In the sites of exception:

Smoking and mental health inpatient facilities

in Aotearoa Zealand

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Abstract

In Aotearoa New Zealand, mental health inpatients are entitled to treatment in smoke-free hospital care environments. However, in 2003, the Parliament of Aotearoa New Zealand exempted hospital care institutions from the smoke-free law, thus permitting designated smoking rooms for patients, subject to specific provisions including ventilation. Subsequently, District Health Boards (DHBs) implemented smoking rooms in mental health inpatient facilities and exempted them from the general smoke-free rule in their smoke-free organisational policies.

My curiosity inspired this research to understand the rationale for the smoke-free policy exceptions in DHB mental health inpatient facilities and the implications of the exceptions for patients, staff, and Smoke-free 2025; the Aotearoa New Zealand Government's national goal, which is "interpreted to mean that less than 5 percent of New Zealanders of all ethnic and social groups will smoke daily by 2025" (Ministry of Health, 2021, p. 4).

The theoretical framework guiding this study is Giorgio Agamben's state of exception. I collected data from 15 semi-structured interviews, archival material, and DHB smoke-free policies. Reflexive inductive thematic analysis was used to code and generate insights from the Participant data.

This study is noteworthy. It is the first academic research examining the use and implications of exceptionalist smoke-free law, policies, and practices in mental health inpatient facilities in Aotearoa New Zealand. It also documents the State's role in purchasing and supplying tobacco and cigarettes to mental health inpatients and begins to fill a gap in the knowledge about the foundations for pervasive smoking in these facilities. The use of Agamben's state of exception to explore one exceptionalist law, policies, and practices in a mental health setting is novel. It adds to the body of literature that uses this lens to examine non-cataclysmic events.

My key findings are that smoke-free exceptionalist law permitting designated smoking rooms and partial smoke-free policies and practices that facilitate and endorse cigarette smoking are forms of patient control and sites of violence. These sites disregard the accepted research evidence of harm from smoking and exposure to second-hand

cigarette smoke, expose patients and, to a lesser extent, staff, to these health detriments, and make it more likely that mental health patients will be among those still smoking in 2025.

Furthermore, the presence of a law permitting patient smoking in hospitals is inconsistent with Aotearoa New Zealand's international and domestic human rights obligations. My thesis concludes that a government serious about improving, promoting, and protecting health and wellbeing must amend the law and ensure hospitals are smoke-free. Smoke-free exceptions denigrate the value of human life: the life of people who smoke and are patients in mental health facilities.

Dedication

To my Nana Davies for her unconditional love and encouragement

To my Mum, who appreciated the interconnectedness of everything

To my Dad, who valued quiet reflection

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Date: 30 June 2021

Ethics Approval

Faculty of Culture and Society / Te Ara Kete Aronui

Re Ethics Application: 16/365 Smoking and mental health inpatient facilities in New Zealand

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC). Your ethics application has been approved until 27 March 2020.

On 4 March 2020, an extension until 27 September (6 months) was approved.

Glossary

Term	Definition and explanations
Designated room	means an internal area in a hospital care institution, a residential disability care institution, or a rest home that is used solely to— (a) enable patients or residents who smoke to smoke or to socialise with each other in a place where smoking is permitted; or (b) enable patients or residents who vape to vape or to socialise with each other in a place where vaping is permitted Smoke-free Environments and Regulated Products Act 1990, s.2. (1). This definition widens the term designated smoking room used from 2003-to 2019.
Designated smoking room (DSR)	an internal area in a hospital care institution, a residential disability care institution, or rest homes that is used solely to enable patients or residents who smoke to smoke, or to socialise with each other in a place where smoking is permitted. Smoke-free Environments Amendment Act 2003, section 3. (1). In 2019, Parliament widened this definition to include vaping– See 'Designated room' above.
District Health Boards (DHBs)	DHBs fund and provide health services in their region. They are established under the New Zealand Public Health and Disability Act 2000 Part 3, section 19. DHBs are Crown entities owned by the Crown for the purposes of s.7 of the Crown Entities Act 2004. At the time of writing, there are 20 DHBs in Aotearoa New Zealand.

Term	Definition and explanations
Exception	Agamben's state of exception For Agamben (2005), the exception refers to the executive's suspension of laws and extension of powers in response to emergencies. *Exception* The Oxford Dictionary defines exception as 'a thing that does not follow a rule'. (Oxford Learner's Dictionaries, n.d.) https://www.oxfordlearnersdictionaries.com/definition/american_english/exception My study also uses the term 'exception' as follows: *Formal exception* 'Formal exception' refers to formal smoke-free legislative provisions that suspend the smoke-free workplace general rule and permit smoking by a defined class or patients or in the designated smoking room in hospital care institutions. *Policy exception* 'Policy exception' refers to smoke-free policies that suspend the smoke-free workplace policy general rule and permit smoking in MHIF. *Other exceptions* 'Other exceptions' includes semi-formal or informal measures used by MHIFs and/or staff to permit patient and/or staff smoking on or off the facility site or the hospital grounds.
Hospital care institutions	Premises used to provide hospital care in accordance with the Health and Disability Services (Safety) Act 2001, section 58(4) See Smoke-free Environments and Regulated Products Act 1990, s.2. (1). Hospital care institutions must comply with the relevant services standards in section 9 of the Health and Disability Services (Safety) Act 2001.
Mental health and addiction inpatient facilities (MHIFs)	For my study, MHIF refers to the mental health and addiction inpatient facilities operated by DHBs during the years 2000 to 2020. Note 'psychiatric hospital' is used for the years 1930 to 1999.
Patient	For my study, 'patient' refers to people who experience or have experienced mental illness, and who use or have used mental health inpatient facilities and who smoked tobacco during their inpatient care and/or were or might have been exposed to second-hand smoke during their inpatient care.

Term	Definition and explanations
Psychiatric hospitals	In my study, this term refers to hospitals that provided inpatient care for patients diagnosed with mental illness between 1930 and 1999. Note: the term mental health inpatient facilities is used during the years 2000 to 2020.
Second-hand smoke (SHS)	SHS is defined 'as the smoke emitted either from the burning end of a tobacco product or by the exhalation of smoke-filled air by a smoker, both of which contain known human carcinogens (International Agency for Research on Cancer [IARC], 2004). The ambient air in the immediate environment of a smoker quickly becomes contaminated with carbon monoxide; large quantities of particulate matter, as well as nitrogen oxides; several substances recognised as human carcinogens, such as formaldehyde, acetaldehyde, benzene, and nitrosamines; and possible human carcinogens, such as hydroquinone and cresol (IARC, 2004; U.S. Department of Health and Human Services, 2006). As these contaminants are absorbed (and later released) by materials in the environment (e.g., furniture covering, curtains), the potential for SHS exposure lasts considerably longer than the act of smoking. No safe level of SHS exposure has been identified. Non-smokers (and smokers) become exposed to SHS when they breathe this contaminated air (IARC, 2009, p.1).

List of Abbreviations

Abbreviation	Explanation
AUT	Auckland University of Technology
AUTEC	Auckland University of Technology Ethics Committee
CESCR	Committee on Economic and Social Rights
COVID-19	'CO' stands for corona, 'VI' for virus, 'D' for disease, '19' for 2019
DSR	Designated smoking room
DHBs	District Health Boards
FCTC	Framework Convention on Tobacco Control
HRA	Human Rights Act 1993
HRBC	Henry Rongomau Bennett Centre
HSEA	Health & Safety in Employment Act 1994
HSWA	Health & Safety at Work Act 2014
ICESCR	International Covenant on Economic, Social and Cultural Rights 1966
MHC	Mental Health Commission
MHF	Mental Health Foundation
MHIF	Mental Health Inpatient Facilities
NZPHDA	New Zealand Public Health and Disability Act 2000
OIA	Official Information Act 1982
OIR	Official information request
PSB	Partial smoking ban
PMI	People with experience of mental illness
SF 2025	Smoke-free 2025
SHS	Second-hand smoke
TSB	Total smoking ban
WHO	World Health Organization

Chapter 1 Introduction

In the lightness of the dark

1.1 Purpose of study

Globally, there is considerable concern about the detrimental effects of smoking and exposure to second-hand smoke (SHS) on people's health and wellbeing (U.S. Department of Health and Human Services, 2020). Nation-states implement tobacco control demand, supply, and harm reduction strategies in response. These include legislation and policies to establish smoke-free environments and protect people from smoking and exposure to SHS. However, in Aotearoa New Zealand, smoke-free legislation requires the implementation of smoke-free indoor environments while also providing discretion for hospital care institutions to establish designated smoking rooms (DSRs).

This study focused on Aotearoa New Zealand. During the first two decades of the 21st-century, DSRs and other smoke-free policy exceptions have been operational in District Health Board (DHB) mental health inpatient facilities (MHIFs). In contrast, patients in the general hospital wards received care in smoke-free hospital indoor environments. In this mental health inpatient context, my study purpose was to:

- contribute to an understanding of the impact of exceptionalist smoke-free law, policies, and practices to the field of public health policy, tobacco control policy, mental health, and law.

I was curious about the use of exceptionalist smoke-free policies and practices and the implications for patients, staff, and Smoke-free 2025 (SF 2025) (the Aotearoa New Zealand Government's aspirational goal to reduce smoking prevalence and tobacco availability to minimal levels by 2025).

This chapter introduces the purpose and rationale for my study and my research focus. I include an overview of the research contributions and significance of the study, and conclude with an overview of my thesis structure.

1.1.1 Statement of research questions

Central to my study is a fundamental question about the worthiness of human life: the lives of people who smoke, those exposed to SHS and are patients in the care of MHIFs located in hospital care institutions.

Specifically, in my research, I examine:

- the rationale for smoke-free policy exceptions in District Health Board mental health inpatient facilities
- the impact of these exceptions for patients and staff in these facilities
- the impact of these exceptions for the national SF 2025 aspirational goal

The international literature I use is drawn mainly from Australia and Great Britain. As with Aotearoa New Zealand, these countries are Commonwealth jurisdictions and provide government-funded mental health inpatient facilities where patient and staff smoking has also occurred in the first two decades of this century.

1.2 Background to research

1.2.1 The big bright beacons of my inquiry

My background has influenced my topic choice.

My childhood and teenage experiences give me a radar for and a curiosity about human decisions and behaviours that discriminate and treat people differently, a desire to understand why people treat others in this way, and a commitment to social justice and the promotion and advancement of human dignity.

I was the curious and questioning child in a very busy farming family. Working with the land had a greater value and priority than 'having my nose stuck in a book' or wanting to know more about pretty much everything around me. Being that child left me with a sense of difference and an awareness of human behaviours which privilege individuals or groups over others and silence inquiry.

Growing up in the Waikato district in the 1950s and 1960s was a smoke-free experience for me. My Mum never smoked. She said that it was a filthy habit. My Dad, a teenage

smoker, said that he could not afford to smoke and be married. My experience was different from other local farming families because so many dads smoked tobacco. Some were well versed at rolling cigarettes as they drove their tractors down the farm. My favourite schoolteacher smoked a pipe, though never in our classroom.

Going to high school changed my smoke-free environment. My peer group smoked, and they introduced me to smoking. Cigarette smoking was the typical, socially acceptable, and desirable thing to do indoors and outdoors, even though we were younger than the legal age to purchase cigarettes. I recall niggling doubts about whether smoking was good for me because I played many sports and, somehow, smoking did not seem healthy. To reconcile this contradiction, I smoked Pall Mall Menthol, the white paper, white filter cigarettes in a green and white packet that had the look and message of 'being attractive and healthier' than the other brands. As intended by the manufacturer, I associated the menthol with cleanliness, and as I inhaled the smoke into my lungs, the presence of menthol seemed to soften the harshness of smoke as it went down my throat.

Cigarette smoking, particularly roll-your-own cigarettes or 'rollies', was normal and expected at university. At the end of my first year in 1971, I worked at a vacation job at Tokanui Hospital, the local inpatient psychiatric hospital south of Hamilton. Working here was my first experience in a workplace where so many people smoked: all occupational groups and the patients. I did not think too much about smoking or that it was in a hospital setting. No one questioned the smoking or complained about it.

After graduation with a social science bachelor's degree, I returned to Tokanui Hospital for a research role in the Alcoholism Treatment Unit. Entering the ward was a daily exercise in 'running the gauntlet' through the patients' plumes of indoor SHS. Smoke clouded the group therapy sessions. In hindsight, I realise that my research did not include patient smoking. Smoking was not on the research radar. Although some staff complained about the smoke smell in group therapy, I do not recall conversations about any contradiction between smoking cigarettes and doing that in a hospital. It was a normal thing for anyone to do.

From 1977 to 1993, I worked in mental health and addiction services. Patients and staff smoked inside and outside the facilities. Sometimes people complained about the smell of smoke and the dead butts, but smoking was an allowable activity.

In 1981, I completed a 12-week residential alcoholism counselling programme at the national alcoholism treatment centre, located at Queen Mary Hospital in Hanmer Springs, Aotearoa New Zealand. I recall that patients and staff smoked inside the facilities and hospital grounds. Yet, while the hospital's clinical focus was alcoholism addiction treatment, there was no nicotine addiction treatment. Smoking was what people did.

Perhaps, not surprisingly, my desire to know more about pretty much everything around me drew me to jurisprudence. In 1997, I began the study of law at the University of Waikato in Hamilton. The Law School's three founding principles of law in the context of society, bi-culturalism, and professionalism informed my studies, culminating in an honours programme where I completed qualitative research in health, human rights, and social justice. I graduated with a Bachelor of Laws (Hons) in 1999. In the same year, I completed professional legal studies followed by admission to the roll of barristers and solicitors of the High Court of New Zealand.

Following law teaching at the University of Waikato, I returned to a mental health and addictions inpatient service (the service) located within a large base hospital in 2007. The service had 80 beds. My role was to support patients and staff to become smoke-free. I was excited. Health policy and addictions were two areas where I had worked. Further, the facility's smoke-free goal aligned with the broader organisation's objectives, and there was good evidence to support smoke-free inpatient facilities.

Importantly, this job aligned well with my professional background in addictions, social justice, and redressing health inequalities. Naively, I assumed that the service and the staff would be on board with the smoke-free goal. Soon after I started work, I discovered that the service was buying tobacco for the patients. I was astonished as this seemed contrary to my role and the stated rhetoric about becoming smoke-free. I was curious that the act of buying tobacco with taxpayer money did not seem to raise any concerns. I learnt buying tobacco was a regular item on the shopping list and that this practice occurred at other similar facilities.

The hospital's organisational smoke-free policy stated that the MHIFs had an exemption for a specified number of years. Although I had worked in mental health and addictions for many years, coming to this role after a time away from mental health, I was puzzled about why the MHIFs were not smoke-free. The presence of the exemption was particularly striking as staff and resources were in place to support the general hospital and its patients to become smoke-free. I was curious why the hospital would treat one group of patients and their indoor environment differently from another group of the same hospital campus.

At that time, I was an appointed member of New Zealand's Human Rights Review Tribunal (Tribunal). This role involves sitting on Tribunal hearings about alleged breaches of the law, including the Human Rights Act 1993 and the Health and Disability Code of Consumer Rights (1996) (the Code). Not surprisingly, I pondered the possibility of discrimination in different treatment between MHIF patients and general hospital patients. I wondered about possible breaches of the Code, such as Right 4, which is an entitlement to services of an appropriate standard; or Right 6, which entitles patients to be fully informed; or Right 7, which secures the right to make informed choices and to give informed consent. I was unsure if my workplace had considered these possibilities or was open to hearing about them.

Part of my role required me to provide staff education about mental health and smoking. The 2006 census data showed a higher smoking rate by mental health nurses than general nurses (Wong et al., 2007). The literature about smoke-free policy implementation emphasised the importance of supporting staff to quit smoking (Lawn & Pols, 2005). I also considered disciplinary measures for staff who smoked in the facility. I drew on my legal background. A senior staff member complained that I had raised the possibility of disciplinary actions. Subsequently, a senior staff member challenged me about my suggestion and told me in front of a colleague that "I needed a good slapping". Apart from feeling ashamed and embarrassed, I was again curious and surprised because consequences for breaches are not uncommon in policies. I was also curious about the staff's reaction because they contradicted my contracted role in implementing a smoke-free workplace.

Working in the 21st-century, in what I assumed to be an evidence-based health environment, I thought it was essential to prepare a review of the latest literature about mental health and smoking. In discussions with professional staff, I realised many were unaware that nicotine dependence and withdrawal had been diagnostic categories in the Diagnostic and Statistical Manual (DSM) since 1980 (American Psychiatric Association, 1980). I saw that the clinical staff rarely used these categories during a patient assessment; an observation reported by Sellman (2005), who observed that the medical community in Aotearoa New Zealand, was slow to respond to the evidence and the diagnostic categories. In my naïve enthusiasm, I talked about the DSM to a senior nurse who said, "Patsi, I am only interested in the patients from here up", as he gestured across his neck and then pointed to the heavens. The apparent lack of knowledge or use of DSM aroused my curiosity because the DSM is the primary psychiatric diagnostic tool. I was even more curious about the senior nurse's response. The gesture indicated that his interest was the head and not the rest of the body. He did not consider that smoking was a mental health issue, and he did not acknowledge that smoking affects physical health. Why was my curiosity heightened? Because I thought that mental health and addictions were by then in the business of treating the whole person, not just mental illness.

Turning to the law, I found that the Smoke-free Environments Act 1990 contained exceptions to allow smoking by patients who could not move or be moved by another person. Parliament's legitimation of smoking for immobile people in hospitals remained 13 years until the 2003 amendment legislation, which again provided for smoking in hospitals. How did the legislature do this? It gave the hospital manager discretion to establish DSRs subject to specific provisions. It had not occurred to me that politicians had endorsed smoking in a health setting funded by taxpayer money. I wondered what evidence they had considered. I imagined that they were briefed well about any evidence of importance to people's health and wellbeing affected by their decisions.

For me, these contradictions have remained big bright beacons. They have beckoned inquiry about the socio-political-historical context of smoking in public sector MHIFs and the rationale and implications of smoke-free policy exceptions for patients, staff, and SF 2025.

1.2.2 Professional background

My research choices were also influenced by my interdisciplinary background and commitment to human rights, social justice, and redressing health inequities. I am legally trained along with qualifications in social science, health management, and alcoholism treatment. I have front-line experience in public health policy, addictions, legal education, health management and funding, maternity, public health education, and governance. I have health policy development experience through my government appointments to health sector reference groups that contributed to Aotearoa New Zealand's primary health strategy (Ministry of Health, 2001) and the Toward Clinical Excellence series; for example, *A framework for the credentialling of senior medical officers in New Zealand*. (Ministry of Health, 2001) and *An introduction to clinical audit, peer review and other clinical practice improvement activities* (Ministry of Health, 2002). Since 2019, I have been a Government Ministerial appointment to the Aotearoa New Zealand Human Rights Review Tribunal. The Tribunal is an independent judicial body that hears claims relating to breaches of the Human Rights Act 1993, the Health and Disability Commissioner Act 1994, and the Privacy Act 2020.

1.2.3 Addressing the literature silence

Finally, my topic choice was influenced by the lack of literature about smoking and smoke-free policy exceptions in MHIFs in Aotearoa New Zealand.

In this 21st-century, there has been a growing body of scholarly literature from Australia and Great Britain about MHIFs, smoking, smoke-free policies, and exceptions. Generally, these publications fall into three categories (See Figure 1.1).

Figure 1.1

Categories of mental health and smoking literature

By contrast, in Aotearoa New Zealand, there is minimal published literature solely about each of these categories. Three publications include Aotearoa New Zealand content relevant to each category. Connolly (2009) examined the beliefs of mental health nurses about smoking by mental health inpatients. Connolly et al. (2013) also examined mental health nurses' beliefs about mental health inpatient smoking. Glover et al. (2014) explored barriers to achieving smoke-free within mental health and drug and alcohol services. Notably, although these publications include some discussion about smoke-free policy exceptions and are relevant to category three, no published scholarly literature focuses solely on the third category; MHIFs, smoking, and smoke-free policy exceptions in Aotearoa New Zealand.

In Aotearoa New Zealand, statutory smoke-free policy exceptions have existed in publicly funded hospitals since 1990. Parliament introduced DSRs in the 2003 smoke-free legislation, and 'designated rooms for smoking' remain in 2021. Thus, it seems puzzling that neither the DHBs nor the tobacco control research community has published impactful and visible research solely about category three nor expanded the research related to categories one and two.

My research is concerned with category three and thus investigates the rationale for and impact of exceptions to the general smoke-free rule for patients and staff in DHB MHIFs and the national SF 2025 aspirational goal.

1.3 Research focus

1.3.1 Research orientation

My desire to explore why DHBs applied smoke-free policy exceptions in MHIFs and the implications, along with my personal and professional backgrounds, indicated a qualitative rather than a quantitative study of smoke-free policy exceptions. I wanted to examine the insights and subjective experiences of people with expertise in the development, approval, and implementation of tobacco control and/or mental health policy rather than, for example, analysing the number of DHBs with partial smoking bans or total smoking bans.

A former law professor knew of my long-standing curiosity about why DHBs exempt MHIFs from the general rule to have smoke-free wards and grounds in hospital care institutions. He suggested examining whether Giorgio Agamben's conceptual framework of the state of exception might offer insight into the use and human implications of these exception spaces because the framework involves state power expansion and exceptionalist law making that has consequences for people subject to the powers. Further, DHB smoke-free policy exceptions might similarly involve an extension of state powers, exceptionalist lawmaking, and consequences for people. His suggestion sounded like a giant leap from my smoke-free implementation work in a hospital setting and quite remote from smoke-free exceptions, which seemed mundane compared to the extremes of national crises like earthquakes and war usually associated with the state of exception.

Agamben reasons by paradigm. He draws on the suffering of people in Nazi death camps and contends that the camp is the paradigm for analysing the violent practice of Western politics (Ross, 2012). In deciding to use the state of exception, I was aware that some readers might find it distasteful to associate the experience of mental health inpatients in Aotearoa New Zealand, with the experience of people in Nazi death camps and/or consider a paradigm derived from the gross extreme experiences in those camps, as an inappropriate lens to frame questions about cigarette smoking in MHIFs.

I was also mindful that I would be ascertaining the extent to which Agamben's framework had explanatory capacity for a real-life contemporary situation in public health policy and mental health policy in Aotearoa New Zealand. In other words, would the state of exception 'travel' in this context? It might travel, but if it did not, that would be a valuable finding because theories evolve, they are not static, and some adaption might be necessary. I found Aneybe's (2018) observation instructive: public policy research needs to focus on what is done instead of what is proposed or intended. Aneybe cautioned that explaining "political behaviour, rather than the validation of one's preferred theoretical approach should be the goal of political inquiry" (p. 17).

1.3.2 Research questions and methods

My research questions are:

- why were smoke-free policy exceptions (exceptional spaces) applied in District Health Board mental health inpatient facilities?
- what are the implications of these exceptions for patients and staff?
- what are the implications of these exceptions for SF 2025?

My methods involved:

- semi-structured interviews with 15 Participants selected using purposive sampling from people with professional experience in the development and implementation of mental health and smoke-free policies
- document study using open-access desktop Government and non-government resources, and officially requested archival Department of Health documents and DHB smoke-free policies and smoking status data
- transcription and thematic analysis of the Participants' interviews undertaken from February 2018 to March 2019
- comparison of DHB general wards and MHIFs smoking status data sets

1.3.3 Out of scope

This study is framed in public health policy, tobacco control policy, mental health, and law context. It focuses on smoke-free policy exceptions and how and why they came into being. It seeks the voices of people from various occupational backgrounds who have a depth of policy experience and insights into the development, approval, and implementation of tobacco control and/or mental health policy, including two former Members of Parliament who contributed to policy development during the Parliamentary Select Committee processes.

Out of scope are patients' voices. Rarely are patients involved in the above aspects of a smoke-free policy. I believe that patient voices must be a separate study that uniquely recognises and investigates their perceptions of the impacts of exceptions on them as the primary group of people for whom the smoke-free policy exceptions have been implemented. This focus provides options for further research.

Also, out of scope is an in-depth focus on smoke-free policy exception implications for Māori or other ethnic groups. Although the published results of the *2019/20 Annual Health Survey* indicate Māori have the highest current smoking prevalence (Ministry of Health, 2020), there is no published literature or data about MHIFs, Māori, and smoking. I strongly believe that the absence of this literature indicates the need for a separate and detailed study by Māori for Māori and informed by the Māori guidelines for Māori research ethics (Hudson et al., 2010).

1.4 Approach in this thesis

1.4.1 Positioning the research

As noted, this study about smoke-free policy exceptions is located within public health policy, tobacco control policy, mental health, and law. The smoke-free policy exceptions in MHIFs have occurred in historical, social, political, and cultural contexts over time. Writing about public health and the importance of the past, Scally and Womack (2004) suggested that we can learn a lot about what is needed to deliver public health improvements when we:

> look back at chronologies of public health history and explore the political and social factors at work behind surges in legislative activity, action on a particular issue…[and] from a 21st-century standpoint, there often seems to belong gaps between advances in knowledge or shifts in public opinion and the taking of action that results in health improvement. (p. 752)

My thesis uses chronology. This approach allows a public health policy readership to consider the factors raised by Scally and Womack (2004); and consider the relationship between events, how and why events occurred as they did, the extent to which actions promote, protect, and improve health and possible policies changes.

My thesis structure follows the conventional path of introduction, historical context, literature review, theoretical framework and methods, results, discussion, conclusion, and recommendations. However, the literature review is presented chronologically and introduces the reader to the published scholarly literature, analyses of my document

studies, including archival material, and DHB smoking status data. It is split across two chapters, with Chapter 2 giving the reader an early introduction to the historical context of smoking in MHIFs during the years 1930 to 2003. Chapter 3 reviews the literature from 2004 to 2021. Chapter 4 sets out the theoretical approach used to understand the phenomenon of smoking policy exceptions in MHIFs and details my research methods and procedures. Chapter 5 presents a thematic analysis of findings from the Participants' interviews. Chapter 6 discusses my results in the context of the reviewed literature and the theoretical approach, followed by conclusions and recommendations.

1.4.2 Positionality: My assumptions

I come to this project as a mixture of an outsider and an insider. I am Kai Tahu, and I grew up in a smoke-free whānau. Although I smoked cigarettes as a teenager, I do not smoke now. As noted, I have worked in a psychiatric hospital and in a MHIF where I observed patients and staff smoking cigarettes. I have also worked as a smoke-free coordinator tasked with supporting a MHIF to become smoke-free. Currently, I teach the undergraduate Tobacco Control course at AUT University. Reflecting on these experiences, I was aware they inform three explicit assumptions I held at the beginning of my study in 2016:

- being smoke-free is desirable
- at times, the behaviour and beliefs of staff constrain the implementation of smoke-free initiatives
- in the absence of Government commitment to the SF 2025 goal, it is unlikely that Aotearoa New Zealand will achieve SF 2025

1.5 Contributions to research and significance of this study

To my knowledge, this study is the first to examine the rationale and impact of smoke-free policy exceptions (exceptional spaces) for patients and staff in MHIFs in Aotearoa New Zealand. It extends the application of the state of exception in a health setting.

My study, which applies Agamben's lens of the state of exception, extends previous studies undertaken in a health setting and offers insights into an under-researched area of public health policy, mental health policy, and tobacco control policy. The study

findings have implications for public health, tobacco control, and mental health policymaking that seek to redress health inequities for mental health inpatients who smoke cigarettes.

This research also extends the application of the mental health and smoking research by bringing to light the previously unexamined role of the state in the 20th-century regarding the purchase, supply, and normalising of tobacco and cigarettes for patients in psychiatric hospitals, the similar 21st -century practices in DHB MHIFs, and the implications of smoke-free exceptionalist law, policies, and practices in MHIFs for patients, staff, and SF 2025.

It is almost two decades since the legislature permitted the exceptional spaces of designated smoking rooms in hospital care institutions. Historical practices and accompanying structures associated with continued normalised smoking in MHIFs mean that a study of exceptional spaces in MHIFs is timely and relevant.

1.6 Schematic overview of thesis structure

Several factors influenced the structure of my thesis:

- the Auckland University of Technology Postgraduate Handbook structure for thesis chapters
- presenting public health policy readers with the historical context at the start of the thesis
- use of chronological order in the historical context and literature review chapters
- the organisation of my discussion using five headings, with the first four providing the platform for the fifth, which then examines explicitly the extent to which the state of exception framework provides understanding and/or offers insights about the rationale for and the impact of the smoke-free policy exceptions

1.6.1 Guide to thesis

Introduction

In this chapter, I introduce the purpose and rationale for my study and my research focus. I include essential terminology to assist the reader, an overview of the study's research contributions and significance, and conclude with an overview of my thesis structure.

Historical context

In this chapter, I examine the socio-political foundation of the smoking culture existing in psychiatric hospitals from 1930 to 1999. Using national archives documents, official information from DHBs, and published local and international literature, I show that smoking was normalised, acceptable, and largely unquestioned and set the scene for 21st-century exceptionalist smoke-free legislation and policies (exceptional spaces) in MHIFs.

Literature review

In this chapter, I draw on national and international published literature to examine the physical and mental health implications of smoking for people with mental illness; Aotearoa New Zealand's 21st-century smoke-free legislation, policies, and practices; along with widely held beliefs that permit smoking by and expose patients, and to a lesser extent, staff, to SHS while in exceptional spaces of smoking in state MHIFs. I critique the gaps and silences about smoking by patients in MHIFs in the published Aotearoa New Zealand literature and research, and I provide an overview of SF 2025, the Aotearoa New Zealand Government's national smoke-free goal.

Research design (and methods and processes)

In this chapter, I outline the focus of my inquiry and my philosophical assumptions. I introduce Agamben's state of exception, its applications, and outline its relevance to my research questions. I provide the reader with a schematic diagram to introduce key aspects of the state of exception. I record my ethical considerations, outline my Participant selection and recruitment process, and identify my data collection strategy and processes, including interviews with the 15 study Participants.

Building blocks of exception

In this chapter, I present my findings from interviews undertaken between February 2018 and March 2019. These findings relate to my Participants' experiences and perceptions from their varied roles in developing and implementing policies concerning smoking, exposure to SHS, smoke-free exceptions for MHIF patients, staff, and SF 2025.

Pointers of exceptional spaces: Discussion and conclusion

In this chapter, I furnish my interpretation of the findings organised under five themes. I present the significance of my research, and I outline the limits of the present research. I present implications of my findings for the state, public health, mental health, and tobacco control policy; and for the state, practice, research, and theory and methods. I conclude with a thesis summary and concluding reflections.

1.7 Chapter review and summary

In this chapter, I have provided the purpose and rationale for my study and research focus. I have outlined my personal and professional background and positioning as a researcher, the significance of the research contribution, the rationale for the structure of this thesis, and an overview of the thesis structure.

Chapter 2 Historical Context

Smoke-free policy exceptions in 21st-century DHB MHIFs are historically situated and did not occur in a vacuum. For example, throughout the preceding century, smoking by patients and staff in MHIFs was an everyday, taken-for-granted, and typical behaviour. Smoking was acceptable, unquestioned, and endorsed by the state.

How smoking became central to patients' and staff's daily lives and set the scene for smoke-free policy exceptions requires examining the temporal, societal, legal, and policy contexts of smoking concerning the wider society and MHIFs.

In this chapter, I examine the socio-political foundation of the smoking culture existing in psychiatric hospitals from 1930 to 1999. Using national archives documents, official information from DHBs and published local and international literature, I show that smoking was normalised, acceptable, and largely unquestioned, and set the scene for 21st-century exceptionalist smoke-free legislation and policies (exceptional spaces) in MHIFs.

2.1 Normalisation of smoking

Before World War 1, cigars and pipes were the predominant ways of smoking tobacco; by 1950, however, cigarettes were the most popular. Normalisation is a helpful concept to examine how this resulted, and it refers to the acceptance and tolerance of smoking, primarily cigarettes. It is evident through the visibility of private and public smoking of cigarettes and tobacco products, media portrayal, the availability and promotion of tobacco products (Hudson & Thomson, 2011), and the uptake and continuation of smoking.

The parameters of normalisation provide an overview of the following considerations:

- how cigarette smoking became a very socially acceptable and widespread activity in the western world
- the extent to which this wider societal acceptance complemented and strengthened the culture of tobacco smoking in MHIFs
- the possibility that the established history of smoking eased the way for smoke-free policy exceptions

2.1.1 Promotion of cigarette smoking

The social acceptance of cigarette smoking was the outcome of a combination of the following factors.

Mechanisation: High-speed machines and lighters

In the early part of the century, mechanisation resulted in high-speed machines that produced more and cheaper cigarettes. Simultaneously, the mass production of matches and, subsequently, mechanical lighters offered speed and convenience to smokers (Proctor, 2011). Cigarettes and matches were significant to the expeditionary forces in World War 1 because cigarettes "were easier to light and quick to finish while standing, marching or …shooting" (Proctor, 2011, p. 45) than were pipes and cigars.

World War 1

World War 1 (the War) played a crucial role in popularising cigarettes (Smith & Malone, 2009). Members of the forces were supplied free cigarettes by Governments (Clark, 2003) and could buy cigarettes at low prices (Diehl, 1969). Consequently, cigarettes became known as the soldier's smoke, and famsily members in New Zealand readily included them in parcels to troops overseas.

During the War, the uptake of cigarette smoking subsequently resulted in millions of soldiers addicted to cigarettes. On returning home, they continued to smoke as smoking became increasingly normalised throughout their countries (Ballard, 2004).

Not surprisingly, tobacco consumption and smoking prevalence increased significantly by the end of the War. For example, in the United States, cigarettes per capita consumption almost tripled from 1914 to 1918 (Proctor, 2011).

During the War, several themes normalised smoking for the forces. For example, both advertising and print media presented smoking as a psychological escape, to reduce the burden of the situation, as an act of solidarity and collegiality, as the only remaining pleasure and relief from the suffering, and as a relief from boredom (Goldsack, 2004). These themes are salient because they are very similar to those used to endorse and normalise smoking in MHIFs (Glover et al., 2014; Lawn & Campion, 2013; Moss et al., 2010).

Flue-cured tobacco

Before World War 1, cigars and pipes were the popular forms of smoking tobacco. When inhaled, however, the smoke was harsh on the throat and smokers rarely inhaled. The introduction of flue-curing changed the smoking experience because this method of drying tobacco leaves involved heated air and produced leaves with higher sugar content and less harsh smoke (Proctor, 2011).

Easy inhalation was significant for an interplay of health and commercial reasons. It increased the possibility of addiction because nicotine, the addictive substance in the smoke, is transported to the lungs. The lungs have larger areas for nicotine absorption than the mouth and tongue (Proctor, 2011). Once addicted, smokers continued to smoke cigarettes. They were then vulnerable to bronchitis, emphysema, and lung cancer from the carcinogenic tar in the smoke (US Department of Health and Human Services, 2014).

In recognising the potential commercial benefits of *smoother smoking*, the tobacco industry developed a series of advertisements that featured celebrities (See Figure 2.1) and appeals to science that promoted the cigarettes' mildness. The industry also used problem-solution advertising, which depicted known problems such as coughing when smoking or the harsh feeling of inhaled smoke on the throat. The advertisements included the solution to smoke a particular cigarette brand that claimed to alleviate or avoid these problems. (see Figures 2.2 and 2.3) In other words, advertising promoted inhalation.

By the 1930s, advertising endorsed deep inhalation, an act bestowed with an "aura of sexual gratification" (Proctor, 2011, p. 35). Of significance to my research, smokers in MHIFs who inhaled deeply ingested more nicotine and carcinogens in their lungs and faced the likelihood of reduced life expectancy (US Department of Health and Human Services, 2014).

Figure 2.1

Celebrity promotes smoother smoking

Note: Celebrity promoting smoke benefits. From *Stanford University Research into the Impact of Tobacco Advertisements* by Stanford University n.d. (http://tobacco.stanford.edu/tobacco_main/index.php)

(See http://fairuse.stanford.edu/overview/fair-use/what-is-fair-use/)

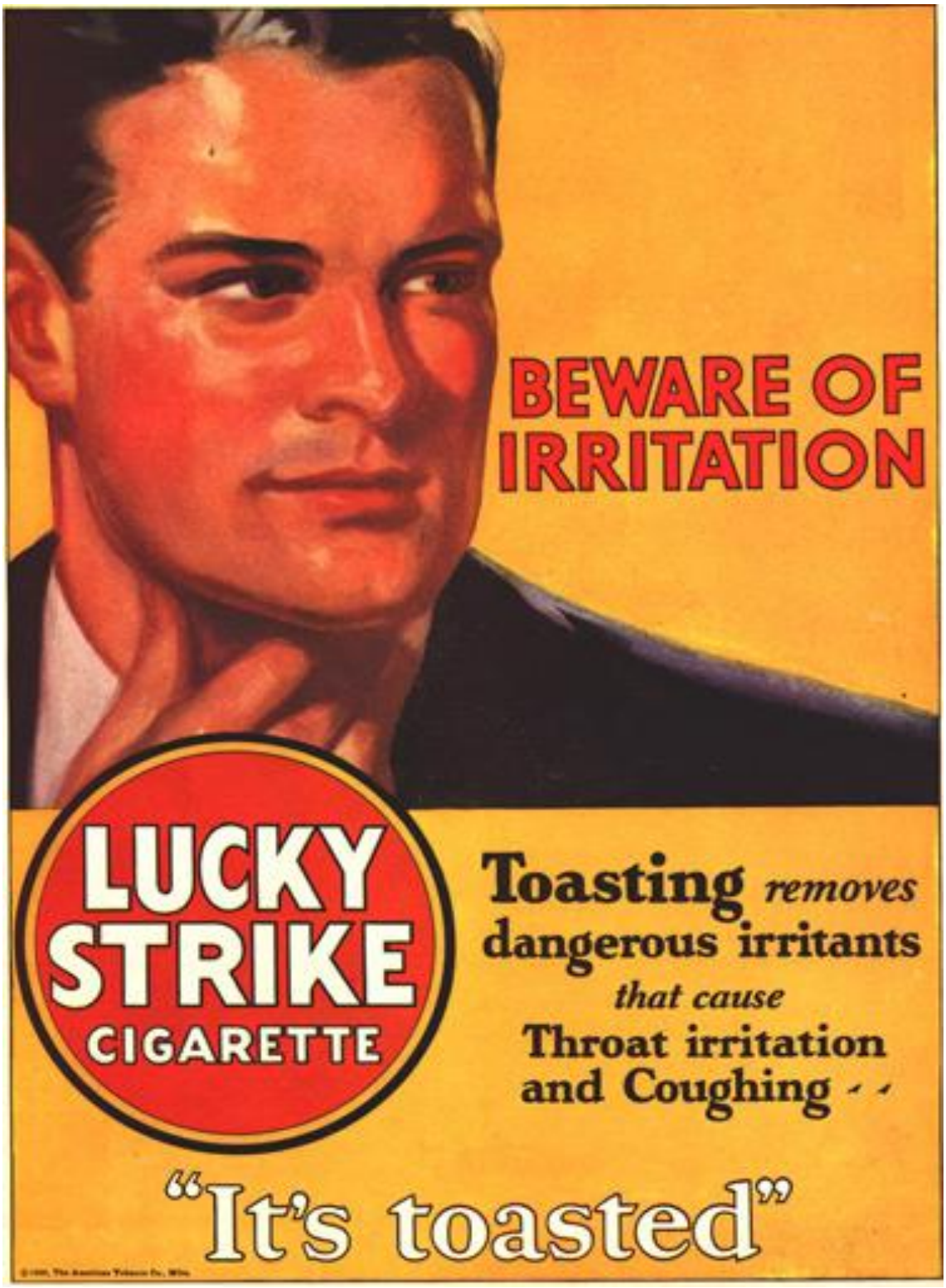
Figure 2.2

Your Adam's Apple

Note: Product problem alleviation. From *Stanford University Research into the Impact of Tobacco Advertisements* by Stanford University n.d. (http://tobacco.stanford.edu/tobacco_main/index.php)

Figure 2.3

Guard your throat



Note: Product problem alleviation. From *Stanford University Research into the Impact of Tobacco Advertisements* by Stanford University n.d. (http://tobacco.stanford.edu/tobacco_main/index.php)

Advertising and campaigns

Sophisticated advertising also played a crucial role in promulgating cigarette smoking in the first half of the 20th-century. The images and words presented smoking as a liberty as in freedom to choose and as the rational choice of an informed adult. Advertisers targeted men and women; emphasised values like individual autonomy and the freedom to smoke in social and public settings; and portrayed smokers as appealing, desirable, and sexy. Advertisements showed smoking as comforting relief for stress and boredom and very acceptable behaviour. Social etiquette centred on the protection of smokers, and it was unfair for non-smokers to decide where smoking should occur (Brandt, 2004).

Although lung cancer rates steadily rose during the first half of the century (Doll & Bradford Hill, 1950), scientists had not established the causal link between cigarette smoking and lung cancer. Relevant to my research, tobacco advertisements from the 1920 to 1940s featured doctors and nurses in hospitals or clinical settings (See Figures 2.4 and 2.7). The advertisements contained health themes such as the *science and safety of tobacco, advice* to patients, *truth and facts*, and references to the *trusted health professional*. Non-health themes included "pleasure, satisfaction (a proxy for satisfying nicotine craving), ritual/habit, sociability, attractiveness/style and sex appeal" (Jackler & Ayoub, 2018, p. 1360).

Figure 2.4

Nurses and smoking

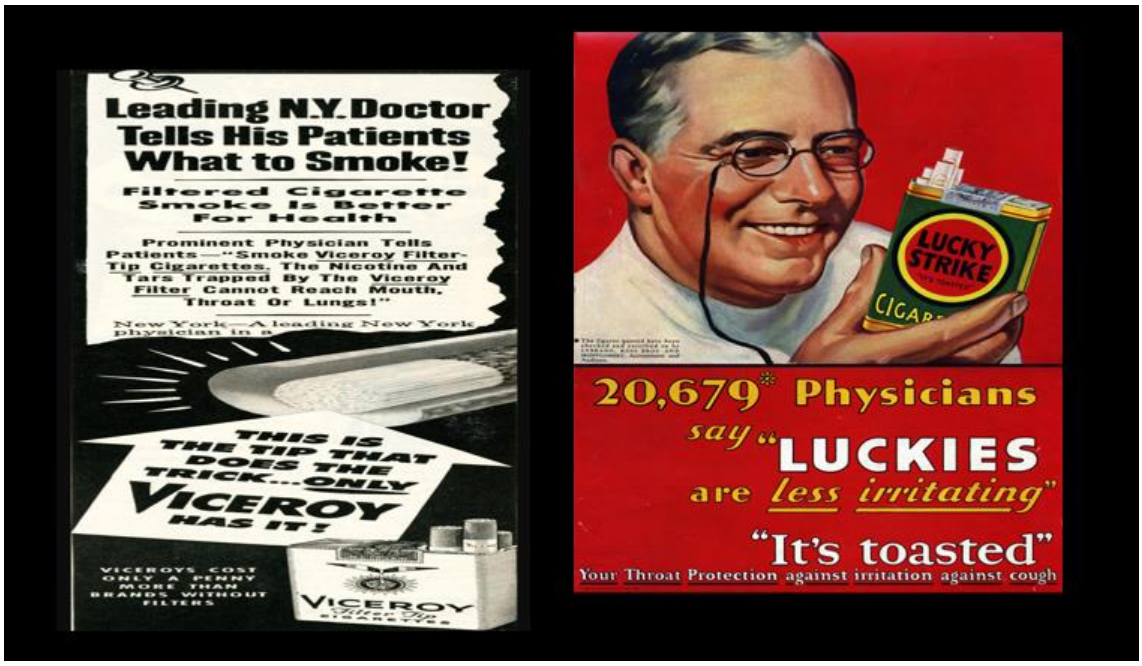
Note: Nurses promoting smoking. (From *Stanford University Research into the Impact of Tobacco Advertisements* by Stanford University n.d. (http://tobacco.stanford.edu/tobacco_main/index.php)

Tobacco companies featured doctors in several high-profile cigarette advertising campaigns. These promotions gave public assurances about product safety from trusted authority figures (Gardner & Brandt, 2006) and used medical science to inform the public about the apparent merits of smoking *toasted* or *flue-cured tobacco* (See Figure 2.5).

Advertisements featuring doctors also appeared in reputable medical journals. In an analysis of doctor-targeted tobacco advertisements in two prominent American medical journals from 1936 to 1953, Jackler and Ayoub (2018) concluded that "tobacco companies targeted physicians as a potential sales force to assuage the public's fear of health risks and to recruit them against negative publicity" (p. 1345).

Figure 2.5

Product assurances

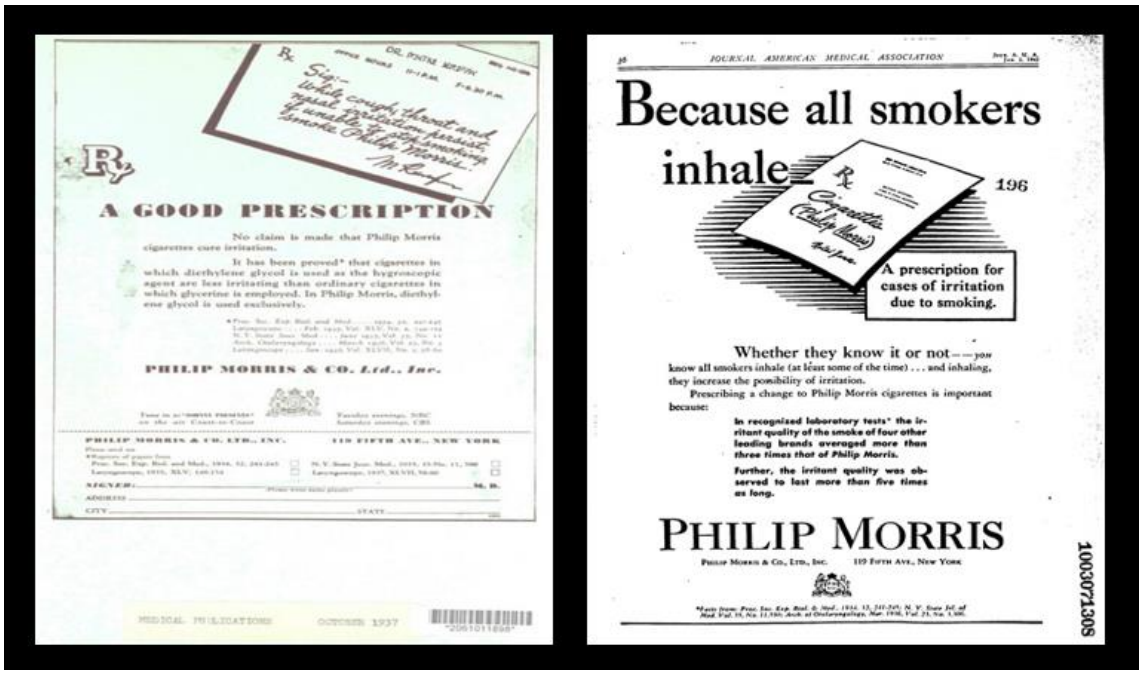


Note: Doctors providing product assurances. From *Stanford University Research into the Impact of Tobacco Advertisements* by Stanford University n.d. (http://tobacco.stanford.edu/tobacco_main/index.php)

Doctors used the clinical practice of prescribing to promote cigarettes to patients (See Figure 2.6). The tobacco industry advertisements explained why a particular brand of cigarettes offered greater therapeutic value than another, and therefore switching brand was desirable. In addition, smoking was normalised by attributing it with medicinal and therapeutic value. For example, like prescribed medicines, providing health reassurance to the patient, and using the doctor's authority to legitimise cigarettes.

Figure 2.6

Prescribe our brand

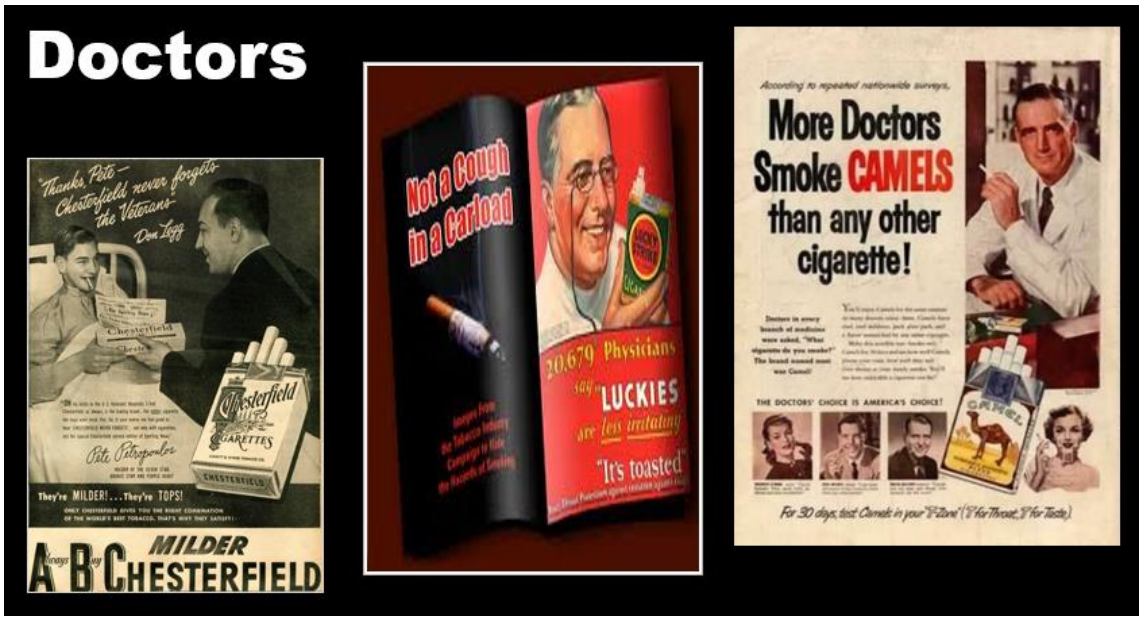


Note: Doctors providing product assurances. From *Stanford University Research into the Impact of Tobacco Advertisements* by Stanford University n.d. (http://tobacco.stanford.edu/tobacco_main/index.php)

The 'More Doctors' campaign showed doctors smoking and stated that "more doctors smoked camels than any other cigarette" (S43eee Figure 2.7)—again, offering the doctor's trusted view (Proctor, 2011).

Figure 2.7

Doctors and smoking



Note: Doctors promoting smoking. From *Stanford University Research into the Impact of Tobacco Advertisements* by Stanford University n.d. (http://tobacco.stanford.edu/tobacco_main/index.php)

By the 1930s to 1940s, most doctors smoked cigarettes, and reputable medical journals such as the *Journal of the American Medical Association* and the *New England Journal of Medicine* featured tobacco advertisements. Tobacco companies offered sponsorship and free cigarettes at medical conventions. To illustrate, the Liggett & Myers tobacco company paid the *New York State Journal of Medicine* to promote its Chesterfield brand with the message "pure as the water you drink… practically untouched by human hands [while advertising claimed] that 20,679 physicians found Luckies less irritating to the throat" (Proctor, 2011, p. 67).

Social acceptance

By the 1940s, cigarette smoking was a highly normalised activity in the Western world. Although smoking's health hazards remained largely unsuspected during the first half of the 20th-century (Doll, 1998), the above factors contributed to the rise in the popularity of cigarettes and smoking prevalence.

Smoking was constructed as a highly desirable, social, pleasurable, safe, and sanctioned behaviour in public and private settings. Cigarettes were also widely available and advertised legal products. By the mid-1950s, more than 50% of men and 35% of women smoked in New Zealand (Hay, 1993).

Smoking was perceived as a harmless recreational behaviour and unbounded by social rules that exempt any groups of adult citizens from smoking in public or private. In general society, there was permission and space for smoking. What was the situation for patients and staff in MHIFs?

2.1.2 The state, psychiatric hospitals, and smoking

Specific details about smoking in psychiatric hospitals during the 20th-century have been overlooked in the few scholarly publications about mental health and smoking in Aotearoa New Zealand (Connolly 2009; Connolly et al., 2013; Glover et al., 2014; Goldsack, 2004; Marlowe & Paynter, 2015; Nordin et al., 2015; Sellman, 2005; Sewell 2010). However, analysis of documents from 1930 to 1970 held by New Zealand Archives reveals that smoking by inpatients was a normalised and accepted behaviour. Further, from the 1930s until the late 1970s, state health institutions' purchase or supply of tobacco to patients was institutionalised and organised by a gratuity and a patient comforts allowance.

1930s: Tobacco as a gratuity

Before introducing Social Security Benefits in April 1939, the Department of Health supplied a gratuity of tobacco, rather than money, to male patients who smoked, worked, and had no personal or other income means. The tobacco gratuity operated as follows:

> Cigarette papers were not supplied, and patients smoked clay pipes… Tobacco was all of one grade – 1oz plugs and as patients were not allowed to have knives, wards were equipped with tobacco cutters. The issue was strictly controlled from Head Office and patients were classified for issue purposes into:
>
> | | |
> |---|---|
> | Good workers | 2oz per week |
> | Medium workers | 1.5oz per week |
> | Poor workers | 1oz per week |
>
> (Department of Health [presumed], 1971).

The quantity of tobacco received by patients was related to work performance, suggesting that the Department of Health and patients regarded tobacco as an acceptable reward. Women and non-smokers did not receive an equivalent financial gratuity (Department of Health [presumed], 1971a).

While there is no indication about the rationale for the gratuity, it is reasonable to speculate that a critical factor was to support former World War 1 soldiers' needs, including their smoking behaviours. The existence of a tobacco gratuity is pertinent to my research, and it reveals that tobacco was more than a work reward. It was also an accepted and normalised part of life for this group of patients in psychiatric hospitals, reflecting the following characteristics of normalisation:

- the state and its psychiatric hospitals endorsed tobacco smoking by patients. The central state institution responsible for citizens' health, the Department of Health, funded and supplied tobacco for use by the patients.
- tobacco was treated as a form of currency and used to reward work, performance contingent upon judgments about a worker's abilities.
- smoking, as formalised via gratuity, was more valued than non-smoking.
- the state gratuity supported patients' nicotine addictions.
- by using the tobacco cutters, psychiatric hospital staff actively assisted patients using tobacco.

1947: Patient comfort fund: Autonomy, choice, and independence

By 1947, smoking was a normalised and institutionalised practice in psychiatric hospitals. The hospitals controlled patients' access to tobacco which contrasted with general society where people who smoked were not subjects of such institutionalised arrangements. They were free to make their own purchasing decisions.

As part of the 1947 reforms of mental hospitals, reformers sought to make the psychiatric hospital patient experience as much like everyday community life as possible (Brunton, 2003). Subsequently, the Department of Health established a *Comforts Fund* (the Fund) to provide certain comforts to patients. The funding mechanism involved "a certain sum each year voted to [the Mental Hygiene Division] then allocated to each

Mental Hospital on a per capita basis calculated on the total patient population" (Lilly, 1957, p. 1).

The Fund was for patients without means to provide comforts. Materially, it was to be used for items such as "cakes, sweets, cigarettes etc or rations or fitting out with some special article of clothing normally not provided from the usual Departmental expenditure" (Lilly, 1957 p. 1). The hospital medical superintendent had discretion about who received the Fund.

The Fund involved a Branch representative of the District Public Trustee choosing a local storekeeper who was "authorised to supply goods to the patient to the value of 2/6d per week" (District Public Trustee, 1948, p. 1). A hospital attendant undertook the purchase and provided the shopkeeper with a docket marked with the psychiatric hospital stamp. In turn, the shopkeeper submitted the docket to the appropriate Department of Health District Office for payment at the end of each month (District Public Trustee, 1948).

What was the significance of this Fund? The Fund's introduction continued the state's role in purchasing and supplying tobacco to patients in psychiatric hospitals. Relevant to normalisation, cigarettes were in the same class as food and clothing; items regarded as 'normal and everyday items' required by people.

Significantly, the state classified cigarettes as a comfort, a term associated with stress relief and a theme that fitted neatly with the preceding decades of cigarette advertising which promoted cigarettes as a comfort and stress relief (See Figure 2.8). Arguably, smoking was now inextricably linked to psychiatric hospitals and patients, and the notion that tobacco smoking had therapeutic value.

Figure 2.8

Comfort and stress relief

Note: Promoting stress and comfort themes (SRITA). From *Stanford University Research into the Impact of Tobacco Advertisements* by Stanford University n.d. (http://tobacco.stanford.edu/tobacco_main/index.php)

By 1949, as with smoking by people in general society, smoking by patients in psychiatric hospitals was a normalised and accepted behaviour. However, the difference was that state health institutions supplied and funded the tobacco for patients. While none of the archival documents refers to any health issues associated with smoking, that is, perhaps, not surprising. The research had not established the link between smoking and lung cancer. The question arises: when the research became available in the 1950s, what was the impact on the well-established normalisation of smoking in MHIFs and general society?

2.2 1950-2003: Denormalisation of smoking: Mental health inpatient facilities an exception

Denormalisation of smoking challenges the idea that smoking is normal and acceptable. It refers to the *erosion of community acceptance and tolerance for smoking* (Winstanley & Wood, 2012, 5.24, as cited in Scollo & Winstanley, 2014); in other words, the weathering away of normalisation. For my research, examples include introducing smoke-free indoor environments, reducing the visibility of cigarette smoking and tobacco products in public and private settings, media portrayal, the availability and promotion of cigarettes, and the uptake and continued smoking of cigarettes.

The following section examines the parameters of denormalisation to provide an overview of the following:

- how smoking became a socially unacceptable behaviour in general society
- whether a similar unacceptance occurred in MHIFs
- the possibility that the legislature laid a strong foundation for 21st-century smoke-free policy exceptions in MHIFs

Science played an influential role in the denormalisation of cigarette smoking. Between 1950 and 1980, several seminal papers and reports presented scientific evidence about the physical health consequences of cigarette smoking and exposure to SHS. This evidence met with opposition from the tobacco industry and provided a platform for global and national public health responses to tobacco use (Lopez, 1999).

At the start of the 20th-century, lung cancer was a rare disease; but by the 1920s, it was more common. Explanatory theories included smoking, the global influenza pandemic of 1918-1919, hidden effects of toxic gases in World War 1, asphalt dust, and industrial air pollution (Proctor, 2012.)

Writing about the forms of evidence that identified smoking as a major cause of lung cancer, Proctor (2012) noted that “In the middle decades of the 20th-century, four distinct lines of evidence converged to establish cigarette smoking as the leading cause of lung cancer” (p. 87). In summary, population studies in the 1930s and 1940s investigated increased lung cancer and cigarette smoking. Muller found that “people with lung cancer were far more likely to have smoked than non-cancer controls to have

smoked" (as cited in Proctor, 2012, p. 87). In the 1950s, published epidemiological studies confirmed Muller's finding (Doll & Hill, 1954; Hammond & Horn, 1954, cited in Proctor, 2012). Animal experiments linked tar from cigarette smoke with tumours on animals (Wynder et al., 1953 as cited in Proctor, 2012), cellular pathology confirmed that smoking damage occurred at the cell level (Hilding, 1956 as cited in Proctor, 2012), and cancer-causing chemicals were found in cigarette smoke (Fishel, 1947 as cited in Proctor, 2012).

Despite the strength of the smoking and lung cancer association, the medical community was slow to respond, until 1962 when the Royal College of Physicians (1962) published its report *Smoking and Health*. This report was described as "the seminal event that finally established in the public mind the extent of the impact of smoking on health" (Royal College of Physicians, 2012, p. 1). It was "intended to give doctors and others evidence on the hazards of smoking, so they may decide what should be done" (Royal College of Physicians, 1962, p. S2).

Similarly, in 1964, the United States Surgeon-General (USSG) released *Smoking and Health: Report of the Advisory Committee of the Surgeon General of the Public Health Service,* the first in a series of reports about smoking (US Department of Health, Education and Welfare, 1964). The report linked smoking and specific diseases and recorded that smoking was causally related to men's lung cancer. Described as "a turning point in the broader public recognition of tobacco hazards" (Proctor, 2011, p. 238), this report is regarded as a landmark document (United States Department of Health and Human Services, 2014).

In 1972, the USSG referred to the health hazards of SHS exposure (USDHEW, 1972 as cited in U.S. Department of Health and Human Services, 2014). By the early 1980s, published research suggested the possibility of SHS playing a causal role in lung cancer (Hirayama, 1981; Trichopoulos et al., 1981). Regarding Hirayama's research, Hong and Bero (2002) described it as "influential because it launched an extraordinary amount of critical debate" (p. 1413), and the tobacco industry tried to invalidate the study.

Arguably, the SHS research was significant for subsequent public health initiatives. It paved the way for tobacco control strategies, including the initial smoke-free indoor environment legislation and hospital smoking policies in Aotearoa New Zealand.

Notably, the legislation and policies focused on harming others from exposure to SHS rather than harm to self from individual smoking, which was considered a matter of individual choice.

2.3 Psychiatric hospitals and smoking: Business as usual

As noted, by 1949, smoking by people in general society and smoking by patients in psychiatric hospitals were normalised and accepted behaviours. As scientific evidence emerged about the physical health effects of smoke and SHS, smoking became increasingly denormalised in general society. Still, it continued to be a normalised behaviour in psychiatric hospitals for the remainder of the century. How can we understand these diverse pathways?

2.3.1 Improving the smoking experience

During the 1950s, the Department of Health increased the Fund's allowance and changed the tobacco types available to patients. For example, it introduced flaked pipe tobaccos and finely cut cigarette tobaccos. These changes to the cuts improved the smoking experience; the flaked tobacco retained its freshness and was more smokable. Cut and fine cut tobacco, commonly known as loose-leaf tobacco, were well suited for hand-rolling or roll-your-own-cigarettes, which were popular ways of smoking tobacco among patients.

In recording the success of what was a normalisation initiative by the state, a Department of Health document records, "although these were packaged in specially branded N.Z.G. [New Zealand Government] cartons, these proved a very popular innovation" (Department of Health (presumed) n.d., p. 2). The same document also records that:

> In the absence of any official policy of gratuity payments tobacco was commonly issued to Section Heads in addition to any quantities sent to ward areas and these special issues were used in many cases as rewards for work done. (p. 2)

2.3.2 Review of gratuities, comforts, and free issue tobacco

In October 1969, the Department of Health signalled the need to review the patient gratuities and comforts system and the free issue of duty-free tobacco. Addressing duty-free tobacco, the Department of Health presents a valuable historical account of several administrative and other issues. Relevant to my research, the letter records, "It has been traditional for duty-free tobacco to be issued to patients without funds" (Department of Health, 1969, p. 4) and that problems with the tobacco issue system included:

- the system was hard to control and was abused
- some psychiatric hospitals issued tobacco for work done, and others did not
- tobacco was stolen and bartered by patients
- jealousies arose because patients with money had to buy tobacco whereas those without money received the free issue
- non-smokers were unhappy that they did not receive an equivalent issue

To resolve these issues, the Department of Health (1969) proposed to end the provision of "cheap duty-free tobacco" (p. 40) and give patients a sufficient gratuity "to enable all tobacco needs to be purchased in a normal fashion, mostly from the hospital canteen" (Department of Health, 1969, p. 40). In effect, this proposal maintained and strengthened the accepted place of smoking in psychiatric hospitals by requiring the patient to buy tobacco. The free issue of tobacco ended on 1 April 1970. In its submission to the Committee of Inquiry into psychiatric services at Oakley Hospital (the Inquiry), the Department of Health reiterated the importance of its new normalised system.

> The withdrawal of the free issue of institution N.Z.G. tobacco and its replacement by the allocation to hospitals of a cash grant equivalent to the retail price of popular brands of cigarette tobacco was made as part of an overall review of patient comforts and gratuities. The new scheme which was introduced… after full discussions with all psychiatric hospitals, had as its main objective, the expansion of the payment of gratuities as an incentive to patients to occupy themselves... a further incentive was to move further away from institutional living and, as far as possible to give patients who formerly received the free issue, an equivalent amount of money so that they

> could personally exercise a choice in the same way as do people in the community generally. (Department of Health, 1971b)

The Minister of Health was more explicit about the purpose of ending the issue and increasing the financial gratuity. In a letter to a reporter, Minister Lance Adams-Schneider wrote, "The objective was to enable patients to select their own preferred brand of tobacco. It also had a therapeutic value in that it encouraged patients to learn to use money and spend it wisely" (Adams-Schneider, 1971).

In its report, the Inquiry accepted the idea that it was therapeutically sound for patients to do their shopping and recommended the continuance of the Department of Health's gratuity scheme in place of the free issue of tobacco (New Zealand Commission of Inquiry into psychiatric services at Oakley Hospital, 1971). Overall, the reviewed archival material was silent about smoking's inequitable impact on people with experience of mental illness (PMI) and/or Māori health and wellbeing.

2.3.3 Smoking remains normalised

By the 1970s, smoking continued to be a normalised and accepted behaviour in psychiatric hospitals. Cigarettes continued to be a comfort, used as a reward and incentive and were either paid for and/or supplied by the state. Tobacco and cigarettes were important to patients, and these products comprised one-third of their canteen purchases (Minister of Health, 1970).

Regarding the impact of science, the archival documents about the revision of the gratuities scheme are silent about the detrimental effect of smoking on patients' physical health in psychiatric hospitals, perhaps because physical health was not the reason for hospital admission and, therefore, not relevant. The embedded place of smoking lends itself to speculation about whether legislative accommodations or exceptions would allow continued smoking in psychiatric hospitals later in the century.

In the absence of post-1970 archival material, but given the increased gratuities, availability of tobacco at hospital canteens, and the embedded place of smoking in psychiatric hospitals, it is reasonable to think that patient smoking continued after the 1970s.

2.4 Tobacco industry responses

Medical evidence linking cancer with smoking and SHS raised concerns for health professionals and the public about cigarette smoking safety, lowered consumer confidence, resulted in declining sales and threats of litigation. In response, the tobacco industry used various tactics to resist public health initiatives and "resist smoking restrictions, restore smoker confidence and preserve product liability defence" (Saloojee & Dagli, 2000, p. 902).

The World Health Organization (WHO, 2008) report provided examples of global tactics (Proctor, 2011). New Zealand did not escape industry attention. The industry sought to assure smokers and the public that the risks of smoking were not accurate. Smoking was presented as a 'habit' rather than an addiction, thus denying the link between smoking and cancer (Thomson & Wilson, 2003).

2.4.1 Mental illness

The tobacco industry also marketed cigarettes to people with mental illness and marginalised populations. Strategies included funding research to endorse the idea that schizophrenia was less vulnerable to harm from smoking and that people with schizophrenia needed to smoke for self-medication (Prochaska et al., 2008).

A 1986 Phillip Morris advertisement for Merit cigarettes depicted a double image of a packet of Merits and text that referred to "schizophrenic" [and] "having two sides is just normal behaviour" (Prochaska et al., 2008 p. 558) (See Figure 2.9). The authors observe that although it is not clear whether the advertisement was aimed at the public or schizophrenics, the reference to *two sides* appeared to reflect the common idea of a split personality being associated with schizophrenia.

Figure 2.9

Merit cigarettes: Schizophrenic reference

Note: Merit cigarettes advertisement with headline 'Schizophrenic', depicting a double image of merit packets and including text 'having two sides is just normal'. From Prochaska, J. J., Hall, S. M., & Bero, L. A. (2008). Tobacco use among individuals with schizophrenia: what role has the tobacco industry played? *Schizophrenia Bulletin, 34*(3), 555-567. https://doi.org/10.1093/schbul/sbm117

Other approaches by the industry in the USA included giving free cigarette samples to psychiatric hospitals, providing cigarettes to mental hospitals in response to staff requests (Apollonia & Malone, 2005), and blocking smoke-free hospital policies.

Addressing common beliefs such as people with schizophrenia are unwilling to stop smoking, that smoking is a type of medication, and that cessation aggravates their symptoms, Prochaska et al. (2008) contended that these have been "some of the biggest barriers to tobacco treatment for schizophrenic patients" (p. 562). Subsequently, Prochaska (2009) identified important reasons to treat tobacco-dependent mental health inpatients.

Scholarly literature has not been found regarding similar industry activities in Aotearoa New Zealand.

2.5 Diagnostic and Statistical Manual of Disorders and smoking

Particularly relevant to my research, in 1980, the American Psychiatric Association (APA) included nicotine dependence and withdrawal in the DSM-111 (Neuman et al., 2005). The DSM is the standard classification of mental disorders used by mental health professionals. It is "considered the most important document for the diagnosis and the classification of mental disorders" (Khoury et al., 2014, p. 1). The inclusion of nicotine dependence and withdrawal in the DSM meant official recognition as medical conditions which would confer benefits such as patient coverage under health insurance in the United States. There were also implications for the tobacco industry because the classifications would pathologise a behaviour it promoted for decades as a desirable and harmless social activity. It would also impact on uptake and cessation of tobacco products.

An examination of tobacco industry documents shows that two major tobacco companies attempted to influence the APA editorial process and might have determined a narrower definition of dependence. Neuman et al. (2005) concluded that these tactics slowed "the spread of a professional and public understanding of smoking and health that otherwise would reduce smoking, smoking-induced disease, and tobacco company profits" (p. 328). Poignantly, Sellman (2005), writing about the neglect of nicotine dependence in the New Zealand clinical setting, observed that the medical community was slow to respond to the evidence and the diagnostic categories. It is likely that this clinical tardiness "resulted in multiple missed opportunities in improving the health and wellbeing of smokers with mental illness" (Nordin et al., 2015, p. 5) and, arguably, also a missed opportunity to denormalise smoking mental health inpatients. Critically, Prochaska et al. (2008) put it like this, "Might it be that the mentally ill are the largest remaining group of smokers, not because they need to smoke but rather because they are among the last to be treated?" (p. 562).

2.6 Tobacco control initiatives

From 1963 onwards, the New Zealand Government implemented a series of tobacco control initiatives in response to scientific evidence and submissions from medical organisations and non-government organisations (NGOs), including the Mental Health Foundation, Action on Smoking and Health (ASH), the Heart Foundation, and the Cancer

Society**.** The initiatives were consistent with efforts to denormalise smoking. A timeline of these initiatives is set out in Thomson and Wilson (1997) and in an online application called History of Tobacco Control (Health Promotion Agency, n.d.a).

Relevant to denormalisation was the ban on cigarette advertising on New Zealand television and radio in 1963, the tobacco industry's voluntary agreement to ban advertising in cinemas and billboards in 1973, and health warnings placed on cigarette packets in 1974.

In 1979 *tobacco prepared for smoking, chewing, or snuffing*, was classed as a toxic substance (Toxic Substances Act 1979, s 2). The classification of tobacco as toxic was an important denormalisation strategy for three reasons. First, the definition had the blessing of the legislature. Second, it opened the door to challenge the tobacco industry's inferences that tobacco was fit for human consumption. Third, as a legislative pronouncement, it had credibility and added weight to tobacco control education programmes for the health workforce.

During the 1980s, the Government increased excise tax and implemented smoking and advertising restrictions and anti-smoking campaigns. Of the other initiatives, the following are pertinent to my research. They are all indicators of denormalisation. The publications highlight the importance of evidence, which was likely to be intentional in leading up to the 1990 smoke-free legislation and the associated Select Committee hearings.

1987	The Department of Health offices became 100% smoke-free indoors (Laugesen, n.d.)
1988	The Department of Health published *The big kill – the human cost of smoking in New Zealand* (Department of Health, 1988a)
1988	The Department of Health published a discussion paper called *Creating smoke-free indoor environments: Options for action* (Department of Health, 1988b)
1989	The Government made tobacco a priority goal in the *NZ Health Charter Goals and Targets* (Department of Health, 1989)
1990	The Department of Health commissioned a review (Reinken, 1990) of the literature used by the Tobacco Institute in its response to *Creating smoke-free indoor environments* (Department of Health, 1988b)

2.7 Hospital policies about smoking

In the 1970s, following a request from the Department of Health, the State Services Commission (SSC) moved to introduce non-smoking policies into state sector hospitals.

The Hospital Boards' Association (HBA) was similarly involved and "adopted a policy recommending the restricting of smoking in hospitals and board offices" (Thomson & Wilson, 1997, p. 17). Hospital administrators' responses were described as "lukewarm in their attitudes to more effective smoking control measures in hospitals" (Hay 1972, p. 11). By 1985, however, more than 50 per cent of hospitals had discontinued tobacco sales on their premises (Morris, 1985, as cited in Thomson & Wilson, 1997); thereby reducing the products' visibility. By 1987, the Department of Health offices became smoke-free (Laugesen, n.d.).

As noted above, between 1988 and 1990, the Department of Health published three influential reports leading to the subsequent smoke-free legislation. *The big kill – The human cost of smoking in New Zealand* (Department of Health, 1988a) detailed the smoking-related hospital admissions and deaths by hospital boards, electorates, and local authorities throughout New Zealand. Notably, this report recorded that 4,920 people had died each year from smoking. *Creating smokefree indoor environments* (Department of Health, 1988b) (the Report), discussed the environmental impact of second-hand smoking, proposed the use of legislation to protect people from SHS in a hospital setting, and proposed that this type of location warranted more action. *Through the smokescreen* (Reinken, 1990), a commissioned review of the tobacco industry's use of scientific literature about SHS, found that the tobacco industry had incorrectly used the literature in trying to minimise cigarette smoke harm.

Three aspects of the Report are particularly relevant to my study.

- Minister of Health David Caygill named the hospital setting a smoke-free indoor environment in the foreword. He asked, "What can be done to ensure that everyone's health is protected by ensuring clean indoor environments in our schools, offices, hospitals and workplaces?"
- in a section that included "all area health board or hospital board buildings and public hospital facilities" (Department of Health, 1988b, p. 24), the

Government expressed its commitment to no smoking and setting a good example in its buildings.

- the Report noted that it was *contradictory* to allow smoking in an environment that treated sick people, some of whom were sick because of smoking. It also noted the difficulty experienced by health practitioners who smoked and attempted to advise about smoking harms (Department of Health, 1988b).

In the absence of other literature about smoking in hospitals in Aotearoa New Zealand, the Report offers a valuable snapshot by recording that:

> Most hospitals had some policy on smoking, and staff generally observed a smoke-free norm in areas where they are in contact with patients and visitors. Some hospitals had designated smoking rooms—staff in smoke-free hospitals were usually free to go outside to smoke if they wished. Patients generally could not do so, except perhaps psychiatric patients. Those whose mobility is most limited include:
>
> - major accident patients
> - the terminally ill
> - geriatric patients
> - psychiatric patients in a secure environment
>
> For compassionate reasons, hospitals have traditionally considered the needs of patients and relatives in distress. This has included the provision of space to smoke. (Department of Health, 1988b p. 24)

Arguably, terms like limited mobility and *distress* concerning psychiatric patients denote types of exceptions from other categories of patients and potentially invite, or perhaps justify, exceptional treatment when it comes to smoke-free policies, for example, spatial dedication in the form of designated smoking areas. Given the significance of this Report and rationale for smoke-free hospitals, the question arises: To what extent were smoke-free policy exceptions included in the subsequent legislation?

2.8 Hospitals and smoke-free legislation 1990

Parliament passed the Smoke-free Environments Act 1990 (the Principal Act) in August 1990. When introducing the Bill to Parliamentarians, the Minister of Health, Hon. Helen Clark (the Minister) referred to the health impact of smoking and highlighted the importance of denormalising smoking:

> The bill is undoubtedly the most important health legislation introduced by the Government. It is one of the major planks in achieving a smoke-free generation in New Zealand... The bill will create a social environment that encourages young New Zealanders to remain non-smokers and protects non-smokers from the effects of tobacco smoke… Every year more than 4000 New Zealanders are dying from diseases directly attributed to their smoking of tobacco, and 273 of them do not smoke at all but are dying from other people's smoke. That clearly makes tobacco smoking by far the biggest single preventable cause of death and chronic illness in New Zealand. There can be no controversy about the health consequences of cigarette consumption. (Clark, 1990, May 17. p. 139)

Generally, the Select Committee received submissions that favoured the Bill; however, there was controversy and resistance, including from Members of the Opposition. Opponents contended that smoking was a choice, and removing that choice was a loss of liberties and rights. These arguments were like those made by the tobacco industry in the preceding decades (Proctor, 2011). To illustrate:

- Deputy Leader of the Opposition, Don McKinnon (1990), said that the bill reflected "excessive legislative measures" (p. 604);
- Hon. Merv Wellington (1990) referred to, "the blotting out of freedoms", "fanaticism", and "the worst of a bossy-boots Government" (p. 612);
- Jim Gerrard (1990) stated that smokers' rights were on the way to becoming non-existent; and
- Murray McCully (1990) said, "if there is to be an interference in liberties of individuals there is an obligation to ask where the evidence is" (p. 351).

2.8.1 Features of the Act

The legislation introduced a regulatory framework for workplace smoking. The following features are relevant to my study. As indicated by the words in bold[1], the framework includes language that means exposure to cigarette smoke harm is not prohibited. For example:

- an overall purpose "to **reduce** the exposure" (a) of non-smokers to the harms of other people's smoke
- the purpose of Part 1 Smoke-free Indoor Environments, which reads "to prevent, so far as is **reasonably practicable**, the detrimental effects of smoking on the health of any person who does not smoke" (s.4)
- the requirement for employers "to have a written policy of smoking" (s.5) "based on the principle that employees who do not smoke, or do not wish to smoke in their workplace, shall, so far as is **reasonably practicable**, be protected from tobacco smoke in the workplace (s.5(3))

The Act included the following definition of workplace, although it did not refer to external areas:

> any indoor or enclosed area that is occupied by an employer and that employees usually frequent during the course of their employment; and includes any aircraft, ship, train, cafeteria, corridor, lift, lobby, stairwell, toilet, and washroom; and also includes any enclosed common areas and employer provided vehicles normally used by employees; but does not include any place of residence occupied by the employer. (s.2)

The concept of a 'permitted smoking area' (PSA) was introduced. It meant "any room or area in a workplace that is designated by an employer… as a place where persons may smoke" (s.2).

[1] I have bolded the words in this section

2.8.2 Special provisions for certain institutions

Notably, the Act also introduced 'special provisions' permitting immobile patients to smoke in non-permitted smoking areas in hospitals and rest-homes. Simultaneously, the institutions had to 'take all such steps as may be **practicable**' to stop cigarette smoke harm to other patients (s.6).

What can we make of these features?

Both PSA and special provisions terms are smoke-free exceptions by different names. Arguably, in the context of the Report, the Act's purpose to protect people from cigarette smoke harm, the Minister's role as sponsor of the bill, and her portfolio responsibilities for the public health sector, the provision of these exceptions was contradictory. After all, in the absence of walls and tight-fitting doors, the smoke knows no boundaries, and it is highly likely to reach the presence of any non-smokers in the vicinity. Further, published research indicated the health impact of smoking in the Aotearoa New Zealand context (Kawachi et al., 1989).

The introduction of the PSA had further significance. The effect was legalising and treating smoking as acceptable behaviour for 'incapacitated people' in hospital settings. The Act did not define incapacitated. In the absence of a definition, using a generic term like 'incapacitated people' left the door open for institutional and staff discretion about that nature of incapacity and whether it was physical and/or mental.

The Government stated its commitment to no smoking and setting a smoke-free example in its buildings. However, by "allowing people to smoke in an environment that treated sick people, some of whom were sick because of their smoking" (Department of Health, 1988b, p. 24), the Government effected the very contradiction referred to in the Report. It did not lead by example.

Writing for the WHO about smoke-free policies in Aotearoa New Zealand, Laugesen (n.d.) stated, "The explicit purpose of the smoke-free part of the 1990 Act was to protect people from other peoples' unwanted cigarette smoke, whether they smoked at work, smoked only at home, or did not smoke at all" (p. 4). That, however, seems too categorical. Although the term smoke-free suggests a state of being free of smoke, words such as *reduce, reasonably practicable,* and *practicable* indicate that the

legislature intended to limit protection from smoke to a feasible or do-able level rather than stopping exposure. Given this was the first Act to address exposure to SHS, the limited protection was likely to receive more generous support from employers than a total ban. Similarly, hospital staff were more likely to welcome the exemption for their patients with incapacities. Nationally, however, this legislation was arguably warming up citizens to use legislation to control tobacco.

In 1994, the Public Health Commission provided advice to the Minister of Health in its report called *Tobacco products* (Public Health Commission, 1994). This report was silent about mental health and smoking. This silence is probably explained by the Commission's focus on population health, whereas, at that time, mental health and smoking was categorised as personal health.

The 1995 Smoke-free Policy for Auckland Healthcare Services Limited, a Crown Health Enterprise, is pertinent. The policy refers to the section 6 special provisions and indicates what is meant by clinical exemptions:

> Auckland Healthcare recognises that nicotine addiction is a powerful addiction and accepts it may be necessary for exceptions to be made in specific circumstances, eg:
>
> secure areas in psychiatric institutions
>
> Such exceptions:
>
> 1. must comply with the provisions of the Smoke-free Environments Act
> 2. may necessitate the provision of separate ventilation
> 3. must be stated in writing as part of the written policy of a particular workplace
> 4. must be reviewed at least annually. (Auckland Healthcare Services Limited, 1995, p. 3)

This policy was in place when the Auckland DHB was established.

2.9 Establishment of District Health Boards

Following its election in 2000, the new Labour Government established DHBs to provide a range of publicly funded health and disability services.

2.9.1 Legislative framework

The New Zealand Public Health and Disability Services Act 2000 (NZPHDA) established the DHBs in 2001. The purpose of the NZPHDA is "to provide for the public funding and provision of personal health services, public health services, and disability support services, and to establish new publicly-owned health and disability organisations" (s. 3(1)).

The DHB objectives and functions are set out in sections 22 and 23. Several objectives and one function are relevant to my research.

> S.22 Objectives
>
> (a) to improve, promote, and protect the health of people and communities:
>
> …
>
> (ba) to seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs:
>
> (c) to promote effective care or support for those in need of personal health services or disability support services:
>
> …
>
> (e) to reduce health disparities by improving health outcomes for Māori and other population groups:
>
> (f) to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:

(i) to uphold the ethical and quality standards commonly expected of providers of services and public sector organisations:

…

(k) to be a good employer in accordance with section 118 of the Crown Entities Act 2004[2].

S.23 Functions of DHBs

to regularly investigate, assess, and monitor the health status of its resident population, any factors that the DHB believes may adversely affect the health status of that population, and the needs of that population for services (s.23 (g)).

Significantly, the legislation clarifies that nothing in the NZPHDA limits section 73 of the Human Rights Act 1993. This section relates to measures to ensure equality (NZPHD Act 2000, 3. (3)(b)), while Schedule 4 (2) (b) states that a DHB's public health advisory committee's advice must maximise the health gain from "all policies the DHB has adopted or could adopt for that population".

The purpose, objectives, and functions can be likened to 'smoke signals' about expected behaviour to measure performance. I suggest that these 'signals' language conveys the following action areas.

- reducing health disparities
- addressing needs
- protecting, promoting, and improving health
- honouring human rights
- improving access
- meeting standards of care and employment

The question arises. To what extent did DHB achieve these action points concerning inpatients in MHIFs during the first two decades of the 21st-century?

[2] Section 22(1)(k): amended on 25 January 2005, by section 118 of the Crown Entities Act 2004 (2004 No 115).

2.10 New Zealand Health Strategy, priority population health goal, and District Health Boards' toolkit

The New Zealand Health Strategy (2000) identified 13 priority population health objectives, including reducing smoking (and the harm from SHS). To assist with implementing this objective, the Ministry of Health provided the DHB with the *DHB Toolkit Tobacco Control* (2001) (Toolkit). Relevant to my research, the Toolkit links the reducing smoking objective with two mental health-related objectives: reducing the suicide rate and attempts, and minimising the harm caused by alcohol use. It notes that smoking is "an independent risk factor for suicide" (Miller et al., 2000, as cited in Ministry of Health, 2001a, p. 6) and "that there is some evidence that increasing the tax on alcohol can reduce smoking" (Jimenez et al., 1994, as cited in Ministry of Health 2001a, p. 6).

In my view, the New Zealand Health Strategy's centrality and the Toolkit's explicit naming of the linkages between smoking and two mental health objectives were important cues for DHBs when developing policies to implement the reducing smoking objective. For example, it would be reasonable to expect that their smoke-free policies addressed the mental health objectives.

2.11 World Health Organization: Framework Convention on Tobacco Control

A further cue for DHB smoke-free policy development came in 2003 when Aotearoa New Zealand signed the agreement on the WHO Framework Convention on Tobacco Control (FCTC), an international public health treaty established to address the harms of tobacco (WHO, 2003). By ratifying the FCTC in 2004, Aotearoa New Zealand became legally bound to implement the FCTC articles and provide periodic reports.

The articles came into force in February 2005, and the following three FCTC Articles are relevant to my research:

- comply with the general obligations and "develop, implement, periodically update and review comprehensive multisectoral national tobacco control strategies" (Article 5 (1)) consistent with the FCTC and to "adopt and implement effective legislation" (Article 5 (2) (b))

- accept that scientific evidence demonstrates that exposure to second-hand smoke causes “death, disease and disability” (Article 8(1)) and to put in place measures to protect people from indoor second-hand smoke (Article 8(2))
- submit periodic reports about the implementation of the FCTC, including information about legislative measures (Article 21(1)(a))

These articles have implications for the development of DHB 21st-century smoke-free policies. To illustrate, acceptance of science would mean drafting smoke-free policies that do not include DSRs because these rooms, even with ventilation, cannot protect people from the smoke.

2.12 DHBs: Features of the 2003 smoke-free legislative process

In December 2003, Parliament passed the Smoke-free Environments Amendment Act, which amended the Smokefree Environments Act 1990. The purposes of the amendment were to “extend the protections for workers, volunteers, and the public in the Smoke-free Environments Act of 1990 to reduce the harm caused to individuals by their smoking, particularly against exposure to second-hand smoke” (Chadwick, 2003a, p. 6609).

Examining the Parliamentary Debates, the Health Committee commentary and its report reveal the following areas relevant to my research.

2.12.1 Evidence, science, and ventilation systems

From the outset, the Committee stated that it had considered the evidence. Its Commentary reads, “We carefully considered all the evidence and suggestions we received, and have recommended many changes to the bill, as a consequence of that consideration” (Health Committee, 2003, p. 2).

Given the clear intention to extend smoke-free indoor environments to other workplaces and the likelihood of opposition, it is not surprising that the Committee referred to its use of the evidence. Arguably, to showcase the importance of scientific evidence and add weight to its decisions, the Committee drew on the credibility of the WHO and its report *World Health Report 2002*. The Committee cited the WHO list of

physical health consequences of SHS. These included “exposure to second-hand smoke is associated with lower respiratory tract infections, sudden infant death syndrome, asthma, ischaemic heart disease, otitis media (ear infection), lung cancer and nasal-sinus cancer” (WHO, 2002, as cited in Health Committee, 2003, p. 2).

Relevant to my research, a Supplementary Order Paper proposed that hospitality sites be exempt from the smoke-free legislation provided, “they met a specified clean air standard…through the use of ventilation systems” (National Advisory Committee on Health and Disability Committee, 2004, p. 19). The scientific debate was whether these systems could adequately remove SHS.

In 2001 and 2002, a sub-committee of the National Health Advisory Committee on Health and Disability, the Public Health Advisory Committee (PHAC), advised the Minister of Health and the Committee, respectively, that evidence supported a total workplace ban and that there was “sufficient evidence to counter… the argument that adequate ventilation systems can minimise risk” (National Advisory Committee on Health and Disability incorporating the Public Health Advisory Committee, 2001, p. 15).

In 2003, the PHAC advised the Minister of Health that:

> Reputable international analysis has consistently found that commercially available ventilation systems are unable to lower the health risks from the presence of SHS to an acceptable level… that no acceptable air quality standard for exposure to SHS currently exists… such a standard would be… involving… expense for regulators and venues. (National Advisory Committee on Health and Disability incorporating the Public Health Advisory Committee, 2003, p. 19)

Pertinently, the PHAC concluded that “subjecting such venues to the same standards [total smoke-free] as other workplaces are a simple, straightforward, inexpensive and above all effective methods of protecting patrons and workers from the adverse health impact of SHS exposure” (National Advisory Committee on Health and Disability incorporating the Public Health Advisory Committee, 2003, p. 19).

The contentious nature of adequate ventilation systems is evident because the Committee recorded that “it heard conflicting evidence” (Health Committee, 2003, p.

6). Some submitters claimed that ventilation could remove SHS. In contrast, others said the ventilation offered insufficient protection because carcinogens remained in the air and the high cost of running high-powered ventilation.

Ultimately, the Committee did not support ventilation for the hospitality sector, and it recommended a total ban on indoor smoking. Yet, the final legislation included the mandatory mechanical ventilation systems for DSRs located at hospital care institutions (Smoke-free Environments Amendment Act 2003, s.6 1 (b) & s.6 2.) What was accepted as insufficient ventilation protection for the hospitality sector was somehow sufficient for hospital care institutions which cared for unwell people.

How might this double standard be explained?

2.12.2 Workplace smoke-free exclusions

Extending smoke-free indoor environments required a definition of workplace that expanded the 1990 definition to include internal area and detailed inclusions and exclusions from the general restrictions on smoking in a workplace.

Both the initial bill and a supplementary order paper proposed smoking be allowed in parts of workplaces, but neither included exceptions clauses about smoking in hospitals or other institutions (Smoke-free Environments (Enhanced Protection) Amendment Bill 2003 (310-11); Supplementary Order Paper (SOP) 2003, 148).

The Committee decided the principle for determining exclusions was whether the excluded area was either temporarily or permanently a person's home; in other words, home-like (Health Committee, 2003). Using the above principle, the final list of exclusions comprised an employer's home, prison cells, motel and hotel rooms, and accommodation on ships and trains.

In the second reading debate, bill sponsor, Steve Chadwick MP, offered a rationale for exceptions: to allow people to smoke in the private sphere. She said, "The select committee recommends making all indoor workplaces completely smoke-free, with some limited exceptions around the areas that are the private sphere" (Chadwick, 2003, p. 6610).

Associate Minister of Health Hon Damien O'Connor offered a similar rationale:

> The bill will provide 100 per cent smoke-free protection in all indoor workplaces where two or more people work in a common airspace… The Health Committee has considered that some exceptions are appropriate, such as workplaces that are a private citizen's home or a temporary residence. (O'Connor, 2003, July 30 p. 7457)

Neither the sponsor nor the Associate Minister named hospitals or other institutions in their rationale.

Could private sphere and home-like assist with understanding why MHIFs were exempt from smoke-free policies? I explore this question further in Chapter 6, section 6.6.

The Health Committee's recommendation expanded the exclusions by introducing DSRs:

> We recommend allowing for dedicated smoking rooms for patients in hospitals, residential care homes and rest homes, to provide for patients who are so incapacitated that they are unable to go outside to smoke. No person other than a patient or resident will be able to smoke in such rooms, including employees and visitors. (Health Committee 2003, p. 5)

The recommendation words suggest that the rationale relates to patient incapacity and that specific institutions have responsibility for invoking and administering the DSRs. The subsequent legislative amendment permitted hospital care institution employers to create DSRs that allowed smoking subject to particular requirements. The effect of these changes made further exceptions to the general principle of smoke-free indoor workplaces.

The Parliamentary Debates generally provide little guidance about reasons for recommending DSRs. Member of Parliament Committee member Dr Lynda Scott, however, offered some insight into the select committee's decision:

> The interpretation provisions in this bill include things like "dedicated smoking room". That means an internal area of a hospital or a care institution. We certainly do not want to see—and I promoted this

> provision—our elderly in residential care having to trundle out into the rain and the cold to have a smoke. By that stage, when they are in residential care, quite frankly, if a smoke is all they enjoy, they should be able to have a smoke. So we did allow for dedicated smoking rooms to exist in rest homes, disability care institutions, and mental health institutions. (Scott, 2003a, p. 7956)

Later Dr Scott said,

> We also looked at dedicated smoking rooms in hospital care institutions, residential disability care institutions, and rest homes. Let us face it, if people get to a rest home and are still alive and still smoking, we should be kind to them. We cannot really kick people out into the rain to have a cigarette outside at that stage, so we were kind and generous and understood that situation… Members will ask why we did that in hospital care institutions. The fact is that some people are absolutely desperate. I would like to see all people, especially in hospitals, not smoking. (Scott, 2003b, p. 9213)

Turning to the Committee's DSR recommendation (Health Committee, 2003), there is no reference that the Committee considered evidence to support continued smoking by patients in the three types of institutions. Instead, it reiterates the 1990s legislative exception language by stating that patients who are so incapacitated and immobile and cannot go outside need institutional support to smoke. Similarly, the Committee does not refer to evidence to support the introduction of lawful internal smoking sites for residents in these institutions.

A geriatrician, Dr Scott does not refer to evidence, and her opinions primarily relate to the elderly in residential care. Notably, her views reflect two common and persuasive beliefs that also apply to patients in MHIFs:

- that signs of desperation in smokers need relief by smoking another cigarette
- that smoking is the only pleasure in life, and ongoing smoking needs to be supported

By 2003, the National Health and Disability Committee (NHC) had published national smoking cessation guidelines in 1999; and a revised version in 2002. In its 2002 Annual Report to the Minister of Health, the NHC reported that:

> The Committee's 1999 smoking cessation guidelines proved a popular resource. Given the importance of the topic and the steady stream of new evidence, the NHC decided to update the guidelines with the latest evidence for best practice that has emerged in the three years since they were first released. (National Advisory Committee on Health and Disability incorporating the Public Health Advisory Committee, 2002, p. 6)

Given these guidelines, and Dr Scott's medical training, it seems surprising that she referred to these beliefs rather than the benefits of providing nicotine replacement therapy to stop withdrawal and the associated feelings of withdrawal and a stimulating environment for residents in healthcare facilities.

The question remains. Why were exceptions made for residents in health settings?

Drawing together the above features of the 2003 legislative process, I make several observations.

All institutions named in section 6 exceptions have some long-stay patients. For example, patients, particularly those in forensics wards in MHIFs, can be in residence for many months. As such, they tend to regard their residence as home-like. The Committee said that exclusions from the smoke-free rule were determined by whether the excluded area was a temporary or permanent home; that is, home-like. Yet, home-like was not the rationale for the Committee's recommended section 6 exceptions. It was the incapacity and immobility of a smoker.

The Smoke-free Environments Amendment Act 2003 (SFEAA) shifted the focus from the individual incapacitated smoker to the three types of institutions and gave the employer discretion to allow smoking subject to specific requirements. Section 6 reads:

> 6 Dedicated smoking rooms in hospital care institutions, residential disability care institutions, and rest homes

"(1) An employer may permit smoking by patients or residents

"(a) the smoking takes place only in one or more dedicated smoking rooms; and

"(b) each dedicated smoking room is equipped with or connected to a mechanical ventilation system to which subsection (2) applies; and

"(c) the employer has taken all reasonably practicable steps to minimise the escape of smoke from the dedicated smoking rooms into any part of the workplace that is not a dedicated smoking room; and

"(d) for each dedicated smoking room, there is available for patients or residents who wish to socialise in a smokefree atmosphere an adequate equivalent room.

"(2) This subsection applies to a mechanical ventilation system with which a dedicated smoking room in a workplace is equipped if, and only if, —

"(a) the system is so designed, installed, and operating that it takes air from the room to a place outside the workplace where any smoke the air may contain will not enter any part of the workplace, either—

"(i) directly; or

"(ii) through one or more other dedicated smoking rooms; and

"(b) no part of the workplace that is not a dedicated smoking room is equipped with or connected to the system.

"(3) Subsection (1)—

"(a) does not authorise an employer to permit a person who is not a patient or resident of the institution or home concerned to smoke in a dedicated smoking room; and

"(b) does not authorise a person who is not a patient or resident of the institution or home concerned to smoke in a dedicated smoking room.

Turning to section 6(1), generally, the word may is permissive in a legal context. Applied to section 6, it means that the hospital care employer can choose to have DSRs or not.

In other words, there is no statutory requirement to have DSRs or any intention by Parliament that smoking would occur. These two conclusions by the Supreme Court endorsed the use of smoke-free policies at the Waitemata DHB (*B v Waitemata District Health Board,* 2017).

During the Parliamentary Debates, Health Committee Chair Steve Chadwick noted that "District Health Board New Zealand has supported hospitals going smoke-free. They have already gone smoke-free which is absolutely wonderful" (Chadwick, 2003, August 13, p. 7965). However, the smoke-free status of the DHBs at that time seems unclear. In a WHO report about smoke-free policies in New Zealand, Laugesen (n.d.) noted that in 2003, DHBs advised they would implement smoke-free campuses the following year, with exceptions for some patients. A commitment to this is found in the Whanganui DHB Smoke-free Policy 2009-2010, which states:

> All 21 district health board Chief Executive Officers committed to the implementation of Smoke-free Hospital Campuses on 31 May 2004. This policy is designed to promote the health of all employees, visitors, and patients by upholding their individual rights to live in a smoke-free environment. (Whanganui DHB, 2009, p. 2)

It seems most likely that on 31 May 2004, DHBs were yet to become smoke-free.

The nature of Laugesen's reference to exceptions is unexplained, but a later section about implementation difficulties refers to secure units for psychiatric patients and the criminally insane. These, together with the above-noted reference to psychiatric patients in secure environments (Department of Health, 1988b), suggest that the exceptions were likely to include patients in MHIFs. Dr Scott's earlier reference to mental health institutions adds weight to this suggestion.

In 2004, the Mental Health Commission (MHC), in a letter to DHBs, set out its position on implementing smoke-free environments in mental health services (Goldsack, 2004). Of relevance, the MHC noted that given the unwellness and vulnerability of inpatients, it was not the place or time to stop patients from smoking. It proposed that the exemptions provided in 2003 smoke-free legislation should be implemented. To what

extent might this guidance have contributed to DHB decisions about smoke-free policy exceptions?

By the end of the 20th-century, smoking became increasingly denormalised in the wider society, including the general hospitals. Yet smoking remained normalised and accepted behaviour in MHIFs, and by 1990, it had statutory protection: a curious circumstance that invites speculation about whether the subsequent provisions of SFEAA section 6 established a class of citizen patients who would be the subjects of different treatment, including exceptions to smoke-free policies in the 21st-century.

2.13 Chapter review and summary

To appraise the reader of the normalised place of smoking in 20th-century psychiatric hospitals in Aotearoa New Zealand, this chapter has examined the socio-historical context of cigarette smoking in general and psychiatric hospitals and the relevant legislative developments. While smoking was increasingly denormalised in parts of the general society, it continued as an accepted and everyday activity in psychiatric hospitals and likely laid a strong foundation for continued smoking in MHIFs during the first decade of the 21st -century.

Chapter 3 Literature Review

Globally, smoking is a leading cause of preventable death. The WHO (2020a) puts it like this:

> The tobacco epidemic is one of the biggest public health threats the world has ever faced, killing more than 8 million people a year around the world… All forms of tobacco are harmful, and there is no safe level of exposure to tobacco. Cigarette smoking is the most common form of tobacco use worldwide.

In 2018, the United Nations General Assembly committed to action about risk factors and conditions common to all non-communicable diseases (NCDs). To recognise tobacco's significant role, tobacco use was included as a risk factor and mental health as one of the conditions (WHO, 2020b).

The previous chapter shows that patient smoking has been part of psychiatric hospitals for much of the 20th-century in Aotearoa New Zealand. In this chapter, I draw on national and international published literature to examine the physical and mental health implications of smoking for people with mental illness; Aotearoa New Zealand's 21st-century smoke-free legislation, policies, and practices along with widely held beliefs that permit smoking by and expose patients and, to a lesser extent, staff, to SHS while in exceptional spaces of smoking in state MHIFs. I provide an overview of SF 2025, the Aotearoa New Zealand Government's national smoke-free goal. I critique the silences in the published literature and research about smoking by patients in MHIFs in Aotearoa New Zealand.

3.1 Smoking trends and people experiencing mental illness

Embarking on my literature review, I became aware of a considerable and growing body of published academic literature from Australia, the United Kingdom, and the USA about smoking, mental health, MHIFs and smoke-free policies (MHIF). In contrast, I found limited Aotearoa New Zealand published academic literature, including specific DHB reports about smoking in their MHIF. I was curious to understand the sparsity of domestic literature on these topics, and I wondered what it might mean for smoke-free policy exceptions in MHIFs.

This section begins with overseas published literature and smoking trends for people experiencing mental illness. I follow this with a review of the Aotearoa New Zealand literature and smoking trends for people experiencing mental illness and a brief examination of patient smoking status data. I include some observations about the absence of published information about smoking trends in MHIFs. Using square brackets, I name the country in which the studies occur.

3.1.1 Published overseas literature

Evidence indicates that PMI are more likely to smoke, have higher smoking rates, and be more dependent on cigarettes (Mendelsohn & Montebello, 2013). At the start of this century, in a USA study, Lasser et al. (2000) found PMI "were about twice as likely to smoke as people without a mental disorder" (p. 2608). More recent studies in Australia, the United States of America and the United Kingdom indicate smoking is two to three times more prevalent for PMI than general population smokers (CDC, 2020; Centre for Disease Control, 2020 [USA]; de Leon & Diaz, 2005 [USA]; Lawrence et al., 2009 [Australia and USA]; Royal College of Physicians & Royal College of Psychiatrists, 2013 [UK]).

Studies also show that PMI have higher nicotine intake, are heavy smokers, and more dependent on nicotine (de Leon & Diaz, 2005; Lawrence et al., 2009; Royal College of Physicians & Royal College of Psychiatrists, 2013; Szatkowski & McNeill, 2015 [UK]; Williams et al., 2005 [USA]). Analysing smoking rates in an Australian MHIF, Reichler et al. (2001) found that 90% of the 160 patients with co-existing alcohol and other drug problems smoked regularly with a "mean cigarette consumption of 22.09 cigarettes per day" (p. 231). With higher smoking rates and heavier cigarette use, the consumption of smoking by PMI was estimated to be half of the cigarettes sold in the USA (Grant et al., 2004; Lasser et al., 2000). In England, one-third of cigarettes are smoked by people with a mental disorder (Royal College of Physicians & Royal College of Psychiatrists, 2013).

Examining recent trends between PMI and people without PMI in England, Szatkowski & McNeill (2015) concluded there had been little change in smoking by PMI with long term mental disorders since 1993. Other studies also report that PMI do not experience a similarly declining prevalence of smoking as the general population smokers (Harker

& Cheeseman, 2016 [England]; Lawrence et al., 2003 [Australia]; Richardson et al., 2019 [Great Britain]).

High smoking rates are also associated with more significant mortality and morbidity for PMI, particularly for cardiovascular disease, respiratory disease, and cancers, indicating disparities between people with and without mental illness (Lawrence et al., 2001).

In an Australian study about ischaemic heart diseases and death rate, Lawrence et al. (2003) found that between 1980 and 1998, there was a significant reduction in cardiovascular mortality for the general population but none for PMI. Reported in the USA, Callaghan et al. (2014) found that tobacco-related conditions constituted 53% of total deaths for schizophrenia, 48% for bipolar, and 50% for the depression cohorts.

Also, in the USA, Tam et al. (2016) sought to quantify the "potential contribution of smoking to life expectancy among individuals with serious psychological distress (SPD)" (p. 958). The authors found that SPD smokers doubled their risk of death. Whereas never smokers without SPD have a reduced life expectancy of 5.3 years, SPD smokers lost almost 15 years of life. Writing about mental health and smoking in England, Harker and Cheeseman (2016) stated that PMI lose an average of 17 years of life due to smoking conditions or those made worse by smoking.

In summary, smoking and mental health trends include high smoking rates, heavier smoking, greater nicotine dependence, slower smoking prevalence rates, and higher mortality, morbidity, and inequalities. Each burden impacts the health and wellbeing of PMI, and, together, these burdens form a very weighty load for PMI. What do we know about smoking and mental health trends in Aotearoa New Zealand?

3.1.2 Published Aotearoa New Zealand literature

There is limited published research about PMI's smoking burdens and an absence of published research about patient smoking and SHS exposure in DHB MHIFs. In reviewing the available literature, I observe references to smoking trends are linked to overseas citations. It is unusual for authors to note the absence of Aotearoa New Zealand smoking and mental health data.

1999-2005: Publications

In 1999, Aotearoa New Zealand researchers observed, "there is a glaring lack of published data from adolescent mental health samples [about] [my insertion] smoking suggesting that cigarette smoking may be a neglected facet of assessment in these clinical settings" (Sellman et al., 1999, p. 870). Aotearoa New Zealand authors note higher cigarette use for MHIF patients, and their supporting citation is from the American Psychological Association (1994).

In 2001, the Ministry of Health examined tobacco's contribution to health inequality in Aotearoa New Zealand. The report concludes that tobacco smoking accounts for "about one-fifth of the gender difference in life expectancy at birth, one-quarter of the inequality between Māori and non-Māori, and one-third of the deprivation gradient" (Ministry of Health, 2001, p. v). The report is silent about mental health and smoking.

In a report prepared for the Ministry of Health, Hill et al. (2003) examined the impact of tobacco control policies on social inequalities from 1981 to 1996. The authors found that "while overall smoking rates fell during the 1980s and 90s, socio-economic and ethnic inequalities in smoking increased" (p. ii). The report is silent about mental health and smoking.

In 2003, Parliament passed smoke-free legislation to permit DSRs in hospital care institutions, for example, DHBs. Subsequently, the DHBs sought advice from the MHC about "the intersection of smoke-free legislation, health policy discouraging smoking, and human and civil rights for people using mental health services – particularly those held compulsorily" (Goldsack, 2004, p. 16). The MHC, a Crown entity responsible for PMI advocacy and communication about mental issues to stakeholders (Mental Health Commission Act, 1998, section 6 (a)(b)), replied that:

> The Mental Health Commission is fully committed to an eventual smoke-free environment within mental health services, with recent evidence suggesting that the incidence of smoking amongst service users remains at unacceptably high levels. However, issues surrounding implementation of a smoking ban are wide-ranging and complex. In this respect, the Mental Health Commission's position is as follows:

> Exemptions under the Smoke-free Amendments Act 2003 should be used by all acute inpatient services. Acute services provide care and treatment for individuals in acute states of unwellness and vulnerability. Clinically, this is neither the time nor the environment for smoking cessation to be imposed.
>
> While all efforts to introduce a smoke-free environment in mental health services are encouraged, the dignity, rights and safety of service users are paramount. All attempts to change smoking behaviour should have service users as leaders and participants in the process. (Goldsack, 2004, p. 2)

The MHC position likely carried weight with the DHBs, and effectively this position maintained the normalised place of smoking in MHIFs. However, I contend the statutory incorporation of DSRs in MHIFs, given the accepted and published evidence of smoking and smoke exposure harm, was a critical non-health-promoting intervention worthy of data collection, including patient smoking status. I have been unable to locate published data about patient smoking status after this law change. Could it be that smoking's normalised status in MHIFs was not essential to record or report?

In 2004, the Mental Health Foundation of New Zealand (MHF) wrote that "there are no firm statistics on smoking among people with mental health problems in New Zealand" (Mental Health Foundation, 2004, p. 5). I suggest this observation was not surprising. As discussed in Chapter Two, smoking had been a normalised patient behaviour in psychiatric hospitals during most of the 20th-century. It is plausible that smoking's normalised status meant there was no recording or reporting of patient smoking status at that time. After all, smoking was what the patients did.

Barnett et al. (2004) investigated social inequality and ethnic differences in smoking in New Zealand. They concluded that policies that address social inequalities would help reduce the high smoking rates for Māori. The paper does not mention mental health.

In 2005, Sellman drew attention to clinicians' neglect of nicotine dependence in MHIFs and the slowly declining smoking prevalence among PMI (Sellman, 2005). The citations

for these concerns are an overseas publication by Lasser et al. (2000) and a domestic publication for the MHC by Goldsack (2004).

In 2006, the Ministry of Health published *Te Rau Hinengaro* (TRH), the New Zealand mental health survey (Oakley-Browne et al., 2006). Using data collected from a nationally representative sample, TRH reported a higher prevalence of current smoking among people with any mental disorder compared with people who did not have a mental disorder (32.3% compared with 20.7%) ($p < 0.0001$).

In a subsequent publication, using the TRH data, Scott et al. (2006) reported that "People with (any) mental disorder, relative to those without mental disorder, had higher prevalences of several chronic physical conditions (chronic pain, cardiovascular disease, high blood pressure and respiratory conditions) and chronic condition risk factors (smoking, overweight/obesity, hazardous alcohol use)" (p. 882).

I observe that the TRH smoking and mental health data are now out of date. Pertinent to my study, which focuses on MHIFs, the TRH report does not include the current smoking prevalence for people who had been in MHIFs. However, the publication of the smoking prevalence data and the link with chronic physical conditions indicates that DHBs had access to data to inform smoke-free policies in MHIFs.

In 2007, the Labour-led Government (Ministry of Health, 2007) introduced a set of 'Health Targets' to:

- reflect Government priorities
- secure health improvement
- provide a level of accountability

The tobacco health target, *Reducing the harm caused by tobacco*, required DHBs to report on measures related to smoking by Year 10 students and smoking in homes. The targets did not include DHB patient smoking status, which is relevant to my study.

Like the USA research, Tobias et al. (2008) sought to quantify the portion of tobacco used by people with 12-month mental disorders in Aotearoa New Zealand. The authors estimated that this group used one-third of the cigarettes consumed. There is no separate presentation of inpatient data.

In the first Aotearoa New Zealand study about premature mortality among people using community and inpatient psychiatric services, Cunningham et al. (2014) found:

> That those with mental illness are experiencing premature mortality here just as they are in other countries. Men and women using mental health services in New Zealand have more than twice the risk of death when compared to the New Zealand population after adjusting for age. Men and women with psychotic disorders have even higher mortality, three times that of the whole population… both men and women using mental health services also had a significantly raised risk of death from natural causes such as cancer and cardiovascular disease. (p. 37)

The inpatients' results are not identified, so we do not know the premature mortality risks for this group. The authors note many reasons for the above high mortality, including smoking, relevant to my study. They offer possible explanations for high smoking rates by PMI, notably that "mental health services have in the past facilitated smoking" (Cunningham et al., 2014, p. 37). They propose that this behaviour has probably contributed to the high rates of smoking, cardiovascular disease, and cancer.

The reference to facilitated smoking indicates that mental health institutions enabled patients to smoke. This inference is possible given my earlier discussion about the tobacco supply to patients in Aotearoa New Zealand MHIFs. However, the researchers cite an international publication (Oliver et al., 2007) regarding smoking facilitation by mental health services. In the absence of Aotearoa New Zealand publications, this is reasonable. However, we remain none the wiser about the facilitation of smoking in Aotearoa New Zealand MHIFs.

Later, in 2009, the Government introduced a new set of health targets. The DHBs reported quarterly on the new smoking target called *better help for smokers to quit*, which involved clinical staff giving smoking cessation advice and assistance to quit smoking to a prescribed percentage of hospitalised smokers (Ministry of Health, 2009a).

Given the apparent absence of data about DHB patient smoking status, I submit that the 2009 target was an important *steppingstone* for three reasons. First, it knitted patient

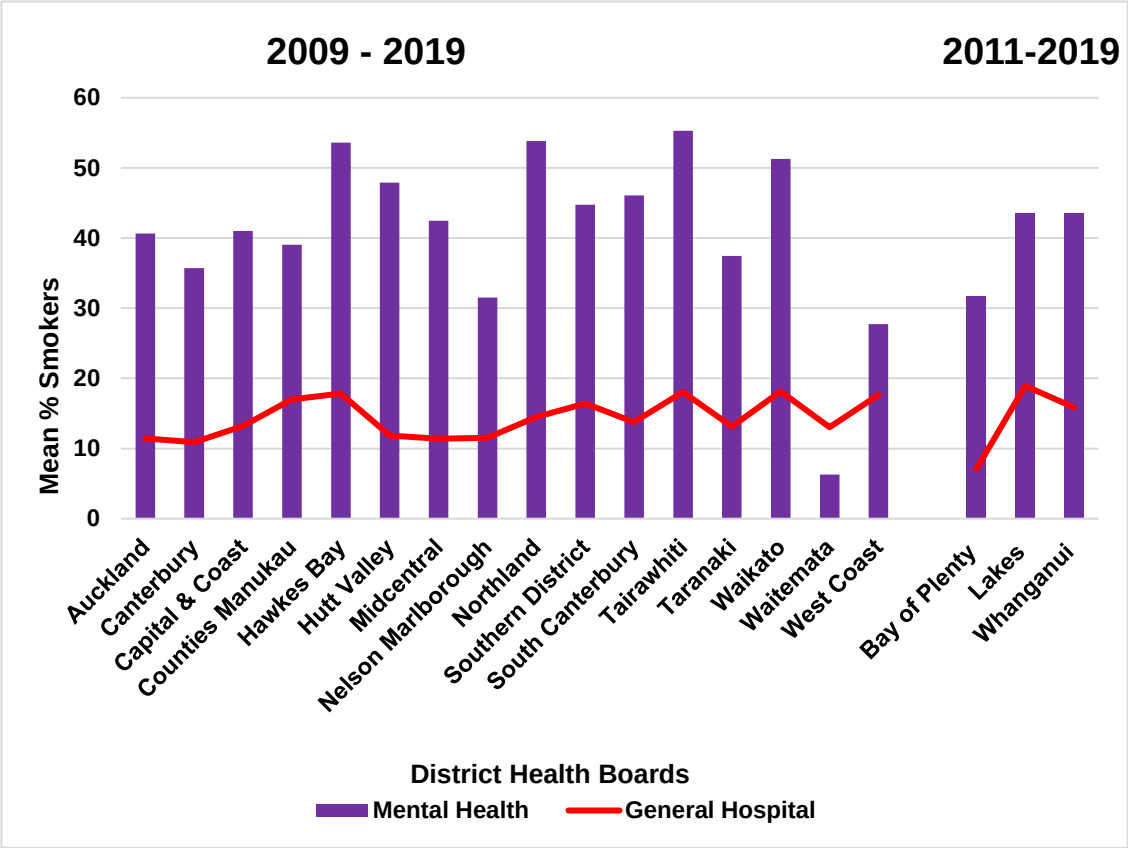
smoking cessation support with the documentation of smoking status. Second, it formalised and systematised the documentation of smoking status in the patient clinical records. Third, it enabled or at least ought to have allowed the collection of patient smoking status into the individual DHB patient management systems, thereby creating databases to guide service planning and meet DHB objectives.

Germaine to my research, the quarterly smoking targets and reporting continued into 2020. How did the reporting work? Across each DHB's services, including MHIFs, patient smoking status data were bundled, and an aggregate DHB figure was reported to the Ministry. During most of this time, the quarterly results were published in newspapers and on the Ministry website. The results, however, were presented as the percentage achieved against the Ministry target. Thus, it was not possible to determine the smoking status of MHIF patients. Further, it was impossible to tell whether the achieved percentage included MHIF data.

I could not locate published data about the patient smoking status for the DHB MHIFs. I made official information requests to all DHBs for patient smoking status from 2010 to 2020 (See Appendix G). The results indicate that most DHBs collected MHIF and general hospital patient smoking status during this time. Using this data, I prepared the graph in Figure 3.1.

Figure 3.1

District Health Boards smoking status: Average percentage mental health versus general patient admissions 2009-2019

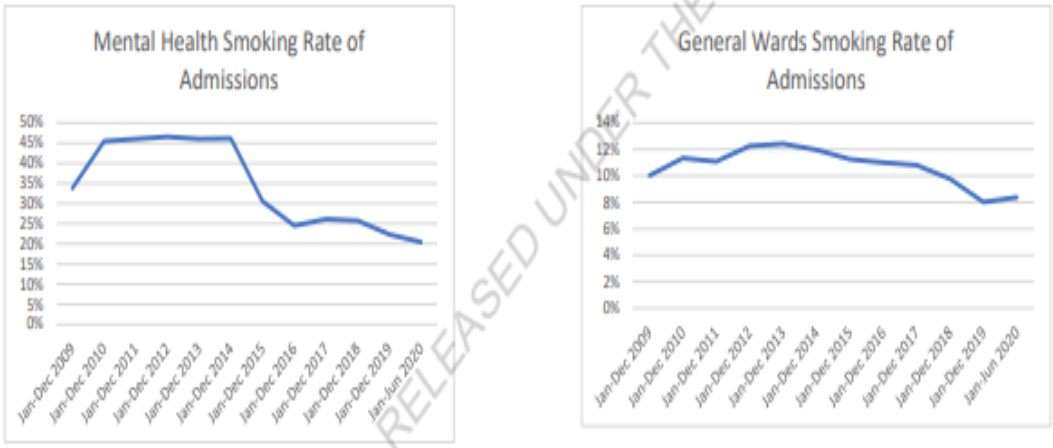


The above graph shows the differential smoking rates. Mental health inpatient facilities' patient admission status has a higher percentage of smokers than the combined general hospital services, suggesting different health outcomes. Three DHBs—Bay of Plenty, Lakes, Whanganui—did not provide data for 2009 to 2010, and each advised MHIF smoking status data were not collected in that period. Rather than comparing MHIF patients and general hospital patient smoking status, overseas studies report higher smoking rates by PMI than the general population (Huddlestone et al., 2018; Royal College of Physicians & Royal College of Psychiatrists, 2013).

The Canterbury District Health Board provided the graphs below (See Figure 3.2) with its official information response. Noting the different Y axes, the mental health smoking rate at admissions is higher than in the general wards.

Figure 3.2

Canterbury District Health Board smoking status: Average percentage mental health versus general patient admissions 2009-2019



I observe the absence of uniquely Aotearoa New Zealand published literature regarding mental health patient smoking status. Suppose there were plausible reasons for the absence of published data about the patient smoking status from 2000 to 2008. In that case, it is difficult to explain the lack of DHB or Government published patient smoking status data during 2009 to 2020.

It is necessary to ask why there has been no publication of this data. For 10 years, most DHBs have collected this data and demographic characteristics such as ethnicity and sex. During this time, the Government and the DHBs had access to this data to publish a uniquely Aotearoa New Zealand picture of patient smoking status.

Such a report could have included patient smoking prevalence estimates, including prevalence by ethnicity and sex compared with the general hospital patient smoking prevalence along with the implications of the high smoking rates for:

- patient life expectancy and inequalities
- smoke-free policy exceptions and policy development
- smoke-free legislation permitting smoking in hospital care institutions such as MHIFs
- equitable resource allocation to ensure clinical staff cessation training to support patients to quit

Instead, there has been a conspicuous lack of published data for 10 years; thus, unaccounted for mental health patient smoking trends. It is reasonable to wonder if the

DHB collection of patient smoking status data for Government imposed health targets was a tick-box political exercise rather than one which provided data to improve, promote, and protect patient health and wellbeing.

Why else is a uniquely Aotearoa New Zealand picture important?

Compared to the United Kingdom (Harker & Cheeseman, 2016), Australia (Greenhalgh et al., 2018), and the USA (CDC, 2020), Aotearoa New Zealand has minimal publications about smoking and mental health and a lack of publications dedicated to MHIFs, patients and smoking. In 2014, Glover et al. (2014) concluded that "Key reports on mental health in NZ largely overlook smoking" (p.184). In 2020, Glover et al. noted that for PMI, along with people from indigenous and the rainbow community, "there is a general dearth of data preventing detailed analysis" (p. 263).

Further, and relevant to my study's focus on smoke-free policy exceptions, there is an absence of published Aotearoa New Zealand research and literature specifically about the patient and staff impact of the legislative exemption allowing hospital care institutions such as DHBs to provide DSRs.

Following an impact evaluation of the 2003 smoke-free legislative exemption, the authors of the subsequent report observed that "there are currently no data available on the experience of implementation of the SEAA (2003) [Smoke-free Environments Amendment Act 2003] in settings where partial restrictions on smoking in indoor areas were introduced. These include residential hospital… institutions" (Ministry of Health, 2007a, pp. 2-3). The authors recommended that the Ministry of Health commission an investigation of staff and non-smoking patient experience of the exemption and that post-investigation and/or using international reviews, the Ministry of Health should implement more stringent policies. I have been unable to locate published material about whether this recommendation was implemented.

A uniquely Aotearoa New Zealand picture is important because otherwise researchers cite overseas studies to highlight smoking trends such as high prevalence and slow decline, premature mortality, and inequalities. Thus, we remain none-the-wiser about the local situation.

3.1.3 Summary

In summary, the overseas published literature indicates PMI experience significant smoking-related burdens. There is minimal published Aotearoa New Zealand literature about smoking trends and people experiencing mental illness. The DHBs have collected patient smoking status data for at least a decade but have not published it. This gap has created a significant vacuum for researchers and policymakers and has likely minimised opportunities to improve, protect, and promote patient health and wellbeing in the hospital care setting. What impact has the available evidence of harm had on staff beliefs about patient and staff smoking in MHIFs? I explore this question in the following section.

3.2 Second-hand smoke and smoking: Effects

With the implementation of exceptionalist smoke-free policies in MHIFs, patient care does not occur in a smoke-free hospital care environment. Additionally, the staff working environment is not smoke-free. Both patients and staff risk SHS exposure and, given their respective high rates of smoking, they also risk re-uptake of smoking and minimal, perhaps no support to stop smoking.

What does a non-smoke-free environment mean for the health and wellbeing of patients and staff in MHIFs? Addressing this question is vital because, despite beliefs (discussed in the next section) about smoking's presumed benefits for patients and staff, each is at risk of adverse health effects from smoking and SHS.

3.2.1 Physical health effects

Second-hand smoke or involuntary smoke is defined in the thesis glossary. The body of published scholarly literature with overwhelming evidence of smoking's adverse physical health effects has grown since the 1950s (Doll & Bradford Hill, 1950; Royal College of Physicians 1962; US Department of Health, Education and Welfare, 1964).

By 1986, significant concern about SHS's health effects (Hirayama, 1981; Trichopoulos et al., 1981) saw the USSG publish *The health consequences of involuntary smoke.* This landmark report noted that following "careful examination of the available evidence"

(US Department of Health and Human Services, 1986, p. vii), conclusions were reached about tobacco smoke's effect on non-smokers.

The following conclusions and three associated protective measures from the report are relevant to my study because of patients and staff exposure to SHS in MHIFs with smoke-free policy exceptions.

Conclusions

- "Involuntary smoking is a cause of disease, including lung cancer, in healthy nonsmokers…
- Simple separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate, exposure of nonsmokers to environmental tobacco smoke". (US Department of Health and Human Services, 1986, p. vii)

Protective measures

- employers and employees need to make sure that smoking does not expose non-smokers to smoke
- smokers need to make sure that their behaviour does not impact the health of others
- non-smokers need to create environments that assist people in quitting smoking

Thus, by 1986, the adverse health effects of exposure to SHS were well established.

In the MHIF context, patients are in a hospital-care environment subject to the DSR provisions (See Glossary), a smoke-free policy, and are protected by workplace safety obligations. Therefore, the responsibility to enact the above protective measures lies with DHBs, which are hospital care institutions.

In 1999, one decade after the Government introduced the principle of smoke-free environment legislation, the Ministry of Health (2009a) published an update about tobacco use or active smoking in Aotearoa New Zealand. The update stated:

> Smoking is the main cause of lung cancer. It is a prominent risk factor for chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), upper aerodigestive cancers (includes cancers of the

> mouth, oesophagus, pharynx, and larynx), and many other cancers and chronic diseases…. The highest proportions of deaths from smoking are due to lung cancer, COPD and CVD, which together account for more than three-quarters of deaths attributable to smoking. (Ministry of Health, 2009a, p. 5)

Five years later, in 2014, the US Department of Health and Human Services published a further report which listed the "diseases and adverse effects for which smoking is identified as a cause" (p. 2). It acknowledged the selective nature of the literature review and provided justifications. The report concluded that "smoking harms nearly every organ of the body, causing many diseases and reducing the health of smokers in general" (p. 8). It listed the specific diseases where there is "sufficient evidence to infer a causal relationship between smoking" and each of the diseases (US Department of Health and Human Services, 2014, pp. 2-6). The categories of diseases included:

- cancers, including lung cancer
- cardiovascular diseases
- respiratory diseases
- reproductive effects
- other effects: cataract, diminished health status/morbidity, hip fractures, low bone density, peptic ulcer disease

Patients and staff who smoke cigarettes risk the above diseases and the associated mortality and morbidity, as do general population smokers. However, compared to the latter group, patients smoke more cigarettes, have higher nicotine dependency, and are at risk of more significant harm to physical health (Royal College of Physicians & Royal College of Psychiatrists, 2013). Thus, patients are likely to experience a higher burden from tobacco use, suggesting that cessation support would be a justified priority in this hospital care setting. Indeed, the United Kingdom public health guideline PH48 assumes that mental health patients receive intensive stop smoking support (National Institute for Health and Care Excellence, 2013).

3.2.2 Mental health effects

The body of published scholarly literature about smoking and mental health is recent compared to smoking and physical health literature. However, the association between smoking and mental health is 'less certain' than for smoking and physical health (Royal College of Physicians & Royal College of Psychiatrists, 2013; Taylor et al., 2014).

During the 1980s in the USA, studies indicated a higher prevalence of smoking among PMI than in the general population (Farrell, et al., 1983; Hughes et al., 1986). Growing concerns about the health impact of tobacco-related diseases led to smoking bans in several psychiatric hospitals (Greeman & McClellan, 1991). But it was into the 21St-century that researchers and health professionals increasingly turned their attention to the association between smoking and mental health.

Studies have investigated the following topics.

Smoking plays a crucial role in reduced life expectancy and "may account for up to two-thirds of the difference in life expectancy between smokers with SPD [serious psychological distress] and never smokers without SPD" (Tam et al., 2016, p. 958). This group of people who smoke more (Richardson et al., 2019) is more heavily addicted to nicotine and inhales cigarette smoke more deeply than people without mental illness experience (Farrell et al., 2001; Royal College of Physicians & Royal College of Psychiatrists, 2013). Thus, the consumption of cigarettes is high. An Aotearoa New Zealand study showed that approximately one-third of cigarettes were consumed by people with mental illness experiences with at least 12 months duration (Tobias et al., 2008), a percentage like that reported in the UK (Royal College of Physicians & Royal College of Psychiatrists, 2013).

People who smoke are more likely to experience a mental illness than people who have never smoked. Smoking is associated with certain illnesses, such as anxiety and depression (Royal College of Physicians & Royal College of Psychiatrists, 2013).

International studies show an association between smoking and mental illness experience (Lasser et al., 2000; Lawrence et al., 2010). Aotearoa New Zealand studies have investigated this association. A longitudinal investigation by Fergusson et al. (2003) reported that "there is evidence of a possible causal linkage between smoking and

depression [and] the direction of causality between smoking and depression remains unknown" (p. 1357). Subsequently, Boden et al. (2010) reported a link between smoking and depression.

Relevant to my study, Wilson et al. (2010) used data from a national health survey in Aotearoa New Zealand and found poorer mental health among smokers. The authors proposed that this finding highlighted the need for population strategies. Specifically, they suggested that the strategies needed to "both prevent smoking uptake and also to increase quitting rates by people at risk of, or with current, poor mental health… [while]… ensuring that smoking cessation services are appropriately tailored to those with mental health needs" (p. 131).

I make several observations. The *New Zealand Medical Journal* published the above study. This journal is likely to have a substantial national readership, including management and staff who worked in MHIFs. The study was published in 2010, just as the Government introduced DHB smoking status reporting. Although it did not link the finding specifically to the importance of appropriate clinical smoking cessation practice in MHIFs, the Wilson et al. (2010) study provided evidence about the effect of smoking on mental health in the Aotearoa New Zealand context. The date and content of the publication were timely. The question arises. Did DHBs use this evidence to guide smoke-free policy exceptions and clinical practice in MHIFs?

Certain mental disorders are associated with increased smoking rates. These include drug and alcohol dependence and suicide attempts in the past year (McManus, 2010) and psychosis and common mental disorder (Szatkowski & McNeill, 2013). Although some people use nicotine to self-medicate and lessen the effects of depression and anxiety, mental illness symptoms are often mistaken for withdrawal symptoms (Royal College of Physicians & Royal College of Psychiatrists, 2013).

Concerns have been raised about smoking cessation and nicotine's effect on certain psychotropic medications' effectiveness and metabolism (Firth et al., 2019). However, given smoking's significant impact on mental health and the benefits of quitting, Mendelsohn et al. (2015) contended that "Psychiatrists have a duty of care to identify the smoking status of their patients and to provide evidence-based support to quit" (p. 37).

Using a systematic review and meta-analysis, Taylor et al. (2014) investigated what change occurred in people's mental health when they stopped smoking compared to continued smoking. The authors found that mental health (depression, anxiety, stress) improved when people quit smoking compared to continued smoking. The Royal College of General Practitioners and Royal College of Psychiatrists (2014) put it like this: "Smoking cessation improves mental and physical health even in the short term and reduces the risk of premature death" (p. 1).

Evidence of this finding has implications for the perpetuation of beliefs and practices that condone smoking in MHIFs.

Smoking and economic impact

An investigation of the economic cost of smoking by people with mental disorders in the United Kingdom concluded that the costs were high and that financial and clinical resources needed to be prioritised for this population (Wu et al., 2015). I have been unable to identify similar studies for Aotearoa New Zealand

3.2.3 Key documents

Relevant to my study are published health reports with content about smoking and mental health in Aotearoa New Zealand. For example, the *New Zealand smoking cessation guidelines* (Ministry of Health 2007b); *Implementing the ABC approach for smoking cessation framework and work programme* (Ministry of Health, 2009); *Tobacco use 2012/13 New Zealand health survey* (Ministry of Health, 2014a); *Review of tobacco control services (*Casswell et al., 2014); *Achieving physical health equity for people with experience of mental health and addiction issues* (Te Pou, 2020a); and, *Equally well physical health* (Te Pou, 2020b). Although these key documents refer to smoking and mental health, none includes patient smoking data related to MHIFs in Aotearoa New Zealand or addresses smoke-free policy exceptions.

Also important to my study are several key documents that are silent about smoking and mental health. For example, *Reducing health inequalities* (Ministry of Health, 2002); the *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori* (Māori Affairs Committee, 2010); *NZ health strategy future directions* (Minister of

Health, 2016); and, the *Report of the Government inquiry into mental health and addictions* (Government Inquiry into Mental Health and Addiction, 2018).

Given the uncontested evidence about smoking and harm to physical health, the higher prevalence of smoking by PMI and the more recent associations between smoking and mental health, it is surprising that key health documents and reports are silent or have minimal context about this critical topic. How might we understand this silence? Could it be that smoking and mental health are unworthy of attention? Perhaps clinical practices and beliefs contribute to or help to explain this silence? In the next section, I examine common and contested *beliefs and practices* concerning smoking and mental health.

3.3 Staff beliefs and practices about smoking

International and Aotearoa New Zealand research literature about smoking, mental health, and/or MHIFs indicate that implementing smoke-free policies in MHIFs has received a mixed reception from staff. Some staff hold beliefs about smoking's presumed benefits for patients and undertake practices that oppose smoke-free policies and support smoke-free policy exceptions. They believe that smoking has benefits for staff too. Other staff oppose the beliefs and the associated practices. They *endorse* the *widely accepted* published evidence of health harm from smoking and smoke exposure, *support* smoke-free policies in MHIFs, and oppose smoke-free policy exceptions (Ashton et al., 2010; Connolly, 2009; Connolly et al., 2013; Glover et al., 2014; Lawn & Condon, 2006; Magor-Blatch & Rugendyke, 2016; Royal College of Physicians & Royal College of Psychiatrists, 2013; Sheals et al., 2016; Wong et al., 2007).

These polarised positions can be viewed as 'contested truths', which are likely to have significant clinical implications for patients and the use of smoke-free policy exceptions in DHB MHIFs (Ratschen et al., 2011). This section uses the following three themes and characterises and summarises the beliefs about smoking's presumed benefits for patients and staff and the evidence-based positions and/or legal argument in response to those beliefs.

- smoking and patient wellbeing
- smoking and patient rights

- smoking and staff practice

3.3.1 Smoking and patient wellbeing

Beliefs related to smoking and patient wellbeing reflect two consistent underlying themes: quitting is arduous, unsuccessful, and harmful to mental health; and smoking benefits mental health.

Quitting: Adverse effects on mental health

Some staff express beliefs that suggest patients' *mental health will deteriorate* if they quit smoking. It is not unusual for these beliefs to be characterised and summarised as follows:

Mental illness symptoms will worsen if patients quit smoking.	Patients are too sick and cannot be expected to quit smoking, especially in early-stage illnesses.
Patients are too emotionally fragile to quit smoking.	It is too hard for patients with psychosis, those overweight and already marginalised, to quit smoking.

(Ashton et al., 2010; Connolly, 2013; Glover et al., 2014; Royal College of Physicians & Royal College of Psychiatrists, 2013).

Smoking remedies deficits

There are also beliefs that *smoking will remedy deficits* in the patient hospital environment and patient happiness. For example:

Tobacco smoking is the only pleasure in life for patients.	Smoking relieves boredom for patients in MHIFs.

(Connolly et al., 2013; Jochelson & Majrowski 2006; Lawn & Condon, 2006; Marshall et al., 2019; McNally et al., 2006).

Quitting is very difficult

Other beliefs present quitting as very difficult for patients to achieve. To illustrate:

Patients have got enough problems in their lives without trying to quit smoking.	Patients do not have the expertise to quit smoking.
Patients are not motivated to quit smoking.	Patients will start smoking again upon discharge from MHIFs.

(Ashton et al., 2010; Gifford et al., 2015; Magor-Blatch & Rugendyke, 2016; Ratschen et al., 2009).

Some of the above beliefs signal that continued smoking is necessary to avoid worsening mental health and remedy *deficits* in the MHIF environment. Other beliefs indicate that quitting is difficult to achieve. It is as though all roads lead to smoking; a situation I suggest is 'Hobson's choice' where there is no choice for patients but to continue smoking. In effect, that is all that is on offer. Given these beliefs, I contend it is not unreasonable to wonder why patients would attempt to quit smoking and why staff would try to provide smoking cessation support.

In response to the belief that *smoking is necessary for people with mental illness,* Prochaska et al. (2008) contended that the tobacco industry, through funding research, opposing smoke-free bans, and marketing cigarettes, has advanced the belief that people with mental illness need to smoke as a form of self-medication. Lawn and Condon (2006) suggested that institutional under-medication of agitation in patients means patients have learnt to use smoking as a form of self-medication.

Although smoking has short term concentration benefits for patients regardless of mental health status, smoking is not considered to be an effective treatment for mental illness (Prochaska, 2011) because this patient group experiences high smoking rates (Richardson et al., 2019), premature mortality (Public Health England, 2016), poor physical health (Royal College of Physicians & Royal College of Psychiatrists, 2013; Royal Australian and New Zealand College of Psychiatrists, 2015; Te Pou o te Whakaaro Nui, 2017), and no amount of tobacco smoke is safe (National Cancer Institute, 2001).

Concerning the belief that *patients are not motivated to quit* smoking, Haukkala et al. (2000), Siru et al. (2009), Prochaska (2011), and Ashton et al. (2010) reported that most

patients with mental illness want to quit smoking. Studies also indicate that rather than mental health patients lacking the motivation to quit, this patient group often does not receive cessation support from staff (Royal College of Physicians & Royal College of Psychiatrists, 2013). Further, patient willingness to quit "appears to be unrelated to the psychiatric symptoms, the severity of symptoms, or the co-existence of substance abuse" (Prochaska, 2011, p. 197).

In response to the belief that mental health patients cannot quit smoking, Hall et al. (2006) and Prochaska et al. (2008) contended that patients can quit smoking. However, patients are more heavily addicted to smoking find it hard to quit and experience unpleasant withdrawal (Leventhal & Zvolensky, 2015; Royal College of Physicians & Royal College of Psychiatrists, 2013).

During the first decade of this century, smoking cessation guidelines and publications indicated that general population cessation interventions, such as prescription medication and nicotine replacement therapy, also work for PMI (USDHHS, 2000; Bradshaw et al., 2005; Ministry of Health, 2007). More recent cessation guidance signals a shift and suggests that patients do not necessarily respond so well to standard cessation interventions and may need a different approach (Hitsman, 2013; Taylor 2019). For example, *The New Zealand guidelines for helping people to stop smoking* (Ministry of Health, 2014) noted that people who smoke and use mental health services are among the Ministry of Health priority population groups. These guidelines state that the priority groups would benefit by quitting and that while the general guidelines apply to these groups, "a more tailored approach may be required in some cases" (Ministry of Health, 2014, p. 3). However, guidance for this approach is not present. At the time of writing, research focuses on whether nicotine electronic cigarette use helps patients quit. For example, an English population survey about mental health and smoking concluded that:

> E-cigarettes were associated with increased success, and they were used similarly across those with and without mental health problems, indicating that improved uptake of e-cigarettes for smoking cessation among smokers with mental health problems could help address inequalities. (Brose et al., 2020, p. 11)

In a recent Cochrane Collaboration review, Hartmann-Boyce et al. (2020) investigated whether "electronic cigarettes help people stop smoking, and if they have any unwanted effects when used for this purpose" (p. 2). The reviewers concluded:

> Nicotine e-cigarettes probably do help people to stop smoking for at least six months. They probably work better than nicotine replacement therapy and nicotine-free e-cigarettes. They may work better than no support or behavioural support alone, and they may not be associated with serious unwanted effects. However, we need more, reliable evidence to be confident about the effects of e-cigarettes. (Hartmann-Boyce et al., 2020, p. 3)

Given the reported challenging nature of quitting for highly dependent smokers, quitting may be more complex for this group than for the general population patients who smoke. Mental health patients' ability to quit appears to be enhanced by staff cessation support and perhaps by the availability of tailored cessation interventions.

Addressing the belief that *smoking is presumed to relieve the experience of boredom* by patients, Marshall et al. (2019), in a scoping review of literature about patient boredom in MHIFs, noted that boredom is "frequently perceived to increase smoking rates among those residing in hospital" (Dickens et al., 2014, cited in Marshall et al., 2019, p. 42). The absence of meaningful activities in MHIFs is often an explanation for the increased smoking rates. Lawn and Campion (2013), in a review of Australian and English literature regarding factors that enable and inhibit smoke-free policy implementation in MHIFs, stated that patient smoking to relieve boredom raises quality of care issues. The authors contend that rather than smoking as a remedy for deficits in the MHIF environment, the solution lies with the provision of structured patient activities and the effective use of cessation support. Enabling patients to use an addictive and known harmful product to relieve boredom is not regarded as an appropriate remedy for hospital deficits, particularly as "people with psychiatric disorders are far more likely to die from tobacco-related diseases than from mental illness" (Prochaska, 2011, p. 197).

Responding to the belief that *smoking is the only pleasure in life* for patients in MHIFs, Prochaska (2011) contended that smoking is neither a form of mental health treatment nor an ethical approach to patient care. In the Aotearoa New Zealand context, this belief

is inconsistent with the Aotearoa New Zealand mental health nursing standards, which indicate that practice outcome is achieved using current evidence (Te Ao Māramatanga New Zealand College of Mental Health Nurses Inc, 2012). The accepted published evidence shows that no tobacco smoke is safe (National Cancer Institute, 2001).

Linking this belief to the MHIF patient smoking culture, Lawn and Campion (2013) argued that "psychiatric hospitals need to be challenged by asking questions such as why is smoking perceived as their (patients) only pleasure, how did it get to be perceived as such, and what responsibility do services have to address this?" (p. 4237).

Poignantly, this belief potentially weds mental health and smoking and perpetuates a stigmatising stereotype that patients and smoking belong together. Given the pleasurable status attributed to smoking, it is reasonable to wonder whether any other addictive, non-medicinal, life-threatening products are constructed by staff as a pleasure and indeed a necessity for patient mental health wellbeing in MHIFs.

Pertinent to the belief quitting harms patient mental health, Zevin and Benowitz (1999) and the Ministry of Health (2007b) noted that smoking increases the metabolism of some psychiatric medications. This increase means that more medication is needed to achieve a therapeutic dose. Thus, when patients quit, medical staff need to adjust the patient dose. Using systematic review and meta-analysis, Taylor et al. (2014) examined changes in mental health when people quit smoking. The authors concluded:

> Smoking cessation is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke. The effect size seems as large for those with psychiatric disorders as those without. The effect sizes are equal or larger than those of antidepressant treatment for mood and anxiety disorders. (Taylor et al., 2014, p. 1)

Arguably, the Taylor et al. (2014) publication was particularly significant. It is an open-access document, and the following findings were likely regarded as essential for mental health practitioners and researchers because they challenged the belief that quitting is harmful to mental health. "Smoking cessation is associated with an improvement in mental health in comparison with continuing to smoke. The effect estimates are equal

or larger to those of antidepressant treatment for mood disorders" (Taylor et al., 2014, p. 9).

Subsequently, Taylor et al. (2021) completed a Cochrane Collaboration review to learn how "stopping smoking affects people's mental health" (p. 2). The review's key message is:

> People who stop smoking are not likely to experience a worsening in their mood long-term, whether they have a mental health condition or not. They may also experience improvements in their mental health, such as reductions in anxiety and depression symptoms. (Taylor et al., 2021, p. 3)

I now consider staff beliefs related to smoking and patient rights.

3.3.2 Smoking and patient rights

Smoking is a patient's right

Some staff hold beliefs about smoking and patient rights, which reflect notions about patient autonomy, choice, and legal entitlement to smoke in MHIFs. These beliefs are characterised as follows:

You have the right to smoke in your home. The MHIFs are the patients' homes; therefore, they have a right to smoke there.	Smoking is a human right.
Staff have no right to force patients to stop smoking.	Banning smoking is discriminatory and a breach of human rights.

(Glover et al., 2014; Woodward & Richmond, 2019)

Human rights and smoking: The legal situation

Regarding the belief that smoking is rights-based, neither international human rights law nor Aotearoa New Zealand law provides a right to smoke cigarettes.

Aotearoa New Zealand is a signatory to the United Nations Covenant on Economic, Social and Cultural Rights (1966) (ESCR). The ESCR does not provide a right to smoke.

Instead, Article 12 provides the right to health. Similarly, Aotearoa New Zealand is a signatory to the WHO FCTC (2003), which is "an evidence-based treaty that reaffirms the right of all people to the highest standard of health" (p. v). The WHO FCTC states that "Parties to this Convention [are] determined to give priority to their right to protect public health" (p. v). The WHO FCTC does not provide a right to smoke.

Turning to domestic law, the Human Rights Act 1993 contains the prohibited grounds of discrimination. Smoking is not a ground in this legislation, a fact confirmed on the website of the Human Rights Commission (n.d.), the national human rights institution.

The Aotearoa New Zealand case law related to this belief was developed in 2017 when the Supreme Court (the Court) considered an appeal concerning the smoke-free policy at the Waitemata DHB MHIFs. The Court's consideration included whether DSRs were of a permissive or mandatory nature and whether the DHB smoke-free policy breached the New Zealand Bill of Rights Act 1990.

The Court held that there was no existing right for the Appellant to smoke, that the DHB was not obliged to provide DSRs, and there was no discrimination on the grounds of disability or any breach of the New Zealand Bill of Rights Act 1990 (*B v Waitemata District Health Board,* 2017).

Relevant to the belief that MHIFs are home for patients, thus entitling them to smoke in the MHIF, the Court considered whether the right to a home or private life included the right to smoke. It determined this contention was "too generalised because it is too removed from the sphere of personal autonomy warranting protection" (*B v Waitemata District Health Board*, 2017, para. 132) and that there are inevitable choice constraints for a patient in MHIFs. The Court referred to evidence about the benefits of smoking cessation and the harm of smoking in MHIFs. It concluded that "The effect of this evidence is to indicate smoking, at least in the context of a short-term ban, can be put in the category of harmful activities appropriately constrained in the mental health institutions in issue here" (*B v Waitemata District Health Board*, 2017, para. 134). In other words, the institution was entitled to stop patient smoking. The Court also noted that even if there had been a breach, the DHB's smoke-free policy is "a reasonable and proportionate one which could comprise a justified limit under s5 of the Bill of Rights" (*B v Waitemata District Health Board*, 2017, para. 135).

Can staff enforce smoke-free policies?

A further staff belief is that staff have no authority to force patients to stop smoking. The Court of Appeal in *B v Waitemata District Health Board* (2016) considered this belief in the context that DHBs are owners and leasees of property. These roles mean the DHBs can regulate people's behaviour on these properties so long as the regulation aligns with the DHBs' purposes and objectives in the New Zealand Public Health and Disability Act 2000 (NZPHDA). Applying this reasoning to smoke-free policies, the Court of Appeal concluded that the NZPHDA gives DHBs the power to implement a smoke-free policy to protect patients, staff, and visitors from smoke and promote smoking cessation. To elaborate, the authority to use smoke-free policies comes from the DHBs' purpose to improve, promote, and protect the health of New Zealanders (NZPHDA, s(1)(a)(i)). Smoking is a hazard for New Zealanders, and confining this hazard comes within the above purpose. A smoke-free policy that bans smoking promotes cessation, improves health, and protects against second-hand smoke. Since MHIF staff are DHB employees, they must carry out and enforce DHB policies, including smoke-free policies.

The overwhelming and accepted evidence of harm about smoking and SHS suggests it extremely unlikely that legislators would establish a human right to smoke or that the judiciary would hold smoking is a human right. However, in the absence of familiarity with the law, the belief that smoking is a human right has some traction.

3.3.3 Smoking and staff practice

Another set of staff beliefs reflects two additional themes: smoking and cigarettes are tools for staff use and are part of the job, but patient smoking cessation is not part of the job.

Smoking: A patient management tool

Some staff express beliefs that smoking patients are easier to manage and that it is the staff's role to control patient cigarette supplies.

It is easier to manage patients who smoke.	Smoking relieves patient stress.
Smoking helps with patient behavioural compliance.	Patient cigarette supplies need to be controlled and provided

(Glover et al., 2014; Smith et al., 2019).

Smoking: not a priority

Mental illness is the clinical priority and not smoking.	Nicotine addiction is less important than other addictions.

(Glover et al., 2014; Magor-Blatch & Rugendyke, 2016; Smith et al., 2019)

Some staff believe that smoking is not a mental illness and is less critical than other addictions.

Not my job

It is not the role of staff to stop patient smoking.	Providing cessation support is on top of the existing job.
Cessation support is demanding and time-consuming.	Smoking is a personal patient choice.

(Connolly 2009; Health and Disability Commissioner, n.d; Glover et al., 2014; Lawn & Condon, 2006; Magor-Blatch & Rugendyke, 2016; Ratschen et al., 2009).

An extension of the above belief, smoking cessation is not a staff role, and it is the patient's individual choice.

Therapeutic relationship

Smoking helps patients to talk.	Smoking with patients helps form a therapeutic relationship.

(Connolly et al., 2013; Dickens et al., 2014; Glover et al., 2014; Lawn & Condon, 2006; McNally et al., 2006).

The idea that smoking with patients helps build a therapeutic relationship is another strongly and widely held belief.

Is smoking cessation a waste of time for staff?

Regarding the belief that smoking cessation support to patients is wasted staff effort because patients are likely to resume smoking post-discharge, Lawn and Campion (2013) contended that the health system needs to ensure continuity of care by providing cessation support for patients in hospital and when they leave the hospital. Connolly et al. (2013) observed that in Aotearoa New Zealand, registered nurses' competencies include educating and promoting health and wellbeing. To illustrate, in the Standards of Practice for Mental Health Nursing in Aotearoa New Zealand (the Standards), a practice outcome is met in standard five when "The mental health nurse's practice is informed by current evidence" (Te Ao Māramatanga New Zealand College of Mental Health Nurses Inc, 2012, p. 10). Given that the benefits of quitting are evidence-based (USSG, 2020), staff who support smoke-free environments contest the belief that cessation is a waste of time.

Both Wong et al. (2007) and Connolly et al. (2013) reported that most nurses in their respective New Zealand studies considered advising patients to quit was part of their job and that it was their role to help patients quit smoking. However, the significance of these findings for mental health has limitations. The first study, which included a range of nurse specialities, reported a low response rate of 4% from mental health nursing (Wong et al., 2007). The second study involved 104 nurse participants, of whom 45% worked in mental health inpatient services (Connolly et al., 2013).

Turning to legal and ethical obligations associated with practice standards, Prochaska (2011) cautioned that "Failure to treat tobacco dependence with effective, available treatments according to recognised clinical practice guidelines is unethical and in violation of the legal duty of health care providers" (p. 180). In the Aotearoa New Zealand context, the registered health practitioners' legal duty requires compliance with the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (the Code) which includes ensuring "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards" (Right 4 (2)).

Several beliefs relate to clinical practice. These include the beliefs that nicotine addiction is a lower clinical priority than mental illness and/or other addictive drugs and that tobacco dependency is not mental.

In addressing these beliefs, Prochaska (2011) stated that mental health patients are more likely to die from a smoking-related illness. High rates of nicotine dependency suggest that in MHIFs, this form of dependency is likely to be a common form of addiction.

The addictive nature of nicotine and the harm related to addiction and smoking are recognised in the *DSM* (5th ed.), (APA, 2013), which is the accepted standard classification of mental disorders and includes the harm from tobacco dependence disorder. Tobacco use and associated diseases are also categories in the International Classification of Diseases (WHO, 2019). Neither classification schema states that smoking is less important than other dependencies. The inclusion of tobacco dependency and the associated mental, behavioural, and physical harm in these widely accepted mental health and disease classifications are global recognition that tobacco use is harmful. They also recognise that diagnosing and treating patient tobacco use is legitimate and expected to be a role for mental health practitioners.

Some staff believe that patients need to recover from other mental illnesses before attempting to quit. This belief reflects the idea that smoking is less harmful and perhaps not a mental illness but affects physical health only. It also implies that other mental illnesses need treatment before patients can quit because quitting will negatively impact their mental health. As noted in the smoking and patient wellbeing section, smoking cessation is associated with improved mental health compared to continued smoking (Taylor et al., 2014) and quitting is not likely to worsen mood long-term (Taylor et al., 2021).

The idea that smoking reduces patient stress is a long-held belief (Shiffman, 1993). Neuman et al. (2005) recorded that the tobacco industry considered that it was in "the business of selling nicotine, an addictive drug effective in the release of stress mechanisms" (p. 328). This message is evident in the tobacco advertisements (See Chapter Two) that portray tobacco smoking as a stress relief mechanism for wartime soldiers and the general population. The Department of Health's inclusion of smoking in

the ‘patient comfort fund’ also implies a comforting and stress relieving role for tobacco smoking.

Challenging this belief, Prochaska (2010) contended that smoking does not reduce stress; instead, it alleviates the symptoms of nicotine withdrawal, which people interpret as stress relief:

> Smokers, however, often confuse the relief of their nicotine withdrawal with the feeling of relaxation. Nicotine is a stimulant and can enhance mood, but only transiently. Smoking increases stress levels due to the constant need to smoke to avoid nicotine withdrawal. The goal is to help patients (and mental health and addiction treatment providers) realise that tobacco is the problem, not the solution. Tobacco does not address the underlying stressors in one’s life. (p.5)

Some staff believe that smoking with patients is crucial to establishing a therapeutic staff-patient relationship (Connolly et al., 2013; Glover et al., 2014; Grant et al., 2014; Sheals et al., 2016). Nurses who smoke are more likely to endorse this position (Connolly et al., 2013; Dickens et al., 2004).

Moreno-Poyato et al. (2017) noted, **“**The Therapeutic Relationship (TR) is one of the most important tools at nurses’ disposal, especially in mental health nursing” (p. 2). Within psychiatry and mental health, there are different ideas about the meaning of *the therapeutic relationship* (Priebe & McCabe, 2006). However, O’Brien (2000), in his study of New Zealand mental health nurses’ perceptions of this relationship, observed that it expresses interpersonal engagement with consumers. Regarding the Standards, standard two states that the therapeutic relationship and therapeutic communication are bases for patient recovery and wellbeing. Using an addictive and harmful legal drug to achieve therapeutic relationships in a hospital-care environment has been the subject of significant challenges (Lawn & Condon, 2006; McNally et al., 2006). These include the contention that there is no justification for using a lethal substance to develop this critical relationship. Further, Lawn and Condon (2006) argued that staff reliance on smoking to establish a therapeutic relationship with patients fosters nursing practice

that replaces valued staff interpersonal skills with cigarettes to communicate with patients.

Turning to the belief that staff need to control patient cigarettes supplies, Grant et al. (2014), in their Canadian study about smoke-free policy implementation in MHIFs, reported that the staff thought tobacco was useful:

> In managing patient behaviors, especially unruly ones. The power of tobacco addiction was instrumentally used by HCPs [health care professionals – my insertion] to influence behaviors in patients through a reward system that included discretionary granting of FABs [*fresh air breaks* – my insertion]. If a patient was a smoker, HCPs, by granting or withholding hourly FABs, could influence behaviors. Confirmed through observation of and conversations with HCPs, the use of FABs emerged as a bargaining tool in this regard. (p. 1737)

The authors also reported that some staff considered that they were required to act as police officers when controlling tobacco, a role that was not comfortable.

How might staff beliefs impact clinical and nursing practice concerning smoke-free policies?

3.4 Implications of staff beliefs for staff practice

Staff beliefs that endorse smoking in MHIFs have existed for several decades. Formal smoke-free policies arose from the smoke-free legislation in 1990. Thus, it is reasonable to consider that by 1990, staff beliefs about smoking were likely tightly woven into the daily clinical and management operation of MHIFs and served to reinforce smoking as an acceptable activity. In an Australian study using mixed methods including thematic analysis, Magor-Blatch and Rugendyke (2016) surveyed mental health professionals' attitudes to smoke-free policy changes. Participants accepted smoking was harmful but justified smoking by PMI, believed that smoking should be permitted in MHIFs, and disagreed that smoking posed more personal health risks than mental illness. The authors concluded there were "commonly held attitudes that were unsupportive of smoking bans and indicated beliefs inconsistent with a smoke-free policy for clinical

populations" (p. 291). Sheals et al. (2016) undertook a mixed-method review and meta-analysis involving 38 studies about mental health professionals' (MHPs) attitudes to smoking cessation among PMI. The MHPs worked in mental health, drug, or alcohol treatment. The results indicated that "a significant proportion of MHPs held negative attitudes towards smoking cessation and permissive attitudes towards smoking and perceived a number of barriers to providing smoking cessation treatment" (Sheals et al., 2016, p. 1549). The commonly held negative attitudes were quitting was too much for patients and patients were not interested in quitting. The barriers were permissive attitudes to smoking and negative views about smoking cessation. The authors concluded that MHPs' beliefs might have implications for clinical practice and behaviour about smoking cessation in mental health and related treatment. In an exploratory mixed-methods study of MHPs' attitudes about providing smoking cessation while an Australian MHIF transitioned to smoke-free, Chambers (2016) found that current smokers were more ambivalent than non-smoking staff. The significant barriers to smoke-free were supporting the patient choice to smoke, the level of patient unwellness, and the belief that the nature of smoke-free policies needed to include partial smoking bans (PSBs).

Clinical practice for doctors involves "Any work undertaken by a doctor that relates to the care of an individual patient" (Medical Council of New Zealand, 2018, p. 1) while mental health nursing practice:

> is a specialised interpersonal process embodying a concept of caring which has a therapeutic impact on the consumer, the family or whānau, and the community in their cultural context, by:
>
> - supporting consumers to optimise their health status within the reality of their life situation
> - encouraging consumers to take an active role in decisions about their care
> - involving whānau and communities in the care and support of consumers. (Te Ao Maramatanga (NZCMHN) Inc, 2004, p. 1)

3.4.1 Endorsing smoking in MHIFs: Staff practice

Staff practice includes action and inaction that endorses or facilitates smoking in MHIFs. The published literature records examples of staff practices that endorse smoking in MHIFs. Examples include:

Action that supports smoking in MHIFs

- authorising smoking breaks for patients (Hawkes Bay DHB, n.d.)
- renaming patient smoking breaks as 'fresh air breaks' (Grant et al., 2014)
- overriding smoke-free policies to allow patient smoking (Glover et al., 2014)
- staff smoking with patients in MHIFs, on the hospital grounds and during escorts (Smith et al., 2019)
- providing designated indoor and outdoor smoking areas and gazebos (Correa-Fernández et al., 2017; Huddlestone et al., 2018)
- permitting patient smoking indoors and/or outdoors (Woodward & Richmond, 2019)
- providing tobacco, cigarettes, lighters (Huddlestone et al., 2018)

Inaction that supports smoking in MHIFs

- retaining designated smoking areas (Lawn & Campion, 2013)
- not participating in staff smoke-free and cessation education and training (Sheals et al., 2016)
- not providing staff cessation assistance and turning a blind eye to smoking by staff and patients (Hawkes Bay DHB, n.d.)
- not assessing and treating tobacco dependence disorder (Guydish, et al., 2007; Sellman, 2005)
- not offering to help patients quit smoking (Smith et al., 2019)
- not recording patient smoking status in the patient records (Sohal et al., 2016)

The above actions and inactions have possible implications for MHIF patients, staff, and SF 2025.

3.5 Implications: Patients and staff

Patients

Mental health inpatient facility patients who do not smoke or have quit are likely to risk resuming smoking in a facility where smoking is normalised. The absence of cessation support and a smoke-free environment exposes both smokers and non-smokers to the established harms of SHS.

If smoke-free policy exceptions are restricted to MHIFs and exceptions do not exist for general hospital patients, MHIF patients who smoke are unlikely to have been provided smoking cessation opportunities. I suggest that MHIF patients will likely be among those smoking in 2025. Those smoking cigarettes will continue to experience the detrimental effects of smoking on their mental and physical health and wellbeing. Should e-cigarettes become the harm reduction tool of MHIFs and PMI choice and enable smoking cessation, smoking's detrimental effect will reduce. However, there is limited evidence of the physical and mental health consequences of nicotine e-cigarette use as of June 2021

Staff

It is likely that Lawn and Condon's (2006) concerns about nurses' deskilling are also contemporary, in which case workforce development will be necessary. Further, mental health nurses have higher rates of smoking. For example, Edwards et al. (2018) reported that relative to doctors and other nurse specialities, psychiatric nurses have "the highest smoking prevalence (15% male, 18% female)", and that " all nurses except psychiatric nurses were on track to achieve" (p. 48) the smoke-free goal of less than 5% smoking prevalence. In the hospital care environments, where the above staff practices have occurred, it is reasonable to infer that tobacco dependence disorder's diagnosis and treatment have not been central, systematic aspects of care in those facilities. Such circumstances are at odds with the recommendations in *Smoking and health,* the joint report by the Royal Colleges of Physicians and Psychiatrists (2013), which concluded:

> Patients with mental health problems should receive at least the same level of access to smoking cessation treatment and aids to quitting as members of the general population... There is no justification for

> healthcare staff to facilitate smoking… It is likely that the persistent acceptance of smoking as normal behaviour in …secondary care, and the failure by health professionals to address smoking prevention as a health priority drives and perpetuates the high prevalence of smoking in people with mental disorders. (pp. 200-201)

Staff practices that endorse smoking in MHIFs are also at odds with diagnostic categories in the *DSM* (5th ed.) (APA, 2013) and the disease conditions in the *International classification of diseases* (WHO, 2019).

Similar access to cessation care

The Royal Colleges (2013) stated that practitioners have a legal and equitable duty to provide cessation care to MHIF patients. As noted above, the Royal Colleges consider that access to smoking cessation treatment needs to be similar for patients and general population members. They concluded that a "Smoke-free policy is crucial to promoting smoking cessation in mental health settings" (Royal Colleges of Physicians and Psychiatrists, 2013, p. 201). Smoke-free policies require staff and patient compliance with a general rule to be smoke-free. However, these policies sometimes offer exemptions to the general rule, thus permitting smoking by authorised populations and sometimes in designated places.

3.6 Summary

The published literature indicates the presence of polarised staff positions regarding cigarette smoking in MHIFs. Some staff hold beliefs about smoking's presumed benefits for patients and staff, and other staff oppose those beliefs drawing on accepted published evidence of harm from smoking and SHS and statute and case law. Staff beliefs have implications for staff practice, exhibited as actions and inactions that endorse and/or facilitate smoking in MHIFs and do not satisfy professional standards and duties.

What is the situation concerning smoke-free policies in MHIFs?

3.7 Smoke-free Policies and mental health inpatient facilities

The term 'smoke-free policies' suggests that people will be free from exposure to SHS and that smoking will not be permitted. However, within hospital care institutions such as MHIFs, smoke-free policies are either in the nature of 'total smoking bans' (TSBs) that invariably prohibit smoking or PSBs that allow smoke-free exemptions and permit smoking under specified circumstances. At times TSBs are flouted (Stockings et al., 2015), which suggests although an organisation has a formal smoke-free policy with a TSB, the practice is more like a PSB. Identifying PSB smoke-free policies and practice gaps is relevant to my research.

This section considers each type of ban, the associated rationale, policy objectives, and impacts, including patient, staff, and visitor reactions. The relevant Aotearoa New Zealand literature is reviewed separately for each ban.

3.7.1 Total smoking bans

Smoke-free policies with TSBs, sometimes called comprehensive smoke-free policies, involve a general rule to be smoke-free. The rule operates by prohibiting smoking both indoors and outdoors (Lawn & Pols, 2005) for patients, staff, and visitors. In practice, this means no smoking inside the buildings or on the grounds of the MHIF, and the rule applies to that site if the MHIF is on the general hospital site. Smoke-free policymakers do not contemplate policy exceptions for TSBs, which are regarded as requiring less enforcement than PSBs (Stockings et al., 2015) and are most effective when MHIFs are 'totally smoke-free' for patients, staff, and visitors (Moss et al., 2010; Olivier et al., 2007).

The primary rationale for TSBs is the protection of all non-smokers from exposure to the established harm of SHS (Hirayama,1981; U.S. Department of Health and Human Services, 2006). The protection rationale may be supported by objectives such as those listed in summary points below:

- incorporating smoking cessation into clinical practice and supporting patients to quit smoking (IARC, 2009)
- compliance with domestic smoke-free legislation and health and safety workplace legislation (e.g., Mid Central DHB, 2011; Waikato DHB, 2005)
- meeting Party obligations under the WHO FCTC 2003 (WHO, 2003)

- improving patient physical health (Campion et al., 2008)
- bettering patient mental health (Taylor et al., 2014)
- demonstrating hospital care leadership (Canterbury DHB, 2005)
- reducing smoking to contribute to a national smoke-free goal and/or local smoke-free initiatives (e.g., Aotearoa New Zealand's SF 2025 national goal; Counties Manukau DHB, 2019)
- contributing to a national health strategy (e.g., the New Zealand Health Strategy 2000; Waikato DHB, 2005)

Thus, the salient feature of a smoke-free policy is focusing on non-smokers rather than smokers. Generally, non-smokers are seen as innocent bystanders subject to smokers' unpleasant, undesirable, and unhealthy smoke in the workplace. Being subject to other people's unwanted SHS invokes the concept of 'harm to others' (van der Eijk, 2015), and this type of harm tends to garner support for smoke-free areas in these workplaces.

3.7.2 Total smoking bans impact in mental health inpatient facilities: International experience

Although TSBs are flouted, they require less enforcement than PSBs (Stockings et al., 2015). Total smoking bans can achieve the protection rationale (Lawn & Pols, 2005; Stockings et al., 2014). Seemingly obvious, a TSB means no patients, staff, or visitors are exposed to unsafe levels of particulate matter from SHS, which, as noted in Chapter Two, cannot be removed entirely by mechanical ventilation. Indeed, a study that measured the air concentration of particulate matter, a marker for second smoke, in 64 Catalonian MHIF concluded that only MHIFs with indoor and outdoor TSBs protected patients (Ballbè et al., 2013). Thus, improved air quality and the associated health benefits are critical impacts of TSBs for patients in MHIFs.

In contrast to the protection rationale, the extent to which TSBs in hospitals impact the smoking cessation-related objectives is not as decisive. Stockings et al. (2014) concluded that TSBs might better assist mental health inpatients with quit attempts. A systematic review undertaken for the Cochrane Collaboration found that "banning smoking in hospitals… increased the number of quit attempts and reduced the number of people smoking" (Frazer et al., 2016, p. 2). However, the reviewers noted that their findings

were reached without “high-quality studies to include in our review” (Frazer et al., 2016, p. 2). The review was not specific to MHIFs.

A recent Australian study reviewing clinical practice improvement to state-wide smoking care in Queensland acute MHIFs found that while recording smoking status and the delivery of cessation care improved, it was unknown whether these interventions supported quitting or smoking fewer cigarettes (Plever et al., 2020).

The report *Smoking cessation* (U.S Department of Health and Human Services, 2020) noted the unwillingness of mental health treatment facilities to implement smoke-free policies and nicotine dependence treatment in routine clinical provision. However, it observed treatment services are implementing more smoking cessation and that:

> These efforts have coincided with increased adoption of smoke-free and tobacco-free policies… by state behavioural health facilities… Overall, the evidence is sufficient to infer that smoke-free policies reduce the prevalence of smoking, reduce cigarette consumption and increased smoking cessation… smokefree policies are particularly effective when coupled with the resources for cessation. (U.S Department of Health and Human Services, 2020, p. 603)

Total smoking bans are associated with a range of other impacts. In a review of findings from 26 international studies about the effectiveness of TSBs in MHIFs, Lawn and Pols (2005) identified the following impacts of TSBs:

- patient aggression did not increase
- patient self-discharge against medical advice did not increase
- patient use of nicotine replacement therapy (NRT) was widespread
- staff smoking declined as they used the opportunity to quit
- staff use of cigarettes to manage patient behaviour was disrupted
- staff experienced fewer problems in achieving patient co-operation and talking about treatment
- staff did not increase the use of seclusion for patients
- staff did not increase the use of as-needed medication for patients
- staff had the opportunity to develop new clinical skills in smoking cessation

- staff developed a more positive view of TSB post-ban

The findings indicated that consistent and total administration support and post-discharge cessation support would strengthen the TSBs.

In a study of staff attitudes and experience about a TSB implementation in a high secure MHIF located in metropolitan Sydney, Hehir et al. (2013) found that "most staff felt that the smoke-free environment had a positive impact on the health of patients (86%) and on themselves (79%) …just over half (57%) of staff surveyed agreed that patient care was easier in a totally smoke-free environment" (p. 315). There was less support from staff who smoked with each of these findings. This study also found that most staff did not consider that the TSB led to increased patient aggression, and it may have helped some staff quit smoking.

In the hospitality sector, the presence of TSBs has been associated with reduced cleaning costs (Ministry of Health, 2006). It is reasonable to infer that a similar reduction in MHIF cleaning costs would also impact TSBs in this setting.

Huddlestone et al. (2018) undertook a mixed-methods evaluation of a TSB in an English inpatient mental health trust. Quantitative data were collected before and after implementing national smoke-free guidance published by the UK National Institute of Health and Clinical Excellence (NICE). The guidance recommended "the implementation of completely smoke-free hospital sites without exemptions, comprehensive policies that promote and support smoking cessation and temporary abstinence, and the development of integrative treatment pathways for tobacco dependence (Huddlestone et al., 2018, p. 543).

The authors found that post TSB implementation, more patients were offered cessation support, challenging patient behaviour had reduced, patients reported more motivation to remain quit post-discharge, and there was an increase in hidden smoking products.

The above impact findings suggest greater benefits for staff regarding aspects of patient management than benefits for patients. No visitor impact was identified. The findings could, however, reflect research designs. Regarding staff, there may have been more focus on the smoke-free policy impacts on staff because before TSB implementation,

some staff hold concerns that if patients cannot smoke cigarettes, they will become more aggressive, less cooperative, need more medication, self-discharge without medical advice, and require more seclusion (Lawn & Pols, 2005; Ratier-Cruz et al., 2020).

3.7.3 Staff, patient, and visitor reactions to total smoking bans

Total smoking bans are most effective when MHIFs are 'totally smoke-free' for patients, staff, and visitors (Moss et al., 2010; Olivier et al., 2007). They tend to be well received by non-smoking staff who are more likely to support smoke-free environments, perceive these environments as health-promoting, and believe that nicotine addiction and offering smoking cessation support is part of their role as mental health practitioners (Lawn & Campion, 2010). However, TSBs have not been uniformly welcomed by MHIF patients, staff, and visitors.

In a comparison of two Australian mental health sites, Lawn (2004) found that TSBs are less likely to be positively received by staff who have:

- beliefs and practices reflecting notions that tobacco is necessary for staff-patient relations
- beliefs that smoking has a medicinal and behavioural role for patients
- beliefs that a smoking ban is a breach of patient rights

In a more recent Australian study of MHPs' attitudes and experience of smoke-free policies in a high-security MHIF, Hehir et al. (2013) found that staff who smoked were less positive about TSBs. Examining clinical and non-clinical staff attitudes about completely smoke-free policies, or TSBs, in a London-based mental health trust, Ratier-Cruz et al. (2020) found that most participants "disagreed with the policy on the ward (59.6%) and throughout all mental health settings (57.4%)" (p. 403). The authors concluded that staff attitudes were policy implementation barriers and that "The embedding of the policy in routine day-to-day clinical practice will be the product of action, not necessarily attitudes or intentions" (Ratier-Cruz et al., 2020, p. 410).

There are minimal publications regarding patient views about TSBs. Stockings et al. (2015) surveyed patients' views about TSB implementation in a MHIF in New South Wales, Australia. Of the 181 participants, 97 were smokers who reported poor TSB

adherence (83.5% smoked), use of NRT (75.3%), and low positivity to TSBs (29.9%). Overall, less than half the patients (45.9%) regarded the TSB as positive, while just over half (53.6%) thought that staff supported the TSB. The authors concluded that the TSB was widely flouted by patients, just over half of whom perceived that the staff did not support the TSB. It is unlikely the intended protection and health benefit impacts of TSBs for all patients and staff would be achieved in these circumstances.

Breaches of TSBs include continued smoking by patients, the absence of total staff support for TSBs and, relative to non-smoking staff and patients, lower levels of support from patients and staff who smoke (Hehir et al., 2013; Stockings et al., 2015). Patient TSB non-compliance has also been reported in the form of 'sneaking' tobacco and smoking paraphernalia into the grounds, wards, and bedrooms or hiding these items on their person when they return from leave. Staff have endorsed these forms of non-compliance, suggesting that patients find a place to 'stash' or hide their cigarettes and by allowing visitors to bring tobacco supplies into MHIFs (Huddlestone et al., 2018).

Overall, TSBs offer several benefits to patients and staff. However, TSB breaches make it more likely that the TSB protection rationale and associated physical and mental health benefits will not be available to all patients and staff. Further, TSBs are likely to be undermined by partial support from patients and staff, and the presence of a smoke-free policy does not necessarily translate into smoke-free organisational practice.

3.7.4 Total smoking bans impact in mental health inpatient facilities: Aotearoa New Zealand

As noted in Chapter 1, to the best of my knowledge, there is minimal published Aotearoa New Zealand literature about:

- MHIFs, and smoking; or
- MHIFs, smoking, and smoke-free-policies; or
- MHIFs, smoking, and smoke-free policy exceptions.

The following three Aotearoa New Zealand publications provide some insight related to the impact of smoking bans, although none directly addresses the impact of TSBs in DHB MHIFs (Connolly, 2009; Connolly et al., 2013; Glover et al., 2014).

Glover et al. (2014) ('Glover study') examined the barriers to mental health and addiction services (MHADS), inpatient and community, becoming smoke-free. Data were collected in 2006 using telephone interviews with 56 key informants. "Most of the respondents worked for DHBs" (Glover et al., 2014, p. 185), although the study did not report the percentage of informants working in DHB MHIFs.

Connolly's (2009) master's thesis examined the beliefs of mental health nurses about client smoking in MHIFs. Data were collected in 2009 using a questionnaire-based survey that 104 mental health nurses completed throughout Aotearoa New Zealand. Forty-five per cent of the participants worked in MHIFs, although the study did not indicate whether these participants worked in DHB MHIFs. The key findings were published later by Connolly et al. (2013) ('Connolly study').

Turning to the Glover study, three categories of organisations were identified to reflect their progress towards a smoke-free culture. The categories were 'permissive smoking culture', 'transitional smoking to smoke-free culture', and 'smoke-free culture' and they were based on the following three indicators " (i) smoke-free environments; (ii) smoke-free attitudes and behaviour of management and staff; and (iii) cessation support for staff and service users" (Glover et al., 2014, p. 185).

Relevant to TSBs, only eight (14%) of the 56 participant organisations were classified as a smoke-free culture. Of the eight organisations, it seems reasonable to assume that these were formally operating a TSB because smoke-free status was an indicator of a smoke-free culture. The study, however, neither reports whether the smoke-free organisations were DHB services and/or MHIFs nor discusses the impact of TSBs on patients, staff, and visitors. The low percentage of smoke-free culture organisations suggests that smoke-free cultures and TSBs were not common in 2006 in MHADS, including MHIFs.

If we assume that the eight smoke-free culture organisations were DHB MHIFs and that all DHBs participated in the study, then the remaining 12 DHB MHIFs (60%) did not have smoke-free cultures; a result I suggest would indicate that TSBs were not common in 2006.

It is important to note that the Glover study was accepted for publication in 2013, seven years after the data collection (Glover et al., 2014). However, the publication states, "Currently, 15 of 20 district health boards (DHB)… have smoke-free policies that include MHS (mental health services)" (Glover et al., 2014, p. 184). The references for these policies indicate that they were cited in June 2013, suggesting that the DHBs' smoke-free policy status is related to 2013. However, since the data relates to 2006, we cannot be sure that the presence of formal smoke-free policies on the three DHB websites in 2013 translates into the practice of smoke-free cultures.

The Glover study also states that "in New Zealand the legislation allowed an exemption, whereby those working in MHADS were not required to implement smoke-free policies" (Glover et al., 2014, p. 184). The relevant legislation is section 6 of the Smoke-free Environments Amendment Act 2003, and I make several observations. First, the authority to invoke the above exemption lies with the employer of a hospital care institution. Second, the exemption does not specify MHADS. Third, the exemption is limited to providing dedicated smoking rooms, and it does not mention smoke-free policies. Fourth, and relevant to my research, implementation of the exemption is discretionary, which means that a hospital care institution was not required to implement the exemption. Put differently, hospital care institutions were able to have a smoke-free MHIF. These legal points of clarification are important because the study informants working in permissive smoking cultures cited the legislative exemption as "a reason for having a dedicated smoking room for patients" (Glover et al., 2014, p. 186). Arguably, this reasoning 'blames' the law for the presence of the DSRs rather than the organisational decision-makers. Secondly, this reasoning ignores the discretionary nature of the legislative provision, a legal position confirmed by the Aotearoa New Zealand High Court in (*B v Waitemata District Health Board,* 2013).

The Connolly study concluded that TSBs were less favoured than PSBs and that nurses' smoking status made a difference to their beliefs: smokers were more supportive of smoking playing a clinical and social role in MHIFs. Examples of these beliefs are discussed in the partial smoking ban section at 3.7.5.

Like the Glover study, this study does not discuss the impact of TSB in MHIFs other than to note that successful smoke-free policies can enhance safety and lessen conflict.

Creating TSBs in MHIFs would help reduce the established physical health impact of smoking. The data for the Connolly study were collected three years after the data for the Glover study. Given the Connolly conclusion, it is reasonable to infer that TSBs and smoke-free cultures were still not common in 2009 in MHIFs.

3.7.5 Partial smoking bans

Smoke-free policies that maintain a general prohibition on smoking but permit smoking under certain circumstances are called PSBs. These policies apply the general smoke-free rule to indoor and/or outdoor areas while allowing exceptions to that rule. The exceptions normalise and permit smoking, usually in designated places for specified people and, perhaps, at certain times. Typically, the exceptions in MHIFs apply to patients, excluding staff and visitors, permit indoor smoking, and, more often, in outdoor spaces within the MHIF grounds (Woodward & Richmond, 2019).

The primary rationale for PSBs in MHIFs is protecting a defined group—patient smokers—from a perceived loss of their right and choice to smoke and anticipated clinical and social consequences of not smoking (Lawn & Condon, 2013). Patient smokers tend to be regarded as innocent victims of government and institutional smoke-free policies.

Partial smoking bans are also justified as a stage towards implementing TSBs to allow smoke-free workforce development before banning patient smoking (Lawn & Campion, 2010; Public Health England, 2016).

My earlier examination of beliefs and practices indicates that smoking has played multiple roles in MHIFs. Overwhelmingly, these roles reveal the embedded nature of smoking in MHIFs, the presumed therapeutic value relative to the established evidence, and staff determination to maintain the status quo by permitting smoking. Simply put, staff acceptance that smoking is necessary for patients has arguably played a significant role in creating PSBs allowing smoking by MHIF patients (Prochaska, 2010).

3.7.6 Impact of partial smoking bans in mental health inpatient facilities: International experience

Compared to smoke-free policies with TSBs, PSBs are regarded as less successful smoke-free policies, and they have several adverse health implications for patients in MHIFs.

When smoking is permitted in designated indoor smoking areas, it is not possible to protect all patients and/or staff in those areas from the harms of SHS. It is also harder to discourage patients from smoking (Campion et al., 2008; Lawn & Pols, 2005; U.S. Department of Health and Human Services, 2006). The right to health and be free of SHS exposure is suspended.

Among the lessons from achieving smoke-free mental health services, Lawn and Campion (2013) contended that "the most significant problem with partial smoke-free policies is their limited impact on the staff and patient culture of smoking" (p. 4228). In essence, patient smoking remains normalised behaviour in MHIFs.

Partial smoking bans also impact patient care systems by undermining the clinical management of nicotine dependence thus deskilling the MHIF workforce and leaving it mainly without expertise in cessation support (Lawn & Campion, 2013; McNally et al., 2006).

A PSB in a MHIF is not conducive to patients quitting smoking, and support for smoking cessation is unlikely to be achieved. In addition, studies report the uptake of smoking by non-smokers and re-uptake of smoking by former smokers in MHIFs (IARC, 2009; Lawn & Campion, 2013; Wye et al., 2009).

3.7.7 Staff, patient, and visitor reactions to partial smoking bans

Staff, patients, and visitors who smoke cigarettes are more supportive of PSBs than non-smokers and pro-smoke-free staff who are more likely to support TSBs. The PSB protection rationale tends to be supported by staff holding beliefs that patients do not want to quit; smoking relieves patient boredom and stress; helps patients stay calm, socialise, smoke, and talk with staff; and offers staff a well-established form of patient control.

Where PSBs operate in MHIFs, conflict between staff and/or between patients can arise when the PSB is applied differently. For example, Lawn and Campion (2013) reported that where some MHIF wards did not have patient leave provisions and other wards did, patients used this leave as smoking breaks, thus raising equity issues about access to smoking and an undermining of smoke-free efforts.

Mental health inpatient facilities' management and staff have endorsed PSBs as a stage towards implementing TSBs. Accepted guidance about the stages of smoke-free policy implementation highlights the importance of developing and training a workforce to be smoke-free role models and provide cessation support to inpatients (Lawn & Campion, 2010; Public Health England, 2016). Thus, the TSB is often applied to staff first and the PSB to patients.

Given the strength of evidence to support the protection objective and the challenge in achieving the quitting goal, particularly where staff have not completed cessation training (Lawn & Campion, 2010), my study seeks to understand how PSBs or smoke-free policy exceptions can be understood or justified.

3.7.8 Impact of partial smoking bans in mental health inpatient facilities: Aotearoa New Zealand

This section considers the findings of the Aotearoa New Zealand studies undertaken by Connolly et al. (2013) and Glover et al. (2014) concerning PSBs. It considers whether DHB smoke-free policy documents offer insight into the nature of the policies and commonality of smoke-free policy exceptions.

Connolly et al. (2013), in their study of Aotearoa New Zealand mental health nurses' beliefs about MHIF patient smoking, found that in 2009 PSBs were favoured over TSBs. The mental health nurses' beliefs included allowing patients to smoke in designated areas, allowing staff and visitors to smoke with patients in designated areas, and that smoking had value in creating therapeutic relationships with patients, were a source of patient pleasure, helped manage mental illness symptoms and kept patients calm. The authors concluded that the documented evidence of the physical harm of smoking on mental health inpatients could be addressed by establishing smoke-free MHIFs, in other words, TSBs.

Glover et al. (2014), in their study of the barriers to Aotearoa New Zealand MHADS becoming smoke-free, found that 'permissive smoking cultures' and 'transitional smoking to smoke-free cultures' were dominant among the participant organisations, with 'smoke-free cultures' comprising only 14% of the organisations. The permissive smoking cultures were characterised as set out in the summary points below:

- most MHADS permitting smoking in semi-enclosed areas, on verandas and in gazebos
- some MHADS permitting staff and patient smoking on the premises, both indoors and outdoors and naming the Smoke-free Environments Amendment Act 2003 as the reason for patients' designated smoking rooms
- some MHADS having different staff and patient policies; for example, patient smoking in designated areas and staff smoking offsite
- some MHADS providing ventilated smoking rooms

The transitional smoke-free cultures were characterised by the provision of patient cessation support and some support for a complete smoke-free policy.

The findings of the above two studies indicate that PSBs, or smoke-free policies with exceptions, were dominant in 2006 and 2009, respectively. These findings may include DHB MHIFs, but the studies do not provide this information.

I have not been able to locate more recent published studies about the impact of PSBs in Aotearoa New Zealand.

3.7.9 DHB MHIF smoke-free policies 2000-2019: Nature and commonality of exceptions

To the best of my knowledge, neither the Ministry of Health nor the DHBs has published a report about the nature and impact of smoke-free policies and exemptions in MHIFs. Thus, using the Official Information Act (OIA) 1982, I requested copies of DHB 2000 to 2019 smoke-free policies, including any smoke-free policies specifically relating to MHIFs.

Determining the nature of DHB smoke-free policies and the commonality of smoke-free policy exceptions is complicated by several factors. First, not all DHBs provided me with

a comprehensive set of policies in response to my OIA requests. The absence of a complete set of policies means it is unknown whether some DHB MHIFs operated TSBs or PSBs in some years. Second, DHBs have not used standardised smoke-free policies throughout Aotearoa New Zealand. For example, some DHB smoke-free policies stated the year they intended to implement TSBs in their MHIF, but other DHBs did not. Third, one DHB used a generic organisational smoke-free policy for its services, which meant it contained no reference to its MHIF and its smoke-free status. The difficulty of relying on a DHB smoke-free policy which states it operates a TSB but is silent about its MHIF smoke-free status was illustrated in the report of the Health and Disability Commissioner (n.d.), who found that smoking occurred in a particular MHIF, despite the DHB TSB. Put differently, there can be a difference between the formal policy (smoke-free status) and the practice (patient and or staff smoking occurs indoors and outdoors on the hospital grounds).

A review of the received DHB smoke-free policies that refer to MHIFs indicates that during the **first decade** of the 21st-century, DHBs gradually implemented TSBs while operating PSBs in MHIFs. Total smoking bans were rolled out through the general hospital hospitals, first banning staff smoking, followed by indoor smoking by patients and visitors. It seems likely that TSB implementation was spurred on in 2004 when DHB CEOs committed to implementing smoke-free hospitals (Whanganui DHB SFP 2009-2010, p. 2).

Regarding PSBs in MHIFs, the most common reason for permitting smoke-free exemptions was the Smoke-free Environments Act 1990 provisions regarding 'special provisions for certain institutions' (Auckland DHB Smoke-free Policy, 2006; Taranaki DHB Smoke-free Policy, 2004). Other reasons included that smoking would 'reduce the likelihood of harm to patients' clinical outcomes', patients were institutionalised under the mental health legislation (CMDHB Smoke-free Policy, 2004, p. 1), the prevalence of the smoking culture in mental health, and the extensive training needed to make changes (CMDHB Smoke-free Policy, 2008). More often, however, the rationale for TSBs was not provided. To illustrate, in 2005, the Waikato DHB established a five-year exception for its MHIF, and no reasons were included in the policy statement (Waikato DHB Smoke-free Policy, 2005). Exceptionalist SFPs were also silent about the inequitable impact of exemptions for PMI and/or Māori health and wellbeing.

The PSBs permitted smoking by MHIF inpatients only. Depending on the DHB, formal smoking sites included indoors in DSRs or areas and/or outdoors in courtyards and gazebos.

Also, during this decade, the majority of DHB smoke-free policies that contained a mental health services section included a smoke-free date for their MHIF. These dates ranged from 2008 to 2012. Subsequent smoke-free policies suggest that TSBs were implemented.

Turning to the **second decade** of this century, one DHB named 2018-19 as the intended smoke-free date for its MHIF. However, the received DHB smoke-free policies indicate that they operate TSBs. Some explicit exceptions provisions remain. One DHB in its 2018-2020 smoke-free policy permitted MHIF inpatients with escorted leave to use the outdoor smoking/vaping area; while another DHB in its 2019 smoke-free policy included a special exemption in a potentially volatile situation; exceptional risk circumstances to use security to escort patients to smoke offsite.

Overall, PSBs were more common than TSBs in DHB MHIFs during the first decade of this century, with PSBs being implemented during the second decade. The significant impact of PSBs meant that not all DHB MHIF patients and staff were protected from the harms of SHS and smoking and smoking remained a normalised patient behaviour.

Several TSB characteristics are significant to my study. In Aotearoa New Zealand, where the MHIF is on a general hospital campus, MHIF patients often have a more extended exemption period than the general hospital patients. For example, the Waikato DHB smoke-free policy banned staff smoking in 2004 and general hospital patient smoking in 2006 but exempted the MHIF until 2011 (Waikato DHB, 2005). Relevant to my research, the exemption sequence raises questions about why MHIF patients were exempt *after* the general hospital patients. That being the case, they likely received different treatment from the comparator group, which comprises general hospital patients who smoke.

To illustrate, before 2006, in the facilities and equipment section of its smoke-free environments policy, the Auckland DHB included the following clause. “There are special provisions only for patients in inpatient Mental Health Services, who may smoke in

designated smoking areas. There are no special provisions for staff" (Auckland DHB, 2006, p. 3).

Regarding the Palmerston North Hospital Campus, Mid Central DHB (2011) wrote:

> Patients in Ward 21 may smoke in the open side courtyard area and in the High Needs Unit (HNU)… The two shelters along the hospital perimeter on Ruahine Street and Heretaunga Street are provided for use by patients, visitors and staff who smoke. All other areas are smoke-free at all times. (p. 4).

In its 2018-2019 smoke-free policy, Whanganui DHB stated that patients:

> That have escorted leave are the only [patients] [my insertion] allowed to use the smoking/vaping area. All other [patients] [my insertion] that are legally allowed to leave the grounds must obey by the WDHB smokefree policy and move off site to smoke/vape… The smoking/vaping area will adhere to the Smoke-free Environments Act 1990 (open and internal areas). (Whanganui DHB, 2018, p. 1)

Also relevant to my study, Aotearoa New Zealand has *formal smoke-free exceptions* based on provisions in the Smoke-free Environments Amendment Act 2003. These exceptions are known as *DSRs* and may be used in hospital care institutions subject to certain conditions, including ventilation requirements. The above Whanganui DHB 2018 smoke-free policy reference to *open and internal areas* is a reference to the 2003 provisions.

In 2006, the USSG published a seminal report, *The health consequences of involuntary exposure to tobacco smoke* which concluded:

- evidence of harm from this smoke was indisputable
- small amounts of smoke cause harm
- only TSBs or smoke-free environments offer complete protection from the smoke.

This document, along with other similar publications, was available to DHB staff. In my view, the presence of TSBs in MHIFs raises questions about the extent to which the

accepted evidence of health harm from SHS and smoking may have been disregarded by DHB smoke-free policymakers and DHB Board members who approved the policy exemptions.

3.7.10 Exceptional space: Implications

In the context of DHB smoke-free policies, the application of a smoke-free policy is the standard rule. The application of an exception to that policy, for example, allowing smoking in a DSR or the hospital grounds is an exception to that rule. In those exceptional spaces, albeit formally established, patients are included in the group excluded from smoke-free policy benefits (policy objectives). At the same time, they are excluded from the group included in those receiving smoke-free policy benefits (policy objectives).

Central to my research, how might this exceptional space advance the understanding of smoke-free policy exemptions in MHIFs?

As Crown Entities, DHBs implement state public health policies and are subject to the rule of law. In the context of a TSB primary goal of *protection*, it is reasonable to consider that smoke-free policy exceptions are responses to actual or anticipated problems thought to warrant exceptional measures. In 2019, few DHBs referred to exception provisions; however, my research concern is the nature and significance of the anticipated or actual problems associated with the use of exceptions.

The act of declaring an exemption for patients establishes an exception to the rule to be smoke-free. While some legal protections remain for these patients, the exception suspends those rights related to protection from smoking and second-hand smoke exposure. These rights are no longer available, as might also be the case for protections in international health and human rights instruments, for example, the Right to Health and those in other domestic legislation.

To illustrate, if patients do not have access to smoke-free indoor MHIF or services such as smoking cessation and education, they will not receive the usual measures associated with protection and cessation objectives. Is that equitable and justifiable? What are the possible implications? In the exceptional space of the smoke-free policy exceptions,

patients are potentially vulnerable to decision-makers. But in the space of exception, what legal, health, and human rights frameworks are likely to be suspended? With smoke-free policies, the prospect of patient exclusion from the benefits of health policy objectives and/or receiving different treatment from a comparator group invites examination of the relevant international, domestic law, and ethical issues in Aotearoa New Zealand.

3.8 Legal and ethical considerations

International and domestic laws have implications for smoke-free policy exceptions in MHIFs. This section covers the relevant instruments and legislation.

3.8.1 International law

Aotearoa New Zealand is a signatory to two international treaties that, for my research, are particularly relevant to tobacco control and smoke-free policies: the United Nations Covenant on Economic, Social, and Cultural Rights (ICESCR) 1966 and the WHO FCTC 2003.

United Nations Covenant on Economic, Social, and Cultural Rights 1966 (ICESCR, 1966)

The ICESCR is a multi-lateral human rights treaty to ensure the enjoyment of economic, social, and cultural rights. The preamble to the treaty recognises that "these rights derive from the inherent dignity of the human person" (ICESCR, 1966).

Upon ratifying the ICESCR in 1978, Aotearoa New Zealand consented to be bound by the treaty's articles, including Article 12, the *right to health* which assures "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" [Article 12.1.] In short, this right is about protecting the health of citizens.

Being a State Party to the ICESCR compels Aotearoa New Zealand to acknowledge the right to health and work progressively towards achieving specific measures within its maximum available resources [Article 2]. Article 12.2 specifies four measures, of which the following three are relevant to my research.

> (b) The improvement of all aspects of environmental… hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational, and other diseases**;**

(d) The creation of conditions which would assure to all medical services and medical attention in the event of sickness.

The United Nations Committee on Economic, Social, and Cultural Rights (CESCR) oversees the State Party's implementation of these measures, considers State Party reports about progress on the measures, and prepares General Comments (GCs) about Article interpretation and implementation.

The *right to health* has not been well understood. Thus in 2000, the CESCR published GC 14 (CESCR, 2000). The former United Nations Special Rapporteur on the right to health describes this clarification as "an authoritative understanding of the right to health" (Hunt, 2007). The GC elaborates on what each measure covers. It also signals that the right to health is an inclusive right that incorporates "timely and appropriate healthcare" [para.11], the determinants of health, and involves populations' participation in decision-making.

Smoke-free initiatives such as prohibitions on indoor smoking and SF 2025 fall within the gambit of the above three measures. A State Party can report against these measures to demonstrate progress and/or compliance. Conversely, where legislation, policies, and practices enable smoking and do not provide indoor smoke-free environments, there may be questions about State non-compliance and implications for MHIF patients and staff and national initiatives like SF 2025.

The CESR has determined that the right to health contains four inter-related elements, and the following three elements are also relevant to my study.

a)	Availability	Functioning public health and healthcare facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party.
b)	Accessibility	Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the

		State party. Accessibility has four overlapping dimensions [Relevant to my study is:] Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.
c)	Quality	As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs (CESCR, 2000)

WHO Framework Convention on Tobacco Control (FCTC) 2003

By the 1990s, tobacco use was the leading global cause of premature death and was described as an epidemic (WHO, 2009). In response, the World Health Assembly initiated work to combine an international law framework with a public health goal. The outcome was the FCTC, an evidence-based treaty that recognises the right to health in the ICESR.

The FCTC objective is:

> To protect present and future generations from the devastating health, social, environmental, and economic consequences of tobacco consumption and excessive exposure to tobacco smoke by providing a framework of tobacco control measures to be implemented by the Parties at the national, regional, and international levels in order to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke. (WHO, 2003, p. 5)

Relevant to my study is Article 4, which addresses implementation principles; Article 8, protection from exposure to tobacco smoke and Article 14, demand reduction measures regarding tobacco dependence and cessation.

In 2004, Aotearoa New Zealand ratified the FCTC. Thus, it is a Party to the treaty and reports two yearly. The most recent 2018 report records:

> C227a. Banning tobacco smoking in indoor workplaces. The Smoke-free Environments Act 1990 requires all indoor workplaces to be

> smoke-free. There is a partial exemption for hospital care (mental health institutions) and for rest homes where residents may be permitted to smoke in a dedicated smoking room which must be mechanically ventilated and from which the escape of smoke is minimised (see section 6 of the Smoke-free Environments Act 1990). Prisons have been smoke-free since 2011. (Ministry of Health, 2018, p. 54)

This report is significant. First, the Ministry of Health completed this official report from Aotearoa New Zealand. Second, it *tells the world* that smoking is possible in a DSR for patients in hospital care in Aotearoa New Zealand. Third, it specifies *mental health institutions* as the type of institution where DSRs are located.

I suggest that the *cat is out of the bag* because the above report neither masks nor is silent about the smoke-free policy exemption location. Mental health institutions are named; and thus, the Crown's knowledge of this exception is established and documented.

Using evidence to assist the Parties in meeting the Article 8 obligations, the 2007 Conference of the Parties prepared *Guidelines on protection from exposure to tobacco smoke* (WHO, 2007). (The Guidelines).

Pertinent to the New Zealand report and my study are the Guidelines reporting the definition for *smoke-free air*. Defined as *air that is 100% smoke-free*, this definition includes, "but is not limited to, air in which tobacco smoke cannot be seen, smelled, sensed or measured" (WHO, 2007, p. 3). Further, the Guidelines state that:

> No exemptions are justified based on health or law arguments… if a Party is unable to achieve universal coverage immediately, Article 8 creates a continuing obligation to move as quickly as possible to remove any exemptions and make the protection universal. Each Party should strive to provide universal protection within five years of the WHO Framework Convention's entry into force for that Party. (WHO, 2007, p. 5)

Party status requires:

- recognition that “scientific evidence has unequivocally established that exposure to tobacco smoke causes death, disease and disability” (WHO, 2003, p. 1)
- addressing Article 4, which states, “the implementation of effective legislative, executive, administrative and/or other measures, providing for protection from exposure to tobacco smoke in indoor workplaces” (WHO, 2003, p. 5)
- addressing Article 14 by disseminating “evidence-based guidelines, consider national priorities, and use effective programmes for tobacco cessation and treatment. Health care facilities need to include ‘diagnosing, counselling, preventing and treating tobacco dependence” (WHO, 2003, p. 13)

The FCTC obligations are likely to have implications for the section 6 DSR exception implemented in 2003.

3.9 Medical ethics

Applying the lens of medical ethics principles, Woodward and Richmond (2019) examined arguments for and against total bans in MHIFs. The authors consider autonomy, justice, beneficence, and non-maleficence and conclude that for an “already significantly disadvantaged group concerted efforts to reduce smoking seem to be the only ethical way forward” (p. 3).

Presenting a different perspective, Lawn and Condon (2006) undertook a qualitative study about psychiatric nurses’ ethical stance about smoking by patients. The authors found that the nurses “made decisions on the issue of smoking and smoking by patients according to two of the ethical principles important in nursing ethical decision-making: autonomy, and beneficence and non-maleficence” (Lawn & Condon, 2006, p. 113).

Autonomy, or enabling individuals to plan and choose their behaviour, was associated with a *presumed* patient right to smoke and a “free and informed choice to smoke” (Lawn & Condon, 2006, p. 113). Both beneficence and non-maleficence, or the obligations to do good and do no harm, raised dilemmas because nurses had many roles ranging from carer to custodian. For example, faced with patients experiencing the immediate effects of mental health issues, the nurses considered it easier to allow or provide smoking than to consider the long-term harm of smoking. The authors

concluded that ethical decision making is contextual and involves developing strategies to address patient and staff smoking.

Ethical considerations also mean asking what paternalism level is acceptable in public health and establishing whether a policy is justified. For example, Voigt (2019) draws attention to the possibility that smoking prohibitions might negatively affect vulnerable populations, such as patients in MHIFs. Yet, the bans might also provide an opportunity for patients to quit smoking in a hospital care environment to benefit their health.

There are also concerns that denormalisation strategies might stigmatise smokers (Stuber et al., 2008) who resort to secretive smoking and are reluctant to seek cessation support. Voigt (2015) contended that stigmatisation has implications for equal and respectful treatment of smokers.

For my study, beneficence and non-maleficence are relevant to using exceptionalist smoke-free policies in MHIFs. Have these exceptions achieved good and/or no harm? The prospect of stigmatisation is also pertinent because it is likely that PMI will be among those people still smoking by 2025.

3.10 Domestic legislation

Smoke-free policies and exemptions in MHIFs invite domestic law examination concerning the protection of patients and staff from exposure to SHS, along with the health practitioner obligations and discrimination.

In 2003, the Principal Act, known as the Smoke-free Environments Act 1990, was amended (Smoke-free Environments Amendment Act, 2003). The Amendment Act furthered workplace protection from smoking. It required employers to "take all reasonably practicable steps to ensure that no person smokes at any time in a workplace" (Smoke-free Environments Amendment Act, 2003, s. 5).

The Amendment Act (2003) defines a workplace as an *internal area, within or on a building or structure occupied by the employer, usually frequented by employees or volunteers during the course of their employment* (s. 3).

Also relevant to my research, the Amendment Act (2003) establishes an exception to the general smoke-free rule and permits smoking by patients in a workplace that is part of a hospital-care institution. Specifically, "An employer may permit smoking by patients or residents of a workplace that is or is part of, a hospital care institution, a residential disability care institution, or a rest home" (s.6(1)), subject to specific statutory provisions.

The exception establishes smoking spaces called *DSRs* to be used subject to provisions including ventilation, availability of non-smoking rooms, minimisation of escaping smoke, and smoking in the DSR only.

Whereas the Principal Act permitted smoking by immobile patients, the Amendment Act is silent about patient characteristics and the precise location of DSRs in the hospital care institutions. Thus, decisions involving DSR location are at the hospital employer's discretion. Further, with its focus on indoor workplaces, the legislation is silent about smoking outdoors.

Prima facie, an exception for hospital care institutions like DHBs, seems contradictory. First, people usually go to the hospital to get better from diseases. Second, the evidence weighs overwhelmingly against health improvements arising from smoking.

This contradiction did not escape former Member of Parliament, the Honourable Peter Dunne, who said:

> One of the lunacies… is that we can have designated smoking areas in hospitals, of all places… I would have thought that hospitals, as a symbol of health protection and health promotion, were the last places within which members would want a designated smoking area… The point is that the definition clause does highlight a number of contradictions and absurdities within this legislation. (Dunne, 2003, August 13).

In my view, the section 6 exemption is particularly significant. The exemption's incorporation into law was the will of Parliament, and the effect of this will permits patient exposure to the harm that the legislation sought to remedy. Nonetheless, this exposure via DSRs is lawful. However, using the word may in section 6 means that DSRs

are not mandatory. In other words, the hospital care institution employer has the discretion and can choose *not* to have DSRs.

Regarding discretion, the Supreme Court decision, *B v Waitemata District Health Board* (2017), offers guidance about the meaning of may as used in section 6. Here the Court determined that may was permissive and reiterated no mandatory obligation for the Waitemata DHB to provide DSRs in its MHIF. The Court also found that the Waitemata DHB smoke-free policy was consistent with specific rights under the New Zealand Bill of Rights Act 1990**.** In other words, there were no breaches of the following rights by the policy:

- right to be treated with humanity and with respect for dignity [para 54]
- cruel or disproportionately severe treatment [para 89]
- discrimination based on disability [para 96]
- right to a home or private life – no right to smoke [para 106]

Thus, by 2017, based on the highest Court decision in Aotearoa New Zealand, we learn that the smoke-free policy content and implementation process used by the Waitemata DHB complied with the New Zealand Bill of Rights Act (1990). We also know that there is no obligation to implement section 6 DSRs. In my view, this decision offers guidance about how to protect patients from smoke in MHIFs. It is reasonable to consider that the smoke-free law exceptions are likely to have implications for DHB smoke-free policies and exception implementation.

In 2020, Parliament amended the Principal Act. Now called the Smoke-free Environments and Regulated Products Act 2020, this law retains the section 6 provision for designated rooms for smoking. However, it also permits the discretionary use of designated rooms for vaping in hospital care environments. I discuss the possible implications of this new provision in the SF 2025 section of this chapter.

To what extent is the section 6 designated smoking room inconsistent with the role of DHBs?

New Zealand Public Health and Disability Act 2000 establishes DHBs. As noted in the historical context chapter, the legislative purpose, objectives, and functions distil into the following six action points against which to consider DHB performance.

- reducing health disparities
- addressing needs
- protecting, promoting, and improving health
- honouring human rights
- improving access
- meeting standards of care and employment

Given its primary goal of protection and its treatment focus on cessation, a TSB appears to be consistent with each action point. Conversely, an exemption where patients are exposed to SHS and not offered help to quit would be inconsistent and unlikely to contribute positively to each action point. Thus, arguably, the section 6 exception is inconsistent with the statutory requirements of the DHBs.

DHBs use smoke-free policies to implement total and/or PSBs in MHIFs; however, the Amendment Act is silent about using smoke-free policies in hospitals. Do DHBs have the authority to use smoke-free policies?

DHBs are owners and leasees of property. They can regulate people's behaviour on these properties so long as the regulation is consistent with the NZPHDA purposes and objectives. The DHB's authority to apply smoke-free policies is set out in *B v Waitemata District Health Board* (2016), the Court of Appeal case where the appellants unsuccessfully contested a smoke-free policy in MHIFs. Briefly, the power to use smoke-free policies derives precisely from the DHBs' *purpose* to improve, promote, and protect the health of New Zealanders (New Zealand Public Health and Disability Act 2000, s(1)(a)(i)). Smoking is a hazard for people in Aotearoa New Zealand and addressing the dangers of smoking is within the above purpose. Thus, DHBs are entitled to implement smoke-free policies that ban smoking, promote cessation, improve health, and protect against SHS.

An overview of official information and publicly available documents about DHB smoke-free policies and tobacco control plans ranging from 2000 to 2020 indicates considerable variation in the practice and the timing of decisions to permit and prohibit smoking in MHIFs and outdoor areas. Points of relevance to my study are:

- staff smoking was prohibited before smoking by patients in general hospitals and MHIFs
- the majority of DHBs, at some stage, have provided DSRs and/or designated outdoor smoking areas for patients
- generally, DHBs with designated smoking areas stated an intention for smoke-free MHIFs to occur between 2009 and 2011, with one DHB naming 2017 to 2018 as its smoke-free timeframe
- a minority of DHBs allow staff to escort patients for *smoking breaks*; and
- a minority of DHBs allow vaping on-site by patients

Exceptionalist smoke-free policies have been applied in DHBs. Have MHIF patients experienced disadvantages from DHBs applying exceptions to smoke-free policies intended to execute their statutory purpose to promote, improve, and protect their health?

The Human Rights Act 1993 (HRA) focuses primarily on the principle of formal equality or *equal treatment***.** This principle means that individuals or groups in the same situation are treated the same. Thus, there is a legal duty to apply equally policies and practices to citizens, regardless of named specific characteristics known as 'prohibited grounds of discrimination'. This principle applies to legislative decisions and Crown policies and actions.

As discussed in the beliefs section, the culture of smoking in MHIFs is associated with the belief that there is a human right to smoke. However, smoking is not a human right. Section 21 of the HRA sets out the prohibited discrimination grounds, and smoking is not among them.

Disability, which includes psychiatric illness, is a prohibited ground of discrimination. Whether a ban on smoking in MHIFs constitutes discrimination on the grounds of disability and/or psychiatric illness was raised in *B v Waitemata District Health Board* (2017). The Supreme Court upheld the High Court decision that there was no discrimination on the grounds of disability or psychiatric illness. The Court also decided that nicotine addiction was not a disability as defined in the HRA.

The Applicant, in this case, challenged the presence of a smoke-free policy (TSB). Whether the absence of a complete ban on smoking in MHIFs constitutes discrimination on the grounds of psychiatric illness has not been tested before the Human Rights Review Tribunal or the higher courts in Aotearoa New Zealand. Relevant to my study is why smoke-free policy exceptions have not been the subject of a legal challenge. Could this reflect the strength of normalised smoking in MHIFs and/or something else?

The HRA includes provisions concerning equality of outcomes at sections 65 and 73. The legal principle of substantive equality recognises that people begin life from different positions and these differences affect outcomes. Such recognition is essential for minority and vulnerable groups' rights (Mosses, 2017), including patients in MHIFs. Remedying outcome differences may involve addressing historical disadvantages and cultural, social, and economic needs. How might this principle assist my study?

As with Aotearoa New Zealand, a well-established and historical culture of patient smoking characterises MHIF in Australia (Woodward & Richmond, 2019). Lawn and Condon (2006) observed that psychiatric nursing staff neglect of patient nicotine dependence and the continuation of patient smoking regardless of known adverse health effects had implications for social inequities. The authors noted that these are systemic issues and expose mental health institutions to negligence claims in Australia's increasingly litigious treatment climate. However, negligence remedies are usually financial, and money paid to harmed individuals does not correct social inequities. A substantive equality lens would likely be a more fruitful approach in these circumstances.

Turning to Aotearoa New Zealand, smoking in MHIFs has been funded and managed by Crown agencies for several decades. Since the 1950s, evidence has shown that smoking negatively affects health and wellbeing significantly. Exceptionalist smoke-free laws, policies, and practices have operated in mental health institutions since 1990. Applying a substantive equality approach would examine health outcomes for PMI and the historical disadvantage of smoke-free and related legislation and Crown policies, practices that have permitted smoking in mental health institutions. Findings of substantive inequality would suggest amending the 'offending' law to achieve substantive equality better.

The Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations (the Code) sets out 10 rights for consumers and establishes duties and obligations for service providers such as DHBs. Regarding MHIFs and alleged Code breaches, the Mental Health Commissioner (the Commissioner) can investigate and report findings and recommendations to the relevant DHB. In the context of smoke-free policies, whether TSBs or PSBs or staff policy resistance, several rights are likely to be at play. These include the rights to:

- be free of discrimination (Right 2)
- services of an appropriate standard (Right 4)
- to be fully informed (Right 6)
- to make an informed choice and give informed consent (Right 7)

To illustrate, Right 4.4 states, "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer" (Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996).

Relevant to my study, in a Right 4.4 investigation conducted by the Health & Disability Commissioner at Canterbury DHB, the Commissioner noted that the CDHB smoke-free policy prohibited smoking within all its sites. He also recorded that staff attitudes ranged from refusal to be present with smokers to being with smokers and that one staff member told the patient that it was "not in her job description to look after patients who smoke" (Health and Disability Commissioner, n.d., p. 6). The Commissioner recommended policy amendments to direct staff to maintain the requisite observation level of smoking patients. Thus, despite patient smoking contrary to the smoke-free policy, Right 4.4 remained in play with staff expected to maintain the requisite observation level to minimise harm. The report is silent about smoking and cigarette smoke harm.

In a paper for the International Labour Organisation (ILO), Hakansta (2004) observed that the health sector smoking discourse constructs smoking as a lifestyle issue and that the sector has responded with health promotion programmes. However, from a workplace perspective, smoking, both active and exposure to SHS, is an occupational

health and safety issue that needs government, employers, and union involvement so that people have smoke-free air in the workplace.

Although the Health and Safety in Employment Act 1994 (HSEA) was repealed in 2014, it is pertinent to my research for 2000 to 2014 because it imposed several duties on DHBs. These included providing and maintaining a safe working environment for employees (section 6 (a)). Applied to smoking, this means implementing smoke-free workplaces to protect employees from SHS and prohibiting smoking.

Effective from April 2014, the Health and Safety at Work Act 2014 (HSWA) places a primary duty of care on a "person conducting a business or undertaking (PCBU) to make sure "so far as is reasonably practicable, the health and safety of" the workers (section 36 (1)). The HSWA emphasis is pro-active identification and management so that everyone is safe at the workplace. Arguably, in a DHB context, management needs to take reasonable care of staff health, and the staff in MHIFs need to take reasonable care of patient health. Staff also need to ensure that their actions do not adversely affect others' health and safety. Applied to smoke-free policies, a TSB would likely be consistent with the Act.

In summary, on the one hand, international treaties endorse smoke-free indoor workplaces, Aotearoa New Zealand has smoke-free legislation to protect people from cigarette smoke harm, and the DHB legislative duty is to protect people's health. On the other hand, the smoke-free legislation allows smoking by patients, and most DHBs have permitted smoking in MHIFs. Given the scholarly evidence about the harm of smoking, the law seems contradictory. How can this contradiction be explained?

Smoke-free legislative and policy exceptions are likely to have implications for national smoke-free goals and practices. The following section examines possible implications for Aotearoa New Zealand's SF 2025 goal and smoke-free policies.

3.11 Smoke-free 2025 and smoke-free policy exceptions

Smoke-free policies promote smoke-free environments and smoking cessation. In contrast, smoke-free policy exceptions support entrenched smoking in MHIFs and do not provide cessation opportunities for patients. Exceptions of this type are likely to

have implications for tobacco control initiatives designed to increase the number of people who have quit smoking. For Aotearoa New Zealand, these policy exceptions are relevant to SF 2025, the Government's goal to achieve an adult smoking prevalence of less than 5% by 2025. This section outlines the origins of SF 2025 and its main goal and considers possible implications of smoke-free policy exceptions for achieving this goal.

In 2009 the Māori Affairs Committee "resolved to conduct an inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori" (Māori Affairs Committee, 2010, p. 43). The subsequent report (MAC Report) recommended that the Government "aim for tobacco consumption and smoking prevalence to be halved by 2015 across all demographics, followed by a longer-term goal of making New Zealand a smoke-free nation by 2025" (Māori Affairs Committee, 2010, p. 5). Globally, this goal was thought to be the first of its kind by an official body and was considered visionary and bold (Blakely et al., 2010).

Helpfully, for government decision-makers, the MAC Report suggested:

> The goal is simple: we want tobacco consumption and smoking prevalence to be halved by 2015 across all demographics, and New Zealand to be a smoke-free nation by 2025. We are suggesting a two-phased approach, as the significant drop in smoking rates by 2015 would dramatically alter the tobacco use landscape in New Zealand. It is hoped that the tobacco market will be much smaller, with altered distribution and sales patterns, and the smoking population will be different, consisting mainly of **heavily addicted smokers concentrated in certain sociocultural or economic groups** [emphasis added]. The second phase of measures would therefore require new tobacco control strategies. This report focuses primarily on innovative changes to New Zealand's tobacco control. (Māori Affairs Committee, 2010, p. 10)

Arguably, less helpful for government decision-makers and the tobacco control field, the MAC Report explained in a footnote that smoke-free "is used to communicate an aspirational goal and not a commitment to the banning of smoking altogether by 2025" (p. 10).

The Government provided an Interim Response (New Zealand Government, 2011a) and a Final Response to the MAC Report (New Zealand Government, 2011b). The following observation arises from the Government responses and the MAC Report.

By describing SF 2025 as an 'aspirational goal', I suggest that the MAC report provided the Government with some wriggle-room; after all, there was no specific end goal about the desired smoking prevalence. Alternatively, and perhaps a strategic stance by the Māori Affairs Committee, the absence of a specific goal also provided the Government with the opportunity to put a stake in the ground and define smoke-free. However, I suggest that the stake took the form of the term 'minimal levels'.

Referring to the MAC report, the Government's Final Response (2011b) states:

> The Committee's report is clear that "the term 'smoke-free' is intended to communicate an aspirational goal and not a commitment to the banning of smoking altogether by 2025" (p. 10). On that basis, the Government agrees with a longer-term goal of reducing smoking prevalence and tobacco availability to minimal levels, thereby making New Zealand essentially a smoke-free nation by 2025. (New Zealand Government, 2011b, p. 4)

In my view, the Government's use of the words, on that basis, suggests it took its lead from the loose description of smoke-free used by the Māori Affairs Committee and settled on using undefined minimal levels by 2025.

In contrast, the Government agreed to set specific mid-term targets to reduce tobacco consumption and smoking prevalence by 2015. Setting these targets was achievable because smoking prevalence data existed.

It is reasonable to wonder if the Government's stance signalled an absence of political will to commit to a specific long-term goal from the outset. Alternatively, the MAC Report was not an initiative of the Government. Instead, it was the initiative of the Māori Members of Parliament, who were concerned about the tobacco industry's impact on Māori and the use of tobacco on Māori. The MAC Report confronted the Government with 42 recommendations, many of which required a fundamental change in funding, policy, and priorities (Blakely et al., 2010) to address tobacco's inequitable impact on

Māori health and wellbeing. Politically, I suggest that it was unlikely that the Government would reject the report. Perhaps, however, despite the presence of tobacco control advocate Associate Minister of Health Tariana Turia, it was a step too far for the Government to address fully Māori health inequities regarding smoking.

Thus, although the Government accepted the MAC Report, the Final Response was silent about:

- a definition of 'minimal levels' for 2025
- a commitment to developing a tobacco control strategic plan and action plan

How is this significant to my proposed research?

In the context of an endorsed longer-term goal by the Government, it would be usual to define minimal levels so that interim and final targets are clear, resources directed to the effort, and progress measured. It is necessary to know what 'minimal levels' mean to achieve SF 2025. Rather than a formal policy statement, the desired national smoking prevalence for 2025 was announced in a press release from the Associate Minister of Health, Hon. Tariana Turia. The Minister said,

> Public health proponents and tobacco control advocates have interpreted the Government's goal of reducing smoking prevalence and tobacco availability to minimal levels to mean a smoking rate of less than 5% of New Zealand adults, and that this should be achieved across all major ethnic groups. (Turia, 2014, p. 12)

Subsequently, achieving an adult smoking prevalence of less than 5% by 2025 has become the SF 2025 goal.

It would also be usual for the Government to establish a tobacco control strategic plan and action plan for a longer-term goal like SF 2025. Despite indications of upcoming plans, no Government from 2011 to 2020 has published a comprehensive plan to achieve smoke-free Aotearoa New Zealand by 2025 (Ball et al., 2016; International Tobacco Control Policy Evaluation Project (ITC), 2020).

Responding to this deficit, the National Smoke-free Working Group (2013), (the Group), with its membership from national organisations and national services, developed the 2013-2015 Smoke-free Aotearoa Action Plan and a logic model. The Group followed this with the 2015-2018 Smoke-free Aotearoa Action Plan (National Smoke-free Working Group, 2015).

In 2017, *Achieving smokefree Aotearoa by 2025* was published (Thornley et al., 2017). This document contains an action plan to achieve the 2025 goal and covers 2018 to 2020. The plan responds to the absence of a government plan for this goal. Professor Richard Edwards, the principal investigator for the Achieving smoke-free Aotearoa project, put it like this:

> The Government promised an action plan for 2025 two years ago but this has not appeared. It is time for someone to act to ensure our legacy to coming generations will be a smokefree future instead of continued death and disease due to smoking. (Edwards, 2017)

What does the plan say about smoking and mental health? First, the plan notes that some population groups are important "because of their relatively high smoking prevalence… these include… people with mental health conditions" (Thornley et al., 2017, p. 6). However, that is the sole reference to this priority group.

In a first for Select Committees, late in 2018, the Health Committee and the Māori Affairs Committee worked together. They presented the Government with a joint report about achieving SF 2025 (Health Committee and the Māori Affairs Committee, 2018). The Committees considered and prioritised the 31 uncompleted recommendations from the MAC report. The report recorded that the "submitters asserted that governments 'cherry picked' certain recommendations. That is, they implemented recommendations that were 'politically palatable' and would 'keep them in favour'" (Health Committee and the Māori Affairs Committee, 2018, p. 33).

It is reasonable to suggest that the Health Committee and the Māori Affairs Committee included the submitters' assertion because the respective Committees had sympathy with this assertion. After all, the Government received the report from the Māori Affairs Committee eight years earlier.

The Government's 2019 response to the joint report records the Government's indication that it would develop a SF 2025 action plan. For example, the response reads:

> As part of developing the action plan to achieve Smokefree 2025, the Ministry of Health will review, consult and advise the Government on the uncompleted recommendations from the 2010 Māori Affairs Committee Inquiry. (New Zealand Government, 2019, p. 4)

Questions arose about what was needed to achieve the less than 5% smoking goal (Ikeda, et al., 2013). From 2018 to 2020, there was no published comprehensive final Government plan to achieve SF 2025.

In 2019, Bates et al. (2019), noting that achievement of the 2025 target was not on track, published a recovery strategy proposing vaping strategies to achieve the 2025 goal. More recently, the ITC report about the awareness, understanding of and measures to achieve SF 2025 recorded the absence of a comprehensive Government plan (ITC, 2020).

Turning to my research, the absence of a final Government plan is significant because smoking has been identified as a major cause of health loss in New Zealand (Ministry of Health, 2016).

The lack of a government plan invites questions about the extent to which patients with already high smoking rates and admitted to Crown funded MHIFs might fare as we near 2025.

Smoking and mental health inpatient facilities

When writing the MAC Report, what data were available about Māori smoking and Māori admissions to MHIFs?

In a 2008 review of the evidence about Māori mental health needs, Baxter noted that compared with other New Zealand population groups, Māori have a higher admission rate to MHIFs (Baxter, 2008).

In May 2010, the Ministry of Health provided the Committee with a report about the prevalence and use of smoking (Māori Affairs Committee, 2010). The MAC Report noted

that the current Māori smoking rate was 45% compared with the non-Māori rate of 21%. It does not include data about Māori admissions to MHIFs or specifically discuss smoking in those settings. There is a reference to 'mental health services' in an appendix related to health cost calculations. There is also a statement that reads, "people who are hospitalized, imprisoned or in other institutions at the time of the survey, and therefore missed groups that have high smoking rates and poorer health status were excluded from this method" (Māori Affairs Committee, 2010, p. 62). While not explicitly stated, this statement may include MHIF patients.

Data about Māori smoking prevalence and admissions to MHIFs were available by 2010. Yet, the MAC Report contains no recommendations about MHIFs and smoking or mental health and smoking, nor does the Government's Final Response (New Zealand Government, 2011b). How might that be explained? A critical aspect of my research relates to understanding policy silence concerning MHIFs and smoking**.**

Smoke-free policy exceptions have implications for SF 2025. The seminal joint report by the Royal College of Physicians and the Royal College of Psychiatrists (2013) sets out the burden of disease caused by smoking for people with mental illness and details what health professionals must do to change the acceptance of smoking. It concludes that:

- all MHIFs need to be completely smoke-free
- smoke-free policies are critical to promoting smoking cessation
- the ongoing high prevalence of smoking signifies non-fulfilment by health services to deal with the needs of an already disadvantaged population
- condoning smoking as a normalised behaviour contributes to the high prevalence of smoking

Exceptions to smoke-free policies legitimise and perpetuate smoking in MHIFs and continue patient exposure to harmful smoke and ongoing associated serious physical and mental health consequences. Under these circumstances, the number of patients who smoke in MHIFs is unlikely to reduce. The literature, however, is silent about the possible impact of continued high levels of smoking in MHIFs for the SF 2025 goal. Instead, the focus has primarily been on the continued high prevalence of smoking by Māori and Pacific people and the prospect that the SF 2025 goal will not be achieved (Ball et al., 2016).

Turning to my proposed research, what might the smoke-free policy exceptions mean for SF 2025?

Lawn and Campion (2013) documented evidence of positive benefits from implementing smoke-free policies in MHIFs. For patients and staff, these include:

Patients	**Staff**
Protection from SHS harm (U.S. Department of Health and Human Services, 2006, 2010).	More positive attitudes about the ability of patients to quit smoking (Ashton et al., 2010).
Appropriate management of their nicotine dependence and withdrawal (Lawn & Pols, 2005).	An increase in skills (Lawn & Campion, 2010).
Improved long-term health outcomes and quality of life (Shahab & West, 2009).	Reduction in their smoking rates (Lawn & Pols, 2005).
Increased capacity and belief by patients in their ability to quit (Hehir et al., 2012).	Easier care of patients (Prochaska, 2009).

Arguably, there is a strong likelihood that few or none of the above benefits would have conferred on patients and staff in MHIFs using smoke-free policy exceptions. Therefore, it is reasonable to infer that the patients in MHIFs and former MHIF patients who still smoke might comprise a significant portion of the heavy smokers by 2025. However, it is unclear whether, as overall smoking prevalence reduces, this group of MHIF smokers will increase in proportion before 2025. In this regard, Edwards (2020), writing about marginalised smokers, including people with mental illness, noted:

> There is already substantial evidence of disparities in smoking prevalence for marginalised groups in many jurisdictions. This surely requires that addressing equity should be a key concern for tobacco control practitioners and that identifying and implementing pro-equity interventions is the highest priority. (p. 251)

Regarding staff, the higher prevalence of smoking by psychiatric nurses suggests that this workforce sector may be a portion of those who smoke in 2025. Staff endorsement of patient smoking has likely contributed to what is regarded as "serious deficiencies in the knowledge of clinical staff and therefore …appropriate training for staff on smoking interventions and culture is an important priority" (Royal College of Physicians & Royal College of Psychiatrists, 2013, p. 122).

People with a mental illness diagnosis have long experienced stigmatisation (Corrigan & Watson, 2002). The risk of further stigmatisation is foreseeable for patients who smoke in 2025. This risk is further compounded by what Warner (2009) described as a public health agenda that used stigma to encourage people not to smoke. In this third decade of the 21st-century, smoking in Aotearoa New Zealand is generally a denormalised and socially unacceptable activity. Continued smoking will likely be constructed as an individual behavioural failure rather than largely the result of a long history of state complicity in endorsing smoking in MHIFs and policy failure (Royal College of Physicians & Royal College of Psychiatrists, 2013; Stuber et al., 2008).

Relevant to my study, by 2025, the portion of MHIF patients and perhaps former MHIF patient smokers might be moderated using electronic cigarettes (e-cigarettes) to help them stop smoking (Bates et al., 2019; Ratschen, 2014). Further, the 2020 amendment to section 6 of the smoke-free legislation permits the discretionary implementation of vaping rooms in hospital care institutions and, therefore, in MHIFs. Vaping, however, is not universally accepted as a cessation tool (Cancer Society, 2019).

The rationale for permitting smoking in MHIFs reflects beliefs that smoking has presumed benefits for patients. In contrast, support for vaping in MHIFs derives from the argument that vaping has the potential as a harm-reduction tool to help patients quit smoking.

Generally, DHBs have similar policy positions about the use of vaping on their sites. Regarding vaping rooms, at the time of data collection, most DHBs did not permit vaping on-site, and this situation has largely continued. To illustrate:

"E-cigarettes are not to be used on Counties Manukau premises in line with Ministry of Health advice on E-Cigarettes."	(Counties Manukau DHB, 2020, p. 2).
"There will be no smoking or electronic cigarette use by staff, patients/clients. Family/whānau. Visitors and contractors at any campus."	(Waikato DHB, 2021, p. 5).

In contrast, Whanganui DHB has a policy for smoking and vaping outdoors in particular areas for patients. The related procedure states:

"Vaping is to be used as a harm reduction tool as opposed to smoking, but NRT is still the safest and preferred option".	(Whanganui DHB, 2018-2020, p. 2).

The Whanganui DHB position shows that it has been possible to vape on a DHB outdoor site before the 2021 section 6 amendment. The amendment allows internal vaping rooms. Are vaping rooms inconsistent with the role of the DHB? If vaping does help patients stop smoking and remain smoke-free, these rooms might be viewed as promoting smoke-free. At this stage, we cannot know. If patients quit smoking but have unwanted side effects from vaping, vaping rooms and vaping are likely to be viewed negatively.

It is uncertain whether DHBs will invoke section 6 and implement vaping rooms. Implementation is discretionary; and, if DHBs do, staff will need appropriate training to support the patients.

Bullen et al. (2018) developed a study protocol to assess the effectiveness and safety of using nicotine e-cigarettes and varenicline for smoking cessation by PMI and addictions in Aotearoa New Zealand. However, the study population involved outpatients of mental health services and not patients in MHIFs.

So, what is the evidence about vaping and smoking cessation? I think it is helpful to consider the possible impact of this law change in the context of the recently published Cochrane Collaboration intervention review, which includes 50 studies (Hartmann-Boyce et al. 2020). The review examines whether e-cigarette use helps people quit

smoking and whether vapers experience unwanted effects. The authors published three key messages from their findings:

- Nicotine E-cigarettes probably do help people to stop smoking for at least six months. They probably work better than nicotine replacement therapy and nicotine-free cigarettes.
- They may work better than no support or behavioural support alone, and they may not be associated with serious unwanted effects.
- However, we need more reliable evidence to be confident about the effects of e-cigarettes, particularly the effects of newer types of e-cigarettes that have better nicotine delivery. (Hartmann-Boyce et al., 2020, p. 3)

Regarding the reliability of the results, the authors acknowledge the results are based on a small number of studies. They also note moderate confidence that e-cigarettes enable more smoking cessation using NRT or nicotine-free cigarettes.

The Ministry of Health & Health Promotion Agency (2020) noted there is scarce information about the long-term effects of vaping and its impact on psychotropic medication metabolism. Bose et al. (2020) suggested that e-cigarettes use by PMI could reduce inequalities.

Could vaping be a panacea to change the culture of smoking in MHIFs?

3.12 Chapter review and summary

In this chapter, I have explored the physical and mental health implications of smoking for people with mental illness. I have critiqued the gaps and silences in the Aotearoa New Zealand literature regarding mental health and smoking, particularly related to inpatients in MHIFs. I have examined Aotearoa New Zealand's 21st-century smoke-free legislation, policies, practices; along with widely held beliefs that have permitted patients and, to a lesser extent, staff to smoke cigarettes and be exposed to harmful SHS while in exceptional spaces of smoking in state mental health inpatient facilities. I have provided an overview of SF 2025, the Aotearoa New Zealand Government's national smoke-free goal and possible implications of continued smoking by mental health inpatients.

Chapter 4 Research Design

> "**If you don't value a citizen, you are not going to be outraged over their death**." (H. Prejean, 2021, February 27).

The preceding two chapters indicate that tobacco smoking by patients has been part of MHIFs for almost a century in Aotearoa New Zealand. There is, however, limited research about smoking and mental health, particularly the exempting of DHB MHIFs from smoke-free policies.

In this chapter, I outline the focus of my inquiry and my philosophical assumptions. I introduce Agamben's state of exception, its applications, and outline its relevance to my research questions. I provide the reader with a schematic diagram to introduce key aspects of the state of exception. I record my ethical considerations, outline my Participant selection and recruitment process, and identify my data collection strategy and processes, including interviews with the 15 study Participants.

4.1 Focus of my inquiry

Central to my inquiry is a question about the **value** of human life: the life of people who smoke and are patients in mental health facilities. Through their admission to DHB MHIFs, these patients who usually have poor physical and mental health have been exempt from the DHB smoke-free policies. Thus, unlike the general hospital inpatients, they did not receive the protection of an entirely smoke-free environment. However, the rationale for these policy exceptions and the implications for patients, staff, and SF 2025 have not been researched in the context of Aotearoa New Zealand. To explore these knowledge gaps, I have examined:

- why exceptions were applied to smoke-free policies in DHB MHIFs
- the implications of the exceptions for patients and staff
- the implications of the exceptions for SF 2025

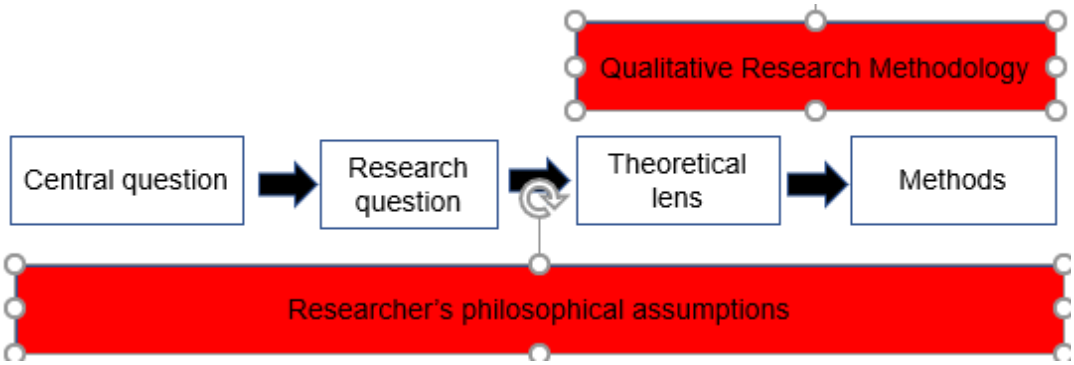
4.2 Philosophical assumptions

Crotty (1998) noted that the research questions and the researcher's beliefs and assumptions drive the choice of research methodology. My research questions are exploratory for this project, so I have chosen a qualitative methodological approach.

As indicated in Figure 4.1, the elements of the research design are interconnected. For example, my choice of a qualitative methodology is informed by my philosophical assumptions about the nature of truth, the nature of reality (ontology) and how knowledge is gathered and used to make sense of that reality (epistemology) (Crotty, 1998). My philosophical assumptions also inform my research questions and my central question about the value of human life.

Figure 4.1

Interconnectedness of research design



My ontological assumptions are broadly informed by bounded relativism, meaning that realities, such as beliefs, are socially constructed and that a shared reality exists within a group. This shared reality is shaped by the belief holders' context; for example, a socio-cultural context such as a workplace smoking culture. Bounded relativism accepts that different realities exist across different groups (Moon & Blackman, 2014). My epistemological assumptions are informed by constructivism, for which relativism is its ontology (Labonte & Robertson, 1996). In a constructivist epistemological approach, the real world is a product of the human mind. People construct knowledge as they engage with the world. In other words, it is socially constructed (Crotty, 1998), and the way people engage with their world is informed by their cultural and social perspectives (Moon & Blackman, 2014). Constructivist methodology is concerned with peoples' lived experiences in a particular socio-historical context, such as the socio-historical culture

of cigarette smoking in 20th-century psychiatric hospitals and MHIFs in Aotearoa New Zealand.

As a researcher, my focus was the meaning that my Participants bought to my study, the meanings they had constructed, and their truths regarding the use and implications of exceptional spaces for smoking in MHIFs. To gain in-depth understanding and insight into these truths, I needed to interact with my study Participants by talking with them via interviews to learn about their subjective experiences. Such interaction meant that I also had an insider relationship with my research, which required me to reflect on my assumptions and previous work in tobacco control, how these might impact my study, and what action I could take.

My previous experience in the tobacco control field and my knowledge of the Participants likely assisted with building rapport, establishing trust, and fostering their willingness to share their experiences. I considered, however, that some Participants might hesitate to talk about their smoking or vaping experiences because they thought that I would be 'rabidly' opposed to smoking and exemptions to smoke-free policies. However, the sole Participant who volunteered her current smoking status talked very openly about smoking and vaping. Other Participants talked openly about their previous smoking experiences. I also considered that Participants might assume I 'knew what they meant' and omit details. Where I sensed this had happened, I invited Participants to explain how they 'knew' that something existed or to give me an example to illustrate their position or observation.

Given my life experiences noted in the 'Big bright beacons of my inquiry' section of Chapter One, and my philosophical assumptions, I drew on Agamben's theory on the state of exception to try and understand the decisions and the human consequences of exceptional spaces for smoking in MHIFs in Aotearoa New Zealand.

4.3 Positioning the state of exception

The exception, or "the way that governments, in extremis, react to a national emergency" (Preston et al., 2014, p. 438) by suspending the law and extending their powers, has implications for the rule of law. It also has implications for the principle of the separation of powers. The rule of law and the separation of powers are central to

the constitutional arrangements in parliamentary democracies such as Aotearoa New Zealand.

The rule of law means that no individual, institutions, or government are above the law. The government's authority is exercised lawfully via written and publicly available laws and accepted procedures referred to as 'due process'. The separation of powers is inherent to the rule of law. This principle intends to prevent the abuse of power by the three branches of government—the judiciary, the executive, and the legislature—acting independently of each other as they carry out their roles (See Figure 4.2). The independence of action provides a check and balance mechanism (Palmer, 2013).

Figure 4.2

Aotearoa New Zealand constitutional arrangements: Separation of powers

	Government Branch	Actors	Roles (summary)
1	Judiciary	All Judges	Interpret & apply law Make case-law
2	Executive	Ministers inside & outside Cabinet & Government Departments	Develop policy Propose laws Administer laws Make delegated laws
3	Legislature	Members of Parliament & the Governor-General representing the Sovereign	Make laws Scrutinise executive

Source: adapted from https://www.govt.nz/browse/engaging-with-government/government-in-new-zealand/

The rights of individuals are also inherent to the above arrangements. For example, and relevant to my study, health and human rights are expressed in the Health and Disability Commissioner (Code of Consumers' Rights) Regulations 1996 and the Human Rights Act 1993, respectively. These rights limit the branches' powers and are enforceable against the state.

4.3.1 Normative order: Times of non-crisis

Applying the above principles, in times of non-crisis, the existing political-legal order, or the normative system, generally functions to address public health and other issues. To illustrate, in Aotearoa New Zealand, concerns about the detrimental impact of smoking on mortality and morbidity were addressed by the executive and legislature, culminating in legislation that established smoke-free workplaces in 1990, and again in 2003. Later, the judiciary interpreted and applied the law in cases related to smoking and smoke-free policies in the workplace, for example (*B v Waitemata District Health Board,* 2016).

4.3.2 Times of crisis: Normative order suspended

What if the *problem* is exceptional, *other than usual*, and involves a crisis or an emergency threatening the state or a geographical area or a community? Take, for example, a disaster like the Canterbury earthquakes in 2010 and 2011 (Potter et al., 2015); or a threat to security such as Christchurch mosques attacks in March 2019 (Royal Commission of Inquiry into Christchurch Mosque Attacks on 15 March 2019, 2020); or a public health pandemic like COVID-19 in 2020 (Borrowdale v Director-General of Health**,** 2020).

Where the sovereign or executive power considers that the normative politico-legal order cannot deal with the crisis and rapid action is needed (Goupy, 2018), it declares a state of emergency. The declaration has the effect of suspending all, or perhaps some, of the usual legal order and human rights protections afforded to all or some people. Thus, executive powers are extended, and laws and legal processes are suspended. This extension of state powers and suspension of the law is what Agamben (2005) described as the *exception* in his theory.

4.4 Agamben's state of exception

This section provides an overview of Agamben's lens on the exception, followed by an outline of the key ideas I have used in my findings and discussion.

Why focus on an exception to a rule? At first sight, an exception appears to be something small and inconsequential, something which might need some attention and is not all

engrossing. It is only an exception to the rule, and the rule's operation is undoubtedly the big thing that warrants attention.

4.4.1 Foundation of western politics

In his general theory of the state of exception, Italian political philosopher Giorgio Agamben 'recasts' the position of the exception. He asserted that "the state of exception tends increasingly to appear as the dominant paradigm of government in contemporary politics" (Agamben, 2005, p. 2). In other words, the operation of the exception has become the big thing and involves the suspension of normative law and an extension of state powers. Agamben conceives that the exception is the site of power upon which western politics is founded (Mills, 2017).

Kukavica (n.d.) contended that Agamben's assertion that the exception is a modern occurrence to be understood in the context of "the framework of the genealogy of the modern state" (p. 3) dating back to the 16th and 17th centuries. Traversing the development of the modern state, he concluded that the exception is inherent to the design of the state so that it can, as necessary, act in a state-like manner and bring order when faced with chaos. Thus, Kukavica considered the exception is a longer duration than the 20th and 21st centuries associated with the modern state.

4.4.2 Suspension of law

The suspension of law is central, and it affects people's lives. By suspending the law, the executive or decision-maker removes the restraints on its power while extending its power against the legal democratic order and thus, "leading to boundaries between the executive, judiciary and legislative becoming porous or even erased entirely (under conditions of dictatorship, for example)" (Griffin, 2010, p. 282). In these conditions, people caught by the suspension are vulnerable to the whims of the decision-maker. For example, encroachments on liberties include political prisoners detained at Guantanamo Bay (Minca, 2006), refugee and detention camps (Gregory, 2006; Hussain, 2007), and "the events of 9/11, the War on Terror… (and) indefinite detention of suspects in terrorist activities" (Damai, 2005, p. 255).

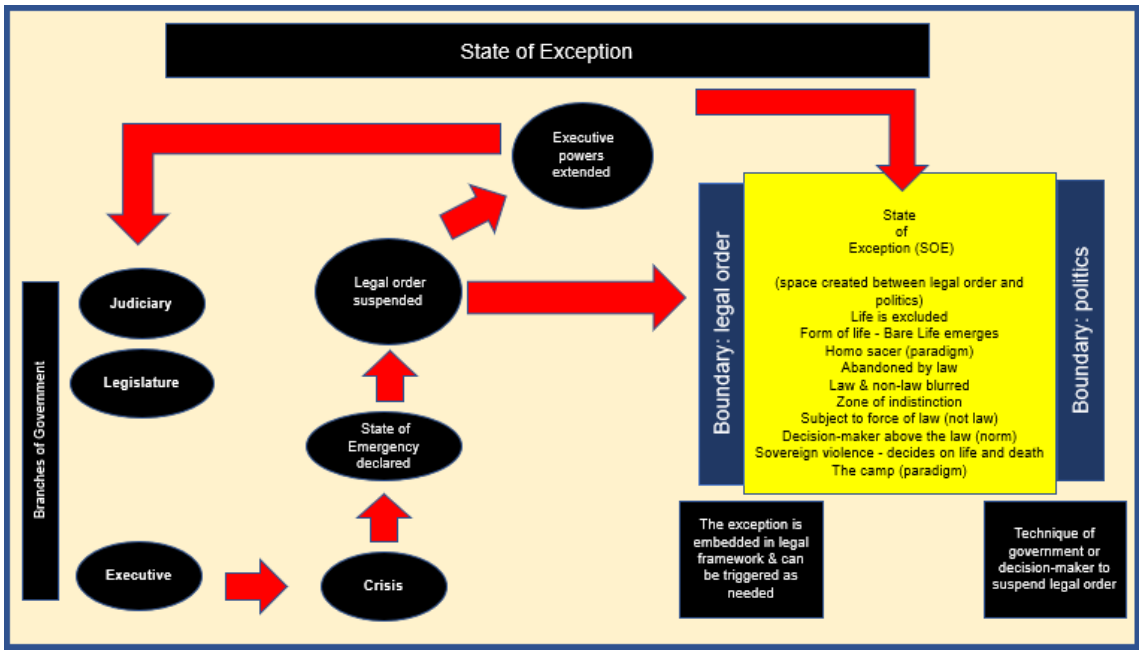
4.4.3 Extension of executive powers

Agamben seeks to expose the 'hidden' or 'invisible' by focussing on the suspension where he examines the 'site' or 'space' that arises from the suspension, the 'mechanisms' used by the decision-maker to control those people situated in that site, and the implications for them. Put differently, he uses the exception to explore what it means to act politically (Dumai, 2005).

I have designed Figure 4.3 to assist the reader. It illustrates the key aspects of Agamben's theory and depicts the exception as the space between the legal order and politics.

Figure 4.3

Agamben's state of exception



4.5 Characterising the space

4.5.1 Above and beyond the law

Agamben conceives the exception as the *space* that opens with the suspension of the normative order and sits between the borders of politics and law (See Figure 4.3). For politics, the exception is the technique used by the executive to suspend the legal order. At the same time, it is part of the legal framework where necessity is used to justify and trigger the suspension.

Although there is a relationship to the law, Agamben contends that the exception is not a special form of law. Why? Because the law is suspended, legal norms do not apply, and thus, it cannot be law. Instead, he posits that it defines the *threshold* or limit of the law, which is where the law is not the law: It is something else that he calls *non-law,* which is above and beyond the law. For Agamben, *above and beyond* are significant concerns because the sovereign or decision-maker in the space of non-law can decide over life and death with impunity.

Thus, he regards the exception as a *site* of power for modern states while also abandoning those caught by the exception. How is this theorised?

4.5.2 Abandonment, force of law, bare life, the camp

Agamben asserts that the exception excludes the biological life of humans from politics but includes what he terms bare life. To create this exclusion and thus exert control over the lives of citizens, the sovereign needs to blur the boundaries or create a zone of indistinction between the private life of people he calls *zoe* and the public sphere, which he calls *bios* (Agamben, 1998).

Using a paradigm to explain bare life, Agamben turns to ancient Roman law and introduces the homo sacer. Greek for the sacred man, the homo sacer was a person removed from society, deprived of all rights and protections, and could be killed by anyone but not as a human sacrifice. Simply, Roman law was no longer applicable; the person was thus, "abandoned by (and to) the law" (Mills, 2017, p. 41) and exposed to violence with impunity.

For Agamben, this process reduces the person to an indistinct form of being; bare life that is vulnerable to whims of the sovereign who is neither constrained nor restrained by law and politics. While the sovereign's actions do not have the force of law since the law is suspended, Agamben (2005) says it is as though the force of law remains in play. Put differently, the effect is to present a façade of lawfulness and justice about the sovereign's actions and signal that the state is maintaining order.

Using the Nazi concentration camp as a paradigm, Agamben (2005) uses the term the camp to refer to the place that opens when the exception starts to rule, and people are

stripped to bare-life. Devoid of citizenship and rights, those in this space are deemed outside the boundaries of humanity and are thus, "bodies subject to political determination" (Ross, 2012, p. 424) and vulnerable to the lethal force of law over human life. In this way, the camp is used to illustrate Agamben's contentions that the exception is biopolitical in nature and that the politics of life is the politics of death.

Agamben's theorisation draws and builds on the work of the others, which I have briefly set out below.

4.6 Influences

Agamben completed studies in law and philosophy, and his orientation is with continental philosophy. He is interested in the philosophy of life and the central question about the meaning of life, and in political philosophy with its focus on governance's institutional apparatus (authority and rules) (Ross, 2012).

Together, his extensive interests culminate in complex and layered theorising, including the use of paradigm and Roman and Greek terms to examine the exception. His approach to the exception also confronts the everyday idea that the sovereign looks after our best interests, is trustworthy, and keeps order.

Central to his work is the writing of 20th-century European theorists examining the nature of sovereign power. Specifically, Carl Schmitt and Walter Benjamin developed the notion that the exception was central to the law. For Benjamin (1942, as cited in Cotula, 2017) the state of emergency was the exception and not the rule. Using a decisionist approach, Schmitt (1985, as cited in Cotula, 2017) conceived that when faced with a threat to the state, only the sovereign was authorised to declare a state of exception. In other words, the sovereign is the sovereign by deciding the exception. Agamben (2005) takes these ideas and extends them with his contention that the exception and bare life constitute a permanent state of exception in modern contemporary politics.

Michael Foucault (2010) is said to have influenced Agamben's thinking about the exception. For Foucault, modernity was characterised by a shift from sovereign power to bio-power. This shift involved the regulation of individuals and populations through

their biological characteristics. In other words, biopower is the tactic of power for determining who lives and dies. Agamben conceptualises this differently, claiming that biopower is built into sovereignty and sovereign power is linked to bare life that is excluded and exposed to violence: the exception is central.

4.7 State of exception: Applications

The state of exception and its concepts have been applied to various situations. The conception of bare life and the camp have appealed to researchers examining the lives of people who are "marginalised, oppressed or other-wise delegitimated within contemporary socio-political arrangements" (Mills, 2017, p. 45). Examples include detention camps in Australia (Crowley-Cyr, 2005), prisoners in Guantanamo Bay prisons (Humphries, 2006), and the status of Native peoples (Rifkin, 2009).

That the rule is the exception has been examined in the Rwandan genocide of 1994 (Ownbey, 2013), German refugee camps (Engler, 2018; Lemke, 2018), and in France and Israel (Feinberg, 2018). Concerning disasters, Preston et al. (2014) applied the exception to disaster education and social justice, while Bignall (2014) has focussed on post-colonial justice in Australia, and Pavlovic (2019) on a post-structural analysis of Fiji's new legal order.

I acknowledge that this framework is derived from a context of gross extreme experiences; however, its relevance is increasingly being tested in other settings. For example, Testa (2018) used Agamben's state of exception, bare life, and the (concentration) camp to evaluate an Italian compulsory fan identity scheme used as a form of risk control to counter football hooliganism. Burke (2019) examined and critiqued Agamben's concept of bare life in relation to the current economic, institutional, and medical practices in dementia care; Duque Silva and Del Prado Higuera (2021) used Agamben's state of exception to "explain how state responses to the COVID-19 crisis have turned science into a new religion" (p. 501); Glitsos (2021) used the Agamben's state of exception to examine the COVID-19 emergency management protocols in Perth city in Western Australia; Waring and Bishop (2020) explore Agamben's concept of bare life in relation to multiple health disciplines in a complex health care system; and Wilson (2020) applied Agamben's state of exception to post-truth political performances.

My study of smoke-free exceptionalist lawmaking and policymaking in MHIFs is sited in that growing tradition of testing whether Agamben's state of exception with its focus on the exceptionalist structure of the law and the expansion of state powers has application to a real-life contemporary situation, in this case, MHIFs in Aotearoa New Zealand.

To elaborate, in 2003, the Aotearoa New Zealand Government suspended the smoke-free protection provisions of the Smoke-free Environments Amendment Act to create an exemption allowing smoking by patients in hospital care institutions such as DHBs. The exceptionalist law permitted DHBs to establish 'DSRs' subject to specific provisions (s.6. (1)) for patient smoking. Relevant to my study, DHBs implemented exceptional spaces of DSRs in MHIFs.

The statutory exemption and the subsequent implementation of patient-DSRs disregarded the accepted clinical evidence of harm from smoking and exposure to SHS and the high rate of smoking by mental health inpatients.

Considering Agamben's state of exception, the use of exceptionalist smoke-free law-making raises important questions about the implications of the increased DHB powers for patients who smoke and are in MHIFs, for the staff, and SF 2025. My study draws on Agamben's state of exception to assess the implications of the expanded state powers associated with the exceptionalist smoke-free legislation and the related smoke-free policies and practices in DHB MHIFs.

4.8 Critique: An overview

Neither the theory content nor its usefulness has escaped critique. Examples include the use of a moralising tone, *messianic hope*, and the exclusive focus on the camp (Ross, 2012); the use of generalising assertions that "we are in states of crisis" (Griffin, 2010, p. 291); the underdevelopment of *bare life* (Ross, 2012); and the use of bare life in "individualising ways" (Rifkin, 2009, p. 90) that do not allow for types of collectivity that are important to indigenous peoples. Further critique includes the contention that "violence and death is the founding political element" (Mills, 2017, p. 42) which has limited application when examining life-extending phenomena, the use of extreme examples (Griffin, 2010), and Agamben's Eurocentric focus, which does not address other forms of violence such as slavery and colonisation (Mills, 2017).

Given the limitations of my thesis, the following section considers two relevant critiques related to my research.

4.8.1 Extreme cases: Venturing into the mundane

Agamben reasons by using extreme cases as the best test to illustrate his notions. For example, he uses the Nazi concentration camps to derive the concept of *the camp* to expose the dehumanisation and vulnerability of those in the camp space to the unlimited power of the decision-maker. Ross (2012) contended Agamben's use of the camp is presented in a pious tone, as though the horrors of the camp have not been previously recognised. Griffin (2010) observed that the exception has been used to examine cataclysmic events and not what she called "more mundane or routine exceptions in contemporary governance arrangements" (p. 284).

The cautionary note for me is that extreme examples often add weight to the issue's size, proportion, and seriousness before me. Extremes can appear convincing at first glance. Equally, they can act as a veil and restrain alternative analyses or applications which might have critical human rights, social justice, and life and death implications.

Pertinent to my research, the spatial location of the exception (the camp) is the DSRs in the MHIF. Prima facie, this room does not seem like the extremes of the Nazi concentration camp referred to by Agamben. It is in a hospital care institution where the normative order is assumed to operate. All looks well, but upon applying the state of exception, more profound truths about the limits of political power become visible. I am drawn to Ross' (2012) statement that "Part of the work of theory is to come up with judicious images that can direct attention to salient issues" (p. 431). Salient issues are not confined to political, climate, or disaster crises. Smoking plays a significant role in premature mortality for PMI. It is a salient issue where the actual practices and the associated institutions warrant examination. For Griffin (2010), salience is presented in the form of the *good governance* model used as part of the institutional reform of the North Seas fisheries, a significant food source for people in the European Union. Big is not necessarily best.

4.8.2 Confronting my decision: Eurocentric focus

Foremost, I am Kai Tahu. We have our indigenous history. We also have a history of colonisation, characterised by the loss of life, land, language, food sources, and culture, following the arrival of European settlers in the latter part of the 18th-century.

I am a researcher in the Pacific contemporary nation-state of Aotearoa New Zealand. To understand and explain exceptions to smoke-free policies in hospital facilities in my country, I have veered towards a political theory constructed by a European political philosopher: a decision that confronts me.

Italian and from the School of Continental Philosophy, Agamben uses the Holocaust, which he calls; the camp, as a starting point to examine the origins of political cruelty. He is concerned to nullify a reoccurrence of the Holocaust (Bignall, 2014). The camp is a central feature of his theorising about the state of exception. His use of the camp has drawn critique in that his Eurocentric account fails "to consider the violence of colonisation or slavery" (Mills, 2017, p. 44).

Agamben uses Roman law, European events, and Greek concepts to examine sovereign power and the exception. Arguably these uses fall into his zone of reflective comfort. Comfort, however, is seductive, and it can constrain the breadth and depth of our reflections. Stating that the exception theory is located "firmly within the Western political tradition" (Amarasinghe, 2020, p. 21), the author contends that Agamben has neglected to examine the exception as a device to "oppress marginalised races and communities" (Amarasinghe, 2020, p. 35). This contention resonated with me because mental health patients are a marginalised group. Should Māori feature disproportionately in DHB inpatient mental health smoking status data, Amarasinghe's view will have significant resonance with me.

Thus, I was 'on notice' as I examined whether Agamben's account of the exception helped engage with smoke-free policy exceptions in the Aotearoa New Zealand context. Central to my thinking was whether sovereign violence was at play in the marginalised communities of MHIFs.

4.9 State of exception: Relevance to my research questions

Agamben writes about the exception and its role in contemporary politics. Researchers have used his theory as an explanatory tool to understand exceptions arising from emergencies related to security and disasters. Arguably, these are macro-events or, as Griffin (2010) put it, "cataclysmic events" (p. 284). They are regarded as big, obvious, or significant exceptions of national importance and a threat to the legal order.

For me, a further question arose. Could Agamben's exception assist with understanding exceptions that fly under the radar and are neither big and obvious nor referred to as national emergencies or crises by political actors or the public?

Specifically, and relevant to my research questions, could Agamben's theory offer explanatory value and assist my understanding of exceptions to smoke-free policies; exceptions that are not usually constructed as a threat to the state and occur at a lower level of executive governance, in this case, Crown entities? Further, could it assist in examining the implications of smoke-free exceptions for patients, staff, and SF 2025?

Addressing these questions was the task of my study.

4.10 Research methods and processes

4.10.1 Background to my study

Good things take time. It was 2008 when I first contemplated this research project, eventually enrolling in my PhD programme in 2016. However, my research journey has not been smooth, encountering patches of turbulence primarily related to the care needs of our Mum, who experienced Alzheimer's disease. As serendipity happens, I found myself reflecting on a peculiar parallel between Alzheimer's disease and my research. Just as there is an absence of a cure for Alzheimer's, there is an absence of explicit guidance about the methods to use when applying the state of exception to smoke-free policy exceptions. While I likened this to being 'up the river in a canoe without a paddle', I was conscious of the opportunity to 'test and try' qualitative research methods to enable data collection about my research questions.

Determinedly, I believed that the absence of guidance should not diminish the value of examining the gaps in knowledge identified in my literature review. Similarly, it ought

not to diminish the value of studying and attempting to make sense of the implications and decisions about smoke-free policy exceptions through the lens of the state of exception via examination of the subjective experiences and insights of people involved with smoke-free policies. Thus, a qualitative methodology was used to gather data about 'sensemaking'. I settled on the following methods (See Table 4.1) for each of my research questions.

Table 4.1

Data collection strategy

Research questions	Methods
Why were exceptions applied to smoke-free policies in DHB MHIFs?	Semi-structured interviews Document analysis (Archival/Crown/DHB/Ministry of Health) Literature review Official information requests
What are the implications of the exceptions for patients and staff?	Semi-structured interviews Document analysis (Archival/Crown/DHB/Ministry of Health) Literature review Official information requests
What are the implications for Smoke-free 2025?	Semi-structured interviews Document analysis (Crown/DHB/Ministry of Health) Literature review Official information requests

The above table presents the data collection methods used in my study. The rationale for my choices and responses to anticipated criticism are discussed later in this chapter.

4.10.2 Participants: Recruitment

My study involved 15 Participants. I selected them purposively because of their work experience in tobacco control policy and/or mental health policy during 1970 to 2019. Their roles included management, education, nursing, medicine, psychiatry, policy analysis, research, social work, and politicians.

The Participants had the following common attributes:

- had worked in one or more public health, central, and non-government organisation sometime during the years 1970 to 2019 in Aotearoa New Zealand
- had experience in developing, and/or approving and/or implementing tobacco control policy and/or mental health policy in Aotearoa New Zealand
- spoke English
- were contactable via publicly available email addresses

With the first two criteria in mind and drawing on my professional experience in tobacco control and the health sector, I created a matrix of the policy-related roles known to be, or likely to be, in the above organisations. This visual image was helpful because it depicted the breadth of experience that I needed to consider when selecting potential Participants. My study's eventual types of Participant experience included smoke-free education, mental health nursing, tobacco control service management, hospital governance, advocacy, education, medicine, psychiatry, social work, mental health service management, policy advice, research, and electorate representation and law-making.

Initially, I considered including patients in my study. However, my research aimed to explore the underlying philosophical/legal/human rights issues related to the development and use of 'exceptionalist policies'; in this case, smoke-free policies that exempt MHIFs. People's perspectives in governance and operational roles are generally the key 'influencers' of these policies. Therefore, the specific views of patients would be a different study and were excluded from this study.

Participants were purposively recruited. This technique lends itself to qualitative research (Patton, 2002) and was chosen because it allows the "identification and selection of information-rich cases" (Palinkas, et al., 2015, p. 533). For example, I chose people who were particularly experienced and knowledgeable about different aspects of tobacco control policy and/or mental health policy. Also, I considered whether people were likely to be available, prepared to take part, and discuss their experiences and views in a clear, concise, and reflective way.

Reflexivity: Selection process complexity

Reybold et al. (2013) contended that participant selection is "one of the most invisible and least critiqued methods in qualitative circles" (p. 699) and that "discussions of selection choices need to go beyond a discrete listing of criteria or description of participants" (p. 713). This challenge resonated with me. Practising being conscious or *on alert* about my selection process and the possible unintended consequences offered greater accountability to the study Participants and justification for my choices. For example, I clearly explained why I had invited them to participate. Further, I realised I was somewhat hesitant to contact people I had not met before and held very senior roles in their fields of expertise. It seemed easier to avoid the possibility of their rejection of my letter of invitation by not sending an invitation. Without this realisation and the recognition that there was no basis for my fear, my study would be missing the voice and insights of information-rich Participants.

My on-alert state was also crucial to saturation. My study did not begin with a pre-set number of interviews to be achieved. Instead, I used saturation, a purposeful participant selection strategy (Miles & Huberman, 1994). Saturation offered me a more in-depth understanding of my topic by sampling to the point where I no longer received new and significant information within and across the interviews. In other words, there was data saturation (Guest et al., 2006). I designed a 'saturation grid' to keep track of the data content, setting out the main question areas and allowing for new information. After each interview, I played the interview recording and noted what had been covered. Regular discussions with my supervisors about saturation were important and assisted my determining the point where no new data had been received, and I discontinued my data collection.

Each prospective interview proved to be a unique moment to reflect and be very aware of why I chose this person rather than a different person. To illustrate my reflections, former Ministers of Health involved with tobacco control legislation were key decision-makers, and they were likely to be repositories of rich information. However, I considered that they might feel constrained by their former roles and not be available or very open with information. However, former Chairs of the Health Committees were also in key roles but likely to have had a more detailed perspective at the *hands-on* level

of the legislative processes and be aware of the Ministers' views. Weighing this up, I opted for the Chairs.

Strategies for recruiting participants

Participants were recruited through my existing professional and personal networks based on my former clinical, health promotion, service management, and education roles in mental health and tobacco control. I initiated contact with potential Participants via their publicly available email addresses and sent each a letter of invitation. In one case, I wanted to be sure that I used the Participant's preferred email address, so contact was initiated by text and then followed up by email.

On acceptance of the invitation, I emailed each person a brief thank you letter along with a copy of the *Consent Form* (See Appendix A) and the *Participant Information Sheet* (See Appendix B). I invited them to return the completed consent form if they wished to participate in the interview.

Of the 18 people invited, I had previously met all but three people. Of the three, two participated in an interview, and one declined.

Only one invitee did not respond to my invitation or the subsequent single follow-up email. Another invitee expressed interest in participating, subject to availability for a 15-minute interview only. I discussed this time constraint with my supervisors. Although the interviews were expected to be 1 to 1.5 hours in duration, I decided to accommodate the request. I considered that this person was likely to provide significant new information related to professional expertise and experience as a former National Party Member of Parliament (MP) during the Labour-Coalition-led Government, which introduced the 2003 smoke-free legislation. The invitee did not follow up my subsequent email; however, I had recourse to the MP's views recorded in the Parliamentary Debates.

The invitee responses are summarised in the following Table 4.2.

Table 4.2

Outcome of invitations to participate

Invitation responses	Number	Notes
Accepted	15	Consent forms signed
Declined	1	
No response	1	Followed up. No response
Expressed interest	1	No response to subsequent communications
Total	18	

4.10.3 Ethical review

This research was reviewed and approved by the Auckland University of Technology Ethics Committee (AUTEC 16/365 27 March 2017) (Appendix C).

The approval process included the following:

- letter of invitation
- participant information sheet (Appendix B)
- confidentiality agreement (Appendix D)
- protocol for digital and voice recording (Appendix E)
- consent form (Appendix A)

The consent form included the participant anonymity option discussed in the data collection section.

Ethical considerations

As a law lecturer at the University of Waikato, I taught ethics and was a Law School's Ethics Committee member. I had also trained in drug and alcohol counselling, and I was familiar with interview skills; however, I felt like a *newcomer* to ethics when I enrolled at AUT. I discussed this with my colleague who taught ethics at AUT. I realised that I was a newcomer to a different institution's approach to ethics approval, and I needed to embrace the requirements.

Because the invitees came from my professional and personal networks and I had met most of them, I was concerned my position that *smoke-free is the healthy and desirable*

option might impact interviewees, particularly people who smoked. Following discussion with my supervisors, I realised that my view might unleash strong views or moderate or have no impact on the Participants' responses during the interviews. Thus, my challenge was to use my best endeavours not to convey the above view or judgment via intonation and words.

Keeping a diary

My supervisors strongly recommended that I keep a diary from the outset of my research. Initially, I was doubtful that I could fit diary writing into my schedule; however, keeping a diary proved to be a meaningful, regular connection with my research. It also established writing as a more systematic activity. In the form of text, diagrams, and mind maps, my entries traversed my insights, ideas, fears, frustrations, reflections, readings, conferences, meetings with my supervisors, and peer and interview planning. They also captured alone thinking moments that produced *oh wow* connections, particularly after listening to the audio recorded Participant interviews while travelling in my car or awake in the early morning hours.

My diary was also a safe place to wrestle with the impact of significant life events on my tightly planned interview schedule and on the ways that these events diverted attention from my research. I knew that the best of plans could go astray. I became more deeply and painfully aware that my interview plans were truly vulnerable to matters over which I had no control: the physical, emotional, and social impact of Mum's experience of Alzheimer's.

4.10.4 Instruments and technologies

Interviews - rationale

Consistent with my epistemological position, research questions, and desire to understand my Participants' experiences and insights, I chose a qualitative research approach, using face-to-face semi-structured interviews with open-ended questions as my principal source of data collection (Bolderston, 2012).

The use of semi-structured interviews was important and appropriate to my research. Although the focus of my study was exceptions to smoke-free policies in MHIFs, it

included smoking behaviours. However, smoking in 21st-century Aotearoa New Zealand is primarily denormalised and often publicly stigmatised. Thus, I was concerned that interviewees might worry about discussing smoking with me as a teacher of tobacco control. The use of semi-structured interviews left the door open to explore *hesitant*, guarded, or incomplete responses. Being in each other's physical presence added a further dimension to ascertain c*omfort* with the interview. I could see body languages, such as head nodding in agreement or puzzled looks. Using open-ended questions allowed me to paraphrase and clarify my questions and the interviewee's responses and seek further information.

Flexibility was necessary. I arranged phone interviews due to four interviewees' geographical isolation and work commitments. Since these were audio calls, there was no face-to-face presence or associated visual cues to determine comfort during the interview. Although I had met these interviewees and had a visual picture of them in my mind, the audio connection required me to listen very carefully to the content, tone, pace, and gaps in the conversation. I made a concerted effort to paraphrase and clarify to demonstrate my interest and respect and build trust.

Interview questions - preparation

I designed the interview to include three sections and two prompt sheets with my research questions in mind. Section A was a practical way to record the information in Table 4.3 below, and sections B and C contained the interview questions.

Table 4.3

Interview structure

Section	Content	Refer
Section A	Table to record interviewee role/s, organisations, period of work experience, type of smoke-free policy involvement	
Section B	Questions related to interviewee smoke-free policy/related perceptions, insights and experience in their role/s	Appendix F
Section C	Questions related to interviewee perceptions, insights and experience about Smoke-free 2025, the DHB protection objective and the exemption provisions of smoke-free legislation	Appendix F
Prompt Card C	Key terms and definitions for Participants	
Prompt Card D	Components of smoke-free policy for the interviewer	

The above table outlines the general content of each section of my interviews. Although all interviewees had varying kinds of tobacco control policy experience, I did not assume they were familiar with current terms. Thus, I designed Prompt Card C to share face-to-face or electronically as needed to be respectful. Prompt Card D was prepared as a reference for me when exploring different components of policies with interviewees: components such as development, consultation, approval, implementation, monitoring/evaluation/review, and legislation/regulation.

Interview - pilot test

Before undertaking my first interview, I reflected on the interview content and process. Eager for the interviews to be respectful, comfortable, and easily understood by interviewees, I identified the following areas to pilot. I was also open to any feedback about improvements:

- letter of invitation. Was it easy to read, did it make sense?
- participant information sheet. Was it easy to read, did it make sense?
- sections a, b, c. Were the questions/instructions straightforward, was there redundancy/overlap?

- what were the advantages/disadvantages of the participant completing section a before or at the start of the interview?
- what other tools could assist with the interview?
- the length of the interview
- location/volume for recording devices
- best place to sit to note-take, monitor recording devices, and engage with the interviewee?

I conducted two pilot interviews with colleagues. One did not meet the inclusion criteria, and, serendipitously, one did, although I did not know that before the interview. This combination proved helpful. It offered me a double-check on language familiar to one pilot interviewee and me but not to the other. Following the pilot interviews, the invitation letter was amended to bullet point the inclusion criteria to make them evident to the reader. Feedback suggested that a diagram of the sequence and sections of the interview would complement my verbal explanation, so I designed a flow chart. I included a reference to the consent form to highlight its centrality.

In hindsight, it would have been helpful to pilot test a phone interview, and I felt somewhat unsure about the first phone interview. A practice run would have guided me about technical aspects such as where to place the digital recorders to best capture the interview, what volume to set the recording devices and where to place my writing pad. It would have provided me with the opportunity to learn whether it was easier for interviewees to complete Section A before or during the interview.

Audio recording devices

I considered that audio recordings and the subsequent transcriptions would more accurately represent the interviewee's voice than if I made contemporaneous notes during the interview. Accordingly, all interviews were digitally recorded using a Sony digital voice recorder and then uploaded to my study laptop. My study laptop was an audio recording backup in case of sound quality or equipment failure.

4.10.5 Data collection

Interview process

All interviews were conducted in Aotearoa New Zealand. I invited the Participants to choose the location and time for their interviews. Two Participants chose to be interviewed at their workplace. The rest opted for their homes, including those interviewed by phone. No one else was present during the face-to-face interviews. One phone interviewee indicated that a family member had heard part of the interview and had commented, but it was ignored. Most Participants emailed me a copy of their completed consent forms before interviews, while others completed the form in my presence. All Participants were offered the choice of anonymity, and four accepted and have pseudonyms.

Following discussions with my supervisors about the safety of interviewers, I instituted a practice of letting my supervisors know when I was about to start and had finished an interview. A further technique I developed was to reflect and record my observations, insights, and experience of each interview as soon as practicable after the interview. Usually, I did this in the confines of my car. I found that this practice enhanced my sense of accountability to the interview process, heightened my awareness of nuances that I might have passed over, and importantly allowed me to debrief. I discuss the importance of my diary in the reflections section below.

I checked that each Participant was happy for me to record the interview and make written notes. For the audio record, I confirmed that consent had been given. Mindful of the possibility that a Participant might disclose information and then have concerns about the implications for themselves or others, I indicated that they were welcome to revisit their decisions not to choose anonymity. This offer was not taken up. I also checked how much time they had available for the interview. This knowledge enabled me to pace the interview within the available time.

The interviews were conducted from February 2018 to March 2019, and they ranged between 45 minutes and two hours, and most were about one and a half hours. At the end of the interviews, I reminded Participants that the recording would be transcribed in confidence by a professional transcriber or me, and that they would receive a copy to verify or seek clarification or give feedback.

Consistent with my ethics approval, I gave Participants a koha or gift to acknowledge and respect their contribution to my research journey. I followed this with a letter of thanks.

Reflections

The use of a post-interview notebook to debrief about *unexpected and distressing disclosures* was an important safety net. For example, my notes record that I was quite distressed following one interview and shed tears over my notebook. The interviewee, who chose anonymity, had described the sight of cigarette burns on very vulnerable inpatients in a mental health facility. I had not anticipated this kind of disclosure, and it cut to the heart of my values about the inherent dignity of all people. Debriefing further with my supervisors was also important. I reflected that while I cannot anticipate or prepare for every possibility, I need to be mindful that the unexpected can happen.

I found the fieldwork very rewarding, and I was very keen to complete my interviews as soon as possible. Once again, the unexpected happened and, due to family circumstances, I could not conduct interviews for a period. I was concerned that my last two potential interviewees might not be available. Each had experiences that were likely to add new and rich information to my data, but I had to wait and be patient. Being patient allowed me to reflect that taking care of myself was also effectively taking care of my research project.

Official Information Requests: Document analysis

My interview data were supplemented and confirmed by document analysis which Bowen (2009) described as "a systematic procedure for reviewing or evaluating documents—both printed and electronic computer-based and Internet-transmitted" (p. 28). Documents were important in my study because they filled gaps identified during my examination of the literature, provided data, broadened my understanding of the subject, and assisted with research design. The following Table 4.4 outlined the Aotearoa New Zealand documents that formed my collection.

Table 4.4

Documents and collection methods

	Date Requested	Document Collections	Collection Method
1	Not applicable	Ministry of Health Crown public health documents from 2000 to 2021	Publicly available via online access
2	December 2019 Initial request to Archives New Zealand: referred to Ministry of Health for approval 7 July 2020 2nd request	Ministry of Health Department of Health documents related to tobacco use in MHIFs from 1930 to 1970 Mental Health – Health Circulars 1939-1974 related to tobacco. (held by Archives New Zealand)	Not publicly available Accessed through Ministry declaration process
3	29 January 2020	DHBs Smoke-free policies from 2000 to 2019 and 1993 to 1999 if held	Not publicly available Accessed through Official Information Request
4	23 August 2020	DHBs smoking status data from 2009 to 2019/20	Not publicly available Accessed through Official Information Request

Crown documents: Collection 1 – publicly available

As indicated in Table 4.4, the Crown documents were publicly available. My literature review showed that from 1990, consecutive Governments identified tobacco as a national health goal or target. Implementation of these measures and accountability for achieving the outcomes was primarily the responsibility of the public sector hospitals. Accordingly, each Government, via the former Department of Health and the current Ministry of Health, published strategic and operational documents either solely or containing some content about tobacco and smoking. These documents, which included Government national strategies, policies and plans, Ministerial announcements, and reports from inquiries, were salient sources of data about tobacco control policy priorities. As the above table indicates, these documents were available publicly and electronically, so I downloaded them.

Collection 1 covered the period from 2000 when the DHBs were established to early 2021. I examined these documents to ascertain the visibility of policy initiatives related

to smoking and mental health in general and, more specifically, smoking in MHIFs and smoke-free exceptions in MHIFs.

My analysis broadened my understanding of tobacco control policy development during 2000 to 2021, while the pre-2018 documents provided insights for crafting interview questions.

Publicly unavailable documents – access processes

Table 4.4 shows that three of the four collections were not publicly available. Collection 2 was held by the Archives New Zealand, a Crown entity, and Collections 3 and 4 by DHBs, which are also Crown entities. These agencies are subject to the OIA 1982. The principle of availability guides the application of the OIA (section 5 OIA). It means that unless there is a good reason to withhold information, it must be made available to a requester.

Cognisant of this principle and following discussions with my supervisors, I requested this information. Mindful of the importance of writing clear and specific information requests, I consulted the Ombudsman's (Office of the Ombudsman, 2019a) publication for guidance about making a request. I also referred to the Ombudsman's (Office of the Ombudsman, 2019b) publication about what Ministers and Crown entities need to consider when responding to an official information request (OIR). Referring to both documents informed me about the process.

District Health Boards: Collections 3 & 4

Using the Ombudsman's suggested template, I drafted OIR letters to each DHB's nominated contact person as stated on its website. These were emailed or submitted through an online portal depending on each DHB's requirements.

My requests subsequently coincided with the 2020 COVID-19 pandemic, affecting the DHBs' workforce and priorities. Thus, I appreciated the DHBs that promptly contacted me for clarification, communicated their decision, and released the information on time. These actions also complemented my data collection timeframe, and I followed up with letters of thanks.

Smoking status data: As discussed in Chapter Three, the DHBs collected patients' smoking status data from their mental health and general hospital facilities, but these data were not published. Therefore, the extent to which smoking features in the lives of mental health inpatients remained invisible. These data are important in the context of smoke-free policy exceptions in MHIFs. To supplement my research strategies, I requested mental health and general hospital smoking prevalence data from 2009 to 2020 from the 20 DHBs. Specifically, the requests sought the annual total admissions and admissions by the Māori, Pacific, Asian, and European smoking status for mental health and general hospital facilities, respectively.

Smoke-free policies: To ascertain the timing and types of smoke-free policy exceptions used by DHBs, I requested smoke-free policies for 2000 to 2019. I anticipated that some policies might also cover 2020 and 2021. I also asked for any policies from 1993 to 1999 to offer a context for DHB policy development.

Ministry of Health and Archives New Zealand: Collection 2

Through an online search of documents held by Archives New Zealand, Wellington, I located material related to the 1947 patient comfort fund for psychiatric hospital inpatients. My December 2019 inquiry to access this data from Archives New Zealand was referred to the Ministry of Health (Ministry) because the records had restricted access and required approval from the Director of Mental Health at the Ministry Health.

Following the Ministry's request to provide the completed declaration form, my AUTEC ethics approval, an outline of my thesis, and my supervisors' contact details and names to the Ministry, my access to the documents was approved on 18 February 2020. Document copying was not prohibited.

I visited Archives New Zealand in Wellington on 20 February 2020, completing the access requirements and obtaining an Archives New Zealand Reader Card. I received four files, and the documents included Ministerial and officials' letters, memos, policies, budgets, and newspaper articles. My second OIR request provided circulars from the Department of Health to the hospitals.

Because of work commitments, I had limited time to review the files. Working chronologically through the files dating from 1923 to 1976, I carefully skimmed the

documents to identify content related to the Crown and hospitals' policy initiatives involving tobacco, smoking, and cigarettes. Care was necessary because of the fragility and age of some documents and my desire to identify relevant documents. I made a written list for each file and then returned to the identified documents, read them, and re-assessed their relevance. Reading and reassessing proved critical because a 'second but considered viewing' refined my final list. I then photographed these documents, excluding material with patients' names. Some documents were not dated, and sometimes, I could not identify the author. I made paper copies of photographs and used these for my analysis discussed in Chapter 5.

My analysis of the historical document collection involved the following four stages. In stage one, I categorised each document by type; for example, whether it was a letter, memorandum, newspaper article, or press release. Stage two involved recording the name of the document's author if the name was on the document, the author's Government department or non-government organisation, the document's date, and the name of the document's intended recipient/s. I carefully read and summarised each document for stage three, highlighting sections that illustrated the state's role in purchasing and providing tobacco and cigarettes to patients in psychiatric hospitals. In stage four, I reflected on and recorded what I had learned from each document that I had not learned from any other document/s in this collection and/or other sources.

4.10.6 Data analysis

Transcription of interview data

It was an attractive proposition to transcribe interviews to become familiar with the data. On balancing work and family commitments with timely and quality transcripts, however, I employed a professional transcriber bound by the AUTEC confidentiality requirements (See Appendix D) who was asked to transcribe verbatim. Each transcript was dated and included either a pseudonym or the Participant's first name. For ease of reading, the transcriptions were organised under the consecutive headings of *interviewer* and *interviewee,* followed by the relevant text. The interviewee sections were typed in bold, and each line throughout the transcription was numbered, making it easy to identify relevant text during coding and writing. I read each transcript to check for gaps where the transcriber could not decipher the speech. I highlighted these and

drew them to the Participant's attention in my email to validate the transcript: all Participants but one confirmed receipt of their transcripts. The majority provided feedback and points of clarification that were incorporated into the transcript and forwarded to the Participants.

Thematic analysis

A recognised qualitative research method, reflexive thematic analysis, was my chosen method to analyse the interview data because it can be "used across a range of epistemologies and research questions" (Nowell et al., 2017, p. 2) to examine people's perceptions, views, and experiences.

Early in 2018, as preparation for using thematic analysis, I attended a thematic analysis training course based on the six phases proposed by Braun and Clarke (2006) and Clarke and Braun (2013). The course introduced the concepts, processes, and offered practice examples of codes and themes. My training notes indicate that I likened the experience to a birthday cake with no cream cheese icing: something significant was missing. That something was my data as my first interview was scheduled a few weeks later. The fuller realisation of my sense of 'missing' came later as I read the transcripts to familiarise myself with the data. Not only did I recall the interviews as I read the text, but I was also aware of my relationship with the interviewee and my involvement with the process. I was not merely the reader at a distance from someone else's data.

After the workshop, I decided that inductive analysis was better suited to my inquiry. Inductive analysis is a qualitative research approach where the researcher works with the data to identify the themes rather than using a pre-determined framework. My research area was new in Aotearoa New Zealand, and I strived to recognise themes peculiar to the local context rather than being constrained by themes related to overseas research. Additionally, a strength of the inductive approach is that the themes do not necessarily reflect the researcher's beliefs or interests about the chosen subject.

Using inductive analysis, I used the following six iterative phases of reflexive thematic analysis (Braun & Clarke, 2006; Clarke & Braun, 2013; Braun et al., 2019). I was mindful that my analysis might move backwards and forward between the phases rather than strictly linear.

Phase one: Familiarisation with the data

To increase my familiarity with the experiences and views of the Participants, I drew on my auditory, visual, and kinaesthetic learning styles. I listened to the transcripts while driving my car, although I felt frustrated because I could not write notes. I read each transcript three times and in three different locations: a rural vista, a seaside view, and an urban setting. Sometimes I used different rooms in the same house. Movement and change of scenery gave me new perspectives. For example, although my inquiry focused on smoke-free policy exceptions in MHIFs, I saw connections that 'flagged' that the facilities did not exist in isolation from the broader organisational values.

I used highlighters on the transcripts to colour areas of possible interest and links with my literature review.

Phase two: Generating initial coding

Coding involves using a phrase or a word to represent an action, feeling or idea in the interview data. Returning to the transcripts, I identified sentences and phrases relevant or possibly interesting in the context of my research questions. Initially, I typed these into tables, using coloured coding for each person (See Appendix H). However, I am primarily a visual kinaesthetic learner. I changed my approach to using paper sticky notes and highlighters and included the transcript line number and the interviewee's pseudonym or initials. I put the notes on big sheets of paper and took photos for future reference and backup copy. Simple codes with key identifying words were used at this stage, and I added more as I went through the transcripts.

Phase three: Generating themes

To generate themes, I looked for patterns of similarity in the codes. Because they were written on sticky notes, it was easy to move them into groups that represented themes and reorganise them into different themes when I considered they offered something helpful about the data. Vague codes were discarded. When satisfied with my initial themes or candidate themes, I developed a visual chart of the themes and codes, which showed the interrelationships and allowed me to determine what themes were umbrella themes under which other themes were subsets or constituted sub-themes.

Phase four: Reviewing themes

This phase involved returning to the data, comparing my themes against them, checking whether I had missed something, whether the themes best represented the data, or whether there was a more effective way to express a theme. I kept in mind the notion of a *central organising concept* that illustrates the story of the data about my research questions (Braun et al., 2019).

Phase five: Defining and naming themes and Phase six: Producing the report

Defining my themes enabled me to identify each theme's parameters and check that each was sufficiently bounded to stand alone and, if not, to combine them. Where the theme name was long or very brief, I identified a name that conveyed the essence of the theme and was sufficiently interesting to capture readers' attention. The following diagram (Figure 4.4) depicts my final themes.

Figure 4.4

Thematic analysis: Six themes

Trustworthiness

Triangulation

A range of strategies can be used to ensure the trustworthiness of data. Triangulation is a research strategy used to establish the credibility of the research findings (Lincoln & Guba, 1985). My study used method triangulation to develop a fuller understanding of the subject (Patton, 1999), "produce a more comprehensive set of findings" (Nobel & Smith, 2015, p. 35), and improve my findings' validity (Denzin & Lincoln, 2018). I used the following methods:

- face-to-face semi-structured interviews
- document analysis: Crown documents/Archival documents/DHB smoke-free policies/DHB smoking prevalence data
- OIR: Archival documents/DHB smoke-free policies/DHB smoking prevalence

The methods were a mix of supplementary and confirmatory. Document analysis of archival material supplemented knowledge about the Crown's historical role regarding tobacco use in mental health inpatients during the 20th-century. Interview data confirmed the Crown's more recent role and supplemented knowledge of the contemporary context, experience and behaviours related to smoke-free policy exceptions. The OIR and document analysis of the Crown and DHB materials supplemented and confirmed the interview data.

4.11 Chapter review and summary

In this chapter, I have outlined my philosophical assumptions, theoretical approach, and methods. Since my study is not of war or the concentration camp-type settings referred to by Agamben, I have provided a rationale for my use of the state of exception lens. I have discussed my interview and data collection processes and analyses, including the five phases of reflexive thematic analysis and trustworthiness of my data.

In the following chapter, I present the interview findings.

Chapter 5 Building Blocks of Exception

In this chapter, I present my findings from interviews undertaken between February 2018 and March 2019. These findings relate to my Participants' experiences and perceptions from their varied roles in developing and implementing policies concerning smoking, exposure to SHS, and smoke-free exceptions for MHIF patients, staff, and SF 2025.

Thematic analysis revealed six themes. I have presented the results under these themes (See Figure 5.1). I have underlined key phrases and words related to each theme in this chapter to assist the reader. In themes 1 and 3, the findings about psychiatric hospitals are presented separately from those associated with DHBs, so the reader has a snapshot of the critical attitudinal, policy, or practice changes over time, particularly from the 1970s to 2019.

Theme 1: **'Doing the acceptable'** reports that cigarette smoking has been common and normal practice undertaken by patients and various occupational groups in former psychiatric hospitals and DHB MHIFs. It has played a crucial role in patient/staff relationships.

Theme 2: **'Knowing the best'** identifies a range of firmly held beliefs about the value and importance of smoking for and by patients.

Theme 3: **'Sites of smoking'** indicates that tangata whai ora and/or staff have used various indoor and outdoor sites in psychiatric hospitals and MHIFs.

Theme 4: **'Keeping the peace'** reports that psychiatric hospitals and MHIFs have provided tangata whai ora with tobacco and cigarettes over several decades and that staff have used cigarettes to calm patients and control their behaviour.

Theme 5: **'Guarding'** identifies how staff have protected and promoted the exception as the desirable option.

Theme 6**: 'Policy perspectives'** sets out the Participants' views related to smoke-free environments, including SF 2025.

Figure 5.1

Building blocks of exception: Interview themes

Figure 5.1 presents the six themes from the interviews. I have included a map of each theme and its sub-themes at the start of each theme's findings.

To reintroduce the Participants, I have included the Participant profiles as follows.

Table 5.1

Participant profiles

Name	Psychiatric hospital experience	DHB MHIFs experience	Related roles/experience
Lynore	No	Yes	Smoke-free educator
Sylvia	Yes	Yes	Nurse (mental health)
Judy	No	No	Member of Parliament Chair Health Select Committee Smoke-free legislation 1990 & 2003
Tania	Yes	Yes	Nurse (mental health) DHB Governance
Steve	No	Yes	Member of Parliament Associate Minister of Health Chair Health Committee Sponsor Smoke-free legislation 2003 Midwife
Hayden	Yes	Yes	Medical practitioner Cessation educator Ministry of Health advisor PhD in tobacco withdrawal symptomatology
Ben	No	No	Policy analyst-tobacco control NGO sector
Jo	Yes	Yes	Anonymous
Sam	Yes	Yes	Anonymous
Lee	Yes	Yes	Anonymous
David	Yes	Yes	Medical practitioner Psychiatrist Clinical leader MHIF smoke-free committee
Robert	No	No	Medical practitioner Researcher public health medicine/NCDs WHO ASH founder
Karen	Yes	Yes	Nurse (general) Smoke-free manager
Ash	Yes	Yes	Anonymous
Murray	Yes	Yes	Medical practitioner Psychiatrist

5.1 The interviews

Whether the Participants supported or opposed exceptions to smoke-free policies, they consistently associated or attributed cigarette smoking with comments about how smoking did or might have helped manage patients.

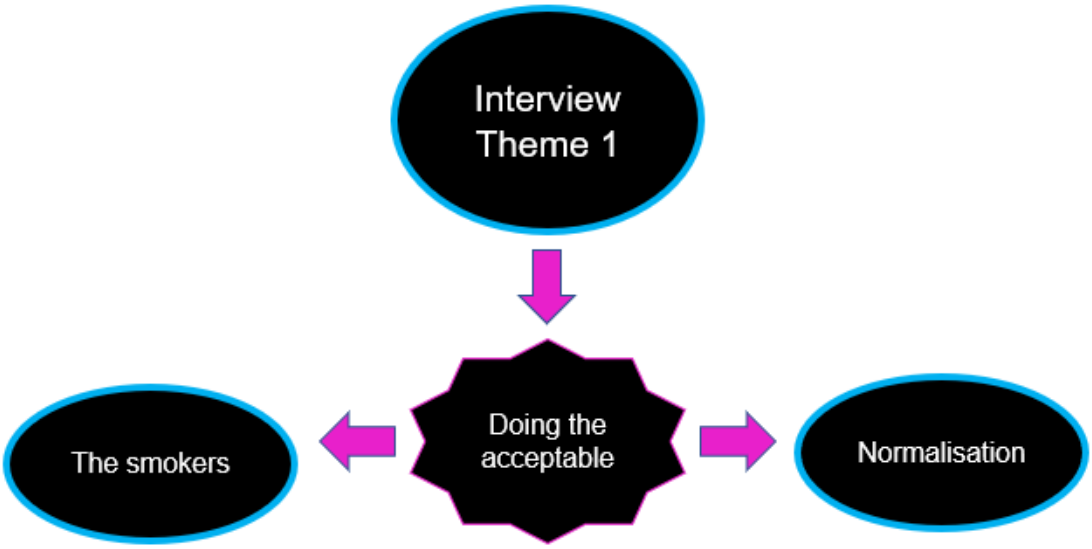
Who smoked cigarettes at the psychiatric hospitals during the last three decades of the 20th-century?

5.2 Theme 1: Doing the acceptable

Figure 5.2 sets out the theme and two sub-themes covered in this section. Often referring to *the smoker,* Participants who had worked in psychiatric hospitals (hospital) and MHIFs identified who smoked at the respective institutions. They named the occupational groups of the staff who smoked. Participants also shared their observations about activities that reflected the *normalisation* of smoking.

Figure 5.2

Theme 1: Doing the acceptable



5.2.1 The Smokers: Psychiatric hospitals 1970-1999

Consistently, and with little hesitation, the Participants who had worked in these hospitals stated that they had observed smoking by patients and staff and that smoking was very acceptable.

In the 1970s

Tokanui Mental Hospital (Tokanui) was a large inpatient hospital for patients. Located south of Hamilton, it closed in 1998.

In 1971, Sylvia began her psychiatric nursing training at Tokanui. Elaborating on her initiation into smoking, she reflected that she had arrived as a non-smoker. Surrounded by smokers, she soon became a smoker:

> I started smoking when I had been nursing; everyone smoked… it was totally cool. I was 17 and a half, and all these older people smoked, and I wanted to be cool too. I was very naive when I went training... very naive. All the old people smoked, mostly Māori… two Māori ladies – and they had been there forever. They taught me the ropes about everything. I thought they were so cool and knew so much. They smoked, and we smoked inside. You had your coffee, and you sat down. The ashtray was in the middle of the table next to the sugar… I think that most patients smoked too.

Smoking was common practice by patients and staff from various occupational groups.

Lee, who worked in a health-related role in a similar hospital to Sylvia, recounted who smoked:

> Most of the psychiatric nurses smoked. It was just the norm; really, patients were always trying to bludge cigarettes. Nurses definitely smoked the most, yes. Then I think probably the medical staff still smoked quite a bit. I wasn't aware of occupational therapy or social workers smoking. I don't know about the psychologist; I can't really remember. I think quite often the kitchen staff would smoke because there were quite a lot of Māori kitchen staff and they were a high

> percentage of smokers, and because often people would go out and have a smoke in the kitchen because they knew the kitchen staff were.

Smoking was a common practice among medical practitioners and psychiatrists. Sylvia put it like this:

> Wherever a doctor went, there was smoke… Doctors smoked. I can see Dr [A] smoking and Dr [B]. He went around. He had 'rollies' and that other doctor he had a pipe… I can't remember any male doctors who did not smoke.

In the 1980s

Like Sylvia, Tania completed her psychiatric nursing training at Tokanui. Although she was there a decade after Sylvia, Tania's observations that staff and patient smoking were common practice closely mirrored those of Sylvia and Lee:

> Smoking was everywhere. You smoked in the wards… You had the big old ashtrays in the wards… the staff used to smoke in the day room while they were on duty with the patients, or you'd take them for walks, and people would be smoking… Smoke was everywhere. In those days, the patients still smoked in the wards… There was just smoke everywhere; it was just they all smoked.

Sam also highlighted that smoking was present in the workplace. Sam had worked in a health-related role in a hospital during the 1980s.

> Yes. Everybody smoked, including me. How we would settle down a patient would be through offering them a cigarette. That was standard in those days. In fact, the main psychiatrist would smoke three to four cigarettes during the morning meetings. It was really amazing. Smoking settled most of us, and most of us, as the workers, smoked as well.

As part of his psychiatry training in the 1980s, Murray worked at Kingseat Hospital, a large psychiatric hospital south of Auckland. He also worked at Carrington Hospital, a

psychiatric hospital in Auckland. Kingseat closed in 1999, and Carrington closed in 1993. He reflected on the smoking practices at Kingseat:

> There was certainly no smoke-free hospital. There would have been smoking rooms in the wards for patients… There was a sort of acceptance that a lot of people in the hospital, both staff and patients smoked, and it was just the way it was. There wasn't, in my recollection, any attempt to modify that behaviour in any way.

As for Carrington, Murray observed that it was "pretty similar to Kingseat".

In the 1990s

By the late 1990s, smoking remained a usual practice for patients and a range of staff. Ash, who worked in a health-related role in a psychiatric hospital, reflected:

> Yes, yes, the nurses smoked, and I do recall that in one ward that they smoked in the tearoom… sometimes in the lounge of the ward… cleaners and caterers on the wards.

During this decade, Hayden completed his medical training. He recalled:

> I remember at North Shore Hospital doing medicine and having to go over to the mental health units, usually for cardiac arrest or acute medical care, and you'd walk in and see the smoke and staff smoking outside.

Although smoking was routine, there were exceptions. Two Participants volunteered their non-smoking status. In contrast to Sylvia and Sam, who smoked while working in the hospitals, Lee did not smoke. She explained that this resulted from a smoking-related experience during the hospital's Christmas pantomime:

> I did try smoking there… I was roped into doing a Christmas pantomime, and I had to smoke a cigar. I think I'd probably had a few puffs…but I got as sick as a dog on the cigarillo thing. I was so sick… I think we had a whole lot of Velluto Rosso [red wine] beforehand to

> bolster us… I obviously must have inhaled way too deeply on it. I thought I was vomiting up blood, but it was just the Velluto Rosso. I was never able to drink Velluto Rosso, and I was never able to smoke again.

Reflecting on non-smoking status relative to the norm of smoking, Lee concluded that "I was probably not the norm because I did not smoke". She recalled that some other staff did not smoke:

> Strangely enough, the charge nurse didn't smoke, the social worker didn't smoke, I don't even remember the psychologist there smoking, and I think they used to sort of try to discourage people from smoking during therapy sessions, but some people would get really anxious and wound up.

Tania was also a non-smoker when she started her training at Tokanui. Along with other non-smoking peers who were student nurses, she wanted a smoke-free space. Although they achieved their goal, Tania described the resistance to their initiative:

> It was just part of our concern that a couple of us had as non-smokers, a minority group of non-smokers in the environment where there was just continual smoke everywhere, and we decided to take a stand and say can we have a space where there's no tobacco… We asked for the tearoom to be smoke-free, and I remember it caused a hell of a shit because what about the rights for smokers? This was in the days when people still drank and smoked in bars and clubs and restaurants and in homes and cars. We were sort of ostracised as what the hell are you doing? …The head of the School of Nursing agreed to it, and we got it through. Then we had to keep fighting with everyone because sometimes the smokers would just come in and just keep smoking, and we'd go, hang on, this is a smoke-free area. There was a bit of backlash, but eventually, it sorted out.

The smokers 1970-1999 summary

While some Participants observed that not all staff smoked, Participants typically reported that smoking was a common practice by patients and staff from a range of occupational groups in psychiatric hospitals during the three decades of the 20th-century.

What did the Participants say about smoking in mental health inpatient facilities into the next century?

5.2.2 The smokers: Mental health inpatient facilities 2000-2018

Like the Participants who worked in psychiatric facilities before 2000, those in MHIFs indicated that smoking was a common practice by patients and staff from various occupational groups.

Near the turn of the century, Ash moved from a psychiatric hospital to a DHB MHIF. Ash observed that smoking continued in the new MHIF:

> Patients smoking? Yes. Definitely. Even after the move to [name removed], they had smoking rooms. Like, they built it with a smoking room in each ward. When we arrived… I think that Doctor [C] did smoke. He was a senior psychiatrist. Staff nurses went out… they had to go out on the street… Several senior staff used to go out on the deck out from an office. They smoked. Another senior staff member also smoked with them. Mmm.

Sylvia reported a similar experience and noted that "When I first got there to the Henry Bennett Centre (HRBC), you could smoke inside".

In 2008, Jo started working in a health-related role in a DHB. Jo was met with a culture of smoking, including smoking leave for patients:

> When I arrived, there was definitely a culture of smoking. Staff and patients smoked. The staff were going out with the patient for the patient's smoking leave and, of course, if the staff member was a smoker, they would take the chance to have a smoke out there as well.

> A certain senior manager is still there today and is a smoker who tried unsuccessfully to quit. Even these days, like 2018, people—staff and patients—are now smoking on the grounds.

Lynore was employed as a smoke-free health educator at the Canterbury DHB (CDHB) from 2009 to 2015. In this time, she worked at Hillmorton Hospital, the MHIF where she observed smoking by patients and staff:

> Patients smoked. Patients used to be allowed to go straight from their ward into an outdoor area, and they could smoke… the proportion of smoking staff was extraordinarily high. If my memory serves me right, something like 69-70% of the mental health staff smoked. A senior manager was a smoker, and this was well known.

Hayden is medically qualified. He has clinical, research, and professional development experience in smoking cessation and has completed a PhD on tobacco withdrawal symptomatology. In 2008, he began as a Clinical Advisor with the Ministry of Health. His work was primarily related to implementing the Government's tobacco health target. Hayden provided an overview of smoking in MHIFs in this observation:

> Even at that time, although many hospitals had a smoke-free policy, they were very varied. They weren't all implemented as well as they could have been, as it was still the case, in some mental health services that there was an exemption applied… There were still some at that time that allowed smoking on the grounds versus complete smoke-free environments, but I think at that time most allowed smoking somewhere on the grounds and they still had smoking gazebos and all those sorts of things. Most got rid of smoking rooms in the buildings, which was great… you have got staff in mental health settings who are more likely to be current smokers than others… You've got staff and patients wanting to smoke.

Through his work as a psychiatrist in 2018, Murray was present at several MHIFs. About smoking in MHIFs, he commented, “look, it is possibly still happening as well. There are some places that haven’t changed all that much”. He explained how he knew this:

> I see it... I have had the opportunity to look quite closely at a few services in the last few months, and I am struck by how much variation there is still in practice around smoking from fairly strict adherence to trying to keep units completely smoke-free through to some which have retained smoking in courtyards and free access to tobacco at any time.

The smokers 2000-2018 summary

Concerning MHIFs, the Participants reported that staff and patients smoked. Smoking occurred in more outdoors settings than indoor.

In what ways did Participants consider that smoking was a normalised activity?

5.2.3 Normalisation of smoking

Chapter 2 defines normalisation for my thesis, and this section uses that definition. Normalisation is the acceptance and tolerance of smoking, primarily cigarettes. It is evident through the visibility of private and public smoking of cigarettes and tobacco products, media portrayal, the availability and promotion of tobacco products (Hudson & Thomson, 2011), and the uptake and continuation of smoking.

Through the course of the interviews, the Participants voiced various expressions of normalised smoking. The acceptance, tolerance, and smoking visibility were apparent for several Participants. For example, in the context of cigarette availability, David observed that smoking “was so entrenched that there’s no way you could have said, stop, don’t do this. It was absolutely part of the culture of particularly the inpatient units”.

Similarly, Sam commented, “Absolutely, smoking seemed to be just a very, very socially acceptable, normalised activity… Yes, people, including staff and patients, were able to smoke anywhere at any time… most of us smoked most of the time wherever we were”.

Highlighting the visibility of smoking, Lee recalled a psychiatrist who "used to smoke while doing ECT. He smoked the whole time".

There was a tolerance for smoking. Examples included where patients could smoke, the practice of smoking by staff during work time, and the smoke smell. Lee explained:

> Some of the charge nurses didn't like people smoking on the wards. Other people didn't care because they smoked themselves. Most of them did. Other ones thought you should just have cigs in your smoko breaks. But the thing was that often people had so many smoko breaks that it was easier to just let people smoke in the villas.
>
> You were meant to have your morning tea, your afternoon tea, and your lunch break, but staff would be taking little mini breaks. They'd say, oh, I just need to have a cigarette if it was a villa where the charge nurse was okay with smoking… there was the odd charge nurse who didn't smoke, and they didn't particularly like being smoked around. I remember one who thought it was a filthy, disgusting habit, but other people just tolerated it even if they didn't smoke. Then they thought, oh well, just let people smoke on the ward.

The acceptance of smoking included its treatment as an everyday item. Sylvia succinctly put it like this, "gosh, yes, if you wanted a cigarette, it was like if you wanted a cup of coffee, just have it". Tania highlighted the giving and taking of cigarettes:

> You'd see… rolling or sharing each other's tobacco – oh, can I borrow one and I'll pay you back, sort of thing. That was amongst patients, mainly amongst patients themselves or some of the staff that might have been there for years and were on the same ward because you had some people that stayed in the same wards for years and years and years. They might give someone a smoke or one of their smokes or something like that.

Participants observed that since the 1970s, smoking has generally occurred in a permissive environment. To illustrate, Sam reflected that with few exceptions, "staff and

patients were able to smoke anywhere at any time". Sylvia commented it was allowable for patients to ask staff for cigarettes. She recalled that "patients would say can I have a cigarette? It was totally acceptable to ask, and they were cheap".

Commenting about the inpatient setting, David observed that "If a patient did not have a cigarette and they couldn't or wouldn't or whatever, then there would be a magical supply that the ward would have". He also remarked that "At the beginning, end, or middle of a shift you'd see nurses in the office rolling patients' cigarettes for them. It was like a currency, really".

Lynore recalled that staff gave and sold cigarettes to patients:

> When I first started patients weren't ever asked whether they wanted to stop smoking. They were pretty much actively encouraged to keep smoking. A lot of the staff used to hand out cigarettes if patients had run out of money and couldn't afford them. I did see this handing out cigarettes …A patient said to me, "Oh, I am not so good. I'm really desperate for a cigarette, but I haven't got any tobacco". There was a staff member standing over the way, having a cigarette. This woman called out to him and said, "Oh, I really need a cigarette?" I'll pay you a dollar for a cigarette". The staff member did not know who I was. He came over, took the dollar and gave her a cigarette. This wasn't, I believe, unusual. So, some of the staff were selling cigarettes to patients… This was after the policy had come in, possibly in 2013. I put in a complaint. The manager said, "Oh yes, I believe that happens quite often, and a dollar is actually cheaper".

Finally, as reported in theme 4, Lee, Tania, and Ash explained the use of patient comforts, forms, and chits by their hospitals or MHIFs to supply cigarettes to patients.

Normalisation summary

Participants who worked in hospitals and MHIFs consistently described smoking as an acceptable and largely tolerated activity in a permissive environment.

5.2.4 Theme summary: Doing the acceptable

Participants who worked in hospitals and MHIFs commented that smoking was a common practice by staff and patients in indoor and outdoor settings. Into the 21st-century, smoking occurred more outside than indoors. Overall, Participants reported that smoking was accepted and mostly a tolerated practice within a permissive environment.

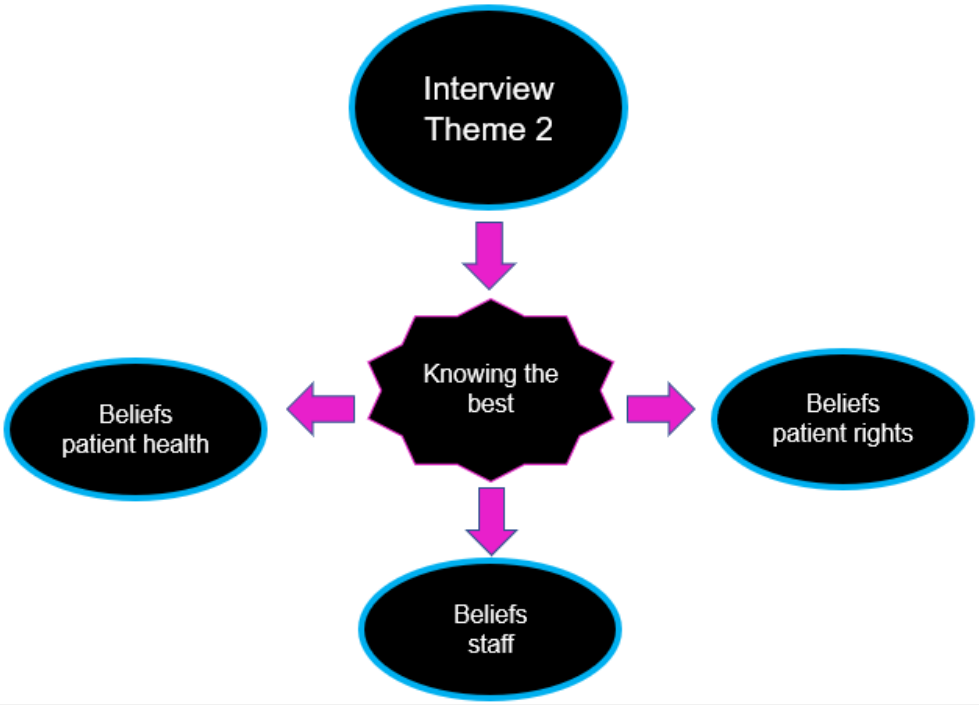
What did the Participants say about the staff and other people's beliefs regarding the value of smoking for patients and the staff?

5.3 Theme 2: Knowing the best

Figure 5.3 shows the theme and three sub-themes covered in this section. Participants identified a range of beliefs about the value and importance of smoking for patients and staff.

Figure 5.3

Theme 2: Knowing the best



What kinds of beliefs operated about the benefits of smoking?

5.3.1 Beliefs: Mental and physical health of patients[3]

Participants mentioned a range of beliefs related to the benefits of smoking for patients' mental and physical health.

Jo provided smoking cessation training to the staff. Jo recalled that it was hard to rally their interest:

> I suppose it is the thing that we still come up against, which was the 'effort of it', the 'difficulty of it', being that the smoking was seen as 'the least of their problems and they have got much bigger things to worry about'… The staff attitudes towards smoking in mental health tended to be that it is not really a problem for the patients because the patients have a lot of other problems.

Referring to policy implementation, Lynore added:

> It was more difficult to get the policy in… the staff seemed to think that people with a mental health condition had quite enough going **on** without them worrying about them giving up smoking… this was without the patients actually being given a choice… they weren't ever asked whether they wanted to stop smoking.

Hayden discussed the benefits of helping patients to quit smoking. He identified the belief that treating mental health is the priority over and above smoking cessation:

> The main benefits, of course, are for the lives of the people that you are helping. You're helping their mental illness, but they don't die from their mental illness. They die primarily because of the physical illnesses caused by smoking, obesity, and lack of physical activity. It is almost like this is the least of their worries. Let us not worry about those; let us just focus on being mentally well. Well, part of being mentally well

[3] I have underlined key words in the beliefs.

> is also having these other things, and we know that smoking is likely to be bad for your mental illness.

Ash discussed the rationale for smoking rooms which included the staff belief that smoking helped patients to relax:

> So that the patients could go in there to smoke and just whenever they wanted to… I thought it wasn't so good for their health, but the staff said it helped the patients' mental health, as the smoking relaxed them. That was the belief, the perceived belief at the time.

Sylvia identified a similar belief:

> If someone was being an arsehole, you could say, "Well, look, why don't you just go outside and have a smoke?" "I haven't got any nurse". "I'll give you one". That kind of stuff… It calmed people. Oh gosh, yes, that is why I was so anti it being taken away from HRBC and the prisons because it was calming. It was a crutch, and it worked.

Like Ash and Sylvia, Judy identified the same belief. Judy had been a Labour Member of Parliament and was involved with the 2003 smoke-free legislation to increase the number of smoke-free workplaces. She chaired the Health Committee (Committee) that received submissions about that legislation. Referring to her notes about a submission to the Committee, she said:

> The mental health workers both argued… that they were looking after these people, and it was a hard enough job to look after them, and the smoking helped them stay a bit calmer. That was their argument. I know that it's a faulty argument when you look at the medication.

Judy then reflected on what she called the 'common understanding' of the belief that smoking has a calming effect:

> I notice when you watch the TV crime dramas when the detective is interviewing the suspect, and they're not making much progress; they reach in their back pocket and pull out a packet of cigarettes and offer

> them a cigarette to possibly hopefully get them talking. So, this is in the popular understanding of things. It may not be correct, but it's a common understanding out there.

Ash and Ben referred to the belief that if patients cannot smoke, their mental health deteriorates. Ash talked about the reasons for introducing a smoke-free environment:

> They were trying to help or assist people to realise that maybe they did not need to smoke so heavily or so much after all. But a lot of them did when they are really unwell. I might have this all wrong, but they really needed that nicotine. They really needed the tobacco, and if they didn't have it, they could get even more unwell. That was the belief.

Ben recalled a similar belief related to his work for a non-government organisation in the United Kingdom. The work was:

> Around smoking cessation for people with mental health, and a lot of that work was around myth-busting because there are pretty high smoking rates and very high smoking rates for mental health nurses. We worked with them because they'd done some really interesting work showing that actually helping people quit smoking was very positive for their overall mental health, and there was this myth that if they quit smoking or you put them under pressure to quit smoking, it will make them worse.

Along similar lines was a belief that smoking helped manage the unpleasant symptoms of mental illness. Hayden explained, "There is the belief that they had to smoke because that helped control their mental illness and take away some of the negative symptoms".

Lynore and Ash identified beliefs that patients need to keep smoking. Lynore discussed the barriers to implementing a smoke-free policy. She explained that one barrier was the staff belief that "the patients are sick, and they need their cigarettes". Ash explained that the belief associated with giving cigarettes to patients in individual wards and the low stimulus area was:

> To help make them not so unwell. They would become more unwell, the belief was, if they had not had their nicotine fix, their tobacco. They couldn't do without their tobacco.

Steve was a former Labour Member of Parliament (MP) and Bill Sponsor of the 2003 smoke-free legislation that increased smoke-free workplaces. Earlier in her career, she trained as a midwife. She reflected on the legislative provision for designated smoking rooms in hospitals and her belief that patients needed to smoke in the acute phase of their disorder:

> The one that stands out for me was acute mental health facilities… it was something that did come up in the House and even my tolerance – I thought let's just do what we can at this stage because I knew the addictive nature of nicotine and with people with depression or acute mental health disorders, they were isolated during the acute phase, and they were desperate to have somewhere still to smoke, and I thought, does that matter at this stage? The greater good is to get the smoke-free environment in the workplaces and schools, and it [acute mental health facility] will come.

David and Lynore identified the belief that patients should be allowed to keep smoking. David commented, "I think there was… 90% of patients with psychotic-type illnesses smoked, so there was the thought that all our patients smoke, and we shouldn't be stopping them from smoking". Concerning the nursing staff, Lynore explained:

> They believed that the same kind of principle applied as for people who were dying in the general hospital. These people are ill. They can't be having to worry about giving up smoking. They've got quite enough to worry about, let them smoke**,** and in fact, they encouraged them to smoke. They used to roll the cigarettes for them… when we first started talking to the hospital about smoking, we knew the staff were rolling them.

Lynore discussed the challenges related to smoking cessation. For example, the staff believed that patients were not able to quit. She explained the staff reasoning:

> They say yes, patients are mentally unwell, like it is an excuse that they are mentally not capable of, yes that is what some of them seemed to believe, these people are not actually capable of giving up smoking and were going to increase their unwellness, their illness by kind of forcing... this is how they saw it forcing them to be smoke-free.

Reflecting on why the smoke-free policy implementation was further ahead in the general hospital relative to the MHIF, David identified the belief patients have different needs. He said, "I think we thought we were different and special… I'm not saying I thought that. But I think that's what people thought - that our patients have a different set of needs".

Patient beliefs summary

Participants identified a range of beliefs about the benefits of smoking for patients. Predominantly these reflected the need for patients to keep smoking.

What were the beliefs about the benefits of smoking for staff?

5.3.2 Beliefs: Staff-related

Participants outlined several beliefs about the benefits of smoking for staff. The most common belief was that staff smoking with patients helped build rapport and a therapeutic relationship.

Participants offered various perspectives about the belief that staff smoking with patients helped build rapport and develop the therapeutic relationship.

Lynore had heard the staff talking about rapport. She explained:

> Yes, always. They said this is how they increased their rapport with patients because they smoked with them. They would often go out into the area and smoke with them and chat with them, and it was

> very, very good for staff-patient relationships – this thing that they had something in common.

David was also familiar with this belief from his psychiatry training:

> When I, as a student in the UK, was encouraged to smoke with patients, to build rapport. So, you'd sit down with a patient and have a cigarette. I think even then, this was in the '80s, and this was in psychiatry, it was probably a fading idea, but the idea was you'd sit there and smoke, and it would relax the patient and relax you, and you'd have a chat.

Although Hayden was familiar with this belief, he did not think that smoking was therapeutic:

> Smoking is used as a tool to have these conversations. I don't know many times I have heard that smoking is a therapeutic tool. You go out, and you smoke with your patients. 'It creates a therapeutic relationship'. I don't think it will be the case. It's just if it's two people who are a bit grumpy and going through withdrawal, then it probably felt great, but it is not necessary.

Murray offered a similar perspective on the role of smoking. He reflected:

> It more often seemed an opportunity for staff to have a smoke rather than a therapeutic interaction… I felt really uncomfortable with it. I was very comfortable with the notion of staff spending time with people to engage with them and find out a little bit more about them and to understand them a bit more. I did wonder how important tobacco was as part of that interaction. It seemed to me that potentially there were other ways to do that.

Lee had observed staff and patient smoking, but she did not perceive it to be a therapeutic activity:

> Yes. I saw a lot of smoking on the wards here… It wasn't necessarily smoking with; it was just they were in the ward, and they were smoking, and so were the patients. Oh, it didn't much look like therapeutic to me, really. Now you've jogged my memory, but I can't remember it that well… They weren't smoking with the patients as much as they were smoking just because they wanted to smoke, but they were in a ward where patients smoked as well. They weren't doing it as a therapeutic interaction… Maybe I was different because I didn't smoke, so maybe I didn't see that, although I don't remember hearing about that.

Reflecting on whether smoking with a patient was an appropriate way to establish a therapeutic relationship, Lee stated:

> I think that it was unnecessary. You can do that anyway just by being around someone, just being empathetic, just being able to listen, being able to pick up on cues… you can do that without cigarettes. It's unnecessary.

As a non-smoker, Lee did not think that this stance had negatively affected the creation of therapeutic relationships. Lee reflected, "it probably affected my working relationship with some staff more because a few of us who didn't smoke would get resentful sometimes that people would go off to have a cigarette and we'd get left in the ward for long periods".

Reflecting on the stressful nature of the work for staff, Ash and Lynore referred to the belief that staff deserved to smoke because of the nature of their hard work. Lynore recalled a senior manager who "considered that he had a very, very stressful job, which he did… his job was stressful, and he should be allowed to smoke". Ash explained the nurses' perception of their role:

> Nurses smoked. They worked really hard, and it was a really difficult job they were performing. They deserved to be able to smoke… Because I guess they felt that in those days, it was believed that it relaxed them. That was what people generally thought, not just

> nurses. That was the perception, I believe. That is how I grew up believing it and thank goodness I did not take it up.

Jo and colleagues provided cessation and brief intervention training to staff. Some staff were interested, but others believed there was insufficient time to do the brief intervention training. Jo explained:

> There were a couple of the units that were really quite proactive, but with most of them…It was hard to rally staff interest… I reflect on a recent training that I was doing. The staff all leapt at me about how you can't do it, and there is no time to do everything, no time to do what you see as your core role, much less anything else. They all—even the medical registrars—feel overworked and underfunded, and they kept saying give us funding to do it.

Reflecting further on brief intervention training and the implications for workload, Jo observed: "Exactly, there could be an irony here, a brief intervention might result in a behaviour change, and that change is going to reduce work".

Reflecting on tobacco use to modify patient behaviours in the wards, David observed that the belief in its use was strong. "There was such a belief in the system that tobacco was a way of behaviour modification on the wards… and as I say, tobacco would never not be there".

Staff beliefs summary

Participants identified several beliefs. These included beliefs about the benefits of smoking to build rapport with patients to relax and manage patient behaviour.

What were the beliefs about smoking and patient rights?

5.3.3 Beliefs: Rights of patients

Participants who had worked in psychiatric hospitals and MHIFs identified several rights-based arguments supporting patients smoking.

In the context of a discussion about why Parliament created the 2003 legislation that allowed DHBs to provide DSRs for patients, Hayden referred to the belief that staff cannot force patients to give up smoking while hospitalised:

> I think that it would have been seen, I assume at the time, that we have got these poor people, they are there against their will and we should make this day as comfortable as possible… at the time it was seen that we can't really make people stop smoking.

He added that "I think we have moved on hugely from then. You've got hotels now that don't allow smoking anywhere, and you get a big fine. I think people are more accepting".

Related to the above belief, Sylvia and Lynore identified beliefs that smoking was a personal choice. Sylvia reflected on her personal belief about choice and where people should smoke. "I just think that smoking's a choice, and you should be given a choice to wreck your health or not... But I do think people should be allowed to smoke outside. That's not just hospitals, that's anywhere".

Lynore recalled that several of the staff held firm views about smoking in her workplace. To illustrate, she recounted that a senior staff member believed there was nothing wrong with people smoking and that "people should be allowed to smoke".

David was a committee member charged with implementing the smoke-free policy at Hillmorton Hospital. He reflected on the use of a rights-based belief that smoking is a human right which surfaced during the committee's smoke-free work:

> We had a goal to be, and I think it was a dropdown goal from the Ministry to say that you've got to be smoke-free by this date. We were given the task, and it was quite fascinating… I think the most serious and aggressive pushback we had was from [a senior staff member who] … took a legal argument that this was actually an illegal act to stop people smoking [on a] human rights basis… We have no right to stop someone doing something.

Patient rights beliefs: Summary

Participants identified three areas of rights-based beliefs: smoking is a human right, a personal choice, and something that patients cannot be forced to stop.

Theme summary: Knowing the best

Participants identified various beliefs about smoking by patients and staff. Whether for patients or staff, the beliefs reflected the benefits of smoking, and for patients, beliefs also reflected an entitlement to smoke.

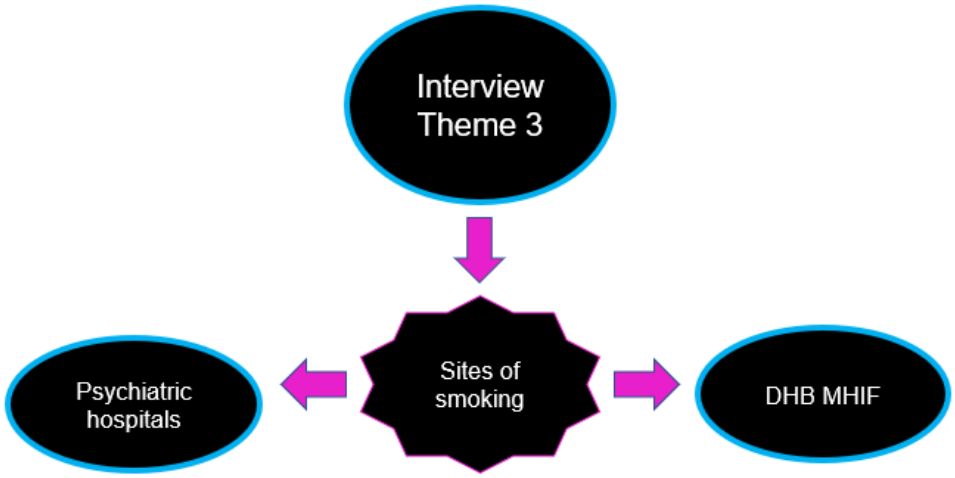
Where were the sites of smoking in psychiatric hospitals and MHIFs?

5.4 Theme 3: Sites of smoking

Figure 5.4 depicts theme three and the sub-themes. Participants identified the sites of smoking in psychiatric hospitals and MHIFs.

Figure 5.4

Theme 3: Sites of smoking



Where did smoking occur?

5.4.1 1970 to 1999 psychiatric hospitals and related facilities

When asked about the places where smoking occurred in psychiatric hospitals, the Participants who had worked in these facilities identified sites used by patients and/or staff. These sites were inside the buildings and outside on the hospital grounds.

Reflecting on her time at Tokanui Mental Hospital, Sylvia recalled, "we always smoked at morning tea, lunch, afternoon tea, tea breaks, and super time". She added:

> You never had to go outside to smoke, but if you wanted a cigarette, people just smoked in the wards... but you didn't have to go outside. You smoked inside. It was totally acceptable.
>
> Bedrooms and dorms were okay 'cause we used to do rounds, and they might have a ciggie, but the clinic was a no-no. In saying that, in Women's Reception, there was an ashtray in there… I remember it because it was Wilson's whisky ashtray, and Dad drank whisky.
>
> Outside… I can recall people smoking on the way to lunch, and myself on the way from the Nurses' Home to work, because the Nurses' Home was on the hill.

Working at the same hospital, but 10 years later, Tania similarly observed that smoking sites were inside and outside. In contrast to Sylvia's experience, however, she noted that smoking was not allowed in the sleeping areas:

> Smoking was just everywhere. You smoked in the wards. You had the big old ashtrays in the wards. They weren't allowed to smoke in the bedroom area, the dorm sort of part, but they were allowed to smoke in the day rooms, which were the big dayrooms. You'd see the big ashtrays. But the staff used to smoke… in the dayroom while they were on duty with the patients, or you'd take them for walks, and people would be smoking. Smoke was everywhere. The only part they used to stop people from smoking was in the dorms, that was more of a fire risk. There was just smoke everywhere; it was just they all smoked.

> There was really nowhere that was out of bounds for smoking apart from the sleeping areas that I can remember.

Lee worked at a different hospital. Lee commented:

> I saw lots of smoking on the wards… depending on the charge nurse, the patients were allowed to smoke anywhere all the time just because often some of them weren't allowed outside. Some of them were in secure wards. Usually, for the staff it was the office, kitchen, sort of just outside the main doors. If charge nurses didn't care, you could smoke all the time.

Concerning bedrooms as a site of smoking, Lee recalled:

> I think not in the bedroom, but there were often – it was really, really common to see cigarette burns in sheets when you were changing beds. It was very common. Either they had them, or else it was staff smoking while they were changing sheets, I don't know. Staff at that time used to do everything. We had to stoke the donkeys for boiling the water and stuff like that and heating.

Murray and Sam also worked at other institutions. Like the other Participants, they identified sites of smoking. For example, at Kingseat Hospital, Murray observed that there "would have been smoking rooms in the wards… for patients". Sam, whose duties involved seeing new admissions and meeting with them, commented that in "the acute admissions ward, where we had a very, very big day room as well… and that was the standard time obviously that we would light a cigarette".

By the early 1980s, the Waikato Hospital Board had established a mental health inpatient facility on the general hospital campus at Waikato Hospital in Hamilton. Known as Ward 29, this facility offered acute care. Sylvia explained that patients were able to <u>smoke inside the building</u> but not in the bedrooms

> I was on nights, and I didn't smoke. Patients used to get up for a smoke. They smoked in the lounge because we'd make them milo. The only reason, in that ward anyway, that they weren't allowed to smoke in

> their bedrooms was the safety thing. It wasn't a health thing. It was somebody might catch on fire or leave a cigarette burning. It wasn't because it was bad for you; it was because it was a fire risk, not a health risk.
>
> There was no need to go outside; you could smoke inside. Why would you go outside?

The variety of smoking sites also involved smoking by staff performing specific work duties. For example, Sylvia recalled: "I can remember sitting on the bath while patients had a bath, and I was having a smoke. You could smoke anywhere".

Lee recalled being horrified that a patient might have become infected after the psychiatrist was smoking while he was doing a spinal tap to check whether the patient had syphilis:

> I pulled a cloth across the patient because I was terrified the ash was going to drop onto the person – the ash was just hanging off his cigarette, and it dropped onto the edge of the cloth. Otherwise, I'm sure it would have dropped in – it may not have. He just laughed and said, 'oh, I was going to flick that off'.

Lee concluded, "You've got to be really careful that those things don't get infected". She also recalled that the psychiatrist "used to smoke while doing ECT. He smoked the whole time".

Some wards held group meetings for patients and staff. Sylvia explained that the staff smoked during the meetings:

> I tell you, another place we smoked was in group meetings in the day room. We used to have these meetings where everybody shared crap – sat and looked at each other because they couldn't talk 'cause they were so drugged up.

Duties that required staff to leave the building also offered staff the opportunity to smoke. Sylvia recalled the circumstances:

> If you took a script or something and went to the pharmacy, that was a good chance to have a smoke... walk down and have a ciggie on the way. I can remember that. People used to queue up to go for jobs 'cause you could have a fag.

Psychiatric hospitals/related facilities summary

About smoking sites, the Participants consistently reported that these were present in various parts of the buildings and outside the buildings in the hospital grounds. They also commented that patients and or staff used the sites. By the 1980s, sleeping areas were no longer sites of smoking.

Where did smoking occur in the mental health inpatient facilities?

5.4.2 Sites of smoking: 2000-2019 District Health Board mental health inpatient facilities

When asked about smoking sites in DHB MHIFs, Participants who had worked in MHIFs identified areas inside the buildings, but generally there were more smoking sites outside.

Smoking sites in hospital care institutions include those established under legislation.

Like Steve, Judy was a Member of Parliament in the Labour-led Government in 2003. She chaired the Health Select Committee (Committee) that received submissions on the Smoke-free Environments Amendment Bill. Judy recounted that once the Committee had redefined the kinds of workplaces that were required to be smoke-free, the decision-making turned to what constituted an exception to this smoke-free rule:

> So, we had this redefinition of what a workplace was, and then we had to decide what was additional to what was in the original bill about workplaces. Then we had to decide what were exceptions, so we had this big discussion as to when would it be an exception. The discussion went a bit like this. Your home is still separate. It is not a workplace. When you go home and you are a smoker, it is your choice to smoke, right? So, when you go to stay at a motel overnight, that is your home

> for the night. So, it is an exception because it is like your home away from home.
>
> Similarly, if you are in a motel room, it is your home away from home. So, this progressed along the line, and then the rest homes situation became part of that conversation, so the person who had shifted from home – home to rest home being their home was in a similar situation. It should be okay for them to have a room where they can smoke, and so that is how that developed… It was a whole conversation about what was a workplace and what was home.

Steve recalled a similar process about working out the definition of a 'workplace' but emphasised that she perceived acute mental health units as an exception.

> Yes. I think that was the first approach that we saw and then hoped that the next stage would be now we look at health facilities. The very difficult time then was acute mental health units.
>
> The one that stands out for me was acute mental health facility… it was something that did come up in the House and even my tolerance – I thought let's just do what we can at this stage because I knew the addictive nature of nicotine and with people with depression or acute mental health disorders, they were isolated during the acute phase, and they were desperate to still have somewhere to smoke, and I thought, does that matter at this stage? The greater good is to get the smoke-free environment in the workplaces and schools, and it will come.

Reflecting on the range of submissions before the Committee, Judy referred to her notes from two submitters. The first was from a group of MHPs who wanted all workplaces to be smoke-free.

> There we go. Problem of effect of smoke on mental health workers and inpatients – 50 to 70% of mental health clients smoke, schizophrenics up to 90% are smokers. Three times more prevalent

> than with the general population. Started on their cigarettes in hospital. Wants the legislation strengthened to cover all workplaces. Smoke rooms only encourage smoking. Smoking affects the effectiveness of medication (e.g. dopamine), because apparently smoking interferes with the dopamine pathways.

A not-for-profit organisation had written the second submission, which expressed concerns about smoking and mental health. Like the health professionals' submission, it noted that patients started smoking in the inpatient setting. Again, Judy recounted from her notes:

> Smoking and mental health. Patients introduced to smoking. Appalling to see people picking up butts from the ashtrays, staff dismiss complaints on personal rights. Smoking affects their wairua, clouds our body and mind. As Treaty partners, we must come together.

When the Bill passed its final reading, the legislature had included 'hospital care institutions' in the exceptions list. Thus, this type of institution could permit smoking in DSRs subject to specific statutory criteria.

Reflecting on this exception, Judy commented that the Ministry of Health had advised the need for <u>some flexibility</u>:

> But, as I remember, there was advice, from the Ministry actually, that we would have to allow a little bit of flexibility because we were working with people who had to kind of make it work. We'd already made great strides, big changes, in making areas smoke-free, but this was an iffy area. And similarly, with the prisons, because the prisons also were like somebody's home. They weren't living at home anymore. They were locked up in prison, and that was their home. But we allowed it because the prison warders and the mental health workers both argued the same thing, that they were looking after these people and it was a hard enough job to look after them, and the smoking helped them stay a bit calmer.

From the former politicians' responses, it is apparent that mental health inpatient facilities, which were part of hospital care institutions, were viewed as home-like and not as workplaces, and that smoking sites helped patients.

Ash reflected on the provision of the smoking rooms in a new facility shortly before the relevant DHB was established and thus managed the facility:

> Even after the move to [X place], they had smoking rooms. Like they built it with a smoking room in the wards… so that the patients could go in there to smoke and whenever they wanted to.

Several years later, the DHB removed the built-in smoking rooms. Ash observed:

> Then they got rid of the smoking rooms, and they built little gazebos outside. Oh, and I did not mention Ward (X)… It also had a smoking room, and they built a gazebo outside. So that was the perceived solution to have these gazebos outside… because they were trying to get the building smoke-free. Like, so that the people smoked outside.

David recalled what he termed "a transition from probably a looser smoking environment" at his workplace:

> It had probably only just gone from being a ward where you could smoke probably anywhere to areas within the ward where you could smoke, and certainly outside in the courtyards. The whole place was quite smoky still, and then probably by 2002-2003, the smoking areas had got smaller, but there were still smoking rooms.

Several Participants identified outdoor sites of smoking. Karen had worked as a nurse educator and Smoke-free Manager at Auckland DHB (ADHB). Te Whetu Tawera is the acute adult mental health inpatient ward at ADHB. Karen explained that smoking was possible in intensive care at Te Whetu Tawera because "they have an area which has very high walls with no roof so that they can go outside in that area".

Recalling her smoke-free education work post-2009, Lynore explained that Hillmorton was "where we worked the most trying to implement the smoke-free policy". She elaborated on the outdoor sites of smoking:

> The patients used to be allowed to go straight out from their ward into an outdoor area, and they could smoke… Each ward (around 10) had its outdoor area. There was no designated smoking room, but they used to smoke in the toilets. Staff used to find butts stubbed out in the hand basins.

Reflecting on smoking sites over time, Ash recalled that "when the smoke-free policy came into being… everyone had to smoke out on the street":

> I am trying to recall that it went out that they [patients and staff] had to go out on the street… Senior staff used to go out onto the balcony. They [the staff] used to take the patients to the other side of the road to [a private property location] and smoke there.

Lynore expressed surprise that some staff attempted to secure alternative smoking sites for patients and themselves. She explained:

> The staff tried to declare that the road that ran right through the middle of the hospital was a public road, so if it is a public road, then it is not owned by the DHB, and so they can go and stand on that road and smoke on the grounds. They tried that one. They tried that one more than once, and… some of the staff were still adamant that that was the case. So, we actually had to prove that that wasn't the case and that even if it was a public road, they were still not going to be allowed to smoke on it. So then, for themselves and for the patients, they found the nearest possible place they could get to off the grounds, like really off the grounds because with this one, the first closest one they found was right by the main entrances. They are all standing, the patients are standing out there smoking and throwing their butts over a neighbour's fence, so then complaints came from the neighbours about the butts. This was for the patients because it

> was off the grounds for some of them who were allowed. You know once the policy came in, they can smoke off the grounds but not on the grounds, so you'd try to help them space them [cigarettes] out, do everything.

Lynore left her job in 2015. She observed, “Yes, the policy said that the general hospital and the mental hospital buildings and grounds would be smoke-free… but smoking breaks were still going for patients”.

Several Participants noted sites of smoking located off the hospital grounds. For example, Karen pointed out that the location of the MHIF meant that “the patients could just go across the inner road for the hospital and go into the bushes there and they were in the Domain”. Private property was also a site of smoking. Ash recalled that staff “used to take the patients to the other side of the road to the [private property place] and smoke there”.

Reflecting on the smoke-free status of the DHBs by 2018, Hayden discerned a difference between policy and enforcement. “They all have smoke free policies, of course. As you know, how well they are enforced… They might have smoke-free grounds, but you need someone to enforce that”.

Mental health inpatient facilities summary

Participants reported that smoking sites included indoor smoking rooms and outdoor places, with more sites outdoors. Smoking rooms and gazebos were provided by the DHBs, whereas to support patients, staff sought out other smoking sites.

5.4.3 Theme summary

Overall, Participants reported that from the 1970s to 2018, smoking sites changed from almost everywhere indoors and outdoors to indoor area restrictions and more outdoor locations. Generally, the staff established outdoor sites.

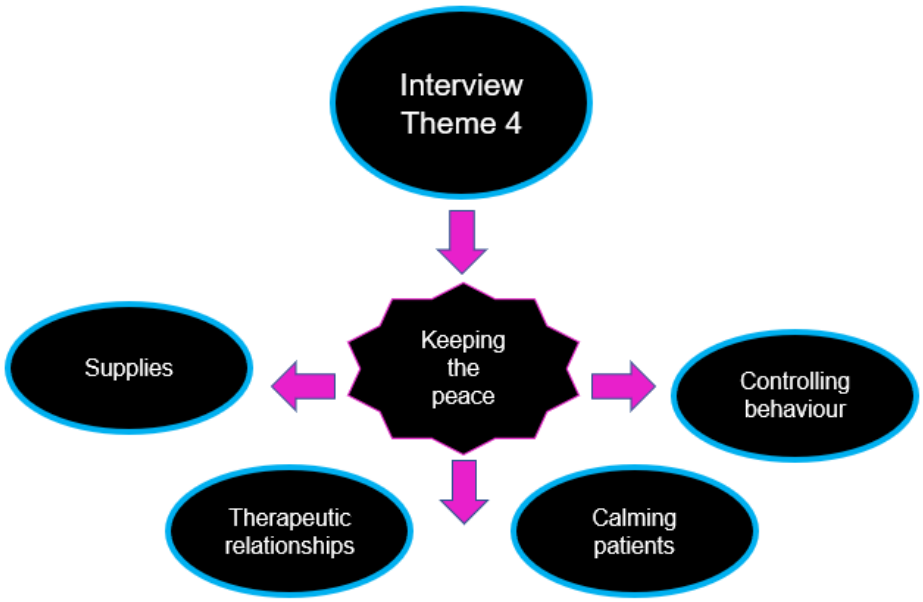
What did the Participants say about how staff used and controlled cigarettes to keep a peaceful workplace?

5.5 Theme 4: Keeping the peace

Figure 5.5 shows the theme and four sub-themes covered in this section. Who worked in psychiatric hospitals and/or MHIFs identified how staff used cigarettes to calm and control patients and keep a more peaceful or restrained work environment?

Figure 5.5

Theme 4: Keeping the peace



To begin, what were the sources of tobacco and cigarette supplies for patients?

5.5.1 Supplies of tobacco and cigarettes

Lynore remarked that MHIFs seemed to be separated from the community, "like they are in a whole category of their own". She explained:

> If you go back a long time ago, when anyone came into Hillmorton and Sunnyside, they actually encouraged them to start smoking, and they used to give them tobacco. There is documentation about it somewhere, but a doctor that I was talking to was a specialist at Burwood who was telling me that in the very early days, he worked at

> Sunnyside; that is what they used to do. Some of the staff would have been there a very long time and would remember that as well. That was probably in the 1950s and 1960s that they were talking about. They used to encourage people to take up smoking when they became unwell because they felt it helped them relax. It's the same era as women were encouraged to take up smoking. Or if people had asthma, taking up smoking would help you cough it up. But when they came into mental health, patients were handed tobacco and then if they were too unwell to roll tobacco, the staff did it for them. They used to have those little machines, and they just rolled everybody's cigarettes and then handed them out, so there was a real culture. And so, some patients who'd been coming in and out for a long time used to say, "you used to help me to smoke", and now it seems like a complete turn-around for them.

Sylvia discussed the sources of tobacco supplies in the early 1970s. She recalled, "Yes, we used to give the patients smokes if they didn't' have them. The cigarettes came from 'cash comforts. They got an allowance, and if patients didn't have any cigarettes, they would ask you".

She elaborated on 'cash comforts' and how it worked:

> I know that the tobacco—they didn't get tailor-made cigarettes through cash comforts, they got packet tobacco—they were entitled to it. It was part of their thing. You could have ciggies or drinks or lollies. There was a certain amount of money. I suppose it was part of a pension or whatever was doled out. At 17 and 18, I never took much notice. A packet was for rolling your cigarettes. It was just something that they got every week, a certain amount of money, and they could spend it however they wanted.
>
> There was a form. At the top of the little white form, they had a card filled in. It was hard cardboard, and it was white. It just had cash comforts on it, and you filled in what they could have. They would say whether they wanted lollies in the canteen or tobacco. They called it

> ‘baccy’, and that was all available at the canteen. As the nurse or most senior person on the ward, though you didn’t have to be the charge, you just signed it. They could go off with their card and get whatever they wanted with it. So, it would have been like a pension thing that people were entitled to. Probably like a benefit. I don’t know what they got in those days. But they got a certain amount of money from the government. It was something they were entitled to. It was their money to spend as they wished because they could also give their purchases to other patients. They could give away what they got off the card. They couldn’t trade their card, but they could give items to other patients.

To illustrate, Sylvia said:

> They used to trade tobacco for sex. I know that because they would tell you. Down’s Syndrome people tell you everything. You’d say, where did you get that? You’d wonder where they got it ‘cause you knew they hadn’t filled in their card. They’d say, “Oh, so and so gave it to me”. What did you give so and so? “Oh, we had a kiss and a cuddle in the little field”. That kind of stuff. Yes, it was barter.

Tania observed that patients and staff participated in sharing their smokes.

> Oh, yes, you’d see that or rolling or sharing each other’s tobacco – “oh, can I borrow one and I’ll pay you back”, sort of thing. That was amongst patients, mainly amongst patients themselves or some of the staff that might have been there for years and were on the same ward because you had some people that stayed in the same wards for years and years and years. They might give someone a smoke or one of their smokes or something like that.

Lee worked in a different psychiatric hospital in the early 1970s and recalled that there were cigarette quotas for patients in that hospital:

> There were some allegations around people… supposedly, the quotas were all going very strictly and under control, but some of it was a bit Mickey Mouse, like patients could have allocations for cigarettes. It was amazing how some of these cigarettes used to disappear. In certain wards, you always knew they were short on cigarettes that were supposedly for the patients. There were certain patients who smoked, and they had an allocation. I don't even know what it was. It could have been a few packets a week or something like that, I don't know, but it was for the ones who smoked. I do remember there was a bit of concern that some patients cottoned onto it and were saying they smoked and were using the cigarettes for bartering for other things for patients. They also got a little allowance to get sweets and things that they could buy. There was a little canteen that they could go to, and they used to get an allowance, I think every week or a month or something like that, and they could spend that. So, people who got cigarettes got that as well. If you had cigarettes, then they would barter them for other things. I think you had to sign for something so that they would tote it up at the canteen. I remember taking groups down there, and the canteen woman would work out what they had.

Lee explained more about the source of cigarettes:

> They didn't come from the canteen, though they were separate. I think they were just allocated by the ward, by the villas. I'm pretty sure they did. Otherwise, they'd had incidences of people going to the canteen and saying they'd take cigarettes for other people or something. I think that got changed very early on in the piece.

Elaborating on the missing allocations, Lee said:

> Some of the allocations seemed to go missing. It was talked about, and often there were certain wards you work in, and they'd be short, and well we thought there were so many for this person, oh they must have been given that and it wasn't signed in the book.

Lee explained that there was talk about what happened to the cigarettes:

> Everyone sort of knew particular staff were siphoning off some of the cigarettes. I think a few people might have got talked to, but I probably wasn't high enough in the pecking order. We did hear about one person who I think was running a bit of a racket, but he wasn't into just cigarettes. Things like toilet paper and toothpaste, would you believe, were disappearing. This guy had a business. We thought it was low. That particular person got shifted to an older persons' ward or something like that where there was less likelihood of them smoking and less cigarette allocation.

Recounting the process of cigarette allocation at Tokanui Mental Hospital in the 1980s, Tania explained:

> People would get chits for money to go and buy smokes at the canteen. They'd have chits to get their money out, money out of the bank, and then they'd use their money to go and buy smokes at the canteen or whatever you'd call it, the shop on the grounds.

Not all staff who worked in psychiatric hospitals were familiar with the systems of cigarette provision. For example, Murray indicated, "I don't remember that as a practice".

Turning to MHIFs, Lynore recalled an occasion post-2009 where she observed a staff member selling a cigarette to a patient:

> I went outside and met the same woman again and asked, "how are you doing?" She said, "Oh, not so good. I'm really desperate for a cigarette, but I haven't got any tobacco". There was a man from cleaning standing over the way having a cigarette. This woman called out to him and said, "Oh, I really need a cigarette. I'll pay you a dollar for a cigarette". The man did not know who I was. He came over, took the dollar and gave her a cigarette. This wasn't, I understand, unusual. Some of the staff were selling cigarettes to patients.

She explained what happened when she complained:

> When this chap did it, and I saw him do it, I was horrified, so I actually went to his manager, and I said, "Our staff are selling cigarettes to the patients at a dollar a cigarette". He just made some throwaway comment like, "Oh yes, I believe that happens quite often, and a dollar is actually cheaper". No, honestly, I was just stunned that not only would staff facilitate people smoking but sell them to them. So, they were actually doing quite nicely, some of them.

Staff also gave cigarettes to patients. Lynore elaborated:

> I heard about the nursing staff providing tobacco quite frequently. They believed that the same kind of principle applied as for people who were dying in the general hospital, that these people are ill. They can't be having to worry about giving up smoking. They've got quite enough to worry about, let them smoke, and in fact, they encouraged them to smoke. They used to roll the cigarettes for them because when we first started talking to the hospital about smoking, we knew the staff we rolling them because they used to tell us they did that. It seemed rather appalling, but this is mental health we are talking about. And I say that because the proportion of smoking staff was extraordinarily high. If my memory serves me right, something like 69-70% of the mental health staff smoked.

Local dairies[4] were also sources of cigarettes for patients. Regarding Kingseat, Murray recalled that "There was a shop just down the road no more than a couple of 100 metres from the main entrance to the hospital". Similarly, but for a MHIF, Ash recalled, "There is a dairy down the road by the intersection, and that is where they would go".

[4] Dairies are small convenience stores where stocks include cigarettes and tobacco and a range of food, confectionary and household items. These stores are often called 'delis' in Australia and 'Mom and Pop' shops in the USA.

Reflecting on smoking by inpatients, David recalled, "If a patient did not have a cigarette and they couldn't or wouldn't or whatever, then there would be a magical supply that the ward would have".

Similarly, Ash commented about the source of ward supplies of tobacco:

> Now I have really got my mind tasked back. They used to buy tobacco for the patients. I am trying to think if that really did happen, or am I imagining it... Yes, they did. I am sure that it was for Ward [name removed] and the low stimulus area… it was to help de-escalate them… it was delivered from the wholesalers… No one [a patient] would have reimbursed it [the cost]. Sad, isn't it?

Ash added:

> I am sure that if they ran out of tobacco in an area, for example, then a psychiatric assist might have got some petty cash to buy a packet down at the dairy. Yes, if someone was really unwell, you know. But that person would repay that money when they got their money through their allowance.

Reflecting on when this practice ended, Ash said, "I can't remember exactly when. I am sure it was when the smoke-free policy came in".

Hayden was not aware of staff supplying tobacco to any patients:

> I'm not aware of that happening. I am sure in some cases it does, but I don't know, and I haven't asked to be honest about what is happening. I suspect that most people would say, "no, no, no, we don't do that".

Both Murray and Hayden expressed concerns about the practice of MHIFs supplying cigarettes to patients. Murray stated:

> I think that is appalling… We just know how damaging tobacco is for people's health, so to be condoning and actively supplying a hazardous substance to someone, I don't think that there is any justification for it at all, especially when there are much, much less harmful alternatives we can be offering to people. I think that is probably the

> primary thing. But I don't think that we should be supplying any sort of addictive substance to people for their addiction. We wouldn't be supplying alcohol for people who are addicted to alcohol. We may supply opiates (methadone) to people who are addicted to opiates as a harm reduction strategy, but that is a very thoughtful and careful way. I don't think there is any way that we could frame giving tobacco to people as part of a harm reduction strategy.

Hayden expressed a similar view and noted the role of cues in triggering smoking:

> I still can't get my head around why you would want to keep supplying in a healthcare setting when we have got some other options. People do manage to abstain in places where you just can't smoke because the cues are not there, but it will probably be because you can smoke in places and that those cues trigger urges which trigger the need to supply.

Several Participants reported that staff helped patients to light and roll cigarettes. For example, Sam recalled:

> I guess if the person was shaking a lot or something, what we could do is light it for them in our own mouth and pass it to them… I do remember that quite a lot of the time, as I walked around, I was asked by a patient to light their cigarette. They wouldn't have their own lighter or matches.

Regarding giving cigarettes, Lynore recalled that the staff told her that they "used to roll the cigarettes". David observed that "At the beginning, end, or middle of a shift you'd see them [nurses] in the office rolling patients' cigarettes for them. It was like a currency, really. I have very vivid memories of that". Similarly, Lee recalled, "No, they weren't already rolled. …I will say that's the other thing – those rollers were really common because sometimes the patients would ask to use them".

Participants generally reported that patients obtained tobacco and cigarettes from a range of sources. These sources included supply by psychiatric hospitals and MHIFs to

patients, the use of state benefits to purchase cigarettes, staff gifting, bartering, and helping with rolling for patients, sharing among patients, and patient purchases from dairies. However, concerns were expressed about the current supply of cigarettes to patients, given the existence of alternative nicotine products.

How did cigarettes assist with the staff-patient therapeutic relationship?

5.5.2 Therapeutic relationships

Several Participants indicated that the smoking of cigarettes by staff with patients helped establish rapport and build a therapeutic relationship between staff and patients.

For David, his training in psychiatry introduced him to the use of cigarettes to build rapport with patients:

> I, as a student in the UK, was encouraged to smoke with patients to build rapport. So, you'd sit down with a patient and have a cigarette. I think even then, this was in the '80s, and this was in psychiatry, it probably was a fading idea, but the idea was you'd sit there and smoke, and it would relax the patient and relax you, and you'd have a chat.

Sylvia, who had worked in a psychiatric hospital and MHIF, considered that cigarettes gave talking time with patients and were preferential to the administration of psychotropic medication to patients:

> We said come outside and have a cigarette with me. We used to go outside and have a smoke with them, and then you talk, and it was a talking time… We actually thought it was therapeutic. How about that? We thought smoking was therapeutic.

She observed that 'talking time' was not important to all staff members:

> That talking time, yes, it was important to me. It wasn't to everybody 'cause I can hear in my head patients saying, "You haven't got a ciggie,

have you?" to some staff and them saying, "fuck off, get your own". But I never said that.

Drawing on psychiatric hospital experience, Sam detailed the act of smoking with patients and inhaling together:

> We saw it as a way of forming a relationship in the act of giving somebody a cigarette, lighting their cigarettes, both taking an inhalation at the same time. We saw it as a way of relaxing the patient and forming a relationship.

In her DHB workplace, Lynore was aware that staff talked about the use of smoking to build patient rapport:

> Yes. They said this is how they increased their rapport with patients because they smoked with them. They would often go out into the area and smoke with them and chat with them, and it was very, very good for staff-patient relationships – this thing that they had, something in common.

In contrast, Hayden and Murray expressed scepticism about therapeutic claims. From Hayden's perspective:

> Smoking is used as a tool to have these conversations. I don't know many times I have heard that smoking is a therapeutic tool. You go out, and you smoke with your patients. 'It creates a therapeutic relationship'. I don't think it will be the case. It's just if it's two people who are a bit grumpy and going through withdrawal, then it probably felt great, but it is not necessary.

Murray put it like this:

> Mmm, yes, I have a pretty cynical view of that. I think it is more likely to be an excuse. There are plenty of other ways that you can engage or should be able to find ways to engage with people. We have seen that so powerfully with the approaches around sensory modulation…

> a fundamental part of that, in my view, is that engagement you have with someone to find out what works for them to start them. That is where you start to develop a relationship, and you begin to understand people. They see that you are genuinely interested in them and that you want to help, and then that might lead to some discussion of sensory approaches that will help their care in some way, but that conversation, that interest in someone, is such a powerful thing. I think that whole approach shows that you can do that without necessarily relying on another substance to be the vehicle for it.

Lee did not perceive patient and staff smoking as a therapeutic relationship. "Maybe I was different because I didn't smoke, so maybe I didn't see that".

Therapeutic relationships summary

Generally, Participants who worked in psychiatric hospitals and or MHIFs reported that staff smoking with patients helped form a therapeutic relationship. Two Participants challenged this belief: one Participant contended staff could develop a therapeutic relationship without relying on a substance, and the other proposed that smoking relieved withdrawal symptoms.

To what extent did smoking calm patients?

5.5.3 Calming patients

Participants identified ways that staff used cigarettes to calm patients. The staff gave cigarettes to patients to alleviate patient stress in the psychiatric hospital where Sam worked:

> How we would settle down a patient would be through offering them a cigarette. That was standard in those days… In the acute admissions ward, we had a very, very big day room as well, and so I would be seeing new admissions and meeting with them, and that was the standard time obviously that we would light a cigarette.

For Sylvia, during her time at Tokanui, smoking was thought to be therapeutic. She explained:

> Well, the calming thing was better than someone getting upset and fighting or getting shitty. We used to say that a shift was a good shift if it was boring. So, you just went for quiet, anything to keep the peace, especially in forensics and at places like Tokanui, where people just got so volatile. Sometimes, it was viewed as a PRN or taken as needed instead of giving medication. I can remember preferring, once I was a staff nurse, to give cigarettes to settle someone than to dole out more Mellaril or Largactil.

Reflecting on what created the calm, she said:

> Oh yes, I don't know what was the calming thing, but for me now, in hindsight, it was a distraction. It took their mind off whatever crap or voices because they'd be distressed. They'd want medication. They used to ask for medication, poor buggers. If they already had what they were allowed, we used to say, why you don't come outside—I am saying outside—and have a cigarette'. Because somebody might have used up their PRN. Really unwell people used their 24 hours of PRN in 10 hours.

Lee made similar observations:

> I guess it was just sort of seen as if someone was really agitated or something like that; make sure they had a cigarette because they'd be seen as that would stop them from being so stressed or 'aggro' if you let them have a cigarette… Sometimes I think some of the staff would say, "better let them have a cigarette now; otherwise, they might get upset".

In contrast to the above experiences in psychiatric hospitals, Jo said that in the MHIF, "I can say I honestly don't believe that they were rewarding patients".

The staff also gave cigarettes to patients who did not behave well: Sylvia explained:

> Good behaviour was probably just met with relief. But if someone was being an arsehole, you could say, "Well, look, why don't you just go outside and have a smoke?" "I haven't got any nurse". "I'll give you one". That kind of stuff… It calmed people. Oh gosh, yes, that is why I was so anti it being taken away from HRBC and the prisons because it was calming. It was a crutch, and it worked.

Calming patients summary

Participants reported that staff used cigarettes to calm patients in different circumstances. These included newly admitted patients, those who had used their medication allocation, and those whose behaviour was considered unacceptable.

To what extent did staff engage in controlling behaviour with cigarettes?

5.5.4 Controlling behaviour

Several Participants explained how staff engaged in controlling behaviour with patient cigarettes.

Murray elaborated on the effect of staff taking possession of cigarettes from newly admitted patients:

> Yes, yes, and then typically, there would be an attempt by staff to take possession of the tobacco and manage access to it. That is my recollection anyway. That sometimes led to some of those interactions that were difficult to manage where staff were not readily available to get tobacco. They had to manage their access to lighters and so on. Many of those things are still a problem in some centres. But generally, that is my memory about how it was managed at that time.

Explaining why staff wanted to control cigarettes and the lighters, he reflected, "I think it was mostly the risk associated with acutely ill people having lighters that are a hazard; the fire hazard rather than anything to do with smoking".

Hayden offered a different perspective regarding control:

> Smoking cigarettes, withholding cigarettes, and distributing them afterwards is a good bit of control, isn't it? You have got all these things with cigarettes where cigarettes are used as a bargaining tool, used as a therapeutic tool. You've got staff and patients wanting to smoke, and it all just becomes too hard. We know that actually, people get better longer term when they stop smoking.

Comparing MHIFs with the general hospital, David discerned the following observation about mental health:

> There was the thought that all our patients smoke, and we shouldn't be stopping them from smoking… they [staff] were rationing… with the tobacco behavioural therapy, as I'm now retrospectively calling it… I think no one would have said that at the time, but I think they were scared that not having tobacco behavioural therapy would have led to us losing control, and I think that's actually what it was about. Whereas in the general hospital, it seems a straightforward health issue – we don't smoke here; we're a hospital. And the pavements outside the hospital always used to be full of people smoking.

In one MHIF, patients had to wait for a specific time in the morning to have their first smoking leave of the day. Jo explained the implications of this requirement.

> There is this business about giving people smoking leave where they have to wait for around mid-morning to get their cigarette leave. So, up to this time, they are having cravings and withdrawal and getting to the end of their tether [patience] where assaults can happen because they're in a state of enforced withdrawal. The staff do not get that this needs to be managed properly so that the person doesn't get into a state of withdrawal.

Sylvia commented that "we rewarded patients for good behaviour, with cigarettes". To illustrate:

> If they washed your car, you gave them cigarettes. If they had spent all their cash comforts and wanted a fag, they came to the staff. "I'll do this for you; I'll do this for you". I can remember having my car washed outside C ward and giving cigarettes when my car didn't even need washing. They'd say, "I'll wash your car". "Okay".

Lee noted the use of partially smoked cigarettes by staff to reward helpful behaviour by patients. "If they'd been particularly helpful doing something, staff would say, 'go off and do this for me, you can have the rest of my cigarette'".

Staff also used cigarettes to punish patients. Describing the behaviour as "really sadistic", Lee outlined the following account:

> There were those things you knew about, and then you were told, oh, that person's not working there anymore. Yes, they got shifted sideways because of such-and-such. This was to do with just neglect and cruelty. One of the things that happened… was that suddenly you started seeing these - these were special needs people who were severely disabled, and suddenly they'd have cigarette burns, and it was almost a form of sadism, it was really sadistic.
>
> We think there was a couple of sadistic staff that used to do that. One particular patient used to bite a lot, so every time she came near them, they'd threaten her with a cigarette, and she used to have cigarette burns on her arms. She obviously backed off… They ended up taking all her teeth out.
>
> I didn't see anyone doing it, but I heard of its use. I was on the night shift at the time, and I was leaving, and I'd see them. I'd go to change the beds, and I'd see the marks on them, on their arms, and they were obviously cigarette burns. I said, how did that happen? Because none of these kids was capable of smoking. When I say they were children, they might have been adults. They maybe had the mental capacity of a one-year-old or two-year-old or something. None of them was able to talk or speak. Oh, there might be a few funny words.

Lee raised the matter with the senior staff member:

> I don't think that the senior staff member was inherently unkind, but there was no stopping staff… I had raised the cigarette burns on patients and that I'd heard that it was being used as a punishment and the staff member said, "oh that happens sometimes, they come, and they go to attack you, and they've got a cigarette in their hand". He just kind of fobbed it off.
>
> It was justified almost as protecting yourself, but I actually think that one of the other staff members had said to me when I said to him how awful it was, "yes, and they do that as punishment, but I never saw it happen because I was on the night shift".

Lee also explained that the ward "was very lackadaisical; it was like the patients didn't matter. There was a whole culture". On resigning from the hospital, Lee 'blew the whistle' to the top management:

> I was leaving, but I did it because I thought it was too terrible. I just thought it was absolutely appalling that they should be treated like that… The other ward I worked in, these kids were treated with such care and dignity.

Controlling behaviour summary

Participants who had worked in psychiatric hospitals and or MHIFs reported that staff controlled and managed patient access to cigarettes and used cigarettes to reward desired behaviour. One Participant stated that cigarette use was also associated with punitive and sadistic actions by staff.

5.5.5 Theme summary

Participants who had worked in psychiatric hospitals and or MHIFs reported that staff used cigarettes to calm and control patients and retain a more peaceful or controlled work environment. Activities included supplying cigarettes, using cigarettes to calm

patients, and smoking with patients. One Participant reported the sadistic use of cigarettes.

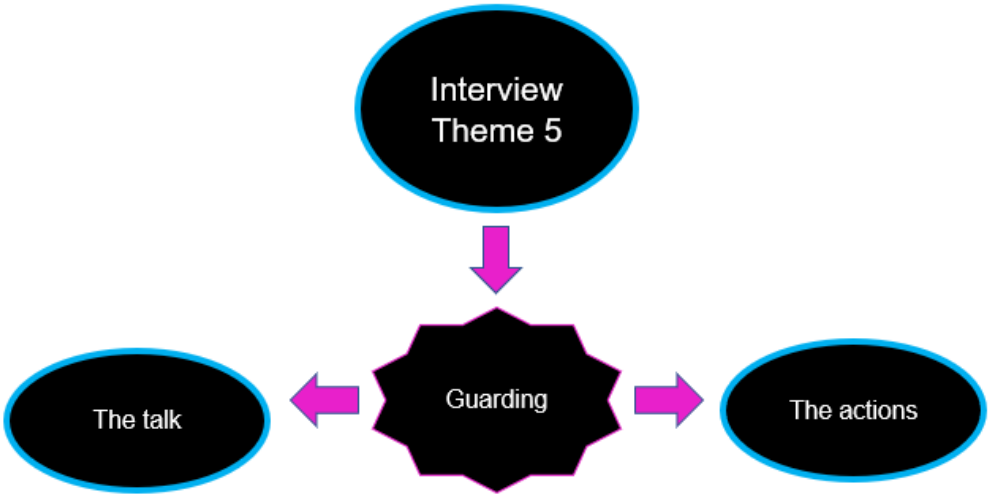
What did the Participants say about how the staff guarded the smoke-free exception?

5.6 Theme 5: Guarding

Figure 5.6 shows the theme and two sub-themes addressed in this section. Participants identified examples of talk and action to ward off threats to the exception.

Figure 5.6

Theme 5: Guarding



5.6.1 The talk

Implementing a smoke-free policy was associated with 'the talk' about what could or would go wrong if smoking was banned. The Participants who worked in MHIFs described a range of examples that either undermined the policy or promoted fears about the policy.

Policy undermining occurred in various ways. Reflecting on the challenges of implementing the smoke-free policy and the talk from senior management, Lynore was aware that some senior staff doubted the policy:

> Oh gosh, I think that a huge amount of work needs to be done in mental health inpatient facilities to change the staff attitudes and the managers. I am talking about the staff as a whole. But when you've got managers and then possibly more senior management not entirely believing in the smoke-free policy, you're really pushing it uphill.

David was a member of the MHIF implementation committee, which experienced talk that the DHB would never achieve a smoke-free status:

> As I said before, selling the fact that it was a cultural step that we were taking, and there were people saying, "we'll never totally be smoke-free". Well, you're probably right, and you'll probably find that the pubs in New Zealand aren't totally smoke-free, but 99% of them are, and that's a hell of a difference from when it was the culture that you could smoke in pubs, and that's what we're trying to do in this hospital. If people continue to smoke on the grounds, they probably will, but we need to make it so it's a smoke-free environment and reflects in the fact that we're a hospital.

In David's workplace, assaults occurred. Staff blamed the smoke-free policy. David recalled:

> There were definitely assaults that occurred that were blamed most definitely through the fact that the inpatient team weren't allowed to do the tobacco behavioural therapy.

Jo recalled the talk by staff. They considered that smoke-free policy implementation training was not part of their core work:

> The staff all leapt at me about how you can't do it. There is no time to do everything, no time to do what you see as your core role, much less anything else. They all—even the medical registrars—feel overworked and underfunded, and they kept saying give us funding to do it.

Staff in Lynore's workplace did not agree with the smoke-free policy. She explained that they started a petition against "a smoke-free policy in mental health… signed their names to it" and involved the patients:

> They had some patient signatures as well... "we all believe there should be no such thing as a smoke-free policy in mental health". So, it didn't just circulate around the staff. The patients knew as well. They knew that the staff didn't believe that the policy was a good idea. So, we were really up against it… Yes, the staff were undermining.

Concerning the smoke-free policy implementation, the talk promoted fears and was about assaults and policing. David observed:

> There was a lot of energy, a lot of interest. A lot of desire. Some really good people wanting this [policy] to happen. But then, interestingly, what was fascinating was you could then see all the things that we've talked about before – this is going to be disastrous. The fears came out long before the implementation happened. How's it going to be policed? How are we going to approach people? ...Concerns that there were going to be assaults against staff because we were going to be restricting smoking, particularly in the inpatient units… A [senior staff member] who by this stage had developed a horror of the madness that was occurring, said, "they're going to make the prisons smoke-free – no, surely not, this can't be, there's going to be riots".

There was the talk that without cigarettes, the health of patients would deteriorate: Ash explained:

> But a lot of them, when they are unwell, I might have this all wrong, they really needed that nicotine, they really needed the tobacco, and if they didn't have it, they could get even more unwell. That was the belief.

The prospect of a smoke-free workplace raised concerns that the lack of cigarettes would threaten patient-staff rapport. Lynore explained that the talk promoted the benefits of smoking:

> They said this is how they increased their rapport with patients because they smoked with them. They would smoke with them and chat with them, and it was very, very good for staff-patient relationships - this thing that they had, something in common.

The talk: Summary

Participants who worked in MHIFs identified examples of 'the talk' used by staff to protect the exception by casting doubt about the smoke-free policy's value and promoting fears concerning staff and patients if the policy eventuated.

Guarding the exception to smoke-free policies also occurred through actions. How did these actions manifest?

5.6.2 The actions

Participants identified actions, including inaction, that guarded the exception and reflected resistance and non-commitment to smoke-free environments.

Jo explained that a senior staff member was visiting the MHIF when a "patient assaulted a staff member. This was ascribed to being in a smoke-free environment". Immediately an exemption was announced:

> We are giving an exemption to [the MHIF] for the smoke-free policy. We can't allow this to happen. So, the [staff member] was completely persuaded by this incident and [the MHIF] had to be given an exemption from the smoke-free policy… Yes, when our policy originally came in. I don't know how official, but it was not expected to exempt mental health, and then the exemption for the policy came out after that incident. I don't think that would have happened if it had happened in the general hospital.

In Lynore's workplace, staff told her that they did not want a smoke-free policy and that they had threatened to leave. She elaborated:

> They didn't want a policy coming in… some of them said to me when I talked with them about it, "There is nothing you can do to stop us smoking inside at night because we are not allowed to leave the building, and we smoke, and we've always smoked inside". So, they were smoking in the actual area. They told me that they've got no intention of stopping it. I said, "so if it becomes law and an employment issue, then what will you do about it?" These are really, really tough people. They said, "we'll just leave and go somewhere else. We threaten the management with leaving, and we haven't got enough staff. They can't manage without us". So, they thought they had the upper hand. In actual fact, they probably did for that very reason. They couldn't get staff who wanted to work there.

Several Participants referred to the presence of a system of leave that enabled patients to smoke offsite. In the context of smoke-free buildings, Lynore explained:

> Even when the hospital ground became smoke-free completely for mental health patients and staff, staff found a way around it. The patients had 'community leave' as they called it and had to be escorted. They used to escort the patients off the grounds so that could be just over the road and then stand there with them and smoke. When we insisted that the staff were not allowed to smoke even off the grounds, they were to set an example… they probably stood there and breathed in, but they just went further away where they couldn't be seen and smoked with the patient. And then what the staff started was when a patient came in, even if it was an acute patient, the staff member would say to the psychiatrist, we need to give this person community leave'. So, on admission, that patient is to be given immediate 'community leave', and it would be 15 minutes community leave, so we knew that, of course, what you can do in 15 minutes. You are not even going to get to the community. All you're going to do is

> get to the other side of the road for a cigarette. So then, the psychiatrists were complicit in enabling people to smoke. I bet they still are, the rotten sods.

She reflected:

> And they kept finding ways around the policy. This is a really good example of one way that they found, and it's very difficult to go against someone like the DHB's head psychiatrist of mental health who supported this.

In Jo's workplace, 'smoking leave' started less than a year after implementing the policy. Jo observed:

> Being in the smoke-free environment meant that they couldn't smoke. It should have been much more straightforward than it actually was, but the psychiatrists started prescribing smoking leave for people. I don't know why they did this. We found it almost impossible to get to talk to the psychiatrists ourselves. It may have been brought in a lot earlier, but we only found out about it.

Jo explained how 'smoking leave' worked:

> When the person had their session with the psychiatrist, the person would tell the psychiatrist that they smoked and they were having a bad time, and the psychiatrist would prescribe smoking leave for them. This was written into the clinical notes. Then the person was allowed to go outside. At that stage, there was reasonable monitoring of people not smoking on the grounds. The grounds are quite big, and there were places where people went smoking, including on the roads.

Karen's workplace also provided 'leave' for patients to smoke outside:

> They weren't allowed to smoke inside… they would be able to smoke outside, they had to be escorted. Actually, Te Whetu had their own local policy as well for smoke-free, just for their own local use. They

> devised it themselves. And it was around being escorted outside to smoke or being given leave—they called it 'leave'—to go outside to smoke… it would only be half an hour.

Patients sectioned under the mental health legislation had to be escorted. Karen explained that "If they were sectioned… then that's when they had to be escorted. If they were voluntary patients who were admitted because they got depressed or something and were not under a section, then they could come and go".

Karen observed that departments in large hospitals do their own "internal thing and that's fine, as long as it connects with the main policy. There's an overarching policy, and there might be sub-policies". She illustrated:

> For example, in the paediatric psychiatric unit, if they had teenagers who wanted to smoke, there was a piece of land. It was internal to the hospital, but it was on a slope with grass, and there were trees, and they would go over there and smoke. So, they would smoke within the grounds, but the staff there turned a blind eye to them… It was easier for them to manage I suppose than having to go with them and either go down on to Grafton Road or walk over to the other side of the hospital to be in the Domain.

Implementing cessation training programmes

Regarding cessation training programmes, Participants explained that although cessation trainers offered staff smoking cessation training, there was little interest shown in participation.

In the context of whether his colleagues participated in the education and training, David said, "Probably not, no" and that it was due to "lack of interest I think".

Lynore stated that in the early stages of policy implementation in 2009 and before "there was any talk about let's make the whole of NZ smoke-free", her team put on seminars for staff. The message was, "come and listen and help your patients become smoke-free". She described the staff reaction:

> Because there is a high percentage of nursing staff that smoke, so something like when I first started something like 39% of nurses smoked themselves. So, they would immediately think, "Oh no, here we are, we are going to get bashed over the head about our own smoking", so they stayed away as much as they could. There was resistance and quite a strong resistance. To look at them, you could tell that they were extremely resistant. Even when you were talking to a group of people, you'd pick out the smokers. They would kind of bristle, bristling until they started to drop their guard, but you could always tell the people who smoked.

Sam explained that facilitating smoking cessation training in two MHIFs was associated with various problems:

> Trying to run training in places like [MHIF A] and out at [MHIF B], but they never really got off the ground. There are too many problems – not enough staff, not enough support. I tried to run courses not only for the staff there, but they were forever being called away because the training was run within the unit. They were being called away because they were needed, so obviously, the staffing hadn't taken into account the fact that people needed to be in this training. Nothing ever happened within those units; nothing constructive ever happened. It was just a mess. I'd go in, and I'd try and even have sessions with the patients, but you'd get there and try to set up a room, but it was just very badly managed, and there was always the kind of excuse, well, you know what it's like in mental health anyway. You know that sort of attitude.

Like Lynore's experience of staff who smoked, Sam said, "I think initially a lot of that attitude was because most of the workers smoked". She reflected:

> But more recently, if I think about (MHIF A), the person who was in charge that day, I don't think they saw it as a priority, and I don't think that the people who they reported to that person saw it as a priority.

> It was like a bit of a nuisance, if you know what I mean. Yes, a nuisance. A bit of interference, really.

Sam, David, and Lynore expressed concern that staff had underdosed patients with nicotine replacement therapy.

Sam considered that adequate dosing would have helped more smokers to quit:

> It's just understanding that a lot of mental health service users see smoking as their one friend and the one thing that they've got left, which they can do. Actually, with the right treatment, you can overcome it, and that treatment generally is NRT. If it was used properly, a lot more people would have been able to quit smoking.
>
> With NRT, there really is no limit as to how much NRT a person can use at once, so therefore people have been underdosed. I have… talked about the fact that NRT was misunderstood and mistreated, the poor cousin sort of thing. Some of the issues were getting it accepted that smoking was something that could be dealt with within a mental health service unit, whether it be residential or otherwise, and then the dosing and who can give NRT, then over the years, the mental health service workers themselves stopping smoking.

Like Sam, David considered that practitioners had not used NRT properly:

> Some people tolerate massive doses, and some less. It's like any other drug. But there's still that reticence… that reticence with stupid things like I still get nurses saying, "can you chart nicotine replacement therapy for her?" No, it should be available widely on this ward. I do not have to chart it. And they still insist on it being charted. But, individual charting, I mean individually allowing permission for people because you hear people saying NRT doesn't work. Well, it doesn't work because they're not giving themselves enough, probably… We actually advised a little bit, when we could, because we've got prisons around Canterbury, and one of the messages we try to get across very

> clearly is just to make NRT so ridiculously available it's coming out their ears.

From Lynore's perspective, the staff needed to keep offering NRT:

> I remember one chap we met was in a hospital gown. He was carting along his bottle on the stand… he's outside smoking, and we stopped and chatted to him about this smoking. We asked him if he'd been offered NRT. He said, "Well, I was when I came in, but I didn't think I needed it. This is four days down the track, and I'm getting desperate". So, we said "would you like to try it now"? He said "Yes". So, we whisked him back up in the lift and got him onto NRT. That happened a lot because when people come in, they don't understand how difficult it's going to be when they withdraw, so we had to start trying to convince the staff to keep offering it. When they offered it to them in the first place when they first came in, then you say to them 2-3 days later or at the time, "You may change your mind when it starts to kick in... the withdrawals... please ask us for NRT".

The Smoke-free Environments Amendment Act 2003 allowed DHBs to provide designated smoking rooms subject to specific requirements. Participants reported that staff sourced or attempted to source alternative smoking sites when and where these rooms were not available. As explained in Section 5.3, other sites included those on and off the grounds: behind trees and bushes, on private property, streets, and public parks. Lynore outlined further examples. She explained how the staff tried to argue that the internal road through the hospital campus was a public road and, therefore, a place where people could smoke:

> Bloody madness, isn't it? The road that ran right through the middle of the hospital was a public road, so if it is a public road, then it is not owned by the DHB, and so they can go and stand on that road and smoke on the grounds… So, we actually had to prove that that wasn't the case and that even if it was a public road, they were still not going to be allowed to smoke on it. They tried that one more than once.

With the road option closed off, the staff located the nearest place off the grounds. Lynore elaborated:

> For themselves and for the patients, they found the nearest possible place they could get to off the grounds… the first closest one they found was… the entrance, you know, one of the main entrances. They are all standing, the patients are standing out there smoking and throwing their butts over a neighbour's fence, so then complaints came from the neighbours about the butts.

As mentioned earlier, some of the staff in Lynore's workplace objected to the smoke-free policy, and they started a petition against the policy:

> Now, how silly is this? Some of the staff started a petition to prevent a policy being implemented and signed their names to it. It was a bit silly because it was clear by that stage that it was going to happen and that it was going to start with the staff, and so these staff were actually putting their name down so that everyone knew that these were the staff members who were resistant. Therefore, you could put a name to the people who were the most difficult. They went on to be those staff to be spoken to by their managers because this wasn't really quite acceptable to be going against what was clearly going to be hospital policy.

She explained the staff reasons for the petition:

> They did not think there should be a smoke-free policy in mental health, so the idea was at the top of the petition it said you know all of these people… they had some patient signatures as well... we all believe there should be no such thing as a smoke-free policy in mental health.

In the context of a discussion about the smoke-free policy and staff resistance, David remarked that staff would opt for a DSA. He concluded that a DSA secured the existence of smoking:

> But that was always my question; whenever people said this is terrible, this is awful, I'd always just say, "so what do you want to go back to? What do you want to create? Do you want a hospital with everyone smoking in all rooms"? Of course, they'd say no, and you'd pull it back to a point, and usually… they'd say we want a designated smoking area… Because it still allowed a foothold for the smoking to occur there.

Using pregnancy as an analogy, David outlined his position about the use of designated smoking areas in a 'smoke-free environment':

> I think there was a lot of pressure… the thing about smoke-free is it's a bit like pregnancy where you're either pregnant or you're not. You're either smoke-free, or you're not. You either have a place where the person is smoking in a smoke-free environment, which is different to having an environment that actually isn't smoke-free. There are some designated smoking areas. There's actually a big difference because the designated smoking areas give the indication that… it's [smoking] possible and allowable, and it will spread from there. So surreptitious smoking in a smoke-free environment to me is far preferable than accepting that there's going to be surreptitious smoking and putting in a designated smoking area.

The actions: Summary

Participants identified staff talk and actions as guarding the exception to the DHBs' smoke-free policies and presenting them as a desirable option. These actions occurred during the early stage of smoke-free policy implementation and post-smoke-free policy implementation. Examples included providing leave to smoke, not engaging with cessation training, inadequate use of NRT, petitioning, finding alternative places to smoke, and establishing designated smoking areas.

In contrast to the talk and actions that supported smoking, Participants also identified a range of strategies that promoted smoke-free environments and initiatives.

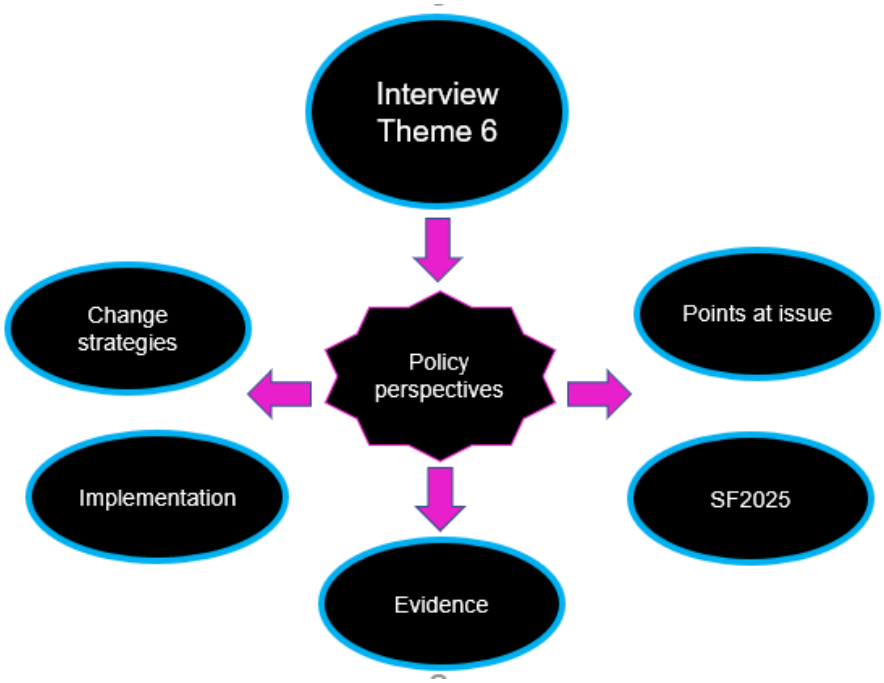
What were strategies promoted smoke-free environments and initiatives?

5.7 Theme 6: Policy perspectives

Figure 5.7 depicts the theme and five sub-themes covered in this section. Participants explained their views related to smoke-free environments, including SF 2025.

Figure 5.7

Theme 6 Policy perspectives



5.7.1 Change strategies

Three Participants were actively involved with the Smoke-free Environments Act 1990. They expressed views about strategies to achieve change and promote smoke-free environments.

Robert has a long-standing academic career which includes research about smoking. He volunteered, “my interest in tobacco began as a medical student because my father died in 1965 from tobacco-induced diseases which I’ve always thought could be preventable”. In 1982, Robert set up Action on Smoking and Health (ASH) in Aotearoa New Zealand:

> I wanted desperately to reduce the preventable impact of smoking on the health of all New Zealanders and realised that that required political change, political activism.

He reflected that achieving this change was through a NGO.

> It's just the way to make changes in New Zealand put pressure on the Government. The early success we had was working with Helen Clark when she became Minister of Health in 1989. I had some meetings with her and talked about what was required, and she was committed to the issue. Out of her leadership came the 1990 Smoke-free Environments Act.

Jo also worked in tobacco control during the lead up the Smoke-free Environments Act 1990. Staff in Jo's organisation realised that doing policy work with community development was necessary to achieve real change. Jo explained:

> It was realised that the activist approach with the alcohol industry was a useful approach for tobacco control as well. It was when Helen Clark was in, and they were having those cottage meetings when they bought in the 1990 smoke-free legislation to galvanise public support to take on big tobacco and the public support for having smoke-free workplaces. It grew from that because people started to see that things can happen when you have got the public behind you. Doing just policy work in the absence of community development work is a much weaker way. You need to have the two together. You need the top-down and the bottom-up happening at the same time to get real change.

Public health: Long term game

Steve explained that she "went into Parliament to certainly change the world view for Māori, young people, and health. Health was my background. It was my driver". She added:

> The work that you'd done in maternity, the work that we'd done with Women's Refuge, the work I'd done with Family Planning was all in a public health paradigm, and so this Bill certainly fitted that paradigm, and so it was the perfect place.

As the sponsor of the 2003 smoke-free legislation, Steve regarded public health as a long-term game:

> I'd learned a lot from Australia. I went over to Canberra, and they were the leading state in the Smoke-free Environment Act there, and they had the jump on us, although they had the problem of convincing other states to follow because of their senate and state. I worked with some senators in South Australia, and they took that line too of public health. It's all about public health, and it's a long-term game. You're talking a 20-year window. We always talked about cycles of five years to get any message through and then get any mitigation strategy. I knew it was a long game, and I was quite prepared to run the long haul because it was the beginning of Parliament. It was a very good Bill for me to put my name to.

The Bill was contentious. Steve attracted what she referred to as 'hatred':

> Controversial. I'll say it, I had guys like [Member of Parliament] got in the lift one day and he said, 'oh you're one of Helen's feminazis with hairy legs". I just said, 'I'm not sure where you're coming from here, what makes you want to say that?" "You're leading that Smoke-free Bill". Yet I think even now; he'd probably say it's had a profound change on society… I attracted a lot of hatred. I had a lot of hate mail, and I had white powder delivered to my office… I had a researcher working to deal with the volume of correspondence coming through. He actually opened an envelope with powder and told me when I came back, and I said, "well we have to get that tested", and we went into shut down, and he was put off, and he was screened and made sure it wasn't anthrax. There was a lot of anger, but that was from people that just didn't want to be told that smoking could be damaging to your health.

The tobacco industry lobbied heavily. Steve considered it did not hurt to hear the views and put these views in the context of what changes the industry would make:

> So nice, so charming when they came to see you, and "we're with you here, Steve, and we're trying to reduce the impact of…" but they never ever admitted that the deaths were attributed to second-hand smoke or smoking. Very cunning. I'll never forget people like [tobacco industry representative] coming in, and others. Charming. Did it very respectfully. Made appointments with my front staff, and I'd walk in and think, [tobacco industry representative] here you are again, what is it this time? What sort of cute mechanism are you trying to put to me to stop me from carrying on with this? It made me more resolute. But it didn't hurt to hear their view, just hear their view, and then put it into the context of are they really going to go to plain packaging? Are they really going to go to graphic images on cigarette packets? Are they really going to accept that these frontline products are going to be taken off the counter and put in closed cabinets? You knew they weren't.

The elephant in the room metaphor

In the context of brief interventions and innovation for change within DHBs, Hayden referred to 'the elephant' used as a metaphor to signify that smoking should not be ignored or remain investigated. He explained that 'the elephant' helped make a change in the general part of the hospital:

> Margie Apa was the Deputy Director-General, and Stephen McKernan would have been the Director-General at the time [in the Ministry of Health]. It was a good time. It was quite innovative. We were really thinking about how we could do this. Then we had 'the elephant', which I must say I didn't like at the beginning, and I thought, for goodness sake, how can a big elephant change, but it caught on. Suddenly this was the branding for a whole intervention. Suddenly everyone was talking about 'the elephant'. It really helped moving forward to change the hearts and minds of clinical staff in the general part of the hospital.

Change strategies: Summary

Several Participants identified strategies to achieve changes and promote smoke-free environments in the areas of political advocacy, public health, anti-smoke-free incidents, and clinical work.

What were the characteristics of successful smoke-free environment implementation? What did the Participants identify?

5.7.2 Implementation characteristics

When asked about the successful smoke-free environment implementation characteristics, the Participants identified several practices related to the implementation process, staff skills, and the patients' interests.

Murray reflected on policy clarity. "The first thing is about having that discussion about what the policy position will be, although I think with the clear view that the preferred position is that there is a smoke-free/tobacco-free environment as the starting point". He elaborated this did not involve

> Inviting debate about… whether or not that is the policy but inviting discussion about what the issues are… so that people do get a sense… what the problems will be and the support in implementing that will be needed to help.

Murray also noted that this process enabled participation as well as organisational implementation support:

> They get an opportunity to participate... I think that getting some clear timeframes for implementation as well but with sufficient lead times that you are able to work through things in a pretty rigorous way. But also, you actually do provide some experienced support in terms of manpower to help make it happen.

Good process

The Waitemata DHB (WDHB) was involved with several court cases related to the smoke-free policy in the MHIF during Murray's time as Clinical Director of Mental Health and Addiction Services at the WDHB. Referring to the Supreme Court (SC) decision that

the WDHB was not obliged to provide designated smoking rooms (See Chapter 3, section 3.2), Murray noted that the SC mentioned the policy implementation process used by WDHB:

> There was attention given to the way in which [the policy was] implemented, involvement of service unit groups, making sure that there was access to NRT for people – that whole thing about how implementation should be applied in practice was a really important part of the consideration in court. I think it demonstrated that if you go through a good process, it will be found to have a proper process. It will be found to have a good standing in the eyes of the court. But if you were to do it in a very rushed and arbitrary way, that might have quite a different result if it was to be argued before the court.

Hayden offered additional thoughts about the implementation process. Noting that the evidence supports smoke-free MHIFs, he observed that "Evidence-based and ease of implementation are different things". In the context of working with patients, Hayden observed, "It is very easy to get frustrated… with this group. You have to remind yourselves that… it also takes time. As a clinician, you want to see success, but success looks different in different ways… you have to have more patience". Similar to Sam, who likened smoking to being the smoker's friend, Hayden commented:

> Be prepared to be in there for the long run when supporting people with mental illness to make difficult behaviour change. It is part of their life. It's their coping mechanism. It's their friend.

Both Hayden and Lynore referred to acting in the interests of the patients. Hayden expressed it like this:

> Support workers can't be saying, "just have another chocolate biscuit, that won't kill you", or "go and have a cigarette". You should be told to stop completely, and likewise, those in the other areas, staff shouldn't be saying things that are not true about the management of mental illness. It is more about working together and knowing what

> each other is doing and having the best interests of our people that we are trying to help… top priority.

For Lynore, patients' access to NRT information was part of addressing their interests. She explained:

> I think that for all the staff, it would be part of their orientation to learn about NRT and how they can help incoming patients or, even if they don't want to help them stop, to at least pass on the information so that they are not depriving them of the information. They are not forcing them to stop necessarily, but what I'm saying is, this is what people need, if and when they decide to stop smoking, they need the information… in the institution itself, just having someone there passing on all the information, making sure that the up-to-date information is coming in and passed around.

Lynore observed that communication skills were necessary. "You've got to have good communication skills and certainly not be frightened of mental health. It surprises me that it [being frightened] is quite common".

David stated, "I believe every hospital, because it is a hospital, has got to say we of all places are smoke-free. That's what I think". He elaborated:

> You're smoke-free, or you're not. You either have a place where the person is smoking in a smoke-free environment, which is different to having an environment that actually isn't smoke-free: there are some designated smoking areas. There's actually a big difference because the designated smoking areas give the indication that smoking… it's possible and allowable, and it will spread from there. So surreptitious smoking in a smoke-free environment to me is far preferable than accepting that there's going to be surreptitious smoking and putting in a designated smoking area.

As noted, several Participants indicated that it was challenging to create smoke-free environments when the DHB leadership did not support the policy. Murray, David,

Lynore, and Hayden reflected on aspects of leadership that contributed to policy success.

Reflecting on her experience in MHIFs, Lynore considered that it was essential to have leaders who did not smoke. "I think it would be extremely helpful to have non-smoking leadership and of course supportive to the idea of smoke-free mental health patients".

For Murray, leadership support needed to be present at the governing board, the clinical governance, and at the chief executive levels:

> Look, it needs to be across all of those, but I think that genuine interest from the board in how the policy is being implemented is really important. Having a clear policy and agreement at the board level about the direction in which things will go and then a clear interest in understanding how it is being implemented and then for the chief executive to reflect that right through to the senior staff within the service. [The clinical governance group] …should be within the service, the representation of the board within the service level so they should have the same interest and commitment to achieving implementation of the policy and should have an interest in how it is progressing and looking at how it can be supported as well. There needs to be support available at all those levels to make sure it is successful, ultimately.

David expressed a similar view. "The leader of the organisation has got to be 100% behind it [smoke-free policy]. The chief executive has got to be behind it wholeheartedly, but also next step down, the general manager".

> We had a general manager …She was great, and she was 100% behind it… you need to go 100% smoke-free. Yes, people would continue [to smoke] we know that, but we can't… allow a little bit. There's no such thing as a little bit.

Hayden also identified that clinical leadership was important, particularly to achieve clinical change:

> I think leadership is critically important. We did try to foster leadership in the District Health Boards. DHBs with good leadership did well. Counties Manukau did a good job… At Auckland DHB, it was… the physician there who really made sure that with the junior doctors when they were coming in, that this was important. We weren't just doing it because the Ministry wanted us to do it.

He elaborated about the value of the personal touch, passion, and commitment:

> We needed that person to take that role and to say, 'look, you know it's a target, and it's important for the people that we're trying to help'. When you put the personal touch on it, it is much easier for the clinicians to accept. When it is a government-driven target, it is very easy to say, 'Oh, it's just another target, it's just another tick-box exercise'. But you see people saying, 'yes, I would like some help in stopping smoking and yes this would help and be good'. The physician, Stephen Childs, I think he just saw this is something that could work. We got buy-in from him. I remember talking to him early on, and he was just particularly passionate about it and championed the cause. He was there. You would go and speak to Grand Rounds, and he would be there just saying this is important. Other DHBs, while they saw it as important because it was a target, but it wasn't really important.

Hayden concluded that "leadership is incredibly important for change in clinical behaviour". He reflected that "Most of the time it's always tobacco control people that were made the champions, but they are not always the people that can get buy-in from the clinicians… you needed someone who was clinically at the top… to drive it".

Implementation characteristics: Summary

Participants identified factors of successful implementation. These ranged from using good policy development and implementation process, addressing the patient's interests, and staff leadership.

What did Participants say about the role of evidence in promoting smoke-free environments?

5.7.3 The evidence

Participants spoke about the evidence related to the harm of smoking and the role that evidence played or did not play in promoting smoke-free environments.

Referring to the Smoke-free Environments Act 1990, Robert observed that passive smoking mobilised non-smokers:

> [The] Smoke-free Environments Act, which, if it wasn't a world first, was way up there in terms of protecting our smoke-free environments… Yes. Interesting, actually, 300 deaths a year from passive smoking, at most, as opposed to the 4,500 from smoking. But the passive smoking mobilised non-smoking people – they were concerned about their own health. Action on Smoking and Health (ASH) spent a lot of time on this issue.

Speaking about the 2003 smoke-free legislation and support for that legislation, Steve reflected on what she saw as an irony concerning the growing evidence of harm:

> I found it very ironic though, during the House process, Paul Hutchinson, who was on the Health Committee with me, was always consistent, but others, they could still vote with the industry voice strongly behind them, and I thought, how can you be a doctor and not see the evidence that is growing and mounting and being collated so cleverly by these other sector groups? It's just you don't want to.

Hayden discussed the introduction of brief interventions in the DHBs and the source of evidence that was considered by the tobacco control team at the Ministry of Health.

> Dr Ashley Bloomfield was the chief public health advisor at the time, and I think a lot of what happened was due to Ashley's influence. I'd already been starting to work with Ashley and his team, looking at how

> we might introduce the brief interventions and mapping out what we could do.
>
> We knew that brief interventions could increase the chances of people stopping smoking long-term primarily by prompting quit attempts… The evidence came mainly from the Cochrane review. What we saw was that even with documentation of smoking status, it [brief intervention] was not done routinely at all. Although there are coding conventions, it was done in multiple ways. If a smoking cessation intervention was coded, it was done in different ways depending on the hospital. There was no standardisation. The recording on smoking status and the screening for smoking was variable. The provision of brief interventions was almost non-existent. I think that it [brief intervention] just seems like a good place to start with the health sector. Of course, that is one part of the bigger tobacco control package. There were all the other things that were done over the years; for example, increasing prices are all important.

He added that implementation began with general hospitals, not mental health. Mental health was considered resistant:

> We had the job of trying to help DHBs to get a smoke free champion, look at their policies, look at their pathways, look at how smoking status was documented, changing admission to discharge planning forms and making sure it was on the discharge letters sent back to primary care. It was very much focused on systems… A few people saw that we should actually do systems, and they were right. If you get the systems right, it really helped clinicians to intervene… Mental health settings were thought about, but it was kind of like 'it's a hard one' so let's just focus on getting it right in the coronary care unit and the respiratory ward and everywhere and move through to surgery'… the large resistance has always been in mental health settings so you naturally wouldn't go and tackle the hardest ones first.

Lynore also referred to resistance in mental health. Specifically, she noted the opposition to evidence supporting smoke-free MHIFs and the manager who voiced the evidence. She put it like this:

> The manager was wonderful with policies and all the evidence. She wrote papers about why smoke-free should happen. She got all sorts of evidence from Professor Sharon Lawn and others, and she would go to these meetings. So she used to arm with screeds of paper and screeds of evidence. You know it would have bowled anyone else over, but for some reason, it was a real battle, so they would just go ooh, something like, you know here she is again. There were couple of times where it became really, really difficult… it was almost looking as if not only might we not get a policy, but they might try and get rid of her as well. She knew always what she was talking about. She didn't really suffer fools, and sometimes the people trying to argue with her didn't know what they were talking about, so she would, I suppose, be a little strident with them, and they did not like it.

In the context of reconciling the evidence for smoke-free environments with practices that did not comply with the evidence, David said, "That was exactly the challenge that we had in the implementation committee. As I said before, selling the fact that it was a cultural step that we were taking, and there were people saying we'll never totally be smoke-free". About the evidence, he added, "We were singing it from the rafters. The evidence was absolutely overwhelming. The one thing that would make the biggest change to a population's health would be to help people become non-smokers".

Asked whether there are any good reasons why anyone should support smoking for people with a mental health diagnosis, Hayden looked surprised and said, "No… I am surprised, I just can't think why you would do that".

He elaborated that there was no evidence to support the continuation of smoking as alternatives are available even if nicotine assists some functioning:

> There may be some evidence that nicotine might be important for some functioning, but we have got nicotine substitutes that are safer.

> Even electronic cigarettes are safer than smoking, so why you would tell people to carry on smoking is completely beyond me… the main benefits [of smoke-free MHIF], of course, are for the lives of the people that you are helping.
>
> You're helping their mental illness, but they don't die from their mental illness. They die primarily because of the physical illnesses caused by smoking, obesity, and lack of physical activity. We know that over time you become less depressed, less stressed less anxious. Okay, there is a bit of a bump when you quit, with tobacco withdrawal symptoms, but over time people get better and not worse. I think that just knowing that and knowing that you can support people through all knowing that it can be a tough road for them, and many people don't succeed the first time… It is a tougher road for someone with a mental illness.

In the context of NCD research about smoking and the big four diseases of diabetes, heart disease, cancer and respiratory diseases, Robert noted that the link with mental health is recent. He explained "the NCD community has been focused on the big four diseases and common perspectives, and mental health links with NCDs have always been a bit tenuous, and the standard risk factors aren't that relevant, necessarily". He elaborated that "the link between [the diseases] and mental health issues at the public health level has only recently been made". The turning point was:

> The Sustainable Development Goals (SDG), actually, 2015, where SDG 3.3 talks about preventing NCDs and promoting mental health and wellbeing generally. The mental health community had struggled to engage with the NCD community for a long time but had not been easily accepted into that community… I think there has been the recognition that people with mental health issues have high rates of smoking, and whether their clinical environment should be smoke-free has been an issue. There's been more research focused recently on the value of e-cigarettes for mental health sufferers. It's come late.

Ben noted that he worked for the Heart Foundation. He indicated that smoking remains the single biggest cause of death and the main cause of health inequity for Māori women. Using evidence from sources including a Ministry of Health document called the Health Independence Report, Ben stated:

> I've been doing some analysis on the mortality statistics for New Zealand, so mortality by ethnicity and by age and then applying that to some of the work that people like Richard Peto have done or Tony Blakely have done… But looking and attributing how many of those deaths are likely to be caused by smoking. I would say smoking is the single biggest preventable cause of premature disease. You have to put all these qualifiers in any way. It's still probably the biggest preventable cause of heart disease… I think smoking is still… probably one of the most main causes of health inequity as well, is another way you can put it… if you look at Māori women, for example.

Reflecting on the impact of delayed onset for cancers, he added:

> I think the smoking [mortality]… it's probably going to increase before it goes down, and I think there's a couple of reasons for that. One is… the delayed onset for cancers. If everyone stopped smoking tomorrow, you'd probably still have smoking deaths for another 50 years before the last one happened. I think that means it's not direct. This is what I've been interested in doing here as well, which is there are certain deaths you'll see an instant impact on heart disease. I think there is a good opportunity to tell some of that success story that also busts some of the myths that even if I quit, I still could get cancer in 10 years. Like, actually, instantly, we're seeing less people dying from heart disease or being admitted with these things.

The evidence summary

Participants reported examples of evidence used to support smoke-free environments. They also identified examples of resistance to the use of evidence concerning MHIFs. One Participant noted no evidence to support smoking by PMI. Another Participant

reported that smoking remained the single biggest cause of death in Aotearoa New Zealand, and one raised the inequitable effect of smoking for Māori women.

What did Participants say about the progress towards achieving SF 2025?

5.7.4 Smoke-free 2025: Progress

Most of the Participants expressed their views about achieving SF 2025 and what was needed to achieve that goal. Participants thought that various factors had hindered SF 2025 progress. To illustrate, Ben listed several factors. Focussing on the National Government's decision to merge Alcohol Liquor Advisory Council (ALAC) with the Health Sponsorship Council (HSC) and form the Health Promotion Agency (HPA) in 2012, Ben observed that the merger had affected the ability of tobacco control services to succeed in their work. "It's not their own fault; it's just too much is being asked of that model [smoking cessation] in terms of getting to SF 2025". He elaborated:

> I think that kind of decimation of the money that was spent on big, good campaigns around building public support and momentum towards SF 2025 through that, the merge of ALAC into the HPA was a catastrophe for tobacco control because it lost its dedicated focus on tobacco. It's not been a good thing at all, unfortunately… Back at the time, I've actually said, "well, what's going to happen is you're going to protect the alcohol spend because that's on the levy, protect the gambling expenditure; everything else is going to be spread far too thin because it's all going to be coming out of a general fund and that includes mental health, SunSmart, and tobacco".

As for achieving SF 2025, Ben considered that the equity gap was widening. He commented that by 2018, "we're well behind". He noted that the expected 2018 smoking prevalence was "20% Māori, about 12% for Pacific, and 10% for the general population" and that:

> Policies have happened, and actions have been taken over the past years, but it's been quite sort of tinkering. I think we probably put too much emphasis on tax… Things like the retail display ban and the plain packaging are all good, but they're not driving at the heart of the issue.

Concerning the Government expenditure on smoking cessation, Ben reflected:

> The other thing I think has not worked as well as it should is the huge investment into the smoking cessation model in individuals because even at maximum capacities, stop smoking cessation could not get the number of smokers needed to quit for SF 2025. They can only help so many, yet it's whatever it is; four-fifths of the spend is on Pharmac therapies and stop smoking services.

Commenting on the Government's appetite for SF 2025, Ben observed:

> There's been quite a limited appetite for it. Actually, the industry should be levied to pay for those things. They're making record profits; they shouldn't be. The more successful they are, the more they should be paid to counter what they're doing.

In contrast, Hayden considered that the Government wanted to plan for changes:

> I think the current Government has an appetite for changing and moving forward. What I have heard so far is that they want a plan. I don't know what is going to be in that plan, but they want to plan. There are plans that are already written that take a multi-component approach to tackling this. And it's not just about reducing the supply or changing the product. It involves increasing the prices as well.

Ben observed that cigarettes "now are extremely unaffordable and we're at a much, much lower smoking prevalence". However, he added:

> The demographic of people who still smoke is quite different now to what it was 20, 15, even 10 years ago. People who find it much, much harder to quit. Smoking plays a much, much bigger role in their life… tax is not the lever that we thought it would have been, and I think it's got limited efficacy to really make that impact going forward.

In contrast, Hayden considered that price was a quitting lever for his clients:

> I know that the price increase is controversial. At Counties Manukau DHB, most of the population I see are from lower socioeconomic groups. People are wanting to stop smoking because of the price.

Hayden observed that getting to SF 2025 needed policy changes, including changing the product. He gave a bit of a sigh and said, "I don't think we will get to SF 2025 unless we have some big policy changes. Those big policy changes need to be big to really drive a lot of these people away from smoking".

He explained:

> I think you have really got to look at changing the product. I think some of the smaller steps that people are proposing, such as reducing supply, for example, reducing the number of outlets that you could sell tobacco, would go some way to reducing smoking prevalence. The argument against that, though, of course, is that it is going to penalise those that smoke, especially from the lower socioeconomic groups who would then spend the only money on petrol to get to the place of sale. Because when you are dealing with an addiction, the addiction takes precedent, so they are valid concerns.
>
> If you really wanted to deal with this, I think you'd probably have to change the product, and by that, I mean reduce the nicotine content in tobacco or bring it to a very, very low level so less than 0.04 mg nicotine/gram tobacco. At that level, you wouldn't get the reward from smoking, so in theory, people would go into withdrawal obviously, but as long as there wasn't any other tobacco available, then they wouldn't switch to that. For many smokers, you would also need to offer them an alternative, so you didn't have them in horrid withdrawals for too long.

Like Hayden, Lynore thought that SF 2025 goal was unlikely to be achieved, but she considered that work needed to continue:

> My understanding is that… it doesn't look as if we are going to make it, but some inroads have been made… young people are taking up smoking less, which is very exciting, and the percentage of smokers is coming down but not quickly enough to make the goal, but things have changed a tremendous amount in the smoking area of New Zealand. I think it's exciting, and I think we need to keep working towards it and eventually, it will happen. Smoking will become completely unacceptable.

Responding to SF 2025 goal, Judy described that goal as "an ideal". She commented, "I see it as an aspirational thing, and I think good on them for having it, and it's good to see National and Labour aiming at the same sort of stuff in a way, like good health". She added, "it's a target that is praiseworthy, but I get nervous about targets that are just sort of zilch".

Several Participants considered that vaping was an alternative to smoking and a possible way to achieve the SF 2025 goal. Ben explained that vaping has the potential to get New Zealand to the 5% target:

> I think the vaping is hugely disruptive and has the potential to – so if we've got 15% of people are smoking at the moment… I've been doing quite a lot of stuff just looking at what could happen with vaping. If you look at the UK model, so there's about 5-6% adult prevalence of vaping at the moment, and just over half are ex-smokers, just under half are dual-use, and about a per cent or two were never smokers who vape. That's of the adult population. If we say we've got 15% of adults smoking in New Zealand, if we could get a third of them onto vaping, a third of them to quit, we'd be to 5%. We don't really have enough knowledge of what the vaping prevalence is like. They estimated around 3% a couple of years ago by HPA. If it followed the UK trajectory, we should be on about 5 to 6% by now. There's a vaping question in the next New Zealand healthy survey, which is great because we'll get a better sense of that. We really, really need to know who's vaping and understand it.

Focussing on the use of vaping by patients, Lynore commented:

> Oh gosh, I think that if it's going to help them, either space out or give up their cigarettes, or at least help see what they could do without cigarettes, it's a fabulous idea. My opinion would be that we should consider providing them with e-cigarettes, the same as we provide NRT.

She reflected on the evidence for vaping.

> I know that there's some evidence which is a bit of a concern, but my question would always be, which is more difficult? I think possibly that smoking tobacco is more of risk to them than the vaping, and people don't vape forever. They only seem to use them for a while till they are through the withdrawal... maybe six weeks, a couple of months and then space out the vaping, and they don't need it anymore. I look at it as a nicotine replacement thing, and they should use it.

Focussing on education, Robert explained why educating people about e-cigarettes was important:

> I think this is where the Health Promotion Agency comes in, in educating people about the relative harms and the much greater safety of e-cigarettes. I think their job is to promote awareness about SF 2025 and be positive about it and show how we can get there and promote the uptake of e-cigarettes in the context of a supportive environment. E-cigarettes don't just work magically. You have to get the right device and the right flavour, and the right dose, and you have to learn how to use them. Vape shops are very good at that. I'd like to empower vape shops to take a greater role in smoking cessation, and I'd like to take the money away from the formal stop smoking services and put it to use where the people are, including going to vape shops and into communities and community groups.

Murray reflected with caution:

> I just don't know enough about vaping to know whether we might be recreating another problem for ourselves. I think that some of the behaviours about smoking may well be represented when tobacco is replayed with vaping: who has access to it, whether people have access to their chargers, all that sort of stuff that has been around cigarettes and lighters may be repeated with vaping devices and so I am not sure. I don't think that it is a panacea.

Ben referred to the 2018 court case where the Ministry of Health charged Phillip Morris (New Zealand) Limited with selling a tobacco product called 'HEETS'[5]. The Court decided that the sale did not breach the law. Ben reflected:

> I think how the Government responds to this court ruling and sensible regulation around it will be critical actually I think is really important. I really think it's the most disruptive thing in smoking tobacco in a long, long time. You look at the epidemiology of smokeless in Sweden and Nordic countries. There's a precedent.

Hayden also raised the use of an alternative source of nicotine:

> If you work on the premise that some people smoke nicotine and that it is important, it may be the case where there are quite a few people that may need to carry on using an alternative source of nicotine. E-cigarettes are probably the best that we have got at the moment. But then we have also got the reduced-harm tobacco products like IQOS. Okay, we don't know a lot about the risks yet, only that they are likely to be less risky than smoking.

David commented about the use of vaping in hospitals "I think we should be really looking at it". He reflected:

[5] HEETS are heated tobacco sticks that are heated not burnt. They are heated tobacco units used in a holder called IQOS which stands for 'I quit original smoking'.

> But I think there needs to be some very good advice given at a government level before 2025, and I think 2025 will provoke this argument. In my view, that's why 2025 is a good thing because it's going to actually make us, in the next six or seven years, actually look at all options but particularly vaping.
>
> Also, Philip Morris, from a commercial point of view, very interesting – they're actually now saying we're against tobacco, we don't want to promote tobacco, we're going to make these HEETS… again, that could be a great solution to the right patient. Maybe going back to what a great tool that could be in an inpatient unit where someone… and I don't know enough about HEETS to be able to argue that, but I would say to someone in an inpatient unit that we don't smoke here, but we can give you education regarding becoming a non-smoker and included in that is vaping.

Hayden raised an ethical question about not providing smokers with an alternative.

> The court definitely had a view on it [HEETS]. Is it unethical to withhold something that might provide a way out of smoking? Is that fair for people that are really struggling, people who we have tried numerous times to help them stop smoking completely? Shouldn't we offer them something else? If it's done in a way that doesn't, of course, open up a new avenue for never smokers to become addicted to nicotine. I think that it is possible.

Smoke-free summary

Overall, Participants considered that SF 2025 was unlikely to be achieved. Reasons included the lack of dedicated Government funding and commitment and a focus on cessation rather than significant policy changes, including vaping availability. Generally, Participants thought that vaping was a way to reach the SF 2025 goal. Some Participants noted reservations about vaping.

Participants raised other issues of concern about smoke-free environments. What were these?

5.7.5 Points at issue

Participants raised further issues of concern. These related to the implications of exceptions for patients, refocussing tobacco control, Ministry of Health leadership, and the Government's role in tobacco control.

When asked about the implications of smoke-free exceptions for PMI by 2025, Lynore, Hayden, and David identified concerns. To illustrate, reflecting on her experiences in MHIFs, Lynore commented that

> I think it means they [patients] are going to be continually left behind, that it's going to become worse and more difficult for them unless someone can make it perfectly clear to the staff that this [smoke-free] is what's going to happen.

She elaborated about the cost of tobacco:

> These people that staff are supposed to be helping by enabling them to smoke, they are making it far, far worse for them because tobacco will become more expensive. Mental health inpatient facility patients are going to end up spending all their benefit on tobacco because they have got to have it, so staff actually have to start helping them. That needs to be made clear, and we need to be firmer about it. We've got to convince the staff that they are earning a wage and if they are going to continue to smoke, they can probably afford to, but the people that they are supposed to be helping are on a benefit—most of them—and they can't afford to smoke, so the staff need to get their bums into gear really.

In the context of patients, both diagnosed and undiagnosed, and smoking, Hayden observed that "there is such a stigma around smoking. Yes, a lot of people say that you just can't go anywhere these days without people looking at you like you are some sort of leper".

> That's becoming a little bit like [a] hierarchy because the people in society who still smoke are the most deprived population as well as those in the lower socioeconomic groups and those with mental illness.

Estimating that patients with mental illness, both diagnosed and undiagnosed, might comprise up to 50% of smokers in Aotearoa New Zealand, Hayden reflected further about stigma:

> I think that is a real risk, and again we are not really focusing on that group. Within people with a diagnosis of mental illness, smoking rates are high. It is going to need to take some careful planning, and we are running out of time. We are already in 2018.

Concerning smoking and patients, David observed, "It [smoking] could add as an extra stigma – oh gosh, you're a mental health person, and you're one of those old smokers".

On why patients with mental illness who smoke are <u>not a priority group</u> within tobacco control, Hayden commented, "I think that they should be one of the priority populations in terms of health, physical healthcare… I don't know why they are not actually".

Reflecting on the make-up of the client population, he observed that "within services and settings, they <u>almost do become priority populations</u> because that is who you see"; however, "Nationally it is certainly not named as a priority population".

> The priority populations are pregnant women, Māori, Pacific. There are crossovers, of course. Rates of mental illness are higher in lower socioeconomic communities and in Māori, and so you end up having a little bit of crossover there anyway, but it is often not... No one wants to label them as a priority group, it seems… But mental health does feature as one of the four priorities in this current Government. So, if that is the priority group, then we should be swinging around within tobacco control to support them. The priorities are mental health, equity, child wellbeing, and primary care.

Reflecting on the decision by DHBs to provide smoking cessation training in the general wards with smoking allowed in MHIFs, Lynore shared her observations about treating one hospital population group differently from another:

> I do think it's completely unfair. It's an injustice, really. So, I feel quite strongly about that. Funny, when I am talking about it, I am thinking, 'ohhhh'. I'd forgotten how strongly I felt about it... and whipping in there and being there to do a bit to help at least. I always felt that even if you change a few people's views, you are still kind of getting somewhere, so it seemed worthwhile. It seems a complete injustice to me that there they are, left there.

Noting that tobacco control is not a national priority, Hayden commented that turning tobacco control into a priority involved aligning it with an existing service priority, for example, mental health:

> Mental health does feature as one of the four [service] priorities in this current government. So, if that is the priority group, then we should be swinging around within tobacco control to support them. The priorities are mental health, equity, child wellbeing and primary care.

He explained how to achieve this:

> I know that [mental health] usually means less suicide. The use of tobacco fits in with mental health, and the people involved might have been using stop smoking services before they have suicidal ideation. It is about making sure that… all tobacco control aligns with the priorities. I think that we can do that.
>
> This is about realigning the focus a little bit and perhaps then in hospital settings instead of worrying about respiratory which I think now you can just leave just now... have the training [and] do the 'ABCs' in those areas, and I think that is fine. Most people are going to be okay. Let's shift our focus to where it is needed... If it is mental wellbeing, smoking has a role to play there because we know that

> helping people stop smoking long-term improves their mental wellbeing.
>
> You just have to find logically where it fits in with the priorities and then swing the funding and the resources around to meet the needs of those populations. It is not about stopping doing what we have been doing completely. That stuff should carry on, but it shouldn't need someone running around hospitals making sure that your respiratory patients… had a brief intervention… That should be completely business as usual. It is in the forms. It is there. We are probably going to get 'Yep you know what? If we take the target away from that it will probably drop a little', but if it drops to 7 out of 10 well, I reckon I'd be happy with that.

Both Hayden and Robert considered that alternative quitting devices must be available. In the context of patients and the ethics of not providing vaping or heated tobacco products to assist in-need populations in stopping, Hayden commented:

> I think that just saying no to all these things and leaving our most in need populations just to fend for themselves; I just can't see how that's good care. I feel quite strongly about that. While this is just a small segment of society, they are a segment of society that's had an awful, awful time over many years of neglect and abuse, and we are getting better, but there is still more we could do. I do not think they deserve just to be told to just 'pull up your socks and give up', because it is so hard for them; it really is. The sort of things go through my mind were, if we did do this and we did feel confident that they are safer, how much safer is always going to be an issue, but then move them along as we know and maybe step them down in terms of risk.

Robert considered that smokers were being punished without an acceptable alternative nicotine source. He also thought that e-cigarettes would help New Zealand to achieve SF 2025:

> I'm not interested in reducing supply until we have another readily available and acceptable form of nicotine available… I think otherwise; we're just punishing people. There's still some debate about that. I actually think we can not only get back on track but get there [for SF 2025]. We need 40,000 quitters a year, and we're getting about 13,000 at the moment. We need to get 40,000 quitters a year, every year until 2025, and we have to prevent the uptake of new smokers, which is pretty much happening apart from migrants. I think e-cigarettes are going to get us there. I think they're going to take off.

David commented that "the conversation more and more, and it's started already, is going to be about delivery systems and that smoke/vape/other delivery systems are going to be the way that I think".

He cautioned:

> I think a lot of it will depend on the flavourings and the other additives that are in vapes. It's not the nicotine. If we just had the plain old glycol or whatever it is, no flavour, and nicotine, which would be pretty horrible to take probably. It's the flavourings that are going to cause the problems, so there needs to be, I think, some very careful look at the industry.

Noting that a DHB had banned vaping, David said, "I really don't agree with that. I think we should be really looking at it".

Participants identified several areas where they considered that leadership was absent. Most of the comments related to the Ministry of Health. Jo and Murray commented about shortfalls and other activities related to leadership by the Ministry of Health.

Jo reflected on the earlier years of the 21st-century and recalled that the Ministry had supported exceptions for MHIFs:

> It was not written into our smoke-free policy, but you must remember that that 2008 letter to DHBs from the Ministry outlines the DHBs' responsibilities around being smoke-free, and that letter itself exempt

> DHBs from including mental health. In mental health inpatient facilities in those days, you had a designated smoking room, and as long it was ventilated, it was okay.

Commenting on the barriers to smoke-free environments, Jo observed that there needed to be pro-active leadership by the Ministry:

> Need a stronger approach through the Ministry of Health (Ministry) through to the mental health division in the Ministry. That they actually start putting some – you see the health targets made a lot of difference because it was the Ministry thing that people had to report on, and there were teeth to it. I believe that the Ministry needs to provide some proactive leadership in terms of mental health and smoke-free. If they did this, that would go a long way because I think of those conditions and psychiatrists, managers, and people in mental health, they'd take notice of the Ministry if they have to report it rather than if they have to take notice of me!

Jo added there was a second letter in 2012 and that "The second one was different. It was encouraging the DHBs to be smoke-free right throughout". Reflecting on the role of the Ministry of Health in enabling, encouraging or otherwise MHIFs to move towards or become all smoke-free, Murray commented:

> I don't have a strong sense that the Ministry of Health is regarded as being particularly relevant to most people within the DHBs… It is not how it should be. It really ought to have a clear role in encouraging the direction and providing some resource nationally in terms of information and strategies that can be picked up by DHBs rather than everyone needing to invent their own or through liaison with other DHBs planning how they managed it.
>
> The central role of the Ministry is as a clearinghouse of information and strategy would be really helpful, but they do seem… I don't know whether they are reluctant or whether they do not have the resource

> to do it as well. They do seem much more inclined to let everyone start all over again rather than being a useful resource in that way.

Reflecting on the 2003 smoke-free legislative provision for hospital care institutions to have designated smoking areas for patients, Robert said, "a hospital is… a public place, that [smoking] would be, I expect, banned by the Smoke-free Environments Act". He described the legislative provision for indoor smoking areas as "very backward" and observed, "that it seems to be a curious situation". Robert added, "if there's going to be a smoke-free environments amendment next year, they might want to look at that as well".

In the context of Government action about funding the Health Protection Agency (HPA) and the legislative requirements for e-cigarettes, Robert stated that "this Government needs to get on with it".

> There are two things it needs. It's got to empower and fund the HPA to take much more action around mass and targeted social media to get the public behind the legislation and the [SF 2025] goal and to encourage more people to make more quit attempts more often. That needs money.

Robert explained that the HPA "used to spend several million, three or four million or something on smoking. Now they're spending less than a million". He speculated that the cut was "because of other priorities":

> They spend the money at the direction of the Minister. If the last Minister who was responsible for them – I don't know who it was, didn't direct them to do more on tobacco, they would have spent it on 'slip, slap, slop' or whatever. The alcohol money, $11 million or $12 million a year, is ring fenced.

The second issue Robert identified was that the Government "needs to… sort out the legislative requirements around effective safe e-cigarettes":

> According to Ashley [Bloomfield], that's in the process, but it's taking a long time. Nicky Wagner would have advanced it much more rapidly if National had been in power. That's probably coming. Part of the problem was that the Associate Minister of Health, Jenny Salesa, was not convinced about the value of e-cigarettes when she came to power, but she's now supportive. I think she is less concerned about the possible gateway effect. Those would be two very good things.

Reflecting on the need for different strategies to help patients quit smoking, Hayden observed that there was no national movement to drive this need:

> We do need to come up with treatment strategies that... for many of them, it might be using a bit of nicotine replacement therapy when you can't afford them, and when you can afford them, you buy your cigarettes just until we move you along a continuum perhaps of actually buying less cigarettes and using more of an alternative nicotine product. I don't think that there is a national move. I think that it's more pockets of passion which always has been. We have got some great people in Auckland that are really trying to push this along. It is a struggle… because it is a hard group [patients] to deal with mostly.

Robert noted that the Minister of Health had delegated ministerial responsibility for tobacco control to an Associate Minister. He commented,

> When he [Hon Dr David Clarke] came into office, I asked him not to delegate it, but he went ahead and delegated it… He kept childhood obesity, which was interesting. I told him it [tobacco control] was a win/win situation; if he took it and ran with it, he'd get a lot of kudos, but he's overwhelmed with other things.

Participants commented about the DHBs objective to improve, promote, and protect people and communities' health and its fit with the 2003 smoke-free legislative provision to allow smoking within hospital care institutions.

Judy chaired the Committee that dealt with the DHB legislation. She recalled:

> [This] Bill was about the work in the community. I mean, the DHB, according to the new Labour-led Government—remember it was the Labour-led Government—was trying to bring in legislation that would not just be about hospitals. Hospitals were only part of the health system; it's about the whole community care thing, and under that Labour Government, which I was part of until July 2002 when I retired… the whole thing was about increasing community care, so we set up all these special nurses. We had diabetic nurses; we had more district health nurses; we had a whole lot more community care.
>
> There was a big emphasis on preventive work and providing more services in the community. So, it was about promoting good health. The promotion was about how to eat properly and how to look after yourself and not to smoke and all these things. But it wasn't really about the short time that most people spent in the hospital; it wasn't about that. It was about care and support, a lot of it in the community, and it was inclusive and everything.

About the smoke-free legislation, she commented:

> The conversation about people being in a workplace and being protected, and people who – at that point in time, your home was sacrosanct, and it was all the conversation of the definition of a home and these people [patients], this [the hospital] was their home. I think I've made that clear.

David said, "I think our discussion earlier was exactly about that, wasn't it? I believe every hospital, because it is a hospital, has got to say we of all places are smoke-free. That's what I think". Jo remarked that "We are not protecting the health of mental health clients at all by enabling them to smoke and not doing something to support them is kind of like proxy enabling".

> It is frustrating. It makes me feel that when we were relaunching our policy in 2010, the DHB had a really good opportunity to be a bit of a leader in this area. We have now lost this. We are more of a follower and sometimes the follower from way back. It is a lost opportunity for the DHB to make some real differences.

Reflecting on staff education, Jo added:

> I feel really, really sorry for the clients who do need a lot of support to stop smoking. If we could get the staff better educated and with better attitudes, a patient couldn't really be in a better place to help stop smoking in mental health inpatient facilities with skilled people around her or him. That is the theory of it.

Hayden observed that a broader focus was needed to be a focus:

> Again, I think that we need to start involving the people that we are caring for a lot more because we take a very paternalistic view sometimes of things, for example, 'Oh, they won't know'. But given the benefits of physical activity, for example, for mental wellbeing, that should really be a focus. It should be almost part of the support and therapy that we provide. Again, coming back to your point, [the objective] I mean this is what you're here for, it is only that, but they spend so long in mental health services that it's neglect if you do not touch on some of the other issues at the same time.

Lee also commented about a more holistic approach:

> I think that obviously, you should be looking at the whole population for smoke-free, not just exempting one. It's just weighing everything up. It's a bit like once again, the tax that it's really hurting, how do you ameliorate, how do you face off the benefits and disadvantages? That's really important. Give people other strategies. Yes, I think it's really important to look at the whole population. Mental health should also be about good nutrition, should be about exercise, all those

> things. It should be taking a more holistic approach rather than just taking a kind of siloed approach.

Lynore concluded, “it’s just that when it comes to the whole smoking issue, it’s not true. They don’t they really do any of that”.

> I always got the impression that they put in a smoke-free policy because they were instructed that was what they needed to do. I suppose it came from the higher powers that be probably the government, I would assume. Somebody instructed them that all DHBs had to have a smoke-free policy, and they better get one in and then the Canterbury DHB instructed mental health that they had to put in a policy, so in the end, they ended up with no choice. That still doesn’t mean that they liked it. They just had to do it, and it still didn’t mean they were going to follow the policy. It just meant that they had to put one in. It was kind of all for show; a lot of it was just for show.

Points at issue summary

Participants considered that patients had been negatively affected by exceptions. Other issues included the non-prioritisation of mental health and smoking, the lack of legal alternative quitting devices, the absence of Ministry of Health and Government leadership in tobacco control and mental health leadership, and the need for broader mental health approaches.

5.8 Chapter review and summary

In this chapter, I have presented my findings from the interviews with my study Participants. Cigarette smoking has been a normalised and tolerated practice in psychiatric hospitals and MHIFs. Both institutions have supplied tobacco and cigarettes to patients, and staff have used cigarettes to calm and control patients. Contested beliefs have prevailed for and against smoke-free policies and exceptional smoking spaces. Mental health staff have not uniformly accepted the agreed evidence of harm to mental health inpatients who smoked and were exposed to SHS. The Ministry of Health and the DHBs were not considered to have provided the desired leadership

regarding mental health and smoking. There was some support for vaping as a tool to help mental health patients quit and doubt whether the Aotearoa New Zealand Government's national SF 2025 goal would be achieved.

Chapter 6 Pointers of Exceptional Spaces: Discussion and Conclusions

I live in the Southern Hemisphere. We see the Southern Cross and its two pointer stars on a clear night. This constellation, known as Te Pae Mahutoka, has long been important for navigation in the Pacific Ocean. The pointer stars are bright in the night sky, and they are important signposts for ocean navigation because they point to the Southern Cross, which finds direction south. This chapter draws on the concept of 'navigational signposts' and presents my findings under five pointer headings set out in Figure 6.1. Pointers 1 to 4 are drawn from the thematic outcome of the findings and combined with the published literature. I make the case that the combination of these pointers—the pervasive culture of smoking, staff behaviours to protect continued smoking, the State's role in sanctioning smoking, and absence of visible and committed leadership regarding smoke-free MHIFs,—are **signposts or pointers** to the value of life: the life of mental health inpatients and, to a lesser extent, staff, in MHIFs with exceptional spaces for smoking. Thus, in pointer 5, I draw together the findings from pointers 1 to 4 and use Agamben's state of exception to examine the extent to which this framework helps us understand the rationale for exceptional spaces for smoking in MHIFs and the implications of the exceptions for patients, staff, and SF 2025.

6.1 Summary of findings

My study indicates tobacco smoking was a normalised and tolerated indoor and outdoor practice by patients and staff in psychiatric hospitals and MHIFs. In both hospital settings, some patients were provided with tobacco and cigarettes. Patients' smoking was generally associated with an entitlement to smoke and beliefs about smoking benefits for them. At the same time, staff used cigarettes as a 'therapeutic tool' to calm and control patients and secure a more peaceful workplace. Using national smoke-free legislation provisions and/organisational policy, DHBs introduced exceptional spaces and permitted smoking in MHIFs. Pro-smoking staff used various strategies and arguments to promote and protect these exceptions. The Government, the Ministry of Health, and the DHBs have not demonstrated visible commitment and leadership to smoke-free environments in MHIFs. These circumstances have exposed staff to SHS and

left patients to receive health care in non-smoke-free environments and are, therefore, less likely to be smoke-free by 2025.

Chapter organisation

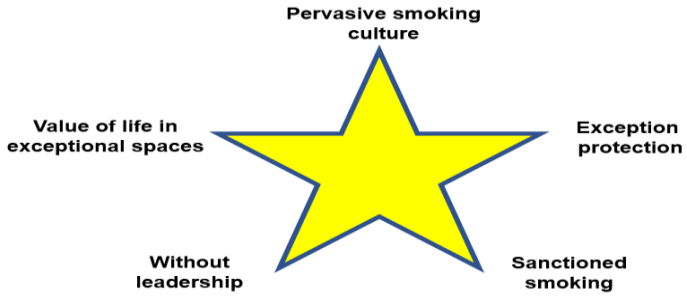
This chapter has two sections.

Section one combines the themes from my interview findings and DHB data and relates them to the literature and my research questions. I discuss these using the first four-pointer headings below. In pointer 5, I draw on the findings from pointers 1 to 4 and, using Agamben's state of exception, examine whether this framework provides insights about the rationale for smoke-free policy exceptions in MHIFs and the implications for patients, staff, and SF 2025.

- pervasive smoking culture
- exception protection
- state sanctioned smoking
- without leadership
- value of life in exceptional spaces

Figure 6.1

Pointers of exceptional spaces



Section two addresses my study's key contributions and implications for the state, public health policy, mental health policy, tobacco control policy, practice, research, and theory and methods. It includes the limits of the present research and a thesis summary, along with my concluding reflections.

Kia whakatōmuri te haere whakamua

I walk backwards into the future with my eyes fixed on my past

But first, the past loomed loud and long as I grappled with presenting my discussion about smoke-free exceptions in MHIFs. The past kept drawing me to it as the place to begin my writing. I knew my research questions intertwined the past and present and future. I knew that my research journey started by reviewing the literature and archival documents about smoking in psychiatric hospitals from the 1930s to 1999.

So, with my eyes fixed on the past, this discussion begins with the first pointer about pervasive smoking. It draws on the six themes; 'sites of smoking', 'keeping the peace', 'guarding', 'policy perspectives', 'doing the acceptable', and 'knowing the best', in Chapter 5, Building Blocks of Exception (See Figure 5.1).

Section One

6.2 Pointer 1: Pervasive smoking culture 1930s-1999

Together, my findings depict a historical smoking culture embedded in Aotearoa New Zealand psychiatric hospitals by 2000, the year of the legislation that established the DHBs.

The pillars or strong supports of this culture include:

1. **acceptability and tolerance of smoking indoors and outside the buildings by patients and staff**
2. **beliefs that reflect narratives about smoking benefits**
3. **visibility of smoking**
4. **Department of Health funding of tobacco and cigarettes, and the availability and supply of tobacco and cigarettes from hospital shops and hospitals**

My study uses the following definition of **normalisation**. It involves the acceptance and tolerance of smoking, primarily cigarettes which is evident through the visibility of private and public smoking of cigarettes and tobacco products, media portrayal, and the availability and promotion of tobacco products (Hudson & Thomson, 2011), as well as the uptake and continuation of smoking.

The reviewed literature indicated that the tobacco industry marketed cigarettes to people with mental illness in overseas jurisdictions, such as the USA (Prochaska et al., 2008). While I did not locate similar media portrayals in Aotearoa New Zealand, the above pillars align with the normalisation definition, indicating that smoking was normalised in psychiatric hospitals. Put differently; smoking was the norm. This finding endorses overseas research that smoking was the norm in similar hospital settings (Lawn, 2001, 2004; Lawn & Campion, 2013; Lawn & Pols, 2005; Prochaska, 2011; Royal College of Physicians & Royal College of Psychiatrists, 2013). It also complements Brunton's (2003) research, which established smoking's presence in Aotearoa New Zealand psychiatric hospitals by the 1950s.

My finding greatly expanded the foundational body of knowledge about the normalisation of smoking in psychiatric hospitals, little reported in Aotearoa New Zealand, to date.

First, I make two observations from this finding of normalisation.

6.2.1 Smoking as cherished and protected

The smoking norm was not just any norm, and I suggest it was a highly significant norm. Why? The duration of smoking in these institutions plus the high probability that most smokers would be nicotine dependent and need to smoke to relieve withdrawal symptoms suggest that smoking was likely to occupy a special status. It would be highly valued, cherished, and protected by pro-smoking staff and management, as well as patients.

6.2.2 Footholds of pervasiveness: Fortress-like

Although the earlier reviewed literature refers to embedded smoking in overseas psychiatric hospitals, it rarely suggests how smoking became pervasive. Yet, this kind of understanding could offer insight into implementing smoke-free policy exceptions in MHIFs. Concerning my finding of the smoking culture and its pillars, a possible explanation for pervasive smoking is that each pillar planted a *firm foothold* that helped secure smoking's pervasiveness. Collectively, the footholds formed a fortress-like wall

that would be hard to dislodge and likely resist legislative and policy initiatives to implement smoke-free environments.

6.2.3 The pillars

The following discussion addresses each pillar, except pillar four, which I discuss under Sanctioned Smoking in pointer 3.

1. **Acceptability & tolerance**

Participant accounts indicate significant acceptability and tolerance for smoking by patients and staff and in almost any place. Thus, it seems likely that the acceptability of smoking was the foundational pillar in the wall. Arguably, if smoking was unacceptable, it would have been challenging to plant further footholds.

2. **Beliefs: Narratives reflect benefits**

My findings identified three core beliefs related to smoking by both mental health patients and most staff.

- smoking is conducive to patients' mental health and needs to be supported
- smoking helps staff with stress and builds therapeutic relationships with patients
- smoking is an entitlement/right for patients

The literature review confirmed these beliefs' presence and widely held nature in similar overseas hospitals. However, being *widely held* does not mean that the beliefs reflected the evidence. Scientifically established evidence was substituted for widely held beliefs treated as received wisdom, another kind of evidence.

In this regard, tobacco control proponents, via the research, rightly characterise these beliefs as *myths* as none reflects the scientific research or health-promoting practice (Mendelsohn & Montebello, 2013; Prochaska, 2011)

In my view, these beliefs point to the presence of the following two dominant narratives:

smoking is beneficial
smoke-free is harmful

Both narratives are significant because they reveal the protected and valued smoking status, attribute benefits to smoking, and provide further footholds for smoking's pervasiveness. There is a difference, however. The first narrative is explicitly reflected in beliefs' language, which positions smoking as beneficial. In contrast, the second narrative is implied by the beliefs' language: if smoking is good, smoke-free is harmful. I discuss the effect of the second narrative in the following Exception Protection pointer at 6.2.

Narrative: 'Smoking is beneficial.'

In simple terms, this narrative positions smoking as *good*, the preferable option and, therefore, *non-problematic*. Presented as helpful, invaluable, and necessary for patient and staff wellbeing, smoking is akin to the *good life*. Recall Sylvia said that smoking "was calming. It was a crutch, and it worked".

Stress relief benefit

Context is important. The first two beliefs above imply or refer to stress relief. During 1930 to 1999, there was a general acceptance that smoking relieved stress. It was sheeted home in tobacco advertising (See Figure 2.8), promoted by the medical profession (See Figure 2.5), and accepted in the general society. Further, a lack of research and published literature about smoking and mental health during these years suggests the firmly established and largely unquestioned validity of the stress beliefs.

Commonly, patients and perhaps staff associated smoking with stress relief; whereas smoking alleviated withdrawal symptoms. Patients do not necessarily understand nicotine addiction, and study Participant Hayden put it well when he said that they know that they feel irritable, and that smoking relieves irritability. While it is understandable for patients to believe that smoking is associated with stress relief, I contend this is not so for clinical staff during the past four decades. After all, nicotine addiction and withdrawal have been DSM-111 categories since 1980 (Neuman et al., 2005). Thus, since at least 1980, clinical staff have had a professional duty to know about nicotine addiction pathophysiology**.**

Silence about physical effects

By 1999, a substantive body of published evidence existed about the detrimental effects of smoking and SHS on physical health. Significantly, the core beliefs fall silent about the physical effects of smoking.

Is this a case of letting sleeping dogs lie? Possibly. However, a feasible explanation is Western medicine categorisation, where patient illness's bifurcation separates the mind from the body. There are *problems of the mind*, usually called mental illness, and *problems of the body* often referred to as physical illness. As the literature shows, historically, psychiatrists, for example, have not regarded physical health as core work (Royal Australian and New Zealand College of Psychiatrists, 2015; Te Pou o te Whakaaro Nui, 2017). Providing care for patients affected by physical health conditions is a phenomenon of the 21st-century. Thus, it is likely that smoking's physical effects were not part of the psychiatric *clinical radar* between the 1930s and 1999.

Therapeutic relationship benefit

Core to the therapeutic relationship belief is the importance of staff smoking with patients to engage, build trust, and learn more about them. This belief's pervasive presence in my interview findings is consistent with overseas studies (Lawn & Condon, 2006; Smith et al., 2019; McNally et al., 2006; Stubbs et al., 2004, as cited in Prochaska, 2010) and New Zealand studies (Connolly, 2009; Connolly et al., 2013; Glover et al., 2014). However, some studies raised concerns about health professionals using an addictive substance to engage with patients and noted that non-smokers could build therapeutic relationships with patients who smoke (Lawn & Condon, 2006; Thomas & Richmond, 2017).

In my study, Participants raised similar concerns, with Murray musing that it seemed *opportune* for staff to smoke rather than being a therapeutic interaction. Similarly, Hayden considered that it probably felt great for both staff and patients who smoked and stopped the withdrawal feelings. How might we understand the construction of staff smoking with patients as a benefit?

Yes, staff and patients smoking together probably offered a sense of mutual relief from nicotine withdrawal. Simultaneously, however, smoking together likely signalled to patients that staff had patient interests at heart and arguably lodged a further foothold

for smoking's pervasiveness. Hark back to study Participant Sam who observed that smoking was like a friend for many patients and one thing that they could still do together.

However, given the building evidence about the harm of smoking, this signal is troubling. It was disingenuous and unprofessional for the staff to use an addictive substance to court such a relationship and then describe it 'therapeutic'.

Entitlement/rights benefit

The foundation for rights belief generally lies in domestic and international law. At no stage in the above years was smoking formally deemed a general right or a human right in our domestic smoke-free or human rights legislation or the relevant international covenants. However, if smoking is your one friend and the one thing you have autonomy with, it probably feels like *your right*. Treating smoking as a right arguably elevates it to an entitlement. In this way, I suggest that the rights belief secured a further smoking foothold for patients and signalled that *patient interests* were again at the heart of staff practice.

Drawing these beliefs together, I am not surprised that they prevailed because seemingly plausible explanations account for the gaps between the beliefs and the evidence. The beliefs also offered smoking additional footholds in the fortress-like wall of pervasiveness while creating a patient-centred appearance.

3. Visibility

My findings indicate the presence of a permissive environment allowing patients and staff to smoke almost anywhere indoors and outdoors. This finding aligns with Lawn and Pols' (2005) review of international studies about smoking bans in MHIFs. Smoking was evident in the hospital context, as illustrated by smoke, ash, and ashtrays during daily work activities such as group therapy and clinical interventions. Smoking on the grounds is visible to anyone, and there was no need to hide or smoke in secret.

However, the visible nature of smoking was not confined to the hospital grounds and work. Recall Lee's experience at the hospital pantomime, a social event. Lee was required to smoke. Here the hospital and its staff were on display to an audience likely to comprise public members, staff, and patients. Smoking was on display to the audience.

Different approaches

It is important to note that while smoking *normalisation* in psychiatric hospitals was secured, active smoking *denormalisation* was occurring concurrently in the general society (Clark, 1990, May 17. p.130; Thomson & Wilson, 1997).

As discussed in the reviewed literature, formal denormalisation initiatives responded to the evidence of harm from smoking and smoke, and sought to protect people from these harms. The evidence was sufficiently concerning that the Government passed smoke-free legislation in 1990 and then funded and extensively promoted smoke-free initiatives. Public hospitals introduced no-smoking areas and stopped cigarette sales in hospital shops. Yet, psychiatric hospitals did not afford similar protection for their patients. Smoking continued, thus indicating different approaches to patient care.

While the above pillars helped entrench normalised smoking in psychiatric hospitals, this pervasiveness laid a robust platform for guarding and protecting smoking (exception protection) in the DHBs from 2000.

6.3 Pointer 2: Exception protection

This pointer about exception protection primarily draws on the findings from the 'guarding', 'doing the acceptable', 'peacekeeping', and policy themes in Chapter 5 (See Figure 5.1.).

The reviewed literature indicates that while no smoking policy initiatives began slowly in the hospital boards from the late 1980s, the 1990 smoke-free legislation signalled a definite policy intention that workplaces would generally be smoke-free.

My findings suggest that pro-smoking staff and management regarded the prospect and presence of smoke-free environments, smoke-free policies, and no smoking (smoke-free) as a significant threat to the well-established comfort of normalised smoking in psychiatric hospitals and subsequently in MHIFs. Consequently, to protect the pervasive and cherished smoking culture and to guard against threats, staff engaged in *exception protection* comprising talk and actions that *problematised* smoke-free environments, smoke-free policies, and no smoking (smoke-free). How?

6.3.1 Narrative

'Smoke-free is harmful'

Returning to the second dominant narrative mentioned in Pointer 1, I contend that the 'problematising' flows from the narrative's notion that 'smoke-free is harmful'. Specifically, the portrayal of smoke-free is *injurious* to patient health and wellbeing and *detrimental* to staff practices. Let us consider each of these portrayals.

Smoke-free: Injurious to patients

My findings reveal two inferences critical to the harmful portrayal of smoke-free.

First, if patients cannot smoke, their *health and wellbeing will deteriorate*. The implicit message is that smoking is essential and needs to continue for patients to avoid adverse mental health consequences. Ash highlighted this potential for injury when recalling the belief that patients "really needed that nicotine, they really needed the tobacco, and if they didn't have it, they could get even more unwell".

The second idea infers that the *patients are too sick to quit*, have other more significant problems, and are unable to quit smoking. The inference is that smoke-free is not an option because it is potentially *harmful* to patients. Patients' attempts to quit smoking and be smoke-free are far less critical than the genuine mental health problems they experience. This idea also infers that tobacco dependency is not a mental health issue which suggests it must be other than mental health and, therefore, perhaps outside the scope of practice for mental health clinical staff. In other words, *it is not our job.*

Recall study Participant Lynore's observation about nursing staff beliefs: "These people are ill. They can't be having to worry about giving up smoking. They've got quite enough to worry about; let them smoke".

The overall message is clear: smoke-free will harm patients. Therefore, it is a problem; a problem to be remedied by continued patient smoking, despite the earlier reviewed published literature that contradicts this stance. In summary:

- the mental and physical health of patients improves when they quit smoking
- patients want to quit and do quit smoking

- nicotine dependency/withdrawal are DSM categories, and smoking is no less critical than other mental health problems
- generally, smoke-free MHIFs do not experience increased aggression when they are smoke-free

Also, as the earlier reviewed literature shows, smoking is associated with high mortality rates among people with mental illness; a converse outcome to the message that smoke-free is harmful.

My findings of the presence of these two ideas—*worsening health* and *too sick to quit*—align with the reviewed overseas and Aotearoa New Zealand literature about beliefs held by staff who worked in psychiatric hospitals and 21st-century MHIFs. Notably, my findings arise in a different context: smoke-free problematisation.

Smoke-free: Detrimental to staff practices

Threat to peace and order

The construction of smoke-free as injurious is patient-centred. In other words, it looks like patients' interests are at heart. However, I suggest that this construction casts a shadow over the staff's interest in continued patient smoking. My findings indicate that the patient injury construction likely reflects staff concerns that patient quit attempts or perhaps being smoke-free would upset the desired peace and maintenance of order in the hospital workplace, a peace secured by patient smoking. Study Participant Sylvia referred to this type of security, that is, *peace by smoking*, in the context of patient volatility in her workplace. Recall she observed that calming patients by smoking was preferable to "someone getting upset and fighting or getting shitty… that a shift was a good shift if it was boring. So, you just went for quiet, anything to keep the peace".

It is plausible that the well-entrenched smoking culture likely meant that the staff *trusted* patient smoking as a reliable tool to achieve an acceptable workplace harmony level. Indeed, Sylvia preferred cigarettes over particular psychotropic medication while other Participants openly discussed cigarette use to calm patients.

Threat to staff smoking

My findings indicate that staff smoking was common among different occupational groups and an accepted indoor and outdoor practice in psychiatric hospitals. Staff smoking also continued in MHIFs, although less so with the gradual introduction of smoke-free policies.

Just as Sam said, patients regarded smoking as a close *friend*. Given the high rates of smoking by nurses who worked in the above types of facilities from 1996 to 2013 (Edwards et al., 2008; Edwards et al., 2018; Hay, 1998), I suggest it likely that nurses and other smoking staff also wished to keep their friend close. In addition, easy access to cigarette smoking would alleviate nicotine withdrawal and, as Lynore and Ash noted, satisfy the belief that smoking helped relax staff who had stressful jobs.

It is reasonable to consider that the staff regarded avoiding these threats as crucial for the hospital wards' smooth running and staff wellbeing. Thus, it is not surprising that they would resist and problematise smoke-free.

Problematising smoke-free

My findings indicate that some MHIF staff problematised smoke-free through different kinds of talk and actions that undermined and promoted fear about smoke-free. Three examples are pertinent to this discussion.

6.3.2 Actions

Resistance: Specialist brief intervention and cessation training

The earlier reviewed literature indicated that in 2009, the Ministry of Health published a smoking cessation framework and programme to integrate a smoking cessation approach into clinical staff daily practice. Later that year, the Minister of Health introduced smoking health targets for the DHBs. Hayden explained the evidence base for using brief interventions.

My findings, however, indicate that the provision of brief intervention and cessation training received a mixed reception from some MHIF staff. Management gave it a low priority, and there was staff disinterest and strong resistance to the training. Recall Jo, who commented,

> It was hard to rally staff interest… staff all leapt at me …there was no time to do what you see as your core role, much less anything else… and they all, even the medical registrars… kept saying give us funding to do it.

Study Participant David thought that his colleagues had probably not attended training because they lacked interest in smoking cessation training. A somewhat exasperated Sam recounted that staff were continuously called away from the training sessions to go back to work.

Resistance comes in many forms. The training resistance package involves the following summary points:

- non-prioritisation of brief intervention/cessation training
- lack of interest in the training subject
- non- attendance at training
- cessation training not deemed core work
- cessation training regarded as additional and possibly doable for an extra payment

I submit that these forms of resistance problematised cessation training by devaluing and delegitimatising the training; thus, undermining smoke-free initiatives. Furthermore, it seems the staff involved did not perceive patient cessation training as core specialist mental health training. Therefore, why would busy clinical staff bother to attend?

Significant to clinical practice, I suggest that this resistance likely meant that some staff were deficient in knowledge and skills about managing and treating tobacco dependency. As a result, patients probably received minimal support for smoking cessation, and this set of circumstances has been reported in overseas MHIFs (Royal College of Physicians & Royal College of Psychiatrists, 2013). Thus, it is little wonder that both Lee and David expressed concern about the under-treatment of nicotine-addicted patients with NRT, and Lynore about staff withholding and supplying cigarettes to patients based on times determined by staff rather than responding to patient withdrawal symptoms. Not relieving drug withdrawal is unprofessional and, I suggest, cruel.

Resistance: Determined efforts to keep smoking alive

My findings show that some staff, faced with restrictions on outdoor smoking sites, employed enterprising efforts to keep smoking alive. Examples are listed in the summary points below:

- smoking in bushes on council land
- smoking on private property
- smoking on the street outside the MHIF
- smoking at the main entrance to the hospital
- insisting that a hospital road is a public place and, therefore, a smoking site
- circulating an anti-smoke-free policy petition to patients and staff

The reviewed literature indicates that staff who smoke tend to support and/or encourage patients to smoke (Dwyer et al., 2009; Lawn & Pols, 2005). Each example above, particularly the latter two rather imaginative efforts, suggests that these forms of staff resistance constituted determined efforts to protect and guard smoking and arguably undermine smoke-free. Therefore, it is not surprising that Lynore considered the behaviour of the petitioning staff to undermine the policy.

Weighty forms of protecting and guarding

While securing alternative smoking sites, proclaiming a road is a public place, and not participating in cessation training are ways to guard smoking, I submit that safeguarding based on law, policy, or medical authorisation likely offers greater certainty and legitimacy. My findings indicate the use of these forms of guarding to secure smoke-free exceptions; thus, continued smoking occurred in MHIFs and grounds. Medical authorisation was also reported overseas (Grant et al., 2014).

For my study, I refer to three types of smoke-free exceptions: *formal exceptions, policy exceptions*, and *other exceptions* (See Chapter One, section 1.3.3 Essential Terminology).

Formal exceptions: The law

Formal exceptions refer to smoke-free legislative provisions that suspend the smoke-free workplace general rule and permit smoking for a defined patient class or in DSRs in hospital care institutions. To illustrate, using the 2003 smoke-free legislation provisions,

several DHBs instituted DSRs for patient smoking in MHIFs. I suggest that the existence of DSRs are like 'the icing on the cake' for staff wishing to guard smoking. After all, DSRs are but legal smoking rooms, and the law is the guardian. There is nothing like having the law on your side.

The DSR provisions require the use of a ventilation system. However, given the established evidence that ventilation systems could not remove all cigarette smoke harm, the use of DSRs in a hospital care institution seems an extraordinary decision. After all, if ventilation systems were deemed inadequate for workplaces, why would they be adequate for hospital patients, particularly a vulnerable patient group?

Equally, in my view, the MHC's endorsement of DSRs seems an extraordinary decision given the ventilation evidence. As the Crown entity charged with patient advocacy and stakeholder communication, it is highly likely DHBs relied on its guidance in their decision-making about smoke-free policy exceptions.

By supporting exemptions and establishing DSRs, the MHC and the DHBs, all Crown entities, placed a stake in the ground that indicates their endorsing positions regarding MHIF patient treatment in non-smoke-free environments. I suggest accountability for any subsequent, related patient adverse health outcomes.

Policy exceptions

Policy exceptions refer to smoke-free policies that suspend the smoke-free workplace policy general rule and permit smoking. My findings indicate that DHBs included exceptionalist provisions in smoke-free policies to allow patient smoking in MHIFs and the grounds. I suggest that the presence of the policy exceptions, authorised by DHB governing boards, signified smoking's acceptability and likely added weight and legitimacy to continued smoking. With policy exceptions, the policy is the guardian together with the governing board. For staff wishing to guard smoking, policy exceptions strengthen the case for their position.

Smoke-free policy exceptions offer another form of guarding. They show that exceptions are possible and thus also a possibility in the future. Recall that the Canterbury and Waikato DHBs faced negative media publicity following patient events related to implemented smoke-free policies. Both DHBs reversed their policies and made smoking

provisions. How does this connect to guarding? I suggest that the past existence of exceptions lays a foundation for a more straightforward future return to those exceptions, particularly for pro-smoking decision-makers. In other words, exceptions have future value.

I suggest that DHBs' inclusion of exceptions in smoke-free policies to permit smoking in hospital care institutions also constitutes a stake in the ground, reflecting Board governance endorsement of MHIF patient treatment in a non-smoke-free environment.

Other exceptions

This form of exception includes semi-formal or informal measures used by MHIFs and/or staff to permit patients and/or staff to smoke on or off the facility site or hospital grounds. In my study, Participants reported that smoke-free MHIF instituted new forms of authorised leave, referred to as *community leave* or *smoking leave* or *leave*, which medical staff usually approved. A similar practice to that identified in the early review literature, this leave gave certain patients a specific amount of time, such as 15 or 30 minutes, to be absent from the building, have a cigarette, and return to the facilities. Recall Lynore considered that the community leave was a way around the Canterbury DHB smoke-free policy. Study Participant Jo wondered if psychiatrists had been prescribing smoking leave longer than was known to Jo.

The Participants' comments infer the development of authorised leave was surreptitious rather than the result of openly developed and sanctioned clinical, organisational initiatives. Indeed, the leave enabled continued smoking, contrary to the organisation's publicly stated smoke-free stance. While my study Participants did not directly comment about the Ministry of Health's role regarding authorised leave, some commented about the need for more Ministry leadership. It is feasible that Ministry officials were aware of authorised leave.

Medical practitioner decisions to approve smoking leave seem extraordinary in the context of the established evidence of harm from smoking and smoke exposure. Furthermore, prescribing leave for patients smoking a known lethal substance is also inconsistent with the professional practice guidance from the Royal College of Physicians & Royal College of Psychiatrists (2013).

In the absence of contrary evidence, these forms of leave likely constituted patient management tools authorised at the discretion of psychiatrists. Put differently, approved leave enabled continued patient smoking and were a staffing mechanism to protect and guard smoking. Therefore, I suggest that medical approval added weight and legitimacy to this form of exception protection.

Exception protection, or guarding and protecting smoking, has occurred in various forms in MHIFs and been endorsed by the actions of Crown entities such as the MHC and the DHBs. State involvement with guarding and protecting smoking also occurred in the 20th-century. I discuss the implication of these activities in the next section.

6.4 Pointer 3: State-sanctioned smoking

This pointer about state-sanctioned smoking primarily draws on the findings from the six themes 'sites of smoking', 'keeping the peace', 'guarding', 'policy perspectives', 'doing the acceptable', and 'knowing the best' in Chapter 5, Building Blocks of Exception (See Figure 5.1).

When the state purchases, supplies, and controls tobacco and cigarette distribution to patients in hospital care institutions, it is reasonable to assume that it sanctions smoking. In other words, the *state permits and supports smoking*. It is also fair to assume that the state considers smoking offers patient health and wellbeing benefits. Otherwise, it is likely to be condemned for its inappropriate use of taxpayer money and perhaps held to account for any subsequent adverse patient health outcomes.

The reviewed archival material, DHB smoke-free policies, and my findings indicate that since the 1930s, the state has sanctioned patient smoking and, to a lesser extent, staff smoking in psychiatric hospitals, MHIFs, and grounds. At first glance, smoking sanctioning or endorsement measures seem limited to schemes giving free tobacco supplies to eligible patients. However, in my view, there have been a substantial number of endorsement measures. The extent and type of measures are illustrated best by drawing them together in the following overview and then moving to my discussion.

6.4.1 Overview of sanctioning measures

Department of Health sanctioning schemes

Between 1930 and 1970, the Department of Health established several schemes to provide free tobacco to eligible patients.

1930s: tobacco for work – male patients, based on their work capacity, received different sized tobacco plugs

1947: patient comfort fund – eligible patients received funds for comforts, including tobacco

1950s: better tobacco cuts – patients received easier to smoke tobacco designed to improve the smoking experience

1970s: a gratuity replaced the patient comfort fund. The gratuity was sufficient to enable patient choice and selection of their tobacco brands.

The above schemes confirm that patient smoking occurred at psychiatric hospitals from the 1930s to 1970s. My study Participants indicated that these hospitals permitted indoor and outdoor smoking by patients and staff during the latter part of the 20th-century. District Health Board smoke-free policies and my findings show similar practices occurred at DHB MHIFs.

Statutory sanctioning

Parliament's endorsement of patient smoking has occurred on three occasions. Since 1990, the legislature has approved hospital-based exemptions to the general smoke-free rule in the smoke-free legislation.

Smoke-free Environments Act 1990 permitted immobile patients to smoke in hospitals.

Smoke-free Environments Amendment Act 2003 permitted hospital care institutions to provide DSRs subject to specific provisions.

Smoke-free Environments and Regulated Products (Vaping) Amendment Act 1990 permits hospital care institutions to provide designated rooms for smoking and for vaping subject to specific provisions.

Ministry of Health and DSRs

Recall Jo's reference to "that 2008 letter to DHBs from the Ministry"? Jo's comments infer that the Ministry of Health was aware of DSR use by DHBs. Evidence of the Ministry's awareness of DSR use is in its publicly available 2018 FCTC report, which notes a partial smoke-free policy exception for mental health institutions allowing them to use DSRs (Ministry of Health, 2018).

DHB smoke-free policy exceptions

Most DHB smoke-free policies initially included exception provisions to allow patient and staff smoking in designated areas. However, staff smoking ceased to be endorsed over time, while exemptions allowed patient smoking in MHIFs. Commenting in 2018 about his observations of smoke-free policy practice in various MHIFs, Murray noted that the degree of practice variation ranged from totally smoke-free to courtyard smoking areas and free access to tobacco at any time.

MHIF sanctioning arrangements

In my study, Participants identified several MHIF arrangements that endorsed smoking. These include the purchase and supply of tobacco and cigarettes to patients and the use of medically authorised leave for patient smoking.

Staff enabling/opposing policy

Individual DHB employees also endorsed smoking. My study Participants recounted a range of examples that enabled and supported patient smoking and opposed the smoke-free policies. Enabling smoking in the presence of a smoking ban was also identified in the HDC (n.d.) report.

Traversing the implications

The above illustrations involve state institutions and/or state employees. For me, the following assumptions arise regarding these illustrations:

- smoking sanctioning signals *support* for patient smoking
- smoking sanctioning has likely *normalised* and *perpetuated normalised* patient smoking

- smoking sanctioning disregards the established *evidence* of smoking's adverse effects on patients' physical and mental health and wellbeing
- the State is *accountable* for adverse health outcomes related to patient care in non-smoke-free hospital care institutions

My discussion considers the first three assumptions and explores how they are evident in the various smoking sanctioning forms. I discuss the fourth assumption in the next section.

Department of Health schemes

Historical architecture

In my view, the Department of Health's free tobacco supply to eligible patients is significant for several reasons. First, arguably these schemes formed the architecture to support consecutive decades of normalised patient smoking and the subsequent weaving of smoking endorsements at, what seems like, almost every turn.

However, context is important. The reviewed literature indicates that little information existed about smoking's adverse health effects before the 1950s. Thus, knowledge of smoking adverse health effects was absent when the Department of Health made its tobacco purchase and supply decisions. How might we understand these decisions? I suggest these schemes reflected the increasing normalised smoking in the broader society and likely supported nicotine-addicted patients who had served in World War 1 and 2. Put differently, the Department of Health normalised a widely accepted practice in a hospital setting. Why would they do otherwise at that time in the history of tobacco control knowledge?

The schemes, however, have two notable features that I contend have had an enduring effect on patient smoking in hospital care institutions.

Transaction tool: Normalisation

At first glance, the scheme that gave tobacco plugs to male patients based on their work capacity looks like a simple reward for work arrangement. However, I suggest that the scheme's transactional nature likely established tobacco as a valuable currency for patients and staff and perhaps *normalised* tobacco use in this way. Indeed, study

Participants talked of cigarettes to reward, manage, and control patient behaviour; a theme also reflected in the published literature.

Entwining: Smoking, stress relief, and patients

Regarding the 1947 Patient Comfort Fund, the Department of Health instituted a psychiatric hospital scheme for eligible patients to receive designated comfort items, including cigarettes. This fund was to support patients with some form of comfort. So the fund title tells us.

I submit that including cigarettes in a *comforting fund* is likely no coincidence. First, the reviewed literature indicates that tobacco advertising promoted smoking as stress-relieving and comforting during previous decades. Thus, the smoking and comfort link was well known. Second, by the late 1940s, it is likely that patients and smoking were sufficiently entwined that cigarettes were an unquestioned choice for the Department of Health; sufficiently unquestioned to form part of a comfort package along with food and clothing. I submit this decision affirmed patient smoking in psychiatric hospitals and probably paved the way for continued *normalised* patient smoking into the second half of the 20th-century.

Colours nailed to the mast

Turning to the 1950s, the Department of Health purchased better tobacco cuts for patients. However, the tobacco was packaged and branded *NZG*, short for New Zealand Government. These initials represent a powerful, explicit, and symbolic state *sanctioning* patient smoking. Put differently; the Government nailed its colours to the mast. I suggest the Government would not permit those initials on the tobacco if it did not endorse its use.

1970s: Personal patient choice

The patient comfort fund review occurred when there was increasing denormalisation of smoking in Aotearoa New Zealand, and accepted evidence of smoking's adverse health effects. Although the review identified administrative and patient issues related to tobacco, the replacement scheme involved a patient gratuity sufficiently funded to allow patients to choose their commercial tobacco brands. Recall that the then Minister of Health confirmed patient cigarette choice, and the Government appointed Oakley

Inquiry Committee supported the new gratuity. Thus, it seems the *evidence* of smoking harm did not prevail. Nevertheless, patient smoking continued to be state-sanctioned and normalised, albeit the Department of Health removed itself from its previous tobacco purchase and supply arrangements.

Permitted environment use

Psychiatric hospitals and DHBs have allowed patients and staff to smoke inside the buildings and on the grounds. In my view, acceptance of smoking on their properties highlights smoking sanctioning and smoking normalisation in these settings. While evidence of harm has likely constrained smoking in DHB MHIFs, the presence of continued smoking, reported by Murray in 2018 and referenced in a DHB smoke-free policy, suggest the *evidence* of smoking's adverse effects on physical and mental health does not prevail.

Parliament speaks

Aotearoa New Zealand's smoke-free legislation established smoke-free workplaces to protect people from SHS harm. However, I submit that the Parliament decisions of 1990, 2003, and 2020 to include the exceptional space of designated rooms for patient smoking speak to Parliamentary patient smoking endorsement. Furthermore, I suggest that these endorsements have set the direction for the continued normalisation of smoking initially in psychiatric hospitals and then MHIFs.

Perhaps that sounds like a harsh submission?

The Parliaments' decisions puzzle me in the context of the evidence of the adverse health effects of smoking and SHS. Judy and Steve, former Members of Parliament, talked about the Select Committee processes and information obtained from submissions and Department of Health and the Ministry of Health officials in 1990 and 2003.

By 1990 and 2003, the adverse health effects of smoking and SHS were published and accepted. Ironically, the legislative purpose was to protect people from SHS exposure; yet, that health-promoting purpose was not fitting for all patients. Hark back to 2003 and Dr Scott's comments that she promoted DSRs for specific residential settings and

noted that some people are desperate for and deserving of a smoke. Steve also noted smoker desperation for patients in acute mental health settings.

Thus, some mental health inpatients have been treated differently in law and not provided care in a smoke-free environment. For example, in 1990, Parliament said that immobile patients, unable to be moved, were permitted to smoke in the wards. In 2003, Parliament declared that hospital care institutions, such as DHBs, were allowed DSRs for patient smoking and DHBs chose to implement these rooms in MHIFs. Yet, there was no statutory requirement to do so and notably none to prevent DSR dis-establishment.

In 2020, Parliament supported the continuation of DSRs in hospital care institutions. Unfortunately, this decision contradicts the reviewed literature that suggests greater effectiveness of smoke-free mental health facilities and mental health improvement when patients quit smoking.

I contend that the lawmakers of the land, unwittingly or otherwise, planted a seed of normalised, non-evidence-based patient smoking that continues to germinate.

Ministry of Health and DSR

The Crown's knowledge of DSRs is established and documented in Aotearoa New Zealand's 2018 FCTC report. Prepared by the Ministry of Health, the report is the country's official response on FCTC progress, including establishing comprehensive smoke-free environments. In addition, this report references the relevant legislation, notes that partial smoke-free exceptions can be used, and names *mental health institutions* as the type of institution for the location of DSRs.

The inclusion of the relevant legislation indicates that this exception is not just any exceptional space for smoking. It is a formal exception established by the legislature, and it is an exception known to the Ministry, which administers that legislation. In my view, given the study Participant comments about continued smoking in MHIFs and the absence of Ministry of Health published reports about mental health and smoking, it is reasonable to infer that the Ministry of Health errs on the side of continued patient smoking in MHIFs, at this time. Indeed, in April 2021, the Minister of Health released a discussion document that seeks feedback about proposals to achieve SF 2025 (Ministry

of Health, 2021). Tellingly, this document is silent about prioritising mental health and smoking, a silence that arguably condones normalised mental health inpatient smoking.

DHBs: Exceptional spaces

Parliament's 2003 smoke-free legislation permitted the use of DSRs. This decision entitled DHBs to provide DSRs for smoking patients and reflect this exceptional space in their smoke-free policies.

What is the problem?

The views of my study Participants who worked in DHBs and the literature converge: all patients are entitled to care in a smoke-free environment. To do otherwise is to perpetuate normalised patient smoking and ignore the evidence (Glover et al., 2014; Prochaska, 2011; Royal College of Physicians & Royal College of Psychiatrists, 2013).

Yet, despite evidence about the adverse effects of smoking on physical health, DHBs implemented DSRs post-2003. Was this simply a case of taking the easy decision? Was implementing smoking cessation in the too hard basket? Call to mind Hayden's comments that brief intervention implementation began in general hospitals, that MHIFs were considered but regarded as "a hard one", and that "the large resistance has always been in mental health settings so you naturally wouldn't go and tackle the hardest ones first".

In addition, the MHC provided its blessing for DSRs, and normalised patient smoking and pro-patient smoking beliefs and practices prevailed in MHIFs. Perhaps these factors over-rode the evidence about the adverse effects of smoking on patients' physical health. However, that would be an extraordinary clinical decision because patients are like other smokers and at risk of cancers, cardiovascular diseases, and respiratory disease. Perhaps the adverse smoking effects on physical health were not on the clinical radar. Indeed, the published literature indicates the clinical neglect of physical health for mental health patients (Te Pou, 2020a, 2020b; Te Pou o te Whakaaro Nui, 2017).

What about published evidence of smoking harm to mental health? The research by Taylor et al. (2014) provides helpful guidance to practitioners. However, smoking in MHIFs invites the conclusion that staff and management disregard this research.

MHIF sanctioning arrangements

In their discussions about MHIFs and smoking, some of my study Participants discussed *localised arrangements* that endorsed and normalised patient smoking. Cast back to study Participant Ash's recollection of using hospital money to purchase tobacco for certain patients, the petty cash to buy patient cigarettes, psychiatric assistants buying cigarettes for patients; and David's musing about cigarette supplies magical appearance for patients.

In my view, whether through petty cash or purchase order, the use of public hospital money to buy patients tobacco and cigarettes is a particularly significant form of smoking sanctioning. Why? Because the money is taxpayer money and expenditure comes with internal budget accountability and external accountability to the public. While authorisation for this type of expenditure likely occurred at a relatively senior DHB level, I suggest that the practice has largely flown under the radar of DHB governance and executive management and the Minister of Health. I muse how the Minister of Health or the Director-General of Health would deal with newspaper headlines such as "Mental health inpatient facilities use taxpayers' money to buy inpatients cigarettes despite Government commitment to SF 2025".

Purchasing and supplying tobacco to patients has other implications. It blatantly disregards the evidence of smoking harm. Second, it perpetuates the belief that patients need to smoke, promoting the stereotype that mental health inpatients and smoking belong together like horses and carriages.

I submit that this form of smoking sanctioning also mirrors nicotine-dependent smokers' behaviour: supplies must be at hand so that patients who smoke do not run out of them. Could it be that the MHIFs are addicted to addiction?

As discussed in Pointer 2, several study Participants spoke of MHIF medically authorised leave to support patient smoking. I suggest this is a form of smoking sanctioning that perpetuates patient smoking normalisation, maintains staff dependency on cigarettes as a behaviour management tool, and significantly undermined the role of staff employed to implement smoke-free policies. As Lynore lamented, when you have managers and possibly senior management "not entirely believing in the smoke-free policy, you're really pushing it uphill".

Staff enabling

Several study Participants conveyed examples of individual staff actions that I suggest are smoking sanctioning. Examples include staff rolling and lighting patient cigarettes, holding and distributing patient cigarettes, and smoking on site. In another form of smoking sanctioning, some staff openly opposed smoke-free policies. For example, Lynore's accounts of staff members who raised the anti-smoke-free policy petition and the staff member who readily accepted a patient payment for a cigarette.

Usually, disciplinary action follows when employees breach organisation policies. Reflecting on Participant comments and the absence of media publicity about DHB staff breaching smoke-free policies, I suggest that employee smoke-free policy breaches have been 'treated with kid-gloves'. No study Participant indicated that policy breaches or opposition resulted in severe disciplinary consequences. Lynore noted that the policy petitioning staff received a 'talking'. What has inhibited more disciplinary severe consequences? Perhaps the disciplinary action reflects an institutional position that smoke-free policies are not to be taken seriously. I think it is more likely that employers would have taken stringent action if staff drank alcohol on-site with patients. Patient smoking continues to be normalised.

State-sanctioned smoking presents in various forms: some obvious, some less obvious. Nonetheless, the effect normalises and supports patient smoking and generally reflects an institutional and individual employee disregard for the published evidence of smoking and SHS harm.

What might smoking sanctioning and its effects tell us about leadership in Parliament, the Ministry of Health, DHBs, MHIFs, and the tobacco control sector? I discuss leadership in my next section.

6.5 Pointer 4: Without leadership

This pointer about the absence of leadership primarily draws on the findings from the 'sites of exception', 'doing the acceptable', and 'policy perspectives' themes in Chapter 5 (See Figure 5.1.)

The reviewed published literature emphasises the importance of smoke-free environments, highlights that no smoke is safe, and states that all healthcare settings for patients be smoke-free, not partially smoke-free. Recall Hayden, a medical doctor with clinical and research experience in smoking cessation? When asked if there was any good reason to support patient smoking, he looked surprised and said, “No… I am surprised, I just can’t think why you would do that”.

Central is the FCTC principle of protection from the harms of smoking and cigarette smoke exposure which aligns with the ICESR right to enjoy the highest attainable standard of health and the implementation of all measures to achieve this principle and the right to health. Given Aotearoa New Zealand’s ratification of these treaties, it is reasonable to assume state institution public health leaders would endorse and implement this principle and the right.

What can we say about the state institutions’ health leadership that effectively sanctions patient smoking?

Parliament speaks

I begin with Parliament, the supreme law-making body in Aotearoa New Zealand. It seems plausible that Parliament’s 1990 decision to allow smoking by immobile patients and its 2003 decision to permit exceptional spaces of DSRs in hospital care institutions reflected the well-established but misinformed belief that smoking relieves stress for patients who are desperate to smoke. Indeed, both Steve’s comments and those of MP Dr Scott reported in the New Zealand Parliamentary Debates refer to this belief.

However, by 1990 and 2003, the accepted published evidence demonstrated adverse physical health effects of smokers’ smoking and smoke exposure. I am unaware of accepted evidence that patients were immune to those effects. By 2020, the accepted published evidence included the adverse impact of smoking on mental health and the mental health benefits of quitting (Taylor et al., 2014).

Thus, I submit that Parliament’s consecutive decisions left open the door for patient smoking, legalised patient mental health treatment in non-smoke-free health hospital care institutions and enabled different treatment of an already vulnerable patient group.

This permissive legislation has implications. So long as the law permits hospital care institutions to provide designated rooms for smoking, there remains a legitimate basis for their use by DHBs. Indeed, the Ministry of Health and the DHBs can say Parliament has spoken and, in this way, distance themselves from pursuing comprehensive smoke-free policies.

I do not consider that Parliaments' decisions reflect leadership of the type consistent with securing smoke-free environments. With his considerable NGO and experience in tobacco control research, study Participant Robert said, "a hospital is… a public place, that [smoking] would be, I expect, banned by the Smoke-free Environments Act". He described the legislative provision for indoor smoking areas as "very backward" and observed "that it seems to be a curious situation". Robert added, "if there's going to be a Smoke-free Environments amendment next year, they might want to look at that as well".

The Government: Wriggle room

As discussed in the literature review, Aotearoa New Zealand is unlikely to achieve the SF 2025 goal without significant tobacco control interventions. Further, in mid-2021, there is no current published Government plan of commitment to achieve this goal, and there is a consultation document only (Ministry of Health, 2021).

Several Participants expressed concerns about the lack of progress towards this goal. For example, Ben considered smoking the single biggest preventable cause of premature disease. He spoke about a diluting focus and policy tinkering, limited Government appetite, and the use of significant funding for smoking cessation when that strategy alone would not achieve the goal. Hayden indicated the need for a product change, such as nicotine content reduction. Robert emphasised that the Government needed to get in behind the smoke-free legislation and SF 2025, including providing more funding to the Health Promotion Agency specifically for tobacco control initiatives. Participants also talked about vaping as a possible measure to help achieve the smoke-free goal and support quitting.

Addressing these concerns lies with Government.

Although the Ministry of Health is consulting about proposals to achieve SF 2025, it seems incomprehensible that there is no current Government plan of commitment to achieve the SF 2025 goal at the time of writing. Arguably, when a government is committed to a public health goal, a plan of action and resourcing mirror the commitment. As a contemporary example, in Aotearoa New Zealand we have seen action and resources with the Government's COVID-19 response.

The recent 2020 legislation provides for vaping rooms in hospital care institutions. However, in my view, successive governments' delay in producing a loud and proud comprehensive plan to achieve SF 2025 does not reflect leadership of the type consistent with securing smoke-free environments. Judy's political insights about SF 2025 are poignant. She said,

> "I see it as an aspirational thing, and I think good on them for having it, and it's good to see National and Labour aiming at the same sort of stuff in a way, like good health… it's a target that is praiseworthy, but I get nervous about targets that are just sort of zilch".

Treating SF 2025 as an *aspirational goal* inevitably allows wriggle room and commitment at the decision-makers' whim.

The Ministry of Health: Arm's length

As the Government Ministry leading the Aotearoa New Zealand's public health and disability system, the Ministry of Health (Ministry) has overall responsibility for managing this system, advising the Minister of Health on relevant issues, and steering improvements to promote and protect people's health. This Ministry is responsible for the smoke-free legislation, is the Government's principal advisor on tobacco policy and legislation, and employs a tobacco control team. As Jo indicated, the Ministry also has a Mental Health Directorate (MHD).

Reflecting on smoke-free barriers, Jo considered there needed to be a stronger approach through the Ministry to the MHD. Jo commented that "Ministry actually needs to provide some proactive leadership in terms of mental health and smoke-free" as that would likely have more influence on psychiatrists, managers, and staff than the health-promoting work of smoke-free staff.

Jo's comments are significant. In my view, they reflect the observation that *something was missing* in the leadership; precisely, that the Ministry needed to show firm and visible collaborative leadership in both the tobacco control team and the MHD to deter smoking sanctioning by MHIFs and staff. Indeed, as Lynore indicates, it is demoralising to see your health-promoting work disregarded by senior staff actions. In this context, it is not surprising that DHB staff would perceive a lack of Ministry leadership; however, as Robert noted, NCDs and mental health have only recently come together. Health and wellbeing are about the whole person. So, arguably, it behoves Ministry teams to work together in the patient's interest.

Providing a different perspective, Murray suggested that Ministry's relevance was not apparent, and it needed to provide role clarity and direction. Expressly, he indicated that the Ministry needed to provide an information clearinghouse function to avoid DHBs rework.

Jo referred to two letters from the Ministry to the DHBs. She indicates that the 2008 letter approved the use of DSRs, while the 2012 letter *encouraged* DHBs to be smoke-free throughout their services. However, several Participants stated there was a presence of patient smoking up to 2018. While acknowledging the DHBs were permitted to use DSRs in both 2008 and 2012, I contend that Ministry leadership expressly requires a visible and public stake in the ground regarding the published evidence of smoking harm for mental health inpatients. Furthermore, a letter described as *encouraging smoke-free* is, in my opinion, likely treading with *jurisdictional care*, mindful that DSR use, and non-use are DHB decisions.

Thus, we should not be surprised about continued smoking.

In my view, pussyfooting around the use of DSRs, given the evidence of cigarette smoke harm, does not reflect a senior leadership firmly intent on securing smoke-free environments in hospital care settings. In contrast, providing a clearinghouse function would reflect leadership.

District Health Boards and Mental Health Inpatient Facilities

Designated rooms for smoking

To recap, since the 2003 smoke-free legislation, DHBs have been allowed to establish DSRs for patients subject to room ventilation and other requirements. Despite published evidence of smoke and SHS harm and ventilation inadequacy, MHIFs have been a site of choice to locate these rooms.

For me, the DHB decisions to establish DSRs are striking. Why? First, DSRs do not achieve patient smoke protection, and they promote normalised smoking. Second, DSRs are discretionary. Third, there is no legal requirement for their establishment, raising the rationale for their use.

I struggle to make sense of the DHB decisions, and I do not consider that they reflect senior health leadership consistent with securing smoke-free hospital care environments. Further, the use of DSRs is contrary to the title of the DHB policies, commonly called *smoke-free policies*. They are not smoke-free. They are partial smoke-free policies and warrant using this terminology until sanctioned smoking ceases. As David noted, you cannot be a bit smoke-free.

Smoking status data

DHBs have captured MHIF smoking status data for 10 to 12 years. Acknowledging that the data capture were for Ministry of Health target reporting, I could not locate published, and detailed DHB reports about mental health and smoking status. The absence of reports is troubling because DHB leadership surely involves more than supplying data to the Ministry to satisfy the Minister of Health's targets. As regional health providers, surely DHBs would be interested in publishing and using an important data set for mental health inpatient and service improvements? Data of value and significance gets attention. When data are invisible, what can we make of that? Perhaps it does not count.

Policy vulnerability

District Health Board smoke-free policies are vulnerable to the whims of decision-makers. Both Waikato and Canterbury DHBs reinstated smoking following incidents involving a patient smoking and patients not smoking, respectively. Notably, the

decision-makers concluded that the smoke-free policy was the problem source and the remedial action necessitated patient smoking. Policy reviews are an essential part of incident reviews. However, I suggest that normalised patient smoking history means DHB tobacco control leadership faces smoking guarding challenges. Where DHB leadership supports normalised smoking, I suggest that smoke-free policies are easy targets from which decision-makers can act in a whim-like manner and announce an *instant solution* to the incident: reinstate patient smoking.

Ignoring policy

Several study Participants identified examples of staff *thumbing their noses* at the DHB smoke-free policy. However, Participants also observed that there were minimal or no disciplinary consequences.

It is as though disciplinary action has been seen a step too far or somehow not warranted for a 'minor matter' like smoking. In my view, tobacco control leadership is apparent when leaders demonstrate a visible commitment to a smoke-free environment. Such commitment includes role modelling that policy breaches are unacceptable and offering cessation support for smoking staff. Silence about policy breaches does not show leadership consistent with smoke-free policy commitment.

Turning to successful leadership, my study Participants identified various leadership characteristics associated with successful smoke-free initiatives. These characteristics are like those in the reviewed published literature. These include the following summary points:

- existence of a comprehensive smoke-free position for hospital care institutions (no exceptions)
- staff implementation discussions to allow participation and time to secure organisational support
- leaders who are smoke-free
- visible commitment to the organisation's smoke-free stance
- visible commitment to smoke-free patients in mental health
- adherence to a smoke-free organisation by all leadership levels
- visible clinical smoke-free leadership and champions
- staff orientation that includes NRT and cessation supporting training

Study Participants also listed the following successful leadership characteristics regarding smoke-free legislation:

- the need for political activism
- recognition that changes involve top-down and bottom-up strategies
- awareness that public health change is a long-term game–take the public with you
- ability to deal with SF opposition and personal attacks

I suggest that awareness of successful leadership characteristics that likely secure smoke-free environments is one thing, but the Participants reported experiences inconsistent with such leadership. Participants identified various examples that they stated or inferred the absence of tobacco control leadership.

Leadership in relevant institutions has not provided smoke-free hospital care environments for all patients in MHIFs. My findings indicate that these practices have a historical context. Moreover, they likely have implications for adverse patient health outcomes from smoking and smoke exposure, suggesting state accountability for these outcomes. The state's role invites examination through a substantive equality lens that considers the impact of permissive legislation for patients in MHIFs. I suggest amendment of section 6 of the Smoke-free Environment and Regulated Products Act 1990 to prohibit smoking in health care institutions. I discuss this amendment in my recommendations.

The previous discussion in pointers 1 to 4 allows me to draw the following conclusions:

- cigarette smoking has been normalised outdoors and to a lesser extent indoors in MHIFs
- pro-smoking staff have employed a range of measures in response to the perceived threat of smoke-free policy initiatives in MHIFs
- the State has implemented measures that effectively supported and sanctioned patient smoking in MHIFs
- there has been an absence of visible Ministry of Health and DHB leadership, publications, and smoking status data regarding patient smoking in MHIFs

I suggest that these combined circumstances are likely to have implications for the value of life for patients and staff in exceptional spaces and for SF 2025. The following section examines these implications using Agamben's state of exception framework.

6.6 Pointer 5: Value of life in exceptional spaces

Discussion of my findings regarding the value of life for patients and staff in the exceptional spaces for smoking draws on Agamben's state of exception together with findings from pointers 1 to 4 and the reviewed literature. I begin by discussing the role of the Aotearoa New Zealand legislature and exceptional spaces for smoking. I follow this by assessing the proposition that these exceptional spaces were perceived as a 'balancing solution'. I then examine the extent to which the state of exception assists with understanding the rationale for exceptional spaces for smoking in MHIFs and the implications of these spaces for patients, staff, and SF 2025.

6.6.1 Agamben's state of exception: Application to exceptional spaces of smoking in mental health inpatient facilities

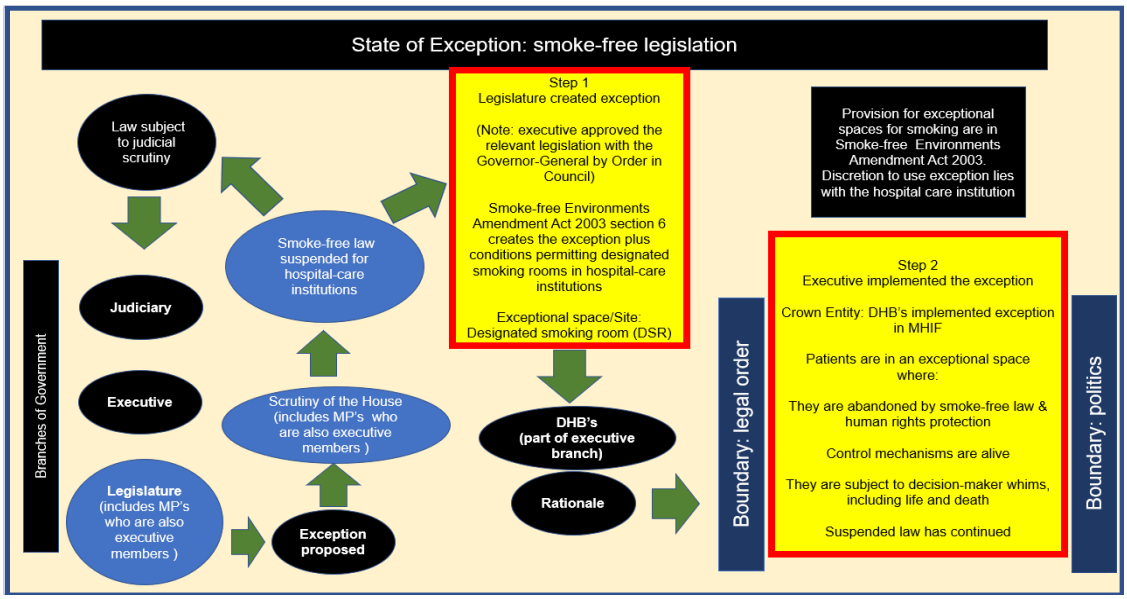
Exceptional spaces and the legislature

In a cataclysmic emergency or disaster, the executive government branch or the decision-maker is central to the state of exception process, declaring the state of emergency in response to the crisis event and deciding the state of exception, which suspends or diminishes the usual laws and protections available to citizens.

Of significance, the executive's actions usurp the intended law-making function of the legislative government branch and increase executive power, an unmediated power and without the usual constraints of checks and balance, including those regarding law-making and its application. However, my study reveals that the exceptional spaces for DSRs in DHBs involved two steps that involved the legislature and the executive. These steps are outlined in Figure 6.2.

Figure 6.2

State of exception: Two-step smoke-free exceptional spaces process



In the first step, the legislature, which in Aotearoa New Zealand includes MPs who are also executive members, decided the exception. In the second step, the DHBs, which are Crown entities and part of the executive, implemented the exception.

I make the following observations. Although the then Labour Government was concerned about the harm of smoking and SHS, the legislature's 2003 exception decision did not respond to a declared or presumed state of public health emergency. This raises questions about the rationale for the exception.

In this case, the legislature carried out its law-making role: nothing unusual and no extension of powers. However, *doing your job* might have unintended consequences. In this regard, I submit that the legislature turned the key and opened the door of exception for the DHBs to enter and allow patient smoking. Thus, there would be no exceptional spaces in the form of DSRs without opening that door and no 'legal' patient smoking or 'legal' patient smoke exposure and associated harms in those sites of exception.

To the best of my knowledge, exceptionalist smoke-free law has received little attention in Aotearoa New Zealand. Given the legislature's role, it is possible that the statutory provision for DSRs has been perceived as legitimate and thus flown under the radar of public health, mental health, and tobacco control scrutiny. There appears, however, to

be no formal check on the executive powers associated with DSR implementation; section 6 does not include a review date or an evaluation process. The exception has the appearance of permanent law.

Exceptional spaces: Balancing solution?

Exceptional spaces of smoking rooms in hospitals and MHIFs could be perceived as a solution to balancing the following three considerations:

- the evidence of harm from smoking and smoke harm
- the liberal need to limit state interference in the private sphere
- the medical priority of protecting patient interests

Evidence: My study findings showed that although by 2003 there was a widely accepted body of evidence about the harms of smoking and exposure to SHS, this evidence was disregarded in MHIFs, where smoking was a normalised and embedded activity in the first decade of the 21st-century. In my view, it seems most unlikely that the evidence of harm regarding patients who smoke was a paramount consideration by the legislature regarding exception spaces of smoking rooms in hospitals and MHIFs.

Importantly, however, I suggest that the creation of exceptional spaces addressed the evidence of harm for non-smokers. To illustrate, specific rooms were designated for patient smoking only, and SHS was not allowed to escape from these rooms. These measures meant that the harm from SHS and smoking was confined to a defined and internal space, thus protecting patients and staff outside the exceptional spaces.

Home-like: The reviewed literature in my study confirmed the presence of strong and widely held staff beliefs that MHIFs are regarded as a private sphere or home for some patients; and therefore, patients ought to be allowed to smoke in the MHIF. My study findings indicated that the Health Committee identified areas where people could or could not smoke. This was based on what was defined as a workplace and a home; for example, whether a place was a private citizen's home or a temporary residence.

Study Participant and former MP Judy recalled a Health Committee conversation about the definition of a home and that hospital was home for the patients. She also recalled advice from the Ministry that the Health Committee "would have to allow a little bit of

flexibility because we were working with people who had to kind of make it work" (See p. 195). Judy referred to a submission from MHPs who wanted the legislation to cover all workplaces, contending that smoking rooms encouraged smoking. Study Participant and former MP Steve indicated that acute mental health facilities were 'difficult', but she believed that the patients were desperate to have a place to smoke. She concluded that the greater good was to achieve smoke-free workplaces and schools. Dealing with MHIFs would follow. Health Committee member Dr Scott, MP, said she promoted the DSRs and referred to smokers' desperation to smoke and patient immobility.

In my view, the MPs' comments indicate their views that MHIFs were home-like, and their beliefs about mental health patients' 'need to smoke' were probably influential in the decision regarding exceptional spaces of smoking rooms in hospitals and MHIFs.

Patient protection: The present study found that MHIF staff held polarised views about what constituted patient interests and the protection of those interests. My study Participants and the reviewed literature revealed that some staff believed MHIF patients needed to smoke and were entitled to smoke in MHIFs. Other staff held beliefs that MHIF patients required protection from the harms of smoking and SHS. However, reflecting on the normalised and embedded place of smoking in MHIFs, it seems likely that in 2003, the medical priority was to protect patients' need to smoke, a factor consistent with the views expressed by the above MPs.

Drawing together the above discussion about the three considerations, it is reasonable to consider that the legislature's decision regarding exceptional spaces of smoking rooms in hospitals and MHIFs reflected balancing the above three issues. But were these considerations sufficient to create exceptional spaces given the 2003 Labour Government public commitment to reducing harm from exposure to SHS and smoking, strengthening the smoke-free legislation and increasing the number of smoke-free workplaces? Prima facie, if a government was seriously committed to smoke-free workplaces and stronger smoke-free legislation, it would not exempt hospitals from smoke-free protections. Yet, exemptions occurred.

Reflecting on the above discussion, I contend that three considerations were insufficient to create exceptional spaces. The more likely tipping point for the legislature's decision

about exceptional spaces for smoking was a significant and security-related consideration.

Exceptional spaces: Risk control and security in mental health inpatient facilities

Drawing on Agamben's theorising, the state of exception has become the customary government tool enabling the law to claim power over life through the suspension of laws resulting in the limitation of usual rights and freedoms. Put differently, the state of exception excludes people from the general rule but retains control over those people through their inclusion in the exceptional rule. The idea that the state of exception is a tool to control populations has resonance with my study findings and the reviewed literature.

In line with previous overseas and Aotearoa New Zealand literature (Connolly et al., 2013; Glover et al., 2014; Grant et al., 2014; Smith et al., 2019), my Participants recounted stories of staff holding, withholding, and regulating the supply of cigarettes to control and manage patient behaviour, and supplying and enabling cigarette smoking to avoid aggression and keep the peace. Hark back to Sylvia, who emphasised the importance of avoiding patient aggression in the ward. Note, too, Judy's comments that the Ministry of Health advised the Health Committee to provide some flexibility because staff had to make the law work. Put differently; I suggest that the Ministry was likely signalling the prospect of patient behavioural difficulties if MHIFs were to be smoke-free.

In my study, while evidence of harm, treating hospitals as home-like, and protecting patients' need to smoke are likely to have informed the section 6 exemption, I submit that the exceptional spaces of smoking rooms in MHIFs were perceived as a security-based solution to *control the* risk of *aggressive* behaviour by patients with *mental illness* and who would be without the presumed *calming* effects of smoking. Adding weight to this contention are Judy's comments that the Ministry of Health advised of the need to provide some flexibility because staff had to make the law work, suggesting that the Ministry anticipated patient behavioural difficulties if MHIFs were to be smoke-free. Here we see the state of exception as a tool to deal with security risks (Testa, 2018) in a

health setting; rather than national security, which is more often associated with the state of exception.

Multiple exceptional spaces in mental health inpatient facilities

My study findings indicate the presence of the following three types of exceptional spaces for smoking:

Exception types	**Sites of exception**
statutory	designated smoking rooms in MHIFs
policy & practices	MHIFs (indoor and outdoor)
practices – largely informal	off the hospital grounds

Agamben theorises that in exceptional spaces, life is:

- abandoned by the law and human rights protections
- is exposed to forms of violence
- subject to various control mechanisms and the whims of decision-makers, including life and death, and that
- the exception is the norm

What was the situation regarding life in all the exceptional spaces for smoking in MHIFs?

Exceptional spaces: Abandoned by law and human rights protections

Have patient and staff legal and human rights been abandoned?

In Aotearoa New Zealand, hospital patients and staff have protections from laws and codes to ensure they receive appropriate services and standards of care. Relevant to my study, the 2003 Smoke-free Environments Amendment Act sought to prevent non-mental health patients' exposure to detrimental smoke in workplaces, including hospital care institutions. However, contrary to this purpose and the accepted evidence of harm from smoking and SHS, the legislature abandoned this health-protective legislation for mental health inpatients. Instead, it decided the exception that permitted hospitals to establish patients' DSRs that are subject to providing ventilation known to be ineffective. The DHBs implemented these exceptional spaces, which normalised and arguably

encouraged smoking, as indicated by Jo's comment that "In MHIF in those days, you had a designated smoking room, and as long it was ventilated, it was okay".

The abandonment of this statutory provision had a flow-on effect. Although the legislature did not suspend other legal protections, relevant health rights, which are human rights, were no longer in play. For example, patient exposure to the detrimental effects of smoking is inconsistent with Right 4.4 of the Consumer Code of Rights. Exposure to indoor smoke neither minimises the potential harm nor optimises the quality of patient lives (Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations, 1996).

Given the normalised smoking in MHIFs, it is little wonder that Hayden acknowledged the ease of starting the smoking cessation and ABC programme in the general hospital wards where smoking was not permitted. The effect, however, was to treat MHIF patients differently, thus denying them the opportunity to quit smoking and participate in nicotine dependence treatment. I suggest that this denial, given the history of state-sanctioned smoking, likely constitutes a claim of substantive inequality against the State.

Further, the denial of patient treatment services is inconsistent with Aotearoa New Zealand's international human rights obligations. For example, mental health inpatients are entitled to the right to health which assures all people of their right to enjoy the highest attainable standard of mental and physical health (ICESCR, 1966). They are also entitled to the FCTC protection which includes the right to be free from smoke exposure (WHO, 2003).

The provision of designated smoking rooms has staff implications. It is not possible to be a 'little bit smoke-free', and ventilation systems do not remove all the harm from cigarette smoke. The DHBs' provision of exceptional spaces like DSRs means that MHIF staff have been in a workplace that is not free of smoke exposure which is inconsistent with the DHB employer's duty of care to address staff health and safety.

The DHBs' objective to improve, promote, and protect people and communities' health is broad and covers DHB patients and staff (New Zealand Public Health and Disability Act, 2000). The presence of exceptional spaces for smoking in MHIFs is inconsistent with this statutory objective which arguably sets the scene for smoke-free MHIFs.

It is reasonable to suggest that the presence of exceptional spaces like DSRs offered legitimacy to the other types of exceptional spaces, such as smoke-free policy exceptions and practices and informal staff practices. My findings indicate patients and staff in these sites were also exposed to the harms of smoke and smoking, arguably raising similar legal inconsistencies to those discussed concerning the statutory exception of DSRs.

The exception is the norm

Is the exceptional space of smoking rooms in DHBs the norm?

Agamben contends that the state of exception becomes permanent or continuing rather than a temporal intervention. Consistent with this contention, my findings show that the exceptional space of smoking rooms in hospital care institutions has been on the statute book since 2003. Recall Robert's observation that this exception was "very backward", "a curious situation", and his suggestion that the exception could be part of a smoke-free legislation review. Significantly, following a review of the smoke-free legislation in 2020, DSRs were retained in the legislation. Arguably, the exception is the norm.

Exposed to forms of violence

To what extent has the abandonment of these rights exposed mental health inpatients and staff to forms of violence in exceptional spaces of smoking?

Violence at these smoking sites is not the kind of violence expressed in war and the concentration camp settings to which Agamben refers. However, I contend it is a different form of violence where the executive power to decide and implement exceptional spaces for smoking has effectively violated patient human rights, maintained patient nicotine addiction, and dictated the consequences of life and death by enabling of use of cigarettes and exposure to SHS that is likely to contribute to patient mortality and morbidity.

Arising from my study findings, I submit that the state sanctioned smoking sites where patients have knowingly been exposed to the harms of smoking and SHS; and have been

supplied, allowed, or encouraged to smoke a deadly product like cigarettes, have exposed those patients to a deadly form of violence.

Similarly, the staff present in these exceptional spaces for smoking have been exposed to SHS. Some staff have smoked cigarettes with patients to help build a therapeutic relationship. Arguably the power relationship is different but, nonetheless, staff have been exposed to a deadly product with implications for their health and wellbeing.

Exceptional spaces: Control mechanisms

Are control mechanisms alive in the exceptional spaces for smoking?

In the absence of legal and human rights protections, various control mechanisms are present in the exceptional spaces for smoking. Outside the law, control of life in these sites has occurred in several ways. These include privileging and suppressing specific health-promoting knowledge, creating patient identity difference, and using behaviours that diminish patient autonomy and agency.

Knowledge suppression and privileging: Consistent with the reviewed literature, my study identified the presence of firmly held staff beliefs about the benefits of smoking for mental health inpatients. Further, these beliefs portrayed the three types of exceptional spaces for smoking as the health-promoting and preferable alternatives to being smoke-free. I submit that these presumed benefits of smoking were privileged as 'the truth' and given legitimacy over and above the evidence of harm from smoking and SHS exposure. I contend that in this way, knowledge of the harm from smoking and SHS exposure was suppressed, and the presumed benefits of smoking were privileged as truths.

Identity difference: Crucial to control is the creation of an identity distinct from others, an identity that sticks and stigmatises. In this regard, my study findings suggest the identity of difference was created and maintained by the oft-repeated mantra that 'people with mental illness need to smoke' or that smoking was 'the patients' only form of pleasure'. Further, I suggest that this 'smoking identity' was bolstered by claims that without smoking, patients' mental health would deteriorate, or patients would become aggressive; thus, the need for continued smoking and the endorsement of smoke-free exceptions. It was also reinforced by the visible presence of exceptional spaces where

'the smokers went to smoke'. Notably, this identity difference wedded mental health inpatients to continued smoking while cigarette smoking was stigmatised in general society and the general hospital wards.

Diminishing autonomy and agency: Control in the exceptional spaces also included staff behaviours, which I suggest diminished patient autonomy and agency and reflected the staff use of power and control. My study indicates that these behaviours included:

- taking, holding, and deciding when patients could have their cigarettes, thus ignoring the clinical management of nicotine addiction withdrawal
- using cigarettes as a form of tobacco behavioural management
- controlling the supply and distribution of state-funded tobacco and cigarettes
- determining the frequency of 'smoking breaks'
- not providing nicotine dependence support for newly admitted patients

Whims of decision-makers: The notion of 'whim' suggests the absence of deliberation. Regarding the decision to create the section 6 exceptional space of smoking rooms, different from Agamben's theory, this was not the whim of the executive but rather the legislature's deliberation. However, at the exceptional spaces of smoking, patients were vulnerable to the decision-making whims of staff. Notable and cruel was the staff practice of withholding cigarettes until mid-morning and leaving patients in stages of nicotine withdrawal. Arguably, a further form of whim-like decision-making occurred when the two DHBs quickly revoked their smoke-free policies and reinstated smoking following the bus and patient aggression incidents, disregarding the harms of smoking and SHS for mental health inpatients.

Agamben theorises that in the camp situation, inmates' identities are erased, and they are reduced to a biological existence or bare life. Reflecting on my study findings and the above discussion, I submit that life in the exceptional spaces of smoking in MHIFs, while not stripped to Agamben's form of bare life, was reduced to 'bodies that need to smoke'; bodies denied patient entitlements to smoking cessation and treatment for nicotine dependence. General hospital patients were provided with smoking cessation and treatment for nicotine dependence, and mental health inpatients were not. They were treated differently and enabled to smoke a deadly product which, I submit, reveals life treated without the value given to other patients. Unless the life of mental health

inpatients is treated with value, it seems likely that they will be among those smoking cigarettes in 2025.

6.7 Major conclusions: Research questions

My findings from pointers 1 to 5 enable me to draw several significant conclusions which address my research questions.

1. Why were smoke-free policy exceptions applied in District Health Board mental health inpatient facilities?

This study is important in the socio-historical context of smoking Aotearoa New Zealand psychiatric hospitals. The historical, systematised, and state-sanctioned purchase, supply, and provision of tobacco and cigarettes in psychiatric hospitals laid a strong foundation for the three types of exceptional spaces for smoking—DSRs, other MHIFs indoor and outdoor areas, and off the hospital ground—in 21st-century MHIFs.

Regarding the use of exceptional spaces of DSRs in MHIFs, my findings suggest that these rooms were looked on as a security-based solution and used to control the risk of aggressive behaviours by patients with mental illness, believed to be unable to quit and who would no longer have the presumed calming and stress-relieving benefits of smoking cigarettes. The visible presence of DSRs legitimised and maintained the historical culture of smoking and arguably paved the way for the other two types of exceptional spaces for smoking in MHIFs.

2a. What are the implications of smoke-free exceptions for patients?

There are several implications for mental health inpatients in MHIFs. My findings show that mental health inpatients have higher rates of smoking and experience significant and detrimental physical consequences from smoking, that exposure to any second-hand smoke is harmful, and mental health improves when people quit smoking. The presence of exceptional smoking spaces in MHIFs is unlikely to have improved or protected the health and wellbeing of mental health inpatients from these harms associated with cigarette smoking and smoke. It is more likely that the exceptional spaces have exacerbated patient health and wellbeing and contributed to the higher smoking rates in MHIFs relative to the general hospital smoking rates.

Smoking is not an effective treatment for mental illness, and MHIF patients are perceived as vulnerable; yet, they have still been allowed to smoke cigarettes. Beliefs have informed this perception that quitting is arduous, unsuccessful, and harmful to mental health and that smoking benefits mental health. However, patients who continue to smoke cigarettes in MHIFs are exposed to the established health harms from their smoking and exposure to SHS from their cigarettes and those of other patients and, perhaps, staff. Thus, mental health inpatients are multiply vulnerable to smoking-related harms, and cigarette smoking by patients in MHIFs remains normalised behaviour.

Further, in my view, the presence of exceptional spaces for smoking, with smoking and the presence of SHS, has exposed mental health inpatients to a deadly form of violence. In these spaces, accepted scientific knowledge about the harms of smoking and smoke exposure was suppressed in favour of beliefs about the benefits of smoking for patients. Significantly, patients were knowingly exposed to the harms of cigarette smoking and SHS, provided with tobacco and/or cigarettes, and encouraged to smoke a product associated with life and death consequences for them. Rather than being treated as mental health inpatients whose identity was unquestionably linked to the right to smoking cessation and nicotine dependence treatment, patient identities have been reduced to 'bodies that need to smoke', which arguably signifies life of lesser value.

2b. What are the implications of smoke-free exceptions exemption for staff?

My findings indicate that the mental health nursing workforce had higher cigarette smoking rates relative to general nurses. The presence of all types of exceptional spaces of smoking in MHIFs is likely to have encouraged, rather than discouraged staff smoking, thus contributing to these rates and negative impacts on staff health and wellbeing. In these spaces, staff have been present in a non-smoke-free workplace, inconsistent with the DHBs' duty of care to provide a safe workplace for all employees and suggesting that perhaps smoke-free workforces were not DHB organisational priorities in the first decade of the 21st-century.

Exceptional spaces have likely made it easier for pro-smoking staff to disregard the accepted evidence of harm from smoking and smoke exposure and continue practices inconsistent with contemporary professional mental health practice standards. My

findings indicate some staff did not participate in professional development and training about tobacco control and smoking cessation. Non-participation has implications for mental health workforce development and has probably contributed to a deskilled workforce unable to provide routine nicotine dependence care to all smoking mental health inpatients.

3. What are the implications of smoke-free exceptions for SF 2025?

As of June 2021, Aotearoa New Zealand was not on track to achieve its national SF 2025 goal. In my view, the use of exceptional smoking spaces has displayed disregard for the accepted evidence of harm from smoking and smoke, along with a lack of tobacco control leadership by the Ministry of Health and DHBs. Neither the Ministry of Health nor DHBs has placed smoking and mental health to the front and fore in published documents or in action plans to achieve the national SF 2025 goal. Smoking and mental health has been left behind.

With the documented historical and continued smoking and smoke disadvantages experienced by MHIF patients, this inpatient group is likely to be among those smoking in 2025, at risk of stigmatisation and judgment for their continued smoking and continued identity characterisation that smoking is the lot of the mental health inpatient. However, what seems likely might be alleviated. Achieving the SF 2025 goal requires dedicated and resourced action. My reviewed literature indicates that vaping has been proposed as a harm reduction method to help people quit smoking. While we do not know whether this method will be successful for MHIF patients, the DHBs' willingness to provide designated rooms for vaping might be pivotal.

Section Two

This section addresses my study's key contributions and implications.

6.8 Contributions

My research contributes to recent scholarly work that uses Giorgio Agamben's state of exception to examine exceptional spaces in a healthcare setting. It builds on scholarly

work about exceptionalist smoke-free policies in MHIFs overseas and Aotearoa New Zealand.

It makes a significant contribution to understanding the 20th-century socio-historical context of the normalised culture of smoking in psychiatric hospitals, the state's role, and the impact of pervasive smoking in MHIFs during the first decade of the 21st-century

Using reflexive thematic analysis, my research provides the insights of 15 Participants who were widely experienced in aspects of public health, mental health, and tobacco control policymaking; and readily shared their experiences related to smoke-free policy exceptions, mental health, smoking.

My final contribution is a cautionary note for public health, mental health and tobacco control policymakers, practitioners, politicians, and researchers to be circumspect about exceptional spaces: they may have detrimental consequences for the people presumed to benefit and, the exception might become the norm.

6.9 Implications for the state

Twenty-first century exceptional spaces of smoking and smoking by MHIF patients in Aotearoa New Zealand have been a case of 'out of sight out of mind'. Patient smoking has largely flown under the political and public radar. It has not been prioritised as a serious mental health, public health, or tobacco control clinical issue, contrary to the recommendations of professional health bodies (Royal College of Physicians & Royal College of Psychiatrists, 2013).

The 2003 smoke-free legislation established exceptional spaces of smoking rooms in hospital care institutions. The DHBs' discretion to permit patient smoking in these spaces was affirmed in the 2020 smoke-free amendments (Smokefree Environments and Regulated Products Act 1990, section 6). However, the section 6 exemption is inconsistent with:

- DHB objectives, particularly that of promoting, protecting, and improving health
- DHB workplace safety obligations
- the Health Disability Consumer Right 4.4 to minimise the potential harm and optimise the quality of life

- Aotearoa New Zealand's FCTC obligations, notably the Article 8 duty to protect people from SHS and the ICESCR right to health

In creating the statutory exemption, the legislature and its executive members abandoned smoke-free protection for patients in hospital care institutions to permit DSRs; thus, creating exceptional spaces of smoking rooms with the conditions of life and death associated with smoking and smoke exposure. The exception perpetuates and reinforces a hierarchy regarding the value of life. Mental health inpatients who smoke have been treated differently, as lives of lesser value and not provided with the evidence-based smoke-free care offered to non-mental health patients residing in state hospital care institutions.

My findings indicate that the state's historical role in sanctioned patient smoking has involved laws, policies, and practices that maintained inherent disadvantages from smoking and exposure to SHS for MHIF inpatients. Alleviation of disadvantages warrants a substantive equality approach to identifying the offending law, policies, and practices, and considering appropriate remedies. Expressly, the Smoke-free Environments and Regulated Products Act 1990, section 6, permits smoking in designated rooms in hospital care institutions. I believe that a government serious about DHBs improving, promoting, and protecting health must alleviate the disadvantages of harm from smoking and smoke exposure. I consider that an appropriate remedy involves amending Smoke-free Environments and Regulated Products Act 1990, sections 2 and 6 to remove the provisions permitting exceptional spaces for smoking in hospital care institutions as was done in Aotearoa New Zealand prisons in 2011 (See Appendix I).

6.10 Implications for policy

Generally, it is accepted that policy initiatives in public health, mental health, and tobacco control aim to foster conditions that promote the health and wellbeing of specific populations.

I hope my study findings directly inform public health, mental health, and tobacco control policymaking, resulting in an amendment to the current smoke-free law so that mental health inpatients, like non-mental health inpatients, receive all their care in smoke-free MHIFs.

The Smokefree Environments and Regulated Products Act 1990 permits hospital care institutions such as DHBs to implement exceptional spaces of designated rooms for smoking cigarettes in MHIFs; yet, smoking in prisons was repealed in 2011. Smoking rooms have been regarded as beneficial to mental health inpatients. However, they expose patients and, to a lesser extent, staff to the known detrimental effects of smoking and SHS in a hospital setting, and arguably perpetuate the historical disadvantages for this group of inpatients.

6.11 Implications for practice

My findings highlight the importance of DHBs and the relevant health professional bodies ensuring that the mental health workforce can routinely provide smoking cessation interventions and nicotine dependence assessment and treatment to all mental health inpatients, and that the workforce is knowledgeable about the evidence supporting smoke-free MHIFs.

To raise the mental health and smoking profile, I suggest that the Ministry of Health and DHBs regularly publish mental health inpatient smoking status data and publish resources dedicated to mental health and smoking, like the UK report, *The stolen years. The mental health and smoking action report* (Harker & Cheeseman, 2016).

6.12 Implications for research

My research has identified silences and gaps regarding Aotearoa New Zealand's mental health and smoking research, particularly regarding mental health inpatients and smoking. The findings from my reviewed literature and the DHB smoking status data strongly point to the need for public health, mental health, and tobacco control researchers to fill the research void with uniquely Aotearoa New Zealand research and publications to foster strengths-based interventions

Examples of further research could include:

- the implications of exceptionalist smoke-free legislation, policy and practices concerning MHIF smoking status by ethnicity
- smoking trends related to MHIF discharges and implications for Crown compliance with the Articles of Aotearoa New Zealand's Treaty of Waitangi

- the implications of exceptionalist smoke-free legislation, policy, and practices from the patient perspective
- types and outcomes of smoking cessation interventions in MHIFs
- changes in staff beliefs and practices regarding smoking in MHIFs
- the ongoing presence or demise of smoking rooms in hospital care institutions
- documenting the processes and rationale for the introduction and vaping rooms in DHBs now permitted by the Smokefree Environments and Regulated Products Act 1990
- the outcome of vaping as a harm minimisation tool leading to smoking cessation

6.13 Implications for theory and methods

My thesis advances the application of Agamben's lens of the state of exception in a health care setting in Aotearoa New Zealand. While acknowledging that mental health inpatient facilities are significantly different settings from war and the camps to which Agamben refers, I think that Agamben's exception is a useful explanatory tool to reveal more than that which is taken-for-granted: that DSRs are not simply places for mental health patients and staff to smoke cigarettes. This lens has enabled insights about the exception as a form of control over mental health inpatients who smoke and about the exception's implications for mental health inpatients and, to a lesser extent, staff, who are caught in the exceptional spaces of smoking rooms and other indoor and outdoor spaces on and off the facility grounds.

The present research shows that Participant interviews enabled me to gather rich data. Both the Participant interviews and reflexive thematic analysis sat comfortably alongside the state of exception formulation, thus indicating the theoretical flexibility of thematic analysis. The thematic analysis offered a structured yet flexible approach to coding the data and developing themes that generated insights about exceptional spaces of smoking in MHIFs.

6.14 Limits of present research

My research has been exploratory in an under-researched topic in Aotearoa New Zealand. In my view, the main limits of my research are as follows:

The scarcity of published scholarly literature specifically about the rationale and implications of smoke-free policy exceptions in DHB MHIFs meant that I could not draw on a large body of Aotearoa New Zealand material to inform my literature review and contribute to my findings and conclusions. Researchers in Aotearoa New Zealand have drawn attention to the lack of data regarding the 2003 smoke-free legislative exemption in residential care institutions (which include hospitals) (Edwards et al., 2007), the fact that key mental health reports have largely overlooked smoking (Glover et al., 2014), and to the lack of data about PMI and smoking (Glover et al., 2020). However, it seems that research on the general area of smoking and mental health inpatients, and the specific area of smoke-free policy exceptions in MHIFs, has not been a priority in mental health, tobacco control, public health policy, and law. The absence of published literature about the above general and particular areas of mental health and smoking indicates a gap, and my study addresses a part of this gap. However, in my view, the breadth and depth of this gap, together with the accepted detrimental impact of smoking on mental health inpatients, strongly suggests the need for further research.

There were often delays in my access to the former Department of Health archival documents and several DHB smoke-free policy documents along with MHIF patient smoking status data. Since none of this material was in the public arena, I made OIR. In the case of the Department of Health documents, my access approval process lay with the Ministry of Health, while Archives New Zealand held the documents in Wellington. The Ministry of Health communication was not consistently prompt, and I had to make several follow-up inquiries. The lengthy time to receive permission to access archival material involved reorganising my flights to Wellington to obtain document copies and significantly reduced the time available to prepare my findings. Some of the DHBs managed my OIR during the early stages of COVID-19. Other DHBs indicated that they were busy responding to COVID information requests and delayed providing the requested data to me. The later than anticipated arrival of these documents reduced the time to prepare my findings. However, I considered that this situation involved balancing my research design plan against the fact that the DHBs faced a new pandemic. Thus, I chose not to make any official complaints about the delay, erring on the side of polite follow-up inquiries.

My sample size of 15 Participants might be considered a limited sample, and it is possible that voices with other perspectives were not included in the sample. However, some of the people interviewed were from very small niche samples and were high-profile key players in developing and/or implementing smoke-free policies. For example, two Participants were former MPs. One MP chaired the Select Committee involved with the Smoke-free Environments Act 1990 and later was the initial chair of the Select Committee involved with Smoke-free Environments Amendment Act 2003. The second MP followed on as the chair of the Select Committee involved with the Smoke-free Environments Amendment Act 2003 and was an Associate Minister of Health. Two Participants were major NGO advocates at the time of smoke-free policy development, and two held senior health management roles. Another Participant had a senior Ministry of Health role during the smoke-free policy rollout, and one Participant was a Crown appointment to a DHB governance board.

I wondered if I had interviewed other people, how different or similar would be their experiences from those that I had heard. Regarding the generalisability of my findings, it is essential to note that the Participant voices are snapshots of their experience at different times, across almost five decades in certain hospital care institutions, and suggest policy and patient implications. These experiences may or may not have occurred in other similar Aotearoa New Zealand institutions. A balancing consideration is my review of a wealth of archival material and other documents. Triangulation (See Chapter 4) across material from these different sources supported the credibility and validity of my findings.

The Participant data regarding the pervasiveness of smoking in psychiatric hospitals, the supply and distribution of tobacco and/or cigarettes to inpatients, and the presence of the 'patient comfort fund' consistently confirmed the information obtained in the archival documents, thus strengthening my confidence in the representativeness of the Participants' data.

As discussed in Chapter 4, the latter interviews in my study were largely re-presenting the earlier Participants' material, generally affirming, and elaborating on earlier Participants' accounts with very little new and/or different material forthcoming, and I considered that saturation was being reached. At this point, I discontinued data

collection and conducted my thematic analysis with a sample of 15 Participants. I considered that saturation was occurring in the interviews, and triangulation from archival document findings supported my findings.

My research study design was based on face-to-face interviews. I had not anticipated conducting phone interviews. However, it was necessary to be flexible and conduct four interviews by phone because of Participant work commitments or remote locations. The phone calls were audio calls that presented me with an unexpected challenge in that I did not have a face-to-face presence where I could use visual cues to observe Participant comfort or nuanced responses. These circumstances required me to listen very carefully, paraphrasing and clarifying what was said to show my interest and respect.

A further initial challenge with the first audio interview was identifying the best place to locate the audio recording equipment to achieve a sound quality recording for transcription. On reflection, conducting a pilot audio interview would have enabled me to determine if the 'Participant' thought I sounded interested and respectful and work out the best location for the audio recorder. Since completing the last audio interview at the start of 2019, Zoom technology has become pervasive. For future interviews and with Participant consent, I would use the Zoom video or similar technology if I could not meet face-to-face for an interview.

As discussed in Chapter 1, out of scope are the implications of smoke-free policy exceptions for mental health inpatients and for those who are Māori.

My study focuses on smoke-free policy exceptions, how and why they came into being and their implications for patients and staff. Thus, it seeks the voices of people with occupational and policy experience in smoke-free policy development, approval, and implementation of tobacco control and/or mental health policy. It does not seek the voices of patients. My decision not to involve patients might be considered a limitation of this study. However, patients have rarely participated in the above aspects of policy development, and I firmly believe that patients must be a separate study. Future research on patients' perception of the impact of smoke-free policy exceptions would make a valuable contribution to data about the effects of exceptionalist smoke-free legislation on mental health inpatients.

Māori have the highest current smoking prevalence. However, there is an absence of published literature and data about MHIFs, Māori, and smoking. I strongly believe that the lack of this literature indicates the need for a separate and detailed study by Māori for Māori and informed by the Māori guidelines for Māori research ethics (Hudson et al., 2010). In my view, future research on the impact of smoke-free exception policies on Māori patients in MHIFs will enable the Crown to be better informed about the implications of exceptionalist smoke-free legislation and policies.

Regarding the risk of bias from the three assumptions I hold (See Chapter 1), I took steps to minimise these influences by framing open-ended questions and clarifying and paraphrasing to double-check responses. Drawing on my legal training, I was conscious of the need to come to interviews and the data with my mind open to all possibilities.

6.15 Chapter review and summary

In this chapter, I have discussed my findings and the present research's significance, implications, and limitations. I have concluded with a thesis summary and concluding reflections. The Smokefree Environments and Regulated Products Act 1990 allows patient smoking in hospital care institutions. At the three types of exceptional spaces of smoking identified in this study, mental health inpatients have been denied health and human rights. They have knowingly been permitted to smoke a recognised deadly product and been exposed to the accepted harms of SHS. Staff present at these spaces have also been able to smoke and have been exposed to the harms of SHS. Action to foster conditions that promote and protect the health wellbeing of mental health inpatients is needed to amend the current smoke-free legislation so that mental health inpatients, like non-mental health inpatients, have care in a smoke-free environment. Action is also required by the DHBs and the relevant health professional bodies so that the mental health workforce is trained to provide the appropriate assessments and smoking cessation support to all mental health inpatients.

6.16 Thesis summary and concluding reflections

This thesis contributes to recent scholarly work that uses Giorgio Agamben's state of exception to examine exceptional spaces in a healthcare setting. It builds on scholarly work about exceptionalist smoke-free policies in MHIFs overseas and Aotearoa New

Zealand. I draw on my findings from interviews with 15 Participants, archival material, official information, and reviewed overseas and Aotearoa published literature.

I demonstrate that the exceptional spaces of smoking in 21st-century Aotearoa New Zealand MHIFs are located in a socio-historical context of normalised and tolerated indoor and outdoor smoking and that the state has played an active role in sanctioning smoking in these facilities. Drawing on the state of exception, I argue that the exceptional spaces of DSRs in MHIFs were created by the legislature and implemented in the DHBs as a security measure to control the risk of aggressive behaviour by patients believed to be unable to quit smoking and who would be without the presumed calming and stress relieving benefits of smoking. I further argue that the types of exceptional spaces of smoking—DSRs, other indoor spaces, and outdoor spaces on and off the facility grounds—are sites of violence. While not violence of war and the concentration camp setting referred to by Agamben, I contend these can be viewed as sites of violence where mental health inpatients have knowingly been permitted to smoke a recognised deadly product, and they have been exposed to the accepted harms of SHS. The persistent smoking culture in MHIFs suggests that mental health inpatients will likely be among those smoking in 2025.

Staff present at the exceptional spaces have also been exposed to the harms of SHS and have smoked with patients as part of accepted practice to help build therapeutic relationships.

To address the historical disadvantages of smoking and smoke exposure experienced by mental health inpatients, I propose a substantive inequality approach, including a legislative amendment to remove the exceptional spaces of smoking rooms in hospital care institutions, as was done in prisons in 2011. This change, together with visible and committed leadership by Government, DHBs and the public health, mental health and tobacco control practice and research communities, is needed to place mental health inpatient smoking to the fore and centre to improve, promote, and protect the health and wellbeing of these inpatients.

Ultimately, the value of life of mental health inpatients who smoke has been disregarded and treated differently from non-mental health inpatients. It is as though their life has been less valued.

This study began with my curiosity about the presence of smoke-free policy exceptions in DHB MHIFs. My curiosity was heightened because these policy provisions were not similarly applied in the general hospital wards. This led to my desire to examine why these exceptional spaces were used and their implications for patients, staff, and SF 2025—Aotearoa New Zealand's national smoke-free goal.

Now, at the conclusion of the thesis, I reflect on where my study started, the dimensions I have traversed, and the insights that have emerged. Central to my study is the value of life. Agamben's lens of the state of exception took me on a journey that examined the value of life in exceptional spaces of smoking rooms and other smoking sites and the use of the exceptional spaces to control human behaviour.

From this examination, I no longer viewed DSRs as simply places for patients and some staff to smoke cigarettes. For example, some health professional staff held beliefs presumed to be for the patients' benefit; yet the beliefs were contrary to accepted practice and evidence. Smoking rooms were said to meet the patients' needs, yet these rooms exposed patients and staff to harm from smoking and SHS.

Poignantly, I am reminded that what can appear to be a 'run of the mill' practice in MHIFs and claimed to be for the patients' benefit might not be the case. Curiosity, inquiry, and the valuing of life are important contributions to strengthening the health and wellbeing of this marginalised population.

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Appendices

Appendix A: Consent form

Consent Form

Project title: Smoking and Mental Health In-patient Facilities in New Zealand

Project Supervisor: Professor Marilyn Waring

Researcher: Patsi Davies

I have read and understood the information provided about this research project in the Information Sheet dated XX

- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○
- ○ I wish to be notified of the thesis url when it is available (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 27 March 2017 AUTEC Reference number #16/365

Note: The Participant should retain a copy of this form.

Appendix B: Participant information sheet

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Participant Information Sheet

Date Information Sheet Produced:

Project Title

Smoking and Mental Health In-patient Facilities in New Zealand

An Invitation

Kia ora/Greetings

My name is Patsi Davies. I am completing a PhD project at the Auckland University of Technology (AUT). I am also a lecturer in health promotion at AUT. I invite you to take part in a face-to-face interview to discuss your views about smoking and mental health facilities in New Zealand. The information from your interview will contribute to my PhD research.

Your participation in this research is completely voluntary. You may stop participating at any time, for any reason, prior to the analysis of data. You will not be asked to state why. Your decision to stop participating or to refuse to answer particular questions, will not affect your relationship with me or AUT. If you withdraw from the research, all associated collected data will be immediately destroyed wherever possible. It is not expected that any issues related to conflicts of interest will arise.

What is the purpose of this research?

This research aims to collect information about the knowledge and views of people with public health, central and non-government experience in developing, approving and implementing tobacco control and/or mental health policy in New Zealand. Findings will be used in my PhD thesis, to produce journal articles, presentations and submissions to government/related bodies to inform and guide tobacco control/mental health public health policy and for comparative studies of mental health facilities and smoking in other countries.

How was I identified and why am I being invited to participate in this research?

You have been identified as someone who fits the criteria of inclusion in this research. That is, you speak English, are over 20 years of age and have experience in one or more of the following: public health, central and non-government experience in developing, approving and implementing tobacco control and/or mental health policy in New Zealand.

How do I agree to participate in this research?

To participate in this research, you need to sign a Consent Form please. Anyone who chooses not to sign this form, will not be included in this study. The Consent Form can be obtained from me.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

This research involves an in-person interview of 1-1.5hours. It will be held an agreed venue at a date and time that suits you. In the interview, I will ask you a range of questions related to smoking and mental health facilities in New Zealand and your thoughts about achieving Smokefree 2025. With your permission, the interview will be audio-recorded and notes will be taken.

Appendix C: Ethics approval

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

27 March 2017

Marilyn Waring
Faculty of Culture and Society

Dear Marilyn

Re Ethics Application: **16/365 Smoking and mental health in-patient facilities in New Zealand**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 27 March 2020.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 27 March 2020;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 27 March 2020 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Patsi Davies

Appendix D: Confidentiality Agreement

Appendix C

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Confidentiality Agreement

Project title: **Smoking and Mental Health In-patient Facilities in New Zealand**

Project Supervisor: Professor Marilyn Waring

Researcher: Patsi Davies

- ✓ I understand that all the material I will be asked to transcribe is confidential.
- ✓ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ✓ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: .....

Transcriber's name: .....

Transcriber's Contact Details:

UniScribe NZ
027 2484299
Box 86 Matangi 3260

.....

Date: 31-7-18

Project Supervisor's Contact Details

Professor Marilyn Waring
Institute of Public Policy
Auckland University of Technology
90 Akoranga Drive, Northcote, Auckland, 0627
mwaring@aut.ac.nz
(P) 099219661

Approved by the Auckland University of Technology Ethics Committee on 28 March 2017 AUTEC reference number [16/365]

Note: The Transcriber should retain a copy of this form.

2 July 2015 page 1 of 1 This version was last edited in July 2015

Appendix E: Protocol for digital and voice recording

Protocol for Digital and Voice Recording

Date Protocol Produced: 02/July/2015

Project Title

Smoking and Mental Health In-patient Facilities in New Zealand

Type of Recording

Each interview will be audio recorded using a digital micro-recorder and notes will be taken. The participants are required to give their consent to participate in this study.

How will the participants be identified in the recordings?

Following receipt of written informed consent to participate in this study, each participant will be assigned a study participant number by the researcher. This study participant number will be recorded by the researcher and be stated at the start of the recording.

How will the identities of the participants be protected?

By using a study participant number, the researcher makes sure that the identities of the participants will remain anonymous.

Who will have access to the recordings?

The project supervisor, the researcher and the employed transcription service will have access to the digital audio recordings. A confidentiality agreement will be signed by the transcription service employed to assist in the transcription of audio recordings.

What are the guidelines for safekeeping and/or destroying the recordings?

Audio recordings of all interviews will be deleted upon completion of the study. All transcripts will be securely stored in a locked filing cabinet at the AUT North Campus in AC 313 for six years. After this time, the data will be destroyed in accordance with the AUTEC protocol.

Approved by the Auckland University of Technology Ethics Committee on 27 March 2017 AUTEC #16/365

Appendix F: Interview structure

Questions for Interviewees - Section A only

Please do not complete until you have consented and signed the Consent Form.

Section A: Questions related to Your Tobacco Control/Mental Health/Related Roles in New Zealand.

1. **Which of the following have you worked in? (tick all relevant options)**

(a)Tobacco Control-related to Public Health Sector District Health Boards General Hospital/s	Tick	(b)Tobacco Control-related to Public Health Sector District Health Board Mental Health In-patient Facility/s	Tick	(c)Tobacco Control in Non-Government Organisations	Tick	(d)Tobacco Control in Public Hospitals prior to DHB's.	Tick

2a. Please complete this question if you ticked '<u>Tobacco Control related to Public Health Sector - District Health Board General Hospital/</u>s in question 1 (use more tables if needed)

Organisation name		**Organisation name**		**Organisation name**	
Period of employment		**Period of employment**		**Period of employment**	
Your role title		**Your role title**		**Your role title**	
Regarding tobacco control policy, what were you involved with in each organisation? (mark with 'X')					
A	Policy development		**A** Policy development		**A** Policy development	
B	Policy consultation		**B** Policy consultation		**B** Policy consultation	
C	Policy approval		**C** Policy approval		**C** Policy approval	
D	Policy implementation		**D** Policy implementation		**D** Policy implementation	
E	Policy Monitoring/ evaluation/review		**E** Policy Monitoring/ evaluation/review		**E** Policy Monitoring/ evaluation/review	
F	Policy legislation/regulation		**F** Policy legislation/regulation		**F** Policy legislation/regulation	
G	Other - explain		**G** Other - explain		**G** Other- explain	

2b. Please complete this question if you ticked 'Tobacco Control related to Public Health Sector District Health Board Mental Health In-patient Facility/s' in question 1 (use more tables if needed)

Organisation name			**Organisation name**			**Organisation name**		
Period of employment			**Period of employment**			**Period of employment**		
Your role title			**Your role title**			**Your role title**		
Regarding tobacco control policy, what were you involved with in each organisation? (mark with 'X')								
A	Policy development		**A**	Policy development		**A**	Policy development	
B	Policy consultation		**B**	Policy consultation		**B**	Policy consultation	
C	Policy approval		**C**	Policy approval		**C**	Policy approval	
D	Policy implementation		**D**	Policy implementation		**D**	Policy implementation	
E	Policy Monitoring/ evaluation/review		**E**	Policy Monitoring/ evaluation/review		**E**	Policy Monitoring/ evaluation/review	
F	Policy legislation/regulation		**F**	Policy legislation/regulation		**F**	Policy legislation/regulation	
G	Other - explain		**G**	Other - explain		**G**	Other- explain	

2c. Please complete this question if you ticked 'Tobacco Control in Non-Government Organisations' in question (use more tables if needed)

Organisation name		**Organisation name**		**Organisation name**	
Period of employment		**Period of employment**		**Period of employment**	
Your role title		**Your role title**		**Your role title**	
Regarding tobacco control policy, what were you involved with in each organisation? (mark with 'X')					
A Policy development		**A** Policy development		**A** Policy development	
B Policy consultation		**B** Policy consultation		**B** Policy consultation	
C Policy approval		**C** Policy approval		**C** Policy approval	
D Policy implementation		**D** Policy implementation		**D** Policy implementation	
E Policy Monitoring/ evaluation/review		**E** Policy Monitoring/ evaluation/review		**E** Policy Monitoring/ evaluation/review	
F Policy legislation/regulation		**F** Policy legislation/regulation		**F** Policy legislation/regulation	
G Other - explain		**G** Other - explain		**G** Other- explain	

2d. Please complete this question if you ticked 'Other' in question 1 (use more tables if needed)

Organisation name		**Organisation name**		**Organisation name**	
Period of employment		**Period of employment**		**Period of employment**	
Your role title		**Your role title**		**Your role title**	
Regarding tobacco control policy, what were you involved with in each organisation? (mark with 'X')					
A Policy development		**A** Policy development		**A** Policy development	
B Policy consultation		**B** Policy consultation		**B** Policy consultation	
C Policy approval		**C** Policy approval		**C** Policy approval	
D Policy implementation		**D** Policy implementation		**D** Policy implementation	
E Policy Monitoring/ evaluation/review		**E** Policy Monitoring/ evaluation/review		**E** Policy Monitoring/ evaluation/review	
F Policy legislation/regulation		**F** Policy legislation/regulation		**F** Policy legislation/regulation	
G Other - explain		**G** Other - explain		**G** Other- explain	

3. Any clarification/questions related to the above questions?

Section B. Indicative questions (face-to-face and phone interview)

Related to smokefree policies: your roles and views.

1. You work/worked at [place and role]. What does/did your role involve, what were you responsible for…
2. Smokefree policies in **Public Sector General Hospital – describe/support/not support - reasons**
3. Smokefree policies in **Public Sector Mental Health In-patient Facilities –describe/ support/not support - reasons**
4. Barriers to the use of smokefree policies in **Public Sector Mental Health In-patient Facilities: what, why, reasons, views**
5. **Views about benefits of smokefree policies for service users and staff in Public Sector Mental Health In-patient Facilities**

Section C. Indicative Questions (face-to face interview and phone interview)

Related to Smokefree Policies and Public Sector Mental Health In-patient Facilities

1. Views about limitations/disadvantages/exceptions re smokefree policies in **Public Sector Mental Health In-patient Facilities**
2. Characteristics of successful policy implementation in **Public Sector Mental Health In-patient Facilities**
3. Factors to consider when working in any of the named areas of tobacco control policy (refer prompt card A)
4. Reflections/learnings about SF policies in **Public Sector Mental Health In-patient Facilities**
5. Any other comments

Section D. Indicative Questions (face-to-face interview and phone interview)

Related to Smokefree 2025

1. Understanding of Smokefree 2025
2. Views about achieving Smokefree 2025
3. Views about role of smokefree policies in **Public Sector Mental Health In-patient Facilities** and Smokefree 2025) (refer prompt card B)
4. Any other comments

Appendix G: DHB official information requests

District Health Boards: Official Information Requests & Dates

Auckland DHB	Northland DHB
Bay of Plenty DHB	South Canterbury DHB
Canterbury DHB	Southern District DHB
Capital and Coast DHB	Tairawhiti DHB
Counties Manukau DHB	Taranaki DHB
Hawkes Bay DHB	Waikato DHB
Hutt Valley DHB	Wairarapa DHB
Lake DHB	Waitemata DHB
MidCentral DHB	West Coast DHB
Nelson-Malborough DHB	Whanganui DHB

DHB Smoke-free Policies

Official Information Request:

1. Smoke-free policies (tobacco and/or vaping), including any specific to mental health inpatient facilities, used by [Name] DHB between and including the years 2000 – 2019.

2. Policies related to smoking (tobacco), including any specific to mental health inpatient facilities, used by the former CHE and Health and Hospital Services between and including the years 1993-1999.

Official Information Received: 17 February 2020 - 7 May 2020

DHB Smoking Status Data

Official Information Request: for 2009 - 2020

1. Smoking status (inpatient) Total number of smokers x ethnicity in the DHB Mental Health and Addictions ward/s (including forensics)

2. Admissions (inpatient) Total number of admissions x ethnicity to the DHB Mental Health and Addictions ward/s (including forensics)

3. Smoking status (inpatient) Total number of inpatient smokers x ethnicity in the DHB General Hospital/s wards including elderly

4. Admissions (inpatient) Total number of admissions x ethnicity to the DHB General Hospital/s wards including elderly

Official Information Received: 25 August 2020 – 12 October 2020

Appendix H: Thematic analysis: Stage 2 initial codes – sample

Thematic Analysis: Stage 2: Generating initial codes: sample

Smoking happened outside	Support patients smoking	Once a smoker always a smoker	Sites of smoking: inside in bathroom	State complicit in supply and health effects
Existence of a smoking room in HRBC	Existing unhealthy lifestyles	Smoking was the normalised	Smoking paraphernalia present	Normalisation of cigarettes
Men desperate to smoke	Cigarettes least of the problems for patients	Smoking: environmental impact on uptake		Cash comforts: entitlement
Nicotine withdrawal	Support for patients smoking	Smoking: is cool	Temporal: staff smoking at all breaks	Patients: traded tobacco
Empathy for smokers	Opposed to SF MHIF	Smoking: is for adults	Sites of smoking: inside	Patients: traded tobacco for sex
Staff have the choice to smoke	Impact of personal smoking	Smoking: inside the buildings	Sites of smoking: in wards	Smokers: included nurses
Empathy for smokers	Staff have a choice to smoke	Smoking: enables inclusion	Normalisation of smoking	Acceptability of smoking
Opposed SF MHIF	Incarceration removes patient choice	Smoking uptake starts with nursing	Smokers included doctors	Normalisation of smoking
Smoking relieves stress	Choice removed by SF for patients	Smoking uptake starts with nursing	Smokers included nurses	Health risks: silence
No alternative to smoking is punitive	Justice is important for patients	Senior nurses were role models for smoking	Smokers included all staff	Rewards: cigs for good behaviour

Appendix I: Smoke-free Environments and Regulated Products Act 1990 – section 6 proposed amendments

Amendments to Smoke-free Environments and Regulated Products Act 1990

Current legislation

Section 2 dedicated room means an internal area in a hospital care institution, a residential disability care institution, or a rest home that is used solely to—
(a)
enable patients or residents who smoke to smoke, or to socialise with each other in a place where smoking is permitted; or
(b)
enable patients or residents who vape to vape, or to socialise with each other in a place where vaping is permitted

Proposed amendment

In Section 2 dedicated room, delete "(a) enable patients or residents who smoke to smoke, or to socialise with each other in a place where smoking is permitted; or"

Current legislation
Section 6 Dedicated rooms in hospital care institutions, residential disability care institutions, and rest homes
(1)
An employer may permit smoking or vaping by patients or residents of a workplace that is, or is part of, a hospital care institution, a residential disability care institution, or a rest home if—
(a)
the smoking or vaping takes place only in 1 or more dedicated rooms for smoking or vaping; and
(aa)
the vaping takes place only in 1 or more dedicated rooms for vaping; and
(b)
each dedicated room is equipped with or connected to a mechanical ventilation system to which subsection (2) applies; and
(c)
the employer has taken all reasonably practicable steps to minimise the escape of emissions from the dedicated smoking or vaping rooms into any part of the workplace that is not a dedicated room; and
(d)
for each dedicated room, an adequate equivalent room is available for patients or residents who wish to socialise in an atmosphere without emissions.
(2)
This subsection applies to a mechanical ventilation system with which a dedicated room in a workplace is equipped if, and only if,—
(a)
the system is so designed, installed, and operating that it takes air from the room to a place outside the workplace where any emissions the air may contain will not enter any part of the workplace, either—
(i)
directly; or

(ii)
through 1 or more other dedicated rooms; and
(b)
no part of the workplace that is not a dedicated room is equipped with or connected to the system.
(3)
Subsection (1)—
(a)
does not authorise an employer to permit a person who is not a patient or resident of the institution or home concerned to smoke or vape in a dedicated room; and
(b)
does not authorise a person who is not a patient or resident of the institution or home concerned to smoke or vape in a dedicated room.

Proposed amendment

In Section 6, delete "smoking or" and "smoke or".