Going 100% Smoke-Free in a Secure Setting: One Hospital's Successful Experience

By the Members of the Mental Health Centre Penetanguishene's Smoke-Free Task Force

When the Mental Health Centre in Penetanguishene, Ontario announced that the use of tobacco products would no longer be allowed anywhere on its 225-acre grounds after May 6, 2003, many patients and staff reacted in disbelief. In this article, the authors discuss the operational, health and safety, clinical and ethical issues surrounding the decision.

100% Smoke-Free

The Mental Health Centre Penetanguishene (MHCP) is a 291-bed psychiatric hospital in central Ontario, Canada. Its Forensic Division includes over half the patients, the majority of whom are housed in the maximum-security Oak Ridge building. MHCP's Tertiary Care and Acute and Community Care Divisions offer a broad range of specialized inpatient and outpatient programs for the seriously mentally ill. The hospital has five major buildings offering treatment and several other administrative and support buildings distributed over 225 acres.

Like most psychiatric hospitals, MHCP has a history of accommodating smoking for both patients and staff, but society's attitude about smoking has changed dramatically in the last two decades, almost certainly due to overwhelming evidence on the ill health effects of the habit.

The passage of Ontario's Tobacco Control Act in 1994 banned smoking in all government buildings. MHCP is directly run by the Provincial Ministry of Health and Long Term Care. Large psychiatric facilities, including MHCP, sought and received special dispensation to allow patients and some staff to smoke in specially ventilated rooms. These "smoking rooms" were already in existence on most wards and some common patient areas at MHCP. The hospital also constructed seven "smoking gazebos" outside various buildings for patients and staff to use.

Despite increasing efforts to contain the smoke, many complaints were received that smoke leaked out of the rooms and was harming the health of non-smokers. Visual observation and a test with a carbon monoxide detector confirmed this hazard. Smoke leakage was a problem when patients and staff entered and left the smoking rooms and non-smoking staff and patients were exposed to second-hand smoke. Non-smoking staff were also exposed to second-hand smoke when they were obliged to enter the smoke rooms to provide patient care or clean. For these reasons, it was clear that the hospital could not provide a smoke-free environment by relying on specially ventilated smoking rooms.

A Smoke-Free Task Force (SFTF) was created in January of 2002. The first ward smoke room closed in August of 2002 with help and encouragement from the SFTF. After careful deliberation, the hospital's administrative team decided in November of 2002 to ban smoking in all hospital buildings and on the grounds beginning May 6, 2003. The phrase used to capture this new policy was "100% smoke-free."

Reasons Behind the Decision

The decision to ban smoking on the hospital grounds and in all buildings, a step viewed as radical by some, was made based on the following reasons and logic. First, it was clear from practical experience and consultations with the Simcoe County District Health Council that the hospital could not operate smoking rooms and protect the health of non-smoking staff and patients.

Second, between 60 and 80% of MHCP patients at any given time must be escorted outside by staff. Taking patients outside at least five times a day to smoke absorbs enormous staff resources. The costs to escort smokers outside of the maximum-security building Oak Ridge were estimated to be $500,000 a year. Additional costs were incurred to escort patients outside to smoke at six other programs in three additional buildings. In short, the costs were prohibitive.

Third, even if the hospital could have mustered the resources to escort smokers outside, it would have been favouring an activity known to be harmful at best and fatal at worst over beneficial therapies such as recreation and education. Can a healthcare facility ethically favour a harmful activity over beneficial ones? Can individual clinicians, all of whom belong to professional colleges that instruct their members to do their patients no harm, ethically facilitate smoking?

Given the health and safety, operational and ethical issues surrounding smoking, MHCP made the only responsible decision and banned smoking in hospital buildings and on the grounds.

Staff and Patient Reaction

Initial reaction from both staff and patients to the change was mixed, and in some cases, disbelief. Most had already accepted that the smoking rooms would be closed, but few expected smoking would not be allowed on the grounds. Some staff and patients welcomed the change, but expressed concerns about how it could be implemented. After the announcement, the SFTF visited all wards at least once to hold focus groups and information sessions to discuss the reasons for the change. People with serious mental illness, the service group of MHCP, are estimated to smoke at a rate as high as 80%. Between 20 and 30% of adult Canadians currently smoke. Observation and logic indicated that these percentages would apply to MHCP patients and staff.

Many staff and patients expressed anger at being denied the "right to smoke." The SFTF explained that they could find no basis for a specific "right to smoke" in Canada, but there was considerable provincial and federal legislation indicating Canadians have a right to a hazard-free workplace and environment. The Ontario Workplace Safety Insurance Board (WSIB) recognizes that environmental smoke can increase the risk of lung cancer in non-smokers and aggravate a number of health conditions such as asthma. A 2002 WSIB award to an Ottawa waitress with lung cancer, a lifelong non-smoker who worked in smoke-filled bars, was a wakeup call for many employers.

The SFTF tried to emphasize gently that tobacco is a controlled substance and tolerances are set based on what's best for the entire community. The SFTF has two representatives who are also members of the hospital's Patient/Consumer and Family Council. They received expressions of anger and concern about the change from many consumers and family members. Some family members said that smoking was the "only pleasure" available to their hospitalized relative. This led to considerable discussion about the need to provide healthier, pleasant activities for inpatients.

MHCP operates on Psychosocial Rehabilitation principles that include an emphasis on self-determination. Many patients/consumers viewed the new policy as reducing their self-determination. Others pointed out that "choosing addiction" did not sound like self-determination and that all hospitals and therapists prevent their patients from pursuing a variety of harmful activities. For example, alcohol, like tobacco, is a controlled substance and many people who require hospital stays have an alcohol dependency, but hospitals do not facilitate drinking on their grounds.

Finally, many staff and patients predicted increased danger on the wards from assaultive patients angered by the new policy and made irritable by nicotine withdrawal (more on this later).

On the positive side, many staff members and patients indicated that the change would give them the final impetus to quit smoking. Many said their families would not let them smoke at home or in the family car. Work, they said, was the last place they could easily smoke. Non-smoking staff members were often enthusiastic, saying they were impressed with the decision and looked forward to a completely smoke-free workplace. Many also looked forward to improvements in their clients' health and were relieved they would no longer be asked to escort patients to smoke breaks or to intervene in smoke-filled rooms.

Some smoking patients (admittedly a minority) were ambivalent about the decision. They wanted to quit for health or financial reasons but could not. For many, their sole source of income is a Personal Needs Allowance of CAN$112 a month. This is not enough to keep a heavy smoker in cigarettes for 31 days and many patients went through nicotine withdrawal in the second half of every month or had to have their cigarettes managed by staff. A number of patients were looking forward to spending this money on other things. Despite a desire to quit for health or financial reasons, they had not been able to prior to the implementation of the smoke-free policy. Many family members of patients also saw these benefits for their relative.

As May 6 approached, many people, some of them clinicians, predicted that the seriously mentally ill would not be able to tolerate an imposed withdrawal from tobacco. For most smokers, including the seriously mentally ill, quitting is a

struggle, but smoking cessation experts and experience at MHCP indicates that, given proper support and encouragement, individuals with mental illness can quit smoking as successfully as any other group.

At the time of this writing (about six months after the change), there seems to be more acceptance of a 100% smoke-free MHCP. Implementation went smoothly, although there are some problems in compliance (more on this later). Some outpatients who are smokers have said they will seek admittance to a hospital with a more liberal smoking policy if they need inpatient care. Staff at the hospital's Georgianwood Concurrent Disorders Program (for those with a drug and/or an alcohol problem plus a major mental disorder) have also expressed concerns that clients may avoid the program if they know they will have to withdraw from cigarettes, drugs and alcohol concurrently. This has not been the case to date. Patients and staff indicate that it is easier to quit smoking and stay off cigarettes if you are in a 100% smoke-free environment. Reformed smokers often relapse in the presence of other people who are smoking and drinking.

Communication Efforts

Effective and consistent communication was extremely important to the hospital's smoke-free initiative. While some new communication tools were developed, information dissemination relied heavily on existing hospital vehicles such as the MHCP intranet site and various hospital bulletins. The SFTF also organized educational events on the clinical implications of smoking and smoking cessation.

Additionally, smoke-free information stations were established in the hospital library and other locations. Material at these stations focused mainly on available cessation supports and the smoke-free contests.

The SFTF accepted presentations and delegations at its meetings and visited all wards to discuss the change and implications. It also produced and distributed a special pamphlet that outlined the new smoking policy and answered frequently asked questions. The pamphlet was distributed to staff and patients. By May 6, 2003, all stakeholders were aware of the change and the reasons, although not all agreed.

Local, provincial and national media took an interest in this story, especially as the May 6 deadline approached. All media inquires were channeled through the hospital's Director of Public Information, who formulated an appropriate response, including arranging for a hospital spokesperson as required. This resulted in reasonably balanced and accurate media coverage. Editorial positions were advanced both for and against the change.

One winner of the "Smoke-Free Week" contest (held one week before the tobacco ban to encourage voluntary withdrawal) was a patient at the Oak Ridge building, Ontario's only maximum-security psychiatric hospital. The prize was a fishing trip on Georgian Bay with MHCP's Psychiatrist-in-Chief. This minor part of the smoke-free initiative caught the attention of some media outlets. Their reporting focused on concerns about permitting a patient from Oak Ridge to go fishing and tended to ignore the important positive changes involved in the initiative.

Support and Literature Indications

During the various stages of planning for the smoke-free initiative, a variety of activities were undertaken to prepare and support patients and staff for the transition of learning to live and work without tobacco products. A number of consultations, meetings, training sessions, information-gathering and information-sharing strategies were used to assure the best resources were made available to all users of the facility and in particular to those who would no longer be smoking.

The following is a list of some of the more significant activities that occurred in the planning and implementation stages of the initiative:

- The Simcoe County District Health Unit was consulted and representatives provided input at several key stages of planning.
- Literature reviews were completed, with the assistance of the facility's librarian, with focus areas including smoking policies in Mental Health facilities, smoking cessation, cessation and schizophrenia, cessation and weight gain and cessation and concurrent disorders.
- Articles and supporting information, such as policies and information pamphlets, were reviewed from the Royal Ottawa Hospital and Ontario Correctional facilities. The Royal Ottawa Health Care Group has a forensic psychiatric program that is 100% smoke-free within the hospital, although other patients can still smoke outside if they have privileges. Provincial correctional facilities went completely smoke-free in 1997.
- The Program Training Consultation Centre in Ottawa was consulted on issues such as cigarette fading strategies (a process for gradually reducing the amount of nicotine in the blood, so that when the subject finally quits withdrawal symptoms are minimized) and for supporting resources.
- Twelve staff volunteers were trained in cessation counselling to assure all patients requesting support would be accommodated.
- Self-help material, hotline numbers and Internet sites from groups such as the Lung Association and the Cancer Society were distributed.
- Three contests were planned at various stages to promote awareness and voluntary cessation.
- The existing smoking policy was updated with the Smoke-Free Environment Policy outlining expectations for patients and staff. This update included satellite buildings, leased facilities, community visits and outings.

- A financial support package to assist staff with the purchase of cessation aids was made available to staff interested in quitting. A maximum of 100 staff members were each allowed to spend up to $150 for these aids. Total financial exposure for the hospital was $15,000. Financial aid was limited to strategies with proven efficacy such as Nicotine Replacement Therapy in conjunction with intensive counselling. At the time of this writing, only 17 staff members had taken advantage of this offer, a fact that still surprises members of the SFTF.
- An expert on cessation in the mental health setting was invited to speak to all interested staff at a clinical rounds.
- Nicotine replacement therapy, Zyban and other pharmacological aids were made available to all appropriate patients. Short-term counselling was consistently provided by the facility's medical staff and Nurse Practitioners to promote voluntary cessation. About 11 (of about 110) patients who smoked at the maximum-security Oak Ridge building quit prior to May 6. The SFTF's reading of the literature and discussions with other maximum-security correctional facilities indicated few clients are reported to quit before the ban date. The SFTF attributes this encouraging statistic at MHCP to the diligent work of the Oak Ridge nurse practitioner and other staff to offer cessation counselling and aids. Designated smoking rooms were promptly cleaned and funds were made available to all wards so these could be refurbished for new and healthier forms of patient activity such as exercise and music.
- Where needed, extra recreation was planned to assist in avoiding periods of boredom and inactivity during the crucial three to four weeks following the smoke-free date.
- Low-calorie snacks were provided twice a day for four weeks after May 6 to assist with cravings and discourage snacking on high-calorie food.
- Signage was updated throughout the facility.

Clinical Considerations

Literature was reviewed on how nicotine levels affect the level of anti-psychotic medications and other pharmaceuticals commonly prescribed in psychiatric hospitals. As a general rule, the presence of nicotine necessitates higher dosages of neuroleptics and other pharmaceuticals because nicotine stimulates the liver to metabolize pharmaceuticals faster.

To prepare for the policy change, one of MHCP's pharmacists went to each program to present an in-service on the interaction between nicotine and mental health pharmaceuticals. Each program was directed to prepare an admission protocol for new admissions who were smokers. The medical department's journal club held a meeting on the subject of nicotine/pharmaceutical interaction. There are a few studies that indicate nicotine can help concentration and memory in patients with schizophrenia or Alzheimer's syndrome, but the dangers of smoking far outweigh the benefits. However, these results may help explain the extremely high tobacco use among people with serious mental illness. It is possible that research may some day establish a therapeutic role for nicotine, but smoking will not be the delivery system.

While many of the patients said they were going to quit "cold turkey," nurse practitioners and doctors placed a PRN for nicotine replacement therapy on each smoking patient's file before May 6 in case they changed their minds and asked for the aid.

One clinical benefit that resulted from the policy change was that dosages for some patients on Clozapine, who could no longer smoke, could be slowly lowered with the efficacy remaining the same. The MHCP pharmacy estimates that about eight inpatients (of 30) had their daily Clozapine dosage lowered by up to 100 milligrams per day. Most would have been taking a daily dosage of about 500 milligrams, so this was a significant decrease of up to 20% in some cases. Any healthcare provider with patients taking Clozapine needs to monitor serum levels closely if the patient reduces or eliminates nicotine intake. High serum levels of Clozapine can lead to tachycardia, convulsions and other health problems. Novartis, the maker of Clozapine, recommends that the maximum blood level threshold for Clozapine should be 1,000 micrograms per litre. Agranulocytosis concerns associated with Clozapine requires regular blood work for Ontario patients who use the drug. Serum levels are readily available to help determine a possible relationship between serum levels and clinical effects.

This adjustment reduced side effects for the patients, made it easier to keep the dosages within the therapeutic range and resulted in less expense for the hospital. By closely monitoring the medication levels of the patients in the first month after nicotine withdrawal, adjustments were made with no negative incidents. Since nicotine has the potential to interfere with a number of medications, this effect is presumably occurring with other pharmaceuticals although it is difficult to be certain since serum levels for drugs other than Clozapine are not so closely tracked.

Another positive benefit was that serum levels stayed constant after May 6 in the patients who were tracked. Traditionally, MHCP patients smoked heavily in the first half of the month after the Personal Needs Allowance arrives. Depending on funds, many patients were forced to reduce their smoking in the second half of the month or did not smoke at all. This left the patient in monthly withdrawal and their fluctuating nicotine levels affected the potency of any pharmaceutical therapies. This is no longer a problem (except for new arrivals who are smokers and policy violators) and patients appear to be benefiting from steady, lower medication levels.

As part of its service, MHCP runs a residential concurrent disorders program (for those with a drug or alcohol dependency and a psychiatric disorder). Staff on this program expressed concern that a smoke-free hospital would dissuade many poten-

tial admissions from voluntarily entering the program and place undue stress on those who were struggling to overcome other drug addictions besides nicotine. The SFTF reviewed the literature on efforts to quit smoking concurrently with a program to break other drug dependencies.

There is a growing body of research knowledge indicating that banning smoking in residential addiction treatment programs and providing smoking cessation counselling can be done safely and effectively. Failing to address nicotine addiction seems a contradiction to the principles of addiction treatment. Cessation counselling does not jeopardize the alcohol recovery process. Indeed, concurrent treatment of nicotine and other dependencies can contribute to fewer relapses with alcohol and drugs (Currie 2003, Kay Bobo 1997, Martin 1997).

MHCP's concurrent disorders program remains fully occupied, although it is likely that some of the patients return to smoking when they leave the hospital for home visits, meetings or after graduation.

The oft-predicted flurry of violent incidents that would result from nicotine withdrawal also failed to materialize. This is consistent with the experience at the one similar highly secure psychiatric facility that has reported on its decision to ban smoking in all its buildings and on its grounds (Hempel 2002). It also appears to be consistent with the experience in Ontario provincial correctional facilities.

However, most of the information about the relationship between smoking and assaults in psychiatric facilities is anecdotal. It is difficult to separate the influence of nicotine withdrawal from other factors if there is an incident of interpersonal violence. To date, the experience at MHCP suggests that there has not been an increase in violent incidents related to going 100% smoke-free. The SFTF expects that by going 100% smoke-free, there will be a significant reduction in the number of incidents that regularly occurred between patients who still had cigarettes at the end of the month and those who did not.

MHCP staff are currently conducting a study of the effect of smoking cessation on the number of significant assaults in the facility and hope to publish the results related to the questions above.

Another significant clinical consideration for any facility that goes 100% smoke-free is weight gain in patients. Froom et al. (1998) showed that quitters gain on average five to six kilograms (about 15 pounds) post-cessation.

The nurse practitioner and the physician in the Oak Ridge building at MHCP have taken a preliminary look at this problem. Patients at MHCP are weighed on admission and each month thereafter. In a six-month period since the smoking ban was implemented, 13 patients in a sampling of 67 former smokers residing on four Oak Ridge wards had gained enough weight to pass a six-kilogram weight-gain threshold established for the purpose by the clinicians. Weight gain in former smokers tends to stabilize at about six months post-cessation.

The Oak Ridge building has an all-male population, but elsewhere at MHCP, and at many psychiatric hospitals or secure facilities, post-cessation weight gain is a bigger concern for female clients. Studies have indicated that a majority of female subjects considered a weight gain of 2.3 kilograms (five pounds) an unacceptable consequence of smoking cessation and a minority of female subjects, particularly young women, endorse smoking as a weight control aid (Seidman and Covey 1999). Clearly weight gain, and the attendant healthcare risks, is a problem that should be considered in any institutional population that becomes 100% smoke-free.

Even prior to instituting the smoking ban, weight gain was a clinical concern at MHCP because of the high-calorie/high-fat nature of standard institutional cooking. The nurse practitioner and a general physisian are working with the dietary department to reduce the amount of fat in the patient diet. The SFTF is also working with the canteen operators at the hospital to provide a wider range of products and healthier foods now that former smokers have more money to spend on non-tobacco items.

Challenges to Policy

MHCP announced the recent change to its smoking policy six months in advance of May 6, 2003. Many expressed disbelief and predicted that the change would not occur. At least one patient at the Oak Ridge building threatened to challenge the smoking policy in court.

In early May, 2003, eight patients brought an application for judicial review alleging that they were denied procedural fairness with respect to the development of the smoking policy. In general terms, the patients' position was that they had not been consulted and the views of patients were not taken into account when the policy was developed. The patients brought a motion for an injunction to prevent the implementation of the smoking policy. However, their motion was dismissed on May 7, 2003 and the patients subsequently abandoned the application for judicial review.

One of the patients brought a second application on May 26, 2003 in which he alleged that the smoking policy violated various rights enumerated in the Canadian Charter of Rights and Freedoms. The patient brought a second motion for an injunction and the motion was dismissed on June 13, 2003. His main application was dismissed by the Superior Court on December 30, 2003. In its decision on December 30, the Court held that there is no constitutional right to smoke.

The Mental Health Centre is also responding to a small number of employee grievances related to the smoking policy. Applicants for employment at MHCP are now routinely informed that the hospital is a 100% smoke-free site and adherence to the policy is a condition of employment.

The lesson that the SFTF takes from these experiences is that healthcare facilities that wish to go 100% smoke-free should expect some legal challenges and should consult with counsel prior to and during the implementation of a smoke-free policy to ensure that legal considerations are addressed.

Compliance Issues

MHCP has experienced a number of problems related to compliance to the smoking policy since May 6, including:

- The day after the new policy went into effect, a patient's relative carried out a threat to distribute free cigarettes to patients and it was necessary to ask the police to remove the individual from the grounds.
- Several weeks after the ban, there were still reports of surreptitious smoking by patients and staff in the maximum-security Oak Ridge building. There were also reports of staff smoking in other buildings and patients with grounds privileges smoking outside.
- A black market in tobacco products developed on the grounds surrounding the regionally mandated programs, a collection of specialized acute and tertiary care psychiatric services where many patients have unsupervised access to the grounds.
- Staff members have willingly explained the smoke-free policy to violators. However, some staff members have complained about a lack of clear direction on what to do if a violator refuses to comply.

The SFTF anticipated some resistance to the smoking policy and the need for ongoing encouragement, support and education for patients, staff and visitors. Each of the challenges mentioned above have been addressed by adding appendices to the policy and continued educational efforts. For example, one of the problems with surreptitious smoking is the increased fire hazard from quickly discarded matches and cigarettes. To help address this problem, the policy has been amended to direct all staff, volunteers and visitors not to bring tobacco products and flame-producing articles into any hospital building.

The SFTF recommends that any institution contemplating significant changes to its smoking policy consider these issues carefully.

Benefits

Two weeks after MHCP went 100% smoke-free, the SFTF met and the most common word used to describe the change was "liberation." Patients have been liberated from spending all their money on an addictive and harmful substance and the staff have been liberated from facilitating this activity. Housekeeping staff have been liberated from cleaning smoking rooms and the butt-strewn entrances of the buildings. Hospital physicians have been liberated from constantly treating smoking-related illnesses that they know are easily prevented.

Hospital psychiatrists can now at least proceed on the assumption that blood serum levels of neuroleptics are not being irregularly and unpredictably varied by nicotine effects. Clinical staff members offering programs have been liberated from having smoke breaks (and related staffing needs) interfere with planned activities. Visitors are liberated from running a gauntlet of smokers at the entrance of every building. The hospital has been liberated from the constant expense of renovation and construction every time society's tolerance of smoking changes.

The health benefits of not smoking have been well documented. Most patients at MHCP currently do not smoke at all and many staff members have quit smoking or are smoking less. While we have no data yet about changes in the health of our patients in a smoke-free facility, nurse clinicians and physicians report much healthier chest sounds in examination. The distinctive sound of "smoker's cough" has disappeared from yards and activities. The patients have more money to spend on other things.

More important, no one in the hospital community is unwillingly exposed to second-hand smoke.

The Mental Health Centre also now stands as an example of a healthcare facility with the will to make a difficult ethical/health and safety decision. Healthcare facilities that prefer to take the "incremental" approach to restricting smoking will probably find that they devote considerably more time and resources to this issue over the next decade. HQ

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Dollars Not the Driving Force

A study done by Canadian Health Services Research Foundation found that the availability of work for their spouses, education opportunities for their children and recreation opportunities for the whole family are all things that doctors and their families consider more important than financial incentives. Family and lifestyle concerns were a major motivation for the 62% of doctors who left rural practices in Quebec's Outaouais region between 1985 and 1990, despite the fact that 76% of rural doctors receive financial incentives in that province.

(*Source:* Canadian Health Services Research Foundation.)