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editorial

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The Department of Health (2004*a*) has declared that the National Health Service (NHS) in England and Wales will be smoke free by December 2006. As one of Europe's largest employers, the NHS is in a unique position to influence public attitudes to tobacco consumption. A 'smoke-free' health service was recommended by the Chief Medical Officer (Department of Health, 2004*a*) and a recent poll indicated widespread public backing (MORI/ASH omnibus poll; http://www.mori.com/polls/2004/ash.shtml). 'Smoke-free' means smoking will not be permitted anywhere within hospital grounds, with no exceptions for staff or visitors, and limited exemptions for certain patients, providing no one is subject to passive smoking as a result.

Such a policy presents challenges within psychiatric settings, particularly in-patient units, as smoking has long been part of the culture of mental illness. Compared with the general population, smoking is significantly more prevalent among those with mental illnesses (Coultard *et al*, 2000), particularly those with alcohol and substance misuse problems. A recent American study estimated that nearly 45% of all cigarettes smoked in the previous month were consumed by people with psychiatric or substance misuse disorders (Lasser *et al*, 2000). In addition to its health risks, smoking places a notable financial burden on patients. McCreadie & Kelly (2000) estimated that an unemployed person with schizophrenia who smoked 26 cigarettes a day would immediately return 18-31% of their state benefits to the UK Treasury in the form of tobacco tax. Furthermore, Lasser *et al* (2000) suggested that the tobacco industry targeted psychologically vulnerable persons.

Potential problems

Interesting and challenging times lay ahead with the implementation of a smoking ban within varied psychiatric populations and locations. Staff appear to be resistant to the proposal (Stubbs *et al*, 2004), with concerns centring around inconsistent application, impact on patient behaviour and issues of civil liberties. Although it is generally acknowledged that a total ban sends a strong message to all, there are obvious problems with its implementation in some in-patient psychiatric settings, such as intensive care units, substance misuse services, locked forensic wards, challenging behaviour units and long-stay residential units. Certain patient groups present similar challenges, particularly those in the acute phase of their illness or those admitted for the management of addiction. One concern is that such policies will deter those with mental illness from accessing services or obtaining treatment. For individuals fighting the ravages of cocaine, heroin and alcohol addiction, smoking cessation on immediate admission to hospital is not top of their list of priorities. At the other end of the spectrum, is it reasonable to tell a long-stay residential patient that they cannot smoke in what is, effectively, their home?

Positive aspects

Despite these concerns, the evidence to date for the success of smoking bans in psychiatric settings is far from negative and suggests that staff members anticipate more difficulties than actually occur. In a recent systematic review of relevant American, Canadian and Australian data, the frequency of aggression, use of seclusion, discharge against medical advice or use of as-needed medication did not increase following a ban (Lawn & Pols, 2005). It is also notable that previously imposed bans in psychiatric wards had some positive effects on patients, such as an increased sense of self-esteem and mastery (Cooke, 1991). However, they had little effect on smoking cessation in the longer term (El Guebaly *et al*, 2002; Lawn & Pols, 2005). This was not the case for staff, however, who were more likely to use the opportunity to cease smoking (Borland *et al*, 1990; Chapman *et al*, 1999).

Implementing the ban

A clear, unequivocal and symbolic message from the NHS, including mental health services, will help marginalise smoking in psychiatric settings. How the ban is implemented is crucial to its success. If implementation is inconsistent or fragmented, it may lead to conflict in various forms. The request by a patient to smoke will focus service users and staff on the negotiation of smoking privileges and increase the value of cigarettes as a tool for escorts off the ward, leading to aggression if

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such requests are not met. The physical environment is also important. Patients on wards without access to a garden or secure outside space are more likely to present with problems, particularly if the implementation is fragmented and appears unfair. Hence, consistent and ongoing enforcement of the ban is paramount to its long-term success; without such enforcement staff morale and anxiety levels may suffer (Lawn, 2005). As a corollary to successful implementation, staff will require specific training. Distinction between psychotic agitation and nicotine withdrawal is important, as is knowledge of how nicotine interacts with the metabolism of antipsychotic drugs (dose requirements fall after cessation). Staff will need to be able to support patients who perceive smoking restrictions as a further infringement of their freedom and an increase of their sense of powerlessness.

The South London and Maudsley NHS Trust plans to introduce a ban on smoking on all sites by July 2006, using a phased introduction and after wide-ranging local consultation (The South London and Maudsley NHS Trust Smoke-free Policy, available on request). As part of the policy, smoking cessation will be a consideration in every patient's management plan from the point of admission to the service, be that community, in-patient or residential setting. Greater awareness of the policy, in association with staff training and patient and carer collaboration, are essential prerequisites. A comprehensive body of literature supports the effectiveness of behavioural and pharmacological treatments for smoking cessation in in-patient (admittedly non-psychiatric) hospital settings, but outcomes in community settings are less clear owing to a paucity of research in this area (Rigotti *et al*, 2001). To assist in longer-term cessation, plans for continued support should be part of the patient's care plan as they move from one part of the service to another. This indicates the need for more coordination between in-patient and community-based staff. As of February 2006, the local primary care trust has given an undertaking to train staff in brief interventions, to provide nicotine replacement therapy to all services and to set up smoking cessation clinics on some sites.

Possible exemptions

Although the White Paper *Choosing Health: Making Healthy Choices Easier* (Department of Health, 2004*b*) states that 'no blanket exceptions will be allowed for particular categories of patients', certain exemptions are inevitable, and their management can influence the success or failure of the policy. The obvious exemptions are those patients in a dangerously heightened state who are detained in hospital under mental health legislation. Individual care planning may recommend smoking in a designated area for a period of time that will be subject to regular review. This may take place in a secure outdoor location or within a designated smoking area on the ward. However, smoking rooms send mixed messages to patients and risk exposure of nursing or domestic staff to passive smoke. Substance misuse services may need to negotiate best policy for their units within local 'smoke-free' work groups. This would reflect the benefits of a total ban and the practical difficulties of its implementation, such as the impact on the availability of staff to act as escorts.

Smoking cessation should be encouraged in psychiatric settings as part of an overall policy of health promotion. However, its implementation needs to be planned, with support from user, carer and staff groups, coupled with appropriate training and consideration of practicalities. To succeed, a ban has to be consistently applied through individual care planning, with full administrative support and coordination between services.

Declaration of interest

None.

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