

**Successful Implementation of Smoking Bans on Health
Properties: Balancing Healthy Public Policy and Personal
Ethics**

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EXECUTIVE SUMMARY

Tobacco use and exposure to second-hand smoke have been scientifically proven to cause serious illness and premature death. Governments have a responsibility for health protection and the implementation of public policy to achieve improved population health. Many governments have implemented smoking ban policy in efforts to reduce exposure to second-hand smoke and curb tobacco use. In 2005 the *Smoke-Free Environment Act* was implemented in the province of Newfoundland Labrador (NL). The *Act* prohibits smoking in workplaces and public places but allows provincial health authorities to provide designated smoking rooms in mental health units and residential long term care facilities. This research reviews the decision of one health authority, Western Health, NL, to implement a smoking ban on health property.

On July 1, 2008 Western Health implemented a smoking ban on all its properties in response to complaints from the public and staff of exposure to second-hand smoke at building entrances and in facilities with designated smoking rooms (DSRs). The policy applies to all health facilities with the exception of residential long term care facilities. In long term care the policy applies to new residents entering facilities after July 1, 2008. Residents in long term care facilities who smoked prior to July 1, 2008 were able to continue smoking in DSRs or in designated outside smoking areas.

This research focuses on the successful implementation of smoking bans in health care facilities, inclusive of grounds. Research objectives were developed in consultation with Western Health and are as follows:

1. To identify the activities that supported the implementation of the 'Smoke-Free Properties policy' of Western Health and to discuss their effectiveness in supporting implementation (i.e., what worked well and what did not).
2. To identify strategies to enhance the success of smoke-free environment policies.
3. To review the literature on the ethics of smoking bans in residential care facilities.
4. To recommend policy revisions or additional supports to address non-compliance with smoking ban policy.

Several methodologies were used to meet the research objectives. A literature review was conducted to identify an ethical approach to public health intervention, identify successful implementation strategies and to determine the effectiveness of place-based smoking bans. Western Health data on smoking-related incidents and occurrences, complaints and compliments were reviewed to determine if there have been compliance and enforcement challenges with the smoking ban policy. Interviews were conducted with senior managers and the working group established to oversee the policy implementation process. The policy rationale and implementation process were reviewed to identify what went well and what may have been done differently.

Research findings indicate an opportunity to analyze the ethical considerations associated with smoking ban policy using Upsur's principles for ethical analysis in public health intervention. Ethical analysis of a public health intervention should consider appropriate

principles for the justification of regulating individual behaviour for health protection considering social, political and cultural contexts. Individual rights must be protected but public rights should be the focus of analysis. Western Health faces an ethical challenge from long term care staff on the ground that the policy violates the individual rights of residents. The matter was referred to the Western Health Ethics Committee for ethical review. Western Health is now reviewing the ethics committee findings and entering into discussions on how/if the policy should apply to long term care residential facilities.

Western Health has experienced implementation challenges with the smoking ban policy including non-compliance in the mental health unit and smoking by visitors in vehicles and on grounds at health facilities. Since the policy implementation there have been no reported smoking-related incidents involving staff. This may indicate staff compliance with the policy or reluctance by staff to report non-complying colleagues. Smoking-related occurrences data involving mental health patients reported an increase in reported smoking-related occurrences of at least 74 occurrences above the previous year, for a total of 88 occurrences. It is not clear whether this data indicates an increase in occurrences or rather an increase in reported occurrences. Contributing factors for increased reporting may be heightened staff awareness of the policy, the availability of electronic reporting since the fall of 2008 and efforts by Western Health over the past year to increase occurrence reporting.

Interview findings indicate the policy rationale was based on public health protection through reduced exposure to second-hand smoke. Communication plans were comprehensive using multiple methods repeatedly. Staff and patients are supported through smoking cessation programming and Nicotine Replacement Therapy (NRT) is provided to patients. All employees are responsible for compliance and enforcement. Senior management remains committed to the policy and will continue to champion the successful implementation of the policy.

This paper offers thirteen recommendations to support Western Health in managing challenges and enhancing the success of the policy. Five key recommendations are highlighted here:

1. Western Health should complete a comprehensive outcome evaluation of the 'Smoke-Free Properties' policy, inclusive of key stakeholders, prior to the policy review scheduled for July, 2011.
2. Long term care should make a clear determination as to whether the smoking ban will be applied to all long term care facilities and grounds.
3. Western Health should continue to support NRT to palliative care, medicine, mental health and long term care patients for support in coping with the policy.
4. Western Health should continue to provide staff training on the role and expectations of staff in compliance and enforcement of the smoking ban policy, providing staff with appropriate ways to approach anyone smoking on Western Health property.

5. Western Health should support health professional advocates in their lobby for legislative amendment to the *Smoke Free Environment Act* to eliminate DSRs and prohibit smoking on all health properties.

Research findings support smoking ban policy as an effective tool in public health protection. Smoking ban policy has been found to reduce public exposure to second-hand smoke, to increase employee cessation and to decrease tobacco consumption of workplace employees who continue to smoke. Smoking bans by health authorities provide healthier environments for staff, patients, residents and visitors of health facilities. Further research is necessary to determine the long term impact of smoking ban policy on smoking behaviour and population health status.

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INTRODUCTION

Active smoking has been scientifically proven to cause serious illness and is the leading preventable cause of premature death. There is also scientific evidence that exposure to second-hand smoke is known to cause cancer, respiratory illness and heart disease. New research is also discovering the harmful health effects of third-hand smoke, chemicals left behind on surfaces from second-hand smoke.¹ The public health risks associated with exposure to second-hand smoke has demanded the attention of governments throughout the world. Organizations such as the World Health Organization (WHO),² the Office of the Surgeon General³ and the Public Health Agency of Canada⁴ advocate for smoke-free public buildings and property to improve population health.

The importance of public health protection from smoking related illnesses and premature death is not to be underestimated. Tobacco use is classified as a global epidemic and is of international concern for public health agencies. Policy success will be dependent upon many factors, including cultural and ethical considerations as governments struggle with the complexities around effective and efficient policy responses to curb tobacco use. This research aims to (1) review the severity of the harm of tobacco use, (2) review legislative and policy responses to the tobacco epidemic, (3) assess the challenges associated with implementation of place-based public policy restricting smoking, (4) explore successful implementation of smoking bans as a public policy response and (5) attempt to identify ways in which organizations can strengthen the success of place-based smoking policy as a public health policy instrument.

Governments at all levels have undertaken initiatives to reduce the harmful effects of tobacco use. Globally, smoking ban legislation has become quite common as a policy instrument for restricting smoking in public and work places. Traditionally, tobacco control strategies have been less intrusive at the individual level; instead, strategies have targeted the tobacco industry and public awareness of the harmful effects of smoking.

1. Legislation as a policy instrument

The WHO⁵ argues that legislation is the only truly effective means of tobacco control that

¹ A new cigarette hazard: 'third-hand smoke' by Rabin, R January 2, 2009 *New York Times*. Retrieved June 4, 2009 from

http://www.nytimes.com/2009/01/03/health/research/03smoke.html?_r=1

² The World Health Organization provides leadership on health issues of international concern to 193 member countries.

<http://www.who.int/en/>

³ The Office of the Surgeon General, US Department of Health and Human Services provides research and education on public health protection.

<http://www.surgeongeneral.gov/>

⁴ The Public Health Agency of Canada provides leadership on health promotion, illness prevention and reducing pressure on health care systems on Canada.

http://www.phac-aspc.gc/about_apropos/index-eng.php

⁵ Protection from second hand tobacco smoke policy recommendations. World Health Organization, 2007. Retrieved March 14, 2009 from

<http://www.wpro.who.int/NR/rdonlyres/7200F101-0E1A-469B-A38A-4DBB7E37D40A/0/SHSEN.pdf>

will produce the necessary cultural shift to eliminate tobacco use and address the tobacco epidemic in global society. The WHO argues legislation is necessary to affect behavioural change to reduce tobacco use and exposure to second-hand smoke. Indeed many countries have enacted legislation and public policy to prohibit smoking activity in public buildings and locations frequented by the public such as parks, beaches, and public events. Many organizations have also implemented policies that exceed legislated smoking bans requirements. Smoking ban policy is becoming common throughout the world, especially in the health care sector. This policy option is less forceful than requiring people to quit smoking; instead it requires people to stop smoking while in specific areas, which can be an effective tool in reducing this public health risk.

Canadian health authorities have demonstrated strong decisive leadership over the past decade to reduce the harmful effects of tobacco use in society through public health policy. Policies prohibiting smoking in and around health care facilities are becoming the norm in Canada. In Canada the federal, provincial, territorial and municipal governments share jurisdiction on public health; each level of government has a responsibility to the public they serve to protect citizen health and well being. All levels of government have the authority to enact laws or by-laws to curb tobacco use and exposure to second-hand smoke in society.

2. Tobacco reduction policies

Governments have engaged in a multitude of initiatives based on research evidence and collaborative partnerships with health professional advocacy groups to reduce and eliminate the harmful effects of tobacco use on society. Tobacco reduction strategies include, but are not limited to the following:

1. Legislation prohibiting smoking in public places and workplaces.
2. Taxes on tobacco products.
3. Restricted access to tobacco by minors.
4. Research on the harmful effects of tobacco use and exposure to second-hand smoke.
5. Public education campaigns on the harmful effects of smoking and exposure to second-hand smoke.
6. Controls on advertising by tobacco companies.
7. Restrictions on the retail industry by limiting venues in which tobacco products may be purchased.
8. Controls on public display of tobacco products such as price advertisements and tobacco power walls.
9. Graphic health warnings on tobacco products.

Such policies, while contributing to decreases in tobacco use in developed countries have yet to realize significant public health protection from exposure to second-hand smoke. In the past decade in Canada there has been considerable public pressure for governments to adopt policies that enhance public health protection and many governments and organizations have implemented smoking ban policy as a next step. Western Health, NL

has implemented such a policy and this research examines the implementation processes.

3. Western Health, NL

Western Health⁶ is responsible for the provision of primary, acute and long term health services in Western Newfoundland Labrador to a population of 79,460 (Statistics Canada, 2006). The health authority employs approximately 2,000 full-time and 1,000 part-time/casual employees, covering a significant geographical area, from the west to Port-Aux-Basques, south to Francois, east to Jackson's Arm and north to Bartlett's Harbour, on the west coast of the island portion of the province.

The organization is governed by an 18 member Board of Trustees appointed by the Government of Newfoundland Labrador. The Board of Trustees is responsible for setting the strategic directions to support the vision for the delivery of health services within the region. The Chief Executive Officer is responsible for achieving the goals and objectives set by the Board of Trustees in collaboration with a ten member senior executive team. The executive as a whole is responsible for implementing initiatives to achieve the goals and objectives in accordance with the vision, mission and mandate of Western Health.

4. Smoking bans at Western Health

As noted in Part III of this report, the *Smoke-Free Environment Act* [SNL2005 CHAPTER S16-2]⁷ came into effect in the province of NL in 2005. The *Act* prohibits smoking in workplaces, public buildings and common areas of multi-unit residential buildings. Section 4.(2) of the *Act* provides discretionary power to provincial health authorities to allow smoking for residents in ventilated designated smoking rooms (DSRs) in mental health units and long term care facilities. Western Health exercised its legislative power in 2005 and continued to provide DSRs in mental health and long term care, adding boundary lines 50 feet from entrances with "No Smoking" signage. Western Health continued to receive complaints from staff and the public of exposure to second-hand smoke at building entrances and within facilities with DSRs leading to a smoking ban policy response for health facility grounds.

Western Health implemented its 'Smoke-Free Properties policy' in all health facilities on July 1, 2008. Included in the July 2008 policy implementation was the mental health unit located in Western Memorial Regional Hospital. The policy allowed facilities that provided long term care to apply the policy to new residents as of July 1, 2008 but to adopt a phased-in approach for residents living in these facilities prior to that date. There are currently DSRs in three health facilities. Three other long term care facilities have outdoor smoking areas. The ethics review completed by Western Health will guide further discussions on how/if the policy is applied in long term care in the future. The

⁶ Western Health was formed in 2005 as a result of an amalgamation of the former Western Health Care Corporation and Health and Community Services within the region.

<http://westernhealth.nl.ca/>

⁷ The Smoke-Free Environment Act [SNL2005 CHAPTER S-16.2] Retrieved January 15, 2009 from <http://www.assembly.nl.ca/legislation/sr/statutes/s16-2.htm>

policy also includes direction for application with all new lease agreements signed after July 1, 2008.

5. Research questions/objectives

This research focuses on the successful implementation of smoking bans on health care properties. Health authorities are particularly interested in implementing smoking bans as leaders in health protection and health promotion. Smoking bans on health care properties often contribute to the vision, mission and mandate of health authorities for optimal population health. However; all levels of government and community groups have a vital role to play in developing and implementing policies that reduce exposure to second-hand smoke. Correctional Services Canada has committed to the implementation of smoke-free grounds for example.⁸ In fact, many prisons throughout Canada and the United States (US) have successfully implemented property smoking bans without some of the anticipated negative responses such as increased violence toward staff/others. Municipalities worldwide have implemented smoking bans policies as a means to reduce/eliminate smoking related illnesses. These policies do not come without significant challenges to decision makers. Challenges include ethical considerations in the balancing of individual rights and operational issues such as compliance and enforcement.

The challenges faced within residential health facilities would be very similar to other residential environments such as correctional centres and psychiatric facilities. It could be argued that challenges (including ethical challenges) may be even greater in prison/psychiatric facilities as there is no opportunity for confined inmates/involuntary patients in these environments to leave the property to smoke. Such populations are forced to not smoke while institutionalized if the property is designated as smoke-free.

This research explores the effectiveness of smoking ban legislation as a leading policy position to de-normalize smoking. The goals of such policy are healthy work environments, healthy living environments, and healthy environments for the visiting public/consumers of public services. In order to improved population health, smoking ban policies require stakeholder support and strong leadership. Implementation strategies should include stakeholder input and multiple targeted communication tools/methods. Staff training, compliance and enforcement strategies, outcome evaluations and supportive policies for assisting individuals in coping with smoking ban policy are all necessary.

Research objectives were developed in consultation with Western Health. This research aims to achieve the following objectives:

1. To identify the activities that supported the implementation of the Smoke-Free Properties policy of Western Health and discuss their effectiveness in supporting

⁸ Commissioner's directive 259 – exposure to second-hand smoke, Correctional Services of Canada, 2005. Retrieved May 15 2009 from <http://www.csc-ccc.gc.ca/text/pley/cdshtm/b248-259-eng.shtml>

- implementation (i.e., what worked well and what did not) through a review of occurrence/incident reports and a comparative review of the documented implementation strategies of others.
2. To identify strategies to enhance the success of smoke-free environment policies.
 3. To review the literature on the ethics of smoking bans in residential care facilities.
 4. To recommend policy revisions or additional supports to address non-compliance.

Western Health will use the findings of this research to assess the success of its policy implementation and to determine if policy amendments or additional supports are required to balance individual rights with healthy public policy for the public good. With plans to expand the policy to new leases for privately owned space and current challenges in long term care, the research findings will support further implementation planning. The findings will be transferable to other government institutional services as well as many provincial, territorial, federal and municipal governments have implemented (or are in the process of considering) similar policy.

6. Methodology

Several methodologies were used to achieve the research objectives. Methodology consisted of the following: (1) literature reviews to identify an ethical approach for public health intervention, to identify implementation strategies used by other organizations when implementing smoking ban policy and to determine the effectiveness of smoking ban policy; (2) review of data provided by Western Health on Employee Incidents Reports, Occurrence Reports, complaints and compliments and (3) interviews with policy actors involved in the development and implementation of the smoking ban policy. This research underwent two ethical reviews to approve the methodology, The Human Research Ethics Board, University of Victoria, British Columbia and the Ethics Committee, Western Health, NL.

6.1 Literature review

The literature review targeted three key areas (1) ethics in public health intervention, (2) smoking ban policy implementation strategies and (3) the effectiveness of smoking ban policy in achieving reduced exposure to second-hand smoke and improved health outcomes. The focus of ethical considerations in public health intervention is often community/societal rights for health protection versus individual rights to autonomy. A review of the literature on the ethical considerations of health protection has led to the identification of an alternate framework for ethical analysis in public health intervention. An examination of implementation strategies of others have met the research objective of identifying what Western Health did well and what may be improved. A literature review of the effectiveness of smoking ban policy was deemed important to align outcomes with the policy for Western Health staff.

6.2 Smoking-related reports, Western Health

Smoking-related reports maintained by Western Health provided information on how policy is being received by those affected and implementation challenges. Reports were

examined to determine if there has been an increase in human resource issues, an increase in smoking-related occurrences within health facilities or an increase in public complaints since the policy implementation.

The Quality Management and Research Branch, Western Health provided a summary report of smoking-related occurrence reports, complaints and compliments filed between April 1, 2008 and March 31, 2009. All staffs are required to file an occurrence report when there is an adverse health event involving a patient or a near miss. A near miss refers to situations in which there is potential harm for a patient, resident or visitor while on health property. Staffs are also to record any complaints and compliments received.

The Employee Wellness and Safety Branch, Western Health also provided a summary report of employee incident reports filed between April 1, 2008 and March 31, 2009. All staffs are required to file an employee incident report when there are incidents or near misses of an adverse event involving staff. These reports inform of issues related to the smoking ban policy for monitoring purposes of policy compliance and enforcement, identifying challenges for the organization in implementation.

6.3 Interviews with policy actors

The interview process was selected for policy actors as interviews allow for open-ended questions in a personal environment that leads to discussion, obtaining valuable information that may be missed in a survey. Sixteen senior managers and the smoking ban policy working group were invited to participate in the interview process with a 50% response rate, for a total of eight interviews completed. Invitations were scripted to ensure a standardized approach (Appendix A). Consent forms (Appendix C) were forwarded by email. Prior to beginning interviews participants were requested to sign the consent form to verify their consent to participate in writing. One interview was completed by telephone; the interviewee did have an electronic copy of the consent form for review prior to the interview.

Individual interviews were conducted during regular business hours in the interviewee's office, except for one which was completed in the office of the researcher. Participants were informed they would not be personally identified in the research; findings would be presented as group responses. Interview participants were asked questions regarding policy rationale, development and implementation activities (refer to Appendix B for the interview tool). They were also asked about challenges since implementation and whether they could identify recommendations to enhance the success of the policy.

7. Report organization and content

PART I: PUBLIC HEALTH EFFECTS OF SMOKE EXPOSURE discusses the harmful effects of tobacco use on society. Second and third-hand smoke are defined and health implications identified. As the majority of legislative responses allow for designated smoking areas in service areas such as mental health, long term care and prison environments, ventilation safety will be discussed. Most legislation also allows outdoor

smoking in designated areas. Safety of outdoor smoking areas is discussed as well.

PART II: THE TOBACCO EPIDEMIC examines the prevalence of smoking from a global, national, provincial and regional perspective for the province of NL. Exposure to second-hand smoke is also discussed within the jurisdiction of Western Health as the *Smoke Free Environment Act* has been in effect since 2005.

PART III: SMOKE-FREE LEGISLATION AND VOLUNTARY POLICY, examines legislative and policy response to the problem of tobacco use and exposure to second-hand smoke. Global, national and provincial-territorial legislation is reviewed. Smoking ban policies of provincial health authorities in NL are also reviewed.

PART IV: THE IMPACT OF SMOKING BANS reviews available literature on the effectiveness of smoke-free policy on worksite staff and patient outcomes.

PART V: VOLUNTARY SMOKING BAN POLICY IN INSTITUTIONAL ENVIRONMENTS: IMPLEMENTATION CHALLENGES reviews implementation of smoking ban policy in residential environments, specifically in health facilities and prisons. Implementation challenges and processes/plans for successful implementation are identified. Ethical considerations and a systematic approach to ethics review are discussed as well.

PART VI: DISCUSSION, RECOMMENDATION AND CONCLUSION. In this section, discussion focuses on the analysis of implementation of smoking ban policy for Western Health. The recommendations made are applicable for any organization implementing smoking ban policy as challenges will be similar. Successful implementation strategies are summarized and will support Western Health in further implementation planning and provide guidance to others.

PART I: PUBLIC HEALTH EFFECTS OF SMOKE EXPOSURE

In this section definitions are provided for second and third-hand smoke. The health effects of both are explored as smoking ban policy is traditionally based on public health protection from exposure to smoke. The provision of ventilated designated smoking rooms (DSRs) and the safety of ventilation systems as a health protection measure are also discussed. As most place-based smoking policy allows for outdoor designated smoking areas, the health and safety issues associated with outdoor smoking in public places is reviewed as well.

1. Second- and third-hand smoke

Second-hand smoke is defined by the WHO⁹ as smoke from burning cigarettes and other tobacco products, including exhaled smoke. Third-hand smoke refers to the chemicals left on clothing, in hair, on furniture and other surfaces from smoking or being around others smoking; eleven of these chemicals are known to be highly carcinogenic.¹⁰

1.1. Health effects of exposure to second- and third-hand smoke.

The WHO¹¹ reports that exposure to second-hand smoke has been found to cause many diseases in adults such as cancer, respiratory illness and heart disease. In children there are chronic illness implications such as asthma, bronchitis and middle ear infections among other health risks. Moreover, the Expert Panel on Tobacco Smoke and Breast Cancer Risk (Ontario Tobacco Research Unit)¹² recently released a report finding that active smoking and exposure to second-hand smoke increase women's risk for breast cancer.

The WHO¹³ has released statistics indicating that smoking related disease kills approximately one in ten adults globally annually and if smoking trends continue by 2030 that number will increase to one in six. They also indicate smoking kills more than one in five Americans and has killed approximately twelve times more people in Britain than deaths in that country from World War II.

⁹ Protection from second hand tobacco smoke policy recommendations. World Health Organization, 2007. Retrieved March 14, 2009 from <http://www.wpro.who.int/NR/rdonlyres/7200F101-0E1A-469B-A38A-4DBB7E37D40A/0/SHSEN.pdf>

¹⁰ A new cigarette hazard: 'third-hand smoke' New York Times Jan. 2 2009 Rabin, R., Retrieved June 2009. Retrieved June 4, 2009 from http://www.nytimes.com/2009/01/03/health/research/03smoke.html?_r=1

¹¹ Protection from second hand tobacco smoke policy recommendations. World Health Organization, 2007. Retrieved March 14, 2009 from <http://www.wpro.who.int/NR/rdonlyres/7200F101-0E1A-469B-A38A-4DBB7E37D40A/0/SHSEN.pdf>

¹² The Expert Panel on Tobacco Smoke and Breast Cancer Risk reviewed all available evidence on the link between breast cancer and tobacco smoke. The panel was a collaborative team with members from the Ontario Tobacco Research Unit and the University of Toronto with support from the Public Health agency of Canada. The report was released April 23, 2009. Retrieved May 1, 2009 from http://www.otru.org/pdf/special/expert_panel_tobacco_breast_cancer.pdf

¹³ Smoking statistics, World Health Organization, May, 2002. Retrieved June 9, 2009. http://www.wpro.who.int/media_centre/fact_sheets/fs_20020528.htm

The Canadian Centre for Occupational Health and Safety¹⁴ also inform of health risks linked to passive/involuntary smoking. They identify multiple health implications in the workplace from interactions between second-hand smoke inhalation and other chemicals found in specific occupations/worksites. They assert there is often a multiplicative effect of chemical interactions as opposed to a sum of individual chemical effects. The available literature on harmful effects of second-hand smoke exposure is vast, all concluding significant public health risks.

There is scientific evidence concluding that third-hand smoke is harmful as well. Third-hand smoke is a new area of study with most of the research addressing the harmful effects of third-hand smoke on children. Rabin¹⁵ quoted paediatrician Dr. Landrigan of the Mount Sinai School of Medicine as saying: third-hand smoke carcinogens pose a cancer risk for anyone who comes into contact with them. Future research may identify even more links to specific health risks from active smoking and exposure to second and third-hand smoke.

1.2 Ventilation in designated smoking rooms (DSRs)

The WHO¹⁶ reports that research findings indicate that there are no known safe levels of exposure to second-hand smoke and that ventilation systems do not protect the public from inhaling large amounts of second-hand smoke. Separating smokers and non-smokers within the same air space does not provide protection, nor does providing ventilation in designated smoking locations. Ventilation dilutes chemicals in the air, it does not eliminate them.

The Ontario Campaign for Action on Tobacco (OCAT)¹⁷ identifies several issues with ventilation systems for DSRs; the most important being that there is no scientific evidence that supports setting an exposure level greater than zero and that there is no technology capable of attaining zero levels of exposure. The WHO¹⁸ provides a summary of the position of the OCAT on designated room safety to non-smokers. In essence DSRs are ineffective in protecting the health of others within facilities: the technology is very costly to meet protective requirements which are questionable at best; ventilation systems are designed for comfort and unable to remove toxins; staff may be pressured to work

¹⁴ Environmental tobacco smoke (ETS): general information and health effects, Canadian Centre for Occupational Health and Safety. Retrieved May 5, 2009 from http://www.ccohs.ca/oshanswers/psychosocial/ets_health.html

¹⁵ A new hazard: third-hand smoke (2009, January 2). *The New York Times*. Retrieved June 4, 2009 from http://www.nytimes.com/2009/01/03/health/research/03smoke.html?_r=1

¹⁶ Protection from second hand tobacco smoke policy recommendations. WHO, 2007. pp.7-10. Retrieved March 14, 2009 from

<http://www.wpro.who.int/NR/rdonlyres/7200F101-0E1A-469B-A38A-4DBB7E37D40A/0/SHSEN.pdf>

¹⁷ Why ventilation does not protect your health. Ontario campaign for action on tobacco. Retrieved May 4, 2009 from <http://www.ocat.org/ventilation/index.html>

¹⁸ Protection from second hand tobacco smoke policy recommendations. WHO, 2007. pp.7-10. Retrieved March 14, 2009.

<http://www.wpro.who.int/NR/rdonlyres/7200F101-0E1A-469B-A38A-4DBB7E37D40A/0/SHSEN.pdf>

inside designated smoking rooms to meet client needs; open doors result in significant smoke exposure in non-smoking areas and they create enforcement difficulties for those responsible for enforcement. Ventilated DSRs are not scientifically supported to be protective of public health. For protection from second-hand smoke while inside buildings, buildings must be 100% smoke-free according to research.

1.3. *Outdoor Smoking areas: public health risks*

Outdoor smoking areas provide better public protection against the harmful effects of exposure to second-hand smoke. The WHO¹⁹ argues that outdoor smoking areas still expose the public to second-hand smoke, especially those who work outside frequently in proximity to areas in which people smoke. Wind speed and direction and the amount smoked at property boundaries influence the level of smoke that remains in the immediate or adjacent air space. Mean ambient concentrations of nicotine in air space adjacent to outside smoking areas have been found to be comparable to concentrations found inside homes of smokers where 50 or fewer cigarettes were smoked per week. As well, smoke can drift into buildings if property boundaries are close to open doorways or windows, affecting indoor nicotine concentrations. These findings support the argument for smoking prohibitions to property boundaries and distancing smoking from buildings as far as possible for the protection of the public accessing services and those who work and reside within institutions.

The harmful effects of third-hand smoke raises new considerations for policy makers as those who smoke off property are still transferring toxins to others when they enter buildings, especially if they smoke in confined spaces such as vehicles resulting in higher chemical concentrations being left on clothing and hair. The effects of third-hand smoke also support the elimination of DSRs as staffs are required to enter such rooms for cleaning.

The evidence appears to support place-based smoking restrictions both within buildings and on grounds of locations utilized by the public. The next section examines the smoking prevalence and public exposure to second-hand smoke. Governments utilize these types of statistical information and evidence based research to shape public policy for improved population health protection through anti-tobacco strategies.

¹⁹ Protection from second hand tobacco smoke policy recommendations. WHO 2007. p.9-10
Retrieved March 14, 2009 from
<http://www.wpro.who.int/NR/rdonlyres/7200F101-0E1A-469B-A38A-4DBB7E37D40A/0/SHSEN.pdf>

PART II: THE TOBACCO EPIDEMIC

While smoking rates are declining in certain regions of the world, tobacco use is rising in others and continues to pose a threat to global health. This section examines smoking prevalence at the global, national and provincial level for NL. As this case study involves the Western region of NL, statistics related to smoking prevalence and exposure to second-hand smoke are also reviewed by health region for the province. The health practices of Newfoundland Labradorians, as a recognized social determinant of health, helps shape public policy at the local level and is therefore, of significance to this research. The last section focuses on the statistical data for NL by health region in relation to exposure to smoke in workplaces and building entrances. Exposure to second-hand smoke demographics support the implementation of smoking ban policy as a public health intervention as exposure rates are still high, even with legislation for smoke-free environments.

1. Prevalence of smoking on a global level

Smoking is recognized as a global epidemic, meaning it is increasing more rapidly globally than expected, posing a risk to the health of society. The WHO²⁰ statistics on global smoking indicate that one third of the adult male global population smokes. Tobacco consumption is decreasing in developed countries but increasing by 3.4% annually, in developing countries. The Western Pacific region has the highest smoking rate in the world. Disturbingly, in 2008 the statistics remain relatively unchanged.²¹

2. Prevalence of smoking in Canada

Levy and Friend²² report that comprehensive public clean indoor air laws have the potential to reduce smoking prevalence and tobacco consumption among the population. Government smoking ban policies implemented over the past decade may therefore, have contributed to declining smoking rates in Canada. *Figure 1* shows the trend of smoking rates in Canada for the period 1999-2008. In 1999 25% of the population in Canada smoked. The smoking rate has decreased by 7 percentage points (or 28%) nationally to a rate of 18% in 2008. The rates were stable at 21% in 2002 – 2003 and again from 2005-2007 at 19%. The 2008 Wave 1 data with smoking rates of 18% reflects a decline in smoking rates within the country for the first time in four years.

²⁰ Global smoking statistics for 2002: Overall stats and youth smoking facts, May 2002. Retrieved June 9, 2009 from <http://quitsmoking.about.com/cs/antismoking/a/statistics.htm>

²¹ Smoking statistics, WHO: Regional Office for Western Pacific, May 2008. Retrieved June 9, 2009 from http://www.wpro.who.int/media_centre/fact_sheets/fs_20020528.htm

²² Levy, D.T. & Friend, K.B. (2003). The effects of clean indoor air laws: What do we know and what do we need to know? *Health Education Research*, 18(5), 592-609. [Electronic Version] Retrieved on July 14, 2009 from <http://her.oxfordjournals.org.ezproxy.library.uvic.ca/cgi/content/full/18/5/592>

Smoking Rates in Canada (1999-2008)

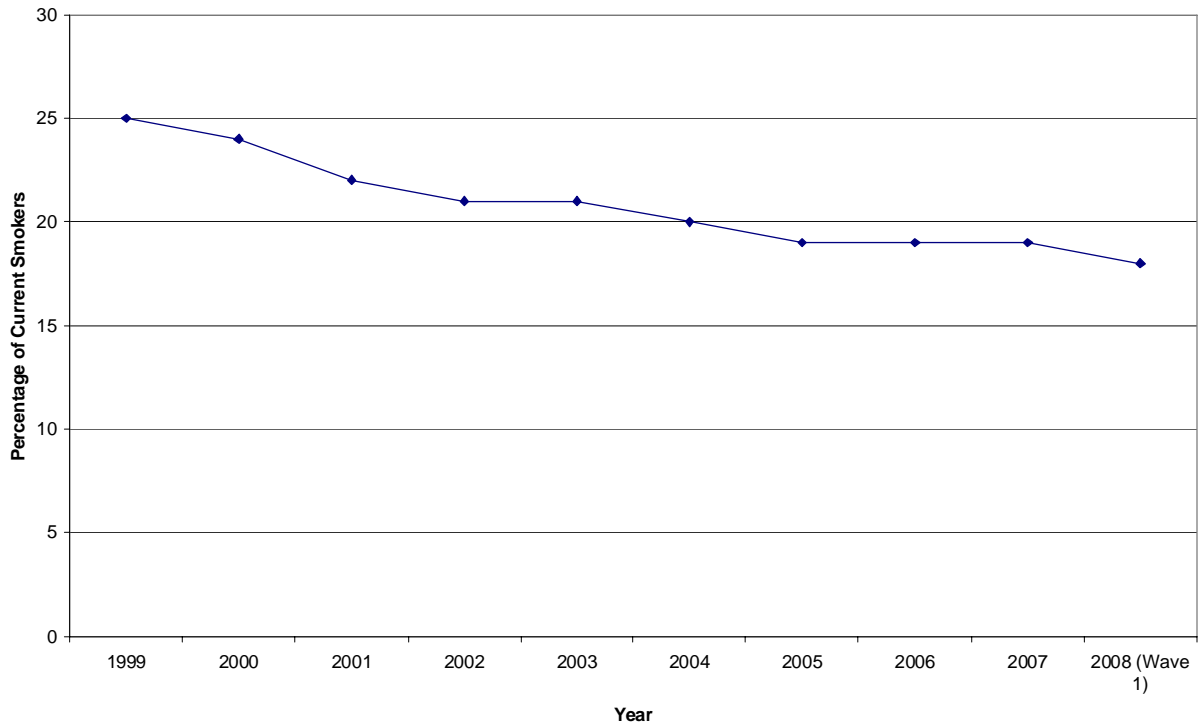


Figure 1. Smoking Rates in Canada (1999-2008)

Source Data: Canadian Tobacco Use Monitoring Survey, 1999-2008 Wave 1.

Figure 2 provides for comparison among provinces and the national smoking rate for those 15 years of age and older for the year 2008 (Wave 1). Saskatchewan had the highest smoking rate of all provinces at 21%; British Columbia had the lowest at 15%. Newfoundland Labrador had the second highest smoking rate of all provinces at 20%; 2% above the national rate of 18%. Five provinces; Nova Scotia, New Brunswick, Quebec, Manitoba and Alberta have similar rates at around 19%, all 1% higher than the national rate. Ontario and Prince Edward Island rates are slightly below the national rate at 17% and 18% respectively. Statistics for the northern regions of Canada in 2005 reflect smoking rates significantly higher than the national rates of 19%. The Yukon, Northwest Territories and Nunavut had the highest smoking rates in the country in 2005 at 25.3%, 27.5% and 45.9% respectively.²³

²³ Canadian Community Health Survey 2005, Statistics Canada.

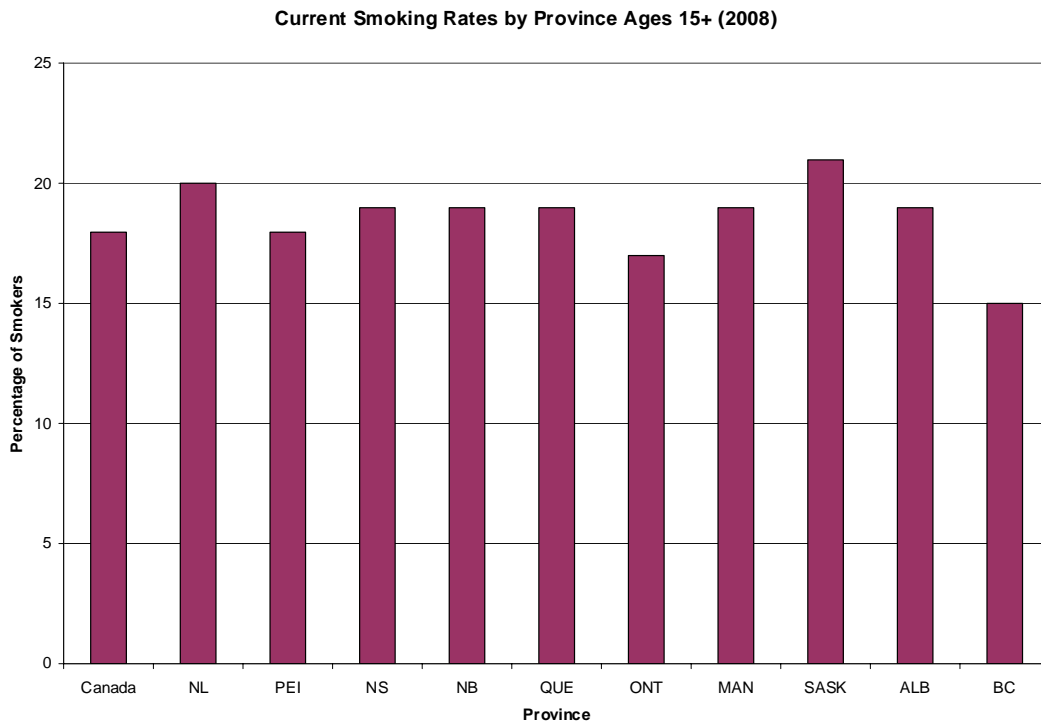


Figure 2. Current Smoking Rates by Province (Ages 15+), 2008

Source Data: Canadian Tobacco Use Monitoring Survey, 2008, Wave 1.

3. Prevalence of smoking in Newfoundland Labrador

Smoking rates in Newfoundland Labrador show a similar decline as in Canada over the past decade which is encouraging. *Figure 3* indicates that the smoking rate in 1999 in the province was at 28%, dropping to 20% by 2008 (Wave 1). Between 1999 and 2005 there was a steady decline in smoking rates down to 21% in 2005. Since 2005 smoking rates appear to have stabilized, fluctuating between 21-22%. Smoking rates declined by 1% in 2008 to a rate of 20%, the lowest it has been in the past decade.

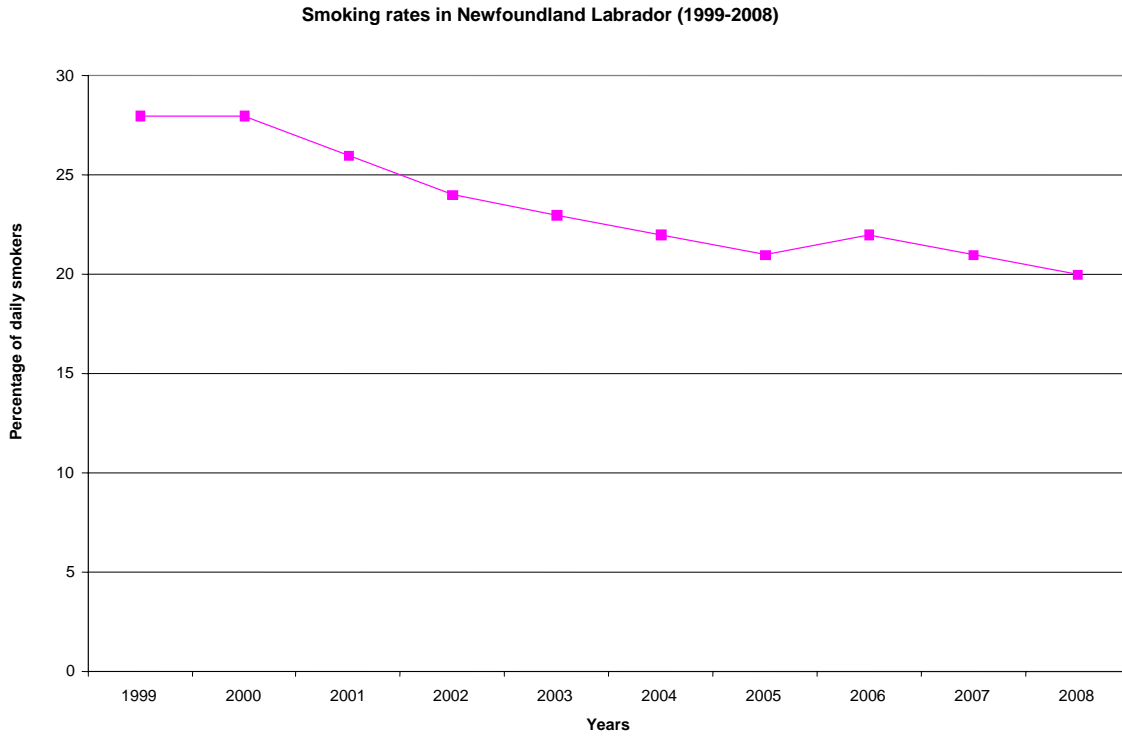


Figure 3. Smoking Rates in Newfoundland Labrador (1999-2008)

Source Data: Canadian Tobacco Use Monitoring Survey 1999-2008 (Wave 1).

Figure 4 shows the 2005 NL smoking rates by health region and provides comparisons for health authorities with the provincial and national smoking rates. The Western region had the second highest smoking rate in the province; higher than the provincial and national rates. Labrador-Grenfell had the highest smoking rate with the Eastern region having the lowest rate (still above the national rate).

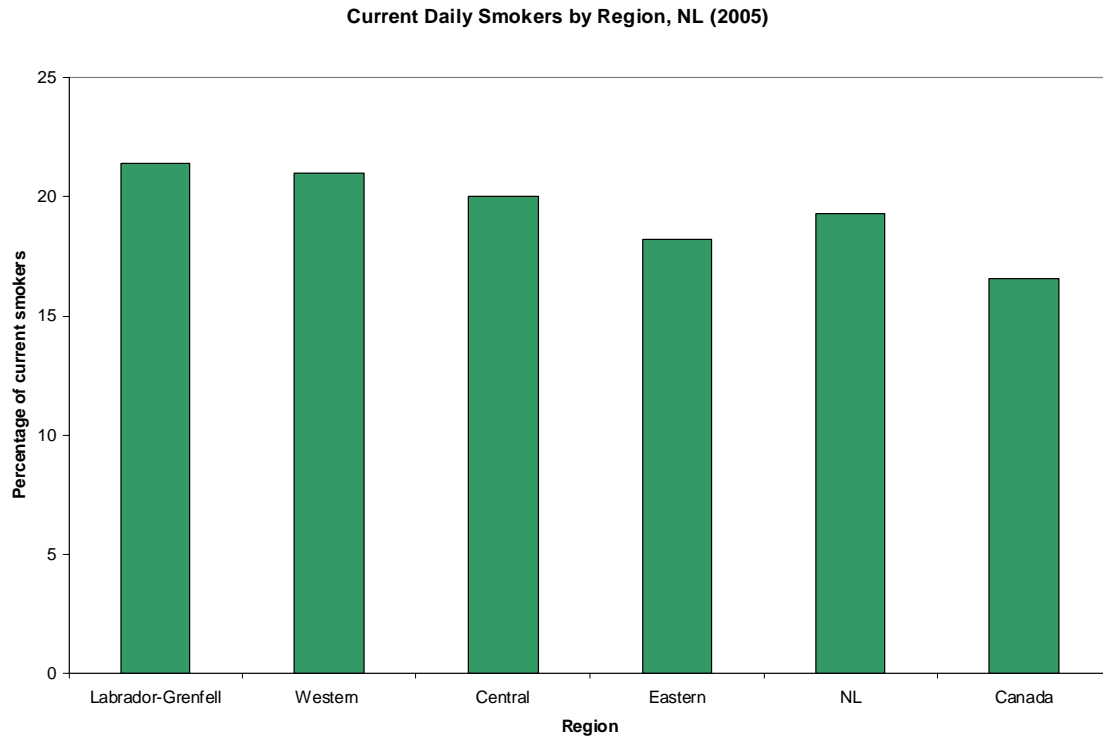


Figure 4. Current Daily Smokers by Region, NL (2005)

Source Data: Community Accounts, Newfoundland and Labrador Statistics Agency. Compiled with data from the Canadian Community Health Survey, 2005, Statistics Canada.

The data indicates smoking prevalence in NL is above the national rate. Western Health has the second highest smoking rate. As complaints were received by Western Health on exposure to second-hand smoke, the next section includes data on public opinion on exposure to second-hand smoke in NL.

4. Regional public opinion and exposure to second-hand smoke in Newfoundland Labrador

The high rate of current smokers in NL is of great concern to the provincial Government and regional health authorities from two perspectives: public health status and economic costs related to tobacco use. Colman and Rainer (2003)²⁴ found that in 2001 smoking directly cost the province of Newfoundland Labrador an estimated \$79.1 million, another \$139.2 million in lost productivity due to premature death of smokers and millions were absorbed by employers. The four regional health authorities in the province: Eastern;

²⁴ Colman, R. & Rainer, R. (2003). The cost of smoking in Newfoundland & Labrador and the economics of tobacco control, measuring sustainable development: genuine Progress Index Atlantic Canada, Executive Summary. Retrieved May 26, 2009 from <http://www.gpiatlantic.org/publications/summaies/costoftobacco-nf-summ.pdf>

Central; Western and Labrador-Grenfell, along with the Government of Newfoundland Labrador and citizens have a vested interest in reducing tobacco use and exposure to second-hand smoke to improve life expectancy, enhance quality of life, increase workplace productivity and to ensure sustainable health and public services.

4.1 Public opinion on smoking in Newfoundland Labrador

Public opinion on smoking and public tolerance of exposure to second-hand smoke has changed significantly over the past few decades. Smoking in the workplace, once quite common, has decreased in response to public pressure for healthy work environments. *Figure 5* depicts public opinion on smoking in the workplace in NL (2008).

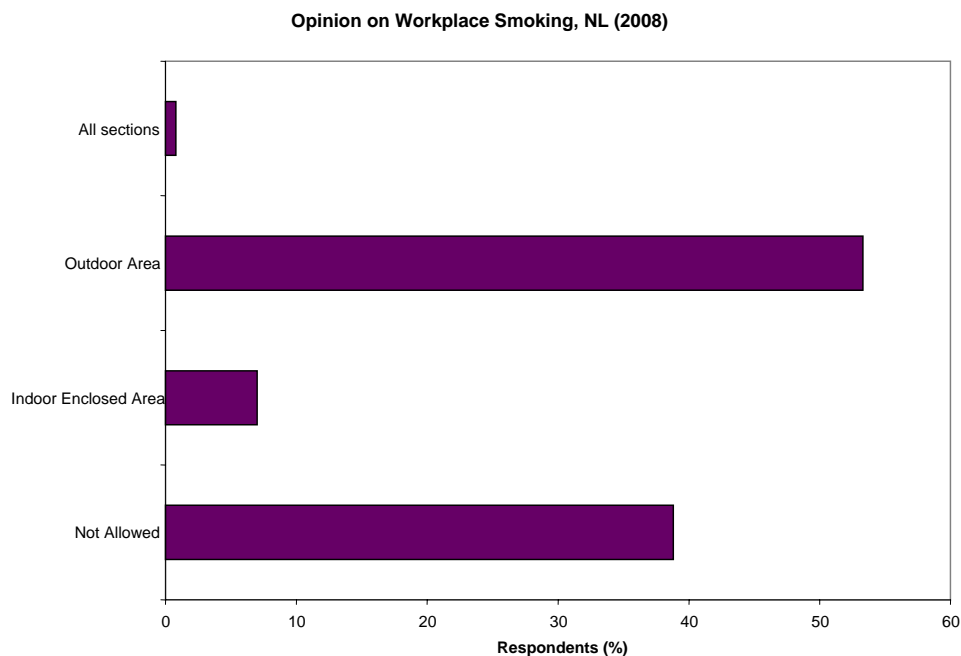


Figure 5. Opinion on Workplace Smoking, NL (2008)

Source Data: Canadian Tobacco use Monitoring Survey, 2008 Wave 1.

According to Wave 1 of the Canadian Tobaccos Use Monitoring Survey (208) a large percentage of respondents from Newfoundland Labrador do not feel smoking should be allowed inside or outside workplaces (38.8%). The majority of respondents felt that a designated area should be provided outdoors at workplaces (53.3%), with a very small percentage (.8%) believing smoking should be permitted in all sections of the workplace. A small percentage thought a designated inside smoking area should be provided indoors (7.9%).

There has been a slight increase in the percentage of respondents that believe smoking should not be allowed in the workplace since 2006, from 34.4% of respondents to the

current 38.8%, reflecting a 4.4 percentage point increase.²⁵ Similarly, fewer respondents (7.0%) supported inside enclosed smoking areas compared to 2006 (11.8%).

4.2 Exposure to second-hand smoke in Newfoundland Labrador

Figure 6 shows the percentage of survey respondents reporting exposure to second-hand smoke by frequency of exposure in NL in 2008. Daily and almost daily exposure to second-hand smoke is reported by 22.9% of the respondents. The majority (44%) of respondents report being exposed to second-hand smoke at least once per month, with 32.3% reporting exposure at least once per week.

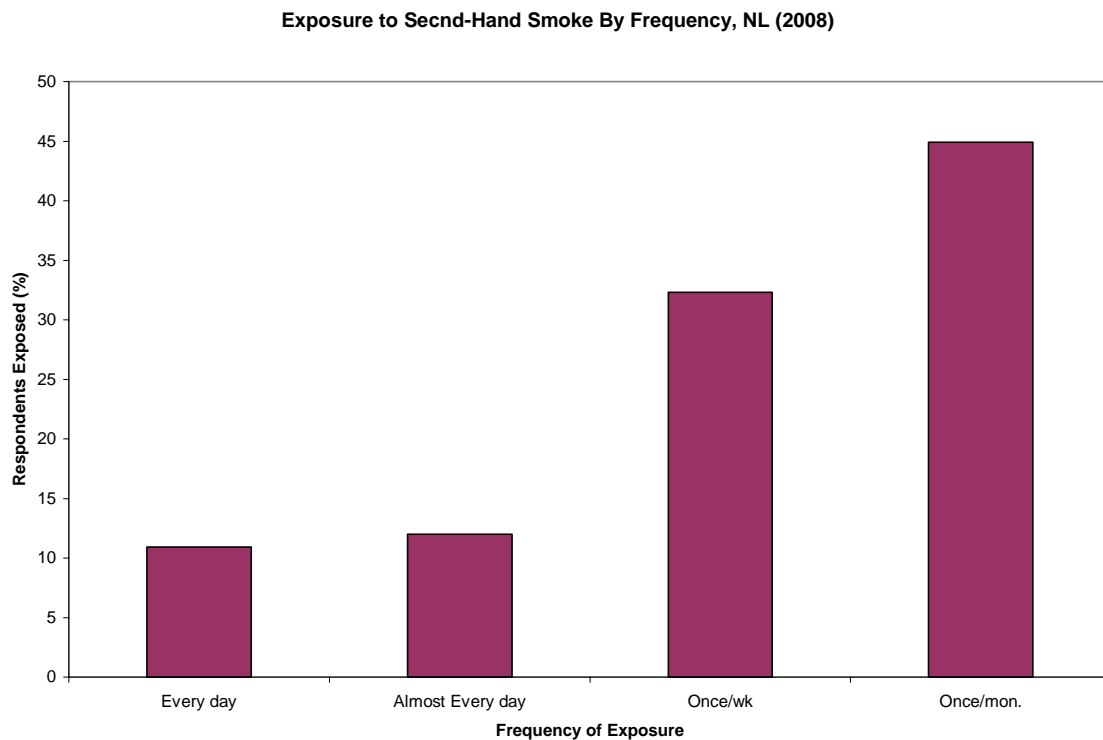


Figure 6. Exposure to Second-Hand Smoke by Frequency, NL (2008)

Source Data: Canadian Tobacco use Monitoring Survey, 2008 Wave 1.

Figure 7 shows the percentage of respondents reporting exposure to second-hand smoke at building entrances and within workplaces in NL in 2008. The percentage of respondents indicating they are not exposed to second-hand smoke in the workplace is 81.5% which is expected since legislation in NL applies to the majority of workplaces, while designated smoking areas are still permitted in some workplaces, accounting for the 18.5% reporting continued exposure in the workplace. The percentage of those reporting

²⁵ Canadian tobacco use monitoring survey, 2006, annual person file.

exposure to second-hand smoke at building entrances is 51.6% as compared to 48.4% reporting they are not exposed. This implies legislation is currently limited in its ability to remove smoking from building entrances and reducing public exposure as people enter and exit publicly used facilities.

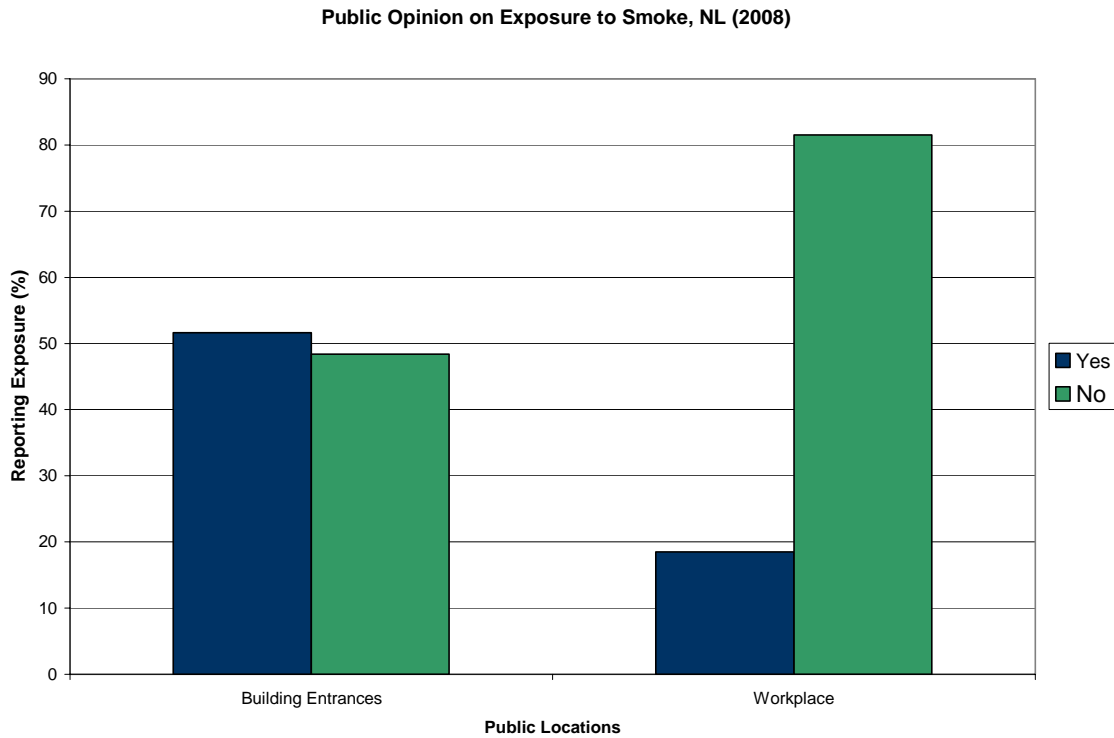


Figure 7. Public Opinion on Exposure to Smoke, NL (2008)

Source Data: Canadian Tobacco use Monitoring Survey, 2008 Wave 1.

Population demographics on smoking prevalence, public opinion on smoking within workplaces and public reports of exposure to smoke at building entrances/within the workplace indicate that current legislation is insufficient in protecting the public from harmful effects of smoking. High smoking rates and continued public exposure to second-hand smoke are evidence that policy responses to tobacco use need further attention by governments.

PART III: SMOKING BAN LEGISLATION AND POLICY

Health professionals have advocated for governments at all levels to implement stricter tobacco controls for public health protection. Strong arguments supported by research have been for smoking ban legislation by organizations such as the US Surgeon General and the WHO. This section examines legislated smoking bans and smoking ban policy implemented at the international, federal, provincial-territorial and municipal levels in Canada. The last section details the voluntary policy implemented by health authorities in NL for smoke-free properties as this policy initiative forms the foundation for this research.

1. International overview

The response to the tobacco epidemic at the international level is positive. There are currently 77 countries with smoke-free environment legislation for public buildings/spaces, with several others in the process of passing similar legislation.²⁶ Many countries have also passed legislation banning outdoor smoking. Many public authorities, including health authorities, have implemented voluntary outdoor bans in public locations.²⁷ Countries with smoking bans can be found throughout the world from Japan and Australia to the US and Canada. A global shift in cultural acceptance of smoking is visible through government legislative responses and voluntary smoking policies within municipalities and public sector organizations at an international level.

2. Federal, provincial-territorial and municipal legislation in Canada

In Canada all three levels of government: federal, provincial-territorial and municipalities have a responsibility and a degree of legislative authority to control tobacco, including the sale and advertising of tobacco products. The provinces-territories also have some jurisdictional authority over tobacco advertising for certain issues, such as whether they allow tobacco power walls. The provinces-territories are also responsible for provincial legislation that protects the health and safety of its citizens such as the environment and health which includes tobacco control measures.

2.1 Public locations: smoking bans

A review of the provincial-territorial laws in Canada indicates that all provinces-territories have place-based legislation restricting the use of tobacco in buildings frequented by the public.²⁸ The laws generally prohibit smoking in workplaces and in

²⁶ List of smoking bans by country, Wikipedia, Retrieved June 9, 2009 from http://en.wikipedia.org/wiki/List_of_smoking_bans#Outdoor_smoking_bans

²⁷ Outdoor smoking bans, Wikipedia Retrieved June 9, 2009 from http://en.wikipedia.org/wiki/List_of_smoking_bans#Outdoor_smoking_bans

²⁸ Compendium of Smoke Free Workplaces and Public Place Bylaws, Non smokers Rights Association, Spring 2009, Retrieved May 13, 2009 from http://www.nsra-adnf.ca/cms/file/Compendium_Spring_2009.pdf

buildings frequented by the public such as restaurants, bars, and government buildings including hospitals. Hospital grounds are not included in legislation in any province-territory, with the exception of designated distances from entrances and open windows. With respect to health authorities, the legislation also allows for DSRs that meet regulatory ventilation requirements in long term care and psychiatric/mental health services. Health authorities are not required to provide DSRs but they are permitted to do so.

In 2008, Prince Edward Island attempted to become the first province in Canada to eliminate smoking on hospital grounds and DSRs in nursing homes.²⁹ The proposed amendments went to a Standing Committee on Social Development for public consultations. The *Smoke Free Places Act* was tabled in the House again in April 2009. The prohibition of smoking on hospital grounds still stands but DSRs in long term care remains an exemption.

2.2 Personal property: smoking bans

There is a movement in Canada to broaden regulation to control individual smoking behaviour while enjoying their personal property. While smoking bans have not been proclaimed for privately owned residential dwellings, there have been public campaigns to encourage people to smoke outside their residences to protect other residents of the property, especially children. It is for the health protection of children that legislation has become more intrusive at the individual level in relation to personal property, specifically in personal passenger vehicles transporting children.

Several jurisdictions in Canada have passed legislation to protect children from exposure to smoke in personally owned vehicles.³⁰ Nova Scotia, Ontario, British Columbia, the Yukon, Prince Edward Island and New Brunswick in addition to three Canadian municipalities have enacted legislation prohibiting smoking in vehicles carrying children under the age of 16 years. Quebec and Manitoba are also considering similar legislation.³¹

3. Newfoundland Labrador legislation

In 2005 the Government of Newfoundland Labrador proclaimed into law the *Smoke Free Environment Act*.³² This Act prohibits smoking in places frequented by the public, including bars and restaurants (and patios), and government buildings. Health care

²⁹ Health Minister Tables Amendments to the Smoke Free Places Act, April 24, 2009. Prince Edward Island, Retrieved June 4, 2009 from <http://www.gov.pe.ca/index.php3?number=news&lang=E&newsnumber=6275>

³⁰ Laws banning smoking in vehicles carrying children – International overview, Canadian Cancer Society, 2008. Retrieved June 17, 2009 from http://www.smokefreecalgary.com/bins/content_page.asp?cid=3-164-172-207&lang=1

³¹ NL asked to join other provinces to ban smoking in cars with kids. Canwest News Services, May 26, 2009. Retrieved May 27, 2009 from <http://www.canada.com/Health/asked+join+other+provinces+smoking+cars+with+kids/1631731/story.html>

³² *Smoke Free Environment Act* SNL 2005 CHAPTER S-16.2, Retrieved January 15, 2009 from <http://www.assembly.nl.ca/legislation/sr/statutes/s16-2.htm>

facilities fall under this legislation. The *Act* provides discretionary authority to health authorities to provide an enclosed designated smoking room for residents in mental health and long term care facilities. DSRs must be constructed and operated in strict adherence to new building codes and air filter systems, to reduce the amount of second-hand smoke to which non-smoking patients, residents, staff and the public are exposed.

There are currently no municipal smoking bylaws in the province of Newfoundland Labrador. However, the Alliance for Tobacco Control (ACT), NL has successfully worked with municipalities to garnish their support for smoke-free public areas. As of May 2009, 53 communities (representing 321,000 people) have designated outdoor recreation spaces, sports areas and local events smoke-free to promote overall community health and well being.³³ There appears to be a political will at various levels to reduce public exposure to second-hand smoke in response to health professional advocacy.

4. Regional health authorities in Newfoundland Labrador

The *Regional Health Authorities Act*, 2006³⁴ requires health authorities “promote and protect the health and well being of its region and develop and implement measures for the prevention of disease and injury and the advancement of health and well being”. It can be argued that permitting smoking on health property contradicts the legislated mandate to promote health and well being. Regional health authorities utilize health practice information (as provided in Part II sections 3 and 4) to shape policy and practices that support the organizational vision for optimal health and well being.

The harmful effects of tobacco use and second-hand smoke exposure contributed to the decision of all health regions to implement (or plan for) smoke-free property policy voluntarily, including broadening the scope of policy to go beyond the restrictions on smoking by provincial legislation. Since the enactment of the *Smoke Free Environment Act*, the exposure rates to second-hand smoke should have lowered in the province within workplaces and public buildings such as restaurants and bars. The smoking ban policy of provincial health authorities was designed to address two issues: firstly, smoking within workplaces in DSRs in mental health and long term care continued to pose health risks to staff, patients and visitors; secondly, required distances from entrances for smoking outside were not significantly reducing public exposure to second-hand smoke for people entering and exiting health facilities.

Health authorities argue the 50 feet smoking restriction from entrances is ineffective in reducing second-hand smoke exposure to required levels for public health protection. This is consistent with the finding of the WHO on decisions to implement voluntary policy expanding smoking restrictions beyond legislative requirements. The WHO³⁵

³³ Alliance for tobacco control, NL is an advocacy group composed of health professionals for tobacco use reduction and smoke free environments. Retrieved June 15, 2009 from <http://www.actnl.com/index2.php#loadPage=00037>

³⁴ *Regional Health Authorities Act*, SNL 2006 CHAPTER R 7.1 Retrieved January 15, 2009 from <http://www.assembly.nl.ca/legislation/sr/statutes/r07-1.htm>

³⁵ Protection from second hand tobacco smoke policy recommendations. World Health Organization,

indicates that once smoke-free inside policies have been in place for a period of time, many organizations move to smoke-free properties as the public demands healthier environments and want expanded public health protection. The health authorities in the province have followed that incremental path moving from legislated requirements to voluntary policy expansion.

Three of the four health authorities within the province have implemented smoking ban policy. Labrador-Grenfell implemented a smoking ban policy January 1, 2008 making it the first health authority in the province to implement policy banning smoking on all health properties. Western Health was the second, implementing policy on July 1, 2008. The Central Regional Health Authority followed, implementing similar policy on “Weedless Wednesday”, January 21, 2009. The fourth authority (Eastern Health) is in the process of ethical consultations/reviews for a fall 2009 policy implementation.

There is definitely a move by governments and policy developers to utilize legislation and smoking ban policy to restrict tobacco use in public places for the protection of public health. The next section examines the effectiveness of such policy by reviewing research available on the impact of place-based smoking bans.

2007. Retrieved March 14, 2009 from
<http://www.wpro.who.int/NR/rdonlyres/7200F101-0E1A-469B-A38A-4DBB7E37D40A/0/SHSEN.pdf>

PART IV: THE IMPACT OF SMOKING BANS

Smoking bans have proven to be successful in achieving policy goals to a degree. While smoking rates are still unacceptably high, the research on the impact of place-based smoking legislation is promising. Since tobacco use is characterized as an epidemic and smoking is an addiction, it has to be accepted that change will take time and be incremental in nature. Short term studies are limited in that cultural norms and behavioural change is usually more visible in the long term. Research findings to date clearly demonstrate benefits from smoking bans within buildings and on property. This section reviews the literature on impacts of smoking bans in workplaces with a focus on mental health and health facilities.

1. Effects of workplace smoking bans on employees

Heloma et al.³⁶ conducted a short term study on the impact of national smoke-free workplace on passive smoking and tobacco use in Finland. Findings indicated that smoke-free workplace legislation was more effective than voluntary smoke-free policy in reducing exposure to second-hand smoke and in reducing cigarette consumption by employees. The authors examined exposure to smoke and smoking behaviour before and after a 1995 legislative reform expanding voluntary workplace smoking restrictions to be inclusive of property or designated smoking areas. The research findings concluded employees were exposed to less second-hand smoke and employees smoked less following the legislation. This finding is consistent with the position of the WHO on legislative requirements for reduced tobacco use and supports the argument of this research.

Bauer et al.³⁷ in a longitudinal study found that smoke-free properties were effective in helping workplace employees quit smoking or reduce their cigarette intake, consistent with Heloma et al. Between 1993 and 2001, smokers were 1.9 times more likely to quit smoking than smokers in workplaces that did not have smoke-free properties policies and continuing smokers reduced their cigarette intake by 2.53 cigarettes per day. Even more promising from a public health protection perspective, workplaces that had smoke-free properties policies in place in both 1993 and 2001 (long term) saw better outcomes. People working in those environments were 2.3 times more likely to have quit smoking than those in work environments absent of policy by 2001 and continuing smokers reported smoking 3.85 fewer cigarettes per day.

2. Effects of smoking bans in health facilities on patient outcomes

³⁶ Heloma, A. et al (2001) The short term impact of national smoke-free workplace legislation on passive smoking and tobacco use. *The American Journal of Public Health*, September 2001). Vol. 91, No.9, pp. 1416-1418.

³⁷ Bauer, J. et al (2005). A longitudinal assessment of impact of smoke-free work site policies on tobacco use. *The American Journal of Public Health*. Vol. 95, No. 6, pp. 1024-1029. [Electronic Version] Retrieved May 6, 2009 from <http://ejournals/ebSCO.com/Article.asp?ContributionID=7333302>

The Mental Health Centre Penetanguishine (MCHP)³⁸ is a psychiatric hospital in Ontario, Canada. MHCP implemented a smoking ban policy in 2003 finding immediate environmental and clinical benefits. Within two weeks of policy implementation the Smoke-Free Task Force identified the policy as a liberating experience for patients and staff. Patients were free from expensive harmful substance use, staffs were free from facilitating patient smoking and cleaning environments containing smoke and smoke residue, and the property was free of litter from cigarette butts and smoke close to buildings for others to walk through. Clinically, psychiatric medical interventions could proceed without concerns of the interaction between nicotine effects and necessary medication, the majority of patients have stopped smoking with physicians reporting a reduction in chest sounds associated with smoking in patients upon examination, and many staff have quit smoking or reduced cigarette intake.

Improved patient outcomes were noted for mental health patients in England as well, following the implementation of legislation closing DSRs in July 2008. Ratschen et al³⁹ found that mental health trusts reported evidence of positive behavioural change in patients following the closure of the designated room in mental health facilities. However, trusts also reported significant challenges in implementation. Since mental health facilities are included in smoke-free buildings legislation policy reversal is not an option and implementation challenges must be addressed through different options. With the relative short time passage since smoking prohibitions have come into effect in the majority of mental health facilities affected by smoke-free policy (be it involuntarily or voluntarily imposed) further evaluation is required within mental health facilities/units to determine policy impact on patient health status.

Bell et al.⁴⁰ studied hospital admission for acute coronary syndrome in Scotland following the implementation of law banning smoking in all enclosed public places. They found that hospital admissions decreased by 17%. A decrease of 4% in hospital admissions was found during the same period in England. England did not have similar legislation at the time. Smokers accounted for 14% decreased admissions, former smokers 19%, and non-smokers 21%. They also found non-smokers reported less exposure to second-hand smoke and this was verified with measurements of serum cotinine concentrations. They concluded that hospital admissions for acute coronary syndrome declined following the implementation of the smoke-free legislation.

As many organizations implement smoking ban policy further research will be required to determine long term policy effects for both staff and patient health outcomes. As an addiction, relapse for those who quit smoking is always a risk. It will be important for

³⁸ Going 100% smoke free in a secure setting: One hospital's successful experience. *Healthcare Quarterly*. Vol. 7, No. 2, pp. 42-48. 2004.

³⁹ Ratschen, E., Britton, J., and McNeill, A. Implementation of smoke-free policies in mental health in-patient settings in England. *The British Journal of Psychiatry* (2009) 194:547-551. This article is available by subscription only, abstract information is reported. Retrieved June 8, 2009 from <http://bjp.rcpsych.org/cgi/content/abstract/194/6/547>

⁴⁰ Bell, J. et al. Smoke-free legislation and hospitalizations for acute coronary syndrome. *New England Journal of Medicine*. Vol. 359, No. 5 (July 2008) [Electronic version] Retrieved May 22, 2009 from <http://ejournals.ebsco.com/direct.asp?ArticleID=474D999C30A4C052BE32>

policy makers to assess whether smoking rates and number of cigarettes consumed by continued smokers is reduced in the long term. Further research is necessary to determine the effect of smoking ban policy within buildings in comparison to smoking ban policy inclusive of property. In the long term one would expect smoking ban policy inclusive of property to be more effective as a public health intervention versus building only restrictions, especially in buildings with DSRs.

Short term and longitudinal research has found that smoking ban policy and legislation has improved outcomes for staff in workplaces and patients in health care facilities. While outcomes are positive there are implementation challenges associated with smoke-free property policy. The next section examines some of these operational challenges for two systems that provide residential and communal living environments; corrections and health care.

PART V: SMOKING BAN POLICY IN INSTITUTIONAL ENVIRONMENTS: IMPLEMENTATION CHALLENGES

Many organizations have implemented place-based smoking restrictions that go beyond the legal requirement. The goal of such policy is healthy work environments, healthy environments for consumers/visitors and overall improved population health and well being. This section focuses on institutional voluntary smoking ban policy implementation. All organizations that provide services to those residing in institutions for a period of time either voluntarily or involuntarily, and those who provide services to the mobility challenged face similar implementation issues when implementing smoking bans. Compliance, enforcement and stakeholder buy-in are all critical to implementation of smoking ban property policy. Implementation challenges and actions to address the challenges will be discussed for correctional centres and health authorities. Ethical considerations will be examined as well, as these considerations add to complexity of policy when policy regulates individual behaviour, especially in residential or communal living environments.

Organizations that serve clients who are immobile, those who reside in institutions or communal living arrangements and those who reside in health owned senior cottages often have additional challenges associated with smoking ban policies. While respecting individual rights to choose to smoke, smoke-free environments in effect, force a percentage (if not all) of the population they serve to stop smoking. Prohibiting people from leaving the grounds in correctional centres, for example, effectively prohibits them from smoking, some for extended periods of time and others indefinitely. Correctional centres, psychiatric institutions, palliative care, medicine units and long term care facilities have to consider how to accommodate individual rights, considering challenges such as confinement and lack of mobility, when planning for policy implementation. This section examines such services and how they are dealing with these complex issues in the interest of staff, client and public health.

1. Correctional centres

Correctional centres are responsible for providing safe, healthy environments for staff and inmates in their care. Smoke-free grounds policy in correctional centres means total prohibition from smoking behaviour for inmates as they have no freedom to leave the grounds. This may pose ethical challenges not faced by health authorities as most patients/residents are still free to leave the property if they are mobile or assisted by a visitor. Still many correctional properties within Canada and the United States are smoke free. Lincoln et al.⁴¹ conclude that the fears of assaults on staff and inmate revolts in the US prisons, due to smoke free grounds have not materialized. They note a distinction between quitting and stopping smoking. They conclude it is easier to stop smoking than quit smoking and that a large percentage of inmates begin smoking approximately six months after release. They report that inmates generally accept the policy and prisons

⁴¹ Lincoln, T. et al (2005) Letter: US experience of smoke-free prisons. *British Medical Journal*. Vol. 331 (7530):1473. Retrieved May 10, 2009 from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1315702>

have not experienced irresolvable difficulties in compliance and enforcement. They indicate they were unable to find a prison that had reversed the decision.

The experience in the Canadian correctional system has been similar; however, there have been policy position shifts based on responses from guards and inmates in the federal system and in one province.⁴² All provinces in Canada have smoke-free prison grounds with the exception of Quebec. In 2008, Quebec reversed its decision for smoke-free prison grounds after a riot at a provincial institution. Correctional Services of Canada (CSC) also reversed its smoke-free grounds decision in 2008 but in relation to guards only. After complaints from guards, CSC designated a smoking area for staff in parking lots outside fenced prisons areas. Some community organizations have called for a policy reversal by CSC arguing the policy now is “hypocritical”⁴³ as it applies only to inmates and the policy rationale for staff health appears not to be the policy driver as initially presented.

In 2000 the Fraser Regional Correctional Centre in Maple Ridge, BC went smoke-free, grounds included. Regina followed suit five days later.⁴⁴ The unique component to the implementation planning in Regina was that the prison established an implementation committee inclusive of inmates as members to prepare the inmate population for the policy. The institution provided access to cessation products such as nicotine gum and patches, requiring inmates to purchase these products. Inmates and anti-smoking groups argued that nicotine replacement therapy (NRT) should be free of charge to inmates. Since 2000 the majority of prisons in Canada have implemented smoking ban policy. Some provide cessation programming and NRT free of charge; others require inmates purchase their own NRT. The issue of purchase is a consideration for all residential facilities implementing similar policy.

2. Health authorities

Rigotti et al.⁴⁵ found that many patients experience cravings and nicotine withdrawal symptoms upon admission to smoke-free hospitals. Patients experiencing these symptoms were more likely to smoke while in hospital (25%) and violate policy (4%). Continued smoking during hospitalization is strongly linked with continued smoking after discharge. Further study is required for the researchers do note pharmacological treatment to reduce patient discomfort may lead to smoking cessation during their stay, increase patient compliance with policy and help patients to continue not smoking upon hospital discharge. Based on this research an argument can be made for health authorities to provide NRT free of charge to realize greater cost savings in future due to improved

⁴² Prisoners, community groups call for end to new smoking ban. Stark Raven Media Collection. 2008. Retrieved May 16, 2009 from http://www.prisonjustice.ca/starkravenarticles/smoking_0808.html

⁴³ Community organizations call for end to smoking bans. July 2008. Retrieved May 16, 2009 from http://www.prisonjustice.ca/starkravenarticles/smoking_0808.html

⁴⁴ Smoke free jails spreading. CBC News, March 2002. Retrieved May 16, 2009 from http://www.cbc.ca/news/story/2000/03/02/bc_jailspreads000302.html

⁴⁵ Rigotti, N. et al. Smoking by patients in a smoke-free hospital: prevalence, predictors, and implications. *Preventative Medicine* (2000), 31. 159-166.

smoking cessation rates and improved patient outcomes. The researchers recommend further exploration into impact on patients of smoke-free hospitals during their stay to identify ways to best meet needs of patients for better patient outcomes.

As was discussed previously, in 2003, The MHCP went 100% smoke-free as advised by the established Smoke-Free Task Force amid much controversy.⁴⁶ They originally attempted to provide designated ventilated smoking rooms but complaints and carbon monoxide detector tests led them to conclude that smoke leakage was occurring into other areas of the Centre, affecting staff, other patients and visitors. This finding is consistent with the WHO claim that ventilation is not effective in protecting people from second-hand smoke exposure risks. The decision to make the facility and grounds 100% smoke-free was based on three key conclusions: (1) the health of non-smoking staff and patients could not be protected by ventilated smoking areas; (2) the human resources required to escort approximately 60-80% of patients outside were estimated at \$500,000 annually; and (3) the health care facility could not ethically support a behaviour known to be harmful and fatal over beneficial activities such as education and recreation. They concluded the responsible decision was banning smoking within buildings and facility grounds.

The MHCP policy decision was legally challenged by eight patients in May 2003 based on lack of consultation prior to policy implementation. They attempted a court injunction to delay policy implementation which the court denied. The patients abandoned their application for judicial policy review. A second challenge was launched late May 2003 by one patient alleging their constitutional rights under *the Charter of Rights and Freedoms* were violated. In December 2003 the Superior Court of Ontario ruled that there is no constitutional right to smoke. Employee grievances were also filed with the end result to date being no policy change. Rather a focus was placed on creating a standard that all new hires be informed of the policy and the employer expectation of full policy compliance by employees.

The compliance issues experienced at MHCP were highest during the first weeks of implementation. One incident the day following implementation involved a patient's relative threatening to distribute free cigarettes. The police removed the individual from the property. In the following weeks additional issues arose; there were reports that some staff and patients continued to smoke, an underground black market developed for tobacco products and staff felt untrained on how to respond to violators if they failed to comply once approached. The administration has continued to champion the policy and has responded to these issues by amending policy to prohibit staff, volunteers and patients from bringing any tobacco products or flame producing materials into any hospital building. The employer has also continued to educate staff and the public about the policy.

The literature reports that one health facility reversed its policy position based on staff

⁴⁶ Going 100% smoke free in a secure setting: One hospital's successful experience. *Healthcare Quarterly*. Vol. 7, No. 2, pp. 42-48. 2004.

reported incidents of patient aggression toward staff. Campion et al.⁴⁷ conducted a case study on a regional hospital in Queensland Australia. The hospital implemented a smoking ban policy on the mental health unit but reversed its decision six weeks later based on incidents of aggressive patient behaviour towards staff. Many of the reported incidents involved the same patient. The issues upon examination were related more to implementation failure rather than policy. Staff and patients smoked together at property boundaries (many of the staff smoked as well), staff perceived that not smoking was causing the aggressive patient behaviour, the policy was not applied consistently and the implementation period was too short to really determine appropriate responses beyond policy revisions. The lesson for policy implementation is that staff training is critical to successful policy implementation, the policy needs to be applied consistently, alternative therapy needs to be considered to help patients cope with not smoking and ongoing critical evaluation of practice is essential. Monitoring and developing creative solutions will offer greater chances of success.

Lawn & Polas⁴⁸ conducted a systematic review of 26 international studies from the US, Canada and Australia concluding concerns in mental health facilities that smoke-free policy implementation would result in increased patient aggression, use of seclusion and self discharge against medical advice are unfounded.

The Calgary Region Health⁴⁹ was the first health authority in Canada to implement voluntary smoking ban policy in 2002. Parle, Parker and Steeves⁵⁰ reviewed the implementation within this region. The success of this program is attributed to strong leadership, inclusive planning and site preparation, monitoring, responsiveness, patient support and organizational communication. The health authority determined that traditional communication mechanisms alone were insufficient to meet the needs of the organization and broadened communications was key, with consistent messaging through repeated communication. The authors indicate that management support is necessary for successful implementation and that policy should be positioned to support what staff routinely do for improved patient outcomes.

In 2008 all six health authorities of the Provincial Health Services Authority in British Columbia⁵¹ went smoke-free. The Provincial Health Services Authority web site contains a question and answer sheet (Q&A) for the public to obtain information on the policy and to answer anticipated questions. The Q&A provides information on policy rationale, cites

⁴⁷ Campion, J. et al (2008). Implementing smoke-free policies in mental health inpatient units: learning from unsuccessful experience. *Australasian Psychiatry*. 2008;16:2, 92-97. [Electronic version] Retrieved May 13, 2009 from <http://dx.org/10.1080/1039856071851976>

⁴⁸ Lawn, S. & Polas, R. Smoking bans in psychiatric settings? A review of the research. *Australian New Zealand Journal Psychiatry* 2005; 39: 855-866.

⁴⁹ The Calgary Health Region (CHR) joined 11 health authorities to form Alberta Health Services (AHS) as of April 9, 2009. Currently two web sites exist for information on the region; the AHS and CHR. Retrieved May 30, 2009 from <http://www.calgaryhealthregion.ca/>

⁵⁰ Parle, D., Parker, S. & Steeves, D. Making Canadian health facilities 100% smoke-free: a national trend emerges, *Healthcare Quarterly*, Vol. 8, No. 4 (2005).

⁵¹ The Provincial Health Services Authority, BC Questions Sheet about Smoking, 2008. Retrieved on June 1, 2009 from <http://www.phsa.ca/WhoWeAre/Questions+about+Smoke+Free+Grounds.htm>

statistics on smoking related deaths annually in British Columbia, identified the trend in health authorities in Canada to go smoke-free and informed the public on compliance and enforcement plans. The public was informed that they could be asked to leave the property if they failed to comply with policy once approached. They also addressed the fact they would not be providing ashtrays at property boundaries, placing the onus on those who smoke to safely dispose of smoking materials, not to litter cigarette butts and to kindly refrain from smoking on neighbouring property as well. The Q&A identified resources for those considering smoking cessation as well. The Q&A is a comprehensive document for the public on expectations and how they may be affected by the policy. The publicly accessible Q&A did not address consequences to staff for non-compliance.

Smoking cessation programming serves as an ancillary policy support when implementing smoking ban policy. Many health authorities have offered these programs to support staff and patients in compliance with policy, encourage them to quit smoking and improve their health status. Christakis & Fowler⁵² studied smoking behaviour in large social networks. They found smoking behaviour is affected by close and distant relationships. They concluded that people engage in smoking cessation as a group when interconnected and that smokers are marginalized socially in today's society. These findings may have implications for smoking cessation ancillary supportive policy when implementing smoking ban policy for staff. Staff may be more likely to avail of cessation programming if it is inclusive of people in their social networks such as family or those residing in their residences.

3. Ethical considerations: smoking ban policy

When policy solutions involve complex societal issues, including the regulation of individual human behaviour it is imperative to engage in ethical analysis when considering policy solutions and outcomes. Ethical analysis involves examining several key questions from a value-based context while removing personal opinion and emotion. This research argues that cultural shifts in societal norms require time, strong leadership and incremental change processes. Whether individual behaviour is to be regulated should not be driven by individual opinion, special interest groups or emotion, but rather by collective societal values at a given time in response to public issues faced. Whether public policy is enforceable or whether it is perceived that the public will comply should not determine a policy position taken. Enforcement and compliance are not ethical issues; they are operational issues.

3.1. A systematic approach to ethics reviews for public health interventions

Policy developers need to be able to justify restrictive policy at the macro, meso and micro levels for the public good. Governments and health authorities are responsible not only for clinical intervention at the individual level, but also for public health protection

⁵² Christakis, N. and Fowler, J. (2008). The collective dynamics of smoking in a large social network. *The New England Journal of Medicine*. Massachusetts Medical Society. 358:2249-58

and health promotion for sustainable services and improved health. Upshur⁵³ argues public health involves the health of a population which is distinguishable from individual clinical intervention in the best interest of a patient. Therefore, ethical analysis in determining public health intervention and healthy policy should look different than clinical ethical analysis, being less evidence-based or scientific, use different principles inclusive of social, political and cultural contexts. Scientific analysis requires proof for intervention while a principle-based analysis from a population health perspective is less stringent upon empirical evidence, but seeks rather to explore values and assess when action is ethically justified for public health protection.

Upshur⁵⁴ identifies four appropriate principles for ethical analysis in public health practice: the harm principle by John Stuart Mills; the least restrictive or coercive means principle; the reciprocity principle and the transparency principle. The harm principle argues government has a right to regulate individual behaviour if it is harmful to others. The least restrictive or coercive means principle requires restrictions on individual freedoms must only be used when necessary; they must be legal and legitimate and use as little coercion as possible. The reciprocity principle requires that action only be taken when society accepts its duty to assist those affected by the action (individual and community level) in meeting their obligations imposed by the action. The last principle, transparency, refers to decision making processes being inclusive of stakeholders having equal input. Processes should be fair and absent from any kind of interference of those with a special/personal interest.

A systematic principle- and value-based approach to ethics in cultural context will produce ethically justifiable policy outcomes. Upshur⁵⁵ reports irrefutable evidence proving harm to the public before public health intervention action is chosen is not required. However, in the case of smoking bans such evidence exists. Smoking and exposure to second-hand smoke causes serious illnesses and premature death posing a significant public health risk.

3.2 Ethical justification for property smoking bans

The application of the above principles can lead to a reasonable conclusion that it is

⁵³ Upshur, R. (2002). Principles for the justification of public health intervention. *Canadian Journal of Public Health*, Vol. 93, No.2, pp. 101-103. [Electronic version] Retrieved May 30, 2009 from <http://66.102.1.104/scholar?hl=en&lr=&q=cache:QjrI8KoTZjsJ:journal.cpha.ca/index.php/cjph/article/download/217/217+author:%22Upshur%22+intitle:%22Principles+for+the+justification+of+public+health+...%22>

⁵⁴ Upshur, R. (2002). Principles for the justification of public health intervention. *Canadian Journal of Public Health*, Vol. 93, No.2, pp. 101-103. [Electronic version] Retrieved May 30, 2009 from <http://66.102.1.104/scholar?hl=en&lr=&q=cache:QjrI8KoTZjsJ:journal.cpha.ca/index.php/cjph/article/download/217/217+author:%22Upshur%22+intitle:%22Principles+for+the+justification+of+public+health+...%22>

⁵⁵ Upshur, R. (2002). Principles for the justification of public health intervention. *Canadian Journal of Public Health*, Vol. 93, No.2, pp. 101-103. [Electronic version] Retrieved May 30, 2009 from <http://66.102.1.104/scholar?hl=en&lr=&q=cache:QjrI8KoTZjsJ:journal.cpha.ca/index.php/cjph/article/download/217/217+author:%22Upshur%22+intitle:%22Principles+for+the+justification+of+public+health+...%22>

ethically justifiable to impose place-based smoking restrictions. The harm principle supports such a public health action; exposure to second-hand smoke is scientifically proven to be very harmful to those who do not smoke. Public health intervention is necessary and ethical to protect the health of the population. Application of the least restrictive and coercive means principle provides a mechanism to assess how intrusive and coercive the policy is, i.e., are smoking bans in the category of least restrictive intervention and the least coercive intervention possible to individuals for public health protection?

Smoking ban policy in health facilities and on health grounds does prohibit people from smoking in specific locations. It logically follows that a person's health and mobility will impact how restricted they are in their ability to exercise their right to choose to smoke. Patients who are immobile due to health status in health facilities will most likely not be able to leave health property to smoke unless escorted (if at all). Policy that does not allow staff to escort patients/residents off the property to smoke may add an ethical concern when patients/residents health status is placed at risk if they choose to leave the property unescorted.

A systematic approach to ethical analysis can be very helpful in considering these types of concerns with standards of care considered in a value-based context. While it can be anticipated that many health patients are capable of leaving the property boundaries alone (being informed by staff of the risks associated with that) others may require visitors escort them. Still, the opportunity to smoke can be provided in most cases, albeit limited. It can be concluded that if tobacco use or smoking was made illegal it would be more restrictive and coercive than place-based smoking restrictions. Least restrictive measures such as education, research and public awareness campaigns have not eliminated the public health risk of tobacco use. The next least restrictive measure is place-based public policy.

Prisons face unique ethical challenges based on confinement; inmates cannot leave correctional boundaries unescorted to smoke. The question as to whether escorts can/should be provided comes down to human resources, staff health issues and whether the behaviour should be facilitated by staff. Guards who do not smoke should not be required to escort prisoners off the property to smoke. There is also a flight risk to be considered with the prison population. The challenges with escorts for smoking are complicated in this environment. A strong argument can be made not to provide this service. Health authority units providing services to involuntary clients would face similar challenges as well.

3.3 Are individual rights violated by smoking ban policy?

In Canada there is no legal right to smoke; rather there is a legal right to choose to engage in smoking; a legal behaviour. While individuals have the right to choose to smoke, they cannot choose to smoke wherever they want. The *Charter of Rights and Freedoms* does not enshrine smoking as a constitutional right. A review of legislation in Canada by the

Non-smokers Rights Association (NSRA)⁵⁶ led them to conclude there is no legal right to smoke *anywhere* in Canada. They found no federal, provincial or territorial law enshrining smoking as a right or grounds for discrimination in human rights legislation following a comprehensive review of the law.

The NSRA also cites court rulings in Canada upholding smoking restrictions in multi-unit dwellings for the protection of non-smoking residents in such environments.⁵⁷ The Canadian courts have consistently ruled that property owners have a right to prohibit smoking in residential multi-unit buildings for the health protection of non-smoking residents. This finding is consistent with the findings of the WHO⁵⁸ that there is no legal right to smoke in existing legislation. Smoking is legal and people can choose to smoke; however, the right to smoke is not protected by law.

Governments and policy makers have a responsibility for public protection. With the overwhelming amount of evidence on the harmful effects of second-hand smoke exposure on the public, no legal rights to smoke in any environment and the obligation to protect the public, it can be expected that smoke-free environments will be upheld by the Courts. It can be anticipated that property smoking ban policy will become the norm throughout global society as public pressure increases for health protection.

Smoking ban policies do not appear to deny individuals the rights they have. When considering the expansion of smoking ban policy to outside grounds, additional value considerations arise. This research argues there is ethical justification for smoking bans on health grounds from a public health protection perspective. However, each institution and culture should consider their values and standards of care when considering criteria for place-based smoking restrictions. Principle-based assessment provides a systematic analysis process for decision makers to decide whether they have a justifiable right or duty to prohibit smoking on their properties for the health of the population. Clearly smoking inside buildings is harmful to those in the building as research indicates that ventilated DSRs do not offer complete protection.

Evidence for outdoor smoke-free grounds is supported by research findings that there is no safe level of exposure to second-hand smoke and smoke lingers and drifts in open air as well as confined buildings. Therefore, policy makers can argue an ethical case for smoking ban policy inclusive of grounds for the public good as public services exist to provide public value.

For the majority of health authorities and prison systems smoke-free policies have come

⁵⁶ Canadian case law on drifting second-hand smoke un multi-unit dwellings, Non-Smokers Rights Association, 2007. Retrieved May 15, 2009 from

http://www.nsra-adnf.ca/cms/file/pdf/Canadian_drift_smoke_case_law_March_2007.pdf

⁵⁷ Canadian case law on drifting second-hand smoke un multi-unit dwellings, Non-Smokers Rights Association, 2007. Retrieved May 15, 2009 from

http://www.nsra-adnf.ca/cms/file/pdf/Canadian_drift_smoke_case_law_March_2007.pdf

⁵⁸ Protection from second hand tobacco smoke policy recommendations. WHO, 2007, p. 33. Retrieved March 14, 2009 from

<http://www.wpro.who.int/NR/rdonlyres/7200F101-0E1A-469B-A38A-4DBB7E37D40A/0/SHSEN.pdf>

with challenges. Successful implementation lies in strong leadership and ancillary policies proven to enhance success. Staff training, resources/tools and creative communication mechanisms are necessary for employees to be effective in their contributory role in policy implementation, compliance and enforcement. Individuals in residential and communal living environments are often vulnerable or confined populations with no control over policy enactment that affects them directly. They need support with smoking cessation through cessation programming and NRT.

PART VI: WESTERN HEALTH CASE STUDY RESULTS

This section reports research findings from (1) the literature review, (2) reported incidents/occurrences from staff and complaints/compliments from patients, public, visitors and patients and (3) policy actor interviews. Findings contribute to future directions for Western Health to build on the success of the smoking ban policy.

1. The literature review

The literature review provides information on an ethical framework for public health intervention and implementation experiences of other organizations who have smoking ban policy.

1.1 *An ethical framework for public health intervention*

PART V, section 3 of this report identifies an ethical framework appropriate in public health intervention. Upshur⁵⁹ argues the application of clinical ethics in public health ethics is problematic as clinical ethics fail to consider social, political and cultural contexts. The focus of public health intervention ethics is community rights for health protection, while considering individual rights in cultural context. In contrast, the focus of clinical ethics is individual rights. The principles applied in clinical ethics of autonomy, beneficence, non-maleficence and justice approach ethics from an individual perspective and do not transfer easily to justification for public health intervention. Upshur⁶⁰ recommends more appropriate principles for justification in public health intervention are harm, least coercive and restrictive, reciprocity and transparency. The Western Health Ethics Committee applied a clinical framework to the Smoke-Free Properties policy.

1.2 *Implementation challenges*

Part V of this report provides a literature review of the implementation challenges experienced by correctional centres and health authorities that implemented smoking ban policy. The implementation challenges experienced by Western Health are consistent with the literature. The majority of case studies reviewed indicate compliance and enforcement pose the greatest challenge, with staff support being critical to smoking ban policy success.

2. Western health reports

⁵⁹ Upshur, R. (2002). Principles for the justification of public health intervention. *Canadian Journal of Public Health*, Vol. 93, No.2, pp. 101-103 [Electronic version] Retrieved May 30, 2009 from <http://66.102.1.104/scholar?hl=en&lr=&q=cache:QjrI8KoTZjsJ:journal.cpha.ca/index.php/cjph/article/download/217/217+author:%22Upshur%22+intitle:%22Principles+for+the+justification+of+public+health+...%22>

⁶⁰ Upshur, R. (2002). Principles for the justification of public health intervention. *Canadian Journal of Public Health*, Vol. 93, No.2, pp. 101-103. [Electronic version] Retrieved May 30, 2009 from <http://66.102.1.104/scholar?hl=en&lr=&q=cache:QjrI8KoTZjsJ:journal.cpha.ca/index.php/cjph/article/download/217/217+author:%22Upshur%22+intitle:%22Principles+for+the+justification+of+public+health+...%22>

This section summarizes all documented data provided by Western Health in relation to the smoking ban policy. Three types of reports were reviewed: employee incidence reports, occurrence reports and public complaints. No compliment information was available through formal documentation. Employee incidents reports inform of the number of smoking related adverse events (or near misses) involving staff. Occurrence reports inform of the number of smoking related adverse events (or near misses) involving patients, residents or visitors to health facilities. Complaints inform of public response to policy through formal documentation.

2.1. Employee incidents

No smoking related employee incidents reports have been filed since July 1, 2008, nor have there been any staff grievances filed or disciplinary actions taken resulting from the smoking ban policy. In the absence of formal documentation it is difficult to assess whether this indicates 100% staff compliance with policy, or whether staff failed to report incidents of non-compliance involving their colleagues which would have resulted in an official organizational response.

2.2 Occurrence reports

Occurrence report data was not available for all health sites for the entire timeframe of interest. Data was not available for any health sites from October 1, 2008 – March 31, 2009 with the exception of the mental health unit. Data was gathered manually for this unit as the authority knew there was a heightened reporting in that service area. Table 1 reports smoking related occurrences reported at Western Health for the past five years as available. There have been few smoking related reports with the exception of the mental health unit since policy implementation.

Table 1. Occurrence Report Data for Western Health (2004-09)

HEALTH SITE	2004-05	2005-06	2006-07	2007-08	2008-09	
					Q1&2	Q3&4
Western Memorial Regional Hospital, Corner Brook	2	6	3	1	0	N/A
Sir Thomas Roddick Hospital, Stephenville	0	0	0	0	0	N/A
Rufus Ginchard Health Centre, Port Saunders	0	0	0	3	0	N/A
Bonne Bay Health Centre, Norris Point	0	1	1	0	0	N/A
Dr. Charles LeGrow Health Centre, Port-Aux-Basques	0	0	4	1	0	N/A
Calder Health Centre, Burgeo	0	0	0	0	0	N/A
Long Term Care –Corner Brook	1	1	0	1	0	N/A
Bay St. George Long Term Care Centre, Stephenville Crossing	2	0	0	6	0	N/A
Mental Health Unit – Western Memorial Regional Hospital, Corner Brook	0	0	0	2	0	86
Region Total	5	8	8	14	2	N/A

Source data: Quality Management and Research Branch, Western Health Information Management System, 2004-2009⁶¹

The data indicates mental health has experienced the majority of formally reported occurrences since policy implementation on July 1, 2008, with no other facility reporting any occurrences of heightened concern to the authority. In the first two quarters of the year there were 2 reported occurrences in mental health. The data was not reported by quarter making it impossible to determine if either of these occurrences happened before policy implementation (quarter 1) or after (quarter 2). It is known that at least 86 of the reported occurrences in mental health followed policy implementation, a significant increase over the previous year in which there 14 reported occurrences. The fourth quarter of the year (January – March, 2009) shows a lower number of occurrences than in

⁶¹ Note: 2008-09 data is for April - September 2008 (Q1&2) for all sites except for the Mental Health Unit. The Mental Health Unit which includes data for the entire 2008-09 fiscal year. There were 44 reports in the third quarter and 42 reports in the fourth quarter for this unit.

the third quarter, albeit a decrease of only two.

The increased occurrences related to patient compliance in mental health are explained in the interview results. The policy did result in increased smoking related reports as was anticipated by staff and managers, as prior to policy implementation patients were permitted to smoke in a DSR in the mental health unit. Long term care residential environments have yet to fully implement the policy. It can be expected that reported occurrences will increase once the policy is fully in effect in that service area as well. Long term care and mental health are the residential/communal living environments in which implementation compliance challenges were anticipated by policy developers.

2.3 Complaints and compliments

One complaint was received from an outpatient receiving cancer treatment 10 days after policy enactment. The individual questioned why Western Health allowed foods containing monosodium glutamate (MSG) in their cafeteria if they were so concerned with citizen health and why cafeteria staff could not identify foods for customers that contained MSG. A manager responded to the complaint in writing acknowledging the concern, clarifying the limited harmful effects of MSG and the misconceptions of ill effects of MSG citing references and followed up with staff. It is impossible to determine the number or nature of informal complaints by staff and patients as front-line staff closest to the population were not involved in this research at the request of Western Health. It was not the goal of the organization to determine attitude toward policy.

3. Interviews

There were 16 policy actors involved in the development and implementation of the property smoking ban policy at Western Health. Of the 16 potential participants, eight participated in the interview process for a 50% response rate. The remaining eight policy actors did not participate for the following reasons: one was on leave from the organization, two were unavailable due to scheduling, two indicated they were peripheral in policy development and efforts to communicate with three were unsuccessful. All participants provided valuable insight into the development and implementation processes, communications and challenges related to policy. The following information was obtained from reported data and interview theme identification.

3.1 Policy rationale, process and adoption

Western Health has long been connected with the Alliance for the Control of Tobacco (ACT).⁶² A senior manager represents Western Health on this provincial organization and this manager was also tasked with establishing the Tobacco Free Network in the Western Region. The Tobacco Free Network is comprised mainly of Western Health staff but also

⁶² The Alliance for Tobacco Control is comprised of government and non-government organizations committed to reducing the negative effects of tobacco use. The organization is responsible for the provincial tobacco reduction strategy.
<http://www.actnl.com/index2.php#loadPage=00029>

connects with community partners on tobacco reduction strategies at the regional level. ACT had discussed advocating governments to adopt smoking ban policy for public locations. The senior management team of Western Health considered this policy direction and determined it was timely. Informal complaints were being received from the public and staff regarding smoking close to entrances, fire hazards, exposure to smoke in buildings with DSRs and senior cottages. Public pressure had been increasing for action to be taken to reduce exposure to second-hand smoke. The policy direction was deemed aligned with the vision, strategic plans and mandate of Western Health.

Respondents indicated the rationale for policy development was based on two key components: public policy for health protection and the need for the health authority to demonstrate leadership in health protection. Mental health and long term care were initially to remain exempt as per provincial legislation. The Vice President of Population Health and the Chief Operating Officer for long term care followed up with directors, managers and staff to engage in discussions on the plans for smoking ban policy and to determine if and how to apply the policy in these program areas.

Mental health had engaged in research with the view that if it was not safe for mental health units to have a complete smoking ban in place, the policy would not be applied and a DSR would continue to be provided. The research was carried out by front-line program area managers and staff were informed and consulted throughout the process. DSRs were deemed to be unacceptable as smoke escapes through opening doors; ventilation does not provide a 100% guarantee of elimination of chemicals in the air containment to the designated space. Furthermore, the health of staff tasked with cleaning DSRs is compromised due to air quality and lingering chemicals from second and third-hand smoke. Managers and staff ultimately decided a complete smoking ban was best practice and the right thing to do for their patients and informed senior management that they would be implementing the smoking ban property policy as well on July 1, 2008. The involvement and control by the unit staff was seen as a very positive thing by all involved in implementation of the policy.

Long term care adopted a phased-in approach to policy implementation. Anyone entering a long term care facility as of July 1, 2008 is now prohibited from smoking on the property and they are required to sign an agreement indicating that they will abide by the policy. Smoking residents in long term care facilities who were admitted prior to July 1, 2008 are being encouraged to quit smoking through the provision of NRT and smoking cessation programming. Three long term care facilities in the region still have DSRs and three others have designated outside smoking areas, both for patients only. There is no set time period for full policy implementation as an ethics review has been completed and discussion are ongoing. However, the new long term care facility for Corner Brook scheduled to open in the fiscal year 2009-2010 has been designated a smoke-free property by the Government of Newfoundland Labrador.

Interview participants were more concerned about the ethics of prohibiting seniors from smoking in their residence than for smoking bans applying to other Western Health sites. This is more of a concern because seniors pay for their residences while other individuals

in residential care do not. All participants indicated that by the end of the smoking ban implementation process, they were satisfied that banning smoking in seniors residences was the more ethical choice. Seniors are no less valuable than anyone else and their health is just as important. Ethically they felt they could not isolate this segment of the population and exempt them. As one participant questioned, “What message is that sending? We don’t value the health of long term care residents?” All policy actors felt the health of those in long term care was as valuable as all others and ethically the culture of caring had to be applied to them as well, in a compassionate, supportive and respectful manner. Moreover, Western Health senior facilities would eventually have to become smoke-free to be compliant with requirements set by Government for new long term care facilities. Since the new long term care facility for Corner Brook would be a smoke-free property, it was deemed prudent and responsible to engage in a phased in approach to prepare residents currently in long term care for relocating to this facility.

In considering outdoor smoking areas, participants indicated it would not be fiscally responsible to spend public monies on the erection of outside smoking structures when faced with so many other competing health priorities. To facilitate smoking is not viewed as best practice and the organization took the position they would not be facilitating smoking behaviour based on its harmful effects to personal and public health. Management decided they could not justify supporting smoking behaviour ethically or financially through any means/service area as a health promoting organization. Ethics review was not deemed necessary prior to policy implementation as research findings support smoking bans.

3.2 Leased properties

Western Health often leases private space for delivery of community-based services, especially in the more rural areas of the region. All participants were aware that the smoking ban policy currently does not apply to any leased properties for which existing contracts were in place on July 1, 2008. Any new leasing agreements entered into as of July 1, 2008 will require the private landlord to provide a smoke-free property for Western Health staff and clients. One participant indicated that while existing contracts were to remain in place, it was their understanding that facilities would be approaching landlords with current lease agreements to inquire as to whether they were willing to adopt the policy at the present time.

At this time, the smoking ban policy has not affected all Western Health staff equally. Those working within properties owned by Western Health are governed by the policy, while those working in leased properties have yet to be affected by the policy. Some policy actors anticipated some difficulty finding leased space under this new policy, while others felt it would be quite manageable. The expectations placed on staff for enforcement was identified as a potential challenge as staff will be required to approach other building residents if they fail to comply and this may affect working relationships. One policy actor indicated managers and landlords would be expected to assume the greatest role in enforcement in leased properties and they would expect staff to inform their manager of any violations for follow up with other leasers or the landlord as deemed

appropriate.

3.3 Communications: internal and external

The smoking ban policy working group was tasked with developing a communications plan for internal and external stakeholders. July 1, 2008 was the date set for implementation as a summer launch was deemed preferable because smoking outside is easier in the summer and those affected would have time to adjust to the change in policy.

The communication plan was developed by late January, 2008 to assist in the preparation of staff, the public and clients/patients/residents for policy implementation. The plan outlined key target groups, timeframes for release of information to targeted groups and the key messages to be delivered. Staffs were prepared over the six months prior to the launch through various means. Senior management site visits over the spring 2008 provided an opportunity for staff to be informed of the policy and have their concerns/opinions voiced. A notice was also provided in advance with paycheques to employees of Western Health. A countdown was launched 30-40 days in advance of July 1, 2008 on the Western Health intranet (internal web page).

The public promotion of the new policy began in early June 2008. The advertising campaign consisted of multiple communication mechanisms. Press releases were issued to local media outlets; identifying a contact for interviews upon request. Notices were placed on the Western Health web site and tent cards were placed in cafeterias and waiting areas. Announcements were made on local radio stations and an article was placed in the Western Health newsletter. A Question and Answer sheet was shared with managers and staff throughout the region and directors and managers discussed the policy at staff meetings. On July 1, 2008, facilities staff throughout the region unveiled signage at all entrances to Western Health properties identifying the property as smoke-free. The policy was placed in the internet and intranet⁶³ immediately upon taking effect. Enforcement cards were provided to all staff to assist in responding to witnessed policy violations. Staff could approach the individual and speak to them about policy, hand them the card containing policy information, contact security where available to deal with the situation, or report the incident to a manager.

3.4. Staff and patient supports and resources

Senior management planned implementation to be supportive of staff rather than punitive and provide them with resources, supports and tools to help them assume their roles in policy compliance and enforcement. However, staff was informed of the potential consequences for non-compliance. Information on available supports was included in the communication material. The Smoking Cessation Support: Community Action and Referral Effort (policy number 6-01-25) and Smoke Free Protocol for Services Provided by Home Based Environments (policy number 6-01-21) were posted on the intranet and

⁶³ The Western Regional Health Authority home page provides a direct link to comprehensive information on the smoke free property policy, communication tools and informational resources. <http://westernhealth.nl.ca/>

staff was informed of these policies at staff meetings.⁶⁴ Although some staff does not have internet access, other communication tools were used to inform of the policy including posters, brochures and notices placed in cafeterias and waiting areas.

Smoking cessation programs were offered to staff and patients, however uptake was low. The cessation programs offered to staff did not include their family. The health authority does not know how many staff or patients smoke. They do know the number of mental health patients that smoke is high and the number of long term care residents who smoke is very low.

NRT was considered for staff but it was decided not to provide prescription aids to staff as they have insurance and the costs were difficult to budget as the number of staff who smoke is an unknown. The decision was made to cover NRT for patients on a trial basis as it was deemed best practice. The expenditures on NRT are monitored closely and to date have not posed a challenge; coverage continues to be provided. This program is re-assessed from a budget perspective approximately every three months. The health authority has the capacity to deliver smoking cessation programs and expect the policy to continue.

In mental health preparation began well in advance of policy implementation for patient transition to smoke-free property. The hours of operation for the designated smoking room were gradually decreased prior to the closing of the room on July 1, 2008. For the launch date healthy snacks were made available for patients such as fresh fruit and vegetables, activities such as puzzles/journals were purchased and on-site and NRT was provided to those assessed medically to benefit from NRT safely.

A process evaluation was completed by Quality Management and Research in December 2008. Staff was invited at that time to attend focus groups to discuss implementation. A small number of managers and staff participated with the results indicating communication was handled well and should continue, enforcement was challenging but everyone understood the importance of their role and supports through smoking cessation programs and NRT for patients and residents was a proactive approach that should continue.

Follow-up plans included featuring the policy in the 2008-09 Western Health Annual Report, ongoing local media updates and ongoing reminder advertisements in the local media as required. An evaluation component was built into the communication plan. An outcome evaluation has not been completed to date. As the policy is new the organization is currently engaged in monitoring and responding to incidents as appropriate. Senior management is apprised of any issues requiring decision making at the senior level such as public communications, policy, legal and ethical issues.

3.5. Implementation challenges

Participants expected transitional challenges. Senior management endeavoured to

⁶⁴ Ancillary internal policies in support of the smoking ban policy, Western Health

establish a supportive environment to help staff, consumers and the public at large to cope with the smoking ban through communications, enforcement procedures and ancillary policy. The goal was not to be punitive as it was recognized that cultural shifts require support and time. Participants identified three areas of challenge:

- I. Stakeholder buy-in in long term care is low. Long term care has yet to fully implement policy as the cultural norm is to provide DSRs. There appears to be little support among staff for the policy because it is perceived as an infringement on personal freedom. The common belief system is that residents should be able to smoke because they are paying for service and space. In essence, they are “living/renting” in long term care facilities and senior cottages respectively. Long term care has sought an ethical review and is currently examining future directions based on the review.
- II. Compliance is still an issue as enforcement is not always consistent because of limited resources and the limited range of options open to staff to deal with witnessed violations. People are still smoking on Western Health property mainly in proximity to property boundaries or in vehicles. If enforcement is not consistent the problem may continue. The policy is a voluntary organizational policy and therefore is not legally enforceable in the absence of legislation. Therefore, if patients, visitors or residents fail to comply no legal action will result. However, the health authority can request visitors leave the property if they refuse to comply once non-compliance has been addressed with them. However, patients and residents would not be requested to leave the property. Managers and staff would have to work collaboratively with patients to help them to achieve compliance.

The reported occurrences in mental health appear challenging however two policy actors contextualized the issues. One indicated the number of occurrences has not really risen dramatically in mental health. They are dealing with the same issues they always did, for example, smoking in bedrooms and refusing to hand in lighters when in violation of policy. Another policy actor commented that the occurrences happened over a short period of time and in each instance involved the majority of patients on the unit. Staff responded appropriately and the issues were resolved. Policy reversal was not and is not a consideration as a result of the occurrence reports filed in mental health.

- III. Neighbouring property owners initially complained of litter and large numbers of people smoking close to or on their property, posing a fire hazard. Complaints were received and a notice was sent out to all staff as the city had indicated they would enact their municipal by-law on littering and fine anyone found to be in violation. While an unintended consequence of policy, the policy did affect properties in proximity to health facilities by relocating smoking behaviour.

3.6. Additional supports

Overall, participants felt the implementation of the smoking ban policy was successful. Transitional challenges have decreased and the policy is well accepted in the majority of health sectors. Senior management is committed to the smoking ban policy, with all

participants indicating that Western Health needs to:

- Continue offering smoking cessation programs.
- Continue to provide NRT for patients and residents.
- Consider the ethical review for long term care and discuss any effect findings may have on the policy.
- Continue to demonstrate strong leadership and championship of the policy.
- Highlight the importance of accountability and consistent application of the policy. It was articulated that agree or disagree, all health employees have to abide by policy and accept the responsibilities assigned by the organization.
- Continue communication with staff on the implementation of the policy.

The interview results indicate the smoking ban policy was implemented as a public health protection intervention to reduce exposure to second-hand smoke. The implementation of the policy has come with challenges that have been manageable. Long term care still faces ethical challenges that require further discussion. The next section discusses these findings.

PART VII: Discussion, Recommendations and Conclusion

This section analyzes results from the key informant interviews, employee incident reports, occurrence reports and complaints. Recommendations follow for Western Health and other authorities considering smoking ban policy for enhanced policy success. The paper concludes with a review of Western Health's policy implementation, successes and challenges and broad application of strategies for smoking ban policy success from planning through to implementation.

1. Discussion

The implementation of the 'Smoke-Free Properties' policy at Western Health has come with challenges. Policy developers anticipated transitional challenges and responded to them, as senior management remained committed to the policy. As noted in literature, strong leadership is a key component to successful implementation of smoking ban policy. The success of Western Health experienced to date can be attributed to the policy process employed, well planned timely communications and supportive implementation strategies. The senior management team fully supported and promoted the policy and established an implementation process that was inclusive and collaborative resulting in a shared vision and clear goals and objectives among most staff.

The authority acknowledges there are still challenges in the mental health unit, long term care facilities and senior cottage properties. These facility types encompass residential, communal living environments and landlord tenant relationships with arguably vulnerable populations that have unique service needs. Ethical and legal issues have to be considered in such environments when policy regulates individual behaviour.

1.1 Ethical challenges in long term care

With respect to ethical concerns, this research suggests organizations considering the ethics of smoking ban policy use a systematic approach to ethical analysis using a principle based approach in a cultural context. Ethics need to be assessed independent of opinion and emotion. The challenge to those tasked with healthy public policy is separating ethical issues from operational issues and balancing rights. In that capacity, the law is quite clear on the fact there is no right to smoke. People have a right to choose to smoke, not a right to smoke in any environment they wish, especially in environments where their behaviour can be harmful to others. All health authorities reviewed indicate smoking ban policy is the right thing to do for public health. Smoking ban policy appears legally defensible. The law is clear in that place-based smoking restrictions for public health are legally justifiable.

The ethical challenges faced in long term care are based on precedent. Residents have always been permitted to smoke whether in a DSR or in proximity to the facility. Ethically it has been more challenging for staff to accept that the seniors could no longer smoke or be escorted to property boundaries to smoke. Implementation is meant to be in a supportive context for improved patient outcomes, not punitive. Working with patients

and families through a collaborative practice approach involving patients in their health care has enabled partial policy implementation as evidenced with new residents entering facilities since July 1, 2008.

1.2 Challenges in mental health

Mental health has experienced implementation challenges as indicated by the number of reported occurrences involving patients. In the initial few months of implementation there were very few occurrence reports filed. In the third quarter of the fiscal year (2008-09), there was a significant spike in occurrence reports, with 44 reported incidents. The next quarter can be considered comparable with a decrease of only 2 reports. The 86 incidents reported in mental health were identified as being over short time frames (usually 3 day periods) involving dynamics of group interaction on the unit at a given time. Less compliant patients appeared to influence those who would normally be compliant with policy. Rather than consider a policy reversal, staff and leadership dealt with occurrences through a team approach and the issues were resolved through consistent policy application.

While the number of reports appears high, they were fairly isolated to brief time periods involving many patients. As well, staff have a heightened awareness of smoking-related occurrences since the smoking ban policy has been implemented. That, combined with efforts by the health authority to increase occurrence reporting over the past year, may have partially contributed to the high number of reported occurrences in mental health. Electronic reporting also became available to mental health staff in the fall of 2008 which may be a contributing factor to increased reports over the last two quarters of the year. In any event, occurrence reports should decrease the longer the policy is in effect and the smoking ban becomes the norm.

1.3 Best practices for successful implementation

Best practices for successful implementation of smoking ban policy identified in the literature indicate that in addition to strong leadership, staff training, communication and supporting strategies need to be comprehensive. Western Health engaged in staff awareness and training; communication was thorough and inclusive using multiple methods for staff training and public awareness. Supportive strategies were also put in place such as ancillary policy and NRT for patients. Practices such as referrals to smoking cessation support; smoking cessation programs for staff and patients and NRT for patients when medically safe need to continue for continued policy success, even though current smoking cessation program uptake has been low. It may be that only a small number of Western Health employees smoke and do not require cessation programming, cessation readiness may be absent or staff may quit smoking unassisted.

Staff in challenging service areas with complex patient needs had a degree of control over the implementation and this is viewed as a positive contributing factor to policy success. Patient safety and best practice in research also guided the planning process which focused the policy on patient health outcomes and improved population health in a

supportive environment, again a factor that contributed to policy success in the area of mental health. Rather than advocate for a policy reversal when challenges presented, staff and management were committed to the policy and worked together to deal with the issues and develop plans to prevent future incidents. Occurrences can be expected to decline the longer the policy is in effect.

The literature reports consistent and standard policy application in facilities is important to the success of smoking ban policy. Long term care will most likely face additional challenges if a two tier system is maintained. New residents are not permitted to smoke, while residents in facilities prior to July 1, 2008 are permitted to smoke. The end result is residents are not treated equally and this can be assumed to augment ethical struggles around acceptance of the policy by staff, residents and the public. Likewise, the new long term care facility for Corner Brook has been designated by Government to be a smoke-free property. If the policy is not implemented in all long term care facilities, residents will be treated differently within the region, dependant upon location of residency. For the policy to be accepted it should provide fair and equal treatment to residents regardless of facility location.

As discussed in the literature, communication needs to involve multiple methods and be repeated. Western Health communications plans involved a number of methods which are consistent with documented success stories. The need for clear public information and staff preparation in advance of policy implementation was recognized and a comprehensive communications plan was enacted to meet informational needs. Not all staff or the public have access to the internet. While this limits information flow to that segment of the population, the various other communication tools were deemed to be sufficient in reaching those without internet access.

Signage was especially helpful at entrances to all health property and posters and brochures placed in all sites would have informed all staff and the public. Discussions with staff during senior management site visits and in staff meetings would have ensured staff was aware. Public literacy levels were also considered through radio announcements, reaching those with low literacy levels. Well implemented communication plans may have contributed to public and staff policy acceptance as key messages were delivered consistently through multiple media sources and publicly released information.

Public acceptance of policy appears to be high as evidenced by only one patient complaint. Staff acceptance has been high as well, evidenced by no employee incident reports and no issues of non-compliance requiring human resource intervention. There is no way to measure staff, patient, resident and visitor displeasure with the policy in the absence of documentation. Neither can compliments be measured in the absence of documentation. However, it can be assumed that a percentage of the population would have been uncomplimentary of policy if they were inconvenienced or required not to smoke on health property; while a percentage would have been very pleased with the policy as they were no longer exposed to smoke within specific buildings and when entering or exiting affected properties.

Challenges still remain in that visitors and out-patients smoke close to property boundaries or in vehicles on health property. This can be directly linked to consistent application of the policy as well as noted in the literature on legislated place-based smoking bans. The response to violations must be consistent and applied when all violations are witnessed versus being ignored by any staff responsible for enforcement. Enforcement, while not meant to be punitive, is required to increase compliance by the visiting public to health care sites. Research argues legislation is necessary for organizations to have enforcement authority and this authority is not available to enforcers of voluntary policy. A policy is only effective if complied with.

The *Smoke-Free Environment Act*, while supportive of the vision, mission and mandate of health authorities, is limited in place-based smoking restrictions. The *Act* still provides for designated smoking areas in health properties which poses challenges to health authorities in achieving their health protection and health promotion mandate because policy is more difficult to enforce than legislation. The lack of legal consequence for non-compliance leaves health authorities vulnerable to individual willingness to comply. Without inclusion in provincial legislation there can also be inconsistency in how people are treated in different health regions. Public health agencies argue legislation is the most effective means of tobacco use control, supporting the need for legislation to reflect best practice in place-based smoking restrictions in the interest of public health.

2. Recommendations for policy enhancements

Western Health can build on the success of the smoking ban policy and address implementation challenges. Recommendations focus on additional strategies to support successful implementation of the policy through staff training and orientation, proactive planning and policy evaluation. The following recommendations are made based on research findings:

I. Western Health should complete a comprehensive outcome evaluation of the smoking ban policy prior to the policy review scheduled for July, 2011. This evaluation should be inclusive of key stakeholders with defined indicators such as:

- Measures of public acceptance and satisfaction with the policy
- Number of occurrence reports in relation to the smoking ban policy
- Measures of public exposure to smoke at building entrances
- Measures of smoking rates within the region

An outcome evaluation will provide evidence to indicate whether the smoking ban policy has been effective in achieving the desired outcomes of reduced exposure to second-hand smoke on health properties and reduced tobacco use among the population. An evaluation will help in communications and planning future policy initiatives in the area of tobacco control. Western Health has the research capacity within Quality Management and Research to conduct this evaluation internally in a cost effective manner.

II. Long term care should make a clear determination of whether the Smoke-Free Properties policy will be applied to all long term care sites considering the ethical review and research on smoking bans in residential environments to inform the decision. This would remove the two tier system now in place. The smoking ban policy currently applies only to new residents as of July 1, 2008 while residents prior to that date are exempt. If the policy is to be applied, a date should be set for full implementation and consultations should begin with staff, residents and their families to prepare them for the policy.

If the policy will not be applied in long term care facilities, Western Health should determine if DSRs or outside areas will be provided for residents and apply the decision to all long term care facilities. If outdoor areas will be provided, the three remaining DSRs in long term care facilities should be closed and all sites should be provided with an appropriate outside smoking area. If outside smoking areas are to be provided, Western Health should engage in discussions with the Department of Health and Community Services to approve a designated smoking area outside the new long term care facility. The costs associated with erecting designated smoking rooms or outdoor smoking areas may be significant.

III. Western Health should place the smoking ban policy as a standing item on staff meeting agendas to promote buy-in and provide the opportunity for staff to discuss their experiences with their role in the policy implementation. This information should be provided to senior management to support further implementation planning.

IV. Communication plans should be developed for staff and the public when the smoking ban policy is applied to leased properties under new agreements to inform of the policy and the expectations for compliance and enforcement options.

V. Western Health should support health professional advocates in their lobby for legislative amendment to the *Smoke Free Environment Act* to eliminate DSRs and prohibit smoking on all health properties. Western Health's membership in the Alliance for Control of Tobacco provides a venue to support advocacy efforts through provision of research and best practice for governments. This group, along with others such as the NL Lung Association continue advocacy at all political levels for smoking bans in public locations. The removal of the voluntary nature of smoke-free health properties policy would send a strong message to the public on health protection priority. Inclusion in legislation would also remove any possibility of lack of consistency in policy application within and between health authorities and provide a means of enforcement. Legislation is supported by the WHO as the best means for tobacco use control and is very cost effective.

VI. Western Health should continue to support NRT to palliative care, medicine, mental health and long term care patients. These patients have limited mobility and are particularly vulnerable. The costs associated with this to date have been manageable but will require budget monitoring.

VII. Western Health should continue working with the medical community to facilitate patient preparation for coping with the smoke-free property policy prior to a planned admission to a health facility. This is aligned with principles of primary health care for citizen engagement in their own health care planning and may reduce costs to Western Health for NRT. Patients may purchase aids to help them stop smoking for the duration of their stay at the health site or cease smoking for a period of time prior to admission and be beyond symptoms requiring NRT for patient comfort.

VIII. Western Health should display smoke-free properties stickers in all its vehicles. This would be a cost effective means of advertising and serve to reinforce the expectation that the public not smoke in vehicles on Western Health property.

IX. Western Health should continue to provide staff training on the role and expectations of staff in compliance and enforcement of the smoking ban policy, providing staff with appropriate ways to approach anyone smoking on Western Health property.

This can be accomplished in cost effective way by including a policy review annually in staff meetings with directors and managers. This would contribute to a consistent response to policy violations as staff would be approaching people with similar key messages. Aligning employee role in policy enforcement with the vision of Western Health may also enhance staff “buy-in” to the role they have in enforcement. Non-clinical staff may not necessarily see the role they have in health protection and this message may need to be promoted quite frequently for buy-in.

X. All new employees should be informed of the Western Health Smoking ban policy upon hire and the responsibility placed upon them for compliance and enforcement. While all employees are required to attend general orientation, many do not participate in orientation sessions until they have been with the organization for a period of time due to scheduling. While the smoking ban policy is reviewed in orientation, the role of employees in enforcement is not. Reviewing the employee role and responsibilities upon hire would be no cost to Western Health and serve to ensure all new staffs are well versed in expectations.

XI. Western Health should include families of staff when offering smoking cessation programs. Uptake has been low for smoking cessation programs for staff. Advertising programs as being available to staff and their families may increase uptake. A cost effective measure that may encourage staff who smoke to engage in smoking cessation programs if family members who smoke are able to attend with them as it is harder to quit smoking if one’s home environment includes other’s smoking in the household.

XII. Western Health should seek an ethical review prior to policy implementation that regulates individual behaviour. This may influence policy direction and assist in implementation planning to avoid ethical concerns once a policy is in place. Western Health has an ethics review committee that performs this function.

XII. Western Health should revise the Question and Answer sheet on the smoking ban

policy to include information on how the policy will be enforced and any consequences for public non-compliance. This would not have any financial implications.

XIII. Western Health should amend the Smoke-free Properties policy to include mental health and relay the policy position adopted in long term care once finalized. This would not have any financial implications but would serve to clarify for staff the policies to be applied in mental health and long term care.

3. Conclusion

The challenges faced by Western Health during the first year of smoke-free properties implementation are consistent with the challenges identified in literature by other residential institutions/communal living environments. Arguably, a policy is only effective if it is complied with and enforced. The hypothesis that legislation versus voluntary policy is one of the most effective methods of tobacco use control is supported by this research. While contributing to improved population health, voluntary policy is limited in enforcement consequences and therefore, is weaker than legislation in requiring public compliance. Strong leadership with policy champions is necessary for smoking ban policy to be successful in achieving policy goals and improved health outcomes. The inclusion of health properties in smoke-free legislation would provide enforcement authority.

The research hypothesis is supported in that policy success is dependent on strong leadership, staff training and support, multiple comprehensive communication mechanisms, monitoring, compliance and enforcement. Successful implementation of smoking ban policy depends on each of these contributing factors. Staff needs support and resources to be effective in carrying out their roles in smoking ban policy. Policy goals, when linked with a vision for improved patient outcomes and healthy communities, provide a clear expectation for employees for their role in goal achievement. Patients need support as well in coping with an addiction in environments that prohibit them from engaging in behaviour that meets the need of the addiction. Findings indicate patients often need support through the provision of alternative replacements to help them cope with physical discomfort of substance removal.

Smoking ban policies are effective in reducing public exposure to second-hand smoke. Exposure to second-hand smoke is reduced for the population and evidence indicates some people quit smoking while others reduce tobacco consumption. If such outcomes occur, it naturally follows that health status improves among the population affected. Population health improvements contribute to reduced dependence on health care and will ultimately reduce health care costs. More importantly, quality of life will be improved and premature death due to smoking-related illnesses will be reduced. As many smoking ban policies are still in infancy and developing through incremental restrictive means on individual behaviour, further longitudinal study is needed to determine if smoking ban policy truly has a long term effect on population health status.

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Appendix A. Script to invite participation

Script for inviting policy actors to participate in the interview process

“Hi, this is Susan Hoddinott calling. You may be aware I am doing research on the smoke free properties policy for my research project for my Masters degree in Public Administration at the University of Victoria. A component of the research involves interviewing those who were directly involved in the development and implementation planning of the policy. I am inviting you to complete an interview with me that will take about 30 minutes. I have a consent form that I can share with you by email before you make your decision. I’ll email it to you and call you in a few days to inquire as to whether you will be participating. If you agree to participate I will ask you to sign the consent form when we meet before starting the interview. Thank you for considering this invitation. I look forward to speaking with you in a few days.”

Appendix B. Interview Questions

1. The legislation prohibits people from smoking within 50 ft of buildings accessed by the public. Why did Western Health develop policy beyond legislation that prohibits smoking on all property?
2. The legislation provided for discretion to designate smoking areas in accordance with code specifications; however, Western Health decided not to offer a smoking area. What was taken into consideration in reaching this decision?
3. What are the plans for leased property?
4. What factors were considered in determining the implementation date?
5. What communication methods were used to inform staff and the public of the new policy and effective date?
6. How was staff prepared for the implementation of the policy?
7. What supports/resources were offered to staffs who smoke to help them cope with the new policy?
8. What supports/resources were offered to patients who smoke to help them cope with the new policy?
9. From your perspective what have been the challenges with the implementation of this policy – for staff and patients?
10. Can you identify additional supports for staff and patients that would address these challenges?

Appendix C. Consent Form



Smoke Free-Properties Research: Consent for Interviews

I am a graduate student in the Public Administration Program at the University of Victoria and I work for Western Health. I am using the Western Logo because they are my client. It is up to you if you speak with me. If you agree to an interview I will ask you to sign this consent form when we meet, before the interview starts. Your signed consent means you are giving me consent to use your answers (without identifying you) in my research report for the University of Victoria and Western Health.

Why am I doing this work?

To finish my MPA program I have to do research and Western Health is my client. The smoke free properties policy is to be reviewed May 30, 2011. This research will help Western Health determine if there are other ways they can support patients in coping with not smoking while in a health facility.

Why do interviews?

You are asked to answer these questions because you were involved in making the smoke free policy. A review of the communication to the public, reasons for decisions, ethical considerations, etc. may help other agencies wanting to action the same policy. Your thoughts on challenges and solutions will help make the policy more successful for better patient outcomes.

What do I have to do? What are the risks to me if I speak with you?

A 30 minute interview with questions on policy development. What kinds of things did you consider? How do you think the policy could be made better? There is little risk to you. While you are known within health as a team member for this policy, you will not be identified personally in the report.

If you have any questions about this interview before you decide to speak with me you can call me at (709-632-2973) or email me at susanhoddinott@westernhealth.nl.ca. Dr. Lynne Siemens is helping me with my research. She can be reached at (250-721-8069) or by email at siemensl@uvic.ca. If you have questions about the ethics approval for this survey you can contact ethics at the school (250-472-4545 or ethics@uvic.ca).

I, _____, give my full consent to be interviewed and consent to my responses being included in the final research report. I understand I will not be personally identified in the report and that I can withdraw my consent by June 5, 2009. If I withdraw consent my data will not be included in the final report.

Date: _____