakness that their psychiatrist smokes onsite, and the smoke-free policy is not enforced in this case.

Many respondents were uncertain about their 'rights' as staff to assert control over service users' smoking. They expressed confusion over what is included in the Mental Health Act regarding smoking. Respondents were also not sure whether the Act included 'telling people not to smoke in inpatient units' or within their own homes. This was reinforced by service users' perceptions that the smoke-free policy is an imposition on their rights. Enforcing the smoke-free policy outside was problematic for staff, as service users 'continually breach' the policy by 'standing outside the buildings smoking'. Staff felt inadequate and said they needed encouragement and training in how to enforce the policy. One respondent did not want to be perceived as 'the smoking police', a view that was shared by others, who said that enforcing the policy was not part of their job description.

For respondents in MHDAS yet to move from a permissive smoking culture, there was a reported lack of support and direction from management for the possibility of inpatient services becoming smoke free. One respondent perceived their clinical practice manager (middle manager) to be unprepared to delegate, there was no leadership from the board, and 'nothing in the community'. Staff resistance to change led one respondent to suggest that staff were 'potentially as institutionalized as the patients' and contributing to the 'reluctance to have cessation services in inpatient services'. Another argued that written warnings should be given, and that a promotion of services be made available to all staff to quit smoking. Some reported that 'high-level staff were not committed' to promoting cessation to service users, and that there was a lack of 'buy-in from staff and clients'.

Cessation support for staff and patients

Twenty-six respondents reported that systems were in place for identifying or recording smoking status, and 17 of those respondents reported referring service users who smoke to cessation services. Despite all DHB having cessation services available, only five respondents (four from DHB) reported routinely providing service users with cessation support from within the organization. Six services provided no cessation support at all for smokers, nor referred them to cessation services. The remaining 32 services provided a range of 'ad-hoc' advice and cessation support to smokers, but it was generally dependent on them requesting help or because a motivated staff member was supportive. In many cases, there was no easy access to cessation support for staff. A number of reasons were given for why some services had no cessation for staff. According to one respondent, it had not 'been thought about in any great depth'; there was a 'lack of information and knowledge about the harm caused by smoking including health inequalities' and 'the consequences of exposure to second-hand smoke'. Smoking was thus seen as a 'personal choice' for service users.

Lack of knowledge on cessation

Some staff were reported to be resistant to the addition of providing cessation support, as they had 'enough problems without dealing with smoking'. Helping service users to quit smoking was 'too hard', 'staff find it too easy to give up on mental health consumers', and there was a fear of patients becoming violent. Some service providers believed that service users under the age of 18 years would not be able to access patches, and the belief that users of these services could not or should not quit hindered cessation. One respondent suggested that there was a 'total lack of knowledge' about the importance of, or the need for, service users to stop smoking.

Respondents commented that many staff 'don't want to have to deal with two drugs at a time', and one MHS respondent spoke of patients with psychoses who were already 'overweight', 'vulnerable', and 'marginalized', making it difficult to address their smoking. Furthermore,

an 'unwillingness to place nicotine addiction high enough to warrant the same attention as other addictions' led to a 'low need to quit'.

In drug and alcohol services, smoking had become a 'way of managing withdrawal for clients, as well as reducing stress levels'. As one informant commented, the prospect of giving up drugs long term could cause smokers 'to panic'. Asking a service user in this state of apprehension to consider quitting smoking might cause them to 'leave the service', so it 'has to be well timed'.

Several respondents said cessation was not a priority. Others argued that cessation needed 'to be lifted up on our priority list'. They felt they needed more support to help service users quit smoking, as 'smoking drops down the list', and suggested that lack of progress in cessation was due to multiple changes going on in the organization, and that this systemic intractability was historical. Several commented that poor cessation support existed because their organization was not funded for it, but they would be more active in cessation if it was supported financially. One respondent did not know how much or even whether or not the DHB had any funding to provide cessation support for service users, and had to assume that they did not, as they had no staff providing cessation support. Another respondent believed their DHB acknowledged the need for cessation services for service users, but was unwilling to finance it. Some drug and alcohol services felt prohibited from providing cessation support, as they believed that they were only resourced for alcohol and drugs.

Nicotine dependence

Staff recognition of nicotine addiction as a problem that needed addressing varied. In general, staff focused on other addictions, citing service users' primary addiction within drug and alcohol services. Respondents also perceived there to be widespread misinformation about the toxicity of nicotine, the role of NRT, the effect of nicotine on medications, and how to use NRT. One respondent saw it as problematic that service users were smoking concurrently with NRT. Another respondent reported that one group of service users 'thought that if they were well enough not to smoke, they didn't need medications either'. Some respondents reported that there was an 'unwillingness to recognize the power of nicotine addiction'.

Smoking and co-existing problems

Co-existing disorders were a frequently-cited barrier in offering cessation services to service users. Respondents believed that a high proportion of service users had 'social stresses' and 'conflicts' and service users themselves were seen to not have the necessary expertise to quit smoking. Respondents from within MHDAS, and cessation providers from DHB, thought that generic cessation services were limited in their ability to effectively support cessation among service users due to insufficient understanding of the illnesses and conditions that they suffer from. Some members who had used Quitline felt discouraged because no clinical support was provided, while others believed that cessation could lead to problems in stabilizing medication. One suggested that service users with bipolar disorder 'end up quite manic when trying to quit', and that supporting cessation could be 'very intense', resulting in increased demands on service time and resources.

Infrastructure

The capacity to provide cessation support was perceived to be limited by exclusion of the requirement to possess the skill or deliver support in employee job descriptions. One respondent doubted that staff had the time to add cessation support on to their existing workload, and staff were perceived to lack the expertise required.

Another suggested that it was not seen as an issue, because 'smoking becomes invisible when people go offsite (to smoke)'. Distance to cessation services was perceived as a barrier, with one respondent stating that the only cessation service was 'out of the way'. Some reported that they had nowhere to refer clients to, and others were unsure if smoking cessation services were easy to access or not.

There was some recognition that MHDAS should be asking about smoking and referring service users to cessation services, but a perception prevailed that MHDAS had poor systems in place for supporting cessation. This was demonstrated by a failure to enquire about a service user's smoking status: 'some patients are not being asked about smoking'.

Some MHDAS had access to cessation services that have since been discontinued. One lost momentum when their smoking cessation coordinator resigned and was not replaced. Some services were in the process of developing their capacity to provide cessation support; therefore, the availability of the support had not been promoted in MHS, nor was it promoted at all for either staff or service users.

Positive attitudes by staff and their recommendations for change

Several respondents suggested that a stronger commitment, as in 'more noise' from the Ministry of Health and

key decision makers, and 'organizational support from management', was needed to achieve a 'clear and robust smoke-free policy'. Respondents made a number of suggestions about how to nudge services along the transition to becoming smoke free. One organization was willing to make changes to align themselves with the smoke-free policies of adjacent organizations, such as a smoke-free marae: 'the will is there . . . have made a conscious decision around image, because we are opposite a smoke-free marae and another Māori organization that is smoke free'.

Other respondents said there was some management support for becoming smoke free and for staff pursuing training in cessation, as well as improving service user accessibility to cessation services. One suggestion was that cessation 'needs a champion'; someone at a senior management level to make a commitment to it. Another respondent believed that they needed a trained cessation person to take on the role and to facilitate the change. Some MHDAS would be large enough to justify a full-time community-based person or resource coordinator who links staff and service users to services. Systems should also be in place for identifying smokers. As one respondent said: 'we shouldn't wait for patients to ask'.

There were several examples of progressive organizations, one of which encouraged staff and service users to contact Quitline and promoted general practitioner assistance to quit free of charge.

Others highlighted the need for education, such as 'reducing staff fear by establishing competence around dealing with nicotine addiction', 'clarifying that nicotine does not impact on "meds" that the smoke does', and 'educational and motivational practices needed to reduce use of cigarettes'. There were also suggestions to make smoking areas less appealing through 'designated smoking areas to smoke not to socialize', and if the smoking area was 'moved further away it would make it easier for people to quit'.

Some felt MHDAS had a 'culture that accepts' smoking, and they suggested that written warnings should be given for staff non-compliance, as well as the promotion of services available to staff for cessation. Other recommendations for change included addressing staff need for information, and better clinical skills to deal with incidents. Respondents also cited 'upskilling to get capability', the 'need for a cessation person/specialist', and 'access to all types of NRT'.

DISCUSSION

The present study highlights a range of challenges facing MHDAS in the transition to a smoke-free culture. Three stages of transition were identified, ranging from a permissive smoking culture, which is how all MHDAS used to be, to a transitioning culture, heading towards a smoke-free culture. There are three measures against which services can be compared: (i) smoke-free status; (ii) management and staff attitudes; and (iii) provision of cessation support.

The barriers identified in this study replicate similar findings reported in other countries, and can be described as policy that exempts MHS, poorly-written or poorly-enforced policy, staff smoking (Poland *et al*. 2006), negative staff attitudes to becoming smoke free, poor knowledge of nicotine dependence and smoking-related harm, and poor knowledge and skills regarding cessation options.

MHDAS have a key role in changing the smoking culture of staff and service users, and providing staff supervision of service users who smoke (Jochelson & Majrowski 2006). The concerns that management might have include fear of aggression, effects on drug therapy, changes in social activity, and managing nicotine withdrawal at a time of stress (Wareing 2006). Some comments suggested that many staff are resistant to smoke-free changes. This study suggests that having a transparent and robust smoke-free policy is needed alongside a visible commitment from senior management. There needs to be dialogue with key stakeholders and senior management to reinforce smoke-free policies across MHDAS, and experts who can adequately train staff in smoking and smoking cessation-related issues.

MHDAS need to support smoke-free environments to reduce the adverse effects of tobacco smoke on staff, service users, and visitors alike. While the MHDAS community is in part changing their view on implementing smoke-free status, the findings of our study suggest that staff attitudes need to be challenged, and key health professionals should be better supported to provide assistance to smokers to quit or referring them to existing cessation services, particularly in DHB where such services now exist. All staff and clients should take ownership of the process. A concerted effort by organizations and management is required to meet their need for information, skills, and funding for a transition to a smoke-free culture.

Limitations

This study was qualitative and collected information and perceptions about services from service staff who were willing to participate. The full range of potential key informants was not surveyed, and data saturation was not achieved. Therefore, the findings do not represent the

comprehensive range of facilitators and barriers to MHDAS progression to becoming smoke free. For example, no service user views were sought. Surveying service users would be an important next step, as their well-being forms the core of these findings.

Further research

Future research could develop and validate the scale proposed here for measuring MHDAS progression to a smoke-free culture. Evaluations could then simply be performed by services still to progress, to identify barriers, and plan steps for change. Further qualitative work is needed to identify effective change management for MHDAS staff who smoke. Service users' experiences and views need to also be determined and considered.

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