23 September 2014

Trevor Ruthenberg MP
Chair
Health & Community Services Committee
Parliament House
George St
BRISBANE QLD 4000

Via email: hcsc@parliament.qld.gov.au

Dear Mr Ruthenberg,

Re: Health Legislation Amendment Bill 2014 and proposed amendment to the Tobacco & Other Smoking Products Act 1998

In response to your recent letter inviting submissions in relation to the *Health Legislation Amendment Bill 2014,* the Private Hospitals Association of Queensland (PHAQ) would like to comment in relation to some of the proposed amendments to the *Tobacco and Other Smoking Products Act 1998.* We have no comment to make regarding proposed amendments to other legislation captured within the *Health Legislation Amendment Bill 2014.*

By way of background information, there are 107 private hospitals in Queensland comprising 53 inpatient facilities and 54 day hospitals with a total of 7,197 licensed beds or 39% of total hospital bed stock. In 2012/13 these private hospitals accounted for 47.2% of total hospital separations and provided 2,219,627 patient days of care *(AIHW Hospital Statistics 2012-13).*

PHAQ is the peak body representing private hospitals operating in the State of Queensland and our membership comprises 76% of inpatient beds and 73% of day hospital beds & chairs.

The comments which follow are broadly similar to those articulated in a submission earlier this year, in response to an invitation to comment on proposed amendments to the *Tobacco and Other Smoking Products Act 1998.*

PHAQ supports the proposed amendment in relation to personal vaporising devices and their associated components being subject to the same restrictions applied to tobacco products, and we also support the intent to prohibit smoking on state and non-state school land and within 5 metres of the perimeter. However, we do not support the proposed blanket prohibition of smoking on all public and private health facilities land including within a five metre non-smoking buffer around the perimeter.

PHAQ is strongly of the view that the current discretion afforded to hospitals to establish a designated smoking area on hospital grounds is an effective balancing mechanism to manage the competing priorities of accommodating the rights and special needs of particularly vulnerable patients who may be smokers; minimising the potential for increased legal and workplace health and safety risks and responsibilities and sensitivity towards local residents whose properties adjoin many private hospitals.

In particular we would make the following comments:

- The practical reality must be accepted that despite hospital attempts at interventions, there will continue to be patients, visitors and staff who smoke and therefore the proposed legislative change will merely push these smokers off the hospital premises and beyond the 5 metre exclusion zone, creating a risk for staff and patients – particularly after dark.

Private Hospitals Association of Queensland
PO Box 370, Kenmore, Qld 4069
ABN 99 240 870 655

Telephone : 07 3279 7600 Email : reception@phaq.org
Facsimile : 07 3279 7601 Web : www.phaq.org

- If these smokers are patients, it does create legal risks and responsibilities for the private health facility. These legal risks would not be addressed simply by the provision of information, signs and requests not to go beyond the property, or a signed waiver from a patient. For example, if a patient is injured and the hospital is aware that he/she is outside the perimeter of the facility (e.g. a witnessed fall, medical incident or patient being hit by a car), then there will likely be a liability for the private health facility – albeit perhaps reduced - for contributory negligence.

- The proposed amendment would result in there being patients out beyond the exclusion zone & off the property that a hospital cannot bring back and yet would have some ongoing legal responsibility towards. This means there will be a cost to address the risk and the risk will not be reduced to zero. It is also quite possible that requiring patients to leave the hospital grounds to smoke, could increase a hospital's indemnity insurance premiums, if it was considered by the insurer, that the risk of injury giving rise to a claim was greater than it would have been, had a safe designated area been available on campus.

- There are a number of suburban private hospitals with domestic residences adjoining their borders. Removing the ability to provide a discrete, designated smoking area within the grounds of the hospital campus, will undoubtedly lead to congregations of patients, visitors & staff smoking outside the gardens of members of the local community. Such activity will not only be unpopular with residents but will project a poor image which the private hospital will be powerless to prevent or remedy and it will therefore give rise to neighbourhood disharmony and complaints.

- There are two groups of patients in particular who smoke, for whom the proposal could cause unnecessary additional stress and anxiety – namely, mental health and palliative care patients. Mental health patients are especially vulnerable, particularly trying to manage voluntary status, but keeping them onsite. It is also worthy of note that a number of private hospitals service a significant veteran population, many of whom are either admitted for acute mental health or palliative care or have physical incapacities which would make leaving the campus to smoke, particularly challenging.

- There are 11 private hospitals in Queensland providing acute mental health care with a total of 507 licensed beds. Of these, 283 beds are in authorised mental health services, meaning that both voluntary and involuntary patients are admitted for care.

- For those patients admitted under an involuntary treatment order (ITO), they are not permitted to leave the premises unless a leave pass has been signed by their treating doctor and they are escorted – generally by a staff member or in rare situations by a relative. The regulatory requirements surrounding leave passes are not designed for multiple daily exits from the hospital premises to smoke and would be extremely difficult to administer, particularly in a private mental health facility where the treating doctor is not generally domiciled in the facility but is a visiting medical practitioner. It would be highly resource intensive and costly for a hospital to accommodate, as an ITO patient would need to be risk assessed by clinical staff on each occasion prior to leaving the premises to smoke, and would also need to be accompanied by hospital staff for the duration that they were off the premises. The staff member escorting the patient would be exposed to passive smoke thereby creating an additional occupational health and safety risk exposure for the organisation.

- Given the mix of voluntary and involuntary patients in most authorised mental health facilities, the fact that voluntary patients would be able to leave the property to smoke, would create significant tension and additional stress for the involuntary patients which could lead to aggressive behaviour by them towards staff and other patients.

...3/

Private Hospitals Association of Queensland
PO Box 370, Kenmore, Qld 4069
ABN 99 240 870 655

Telephone : 07 3279 7600 Email : reception@phaq.org
Facsimile : 07 3279 7601 Web : www.phaq.org

- Private mental health facilities currently provide a designated smokers area that is in line with the current legislation and in accordance with the *Private Mental Health Consumer Carer Network (Australia) Policy* – noted in the dot point below. The decision to provide a designated smoking area within the hospital grounds is one which has generally been made after careful consideration of both clinical and duty of care type issues whilst putting in place various strategies to encourage patients to attempt to quit smoking. Such strategies may include Quit programs, nicotine replacement therapy and general psycho education and support for the nursing and allied health professional staff as well as the patients admitting Psychiatrist.

- The Private Mental Health Consumer Carer Network (Australia) in its policy *Smoking by Mental Health Patients within Private Hospital Settings* states:

    - *The Network believes that to require a mental health patient (who is most likely already in a sufficiently vulnerable state to require hospitalisation) to cease smoking during their stay could cause extreme distress and possibly impede recovery. The provision of nicotine patches alone would be insufficient to address all aspects of smoking withdrawal*
    - Recommendation 2 of the Network's Smoking policy states that*: (2) there is a designated smoking area for patients, one that is functional yet discourages lengthy personal interactions or individual isolation.*

- In 2012 we surveyed our member organisations to inquire about their Smoking/Smoking Management Policies and it was evident from the responses received that with very few exceptions, private hospitals have elected to provide designated smoking areas rather than operate an entirely smoke free campus. Generally such decisions had been made after wide consultation with the hospital Medical Advisory and Workplace Health and Safety Committees who took into consideration concerns about staff and patient safety, the particular patient case mix of the facility and in some instances the location of the facility within residential communities. Significantly several hospitals commented that they had initially introduced an entirely smoke free campus but reverted back to providing designated areas due to a range of problems which the smoke free policy had created. One of the reasons cited for the policy reversal was the increased fire risk as smokers in an entirely non-smoking environment sought hidden places to smoke many of which created an added fire risk.

- It is unclear whether the workplace health and safety obligations of private healthcare facilities would also now extend if hospitals know that people were congregating in certain areas off their licenced premises.

PHAQ would also like to comment on the proposed implementation date of 1 January 2015 and the implications this will have for all private hospitals but particularly those who treat mental health patients. We understand that the Department of Health is preparing information and advice to assist with implementation of the proposed new laws which will include examples of strategies known to assist with the successful implementation of totally smoke free environments, together with a communication plan and public awareness campaign. To date we are not aware that any of these materials have been released hence the lead time is becoming very short for implementation to be efficient.

...4/

Private Hospitals Association of Queensland
PO Box 370, Kenmore, Qld 4069
ABN 99 240 870 655

Telephone: 07 3279 7600 Email: reception@phaq.org
Facsimile: 07 3279 7601 Web: www.phaq.org

As noted in the *UK Medicines Information Centre Pharmacy Department Bulletin – Smoking and Drug Interactions (June 2007):*

> *"Several studies have shown that smokers require and are prescribed higher doses of psychotropic medication than non-smokers. When smoking is reduced or stopped, enzyme induction reduces or ceases, the rate of metabolism decreases, leading to a rise in serum drug levels. Dose adjustments may be required for certain drugs. This applies also when using therapies for smoking cessation, therefore it is important to recognise that on stopping smoking a person may experience increased side effects despite taking the same dose of medication as that prescribed while smoking."*

Given the potential for sudden smoking cessation to impact on a patient's current medication levels, it is preferable, where possible, that there is sufficient lead time for treating mental health clinicians to work with their patients to encourage them to stop smoking before they are admitted to hospital. Introducing a total smoking ban in the middle of the peak holiday season when many medical practitioners are on leave is not ideal timing. Studies elsewhere have demonstrated that 6 months is a minimum lead time and preferably 12 months.

In summary, PHAQ does not support the proposed amendment to prohibit smoking on private health facility grounds including within a five metre non-smoking buffer around the perimeter, and considers that it should continue to be at the discretion of private health facilities whether they choose to operate an entirely smoke free campus, or provide discrete designated smoking areas for inpatients.

A private hospital policy decision to provide designated smoking areas in preference to entirely smoke free, may in part be informed following a risk assessment of factors such as the physical location of the hospital (for example a busy road or residential street) and/or the mix of patients who attend for treatment, some of whom may have special needs which need to be taken into consideration (e.g. palliative; mental health; etc.).

A total smoking ban would be particularly harsh on palliative patients who smoke, the majority of whom would be physically unable to move 5 meters from the hospital grounds, or for acutely unwell mental health patients. As one Psychiatrist noted in his feedback to the Association *"Whilst in general I am in favour of stopping smoking as a preventive method, when a person is admitted to hospital with a nervous breakdown, the time for prevention is not there. It is barely masked sadism to insist that a person should cease smoking when they are in the middle of a breakdown"*

Given that smoking is a behaviour/addiction that is not possible in all cases to immediately cease, despite replacement therapies which may be offered, PHAQ considers that providing discretion to confine smoking to a designated area within the hospital grounds is preferable to a total ban. In addition we can see no point in introducing a legislative requirement which is not only virtually impossible to enforce with any effect, but is also one which increases the legal liability of a hospital, potentially exposes patients to a greater risk of injury or medical mishap whilst off campus smoking, and fails to take into account the psychological needs of a few particularly vulnerable patient groups.

This correspondence has been approved for submission by the Management Committee of the Private Hospitals Association of Queensland. Should you wish to discuss any aspect of this letter please do not hesitate to contact me on 07 3279 7600 or [redacted] or email – [redacted]

Yours sincerely

[redacted]

LUCY FISHER
EXECUTIVE DIRECTOR

Private Hospitals Association of Queensland
PO Box 370, Kenmore, Qld 4069
ABN 99 240 870 655

Telephone : 07 3279 7600 Email : reception@phaq.org
Facsimile : 07 3279 7601 Web : www.phaq.org