THE KING'S FUND REPONSE TO THE CONSULTATION ON SMOKE-FREE PREMISES AND VEHICLES

The King's Fund is an independent, charitable foundation whose goal is to improve health and challenge health inequalities. It undertakes research into health care and public health policy and tests out policy in London-based development projects.

Our response is limited to questions six and seven. The King's Fund recently published *Clearing the Air: debating smoke-free policies in psychiatric units* (King's Fund 2006) and our response draws on this research. A copy of the report is appended to this response.

Question 6: Views are invited on proposals in these regulations for exempting … treatment facilities

The regulations propose that certain types of residential accommodation may be exempt from smoke-free legislation and may provide a designated room for smoking. The exemptions apply to care homes, hospices, prisons and mental health units, which 'normally' provide long-term residential accommodation (that is for over six-months). The proposed regulations are flexible and such residential institutions may choose not to apply the exemption.

The King's Fund welcomes the decision to include mental health units in the exemption. 34,000 service users are resident in mental health units on any day (Commission for Healthcare Audit and Inspection 2005) of whom about 15,000 are detained formally under the Mental Health Act 1983. Mental health patients spend on average 58 days as inpatients (Office of National Statistics 2006, p 122). The King's Fund believes that patients who wish to smoke should be able to do so but this right must not be exercised at the expense of other patients or staff. Where patients are living long-term ininstitutions that are in effect their homes it is reasonable that they should be allowed to smoke indoors in a way that does not affect staff and patients' access to a smoke-free environment.

However studies of psychiatric patients show that up to 70% smoke and around 50% are heavy smokers (O'Brien, Singleton, Sparks, Meltzer and Brugha 2002; Farrell et al 2001; Coulthard, Farrell, Singleton and Meltzer 2002; Meltzer, Gill, Hinds, Petticrew 1996, Kelly and McCreadie 1999, McCreadie 2003). This exposes smokers to considerable health risks (Jochelson and Majrowski 2006), but crucially also exposes non-smoking patients and staff to second-hand smoke. In a recent survey of staff in an English, large psychiatric hospital, 83% said they were 'worried about the effects of passive smoking on non-smoking staff and patients', with 89% of non-smokers and 61% of smokers agreeing (Stubbs, Haw and Garner 2004).

1. Benefits of a smoke-free environment

1.1 A smoke-free environment

A recent King's Fund survey showed that smoking in designated areas is already a norm in psychiatric units and 111 of 151 units (73.5%) responding to the King's Fund survey provided a smoking room for patients. These often also served as TV or coffee lounges used by smoking and non-smoking patients and were the only place to socialise. Smoke drifted from smoking rooms into other areas of the unit. 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 enclosed, and sometimes amounted to little more than smoking by an open window. A recent survey of patient attitudes in an English hospital, found that 88% of smoking patients felt 'the rules of smoking on my ward are just about right', whereas only 46% of non-smokers believed this (Dickens, Stubbs, Popham and Haw 2005). This suggests that in this hospital the needs of non-smoking patients to a safe, smoke-free environment were not fully acknowledged by smokers and not adequately catered for by the design of the healthcare environment. Conditions in this hospital are likely to be representative of other mental health units.

The proposed smokefree legislation will prohibit indoor smoking and so provide a safer indoor environment for staff and patients. Patients who wish to smoke will be able to do so outside.

1.2 Smoking cessation

About 60% of patients would like to quit smoking (Meltzer et al 1996; McCreadie 2003; Doherty 2006.). Dickens et al (2005) found that 74% of patients believed it was 'too difficult to give up smoking' and identified as barriers seeing other patients smoking (79%), a smoky atmosphere (59%), and seeing staff members smoking (56%). Smoke-free regulations may help those who want to quit to do so.

Studies show that mental health patients respond well to smoking cessation methods, such as cognitive and 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 Quit Smoking advertisements are aimed at them (Brown 2004). Many psychiatric units do not currently offer smoking cessation advice and aids. International studies also suggest that despite smoke-free regulations, many patients resume smoking after discharge partly due to poor co-ordination between in and out-patient and smoking cessation services (Lawn and Pols 2005; el-Guebaly, Cathcart, Currie, Brown, Gloster 2002).

In England, a few mental health trusts have successfully introduced smoke-free policies in in- and out-patient units. For example, Worcestershire Mental Health Partnership Trust have linked smoking cessation to to recent efforts to improve the quality of clinical care. Norfolk and Waveney Mental Health Partnership Trust introduced a smoke-free policy in 2004 to fulfil its duties as an employer and

protect the health of staff, and to promote the physical health of mental health patients. The former smoking rooms are now used for clinical and therapeutic activities and staff anecdotally reported that patients were more involved in daily living skills, activities and therapeutic interventions. The Amber Valley Day Service at the Croft Resource Centre, an out-patient facility, had offered tailored smoking cessation programmes and found a high degree of interest in quitting among its mental health service users, a high percentage of service users who had quit had remained abstinent, and service users had eventually requested the Centre be smoke-free.

We would support smoking cessation as part of a holistic approach to patient health which also includes attention to improved diet for inpatients, regular access to fresh air and to exercise, mainstreamed health promotion activities and regular medical examinations for longer stay patients.

2. Possible obstacles to proposed regulation

2.1 Staff attitudes to smoking and mental health

An obstacle to implementing smoke-free legislation in psychiatric units will be staff attitudes. Smoking rates are higher among psychiatric nurses, than in other medical specialities (McNeill 2001). International studies of the culture of psychiatric units suggests that staff view smoking as a 'normal' part of being a mental health patient and believed that smoking calmed patients, helped staff create a rapport with patients, and manage aggressive patients (Lawn 2004, Hempel et al 2002). English evidence is similarly suggestive. In the surveys cited above, 60% of staff believed that they should smoke with patients and 78% of patients believed likewise. Fifty four percent of staff (and 79% of staff who smoke) also believed that smoking played a therapeutic role and 93% believed that patients would deteriorate without access to cigarettes (Stubbs, Haw and Garner 2004; Dickens, Stubbs, Popham and Haw 2005). Respondents to the King's Fund survey believed that psychiatric patients should be allowed to smoke because it was a 'comfort', they had 'nothing else to live for', and '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 control patient behaviour. Offering a cigarette could defuse a difficult situation and had 'a pacifying effect' (Jochelson and Majrowski 2006).

Widespread acceptance of smoking meant that many respondents to the King's Fund survey believed that smokefree legislation would lead to an increase in stress and anxiety among patients, and provoke 'aggressive and agitated behaviour', verbal abuse and 'serious violence' from patients.

However, an emerging body of evidence suggests that it may be possible to introduce smoking free legislation in psychiatric units without some of the predicted problems. Psychiatric institutions have introduced partial bans, which ban smoking indoors, or restrict smoking to designated places inside or outside, and some have even brought in total bans which prohibit smoking indoors and outdoors.

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% of all study sites regardless of the type of ban and in 90% 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. el-Guebaly, Cathcart, Currie, Brown, Gloster (2002) 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, Gorts, van Soelen, Jonkers and Hilberink 2004).

2.2 Environmental obstacles to smoke-free regulations

Some mental health units that serve patients whose length of stay is under 6 months, do not have access to outside space. Some units are housed in high-rise buildings, with no access to outside space, or only unsafe access, and will find it difficult to implement the proposed regulations. However, the *Mental Health Policy Implementation Guide - Adult Acute Inpatient Care Provision* (Department of Health 2002, 6.1.5-6.1.7) notes that appropriate space is necessary to stimulate therapeutic engagement, social interaction and recreation, and that service users need to be able to access outdoor space and require activity space on and off the ward.

We support moves to ensure that every psychiatric unit has a safe and secure outside space for patients. This is essential to create a general therapeutic environment, quite apart from the question of creating a safe smoking area.

Question 7: Views are invited on the specific conditions for exempted premises proposed in these regulations to ensure that protection from secondhand smoke is provided.

The King's Fund supports item 3.22 which allows managers of long-stay institutions covered by the exemption to introduce smoke-free regulations. This flexibility allows institutions to implement smoke-free policies and to support the views of staff and patients where these are in favour of a smoke-free environment.

The King's Fund supports the conditions for premises with designated rooms for smoking outlined in items 3.13 and 3.14. Mental health units exempt from the smoke-free legislation that provide a designated smoking room solely for smoking should be urged to provide a non-smoking lounge to satisfy the needs of smoking and non-smoking patients for leisure facilities.

References

Brown, C (2004). *Tobacco and Mental Health: A Literature Review*. Edinburgh: ASH Scotland. http://www.ashscotland.org.uk/ash/files/tobacco%20and%20mental%20health.pdf

Commission for Healthcare Audit and Inspection (2005). *Count me in. Results of a national census of inpatients in mental health hospitals and facilities in England and Wales.* Commission for Healthcare Audit and Inspection. http://www.lancashirecare.nhs.uk/documents/ud/Count_Me_In/Results_2005.pdf

Coulthard M, Farrell M, Singleton N and Meltzer H (2002). *Tobacco, alcohol and drug use and mental health.* London. The Stationary Office.

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, 672-678.

Department of Health 2002. *Mental Health Policy Implementation Guide - Adult Acute Inpatient Care Provision* http://www.dh.gov.uk/assetRoot/04/06/91/94/04069194.pdf

Doherty K 2006. 'Giving up the habit'. *Mental Health Today*, May 2006, pp 27-29.

El-Guebaly N, Cathcart J, Currie S, Brown D, Gloster S (2002). 'Public health and therapeutic aspects of smoking bans in mental health and addiction settings', *Psychiatric Services*, 53 (12), pp 1617-1622.

Farrell M, Howes S, Bebbington P, Brugha T, Jenkins R, Lewis G, Marsden J, Taylor C and Meltzer H (2001). 'Nicotine, alcohol and drug dependence and psychiatric co-morbidity. Results of a national household survey'. *British Journal of Psychiatry,* 179, pp 432-437.

Hempel AG, Kownacki R, Malin DH, Ozone SJ, Cormack TS, Sandoval BG and Leinbach AE (2002). 'Effect of a total smoking ban in a maximum security psychiatric hospital'. *Behavioral Sciences and the Law*, 20, pp 507-522.

Jochelson K and Majrowski W 2006. *Clearing the Air: debating smoke-free policies in psychiatric units*. London: King's Fund.

Kelly C and McCreadie RG (1999). 'Smoking habits, current symptoms and premorbid characteristics of schizophrenic patients in Nithsdale, Scotland', *American Journal of Psychiatry* 156 (11), pp 1751-1757.

Lawn SJ (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), pp 204-215.

Lawn S and Pols R (2005). 'Smoking bans in psychiatric inpatient settings? A review of the research'. *Australian and New Zealand Journal of Psychiatry*, 39, pp 866-885.

McCreadie RG (2003). 'Diet, smoking and cardiovascular risk in people with schizophrenia. Descriptive study'. *British Journal of Psychiatry*, 183, pp 534-539.

McNeill A (2001). *Smoking and mental health - a review of the literature.* Smoke Free London Programme. London Region NHS. http://www.ash.org.uk/html/policy/menlitrev.pdf

Meltzer H, Gill B, Hinds K and Petticrew M (1996). *OPCS Surveys of Psychiatric Morbidity in Great Britain, Report 6: Economic activity and social functioning of residents with psychiatric disorders,* HMSO: London.

O'Brien M, Singleton N, Sparks J, Meltzer H and Brugha T (2002). *Adults with a Psychotic Disorder Living in Private Households, 2000.* London. The Stationary office.

Office of National Statistics (2006). 'Table 8.13: NHS inpatient activity for sick and disabled people' in *Social Trends 3*6. London: Office for National Statistics.

Stubbs J, Haw, C, Garner L (2004). 'Survey of staff attitudes to smoking in a large psychiatric hospital', *Psychiatric Bulletin*, 24, pp 204-207.

Willemsen MC, Gort CA, Van Soelen P, Jonkers R, and Hilberink SR (2004). 'Exposure to environmental tobacco smoke (ETS) and determinants of support for complete smoking bans in psychiatric settings'. *Tobacco Control*, 13, pp 180-185.