

Evaluating a Complete Tobacco Ban



by Dr. Zoe Hilton

The highest rates of death due to smoking are among persons with serious mental illness. People with addictions are more likely to die from tobacco related illnesses than from those related to all other addictions. At our institution, some clinicians feared a smoking ban would worsen psychiatric symptoms and increase aggression. Some people believe that persons with mental illness benefit from smoking, cannot quit, and should not try to quit all addictions simultaneously. Previous research showed these concerns to be unfounded. Prior research also showed that stopping tobacco use leads to the long-term benefit of reduced medication without increases in psychiatric symptoms.

At this institution, we used to sell tobacco at subsidized prices in canteens; built smoking rooms; and assigned staff to manage tobacco (often as informal rewards), escort patients outdoors to smoke, and light cigarettes. The announcement of a strict tobacco ban to take effect on May 6, 2003 met with surprise and dissatisfaction from some clients and staff members.

The ban was evaluated many months after it went into effect, and relied on information already routinely gathered. But we did attempt to measure the effects of the ban in as many domains as possible. We compared smoker and nonsmoker clients who were inpatients for the entire two-year period starting one year before. Weekly counts of medication blood levels, prn medication, physical aggression, verbal aggression, restraints and seclusions, psychotic symptoms, and mood were taken from clinical records for all 104 study weeks.

In maximum security, there were no detectable ill effects of the ban on incidents, restraints, aggression, symptoms, or mood. On the other, non-forensic wards, there was an increase in aggression by smokers towards staff members. There was no corresponding increase in psychiatric symptoms.

A likely explanation is that the non-forensic staff were less successful in stopping the use of tobacco because patients on those wards had more opportunities to obtain it. It seems likely that many tobacco-addicted non-forensic patients spent the year after the ban in partial and intermittent nicotine withdrawal. Had the non-forensic staff in the present study been better able to prevent access to tobacco, the results there might have mirrored those in maximum security. Indeed, redoubled efforts at the end of the second year to eliminate tobacco might have been partly responsible for a return of aggression to pre-ban levels.

Among patients who had been smokers, there was an average weight gain of almost five kilograms; about what would be expected from previous research. Also associated with the tobacco ban, Clozapine dosage significantly declined about 20 percent while serum levels increased and became more stable. Finally, of 23 smokers who had evidence of lung disease in the year before the tobacco ban, 17 had a healthy assessment the next year, a significant improvement.

Although, many aspects of psychiatric symptoms and overall psychological well-being were examined, there was no evidence of any other adverse effects of the ban. Beforehand, there were dire predictions from some staff members and patients that it would surely cause mayhem, especially in maximum security. The prediction was that, for lifelong, severely mentally ill smokers who also had a history of violent crime, the compulsory tobacco ban would produce an explosion in violence. The results clearly did not support this; in fact, no evidence of even the most minor troubles was found in maximum security, perhaps because nicotine withdrawal was quick and complete for most smokers.

Afterwards, some staff said the biggest problems had been on short-stay, non-forensic wards. We then studied every incident report on the ward with the most acute and transient patients. There were fewer incidents recorded in the year after than in the year before the ban. Incidents involving assaults declined and no category increased. Incidents attributed to tobacco increased, but in the context of a greater drop in incidents involving all other causes. We could find no evidence that the ban had worsened staff-patient conflict.

The tobacco ban does remain a challenge. Some staff and clients continue to disagree with it. Clandestine smoking on the grounds continues despite resources devoted to eliminating it. We believe that this evaluation was important for several reasons, however. It showed that the real problems with the ban lay in gaining compliance, not in any ill effects on the mental or physical health of our clients. It eliminates mere complaining as a basis for reversing or altering policy. Overall, it shows the real value in systematic measurement, as opposed to informal opinion, in assessing the value of what we do.

(This article is edited from one by Grant Harris, Dan Parle, and Jos Gagné published in the Journal of Behavioral Health Services and Research)

Note: This article is copyright. Readers are invited to print this article for personal and educational uses but it cannot be put to any other use without permission of the author.