Exemption from the smoking ban in mental health hospitals in Wales

Violet Ann Borgia and Gillian Olumide investigate staff attitudes about this regulation and their professional responsibilities concerning patients who smoke.

IN 2006, the UK central government banned smoking tobacco in all enclosed public places and most hospital environments (Department of Health (DH) 2006), however, the implementation of the smoking regulations in mental health hospitals differ between the four countries of the UK. In Wales an exemption in the regulations allows relevant premises to have ‘designated rooms’ where smoking by patients is permitted, provided that certain conditions, as laid down in The Health Act 2006 (DH 2006), are met (Welsh Assembly Government (WAG) 2007). The decision whether or not to provide a designated smoking room rests with the relevant health boards (WAG 2007). This approach, according to Miller and Pashall (2006), is a contentious decision considering smoking rates are much higher among people with mental health problems than the rest of the population, and especially as the Welsh Government points out that smoking is one of the main causes of health inequalities in Wales (Welsh Government 2012).

The intention of this research is not to question the rights or wrongs of the smoking ban, or whether smoking is detrimental to health; it aims to explore the views of a selection of healthcare professionals working in a secure hospital in Wales about the exemption from the ban for all mental health hospitals in Wales. Also of interest is the identification of consensus and conflict among health professionals about the smoking situation in relation to professional responsibility.

The research available suggests that the idea of a smoke-free policy in mental health inpatient and outpatient hospitals appears to be accepted by the staff. Lawn and Pols (2005) found that staff generally anticipated more smoking-related problems than actually occurred, despite the non-smoking regulations being imposed. When patients were prohibited from smoking, staff noted that there was no increase in aggression, use of seclusion, discharge against medical advice, nor was there an increased requirement of medication. Similarly, el-Guebaly et al (2002) conducted a review of 22 studies and found that both total and partial smoking bans had no significant effect on aggression and compliance issues by patients, particularly when the smoking ban was introduced in conjunction with an extensive preparation programme that included smoking cessation groups and individual sessions, nicotine replacement therapy, staff training, poster communication and patient advocates (Shetty et al 2010).
It was also noted in a study conducted by Rich and Knowlden (2002) that nicotine replacement therapy was effective in reducing anxiety, aggression and acting out behaviour for people with mental illness when a smoke-free service was being developed. Despite these studies, other research suggests that the implementation of smoke-free polices in mental health hospitals represents a significant challenge due to staff fearing patients’ reactions to ‘no smoking’ rules and regulations, which could result in adverse consequences, such as verbal and physical aggression. Jochelson and Majrowski (2006) found that 90% of nurses were against a smoking ban in psychiatric hospitals, believing that patients use smoking to de-stress.

While there is some research exploring the views of staff towards the implementation of the smoking ban in the UK, the author has not found any articles specifically looking at the Welsh exemption from the smoking ban or staff views about this decision. In view of these findings, this small-scale project aims to help bridge the gap by identifying the views of staff towards the exemption of the smoking ban.

The Welsh Government has given local health boards in Wales the power to decide whether to allow smoking on mental health hospital sites. The Welsh Government has made a commitment to review this exemption for mental health units under the smoke-free premises exemption (Welsh Government 2011). However, the Welsh Government has made no commitment that this exemption should be phased out by any particular date (Welsh Government 2011). It is within this context that concerns, and any tentative recommendations identified from this research, should be explored.

**Ethical considerations**

Ethical approval was sought and approved from Swansea University, research ethics committee, College of Human and Health Sciences, Bro Morgannwg University Health Board and the South West Wales Research Ethics Committee. This was an interview study based on a purposive approach to sampling. Hospital managers agreed that information, assurance of confidentiality and a request to participate in the study could be sent to individual wards. Confidentiality and anonymity were maintained through a system of coding with no names on transcripts or identifying features in any written work.

**Participants**

Clinical staff working on five wards were informed of the intended research and asked to express an interest in participating. From 35 respondents, 13 participants were recruited. Although a small number, they did represent a broad skill group and the final sample was chosen to ensure views were obtained from across the spectrum in terms of staff roles and experience working in secure care.

Two staff members from each of the five wards at the hospital attended with three additional participants representing all five wards. Both male and female participants were represented and were either qualified or non-qualified staff and registered with an official health or social care professional body. The clinical experience of the participants varied. Some participants had worked as healthcare professionals for more than 20 years while others were relatively new to health care, which provided historical experience along with new ideas about the delivery of healthcare services and nursing practice. Nine of the participants had worked on mental health wards for more than 20 years, while four had worked for between 18 months and three years. These reflected a broad spread of those with a professional registration and those in the role of healthcare support workers.

The final sample is presented in Table 1.

**The interview**

Once the recruits had agreed to participate and had been given time to understand the purpose of the study and consider this decision, interviews, lasting around 30 minutes, took place in a private room convenient to work locations. Six questions formed a topic guide and were used to form an interview structure. These questions ranged from exploring the participant’s knowledge and opinions about the smoking ban through to the advantages or disadvantages of a total smoking ban being introduced in Wales. These questions were used to structure the interviews and to ensure as many aspects as possible were covered. All interviews were recorded, with permission, and transcribed at a later date. These transcriptions were then thematically analysed, the results of which are discussed in the six emergent themes below.

<table>
<thead>
<tr>
<th>Number of staff</th>
<th>Staff role</th>
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<tbody>
<tr>
<td>5</td>
<td>Registered mental health nurses</td>
</tr>
<tr>
<td>1</td>
<td>Registered general nurse</td>
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<tr>
<td>1</td>
<td>Community psychiatric nurse</td>
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<tr>
<td>1</td>
<td>Consultant psychiatrist</td>
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<tr>
<td>1</td>
<td>Social worker</td>
</tr>
<tr>
<td>4</td>
<td>Support workers</td>
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</tbody>
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Knowledge of the smoking ban legislation/regulations

The participants were aware of the smoking ban regulations, however, the degree of knowledge varied significantly between the participants. Eight participants were aware of the difference in the regulations for Welsh psychiatric hospitals, as one participant said: 'Yes, my understanding is that Wales or the Welsh Assembly have made a blanket statement that they will not take any steps to ban smoking in hospitals which are deemed to be long stay, residential, mental health units’ (interview 6). The remaining five were unaware that the smoking ban regulations differed between the countries of the UK. As one participant said: 'I'm not sure about the difference in law or why it is different’ (interview 1). The participants were generally unaware that, although the Welsh Government took the decision to impose a partial smoking ban for mental health hospitals in Wales, it is the responsibility of the NHS managers to implement this, or take the decision to allow smoking rooms to remain in the hospital wards.

Each participant acknowledged they had little or no guidance or clinical supervision about the Welsh smoking ban regulations and how they might respond to a total smoking ban. To address this issue the view expressed by several of the participants was that some basic training sessions might help them understand the regulations better, which would in turn help them explain to patients the ward’s rules and regulations about smoking. As one participant pointed out: 'They just tell us what to do and we get on with it, no rationale’ (interview 6). This decision appears to have excluded staff from any consultation about the smoking ban exemption; this approach could affect staff satisfaction and ultimately have an effect on patient care, especially when the decisions made by management are not welcomed.

Duty of care

The National Institute for Health and Care Excellence (NICE) says that all NHS hospitals and clinics should become completely smoke free to help all patients who smoke to stop smoking while they receive care (NICE 2013). The participants shared a view that smoking and passive smoking is bad for the patient’s health and confirmed that there was a conflict between evidence-based nursing practice and the smoking-ban regulations. As one participant suggested: 'If I worked on a general ward I wouldn't be allowed to light a patient's cigarette. It's double standards and, yeah, it does become difficult when a patient is coughing and got a bad chest infection and asks you to give them a fag and light it’ (interview 10). However, even with this acknowledgment, nine of the participants were willing for patients to make their own choice about smoking and saw their role as educators about the positives of being smoke free and the negatives of smoking. One participant put it this way: ‘All we can do is educate and inform them about the dangers of smoking and they have the right to choose’ (interview 3).

Overall there was sympathy and concern expressed for patients who want to smoke. A commonly expressed theme was that most participants acknowledged their responsibility as set out under their professional registration to deliver evidenced-based best practice. One participant who summed this up noted: 'I suppose it’s a double-edged sword, we are told to deliver care that is evidence based but by the same token we are told our patients can smoke. Everybody knows the research but in reality we are still going against best practice’ (interview 4).

Culture of smoking on psychiatric wards

Smoking has been accepted as part of the culture of mental health units for many years (Jochelson and Majrowski 2006). Studies have shown that 74% of psychiatric inpatients are smokers (Meltzer et al 1996), compared with 24% of the general population (Office for National Statistics 2007).

It was noted by some of the long-standing staff members in mental health services that smoking in psychiatric hospitals had long been perceived, by healthcare professionals and patients, to be part of everyday life. It was seen as an activity that helped to build therapeutic relationships and calmed potentially aggressive situations. As one person explained: 'The difficulty is that some patients have been inpatients for years and years and others are what we call revolving door patients. They have always smoked, it is almost like it’s part and parcel of having a mental illness - you smoke, you know, that’s the way it is, so I envisage that if they were not allowed to smoke that this could cause huge problems on the ward, especially when patients who haven’t got community or home leave smell smoke on other patients and staff, this could create an environment that is potentially very dangerous’ (interview 13). Such perceptions of potential difficulties were common although no one actually offered examples of violence or a rationale for such beliefs.

Patients’ right to smoke

One participant expressed the view: ‘Political intervention in private decision making is increasing as government uses legislation to reduce the power individuals have to make a decision about potentially unhealthy habits such as
smoking’ (interview 10). Another person commented: ‘The problem is the government wants it both ways, they want to be seen as acting in the public’s best interest but they still want to receive the tax revenue tobacco products produce’ (interview 2). One person made this issue a matter of human rights and noted that patients should have a right to smoke just like inmates in prison: ‘Human rights are respected in prisons; inmates are allowed to smoke, what’s the difference? Yes, we are a hospital but our patients have more serious things to worry about than whether smoking will kill them. Most of our patients are living with an illness that requires high doses of medication to enable them to have some quality of life and recover or live as independently as possible. The smoking rules just give them something else to worry about’ (interview 12).

Another participant emphasised the matter of personal choice in private spaces: ‘The argument is that in somebody’s home we shouldn’t be dictating what they can and can’t do, technically this is their home so why shouldn’t they smoke. It’s all about choice; if the government don’t want people to smoke why sell them? Cigarettes are a legal substance so why should governments tell patients that they can buy them but not smoke them? It is an infringement on their human rights. I mean every individual has got a right to make choices whether they are good or bad. We all make bad choices at different times in our lives. So they do have a right to choose and I don’t think it’s my responsibility or my right to try and stop them. It is a personal choice’ (interview 13).

The general conclusion was that smoking should be a personal choice and that staff should only inform patients of the negative effects of smoking.

Smoking and prescribed medication All of the participants expressed concerns about the risk of smoking and the associated risk with antipsychotic medication, clozapine; mainly the potential serious side effect of agranulocytosis. This is a drop in white blood cells that occurs in approximately 1% of the patient population (British National Formulary 2015). One participant stated: ‘The problem with this medication is that there is a very high risk of patients becoming very ill if not closely monitored as patients don’t realise that smoking can have a severe effect on them when they are on certain Clozaril [clozapine] antipsychotic medication’ (interview 8).

There was also concern expressed about patients being discharged, while still using the medication, from an environment where smoking was banned back to the community, where they could smoke as much as they liked. ‘The effects of smoking on people’s medication regimes can have serious outcomes if not controlled and monitored properly. People on Clozaril could effectively double their serum levels within a day or two of ceasing to smoke’ (interview 10).

This is a practical problem that presents a challenge to the participants when planning a discharge.

Inconsistent legislation throughout the UK There was a mixed response from the participants to the different smoking ban regulations. Ten participants raised concerns about the conflict the smoking ban has with the Equality Act 2010, which makes it illegal to discriminate directly or indirectly against people with mental health problems. ‘In my opinion the different rules around the smoking ban just adds to the brittle situations for both staff and patients’ (interview 8).

There was not a clear consensus about whether the ban should be extended to Wales with some suggesting that this would be a further curtailment of liberty. One participant commented: ‘Patients having their right to smoke curtailed is a direct infringement on their liberty.’ (interview 9), while others suggest that a smoking ban might be justified in the name of equality: ‘People with mental health problems have argued for years to be treated the same as the rest of society - there is a certain irony in all this, you cannot have it all ways. You cannot on the one hand say that you want to be treated in the same manner as the general population, but then make exceptions in some incidences because you’d prefer it that way - either you do or you don’t want to be treated the same’ (interview 12).

There was significant concern expressed about how the smoking regulations would be managed and the effect on staff and patients if the current regulations were changed. One participant expressed a view: ‘Who will be responsible for policing the ban? I’m a nurse not a police officer’ (interview 2). Another participant raised a concern about staffing levels on the wards to manage the smoking regulations: ‘If nursing staff are forced to manage the smoking regulations this could potentially prevent them from delivering other important nursing care tasks, which in itself could lead to an increase in violent and aggressive behaviour’ (interview 6). This is another example that smoking is perceived as holding back aggression and providing some stability for patients.

Limitations The limitation of the study was that only a relatively small number of interviews were conducted. During the interviews, and without prompting,
all 13 participants disclosed their smoking status: six were smokers and seven were not. Interestingly, the smokers did not argue against the ban and participants looked at the broader questions, such as implementation and rights-based arguments.

Discussion
The participants’ views demonstrate that positive and negative attitudes exist towards the exemption from the smoking ban and smoking behaviour in general. The smoking regulations have raised concerns because of patient medication. Several participants noted that smoking regulations in the UK should be the same in all four countries to avoid differing patient experiences in relation to smoking when transferring between geographical boundaries.

Most of the participants expressed a view that while there was not a total smoking ban in place, there were rules and regulations about smoking that require policing. This can leave staff feeling frustrated because it is additional work and can interfere in relationships with patients. While most of the participants suggested that they would be prepared to offer advice to their patients about the harmful effects of smoking and many suggested that they regularly try to educate patients, they were not specialists in this field and noted their concern about the lack of contact with community-based smoking cessation services.

Conclusion
The findings of this article suggest that there is a lack of discussion and formal training on the smoking regulations in Wales. There does, however, need to be an infrastructure in place should a total smoking ban be implemented in Wales. In view of the Welsh Government’s plans it would be expedient to arrange a forum for consultation. Staff could express concerns about the smoking ban regulations and inform policy when the exemption is reviewed in Wales. There was no clear view about whether a total ban should be implemented in Wales, but there were a number of concerns raised, including the idea of improved continuity for all patients to reduce confusion, and promote physical and mental health wellbeing.

Healthcare professionals working in mental health environments need clarity about their role, responsibility and accountability when regulating a patient’s right to smoke. This could be achieved through a partnership approach between patients, staff and policy makers that would ensure consistency for all healthcare professionals working in mental health hospitals in Wales. This approach would aim to offer protection to staff handing out and lighting cigarettes for patients. Some participants suggested that if the smoking ban was extended to Wales, it would be a health gain and help to reduce the health inequalities, while others suggested that this would be a further curtailment of a patient’s liberty. However, the findings did show that all the participants agreed that the current legislation was confusing for both staff and patients, with the consensus being that the smoking regulations should be the same across the UK. There is further scope for research in this area to explore the views of patients, particularly as any change to regulations will have a direct effect on them.

Implications for practice
- Improve mental health staff links with community-based smoking cessation services
- Develop discussions and formal training on the smoking regulations in Wales in preparation for a possible total smoking ban
- Give clarity to healthcare professionals working in mental health about their role, responsibilities and accountability when regulating a patient’s right to smoke

References

Conflict of interest
None declared

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