

A survey of staff attitudes to smoking-related policy and intervention in psychiatric and general health care settings

Lisa McNally¹, Adenekan Oyefeso¹, Jan Annan², Katherine Perryman¹, Roger Bloor³, Steve Freeman³, Barbara Wain³, Hilary Andrews⁴, Martin Grimmer⁵, Arthur Crisp¹, Deji Oyeboode⁶, A. Hamid Ghodse²

¹Department of Mental Health—Addictive Behaviour, St George's, University of London, Cranmer Terrace, London SW17 0RE, UK

²International Centre for Drug Policy, St George's, University of London, Cranmer Terrace, London SW17 0RE, UK

³Keele University Medical School, Academic Psychiatry Unit, Harlands Hospital, Stoke-on-Trent ST4 6TH, UK

⁴Suffolk Stop Smoking Service, The Ipswich Hospital NHS Trust, Heath Road, Ipswich IP4 5PD, UK

⁵The Ipswich Hospital NHS Trust, Heath Road, Ipswich IP4 5PD, UK

⁶South West London and St George's Mental Health Trust, Springfield University Hospital, London SW17 7DJ, UK

Address correspondence to A. Hamid Ghodse, E-mail: hghodse@sgul.ac.uk

ABSTRACT

Background Although the move to smoke-free hospital settings is generally a popular initiative, it may be a more challenging and controversial issue in mental health care. A survey was carried out to investigate differences in attitudes between clinical staff in psychiatric and general medical settings to smoke-free policy and intervention.

Method The sample comprised 2574 NHS staff working in two Acute Hospital Trusts and one Mental Health Trust in England. Attitudes were examined on two factors: health care settings as smoke-free environments and the role of staff in stop smoking intervention.

Results The findings indicated that attitudes on the two factors were only moderately correlated. Psychiatric staff expressed significantly less favourable attitudes than general staff to smoke-free health care settings and also to the role of staff in stop smoking intervention. The largest difference between the settings concerned the implementation of smoking bans. While approximately 1 in 10 staff in the general setting disagreed with a smoking ban in their wards or clinics, nearly one in three psychiatric staff was against such a ban in their setting.

Conclusions Staff attitudes need to be carefully considered, particularly in psychiatric settings, in attempts to implement smoke-free policies in health care settings.

Keywords smoke-free policy, smoking, staff survey, tobacco

Introduction

The question of whether smoking in public places should be prohibited is currently high on the agenda in many countries, including the UK. It is unsurprising, and maybe appropriate, that among those organizations leading the way towards a smoke-free environment are health care settings such as hospitals and outpatient clinics. However, while the adoption of smoke-free policies in health care settings is a generally popular move,¹ one area in which less favourable attitudes to smoke-free policy can be found is inpatient mental health care, which many see as appropriate for exemption to policies prohibiting smoking.²

Policy changes are not the only relevant factor in creating smoke-free environments. The recent 'Guidance for Smoke-free Hospital Trusts' from the UK Health Development Agency identifies the widespread accessibility of stop-smoking

support as a fundamental step towards achieving a smoke-free NHS and advises that, 'training should be provided for

Lisa McNally, Honorary Lecturer in Tobacco Addiction

Adenekan Oyefeso, Reader in Addiction Psychology

Jan Annan, Associate Director

Katherine Perryman, Research Fellow

Roger Bloor, Senior Lecturer in Addiction Psychiatry

Steve Freeman, Researcher

Barbara Wain, Researcher

Hilary Andrews, Co-ordinator

Martin Grimmer, Consultant Physician

Arthur Crisp, Emeritus Professor of Psychiatry

Deji Oyeboode, Medical Director

A. Hamid Ghodse, Director

all health professionals on how to give opportunistic stop-smoking advice to smokers'.³

Despite such clear messages, the effectiveness of smoking-related policy and intervention would inevitably depend on the attitudes of health care staff to these initiatives. There is already some evidence that smoking-related attitudes differ by professional groups.⁴ So far, however, no direct comparisons have been made between staff attitudes in general and psychiatric settings.

Such comparative data would be of value in view of the widespread perception that psychiatric settings are one of the most difficult hospital settings within which to implement smoking restrictions.⁵ This may be related to the unique place occupied by smoking within the practice and culture of psychiatric care. For example, smoking rooms are frequently the social hub of a mental health unit and smoking is often a major source of structure and activity to the patients' day.⁶ Studies have also reported that mental health staff may often use cigarettes to appease or engage patients.⁷ Arguments for exempting mental health units from smoke-free policy also often make reference to human rights and to the fact that many patients are resident in hospitals for extended periods and often against their will.

The study reported here compared attitudes to smoke-free health care environments and to stop-smoking intervention between clinical staff in psychiatric and general NHS settings.

Methods

The postal survey employed a cross-sectional design, with questionnaires administered to staff across three NHS Trusts. Questionnaires were sent to clinical staff employed at South West London and St Georges Mental Health Trust, University Hospital of North Staffordshire NHS Trust and The Ipswich Hospital NHS Trust. Local research ethics committee approval was obtained at all the three sites. The survey was confidential, and no attempt was made to identify staff through the information they provided.

An eight-item questionnaire was administered to staff asking about opinions on issues relating to smoking. Answers were given on a 5-point Likert-type scale ranging from 'strongly agree' to 'strongly disagree' (items were reversed in analyses so that a higher score indicated a more positive attitude). Pilot work demonstrated that the questionnaire took 2–3 min to complete. Each questionnaire was distributed along with a return envelope addressed to the research team. Staff were able to return their questionnaire by post, by hand to a member of the project team or by email on request.

Because smoking-related attitudes in an organization are likely to be determined by a range of factors, including organizational policy and personal clinical experience, principal component analyses were performed to examine the underlying factor structure of the questionnaire. Analyses of variance (ANOVAs) were carried out to investigate differences in attitudes across health care settings (i.e. psychiatric versus general) while controlling for the influence of smoking status.

Results

Sample characteristics and response rates

Overall, the survey achieved a sample of 2574, comprising 1737 general hospital staff and 837 psychiatric staff. The response rate was 51% overall, and higher in the general setting (53%) than in the psychiatric setting (46%). The largest professional group represented in the survey was that of nurses (including midwives and health care assistants) who made up 68% of the total sample. The next largest group was that of professionals allied to medicine (including physiotherapists, occupational therapists, social workers and psychologists) who made up 17% of the sample. Medical doctors (physicians, surgeons and psychiatrists) accounted for 10% of the sample. A further 5% of the sample declined to indicate their professional group. The sample proportions representing each of the professional groups were similar between the two settings. Concerning smoking status, 17% of the sample were current smokers, with nearly a quarter of the respondents being ex-smokers.

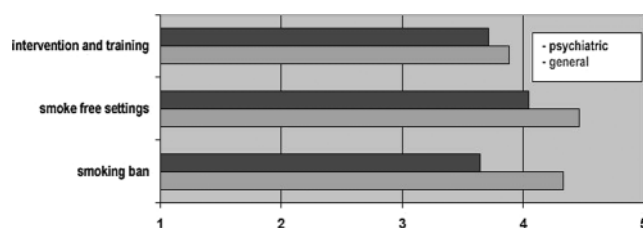
Internal reliability and data reduction

The questionnaire had a high level of internal reliability (Cronbach's $\alpha = 0.84$). The underlying factor structure of the attitude questionnaire was examined to distinguish key themes related to the issue of smoking. Principal component analysis was performed, with a subsequent Varimax rotation on the data relating to the eight attitude items. The criterion for extraction was an eigen value >1 .

The analysis extracted two factors (see Table 1). Items 1, 2 and 3 reflected an 'organizational' (anti-smoking) orientation and explored views on health care settings as smoke-free environments. Alternatively, items 4, 5, 6, 7 and 8 tapped into a 'good practice' orientation and reflected views on the role of staff in stop-smoking intervention (including training and delivery). The two factors were only moderately correlated ($r = 0.49$), indicating that, while there was some shared variance between them, they tapped into distinct issues.

Table 1 Questionnaire items: rotated component matrix

	Factor	
	Good practice	Organizational
1. Patients should be encouraged to quit	0.328	0.709
2. Staff should not smoke in the presence of patients	0.097	0.797
3. Smoking should be banned in ward/clinic	0.152	0.785
4. Staff should offer advice routinely	0.692	0.316
5. Staff should be trained to offer advice and support	0.807	0.173
6. Hospitalization is a good opportunity for intervention	0.551	0.374
7. A qualification would be useful for me	0.814	-0.017
8. A cessation programme would be useful in my ward/clinic	0.744	0.267

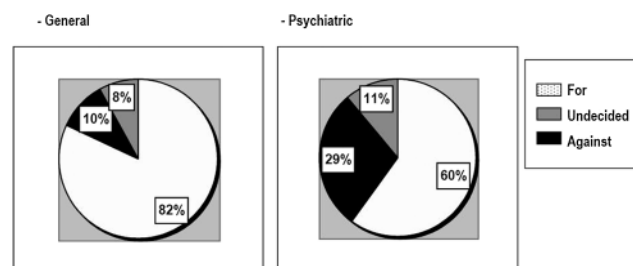
**Fig. 1** Differences in attitudes between settings ($n = 2509$). All group differences significant at $P < 0.001$.

'Organizational orientation' factor: attitudes to health care settings as smoke-free environments

The 'organizational' factor explored staff attitudes to health care settings as no-smoking environments. The mean score on this factor for the entire sample was 4.32 (95%CI = 4.29–4.35), indicating an overall response somewhere between 'agree' and 'strongly agree'. In the general setting sample, the mean response was 4.46 (95%CI = 4.42–4.49), whereas in the psychiatric sample, the mean response was 4.04 (95%CI = 3.99–4.09) (Figure 1). One-way ANOVA revealed that staff members working in the psychiatric setting were significantly less favourable than general setting staff to smoke-free health care settings (mean difference = 0.42, 95% CI = 0.36–0.47) ($F_{1,2516} = 195.50$, $P < 0.001$). This effect remained significant after controlling for age, sex, smoking status and professional group.

'Good practice orientation' factor: attitudes to stop-smoking interventions in health care settings

The 'good practice' factor explored attitudes to stop-smoking supportive interventions, including the role of staff in such intervention and the value of training in intervention techniques. The mean score on this factor for the entire sample was 3.83 (95%CI = 3.80–3.86), indicating a response some-

**Fig. 2** Staff for, against and undecided in relation to smoking bans in health care settings ($n = 2544$).

where between 'undecided' and 'agree'; this score is less favourable than the response to the organizational orientation factor. In the general setting sample, the mean score was 3.88 (95%CI = 3.85–3.92), whereas in the psychiatric sample, the mean attitude score was 3.71 (95%CI = 3.66–3.76) (Figure 2). ANOVA revealed that staff members working in the psychiatric setting exhibited significantly less favourable attitudes than general setting staff to stop-smoking intervention (mean difference = 0.17, 95% CI = 0.11–0.23) ($F_{1,2455} = 30.34$, $P < 0.001$). This difference was less than that observed on the previous factor, and it should be noted that the large sample size allowed for the detection of relatively small differences. However, group differences on this factor were again independent of age, sex, smoking status and professional group.

Attitudes to smoking bans in health care settings

Owing to the central position of smoking prohibition in recent NHS policy developments, staff views on the proposal that smoking should be banned in their ward or clinic (item 3) were examined separately. Overall, the average rating approximately corresponded to an 'agree' rating (mean = 4.11, 95%CI = 4.06–4.15). In the general setting sample, the mean response exceeded the 'agree' rating with a mean

of 4.33 (95%CI = 4.28–4.39), whereas in the psychiatric sample, the mean attitude score was 3.64 (95%CI = 3.56–3.72) (Figure 1). ANOVA revealed that psychiatric staff expressed significantly less positive attitudes than general setting staff to smoking bans (mean difference = 0.69, 95% CI = 0.60–0.79) ($F_{1,2544} = 203.81$, $P < 0.001$). This was again independent of age, sex, smoking status and professional group.

In relation to the item on smoking bans, respondents were divided into whether they were supportive of a smoking ban ('strongly agree' or 'agree'), against a smoking ban ('strongly disagree' or 'disagree') or undecided. The proportion of staff indicating that they were against a smoking ban differed markedly between the groups, with only 10% of general setting against a ban compared to nearly one-third (29%) of psychiatric staff (see Figure 2).

Attitudes by professional group

ANOVAs were also used to examine differences in responses to the survey across professional groups. In relation to staff attitudes to health care settings as no-smoking environments, doctors exhibited significantly more positive attitudes than nurses or professionals allied to medicine ($F_{1,2737} = 16.08$, $P < 0.001$). Regarding attitudes to intervention, however, it was nurses who exhibited significantly more positive attitudes than the other two groups, although the group differences on this factor were of a lesser magnitude than in relation to no-smoking environments ($F_{1,2576} = 6.29$, $P < 0.001$). All professional group differences remained significant after controlling for age, sex and smoking status.

Discussion

Main findings of this study

More favourable attitudes to smoke-free health care environments, smoking bans and stop-smoking intervention were observed among clinical staff in general medical settings compared with staff working in psychiatric settings. The largest group difference in attitudes was observed in relation to smoking bans. While approximately 1 in 10 staff in the general setting disagreed with a smoking ban in their wards or clinics, nearly one in three psychiatric staff was against such a ban in their setting. In relation to professional group, doctors exhibited the most favourable attitudes towards smoke-free health care environments, while nurses were the most positive towards taking a role in smoking cessation intervention.

What is already known on this topic

Findings from literature reviews have demonstrated that staff in psychiatric settings develop a much more positive view

towards smoke-free policies after the policy has been put in place for some time. This shift in opinion may flow from the fact that smoking bans have rarely been found to lead to increased aggression and adverse incidents and, in fact, have even had a positive effect on ward functioning in many cases.^{8,9} However, despite claims that smoking occupies a unique place within the culture of psychiatric care,⁶ this may lead to smoke-free policies facing unpopularity in psychiatric settings. There is currently no published data directly comparing attitudes to smoking policy and intervention among staff in psychiatric settings with those of staff in general medical settings. This is because previous work on smoking cessation in health care environments has either excluded psychiatric settings or confined analyses to either general or psychiatric settings.^{4,10}

What this study adds

This survey is the first in the UK to provide direct comparative data on smoking-related attitudes between staff in general and psychiatric settings. The implication of the findings is that the enactment of no-smoking policy, and the concurrent provision of routine stop-smoking intervention, may well encounter more resistance from staff in psychiatric settings than in general settings. The study is salient in the light of the recent stipulation from the UK Government that 'by the end of 2006... the NHS will be smoke-free'.¹¹ Attitudes to no-smoking policies and smoking cessation strategies among the staff are likely to be crucial in achieving this aim, and the findings of the present study serve to reinforce the need for careful consultation and inclusion of staff in the decision-making process. In particular, organizations may benefit from ensuring that policy changes are made within the context of a widespread system of staff-led smoking cessation support, which, as the previous research suggests, would be welcomed by staff as an opportunity to learn new clinical skills.⁹

Limitations of this study

The response rate from staff to the survey was only moderate (51%), and questions may be raised as to whether the sample represents the full range of views held by health care staff. However, it should be noted that the response rate is comparable to that achieved in most other UK surveys of clinicians' attitudes to smoking-related practice^{4,12,13} and also that the sample size was large and represented all the main groups of NHS staff having clinical contact with patients.

In addition, while a response bias was possible, it was found that the emergent group differences were significant after controlling for age, sex and smoking status and are therefore likely to be robust.

The present study did not examine attitudes to indoor and outdoor smoking policies separately. It may well be that resistance towards smoking bans in mental health settings may be motivated by the fact that a policy covering grounds and buildings would in practice equate to an enforced abstinence on patients unable to leave the grounds. This may be seen as unrealistic as well as unethical. Alternatively, designated outdoor smoking areas may lead to challenges and staff anxiety towards the practicalities of how patients can be supervised in these areas when available staff numbers are limited. Furthermore, research into the effects of allowing outdoor smoking areas on attitudes to smoking policy may therefore prove valuable.

Acknowledgements

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