# Smokefree Mental Health Project

National Mental Health Services
Smokefree Guidelines Development:
"Shifting the Culture"

Funded by the Pathway to Smokefree New Zealand 2025 Innovation Fund Project

WHAKAWATEATIA

HAWKE'S BAY
District Health Board
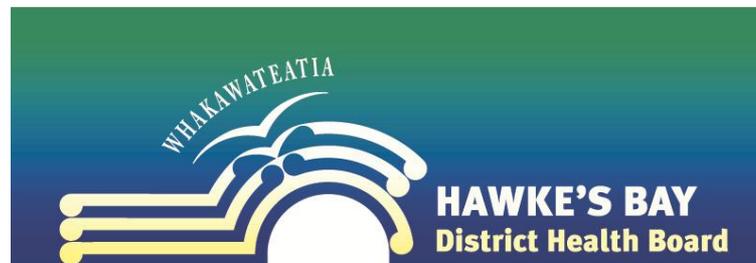
Mental Health Services

❖ historically – a strong culture of acceptance and encouragement of tobacco use across MHS (Hitsman et al, 2013)…

❖ this culture has been a major contributor to the prevalence rate (32%) and higher levels of dependence amongst MHS users (Olivier et al, 2007).

❖ this tolerance of tobacco use is underpinned by a number of strongly held myths associated with tobacco, including "one substance at a time" and "it's the least of peoples' worries" (Oakley Browne et al 2006)…still happening

❖ widely acknowledged that when spending time in inpatient settings, where tobacco is entrenched in the ward culture, PWMHI _start_ smoking and _relapse_ (Hitsman et al 2013) – still happening…

❖ PWMHI purchase around 30% of the tobacco products sold in NZ (Tobias, 2008)

❖ Much of the reduction in life expectancy among people with serious MHI is attributable to smoking (Royal College of Physicians, 2013)

equity of care issue

the challenges…

- ❖ "Smoking goes hand in hand with mental health illness" (all roles)

- ❖ PWMHI "smoking with staff is a rapport building time…a chance to open up" (Community MH Team RN)

- ❖ "…consultants allocate smoking leave" - literally – noted on whiteboard (acute service manager)

- ❖ "smoking regulates psychotic thinking" (psychiatrist)

- ❖ "Targets are important but only if you know why you are doing it' (Nurse Director)

- ❖ MH workforce staff making value judgements about whether PWMHI want/need SF support (NGO Workplace Lead)

- ❖ "…someone I know was admitted to the inpatient service SF but came out a smoker…"

individual comments…

Stakeholder Engagement

- ❖ 6 DHBs gave consent for staff to participate
- ❖ HBDHB, TDH, TDHB, CMDHB, SDHB-Invercargill, SDHB-Dunedin
- ❖ DHB Inpatient wards including lock-down, Acute Intervention Teams, DHB Community Teams &/or Addiction services, DHB Day Activity centres, DAMHS, NASC
- ❖ psychiatrists, psychologists, psychotherapists, GP Liaison, RNs, Com MH RNs, SCs, CSW, CNM, CSM, Portfolio Managers, Managers, Team Leaders, CEO, Clinical Nurse Directors, Quality & Risk, Social Workers, Counselors, OTs, Cultural Advisors, Family Advisors, Youth Advisors

- ❖ 19 NGOs gave consent for their staff to participate
- ❖ CEO
- ❖ managers
- ❖ Support workers
- ❖ Field officers
- ❖ Service & Relationship Manager
- ❖ Service Operations Leader
- ❖ Family support members

Data Collection Methods

❖ 42 sessions in total

❖ 149 participants in total

❖ 63 participants completed online surveys

❖ 17 discussion groups

❖ 25 people were interviewed

❖ 22 services completed online surveys

Data Collection Methods:
within each session; across each site; across all sites

What we did…

Overall…

Before we go any further the good news is…

❖ much smokefree progress has been made within the MH sector

❖ *some* staff & *some* services demonstrate strong SF commitment

❖ in general, staff increasingly view ABC as core practice

❖ more staff are encouraged to become SF as a result of their organisation's SF commitment

❖ therefore we start this programme of culture change further along the continuum of change than first anticipated and

❖ we can build on some of the initiatives already underway

The key will be to develop & implement changes that create consistency for PWMHI & are therefore sustainable in the long term…

Theme: Undermining behaviour

this applies…

- ❖ to staff returning from breaks smelling of tobacco smoke & visibly handling tobacco paraphernalia
- ❖ when patient breaching of organisational SF environment is unaddressed
- ❖ when staff smoke with patients
- ❖ to staff perceiving that accompanying patients/clients on smoke breaks is an opportunity for rapport building & assessment of mental health status
- ❖ when medical staff on inpatient wards overtly allocate 'smoke breaks'
- ❖ when staff 'turn-a-blind-eye' when leave breaks are used for 'smoke breaks'
- ❖ when PWMHI return to a smoking environment either after a period of STA or when making a long term SF attempt

What we think it means…

the importance of SF role-modelling…

THEME: There is poor communication between all the MHSs a PWMHI accesses

❖ Develop & implement a mechanism of communication that all MHSs contribute to based on a person-centred model of care

❖ Develop & implement a paperwork process (or alternative tool) that follows the PWMHI

❖ Develop streamlined referral/discharge tools that are transferable across MHS settings & follow the PWMHI as opposed to being attached to individual services

❖ To include family support service staff & family members
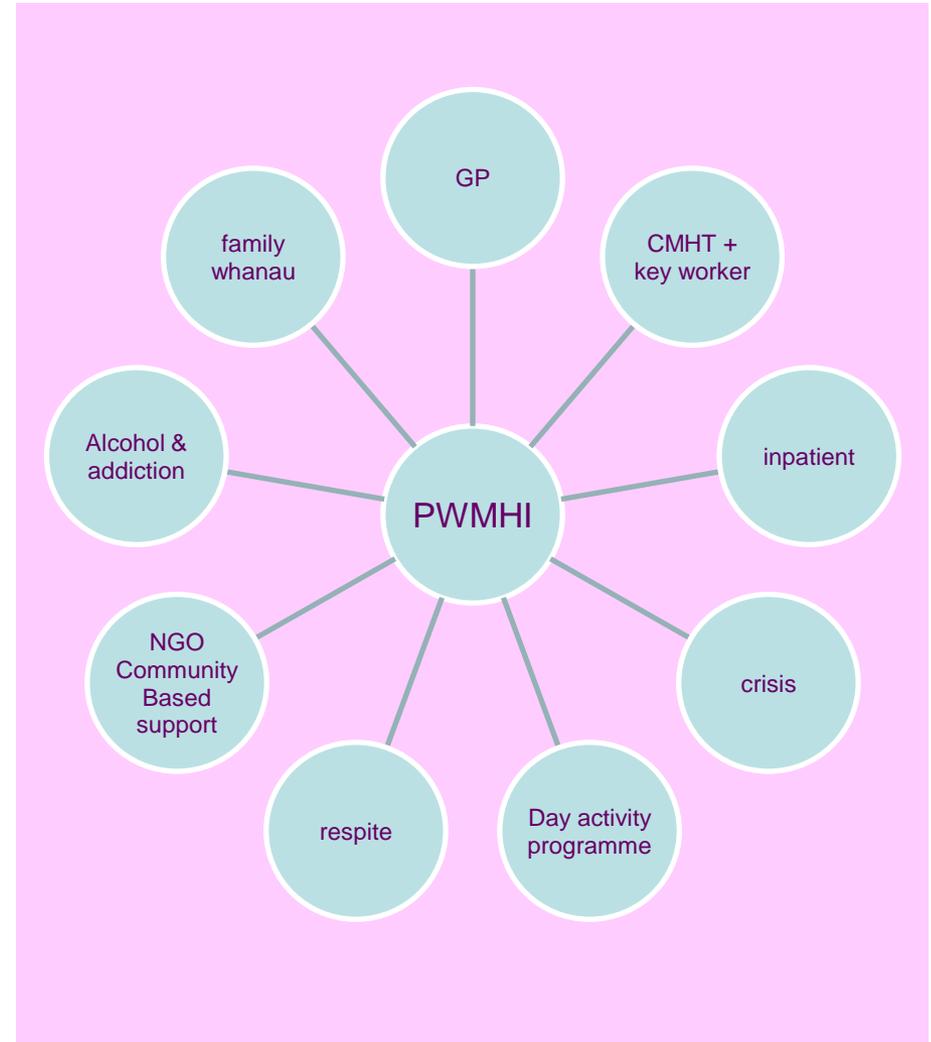
THEME: There is inconsistent smokefree messaging/attitudes/practice amongst staff & between services which erodes smokefree team/organisational commitment

Develop & implement a comprehensive SF education programme specific to MHS

- ❖ for all staff (including management roles) within each MHS setting
- ❖ for each professional body including SF role clarification
- ❖ strengthen ABC intervention & make MHS-specific
- ❖ mandate this extended educational programme to be part of orientation & on-going refresher training
- ❖ develop & implement SF education programme for family support services & family support members

THEME: There is a practice of prioritising the presenting issue at the expense of smoking harm because nicotine addiction is often perceived by health professionals as less of a health risk…

Provide specialist nicotine addiction/NRT education & training for all staff, irrespective of roles

❖ how to get SF support from managers & those in leadership roles
❖ how to assess nicotine addiction and monitor nicotine withdrawal
❖ how to prescribe NRT to manage both short term abstinence (STA) & long term support to become SF
❖ the methods for prescribing NRT (standing order/quit card/charting)
❖ how _correct_ dosage & use of NRT products supports nicotine withdrawal
❖ how _incorrect_ NRT dosage & use undermines quit attempts
❖ how smoking impacts on titration of other medications
❖ how to differentiate between nicotine withdrawal & exacerbation of MHI

Proposed programme of culture change

Proposed principles…

these principles underpin the programme of change…

Principle 1:

No assessment of mental health status will be complete without assessment of smokefree status

Principle 2:

No mental health recovery plan is complete without assessing interim nicotine management and long term support towards smokefree

NOTE: these two principles strip away all the history, rhetoric and prejudice and provide simple clinical best-practice foundations

100% agreement in principle

THEME: more support for MHS workforce to become smokefree

Because staff become self-motivated by their smokefree work with clients…

- ❖ resource quit programmes and incentives for MHS workforce staff
- ❖ include management in SF training in order to clarify their role in supporting staff and clients to become SF

An individual knowing what to do (role clarity) is the practical, visual expression of "organisational commitment"

Proactive actions our services are already undertaking and examples of best practice that have induced change…

- A virtual community support worker system
- A wraparound recovery plan inclusive of physical health
- A regional DHB MHS alliance dedicated to addressing challenges
- Generic regional MHS alliances (northern & southern)
- MDT inpatient admission meeting
- Tracking patient quit attempts
- NRT as PRN study to address & differentiate nicotine withdrawal symptoms
- Multi-patching approach
- New registrar SF training approach
- Training with Mark Wallace-Bell
- Activity programmes within inpatient wards (including lock-down) which have created new social relationships/interactions
- Mandating tobacco product removal within inpatient settings backed up with search policy training

Proposed programme of culture change

Further Recommendations

- DHBs/PHOs/NGOs to strengthen, mandate & audit all SF contractual requirements

- Seek agreement from professional bodies on addressing more than one addiction at a time

- Re-orient MHS inpatient wards to shift their focus to nicotine withdrawal management

- In con-junction with the above, mandate removal of tobacco products within inpatient settings & implement search policy training

- Recommend MoH/MH sector subsidise a greater range of NRT products specifically for PWMHI accessing MHS

- Recommend MoH/MH sector widen NRT access criteria specifically for PWMHI accessing MHS

Demonstration site process reasoning

- very clear that a one-size-fits-all-approach is unworkable

- due to the diversity of each mental health service setting

- due to the regional diversity of mental health services

- requires a practical approach with tangible processes

- requires a practice shift from service-centric to a person-centred approach

- need to develop a mechanism that empowers MHS to act together to create sustainable SF practice

- it must be self-sustainable

- the spin-off could be that it improves communication in general between all MHS a PWMHI accesses

NOTE: focus is not on (or may be expressed through) individuals but is primarily a focus on ORGANISATIONAL CHANGE

Solutions need to match the problems

❖ clinical knowledge gap = education

❖ poor current practice (norms) = revise procedures & processes

❖ services unavailable (for example cessation) = make them available

❖ some staff opt out = clarify role requirements

*individually the problems are situation-specific
but taken as a whole they require a collective process
that is, an organisational solution
not simply addressing each issue in isolation*

*Facilitating a <u>local</u> process to find <u>local</u> solutions to implement
and achieve <u>national</u> best-practice*

Demonstration site phase

1. Develop mechanism of communication between all MHS a PWMHI accesses (working group/MOU)

2. Develop tools to track SF journey across MHS

3. Develop MHS-specific SF education programmes focusing on nicotine dependence/NRT

4. Implement MHS staff SF support & quit incentives

5. Make wider recommendations to MoH/MHS sector

Summary of key themes + what we think it means + what we think can be put in place…

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Presentation to participants & external stakeholders

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Feedback step

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Brief evidence review

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Programme of change developed

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Peer review processes & changes made

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Demonstration site phases

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Evaluation processes

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Guidelines published including programme of change

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Submission to MoH for national roll-out

What we are doing…

Summary of project outline