Author's response to reviews

Title: Total smoking bans in psychiatric inpatient services: A survey of perceived benefits, barriers and support among psychiatric hospital staff

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Author's response to reviews: see over
Response to Reviewer Comments

Reviewer 1
Major Compulsory Revisions
p.3 The term ‘Partial bans’ needs to be defined and the authors need to offer reasons for this evidence, or at least suggest reasons for it. This is an extremely important point and one that often lies at the centre of debates within systems in which stakeholders are sometimes fiercely deciding how to proceed, either with total or partial bans. It is strongly linked to a fundamental flaw that I often observe in staff group debating this layer of implementation, and whether to apply for exemptions to allow smoking in designated places specifically for mental health patients. The authors go on to mention NRT use being more likely in settings that are totally smokefree but likewise don’t offer suggestions for why this is so. Evidence from a recent national consultation with Lawn and Campion (2009) and Lawn and Campion (in press) suggests that partial bans do little to alter clinicians’ behaviour, or patients’ behaviour. It is these notions of what it takes for staff and patients to take action for change that are fundamental to this area. If we leave this issue to the good conscience of stakeholders, ‘what sounds like a good thing for health’, and rely solely on staff encouraging patients to try NRT whilst still allowing them to smoke in designated spaces, the evidence is that little changes. We are all creatures of habit, so staff take the easy path and so do patients and nothing changes to address this vexing issue in these setting. This pivotal and central point about actual behaviour change, as distinct from perceptions, is one that would enhance the value of this paper.

Term ‘partial ban’ defined, and further explanation provided, including references.

p.4 The authors assert that no Australian research has yet been reported for either total or patient bans. The above references do this and I believe there is a published paper from research in Western Australia that discusses this issue.

We have conducted a review of the literature regarding actual levels of support for smoking bans in mental health services in Australia, and no papers were identified related to the Australian context.

The reviewer has identified some important papers, and these have been cited in the relevant sections of the paper:
Wakefield, Roberts & Owen, 1996
Reilly et al 2006
Lawn & Campion, 2010

p.8 Design and Setting section – The authors make very little reference to training issues here and throughout the paper. In our research (Lawn and Campion, 2009,in press) we found that the level and type of training provided was associated with the success of smokefree policy. Given the topic of this
paper and the importance of addressing staff perceptions and misperceptions, the issue of training could be discussed in more detail in the discussion and conclusions section.

Yes, training was provided in the implementation of the smoking ban, and this has been added, although the authors are aware that the uptake of such training was low. Given this, and the aim of this paper to report staff views and levels of support for a total smoking ban, rather than views on the implementation, the issue of training was not prominent in the design. Additional reference to the importance of training has been added to the conclusion section.

p.9-10 The authors could provide more discussion of how the questions for staff were determined, what the domains of interest were, etc. They state that the questions were developed from previous similar studies and the reader can see generally what was covered from the tables. What is needed is some sense of the rigour aimed for in using these questions.

Information inserted.

p.10 in the Analysis section, the authors needs to justify why they reduced some response categories and what impact this may have had.

Collapsing of variable categories was necessary for statistical analysis, given the sample size. Collapsing of variables did not compromise or detract from the ability to address levels of support or otherwise for total smoking bans.

p.11 The authors could provide a practical example of a type 1 error in this context to assist the lay reader.

Further description of a type 1 error provided in brackets.

p.12 Last paragraph about smokefree status and quality of care – This is a very concerning result that needs further discussion in the context of broader arguments pertaining to this issue, as part of the discussion section.

Further consideration of this result has been added to the discussion.

p.15 Several studies from the US in the 1990s report pre and post staff views. These are not mentioned by the authors. This is particularly relevant given such studies report that staff views usually changed in favour of smokefree policy after implementation, that is, their fears were allayed. Given this current paper is about staff perceptions, such information is worth emphasizing. This point could also be noted more clearly on p.17, given previous studies also confirm that staff appear to have more negative perceptions about smokefree policy that patients.

Have referenced three additional studies dating from 1989 – 1995.

p.16 The paragraph commencing ‘The findings of …’ could be clearer, particularly the comment about low levels of aggression.
p.27 Table 1 – The authors did not refer to some variables within the text discussion of results. Examples are length of time in job and smoking status. These would be of interest to readers.

Table 1 refers to the demographic characteristics of the sample. For space limitations, the information is provided in table form.

In general, the authors need to refer to reader more directly to the tables, to assist them to navigate through the depth of information they contain.

Addressed.

- Minor Essential Revisions
The first line in the results section of the abstract is confusing. In particular, it is not clear what the 41% and 92% represent overall. I assume the former represents 41% of the total potential sample of clinical staff and the latter represents 92% of the total potential sample of non-clinical staff at the psychiatric inpatient service. If so, this difference, and its implications, could be more clearly noted in the limitations section/conclusions.

Hopefully clearer for the reader now.

Spelling mistakes and other changes suggested:
- p.2 Results section, line 4, ‘…improve patients’ physical health…’
- p.2 Conclusions section, line 2. The authors could split this into 2 sentences to improve flow ‘…bans do not increase patient aggression…’
- p.4, line 11 ‘…both buildings and grounds; that is, a total smoking ban.’
- p.4 The Willemsen et al study needs to be referenced. [19]
  Also, the authors haven’t discussed the results, therefore the comment, ‘These results suggest differences in staff support…’ sits awkwardly here. Overall, this section could be clearer.
  p.5 6th line from the bottom, ‘…particularly a person’s response…’
  p.6 line 11, ‘…support for smoking bans in public officials…’ sounds awkward. Suggest ‘among’ or ‘by’.
  p.8 line 12, ‘…establishment of [a – delete] service-wide…committees.’
  p.9 4th line from bottom, ‘…current smoking status, and [add - whether] exposure…’
  p.13 line 6, ‘Details of clinicians’ perceived barriers…indicated a fear of patient aggression(89%) [in relation to smoking bans]…’
  p.13 line 9, staff capacity needs clarification; capacity for what?
  p.18, 7th line from bottom, ‘…the response rate, particularly for clinical staff, suggest…’
  p.19 line 5, ‘…has an historical culture…’

All addressed, and thank you to the reviewer for such thorough editing.
- Discretionary Revisions

p.3 Background section, reference 8 seems to be an odd reference to use here. The authors may wish to check the recent work of Chapman, or Ragg and Ahmed’s review of the controversies about smoking rates, in order to revise this point.

Thank you, agreed, and replaced with more relevant reference.

p.5 The authors could more clearly define clinical and non-clinical staff roles earlier in the paper.

Agreed, and addressed.

p.9 Procedure – were any steps taken to encourage an increased response rate from clinical staff?

Information added.
Reviewer 2

The questionnaire contains measures of perceived benefits and barriers to a total smoking bans, and questions about support to it. The authors do not explain how they got to develop such a questionnaire. Although they say it was developed based on those used in previous studies, the reader can not find many similarities with the tools used in the quoted papers. A few sentences on the rational of the questionnaire development can be helpful - environmental, health, relationship/social, psychiatric, organizational, cultural areas, and reasons for the differences from other tools (minor essential rev.).

Agreed, and this information has been added to the methods section.

Moreover, the authors say that comparison with other studies was difficult because of different methodologies between studies, but their tools contribute to the difficulty in comparing studies conducted with different methodologies. They might attenuate the sentence at bottom of page 6 about limited generalisability of past research, and use only the issue of the importance of identifying barriers and facilitators of staff support to a total smoking bans (discretionary rev.).

The reviewers’ point is taken, and revision to the sentence has occurred.

The comparison with non-clinical staff does not add much to the paper. The views of the two groups are only marginally different and the authors base their main findings on data from clinicians. Therefore, non-clinical staff views in Table 2 do actually make the table heavier, without giving any meaningful clues for discussion. The authors may keep the table as it stands, but suggest some more useful considerations on Table 2 (discretionary rev.)

Agreed, that the views of clinical and non-clinical staff do not differ greatly, however this might be an interesting result for the reader (as it was for the authors). Comment added to discussion.

Anyway, I suggest to not mention clinical and non-clinical staff in the title, which would become “Total smoking bans in psychiatric inpatient services: A survey of perceived benefits, barriers and support among psychiatric hospital staff” (discretionary rev.).

Agreed, and title modified.

Table 6 shows the logistic regression analysis of the association between perceived benefits and barriers to a total smoking bans and support to such a bans in their unit. The authors use a stepwise logistic regression where they conservatively accept as significant only associations with p values <0.01. This is quite unusual even in a stepwise logistic regression model, and I would suggest the authors to consider again whether this is necessary with their statistician. If they consider significant the two additional associations with <0.05 p values, the finding of support to total bans according to smoking status can be better underlined, and more emphasis on that of insufficient knowledge of staff can be
After seeking statistical advice, I have rewritten the analysis section to give a clearer explanation of the methods used, and removed the last row from Table 6.

Although the aim of the study was to analyse staff views in relationship to their support to implement a total smoking bans, the authors should spend some words about the lack of information from patients (discretionary rev.). Since the aim of the study was to obtain indications about what to do in order to implement a total smoking bans in the unit, patients views would be useful too. Moreover, their perception of benefits and barriers related to a total smoking bans can help having a more realistic idea of their position.

Agreed, added to discussion.

A critical point is the relationship between smoking bans and quitting smoking. The aim of smoking bans is double: having safer places for non-smokers and smokers, and help people quitting smoking. This is addressed in Discussion and Conclusions. Nonetheless, in the Discussion, top of page 17, the topic is quite quickly treated. I suggest to add a sentence about the risk of no effect of smoking bans on smoking habits after discharge from a psychiatric setting (see Lawn and Pols, 2005 and el-Guebaly, 2002), and the non-straightforward nature of the relationship between the two, being smoking bans useful first of all in enhancing motivation and the effects of other treatments aimed at smoking cessation and relapse prevention (minor essential rev.).

Agreed and added.

The main reason why clinical staff thought a smoking total bans useful was to help patients stop smoking: to have this belief motivate staff in supporting a smoking total bans, not only information on this point should be strengthened, but also skills given – in helping patients in coping with their concerns about quitting and tolerating abstinence, giving motivation and delivering treatment for care cessation - and tasks and responsibilities attributed.

Agreed and added.

The point of fear of patient aggression is well addressed by the authors, but it might be helpful to put it in relationship with the staff lack of skills in smoking cessation care. Without such skills staff may likely feel uncomfortable in just making the bans respected (discretionary rev.).

Agreed and added.

The authors wish to thank the reviewers for their thoughtful comments and suggestions.