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**Smoke-free Initiatives  
In Psychiatric Inpatient Units:  
A National Survey of Australian Sites**

**An Independent Report**

**August 2008**

## Prepared By

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### Acronyms:

CALD Culturally and Linguistically Diverse  
ETS Environmental Tobacco Smoke  
HDU High Dependency Unit / Closed Ward  
NRT Nicotine Replacement Therapy  
OHS Occupational Health and Safety  
PECU Primary Emergency Care Unit  
PRN Pro re nata / medication taken as needed  
SRF Supported Residential Facility / Hostel Accommodation

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## Executive Summary

Much debate has surrounded the issue of smoking within psychiatric facilities both in the research literature and within clinical settings internationally. Direct causal links between smoking and onset and exacerbation of multiple health problems is well established. The World Health Organization (2006) estimated that tobacco consumption accounted for 5 million deaths worldwide in 2006 and that this figure will double by 2020. In the current climate of growing concern for the harmful effects of cigarette smoking and passive smoking (VicHealth Centre for Tobacco Control, 2002; NH&MRC, 1997; OEHHA, 1997), the high prevalence of this activity within psychiatric settings can no longer be ignored.

Those with mental health problems smoke significantly more and consequently experience greater smoke-related physical harm than the general population. However, smoking also affects mental health by not only increasing the risk of first developing a mental illness but also by its dose dependent relationship with depressive and anxiety symptoms. To this end, many mental health services are attempting to be smoke-free or are discussing ways that they can place restrictions on tobacco smoking within their inpatient facilities as part of Occupational Health, Safety and Welfare concerns for both patients and staff.

This survey of Australian psychiatric inpatient facilities was a direct response to the growing number of contacts for assistance and advice received by the first author, and the limited research in this area. In particular, there appears to be a lack of detailed information about the practical steps made by facilities that have successfully gone smoke-free or the reasons for failure in those facilities that have attempted to be smoke-free. The goal of this study was to engage with people working in these settings, where policies often take on a very different meaning for those who deliver them and so determine the true measure of what actually works.

The study involved interviewing 60 clinical staff with a broad range of roles in 99 open (n=56) and locked (n=43) inpatient units across all Australian states and territories. This included units that had successfully gone smoke-free (n=39), units that were actively planning to become smoke-free (n=15), units that had attempted and failed (n=14) and units that were not currently planning to be smoke-free (n=31). Adult acute units made up the majority of the sample with forensic units, veteran units, geriatric care units and detoxification units included in the sample in smaller number.

A previous systematic review of the existing research in this field (Lawn & Pols, 2005) revealed a number of core principles required for successful implementation of smoke-free policy in psychiatric inpatient units. This current survey confirmed the applicability of these core principles which included the importance of clear and consistent leadership, team cohesion across professional disciplines, effective use of Nicotine Replacement Therapy (NRT) and incorporation of nicotine withdrawal management into routine clinical management, preparation, education and training of staff, and the importance of staff smoking status. These and other core themes are discussed in this report. A number of case studies are provided together with a checklist of steps to ensure success in going smoke-free based on the lessons learned from the experience of sites in this sample.

This survey found that smoke-free policy is possible within psychiatric inpatient settings, but that a number of core interlinking features are important for success and ongoing sustainability.

## **Summary of Key Findings**

### **Locked/ open status:**

No association was found between locked and open status and smoking policy status.

### **Geographical:**

Regional sites may be more successful at implementing smoke-free policy than urban sites.

### **Planning time:**

Increased success in policy implementation was evident in sites that took more than 6 months to plan their smoke-free initiative compared to sites that took less than 6 months.

### **Combination NRT provision:**

There was improved success of smoke-free initiatives where there was provision of a combination of NRT products to patients and matching it with individual patients' withdrawal needs.

### **Leadership:**

Clear, consistent and visible leadership was associated with success of smoke-free initiatives

### **Teamwork:**

Cohesive teamwork was associated with success of smoke-free initiatives

### **Education/ training:**

Education and training was associated with smoke-free status, with smoke-free sites being more likely to have extensive or standard education and training provided to staff, and failed sites or those not considering going smoke-free more likely to have provided no or minimal training to staff.

### **Staff smoking rates:**

There was a relationship between staff smoking rates and failure of smoke-free initiatives.

### **Staff NRT provision:**

A positive association was found between whether NRT was offered to staff and units' smoke-free status.

### **Staff smoking cessation:**

Better quality leadership, education and training, and teamwork played an important role in supporting staff to quit smoking.

### **Enforcement:**

The presence of enforcement increased success of smoke-free policy.

### **HDU access:**

No association was found between access to HDUs and success of a smoke-free policy.

## 1. Introduction

Globally, tobacco is the leading risk factor for disease burden (Houston & Kaufman, 2000). Of those who smoke regularly, one in two die 15 years early and one in four dies 23 years early (Doll *et al*, 2004). Exposure to environmental tobacco smoke also increases the risk of lung cancer and ischaemic heart disease by up to 25% (Scientific Committee on Tobacco and Health, 2004) with heavy passive smoking associated with a 50-60% increase in the risk of coronary heart disease (Whincup *et al*, 2004).

Smoking prevalence is among the highest for people with mental illness who are in psychiatric units where up to 70% are smokers and 50% heavy smokers (Jochelson & Majrowski, 2006) with rates of smoking lower for those patients living at home. Smokers with mental health problems are also heavier, more dependent smokers and have smoked longer than smokers in the general population (Kumari & Postma, 2005). The high prevalence of smoking amongst all people with a mental illness is a major public health problem.

Links between smoking and higher premature death rates from all major physical health conditions have been noted for this group when compared to the general population (Brown, Birtwhistle, Roe, & Thompson, 1999; Coglean, Lawrence, Holman & Jablensky, 2001). This has resulted in much greater smoking-related morbidity in those with mental illness with a diagnosis of schizophrenia increasing risk of death from respiratory disease ten times more than for the general population (Joukamaa *et al*, 2001). Since one in two regular smokers dies 15 years prematurely (Doll *et al*, 2004), at least 50% of those with mental illness who persist in regular smoking will die prematurely from smoking related diseases. The increased risk of many smoking related diseases is responsible for a large proportion of the excess natural mortality of those with mental health problems (Brown *et al*, 2000).

As well as impacting on physical health, smoking increases the risk of first developing a mental health problem (Cuijpers *et al*, 2007). Smoking is associated with an increased prevalence of all mental illness (Farrell *et al*, 2001) and higher suicide rates (Malone *et al*, 2003). A clear relationship exists between the amount of tobacco smoked and the number of depressive and anxiety symptoms; however, symptoms reduce after cessation and wellbeing improves, with anxiety reducing as soon as one week after cessation (Campion *et al*, 2008a).

Despite those with mental illness being about twice as likely to smoke, they are also able to stop smoking (Lasser *et al*, 2000) with half of smokers with mental health problems in the UK expressing a desire to stop smoking (Jochelson & Majrowski, 2006). Smoking cessation medication and other non-pharmacological support such as support and advice from individuals or groups, healthcare professionals or via the telephone/internet, can increase abstinence rates in those with mental health problems to as high as those in the general population (Campion *et al*, 2008b, Foulds *et al*, 2006). Smoking also increases the metabolism of a number of medicines, including anti-depressants and anti-psychotics, meaning that larger doses may be required. However, significant reductions in the medication dose may be needed following cessation (Campion *et al*, 2008b).

The culture of smoking in psychiatric settings is perceived to be an entrenched process that has been central to the history of mental institutions with the development of asylums and their evolution into our current psychiatric inpatient facilities. Tobacco rations were an assumed part of day to day life in many such institutions (Shlomowicz, 1990). The idea of imposing smoking bans in psychiatric settings is thought to be a recent phenomenon though there is clear evidence from a number of 19<sup>th</sup> Century documents that this is not entirely so (Gellar & Kaye, 1999; Pinta, 1991). The British College of Physicians and US Surgeon General reports of the 1950s and 1960s highlighted the physical harms of smoking and triggered a new wave of concern. These reports eventually influenced and prompted a number of US psychiatric institutions to introduce smoking

bans from the late 1980s and early 1990s. Concern about smoking within psychiatric facilities is now an international phenomenon with mental health services in many countries recognising that more needs to be understood about this population.

In addition, all workers including those working in mental health facilities are entitled to a smoke-free workplace (AMA, 2005).

### **Rationale:**

Systematic research on smoking bans is scarce. The 2005 review of 26 published studies (Lawn & Pols, 2005) has been the most recent and is cited in most publications being produced internationally because of this gap in research. Its predecessor (Patten, Martin & Owen, 1996) was the first known systematic review on this topic internationally. The 2005 review was useful for its articulation of the general processes followed in order to achieve smoking bans and the general lessons learned along the way. Consistency, co-ordination and full clinical and administrative support for smoking bans are seen as essential to their successful implementation as part of the following known general principles required in order to introduce effective smoking bans:

- Availability of and effective use of NRT.
- Extensive consultation and collaboration, and co-ordination of efforts across the disciplines, in order to provide a consistent focus that will not be undermined by subgroups or individuals.
- Support at all levels, from direct care of patients to hospital administration and policy.
- A preparation period, prior to the ban, involved community agencies and groups and inpatient staff involving education and advertising of the impending ban to patients and carers i.e. communicate the intention to impose a ban to all stakeholders.
- Provision of alternative activities, dietary changes, clear protocols and family support for the bans.
- More effective measures to accommodate patients who are unable to tolerate abrupt abstinence.
- Greater awareness of the ban prior to admission. This would involve co-ordination and partnership across the mental health sector between community and inpatient services.
- Greater support for and education of direct-care staff on distinguishing mental illness symptoms from nicotine withdrawal symptoms.
- Development of alternative supports to assist staff to manage their own nicotine withdrawal and associated stress levels whilst at work.
- Sensitivity to the potential for restrictions to be perceived as a further source of powerlessness and control, with implications for staff morale as agents of further social control and patients as recipients.
- Clear policies and protocols for managing potential increases in trade and standover for cigarettes between patients, black market use and sale of tobacco on hospital grounds.
- Improved understanding of nicotine's interaction with anti-psychotic drug metabolism so that patients who are smokers receive appropriate medication prescription, review and

coordination as they transition through the various stages of the service, inpatient and community.

- More co-ordinated efforts between hospital and community staff to help patients who wish to stay quit as part of discharge planning.
- Development of clear policies with regard to smoking and occupational health and safety concerns for staff and patients as part of the process of imposing bans and maintaining them. This would include clearer clinical and ethical guidelines that address the issue of distress and withdrawal, patient autonomy and legal aspects of imposing a ban.

However, the studies reviewed did not articulate or analyse local variations in geography, culture, population served or other factors that may well be the determinants of success or failure at the local level. Currently in Australia, several psychiatric facilities are attempting to impose smoking bans and failing, while others are succeeding. The reasons for this still remain unclear. However, it appears that merely applying the general principles revealed by the international systematic review are not enough and that local variations and emphases must also be carefully considered. The experience of Cairns Hospital (Campion, Lawn et al., 2008) is evidence for this; at this site, the general principle of “Communicate the intention to impose a ban to all stakeholders” was impractical; with a catchment area of largely Indigenous population served involving several hundred square kilometres. Therefore, local variations on how the principles are applied are important as is the need for rigour applied to the research and evidence, given the highly emotive debates in this area and ethical dilemmas inherent in it. It is important to build the evidence for the smoke-free policy implementation in different settings, so that smoke-free policies have the greatest chance of success with least distress to people with mental illness and frontline staff.

The introduction of smoke-free policy in psychiatric units is possible but needs to be a carefully planned process involving all parties affected by the bans with consistency, co-ordination, and full clinical and administrative support for smoking bans. In the UK, this has begun with the recent release of the NHS document “Where Do We Go From Here”, which discusses management responsibilities, staff responsibilities and setting realistic goals for tobacco control within psychiatric settings (Seymour, 2004). Further UK guidance was developed to support mental health trusts to implement smoke-free policies, working with staff and patients to overcome their concerns (McNeill & Owen, 2005). Other examples are the Canadian Tobacco-Free Living toolkit available from the National Association of State Mental Health Program Directors (NASMHPD, 2007). Systematic guidelines for successful introduction of smoke-free policy based on the Australian experience would be useful. This report is intended to provide a framework and context for Australian Guidelines and to further assist those mental health services that are considering becoming smoke-free, both in Australia and elsewhere.

## 2. Methodology

### Objectives:

This survey incorporated a range of objectives:

- To undertake a national survey of attempts to implement smoking restrictions within psychiatric inpatient facilities in Australia.
- To describe the range of efforts being undertaken by sites throughout Australia and to analyse reasons for their success or failure.
- To test the general principles that emerged from the most recent international systematic review of smoking ban studies and their application and generalisability to Australian sites, given that most reviewed studies were of American sites.
- To test the hypothesis that local variations in emphasis when using the general principles are important to the success of efforts to implement smoking restrictions in these settings.
- To contribute greater knowledge to the field in order to assist psychiatric facilities in their efforts to manage the smoking issue better.

### Design of Study & Justification of Methodology:

A telephone survey (range 30-90 minutes) in the form of a teleconference in-depth discussion was undertaken with key stakeholders in psychiatric inpatient facilities across Australia. This included contact with a number of stakeholders already known to the researchers and those identified as spokespersons by the directors of each facility in circumstances where they were not already known to the researchers. In late 2007, the main investigator was contacted for advice by the second investigator, two consultant psychiatrists and the clinical nurse consultant for the psychiatric ward at Cairns Base Hospital. At this unit, introduction of a smoke-free policy had been unsuccessful. The ensuing teleconference analysed how the policy was introduced, lessons learned and how implementation might have been improved. This led to a greater understanding of how to successfully proceed, if they chose to, in future. During this process, the idea emerged to survey other Australian psychiatric settings, given the conclusion about the importance of the general principles and their relationship to local circumstances and variations (Campion, Lawn, et al., 2008). The Cairns group found this interactive dialogue via teleconference to be very fruitful in helping them to understand why their initiative had struggled. We believed that a similar action research method using 'Realistic Evaluation' techniques would suit stakeholders in our current survey. Pawson and Tilley (1997) describe Realistic Evaluation as a method which challenges the practical usefulness of evaluation and research based on orthodox experimental design, particularly in the context of complex social systems where the goal is to inform policy and practice. In emphasising the importance of considering context as a key analytic factor, Realistic Evaluation shifts from attempting to identify 'What works?' or 'Does this work?' to developing an understanding in depth of 'What works where, for whom, and in what circumstances?' thus taking into account the local conditions in which changes are introduced (Tilley, 2000).

### Duration, Sampling and Recruitment:

Teleconferences with participants occurred between October 2007 and July 2008.

Internet searches of Department of Health websites were done for each state to determine locations and contact details for sites that met the inclusion criteria. Letters of request were sent to the

Director of each service via email requesting the participation of their sites and nomination of a key stakeholder(s) who could be contacted for consent to undertake a teleconference with the researchers.

Ethics approval for the study was gained from the Flinders Clinical Research Ethics Committee in South Australia and the Aboriginal Health Research Ethics Committee of South Australia, given the understanding that some facilities would serve regions with high Indigenous populations and may experience particular issues as a result of this in relation to smoking policy and management of smoking. Further ethics approval from interstate committees was sought where indicated by them. The research was deemed ‘Low Risk’ by several committees and this status and South Australian approval was acceptable to all other sites. Where committees required a further full ethics application, and subsequent fee for considering the protocol, we did not pursue contact with these sites, given that we had no access to formal funding for this research to meet this expense. This research project complied with all requirements of the NH&MRC National Statement on Ethical Conduct in Research Involving Humans.

Convenience sampling was the main process for identifying sites, supplemented by snowball sampling where progress in hearing back from some contacts was slow or failed to occur. The researchers chose sites not based on any prior knowledge of their smoking policy status. Only a small number of sites were known by us to be smoke-free when the study started. Participants included project staff, clinical nurse consultants, nurse unit managers, directors of nursing, service directors, team leaders, clinical nurses, psychiatrists, and allied health staff. These people were approached based on their identification to us as clinical leaders with direct regular experience and knowledge of day to day practices in the inpatient facilities and/or their direct involvement in smoke-free initiatives within the service.

### **Inclusion and Exclusion Criteria:**

All consenting Australian adult public psychiatric inpatient facilities were included. This includes stand alone psychiatric hospitals and those with dedicated psychiatric wards within general hospitals. It included open and locked facilities and forensic psychiatry inpatient units. Veteran hospitals were included based on the understanding that they increasingly admit general public patients to their facilities.

Non-psychiatric facilities were excluded. However, drug and alcohol detoxification units that were directly linked with mental health services or who identified as having a high proportion of patients with concurrent mental illness were included. Private psychiatric hospitals were excluded, based on the understanding that they potentially have different drivers determining such policies based on business models of service. Child and Adolescent units (under 18 years) were excluded, as were mother and baby units and eating disorder units based on the belief that there would be specific needs and practices related to such units worthy of their own targeted study.

Primary Emergency Care Units (PECUs) located within Emergency Departments, were also excluded due to the short length of stay (often only 1-2 days then discharge to community) by patients in these units and concern that this would therefore bias the sample. We determined that PECUs are not the same as dedicated High Dependency Units (HDUs) for this and other reasons related to overall clinical practices. Some of these units were known to be closed and some gave patients ready access to leave to smoke. During the interview process, some participants made reference to PECUs and we are aware of one such unit that has been successfully smoke-free since its inception in 2001. Concerns about smoke-free policy leading to increased assaults on staff and other patients and increased distress of patients has not been evident in this setting.

### **Preserving Anonymity:**

Many sites were satisfied with being identified and wanted to share their success about becoming smoke-free. However, it was decided to maintain anonymity of all participants, sites and locations in order to preserve overall anonymity and confidentiality of comments. Some states possess few inpatient psychiatric facilities, so to identify the number of sites spoken to in some locations would clearly identify them. This particularly applied to states and territories with smaller populations.

### **Data Collection & Analysis:**

Data was collected via direct phone contact involving semi-structured interviews with participants, following contact time negotiated via email or phone contact prior to the interview, at a time convenient to participants. Most interviews were performed by the first researcher alone, as the second researcher returned to the UK during the study period and coordination of teleconference became problematic regarding fitting in with times that suited participants' workloads. In the beginning months, a number of interviews were performed as planned teleconferences where both researchers were able to be involved from their respective locations in Australia or where multiple participants requested phoning in from different sites within their service. All costs of formal teleconferences were borne by the first researcher through their consulting fund with Flinders University. In most cases, standard landline and speaker phone function sufficed. Extensive notes were taken for all interviews. Some participants provided supporting policy and procedural documents from their services or followed up with emailed responses to questions where they were limited by time. The average length of most interviews was 45 minutes, with the shortest being 15 minutes (a site that was not smoke-free) and the longest being 90 minutes.

The interview involved a general interactive conversation guided by the following question areas:

- The status of smoking policies within the psychiatric facility?
- What efforts have been made to introduce smoking restrictions?
- What components of planning for smoking restrictions have been undertaken?
- What level of success has occurred related to these efforts and why?
- The demographic make up of the service, the staff and population served, and the region in which it operates, estimated % of staff smokers?

This was followed by open questions in the context of the general principles determined by the 2005 systematic review, covering such issues as NRT, use, leadership issues, teamwork, communication and linkage with community services, communication and working relationships between the disciplines, and discharge processes regarding NRT and support.

Data from all interviews was thematically arranged as per the interview guide question areas as part of the first layer of coding. This included consideration of how the actions within each site applied to the general principles suggested by the 2005 international systematic review. By undertaking an 'analytic comparison' of these issues across each site (or case), we were able to show what was common across each case (method of agreement) and what was different in those cases that had a different outcome than was expected (method of difference)(Neuman, 2003. pp.456-7). In this way, we gained an understanding of the importance afforded to each principle and perceptions from the stakeholders, that is, which principles they found most relevant to their context and why. The analysis also aimed to identify unique 'local' data where this might emerge. Emergent themes were subject to further levels of scrutiny by the second investigator providing inter-rater reliability to the data themes. The researchers undertook extensive discussion and debate, questioning the meaning of the data as part of this process. This added rigour to the interpretation of the data and alleviated any bias.

### **Limitations of the research:**

Limitations included relying on detailed verbal information alone and not both verbal and observed interaction and procedures at the sites. As much as possible, the researchers verified that participants had a clear working knowledge of the day to day activities in the inpatient facilities. If service Directors were interviewed, clinical staff within the psychiatric facilities were also contacted to verify details further.

In one state, only metropolitan sites were contacted and in another state, only three sites (or approximately 10% of facilities in that state) were contacted. We were however aware that smoke-free sites that were not in the sample existed in that state. The percentage of total sites contacted by state ranged from 10% to 100% with the mean being 58% across all states and territories.

The number of veteran and forensic sites canvassed was small. It was acknowledged that they may have specific needs, culture, and make-up of patients and staff that may vary from other adult acute units. Some comments have been included on this based on interviews with those within our sample.

This research does not intend to compare rates of successful smoke-free policy between each state and territory. This was in part due to the recognition that this area of policy is sufficiently difficult without contributing to processes that may be used to blame or judge individual locations for their practices. The difficulty involved in implementing smoke-free policies are acknowledged and the efforts of all locations have been valued in what is a difficult area of health care.

This research has not attempted to gain the perspectives of patients and has relied on participants' perceptions of how patients view smoke-free policy initiatives.

Clearly more rigorous research is needed in a range of areas to fully understand the impact of such changes on patients, staff and systems.

### 3. Results Quantitative Analysis

#### (1) Participants and Demographic Information about Sites

Sixty participants with direct knowledge of the clinical, day to day operation of their units were interviewed for the study. Nurses were overwhelmingly represented in the sample, indicating their primary acknowledged role in the management of staff with primary responsibility for managing smoking and hands-on clinical care within the inpatient environment.

**Table 1: Professional roles of participants of the survey**

<b>Title and Role</b>	<b>No.</b>
Project officer	9
Clinical Nurse Consultant (CNC)	16
Nurse Unit Manager (NUM)	7
Director of Nursing (DON)	7
Consultant Psychiatrist	4
Psychiatric Registrar	1
Clinical Nurse (CN)	2
Service Director	4
Team leader	5
Acute Inpatient Service Manager	3
Allied Health Professional	2
<b>Total</b>	<b>60</b>

NB – Project Officers, Team Leaders and Acute Inpatient Services Managers were predominantly nurses also.

To ensure anonymity of sites, comparison between states and territories has not been part of this analysis. Between 10-100% of public inpatient sites within scope for each state and territory were canvassed, with the mean being 55% across all states and territories of the total sample of Australian adult inpatient psychiatric sites that met the inclusion criteria. This estimate is based on information from the national survey of Mental Health in Australia 2005 -2006 undertaken by the Australian Institute of Health and Welfare (AIHW, 2008). Our sample of 99 units comprised 70 wards, in which 29 of the open units contained High Dependency Units (HDUs) of varying size (2-8 beds) that were purpose built and staffed accordingly. With reference to the AIHW information, the sample comprised 4 stand alone psychiatric hospitals from a possible 15 (26% of total in Australia), 63 specialist psychiatric units from a possible 109 # (58% of total in Australia) (AIHW, 2008 and personal correspondence with AIHW and Veteran Affairs) and 3 Drug and Alcohol Detoxification inpatient units (proportion not known). The sample comprised 56 open units and 43 locked units.

Former dedicated Veteran hospitals, serving past and present members of the armed services, were previously administered by Veteran Affairs and are now classified as general hospitals within the Australian health system. However, they are separated from the above figure, given that they are still largely populated by this unique group. Units dedicated to serving patients under the age of 18 are also removed from this total. AIHW have confirmed that there are 6 former dedicated Veteran units and 21 dedicated child and Adolescent units in Australia.

Patient turnover rates of all units reflected standard care practices within Australian mental health inpatient units, reflecting diverse acuity issues. Drug and alcohol abuse was common in patient populations across all sites. Inner urban inpatient sites with high proportions of homeless people

and those living in Boarding House or Supported Residential Facilities (SRFs) displayed particular acuity issues as did sites with higher Culturally and Linguistically Diverse (CALD) and Indigenous populations. These are discussed further in the thematic analysis below.

A diverse range of sites were included from across each state and territory, with 74 Urban and 25 Regional sites canvassed. Capital cities were defined as urban, with Central Business District (CBD) and suburban psychiatric facilities included in this definition based on the understanding that they are regarded as part of the greater urban area. One state had 2 district urban centres due to its geographical nature. Regional centres were those that clearly serviced areas beyond the urban sites as well as their surrounding rural and remote populations. There appeared to be no significant relationship between location type and smoke-free status.

Units ranged in size as shown by Table 2 below. Where open units incorporated a dedicated HDU, the bed numbers for each have been separated and reported as distinct entities to reflect the actual number of bed dedicated for each purpose. The largest open units had 40 beds (smoke-free) and were located in urban areas; the smallest open units had less than 10 beds and were located in regional areas. The most prevalent size for an open unit was 20 beds. The largest locked units had 30 beds (smoke-free) and were located in a large stand alone psychiatric facilities; the smallest locked unit had 2 beds and located in a regional general hospital. The most prevalent size for locked units was 3 beds (N=15), reflecting the specialist, high care needs within these units.

**Table 2: Bed numbers for open and locked units in either large psychiatric hospitals or as special facilities in general hospitals**

<b>Open Units</b>	<b>Bed Numbers</b>	<b>Locked Units</b>	<b>Bed Numbers</b>
3	40	2	30
1	38	1	25
2	30	1	21
1	28	1	20
1	27	1	12
1	26	7	10
3	25	4	8
1	24	4	6
8	22	4	5
1	21	1	4
13	20	15	3
3	19	2	2
2	18		
4	17		
2	16		
5	15		
1	12		
1	10		
2	8		
1	6		
<b>Total 56</b>		<b>Total 43</b>	

## (2) Smoking Policy Status and General Demographics of Units

Participants provided detailed information about the smoking policy status for both open units (n=56) and locked units (n=43). The overall sample showing population served and their smoking policy status is shown in Table 3 below. The sample of detoxification, veteran, geriatric and forensic units was insufficient for comparison. No association was found between locked and open status and smoking policy status as shown by Table 4 below. That is, locked units were as likely as open units to be smoke-free, to have tried and failed, to be planning to become smoke-free in the near future, or not to be pursuing this at this stage. Other factors appear to be more important than unit type for determining success or failure of smoke-free initiatives.

**Table 3: Unit type in relation to smoking policy status**

Unit Type	Number	Smoking Policy Status			
		No	Plan	Yes	Failed
Locked Acute *	38	12	6	14	6
	%	32	16	37	16
Locked Forensic	2	1		1	
Locked Chronic/Extended Care	2	1	1		
Locked Geriatric	1			1	
Open Acute #	51	14	8	21	8
	%	27	16	41	16
Open Veterans acute	2	2			
Open Detoxification Unit	3	1		2	

\* - 11 of these wards were located within/across 4 large urban hospitals and 1 regional hospital

# - 18 of these open wards were located within/across 6 large urban hospitals and 1 regional hospital

**Table 4: Smoking policy status in open and locked psychiatric units**

Status	Locked	Open	Total
Failed attempt	6	8	14
%	43	57	100
No attempt made	14	17	31
%	45	55	100
Planning attempt	7	8	15
%	47	53	100
Smoke-free	16	23	39
%	41	59	100
Total	43	56	99
%	43	57	100

$\chi^2 = 0.1954, df = 3, p < 0.98$  - No association.

Comparing the success rates for urban sites as part of overall urban sites (25/74 or 34%), with success rates for regional sites with overall regional sites (14/25 or 56%) suggests that regional sites may be more successful at implementing smoke-free policy. Further Pearson's Chi square analysis showed  $\chi^2 = 4.99, df = 2, p < 0.08$  when the variables of smoke-free and planning were collapsed into one group. This suggests that there may be an association between location type and smoke-free status or intention for this sample, with regional sites more likely to be smoke-free. Regional staff

may have a higher proportion of patients who are already known to them, particularly in locations with smaller population sizes. In some regional areas, the layers of management may be less removed from the clinical staff interface and they may have more sense of ‘community’ that promotes greater cohesion within teams and therefore greater consistency for implementing such initiatives. Comparing failure rates for urban sites as part of overall urban sites (8/74 or 11%) with failure rate for regional sites with overall regional sites (6/24 or 24%) suggests that regional sites may be more likely to try and fail at implementing smoke-free policy. Clearly, failed attempts to implement smoke-free policy exist in both location types within this sample. However, clear conclusions are limited by the convenience sampling method and cannot be generalised.

**Table 5: Smoking policy status by location in either urban or regional settings**

Smoke-free Status	Urban	Regional	Total
Failed attempt	8	6	14
%	57	43	100
No attempt made	27	4	31
%	87	130	100
Planning attempt	14	1	15
%	93	7	100
Smoke-free	25	14	39
%	64	36	100
<b>Total</b>	<b>74</b>	<b>25</b>	<b>99</b>
%	758	25	100.0



### (3) Timing and Implementation of Smoke-free Initiatives

The sample size is insufficient to determine whether length of planning time bore any relationship to success or failure of smoke-free initiatives. However, the results show that many sites that were smoke-free (n= 29) had taken 12 months planning to do so (see Table 6 below). Similarly, many sites currently in the active planning stage were taking at least 6 months to prepare. However, analysis based on whether units took more than or less than 6 months to plan their initiative did show an association, with those taking more than 6 months being more successful ( $\chi^2 = 106.87$ ,  $df = 4$ ,  $p < 0.001$ ), as shown by Table 7 below.

**Table 6: Length of smoke-free planning time in relation to smoke-free status**

Status	3 months	6 months	9 months	12 months	Total
Failed attempt	2	8	2	2	14
Planning attempt	0	5	1	9	15
Smoke-free	4	4	2	29	39
<b>Total</b>	<b>6</b>	<b>17</b>	<b>5</b>	<b>40</b>	<b>68</b>

Integration of strategies and preparation of staff are what was noted as important by participants and this needed time. Interestingly, participants of all sites in one state reported that smoking policy changes had taken too much time (more than 12 months). They expressed concern that staff had responded by becoming disinterested and disengaged in the initiative as a result. This suggests that staff value clear leadership, knowing where they stand, with clear expectations of what is happening and when in order for them to remain engaged and motivated to change their behaviour.

**Table 7: Planning time and success rate**

Smoke-free status	> 6 months Planning	≤ 6 months Planning	Total
Failed attempt	4	10	14
%	28.5	71.5	100
Smoke-free	31	8	39
%	79.5	20.5	100.0
Total	35	18	53
%	66	34	100

Further descriptive data is detailed in Table 8. The average length of time smoke-free for these sites was approximately 2 years, with several sites being smoke-free for less than a year and 2 sites being smoke-free for 5 years or longer, one of these being a detoxification unit and the other being a locked psychiatric unit.

Range = 1 month to 6 years  
 Median = 1.25-2 years (1.65 years)  
 Mean = 2 years/1 month  
 Mode = 2 years

**Table 8: Length of time for which smoke-free sites had remained smoke-free**

Time	No. of Sites
1 month	1
2 months	2
7 months	10
9 months	2
1 year / 3 months	1
2 years	12
2 years / 6 months	3
2 years / 9 months	4
5 years	1
6 years	1

Of the 15 units that were making clear plans to go smoke-free in the near future, 1 was planning to do so by September 2008, 5 by November 2008 and 9 by March 2009.

#### (4) Smoke-free Status by Provision of NRT

Most units had capacity to provide NRT, regardless of whether they were intending to be smoke-free or not, as shown by Table 9 below. Clear protocols for offering NRT to patients, consistency in approach to clinical use of NRT, and persistence in offering NRT were cited by participants as factors that were important.

**Table 9: Capacity of psychiatric units to provide NRT depending on smoke-free status**

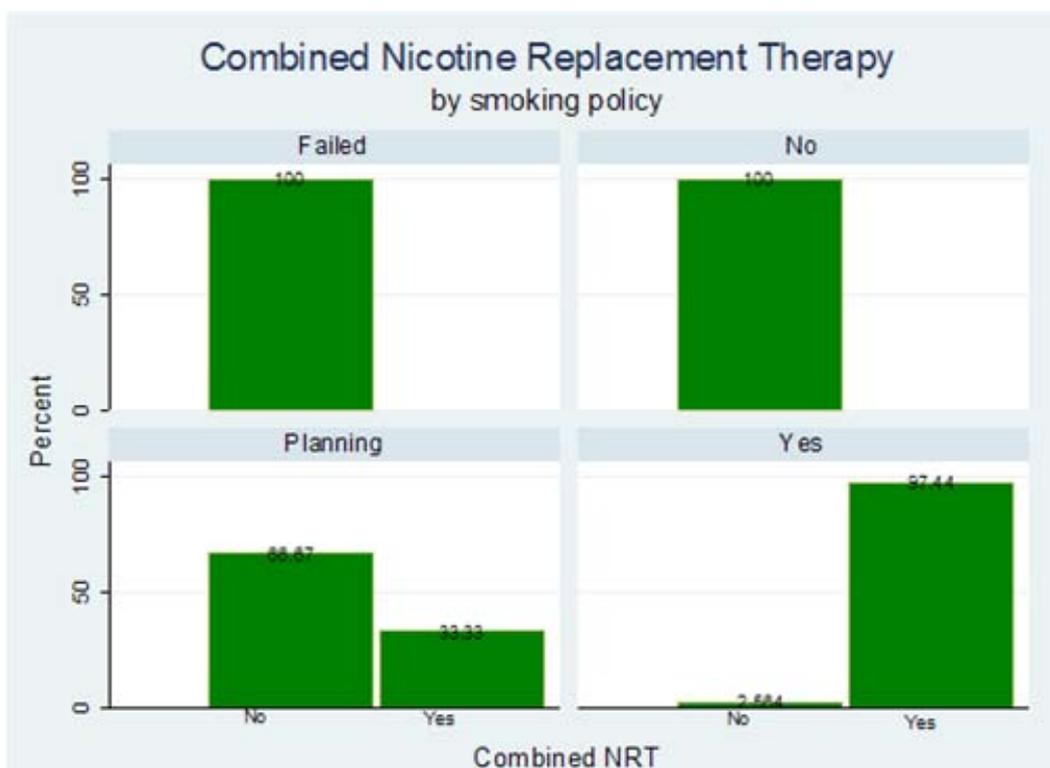
Smoke-free Status	No	Yes	Total
Failed attempt	0	14	14
%	0	100	100
No attempt made	6	25	31
%	19	81	100
Planning attempt	9	6	15
%	60	40	100
Smoke-free	0	39	39
%	0	100	100
Total	15	84	99
%	15	85	100

#### Impact of Combined NRT

Further analysis of the provision and use of combined NRT confirmed that sites that understood the importance of providing a combination of NRT products to patients and matching it with individual patients' withdrawal needs was associated with the success or failure of smoke-free initiatives, as shown by table 10 below. Sites that did so were more likely to be smoke-free ( $\chi^2 = 81.47$ ,  $df = 3$ ,  $p < 0.001$ ).

**Table 10: Relationship between use of combination NRT and by smoking policy status**

Smoke-free Status	Not smoke-free	Smoke-free	Total
Failed attempt	14	0	14
%	100	0	100
No attempt made	31	0	31
%	100	0	100
Planning attempt	10	5	15
%	67	33	100
Smoke-free	1	38	39
%	3	97	100
Total	56	43	99
%	57	43	100



## (5) Leadership and smoke-free status

Clear leadership was shown to be more likely to be associated with success of smoke-free initiatives and sites which were actively planning to become smoke-free than leadership that was detached from the clinical field, mixed or poor, as perceived by participants about their service. When these variables were collapsed, an examination of the frequencies of smoking status showed group differences for leadership qualities ( $\chi^2 = 95.08$ ,  $df = 3$ ,  $p < 0.001$ ). Table 11 and Table 12 below show the pre and post collapsed data.

**Table 11: Variation in leadership qualities in relation to successfully achieving smoke-free status**

Smoke-free Status	Clear leadership	Detached leadership	Mixed leadership	Poor leadership	Total
Failed attempt	0	4	10	0	14
%	0	29	71	0	100
No attempt made	0	13	17	1	31
%	0	42	55	3	100
Planning attempt	15	0	0	0	15
%	100	0	0	0	100
Smoke-free	38	0	0	1	39
%	97	0	0	3	100
Total	53	17	27	2	99
%	54	17	27	2	100



**Table 12: Variation in leadership qualities in relation to successfully achieving smoke-free status - collapsed variables (detached/mixed/poor)**

Smoke-free Status	Clear leadership	Detached/ Mixed/Poor leadership	Total
Failed attempt	0	14	14
%	0	100	100
No attempt made	0	31	31
%	0	100	100
Planning attempt	15	0	15
%	100	0	100
Smoke-free	38	1	39
%	97	3	100
Total	53	46	99
%	54	46	100.00



## (6) Influence of teamwork on smoke-free status

Teamwork was reported by participants according to a range of criteria. Good teamwork was described as the majority of staff working collaboratively together with few splits and conflicts with regard to clinical management issues. Teams that showed promise were those where relationships between staff were both collaborative and non-collaborative at times but with clear change champions evident. Fragmented teams were those described as not generally supportive of each other with splits and tensions evident, in a state of upheaval or disjointed in their relationships due to the casualised workforce. Cohesive teamwork was shown to be more likely to be associated with success of smoke-free initiatives and sites who were actively planning to become smoke-free than teamwork that was fragmented, as perceived by participants about their service ( $\chi^2 = 43.55$ ,  $df = 2$ ,  $p < 0.001$ ). When these variables were collapsed, an examination of the frequencies of smoking status showed group differences for teamwork qualities ( $\chi^2 = 47.39$ ,  $df = 3$ ,  $p < 0.001$ ). Table 13 and Table 15 below show the pre and post collapsed data.

**Table 13: Variations in teamwork quality in relation to smoke-free status**

Smoke-free Status	Good teamwork	Promising teamwork	Fragmented teamwork	Total
Failed attempt	0	2	12	14
%	0	14	86	100
No attempt made	4	3	24	31
%	13	10	77	100
Planning attempt	9	0	5	14
%	64	0	36	100
Smoke-free	36	0	2	38
%	95	0	5	100
Total	49	5	43	97
%	51	5	44	100

**Table 14: Variation in teamwork qualities in relation to successfully achieving smoke-free status - collapsed variables (good = promise)**

Smoke-free Status	Good or promising teamwork	Fragmented teamwork	Total
Failed attempt	2	12	14
%	14	86	100
No attempt made	7	24	31
%	23	77	100
Planning attempt	9	5	14
%	64	36	100
Smoke-free	36	2	38
%	95	5	100



## (7) Staff Education and Training and Smoke-free Status

Participants were asked to report on the type and extent of education and training provided to staff that was directly related to smoking and mental illness and how staff could assist patients to manage nicotine withdrawal whilst in hospital. No education and training equated to none at all in the past 2 years. Minimal education equated to general information sessions that relayed information about smoking and mental illness but which did not provide any clear detail about its application to clinical practice. One-off training was included in this group. Standard education and training equated to the provision of a range of information sessions on a range of expected topics such as medication interactions and general quit smoking education. Extensive education and training equated to standard criteria with the addition of the provision of staff in the setting post training to help model the clinical responses and supporting behaviours learned from translating the information and knowledge into practice.

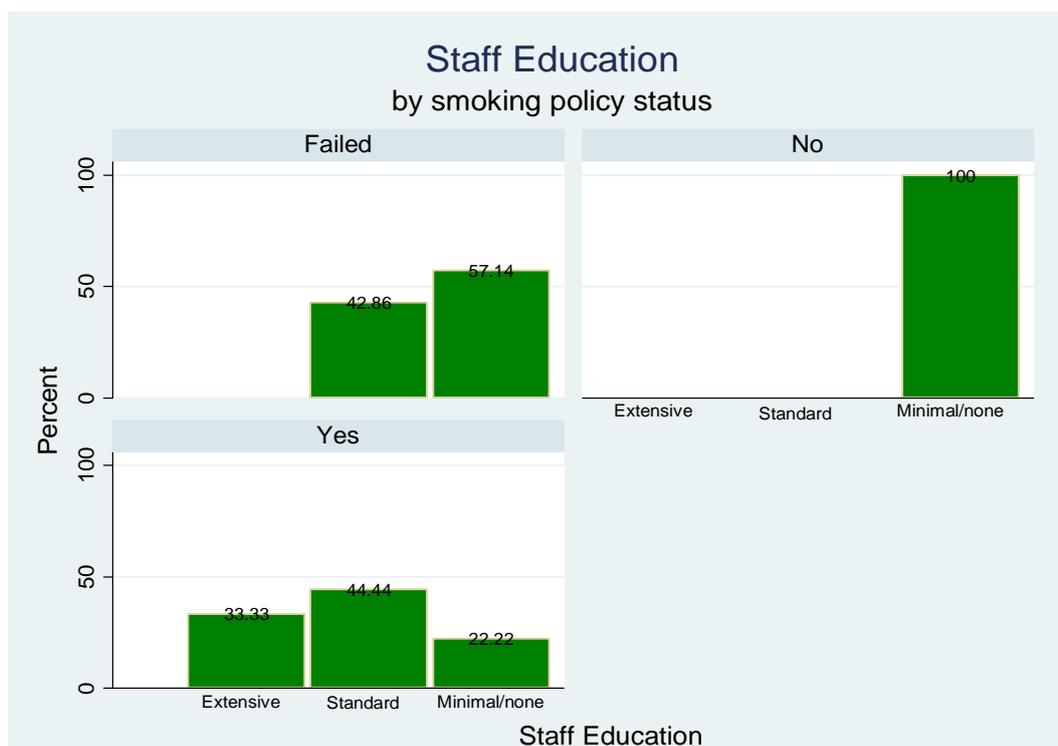
When the categories of 'minimal' and 'none' were collapsed and smoke-free and planning sites were combined, an association was found between education and training provided and smoke-free policy status ( $\chi^2 = 51.91$ ,  $df = 4$ ,  $p < 0.001$ ). See Tables 15 and 16 for further detail.

**Table 15: Level of staff education and training and relationship with smoke-free status of the units they work on**

<b>Smoke-free Status</b>	<b>Extensive staff education</b>	<b>Standard staff education</b>	<b>No staff education</b>	<b>Minimal staff education</b>	<b>Total</b>
Failed attempt	0	6	0	8	14
%	0	43	0	57	100
No attempt made	0	0	18	13	31
%	0	0	58	42	100
Planning attempt	6	0	0	9	15
%	40	0	0	60	100
Smoke-free	12	24	0	3	39
%	31	62	0	8	100
Total	18	30	18	33	99
%	18	30	18	33	100

**Table 16: Level of staff education and training and relationship with smoke-free status of the units they work on - Collapsed (Minimal/None)**

<b>Smoke-free Status</b>	<b>Extensive staff education</b>	<b>Standard staff education</b>	<b>Minimal or no staff education</b>	<b>Total</b>
Failed attempt	0	6	8	14
%	0	43	57	100
No attempt made	0	0	31	31
%	0	0	100	100
Planning or smoke-free	18	24	12	54
%	40	0	60	100
Total	18	30	51	99
%	18	30	52	100



## (8) Influence of Staff Smoking Rates

Participants were asked to estimate the total percentage of staff smokers working within the unit, over all shifts and for all disciplines, based on their direct knowledge of their team. Several participants could define the exact number of staff smokers and staff numbers; others provided near as possible estimates. Previous research has suggested that when staff smoking rates are higher, there is likely to be more concern about going smoke-free and more pro smoking attitudes. Analysis of the data confirmed that there was relationship between staff smoking rates and failure of smoke-free initiatives when compared to sites that had gone smoke-free successfully ( $\chi^2 = 98.10$ ,  $df = 9$ ,  $p < 0.001$ ). See Table 17 below for further detail. Participants from successful sites clearly reported that they focused on reducing staff smoking, as a priority strategy, in the months prior to their smoke-free status.

**Table 17: Percentage of Staff Smokers by Smoke-free Status of Inpatient Units**

Smoke-free Status	0-9%	10-19%	20-29%	30%+	Total
Failed attempt	0	0	2	12	14
%	0	0	14	86	100
No attempt made	2	6	6	17	31
%	6	19	19	55	100
Planning attempt	1	2	12	0	15
%	7	13	80	0	100
Smoke-free	20	17	2	0	39
%	51	44	5	0	100
Total	23	25	22	29	99
%	23	25	22	29	100

Of note, within the units where participants reported more than 30% of staff were smokers, one reported 50% and another reported 60% of staff were smokers. No participants reported 0% staff smokers.



### (9) Staff Access to NRT

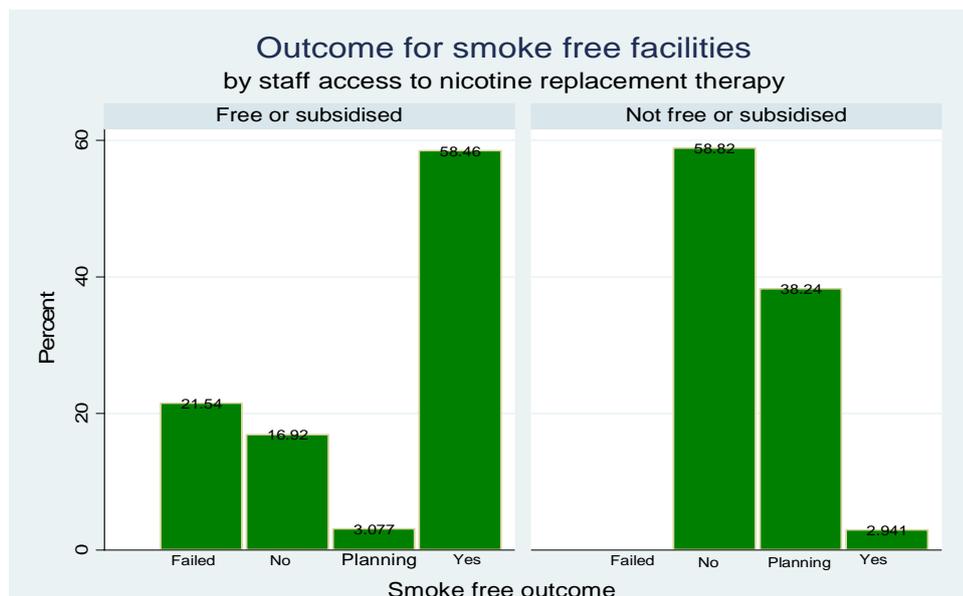
It was hypothesised that whether staff had access to NRT or not would influence the success of failure of smoke-free initiatives and that this may vary according to whether NRT was offered free or subsidised to staff. Although it did not appear to matter whether NRT was offered free or subsidised, there was an association between whether it was offered at all and smoke-free status ( $\chi^2 = 55.52$ ,  $df = 3$ ,  $p < 0.001$ ) and when planning and smoke-free sites were combined ( $\chi^2 = 21.54$ ,  $df = 2$ ,  $p < 0.001$ ). See Tables 18 and 19 below.

**Table 18: Staff access to NRT and relationship with smoke-free status of the units**

Smoke-free Status	Free NRT	Subsidised NRT	NRT Not Provided	Total
Failed attempt	6	8	0	14
%	43	57	0	100
No attempt made	2	9	20	31
%	6	29	65	100
Planning attempt	2	0	13	15
%	13	0	87	100
Smoke-free	20	18	1	39
%	51	46	3	100
Total	30	35	34	99
%	30	35	34	100

**Table 19: Staff access to NRT and relationship with smoke-free status of the units they work on – Collapsed (Free/subsidised)**

Smoke-free Status	Free or subsidised NRT	NRT Not Provided	Total
Failed attempt	14	0	14
%	100	0	100
No attempt made	11	20	31
%	65	35	100
Planning	2	13	15
%	13	87	100
Yes	38	1	39
%	97	3	100
Total	65	34	99
%	66	34	100



### (10) Impact of Leadership, Education and Training, and Teamwork on Staff Smoking

Further analysis was performed to see whether there was any relationship between the quality of leadership shown to staff, the extent of education and training about mental illness and smoking provided to staff, the quality of teamwork and the rates of staff smoking. All were found to show significant associations confirming that better quality leadership, education and training, and teamwork played an important role in supporting staff to quit smoking. Results have already confirmed that this was an important determinant of the success of smoke-free initiatives for this sample. See Tables 20, 21, 22 and 23 below for further details.

**Table 20: Relationship between different types of leadership and rates of smoking amongst staff**

Proportion of staff who smoke	Leadership Quality				Total
	Clear	Detached	Mixed	Poor	
0-9%	20	0	2	1	23
10-19%	19	2	4	0	25
20-29%	14	4	4	0	22
30%+	0	11	17	1	29
Total	53	17	27	2	99

( $\chi^2 = 52.62, df = 9, p < 0.001$ )



**Table 21: Relationship between different types of leadership and rates of smoking amongst staff (collapsed)**

Proportion of staff who smoke	Leadership Quality		Total
	Clear	Detached /Mixed /Poor	
0-9%	20	3	23
10-19%	19	6	25
20-29%	14	8	22
30%+	0	29	29
Total	53	46	99

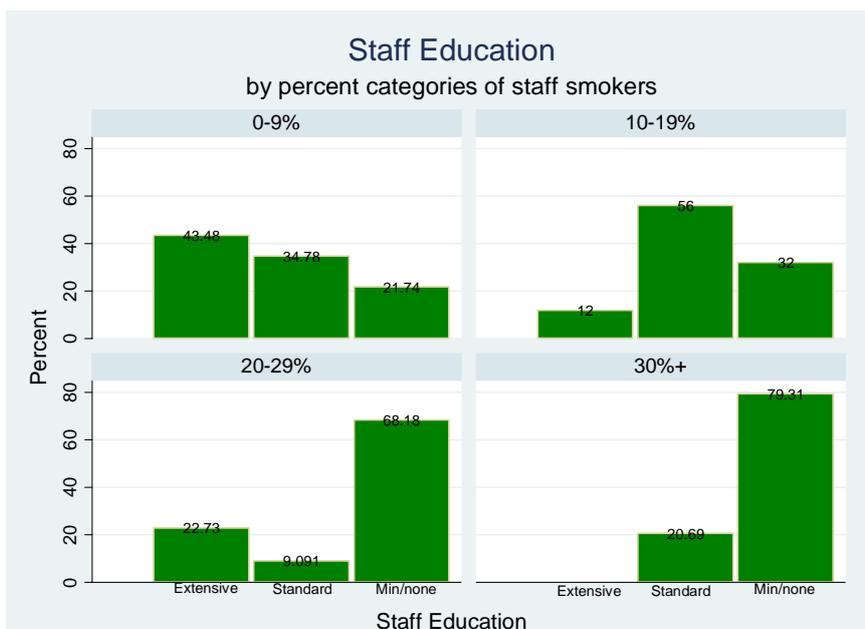
( $\chi^2 = 49.72, df = 3, p < 0.001$ )



**Table 22: Association between education level of staff and their smoking status**

Proportion of staff who smoke	Education and training level of staff			Total
	Extensive	Standard	Min/None	
0-9%	10	8	5	23
10-19%	3	14	8	25
20-29%	5	2	15	22
30%+	0	6	23	29
Total	18	30	51	99

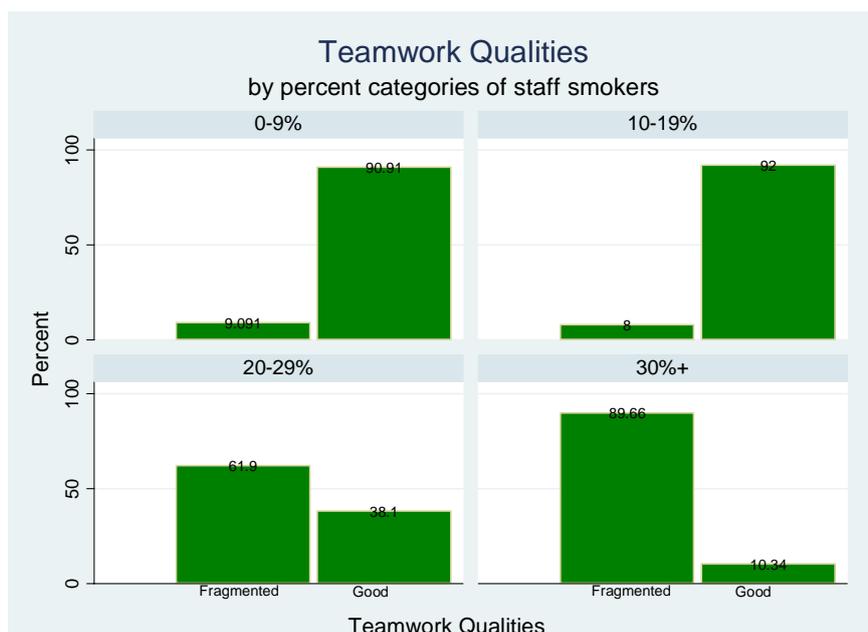
( $\chi^2 = 35.24, df = 6, p < 0.001$ )



**Table 23: Association between level of teamwork amongst staff and their smoking status collapsed (good=promise)**

Proportion of staff who smoke	Teamwork Quality		
	Fragmented	Good / Promise	Total
0-9%	2	20	22
10-19%	2	23	25
20-29%	13	8	21
30%+	26	3	29
Total	43	54	97

( $\chi^2 = 51.21, df = 3, p < 0.001$ )



### (11) Smoke-free status and consistency of policy enforcement

Enforcement of smoking policy included providing verbal reminders to patients, visitors and staff about the policy and providing further action if this verbal reminder was not followed. Some units had developed written contracts for patients to sign upon being admitted to the ward. Most smoke-free units enforced the policy in non-confrontational ways, by verbally reminding patients of the policy and offering NRT if they already been provided with it, verbally reminding them again if needed, then having a clear process for raising the issue within the clinical team decision-making process for further action if the patient continued to smoke despite reminders not to do so. This further action included consideration of the person's level of wellness, whether NRT use needed further review beyond the routine review, and the person's tenure in the unit. Few reported that this step ever eventuated. Only one site was reported to use the threat of fines.

We hypothesised that the consistency to which staff enforced smoking policy would influence its outcome within the sites. An association was confirmed ( $\chi^2 = 59.80, df = 3, p < 0.001$ ). See Table 24 below.

**Table 24: Consistency of smoke-free policy enforcement and outcome**

Smoke-free Status	No Enforcement	Enforcement present	Total
Failed attempt	14	0	14
%	100	0	100
No attempt made	28	3	31
%	90	10	100
Planning attempt	10	5	15
%	67	33	100
Smoke-free	4	35	39
%	10	90	100
Total	56	43	99
%	57	43	100

### Staff Education and Enforcement of Smoke-free Policy

Further analysis was performed to see whether there was any association between the level of education and training staff had received with regard to smoking and mental illness and whether or not they enforced smoke-free policy in the units. An association was found ( $\chi^2 = 46.47$ ,  $df = 2$ ,  $p < 0.001$ ) with minimal or no education and training being more likely in units where smoke-free policy was not enforced and extensive training being more likely in units where smoke-free policy was being enforced.

**Table 26: Level of education and smoking policy status**

Smoke-free Status	Extensive	Standard	Minimal /None	Total
No	1	10	45	56
%	2	18	80	100
Yes	17	20	6	43
%	40	46	14	100
Total	18	30	51	99
%	18	30	52	100



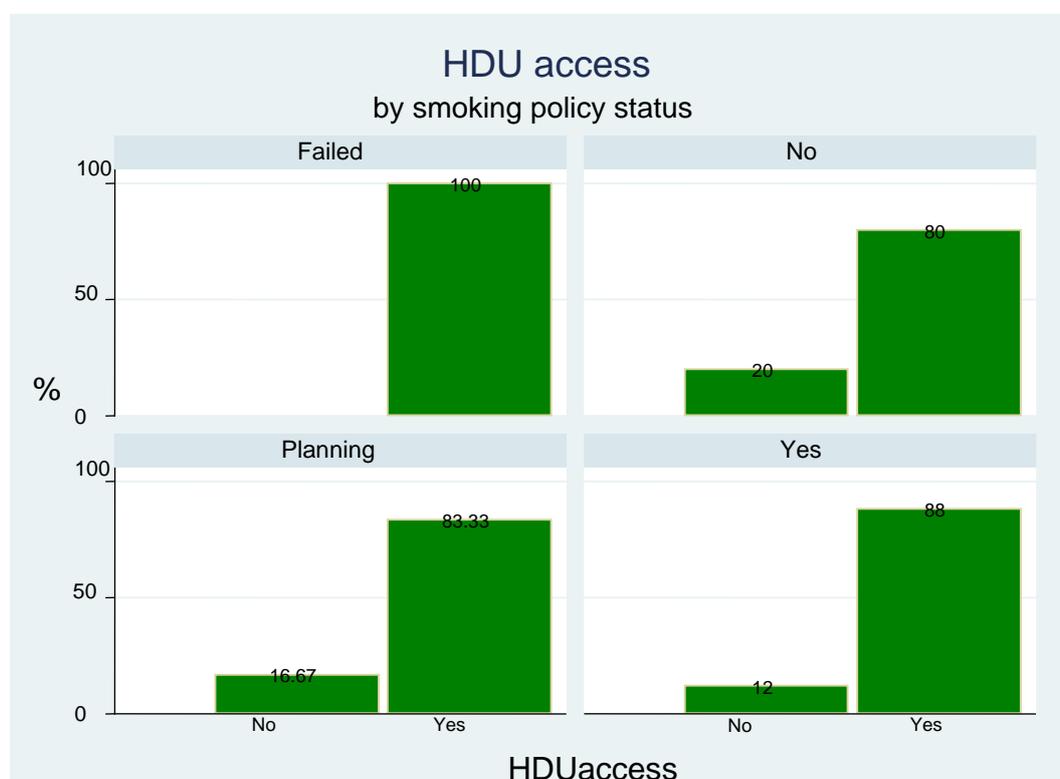
## (12) High Dependency Unit (HDU) access and smoke-free status

Participants were asked whether their open unit teams had access to HDUs, based on the hypothesis that this may have some influence on their options for managing highly distressed patients who may be struggling with nicotine withdrawal, and this in turn having some influence on the success of their smoke-free initiatives. The analysis showed no association. See Table 27 below. When variables were collapsed so that smoke-free and planning sites were combined and sites that were HDUs were excluded from the analysis, there was still no association found ( $\chi^2 = 3.15$ ,  $df = 2$ ,  $p < 0.21$ ). These results need to be treated with caution as there were low expected frequencies for the 'No' cells. The Fishers Exact test showed similar results (fishers exact= 0.24). See Table 28 below.

**Table 27: Relationship between access to HDUs and smoke-free status**

Smoke-free Status	Not Applicable	No access to HDU	Access to HDU	Total
Failed attempt	0	0	14	14
%	0	0	100	100
No attempt made	6	5	20	31
%	19	16	65	100
Planning	3	2	10	15
%	20	13	67	100
Yes	14	3	22	39
%	36	8	56	100
Total	23	10	66	99
%	23	10	67	100

NB. 'Not Applicable' as already a HDU



**Table 28: Relationship between access to HDUs and smoke-free status – collapsed (yes/planning)**

Smoke-free Status	No access to HDU	Access to HDU	Total
Failed attempt	0	14	14
No attempt made	5	20	25
Smoke-free	5	32	37
Total	10	66	76

NB. 'Not Applicable' as already a HDU

|

### (13) Smoke-free Status and Discharge Support Practices

No association was found between smoke-free status and whether sites had capacity to provide discharge NRT to patients. In sites that were not planning to go smoke-free, many had capacity to provide NRT. However, participants in these sites reported that it was not provided because patients rarely took up the offer of using NRT in the first place, while smoking was allowed in the unit, and there was not formal process for adding it to discharge medication regimes. See Table 29 below for data.

**Table 29: Relationship between smoking status of units and whether they provided discharge NRT to patients**

Smoke-free Status	NRT not provided	Not Applicable	NRT Provided	Total
Failed attempt	6	0	8	14
%	43	0	57	100
No attempt made	31	0	0	31
%	100	0	0	100
Planning attempt	13	0	2	15
%	86	0	13	100
Smoke-free	0	1	38	39
%	0	3	97	100
Total	50	1	48	99
%	51	1	48	100

### Nature of Discharge Support for Patients to Remain Quit

Participants were asked about the unit's practices related to discharge support and communication with other support providers once the patient left hospital. Limited support included making patients aware of the Quitline number and providing them with general printed resources on quit smoking information. Linked support involved a clear written notification about NRT use during admission to other service providers such as community mental health workers and GPs as well as Quitline and written resources. Extensive support involved all of the above plus hands-on support provided to remain quit where patient chose to do so. A number of planning sites reported that they were planning to include a linked support aspect in their implementation plan. All sites that were not planning to be smoke-free had no plan in place as part of their routine discharge process, as did more than half of sites whose smoke-free policy had failed and two thirds of planning sites. No association was found between smoke-free status and discharge support plans. See Table 30 for details of data.

**Table 30: Discharge Support for Remaining Quit**

Smoke-free Status	Extensive support	Limited support	Link planned	Linked	No plan	Total
Failed attempt	0	6	0	0	8	14
%	0	43	0	0	57	100
No attempt made	0	0	0	0	31	31
%	0	0	0	0	100	100
Planning attempt	0	0	5	0	10	15
%	0	0	33	0	67	100
Smoke-free	7	16	0	15	1	39
%	18	41	0.00	38	3	100
Total	7	8	5	19	1	99
%	7	8	5	19	1	100

## **14. Summary of Key Findings**

### **Locked/ open status:**

No association was found between locked and open status and smoking policy status.

### **Geographical:**

Regional sites may be more successful at implementing smoke-free policy than urban sites.

### **Planning time:**

Increased success in policy implementation was evident in sites that took more than 6 months to plan their smoke-free initiative Compared to sites that took less than 6 months.

### **Combination NRT provision:**

There was improved success of smoke-free initiatives where there was provision of a combination of NRT products to patients and matching it with individual patients' withdrawal needs.

### **Leadership:**

Clear, consistent and visible leadership was associated with success of smoke-free initiatives

### **Teamwork:**

Cohesive teamwork was associated with success of smoke-free initiatives

### **Education/ training:**

Education and training was associated with smoking policy status, with smoke-free sites being more likely to have extensive or standard education and training provided to staff, and failed sites or those not considering going smoke-free more likely to have provided no or minimal training to staff.

### **Staff smoking rates:**

There was a relationship between staff smoking rates and failure of smoke-free initiatives.

### **Staff NRT provision:**

A positive association was found between whether NRT was offered to staff and units' smoke-free status.

### **Staff smoking cessation:**

Better quality leadership, education and training, and teamwork played an important role in supporting staff to quit smoking.

### **Enforcement:**

The presence of enforcement increased success of smoke-free policy.

### **HDU access:**

No association was found between access to HDUs and success of a smoke-free policy.

## **4. Results Qualitative Themes**

Several themes emerged from the qualitative analysis of data. These related broadly to the domains within the interview guide and systematic review of smoking bans (Lawn & Pols, 2005) that informed the interview process.

### **(1) Making the Choice – To be Smoke-free or not to be**

#### **Choosing to be Smoke-free**

##### **Policy directives**

For all sites located within general hospitals, the overwhelming influence on their decision to go smoke-free was reported to be due to pressure from general hospital administration, especially where other areas of the hospital were already smoke-free. Many units had been granted exemptions over previous years that enabled them to maintain smoking courtyards within the grounds of the hospital. However, more recently, this was increasingly being refused, with clear expectations that psychiatric wards fall in line with other parts of the health service within set timeframes. For some units, a state-wide mandate for change to be smoke-free fundamentally informed their decision as part of standard process and practice across all sites. For others there was a clear directive from the head of their service. As a consequence, most staff in these settings resigned themselves to becoming smoke-free.

##### **Staff awareness of effects of smoking on health**

Participants also cited greater staff awareness and concern for the physical health of patients, with greater awareness of issues regarding substandard care and greater focus on meeting best practice standards as a reason for their decision. In general, participants reported that staff attitudes had evolved over recent years, with increasing public pressure to quit and fewer staff smoking. They also reported increasing staff awareness of and concern about passive smoking or environmental tobacco smoke (ETS) and personal experience of negative impacts of smoking. Interestingly, at one site, the existence of a management staff member with lung cancer directly related to past smoking was a potent motivator for staff and patients. Other participants cited concern for inequity in the workplace between smoking and non-smoking staff where smoking staff were perceived to have more breaks from their shift in order to smoke. One participant cited recent incidents of ETS litigation involving psychiatric nurses in their region which prompted the service to look more closely at the smoking issue. This was confirmed in Tables 15 and 16 which showed that education and training was associated with increased smoke-free policy

##### **Good practice initiatives**

Participants from several smoke-free and planning sites reported that the current national Beacon Project designed to improve clinical practice around the use of seclusion and restraint had been a pivotal and cathartic component of the decision to go smoke-free. They had been given the opportunity to witness alternative effective ways that staff could manage patient distress and agitation that did not involve smoking and were unrelated to it. In fact, many of the HDU overseas sites observed as part of that project were smoke-free. This challenged many entrenched notions of patients' need to smoke when acutely unwell and created the desire by staff to increase their clinical skills in this regard. These participants were senior nurses who returned to their teams to spread the news.

##### **Architectural constraints**

For other sites, the decision to go smoke-free was related to pragmatic issues such as the building not being physically structured to accommodate courtyards that would allow for smoking. This was particularly so for several HDUs with small bed numbers attached to open wards which did not structurally meet ventilation accreditation requirements to ensure the occupational health and safety

(OHS) of non-smoking staff and patients. For others, planned moves to new premises were seen as an opportunity for change. Evidence of success by other sites was also a clear motivator.

### **A solution to conflict over tobacco**

For dual diagnosis detoxification units, managing addiction was perceived as part of their core business; it made sense. Interestingly, participants in Detoxification units and some psychiatric inpatient units cited staff being tired of the heightened aggression and arguments because of cigarettes in exchanges between staff and patients, and patients and patients as the main motivator; the very reason that some other units were citing as the reason why they could not go smoke-free. One smoke-free unit with a high Indigenous patient population and mandated to accept all comers for admission as the only inpatient unit for the region, found smoking especially problematic for patients under 18 years old who made up a substantial group within the ward. Many of these patients had been smoking for years, but could not do so legally once they came to the ward. This caused regular arguments between staff and patients, and between patients, with routine use of seclusion and 'specials' (requiring 24 hour one-on-one direct monitoring of the patient by an individual staff member) for these patients. The change to smoke-free relieved much of this tension, highlighting that consistent treatment becomes important to manage aggression and promote equity with patients in the ward environment. There was increasing recognition that smoking caused arguments and that removing it from equation removed this dynamic; a paradoxical realisation for many participants and their staff.

### **Choosing not to be Smoke-free**

#### **Smoking to reduce symptoms and improve therapeutic relationships**

The main reason cited by participants for their unit choosing to continue to allow smoking was the belief that smoking was needed by patients to manage agitation and symptoms and that smoking was helpful for staff establishing rapport with patients. It was also reported that staff felt that it was an inappropriate time for smoking cessation when people were acutely unwell and that becoming smoke-free would fail because of this.

#### **Fear of violence against staff**

Staff feared increased violence with smoke-free policy and feedback included that nurses were reluctant to police the removal of tobacco from patients as the 'frontline' for any such initiative. Many staff felt unsupported by other professionals within the team in this regard and felt that such an initiative would fail without full support.

#### **Staff smoking and resistance**

Other participants cited a general lack of impetus for change of any sort by their colleagues. Several participants cited active resistance by staff to change. In these units, many staff were smokers and many actively engaged in reinforcement of smoking with patients. Some sites reported being in recent states of flux with moving premises or experiencing other significant changes. Planning to become smoke-free was perceived as a lesser priority to settling work teams.

#### **Veterans units**

Veteran units had unique concerns related to the welfare of their patient group who were largely returned war servicemen or current serving members of the Australian Armed Forces. These patients were perceived to have significant complex health and mental health issues and to be highly political about the care they received and felt entitled to. A strong history of perceived government sanction of smoking, with cigarettes traditionally provided as part of their kit, was apparent. Staff participants reported that the service feared political and funding backlash from veterans who they perceived would go elsewhere to receive service if their units became smoke-free. This was based on actual formal and informal consultations with patients who stated that they

would stand out on the road and picket to protest against services that tried to impose smoke-free. It is not clear whether these patients reflected the majority view held by this patient group.

## **(2) Leadership quality to ensure smoke-free success**

The most significant factor determining the success of failure of smoke-free initiatives, and the decision to go smoke-free in the first place, appeared to be the quality of leadership as detailed in Tables 11 and 12). This related to leadership at both the executive and clinical level and pervaded every aspect of staff and patient perceptions about the service, staff motivation to follow management objectives, and ultimately the style and quality of practice and service delivery. Staff having a clear vision of the service and knowing where they stood in the process was clearly gained from clear and consistent leadership. Leaders in each profession or role were important for different reasons; Executive leaders were important for setting the tone and vision for the service, Psychiatry leaders were important for the political power they held within services, and nursing leaders were arguably the most important for the practical application of change initiatives and their success or failure at being embedded into ongoing practice. There were many diverse examples of these forms of leadership, and problems with them, reported by participants:

### **Change champions**

In one region that had gone smoke-free, executive management and several senior nursing staff were highly supportive. However, there were two senior nurses who actively sabotaged the process and required disciplinary action. This is an extreme example although the more subtle opposition was more widespread. Hence, the ability of senior nurses to build team cohesion was seen as pivotal. In a small number of units, senior nurses were clear change champions who had the full respect and support of their staff, and the respect of other disciplines. These people had strong leadership qualities, political skills and fine tuned problem-solving skills and were able to manage the culture of their nurses and to effectively communicate with executive management. They listened to their staff and were highly respected for it. They also displayed a strong consumer focus and clear clinical skills that helped put other staff and patients at ease. Staff believed in themselves more because of these senior nurses. Senior nurses who were 'acting' in their positions found it more difficult to build staff support.

### **Qualities of change-effective manager**

A number of qualities were evident in effective managers of change. They were:

- Persistent and unwavering
- Highly tuned into the clinical challenges on the ground and not distant from practice
- Active in modelling good clinical care and were routinely a strong role model for others
- Calm, clear, consistent and fair and were perceived to be so by their staff
- Known by staff to talk with pride about their service and its staff
- Non-smokers or ironically had even greater impact if they were a smoker who was attempting to quit i.e. modelling the commitment as part of the change! "Leading by example" There were 8 examples of this for NUM or CNC from sites that are planning or are smoke-free]
- Clear and understood that smoke-free means the need to redefine the ward and how the staff interact with patients on a day to day basis.

### **Leadership and medical staff**

Underlying much clinical practice is the traditional hierarchical structure which places doctors' leadership as significant. Within this study, they were an important group who could provide significant political impetus for change to smoke-free or conversely, could be a significant undermining influence. In 5 of the settings that failed in their attempts to be smoke-free, some of the first undermining activities came from doctors who took it upon themselves to begin issuing smoking leave for patients, despite clear policies not to do so. In another where this was occurring but that successfully went smoke-free, the political skills of the senior nurse ensured that this issue was quickly addressed by raising it with the larger group of psychiatrists and management.

### **Leadership and unions**

Politics were also played out in other ways in some sites. It was important to have leaders who knew the overall policy context and were prepared to follow-through on advice seeking and clarifying the legitimacy of their actions and plans to go smoke-free so that they could effectively meet staff concerns. Where nursing staff groups approached their union, the nursing leaders put clear and sound OHS arguments to the union which were difficult to challenge. Some sites commenced their initiative under the umbrella of OHS with the nurses union squarely in mind from the beginning. Others sought legal advice regarding the legality of confiscating lighters and cigarettes from patients whilst they were in the ward as part of the planning stage and were able to confirm the legitimacy of this for staff.

### **Understanding change**

Other participants reported more subtle, though no less influential, actions taken by leaders to drive smoke-free initiatives. One of these was to place the smoking issues as standing item on OHS committee agendas so that it was routinely discussed and recognised as core business for the service. One region that had been successfully smoke-free for a year was in the process of reinstating a dedicated committee to progress to the next steps of community linkage around the initiative, as they perceived that there was no existing structure of committees within their service able to do justice to the problem-solving and planning needed. Its leaders recognised this need, fully understanding how organisation change plays out in their service and matching change strategies to this reality.

### **Effects of lack of leadership**

As shown in Table 12, clear leadership is associated with success of smoke-free initiatives; more so than leadership which was detached from the clinical field, mixed or poor. One region reported that the lack of continuity of leadership was a significant reason why these, and many other service improvement initiatives in the region, had not proceeded. Staff in several management positions were continually changing, giving clinical staff the feeling that 'no-one was steering the ship!' As mentioned already, several units in one state reported that the central leadership group had spent a long time perseverating on the issue of smoking, portraying confusion which therefore stalled staff momentum. Clinical staff in one unit, in particular, were highly cohesive and motivated to proceed 2 years earlier, but were held back by management. Ironically, it appears that the move to go smoke-free across that state is now likely. This example shows that clarity of decision-making from the top as a first step is important for staff, especially in uncertain times. A number of participants stated that their leaders being smokers had a direct negative influence on staff perceptions and support for smoke-free initiatives: 'The nursing director and service director are both heavy smokers. They're supportive but what message does it send to staff?' They clearer were important role models for staff. As stated, several participants were senior nurses who were actively attempting to quit smoking, recognising that it was important for staff to see them in this way. This is supported by the results of Tables 20-23 which showed that better quality leadership as well as education, training and teamwork played an important role in supporting staff to quit smoking.

### **Leadership and resourcing smoke-free policy**

Other survey participants cited a mixture of effective lobbying for project support, and leadership groups recognising the need for dedicated support, time and resources for a smoke-free initiative; 'If you want a job done then you have to pay for it.' Interestingly, a number of successfully smoke-free sites did not have a dedicated project officer for the smoke-free initiative. However, all such sites had clear nursing leaders as change champions who had fulfilled many of the organisational, consultative and leadership qualities of such a role and were people with influence. Dedicated support in the first few months following implementation of smoke-free policy was also associated with greater success, providing momentum, accountability and support to staff to problem-solve issues as they arose.

### **Promoting pride**

In some regions where inpatient sites had successfully gone smoke-free, there was a clear link effectively built between the leadership of the service and the field. One example was of a service Chief Executive Officer who regularly, openly and genuinely acknowledged the success of the unit in public forums. In one state, the Health Minister had reportedly acknowledged the efforts of services in their public media communications. These types of actions promoted pride in the services and strongly influenced and motivated staff to continue to be smoke-free. This positive influence flowed through to patients with a general ethos of the services being valued. Other sites reported that they possessed a clear ethos of being innovative and leading as part of their service culture (verging on competition to succeed), due largely to a history of clear leadership and success in a range of innovations over time. Belief and pride were important qualities that leaders in such services were able to instil in their services.

## **(3) Team Cohesion and Support for Smoke-free Policy**

Clear planning and leadership were found to be important factors for ensuring the success of smoke-free initiatives. However, building and ensuring ongoing teamwork and cohesion among staff in clinical settings was found to be equally important to going smoke-free. This was defined as work groups that held a shared belief and consistency around clinical management. In sites that attempted to go smoke-free and failed, problems with this were readily apparent, with clinical staff remaining divided despite other aspects of smoke-free planning being often well covered. What each of these sites had in common was a core group of staff (either nurses and/or doctors) who were never really convinced and maintained resistance to change, applying policies and practices inconsistently, with some actively undermining the policy. In many of these settings little appeared to have been done to adjust staff reliance on cigarettes for de-escalation and rapport building with patients prior to the smoke-free policy change.

Participants in some sites spoke of 'Old Culture' holders among staff who variously held positions of informal power within their teams. In regional sites which relied on new graduates to fill positions, participants reported that these new staff were often keen to support smoke-free initiatives. However, many were readily enculturated into smoking practices or simply gave up because of their inexperience in being able to influence change in the team. This created divisions between staff and inaction generally on the smoking issue and other change initiatives. Regions which relied heavily on a casualised workforce reported similar problems. Divided teams tended to be less able to achieve clinical change improvement goals across other areas, not just with regard to smoking policy. This highlights the importance of understanding what staff need to feel confident to change. It often appears too easy to blame their stance on cultural beliefs alone.

A number of sites that were not considering going smoke-free or were planning to do so in future cited the need to settle their clinical teams (especially nurses) before they proceeded. This was

especially so in regions that had experienced restructuring of teams, moves to new premises, and other circumstances in which team cohesion was tenuous or still developing.

### **Providing training and support specific to day to day needs**

Many sites that had gone smoke-free successfully had clearly understood the importance of not only providing general education sessions to staff about such topics as smoking and mental illness interactions and use of NRT. They focused specifically on providing staff with ongoing and detailed education about how they could approach patients who were withdrawing from nicotine. This modelling allowed staff to practice responses and be well prepared, to problem-solve as new issues arose, and to respond effectively, building self-efficacy among staff and teams. They realised that didactic, token information was insufficient to prompt staff to change their clinical practice. During the planning period, initiative leaders in some sites, fully aware of staff concerns and the need for them to feel confident, were highly inclusive by actually asking staff through focus groups to identify skills they said they needed as part of this practical implementation of the policy. Tables 15 and 16 also highlighted the association between education and training with increased smoke-free policy.

### **Sustaining support for smoke-free**

Initiative leaders in sites with realistic expectations of the first 1-3 months appear to have been more successful at sustaining smoke-free status. They recognised that assertive support to staff and patients was needed. They did not just tell them it was happening, expect the change and then leave them to it. Several sites had either a project officer or dedicated clinical staff who provided ongoing support for at least 3 months post implementation, to move among staff, address their concerns, provide regular modelling of interactions with patients who were finding smoke-free difficult, nip any staff splitting in the bud, and maintain momentum generally. One site kept a dedicated committee going for 12 months post implementation of the policy. This also involved management prepared to provide added support and resources where and when needed. Of significance, staff in these sites understood that becoming and maintaining smoke-free is an ongoing 'process' not a finite event. They understood that they just need to keep reemphasising policy, rather than assume that patient breaches mean it is not working and therefore give up. They understood this as a team and worked together to support each other.

### **Staff rotation, skill sharing and teamwork**

A number of sites reported benefit in actively rotating nursing staff between HDU and open wards to build open ward staff skills in managing highly agitated patients, build confidence, build team cohesion, and create consistency in approach across the service. Some regional sites enhanced this in innovative ways by using routine video-conferencing to link sites that are smoke-free with ones that are planning and 'cross-fertilize' staff from across sites. They were also astute enough to know that this was an effective strategy for managing resistance among some pockets of staff. Other innovations were the planning and deliver of cultural skill training aimed at supporting staff skills in engaging with patients, and employment of Aboriginal Health Workers and Consumer Consultants to work within the units to build connection between staff and patients.

Several smoke-free sites also had strong working links with drug and alcohol services, either because of their catchment features as inner city or collocation and nearby access to them. They recognised the need to integrate the learning of these skills across both service types. Successful sites also recognised the need to repeat any training so all staff, from various shifts, had the opportunity to attend. This included night staff, many reported to be among those who were likely to smoke on duty if they were smokers and allow breaches in smoke-free policy by patients.

One region provided the example of involving all staff from across open and HDU units to build consistency and overcome turf issues and internal tensions with inconsistent practice. “We decided as a complete service to look at the model of care and service regarding the smoking policy and decided to apply the policy to the whole of the service, not just inpatient units. We wanted to send a clear and consistent message across the whole of the service and to all service staff and consumers.”

#### **(4) Assessment of Nicotine Withdrawal and Use of NRT**

The understanding that NRT was an important part of any smoke-free initiative was widely recognised across most sites with the majority of participants reporting that their clinical teams could access NRT if needed from hospital pharmacies as per other drug treatments used during the patient’s admission. This was reflected in the positive association between whether NRT was offered to staff and smoke-free status shown in Tables 18 and 19. However, access was variously streamlined or made complicated by hospital pharmacies which facilitated access to a full range of NRT products, restricted the hospital supply to patches only, or did not provide free NRT at all to patients.

##### **Importance of involvement of appropriate staff**

The importance of who was involved in distribution of NRT to patients, how dependence was assessed and responded to, and the context in which it was offered was repeatedly emphasised. Distribution of NRT was described variously as the domain of a select few versus being an expected competency of a range of disciplines and points of entry and contact; of core business versus specialisation with coveting of the role potentially limiting its dispersal as core clinical practice. In one site, the pharmacist held the lone the role of visiting the ward and explaining NRT use to patients. Their intent was clearly good although it limited broader impact and knowledge dispersal. Some sites relied on doctors’ authority to prescribe NRT while others pursued clinical clearance for nursing staff to do initial prescribing. One region had stamps made up for the doctors to make it even easier and quicker for them to incorporate information about smoking on drug charts and manage as part of clinical process. Such options appeared to have a number of benefits for patients and staff. In emergency departments, patients could receive NRT sooner and therefore were less likely to arrive at the ward highly agitated from nicotine withdrawal. Doctors were less inclined to become overloaded if nurses performed this function. They were therefore likely to be less annoyed, more supportive of the smoke-free policy and ultimately less likely to undermine it down the track. Nursing staff were often actively involved in leading the clinical management of nicotine withdrawal and thereby developing skills which could be incorporated into their daily interaction with patients during admission. What these sites recognised was the importance of making the process fit with practice routines and time pressures, and for it to be core business across the clinical team.

##### **Measuring nicotine dependence**

The Fagerstrom Test of Nicotine Dependence (FTND) (Fagerstrom, 1978) was widely used to assess nicotine dependence across sites, regardless of their smoking policy status. However, the difference lay in how this information was used. Smoke-free sites had a clear plan of how to use the scores obtained as part of ongoing clinical management of nicotine withdrawal and, in particular, how these scores influenced the use and dose of NRT. In one region that had been smoke-free for some time, a score of equal to or more than 8 indicated that 2 NRT patches be offered. This region was known to offer 3 patches for highly addicted patients. Daily monitoring brought the decision-making process into the clinical team so that patients were not simply assessed as nicotine dependent, provided a patch then left to monitor its effectiveness without staff support and oversight. In sites where this was the practice, smoke-free initiatives failed, because patients simply did not get the withdrawal support they needed and chose to refuse NRT as a consequence.

### **Access to a range of NRT**

All successful smoke-free sites all had in common the capacity to use a range of NRT products simultaneously with patients. This included patches, inhalers, lozenges and gum to a lesser extent. This was highlighted in Table 10 which showed improved success of smoke-free initiatives where there was provision of a combination of NRT products. The most common combination was patches and inhalers, the latter reported by many to give withdrawal relief whilst patients waited for the patches to take effect, provided 'top up' support when patches did not fully relieve withdrawal. Inhalers also offered a hand-to-mouth ritual akin to smoking which also appeared to alleviate agitation particularly when patients were more acutely unwell and distressed and found it difficult to engage in other diversional activities. Although lozenge use was not widespread, a small number of such sites said that this was equally effective and preferable, given that many of their higher acuity patients would routinely misplace the inhaler holders. Patients misplacing inhaler cartridge holders was a common problem and some sites' pharmacies found the cost of continually having to purchase starter packs in which holders could be found was prohibitive. However, other sites had been successful at approaching the inhaler manufacturers and obtaining further supplies of holders, whilst others had tried and were refused. These latter sites either carried this cost or stopped using inhalers from their list of NRT options, which they found was unfortunate for patients and the unit's smoke-free initiative. It made a difficult job even more difficult. A collective approach by mental health services to the manufacturer appears to be indicated.

Another feature of many successful smoke-free sites was that they had clearly thought out the practical aspects of managing, tracking and monitoring the distribution of NRT to patients on a day to day basis. They were prepared to undertake trial and error, to use group problem-solving processes within the clinical team and to involve patients in this process, either through group meetings or consultation with consumer groups and consumer consultants. An example of this was a trial of use and placement of lockers to store cigarettes and lighter for patients returning from leave. Linked to the importance of teamwork, the team undertook plan, do, study and act (PDSA) cycles to sort many such practical details of what would work in practice; and they owned the outcomes.

### **Smoke-free policy facilitating use of NRT**

As stated, most sites had capacity to offer NRT to patients. However, in sites where smoking was still readily available to patients, few took up the offer. This reinforced beliefs held by staff that patients either did not want to or were unable to stop smoking during admission. Neither were patients able to see if they could stop smoking. Likewise, it offered no incentive for staff smokers to take up the offer of free or subsidised NRT or to change the way they used smoking to relate to patients. Provision of NRT alone was no guarantee that patients or staff would take up its use. In this regard, they appear to be no different to anyone else when it comes to understanding behaviour change and motivation. If they continue to be offered the option to smoke or use NRT they will choose to smoke; if a clear understanding of smoke-free policy exists, then they will choose NRT. This was apparent across all sites in the study and confirmed by quantitative analysis.

## **(5) Consumer Perspectives**

Gaining consumer advocacy group support was a strategy reported by several successfully smoke-free sites. It was not found to be the deciding factor for success or failure, though it was certainly acknowledged as one of a number of important steps taken as part of planning and sustaining smoke-free policy. This usually involved consultation with the region's local consumer and carer advisory group or other consumer oriented collectives. For some sites, it involved actively recruiting consumer representatives to their smoke-free project reference group. This was reported to be instrumental in shifting attitudes and support towards smoke-free in one region, with the particular consumer displaying influence among their peers and clear leadership qualities.

Participants in 5 sites reported consumer consultants actively working on wards to support patients in group programs and individual contact to assist them to manage their nicotine withdrawal whilst in hospital and to help offer alternative activities to smoking. One region was also using this as a strategy to address undermining by some of its nurses and doctors who held beliefs that patients needed to smoke. Other regions were actively recruiting consumer role models to provide patients with evidence that they can quit or tolerate non-smoking whilst in hospital.

### **Consumer responses to smoke-free**

Only one participant reported formal opposition by a consumer group. The main argument of this group was that smoking was patients' 'only pleasure and therefore should be allowed', an argument that indicates a clear level of disempowerment.

In the wards, participants in smoke-free sites reported paradoxical instances where former peer pressure to smoke was now becoming apparent to foster a non-smoking peer culture among patients. This has implications for some patient groups such as Veterans who are known to have a particularly strong pro-smoking peer circle. The 'groupthink' could be used positively to build support for smoke-free policy. Others reported patients increasingly talking with each other about smoke-free policy, their attempts to quit, reminding other patients about the policy when they noticed them smoking, and providing each other with advice about the nuances of NRT use, withdrawal, and coping strategies. Although patients were not always happy with the smoke-free policy, its existence prompted them to debate and discuss it in ways that put the issue firmly on the agenda of consumer groups, staff and mental health services. This was perceived as a positive by many participants, where previously it had been largely ignored. Some participants reported awareness that the policy change had prompted more patients to seek more support to quit while in the community and longer term support once discharged.

Participants in sites where there was no separation of smokers and non-smokers in patients' courtyards reported that this often involved non-smoking patients complaining about ETS. Several participants spoke about the strong smoking culture where patients experience a lot of peer pressure from other patients and from staff to use cigarettes for coping while in hospital, even if they have significant physical health problems related to their smoking. One participant from a unit that disproportionately serves patients with high acuity, and higher rates of homelessness and hostel living, reported incident where such a patient experienced respiratory arrest.

Several participants reported that, when NRT use and clinical management were effective, patients just accepted it as part of the treatment in that setting. One participant stated that "Previously staff had been involved in lighting up to 200 cigarettes per day and being drawn into a lot of arguments between them and patients, and patients and patients, because those without cigarettes had restrictions placed on them. Now the HDU staff and patients are much happier without this problem." Another participant stated, "The key for us was that many patients previously had the belief that they couldn't quit. They often had no past experience of trying to quit (especially in the long term unit) and this provided them with an opportunity to see that they could give it a go and manage with support."

### **Alternative activities to assist smoke-free initiatives**

One unit was enlisting the services of an architect to look at how they could change the ward environment to provide more distractions for patients. They had recently consulted with patients who indicated that they wanted an area where they could make cups of tea and coffee, more cooking groups and more smoke-free areas. Interestingly, cooking and music groups, in particular, were consistently mentioned by several smoke-free sites as well attended and patients stating they are amongst the most helpful alternative activities to smoking. Like other sites, they linked much of this understanding to the National Mental Health Seclusion and Restraint Project: Beacon Project

(ACT Health, 2007) recognising the importance of sensory materials and other positive alternatives. This project is a collaborative initiative between the Australian Government and State and Territory Governments and aims to reduce and, where possible, eliminate the use of seclusion and restraint in public mental health services.

Many sites which had not gone smoke-free were reported to have introduced restrictions on access to courtyards for overnight times (usually 11pm to 6am), during groups to promote attendance and during meals. One site had done so because of refurbishment of the site's courtyard which, as with other examples of restricted access to courtyards, gave staff and patients the opportunity to see that patients could exercise some control over their smoking whilst acutely unwell. This challenged the perception of patients having no control over their smoking. One participant from a Veteran site reported that they had seen patients taking the opportunity to try NRT while in hospital because it was deemed a safe, supportive environment in which to try it.

## **(6) Importance of Context in Planning Smoke-free Initiatives**

As found in a study by Campion, Lawn, et al (2008), this study highlighted that the context in which the unit operated, its location and the population it served were important considerations for the planning of any smoke-free initiative and that ignoring such contextual factors could contribute to failure of smoke-free initiatives. This was thought to be particularly important when considering how the general principles understood to achieve smoke-free were applied to the field and how emphases may vary according to the unique contexts expected in several sites. A diversity of contexts amongst the sites canvassed supported this hypothesis.

### **Examples of Unique Contexts and their Implications**

One region was known for its 'tough' community, with significant drug and alcohol issues apparent in its community. Despite these factors, and fully acknowledging them, its smoke-free initiative was successful because staff were supported with clear leadership, a specific focus on providing them with training and support that involved on the job practice and modelling of the clinical management of nicotine withdrawal and aggression, and the team was particularly cohesive because of these 'tough' conditions.

In an inner city site with a patient population of often highly distressed, very unwell individuals with, multiple problems, significant drug and alcohol problems and high rates of homelessness, the service was well aware in its planning for smoke-free status, that particular attention was needed regarding how NRT was used and how staff were trained to manage this population's nicotine withdrawal and agitation.

Both Veteran units were well aware that their patient population was comprised of individuals with high prevalence of Post Traumatic Stress Disorder (PTSD) and sleep disturbance and that this particularly required focus on the needs of patients after hours in particular. Neither unit was actively planning to go smoke-free, but recognised that this would need to be factored in to any future initiative and clinical team process.

One regional site possessed a high prevalence of Indigenous patients and new arrivals to Australia with significant language issues and few formal interpreter services. Mindful of this, they were working to actively engage those communities as part of the wider service approach to maintain the success of their smoke-free initiative.

Another site was aware of its high prevalence of patients who would normally live in Supported Residential Facilities (SRFs), as with other sites with high boarding house and itinerant populations,

higher acuity, poorer control of smoking behaviour, greater prevalence of intimidation and begging, and more staff involvement in supply of tobacco. Participant recognised that staff in this site would likely be highly sympathetic to these patients' 'need to smoke' and the dilemmas and powerlessness they might feel when contrasted with the poverty, psychosocial and physical health problems apparent in this population. A paradox for such populations is that they are often able to smoke more in hospital and have less to do than in the more structured environment of the hostel, where rationing of cigarette supply and their usual raft of psychosocial support services and activities are available to them. In addition, attaching a cigarette lighter on a string in this setting's HDU was not as successful for this population due to safety issues regarding fires and assaults on other patients. Staff had returned to lighting patients' cigarettes and were perceived to be "caught between a rock and a hard place" and were increasingly recognising that removing smoking altogether would remove these dilemmas.

In detoxification units, staff commented that patients frequently talked about drugs and criminal activity and also commented on more frequent intimidation between patients. They recognised the role smoking played in this and decided to go smoke-free to alleviate this problem by removing the tobacco which acted as a focal point for such exchanges.

One smoke-free site with a high proportion of intellectually disabled, highly disturbed patients with clear behavioural management problems and poor control over their smoking, had paid particular attention of the types of diversionary activities it offered to patients, recognising that this was important consideration for this population.

One regional site planning to go smoke-free was aware that its vast catchment area meant that it would need to employ specific communication strategies to help inform staff in referring sites and patients about their smoke-free policy and that discharge processes would also need to recognise this.

One inner city urban site whose catchment included itinerant, homeless, tourist and weekend 'party' populations who were likely to be unknown to them, were aware that they would need to pay particular consideration to how they assessed drug dependence generally, how they used prn 'as required' medication and seclusion, and how they supported staff with smoke-free initiatives.

Managers in another region with sites that were correspondingly staffed with younger more innovative staff in one location and disproportionately populated by older, more entrenched staff in another location, were aware that timing and sequencing of where they commenced their smoke-free initiative first, staff dynamics and education and training support would be important considerations in their plans to go smoke-free.

## **(7) Planning for Smoke-free - The Need for a Multi-layered Strategy**

### **Interdependence of strategies**

Sites that had gone smoke-free, were planning to, or who had tried and failed had implemented a range of strategies to achieve their goal. However, key factors which differentiated them appeared to be their level of recognition of the interdependence of these strategies. Recognising the interdependence of strategies was clearly important for success and there are multiple examples through the data collected of how this led to success and failure. The following contributed to reduced success implementing smoke-free policy:

- Failure to engage the staff who would largely be responsible for implementing the initiative

- Sites that appeared to put many strategies in place yet still failed because of one component that served as a weak link such as lack of ongoing support to staff post implementation or a continuing high percentage of staff smokers (see Table 17), or fragmented teams.
- Lack of awareness of the needs of the patient population, especially those with heavy nicotine dependence, so that offering only one patch becomes and futile exercise.
- Failure to consult staff regarding training; although training might have been put in place, lack of initial consultation with staff regarding their educational needs resulted in education sessions being poorly attended or being attended only by those who were already well attuned to the topic. Although education about withdrawal was available, the structure of staff workloads and the timing of this education often resulted in little time to practice skills learned.
- Lack of effective translation of staff training on the harms of smoking to effective practical support of smoke-free policy i.e. it remained an 'intellectual' exercise with no translation to the practice reality of overwhelming reinforcement to smoke and no practical point of entry for staff to change practice. "No amount of telling people it's harmful to their health will stop them from relapsing to smoking or stop them from using it to cope with their illness." Providing education and training to staff on how to help clinically manage their withdrawal is often lacking in such approaches.
- Widespread opportunity for patients to continue smoking resulted in them not taking up NRT even though it was available with the support of clinical staff.
- Lack of reinforcement; initiatives where the policing of staff smoking were not addressed resulted in inability to respond to patient breaches on the grounds of equity and fairness.
- Staff inconsistency; some sites reported that doctors had breached the policy by allowing leave for patients to smoke despite the policy. This was due to these staff not being engaged in the development of the policy. In another example, patients proceeding for admission from the Emergency Department (ED) to smoke-free units had been told by ED staff that they would be able to smoke on arrival at the ward. This inconsistency resulted in increased patient agitation and hostility which then heightened the likelihood of staff adopting a more forceful approach or backing down and allowing the person to smoke, and ultimately seeing the policy as just too hard. Conversely, other well primed staff in ED were skilled and able to initiate NRT from the first point of contact with patients so that patients arrive at the ward more settled and fully aware of the policy.
- Lack of consistency and enforcement; despite the presence of group programs for patients (including smoking cessation groups, coping strategies groups, relaxation and stress management groups) these were poorly attended by patients because there was little incentive to do so when smoke-free policy was not enforced and NRT was not consistently offered.
- Lack of leadership and reduced smoking cessation; staff NRT was offered but there was little incentive to pursue its use as the smoke-free policy is not perceived as inevitable due to management's indecision or confusion. Some participants reported that because staff smoking and education about reinforcement problems had not been addressed adequately, this contributed to the congregation of patient and staff smokers together on roadsides directly across from units which become an alternative hub for social contact and reinforcement.
- NRT not viewed as important; patients were offered NRT but it was often inconsistent. There was a lack of follow-up with offering it during admission because the process was not linked to the clinical team's ongoing assessment as the person proceeds through the stay in hospital. NRT is ultimately not seen as a form of treatment because education of staff has not been adequate and they have not realised its value and their attitudes have not been adjusted.

However, where one component was weak, its impact did not seem to be too detrimental so long as other strategies were strong and able to compensate:

- Teamwork and leadership; where leadership was less than optimal, inactive or distant, strong team cohesion enabled staff to drive the initiative anyway.
- Leadership overcoming resistance; where the 'old culture' was strong, the sheer persuasiveness and qualities possessed by the nursing leader outweighed this resistance to change.
- Staff from successful smoke-free sites; where there was ambivalence to the introduction of smoke-free policy, the NUM from a nearby successful site was brought in to talk to nursing staff and challenge their concerns about increased aggression, increased absconding and shorter bed day stays with real evidence that this did not occur.
- Management support; the absence of a dedicated project officer was outweighed by strong middle management who were visible and accessible to staff on a day to day basis and actively problem-solved with them throughout the planning and implementation phase.
- Leadership and Education; problems with an ED doctor refusing to provide patients with NRT after the first 12 hours of their admission, based on the wrong assumption that physical withdrawal has passed and NRT is therefore no longer needed. This lack of proper understanding and education about withdrawal was countered by strong leadership to correct this practice and clear processes ensuring the correct use of NRT in the ward.

### **Timing issues**

Participants clearly identified a range of issues related to the timing of smoke-free initiatives and strategies within it.

One participant reported that their initiative failed largely because the implementation date was set for the height of summer, when outside temperatures were very high. Staff and patient complaints about being forced to smoke outside the grounds of the hospital where there was little shade quickly led to the policy being undermined.

Likewise, going smoke-free as part of moving to a new unit was reported to be not the best time to think of going smoke-free, given the upheaval caused for staff and patients. Two sites that were successfully smoke-free, reported temporary problems with sustaining smoke-free policy after moving to new facilities, indicating that more attention to the policy is required in such instances.

Several participants reported the positive impact of the national Beacon project, as mentioned already. Smoke-free project staff and change champions were able to use the impetus from this project to build staff confidence in going smoke-free.

As previously noted (see Table 6 and 7), too much time spent planning without a clear end point caused staff in one state to lose interest, for the initiative to stall and for many staff to revert to previous practices. Staff also then developed scepticism about any future smoke-free initiatives as well as apathy towards their service leaders on this issue. From participants' reports, success did not appear to be solely dependent on the length of planning lead time. One region had a short planning time and drew heavily from the learning that had already taken place within its general hospital wards, translating this readily to its psychiatric units. However, most successful smoke-free initiatives appear to have taken at least 6 months to plan and prepare to go smoke-free.

Addressing staff smoking rates was reported by many participants to be a clear for-runner to success. However, they also reported that, while some staff smokers may take up quitting early in the preparation stage, many staff did not take up the NRT offer until close to the smoke-free date, suggesting the need to focus such staff support especially in the last 3 months prior to smoke-free implementation.

## **(8) Maintaining Smoke-free Policy – Steady as She Goes**

### **Enforcing smoke-free policy**

Participants from successful smoke-free sites were overwhelmingly realistic about their expectations for implementation, especially in the first few weeks. They understood that breaches would still occur and the policy would need ongoing enforcement, ongoing support to staff and ongoing reminders to patients, families and other visitors. They reported using an approach that avoided being punitive. Such an approach was reported to work best at maintaining staff morale and confidence, and supporting and gaining patients' cooperation with the initiative. Staff were encouraged to provide gentle reminders about the policy and its intent, work with patients collaboratively, re-offer NRT routinely beyond the initial period of entry to the ward, and engage patients in supportive counselling as part of day to day interaction. One participant stated, "We believe that people respect what we are trying to do, if done in this way. If further enforcement is needed, then we deal with this within the team process with the person, that is, collaborative and consistent reminders delivered in a non-threatening way". Most participants from these sites reported that they had not needed to take enforcement further as yet, because patients generally abided by smoke-free rules and reminders. Only one site, an inner city high-density large hospital was reported to be actively using the threat of fines. All other sites with this capacity stated that they had not needed to resort to this extreme and that such an approach fostered a detrimental relationship between staff and patients. However, a clear process appeared to be important for staff; "There is a system in place where staff know there is a process to cope with such incidents. There is a back up plan and they feel more supported as a result."

One participant provided the example of their site employing two security guards to do rounds of their large hospital to remind people of the policy; stating that this worked very well while in place and highly cost effective given that the site previously had a high rate of violence towards staff. Several participants reported that their sites had developed clear signage about the policy for staff, patients and visitors. One region had incorporated contracts to abide by smoke-free policy as part of the patients entry into their units. Several sites had developed clear procedures which patients were made aware of related to smoking while on leave and handing in cigarettes and lighters for safekeeping once they returned to the ward. This was reported to work adequately with overall patient cooperation. No participants reported patients leaving against medical advice because of smoke-free policies. Neither did they report that aggression increase as a result of the policy. Conversely, several reported that levels of aggression declined following the introduction of smoke-free policy.

### **Maintaining smoke-free momentum**

The importance of maintaining vigilance in the months following implementation has already been mentioned. Several participants described a 'honeymoon period' immediately following implementation where motivation by staff was high and the policy and strategies were followed closely. However, mirroring the individual smoker's attempts to quit, the group process also had potential to flounder as time went on when concentration and focus had lapsed. Participants described this as a high risk time when some staff may begin to undermine the policy and revert back to previous practices. Examples included doctors beginning to give leave to smoke to patients who they would not have otherwise given leave to at that point in their treatment and night staff allowing smoking and smoking with patients, suggesting that these areas required focus of attention. One site held weekly planning meetings with staff to provide support and problem-solve concerns as they arose to help alleviate any lapses. Mirroring other qualities of good leadership (and to take the marriage metaphor further, of most relationships), such challenges appeared to be handled well in those sites that were successful with senior staff recognising and being realistic

about such challenges; “It was as good process to go through to learn from our mistakes. It also strengthened the vision and staff cohesion, brought them together and lessened splitting.”

### **Smoke-free for the Long Term**

A range of measures were reported by sites that had been smoke-free for some time. These included clear policy boundaries and persistence, clear integration of the clinical management of nicotine withdrawal into routine care with clear systems for recording and monitoring this within the clinical process, the presence of a steering group comprising all stakeholders, continuing reminders and education especially with new staff, and learning from mistakes and moving on.

### **Post Discharge Support**

Many smoke-free and planning sites focused on how to maintain a smoke-free policy as part of the overall hospital policy rather than having the goal of imposing long-term quitting attitudes on patients. For many this more immediate focus was enough of a step initially and they took the occupational health and safety (OHS) stance that avoided imposing any moral attitudes on patients about their smoking behaviour. They reported, albeit realistically, that they believed many patients would return to smoking upon discharge from hospital either due to choice, addiction, peer pressure, lack of ongoing support to remain quit, or other reasons that they saw as ‘not our business.’

However, many sites had attempted to be more health promoting in their interactions with patients and many had instituted an increased number of occupational therapy and activity programs to this end as part of planning for becoming smoke-free. All sites that offered NRT during the person’s admission provided NRT as part of discharge in line with other medications (Table 29). This varied from 3 to 7 days supply of patches. Table 30 highlighted that it was only sites that had gone smoke-free which were either planning or actually providing post-discharge support. One site that had been smoke-free for some time was undertaking a trial of 3 months NRT support for willing patients to stay quit post discharge. Two other sites were actively planning their next steps in linking support for staying quit more closely with community mental health and other services, recognising that this care was part of continuity of care. Likewise, participants reported that patients were chasing more support to maintain cessation or quit post discharge as a direct result of smoke-free policy. Many participants reported that links with primary care cessation follow up was usually poor.

## **(9) Features of Sites without Smoke-free Policy**

Participants’ comments indicated that most teams in these sites without a smoke-free policy recognised the problems that the smoking culture creates and were aware of the need to eventually consider changing their practice. Many said they simply did not know how to start and that it was ‘in the too hard basket’. Most of these sites had moved to having designated courtyards for smoking, with segregation for non-smoking patients to avoid ETS, and movement of smoking areas away from entrances. Many were actively moving towards practices that limited staff involvement in the supply and management of cigarettes such as placing lighters on strings in the courtyards and several had already done so. Some sites had moved to limiting the amount of seating in courtyards to discourage patients from congregating to smoke. One participant expressed concern that this may not be an option in HDUs where patients were often highly medicated and unsteady on their feet.

However, many staff in these sites (especially nurses and social workers) were reported to be still closely involved in traditional roles around the supply and management of cigarettes for patients such as supplying cigarettes when the patient has none and smoking with patients. One participant stated that “Once a month, a packet of cigarettes magically appears in the HDU nurses station.” They were also reported to be heavily reliant on cigarettes to help settle patients rather than

focusing more closely on the use PRN medication and other clinical strategies; “To be honest, if they have their tobacco then we tend to leave them alone.”

However, an equal number of participants reported that their staff appeared to be trying to change such practices by removing staff smoking to alternative areas, banning smoking for staff, fixing lighters on walls, creating separation of smokers and non-smoker areas for patients, and limiting access to courtyards during group treatments and at night.

From the comments made by participants, it appeared that these sites generally had less Occupational Therapy and other activity programs available to patients and more disconnection between the disciplines that made up their multidisciplinary teams. This is supported by the findings in Tables 13 and 14 showing that an improved teamwork culture was associated with smoke-free status. In smoking sites there was a clear distinction between the doctors and their counterparts in smoke-free sites. This ranged from complete non-involvement to concern but little action. In smoke-free sites, they were actively assessing and treating withdrawal and incorporating it into clinical management of the patient whilst they were in hospital.

## **(10) Features of Smoke-free Sites with Ongoing Problems**

Clear patterns that emerged from the data on smoke-free sites that were determined to continue being smoke-free but that reported ongoing problems with compliance with and enforcement of smoke-free policy in their settings:

- Lack of dedicated smoke-free support; most such sites experienced ongoing problems and had no dedicated project support currently active in the site, or otherwise dedicated personnel were spread so thin across the region that their efforts were largely ineffective or only making an impact at the committee level. All of these sites had no dedicated ongoing support staff to model and problem-solve day to day issues related to patients and their nicotine dependence as they arose with staff.
- Lack of support from medical staff; doctors in these sites were more likely to be ambivalent and less engaged with the smoking cessation which often resulted in nurses disproportionately taking the load in managing this issue.
- Staff turnover issues were common in these settings.
- Leadership; the leadership of these services were likely to be less engaged or giving mixed messages to staff about the smoking policy (see Tables 11 and 12).
- Lack of staff smoke-free education and training; many staff in such units appeared not to have fully understood the implications of nicotine dependence for their client group and where specific emphases were needed. Many were still determining best practical processes for using NRT. This is supported by the findings in Tables 15 and 16.
- Staff smoking; one region was experiencing the problem of staff still smoking in the hospital grounds, and then returning to the ward smelling of cigarettes which patients would then complain that it was unfair that staff could smoke while they were unable to. In these settings, staff were routinely and blatantly undermining the policy and their non-smoking colleagues were angry with them.

Despite these concerns, it should be said that many of these sites were taking a realistic, incrementally supportive approach with staff teams by maintaining the expectation of becoming smoke-free and accepting that it is a process for staff and the system to adjust to over time.

## **(11) Features of Sites which had Unsuccessfully Introduced Smoke-free Policy**

As with their counterparts in other sites, there appeared to be clear patterns that emerged from the data on sites that had attempted to implement smoke-free policy and failed. Many of these patterns were the same as patterns for sites that were smoke-free but with ongoing problems, as mentioned above. Of the 14 units which had attempted to go smoke-free and failed, 6 did so after 12 months, and 2 each did so after 6 weeks, 4 weeks, 2 weeks and 1 week. Many of the issues that led to the failure of smoke-free policy for these units have already been mentioned within other themes and are listed here for clarity:

- Leadership and management style; there was a clear pattern of individuals or small groups of staff who undermined the policy. These were people who held either formal or informal power in their teams. Individual 'old culture' holders were evident in these sites. Their influence was generally not well managed and there was a lack of leadership resolve or understanding as to how to address staff undermining practices.
- Lack of understanding by senior management of smoke-free policy introduction and maintenance; participants often reported that policy planners in these sites appeared to believe that by announcing intention, setting up a committee, providing one-off training and getting NRT patches through pharmacy was enough for success. Smoke-free policy was commonly given as a directive with few resources or real power to back it up following which project staff struggled to influence the 'old guard'.
- Lack of clinical training regarding nicotine withdrawal; nicotine withdrawal was often managed with the offer of only one NRT patch or one method of NRT rather than combinations tailored to the needs of the patient (see Table 9 and 10).
- Preparation of smoke-free policy; timing problems were apparent as part of the planning stages, consultations were poorly attended and there seemed to be general mismatch in how to engage with the audience of staff and consumers.
- Lack of support; staff teams in many sites gave up quickly and there appeared to be no process to support them to pull together when needed
- Appropriate resourcing; some of these sites had experienced reactionary rather than proactive planning for their smoke-free implementation such as one project officer still awaiting resources and catching up 4 months after smoke-free announced. Three of the sites had been smoke-free for some time and had been going well until funding for the project officer time and other supports were ceased.
- Lack of patient inclusion; participants' comments suggest that consumer participation in the service as a whole was in need of some attention.

## 5. Case Studies

This 20 bed inpatient unit was part of a general hospital and incorporates 3 HDU beds. It had been smoke-free for more than 6 months. The hospital served a population of 200,000 people across an area of approximately 16,000 square kilometres and the area had a very large non-English speaking refugee population. Family members largely served as interpreters with mental health services and it was difficult to find community leaders within these groups as they were still very new to the area... There was also a large Indigenous population who were very heavy smokers. The community had high levels of acceptance of diversity.

The mental health service had worked hard to engage communities which were more impacted upon by the smoke-free policy. Community consultant liaison officers for these populations were heavy smokers but were very supportive of smoke-free policy and had attended education and training workshops on this. Most carers supported the smoke-free policy. One influential carer was initially sceptical but had changed this view when his son was admitted to the ward and had told his parent that he wished it had happened years ago. The local consumer and carer group had also been helpful.

### Preparation

The unit started thinking about going smoke-free nine months prior to smoke-free policy implementation. Within the first four months of preparation the service decided as a group to become smoke-free. Smoking had become a huge problem within the clinical environment with staff increasingly dissatisfied with supervising patients' smoking and handing out of cigarettes to patients. 'The whole focus of treatment had become around when I have my next cigarette'. For some time, staff had been debating whether to limit or restrict smoking altogether. Two consumer consultants on the ward were both non-smokers and acted as good role models to patients and staff during the period. The carer consultant was a heavy smoker who was against the idea of smoke-free policy.

With managers' support, the service undertook a literature review of the 'for' and 'against' issues. Management fully recognized that they needed to bring staff along in the process. At that stage, 50% of staff were smokers and most psychiatrists had been heavy smokers in the past. Staff were equally split and fully convincing them took until several months. Some senior staff were sent to look at smoke-free units in another part of the state to gather ideas and advice. The nurse unit manager spoke at length with staff in the months leading up to implementation of the policy and most staff eventually came on board. Many staff perceived that patients would get more aggressive if they were unable to smoke despite the evidence against this from neighbouring successfully smoke-free sites which had been visited. Some nurses contacted nurses at one of those sites visited, seeking confirmation that aspects implementation were worse than the senior nurse there had portrayed since they had reported less aggression, less absconding, and fewer bed day stays post smoke-free policy implementation. These staff did not believe this was possible so kept looking for evidence to refute it although were unable to find such evidence. Senior nursing management were well aware of this splitting behaviour and the need for provision of evidence, education and support for these staff although also mindful not to make them the focus of attention. Previously, staff non-smokers did not feel confident to challenge smokers and would go to management quietly to advocate for smoke-free policy or express their concerns regarding Occupational Health and Safety (OHS).

The hospital courtyards were too small and were unable to comply with accreditation standards. This was especially so for the HDU courtyard which was very small with no capacity to ensure OHS for non-smokers while also accommodating smokers, and no capacity to structurally change this.

Education and training to support smoke-free policy was looked at as an issue across the whole of the service. Both inpatient and community staff (three of each) undertook train-the-trainer quit courses and one day workshops were run with Quit services for staff. Extensive written materials and resources were acquired and distributed for access by staff and patients.

Guidelines were developed regarding use of medications and potential interactions with nicotine withdrawal. Psychiatrists were not formally trained but one of them looked at the research and then reported back to the group which met weekly and had extensive discussion.

### Going Smoke-free

From the implementation date when 75% of staff were supportive of the policy, senior staff held weekly meeting with staff in attempts to be very supportive and problem-solve concerns as they arose, creating a learning environment as a team. . A whole of staff team approach was taken to clinical assessment and management of nicotine withdrawal from the beginning which the following clinical practice guidelines:

- Fagerstrom assessment of nicotine dependence
- Talking to all patients and carers as a standard part of admission and assessment
- Provision of free NRT patches to patients
- The Minnesota withdrawal scale to guide clinical practice
- Medical officers had a dedicated role in reviewing PRN medication based on these assessments and feedback from nursing staff.

The psychologist on the unit took an active role in seeing all people who wanted to quit and have revised sleep management on the ward to look at strategies for its improvement. Occupational therapy and psychology staff worked actively with patients, providing groups with patients each week. During a period without a nurse unit manager, allied health staff increased their input so that all was not left to the nurses. Staff thereby pulled together and work as a team to fill this gap, providing good team cohesion and healthy team approach that has supported nurses especially.

Regarding medication support for cessation, pharmacy staff had advised the mental health staff that NRT inhalers were harder to regulate than patches. Consumer consultants advised that lozenges tasted awful and gum was understood to be problematic in that it posed hazards to safety with this setting when gum was pushed into door locks. NRT patches were the clear and agreed treatment with capacity to prescribe two patches where patients scored high on assessment for dependence to nicotine. Nursing staff developed a process to name and date each patient's NRT as well as a system for tracking it, especially for very disturbed patients who were sometimes too confused to remember/manage how the NRT they had used and inadvertently smoking while wearing patches. No side effects of NRT use were noted. Some patients refused NRT and some still smuggled in lighters and cigarettes. The team decided that patients would get no NRT patches for two days until they handed over lighters and cigarettes.

A media campaign coincided with implementation of the policy, with local health leaders openly acknowledging the leadership shown by mental health staff and the service for the community. This created a sense of pride within the mental health service and was perceived to be important and highly motivating for staff and clients of the service.

### Learning from trial and error

No leave was given for smoking purposes and doctors were fully briefed on this plan. In the open unit, patients were initially required to hand their cigarettes and lighters in on admission which were returned to them on discharge. Most realized and accepted this rule and only a few found this a

problem. However as a team, staff decided that this approach was too punitive for some patients. Since staff did not want to handle their cigarettes and there were lockers for visitors in the reception area, they decided to use these for a couple of their long term patients who considered the hospital as home. Although this worked for a couple of weeks, subsequently other patients also started requesting a locker and staff continued to grapple with finding a less punitive towards patients.

About two months after initial implementation of the policy, psychiatrists (without consultation) decided to give patients smoking leave every 2 hours for 5 minutes. This resulted in chaos for a couple of weeks, with increased fighting between patients and patients, and patients and staff. Many staff became dissatisfied and teamwork began to deteriorate. An informant commented: 'It was a good process to go through to learn from our mistakes'.

#### Leadership Issues

At this time, the ward had also been without a nurse unit manager to provide consistency and reinforcement support to staff for the policy which contributed to its undermining. The nurse leader decided to confront the psychiatrists about this and found them very angry and against the policy. The nurse leader acted quickly and called a meeting the next day and which was attended by the majority of staff. The outcome of the meeting was that almost all staff wanted to proceed with the unit being smoke-free. It proved to be a very useful exercise in building staff cohesion and support.

Throughout the period, the nurse leader had displayed resolve regarding smoke-free policy implementation, routinely connecting with staff on a near daily basis to offer support and reinforce the clear health concerns from smoking with both staff and patients. The nurse leader drove the initiative and maintained momentum from the beginning with a clear impact on the whole of the service. They remained visible, collaborative and accessible to staff, listened to concerns and responded with clear actions. They were highly persuasive, not easily unsettled and their calmness was valued by staff, especially during this major changes processes.

#### Current status

The unit returned to patients handing in cigarettes and lighters upon admission. The two long term patients coped and knew where to leave their supply of cigarettes (hollow trees, vacant houses along their path in the neighbourhood) Since the leave issue was resolved, the unit had had only two incidents of cigarettes being brought into the unit. Although the courtyards remained open to the public, staff or security talked to them and requested them to hand over cigarettes when visiting patients in the ward. Staff had been briefed routinely as part of preparation and ongoing implementation support on how to manage this type of situation. Dedicated time was spent on modelling how to do this. If any request by staff to patients or visitors to hand in cigarettes while in the ward failed to get the desired response, they reported such issues to the treating team for clinical management review although this had not needed to happen at the time of interview. Hence, a system was in place which allowed staff to cope with such incidents and be supported. Patients had also been increasingly supportive and become greater advocates for each other to quit, responding to positive non-smoking peer pressure.

In the HDU, staff also came on board with strategies and alternative activities for patients. As part of admission, there had been no problems with patients having acute needs related to nicotine withdrawal. The unit had not needed to institute a nurse prescriber to provide more rapid response, and fast acting NRT had likewise not been needed yet. This was in part to other aspects of team clinical management being well coordinated. All staff were on board and had clear clinical guidelines and strategies. They reported that they responded to it as any other behavioural problem, using as required medication, diversional strategies and activities as part of a more holistic, health promoting approach.

### Beyond Inpatient Smoke-free Policy

The mental health service was committed to looking at patients' overall health and well-being, going beyond managing non-smoking while patients were in hospital to help support people to quit and stay non-smoking once they left hospital. Good relationships existed between inpatient and community team staff which was helped by the services being small in size and located close to each other. A significant motivator for staff (and clients) of the service was one of their well known colleagues who was a heavy smoker developing cancer which had a significant impact on the whole service. Inpatient and community teams were integrated with one director across both, enhancing consistency across the service for existing and new staff.

### Overall

This example showed clear teamwork, cohesion, group problem-solving and respect and trust from managers in their staff to do so. Leadership was very supportive and aware of the tensions which smoke-free policy raised. The team clearly recognised the need to clinically manage patients' withdrawal from cigarettes and had taken ownership of their success.

## **(2) Successful Smoke-free Policy in an Urban Acute Psychiatric High Dependency Unit**

This setting was a 30-bed locked unit that had been smoke-free for 10 months. It was part of a large stand alone psychiatric facility with a high turnover of patients, similar to open units. A dedicated project officer was employed to drive the introduction of smoke-free policy and this was seen as critical to success of the policy. This officer was a senior nurse who was well known and respected throughout the service and who maintained a regular presence and was highly collaborative with clinical staff on the ward. .

In the beginning, staff were very motivated and patients were cooperative. However, patients later began to test the boundaries and breeches appeared to be most prevalent three months after implementation of the policy with visitors bringing in tobacco. The majority of staff felt that the smoke-free policy had improved the environment. Only 5% of patients supported the smoke-free policy prior to its implementation which changed following implementation when patients were found to be very positive about the policy, seeing it as a good incentive to quit.

### Leadership

The service had been increasingly concerned about the smoking issue in its units, further fuelled by recent litigation cases involving mental health nurses. The state health minister pushed the policy at every opportunity and took every opportunity to praise the service for its efforts. Once the clear message had come from the Minister that the services were not going back to smoking, staff made a greater commitment to the process. The nursing director and senior nurses were also committed to smoke-free policy.

Implementation of the policy in this setting was part of a larger central working group which coordinated the effort across multiple sites in the state. This was important and allowed units to learn from each other and motivated them to keep going. Smoke-free policy was being implemented across all wards within the facility to ensure consistency for both staff and patients. The service planned to rotate staff around the wards every few months to build and maintain this consistency and skill sharing.

Staff reported that it now felt like they had never had a smoking problem or had smoking so widely in the facility. Prior to implementation, several staff smoked with this number being halved post-implementation.

#### Preparation strategies

The smoke-free policy process was initially commenced as an occupational health and safety (OHS) initiative. This was important politically because it meant the nurses union could not argue with this approach. There was a lead up to policy implementation during which all staff were given clear direction and information of the intention to introduce the policy.

Triage operated from the campus and could brief people prior to them going to the wards. Letters were also sent out to all GPs and all services that would have any contact or potential for contact with people with mental illness to notify them of the planned smoke-free date.

#### Use of NRT

A combination of NRT patches and inhalers were used with patients. The unit experienced problems with the supply of inhalers related to packaging (only two inhalers in large packs with patients often misplacing them). However, staff found that patients found this form of NRT very helpful since it involved them using their hands in a similar way to smoking. Gum was not used due to concerns about safety. Consumers reported that they did not like the taste of lozenges.

A nurse initiated NRT program was found extremely valuable, allowing them to sign for one-off patch or inhaler use by the patient on their entry to the ward. This was clearly felt to empower staff and build their confidence in interacting with patients and was used in the locked ward especially to help settle people in as well as assisting with acute agitation. Staff became increasingly confident in explaining smoke-free policy as a consequence of having this back up. Patients also settled when they saw that no one else was smoking

#### Importance of consistent message across departments

It was important for triage nurses and doctors in the ED to tell patients about the unit's smoke-free policy prior to their arrival. There had been initial problems although the service worked quickly to address this problem with the assistance of the project officer who had liaised with ED staff regarding how this had caused problems for nurses on the locked ward.

#### Ongoing support

Staff initially took the view of emphasising the non-smoking environment of the unit while the person was there as opposed to focusing on the need for people to quit smoking. They focused on managing the smoking in their environment, not about making moral judgements about people's smoking behaviour. This had been a positive approach that alleviated staff anxiety and pressure to support quitting for patients in the longer-term. As part of gaining momentum, the service more recently began trialling a program to assist patients to stay quit as part of a post discharge program. Part of this involved using positive role models which proved to have a significant influence on patients.

The service had begun to increasingly think of linking with the community post discharge to support patients who wished to stay non-smokers in the longer term. Groups run by consumers were also planned and genuine consultation and involvement from them was perceived as an essential component of success throughout the process.

#### Overall

Strong leadership was evident, as was consistency in the message to staff and patients.

### **(3) Successful Smoke-free Policy in a Detoxification Unit**

#### Context

The setting was a 15 bed voluntary, state-wide, urban-based detoxification unit which provided a focus on drug and alcohol withdrawal management. The average length of stay (ALOS) was 7 days for alcohol withdrawal and 14 days for benzodiazepine reduction with shorter ALOS for other drug withdrawal. The unit had strong links with mental health services, with routine consultation and cross referral occurring between the two services, given the high proportion of people with both mental health and substance misuse issues in each service. More than 95% of patients were smokers while less than 10% of staff were smokers. More than 30% of patients admitted to the unit had a mental health diagnosis.

This unit did not readily accommodate those who were acutely psychotic or detained under mental health legislation but instead mainly served people with depression and anxiety. Smoking prevalence was high within this patient group. The team did not have psychiatrists attached to the unit but used consultation liaison if needed.

#### Preparation and Steps to becoming Smoke-free

The unit had been completely smoke-free for the past 4-5 years and was one of the first to go smoke-free in the state. The team had decided to proceed because of problems with the behavioural management of patients, especially around their interactions with each other over cigarette supply. Some patients had no access to money and no people to buy cigarettes for them.

Staff had looked forward to the ban as a way of addressing unhelpful behaviours among patients as well as offering them an opportunity to stop smoking. In this setting, there was a lot of conversation about drugs, gaol and violence. Congregating to smoke was observed by staff to reinforce this problematic interaction between patients. Staff had also wanted more patient compliance with the unit's group programs and were frustrated that groups which were usually a mandated part of peoples' treatment were constantly being interrupted by people going out for a smoke.

Underpinning these staff shifts in attitude, there had been a clear policy message across the state about smoking in inpatient settings and encouragement regarding going smoke-free. This has also included active steps to bring mental health services and drug treatment services closer together administratively, with increased opportunities for future cross-collaboration.

Community staff spent a lot of time informing clients in the community so that they would be aware of the smoke-free policy as part of making the choice to enter the detoxification unit. Unit staff attended general training on nicotine withdrawal, use of NRT and management of people with comorbid mental health problems. Since they were already skilled at managing agitation and withdrawal from drugs, this information was readily incorporated into their skill set. Clear protocols were developed in collaboration with the pharmacy department.

#### Results of smoke-free success

Prior to becoming smoke-free, a lot of problems existed with trade in cigarettes, disputes between patients in the smoking areas and staff having to manage arguments over cigarettes. This was now no longer an issue and all felt better for it. Many patients saw the policy as an opportunity for them to give up smoking or at least to experience attempting to quit, to detoxify from all drugs at the same time within a highly supportive environment. More recently, the unit had accepted patients purely for tobacco detoxification which represented a clear shift in attitude by services.

The following were identified as part of successful treatment;

- Information; before and on admission, people were given written information about NRT and what they could expect.
- Assessment of nicotine dependence; the Fagerstrom Nicotine Dependence assessment is done and NRT requirements matched with this.
- NRT was nurse initiated, not reliant on doctor decision, and was part of core nursing clinical assessment and management.
- Provision of combination NRT; a combination of NRT delivery types (patches, inhalers and lozenges) has been found to work best. Most patients were heavy smokers often using high tar products and therefore needed 21mg patches. The clinical team rarely used less than this so usually assumed the stronger dose was needed. Inhalers were found to be useful in giving people something to 'fiddle with' in their hands. Very heavy smokers received two patches which was regularly monitored. Those who were unable to tolerate these received sublingual NRT microtabs.

Interestingly, the staff found patients displayed no difference in their ability to cope with withdrawal whether they had a mental health diagnosis or not. If people became acutely unwell with mental health issues while in the unit, the team was able to contact consultation liaison services although this was rarely required. There was a perception that mental health and detoxification services were still operating largely as separate services and this represented a lost opportunity for greater collaboration and knowledge exchange.

Becoming smoke-free was much easier than staff had anticipated, with only minor problems that were no greater than usual issues faced in such settings. Some smuggling of cigarettes was more apparent whereas this had previously been more illicit drugs although warnings were usually sufficient to stop this. Patients signed an acceptance of rules on admission which included any drug smuggling so that management of tobacco breaches were handled as any other drugs. No differences in patients' length of stay had been observed pre and post smoke-free implementation.

The overall clinical goal was to support drug withdrawal within the context of the unit's smoke-free environment. Staff did not actively get involved in managing patients' quit smoking long term. The unit provided three days of free NRT post discharge and referred people to the Quitline cessation service and provided written resources about quitting. Only piecemeal community services were available for highly dependent smokers with drug and alcohol and mental health problems.

#### **(4) A failed attempt to become smoke-free**

##### Context

The setting was a metropolitan 20-bed inpatient psychiatric unit with three High Dependency Unit (HDU) beds. The ward was situated within a general hospital and patients were a general mix of predominantly Caucasian and English speaking population. Drug and alcohol issues were perceived to be the 'usual' for mental health service settings.

In mid 2007, the whole hospital went smoke-free. In the preceding 12 months, the mental health inpatient team thought there was no way for their ward to succeed in becoming smoke-free. They therefore wanted to seek an exemption although the director of the hospital insisted that they persist and attempt to implement smoke-free policy. The attitude of psychiatric staff during the whole period of planning was that it would be too hard.

In this setting, cigarettes had been used over a long time for de-escalation of agitation and to build rapport with patients. Several staff were still smokers. The service has come under some media scrutiny with reports of substandard care. Therefore, they were attempting to address and improve the culture and clinical practice although several staff remain resistant to change.

#### Preparation

A consultant expert was brought in to talk to staff as part of an education session. Although this session was widely advertised, few staff attended and these staff were those who were already supportive of the change process. Letters were sent out to known mental health service users deemed to be 'frequent flyers' through the inpatient services, to community teams to hand out to their patients, and to outpatient departments. The community mental health team was located very close to the hospital and had a good relationship with the inpatient unit so the potential for collaboration and coordination of support to patients wishing to continue to remain non-smokers once they left hospital was seen to be possible.

The Nurses' Union expressed concern for the potential for increased aggression and hence the welfare of nurses if a smoke-free policy was introduced. The local consumer advisory group was consulted and expressed support for anything in the best interests of mental health service users and were in favour of pursuing a smoke-free policy. Although there were no consumer consultants on the ward due to funding cuts, there were a small number of service user role models who had successfully quit smoking and who could be called upon for support for staff and patients.

#### Staff training

A drug and alcohol services nurse with mental health background was brought in to provide education to inpatient staff about nicotine withdrawal. Staff were also offered subsidised NRT but few took it up because of the absence of a consistent message that smoke-free policy was inevitable. The opportunity to test the effectiveness of any of this training or for staff to learn via implementing what they had learned never arose because the smoke-free policy began to fail within the first few days of implementation with several staff not abiding by the ban either for patients or for their own smoking as soon as the policy was implemented.

#### NRT availability

Standard orders were sought for all nurses to be able to administer NRT. However, many patients did not take up the offer because there was so much opportunity for them to continue smoking with staff support to do so. Staff also continued to openly smoking despite the ban on staff smoking throughout the hospital. There was also no system where people could be given NRT in the Emergency Department or as part of emergency admission so they were often receiving patients who were already in highly agitated states made worse by nicotine withdrawal by the time they arrived on the ward.

Both NRT inhalers and patches were used although they experienced a supply problem and a shortage of mouthpieces for inhaler cartridges because patients would often lose them. Staff wrote to the manufacturer who was not prepared to supply additional mouthpieces. Due to the cost of NRT inhaler starter kits, they were subsequently often not available. Low levels of medication were used compared to other similar settings.

#### Staff ambivalence

Staff had considerable debate about whether cigarettes could be confiscated when people were admitted to the unit and they sought legal advice which confirmed that this was possible. However, several staff felt uncomfortable doing this and so it was left to a few staff who then felt targeted and more at risk as a consequence. The greatest concern for nurses was patients refusing to hand over their cigarettes and what they would then do in response to this. They feared code black (the highest

level of staff security response) if patients refused and had some previous experience of this. In general, staff practices and lack of skills meant that they felt unable to manage patients who refused to hand over their tobacco other than adopting a more forceful approach.

#### Lack of enforcement

They organised an increase in security guard presence as part of the policy implementation and were assured that the security guards were trained and that only those who were also trained in issuing fines if needed would be appointed to this work. However, the guards were largely smokers themselves who would smoke on the job and openly argued with staff against the need for a smoking ban.

#### Lack of cohesive teamwork to allow implementation

Allied health staff were very supportive of the smoke-free plan. However, although the occupational therapist had planned to run a regular smoke-free group on the ward, it did not start due to the undermining of the smoke-free policy soon after it began. Doctors were unsupportive of the policy and started issuing leave for voluntary patients to smoke within the first week of the smoke-free period despite prior policy developed which clearly confirmed that staff escorting patients for smoking and leave for smoking were not allowed. Although the team had spent a lot of time developing policies, thinking through processes and how people could respond to scenarios, staff on the ward did not implement them. The smoke-free policy was actively undermined by smoking staff in both the open ward and HDU. Cigarettes continued to be distributed hourly in the HDU and bought for patients. Outcome

This service was applying for an exemption from the smoke-free policy because the current policy breaches were seen as embarrassing for hospital administration and service management. Overall, support for the smoke-free policy was never really present among staff largely responsible for its successful implementation on a daily basis. Leadership was not respected and change was actively resisted by staff who continued to rely on cigarettes to support the clinical and behavioural management of patients.

### **(5) An Inpatient Facility Not Considering Smoke-free Policy**

#### Context

The setting was a 25-bed open unit with entrance doors locked to assist staff in monitoring the patient and visitor traffic in and out of the unit. Patients were drawn from across the state and tended to be those who were more acutely unwell with a higher prevalence of psychotic illness. The multi-disciplinary team comprised of medical, nursing, occupational therapy, social work and psychology staff. Although the unit had more than one courtyard, only one was in use because of the problems associated with increased absconding from the other courtyards. Therefore, there was no alternative courtyard area for non-smoking patients.

Non-smoking had been introduced for staff several months previously and staff were not allowed to smoke within 20 metres of entrances. However, the nurse leader was not aware of how well staff abided by this policy or indeed what proportion of staff smoked although assumed that they were abiding by the no smoking policy on hospital grounds. The ED staff allowed patients to smoke, often escorting them to outside areas if needed.

Open unit patients kept their cigarettes and lighters on them during the day unless they were deemed to be unsafe to do so. Lighters were handed in at night. Staff were closely involved in assisting patient to obtain cigarettes, especially patients who did not have any money. This was a major concern for staff especially since the hospital's welfare assistance program to help patients

purchase cigarettes had been stopped although staff were continuing to discretely purchase cigarettes for patients from their own money. Senior nurses were aware of this practice and condoned it.

#### Provision of NRT

Free NRT was provided to patients although this was not routinely done as part of clinical interactions and assessments. NRT was rarely taken up by patients and the senior nurse was unsure whether free or subsidised NRT was provided for staff.

#### Leadership

The overwhelming view of staff and leadership was that the period during inpatient admission when patients were acutely unwell was not the time for imposing restrictions on smoking by patients since “they have enough stressors to deal with”. Leaders and staff generally felt that smoking helped patients to cope with their symptoms and illness generally.

Senior clinical staff in the unit were vague about what their leadership group thought of smoke-free policy and the area generally; “It’s not crunch time yet so perhaps they aren’t really looking at it”. Although doctors were interested in the smoking issue, it remained under the radar for many of them and was perceived as a lesser priority than other aspects of care.

Recently, the national beacon project had raised discussion among the staff with clear evidence for how nicotine withdrawal agitation could be managed effectively along with other issues in the ward environment. The nurse leader felt hopeful that in future, the unit would move towards smoke-free status though the timing of this was unsure. They clearly recognized and talked about the need for a comprehensive clinical governance approach to patients’ smoking if the unit went smoke-free rather than a public policy one where the assumption would be to enforce it with a set date and provide patches and that would be all that was required. They understood that such an approach would fail.

## 6. Conclusions - Going Smoke-free

The following points is a summary of the most salient lessons to emerge from this survey. Many of these suggestions are important for any change process. Formal smoke-free guidelines are yet to be developed for the Australian context. This summary provides a starting point.

### Preparing for Smoke-free Policy

- Leadership; importance of leadership that is clear, consistent and routinely visible and accessible to clinical staff and actively role models the desired change.
- Team cohesion; build and maintain team cohesion around the change. Be inclusive of all staff groups and disciplines as part of broad and meaningful consultation.
- Local context; understand the nature of the population served and implications for each service and clinical practice. Understand the organisational culture and practices of staff and your service.
- Staff smoking; support as many staff as possible to stop smoking in the months prior to implementation of smoke-free policy. Encourage nursing leaders to lead this process by example. Provide free or subsidised NRT to staff smokers as part of their employment.
- Change champions; support clinical change champions from within the staff group that will be directly implementing and enforcing smoke-free policy. Recognise the importance of nursing leaders in this process.
- Preparation time; allow at least six months for planning and preparation of the field. Allow at least a further six months post implementation support to the unit and that ongoing monitoring and support will be needed to sustain the change and check any reversals in progress. Integrate this into service management for the longer term.
- Understand that smoke-free policy is a process not an event.
- Staff education needs; assess the education and training needs of clinical staff. Provide all clinical staff with education and training that moves beyond didactic information about the harms of smoking and the broad concerns about smoking for mental health populations. Actively engage with staff regarding how they want training to occur and enlist their peers to lead its planning and delivery. Provide on the job training in the ward where staff can practice their skills and receive feedback. Model the skills required by staff. Consider the timing of education and training so that it remains relevant to staff when they need to put it into practice.
- Unit design factors; consider the physical environment of the unit and get advice on how it may be altered to foster non-smoking.

### Implementing Smoke-free Policy

- Implementation date; choose a smoke-free implementation date that will be feasible and minimise adverse impacts for patients and staff. Consider other events, activities and demands to avoid overloading staff. Choose a salubrious time of year.
- Consumer and carer support; enlist support from consumer groups, consumer consultants who may be working on the unit, and carers/family.
- Recognise the interdependence of smoke-free strategies; the unit's attempts to be smoke-free mirror the individual's attempt to quit smoking and requires patience, diligence, persistence, consistency, encouragement and support and a range of strategies
- Policy monitoring; make monitoring of progress of the policy a routine item for clinical staff in the unit. Encourage them to lead the process of finding solutions to issues as they arise. Beware of the 'honeymoon' period and relapse risk if staff are not diligent and work cohesively as a team.

- Team cohesion; address splitting and undermining behaviours by staff individuals without delay. Address grievances early. If staff turnover is an issue, ensure that core staff are supported to provide a consistent approach.
- Practical issues around tobacco control and NRT; consider practical aspects such as storage of cigarettes and lighters while the patients are on the ward. Clarify tobacco policy for leave, develop processes for keeping track of NRT prescription and distribution to patients and make this part of general medication monitoring and tracking processes. Involve clinical staff involved in completing paperwork and handling NRT in developing best local practice.
- Use of diversional activities; the lessons from the National Seclusion and Restraint project highlighted the importance of diversional activities and are closely related to management of nicotine withdrawal. It is important to review the level of diversional activities offered to patients and ask them what they think would help with nicotine withdrawal.
- Consistent team approach; have a clear layer of response options for staff to implement as part of their interactions with patients who are smokers. Staff need to feel supported by the team, and that any difficulties will be the team's responsibility to resolve and that this will be done consistently and promptly.
- Best practice dissemination; consider rotating staff between open and locked settings to maximise skill sharing, exposure to learning how to support highly distressed patients, and to promote consistency of approach to patients.
- Staff support; provide dedicated staff in the unit to support the staff team for at least 6 months post implementation, acknowledging that staff will need a level of ongoing support to problem-solve issues as they arise beyond delivery of education and training as part of preparation for the policy. Encourage staff to share their learning and to model effective strategies for interacting with agitated patients with their peers. Show them how to respond in collaborative, non-confrontational ways that minimise patient distress.
- Liaison with community services; communicate the policy with community clients, staff and related services.

## **NRT Management**

- Use a combination of NRT tailored to the individual and their experience of nicotine withdrawal.
- Consider patches primarily with other forms of NRT used in conjunction with patches for acutely unwell patients, as needed. In particular, inhalers and lozenges provides more immediate relief for patients awaiting transfer from the emergency department to the ward. Use more than one patch if needed.
- NRT prescribing by nurses; consider seeking clearance for nursing staff involved in emergency admission to have capacity to undertake one-off prescribing of NRT to patients to avoid any delays during the admission process.
- Routinely assess the effectiveness of NRT as part of clinical management support to the person during their stay in hospital. Make this part of clinical management along with other treatments and team decision-making processes.

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