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Risk management is the key to comprehensive tobacco control in mental health services

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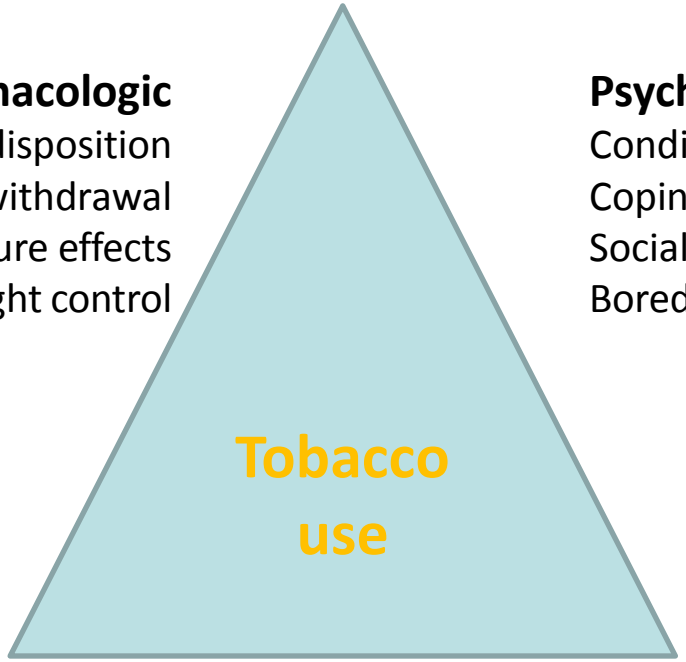
Factors associated with tobacco use in clients with mental illness

Biologic & Pharmacologic
Genetic predisposition
Alleviation of withdrawal
Pleasure effects
Weight control

Psychological/Behavioural
Conditioning effects
Coping tool
Social interactions
Boredom



Systematic & Treatment
Use of cigarettes for reinforcement
Failure to treat

Why treat tobacco in clients in mental health services?

- Smoking **IS** a clinical issue relevant to mental health treatment
- Mental Health clients **ARE** interested in quitting
- Mental health clients **CAN** quit successfully **WITHOUT** threat to their recovery
- Clinical health staff in mental health services **ARE INTERESTED** in training and training programmes **IMPACT** clinical practice
- Tobacco treatment is **COST-EFFECTIVE** and can be done effectively

General Principles in Treating Smoking in Mental Health Services

- Similar in principle to smoking cessation in other populations (Hall et al 2006)
- Has been noted that patient's within mental health service may need more support especially one-to-one support (Clancy et al 2013)
- Need to be aware of effects of quitting smoking on medication and adjust dosages if necessary

Eg. When a patient stops smoking, clozapine and olanzapine dosages may need to be reduced by 30% to 40% to avoid elevated serum concentrations and risk of toxicity (Fankhauser 2013)

- Smoking cessation in mental health services needs a multipronged approach across a continuum of care (Lawn et al 2013)

Mental Health Implications of Quitting Smoking

- Quitting smoking was associated with significant **decrease** in anxiety, mixed anxiety and depression, depression symptoms & stress & an **increase** in psychological quality of life.

- Strength of association is similar for the general populations

- Meta-analysis of the effect size for SSRI antidepressants in mild to severe depression is less than that seen for stopping smoking

- "This should reassure doctors treating patients with mental illness that cessation is unlikely to have negative effects" (Taylor et al 2014)

Smoking Cessation in Mental Health Settings

Study run in an Acute locked psychiatric ward

- Motivational tobacco cessation treatment combined with nicotine replacement
  - Psychiatric measures did not predict abstinence
  - measures of motivation and tobacco dependence did
- Cessation treatment appeared to decrease the risk of rehospitalisation
- Did smoking cessation provide a broader therapeutic benefit?

Efficacy of Initiating Tobacco Dependence Treatment in inpatient Psychiatry: A Randomized Controlled Trial Prochaska J, Hall SE, Delucchi K, Hall SM American Journal of Public Health: August 2014, Vol. 104, No. 8, pp. 1557-1565

Smoking Cessation in Mental Health Services

- Nicotine replacement therapy (NRT)
  - May require combination of patch and faster acting form and may require higher doses (Piper et al 2009)
  - Longer term use of NRT may be needed compared to general population (Horst et al 2005)
- Bupropion triples rates of non-smoking in those with schizophrenia with no adverse effects (Tsoi et al 2010)
- Varenicline - evidence to support use in Depression more so than in Schizophrenia (RCP/RCPsych 2013; NICE 2013)
- No evidence that Varenicline is associated with adverse neuropsychiatric events (Gibbons 2013).

Simple changes to address tobacco use

- Use the phrase ‘Alcohol, tobacco & other drugs’
- Modify assessment forms to include tobacco use & motivation to change
- Identify smokers/tobacco users in the clinical chart
- Make sure tobacco addiction/dependence is on the problem list
- Provide educational materials on tobacco
- Discontinue use of the term ‘smoke-breaks’

YOU = CHANGE AGENT

What can you do to move your system along the stages of change to support tobacco treatment for clients with tobacco addiction/dependence and mental health disorders?

Organisational change

- "Organisation-centred"
  - Engage practitioners at all levels
- "Needs-focused"
  - Address concerns of the particular organisation
- Flexible
  - Responsiveness to readiness for change

Amodeo et all(2006), Am J Drug Alcohol Abuse

Managing change contd.

- Develop comprehensive tobacco management policy using ENSH-Global Standards for Tobacco Free Health Services

  - **Governance and Commitment**
  - **Communication**
  - **Education and Training**
  - **Identification, Diagnosis and Tobacco Cessation Support**
  - **Tobacco-free environment**
  - **Healthy workplace**
  - **Community Engagement**
  - **Monitoring and Evaluation**

Implementing change

- Communicate policy to all staff/clients/visitors
- Get ‘Buy-in of ALL staff’
- Develop system to routinely identify ‘ALL’ clients who use tobacco
- Commence ‘Treatment of Tobacco Addiction’ for ALL clients who use tobacco at the earliest opportunity
- Identify clients with TFC policy compliance difficulties
- Develop a plan to manage same based on best practice

‘Exemption Protocol’

‘Exemption Protocol - factors’

- Best possible location to facilitate clients
- Minimise need for supervision
- Documentation required to support the protocol
- Signing-off on an exemption is a clinical judgement

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Key considerations!

- Does the client have a history of poor judgement regarding safety?
- Has the client put themselves at risk previously in relation to tobacco use?
- Has the client used tobacco without supervision previously?
- Can the client mobilise independently to the 'exemption' area?
- Is the client able to safely hold the lighted tobacco product?
- Have any visible burn marks been noted by staff on the clients clothing or hands?
- Can the client independently light their own tobacco product?
- Would the client be able to extinguish tobacco ash or a lit tobacco product if it fell onto their clothing?
- Can the client extinguish & dispose of the tobacco product completely?
- Is the client able to call for help in an emergency?
- Does the client suffer from hand tremors/shakes?
- Does the client suffer from drowsiness, syncope, visual impairment etc?

‘Exemption Protocol’

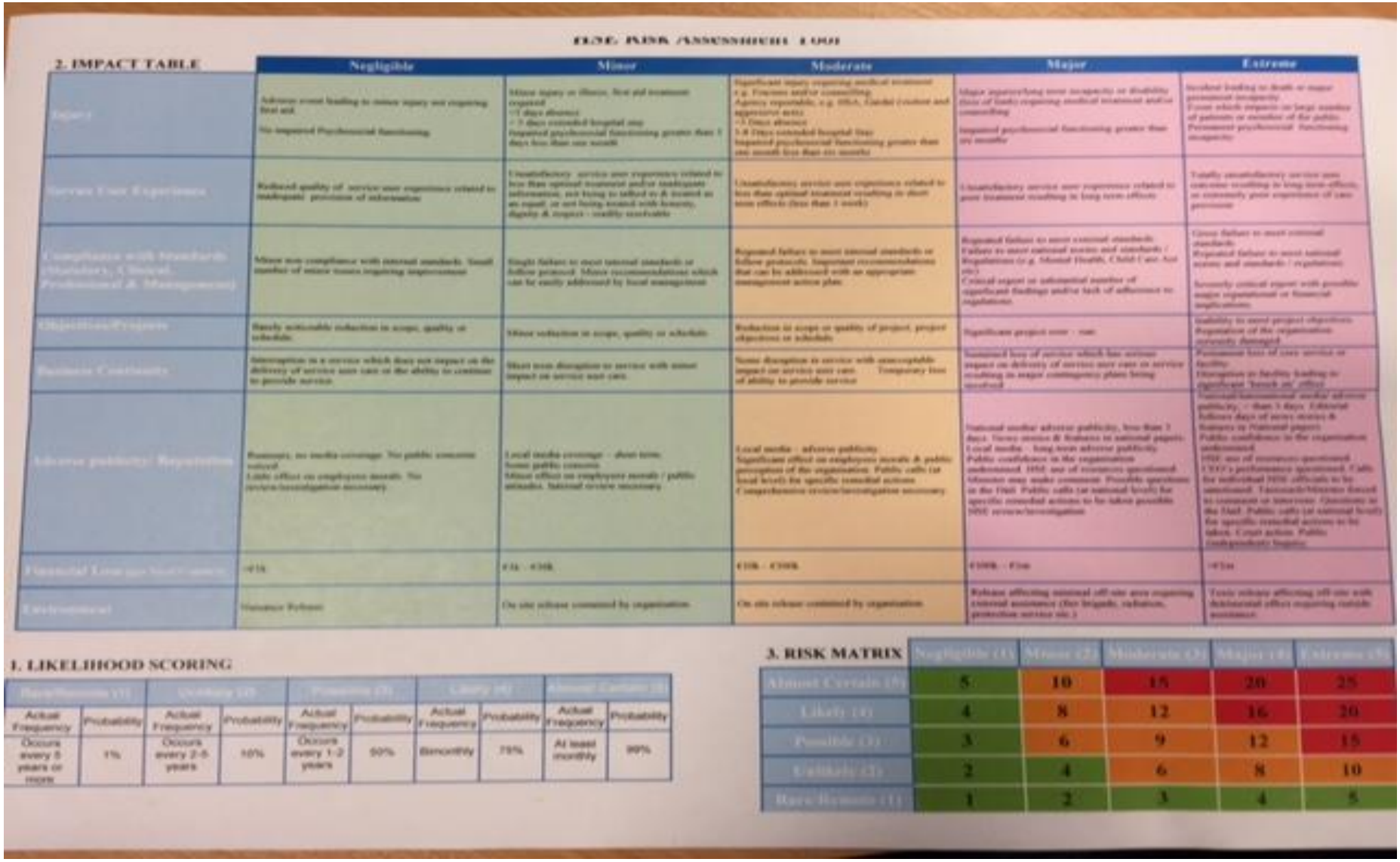
Some clients may have circumstances that will require clinical staff to make an assessment as to whether special arrangements need to be made so that the client will be permitted to use tobacco on the health service tobacco free campus at this time.

Such circumstances might include detention under the Mental Health Act, being acutely psychotic or traumatised, being unable to give informed consent for smoking cessation support or being terminally ill. This is not an exhaustive list.

Exemptions from Tobacco Free Policy

- Exemptions should be given on an extraordinary basis **only** and are solely for inpatients/residents. Blanket exemptions do not apply; each client should be assessed on an individual and case-by-case basis using a risk assessment process. All members of the multidisciplinary team caring for the client must be aware of the local exemption protocol to ensure client safety at all times.
- Signing-off on an exemption rests with either the clients' consultant or registrar or perhaps senior nursing staff outside of normal working hours.
- Consistent with the service's approach to clinical governance, exemptions must be audited by quality/risk personnel.

It is the responsibility of all clinical staff to be familiar with the exemption protocol



RISK ASSESSMENT TOOL

2. IMPACT TABLE

	Negligible	Minor	Moderate	Major	Extreme
Injury	Adverse event leading to minor injury not requiring first aid. No impaired Psychosocial functioning.	Minor injury or illness, first aid treatment required. <3 days absence. <3 days extended hospital stay. Impaired psychosocial functioning greater than 1 days less than one month.	Significant injury requiring medical treatment e.g. Fracture and/or counselling. Agency responsible, e.g. HSA, Gardaí (violent and aggressive acts). 3-8 Days absence. 3-8 Days extended hospital stay. Impaired psychosocial functioning greater than one month less than six months.	Major injury/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling. Impaired psychosocial functioning greater than six months.	Incident leading to death or major permanent incapacity. Event which impacts on large number of patients or members of the public. Permanent psychosocial functioning incapacity.
Service User Experience	Reduced quality of service user experience related to inadequate provision of information.	Unsatisfactory service user experience related to less than optimal treatment and/or inadequate information, not being treated as an equal; or not being treated with honesty, dignity & respect - readily resolvable.	Unsatisfactory service user experience related to less than optimal treatment resulting in short term effects (less than 1 week).	Unsatisfactory service user experience related to poor treatment resulting in long term effects.	Totally unsatisfactory service user outcome resulting in long term effects, or extremely poor experience of care provision.
Compliance with Standards (Statutory, Clinical, Professional & Management)	Minor non compliance with internal standards. Small number of minor issues requiring improvement.	Single failure to meet internal standards or follow protocol. Minor recommendations which can be easily addressed by local management.	Repeated failure to meet internal standards or follow protocols. Important recommendations that can be addressed with an appropriate management action plan.	Repeated failure to meet national standards. Failure to meet national norms and standards / Regulations (e.g. Mental Health, Child Care Act etc.) Critical report or substantial number of significant findings and/or lack of adherence to regulations.	Gross failure to meet external standards. Repeated failure to meet national norms and standards / regulations. Severely critical report with possible major reputational or financial implications.
Objectives/Projects	Barely noticeable reduction in scope, quality or schedule.	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project, project objectives or schedule.	Significant project over - run.	Inability to meet project objectives. Reputation of the organisation seriously damaged.
Business Continuity	Interruption in a service which does not impact on the delivery of service user care or the ability to continue to provide service.	Short term disruption to service with minor impact on service user care.	Some disruption in service with unacceptable impact on service user care. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of service user care or service resulting in major contingency plans being invoked.	Permanent loss of core service or facility. Disruption to facility leading to significant 'knock on' effect.
Adverse publicity/ Reputation	Rumours, no media coverage. No public concern voiced. Little effect on employee morale. No review/investigation necessary.	Local media coverage – short term. Some public concern. Minor effect on employee morale / public attitudes. Internal review necessary.	Local media – adverse publicity. Significant effect on employee morale & public perception of the organisation. Public calls (at local level) for specific remedial actions. Comprehensive review/investigation necessary.	National media/ adverse publicity, less than 3 days. News review & features in national papers. Local media – long-term adverse publicity. Public confidence in the organisation undermined. HSE use of resources questioned. Minister may make comment. Possible questions in the Dáil. Public calls (at national level) for specific remedial actions to be taken possible. HSE review/investigation.	National/international media/ adverse publicity, > than 3 days. Editorial follows days of news stories & features in national papers. Public confidence in the organisation undermined. HSE use of resources questioned. CEO's performance questioned. Calls for individual HSE officials to be sanctioned. Taoiseach/Ministers forced to comment or intervene. Questions in the Dáil. Public calls (at national level) for specific remedial actions to be taken. Court action. Public confidence hugely.
Financial Loss (per local cases)	<€1k	€1k - €10k	€10k - €100k	€100k - €1m	>€1m
Environmental	Nuisance Release.	On site release contained by organisation.	On site release contained by organisation.	Release affecting minimal off site area requiring external assistance (fire brigade, radiation, protection service etc.)	Toxic release affecting off-site with detrimental effect requiring outside assistance.

1. LIKELIHOOD SCORING

Rare/Remote (1)		Unlikely (2)		Possible (3)		Likely (4)		Almost Certain (5)	
Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability	Actual Frequency	Probability
Occurs every 5 years or more	1%	Occurs every 2-5 years	10%	Occurs every 1-2 years	50%	Bimonthly	75%	At least monthly	99%

3. RISK MATRIX

	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Rare/Remote (1)	1	2	3	4	5

3. RISK MATRIX

	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	5	10	15	20	25
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Unlikely (2)	2	4	6	8	10
Rare/Remote (1)	1	2	3	4	5

Key considerations

- The risk of fire hazards in smoking on campus even if smoking is outside
- The risk to staff in accompanying a client to a designated area and the loss of this person to the service for this time
- Infection control risk/interference with medical management in allowing someone to smoke (for example with drips and drains chest tubes in and disconnecting same)
- Post operative and other infection risks

Conclusion

- Smoking is a significant problem among those with mental health
- Need a consistent comprehensive approach across the continuum of care
- Smoking cessation interventions are successful in mental health settings
- Adapting a person-centred approach is the key to delivering quality care
- Smoking cessation can have physical and mental health benefits

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Thank you

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