

Clearing the Air

DEBATING SMOKE-FREE POLICIES
IN PSYCHIATRIC UNITS

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Debating smoke-free policies in psychiatric units

Karen Jochelson
Bill Majrowski

King's **Fund**

Smoking and exposure to second-hand smoke lead to poor physical health, yet there are concerns that extending the proposed ban on indoor smoking to psychiatric units would infringe patient rights and could provoke aggressive reactions from patients. This paper explores the arguments for and against such a ban, examining the international literature on the prevalence and impact of smoking in psychiatric units and looking at the impact of smoking bans in these settings. It also presents the findings of a survey of staff in UK psychiatric units about their views on a smoking ban and the feasibility of implementing it.

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Introduction

There are about 34,000 people resident in mental health facilities in England and Wales on any one day (Commission for Healthcare Audit and Inspection 2005) and many of them smoke. Most facilities allow smoking in a designated indoor area, thus exposing patients and staff to second-hand smoke. Smoking and exposure to second-hand smoke lead to poor physical health, yet policy-makers, health practitioners and voluntary sector organisations representing patients and carers have been reluctant to extend the proposed ban on indoor smoking to residential institutions such as psychiatric units.

Some believe that a ban infringes patients' rights and may provoke an aggressive reaction from patients. Others argue that the right to breathe clean air is more important, and that patients would still have opportunities to smoke outside, away from non-smokers.

To understand the likely challenges facing psychiatric units, we examined the international literature on the prevalence and impact of smoking among psychiatric patients, and looked at the impact of smoking bans in psychiatric units. We also surveyed staff in psychiatric units throughout the United Kingdom about their views on a smoking ban and the feasibility of implementing it.

Our findings suggest that many people with mental illness smoke and that this has a serious impact on their physical health. International and local examples show that it is possible to introduce a ban on indoor smoking, while allowing supervised smoking outdoors. However, our survey suggests that the greatest challenge to doing so will be overcoming staff fears about provoking violence in patients and the belief that patients need nicotine to cope with stressful situations. Institutions that have banned indoor smoking educated their staff and patients about the ban, provided smoking cessation aids and did not find that the ban provoked violence among patients.

Smoking ban legislation and psychiatric units

During the summer of 2006, the government is likely to consult on regulations arising from the Health Bill. The Bill proposes a ban on smoking in public places and is the culmination of the government's strategy to reduce deaths and illness caused by smoking. Since 1998, the government has introduced smoking cessation services, restricted advertising of tobacco products, funded mass-media campaigns, attempted to reduce tobacco smuggling and increased the duty on cigarettes. Banning smoking in public places, it hopes, will reduce smoking and exposure to second-hand smoke, and lead to a decline in smoking-related diseases.

A key issue in the public consultation will be exemptions from a general ban. In the consultation preceding the Bill, hospices and long-stay residential care homes for adults, prisons and psychiatric hospitals were to be exempt, as they were considered to be places of residence (Department of Health 2005a). Psychiatric units are not specifically mentioned in the current Bill, but are likely to be covered by the same exemption.

In the run-up to the Bill, opinion has been divided over the practicality of a ban. Submissions during consultation were split between those supporting an exemption, as they believed a ban would lead to violence among patients, and those rejecting a blanket exemption and favouring a case-by-case approach. A 'minority' of submissions, noted the Department of Health's summary of the responses, argued that a ban would run counter to 'smokers' rights', but the 'majority' of submissions believed that the 'rights of non-smokers to breathe clean air' took precedence (Department of Health 2005b). The House of Commons Health Select Committee, reporting on the Bill, heard a similar range of evidence, and concluded that psychiatric institutions should not be exempt and should be included in plans for the NHS to become smoke-free by the end of 2006 (House of Commons Health Committee 2005).

Three rights issues framed the debate. The first is the right of staff to work in a safe environment. This means limiting exposure to second-hand smoke. Staff supervising patients in designated smoking room are exposed to second-hand smoke – even where there are ventilation systems – as these remove the smell of tobacco but not the dangerous particles and gases. Staff supervising patients smoking outside, or visiting patients in their own homes also risk exposure to second-hand smoke. Representatives from an NHS trust and the voluntary sector emphasised their legal duty under the Health and Safety Act to provide a safe workplace for staff or potentially risk legal action (House of Commons Health Committee 2005, questions 238, 248).

The second issue was the right of patients to choose their lifestyle, that is, their 'right' to smoke. Most patients with mental health problems are treated in primary care, but those with severe illness can admit themselves voluntarily to psychiatric units, or be detained

compulsorily. On average, patients spend 58 days in psychiatric units (Office for National Statistics 2006, p 122) and these effectively become their 'home', although one in which their rights to live as they wish are limited by the rules of the institution. Long-stay care homes and prisons similarly become 'places of residence', with care-home residents effectively confined to an institution because they are unable to live independently, whereas prisoners' detention is compulsory. For Rethink, a voluntary sector organisation representing patients and their carers, a 'complete smoking ban' was 'difficult to imagine' as 'a significant proportion' of patients 'will be there under compulsion' (House of Commons Health Committee 2005, question 237).

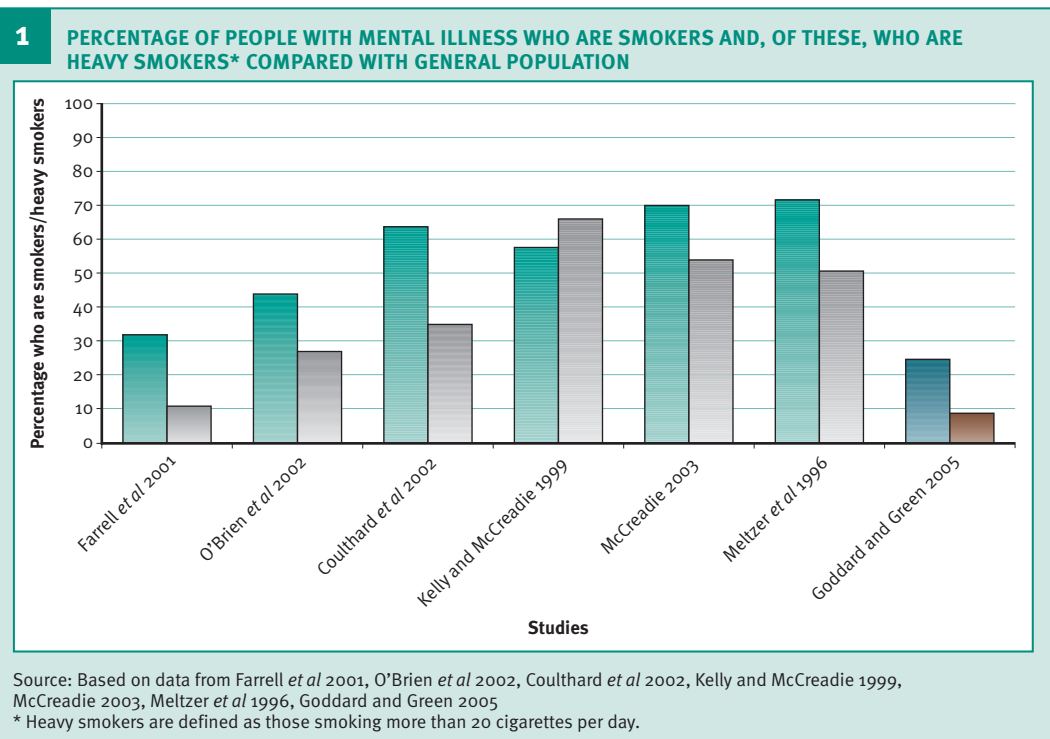
Finally, the 'rights' of patients to smoke need to be balanced against the rights of non-smoking patients to a safe environment. Smoking rooms are often the social hub of psychiatric wards, and smoking is part of the culture. One trust that had introduced a ban on indoor smoking explained to the Health Committee that it was 'trying to support people who do not smoke' because people 'enter the service as non-smokers and come out ... as smokers because of the culture' (House of Commons Health Committee 2005, question 239). The Royal College of Nursing believed that psychiatric units needed to move towards "denormalising" smoking, not seeing it as an accepted part of the package of being a mental health client' (House of Commons Health Committee 2005, question 249). Prison authorities found that non-smoking prisoners complained when forced to share a cell with smokers (House of Commons Health Committee 2005, questions 226, 227).

The issue of whether to exempt psychiatric units, and other places of residence, from indoor smoking bans has vexed governments and legislators in other countries. Northern Ireland is as yet undecided about whether to include psychiatric units in the ban. Ireland has exempted psychiatric units, although employers may override the exemption and introduce a ban. In Scotland the ban covers NHS premises, including psychiatric units, but institutions may (although they are under no legal obligation to do so) offer an exempt, enclosed, designated smoking room, providing that it does not ventilate smoke into other parts of the building, that it is for the use of residents, not staff or visitors, and that staff exposure is minimised (Scottish Executive 2005).

Smoking prevalence and health impacts in psychiatric patients

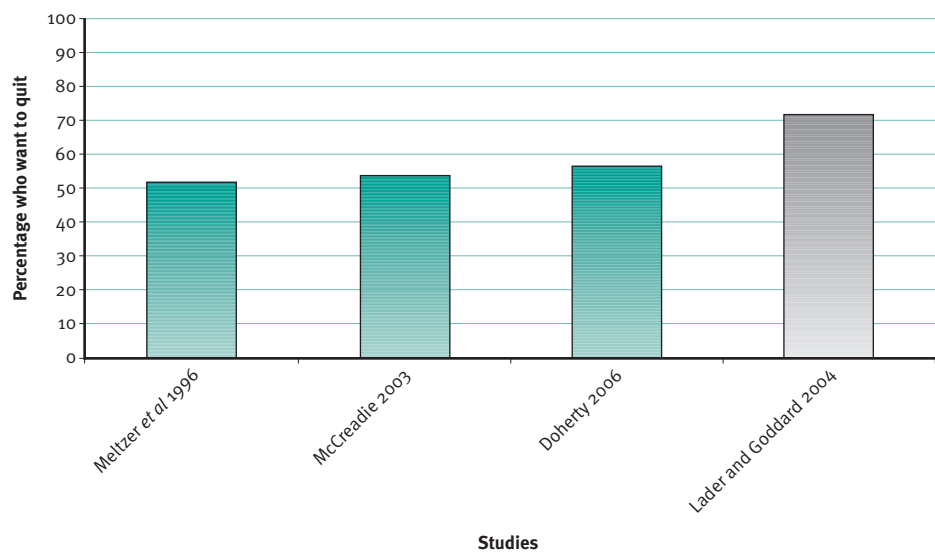
At any one time up to 630,000 people are in contact with specialised mental health services and about 34,000 people are resident in mental health facilities (Department of Health 2004b, Commission for Healthcare Audit and Inspection 2005). Mental illness is associated with an increased risk of starting smoking. People with mental health problems are more likely to smoke, smoke more heavily and for more years than the general population (McNeill 2001, Kumari and Postma 2005).

About 25 per cent of the UK adult population smokes, and 9 per cent are heavy smokers, consuming more than 20 cigarettes a day (Goddard and Green 2005). Studies of psychiatric patients in hospitals show that up to 70 per cent smoke, and around 50 per cent are heavy smokers (Coulthard *et al* 2002, Foster *et al* 1996, Kelly and McCreadie 1999, Meltzer *et al* 1996). People with mental illness who are living in the community and who are less ill, smoke less, with up to 40 per cent smoking and close to 30 per cent smoking heavily (O'Brien *et al* 2002, Farrell *et al* 2001). US studies also show that people with mental illness are more likely to smoke (Lasser *et al* 2000). Figure 1 (see below) presents the findings from several studies and shows the percentage of people with a severe mental illness who smoke and, of these, the percentage smoking over 20 cigarettes a day.



2

PERCENTAGE OF SMOKERS WITH MENTAL ILLNESS WHO WANT TO QUIT COMPARED WITH GENERAL POPULATION



Source: Based on data from Meltzer *et al* 1996, McCreddie 2003, Doherty 2006, Lader and Goddard 2004

KEY

- Smokers with mental illness
- Smokers in general population

Despite a high prevalence of smoking, many mental health patients would like to quit (see Figure 2, above). However, many studies show that quit rates for people with a mental illness are very low. This may be because smoking is part of the culture of psychiatric institutions, but also because staff and patients believe nicotine helps patients to cope with the symptoms of their illness or with the side effects of medication (Lawn 2004, Lawn and Pols 2003, Lawn and Pols 2005). People with mental illness also may find it hard to get access to smoking cessation services, and are not directed there by medical professionals (McNeill 2001, El-Guebaly *et al* 2002, Dickens *et al* 2005, Prochaska *et al* 2004).

Health impacts of smoking

About 10 million adults in England smoke and smoking kills about 120,000 people in the United Kingdom every year (Department of Health 2004a). Smoking is an established cause of a wide range of diseases, of which the most common are lung cancer, cardiovascular disease and chronic obstructive pulmonary or respiratory disease. Passive smoking or exposure to second-hand smoke causes about 12,000 deaths per year. Most of these deaths are caused by exposure in the home, but about 500 deaths are due to exposure at work (Royal College of Physicians 2005). Exposure to second-hand smoke increases the risk of lung cancer and ischaemic heart disease by up to 25 per cent (Scientific Committee on Tobacco and Health 2004).

Epidemiological studies indicate that significant risk occurs at low levels of exposure. For example, Bjartveit and Tverdal (2005) report that smoking just one to four cigarettes a day is associated with a significantly higher risk of death, particularly from heart disease, and for women, from lung cancer. Whincup *et al* (2004) found that heavy passive smoking is comparable to light active smoking (one to nine cigarettes a day) and is associated with a 50 to 60 per cent increased risk of coronary heart disease.

The extremely high levels of smoking, in addition to high levels of obesity, cholesterol and hypertension, in psychiatric populations, puts them at particular risk of developing heart and respiratory diseases (McCreadie 2003). Although the risk of suicide is higher than the risk of death from heart or respiratory diseases, more psychiatric patients are likely to die from the latter (Joukamaa *et al* 2001). For example, a US study shows that 10 per cent of people with schizophrenia die by suicide, but that more than two-thirds die of coronary heart disease (compared with about half of the general population) (Hennekens *et al* 2005). A UK study found that heart disease is 1.6 times more common in people with schizophrenia and bipolar disorder than in the general population (Disability Rights Commission 2006). A Canadian study found that deaths from ischaemic heart disease in people with mental illness are more than twice that of the general population (Kisely *et al* 2005). Another study found the prevalence of respiratory disease in a random sample of psychiatric patients was 23 per cent and that they were more likely to have chronic bronchitis (15.9 per cent versus 6.1 per cent) and emphysema (7.9 per cent versus 1.5 per cent) than the general population (Himelhoch *et al* 2004).

Chronic smoking is also associated with and may intensify some mental disorders. Epidemiological studies suggest chronic smoking is associated with agoraphobia, generalised anxiety disorder and panic disorder (McNeill 2001). Smokers have higher rates of and experience more severe depression, are more likely to think about suicide, and have higher suicide rates (Wilhelm *et al* 2004). Heavy smoking is also associated with more severe psychotic and schizophrenic illness, poorer outcomes and more frequent hospital admissions (Corvin *et al* 2001, Aguilar *et al* 2005).

Smokers need higher doses of anti-psychotic drugs. Smoking increases the activity of liver enzymes that break down the drugs and so lowers the level of the drug in the blood, sometimes by as much as 50 per cent (Lyon 1999, Wilhelm *et al* 2004, Ziedonis *et al* 1994). Some anti-psychotic drugs also seem to encourage smoking, with older 'typical' anti-psychotic drugs associated with an increase in smoking, and newer 'atypical' drugs associated with a decrease in smoking (Health Development Agency 2005). Some anti-psychotic drugs are also associated with weight gain and increased cholesterol levels and blood pressure, which, together with smoking, are risk factors for heart disease (Hennekens *et al* 2005). Smoking cessation and treatment with atypical drugs result in better control of symptoms and a decreased desire to smoke (Hempel *et al* 2002).

Despite the impact on physical and mental health, staff and patients believe that patients use smoking to self-medicate and to alleviate the symptoms of their mental illness or the side effects of their medication. Staff accept patients' smoking as routine, and offer cigarettes to help them deal with stress, or smoke with patients as a way of offering comfort and support (Lawn and Pols 2003). Mentally ill smokers report that smoking overcomes problems with attention, concentration and memory (Lawn and Pols 2005). Staff and patients also interpret symptoms of nicotine withdrawal as a sign that mental illness symptoms are escalating and require relief with cigarettes (Lawn and Pols 2003). However, studies suggest that smoking induces a cycle of smoking as 'withdrawal relief': it initially stimulates an alert, relaxed state, which then gives way to withdrawal symptoms such as irritability or aggression, impaired concentration, feeling miserable and increased cravings, which a smoker alleviates by smoking. This is interpreted as self-medication but is effectively withdrawal relief (Jarvis 2004, Brown 2004).

The medical evidence on smoking as self-medication is inconclusive. Wilhelm *et al* (2004) suggest that depressed people smoke to lift their mood, and Kumari and Postma (2005) suggest that nicotine helps alleviate some cognitive symptoms of schizophrenia and reduces some of the side effects of anti-psychotic medication. But Punnoose and Belgamwar (2006) did not find randomised clinical trials to support the self-medication hypothesis for schizophrenia. More research is needed to understand the relationship between nicotine addiction and mental illness.

Impact of smoking bans in psychiatric settings

International studies show that a complete ban on smoking in public places and workplaces is more effective than policies restricting smoking to a few designated areas. Total smoking bans help smokers to reduce the number of cigarettes consumed, encourage smokers to quit and increase the likelihood of current and past smokers living in a smoke-free home. A complete ban on smoking in public places and workplaces also offers protection from second-hand smoke for smokers and non-smokers. International reviews assessing the impact of smoking bans show that a total ban reduces exposure to second-hand smoke and improves the respiratory health and self-reported health of hospitality workers (Fichtenberg and Glantz 2002, Chapman *et al* 1999, Merom and Rissel 2001, Borland *et al* 1999, Gilpin *et al* 2002).

Ethnographic studies show that smoking is part of psychiatric ward culture. Patients smoke to relieve boredom and stress, and to relax or to ease social contact. Staff use cigarettes to create a rapport with patients, or to manage threatening behaviour. Access to cigarettes is often a source of conflict between staff and patients and between patients. Predatory patients may bully vulnerable ones into handing over their cigarettes, or trade cigarettes for sexual favours. Non-smokers are often initiated into smoking when admitted to a unit (Lawn 2004, Hempel *et al* 2002). This smoking culture, Lawn suggests, creates 'systemic barriers' to smoking cessation for staff and patients. It also explains the considerable concern among mental health practitioners about the feasibility of banning smoking in psychiatric settings.

However, an emerging body of evidence shows that it is possible to introduce such a ban. Psychiatric institutions have introduced partial bans, which prohibit smoking indoors or restrict smoking to designated places, and total bans. Lawn and Pols (2005) reviewed the findings of 26 international studies reporting on the effectiveness of smoking bans in inpatient psychiatric settings, and found that simple smoking policies, applied in a consistent way to all patients, were more effective than selective or gradually introduced bans. The review found no increase in patient aggression in 75 per cent of all study sites regardless of the type of ban and in 90 per cent of sites imposing a total ban. Complaints and verbal aggression were associated with selective bans, which tended to focus staff and patient attention on negotiating smoking privileges, and increased the possibilities for conflict.

In 2002, El-Guebaly *et al* conducted a review of 22 studies and also found that total and partial bans had no long-term impact on unrest or compliance by patients. A Dutch study found that compliance by staff and patients was better with a total than a partial ban, and that exposure to second-hand smoke declined more dramatically with total indoor bans (Willemsen *et al* 2004).

Studies of smoking bans in psychiatric units also suggest that their success depends on a consistent approach across management and clinical staff and widespread education of staff and patients about an impending ban. Staff need support to deal with their anxiety about the impending change and to build up their morale, and education so that they learn to differentiate between nicotine withdrawal and psychotic symptoms. Several studies show that before psychiatric units introduced bans, staff anticipated difficulties but after the ban, staff and patient attitudes to smoking bans became more positive (Lawn and Pols 2005, Hempel *et al* 2002, El-Guebaly *et al* 2002).

The literature does not address the impact of bans on rates of quitting and relapse in staff and patients in much detail. Research suggests that smoking is higher among psychiatric nurses than other groups of nurses or other parts of the psychiatric profession, and smoking bans may encourage staff to stop smoking (McNeill 2001). However, Hempel *et al* (2002) suggest that staff experience more difficulty with a total ban than patients because they continue to smoke during work breaks, and so are still subject to cycles of addiction and withdrawal. Many patients also resume smoking after discharge, and co-ordination between inpatient, outpatient and smoking cessation services is poor (Lawn and Pols 2005, El-Guebaly *et al* 2002). Studies show that mental health patients respond well to smoking cessation methods, such as cognitive behavioural therapy, or nicotine replacement therapy, and that they may significantly cut down or quit smoking (McNeill 2001). However, service users appear to find it difficult to access these services, are often unaware that nicotine replacement therapy is available on prescription, and do not believe that 'quit smoking' advertisements are aimed at them (Brown 2004).

Talking to staff: attitudes to a smoking ban in England

To understand the challenges that an NHS or independent service provider may expect if deciding to introduce a ban on smoking, we surveyed staff in psychiatric units and interviewed professional organisations and tobacco and mental health groups in the voluntary sector. We sent a questionnaire to 268 NHS psychiatric units and 159 independent psychiatric units, drawn from Binley's commercial database of NHS contacts and the Healthcare Commission. We received a total of 151 responses, of which 85 (56.3 per cent) were from NHS respondents and 66 (43.7 per cent) from independent sector respondents, giving an overall response rate of 35.4 per cent. The findings of the survey reflect the views of a self-selected sample of respondents. The survey consisted of structured questions on existing policy and unstructured questions, allowing respondents to comment on issues ranging from the success or otherwise of existing policy to likely challenges, benefits and drawbacks if they banned smoking.

The responses ranged across staff and care settings. Hospital directors and senior managers as well as nursing staff and ward managers, who have closer contact with patients, responded. Care settings included large and small psychiatric units, psychiatric hospitals, secure units, rehabilitation units, psychiatric intensive care units, learning disability units, elderly mentally ill units and a range of small, specialist psychiatric units, such as eating disorder units and drug and alcohol treatment units. These units included both patients admitted compulsorily under the Mental Health Act and voluntary patients.

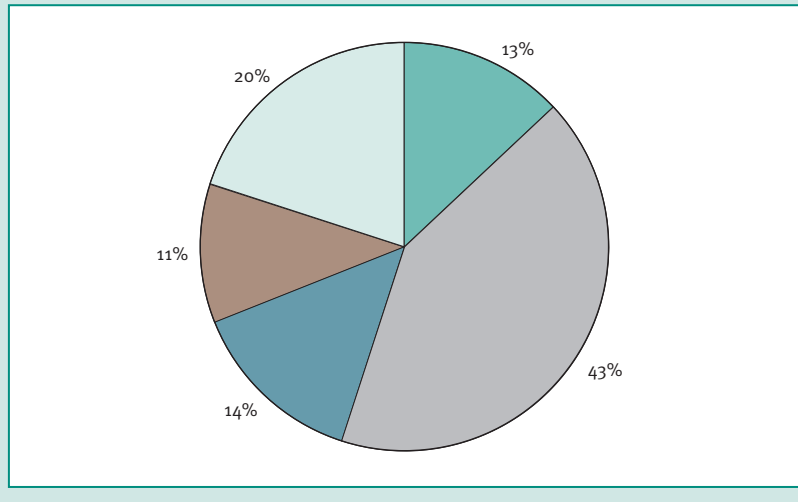
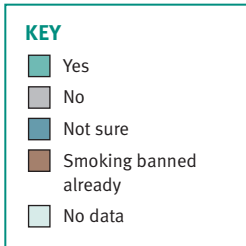
Smoking in designated areas is already a norm in psychiatric units and 111 (73.5 per cent) units provided a smoking room for patients. These also sometimes served as television or coffee lounges used by smoking and non-smoking patients. In some units staff and patients had to pass through the smoking room to get to other areas. In other units the 'designated smoking areas' were not always enclosed, and sometimes amounted to little more than smoking by an open window. Four units (0.7 per cent) allowed smoking in patients' bedrooms. Sixteen units (10.6 per cent) did not have smoking rooms, and did not allow smoking inside, though smoking was allowed outdoors.

Forty-three per cent of units (65 units) did not intend to introduce an indoor smoking ban and only 13 per cent (19 units) said they were considering it (see Figure 3, overleaf).

Attitudes against a ban

Many respondents rejected a smoking ban, describing it as 'impossible', 'unachievable' and 'unrealistic' to implement. Many felt that supervising patients smoking outside was wasted staff time. Some feared patients would abscond from their unit, others that patients would refuse to be admitted. Others believed that patients would refuse to comply, or would find it difficult to do so because of learning difficulties or their mental

3 RESPONSES FROM 151 PSYCHIATRIC UNITS ASKED WHETHER THEY PLAN TO BAN SMOKING INDOORS



illness. Respondents repeatedly stated that they believed a ban would lead to an increase in stress and anxiety among patients, and provoke ‘aggressive and agitated behaviour’, verbal abuse and ‘serious violence’ from patients. Typical comments were:

Patients use smoking as a de-stressor. Many cannot cope without a frequent cigarette. A ban will impact their mood and mental health.

A ban will lead to total rioting! It will cause mental deterioration and agitation leading to violence and aggression.

Many felt that psychiatric patients should be allowed to smoke because it was a ‘comfort’, that they had ‘nothing else to live for’, and that ‘there is nothing else to do’. They believed that patients needed smoking as a coping strategy. It helped to ‘normalise’ the ward environment for patients and acted as a ‘social leveller’, offering patients an easy way to make social contact. For some respondents, controlling access to cigarettes was a means to influence patient behaviour. Offering a cigarette could defuse a difficult situation and had ‘a pacifying effect’.

Respondents recognised that quitting smoking brought positive health benefits; however, for many, their primary concern was patients’ mental and not their physical health:

A smoking ban would be counterproductive in the management of psychiatric illness. Smoking and not the illness would be the main focus.

A ban for psychiatric patients would be excellent for physical health, poor for mental health. Our responsibility is to mental health care in the main.

They felt that smoking was so prevalent among patients that ‘nothing much could be done about it’, and believed that patients too would prefer to prioritise their immediate need to relieve distress over their long-term health needs. Complying with a smoking ban would be ‘a step too far for service users’.

Several respondents argued that a ban infringed human rights, especially when patients had been sectioned and the ward was effectively their home. Other respondents believed

the ban limited 'patient choice' and patients 'should not be forced to stop smoking against their will'. With their 'liberty already compromised', patients would experience the ban as 'further punishment for being mentally ill'.

Finally many staff were smokers themselves and respondents felt that a ban would make their working lives more difficult. Smokers did not believe that they would 'last' a long shift without smoking breaks and that they would have no way to relieve their stress. They feared that some staff would leave, and seek jobs in units that allowed smoking. They also felt that managing the ward would be more difficult if their colleagues left the hospital for a smoking break, and that they no longer could use cigarettes to pacify or interact with patients. They believed that it was 'therapeutic to smoke with patients'.

Attitudes favouring a ban

Sixteen (10.6 per cent) psychiatric units reported that they had introduced smoke-free policies. Smoking was prohibited indoors, but permitted outside. A further 19 (12.6 per cent) units reported that they were planning to introduce an indoor smoking ban.

Many respondents recognised that a complete ban on indoor smoking could offer benefits to staff and patients, and these were already evident for the smoke-free units. Respondents favouring a ban believed it was part of a 'new health culture', encouraged 'healthier living for all' and meant that health promotion was part of mental health services. They believed that the ban would encourage staff to quit smoking but were unsure about its impact on patients.

Far from being 'impossible' to implement, units that had introduced bans on indoor smoking experienced relatively few problems. Two units were new and had introduced a no-smoking policy from the outset. Other units had made the transition from smoking rooms to no indoor smoking, and also had not experienced patient resistance. Certainly there were complaints from patients, and some tried smoking in their rooms, but staff reported that patients 'conformed' to the smoking ban once they understood the reasons for it and the policy was made clear. 'The rules are there to be adhered to', explained another respondent. At one unit, patients initially had lobbied against the smoke-free policy, but staff now observed patients challenging their peers who breached it. Staff also 'adjusted' to the new rules, or were 'resigned' or 'used to' the policy and did not object or resign from their jobs.

The box overleaf outlines key strategies used by units to go smoke-free.

The units that were already smoke free rejected the idea that banning smoking would spark off patient aggression. Two respondents mentioned that it was easy to confuse nicotine withdrawal symptoms with the side effects of medication, or worsening mental illness symptoms, but that patients still had the opportunity to smoke outside. Staff believed that closing smoking rooms and removing cigarettes as a bargaining tool or reward helped to prevent and resolve difficult situations. They did not believe that smoking with a patient was the best way to build rapport and interact with them.

Closing the smoking rooms, respondents believed, had led to therapeutic benefits. The rooms were now used for clinical activities or as lounges. One respondent commented that 'patients were staying up in the night smoking and were unable to get up in the morning

PLANNING A SMOKING-FREE STRATEGY

Five units that were already smoke free were interviewed to find out how they had introduced their no-smoking policies. The key elements of their strategies were:

- regular consultation with staff and patient groups to explain the reason for the new policy, and to allow staff and patients to register their fears and objections
- information for staff, service users and visitors about the ban on posters and banners and in information leaflets, and reminders about the ban in user group meetings
- training for staff in smoking cessation and nicotine replacement therapy, in distinguishing mental illness symptoms from nicotine withdrawal symptoms and in different ways of managing patients
- education for staff and patients about the health effects of smoking and its interaction with medication and psychiatric conditions
- co-ordination with existing smoking cessation services
- access to nicotine replacement therapy for staff and patients and access to advice and support for quitting
- planning the closure of the smoking room and its replacement with a safe, outdoor smoking area
- creation of alternative activities to interest patients.

Reviews of smoking bans internationally (Lawn and Pols 2005) also indicate that psychiatric units should:

- co-ordinate with community health teams, as some patients might return to smoking on discharge, which would have implications for their medication
- co-ordinate with community health teams to provide support for outpatients who have quit and who wish to continue smoke free.

to attend to daily living skills, activities or therapeutic interventions'. Now the smoking room was used for activities that 'stopped them being so bored'.

Respondents favoured a ban on smoking indoors as it meant that nurses were no longer exposed to second-hand smoke when working or when supervising smokers in the smoking room. A ban also protected non-smoking patients who were exposed to second-hand smoke where smoking rooms also served as television or coffee lounges. One respondent commented that 'going past or through these areas is intense passive smoking'. With a non-smoking policy, commented another, 'non-smokers will not have to be subjected to smoke when they want to sit and talk to their friends in the smoking lounge'.

Respondents also believed that a ban on indoor smoking would and did improve the ward environment. They typically described smoking rooms as 'dilapidated and dirty' or 'dark, dirty and miserable' and believed that the unpleasant environment encouraged smokers to smoke elsewhere. Smoking rooms were noisy and too small, which sometimes caused conflict. For example, the smoking room in one unit had space for only eight smokers, yet there were often up to twenty patients in it. The smoking rooms were also poorly ventilated and smoke seeped into surrounding areas. Closing the smoking rooms, they believed, would reduce redecoration costs as there would no longer be cigarette and smoke damage to decor.

Discussion and conclusions

Our survey of staff in NHS and independent psychiatric units suggests that staff think that a ban is impractical as they believe that patients need to smoke to alleviate social and emotional stress. They also believe that a ban would provoke aggressive and violent abuse directed at staff and that their primary focus should be patients' mental rather than physical health. Staff who smoked also felt that a ban would make their working conditions more difficult.

In contrast, staff who supported an indoor ban saw it as part of a holistic approach to health care for people with mental ill health. A few units had introduced an indoor smoking ban, and found that staff and patients adjusted to the new rules and, beyond some complaints, the ban had not caused conflict between staff and patients. Indeed some units had introduced new activities for patients, which they believed improved therapeutic care.

Our survey findings support the conclusions of the international literature, which suggests that patient and staff smoking is ingrained in the culture of psychiatric units and that staff believe that a smoking ban will cause patients to react aggressively. However, reviews of partial and total smoking bans in psychiatric institutions also show that this has rarely occurred, and fears may well be largely unfounded.

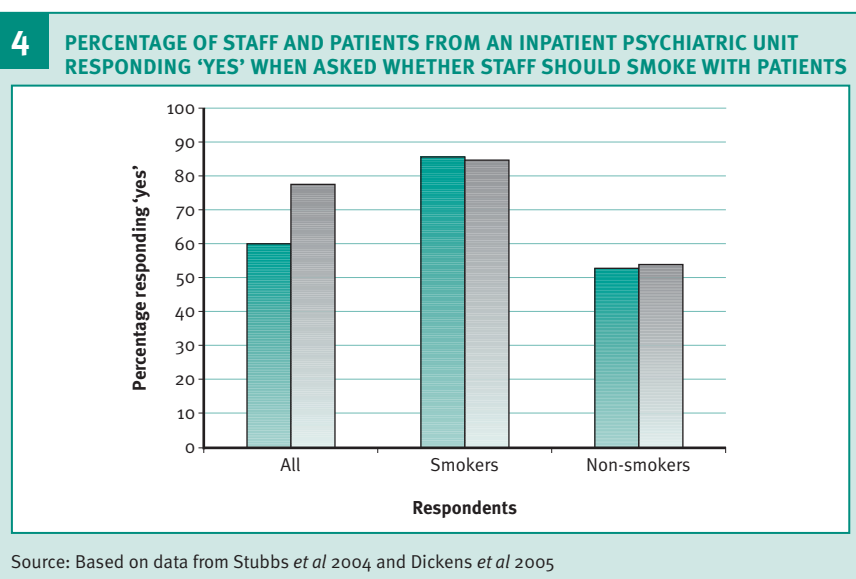
At the outset of the paper we suggested that the decision of whether to extend the indoor smoking ban to psychiatric units or to exempt them raised three issues regarding rights. The first was the right of staff to work in a safe environment. Our survey suggests that staff are exposed to second-hand smoke in smoking rooms and to seepage from those rooms. In a recent survey of staff in a large psychiatric hospital, 83 per cent said they were 'worried about the effects of passive smoking on non-smoking staff and patients', with 89 per cent of non-smokers and 61 per cent of smokers agreeing (Stubbs *et al* 2004). Evidence to the consultation preceding the Health Bill and to the House of Commons Health Committee also showed that, despite difficulties in creating a smoke-free workplace, there was broad consensus about the need to protect the health of staff and to fulfil employers' legal duties.

The more difficult issues were the rights of patients who smoked, and the rights of non-smoking patients to a safe environment. It is evident from our survey that smoking rooms are often the common social centre for all patients, and that non-smoking patients do not always have other options. Yet there is little recognition of this among staff and patients. A recent survey of staff in a psychiatric hospital showed that 94 per cent supported patients smoking in a designated area on a ward, rather than a total indoor ban on a ward (Stubbs *et al* 2004). A survey of patients' attitudes in the same hospital found that 88 per cent of smoking patients felt that 'the rules of smoking on my ward are just about right', whereas only 46 per cent of non-smokers believed this (Dickens *et al* 2005). This suggests

that the rights of non-smoking patients to a safe, smoke-free environment are not adequately catered for. To those who are concerned that the proposed Health Bill infringes smokers' rights, it is important to point out that the ban will prohibit only indoor smoking and that patients will still be able to smoke outdoors. There may still be an issue about staff availability to supervise outdoor smoking or access to outdoors, but these should not prove insuperable. On the other hand, for those who argue that the right to a safe environment should take priority, the indoor smoking ban will offer staff and patients protection against second-hand smoke.

Should the ban on indoor smoking be extended to psychiatric units, staff will need to provide smoking cessation advice and aids. The choice to smoke or to quit must ultimately be a private decision for the individual, and given that many psychiatric patients are detained compulsorily, it is right that proper consideration is given to the degree of choice that they will be able to exercise. At the same time, it is important to recognise that people with mental health problems are interested in their own physical health and accept that health care staff have a duty to help them keep healthy (Brown 2004). The two surveys cited above, for example, found that 56 per cent of staff and 85 per cent of patients believed that staff should encourage patients who smoke to stop or to cut back (Stubbs *et al* 2004, Dickens *et al* 2005).

Lawn (2004) suggests that barriers to quitting smoking are systemic. Our survey supports this. Staff viewed smoking as a 'normal' part of being a mental health patient, an activity that calmed patients, helped staff create a rapport with patients, and helped them to manage aggressive patients. In the surveys cited above, 60 per cent of staff believed that they should smoke with patients and 78 per cent of patients considered likewise (see Figure 4, below). Fifty-four per cent of staff (and 79 per cent of staff who smoke) also believed that smoking played a therapeutic role and 93 per cent thought that patients would deteriorate without access to cigarettes (Stubbs *et al* 2004, Dickens *et al* 2005). This suggests that a first step towards implementing an indoor smoking ban should



KEY

- Staff
- Patients

be consultation with staff and patients about the impact of smoking on their physical and mental health, including the difference between nicotine withdrawal and psychotic symptoms.

Over 70 per cent of institutions answering our survey reported that they had smoking rooms. Although this suggests that staff and patients are already accustomed to some smoking restrictions, their partial nature and the ingrained smoking culture in psychiatric units makes it difficult for individuals to stop smoking, and can initiate non-smokers into smoking. Dickens *et al* (2005) found that 74 per cent of patients believed that it was 'too difficult to give up smoking' and identified as barriers seeing other patients smoking (79 per cent), a smoky atmosphere (59 per cent) and seeing staff members smoking (56 per cent). International studies suggest that total bans are more effective than partial bans and that compliance is better, but that even partial bans on smoking indoors lead to reduced second-hand smoke exposure.

Should the proposed Health Bill be enacted, and should it include psychiatric units, it will be a first step towards changing the smoking culture of psychiatric units, and make it easier for staff and patients to avoid second-hand smoke exposure and to cease smoking should they wish to do so. If smoking is less evident in a ward, and patients have access to a programme of activities to alleviate boredom, then it may help to prevent non-smokers taking up smoking. If an indoor ban is to help staff and patients to quit, then psychiatric services will need to integrate existing smoking cessation services across inpatient and outpatient services.

In recent years the government has committed itself to reducing smoking and smoking-related diseases and the Health Bill is a clear step in this direction. The government is also committed to reducing health inequalities, and has a particular focus on high smoking rates among social groups with lower incomes. The poor physical health of mentally ill patients, particularly the high prevalence of heart and respiratory diseases in which smoking plays a role, is cause for concern.

Introducing an indoor ban is controversial and, at least initially, will be unpopular with a significant number of patients and staff. However, the proposed ban can offer patients who wish to smoke a safeguard: they will still be able to access outdoor space in which to smoke and units without outdoor access may offer alternatives that do not put staff or patients at risk. The decision not to exempt psychiatric units should then emphasise to service users and their professional carers that their physical health is a matter of concern and importance.

Should the proposed regulations exempt psychiatric institutions from the ban, then there will be little incentive to challenge the smoking culture of psychiatric units, and the exemption will confirm the professional focus on mental illness rather than an holistic approach to patient health. As smoking trends change and the number of non-smokers grows, the health and cultural divide between psychiatric patients and the general population will widen.

Winning over staff and patients is likely to be challenging, but not impossible, and should lead to a healthier living and working environment, and better health.

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