

Perspectives on smoking cessation for people with severe and enduring  
mental health and substance misuse: A qualitative investigation

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### **Thesis Portfolio Abstract**

**Context:** Smoking is the largest avoidable cause of death in the UK. Although smoking rates are decreasing among the general population, people with mental health difficulties and substance misuse continue to smoke at a considerably higher rate.

**Aim:** The aim of this thesis portfolio is to contribute to a greater understanding of the perspectives of people with mental health difficulties and substance addictions about smoking and smoking cessation. It also aims to provide insight into how healthcare providers can better support this vulnerable group of people to stop smoking.

**Design:** This thesis is presented in a portfolio format. It includes: a brief introduction, systematic review, bridging chapter, empirical paper, extended methodology chapter and an overall discussion and critical evaluation. The systematic review synthesises qualitative literature investigating the views of staff and service users about smoke-free mental health inpatient units. The empirical paper uses a grounded theory approach to explore the process of smoking cessation for people with dual-diagnosis.

**Findings:** The systematic review identified five themes relating to the barriers and facilitators to the implementation of smoke-free policies: ward culture, resources, attitudes, smoking cessation and policy strategy. The findings from the empirical paper suggest that intrapersonal factors, such as motivation and ability, play a significant role in the process of smoking cessation. The results emphasise the layers of interpersonal, social and system factors that influence individual behaviour change.

**Conclusions:** Findings of this portfolio are presented tentatively, as further research is required. However, the results have clinical implications for healthcare providers and for the development of appropriate smoking cessation interventions for people with mental health and addictions.

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## **Chapter 1: Introduction to the Portfolio**

The World Health Organisation estimates that tobacco smoking results in approximately 7 million deaths per year worldwide (WHO, 2018). In the UK, it is estimated that nearly 100,000 people die each year from tobacco related causes, including cancer, respiratory diseases and heart disease (ASH, 2015). Smoking is the largest avoidable cause of death in the UK (WHO, 2018) and yet rates of smoking among people with substance use and mental health difficulties are estimated to be four times that of the general population (Aubin, Rollema, Svensson & Winterer, 2012). Not only are there significant risks of smoking to the health and wellbeing of the individual and those around them (Doll & Hill, 1950; Centres for Disease Control & Prevention, 2006) but smoking also leads to considerable financial costs for the smoker and for healthcare services (Public Health England, 2017). A recent report by the Royal College of Physicians (2018) has emphasised that preventing smoking should be the highest priority for health services, but it identifies that currently the management of smoking in secondary care settings is significantly lacking.

Tackling and preventing smoking among vulnerable populations, including those with mental health difficulties and addictions, has been highlighted as a priority for the UK National Health Service (NHS) for the coming years (NHS Long Term Plan, 2019). In line with this, NHS England recommended that all mental health inpatient services should be smoke-free by the end of 2018 (Public Health England, 2016). This means that inpatient services should no longer permit smoking either inside hospital buildings, or on hospital grounds (National Institute for Health and Clinical Excellence, NICE; 2013).

Smoke-free policies are one method that the Government has employed to manage smoking for people with mental health difficulties. The systematic review in the following chapter presents a synthesis of qualitative research that investigates the views and experiences of staff and patients on inpatient wards which have implemented smoke-free policies. The aim is to understand the barriers and facilitators to the successful implementation of such policies. In order to change a health behaviour, such as smoking, and encourage support for the implementation of a smoke-free policy, a clear understanding of staff and patient perceptions and experiences of such a policy is crucial.

Although the implementation of smoke-free policies in mental health inpatient services offers an important opportunity to support a group at considerable risk of developing smoking-related illnesses to cut down or stop smoking, many people with substance misuse and mental health difficulties do not get admitted to inpatient services. Estimates suggest that 96% of people with mental health difficulties are never admitted to such services (Health and Social Care Information Centre, 2018). Therefore, it is important to also understand the challenges for people with mental health difficulties in the community who are trying to stop smoking. This is the aim of the empirical paper in Chapter 4. The empirical paper offers a qualitative exploration of the process of smoking cessation for people with severe and enduring mental health and comorbid addictions. The study reported aimed to understand the unique barriers to smoking cessation that this group face.

Overall, this portfolio aims to contribute to a greater understanding of the experiences and perspectives of people with mental health difficulties and substance misuse about smoking and smoking cessation, and to provide insight into how

healthcare providers can better support this vulnerable group of people in clinical practice.

### **Outline of the Portfolio**

This thesis was completed as part of the lead researcher's degree of Doctor of Clinical Psychology. This portfolio consists of two main papers: a systematic review and an empirical paper. There is also a bridging chapter to link the two main papers and an extended methodology chapter to give greater depth and rationale for the chosen methodology. The final chapter discusses the conclusions of the portfolio as a whole and considers implications for clinical practice and future research.

## **Chapter 2: Systematic Review**

Views of patients and staff towards smoke-free grounds policies in psychiatric  
inpatient services: a qualitative systematic review

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**Views of patients and staff towards smoke-free grounds policies in psychiatric  
inpatient services: a qualitative systematic review**

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## **Views of patients and staff towards smoke-free grounds policies in psychiatric inpatient services: a qualitative systematic review**

### **Abstract**

This review summarises qualitative data on the barriers and facilitators to the introduction of smoke-free grounds policies (SFGP) in inpatient mental health services and the perceived impact of such policies from the perspective of staff and patients. Five databases were searched for peer-reviewed articles. 2810 articles were screened and 282 of these underwent a full-text review. Thirteen studies were identified and quality assessed using the Critical Appraisal Skills Programme (CASP) checklist. Three themes were identified relating to the impact of SFGP (wellbeing, clinical practice, ward atmosphere) and five themes were related to the barriers and facilitators to SFGP implementation (ward culture, resources, attitudes, smoking cessation and policy strategy). Overall, staff and patients generally held negative views about the introduction of SFGP in inpatient settings and many more barriers were identified to their introduction than facilitators. This review has clinical implications for inpatient services implementing SFGP, but further research is still needed.

### **Keywords**

Smoke-free policy; mental health; smoking cessation; health policy; thematic analysis; systematic review; qualitative research

## **Introduction**

Smoke-free policies offer an important opportunity to influence the physical health and health related behaviour of the public. The Health Act (2006) outlined that all enclosed public and workplaces in England should be smoke-free from July 2007. The general public has benefitted from these changes and the rates of smoking reflect this. Smoking prevalence among the general population has continued to decline from year to year. Current estimates suggest that in the UK 15% of people smoke (Office for National Statistics, 2018). However, these patterns are not replicated among people with mental health disorders. Estimates suggest that rates of smoking among people with mental health difficulties are about three to four times higher than the general population, with a tendency towards heavier smoking and lower rates of cessation (Aubin, Rollema, Svensson & Winterer, 2012).

In the UK there has been a public health drive to positively impact smoking cessation in the general population, but this emphasis on smoking cessation does not seem to be reflected in the continued prevalence of smoking among individuals with mental health problems. In fact, the difference in smoking prevalence among the general population compared to those with mental health difficulties has continued to increase (Le Cook et al. 2014). This is just one of a number of widening inequalities between those with and those without mental health difficulties.

People with mental health difficulties experience multiple layers of deprivation and inequality, compounding the negative impact of smoking in this group (Lawn & Campion, 2013). Even without taking into account the added health risk of smoking, people with psychiatric diagnoses have considerably poorer physical health than the general population, including higher rates of cardiovascular disease and certain cancers (Pack, 2009; Ratschen, Britton & McNeil, 2011). These pre-existing risk

factors, combined with high prevalence of smoking, contribute to people with severe mental health illnesses dying 15-20 years earlier than the general population (Mental Health Taskforce NHS England, 2016). Similarly, many people with enduring mental health difficulties are in financially challenging positions and this is only increased by their tobacco dependence. Estimates suggest that smokers with schizophrenia spend almost 30% of their monthly income on tobacco (Steinberg, Williams & Ziedonis, 2004). Not only are there financial and health-related costs to the individual of smoking but the costs to healthcare providers are also significant. Estimates suggest that smoking-attributable illnesses among people with mental health disorders in the UK cost the National Health Service (NHS) £719 million in 2009–2010 (Royal College of Physicians, 2018).

The relationship between mental health and tobacco smoking is complicated. A number of potential explanations have been suggested to explain the association: there may be a common causal factor for both smoking and poor mental health (Kendler et al., 1993); poor mental health may lead to increased smoking as a way of regulating difficult feelings (Khantzian, 1997); or smoking may cause or exacerbate poor mental health (Parrott, 1999). Although it is difficult to pick apart the relationship between smoking and mental health, what is clear is that this group need tailored, targeted smoking cessation interventions to help reduce the health inequalities they face. Healthcare providers have a responsibility to offer equality of care to everyone, they therefore have an obligation to integrate smoking cessation into mental health treatment in order to reduce smoking rates among this vulnerable group.

### **Smoking cessation and mental health**

There is little doubt about the benefit of smoking cessation for protecting individuals from the negative effects of smoking, and families, friends and carers from

second-hand smoke (National Institute for Health and Care Excellence; NICE, 2018). However, there has historically been resistance to addressing smoking in mental health settings. Dickens, Stubbs, Popham & Haw (2005) conducted a survey of staff in a psychiatric inpatient unit and found that 54% of staff felt that smoking had a therapeutic role and 93% thought that patients' mental health would deteriorate if they stopped smoking. Smoking has been described as a "cultural norm" in psychiatric settings (Crockford, Kerfoot & Currie, 2009). In these settings, tobacco is often seen as a commodity and currency by patients, and a method of changing or controlling behaviour for staff (Lawn & Condon, 2006).

Prochaska (2011) outlined five "myths" related to mental health that create barriers for smoking cessation in mental health settings. These myths are as follows: 1) smoking tobacco is used as self-medication; 2) people with mental health difficulties have no interest in stopping smoking; 3) people with mental health difficulties cannot quit; 4) smoking is a coping strategy, so to stop would interfere with recovery; 5) people with mental health difficulties do not consider smoking cessation a priority. Research evidence provides a counter-argument to these misconceptions. Research has indicated that the majority of people with mental health difficulties report that they would like to stop smoking (Hall & Prochaska, 2009). Although research suggests that people with mental health difficulties have higher rates of relapse (Perkins, Karelitz, Giedgowd, Conklin & Sayette, 2010) and take longer to reach cessation (Tsourtos et al., 2011), success is possible. Hall and Prochaska (2009) found that smoking cessation does not exacerbate mental health symptoms. Although, as is the case for smokers without mental health difficulties, tobacco withdrawal symptoms (e.g. irritability, anxiety and depression) can often mirror mental health symptoms (Hughes, 2007). Therefore, smoking may be misattributed as a benefit to mental health,

whereas, for an addicted smoker, smoking is actually temporarily relieving nicotine withdrawal symptoms (Twyman, Bonevski, Paul & Bryant, 2014).

### **Smoke-free policies in mental health settings**

In an attempt to address smoking cessation for people with mental health difficulties, NICE (2013) outlined that all buildings and grounds of acute mental health services in the UK should be smoke-free and NHS England recommended that all mental health in-patient units are smoke-free by the end of 2018 (Public Health England, 2016). This is in line with NHS England's priority to prevent and tackle areas of longstanding unmet health needs, such as smoking among mental health populations (NHS Long Term Plan, 2019).

Data indicate that over 49,000 people were compulsorily detained under the Mental Health Act 1983 in England in 2017/2018 (Health and Social Care Information Centre, 2018) however the number of people actually admitted is likely to be considerably higher than this once people who take voluntarily admission are also included. The implementation of smoke-free policies in mental health inpatient services therefore offers a unique opportunity to encourage people, from a group at considerable risk of developing smoking-related illnesses, to cut down or stop smoking. There is a clear policy drive suggesting that all inpatient settings should be implementing these policies (NHS Long Term Plan, 2019) and not intervening in these settings is a missed opportunity that would further serve to emphasise the health inequalities this group already face.

Among mental health professionals, there appears to be reluctance to implement smoke-free policies. It has been suggested that such policies raise concerns about patient welfare and civil liberties. In 2009 there was a legal challenge to a smoking ban within a secure mental health setting (*R(N) v SSH; (E) v Nottinghamshire*

Healthcare Trust, 2009) which claimed that the ban breached Article 8 of the European Convention on Human Rights (the right to respect for private and family life). This claim was rejected by the Court of Appeal because the secure unit was a public institution operating as a hospital, not just a patient's home, and the smoking ban was considered a justified breach of personal autonomy. Nevertheless, concerns about the human rights of patients in relation to smoking still remain, particularly among staff (Magor-Blatch & Rugendyke, 2016). Staff have also raised concerns about the potential for increased aggression or violent incidents as a result of a strict smoking ban, which would have an impact on the safety of the work environment for staff and living environment for other patients (Lawn & Campion, 2013).

Research carried out in Australia at a hospital with a smoke-free grounds policy found that the introduction of the policy led to a 44% reduction in staff smoking and a 37% reduction in visitor smoking but had no impact on the rates of inpatient smoking (Poder, Carroll, Wallace & Hua, 2012). It is vital to understand the factors that might be influencing whether the introduction of a smoke-free policy has an impact on smoking behaviour, so that steps can be taken to address any barriers to successful behaviour change. Ratschen et al. (2011) have suggested that staff attitudes are the main barrier to the successful implementation of a smoke-free policy. Further research has suggested that staff smoking leads to more permissive attitudes towards patient smoking and reduced support for the implementation of smoking cessation interventions (McNally et al., 2006). Health behaviour models have highlighted the importance of attitudes as an antecedent of behaviour. For example, the Theory of Planned Behaviour hypothesizes that attitudes combined with subjective norm and perceived behavioural control, have an impact on behaviour through their influence on intentions (Ajzen, 1991). So, in order to change a behaviour, and encourage support

for the implementation of a smoke-free policy, a clear understanding of staff and patient perceptions and experiences of such a policy is crucial.

A number of studies have investigated the attitudes of staff and patients towards going smoke-free in mental health inpatient settings, but there has been no attempt to systematically review the qualitative literature. For the purposes of this review, in line with NICE (2013) guidelines, the focus will be on “smoke-free grounds policies” (SFGP). This type of policy extends the smoke-free area from within health care buildings to also include all outside space owned by the health care provider (Public Health England, 2016). References made in the remainder of this paper to “smoke-free policy” refer to “smoke-free grounds policies” unless otherwise stated. This type of policy has been selected for the focus of this review to keep it relevant to the policies that are currently and soon to be implemented in health care settings. Although this is a policy that applies to the UK, it has also been trialled and implemented in other countries, such as Australia and Canada (Kunyk, Els, Predy, & Haase, 2007; Lawn & Champion, 2010).

This review aims to address research need and provide a context for interpreting and explaining the results of existing qualitative research that have explored the attitudes and experiences of staff and patients to going smoke-free, in the context of mental health inpatient services. A qualitative synthesis aims to go beyond localised, context specific studies and draw broad, transferable concepts from the data.

The protocol for this review was registered and published in PROSPERO (Marshall, Workman & Notley, 2018). The primary review question was:

- What are the views of service users and clinical staff about the implementation of SFGP in psychiatric inpatient services?

Supplementary questions were as follows:

- 1) What are the benefits and concerns for staff and patients about mental health in-patient services becoming smoke-free?
- 2) What do staff and patients perceive as the barriers and facilitators to the successful implementation of an SFGP in an inpatient setting?

## **Method**

### **Inclusion Criteria**

**Participants.** Adults accessing treatment from mental health inpatient services or forensic units ('service users') and professionals ('clinical staff') involved in providing treatment, were included in this review. Research from any country and of any age (from database inception) was included. Research undertaken with any other participant group (i.e. substance misuse populations, physical health patients, community mental health service users, adolescents) was excluded.

**Interventions.** Studies that investigated attitudes and experiences related to the implementation or potential implementation of a SFGP were included in this review, this could either be related to a pilot or permanent policy. SFGP is defined as: a policy that means that the hospital buildings and grounds are free from tobacco smoking for staff, patients and visitors (Health Act, 2006; NICE 2013). Research concerned with views related to indoor smoking bans only was not included.

**Outcomes.** Studies that reported on at least one of the following outcomes were included:

- Staff and service user views about a current or proposed SFGP

- Staff and service user perceptions about the barriers and facilitators to the introduction of SFGP in inpatient setting
- Staff and service user perceptions about impact of an SFGP on themselves and service provision generally
- Staff and service user experiences of the implementation of an SFGP

**Types of studies.** Qualitative studies with any method of qualitative data collection and analysis were included in this review. Qualitative data reported in mixed methods studies were included, if it was clear in the title and abstract that qualitative data was collected. Due to the scope of the study, only peer-reviewed studies published in English were included.

### **Search Strategy**

The Cochrane Collection was searched for prior registered reviews on this subject area. This search confirmed that there were no previous systematic reviews. A draft search strategy was developed in MEDLINE using a combination of MeSH and free text terms. Qualitative studies are often poorly indexed (Centre for Reviews and Dissemination, 2009) so study type was not specified in the search terms. The search strategy was measured against a sample of previously identified relevant papers that had been collected through unstructured searching. The finalised search strategy was adapted for other databases. The following databases were searched: MEDLINE (via EBESCOhost), PsychINFO (via EBESCOhost) Cumulative Index to Nursing and Allied Health Literature (CINAHL; via EBESCOhost), EMBASE (via OVID SP), and Scopus. The following search terms were used:

‘Smoke free’ OR ‘smoke free polic\*’ OR ‘smoking ban’ OR ‘nicotine management’ OR ‘tobacco free’ OR (MM “Smoke-Free Policy”)

AND

‘mental health’ OR ‘mental illness\*’ OR ‘mental disorder’ OR ‘psychiatr\*’  
OR ‘forensic’ OR ‘secure unit’ OR ‘inpatient\*’ OR (MM “Hospitals,  
Psychiatric”)

The searches included papers from database inception to March 2018. Reference lists of included studies and relevant systematic reviews were screened for references.

### **Study Selection**

Search results were merged across databases using Covidence and duplicates were removed. Titles and abstracts were screened and assessed for eligibility according to the inclusion criteria by the primary researcher. A random sample of 20% of the total number of extracted studies (after duplicates were removed) were screened by a second reviewer (PW). PW agreed with the decisions made for 98% of the papers screened. Uncertainties were discussed with a third member of the research team (CN). Full texts that met the inclusion criteria were screened by the primary researcher (LM).

### **Assessment of study quality**

The quality of the included studies was assessed using the Critical Appraisal Skills Programme Qualitative Research Checklist (CASP, 2013). CASP helps readers to identify whether the research and recruitment methods were appropriate, whether data were rigorously analysed and whether the findings are clear. A score was calculated for each included study, with a maximum of 10 points. One point was given if an item on the checklist was met, 0.5 if it was partially met and 0 if not met.

## **Data extraction**

Data were extracted using a data extraction sheet which had been piloted for a previous systematic review (Gentry, Craig, Holland & Notley, 2017). Data extracted included: aims, recruitment method, inclusion and exclusion criteria, participant characteristics, data collection method, analysis methods, study limitations and findings.

## **Qualitative Synthesis**

Thematic analysis was undertaken of the qualitative data reported in the included studies (Barnett-Page and Thomas, 2009). All relevant data were entered into NVivo version 11 (QSR International, Southport, UK) and were coded by LM. An inductive approach was used to establish an emergent coding scheme. First-level codes were used to summarise the meaning of the text. Coding identified data as quoted original data or author interpretation. First-level codes were then organised in to second-level descriptive themes. Third-level analytical themes were then developed to allow the researcher to interpret and draw analytical conclusions from the data (Thomas and Harden, 2008). By doing this, the analysis builds on and goes beyond the data that already exists to generate new findings. See Appendix (B) for diagrammatic representation of the synthesis process. The primary researcher met with another member of the research team (CN) to verify and agree analysis as an iterative process.

## **Ethical Considerations**

No ethical approvals were required as this was a systematic review of existing qualitative literature.

## Results

The electronic database search identified 2810 potentially relevant studies, once duplicates were removed. The screening process identified 13 studies. Table 1 details the included studies and their quality as measured by CASP. Figure 1 illustrates a PRISMA flow diagram (Moher, Liberati, Tetzlaff, & Altman, 2009) of the study selection process.

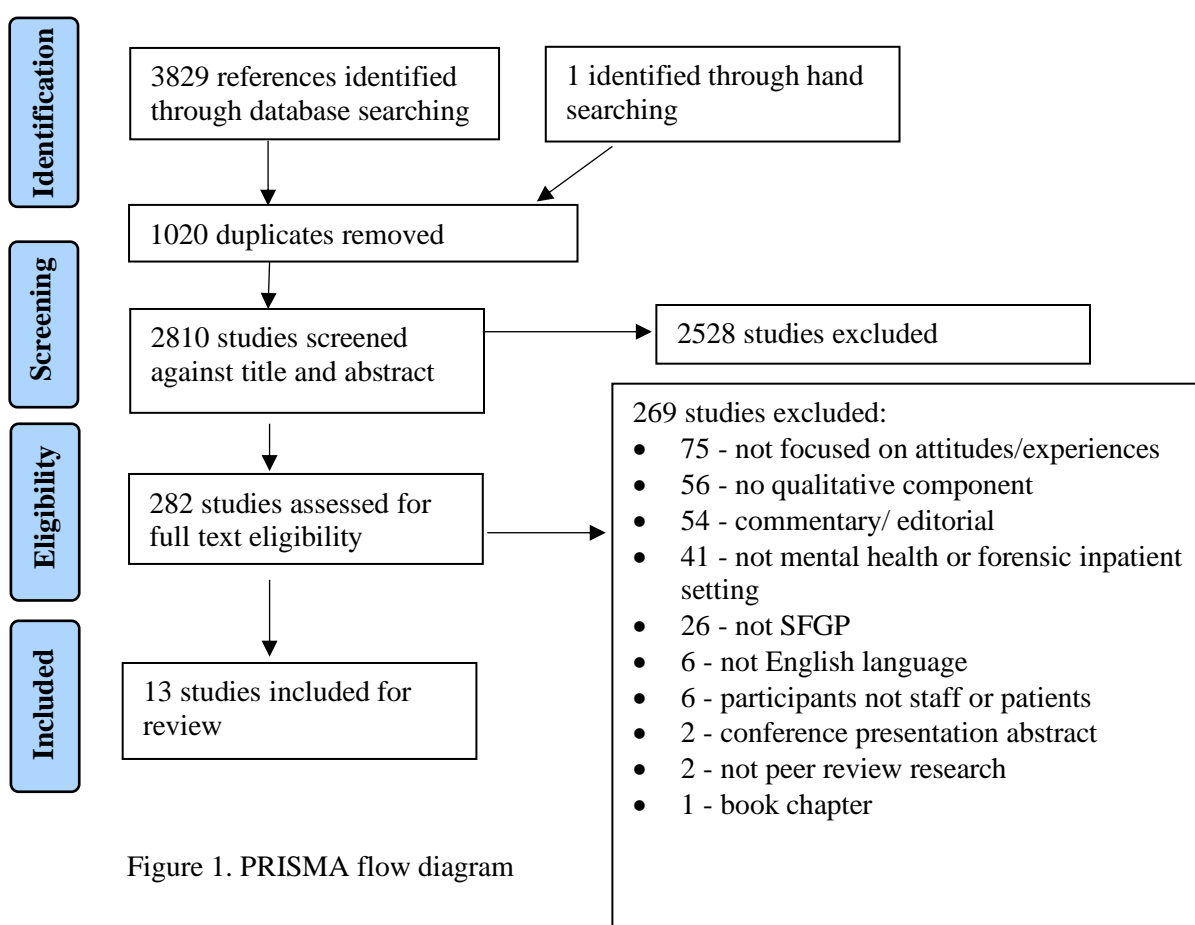


Figure 1. PRISMA flow diagram

Six of the included studies had only staff members as participants (Dean et al., 2018; Ratschen et al., 2009; Magor-Black & Rugendyke, 2016; Grant et al., 2014; Lawn et al., 2015; Glover et al., 2014), four included only service users (Filia et al., 2015; Huddleston et al., 2018; Calciu et al., 2017; Hehir et al., 2012) and three included both (Pritchard & McNeill, 2008; McAllister et al., 2016; Ratschen et al., 2010).

Table 1. Summary of included studies

Lead author, year, country	Aims	Study design	Analysis method	Participant description and demographics	Summarised findings and conclusions	CASP Rating  /10
Calciu et al. 2017  UK	To describe the implementation of a smoke-free policy in a recovery unit and to look at the associated challenges	Mixed method qualitative approach, using a survey with a semi-structured format and a focus group using World Café method	Thematic analysis	9 inpatients at the completed the survey. A further 14 participants attended the focus group (comprising of 6 in-patients and 8 members of staff). Participants ranged from 18-60 years old and included men and women.	<i>Concerns:</i> boredom, more anxiety and stress, not enough 1:1 time from staff, NRT not effective, other harmful habits replacing smoking, threat to human rights, having enough staff and resources, knowledge about NRT, risk of increased violence. <i>Benefits:</i> physical health, patients finding healthier ways to use time, improved hygiene and environment	6
Dean et al. (2018)  Australia	To explore Associate Nurse Unit Managers (ANUM) perspectives' about the use of smoke-free policies	Qualitative approach using semi-structured interviews	Thematic analysis	Participants: ANUMs employed at the recruitment site for at least 12 months. 4 females and 2 males, ranging from 28 to 43 years old	Three themes identified: leadership, resources and education. Positive views of SFGP: cleaner and safer environment, better health, less complaints about passive smoking, staff encouraging patients to quit.	7
Filia et al. 2015  Australia	To explore views and experiences of inpatients admitted to an acute psychiatry unit before and after the implementation of a smoke-free policy	Mixed methods; questionnaires with structured and open-ended items	Thematic analysis	52 inpatients participated in qualitative aspects of the research. 57.7% male, mean age was 39.1 years (10.8 SD), mean self-reported length of ward stay was 23.7days (37.1 SD), 51.9% were current smokers	Over half of inpatients had positive views about the implementation of the smoking ban, but smokers had negative perspectives. Most difficult thing about ban was patients experience of more negative emotions. Most common positive aspect was that the ban had improved environment of the ward.	5
Glover et al. 2014	To identify and examine barriers in the transition	Qualitative design, using semi-	An inductive approach	56 staff members: 15 smoke-free coordinators, 6 cessation	Themes related to barriers of implementing SFGP: staff smoking, negative staff	5

New Zealand	to smoke-free status and review staff attitudes to providing support for patients to quit smoking	structured interviews		specialists, 2 community mental health workers, 15 managers, 7 team leaders, 8 counsellors, 3 nurses	attitudes to policy, poor knowledge of nicotine dependence, smoking-related harm and comorbidities, and poor knowledge and skills regarding cessation support	
Grant et al. 2014	To describe how the implementation of a smoke-free grounds policy was affected by institutional cultures.	Ethnographic study across two sites. Data collection methods: interview, fieldwork, observation, document review	Thematic analysis	Recruitment site A: 16 participants (12 female, 2 current smokers and 2 former smokers) Recruitment site B: 11 interviews and 3 informal discussions (9 female, 1 current smoker, 4 former smokers)	Themes at Site A: resistance to policy, patient advocacy, a culture of ignoring, and tobacco as essential for patient relations. Themes at Site B: strong leadership, staff discretion in practice, challenges of compliance, limited resources	8
Canada						
Hehir et al. 2012	To describe the experience of patients admitted to the smoke-free facility and its impact on smoking intentions and practice	Mixed methods design: semi-structured focus groups with current patients, current patient surveys; follow-up survey from 15 discharged patients.	Thematic analysis of the focus group data	Participants were current or recently discharged patients from a forensic hospital. 21 participated in focus group (81% male), 45 completed the patient survey (93% male). 15 discharged patients completed the discharged patient survey (93% male). All smoked prior to admission.	Themes identified from the focus groups were: 1) preparation of what to expect of a smoke-free service prior to admission; 2) experience of nicotine withdrawal; 3) emotions and attitudes related to not smoking; 4) what helps and what doesn't; 5) perceived impact of not smoking.	5
Australia						
Huddleston et al. 2018	Aim of qualitative aspects: 'Explore inpatient experience with the smoke-free policy and its impact on smoking and on intentions relating to smoking after discharge	Mixed methods, included qualitative exploration of inpatient experience of introduction of a smoke-free policy	Thematic analysis	9 patients took part in qualitative section, they were patients from rehabilitation and acute adult MH wards. 6 male. Mean age: 32.6 (SD 5.81) years. 2 quit smoking since admission to ward, 6 reported smoking less than they had before admission.	Four themes: 1) Past and present smoking behaviour influencing adjustment to policy; 2) The reality of the policy in terms of adherence, enforcement and support; 3) Challenges to maintaining abstinence, 4) Motivation to quit.	6.5
UK						
Lawn et al. 2015	To determine staff perceived facilitators	Secondary qualitative analysis	Summative and latent	147 managers from various mental health units. 23%	Positive views about SFGP: facilitates staff and patients' cessation, reduces ambiguity	5.5

UK	and benefits to implementing smoke-free policy in their units and to identify possible problems and barriers arising from the policy	of 2010 mixed methods audit data	content analysis	residential rehabilitation units; 7% day care; 30% acute inpatient; 14% low secure; 11% medium secure; 2% high secure; 9% PICU; 3% alcohol/drug detox unit; 1% other	about smoking, policy implementation was relatively straightforward Perceptions about the issues of SFGP: perception that patients are resistant to the policy, greater consistency of communication, system support and staff response is needed for policy success	
Magor-Blatch & Rugendyke 2016 Australia	To discover attitudes toward a smoking ban in mental health units and whether attitudes towards smoking predict agreement with current smoke-free policies.	Mixed-methods approach, using an online survey design with space for free text answers	Thematic analysis	98 participants from variety of staff groups Ages of participants ranged from 22 to 75 years, (M= 38.82, SD = 12.76). 32 males, and 66 females. 76 participants were non-smokers, 11 smokers, 11 social smokers	Low endorsement of total smoking bans among mental health professionals. Themes included: health risks of smoking, negative effects of smoking ban (including increase in symptoms, aggression and barriers to treatment), human rights concerns, smoking as a lowest priority concern.	6.5
McAllister et al. 2016 Australia	To establish what the factors may contribute to or hinder the implementation of smoke-free policies in mental health service	Qualitative study using structured interviews with staff and service user	Stebbins' (2001) process of qualitative analysis was followed	10 participants were recruited consisting of 6 clinicians, 2 lead clinicians and 2 service users	Three themes: culture (socio-cultural influences on the staff and service users), well-being (emotive and psychological elements) and strategy (implementation of SFGP and the operational barriers)	5
Pritchard & McNeill 2008 UK	To evaluate the impact on staff and patient advocates of SFGP within a mental health trust	Data collected using individual interviews. A Realistic evaluation framework design was used.	Thematic analysis	19 participants (11 females). Participants were staff (n=15) and patient advocates (n=4) in an NHS trust.	Early consultation about the policy with people is central to the ownership of smoke-free policies. Clarity and consistency with regards to the implementation and enforcement of the policy, is vital for its success.	6

Ratschen et al. 2009 UK	To explore experiences and views of staff in an acute mental health setting where a smoke-free policy had been introduced 1 year previously	Qualitative study that uses structured interviews with staff members	Framework approach	Total of 16 (6 male and 10 female) participants. Participants were employed as: nurses, health-care assistants, doctors, OTs and one OT assistants, ward management. 7 participants were smokers.	Barriers to implementation of SFGP: lack of staff resources/time, staff ambivalence, lack of smoking cessation resources, views of smoking as a coping mechanism for patients, regular infringements to the policy, impact of policy on therapeutic relationship.	7.5
Ratschen et al. 2010 UK	To explore patient experience, smoking and symptoms of nicotine withdrawal in the context of a smoke-free policy on mental health wards	Semi-structured face to face interviews with inpatients	Framework approach	Inpatients from an acute mental health ward who smoked. 15 participants (9 male). Mean age 42.3 years old (range = 27–61).	Patients generally approved of the smoke-free policy. Most participants had changed their smoking behaviour following admission. Most had little knowledge of nicotine dependence, reported lack of support for smoking cessation, and an interest in this being made available.	7

The views of 386 staff members and 174 service users, from the 13 included studies, have been analysed for this review. The narrative synthesis identified three themes related to the impact of SFGPs and five themes related to the barriers and facilitators of the implementation of SFGPs. See Table 2 for the frequencies of each theme. Views of service users and staff are discussed together under the relevant analytical themes. Sample quotes have been selected that best illustrate the theme.

Table 2. Frequency of themes

Theme	Impact of SFGP			Barriers and facilitators to SFGP implementation					Total /8
	Wellbeing	Clinical Practice	Ward atmosphere	Ward culture	Resources	Attitudes	Smoking Cessation	Policy Strategy	
Calciu et al. (2017)	✓	✓	✓		✓	✓	✓		6
Dean et al. (2018)	✓	✓	✓	✓	✓	✓	✓	✓	8
Filia et al. (2015)	✓		✓	✓		✓			4
Glover et al. (2014)	✓	✓	✓	✓	✓	✓	✓	✓	8
Grant et al. (2014)		✓	✓	✓	✓	✓		✓	6
Hehir et al. (2012)	✓	✓			✓	✓	✓		5
Huddleston et al. (2018)	✓			✓	✓	✓	✓	✓	6
Lawn et al. (2015)	✓	✓	✓	✓	✓	✓	✓	✓	8
Magor-Blatch & Rugendyke (2016)	✓	✓	✓			✓	✓		5
McAllistair et al. (2016)	✓	✓	✓	✓	✓	✓	✓	✓	8
Pritchard & McNeil (2008)	✓	✓	✓	✓	✓	✓	✓	✓	8
Ratschen et al. (2009)	✓	✓	✓	✓	✓	✓	✓	✓	8
Ratschen et al. (2010)	✓		✓	✓	✓	✓	✓	✓	7

### **What do staff and service users consider to be the benefits and negatives of an SFGP policy on an inpatient unit?**

Three overarching themes were identified in relation to the above question.

These are: wellbeing, clinical practice and ward atmosphere.

**Wellbeing.** This theme relates to physical, psychological and social factors that impact the wellbeing of staff and patients. It was comprised of three sub-themes: physical health, mental health and human rights.

***Physical health.*** Staff and service users from 11 papers identified the SFGP as having benefits for their physical health. Six papers reported that there was a decrease in service user and staff smoking as a result of the smoking ban. Many participants also commented that the SFGP reduced second-hand smoke on the ward and viewed this as a benefit for service user, staff and visitor health.

*“The smoke-free environment creates a safe, healthy workplace/environment; it has reduced the health hazards and discomfort, and there is no longer any shared health risks to non-smokers in terms of passive smoking.”* Staff quote (Lawn et al., 2015)

Two papers noted that the reported decrease in service user smoking as a result of SFGP, led to psychoactive medication being reduced. This was perceived to have a positive impact on patients in terms of their physical health and reduction in medication related side-effects. Conversely, concern was expressed that nicotine withdrawal symptoms, which some thought had increased as a result of SFGP reducing access to cigarettes, were being misattributed to symptoms of a mental health disorder. This then increased the likelihood of service users being unnecessarily medicated.

*“If somebody stood out there with withdrawal from nicotine, it would be classed —because they're on a mental health ward — as illness.”* Staff quote (Ratschen et al., 2009)

Despite many participants commenting on a reduction in smoking as a result of SFGP, five of the included papers referred to service users increasing their smoking during admission to a smoke-free ward. The presence of SFGP led some service users

to adopt “atypical” smoking behaviours, such as increasing the number of cigarettes smoked during their breaks.

*“I usually smoke two when I am out...That’s because of the leave I need to make sure I keep my nicotine levels up. Having the one cigarette now is not enough, I’ve got to have two.”* Service user quote (Huddleston et al., 2018)

Other participants felt that the policy increased the incidences of covert smoking on the ward, which subsequently lead to increased exposure of service users and staff to second-hand smoke and fire.

*“The policy has increased secondary smoke in the ward and the only place that’s smoke-free is the smoke room that’s been locked.”* Staff quote (Ratschen et al., 2009)

**Mental health.** Staff and service users across nine papers felt that SFGP would be detrimental to service users’ mental health. Participants reported that they had observed or experienced increases in negative emotions among service users.

*“You can’t expect someone to quit during times of crisis. This exacerbates stress and increases depression, anxiety and suicidal ideation”* Staff quote (Magor-Blatch & Rugendyke, 2016)

Participants also felt that the removal of smoking as a way of service users coping with their mental health would lead to the development of other harmful coping strategies. However, participants in seven papers thought that the removal of smoking as a coping strategy would have the benefit of enabling service users to develop alternative, healthier ways of coping with their mental health.

**Human rights.** Participants in seven papers perceived the SFGP to have removed service users’ choice about whether to smoke. Some service users considered the SFGP to be a breach of their human rights.

*“I see this as a threat to my human rights and a challenge towards choice and autonomy”* Service user quote (Calciu et al., 2017).

Four papers referred to the idea of the ward being “home” for patients and that therefore they should be able to smoke on the ward, just as they would in their own homes. There was a general feeling among many participants that SFGPs were “unfair” and further discriminated a group that were already marginalised.

*“This is our home, and we haven’t done anything wrong to end up here, so why should they take that [smoking] off us?”* Service user quote (Ratschen et al., 2010)

**Clinical practice.** Clinical practice encompasses the clinical aspects of the day-to-day running of the ward that were impacted by SFGP. This theme is comprised of two sub-themes: patient care and changing clinical roles.

**Patient care.** Some participants felt that SFGPs had a positive impact on therapeutic relationships between staff and service users because it allowed them to engage in different activities together, rather than those related to smoking. But others thought the policy had a negative impact on relationships. Some staff members felt that opportunities to smoke with patients, which had now been removed due to SFGP, had previously been helpful for developing trusting relationships. Similarly, staff felt that their new responsibility of enforcing SFGP on the ward had a negative impact their relationships with patients and subsequently on the care they were able to give.

*“We can come across like prison officers essentially [...]. How do you then work with somebody for the remainder of the day saying ‘do you want to do anything?’, ‘no you can f\*\*\* off, you’ve just taken my fags and my lighter.”*  
Staff quote (Ratschen et al., 2009).

There were also some concerns that the introduction of a SFGP may make

smokers more resistant about being admitted to the ward or informal patients may want to leave the ward early.

***Changing clinical roles.*** Several papers commented that the introduction of SFGP helped to reduce ambiguity about staff roles. Some staff members felt that the policy made it clear that they had a responsibility to address smoking as part of treatment on the ward. However, others thought that the SFGP had led to them having to take on additional tasks and responsibilities that were not part of their clinical roles.

*“A member of staff the other day told me that the smoking policy had made our job 20 times harder”* Staff quote (McAllistair et al., 2016)

**Ward atmosphere.** Ward atmosphere relates to the ways in which the feel of the ward, either physically or psychologically, changed as a result of SFGP. This theme has two sub-themes: physical aspects of the ward and ward safety.

***Physical aspects of the ward.*** There were reports that the ward had become cleaner as a result of SFGP. Some participants talked about the benefits of using areas previously used as smoking-rooms for other purposes:

*“We have been able to convert the smoking room into a ‘quiet room’ which is utilised by both patients and staff ...”* Staff quote (Lawn et al., 2015)

However, other participants felt the policy had negatively impacted the ward environment. There were reports of a perceived increase in the risk of physical damage to wards, mainly due to fire, because of more covert smoking by service users.

***Safety.*** A significant area of concern for staff was about an increase of physical and verbal aggression from service users, due to the introduction of SFGP.

*“You may (slightly) reduce staff risk of developing lung cancer in the long term, but you’ve got to offset that against the likely massive increase in risk of being injured in an assault by a distressed patient.”* Staff quote (Magor-Blatch

& Rugendyke, 2016)

Some service users felt less safe because the SFGP resulted in smoking areas being moved. Participants reported that having to leave the hospital site to smoke made them concerned for their safety.

*“You should be allowed to smoke anywhere in the grounds. ... When I go to the main road, it’s dangerous ....”* Service user quote (Ratschen et al., 2010).

### **What do staff and service users consider to be the barriers and facilitators to the successful implementation of an SFGP?**

Five overarching themes were identified in relation to the above question. These are: ward culture, resources, smoking cessation, attitudes and policy strategy.

**Ward culture.** Ward culture refers to socio-cultural factors of the ward that may influence the implementation of SFGP. This theme was made up of two sub-themes: compliance and sense of unity.

**Compliance.** Ten of the 13 included papers referred to compliance with the policy being a barrier to its successful implementation.

*“The amount of visitors and other patients that I see smoking next to that [sign warning of the penalty for smoking] makes me smirk”* Staff quote (McAllistair et al., 2016)

Participants identified that there had been an increase in covert smoking on the ward because of the policy. This was identified as a considerable barrier to the success of the SFGP. There were also reports of staff members encouraging and sometimes even facilitating service users’ resistance to the policy.

*“Within 24 hours of me being here, I was advised by the staff, by one member of staff, to ‘find a stash’ for my cigarettes outside... I appreciated him doing it.”* Service user quote (Huddleston et al., 2018)

Although not all participants reported incidents of staff actively facilitating smoking, there were reports of staff being complicit to breaches to the SFGP. Some staff reported being reluctant to enforce the policy if it put their safety at risk. Risk to safety and fear of being the victim of physical or verbal aggression, was a barrier for staff members enforcing the SFGP.

***Sense of unity.*** Participants noted that if services could foster a sense of unity and ownership of the policy then this was a facilitator to its success and resulted in fewer breaches of the policy.

*“It’s been a whole of service approach...I think everyone was in it together...both smokers and non-smokers, staff, clients.”* Staff quote (McAllistair et al., 2016)

Several participants said that feeling “supported” was important. For example, by either board members, managers, or other colleagues. If staff did not feel supported, then it presented a barrier to policy implementation.

**Resources.** This theme refers to the availability of materials or other assets on the implementation of SFGP. It is comprised of three sub-themes: interventions, knowledge of staff and patients, and staffing.

***Interventions.*** One of the main facilitators for the successful implementation of SFGP related to the availability of smoking cessation support, particularly Nicotine Replacement Therapy (NRT); this was commented on in eight of the included papers.

*“What helped the most? user replacement treatments...and the staff being much more up to speed”* Staff quote (McAllistair et al., 2016)

Other participants also referred the importance of the availability of other smoking cessation interventions in contributing to the success of SFGP. Such interventions included: groups, alternative activities to distract from smoking, brief

smoking cessation interventions, presence of a smoking cessation specialist, incorporating smoking cessation into care plans and offering patients rewards for cessation. Linked to this, five papers reported that more education and training for staff about smoking cessation options would facilitate the introduction of a SFGP.

*“reducing staff fear by establishing competence around dealing with nicotine addiction”* staff quote (Glover et al., 2014)

However, in practice smoking cessation interventions were not always consistently available. Lack of availability of cessation interventions was considered to be a barrier to the implementation of a SFGP.

**Knowledge of staff and patients.** Eight papers commented on the positive impact that providing staff and service users with information about the policy and how to enforce it, could have on its success.

*“The most important intervention for successful smoke-free policies is information provision, that is education given to the patients and the nurses. Clarity of information is important as well”* Staff quote (Dean et al., 2018)

**Staffing.** Participants in eight studies identified that lack of staff was a major barrier to a policy’s success. Some participants felt that the use of a smoke-free champion to help train staff and support SFGP was a facilitator in the policy’s success.

**Smoking cessation.** This theme refers to the priority that was given to smoking cessation on the ward. Wards that prioritised smoking cessation were better able to implement SFGPs than those who did not.

Patients’ motivation to quit was related to the success of smoking cessation interventions on the ward and was therefore both a barrier and facilitator to successful implementation of SFGP. Patients who were motivated to quit were considered to be more likely to engage with smoking cessation interventions and adhere to SFGP rules,

while the reverse was true for those lacking motivation to quit. As alluded to in the following quote, boredom seemed to play a role in patients' motivation to stop smoking.

*"Yes but what would be the benefit of giving up? ... My life is sitting watching telly, sitting around, having tea and then sleeping. There's no motivation to give up, is there?"* Service user quote (Ratschen et al., 2010).

Staff perceived service users' mental health to be a barrier to policy implementation. They reported that service users' reliance on smoking as a coping strategy impacted their ability to stop smoking, which therefore had an impact on service user adherence to the SFGP.

Four papers referred to the presence of a culture of smoking on the ward as being a barrier to the implementation of a SFGP. There were reports of staff members continuing to smoke with service users after the implementation of SFGP.

*"I've seen at least five cleaners smoking, I've seen three staff, one from this ward and a couple from another... I've even seen them smoking with patients as well."* Service user quote (Huddleston et al., 2018)

In contrast, there were reports that staff cessation could be a facilitator to the implementation and adherence to the SFGP because staff felt able to encourage others to do the same.

**Attitudes.** This theme relates to the perceptions of staff and patients about the introduction of SFGPs. This theme had two sub-themes: staff views and patient views.

**Staff views.** Eleven papers referred to staff attitudes towards the policy and towards smoking, as having a considerable impact on the success of a SFGP. Eight papers referred to staff members expressing views that were resistant towards or in disagreement with a SFGP in mental health inpatient settings.

*“Not having everyone on board with the same policy, I think, is probably the main issue... I just think it’s a mistake to try and enforce a no-smoking policy”*

Staff quote (Dean, Cross & Munrow, 2014)

Many of the negative views held by staff towards the SFGP, seemed to stem from a general pessimism about service users’ abilities to adhere to the policy. There appeared to be belief among staff that patients had no ability or interest in quitting. There was a theme across several papers of staff “knowing best” about what would be good for service users and subsequently therefore taking steps to support service users to ignore the SFGP. This was a considerable barrier to the implementation of a SFGP.

*“[the] psychiatrist overrode management and allowed an exemption (to the smoke-free policy) in the day rehab area”* Staff quotes (Glover et al., 2014)

**Patient views.** Service users had a range of views about whether SFGP should be implemented on mental health inpatient wards. In contrast to staff perceptions that SFGPs would have a negative impact on service users, many service users supported the introduction of SFGPs.

*“I’m glad that I came to this hospital. The reason why is because my brother’s got cancer from smoking and I promised him I would give it up. So the chance is here, I’m not regretting it.”* Service user quote (Hehir et al., 2012)

**Policy strategy.** Issues related to operational aspects of the implementation of SFGP were covered under this theme. Policy strategy includes three sub-themes: role of management, implementation issues and the physical environment of the ward.

**Implementation issues.** Nine papers identified inconsistency in policy implementation and enforcement within a staff team as a barrier to the success of a SFGP. Similarly, inconsistency in implementation across hospital sites was also seen as barrier. Participants commented that inconsistencies in enforcement of SFGPs on different wards, or across different buildings in the same hospital led to conflict

between staff teams and confusion for patients. Conversely, consistent implementation and enforcement of the policy was a facilitator to its success.

*“The main reasons are inconsistent staff approaches to the enforcement of the policy; also poor/inconsistent management of breaches of policy regarding smoking.”* Staff quote (Lawn et al., 2015)

**Role of management.** Participants felt that management had an important role to play in the implementation of SFGPs. Clear and consistent leadership facilitated the success of a policy. Some service users felt that strict policy enforcement by staff could be a barrier for them adhering to the SFGP. Their concerns were particularly in relation to feeling intimidated or not respected by authoritarian staff. On the other hand, involving staff and service users in policy design and implementation, facilitated its success. Engagement with staff and service users helped to foster a feeling of empowerment and made people more likely to agree with and adhere to the policy.

*“People in charge of implementing this time listened to our fears and anxieties instead of trying to steamroller it.”* Staff quote (McAllistair et al., 2016)

**Physical environment.** Six papers referred to the role of the physical environment of the ward for the successful introduction of a SFGP. Some participants felt that the presence of off-site smoking areas helped to facilitate the success of the policy because people knew where they could smoke, if they needed to.

*“I don’t mind this policy, I’m agreeable. As long as they give us somewhere when we do want that cigarette”* Service user quote (Ratschen et al., 2010).

However, other participants were concerned that the presence of off-site smoking areas led to some service users becoming fixated on accessing them, just as they had been before the introduction of SFGP when smoking areas were on-site.

## **Discussion**

The objective of this review was to synthesise the qualitative literature on the perspectives of staff and patients about the introduction of SFGPs in mental health inpatient services. This review summarised the perceived impact of SFGPs and the barriers and facilitators to their implementation.

### **Impact of SFGPs in inpatient services**

As might be expected, staff and service users had a wide range of views about whether SFGPs should be implemented in mental health inpatient services. Findings from this review suggest that participants were more likely to identify negatives of SFGPs than positives. Three themes emerged relating to participants views on the impact of SFGPs, these were: wellbeing, clinical practice and ward atmosphere.

Participants were particularly concerned about the impact of SFGPs on service users' wellbeing, which related to their physical health, mental health and concerns about their human rights. Interestingly, most of the concerns about the impact of the policy on service user mental health came from staff rather than service users. This perhaps reflects the negative attitudes that previous research has found staff to have towards smoking cessation more generally in mental health settings (McNally et al., 2006). However, it should be noted that findings may be skewed, as more staff were included as participants in the reviewed studies than service users.

Many of the aspects that were perceived to be positively impacted by SFGP were also perceived to be negatively impacted, and vice versa. For example, almost all studies talked about the physical health benefits of SFGPs, but most also commented on the perceived negative impact that the policy had on physical health. Although the aim of a smoke-free policy is to reduce smoking and improve physical health (Public Health England, 2016) this review concludes that staff and patients did not

unanimously perceive the introduction of an SFGP to have improved their physical health. In fact, several participants felt that there was an increased risk of exposure to second-hand smoke due to increased incidences of covert smoking on the ward as a result of SFGP. The findings of this review therefore offer important insight into the perceived impact of SFGPs in real life settings, and emphasise the importance of not overlooking the views and experiences of staff and service users when designing and implementing policy changes.

Participants also commented on the impact of SFGPs on clinical practice, particularly in relation to patient care and changing clinical roles. As supported by previous research, there was a prevailing sense of the importance of tobacco in staff and service user relationships and illness management (Lawn 2004; Voci et al. 2010). Many staff members therefore had concerns about the impact of SFGPs on their relationships with patients, particularly as they would have to enforce a potentially unpopular policy. There was a general sense among staff that higher management had decided to implement the policy without much consideration of the practical difficulties that might arise in daily clinical work. Research has emphasised the importance of an organisation's shared belief in its capabilities to implement change for successful policy change to occur (Weiner, 2009). However, the clinical staff in this review alluded to a sense of paternalism from management in relation to policy enforcement, with limited support and resources to assist in successful implementation.

### **Barriers and facilitators to the implementation of SFGPs**

Five themes emerged in relation to the barriers and facilitators to SFGPs: ward culture, resources, smoking cessation, attitudes and policy strategy. Overall, participants identified more barriers to the implementation of SFGPs than facilitators. The barriers most frequently discussed were staff attitudes towards SFGPs, the

availability of resources (such as cessation interventions, enough staff and training) and inconsistencies in the implementation of SFGPs.

This review concludes that staff attitudes towards the introduction of SFGPs in inpatient mental health services were generally negative. In line with Prochaska's (2011) myths about smoking cessation and mental health, participants commented on the negative impact of removing smoking as coping strategy for service users, the lack of motivation of service users to quit, the presumption that service users may be unwilling or unable to quit, and that smoking cessation isn't a priority and should not be addressed in mental health services. The attitudes that staff held about smoking cessation appeared to act as a barrier for the implementation of SFGPs. These results are in line with previous research which has highlighted that the value people place on an organisational change, such as policy implementation, is linked to their motivation to engage in and implement that change (Fishbein & Ajzen, 1975; Weiner, 2009).

Although the prevailing sense was one of reluctance to implement SFGPs, participants identified that there were some steps that could be taken to encourage support and understanding of the policy. These include: providing information about the policy and smoking cessation interventions, training about the impact of smoking on mental health, NRT provision, engaging staff and service users in the design and implementation of SFGPs and fostering a sense of unity and support in the service. Models of learning and organisational change have highlighted the influence of an organisation's perceptions of resource availability, task demands and situational factors on its sense of efficacy to implement policy change (Gist & Mitchell, 1992). Resource availability was a particular concern for participants because lack of access to smoking cessation interventions is a clear, practical barrier to the implementation of a smoke-free environment.

Another significant difficulty that participants had with SFGPs related to the policy strategy. Participants commented in particular on difficulties due to inconsistent enforcement and implementation of SFGPs both in individual services and between different services or treatment sites. Participants identified that clear, consistent and supportive leadership in the implementation of SFGPs has a significant role in facilitating the success of a policy. Previous research has emphasised the importance of consistent leadership messages and actions for promoting organisational readiness for change (Klein & Kozlowski, 2000; Weiner, 2009). Having a consistent approach to leadership with a focus on engaging staff and service users with the policy, may therefore be one way of reducing inconsistencies in SFGP implementation. This finding has significant clinical implications for Directors, Consultants and Managers who may be responsible for implementing SFGPs.

This review emphasises the numerous barriers that services may face when introducing a SFGP onto an inpatient mental health ward. The findings suggest that it is important for healthcare managers to carefully consider and plan for difficulties that they may face in the introduction of SFGPs and develop strategies to overcome these. Although it is possible that many of the difficulties outlined in this review can be overcome through careful planning, training, resources and appropriate leadership. The importance of understanding and validating the concerns of staff and service users should not be under-emphasised.

### **Limitations and Future Research**

This review has some limitations. Study selection excluded research from non-peer reviewed publications and grey literature, potentially affecting the ability of this review to fully reflect the existing evidence (Conn, Valentine, Cooper & Rantz, 2003). Studies that did not refer to a “smoke-free grounds policy” were excluded for the purposes of this review. Research that related to earlier versions of smoke-free policies

(e.g. those relating to the introduction of smoking rooms on wards) which may have added interesting contextual data for current policies, was not included. It was beyond the scope of this review to consider changing attitudes to smoke-free policies over time, but this is something that future research could investigate, since attitudes have been noted to shift in other related settings before, during and after policy changes (Hilton et al. 2007).

Previous research shows that mental health staff attribute their negative views about encouraging smoking cessation for their patients to their own smoking status (Lawn, 2004; Sarna, Bialous, Wells, & Kotlerman, 2009). Staff who smoke appear to hold more negative views about smoking cessation for others. Only three of the papers included in this review reported on the smoking status of the staff they included. However, research indicates that there are elevated rates of smoking among healthcare staff, compared to the general population, with some studies suggesting rates may be as high as 45% (Cookson et al., 2014). It is possible that mental health inpatient staff who smoke may view SFGPs more negatively as such policies have an impact on their own access to cigarettes during the working day and therefore this may be impacting their adherence to policy. Unfortunately, due to the limited reporting of smoking status in the included studies, it is not possible for this review to comment directly on the link between staff smoking status and attitudes towards smoke-free policies, but it is an area for future research to consider.

The notion of ‘barriers’ and ‘facilitators’ as a focus of the analysis of this review reflects the language used in the literature on smoke-free policies. Perhaps this has led to the researcher being unintentionally aligned with a view that the implementation of SFGPs is unequivocally correct, and something that staff and patients should ‘fit in’ with. This unintentional alignment with the idea of SFGPs being correct, also perhaps reflects the current NHS context, where there is a particular focus on tackling

longstanding unmet health needs, such as smoking among mental health populations (NHS Long Term Plan, 2019). Although this may have had some influence on the interpretation of the results, it is acknowledged that researchers are not passive analysts of data, instead they bring their history and cultural context to the research process (Hayes & Oppenheim, 1997).

## **Conclusion**

Staff and service users have generally negative attitudes towards the introduction of SFGPs in inpatient settings and they identify many more barriers than facilitators to successful implementation. The findings particularly emphasise staff perceptions, limited resources and the process of policy implementation as significant barriers to the implementation of SFGPs. This review highlights the potential influence that attitudes and experiences of staff and service users may have in impacting the success of SFGPs. The findings therefore emphasise the importance of empowering and engaging with staff and service users when designing and implementing policy change.

Despite its limitations, this review has clear implications for clinical practice as it offers insight for services developing and implementing SFGPs. Furthermore, it is particularly timely in a UK context where services are becoming smoke-free in line with Government recommendations (Public Health England, 2016; Royal College of Physicians, 2018; NHS Long Term Plan, 2019).

## References

- Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50(2), 179-211.
- Aubin, H. J., Rollema, H., Svensson, T. H., & Winterer, G. (2012). Smoking, quitting, and psychiatric disease: a review. *Neuroscience & Biobehavioral Reviews*, 36(1), 271-284.
- Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: a critical review. *BMC Medical Research Methodology*, 9(1), 59.
- Calciu, C., Khan, R., Macpherson, R., Garton, C., Durrant, L., Jackson, R., & Elliot, H. (2017). Attitudes towards going smoke-free at an inpatient recovery unit. *Mental Health Practice (2014+)*, 20(5), 17.
- Care Quality Commission (2018). *Mental health rehabilitation inpatient services*, Retrieved from: [https://www.cqc.org.uk/sites/default/files/20180301\\_mh\\_rehabilitation\\_briefing.pdf](https://www.cqc.org.uk/sites/default/files/20180301_mh_rehabilitation_briefing.pdf)
- Centre for Reviews and Dissemination (2009). *Systematic Reviews: CRD's Guidance for Undertaking Reviews in Health Care*. Retrieved from: [https://www.york.ac.uk/media/crd/Systematic\\_Reviews.pdf](https://www.york.ac.uk/media/crd/Systematic_Reviews.pdf)
- Chang, C. K., Hayes, R. D., Perera, G., Broadbent, M. T., Fernandes, A. C., Lee, W. E., ... & Stewart, R. (2011). Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London. *Library of Science*, 6(5), e19590.
- Cookson, C., Strang, J., Ratschen, E., Sutherland, G., Finch, E., & McNeill, A. (2014). Smoking and its treatment in addiction services: Clients' and staff behaviour and attitudes. *BMC Health Services Research*, 14(1), 304.
- Conn, V. S., Valentine, J. C., Cooper, H. M., & Rantz, M. J. (2003). Grey literature in meta-analyses. *Nursing Research*, 52(4), 256-261.
- Critical Appraisal Skills Programme (2013). *Qualitative Checklist*. Retrieved from: [http://media.wix.com/ugd/dded87\\_29c5b002d99342f788c6ac670e49f274.pdf](http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf)
- Crockford, D., Kerfoot, K., & Currie, S. (2009). The impact of opening a smoking room on psychiatric inpatient behavior following implementation of a hospital-wide smoking ban. *Journal of the American Psychiatric Nurses Association*, 15(6), 393-400.
- Dean, T. D., Cross, W., & Munro, I. (2018). An exploration of the perspectives of associate nurse unit managers regarding the implementation of smoke-free

policies in adult mental health inpatient units. *Issues in Mental Health Nursing*, 39(4), 328-336.

- Dickens, G., Stubbs, J., Popham, R., & Haw, C. (2005). Smoking in a forensic psychiatric service: a survey of inpatients' views. *Journal of Psychiatric and Mental Health Nursing*, 12(6), 672-678.
- Eadie, D., MacDonald, L., Angus, K., Murray, R., O'Mara-Eves, A., Stansfield, C., & Leonardi-Bee, J. (2013). *A review of the barriers to and facilitators for implementing smokefree strategies and interventions in secondary care settings*. National Institute for Health and Care Excellence (NICE) PH48 Smoking cessation - acute, maternity and mental health services, Review 7. Retrieved from:  
<http://www.nice.org.uk/nicemedia/live/14306/65877/65877.pdf>
- Filia, S. L., Gurvich, C. T., Horvat, A., Shelton, C. L., Katona, L. J., Baker, A. L., ... & Kulkarni, J. (2015). Inpatient views and experiences before and after implementing a totally smoke-free policy in the acute psychiatry hospital setting. *International Journal of Mental Health Nursing*, 24(4), 350-359.
- Gentry, S., Craig, J., Holland, R., & Notley, C. (2017). Smoking cessation for substance misusers: A systematic review of qualitative studies on participant and provider beliefs and perceptions. *Drug and Alcohol Dependence*, 180, 178-192.
- Glover, M., Fraser, T., Bullen, C., Wallace-Bell, M., McRobbie, H., & Hadwen, G. (2014). Transition to a smoke-free culture within mental health and drug and alcohol services: A survey of key stakeholders. *International Journal of Mental Health Nursing*, 23(2), 183-191.
- Grant, L. G., Oliffe, J. L., Johnson, J. L., & Bottorff, J. L. (2014). Health care professionals implementing a smoke-free policy at inpatient psychiatric units. *Qualitative Health Research*, 24(12), 1732-1744.
- Hall, S. M., & Prochaska, J. J. (2009). Treatment of smokers with co-occurring disorders: emphasis on integration in mental health and addiction treatment settings. *Annual Review of Clinical Psychology*, 5, 409-431.
- Hayes, R. L., & Oppenheim, R. (1997). Constructivism: Reality is what you make it. In T. L. Sexton & B. L. Griffin (Eds.), *Counseling and development series, No. 3. Constructivist thinking in counseling practice, research, and training* (pp. 19-40). New York, NY, US: Teachers College Press.
- Health Act (2006). Chapter 28. London, Stationery Office; Retrieved from:  
[http://www.legislation.gov.uk/ukpga/2006/28/pdfs/ukpga\\_20060028\\_en.pdf](http://www.legislation.gov.uk/ukpga/2006/28/pdfs/ukpga_20060028_en.pdf)

- Health and Social Care Information Centre (2018). Mental Health Act Statistics, Annual Figures 2017-18, Retrieved from: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures>
- Hehir, A. M., Indig, D., Prosser, S., & Archer, V. A. (2012). Evaluation of a smoke-free forensic hospital: Patients' perspectives on issues and benefits. *Drug and Alcohol Review*, 31(5), 672-677.
- Hilton, S., Semple, S., Miller, B. G., MacCalman, L., Petticrew, M., Dempsey, S., ... & Ayres, J. G. (2007). Expectations and changing attitudes of bar workers before and after the implementation of smoke-free legislation in Scotland. *BMC Public Health*, 7(1), 206.
- Huddleston, L., Sohal, H., Paul, C., & Ratschen, E. (2018). Complete smokefree policies in mental health inpatient settings: results from a mixed-methods evaluation before and after implementing national guidance. *BMC Health Services Research*, 18(1), 542.
- Hughes, J. R. (2007). Effects of abstinence from tobacco: valid symptoms and time course. *Nicotine & Tobacco Research*, 9(3), 315-327.
- Kendler, K. S., Neale, M. C., MacLean, C. J., Heath, A. C., Eaves, L. J., & Kessler, R. C. (1993). Smoking and major depression: a causal analysis. *Archives of General Psychiatry*, 50(1), 36-43.
- Kerr, S., Woods, C., Knussen, C., Watson, H., & Hunter, R. (2013). Breaking the habit: a qualitative exploration of barriers and facilitators to smoking cessation in people with enduring mental health problems. *BMC Public Health*, 13(1), 221.
- Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: a reconsideration and recent applications. *Harvard Review of Psychiatry*, 4(5), 231-244.
- Lawn, S. J. (2004). Systemic barriers to quitting smoking among institutionalised public mental health service populations: a comparison of two Australian sites. *International Journal of Social Psychiatry*, 50(3), 204-215.
- Lawn, S., & Champion, J. (2013). Achieving smoke-free mental health services: lessons from the past decade of implementation research. *International Journal of Environmental Research and Public Health*, 10(9), 4224-4244.
- Lawn, S., & Condon, J. (2006). Psychiatric nurses' ethical stance on cigarette smoking by patients: determinants and dilemmas in their role in supporting cessation. *International Journal of Mental Health Nursing*, 15(2), 111-118.

- Lawn, S., Feng, Y., Tsourtos, G., & Campion, J. (2015). Mental health professionals' perspectives on the implementation of smoke-free policies in psychiatric units across England. *International Journal of Social Psychiatry*, 61(5), 465-474.
- Lê Cook, B., Wayne, G. F., Kafali, E. N., Liu, Z., Shu, C., & Flores, M. (2014). Trends in smoking among adults with mental illness and association between mental health treatment and smoking cessation. *Journal of the American Medical Association*, 311(2), 172-182.
- Magor-Blatch, L. E., & Rugendyke, A. R. (2016). Going smoke-free: attitudes of mental health professionals to policy change. *Journal of Psychiatric and Mental Health Nursing*, 23(5), 290-302.
- Marshall, L., Workman, P., Notley, C. (2018). The attitudes and experiences of patients and staff towards the implementation of smoke-free policies in psychiatric and forensic inpatient services. PROSPERO (CRD42018086576).
- McAllister, M., Halliday, L., Jobson, H., Jacobs, T., Flynn, T., Kargillis, C., ... & Lowe, J. B. (2016). A mountain not too high to climb: a qualitative study exploring facilitators and barriers to smoking cessation in a regional mental health service. *Advances in Mental Health*, 14(1), 26-37.
- McNally, L., Oyefeso, A., Annan, J., Perryman, K., Bloor, R., Freeman, S., ... & Oyebode, D. (2006). A survey of staff attitudes to smoking-related policy and intervention in psychiatric and general health care settings. *Journal of Public Health*, 28(3), 192-196.
- Mental Health Taskforce to the NHS in England (2016) The Five Year Forward View for Mental Health. Retrieved from: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>
- Michie, S., Van Stralen, M. M., & West, R. (2011). The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implementation Science*, 6(1), 42.
- Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Annals of internal medicine*, 151(4), 264-269.
- National Institute for Health and Care Excellence (2018). *Stop smoking interventions and services*, Retrieved from: <https://www.nice.org.uk/guidance/ng92>
- National Institute for Health and Care Excellence (2013). *Smoking: acute, maternity and mental health service*. Retrieved from: <https://www.nice.org.uk/guidance/ph48>

- NHS Long Term Plan (2019). *Long Term Plan 2019*, Retrieved from:  
<https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf>
- Office for National Statistics (2018). *Adult Smoking habits in the UK: 2017*, Retrieved from:  
<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2017>
- Pack, S. (2009). Poor physical health and mortality in patients with schizophrenia. *Nursing Standard*, 23(21).
- Parrott, A. C. (1999). Does cigarette smoking cause stress? *American Psychologist*, 54(10), 817.
- Perkins, K. A., Karelitz, J. L., Giedgowd, G. E., Conklin, C. A., & Sayette, M. A. (2010). Differences in negative mood-induced smoking reinforcement due to distress tolerance, anxiety sensitivity, and depression history. *Psychopharmacology*, 210(1), 25-34.
- Poder, N., Carroll, T., Wallace, C., & Hua, M. (2012). Do smoke-free environment policies reduce smoking on hospital grounds? Evaluation of a smoke-free health service policy at two Sydney hospitals. *Australian Health Review*, 36(2), 158-162.
- Pritchard, C., & McNeill, A. (2008). Are smoke-free buildings and grounds in mental health units a realistic aspiration? *Mental Health Review Journal*, 13(4), 27-32.
- Prochaska, J. J. (2011). Smoking and mental illness—breaking the link. *New England Journal of Medicine*, 365(3), 196-198.
- Public Health England (2016). *Smoke free mental health services in England*. Retrieved from:  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/509262/SF\\_MH\\_services\\_in\\_England\\_Guidance\\_for\\_Providers.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/509262/SF_MH_services_in_England_Guidance_for_Providers.pdf)
- R (N) v SSH; R (E) v Nottinghamshire Healthcare NHS Trust (2009) EWCA Civ 795.
- Ratschen, E., Britton, J., Doody, G. A., & McNeill, A. (2009). Smoke-free policy in acute mental health wards: avoiding the pitfalls. *General Hospital Psychiatry*, 31(2), 131-136.
- Ratschen, E., Britton, J., Doody, G., & McNeill, A. (2010). Smoking attitudes, behaviour and nicotine dependence among mental health acute inpatients: an exploratory study. *International Journal of Social Psychiatry*, 56(2), 107-118.

- Ratschen, E., Britton, J., & McNeill, A. (2011). The smoking culture in psychiatry: time for change. *The British Journal of Psychiatry*, 198(1), 6-7.
- Royal College of Physicians (2018). *Hiding in plain sight: Treating tobacco dependency in the NHS*, Retrieved from: <https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs>
- Sarna, L., Bialous, S. A., Wells, M., Kotlerman, J., Wewers, M. E., & Froelicher, E. S. (2009). Frequency of nurses' smoking cessation interventions: report from a national survey. *Journal of Clinical Nursing*, 18(14), 2066-2077.
- Sheals, K., Tombor, I., McNeill, A., & Shahab, L. (2016). A mixed-method systematic review and meta-analysis of mental health professionals' attitudes toward smoking and smoking cessation among people with mental illnesses. *Addiction*, 111(9), 1536-1553.
- Shore T.H., Tashchian A. & Adams J.S. (2000) Development and validation of a scale measuring attitudes toward smoking. *Journal of Social Psychology*, 140, 615–623.
- Steinberg, M. L., Williams, J. M., & Ziedonis, D. M. (2004). Financial implications of cigarette smoking among individuals with schizophrenia. *Tobacco Control*, 13(2), 206-206.
- Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, 8(1), 45.
- Tsourtos, G., Ward, P. R., Muller, R., Lawn, S., Winefield, A. H., Hersh, D., & Coveney, J. (2011). The importance of resilience and stress to maintaining smoking abstinence and cessation: a qualitative study in Australia with people diagnosed with depression. *Health & Social Care in the Community*, 19(3), 299-306.
- Twyman, L., Bonevski, B., Paul, C., & Bryant, J. (2014). Perceived barriers to smoking cessation in selected vulnerable groups: a systematic review of the qualitative and quantitative literature. *British Medical Journal Open*, 4(12).

## Chapter 3: Bridging Chapter

### Smoking in mental health inpatient services

The systematic review synthesised research into the attitudes and experiences of staff and patients in mental health inpatient services towards the implementation of smoke-free ground policies (SFGP). It considered the impact of SFGPs in inpatient services and it reviewed the perceived barriers and facilitators to a policy's successful implementation. The review identified three themes relating to the perceived impact of SFGPs, these were: patient and staff wellbeing, ward atmosphere and clinical practice. It also identified five themes related to the barriers and facilitators to the implementation of SFGPs: ward culture, resources, attitudes, policy strategy, and prioritisation of smoking cessation. Overall, staff and patients generally held negative views about the introduction of SFGPs in mental health inpatient settings.

NHS England recommended that SFGPs were introduced to mental health inpatient services by the end of 2018 (Public Health England, 2016). This is one strategy employed by the Government to try to address the high rates of smoking among people with severe and enduring mental health difficulties. However, estimates suggest that only 4% of the 2.5 million people accessing secondary mental health services in England in 2017-2018 spent time in mental health inpatient services (Health and Social Care Information Centre, 2018). This means that most people who accessed support for their mental health did so through community services, where smoking cessation may not be addressed (Lawn, Pols, Barber, 2002; Morris, Waxmonsky, May & Giese, 2009). It is therefore important to also consider the views of people accessing community services to understand the attitudes they have towards smoking and the specific barriers that they face to smoking cessation.

## **Smoking in the community**

The qualitative research study presented in the following chapter aims to explore the process of smoking cessation for people with dual-diagnosis. Dual-diagnosis refers to people with a diagnosis of a severe mental illness combined with misuse of substances (NICE, 2016). People with dual-diagnosis are among the most vulnerable in our society, often facing multiple layers of deprivation and inequality, including poor physical health, poverty and a greater likelihood of having experienced childhood abuse and community exclusion (Neale, 2004; Parks, Svendsen, Singer, Foti & Mauer, 2006). Smoking has been suggested as one of the most significant contributors to the continued cycles of mental health, physical health and social instability that this vulnerable group face (Lawn, 2012; Morris et al. 2011).

Tobacco smoking not only has a significant impact on an individual's physical health and disposable income (Doll & Hill, 1950; Steinberg, Williams & Ziedonis, 2004), but research also suggests that among those with mental health illnesses, psychiatric outcomes are less favourable for those who smoke (Berk et al., 2008). People with mental health difficulties who also smoke tobacco experience more psychiatric symptoms, more frequent periods of hospitalisation, require higher doses of medications and achieve poorer treatment outcomes (Berk et al., 2008; Desai, Seabolt & Jann, 2001; Williams & Ziedonis, 2004). On the other hand, cessation has been associated with mental health, physical health and financial benefits (Malpass & Higgs, 2009; Taylor et al., 2014).

Despite the increased focus on smoking cessation as a public health priority, and the increasing rates of smoking cessation among the general population, smoking prevalence among people with dual-diagnosis remains high (Cookson et al. 2014). The purpose of the empirical research discussed in the following chapter is therefore to

explore qualitatively the barriers to smoking cessation for people with dual-diagnosis and to give a voice to a vulnerable group of people who are often overlooked by research.

One of the discussion points that emerged from the systematic review in the previous chapter, is that more of the studies included in the review explored staff views than service user views. It is therefore important that the following research explored service users' views about smoking and smoking cessation in order to not only add to the current limited research literature, but also to increase our understanding of the experiences and attitudes of this vulnerable group. The aim is for this study to build on our existing understanding of the barriers and facilitators to smoking cessation for people with co-morbid mental health and substance misuse and to contribute to the development of specific, targeted smoking cessation interventions.

## **Chapter 4: Empirical Paper**

A qualitative exploration of the process of smoking cessation for people with dual-  
diagnosis

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**A qualitative exploration of the process of smoking cessation for people with  
dual-diagnosis**

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### **Abstract**

This study aimed to explore the process of smoking cessation for people with comorbid substance misuse and mental health diagnoses (dual-diagnosis). Semi-structured interviews were undertaken with eight people with dual-diagnosis. A grounded theory approach was used to analyse the data and generate a model of the process of smoking cessation for this group. Overall, participants felt pessimistic about their ability to achieve cessation. Intrapersonal aspects of motivation and ability to achieve cessation were perceived as key barriers to behaviour change. Results also emphasised the multiple layers of interpersonal, social and system factors that interact with intrapersonal factors to influence smoking cessation. If smoking cessation interventions are to be successful for people with dual-diagnosis, they not only have to address individual barriers to change, but also the wider social, cultural and systemic context.

### **Keywords**

Smoking cessation; mental health; substance misuse; qualitative research; grounded theory

## **Introduction**

The National Institute of Clinical Excellence (NICE; 2016) defines dual-diagnosis as severe mental illness combined with misuse of substances. Severe mental illness refers to diagnoses such as schizophrenia, bipolar affective disorder, personality disorders and major depressive disorder (Lehman, 1994; Todd et al., 2004). It is difficult to precisely estimate how many people in the UK have dual-diagnosis due to differences in how it is defined, difficulties with diagnosis (i.e. substance misuse may mask an underlying mental illness or vice versa) and difficulties encouraging this client group to engage with services (NICE, 2016). However, a systematic review of studies conducted in the UK reported a dual-diagnosis prevalence rate of 12-61% across secondary mental health settings and 6-39% in community drug and alcohol addiction settings (NICE, 2015).

People with co-occurring mental health and substance misuse are among the most vulnerable in our society. Homelessness, poverty, childhood abuse, unemployment, crime and violence are higher among people with dual-diagnosis compared to the general population (Johnson & Cnaan, 1995; Neale, 2004). These social factors, in combination with their mental health and substance misuse, put this group at significant risk of victimisation and social isolation.

In addition to this, people with mental health and substance misuse face numerous health inequalities. Research suggests that life expectancy of people with schizophrenia may be 25 years less than the general population (Parks et al. 2006) and mortality rates of heroin users has been reported to be between 6-30 times that of the general population (Darke, Degenhardt & Mattick, 2007). This increase in mortality is not just due to drug overdose, but also to suicide, homicide and increased risk of physical health issues (Clausen, Waal, Thoresen & Gossop, 2009). Research suggests

that people with dual-diagnosis have poorer overall physical health than the general population (Pack, 2009). They are twice as likely to die from heart disease and four times more likely to die of respiratory disorders compared to people without dual-diagnosis (Department of Health, 2006), and they exhibit higher rates of non-compliance with medication (Marder, 2003). The cause of the health inequalities that people with dual-diagnosis face are multiple and complex, but health behaviours are known to play an important role. One health behaviour of particular note in this group is tobacco smoking (Coulthard, Farrell, Singleton, Meltzer, 2002).

### **Dual-diagnosis and Smoking**

Estimates suggest that between 50-98% of people with dual-diagnosis also smoke tobacco (Cookson et al. 2014). This is in stark contrast to a decreasing prevalence of smoking in the general population, down from 46% in 1974 to 15% in 2018 (Health and Social Care Information Centre; HSCIC, 2016; Office for National Statistics; ONS, 2018). It is not just the high prevalence rate that is of concern, evidence also suggests that people with mental health problems tend to smoke more heavily, have greater dependence and extract more nicotine from each cigarette, thus taking in more carcinogens, than smokers in the general population (Williams et al., 2007; Coulthard et al. 2002). Longitudinal research has indicated that more than half of all deaths in a group of individuals who received addiction treatment, were tobacco related (Hurt et al. 1996).

It has been clearly demonstrated that smoking is linked to numerous physical health problems, including lung cancer (Doll & Hill, 1950). As well as the physical health risks of smoking, there are other implications that are particularly relevant for smokers with dual-diagnosis. For example, smoking is a contributory factor to the variations observed in individual responses to psychotropic medication (Wu et al.

2008). Smoking can decrease the effectiveness of some medication (including diazepam, olanzapine, haloperidol and mirtazapine) by lowering therapeutic blood levels which in some cases means that heavy smokers need a 50-100% increase in dose in order to achieve the same therapeutic level as a non-smoker (Desai, Seabolt & Jann, 2001; Wu et al. 2008). Clearly, this has clinical implications for prescribing, but also in terms of medication related side effects and increased risk of toxicity for patients. Smoking also has a considerable financial impact, both for the individual smoker and for healthcare services more generally (Royal College of Physicians, 2019). Smoking is expensive and people with dual-diagnosis are likely be in receipt of benefits and live close to the poverty line; this is only worsened by their tobacco addiction (Steinberg, Williams & Ziedonis, 2004). Although smoking has significant negative effects for all smokers, the negative implications of smoking appear to be more significant and wider reaching for people with dual-diagnosis, due to the complex physical and social co-morbidities that this group face.

### **Smoking cessation among people with dual-diagnosis**

Given and that there is a public health drive to increase smoking cessation among the general population, it is concerning that smoking rates among people with dual-diagnosis remain so high. Despite the high prevalence rates, estimates suggest that 50-70% of people with mental health and substance misuse who smoke, would like to stop smoking (Coulthard et al. 2002). However, given the high levels of social disadvantage and complex physical health comorbidities of people with dual-diagnosis, it is likely that this group would have difficulty quitting smoking without support (Baker et al. 2006). Correspondingly, research suggests that successful quit rates among people with substance use and mental health are significantly lower than that of the general population. Quit rates of at least a year amongst smokers with no

diagnosis of mental health or substance misuse disorder are around 51% compared to those for people with alcohol dependence (16%), bipolar (25%) and major depression (26%) (HSCIC, 2015; Lasser et al. 2000).

It is unclear why there is such a difference between the percentage of people with dual-diagnosis who are motivated to quit and the percentage that are able to achieve cessation. Models of health behaviour offer a framework to understand different behaviours and provide a starting point for developing interventions. The COM-B model of health behaviour (Michie, Van Stralen & West, 2011) suggests three overarching components that interact to produce a behaviour: capability to execute it, opportunity to take part in it and motivation to engage with it over other competing behaviours. Although other models of health behaviour exist, such as the Theory of Planned Behaviour and Health Belief Model (e.g. Ajzen, 1985; Hochbaum, 1958), they have been criticised for not addressing the role of important aspects such as impulsivity, habit and emotional processing (West, 2006) and these aspects have been identified as playing an important role in smoking cessation for smokers with mental health and substance misuse (Twyman, Bonevski, Paul & Bryant, 2014).

COM-B not only offers a model of health behaviour, but also provides the basis for designing appropriate interventions. There is strong evidence for the success of smoking cessation interventions in the general population (NICE 2006; 2018). However, there are no specific guidelines for smoking cessation interventions for people with dual-diagnosis. There is a need to better understand the factors that make it difficult for people with dual-diagnosis to translate their desire to stop smoking into successful cessation in order to design interventions that might be appropriate.

People with severe and enduring mental health difficulties and co-morbid substance misuse problems are a group whose voices are often not heard in research. It

is important to understand their perceptions of smoking and smoking cessation so that we can begin to recognise the unique difficulties this group face in moving from high rates of reported motivation, to successful quit attempts. It is the responsibility of health care professionals to meet the health needs of vulnerable populations but at the moment there is a clear unmet clinical need for smoking cessation among people with dual-diagnosis (Royal College of Physicians, 2019). Unless health services begin to effectively engage with and manage the tobacco dependence of this population, there is a risk that people may pass through services and may overcome their primary addiction and stabilise their mental health, but then later die of tobacco related causes (Action on Smoking and Health, 2015).

### **The Current Study**

There is some limited research exploring the experiences and attitudes towards smoking cessation of service users with substance addictions (Wilson et al. 2016) or mental health difficulties (Kerr, Woods, Knussen, Watson & Hunter, 2013), but to our knowledge, no research has explored qualitatively the views of people with co-morbid mental health and substance misuse disorders on smoking and smoking cessation.

Qualitative research offers the opportunity to understand the experiences and perceptions of individuals, situated in their social contexts. It is important to explore factors that may enable and prevent smoking cessation for people with co-morbid mental health and substance dependency as this is a group who face high health inequality, multiple deprivations and limited support.

This study aims to explore the process of smoking cessation from the perspective of people accessing community drug and alcohol treatment with a dual-diagnosis of both substance misuse and a diagnosed mental health problem. It aims to

gain an understanding of participants' experiences, attitudes and beliefs about smoking and smoking cessation.

## **Method**

### **Study Design**

This study takes a critical realist perspective. Critical realism bridges the realism – relativism epistemological divide and suggests that a real and knowable world sits behind the subjective and socially located knowledge that is accessible to a researcher (Madill, Jordan & Shirley, 2000). Retroduction is a central tool of critical realist research (Bhaskar, 1978). It involves reflexivity about theoretical positioning and recurrent movement between theory and the evidence being gathered (Oliver, 2012).

Although critical realism is compatible with a number of different qualitative methods (Braun & Clarke, 2013), a Grounded Theory (GT) approach was chosen because it offers the opportunity to generate a theory that explains the phenomenon under investigation (Birks & Mills, 2015). GT transcends a description of what is happening, to achieve an understanding of the process by which it is happening. It facilitates the development of a theory, with explanatory power, 'grounded' in the data (Corbin & Strauss, 2008). Over the years, GT has shifted from a methodology focused on pure induction towards an approach that accommodates researchers' pre-existing theoretical knowledge, as long as researchers are transparent about any theoretical starting point (Charmaz, 2006; Corbin & Strauss, 2008). The critical realist approach to GT used for this study allows for the recognition of the influence of pre-existing models of health behaviour on the research process.

This study used GT-lite (Braun & Clarke, 2013) which involves some stages of full GT, such as initial coding and category development, which allow for an understanding of the relationships between categories but may not lead to the generation of a full theory. Full GT is usually only achievable in large-scale research projects and as a result it has been suggested that very few studies actually use a full GT approach (Pidgeon & Henwood, 1997).

## **Procedure**

Participants were adults with dual-diagnosis who smoke tobacco daily (see Table 1). Dual-diagnosis is defined by NICE (2016) as “severe mental illness combined with misuse of substances”. For the purposes of this research ‘severe’ mental illness refers to schizophrenia, delusional disorders, bipolar, severe depressive episodes, personality disorders (Todd et al., 2004). Individuals with any combination of substance misuse and severe mental health diagnosis were eligible to participate. The aim of this research was to gain a broad understanding of the experiences of this group without restricting the sample. Individuals who could not speak English were not eligible to participate. A total of eight participants were recruited, with 6-10 participants being enough for GT-lite (Braun & Clarke, 2013).

Participants were recruited from two community drug and alcohol treatment services, one in a city and the other in a small rural town. Clinical staff members identified eligible service users from their caseloads. These staff members distributed participant information sheets (Appendix C) and gained written consent for participants to be contacted by the primary researcher, LM (Appendix D).

Informed written consent was obtained from all participants (Appendix E) and a brief demographic questionnaire was administered (Appendix F). Face-to-face semi-structured interviews were undertaken by LM. Seven interviews took place in the addiction treatment clinics and one took place in a participant’s home. An interview

guide was used during the interviews (Appendix G), but the interviews were conducted with a degree of flexibility to allow participants to discuss emergent themes and ideas. Participants were offered a £10 voucher to acknowledge the time that they put into the research.

Table 1. Demographic information for participants

<b>Pseudonym (gender, age) *</b>	<b>Diagnosis</b>	<b>Primary Substance</b>	<b>Additional substances</b>	<b>Amount smoked</b>	<b>Tried to quit? Y/N</b>	<b>Interest in quitting smoking</b>
Alex (M, 32)	Emotionally Unstable Personality Disorder	Heroin	Alcohol, crack cocaine, amphetamines	10 cigarettes daily	Y	Unsure
Paul (M, 47)	Schizophrenia	Crack cocaine	Cannabis, LSD	20 cigarettes daily	Y	No interest
Sean (M, 30)	Depression	Crack cocaine	Alcohol	30 cigarettes daily	Y	Want to quit in the next 6 months
Megan (F, 42)	Schizophrenia	Crack cocaine	-	5 cigarettes daily	Y	Want to quit now
Adam (M, 53)	Bipolar	Alcohol	Diazepam (unprescribed)	25 cigarettes daily	Y	Unsure
Jack (M, 46)	Depression	Heroin	Alcohol	5 cigarettes daily	Y	Want to quit in the next 6 months
Scott (M, 42)	Depression and Post-traumatic Stress Disorder	Cannabis	Alcohol, cocaine	50g tobacco weekly	Y	No interest
Laura (F, 25)	Emotionally Unstable Personality Disorder	Alcohol	Cocaine, heroin	20 cigarettes daily or 12mg vape	Y	No interest

The interviews were audio recorded and transcribed verbatim by LM for qualitative analysis. See Appendix H for transcription guide. During and at the end of each interview, the researcher made notes about participants' non-verbal cues. Data

were anonymised through the use of pseudonyms. Any identifying information discussed during the interview was removed during transcription.

### **Data Analysis**

Data were analysed in line with a GT approach (Bryant & Charmaz, 2010). The technique of constant comparative analysis was used to go back and forth between the data collection and analysis (Glasser & Strauss, 1967); this ensured that the complexity of the data was represented in the developing theory.

Data collection and analysis were led by LM and assisted by using NVivo 11 (QSR International, Southport, UK). Interviews were initially analysed using an inductive line-by-line approach to coding which allowed the researcher to stay close to the data and begin to conceptualise participants' ideas. Second order themes were then identified and defined by LM to establish which codes occurred most frequently. Higher order themes were influenced by theoretical models of health behaviour, particularly COM-B (Mitchie et al. 2011), and Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1979). Coding was discussed at meetings with the research team until a consensus was reached about emerging themes. In line with the GT approach, the later interviews were guided by the analysis of earlier interviews which allowed for interview questions to be changed and adapted slightly in line with emerging themes. This process ensured that the developing theory fit with the data.

Throughout the research process, a journal was kept and memos were written in order to record insights arising from the data and reflect on developing ideas. Memos were used to ensure trustworthiness by demonstrating the process by which the researcher arrived at themes. The researcher spent time reflecting on pre-existing conceptualisations that might influence theoretical sensitivity to the concepts evident in the data (Birks & Mills, 2015). Mapping of emerging theoretical connections

between themes took place throughout the analysis process as a precursor to the development of a theoretical model. See Appendix I for an example of a thematic map.

Theoretical saturation is a concept about which there is little agreement among grounded theorists (Charmaz, 2014). Instead of theoretical saturation, Dey (1999) argues that recruitment and data collection should continue until ‘theoretical sufficiency’ is reached. Theoretical sufficiency occurs when sufficient conceptual depth has been reached to allow the development of a theory, but it does not necessarily mean that data sources have been exhausted (Guest, Bruce & Johnson, 2006). In the current research, data collection ended when it was agreed that the sample was comprehensive enough in depth and breadth to provide enough data to allow for the exploration of conceptual relationships and development of conclusions in relation to the research questions.

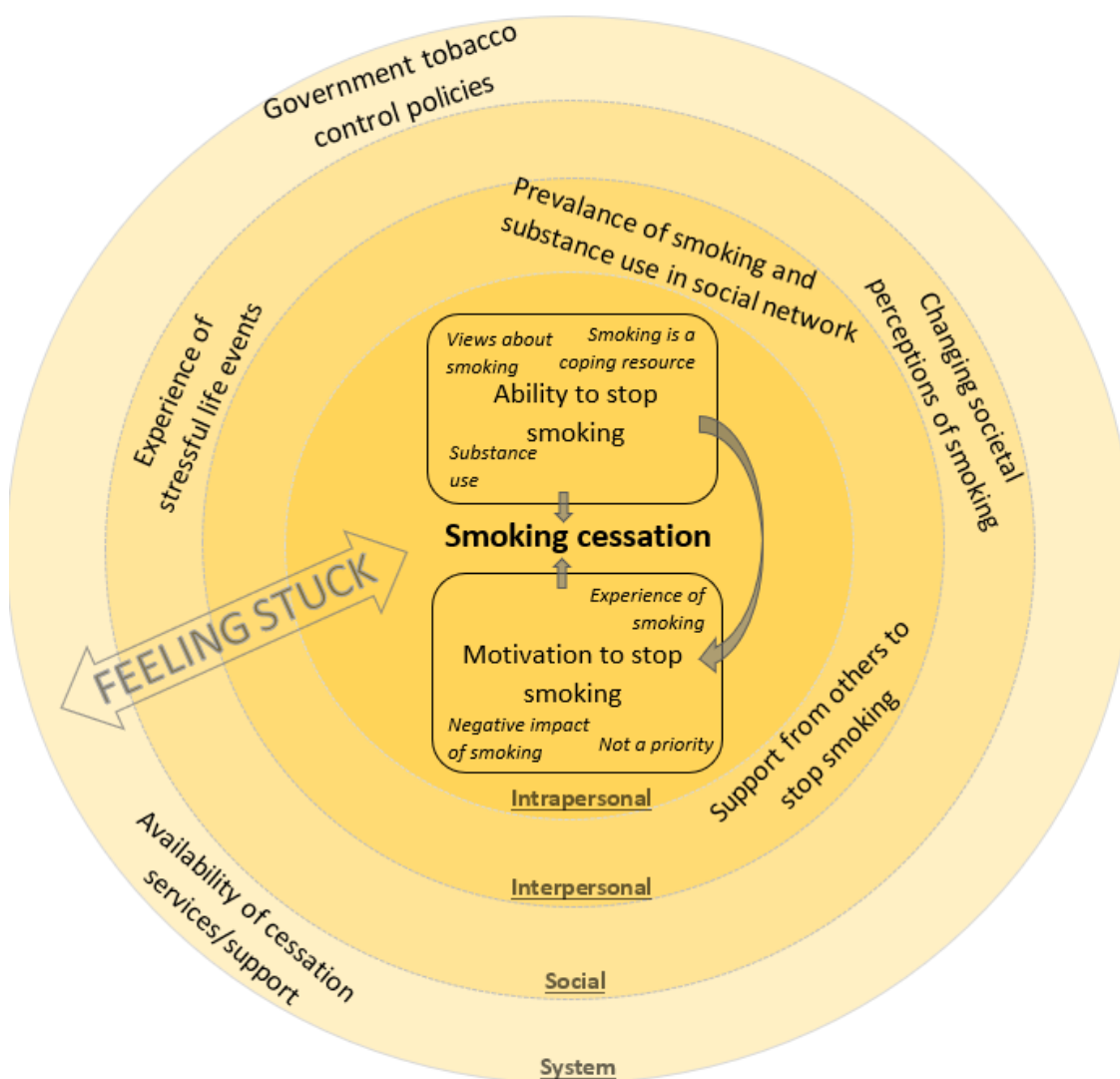
### **Ethical approval**

Ethical approval for this study was granted by University East Anglia’s Faculty of Medicine and Health Sciences Research ethics committee and by Change Grow Live research committee in June 2018 (Ref 2017/18 – 130 SE; Appendices J-M).

## **Results**

A grounded theory of the process of smoking cessation for people with dual-diagnosis emerged from the data. Four over-arching themes were identified which related to the layers of influence on the process of smoking cessation. These themes were influenced by Bronfenbrenner’s (1979) ecological systems theory and related to

intrapersonal, interpersonal, social and system factors. Emergent themes were organised around these four higher-level themes. Figure 2 displays a diagrammatic representation of the conceptualised themes.



The diagram shows the layers of influence on the process of smoking cessation for people with dual-diagnosis, as evident in the data. Each circle represents a layer of influence from the intrapersonal factors in the centre, moving out to system factors at the external layer. Intrapersonal factors are represented in the middle of the model because the individual is at the centre of the process of smoking cessation. In the centre layer there are two boxes which represent the two overarching themes that emerged at an intrapersonal level: motivation to quit and ability to quit. The sub-

themes in each of these boxes are in italics font. As shown by the arrows on the diagram, it is proposed that an individual's ability to stop smoking influences an individual's motivation to quit, and both ability and motivation independently impact whether someone can achieve smoking cessation. The themes in the other three layers (interpersonal, social and system) relate to participants' opportunity to engage with smoking cessation. Themes at these levels interact at an intrapersonal level to influence an individual's ability and motivation to achieve cessation. Across each layer of influence there is an overarching, implicit theme of participants being "stuck" in their situation and their tobacco addiction.

Although the diagram may appear to emphasise the distinction between the levels of influence (intrapersonal, interpersonal, social and system) the use of gradient across the circles is to indicate that these aspects interact and often overlap. This will be explored further in the following discussion of each of the themes.

### **Intrapersonal factors influencing smoking cessation**

Intrapersonal factors were the most frequently discussed aspects that influenced smoking cessation for participants. These could be split into factors that related to participants' motivation to stop smoking and factors that related to participants' ability to stop smoking.

**Motivation to stop smoking.** This theme had three sub-themes: perceived experience of smoking, smoking cessation not a priority and the perceived negative impact of smoking.

***Perceived experience of smoking.*** The majority of participants spoke about enjoying smoking. They talked about enjoying the taste and the feeling it gives them.

*“I like the taste ... I don’t get the high that I did when you have the first one ...  
I like, I like, just relax ...”* – Paul

There was a split among participants about whether they wanted to stop smoking or not. Some participants did not want to stop due to concerns about whether they would be able to cope with their mental health and, particularly, stress without it. However, others felt that the benefits of stopping, such as the health and financial benefits, outweighed the negatives.

*“I’d love to stop smoking just financially, you know, its twenty quid basically that I might as well just burn, you know, every time I’m smoking a pack of fags”* – Alex

***Smoking cessation is not a priority.*** Most participants spoke about having “bigger problems” than stopping smoking. Participants identified various difficulties in their lives which they felt needed to be addressed before they could consider stopping smoking. These ranged from wanting to get back into work, find a stable home, stop other substances, and become emotionally stable.

*“I’d like to stop [smoking], I don’t think I’ll be able to do it all at once ... just block the heroin out that- that’s the good- that’s the starting point, then I’m gonna move on to cigarettes and then maybe crack”* – Sean

*“get somewhere to live and stabilise my life, which I want to do ... and then address some of my issues like the alcohol and the prescription drugs”* – Adam

***Perceived negative impact of smoking.*** Most participants recognised the physical health and financial impact of smoking. Some spoke about relatives or friends who had died due to cancer and other respiratory diseases associated to smoking and others spoke about their own experiences of difficulties with their physical health as a

result of smoking. However, the knowledge of the negative impact of smoking did not appear to influence participants' motivation to quit.

*"I think it will kill you one day I suppose but that's only like 10% of bad luck"*

– Paul

*"Yeah, it is a worry yeah, I know it's there but I don't want to give up"* – Jack

**Ability to stop smoking.** This theme relates to participants' capacity to engage with smoking cessation. It has three sub themes: views about smoking cessation, smoking as a coping resource, and association between substance use and smoking. Participants' ability to stop smoking influenced their motivation to try to stop smoking.

**Views about smoking cessation.** All participants perceived quitting smoking to be hard. Participants felt that stopping smoking would be difficult for a number of reasons including the length of time smoking, their physical addiction to nicotine, the perceived negative impact of stopping smoking on their mental health, and the habitual nature of their use and concerns about how they would cope with stress without smoking. These reasons contributed to participants feeling less motivated to try to stop smoking.

*"I just think I've been smoking so much longer than I have been, well I've been doing drugs and smoking since kinda the same time but smoking has been always sort of a consistent thing the drugs have been sort of like on off on off you know, it's never been like, other than sort of lately, been a daily thing that I do, smoking is daily and that's probably one of the biggest habits that I've ever had is smoking, I – I definitely think that will be the hardest thing that I'll ever do if I ever do it"* – Alex

*“Because ... oh it’s like an addiction in itself, it just a habit really innit, it’s not easy to quit smoking, I tried to quit” – Paul*

All participants spoke about experiences of attempting to stop smoking but being unable to sustain cessation. Most participants felt that this was an indicator of how hard it was to stop, and it provided evidence for them of their inability to quit. The majority of participants talked about having no, or very little, confidence in their ability to stop smoking. Some said that this was because they considered themselves to have addictive personalities and others felt that they lacked the willpower to successfully achieve cessation.

*“...just went back to how I was doing it before, think I’ve got an addictive personality and that’s why it’s probably doing it, do it to excess” – Sean*

Participants had a variety of views about the utility of nicotine replacement therapy (NRT) in supporting them to achieve cessation. Most participants felt that NRT, particularly the use of e-cigarettes, helped them to abstain from smoking.

*“I’m smoking so much less than I ever smoked ... (Interviewer - “Much less than you’ve ever smoked?”) Yeah the best thing I done was going on the vaper” – Megan*

However, not everyone had positive views about e-cigarettes. Negative views of past experiences of e-cigarettes presented a barrier for their future use.

*“They gave me that stupid, crappy e-cigarette that tastes like a cigarette ... (Interviewer – “Oh the nicotine thing, yeah I know what you mean”) Nicotine thing yeah and it was just- it didn’t take away the craving for me, it didn’t really taste like fags and it got to the point where it didn’t feel like it was working so I might as well just have a cigarette” – Scott*

***Smoking as a coping resource.*** Almost all participants spoke about the use of smoking as a coping resource. A small number of participants talked about the role of cigarettes to cope with aspects such as sleep and physical pain, but most felt that smoking helped them to cope with stress.

*“...feel like I'm gasping for breath and then if my lungs fill up with smoke then I feel relaxed and happier at the same time” – Megan*

Participants also felt that smoking helped them to cope with their mental health. Participants spoke in depth about their experiences of anxiety, depression, trauma and psychosis, and the ways in which substance use and smoking helped them to cope with these experiences. Participants identified the different ways that smoking had an impact on their mental health. Some participants felt that smoking “enhanced” the voices they heard, whereas others felt that it offered a distraction from their negative thoughts and anxiety.

*“With anxiety you're worried about other people, are people looking at you, then if you're just focusing on smoking a cigarette you're focusing on that one thing not everything else that's going on around you ... do you understand, do you see what I'm coming at? (Interviewer – “Yeah, you've got your focus on that thing haven't you”) Yeah ... whereas if I'm not smoking I'm kind of focusing on what's going on around me, focusing on what's going on in my head and what I'm thinking about more than if I had a distraction” – Alex*

Most participants felt that they would struggle to cope with their daily life if they didn't have access to cigarettes. Participants' reliance on smoking as a coping resource appeared to significantly impact their motivation to attempt cessation. This was particularly highlighted by some participants who described difficulties coping with stress and their mental health when they had previously been without cigarettes.

*“I always relied on my smoking and yeah not having that was awful ... and my mental health really got bad in there [mental health hospital], really bad, I ended up taking a massive overdose” – Laura*

**Association between smoking and other substance use.** Most participants talked about the link between their smoking and their use of other drugs and alcohol. The link between smoking and drug and alcohol use made it difficult for participants to consider stopping smoking while they were still using substances. For many, it felt that this association would be difficult to break because it was habitual and because smoking helped them to cope with some of the negative impacts of substances, this therefore affected their perceived ability to stop and subsequently affected their motivation.

*“yeah I definitely increase the amount I smoke when I'm on alcohol or kind of any substance that makes me sort of like ... speed ... anything that makes you sort of like racy” – Alex*

*“your heart rate can go through the roof and anxiety was just so heightened when I took drugs and yeah the smoking was there to holy shit I need to calm down I need to slow my heart rate down I need to chill just for one minute ... um definitely linked to drugs yeah absolutely” – Laura*

Some participants also spoke about smoking when they were withdrawing from substances or when they were experiencing a “come down” after a period of using.

*“Yeah ... well when I haven't got anything I just get a bit shaky and agitated and just smoke a cigarette just to wait and try to calm down a bit” – Megan*

## Interpersonal factors influencing smoking cessation

All participants commented on the influence of other people on starting, continuing and quitting smoking. Interpersonal factors were split into two themes: prevalence of smoking in social network, and support from others to stop.

**Prevalence of smoking in social network.** All participants talked about the prevalence of smoking among their friends and families.

*“I don’t think any really any of my friends don’t smoke ... I’ve got like a couple but I mean it’s rare to find someone that doesn’t smoke now a days” – Alex*

*“Everybody I know smokes” – Jack*

Some participants wondered if perhaps they had selected, or been drawn towards, particular people because they also used substances and smoked.

*“My partner is a smoker yeah and uh ... but then I think you kind of angle your parties to what- whether you do or don’t smoke” – Scott*

Participants felt that the prevalence of smoking in their social network negatively affected their beliefs about their ability to stop smoking. Socialising with other smokers was seen as a significant barrier to smoking cessation.

*“it would I think be harder if people around you were smokers and weren’t prepared to quit then yeah it would be hard ...” – Scott*

*“... people around you, if you’re around people that smoke you’re never gonna quit” – Laura*

Some participants alluded to feeling almost hopeless about any prospect of cessation, due to the considerable influence of their peers. Therefore, this interpersonal theme interacts with themes at an intrapersonal level by influencing participants’

perceived ability to stop smoking and their subsequent motivation to quit. One participant particularly commented on the lengths that others go to in order to try to continue substance use and smoking among the social group.

*“But it’s always the way, as soon as you say to someone ‘I’ve stopped taking drugs or I’ve stopped smoking’ they’ll offer it to you but if you’re sitting there all ‘Oh...I think I need a rollup’ they won’t give it to you ... (Interviewer – “Why’s that? Why do you think that-”) I don’t know, I’ve always found it like that way ... cos if someone thinks ‘Oh cor he’s doing better than me, he’s sorting this or-’ then they’re going to offer it to you, try and entice you back into it” – Sean*

**Support from others.** Despite the general feeling among participants that their social network negatively influenced their ability to stop smoking, some participants felt that if they had support from someone else, then cessation would be considerably easier. Having support from a partner, friend or family member who was also trying to or had achieved cessation increased participants’ perceived ability and motivation to also reach this goal.

*“because I was living at my mum’s it was easier ... and she wanted me to stop smoking while I was living in her house” – Megan*

### **Social factors influencing smoking cessation**

This theme relates to aspects in the social environment that influenced participants’ lifestyles and attitudes. This theme was split into two subthemes: experience of stressful life events, and societal perceptions of smoking.

**Experience of stressful life events.** The experience of challenging life events was referred to by all participants, these include homelessness, poverty, trauma and unemployment. These social difficulties led to an increase in stress and therefore an

increased use of smoking to cope with this experience of stress.

*“just having to struggle, which makes it harder which makes you think what the fuck am I doing it for, might as well just smoke and not be as stressed as I am” – Scott*

Some participants spoke about certain traumatic life events as the trigger for starting smoking and substance use, as a way of coping with the stress and trauma of these events.

*“I was abused from quite a young age um and ... drinking and smoking and drug taking was really all linked to that ... it was- you had to do drink or use drugs otherwise it was too painful to get through” – Laura*

Homelessness, financial difficulties and unemployment often result in people having lots of time with limited access to rewarding activities. Boredom then potentially leads people to smoke more and spend more time socialising with others who also smoke.

*“without work I had nothing to do you know what I mean, I was working all the time but next thing you know I lost my job and boredom set in” – Jack*

The experience of stressful life events therefore appears to operate as a factor that influences smoking not only at a social level but also through interactions at an interpersonal level, through being around a social group that smokes, and intrapersonal level, through using smoking to cope with stress.

**Societal perceptions of smoking.** A few participants spoke about the changing perceptions of society to smoking over time. Some felt that there used to be a culture of accepting and encouraging smoking, but that this has shifted to a dominant narrative of condemning smoking and those that smoke.

*“It looked cool, I dunno back in my day I was into all that stuff, The Jam and that ... and I dunno, it just, it’s not cool obviously it’s not cool but everybody did it you know ... it was just what you did, you drank you smoked” – Adam*

There was a sense, among some of these participants, of being different to others and isolated from the rest of society due to their smoking. Although some referred to this feeling explicitly, others alluded to a sense of isolation and stigma.

*“Makes me feel isolated, it makes me feel ... um ... it makes it difficult to wanna go out, because you don’t wanna offend people because now the regime is that it is so bad and we all must stop” – Scott*

However, not everyone agreed with these views. Some felt that smoking was still too accepted and available in our society, and that this was a barrier to successful cessation at both a social level but also through interactions at an intrapersonal level by influencing participants’ ability and motivation to quit.

*“cigarettes are accepted aren’t they whereas drugs, drug use isn’t, you know, um ... I can go to the shop and buy fags but I can’t go to the shop and buy fucking crack can I” – Alex*

### **System factors that influence smoking cessation**

This theme was split into two subthemes: Government tobacco control policies, and the availability of cessation services.

**Government tobacco control policies.** Almost all participants had some experience with and opinions about Government tobacco control policies. Several participants had experienced smoke-free prisons and had managed to achieve smoking cessation in this environment.

*“went to jail for a year ... uh ... umm ... uh then stopped all the drugs, which was fantastic, like a blessing in disguise” – Alex*

However, none of these participants managed to maintain their cessation when they were released from prison.

*“I hadn’t smoked, you weren’t allowed to smoke, for 9 months and I got out and I had a fag and I was coughing and throwing up and that but I still did it” – Adam*

Two participants had experience of being on smoke-free mental health wards, but both of these participants smoked more when they were in these environments.

*“you always get searched when you come in but we just stick cigarettes in our bra and a lighter and we’d go in our rooms and smoke it ...” – Laura*

*“that’s the most I’ve ever smoked ... that was loads ... (Interviewer – “Why were you smoking so much when you were in [inpatient ward]?”) Stress ... we always all did a routine and everything there wasn’t anything to do and the routine was like smoke breaks and you had about 6 smoke breaks, 7 maybe” – Megan*

Overall, most participants felt that Government attempts to control smoking, by introducing different policies and campaigns, didn’t work.

*“it’s the way government are trying to stop people smoke ... I just don’t think it works at all, I really don’t ... (Interviewer – “Yeah, I don’t know...”) you can hike the prices up you can fucking make it as expensive as you like, people are still going to do it still going to find way aren’t ya” – Alex*

*“put campaigns up, but a lot of people don’t listen to campaigns do they?”*

(Interviewer – “No...”) *You got all those stop smoking things and they just walk away” – Jack*

Although the use of smoke-free policies and anti-smoking campaigns increased participants’ awareness and offered them the opportunity to engage with smoking cessation, for most participants the existence of these opportunities did not translate to an increased ability or motivation to engage with smoking cessation.

**Availability of cessation services.** For many participants, the availability of services to help them stop smoking was an important factor in whether they felt able to achieve cessation. A few participants had sought cessation support through their GP, but most had not received any medical support, neither through primary care health settings nor secondary mental health or addictions services. Some participants felt that addressing smoking in addiction services would be helpful.

*“having smoking services here [addiction service] yeah to help you and to show you why you're doing it and to give you tools to- to not smoke to use other therapies or other stuff like meditation to stop you from having that extra cigarette” – Laura*

The availability of cessation services offers participants the opportunity to engage with smoking cessation. This theme also relates to themes at an intrapersonal level, of increasing perceived ability to stop smoking, and an interpersonal level, by encouraging participants to feeling supported by others.

## **Discussion**

This paper has drawn together qualitative data from a selected sample of people with dual-diagnosis to gain an understanding of the process of smoking cessation. This study conceptualised smoking cessation as being subject to influence from multiple layers. Across all layers of influence, there was a sense among participants of feeling stuck in their tobacco addiction, and in their situation more generally. Although the action of smoking ultimately relates to an individual's behaviour, the data indicate that participants perceive several factors, external to themselves, that influence their behaviour and present a barrier to behaviour change. This idea is congruent with the social determinants of health framework, which argues that an individual's health is influenced by factors across individual, social, cultural and environmental levels (Dahlgren & Whitehead, 1992).

### **Individual Barriers to Smoking Cessation**

Overall, participants felt that there were more barriers to smoking cessation than facilitators. Participants seemed to have a low sense of perceived self-efficacy, which in turn seemed to considerably, and perhaps understandably, affect their motivation to quit and contributed to a feeling of being stuck in their tobacco addiction. Most pertinent were participants' perceptions of smoking as an important coping resource and their concern about the impact of smoking cessation on their mental health and management of stress. The role of smoking as a coping resource has been emphasised in previous research with smokers with mental health difficulties (Kerr et al., 2013), substance addictions (Wilson et al., 2016) and smokers in the general population (Guirguis et al., 2010). Participants also emphasised the link between tobacco use and use of other substances. Despite using different substances, with different patterns of use, most participants felt that there was a link between their substance use and smoking. Previous research has also highlighted this relationship,

particularly among those who use cannabis (Amos, Wiltshire, Bostock, Haw & McNeil, 2003).

Previous research with vulnerable groups of smokers (i.e. pregnant Aboriginal women, people with low socioeconomic status) found that an inadequate knowledge of smoking-related risks was a significant barrier to cessation (Gould et al. 2013; Gollust, Schroeder & Warner, 2008). These results were not replicated in the present study. Participants in the current study identified and understood the health and financial costs of smoking, but this knowledge was not enough to motivate behaviour change. Perhaps this is related to participants' perceptions of needing to sort out other issues before they could consider stopping smoking, such as homelessness, unemployment, substance use and their mental health. In line with Maslow's (1943) hierarchy of needs, individuals need to satisfy lower level needs (e.g. safety, warmth, food) before they can meet higher level psychological or self-fulfilment needs (e.g. achieving one's full potential).

### **Systemic Barriers to Smoking Cessation**

Research has consistently identified the higher rates of social deprivation and poverty among people with dual-diagnosis (Johnson & Cnaan, 1995). Social aspects, such as these, presented a significant barrier to smoking cessation for participants in the current research, and they interacted with factors at an intrapersonal and interpersonal level. At an intrapersonal level, the presence of social deprivation and challenging life events lead to an increased level of stress for participants and therefore increased smoking to cope with this stress. At an interpersonal level, the presence of social aspects, particularly poverty and unemployment, left participants with a limited number of rewarding activities and therefore more time spent with peers who also smoke. The prevalence of smoking among participants' friends and families was particularly notable.

All participants in this research commented on the prevalence of smoking among their social group, in fact most participants could not identify anyone they associated with who did not smoke. This appears to be at odds with smoking prevalence data that indicates that smoking rates have been declining year on year in the general population (ONS, 2018). However, this finding is in line with previous research that has emphasised the norm of smoking among mental health and substance misuse populations (Campion et al. 2008). Previous research has suggested that the lack of positive role models for people with mental health and substance misuse difficulties who want to stop smoking, limits the opportunities for social learning and positive behaviour change (Kerr et al. 2013; Bandura, 2004). Perhaps this also links to the presence of a culture of smoking more generally in mental health and addictions services, including among staff (Schroeder and Morris, 2010).

At a system level, many participants were disillusioned by Government attempts to control tobacco consumption. Although the aim of these types of interventions is to increase the opportunity for individuals to engage with smoking cessation (Mitchie et al. 2011), they did not appear to have the desired result for most participants in this research. For two participants, the norm of smoking seemed to prevail even despite the presence of a smoke-free policy on a mental health ward. Having said that, some participants were able to achieve cessation whilst in a smoke-free prison environment, but this was not sustained once they were released. Perhaps this was because of the influence, at an interpersonal level, of the norm of smoking in participants' social circles, or perhaps it was because participants were returning to social deprivation, poverty and homelessness resulting in more stress and the association of smoking as a coping resource.

## **Findings in Relation to COM-B**

Many of the findings of this research are in line with the COM-B model of health behaviour (Mitchie et al. 2011). The themes of motivation to change and ability to change, as outlined in this research, map onto the motivation and capability elements of the COM-B model respectively. The interpersonal, social and system factors identified in the current research, relate to the COM-B component of opportunity. However, the current findings go beyond explanations that can be incorporated within the COM-B model, by placing more emphasis on factors that are external to the individual (i.e. social, cultural, societal) and highlighting a general sense of participants 'feeling stuck' with regards to their smoking cessation. There is a tendency for established theories, such as COM-B, to be based on the understandings of dominant social groups (Burr, 2015). It therefore stands to reason that research with a marginalised group, such as those with dual-diagnosis (Fraser et al. 2003), would bring to light aspects that do not completely align with such theories.

## **Clinical Implications**

The findings of this research identified a number of internal and external factors for people with dual-diagnosis that present challenges for smoking cessation. Bronfenbrenner's ecological framework suggests that in order to design and implement appropriate interventions, barriers at all levels need to be identified and addressed (Bronfenbrenner, 1979).

Smoking was identified as an important coping resource for participants. Healthcare staff and services need to emphasise equipping this group with alternative methods of coping to decrease their reliance on the use of substances. Many participants felt that smoking relieved their mental health symptoms, particularly anxiety. However, what people may not understand is that nicotine withdrawal can mirror mental health difficulties, such as feelings of anger, depression and anxiety

(Hughes, 2007). In this regard, continuing to smoke has the effect of actually relieving withdrawal symptoms (return to equilibrium), rather than having a positive effect on mental health, although this is the perception. Education about the influence of nicotine on mental health may therefore be important.

The high prevalence and acceptability of smoking among participants' social groups was particularly notable. Participants particularly commented on the difficulty of achieving cessation without support and several felt that addictions services should offer smoking cessation interventions. By emphasising the development of supportive relationships with healthcare staff and providing the opportunity for people with dual-diagnosis to meet positive role models who have themselves given up smoking, services may begin to address some of the interpersonal barriers identified in the current research. Previous research has identified that people with enduring mental health difficulties are often reluctant to access mainstream services (De Hert et al., 2009), so offering smoking cessation in services they are familiar with (i.e. mental health and addictions settings) could go some way to address this. Research also suggests that concurrent smoking and substance misuse interventions can be effective (Thurgood et al. 2016). Furthermore, the results of this research suggest there is a relationship between participants' substance use and smoking, so addressing one without the other would perhaps make it difficult for cessation to be sustained.

### **Limitations and Future Research**

This study was approached from a critical realist position, implying that there is inherent subjectivity in the production of knowledge because the perception of information depends partly on an individual's beliefs and expectations (Bunge, 1993; Watkins, 1994). Therefore, no claim is made that the findings of this research are generalisable, in a statistical sense, to other populations. It is acknowledged that the participants in this research were recruited from a rural area of England with a

predominantly White British population. People with dual-diagnosis in more urban settings or with different ethnic and cultural backgrounds may conceivably report different experiences.

The GT approach used in this research focused on understanding and describing the process of smoking cessation for the participants. However, the emotional impact of the cessation process was difficult to capture using this methodological approach. Future research could consider focusing more explicitly on the emotional experience and impact of individuals going through the process of smoking cessation.

Due to the exploratory nature of this research no attempt was made to recruit participants with particular combinations of mental health and substance misuse diagnoses. However, previous research has suggested that different mental health diagnoses may be associated with different barriers to smoking cessation, due to the heterogeneity of symptoms and differing experiences of stigma (Ferron et al. 2011). Future research could consider exploring whether there are differences between dual-diagnosis smokers and smokers with and without a diagnosis of either mental health or substance misuse.

## **Conclusions**

Overall, this study concludes that a number of interpersonal, intrapersonal, social and system factors influence smoking cessation for people with dual-diagnosis living in the community. Despite its limitations, this research has clear implications for clinical practice by offering an insight into factors to consider in the development of appropriate smoking cessation interventions for people with dual-diagnosis. Interventions need to address the wider social, cultural and systemic context as well as individual factors, if they are to be successful for this group of vulnerable people.

## References

- Action on Smoking and Health (2015). *Smoking and mental health: a neglected epidemic*. Retrieved from:  
<http://www.ashscotland.org.uk/media/6671/ASHScotlandSmokingandmentalhealth.pdf>
- Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In *Action control* (pp. 11-39). Springer, Berlin, Heidelberg.
- Amos, A., Wiltshire, S., Bostock, Y., Haw, S., & McNeill, A. (2004). 'You can't go without a fag... you need it for your hash'—a qualitative exploration of smoking, cannabis and young people. *Addiction*, 99(1), 77-81.
- Baker, A., Richmond, R., Haile, M., Lewin, T. J., Carr, V. J., Taylor, R. L., ... & Wilhelm, K. (2006). A randomized controlled trial of a smoking cessation intervention among people with a psychotic disorder. *American Journal of Psychiatry*, 163(11), 1934-1942.
- Bandura, A. (2004). Health promotion by social cognitive means. *Health education & behavior*, 31(2), 143-164.
- Bhaskar, R. (1978). On the possibility of social scientific knowledge and the limits of naturalism. *Journal for the Theory of Social Behaviour*. 8(1), 1-28.
- Birks, M., & Mills, J. (2015). *Grounded theory: A practical guide* (2<sup>nd</sup> ed.). Los Angeles, CA: SAGE Publications.
- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard university press.
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: SAGE Publications.
- Bryant A, & Charmaz, K. (2010). *Sage Handbook of Grounded Theory*. London: SAGE Publications.
- Bunge, M. (1993). Realism and antirealism in social science. *Theory and Decision*, 35(3), 207-235.
- Burr, V. (2015). *Social constructionism* (3rd ed.). London, UK: Routledge.
- Campion, J., Lawn, S., Brownlie, A., Hunter, E., Gynther, B., & Pols, R. (2008). Implementing smoke-free policies in mental health inpatient units: learning from unsuccessful experience. *Australasian Psychiatry*, 16(2), 92-97.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.
- Charmaz, K. (2014). *Constructing grounded theory*. London: SAGE Publications.

- Clausen, T., Waal, H., Thoresen, M., & Gossop, M. (2009). Mortality among opiate users: opioid maintenance therapy, age and causes of death. *Addiction*, 104(8), 1356-1362.
- Cookson, C., Strang, J., Ratschen, E., Sutherland, G., Finch, E., & McNeill, A. (2014). Smoking and its treatment in addiction services: Clients' and staff behaviour and attitudes. *BMC health services research*, 14(1), 304.
- Corbin, J., & Strauss, A. (2008). *Basics of Qualitative Research (3<sup>rd</sup> ed.): Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: SAGE Publications.
- Coulthard, M., Farrell, M., Singleton, N., & Meltzer, H. (2002). *Tobacco, Alcohol and Drug Use and Mental Health*. London: The Stationery Office.
- Dahlgren, G., & Whitehead, M. (1992). Policies and strategies to promote equity in health. Copenhagen: Regional Office for Europe. *World Health Organization*.
- Darke, S., Degenhardt, L., & Mattick, R. (2006). *Mortality amongst illicit drug users: epidemiology, causes and intervention*. Cambridge, UK: Cambridge University Press.
- De Hert, M., Dekker, J. M., Wood, D., Kahl, K. G., Holt, R. I. G., & Möller, H. J. (2009). Cardiovascular disease and diabetes in people with severe mental illness position statement from the European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (ESC). *European psychiatry*, 24(6), 412-424.
- Department of Health (2006). Choosing Health: supporting the physical health needs of people with severe mental illness.
- Desai, H. D., Seabolt, J., & Jann, M. W. (2001). Smoking in patients receiving psychotropic medications. *CNS drugs*, 15(6), 469-494.
- Dey, I. (1999). *Grounding Grounded Theory*. San Francisco, CA: Academic Press.
- Doll, R., & Hill, A. B. (1950). Smoking and carcinoma of the lung. *British Medical Journal*, 2(4682), 739.
- Ferron, J. C., Brunette, M. F., He, X., Xie, H., McHugo, G. J., & Drake, R. E. (2011). Course of smoking and quit attempts among clients with co-occurring severe mental illness and substance use disorders. *Psychiatric Services*, 62(4), 353-359.
- Fidler, J. A., & West, R. (2009). Self-perceived smoking motives and their correlates in a general population sample. *Nicotine & Tobacco Research*, 11(10), 1182-1188.

- Fraser, A., Barlow, J., Bland, N., Carroll, J., Colvin, I., Crome, I., et al. (2003). *Mind the gaps. Meeting the needs of people with co-occurring substance misuse and mental health problems*. Scottish Executive: Edinburgh, Scotland.
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. London: Weidenfield & Nicolson.
- Gilchrist, G. (2002). Results from the study on psychiatric morbidity among female drug users in Glasgow. *Report to the working group on multi-mental health problems among alcohol and drug users*. Glasgow: Greater Glasgow NHS.
- Gollust, S. E., Schroeder, S. A., & Warner, K. E. (2008). Helping smokers quit: understanding the barriers to utilization of smoking cessation services. *The Milbank Quarterly*, 86(4), 601-627.
- Gould, G. S., Munn, J., Watters, T., McEwen, A., & Clough, A. R. (2012). Knowledge and views about maternal tobacco smoking and barriers for cessation in Aboriginal and Torres Strait Islanders: a systematic review and meta-ethnography. *Nicotine & Tobacco Research*, 15(5), 863-874.
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field methods*, 18(1), 59-82
- Guirguis, A., Ray, S., Zingone, M., Airee, A., Franks, A., & Keenum, A., (2010). Smoking cessation: barriers to success and readiness. *Tennessee medicine: Journal of the Tennessee Medical Association*. 103(9), 45-49.
- Health & Social Care Information Centre (2015). *Statistics on NHS Stop Smoking Services*. Retrieved from: <http://content.digital.nhs.uk/catalogue/PUB21162/stat-stop-smok-serv-eng-q4-1516-rep.pdf>
- Heath & Social Care Information Centre (2016). *Statistics on Smoking*. Retrieved from: <http://content.digital.nhs.uk/catalogue/PUB20781/stat-smok-eng-2016-rep.pdf>
- Hochbaum, G. M. (1958). *Public participation in medical screening programs: A socio-psychological study* (No. 572). US Department of Health, Education, and Welfare, Public Health Service, Bureau of State Services, Division of Special Health Services, Tuberculosis Program.
- Hughes, J. R. (2007). Effects of abstinence from tobacco: etiology, animal models, epidemiology, and significance: a subjective review. *Nicotine & Tobacco Research*, 9(3), 329-339.
- Hurt, R. D., Offord, K. P., Croghan, I. T., Gomez-Dahl, L., Kottke, T. E., Morse, R. M., & Melton, L. J. (1996). Mortality following inpatient addictions treatment: Role of tobacco use in a community-based cohort. *Journal of the American Medical Association*, 275(14), 1097-1103.

- Johnson, A. K., & Cnaan, R. A. (1995). Social work practice with homeless persons: State of the art. *Research on Social Work Practice*, 5(3), 340-382.
- Kerr, S., Woods, C., Knussen, C., Watson, H., & Hunter, R. (2013). Breaking the habit: a qualitative exploration of barriers and facilitators to smoking cessation in people with enduring mental health problems. *BMC Public Health*, 13(1), 221.
- Lasser, K., Boyd, J. W., Woolhandler, S., Himmelstein, D. U., McCormick, D., & Bor, D. H. (2000). Smoking and mental illness: a population-based prevalence study. *Journal of the American Medical Association*, 284(20), 2606-2610.
- Lehman, A. F., Myers, C. P., Dixon, L. B., & Johnson, J. L. (1994). Defining subgroups of dual diagnosis patients for service planning. *Psychiatric Services*, 45(6), 556-561.
- Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91(1), 1-20.
- Marder, S. R. (2003). Overview of partial compliance. *The Journal of Clinical Psychiatry*. 64(Suppl16), 3-9.
- Maslow, A. H. (1943). A theory of human motivation. *Psychological review*, 50(4), 370.
- Michie, S., Van Stralen, M. M., & West, R. (2011). The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implementation Science*, 6(1), 42.
- National Institute for Health and Clinical Excellence (2006). *Brief interventions and referral for smoking cessation in primary care and other settings*. Retrieved from: <http://www.nice.org.uk/nicemedia/live/11375/31866/31866.pdf>
- National Institute for Health and Care Excellence (2015). *Review 1: The epidemiology and current configuration of health and social care community services, for people in the UK with a severe mental illness who also misuse substances*. Retrieved from: <https://www.nice.org.uk/guidance/ng58/documents/evidence-review>
- National Institute for Health and Care Excellence (2016). *Coexisting severe mental illness and substance misuse (dual diagnosis): community health and social care services*. Retrieved from: <https://www.nice.org.uk/guidance/ng58>
- National Institute for Health and Clinical Excellence (2018). Stop smoking interventions and services. Retrieved from: <https://www.nice.org.uk/guidance/ng92/resources/stop-smoking-interventions-and-services-pdf-1837751801029>
- Neale, J. (2004). Gender and Illicit Drug Use. *British Journal of Social Work*, 34(6), 851-870.

- Office for National Statistics (2018). Adult Smoking habits in the UK: 2017, <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2017>
- Oliver, C. (2011). Critical realist grounded theory: A new approach for social work research. *British Journal of Social Work*, 42(2), 371-387.
- Pack, S. (2009). Poor physical health and mortality in patients with schizophrenia. *Nursing standard*, 23(21).
- Parks, J., Svendsen, D., Singer, P., Foti, M. E., & Mauer, B. (2006). Morbidity and mortality in people with serious mental illness. *Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council*, 25(4).
- Paul, C. L., Ross, S., Bryant, J., Hill, W., Bonevski, B., & Keevy, N. (2010). The social context of smoking: a qualitative study comparing smokers of high versus low socioeconomic position. *BMC public health*, 10(1), 211.
- Pidgeon, N., & Henwood, K. (1997). Using grounded theory in psychological research. In N Hayes (Eds). *Doing qualitative analysis in Psychology*, England: Taylor & Francis.
- Royal College of Physicians (2018). *Hiding in plain sight: Treating tobacco dependency in the NHS*, Retrieved from: <https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs>
- Schroeder, S. A., & Morris, C. D. (2010). Confronting a neglected epidemic: tobacco cessation for persons with mental illnesses and substance abuse problems. *Annual Review of Public Health*, 31, 297-314.
- Steinberg, M. L., Williams, J. M., & Ziedonis, D. M. (2004). Financial implications of cigarette smoking among individuals with schizophrenia. *Tobacco Control*, 13(2), 206-206.
- Thurgood, S. L., McNeill, A., Clark-Carter, D., & Brose, L. S. (2016). A systematic review of smoking cessation interventions for adults in substance abuse treatment or recovery. *Nicotine & Tobacco Research*, 18(5), 993-1001.
- Todd, J., Green, G., Harrison, M., Ikuesan, B. A., Self, C., Baldacchino, A., & Sherwood, S. (2004). Defining dual diagnosis of mental illness and substance misuse: some methodological issues. *Journal of Psychiatric and Mental Health Nursing*, 11(1), 48-54.
- Twyman, L., Bonevski, B., Paul, C., & Bryant, J. (2014). Perceived barriers to smoking cessation in selected vulnerable groups: a systematic review of the qualitative and quantitative literature. *British Medical Journal Open*, 4(12).

- Watkins, J. M. (1994). A postmodern critical theory of research use. *Knowledge and Policy*, 7(4), 55-77.
- West, R. (2006). *Theory of addiction*. Oxford, UK: Blackwells.
- Williams, J. M., Gandhi, K. K., Steinberg, M. L., Foulds, J., Ziedonis, D. M., & Benowitz, N. L. (2007). Higher nicotine and carbon monoxide levels in menthol cigarette smokers with and without schizophrenia. *Nicotine & Tobacco Research*, 9(8), 873-881.
- Wilson, A. J., Bonevski, B., Dunlop, A., Shakeshaft, A., Tzelepis, F., Walsberger, S., ... & Guillaumier, A. (2016). 'The lesser of two evils': A qualitative study of staff and client experiences and beliefs about addressing tobacco in addiction treatment settings. *Drug and Alcohol Review*, 35(1), 92-101.
- Wu, T. H., Chiu, C. C., Shen, W. W., Lin, F. W., Wang, L. H., Chen, H. Y., & Lu, M. L. (2008). Pharmacokinetics of olanzapine in Chinese male schizophrenic patients with various smoking behaviors. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, 32(8), 1889-1893.

## **Chapter 5: Extended Methodology**

The purpose of this chapter is to add to the methodology sections of the systematic review and empirical paper. First, this chapter will discuss ontology and epistemology, then it will outline the specific qualitative methods chosen for the systematic review and empirical paper, and the rationale for these. Next, there is an exploration of some of the ethical issues relevant to this portfolio. Finally, the chapter discusses the context and position of the lead researcher, and offers some reflections on the research process.

### **Ontology & Epistemology**

Most qualitative researchers acknowledge that the researcher cannot be objective, so it is important for researchers to have an awareness of their own ontological and epistemological beliefs. In order to ensure a strong research design, researchers much chose a paradigm that matches their beliefs about the nature of reality (Mills, Bonner & Francis, 2006).

Ontology and epistemology are philosophical concepts that relate to how knowledge is understood and how we view ourselves in relation to this knowledge. Ontology seeks to answer the question ‘What is reality?’ and epistemology answers the questions ‘What and how can I know about reality?’ (Crotty, 1998). This thesis was approached from a critical realist position. Critical realism suggests that “the way we perceive facts, particularly in the social realm, depends partly on our beliefs and expectations” (Bunge, 1993, p.231). This approach bridges the realism – relativism epistemological divide (Sheppard, 1998; Taylor & White, 2001) as it combines a

realist's search for evidence of a reality external to the human consciousness, with the relativist's view that all meaning made of reality is socially constructed (Oliver, 2012). Epistemologically, this thesis was approached from a contextualist standpoint. Contextualism assumes that meaning is related to the context in which it is produced (Braun & Clarke, 2013). Hence, it suggests that results may vary depending on the context in which they were collected and analysed (Madill, Jordan & Shirley, 2000). In line with this, Pidgeon and Henwood (1997) identify four factors that may affect the production of knowledge: participants' understandings, researchers' interpretations, cultural influences on participants' and researchers' interpretations, and judgements of particular interpretations as valid by the scientific community.

The epistemological and ontological approaches taken in this portfolio acknowledge that knowledge is not static, instead it is influenced by various factors including the researcher's beliefs and interpretations (Jones & Alony, 2011). This means that researchers are part of the research process, rather than passive, unbiased observers, and therefore the values of the researcher must be acknowledged because they are an inevitable part of the research outcome (Appleton, 1997; Guba & Lincoln, 1989).

### **Study Design**

In selecting the study design and methodology for the systematic review and empirical paper, the phenomena under investigation were considered, as well as the epistemological and ontological stance of the researcher. A qualitative approach was selected for both pieces of research. Qualitative methods focus on understanding participants' subjective accounts of their experiences (Yardley, 2000).

## **Systematic review**

The overarching aim of a systematic review is to bring together the results of primary research in order to answer a particular question through the use of rigorous and explicit method (Cooper & Hedges, 1994). A qualitative systematic review was undertaken because by focusing on qualitative literature we were able to increase the breadth and depth of understanding of the views of the key stakeholders (service users and staff) to whom smoke-free ground policies (SFGPs) are directed. Qualitative synthesis goes beyond simply pooling effectiveness data about SFGPs, as a quantitative meta-analysis would do, and instead seeks to synthesis views about how, why and in what specific contexts SFGPs may or may not be successfully implemented.

The review discussed in Chapter 2 used a thematic analysis approach to synthesise the literature. This is a common approach for qualitative systematic reviews (Popay et al. 2006). The aim of a thematic synthesis of this nature is to ‘go beyond’ the content of the original studies by interpreting corroborating concepts together and developing a line of argument (Thomas & Harden, 2008). This approach to synthesis has three stages: line-by-line coding, development of descriptive themes and development of analytical themes. The development of analytical themes represents the reviewers going beyond the data in the primary studies to generate new explanations (Thomas & Harden, 2008).

Research recommends that a thematic synthesis approach should be used, over other qualitative synthesis approaches such as meta-ethnography, when there is a specific question to address (Thomas & Harden, 2008). This is often the case when a review seeks to inform policy and practice. Thomas and Harden (2008) suggest that other approaches may be more relevant when the literature is being explored in itself,

or when there are broad or emergent review questions. It is for these reasons that a thematic synthesis approach was chosen, over other qualitative methods, for the systematic review paper.

### **Empirical Paper**

A Grounded Theory (GT) approach was used for the empirical paper. GT was developed in the 1960s to analyse and explain social and psychological processes (Glaser & Strauss, 1967). Glaser and Strauss (1967) aimed to move qualitative methods beyond ‘description’ and argued that systematic qualitative analysis could lead to the construction of theoretical explanations of social processes.

In the 1990s criticism began to emerge of Glaser and Strauss’ approach to GT. Traditional approaches to GT were criticised for assuming the existence of an objective external reality that a passive, neutral researcher could observe (Charmaz, 2000, Charmaz, 2002). Researchers started to move away from the positivist paradigm of earlier versions of the GT method (Bryant, 2002) towards a constructionist approach. This approach assumes that social reality is multiple and constructed through interactions, therefore emphasising the importance of taking into account the researcher’s position, privileges and perspectives (Charmaz, 2014).

Although there was a divergence of theoretical standpoints among grounded theorists, GT ultimately offers a methodology that is a framework for enquiry, upon which researchers can pin their own conceptual agendas. It was intended to be useful within a broad range of theoretical perspectives (Glaser & Strauss, 1967). In line with the earlier discussions about ontology and epistemology, the GT approach used in the empirical paper is based on a critical realist approach. Critical realism acknowledges that while reality cannot be known for sure, research can aim to search for the account

that comes closest to approximating and explaining reality (Oliver, 2012). Regardless of ontological and epistemological position, the aim of all grounded theorists is to ultimately generate a theory, grounded in the data, that may be helpful for informing policy and practice (Charmaz, 2014).

Retroduction is a central tool of critical realist research (Bhaskar, 1978). Retroduction allows for reflexivity about the researcher's theoretical positioning and encourages iterative movement between theory and evidence during the research process (Bhaskar, 1986; Sheppard, 1998). Some researchers have argued that uncritical use of theories in qualitative research can obscure the understanding of the experiences of less privileged and marginalised groups (Dodgson, 2018; Horrocks & Johnson, 2014). However, others have emphasised the inevitability of existing conceptual frameworks being brought to the research process, and emphasise the importance of articulating these (Bendassolli, 2014; Maxwell, 2013). In the current research, there is an acknowledgement of the influence of COM-B model of health behaviour (Mitchie et al. 2011) and Bronfenbrenner's ecological model (Bronfenbrenner, 1979) on the development of higher order themes.

Although other qualitative methods were considered for the empirical paper, such as thematic analysis, it was felt that a critical realist GT approach would be most appropriate to meet the aims of research. Birks and Mills (2015) argue that GT should be used when: little is known about the research area, there is a process embedded in the research situation, and there is a desire to generate a theory with explanatory power about this process. The aim of the empirical paper was to understand the process of smoking cessation for people with dual-diagnosis (see Chapter 4 for further details), therefore it was important to select a qualitative methodology that was appropriate for this aim.

### **Ethical Concerns**

The British Psychological Society's *Code of Ethics and Conduct* (BPS, 2014) is organised around the four principles of respect, competence, responsibility and integrity. The section that follows discusses the key ethical issues that apply to this research.

**Informed consent.** Informed consent can be a complicated issue in qualitative research due to this type of research being relatively open ended and iterative, implying that it can be difficult to know at the outset of the interview exactly what might be discussed (Weatherall, Gavey & Potts, 2002). Despite this, it was possible to be transparent about the topic of the interviews, so participants were aware of the broad area of discussion and could decide whether or not to participate based on this. Furthermore, the direction of the interviews was ultimately guided by the participants and what they chose to talk about. This meant that they could choose to avoid topics that may have been particularly distressing.

All participants were advised that their participation in the research was voluntary and that they had the right to withdraw themselves and their data up until two weeks after the interview. Withdrawal of data can become difficult in qualitative research once transcription and analysis has begun, so a window of two weeks for withdrawal was established and made clear to participants before interviews began. Participants were also made aware that they could stop the interview at any point and/or choose not to answer questions. They understood that any decision to withdraw would not affect their ongoing treatment at the addiction service.

**Risk, burdens and benefits.** It is hoped that the benefits of taking part in this research greatly outweighed any potential risks or burdens. Although it was difficult to

predict how distressing the participants would find the interviews, upon completion of the interviews all participants reported finding the experience a positive one. The researcher was vigilant to signs of potential distress from participants during the interviews, but thankfully no distress was observed or reported by participants. Participants were given a debrief sheet, with information about where to access support with their mental health, substance use and smoking, at the end of the interview (Appendix N).

Participants were given a £10 "Love2Shop" voucher to acknowledge the time that they had given to the research. These vouchers can be used in multiple high street shops but cannot be used to buy alcohol or cigarettes. This is a proportionate amount of money, in line with other similar student research projects.

**Researcher wellbeing.** The lead researcher followed appropriate health and safety policies when at the recruitment sites, including signing in and out accordingly and ensuring another member of staff was aware that an interview was taking place and which room the researcher was using. In November 2018 an amendment to the research protocol was approved, which allowed the researcher to undertake interviews in participants' homes. Only one interview took place in a participant's home. The University of East Anglia lone working policy (UEA, 2013) was followed for this visit. The policy required the researcher to advise a colleague of the date, time, location and expected length of the research interview. Contact was made with this colleague once the interview was completed, to let them know that the researcher was safe.

Participants were able to contact the researcher on a designated research contact number and university email address, but they did not have access to the researcher's personal contact details. Participants were asked not to attend the research

interviews intoxicated. This was in order to protect the researcher and the participant (by minimising the likelihood of them discussing information that they would not do if they were sober).

**Confidentiality.** Participants were advised, prior to commencing the interview, that all information would remain confidential unless there were concerns about risks of harm to either themselves or others. No risks were disclosed by any participants during this research. The Data Protection Act (1998) and General Data Protection Regulation (GDPR; 2018) were adhered to in order to ensure that data were used fairly and stored securely. The lead researcher was not part of the staff team at the research site and was therefore independent of clinical provision. This helped to reassure participants that any information discussed during the research interview would not impact their ongoing treatment.

Data were anonymised through the use of pseudonyms. Any identifying information disclosed during the interviews were removed during transcription, but care was taken to not change too much to the point of altering meaning (Guenther, 2009). The audio recording of data, as was the case for this research, raises ethical concerns due to data being more recognisable in audio form than in text. To address this, audio files were stored on encrypted devices and deleted once transcription was completed. All hard copies of participant forms (e.g. consent forms, demographic questionnaires) were stored in a locked cabinet in the office of the primary research supervisor, separately from anonymised transcriptions. These data will be stored for 10 years before being destroyed.

## **Context and Researcher Position**

As discussed earlier in the chapter, a critical realist paradigm emphasises the influence of researcher's beliefs and interpretations on the research process (Jones & Alony, 2011). Our experiences and perspectives, shaped by our history and cultural context, influence how we interact with the data and play a role in the generation of knowledge (Hayes & Oppenheim, 1997; Mills et al. 2006). The following section explores the researcher's position and experience. This is an important part of ensuring that there is rigour and transparency in the research process.

### **Researcher Position and Experience**

I am a 27-year-old white British Trainee Clinical Psychologist with experience of working for two years as an Assistant Psychologist in a community drug and alcohol service in London. I don't smoke and there are only a small number of people in my personal life who do currently smoke.

Although I have not experienced addiction or mental health difficulties myself, I worked almost exclusively with people who had been dually diagnosed with mental health and substance misuse difficulties when I was working in addictions. This experience shaped my understanding and views about the complex relationship between mental health and substance use. It also exposed me to not just addictions and mental health difficulties, but also to the complex social and physical health needs of this group. These ranged from COPD, Hepatitis C and cirrhosis of the liver to homelessness, involvement with social services, criminal convictions and experiences of abuse.

When I became involved with this research it gave me the opportunity to reflect on my experiences of working in addictions and to think about the role of

cigarettes in addiction and mental health settings. Anecdotally, I thought that smoking prevalence must be higher among those with substance misuse and mental health difficulties than the general population, but the actual statistics were quite shocking. I felt somewhat embarrassed that I had overlooked smoking when I had been working in addictions, I think I had considered it to be insignificant in comparison to the other difficulties that the people I was working with faced. I realise now that I held the view, commonly held by mental health professionals, that people with mental health and addictions have no interest in stopping smoking.

My experience working with people with co-morbid mental health and addictions gave me the opportunity to help people who, in many cases, had fallen through the “gaps” between different services and were in desperate need of support. It also fuelled my desire to carry out research with this group and to have the opportunity to give a “voice” to a group of people who are often overlooked by research, services and society in general. I wanted to use qualitative research to gain an understanding about their experiences and views about smoking in the context of mental health and addiction. Despite having worked with people with mental health and addictions, I had never asked anyone about smoking or the place it had in their lives.

I used a reflective diary during this research not only to consider my own views about smoking, substance use and mental health and how these may have changed during the course of the research, but also to reflect upon my interactions with participants. I used the diary as a place to consider how my own experiences may impact my interactions with participants and potentially shape my interpretations and analysis of the data, such as is discussed in the example below.

*“I wonder how much my non-smoking status is influencing my interviews. Two participants so far have asked me if I smoke and although I was unsure about whether to share that information with them but it felt important for our relationship to tell them that I don’t smoke. I think it was right to have shared this, but I wonder whether it changed their perception of me and the questions I was asking them. It made me think about why the participants wanted to know. Perhaps they were judging whether I had the appropriate experience and knowledge to be asking them these questions. One of the participants said, “I didn’t think so” (in a jokey kind of tone) when I told him that I wasn’t a smoker, which made me wonder what sort of perception I am giving that makes him assume that I don’t smoke. Despite not being a smoker, I hope that by empathising with my participants I can join them in understanding their experiences and views about smoking, mental health and addiction. I just wonder what sort of influence their perception of me is having on their responses to my interview questions, if at all.” (September 2018)*

## **Reflections on the Research Process**

Despite facing numerous challenges along the way, the research process overall has been an invaluable learning experience. I feel that I have gained a realistic understanding and experience of the challenges that can arise when conducting research in clinical settings. Such challenges included extended ethics processes due to the recruitment site changing from NHS to a third sector provider mid-research and considerable recruitment difficulties. Due to my experience working in addictions, I had approached recruitment for the empirical paper with the idea that it would be easy because I assumed there would be lots of people who would meet my inclusion criteria. However, I hadn’t considered the time and effort that I needed to put into building relationships with staff at the recruitment sites in order to get access to eligible service users. I also hadn’t considered the impact that severe and enduring mental health and addictions can have on appointment attendance. Despite these

challenges and with considerable persistence, I was able to recruit a suitable number of participants.

Prior to commencing this research, I had no experience of Grounded Theory and I had very limited experience of qualitative research methods. I spent a considerable amount of time in the early stages of this project trying to gain an understanding of qualitative approaches. Through supervision, reading texts, attendance at qualitative research lectures and discussion with other Trainee Clinical Psychologists in a qualitative research forum, I was able to improve my understanding of the processes involved in undertaking qualitative research. Using methodology that was almost entirely new to me, for both my systematic review and empirical paper, was a considerable challenge. I was lucky to have a supportive, and very knowledgeable, supervisor to advise me when I became overwhelmed or confused, particularly during the seemingly never-ending process of data analysis. Nevertheless, I am glad that I was able to challenge myself and learn new skills in qualitative research.

Although I have worked clinically with people with mental health difficulties and addictions for several years, this was the first time that I had the opportunity to interview people for research purposes. My clinical training and previous experience have given me skills in clinical interviewing and the confidence to be able to speak to people about difficult topics, which was useful during the process of interviewing for this research. Overall, I felt privileged that people were willing to share with me their experiences of addictions, mental health and smoking. Many of the people I interviewed had experienced traumatic and challenging life experiences and I was struck by and thankful for their honesty and openness.

Despite the overall positive experience of conducting the research interviews, a small minority of the interviews were slightly more challenging. Due to the nature of severe and enduring mental health difficulties, some participants found it difficult to engage fully with the interview process. One participant experienced delusional episodes during the interview and spoke about different spirits and auras they could see in the interview room around us. This made it challenging not only for the flow of the interview, and subsequent transcribing, but also for engaging with and building rapport with the participant. A few other participants were particularly flat in affect, and although they were keen to take part in the research, their answers were predominantly single words or short sentences. This again made it more difficult to build rapport and engagement with these participants. It also influenced which quotes were able to be used in the empirical paper, leading to some participants being referenced more than others. Despite the challenges that arose, all eight participants reported finding the interview process an overall enjoyable experience.

Following the interviews, during the process of data analysis and write-up, I felt a sense of responsibility to my participants to understand and use their experiences to build a theory that could be helpful to others. However, delays to the earlier stages of the project meant that the time-frame for analysis and write up was shorter than had been originally planned. This led to competing pressures of feeling a responsibility towards the participants but at the same time needing to meet course deadlines. At times it was challenging to find a balance between these two pressures, but ultimately, I think I have produced a piece of research that does justice to the views and experiences of the participants involved.

## **Chapter 6: Discussion and Critical Appraisal**

This chapter presents a summary and critical evaluation of the systematic review and empirical paper. It also includes a discussion of how the results of this portfolio may contribute to the research literature and clinical practice.

### **Summary of Findings and Relation to Clinical Practice**

This portfolio set out to understand the experiences and perspectives of people with mental health difficulties and substance misuse about smoking and smoking cessation, and to provide insight into how healthcare providers can better support this group of vulnerable people in clinical practice. The findings of this portfolio are particularly timely for a UK healthcare context, which has recently emphasised a priority for the National Health Service (NHS) to prioritise tackling and preventing smoking among vulnerable populations (NHS Long Term Plan, 2019).

As part of this priority, all mental health inpatient services in England should be moving towards implementing smoke-free grounds policies (SFGP; Public Health England, 2016). Other international healthcare contexts, such as Australia and Canada, are also making steps to implement SFGPs in mental health inpatient settings (Kunyk, Els, Predy, & Haase, 2007; Lawn & Campion, 2010). The results of the systematic review therefore offer a timely insight into some of the difficulties that may arise for services implementing such policies. The review indicates, in line with previous research, that it is possible to successfully implement SFGPs in mental health inpatient units (Bloor et al., 2006; Wye et al., 2010) but there are a number of factors that need to be considered.

Overall, the findings emphasise the impact that negative staff attitudes towards SFGPs, and smoking cessation in mental health services generally, can have on the implementation of policies. Staff members alluded to a sense that higher management and Government had adopted a paternalist approach in relation to the enforcement of SFGPs. This left clinical staff feeling that they were forced to ‘fit in’ with the policy, often with limited resources and numerous concerns for service users. This therefore creates difficulties for policy implementation, and results in a reduced sense of change efficacy and commitment at an organisational level (Weiner, 2009). Although SFGPs are in line with the current NHS Long Term Plan in relation to tackling and preventing areas of unmet health needs for vulnerable populations (NHS Long Term Plan, 2019), policy makers should be cautioned against adopting a paternalist approach to SFGP enforcement. In line with research about organisational readiness for change (Weiner, 2009), the current research highlights the importance of working with staff and service users to generate a shared sense of understanding and ownership over policy implementation.

With regards to the implementation of SFGPs, staff were concerned about lack of information and resources, limited availability of cessation interventions and inconsistent leadership during the implementation of the policy. This is consistent with previous research (Lawn & Pols, 2005; Campion et al., 2008; Wye et al. 2010) which suggests a need for services to implement SFGPs in the context of clear leadership and organisational support, staff training and sufficient resources. Lack of resources is a barrier that has specifically been associated with SFGPs in a mental health context, compared to other healthcare settings (Eadie et al. 2012). Service users across both the systematic review and empirical paper understood and could identify the negative impact of smoking, particularly in terms of the impact on their physical health and finances. They also generally seemed to want to stop smoking, whether imminently or

at some point in the future, although participants with dual-diagnosis living in the community identified several barriers to being able to achieve this. The barriers that were identified related to intrapersonal factors, such as motivation and ability, and also contextual factors such as their interpersonal relationships, social context and system factors. In contrast, patients in inpatient mental health settings with SFGPs were exposed to an environment that made cessation possible and they were generally open to attempting cessation whilst in a smoke-free environment.

Although the use of SFGPs in inpatient services offers an important opportunity for changing the smoking behaviour of people with severe and enduring mental health difficulties, the continuity of care between inpatient and community settings is important. Without adequate support in the community, any smoking cessation achieved whilst in a setting with a SFGP is not likely to be sustained (Prochaska, Fletcher, Hall & Hall, 2006). Perhaps, this is due to the considerable barrier that environmental factors can present for successful smoking cessation for people with severe and enduring mental health difficulties. SFGPs offer a unique environment within which cessation is possible, but when people go back to their communities the findings of the empirical paper suggest that they are exposed to multiple interpersonal (i.e. the social norm of smoking among their friends) and social factors (i.e. poverty, homelessness) that can make sustained cessation difficult.

People with dual-diagnosis in the community emphasised the influence that environmental factors, such as the prevalence of smoking among their friends and limited access to cessation services, have on their motivation and ability to achieve smoking cessation. These contextual aspects may offer some targets for interventions, perhaps through the use of modelling, environmental restructuring, fostering enablement and/or legislation (Michie et al. 2011).

Considerable regulation and legislative measures have been taken to address and denormalise smoking in the general population, and many of these have had significant, positive effects (Bell et al. 2010). However, there have been few attempts to investigate the effectiveness of population-level tobacco control policies on specific groups, such as those with mental health and addictions. SFGPs in mental health inpatient services are one measure that has been taken to specifically address smoking among people with mental health difficulties, but the prevalence of smoking for people with mental health difficulties continues to remain high. There has been some suggestion that while tax increases on cigarettes reduce rates of smoking among the general population and prevent young people starting smoking (Ross et al. 2011), it may not have the same impact for long-term smokers and smokers with severe and enduring mental health difficulties (Ashton, Rigby & Galletly, 2014; Bader, Boisclair & Ferrence, 2011). These findings, combined with conclusions from the empirical paper that emphasise participants' general dislike of and non-compliance with Government tobacco control policies, suggest that policy makers may need to find other ways to address smoking rates in this population. The current research suggests that efforts should be made to encourage the denormalization of smoking in the environments of people with severe and enduring mental health difficulties. Perhaps this may involve improving access to appropriate smoking cessation support services in particular areas, or healthcare providers taking a more pro-active approach to identify and work with vulnerable communities.

## **Critical Appraisal**

### **Systematic Review**

The systematic review contributes to and expands on a limited existing evidence base about the experiences and views of staff and service users towards the implementation of SFGPs in mental health inpatient services. As far as we are aware, it is the only review to synthesise qualitative literature that has focused specifically on SFGPs. It therefore offers a novel contribution to the research area and offers a timely insight for services developing and implementing SFGPs.

There has been some debate about the utility of synthesising qualitative research (e.g. Sandelowski & Barroso, 2007; Thomas & Harden, 2008). It is often emphasised that qualitative research cannot be generalised beyond the specific context, time and group of participants it focuses on. Therefore, it has been argued that bringing qualitative research together, in a systematic review, leads to the research being de-contextualised and subsequently losing its value (Campbell et al. 2003). However, there is a strong case for the utility of qualitative synthesis, particularly in relation to informing healthcare policy and practice by understanding the views and experiences of those involved (Popay, 2003). In the systematic review, in Chapter 2, attempts were made to preserve the context of the studies by providing readers with details about the study aims, methods, setting and sample.

There is further debate about how the quality of qualitative research should be assessed, who should assess it and indeed if it should be assessed at all (Seale, 1999; Spencer, Ritchie, Lewis & Dillon, 2003). Researchers have argued that it is important to assess the quality of papers included in a systematic review in order to avoid making unreliable conclusions from poor quality research (Thomas & Harden, 2008). However, there is little consensus about the criteria that constitute quality standards

for research to be included in a qualitative systematic review (Khan, Ter Riet, Glanville, Sowden & Kleijnen, 2001). Without the existence of these standards, it was appropriate to include all studies, regardless of their assessed quality (Dixon-Woods et al., 2006). The Critical Appraisal Skills Program qualitative checklist (CASP, 2013) was used to assess the quality of the studies included in the systematic review. Overall, the methodological quality was moderate, suggesting that it is unlikely that the results have been influenced by poor-quality research.

### **Empirical Paper**

The empirical research adds to the relatively limited evidence base that has focused specifically on the process of smoking cessation for people with dual-diagnosis. It provides a rich and detailed account of participants' views about smoking cessation and contributes to the existing literature by building upon an existing model of health behaviour. This research offered a group of people, who are often not included in research, the opportunity to have their voices heard and it therefore provides a unique insight into the particular barriers they face to smoking cessation.

Staff members within the recruitment sites acted as 'gatekeepers' and participants were recruited through them. Staff members discussed the research with service users who they deemed to meet the inclusion criteria and asked them to give consent to be contacted by the lead researcher. There are some clear benefits to the use of gatekeepers in research particularly in terms of safeguarding vulnerable populations (British Psychological Society, 2014) but it can also present some difficulties and may have an impact on which participants are recruited. Through their understandable desire to protect vulnerable people, gatekeepers can prevent potential participants from taking part in research. Questions have therefore been raised about the philosophical nature of gatekeeping (Miller & Bell, 2002). It is acknowledged, that gatekeepers

played a role in the recruitment process for this research and therefore it is not possible to be transparent regarding the decisions that were made about who should be approached to participate in the research.

It is important to evaluate the quality of research, especially if findings are to be used in clinical practice. There has been debate among qualitative researchers as to whether the terms validity and reliability, which are associated with quantitative research, are appropriate in their application to qualitative research (Noble & Smith, 2015). Rather than reliability, validity and generalisability, Lincoln and Guba (1985) offer alternative criteria for demonstrating rigour within qualitative research: truth value, consistency and applicability.

**Truth value.** This acknowledges the existence of multiple realities. In order to address this, it is important for the researcher to be aware of and outline their own personal experiences and views, in order to understand any potential methodological bias that may have emerged as a result of these. The use of reflective journals, memo-writing and supervision helps to encourage this transparency by allowing researchers to be explicit in understanding and sharing their own views and context (Charmaz, 2008). Discussion of the researcher's context and position, including examples from the reflective journal, is included in the Extended Methodology chapter.

The value of 'truth' also relates to the importance of accurately representing participants' perspectives. Audio recording was used during data collection, which allowed for repeated listening of the data to check emerging themes and helped the researcher to remain true to the participants' accounts. Rich, verbatim extracts from all participants were used in the write-up of the research to allow the reader to make their own judgements about whether the identified themes are true to participants' experiences.

**Consistency.** This relates to the idea of the ‘trustworthiness’ of the researcher’s decision making in the analysis process. The researcher’s decisions should be transparent and there should be a clear ‘decision trail’ which would lead an independent researcher to ultimately arrive at the same or similar conclusions. Grounded Theory (GT) highlights the importance of the use of memo writing to allow for transparency in the research process (Glasser, 1998). Memos can be used for anything that is appropriate to the research, including to document emerging analysis, highlight challenges in the research process and direct further data-gathering (Charmaz, 2014). Emerging themes, for both the systematic review and empirical paper, were discussed with the primary research supervisor who has considerable experience with qualitative research, and particularly GT. Appendix O offers an example of the analysis process for a segment of interview transcript. Appendix I gives an example of a thematic map that was used during the analysis process to explore emerging connections between theoretical categories.

**Applicability.** This criterion considers whether findings can be applied to other settings, contexts or groups. Details of the research context and participants can facilitate the evaluation of conclusions that have been drawn and their transferability to other similar settings and groups. However, a balance must be struck between providing some details of the research context and participants, whilst also ensuring the anonymity of those involved. A demographic questionnaire (Appendix F) was used to gather information about the participants, such as the amount they smoke, their interest in quitting and their mental health diagnosis. This information is detailed in the in the empirical paper and provides further context to participants’ accounts.

Participants for the empirical paper were recruited from a third-sector drug and alcohol addictions service, which uses a recovery model to help adults achieve

abstinence from substances. This organisation offers support to people with addictions nationally across the UK, but only two services were used to recruit for this research, one in a city and the other in a small rural town, both in the same county in England. Both services covered a wide population of both rural and urban areas and areas of both high and low relative deprivation. This area of the UK has a population that is 96.5% White British (Office of National Statistics, 2011) and the demographics of the participant group reflect this.

It is acknowledged that the participants in this research were recruited from a specific setting and, although participants reflect the overall composition of the population from which they were recruited, they may not be representative of other people from other geographic locations. It is possible that people with dual-diagnosis in different settings or with different ethnic and cultural backgrounds may therefore report different experiences.

### **Direction for Future Research**

This portfolio offers a starting point for future research. The systematic review focused specifically on the views of staff and patients about SFGPs, but it may also have been interesting to consider the views of visitors to the hospital because they are also affected by the introduction of SFGPs. There was a sense from staff members about the influence of higher-level organisational issues in relation to the implementation of SFGPs, particularly in regard to a sense of paternalism from management and policy makers. Future research could consider exploring these organisational issues, such as readiness to change and the influence of power, in relation to policy design and implementation in healthcare settings.

The empirical paper focused on the views of individuals with dual-diagnosis, but future research may want to consider the views of others in the system, such as partners, family members, friends and mental health and addiction staff members. Previous research has emphasised the negative views that healthcare staff have about smoking cessation for people with enduring mental health and substance misuse (Kerr et al., 2013), so staff members are likely to offer an important target for intervention.

The studies synthesised in the systematic review primarily collected data through focus groups and interviews. Future qualitative research in this area may want to consider an ethnographic approach to data collection. The systematic review emphasised the influence of the culture of a service on the implementation of SFGPs, so an ethnographic approach to data collection, either on its own or in combination with interview data, may allow for greater understanding of the specific influence and characteristics of a service's culture.

The empirical paper collected data from individuals with dual-diagnosis about their personal experiences and perceptions, through the use of interviews. This has understandably led to the results being heavily focused on intrapersonal barriers to behaviour change. External barriers to cessation, such as interpersonal, social and system factors, were discussed in relation to their impact on individual experience. An ethnographic approach to understanding the role of smoking in the social context of people with dual-diagnosis would build upon the current findings and may serve to increase our understanding of the environmental barriers to smoking cessation that were identified by participants in the empirical paper. This may ultimately provide additional insight into appropriate smoking cessation interventions for this group and a greater understanding of smoking behaviours in vulnerable communities.

## **Conclusion**

Overall, this portfolio emphasises the culture of smoking among people with mental health and addictions and highlights the gaps in smoking cessation provision for this group. This portfolio provides important and timely insight into the difficulties that can arise when implementing SFGPs and explores the barriers that community dwelling people with dual-diagnosis face when considering smoking cessation. If healthcare professionals and providers do not seek to better understand and serve the healthcare needs of the most vulnerable in our society, then the health inequalities of this vulnerable group of people will continue to be perpetuated.

## References for additional chapters

- Action on Smoking and Health (2015). *Smoking and mental health: a neglected epidemic*. Retrieved from:  
<http://www.ashscotland.org.uk/media/6671/ASHScotlandSmokingandmentalhealth.pdf>
- Appleton, J. V., & King, L. (1997). Constructivism: A naturalistic methodology for nursing inquiry. *Advances in Nursing Science*, 20(2), 13-22.
- Ashton, M., Rigby, A., & Galletly, C. (2014). Do population-wide tobacco control approaches help smokers with mental illness? *Australian & New Zealand Journal of Psychiatry*, 48(2), 121-123.
- Aubin, H. J., Rollema, H., Svensson, T. H., & Winterer, G. (2012). Smoking, quitting, and psychiatric disease: a review. *Neuroscience & Biobehavioral Reviews*, 36(1), 271-284.
- Bader, P., Boisclair, D., & Ferrence, R. (2011). Effects of tobacco taxation and pricing on smoking behavior in high risk populations: a knowledge synthesis. *International Journal of Environmental Research and Public Health*, 8(11), 4118-4139.
- Berk, M., Ng, F., Wang, W. V., Tohen, M., Lubman, D. I., Vieta, E., & Dodd, S. (2008). Going up in smoke: tobacco smoking is associated with worse treatment outcomes in mania. *Journal of Affective Disorders*, 110(1-2), 126-134.
- Birks, M., & Mills, J. (2015). *Grounded theory: A practical guide* (2<sup>nd</sup> ed.). Los Angeles, CA: SAGE Publications.
- Bell, K., Salmon, A., Bowers, M., Bell, J., & McCullough, L. (2010). Smoking, stigma and tobacco 'denormalization': Further reflections on the use of stigma as a public health tool. A commentary on Social Science & Medicine's Stigma, Prejudice, Discrimination and Health Special Issue (67: 3). *Social Science & Medicine*, 70(6), 795-799.
- Bendassolli, P. F. (2014). Reconsidering theoretical naïveté in psychological qualitative research. *Social Science Information*, 53(2), 163-179.
- Bhaskar, R. (1978). On the possibility of social scientific knowledge and the limits of naturalism. *Journal for the Theory of Social Behaviour*, 8(1), 1-28.
- Bloor, R. N., Meeson, L., & Crome, I. B. (2006). The effects of a non-smoking policy on nursing staff smoking behaviour and attitudes in a psychiatric hospital. *Journal of Psychiatric and Mental Health Nursing*, 13(2), 188-196.
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: SAGE Publications.

- British Psychological Society (2014). *Human Code of Research Ethics*, Retrieved from:  
[http://www.bps.org.uk/sites/default/files/documents/code\\_of\\_human\\_research\\_ethics.pdf](http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf)
- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard university press.
- Bryant, A. (2002, January). Grounding systems research: Re-establishing grounded theory. In *Proceedings of the 35th Annual Hawaii International Conference on System Sciences*, pp. 3446-3455. IEEE.
- Bunge, M. (1993). Realism and antirealism in social science. *Theory and Decision*, 35(3), 207-235.
- Campbell, R., Pound, P., Pope, C., Britten, N., Pill, R., Morgan, M., & Donovan, J. (2003). Evaluating meta-ethnography: a synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Social Science & Medicine*, 56(4), 671-684.
- Campion, J., Lawn, S., Brownlie, A., Hunter, E., Gynther, B., & Pols, R. (2008). Implementing smoke-free policies in mental health inpatient units: learning from unsuccessful experience. *Australasian Psychiatry*, 16(2), 92-97.
- Centers for Disease Control and Prevention (2006). *US Surgeon General's report – the health of involuntary exposure to tobacco*, Retrieved from:  
[www.cdc.gov/tobacco/data\\_statistics/sgr/2006/index.htm](http://www.cdc.gov/tobacco/data_statistics/sgr/2006/index.htm)
- Charmaz, K. (2000). Constructivist and objectivist grounded theory. In N. K. Denzin & Y. Lincoln (Eds.), *Handbook of Qualitative Research*, Thousand Oaks, CA: SAGE Publications.
- Charmaz, K. (2002). Grounded theory analysis. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview Research*, Thousand Oaks, CA: SAGE Publications.
- Charmaz, K. (2008). Grounded theory as an emergent method. *Handbook of Emergent Methods*, 155, 172.
- Charmaz, K. (2014). *Constructing grounded theory*. London: SAGE Publications.
- Cookson, C., Strang, J., Ratschen, E., Sutherland, G., Finch, E., & McNeill, A. (2014). Smoking and its treatment in addiction services: Clients' and staff behaviour and attitudes. *BMC Health Services Research*, 14(1), 304.
- Cooper, H., & Hedges, L. V. (Eds.). (1993). *The Handbook of Research Synthesis*. New York, NY: Russell Sage Foundation.
- Critical Appraisal Skills Programme (2013). *Qualitative Checklist*. Retrieved from:  
[http://media.wix.com/ugd/dded87\\_29c5b002d99342f788c6ac670e49f274.pdf](http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf)

- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sydney, Australia: SAGE Publications.
- Desai, H. D., Seabolt, J., & Jann, M. W. (2001). Smoking in patients receiving psychotropic medications. *CNS Drugs*, 15(6), 469-494.
- Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, E., Arthur, A., Harvey, J., ... & Riley, R. (2006). Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC medical research methodology*, 6(1), 35.
- Dodgson, J. (2018). The intersection of power, social justice, and lactation. *Journal of Human Lactation*, 34(3), 411-412.
- Doll, R., & Hill, A. B. (1950). Smoking and carcinoma of the lung. *British Medical Journal*, 2(4682), 739.
- Eadie, D., MacDonald, L., Angus, K., Murray, R., O'Mara-Eves, A., Stansfield, C., & Leonardi-Bee, J. (2013). *A review of the barriers to and facilitators for implementing smokefree strategies and interventions in secondary care settings*. National Institute for Health and Care Excellence (NICE) PH48 Smoking cessation - acute, maternity and mental health services, Review 7. Retrieved from:  
<http://www.nice.org.uk/nicemedia/live/14306/65877/65877.pdf>
- Els, C., Kunyk, D., Predy, G., & Haase, M. (2007). Peer Reviewed: Development and Introduction of a Comprehensive Tobacco Control Policy in a Canadian Regional Health Authority. *Preventing Chronic Disease*, 4(2).
- Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: Sociology Press.
- Glasser, B., & Strauss, A. (1967). *The discovery of grounded theory*. Chicago: Aldine.
- Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. SAGE Publications.
- Guenther, K. M. (2009). The politics of names: rethinking the methodological and ethical significance of naming people, organizations, and places. *Qualitative Research*, 9(4), 411-421.
- Hayes, R. L., & Oppenheim, R. (1997). Constructivism: Reality is what you make it. In T. L. Sexton & B. L. Griffin (Eds.), *Counseling and development series, No. 3. Constructivist thinking in counseling practice, research, and training* (pp. 19-40). New York, NY, US: Teachers College Press.

- Health and Social Care Information Centre (2018). *Mental Health Act Statistics, Annual Figures 2017-18*, Retrieved from: <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures>
- Horrocks, C., & Johnson, S. (2014). A socially situated approach to inform ways to improve health and wellbeing. In S. Cohn (Ed.), *From health behaviours to health practices: Critical perspectives* (pp. 19-30). Chichester, UK: Wiley.
- Jones, M., & Alony, I. (2011). Guiding the use of grounded theory in doctoral studies—An example from the Australian film industry. *International Journal of Doctoral Studies*, 6, 95-114.
- Khan, K. S., Ter Riet, G., Glanville, J., Sowden, A. J., & Kleijnen, J. (2001). *Undertaking systematic reviews of research on effectiveness: CRD's guidance for carrying out or commissioning reviews* No. 4 (2n). NHS Centre for Reviews and Dissemination.
- Lawn, S. (2012). In it together: physical health and well-being for people with mental illness. *Australian & New Zealand Journal of Psychiatry*, 46(1), 14-17.
- Lawn, S., & Campion, J. (2010). Factors associated with success of smoke-free initiatives in Australian psychiatric inpatient units. *Psychiatric Services*, 61(3), 300-305.
- Lawn, S., & Pols, R. (2005). Smoking bans in psychiatric inpatient settings? A review of the research. *Australian and New Zealand Journal of Psychiatry*, 39(10), 866-885.
- Lawn, S. J., Pols, R. G., & Barber, J. G. (2002). Smoking and quitting: a qualitative study with community-living psychiatric clients. *Social Science & Medicine*, 54(1), 93-104.
- Lincoln, Y. S., & Guba, E. G. (1985). Establishing trustworthiness. *Naturalistic Inquiry*, 289, 331.
- Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91(1), 1-20.
- Maxwell, J. A. (2013). *Qualitative research design: An interactive approach* (3rd ed.). Thousand Oaks, CA: SAGE.
- Malpass, D., & Higgs, S. (2009). How is cigarette smoking maintained in depression? Experiences of cigarette smoking in people diagnosed with depression. *Addiction Research & Theory*, 17(1), 64-79.

- Michie, S., Van Stralen, M. M., & West, R. (2011). The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implementation Science*, 6(1), 42.
- Miller, T., & Bell, L. (2002). Consenting to what? Issues of access, gate-keeping and 'informed' consent. *Ethics in Qualitative Research*, 53-69.
- Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods*, 5(1), 25-35.
- Morris, C. D., Waxmonsky, J. A., May, M. G., & Giese, A. A. (2009). What do persons with mental illnesses need to quit smoking? Mental health consumer and provider perspectives. *Psychiatric rehabilitation journal*, 32(4), 276.
- Morris, C. D., Waxmonsky, J. A., May, M. G., Tinkelman, D. G., Dickinson, M., & Giese, A. A. (2011). Smoking reduction for persons with mental illnesses: 6-month results from community-based interventions. *Community Mental Health Journal*, 47(6), 694-702.
- National Institute for Health and Care Excellence (2013). *Smoking: acute, maternity and mental health service*. Retrieved from: <https://www.nice.org.uk/guidance/ph48>
- National Institute for Health and Care Excellence (2016). *Coexisting severe mental illness and substance misuse: community health and social care services*, Retrieved from: <https://www.nice.org.uk/guidance/ng58/>
- Neale, J. (2004). Gender and illicit drug use. *British Journal of Social Work*, 34(6), 851-870.
- NHS Long Term Plan (2019). *Long Term Plan 2019*, Retrieved from: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf>
- Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-based Nursing*, 18(2), 34-35.
- Office of National Statistics (2011). *Ethnicity and National Identity in England and Wales: 2011*. Retrieved from: <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityandnationalidentityinenglandandwales/2012-12-11>
- Oliver, C. (2011). Critical realist grounded theory: A new approach for social work research. *British Journal of Social Work*, 42(2), 371-387.
- Parks, J., Svendsen, D., Singer, P., Foti, M. E., & Mauer, B. (2006). Morbidity and mortality in people with serious mental illness. *Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council*, 25(4).

- Pidgeon, N., & Henwood, K. (1997). Using grounded theory in psychological research. In N Hayes (Eds). *Doing qualitative analysis in Psychology*, England: Taylor & Francis.
- Popay, J. (Ed.). (2006). *Moving beyond effectiveness in evidence synthesis: Methodological issues in the synthesis of diverse sources of evidence*. National Institute for Health and Clinical Excellence.
- Prochaska, J. J., Fletcher, L., Hall, S. E., & Hall, S. M. (2006). Return to smoking following a smoke-free psychiatric hospitalization. *American Journal on Addictions*, 15(1), 15-22.
- Public Health England (2016). *Smoke free mental health services in England*. Retrieved from: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/509262/SF\\_MH\\_services\\_in\\_England\\_Guidance\\_for\\_Providers.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/509262/SF_MH_services_in_England_Guidance_for_Providers.pdf)
- Public Health England (2017). *Cost of smoking to the NHS in England: 2015*, Retrieved from: [www.gov.uk/government/publications/cost-of-smoking-to-the-nhs-inengland-2015/cost-of-smoking-to-the-nhs-in-england-2015](http://www.gov.uk/government/publications/cost-of-smoking-to-the-nhs-inengland-2015/cost-of-smoking-to-the-nhs-in-england-2015)
- Ross, H., Blecher, E., Yan, L., & Hyland, A. (2011). Do cigarette prices motivate smokers to quit? New evidence from the ITC survey. *Addiction*, 106(3), 609-619.
- Royal College of Physicians (2018). *Hiding in plain sight: Treating tobacco dependency in the NHS*, Retrieved from: <https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs>
- Sandelowski, M., Barroso, J., & Voils, C. I. (2007). Using qualitative meta-summary to synthesize qualitative and quantitative descriptive findings. *Research in Nursing & Health*, 30(1), 99-111.
- Seale, C. (1999). Quality in qualitative research. *Qualitative inquiry*, 5(4), 465-478.
- Sheppard, M. (1998). Practice validity, reflexivity and knowledge for social work. *The British Journal of Social Work*, 28(5), 763-781.
- Spencer, L., Ritchie, J., Lewis, J., & Dillon, L. (2003). National Centre for Social Research. *Quality in qualitative evaluation: a framework for assessing research evidence*. London: Government Chief Social Researcher's Office.
- Steinberg, M. L., Williams, J. M., & Ziedonis, D. M. (2004). Financial implications of cigarette smoking among individuals with schizophrenia. *Tobacco Control*, 13(2), 206-206.
- Taylor, C., & White, S. (2001). Knowledge, truth and reflexivity: The problem of judgement in social work. *Journal of Social Work*, 1(1), 37-59.

- Taylor, G., McNeill, A., Girling, A., Farley, A., Lindson-Hawley, N., & Aveyard, P. (2014). Change in mental health after smoking cessation: systematic review and meta-analysis. *British Medical Journal*, 348, 1151.
- Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, 8(1), 45.
- Weatherall, A., Gavey, N., & Potts, A. (2002). So whose words are they anyway? *Feminism & Psychology*, 12(4), 531-539.
- Williams, J. M., & Ziedonis, D. (2004). Addressing tobacco among individuals with a mental illness or an addiction. *Addictive Behaviors*, 29(6), 1067-1083.
- World Health Organisation (2018). *Tobacco Factsheet*. Retrieved from: <http://www.who.int/mediacentre/factsheets/fs339/en/>
- Wye, P., Bowman, J., Wiggers, J., Baker, A., Knight, J., Carr, V., ... & Clancy, R. (2010). Total smoking bans in psychiatric inpatient services: a survey of perceived benefits, barriers and support among staff. *BMC Public Health*, 10(1), 372.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15(2), 215-228.

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## Appendix A – Author Guidelines for Qualitative Health Research Journal

### Author Guidelines: *Qualitative Health Research* (QHR)

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7. Additional information

**Please read the guidelines below then visit the Journal's submission site <http://mc.manuscriptcentral.com/qhr> to upload your manuscript. Please note that manuscripts not conforming to these guidelines may be returned.**

**Only manuscripts of sufficient quality that meet the aims and scope of QHR will be reviewed. As part of the submission process you will be required to warrant that you are submitting your original work, that you have the rights in the work, that you are submitting the work for first publication in the Journal and that it is not being considered for publication elsewhere and has not already been published elsewhere, and that you have obtained and can supply all necessary permissions for the reproduction of any copyright works not owned by you.**

## 1. Article types

Each issue of QHR provides readers with a wealth of information — book reviews, commentaries on conceptual, theoretical, methodological and ethical issues pertaining to qualitative inquiry as well as articles covering research, theory and methods.

### 1.1 What types of articles will QHR accept?

QHR asks authors to make their own decision regarding the fit of their article to the journal. Do not send query letters regarding article fit.

- Read the Mission Statement on main QHR webpage.
- Search the QHR journal for articles that address your topic. Do we publish in your area of expertise?
- Ask these questions: Does it make a meaningful and strong contribution to qualitative health research literature? Is it original? Relevant? In depth? Insightful? Significant? Is it useful to reader and/or practitioner?
- Note the sections: General articles, critical reviews, articles addressing qualitative methods, commentaries on conceptual, theoretical, methodological, and ethical issues pertaining to qualitative inquiry.
- QHR accepts qualitative methods and qualitatively-driven mixed-methods, qualitative meta-analyses, and articles addressing all qualitative methods.
- QHR is a multi-disciplinary journal and accepts articles written from a variety of perspectives including: cross-cultural health, family medicine, health psychology, health social work, medical anthropology, medical sociology, nursing, pediatric health, physical education, public health, and rehabilitation.
- Articles in QHR provide an array of timely topics such as: experiencing illness, giving care, institutionalization, substance abuse, food, feeding and nutrition, living with disabilities, milestones and maturation, monitoring health, and children's perspectives on health and illness.

### Look Out for These Regular Special Features

**Pearls, Pith and Provocation:** This section fosters debate about significant issues, enhances communication of methodological advances and encourages the discussion of provocative ideas.

**Book Review Section:** *Qualitative Health Research* includes a book review section helping readers determine which publications will be most useful to them in practice, teaching and research.

**Mixed Methods:** This section includes qualitatively-driven mixed-methods research, and qualitative contributions to quantitative research.

**Advancing Qualitative Methods:** Qualitative inquiry that has used qualitative methods in an innovative way.

**Evidence of Practice:** Theoretical or empirical articles addressing research integration and the translation of qualitatively derived insights into clinical decision-making and health service policy planning.

**Ethics:** Quandaries or issues that are particular to qualitative inquiry are discussed.

**Teaching Matters:** Articles that promote and discuss issues related to the teaching of qualitative methods and methodology.

## 2. Editorial policies

### 2.1 Peer review policy

QHR strongly endorses the value and importance of peer review in scholarly journals publishing. All papers submitted to the journal will be subject to comment and external review. All manuscripts are initially reviewed by the Editors and only those papers that meet the scientific and editorial standards of the journal, and fit within the aims and scope of the journal, will be sent for outside review.

QHR adheres to a rigorous double-blind reviewing policy in which the identity of both the reviewer and author are always concealed from both parties. Ensure your manuscript does not contain any author identifying information. Please refer to the editorial on blinding found in the Nov 2014 issue: <http://qhr.sagepub.com/content/24/11/1467.full>.

QHR maintains a transparent review system, meaning that all reviews, once received, are then forwarded to the author(s) as well as to ALL reviewers.

Peer review takes an average of 6–8 weeks, depending on reviewer response.

### 2.2 Authorship

Papers should only be submitted for consideration once consent is given by all contributing authors. Those submitting papers should carefully check that all those whose work contributed to the paper are acknowledged as contributing authors.

The list of authors should include all those who can legitimately claim authorship. This is all authors who:

- (i) Made a substantial contribution to the concept and design, acquisition of data or analysis and interpretation of data,
- (ii) Drafted the article or revised it critically for important intellectual content, (iii) Approved the version to be published.

Authors should meet the conditions of all of the points above. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content.

When a large, multicenter group has conducted the work, the group should identify the individuals who accept direct responsibility for the manuscript. These individuals should fully meet the criteria for authorship.

Acquisition of funding, collection of data, or general supervision of the research group alone does not constitute authorship, although all contributors who do not meet the criteria for authorship should be listed in the Acknowledgments section.

Please refer to the International Committee of Medical Journal Editors (ICMJE) authorship guidelines for more information on authorship.

## **2.3 Acknowledgements**

All contributors who do not meet the criteria for authorship should be listed in an Acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, or a department chair who provided only general support.

### **2.3.1 Writing assistance**

Individuals who provided writing assistance, e.g., from a specialist communications company, do not qualify as authors and should only be included in the Acknowledgements section. Authors must disclose any writing assistance — including the individual's name, company and level of input — and identify the entity that paid for this assistance.

It is not necessary to disclose use of language polishing services.

Please supply any personal acknowledgements separately from the main text to facilitate anonymous peer review.

## **2.4 Funding**

QHR requires all authors to acknowledge their funding in a consistent fashion under a separate heading. Please visit the Funding Acknowledgements page to confirm the format of the acknowledgement text in the event of funding. Otherwise, state that: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

## **2.5 Declaration of conflicting interests**

It is the policy of QHR to require a declaration of conflicting interests from all authors enabling a statement to be carried within the paginated pages of all published articles. Please ensure that a “Declaration of Conflicting Interests” statement is included at the end of your manuscript, after any acknowledgements and prior to the references. If no conflict exists, please state that “The Author(s) declare(s) that there is no conflict of interest.”

For guidance on conflict of interest statements, please see the ICMJE recommendations here.

## **2.6 Research ethics and patient consent**

Medical research involving human subjects must be conducted according to the World Medical Association Declaration of Helsinki.

Submitted manuscripts should conform to the ICMJE Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals, and all papers reporting animal and/or human studies must state in the methods section that the relevant Ethics Committee or Institutional Review Board provided (or waived) approval. Please ensure that you have provided the full name and institution of the review committee, in addition to the approval number.

For research articles, authors are also required to state in the methods section whether participants provided informed consent and whether the consent was written or verbal.

In terms of patient privacy, authors are required to follow the ICMJE Recommendations for the Protection of Research Participants. Patients have a right to privacy that should not be infringed without informed consent. Identifying information, including patients' names, initials, or hospital numbers,

should not be published in written descriptions, photographs, and pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives written informed consent for publication. Informed consent for this purpose requires that a patient who is identifiable be shown the manuscript to be published. Participant descriptors should not be listed individually. Because qualitative research is descriptive, it is recommended that participant quotations not be linked to identifiers in the manuscript.

## **2.7 Clinical trials**

QHR conforms to the ICMJE requirement that clinical trials are registered in a WHO-approved public trials registry at or before the time of first patient enrolment as a condition of consideration for publication. The trial registry name and URL, and registration number must be included at the end of the abstract.

## **2.8 Reporting guidelines**

The relevant EQUATOR Network reporting guidelines should be followed depending on the type of study. For example, all randomized controlled trials submitted for publication should include a completed Consolidated Standards of Reporting Trials (CONSORT) flow chart as a cited figure, and a completed CONSORT checklist as a supplementary file.

Other resources can be found at NLM's Research Reporting Guidelines and Initiatives.

## **2.9 Data**

SAGE acknowledges the importance of research data availability as an integral part of the research and verification process for academic journal articles.

QHR requests all authors submitting any primary data used in their research articles alongside their article submissions to be published in the online version of the journal, or provide detailed information in their articles on how the data can be obtained. This information should include links to third-party data repositories or detailed contact information for third-party data sources. Data available only on an author-maintained website will need to be loaded onto either the journal's platform or a third-party platform to ensure continuing accessibility. Examples of data types include but are not limited to statistical data files, replication code, text files, audio files, images, videos, appendices, and additional charts and graphs necessary to understand the original research. [The editor(s) may consider limited embargoes on proprietary data.] The editor(s) [can/will] also grant exceptions for data that cannot legally or ethically be released. All data submitted should comply with Institutional or Ethical Review Board requirements and applicable government regulations. For further information, please contact the editorial office at [vshannonqhr@gmail.com](mailto:vshannonqhr@gmail.com).

# **3. Publishing Policies**

## **3.1 Publication ethics**

SAGE is committed to upholding the integrity of the academic record. We encourage authors to refer to the Committee on Publication Ethics' International Standards for Authors and view the Publication Ethics page on the SAGE Author Gateway.

### **3.1.1 Plagiarism**

QHR and SAGE take issues of copyright infringement, plagiarism or other breaches of best practice in publication very seriously. We seek to protect the rights of our authors and we always investigate claims of plagiarism or misuse of articles published in the journal. Equally, we seek to protect the reputation of the journal against malpractice. Submitted articles may be checked using duplication-checking software. Where an article is found to have plagiarized other work, or included third-party copyright material without permission, or with insufficient acknowledgement, or where authorship of the article is contested, we reserve the right to take action including, but not limited to: publishing an erratum or corrigendum (correction); retracting the article (removing it from the journal); taking up the matter with the head of department or dean of the author's institution and/or relevant academic bodies or societies; banning the author from publication in the journal or all SAGE journals, or appropriate legal action.

## **3.2 Contributor's publishing agreement**

Before publication, SAGE requires the author as the rights holder to sign a Journal Contributor's Publishing Agreement. SAGE's Journal Contributor's Publishing Agreement is an exclusive license agreement which means that the author retains copyright in the work but grants SAGE the sole and

exclusive right and license to publish for the full legal term of copyright. Exceptions may exist where an assignment of copyright is required or preferred by a proprietor other than SAGE. In this case copyright in the work will be assigned from the author to the society. For more information please visit our Frequently Asked Questions on the SAGE Journal Author Gateway.

### 3.3 Open access and author archiving

QHR offers optional open access publishing via the SAGE Choice program. For more information please visit the SAGE Choice website. For information on funding body compliance, and depositing your article in repositories, please visit SAGE Publishing Policies on our Journal Author Gateway.

### 3.4 Permissions

Authors are responsible for obtaining permission from copyright holders for reproducing any illustrations, tables, figures or lengthy quotations previously published elsewhere. For further information including guidance on fair dealing for criticism and review, please visit our Frequently Asked Questions on the SAGE Journal Author Gateway.

## 4. Preparing your manuscript

### 4.1 Article Format (*see previously published articles in QHR for style*):

- ☐ **Title page:** Title should be succinct; list all authors and their affiliation; keywords. Please upload the title page separately from the main document.
- ☐ **Blinding:** Do not include any author identifying information in your manuscript, including author's own citations. Do not include acknowledgements until your article is accepted and unblinded.
- ☐ **Abstract:** Unstructured, 150 words. This should be the first page of the main manuscript, and it should be on its own page.
- ☐ **Length:** QHR does not have a word or page count limit. Manuscripts should be as tight as possible, preferably less than 30 pages including references. Longer manuscripts will be considered.
- ☐ **Methods:** QHR readership is sophisticated; excessive details not required.
- ☐ **Ethics:** Include a statement of IRB approval and participant consent. Present demographics as a group, not listed as individuals. Do not link quotations to particular individuals unless essential (as in case studies) as this threatens anonymity.
- ☐ **Results:** Rich and descriptive; theoretical; linked to practice if possible.
- ☐ **Discussion:** Link your findings with research and theory in literature, including other geographical areas and quantitative research.
- ☐ **References:** APA format. Use pertinent references only. References should be on a separate page.

Additional Editor's Preferences:

- ☐ Please do not refer to your manuscript as a "paper;" you are submitting an "article."
- ☐ The word "data" is plural.

### 4.2 Word processing formats

Preferred formats for the text and tables of your manuscript are Word DOC or PDF. The text should be double-spaced throughout with standard 1 inch margins (APA formatting). Text should be standard font (i.e., Times New Roman) 12 point.

### 4.3 Artwork, figures and other graphics

- ☐ **Figures:** Should clarify text.
- ☐ Include figures, charts, and tables created in MS Word in the main text rather than at the end of the document.
- ☐ Figures, tables, and other files created outside of Word should be submitted separately. Indicate where table should be inserted within manuscript (i.e., INSERT TABLE 1 HERE).
- ☐ **Photographs:** Should have permission to reprint and faces should be concealed using mosaic patches – unless permission has been given by the individual to use their identity. This permission must be forwarded to QHR's Managing Editor.
- ☐ ☐ TIFF, JPED, or common picture formats accepted. The preferred format for graphs and line art is EPS.

- □ Resolution: Rasterized based files (i.e. with .tiff or .jpeg extension) require a resolution of at least **300 dpi** (dots per inch). Line art should be supplied with a minimum resolution of **800 dpi**.
- □ Dimension: Check that the artworks supplied match or exceed the dimensions of the journal. Images cannot be scaled up after origination.
- Figures supplied in color will appear in color online regardless of whether or not these illustrations are reproduced in color in the printed version. For specifically requested color reproduction in print, you will receive information regarding the costs from SAGE after receipt of your accepted article.

#### 4.4 Supplementary material

This journal is able to host additional materials online (e.g., datasets, podcasts, videos, images, etc.) alongside the full-text of the article. These will be subjected to peer-review alongside the article.

Supplementary files will be uploaded as supplied. They will not be checked for accuracy, copyedited, typeset or proofread. The responsibility for scientific accuracy and file functionality remains with the author(s). SAGE will only publish supplementary material subject to full copyright clearance. This means that if the content of the file is not original to the author, then the author will be responsible for clearing all permissions prior to publication. The author will be required to provide copies of permissions and details of the correct copyright acknowledgement.

#### 4.5 Journal layout

In general, QHR adheres to the guidelines contained in the Publication Manual of the American Psychological Association ["APA"], 6th edition (ISBN 10:1-4338-0561-8, softcover; ISBN 10:1-4338-0559-6, hardcover; 10:1-4338-0562, spiral bound), with regard to manuscript preparation and formatting. These guidelines are referred to as the APA Publication Manual, or just APA. Additional help may be found online at <http://www.apa.org/>, or search the Internet for "APA format."

#### 4.6 Reference style

QHR adheres to the APA reference style. Click here to review the guidelines on APA to ensure your manuscript conforms to this reference style.

#### 4.7 English language editing services

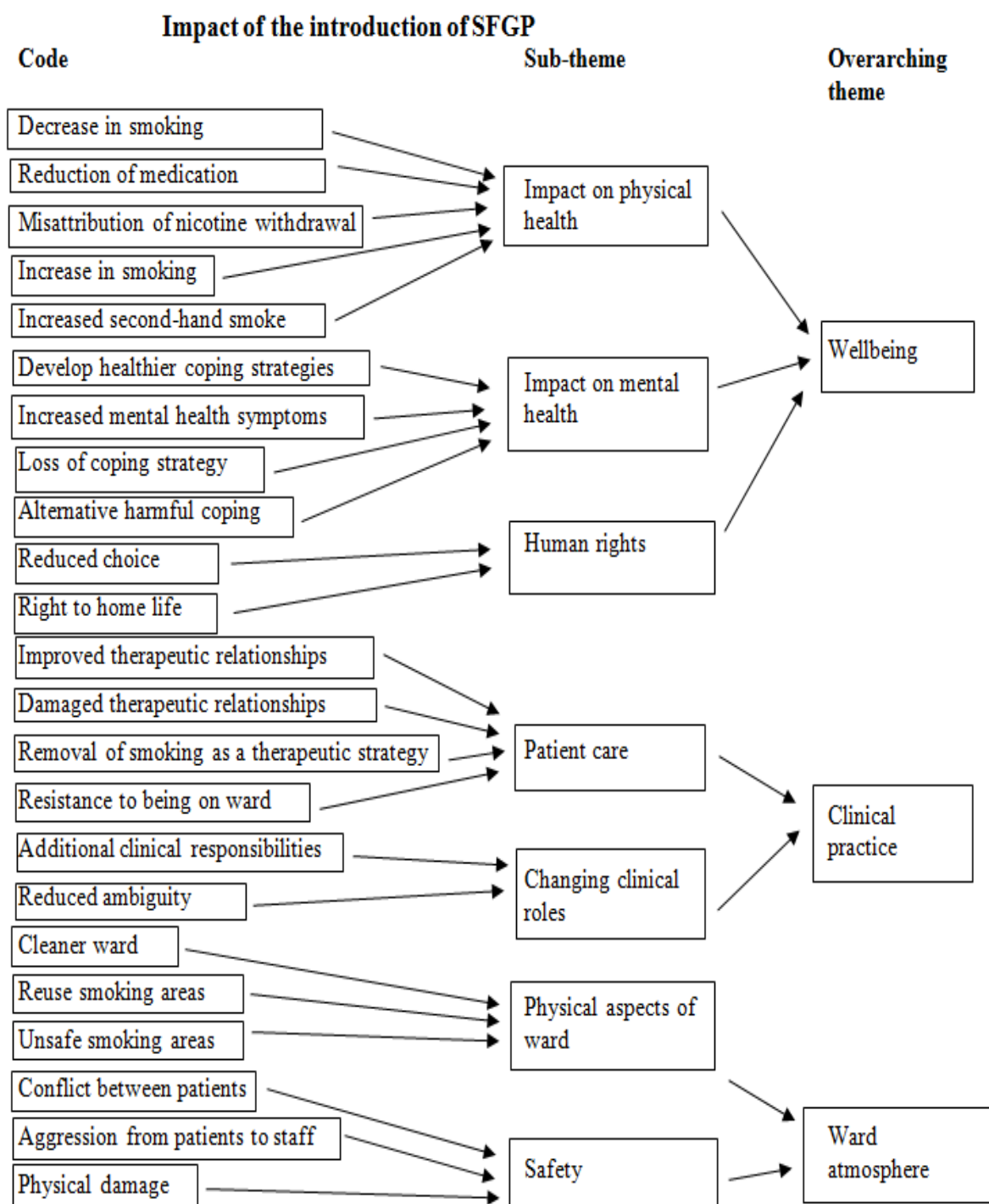
Articles must be professionally edited; this is the responsibility of the author. Authors seeking assistance with English language editing, translation, or figure and manuscript formatting to fit the journal's specifications should consider using SAGE's Language Services.

#### 4.8 Review Criteria

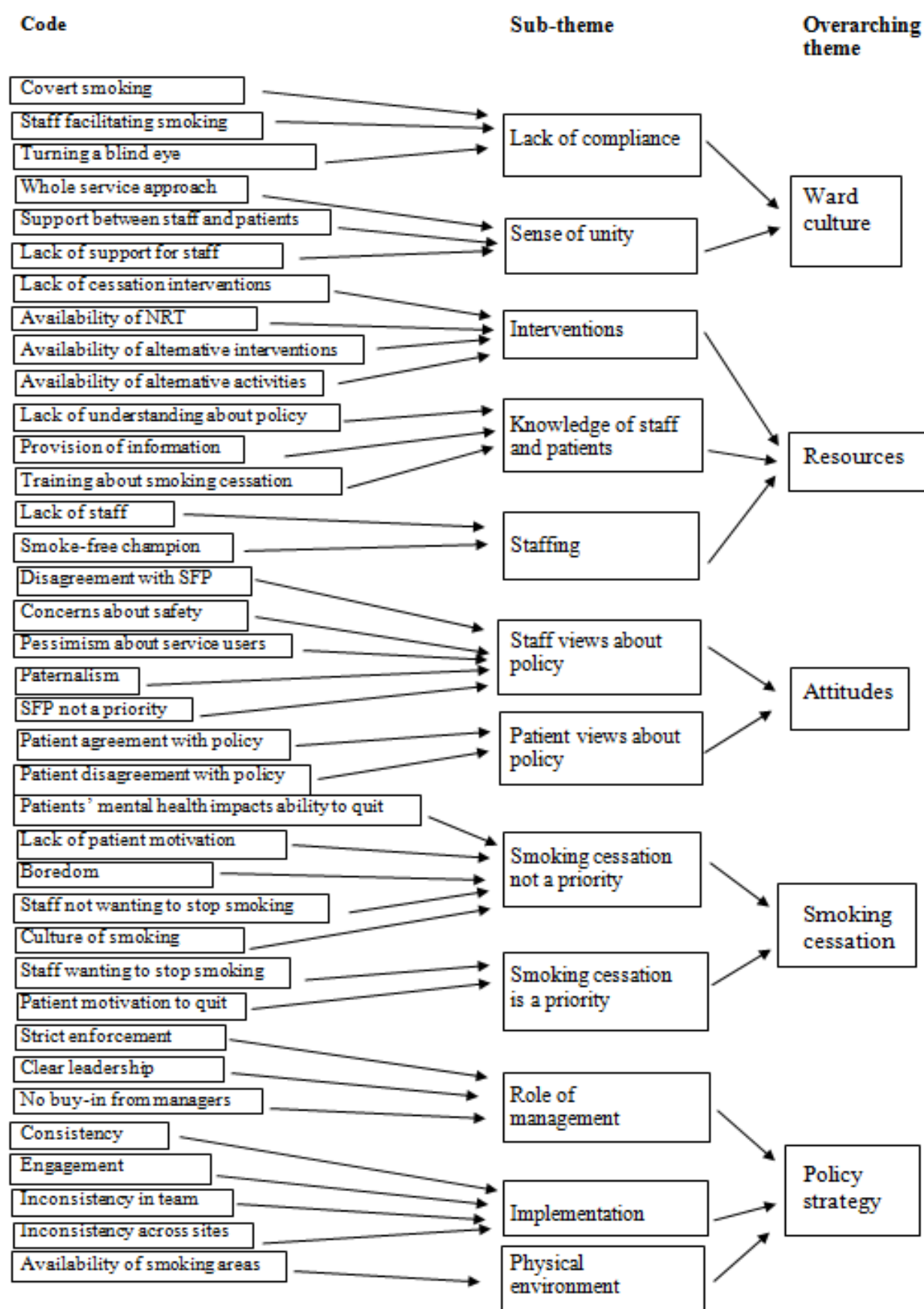
Before submitting the manuscript, authors should have their manuscript pre-reviewed using the following QHR criteria:

- 1. Importance of submission:** Does it make a meaningful and strong contribution to qualitative health research literature? Is it original? Relevant? In depth? Insightful? Significant? Is it useful to reader and/or practitioner?
- 2. Theoretical orientation and evaluation:** Is it theoretically clear and coherent? Is there logical progression throughout?
- 3. Methodological assessment:** Appropriate to question and/or aims? Approach logically articulated? Clarity in design and presentation? Data adequacy and appropriateness? Evidence of rigor?
- 4. Ethical Concerns (Including IRB approval and consent):**
- 5. Data analysis and findings:** Does the analysis of data reflect depth and coherence? In-depth descriptive and interpretive dimensions? Creative and insightful analysis? Linked with theory? Relevant to practice/discipline?
- 6. Data analysis and findings:** Does the analysis of data reflect depth and coherence? In-depth descriptive and interpretive dimensions? Creative and insightful analysis? Linked with theory?

## Appendix B: Process of thematic analysis for systematic review



### Barriers and facilitators to SFGP implementation



## **Appendix C: Participant information sheet**



### **Exploration of the barriers and facilitators to smoking cessation for people with dual diagnosis**

I would like to invite you to take part in a research study. Joining the study is completely up to you but before you decide, you need to understand why the research is being carried out and what it will involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish.

#### **What is this research about?**

The aim of this research project is to find out about the factors that might impact whether people with dual diagnosis are able to stop smoking. Dual diagnosis is a term used to refer to people who have both substance misuse and mental health problems. As there has not been much research on this topic so far, this study will mainly be about exploring people's views about smoking and stopping smoking. This research will use people's experiences to build a theory about why people with dual diagnosis smoke and what may make it harder for them to stop compared to other people. We also hope that the results of this study help us to better support people with mental health and substance misuse problems to stop smoking in the future.

#### **What will the study involve?**

This research will involve an interview with the lead researcher, Leonora Marshall. The interview will explore your experiences and beliefs about smoking and the process of quitting. Questions will be asked about the things that might make it more difficult and the things that might make it easier for you to stop smoking. Even if you are not interested in stopping smoking, we are still interested to hear your thoughts on this topic. It is up to you whether you choose to volunteer to be in this research. If you are interested in volunteering, your keyworker will ask you to complete a form with your contact details and they will pass this onto the researcher, who will then contact you and arrange to meet.

The interview is expected to last between 1 and 1.5 hours and will take place at Change Grow Live (CGL) in one of the clinic rooms. The interview will be recorded, on an audio

recording device, to help with data analysis. As well as the interview, you will also be asked to complete a short form which asks for some details about you, such as how many years you have been smoking and how many cigarettes you smoke each day, this should take about 5 minutes to complete. Once the interview has finished, you will be given the chance to opt-in to receiving a brief information sheet about the results of the study.

### **Why should I take part?**

If you choose to participate in this study, you will be offered a £10 "Love2Shop" voucher to acknowledge the time that you will have spent being interviewed and to thank you for taking part. These vouchers can be used in multiple high street shops but cannot be used to buy alcohol or cigarettes. An additional benefit for taking part in this study is that you will have the opportunity to contribute to the very limited, knowledge base that currently exists in this area. You will have the opportunity to talk about your own views and experiences about smoking, substance use and mental health in a safe and secure environment.

### **Are there any risks in taking part?**

The interview will involve questions about your tobacco smoking, substance use and mental health. It will be up to you how much information you wish to share with the researcher and you can choose not to answer questions without giving a reason. However, it is possible that during the interview something might be discussed that causes you distress. If this happens, the researcher will stop the interview and check that you are ok and whether you wish to proceed. If you do become upset and wish to stop the interview, the researcher will, with your consent, call you in a few days to check how you are. You can stop the interview, without giving a reason, at any time.

### **Who can participate in this research?**

This research is open to cigarette smokers who are currently in substance misuse treatment at the CGL and who also have a mental health diagnosis. You must be over 18 years old to participate and have a reasonable understanding of written and spoken English.

### **Do I have to take part?**

It is entirely up to you if you would like to take part. If you do decide to take part, you may choose to not answer questions and may choose to opt-out at any stage during the interview without giving a reason. Following the interview, you will have the option to request a copy of a transcript of the interview on which you may choose to make any alterations, or to withdraw from research participation. Once you have completed the interview, you will still be free to remove yourself and your data from the study for a period of one week after being interviewed. After this point, it becomes tricky to remove individual people's data because the data analysis process will have started.

Your treatment with CGL will not be affected by your decision to take part in this research.

### **Will the things I say during the interview be kept confidential?**

All data will be stored as per the Data Protection Act (1998) and UEA Policy which means that anonymised data will be securely stored for 10 years. The audio files from the interview will be deleted once the interview has been transcribed into an anonymous format. Any paper documents will be kept in a locked cabinet and your interview data will be kept on a computer in a password protected file. Only the researcher will be able to identify interview data that belongs to you. Any data that has identifiable information will be stored securely for the length of the study (6-12 months) and will then be destroyed. Your participation and information given during the research process will not be shared, unless concerns are raised about your own, or someone else's safety. You will be informed in advance should this be necessary.

The information collected during this research project will be stored in an anonymised format. Your data will be used with that of other participants to produce written reports and submitted for submission as part of the researcher's doctoral thesis submission. This research may be submitted for publication in academic journals. As part of this process, quotes may be used from your interview in the written report but all steps will be taken to ensure that your anonymity will be protected (e.g. the use of pseudonyms and the removal of any identifying information). Potentially, interview material may be used to support the development of resources to support others in similar situations – again, this will be in an anonymised format.

### **Who has reviewed this study?**

All research is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and approved by the University of East Anglia Faculty of Medicine and Health Sciences Research Ethics Committee (Reference 2017/8 – 130 SE).

### **Any questions?**

If you have any questions, comments or concerns about any aspect of this study, you should ask to speak to the researcher (Leonora Marshall), who will do her best to answer your questions. Alternatively, you may contact her Research Supervisor from University of East Anglia (Dr Caitlin Notley). Please see information about the contact details of the study team at the end of this information sheet.

If you are unhappy about this research and wish to complain formally you can contact University of East Anglia Faculty of Medicine and Health Sciences.

**Deciding to participate in the research**

If you would like support in deciding whether or not to participate in this research project, you may wish to discuss this with your keyworker, friends, or family. The researcher, Leonora Marshall, will also be able to answer any questions you have about the research.

**Research team contact details:**

This study is an educational project that is being undertaken as part of the Doctorate of Clinical Psychology.

Researcher: Leonora Marshall (leonora.marshall@uea.ac.uk; 07943719262)

Primary Supervisor: Dr Caitlin Notley (c.notley@uea.ac.uk; 01603 591275)

**Appendix D: Consent to Contact Form****Consent to Contact****Exploration of the barriers and facilitators to smoking cessation for people with dual diagnosis**

Researcher: Leonora Marshall, [leonora.marshall@uea.ac.uk](mailto:leonora.marshall@uea.ac.uk)

Please initial box

if you agree:

I confirm I am potentially interested in taking part in the above study and give consent for the researcher to contact me using the following details to discuss the study further.

☐

Name: \_\_\_\_\_

Preferred method of contact (please tick):

☐

Phone number: \_\_\_\_\_

☐

Email: \_\_\_\_\_

## Appendix E: Consent Form



### Consent Form

**Title of Project:** Exploration of the barriers and facilitators to smoking cessation for people with dual diagnosis

**Name of Researcher:** Leonora Marshall

Please  
initial box

I confirm that I have read the information sheet dated \_\_\_\_\_  
(Version 2) for the above study. I have had the opportunity to consider  
the information, ask questions and have had these answered satisfactorily.

☐

I understand that my participation is voluntary and that I am free to  
withdraw at any time without giving any reason, without my medical  
care or legal rights being affected.

☐

I consent to use of audio taping and the possible use of anonymised verbatim  
quotation in the writing of the research report.

☐

I understand that relevant sections of the data collected during the  
study, may be looked at by individuals from UEA or from  
regulatory authorities for audit purposes.

☐

I would like to be sent a summary of the results of the study when they are  
available.

☐

I agree to take part in the above study.

Name of Participant

Date

Signature

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of person taking consent

Date

Signature

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Appendix F: Demographic Questionnaire

### Participant Demographic Form

Please circle your answer or write in the space provided as appropriate.

- 1) How old are you? \_\_\_\_\_
  
- 2) Are you:      Male                  Female                  Other: \_\_\_\_\_
  
- 3) How would you describe your racial/ethnic background? (e.g. White, Black British, White Jewish, Asian Muslim etc.)  
\_\_\_\_\_
  
- 4) Primary substance:
  - a. Alcohol                  b. Heroin/Opiates                  c. Crack/Cocaine                  d. Cannabis
  - e. Amphetamines                  f. Other: \_\_\_\_\_
  
- 5) Do you use any other substances, apart from the one listed above?  
Please list: \_\_\_\_\_
  
- 6) Do you have a MH diagnosis? (please circle)                  Yes                  No
  - a. If yes, what is your primary diagnosis?  
\_\_\_\_\_
  
- 7) How old were you when you first started smoking? \_\_\_\_\_
  
- 8) How many cigarettes do you smoke on average each day? \_\_\_\_\_
  
- 9) Have you ever tried to stop smoking?                  Yes                  No
  7. a) If you answered yes: how long is the longest you have gone without smoking?  
\_\_\_\_\_
  
- 10) In relation to stopping smoking, I intend to:
  - a. Quit in the next month                  b. Quit in the next 6 months
  - c. Quit, but not in the next 6 months                  d. Never quit
  - e. Don't know

## Appendix G: Interview Guide

### Semi-structured Interview Guide

#### 1. Background to smoking, substance misuse and mental health problems,

Tell me about your first experiences of substance misuse (including smoking) and mental health problems

*Probe: Explore early experiences of substance misuse and mental health problems*

*Prompt: How and when did substance misuse start? How and when did mental health problems start?*

#### 2. Exploration of the development of smoking, substance misuse and mental health problems

In what ways has your smoking and substance misuse changed over time?

#### 3. Current smoking, substance misuse and mental health

Tell me about how your substance misuse (including smoking) and mental health affects you currently

*Prompt: how much is currently smoked? What/how much substances currently used? Current involvement of mental health services?*

#### 4. Exploration of the interaction of smoking, substance misuse and mental health?

Tell me about the relationship between substance misuse (including smoking) and your mental health

*Prompt: Do you use substances/smoke at particular times? Does substance use/smoking impact mental health?*

#### 5. Views/beliefs about smoking

Tell me about your opinions on smoking

*Probe: let the interviewee give their understanding of the harm/benefits of smoking in general and for them (as an individual)*

#### 6. Experience of smoking

Tell me about your experience of smoking

*Probe: Explore quit attempts, explore desire/motivation to quit, support around quitting, reasons for smoking*

*Prompt: Have you ever received advice/support for smoking cessation while in treatment for substance misuse or mental health problems? Should smoking be addressed during substance misuse/mental health treatment?*

### **7. Barriers/facilitators to smoking cessation**

What things may impact whether you are able/want to stop smoking?

*Prompt: What may make it harder/easier to stop for you to stop? What may make it harder/easier for people with substance misuse/mental health problems in general to stop?*

### **8. Changing Services**

What needs to change to better support people with substance misuse and mental health problems to stop smoking?

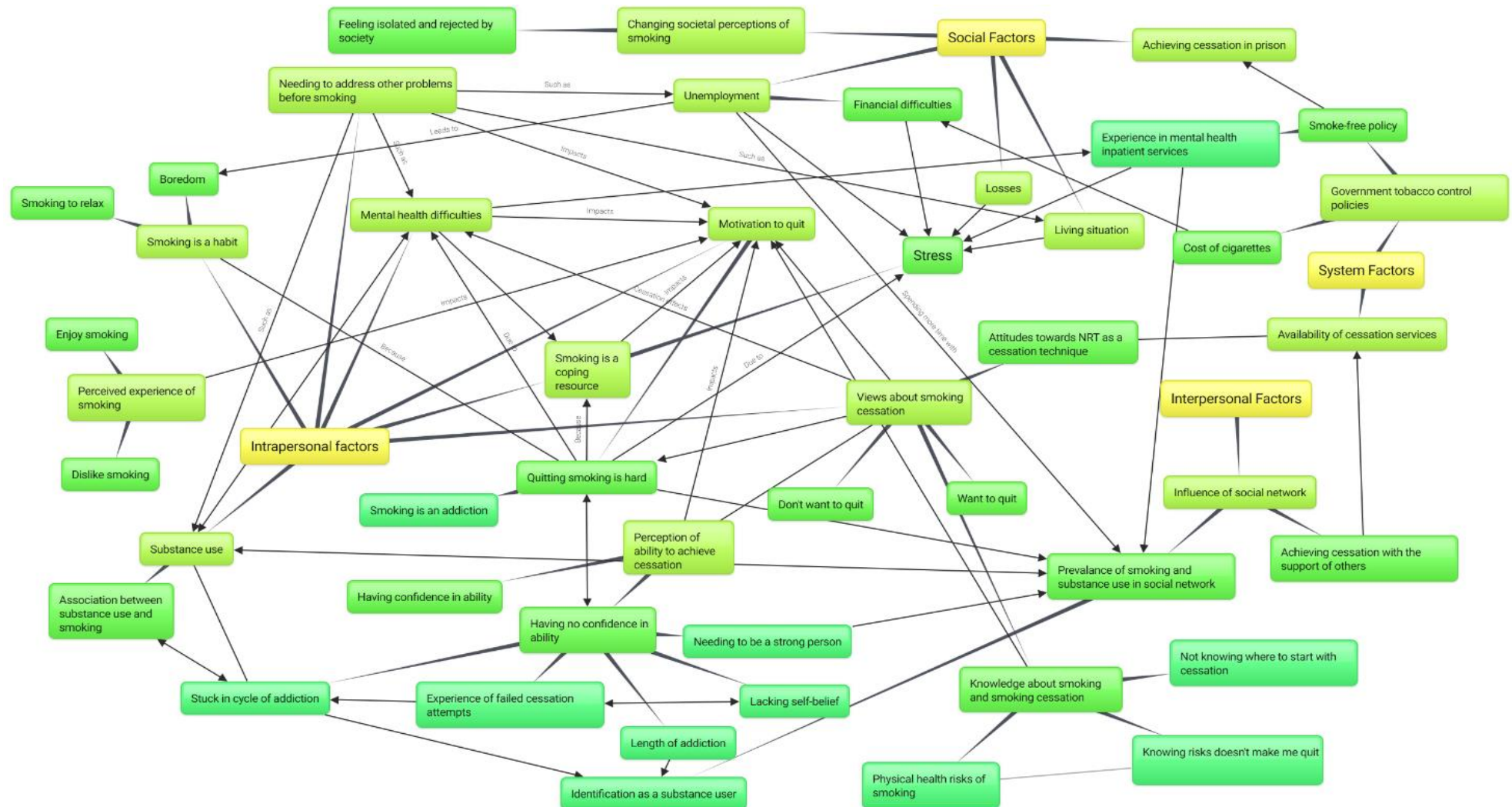
*Probe: Review the barriers to smoking cessation mentioned previously and ask them to give suggestions about how services may be able to meet these needs*

*Prompt: How can services better meet your needs?*

## Appendix H: Transcription guide

Transcription Formatting	Meaning
...	Pause in speech of approximately 3 seconds or more
[Text in square brackets]	Information to provide clarity to participant's speech but not spoken directly by participant. Most frequently used to anonymise a service or someone's name
("Non-italicised text in rounded brackets")	Questions or comments made by the researcher.
*words between asterisks*	Indicate non-verbal communication, such as laughing, crying, sighing etc.
Word-	A word followed by hyphen indicates that the word was cut short by the participant

## Appendix I: Exploration of the conceptualised connections between themes that emerged during the analysis process



## Appendix J: REC ethics approval

Re-issued 14/05/2018 – due to document checklist error GM



**Please note:** This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

30 April 2018

Miss Leonora Marshall  
 Trainee Clinical Psychologist  
 University of East Anglia  
 Norwich Research Park  
 NR6 5PE

Dear Miss Marshall

<b>Study title:</b>	<b>Exploration of the barriers and facilitators to smoking cessation for people with dual diagnosis</b>
<b>REC reference:</b>	<b>18/EE/0033</b>
<b>IRAS project ID:</b>	<b>229973</b>

Thank you for your letter of 05/03/2018, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net) outlining the reasons for your request.

### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation

as revised, subject to the conditions specified below.

### **Conditions of the favourable opinion**

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).*

*Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at [www.hra.nhs.uk](http://www.hra.nhs.uk) or at <http://www.rdforum.nhs.uk>.*

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of management permissions from host organisations*

### **Registration of Clinical Trials**

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net). The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

#### **Ethical review of research sites**

##### **NHS sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

#### **Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering letter on headed paper [REC Cover Letter]	1	05 March 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance/Indemnity Letter from Sponsor]	1	19 December 2017
GP/consultant information sheets or letters [Letter to Clinicians]	1	10 November 2017
Interview schedules or topic guides for participants [Interview Topic Guide]	1	17 October 2017
IRAS Application Form [IRAS_Form_14032018]		14 March 2018
Non-validated questionnaire [Demographics Form]	2	25 February 2018
Other [Thank you letter]	1	05 March 2018
Other [Debrief Sheet V2]	2	05 March 2018
Other [Consent to Contact]	1	17 November 2017
Other [Secondary Supervisor CV]	1	05 January 2017
Participant consent form [Consent Form]	2	05 March 2018
Participant information sheet (PIS) [Participant Information Sheet]	2	05 March 2018
Referee's report or other scientific critique report [Feedback Report from UEA Review]	1	03 July 2017
Research protocol or project proposal [Research Proposal]	2	01 March 2018
Summary CV for Chief Investigator (CI) [Research CV]	1	20 October 2017
Summary CV for supervisor (student research) [Primary Supervisor CV]	1	17 October 2017
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Distress Protocol Flowchart]	1	17 October 2017

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### After ethical review

#### Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

### User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

### HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at

<http://www.hra.nhs.uk/hra-training/>

18/EE/0033	Please quote this number on all correspondence
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With the Committee's best wishes for the success of this project.

Yours sincerely

P.P. Gelling

**Dr Leslie Gelling**  
**Chair**

Email: [nrescommittee.eastofengland-cambridgesouth@nhs.net](mailto:nrescommittee.eastofengland-cambridgesouth@nhs.net)

*Enclosures:* "After ethical review – guidance for  
researchers"

*Copy to:* Rachel Lindley  
Dr Bonnie Teague, Norfolk and Suffolk NHS Foundation Trust

## Appendix K: Health and Research Authority approval



Miss Leonora Marshall  
Trainee Clinical Psychologist  
University of East Anglia  
Norwich Research Park  
NR6 5PE



Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)  
[Research-permissions@wales.nhs.uk](mailto:Research-permissions@wales.nhs.uk)

14 May 2018

Dear Miss Marshall

**HRA and Health and Care  
Research Wales (HCRW)  
Approval Letter**

<b>Study title:</b>	Exploration of the barriers and facilitators to smoking cessation for people with dual diagnosis
<b>IRAS project ID:</b>	229973
<b>REC reference:</b>	18/EE/0033
<b>Sponsor</b>	University of East Anglia

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

**How should I continue to work with participating NHS organisations in England and Wales?**  
You should now provide a copy of this letter to all participating NHS organisations in England and Wales\*, as well as any documentation that has been updated as a result of the assessment.

\*'In flight studies' which have already started an SSI (Site Specific Information) application for NHS organisations in Wales will continue to use this route. Until 10 June 2018, applications on either documentation will be accepted in Wales, but after this date all local information packs should be shared with NHS organisations in Wales using the Statement of Activities/Schedule of Events for non-commercial studies and template agreement/ Industry costing template for commercial studies.

Following the arranging of capacity and capability, participating NHS organisations should formally confirm their capacity and capability to undertake the study. How this will be confirmed is detailed in the "summary of assessment" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site

IRAS project ID	229973
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initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed [here](#).

#### **How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?**

HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

#### **How should I work with participating non-NHS organisations?**

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

#### **What are my notification responsibilities during the study?**

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

#### **I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?**

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Rachel Lindley

Email: [r.lindley@uea.ac.uk](mailto:r.lindley@uea.ac.uk)

#### **Who should I contact for further information?**

Please do not hesitate to contact me for assistance with this application. My contact details are below.

IRAS project ID	229973
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Your IRAS project ID is 229973. Please quote this on all correspondence.

Yours sincerely

Maeve Ip Groot Bluemink  
Assessor

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

Copy to: *Rachel Lindley, University of East Anglia – Sponsor Contact*  
*Dr Bonnie Teague, Norfolk and Suffolk NHS Foundation Trust – Lead R&D Contact*

IRAS project ID	229973
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## List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [REC Cover Letter]	1	05 March 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance/Indemnity Letter from Sponsor]	1	19 December 2017
GP/consultant information sheets or letters [Letter to Clinicians]	1	10 November 2017
HRA Schedule of Events	1 (HRA final)	31 January 2018
HRA Statement of Activities	1 (HRA final)	31 January 2018
Interview schedules or topic guides for participants [Interview Topic Guide]	1	17 October 2017
IRAS Application Form [IRAS_Form_14032018]		14 March 2018
Non-validated questionnaire [Demographics Form]	2	25 February 2018
Other [Thank you letter]	1	05 March 2018
Other [Debrief Sheet V2]	2	05 March 2018
Other [Consent to Contact]	1	17 November 2017
Other [Secondary Supervisor CV]	1	05 January 2017
Participant consent form [Consent Form]	2	05 March 2018
Participant information sheet (PIS) [Participant Information Sheet]	2	05 March 2018
Referee's report or other scientific critique report [Feedback Report from UEA Review]	1	03 July 2017
Research protocol or project proposal [Research Proposal]	2	01 March 2018
Summary CV for Chief Investigator (CI) [Research CV]	1	20 October 2017
Summary CV for supervisor (student research) [Primary Supervisor CV]	1	17 October 2017
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Distress Protocol Flowchart]	1	17 October 2017

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Section	Assessment Criteria	Compliant with Standards	Comments
	assessed		been made.  There will be no financial provisions to the sites.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	REC Favourable Opinion has been issued by the East of England - Cambridge South REC.
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

### Participating NHS Organisations in England and Wales

*This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.*

There is one type of participating NHS organisation; therefore, there is only one site type.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or

IRAS project ID	229973
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HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at [hra.approval@nhs.net](mailto:hra.approval@nhs.net) or HCRW at [Research-permissions@wales.nhs.uk](mailto:Research-permissions@wales.nhs.uk). We will work with these organisations to achieve a consistent approach to information provision.

### Principal Investigator Suitability

*This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).*

Principal Investigators (PIs) are expected for this type of study. The PI has been identified at the NHS site and is listed in IRAS Form [Part C].

GCP training is not a generic training expectation, in line with the [HRA/HCRW/MHRA statement on training expectations](#).

### HR Good Practice Resource Pack Expectations

*This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken*

Use of identifiable patient records held by an NHS organisation to identify potential participants should be undertaken by a member of the direct care team for the patient, so it would not normally be acceptable for this to be done by staff not employed by that organisation.

Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.

### Other Information to Aid Study Set-up

*This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.*

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

**Appendix L: UEA FMH ethical approval**

Research & Innovation Services  
Floor 1, The Registry  
University of East Anglia  
Norwich Research Park  
Norwich, NR4 7TJ

Email: [fmh.ethics@uea.ac.uk](mailto:fmh.ethics@uea.ac.uk)

Web: [www.uea.ac.uk/researchandenterprise](http://www.uea.ac.uk/researchandenterprise)

Leonora Marshall  
(MED)

12.06.18

Dear Lenora,

**Project title:** Exploration of the barriers and facilitators to smoking cessation for people with dual diagnosis

**Reference:** 2017/18 – 130 SE

The submission of your above proposal has been considered by the Faculty Research Ethics Committee and I can confirm that your proposal has been approved by Chairs' action.

Please could you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance and also that any adverse events which occur during your project are reported to the Committee. Please could you also arrange to send us a report once your project is completed.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'M J Wilkinson', is written over a horizontal line.

Professor M J Wilkinson  
Chair  
FMH Research Ethics Committee

## Appendix M: Confirmation of approval from the recruitment site

### Registered and regional office

3rd Floor Tower Point, 44 North Road, Brighton, East Sussex BN1 1YR  
T: 01273 677 019 F: 01273 693 183 E: south@cgl.org.uk  
W: changegrowlive.org



28/09/2018

Dear Ms Marshall

### Exploration of Smoking Cessation in Dual-Diagnosis Groups

As requested this letter is to confirm that your research application, named above has been approved by CGL's Research Oversight Group.

As advised by Dr Prun Bijral, our Executive Medical Director and chair of the research oversight group.

Please note that we will seek progress reports from you at various times during the course of your research project. A copy of this progress report will be emailed to you along with this letter for your information. We will be in touch with you at a later stage to see if you are in a position to provide an update on your research.

If you have questions in relation to this please don't hesitate to contact us

Thank you for considering us for assistance with your research and Good Luck with the study.

Harry Wallace

For ~~Prun Bijral~~

Executive Medical Director, change, grow live



Change, grow, live (CGL) Registered Office: 3rd Floor, Tower Point, 44 North Road, Brighton BN1 1YR, Registered Charity Number in England and Wales (1079327).  
Company Registration Number 3861209 (England and Wales).



Our goal is to help service users regain control, change the direction of their lives, grow as a person and live life to its full potential.

## **Appendix N: Participant debrief sheet**



### **Participant Debriefing Sheet**

#### **Exploration of the barriers and facilitators to smoking cessation for people with dual-diagnosis**

Thank you for your participation in this research. The information you have shared will allow a greater understanding of the experience of people with substance use and mental health diagnoses on smoking.

Your data will be anonymised, and your information kept confidential. Data will be used in submission towards the researcher's doctoral thesis in the University of East Anglia Clinical Psychology Doctorate Programme. Data and individual anonymised quotes may be used in academic research publications.

Should you wish to discuss further your participation in this research project you may contact the researcher, Leonora Marshall on 07943719262.

We hope that you have found participating in this research a positive experience, however if you feel concerned about anything that has been discussed or feel that you need additional support, please speak to your CGL care coordinator.

Additionally, your GP or other healthcare services may be able to provide support regarding feelings around substance misuse, mental health and smoking cessation.

Further support on substance misuse can be obtained from:

NHS Choices – <http://www.nhs.uk/Livewell/drugs/Pages/Drugshome.aspx>

Talk to Frank - <http://www.talktofrank.com/>

Samaritans - <http://www.samaritans.org/> or Freephone 116 123

Smokefree Norfolk offer specialist stop smoking advice and support to smokers from across Norfolk who want to quit.

- Call freephone 0800 0854 113
- Visit the Smokefree Norfolk website: <http://www.smokefreenorfolk.nhs.uk/>

**Appendix O: Example of process of analysis for one participant using a  
Grounded Theory method**

Excerpt of interview with Alex	Open codes (gerunds)	Axial code	Theoretical category
<p>I – Yeah ... are there- like particular things will ... trigger-</p> <p>P – That will trigger me? Yeah, eating, after eating</p> <p>I – Eating ...</p> <p>P – After eating, every single time I've eaten I have to have a cigarette I don't know what that is, that's a strange one, but I know so many people that say that as well, there like oh I need a fag after I've had like after I've had a meal, so do I ... I'm glad I aint the only one *laughs*</p> <p>I – So food, that's a trigger for you ... are there any other things that trigger you needing a cigarette?</p> <p>P – Uh ... actually saying that, actually drug use will actually trigger me needing a cigarette like if I'm on like, if I take cocaine I'll smoke a lot more um ... not so much with the opiates I don't increase it, I definitely don't increase on the opiates but any kinda like amphetamine kind of, anything that makes you sort of a bit more racy a bit speedy as I call it um ... yeah, that I will smoke a lot more when I'm on that, than I would if I wasn't (Interviewer – “Yeah”) definitely ... and alcohol as well</p> <p>I – And alcohol as well, so if you're using amphetamines (Participant – “Yeah”) or coke, powder coke (Participant – “Yeah”) or alcohol (Participant – “Yeah”) you smoke a lot more</p> <p>P – Smoke a lot more, yeah definitely ... yeah, yeah</p>	<p>Eating triggers smoking</p> <p>Eating triggers smoking</p> <p>Noticing other smokers needing a cigarette after smoking</p> <p>Using drugs triggers smoking</p> <p>Cocaine use leads to increased smoking</p> <p>Opiates doesn't increase smoking</p> <p>Needing cigarette when feeling 'racy' from drug use</p> <p>Smoking more when drinking alcohol</p> <p>Smoking more when using substances</p>	<p>Smoking is a habit</p> <p>Smoking is a habit</p> <p>Smoking increases with substance use</p> <p>Smoking increases with alcohol use</p> <p>Smoking increases with substance use</p>	<p>Ability to quit: habit</p> <p>Ability to quit: habit</p> <p>Ability to quit: substance use</p> <p>Ability to quit: substance use</p>

