Tobacco Free CAMH: Evidence Based Support

Behavioural, Mental Health and Addictions Outcomes

Tobacco use is associated with worsened substance abuse and psychiatric treatment outcomes, increased depressive symptoms and suicidal risk – smoking cessation supports better treatment outcomes (Prochaska, 2010). Addressing tobacco use is consistent with a harm reduction approach.

Systematic reviews from Canada, the U.S., and Australia report no increase in aggression, patient seclusion, discharge AMA, or use of PRN medications (Campion et al., 2008). Rather, a reduction in behavioural problems and violence is suggested (Williams, 2008) as long as nicotine dependence and withdrawal were appropriately managed (Prochaska, 2010)

Smoking cessation is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke (Shahab et al., 2013; Taylor et al., 2014)

Common myths that staff have about tobacco use include: that patients are not interested in quitting and are unable to quit (Lawn & Campion, 2013)

Implementation and Efficacy of Full Tobacco bans

Partial smoking bans have been shown to be less effective than complete smoking bans– "Settings that implement selective bans may find increased conflict and verbal aggression as a result of an increased focus on negotiating smoking privileges" (Lawn & Campion, 2013; Moss et al., 2010; Voci et al., 2010)

Policy exceptions , (such as partial smoking bans) undermine successful adoption & create resistance to implementation (Campion et al; 2008; Ratschen et al., 2009)

At CAMH, following the move to smoke-free in 2010, staff did not perceive any change in verbal or physical aggression, as corroborated by code white data (Voci et al., 2010). There was additionally no change in number of emergency department visits (Kurdyak, 2008)

Impacts to Clients/Patients

"One in two daily smokers dies 15 years early and one in four dies 23 years early. People with mental health problems are both more likely to smoke and to smoke more heavily than is the case in the general population. Consequently, they are likely to be disproportionally affected by smoking. This includes both direct health effects and social impacts" – (Campion, 2008).

"Historically, the tobacco industry marketed their product to persons with mental illness, provided tax free cigarettes to psychiatric facilities, and funded research promoting a self-medication hypothesis for nicotine…some patients first start to smoke while hospitalized" (Lawn & Campion, 2013; Prochaska, 2010)

With time, more patients, family members and patient advocates are requesting protections from exposure to tobacco smoke (Campion, 2008)

Nicotine may provide cognitive benefits to persons with MH&A, however, nicotine can be delivered via a clean delivery system such as NRT products – (Levy, 2007; Prochaska, 2010)

This policy has been in effect in many hospitals and the majority of psychiatric hospitals are in the process of adopting a full tobacco free ban – (Williams, 2008)
"Exempting mental health hospitals from smoke-free laws aimed at protecting the public also has the potential to worsen health inequities for people with mental illness and further their stigmatization"; most places no longer allow indoor smoking, we need to prepare patients for this reality post discharge from hospital (Williams, 2008)

"Examples of how cigarettes have mediated relationships between patients include the trade, barter, and intimidation of some patients by other patients in order to gain cigarettes. For some more vulnerable patients, this has included sexual favors" (Lawn & Campion, 2013)

Therapeutic Rapport and Staff satisfaction

"Staff generally anticipate more smoking-related problems among patients than actually occur and that staff develop a more positive view after a smoke-free policy has been in place for some time" (Voci, 2010)

Negotiating smoking privileges with clients damages therapeutic rapport and may induce symptoms of nicotine withdrawal if patients are unable to smoke the same amount they smoked prior to admission. "Patients are rarely allowed to have possession of tobacco products and lighters...Much time is spent in the bartering and control of tobacco products between staff and patients and this can be the source of conflicts and incident reports" (Williams, 2008)

"Smoking increases stress levels due to the constant need to smoke to avoid nicotine withdrawal" (Prochaska, 2010)

Facilities that have become tobacco free noted patient's health had improved, cleaner indoor and outdoor spaces, increases in staff satisfaction and more time to provide treatment – (Williams, 2008)

Tobacco Harm Reduction includes nicotine replacement therapies in the same way that opiate harm reduction strategies include methadone (Garter & Hall, 2010; Prochaska, 2010)

"[Nicotine] is the biggest contributor to chronic disease and death for all patients, To do nothing about it would therefore seem, on its face, absurd in a therapeutic environment that strives to promote health" (Lawn & Campion, 2013)