Health (Tobacco, Nicotine etc. and Care)(Scotland) Bill

The Royal College of Psychiatrists in Scotland

Part One:

Smoking in hospital grounds

Members of the College’s Executive Committee have reviewed the proposed amendments to the Smoking, Health and Social Care (Scotland) Act 2005, and some common themes have emerged.

Smoking rates are higher in psychiatric patients than the general population and are one of the factors that contribute to early mortality in patients with mental disorders. The College acknowledges the detrimental effects caused by smoking and fully supports the importance of encouraging non-smoking and other improvements in patients’ physical health. Although the legislation is worded to prevent smoking outside hospital buildings, this has been generally interpreted as the hospital grounds rather than discrete areas outside hospital buildings.

The State Hospital has successfully introduced non-smoking in the hospital grounds but the general view expressed was that a blanket ban on smoking on hospital grounds raises particular issues for some psychiatric units. This is due to patients recommencing smoking on discharge, the length of stay for some patients, and issues relating to detention under the Mental Health Act. Some of the key issues are as follows:

- A risk of patients refusing to stay voluntarily if they are not permitted to smoke. One College member (who works for a newly smoke-free Health Board) cited a recent example of having to detain a lady who would likely have stayed voluntarily had she been allowed to smoke. This was a very uncomfortable situation for the clinician, calling into question the principle of ‘least restrictive practice’.

- Another point raised is the fact that smoking is not illegal, and provided it is managed in a way that does not put others at risk, nor - in contrast to alcohol - cause problems in maintaining good order within hospitals, then it would be better to respect the individual autonomy of a patient as far as possible, particularly in regard to detained patients and patients with complex needs who remain inpatients for long periods.

- A further issue which caused particular concern is that of the impact a smoking ban would have on pharmacokinetics (particularly Clozapine) which are affected by smoking. Compelling a patient to give up smoking and take nicotine replacement would make effective prescribing very difficult; nicotine affects drug metabolism and many patients will likely resume smoking when discharged or on pass, thus making a consistent approach very difficult to maintain. This is a particular problem in psychiatric wards where patients will often go on pass prior to discharge. For example there are numerous case reports of patients
on Clozapine relapsing when they restart smoking due to the effect of smoking on reducing Clozapine blood levels.

- Most psychiatric patients are admitted due to risk of harm and being an inpatient provides some degree of protection. If patients who wanted to smoke, removed themselves from hospital grounds in order to do so, then this protection would potentially be lost.

The College actively supports and encourages smoking cessation and believe that all patients should be supported with advice & encouragement; the work carried out in this regard has led to a marked improvement in recent years. We believe that if the intention is to stop people from smoking then it would be absolutely essential to provide the necessary help and resources to do so both in the hospital and the community.

**Offence of permitting others to smoke on hospital grounds**

We believe that the suggested amendment proposing an offense for those knowingly permitting smoking on hospital grounds is simultaneously unworkable and has the potential to put staff at risk. Arguments to this effect are as follows:

- Efforts should be made to discourage smoking, to keep smoking off the wards and to offer all support and help to encourage cessation, all of which have massively improved in recent years. However, it is difficult enough to nurse and treat acutely mentally ill or chronically severely ill people who do not wish or intend to stop during admission, without facing the prospect of prosecution regarding this as well.

- It sets up yet another "us" and "them" barrier which at best, isn't helpful, at worst, puts staff at risk.”

To make it a criminal offence if staff have no choice but to allow an individual to smoke (after exploring all other options) is unacceptable, and it would be detrimental to helping staff engage with what is a very complex and controversial area. Staff deal with distressed patients regularly and can be put in a very difficult situation.

The safeguard of having ‘no lawful or reasonably practicable means’ of prevention is inadequate when staff are involved in making complex assessments of relative risks in distressed patients and acting in the patient’s best interests. A member of staff may make a judgement that it is less risky for the patient to remain within the hospital grounds and smoke in a garden area, rather than taking their own discharge, being detained under the Mental Health Act or, if they are already detained, physically restraining them. These arguments are about one-off judgements to de-escalate particular situations rather than a blanket argument for allowing patients to smoke.

It is unreasonable and also unworkable to suggest that staff can and should be responsible for stopping others smoking on NHS grounds. There are already significant pressures and concerns from nurses, particularly in acute
wards. There are concerns that diverting staff time and resources to monitoring the area outside a hospital building would be to the detriment of providing care within the hospital building. Although this legislation appears to be intended to apply to the hospital management, the hospital managers are likely to be able to argue that they took reasonable precautions. The concern is that the responsibility will be left with individual ward managers or the nurse in charge of the ward to deal with patients and visitors smoking outside wards.

**Part 2:**

**Duty of Candour**

In regard to the proposed Duty of Candour legislation, the general view is that there are already sufficient mechanisms in place on this matter. Existing structures such as the GMC Good Medical Practice guides, professional standards, and a number of agencies (Procurators Fiscal, Mental Welfare Commission, Care Inspectorate, Health Improvement Scotland, Health and Safety Executive, Ombudsman as well as internal inquiries) lead us to question the value of further legislation on the topic.

Our consensus, on reviewing the provisions, is that at best, they would lead to no change, at worst, it would add to the burdens of health care providers for no obvious gain. It is also unclear how harm would be defined, what cut off would be used and by whom; and how the causal relationship between care and harm would be demonstrated.

Common harms in mental health are suicide and self harm. These involve a complex interaction of patient and service factors. For example, for suicides, there are some cases where the service caused or contributed to the harm but in most cases the situation is more complex. It is unclear how it would be decided whether a suicide was a harm caused by the service that required reporting under the new legislation and what additional value this would add. All suicides are already investigated, reported to Health Improvement Scotland and are already part of a National Confidential Inquiry. Further improvements in investigation are best supported through training and improvement methodology rather than legislation.

The proposed legislation suggests that near misses as well as cases of actual harm would be regarded as incidents. There is a risk that this will cover so many incidents that it will skew service priorities. Incidents would need to be reviewed by an individual (not involved in the patient's care) who would then give an opinion on whether a duty of candour applies. In practice, incident reporting systems within Health Boards rely on the individuals involved in a patient's care making a judgement if the care provided contributed to an adverse effect. These would then be reviewed by their line manager who would often have been involved in the patients care and could therefore be regarded as part of the incident. This is because 'incidents' are usually not isolated events but usually involve a number of events over a period of time. To have another practitioner - not involved in the care - review each incident would have potential resource implications.
If the duty of Candour is introduced then the procedures (Section 22) should be kept as part of the Regulations rather than as primary legislation, and this should include the procedures around the activation of the duty of Candour.

**Part 3 Ill-Treatment and Wilful Neglect**

In regard to the proposal to make wilful neglect or ill-treatment of patients a criminal offence, it is our understanding that individuals can be prosecuted under pre-existing laws. The registration of healthcare professionals provides another level of protection for the public.

Furthermore, there is already a safeguard in the Mental Health Act for ill treatment and wilful neglect of mentally disordered persons and it is therefore unclear what the need is for additional legislation.

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