Frequently Asked Questions (FAQs): Smokefree Health Services

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The *Tobacco Act 1987* (Tobacco Act) (Vic) prohibits smoking within four metres of building entrances (pedestrian access points) to public hospitals and registered community health service in Victoria. Electronic cigarettes are also prohibited in all legislated smoke-free areas.

Under the Tobacco Act, smoking is also banned inside hospital buildings.

The legislation forms a minimum standard. In addition to the law banning smoking inside, and within four metres of entrances to all public hospital buildings, a health service may choose to put in place a policy which further restricts smoking on the hospital site.

Why a smokefree health service?

Smoking remains the leading preventable cause of disease and death in Australia. Health services should play an active role in tobacco control as their primary goal is to promote health by treating acute illness or injury or exacerbations of chronic disease, many of which have links to smoking (1). Smoking related diseases account for a high proportion of admissions to hospital and deaths across the population (1). Furthermore, people accessing health services are likely to demonstrate higher rates of smoking than the general population.

Stopping smoking has considerable health benefits for people who smoke as well as those around them. For people accessing health services, benefits include reduced length of stay, lower medication doses, fewer complications, improved wound healing and reduced re-admissions (2).

Secondhand smoke (SHS), also known as environmental tobacco smoke (ETS) or passive smoke, is the combination of side-stream smoke, i.e. smoke that is emitted between puffs of burning tobacco, and mainstream smoke, i.e. smoke that is exhaled by the smoker (3). SHS is a complex mixture of thousands of gases and particulate matter and has been declared carcinogenic by the International Agency for Research on Cancer (4). The health effects of SHS are well documented.

Long-term exposure to SHS can cause heart disease and lung cancer, and cause asthma in children. Short exposures to incidental SHS also have immediate health effects. A healthy environment is a prerequisite for the provision of high-quality patient care.

Smokefree health services are important to:

- Protect patients, staff and visitors from the harmful effects of second-hand smoke
- Support smoking cessation among both patients and staff
- Demonstrate public leadership about reducing the harms associated with smoking

The World Health Organisation (WHO) recommends that all health services be smokefree with no exemptions (5). Smokefree policies are one of the most effective measures recommended by the WHO Framework Convention on Tobacco Control to control the tobacco epidemic (6). There is also considerable community support for smokefree environments. A total smokefree policy places tobacco on a par with the use of alcohol and illicit drugs (7).

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Achieving smokefree health services is far from straightforward; they require substantial structural, practical and cultural changes.

Like many policies, implementation is a process, not an event. The extent to which a smokefree policy has been successfully implemented will be expected to impact on the extent and nature of perceived benefits, barriers and support for the policy. Evidence of problems does not mean the policy is inappropriate or a failure.

What will a total smokefree policy do for our health services?

Overall, the literature on smokefree policies in health services suggests that there is benefit to be gained from both patients and staff by implementing a total smokefree policy.

Supporting staff to quit

Total smokefree policies have been associated with reductions in staff smoking (4, 8). A systematic review of smokefree workplaces showed that totally smokefree policies had approximately twice the effect on reducing staff smoking rates compared to partial policies that included designated smoking areas (9). An Australian study at North Coast Area Health Service in NSW (10), also found that staff smoking rates decreased significantly (a 10% reduction) upon implementation of a smokefree workplace policy. Workplace smoking is a cause of lost revenue as well as associated with morbidity of the workforce. A study by Berman (11) estimated the excess annual cost per smoker from absenteeism to be US$517, and a further $US3077 from lost productivity due to smoking breaks.

Protecting staff from second hand smoke

Another consideration is staff exposure to SHS. A Dutch study found that 87% of psychiatric facility staff surveyed reported being exposed to SHS in facilities with a partial smoke-free policy and concluded that only total smokefree policies would protect staff from exposure (12). Only total smokefree policies are effective in ensuring that staff are not exposed to particulate matter that surpasses the safety threshold indicated by the World Health Organisation (13). Any smoking on site is very likely to result in some SHS exposure. There is no risk-free level of exposure to SHS and breathing it in can have both immediate and long-term health consequences.

Supporting patients to quit

There is also some evidence that total smokefree policies may better support patient's attempts to quit smoking. Patients report that it is easier to quit when no-one else smokes (14). A recent systematic review (15) showed that patients in mental health services with total smokefree policies had beneficial changes in their smoking behaviour; significant reductions in daily cigarette consumption at 14 days post discharge (16) and 3 months (17). Etter (18) describes the effect after the implementation of a total smokefree policy in a mental health unit. There was substantial increase in the percentage of patients who smoke that attempted to quit during hospitalisation (from 2% to 18%); an important result considering the difficulty patients with mental illness experience with quitting smoking.

While it is true that often patients will resume smoking once discharged, a period of abstinence has a direct health and financial benefit for the patient and has been found to change patient's perception of their need to smoke, thereby increasing the likelihood that they will successfully quit in the future (19).

Self-efficacy (a person's belief in and confidence) to quit smoking or manage withdrawal is clearly influenced by the environment. Environments that facilitate smoking negatively (such as total smokefree environments) improve their self-efficacy (20).

Should we implement a partial or total smokefree policy?

As outlined above in addition to the law banning smoking inside, and within four metres of entrances all public hospital buildings, a health service may choose to put in place a policy which further restricts smoking on the hospital site.

A total smokefree policy is where no smoking (or use of other tobacco related products) is permitted on the health service premises (i.e. all outdoor areas). A partial smokefree policy typically allows for the creation of designated outdoor smoking areas (19).

Research demonstrates clearly that total smokefree policies are more successful than partial smokefree policies (18); providing consistency, avoiding negative consequences of persistent nicotine withdrawal, minimising fire risk and exposure to SHS (21).

Having a total smokefree policy that covers the entire hospital grounds is unambiguous, promotes the message of the harms associated with tobacco use, and demonstrates that people have the right to work and receive health care in a smokefree environment. Partial smokefree policies send the message that smoking is still an acceptable practice (22).

A partial smokefree policy may appear easier to implement due to the less restrictive nature; however one of the most significant issues with these is their limited impact on the staff and patient culture of smoking. Health services that retain designated smoking areas can expect fewer staff to quit smoking and very little change in staff cigarette consumption (9). The more restrictive the smokefree policy, the greater the effects on staff smoking behaviour (6).

It is important to remember that nicotine delivered through cigarette smoking is highly addictive. There is evidence that partial smokefree policies may place patients who smoke in a chronic state of nicotine withdrawal (23). Continued smoking while in hospital is generally restricted; a smaller and/or set number of breaks to smoke may have negative consequences for both patients and staff (24). Patients who are limited to fewer cigarettes than they smoke regularly may experience significant and persistent withdrawal. Smoking breaks in facilities where there are partial smokefree policies can become a fixation for patients and ultimately disruptive to their treatment (25). Allowing patients to continue to smoke is not only harmful for their health but can undermine their treatment, especially treatment of substance dependence (26). There is also evidence that patients may increase their cigarette consumption in units with partial smokefree policies (19).

A partial smokefree policy which designates where to smoke can give preference to some patients over others, for example patients who are voluntarily admitted, are in an open access ward or have been given medical permission to leave the ward.

A study by Etter (18) demonstrated that a total smokefree policy did not harm the staff-patient relationship. Staff should not be relying on cigarettes to facilitate a therapeutic relationship with patients, especially given the health risks posed by tobacco use.

Furthermore to achieve the best SHS reduction, policies must be comprehensive (27)- that is, totally smokefree without exemption. In comparison, partial smokefree policies that allow designated smoking areas do not offer adequate SHS protection.

Will implementing a total smokefree policy increase risk of aggression or violence?

A major barrier to implementing smokefree policies is the perceived association that increased aggression or violence will result. This perception remains despite the growing body of literature on smokefree policies which show no increases in aggression or violence (21).

Management of nicotine withdrawal should be a routine part of clinical care. Failure to adequately do so may result in the increased potential for patient aggression and violence (28). Nicotine withdrawal symptoms include irritability and agitation, symptoms that— if not well managed—can cause disruption within the health service setting.

Concerns about increased patient aggression are not realised in health services with well-implemented comprehensive policies (21, 29). There is little evidence for increased aggression, increased use of restraints, discharge against medical advice, or use of 'as required' medications (29, 30). Two studies have found that episodes of physical aggression and verbal aggression actually *decreased* after the tobacco ban was implemented; by 50% and 45% respectively (31). Generally, staff tend to anticipate more problems than actually occur (29). Interestingly in one study, not only did the use of 'as required' benzodiazepines and antipsychotics not increase, there was a statistically significant decrease in the average dose of regular antipsychotic medications (32). These are similar findings to another study whereby there was no marked increase in medication use, self-harm or behavioural disturbance (33). Another study (34) showed a reduction in the number of hospital incidents that led to seclusion and restraint after implementation of a smokefree policy; thereby suggesting a positive effect on staff and their interactions with patients.

However, within health services where partial smokefree policies operate, conflict can arise among patients and staff. Partial smokefree policies raise equity concerns about access to smoking. Inconsistent enforcement is also a more common problem with partial smokefree policies, and may lead to negative outcomes that could have otherwise been avoided with the implementation of a total smokefree policy (35). A review of 26 international studies reporting the effectiveness of smokefree policies in psychiatric settings found no evidence of increased aggression or other smoking related problems among 90% of sites with a total smokefree policy, but found no evidence of increased aggression among only 76% of sites with a partial smokefree policy (29). In this review, inconsistency and an increased focus on negotiating smoking privileges resulted in increased damage and disruption for health services that implemented partial policies as opposed to total policies (29).

Robson and colleagues (36) demonstrated that the introduction of an adequately resourced, comprehensive smoke-free policy appeared to reduce the incidence of physical assaults; a larger decline was apparent in patient-toward-staff violence than patient-toward-patient violence. Importantly, this smokefree policy included the prohibition of smoking in the buildings and grounds of all hospital premises, staff-facilitated smoking, and a well-established tobacco dependence treatment pathway. Treatment included offering patients who smoke nicotine replacement therapy (NRT) within 30 min of arrival on the ward, and combination NRT for the duration of admission from ward staff trained in smoking cessation.

What about mental health settings?

The prevalence of smoking among individuals with mental illness is significantly higher than the general population, with more than two thirds of inpatients at Australian public mental health units with psychotic illness being reported as current smokers (37). People with mental illness also smoke more cigarettes per day and have greater adverse health outcomes associated with their tobacco use. This group experiences two to three times the mortality and morbidity from the leading chronic health conditions such as cardiac and respiratory disease (19). Tobacco use is also responsible for contributing to financial and social harms for people living with mental illness (38).

Overall, the mental health system has been slower to implement tobacco cessation interventions (19). Smoking has traditionally been an acceptable part of the culture. Staff tend to perceive smoking to be a source of pleasure and comfort for patients and an important way of socialising (39). Furthermore, cigarettes have been used as a currency between patients and as a patient management tool by staff (20). There is some evidence that many patients with mental health conditions began smoking while admitted to an inpatient mental health unit, possibly up to 10% of patients (19).

Exempting mental health facilities from smokefree policies have the potential to worsen health inequalities for people with mental illness and further their stigmatisation (24). When groups are excluded from policies, it can be perceived as a form of stigma. Stigma is a resonating issue as the mental health community strives for greater acceptance and integration. People who smoke are increasingly facing stigma, as population smoking rates decline and smoking becomes more and more marginalised from society.

Legal challenges made on behalf of mental health clients have almost all been in the name of smoker's rights despite the fact that the legal precedent for support of smokers' rights has been almost non-existent (24). Certainly in the US, tobacco use has been deemed in courts to not be a right but a privilege that can be restricted when it is detrimental to others (24).

Furthermore, there is strong evidence that many people living with mental illness want to reduce or cease smoking. Most people who smoke understand the harm it causes to their health, and expect clinicians to address their smoking. Failure to do so may inadvertently communicate that quitting is not important, or that their life is not worth saving (23).

Why is clinical managing nicotine dependence so important?

Clinically managing nicotine dependence in health services is first and foremost a question of good clinical practice. It is also a key determinant of the likely success of a smokefree policy (15). When nicotine dependence is considered a habit, rather than an addiction which requires clinical support, this can have adverse consequences on the success of the smokefree policy (40). The inpatient stay is a unique opportunity for health professionals to deliver brief interventions for smoking cessation at a receptive time (41). Also, supporting people who smoke to quit is a cost effective healthcare interventions (42).

It is also important to remember that patients are likely to experience nicotine withdrawal in the inpatient setting, with or without a health service smokefree policy. Acute nicotine withdrawal in smokers has been shown to increase aggressive behaviour (43). During hospitalisation it is likely that patients will be unable to smoke where or as often as they like to relieve their nicotine withdrawal symptoms. Periodic provision of cigarettes is a poor way

to manage nicotine withdrawal; this simply places the patient in a continual state of nicotine peaks and then troughs. It can also be difficult to distinguish between nicotine withdrawal symptoms and worsening of psychiatric symptoms.

Non-compliance has been documented extensively in the literature (44) and is a cause of concern for many health services. One study that examines compliance, in particular, concluded that approximately one quarter of patients who smoke admitted to violating the smokefree policy during their hospital admission; not surprisingly this occurred more often when experiencing nicotine withdrawal symptoms (45). Failure to address hospitalized psychiatric patients' nicotine withdrawal through use of NRT is associated with a two-fold higher discharge against medical advice rate relative to smokers who were prescribed NRT and relative to non-smokers (23). Successfully managing nicotine withdrawal symptoms will reduce the need for hospitalised smokers to leave the site to smoke.

Prochaska and colleagues posited that the staff time spent negotiating and managing a patient's smoking behaviours could be more productively used to deliver smoking cessation interventions (17).

Supporting staff to quit is also important, as it has been shown that staff who smoke are less supportive of smokefree policies (21).

The management of nicotine dependence should be embedded into routine care. The Victorian Government is committed to building the capacity of Victorian health services and health professionals to provide the best possible support for people who smoke to quit. Ideally, all health services would adopt a systematic approach to identifying people who smoke, providing a brief intervention and including smoking status and action taken within discharge communication.

Clinical guidelines have been found to be an important step in changing clinical practice. Successfully implementing clinical guidelines for managing nicotine dependency will not only better manage a patient's withdrawal symptoms, reduce distress, encourage compliance with smokefree policies but also contribute to population health outcomes through promoting long term cessation.

Resources

Department of Health and Human Services Tobacco Reforms website

An ABCD approach to supporting people who smoke: a guide for health services

Pharmacotherapy for smoking cessation

Start the conversation

Totally Smokefree at Alfred Health

Achievement Program

Quit Victoria

Quit online Learning Hub

Victorian Network of Smokefree Healthcare Services

References

1. Lawn S. Habit or addiction: the critical tension in deciding who should enforce hospital smoke-free policies. Cmaj. 2011;183(18):2085-6.

2. Khullar D, Maa J. The impact of smoking on surgical outcomes. J Am Coll Surg. 2012;215(3):418-26.

3. Frazer K, McHugh J, Callinan JE, Kelleher C. Impact of institutional smoking bans on reducing harms and secondhand smoke exposure. Cochrane Database Syst Rev. 2016(5):CD011856.

4. Frazer K, Callinan JE, McHugh J, van Baarsel S, Clarke A, Doherty K, et al. Legislative smoking bans for reducing harms from secondhand smoke exposure, smoking prevalence and tobacco consumption. Cochrane Database Syst Rev. 2016;2:CD005992.

5. Raw M, Anderson P, Batra A, Dubois G, Harrington P, Hirsch A, et al. WHO Europe evidence based recommendations on the treatment of tobacco dependence. Tob Control. 2002;11(1):44-6.

6. Martinez C, Fu M, Martinez-Sanchez JM, Anton L, Fernandez P, Ballbe M, et al. Impact of a long-term tobacco-free policy at a comprehensive cancer center: a series of cross-sectional surveys. BMC Public Health. 2014;14:1228.

7. Shetty A, Alex R, Bloye D. The experience of a smoke-free policy in a medium secure hospital. Psychiatrist. 2010;34(7):287-9.

8. Fathallah N, Maurel-Donnarel E, Baumstarck-Barrau K, Lehucher-Michel MP. Three-year follow-up of attitudes and smoking behaviour among hospital nurses following enactment of France's national smoke-free workplace law. International Journal of Nursing Studies. 2012;49(7):803-10.

9. Fichtenberg CM, Glantz SA. Effect of smoke-free workplaces on smoking behaviour: systematic review. Bmj. 2002;325(7357):188.

10. Dart GS, van Beurden EK, Zask A, Lord C, Kia AM, Tokley R. Reduction in staff smoking rates in North Coast Area Health Service, NSW, following the introduction of a smoke-free workplace policy. N S W Public Health Bull. 2010;21(11-12):263-6.

11. Berman M, Crane R, Seiber E, Munur M. Estimating the cost of a smoking employee. Tob Control. 2014;23(5):428-33.

12. Willemsen MC, Gorts CA, Van Soelen P, Jonkers R, Hilberink SR. Exposure to environmental tobacco smoke (ETS) and determinants of support for complete smoking bans in psychiatric settings. Tob Control. 2004;13(2):180-5.

13. Ballbe M, Sureda X, Martinez-Sanchez JM, Salto E, Gual A, Fernandez E. Second-hand smoke in mental healthcare settings: time to implement total smoke-free bans? Int J Epidemiol. 2013;42(3):886-93.

14. Prochaska JJ, Gill P, Hall SM. Treatment of tobacco use in an inpatient psychiatric setting. Psychiatric Services. 2004;55(11):1265-70.

15. Stockings EA, Bowman JA, Prochaska JJ, Baker AL, Clancy R, Knight J, et al. The impact of a smoke-free psychiatric hospitalization on patient smoking outcomes: A systematic review. Australian and New Zealand Journal of Psychiatry. 2014;48(7):617-33.

16. Siru R, Hulse GK, Khan RJ, Tait RJ. Motivation to quit smoking among hospitalised individuals with and without mental health disorders. Aust N Z J Psychiatry. 2010;44(7):640-7.

17. Prochaska JJ, Fletcher L, Hall SE, Hall SM. Return to smoking following a smoke-free psychiatric hospitalization. American Journal on Addictions. 2006;15(1):15-22.

18. Etter M, Khan AN, Etter JF. Acceptability and impact of a partial smoking ban followed by a total smoking ban in a psychiatric hospital. Prev Med. 2008;46(6):572-8.

19. Lawn S, Campion J. Achieving smoke-free mental health services: Lessons from the past decade of implementation research. International Journal of Environmental Research and Public Health. 2013;10(9):4224-44.

20. Lawn SJ, Pols RG, Barber JG. Smoking and quitting: a qualitative study with community-living psychiatric clients. Soc Sci Med. 2002;54(1):93-104.

21. Hehir AM, Indig D, Prosser S, Archer VA. Implementation of a smoke-free policy in a high secure mental health inpatient facility: staff survey to describe experience and attitudes. BMC public health. 2013;13:315.

22. Wye P, Bowman J, Wiggers J, Baker A, Knight J, Carr V, et al. Total smoking bans in psychiatric inpatient services: a survey of perceived benefits, barriers and support among staff. BMC public health. 2010;10:372.

23. Prochaska JJ. Ten critical reasons for treating tobacco dependence in inpatient psychiatry: Journal of the American Psychiatric Nurses Association. 15 (6) (pp 404-409), 2009. Date of Publication: 2009.; 2009.

24. Williams JM. Eliminating tobacco use in mental health facilities: Patients' rights, public health, and policy issues. JAMA - Journal of the American Medical Association. 2008;299(5):571-3.

25. Ratschen E, Britton J, McNeill A. Implementation of smoke-free policies in mental health in-patient settings in England. Br J Psychiatry. 2009;194(6):547-51.

26. Moss TG, Weinberger AH, Vessicchio JC, Mancuso V, Cushing SJ, Pett M, et al. A tobacco reconceptualization in psychiatry: Toward the development of tobacco-free psychiatric facilities. American Journal on Addictions. 2010;19(4):293-311.

27. Li Q, Hyland A, O'Connor R, Zhao G, Du L, Li X, et al. Support for smoke-free policies among smokers and non-smokers in six cities in China: ITC China Survey. Tob Control. 2010;19 Suppl 2:i40-6.

28. Lawn S, Pols R. Nicotine withdrawal: Pathway to aggression and assault in the locked psychiatric ward? Australasian Psychiatry. 2003;11(2):199-203.

29. Lawn S, Pols R. Smoking bans in psychiatric inpatient settings? A review of the research. The Australian and New Zealand journal of psychiatry. 2005;39(10):866-85.

30. El-Guebaly N, Cathcart J, Currie S, Brown D, Gloster S. Public health and therapeutic aspects of smoking bans in mental health and addiction settings. Psychiatric Services. 2002;53(12):1617-22.

31. Quinn J, Inman JD, Fadow P. Results of the conversion to a tobacco-free environment in a state psychiatric hospital. Administration and Policy in Mental Health. 2000;27(6):451-3.

32. Cormac I, Creasey S, McNeill A, Ferriter M, Huckstep B, D'Silva K. Impact of a total smoking ban in a high secure hospital. Psychiatrist. 2010;34(10):413-7.

33. Hempel AG, Kownacki R, Malin DH, Ozone SJ, Cormack TS, Sandoval IBG, et al. Effect of a total smoking ban in a maximum security psychiatric hospital. Behavioral Sciences and the Law. 2002;20(5):507-22.

34. Hollen V, Ortiz G, Schacht L, Mojarrad MG, Lane Jr GM, Parks JJ. Effects of adopting a smoke-free policy in state psychiatric hospitals. Psychiatric Services. 2010;61(9):899-904.

35. Campion J, Lawn S, Brownlie A, Hunter E, Gynther B, Pols R. Implementing smoke-free policies in mental health inpatient units: learning from unsuccessful experience. Australasian Psychiatry. 2008;16(2):92-7.

36. Robson D, Spaducci G, McNeill A, Stewart D, Craig TJK, Yates M, et al. Effect of implementation of a smoke-free policy on physical violence in a psychiatric inpatient setting: an interrupted time series analysis. The Lancet Psychiatry. 2017;4(7):540-6.

37. Thomas M, Richmond R. Smoke-free mental health inpatient facility policies in Australia: variation across states and territories. Australian and New Zealand Journal of Public Health. 2017;41(4):329-32.

38. Johnson JL, Moffat BM, Malchy LA. In the shadow of a new smoke free policy: A discourse analysis of health care providers' engagement in tobacco control in community mental health. International Journal of Mental Health Systems. 2010;4 (no pagination)(23).

39. Voci S, Bondy S, Zawertailo L, Walker L, George TP, Selby P. Impact of a smoke-free policy in a large psychiatric hospital on staff attitudes and patient behavior. General Hospital Psychiatry. 2010;32(6):623-30.

40. Schultz AS, Finegan B, Nykiforuk CI, Kvern MA. A qualitative investigation of smoke-free policies on hospital property. Cmaj. 2011;183(18):E1334-44.

41. Freund M, Campbell E, Paul C, McElduff P, Walsh RA, Sakrouge R, et al. Smoking care provision in hospitals: A review of prevalence. Nicotine and Tobacco Research. 2008;10(5):757-74.

42. Parrott S, Godfrey C. Economics of smoking cessation. Bmj. 2004;328(7445):947-9.

43. Allen MH, Debanne M, Lazignac C, Adam E, Dickinson LM, Damsa C. Effect of nicotine replacement therapy on agitation in smokers with schizophrenia: a double-blind, randomized, placebo-controlled study. Am J Psychiatry. 2011;168(4):395-9.

44. Shopik NA, Schultz AS, Nykiforuk CI, Finegan BA, Kvern MA. Impact of smoke-free hospital grounds policies: patient experiences and perceptions. Health Policy. 2012;108(1):93-9.

45. Rigotti NA, Arnsten JH, McKool KM, Wood-Reid KM, Pasternak RC, Singer DE. Smoking by patients in a smoke-free hospital: prevalence, predictors, and implications. Prev Med. 2000;31(2 Pt 1):159-66.