

NAMHSCA
(National Association of Mental Health Services Consumer Advisors)

Best Practice Recommendations from a Consumer Advisor Perspective
on Mental Health Inpatient Units becoming “Smokefree”

2 July 2010

To:

Mental Health Commissioners: Dr Peter McGeorge
Ray Watson
Bice Awan

Ministry of Health: Dr David Chaplow, Director, Mental Health
Dr Janice Wilson, Deputy Director General, Population Health
Teresa Wall, Deputy Director General, Maori Health Directorate

EXECUTIVE SUMMARY:

In the absence of any prescriptive leadership regarding DHB mental health services going Smokefree, each district is approaching the matter differently in terms of time frame and definition of ‘Smokefree’. This ad hoc approach is confusing for staff, managers, service users and their families and whanau.

Accordingly, NAMHSCA offers the recommendations below as a Consumer Advisor perspective on best practice:

- to assist DHBs to implement Smokefree services, and
- to help ensure that mental health service users receive consistent, humane management of their nicotine dependence.

The recommendations are congruent with the Ministry of Health’s target for offering hospitalised smokers advice and support to quit.

Recommendations:

1. **Smokefree begins in outpatient / community settings**
 - a. Assessments routinely include nicotine dependence
 - b. Support and assistance is offered for quitting
 - c. Advance Directives are made to cope with Smokefree as an inpatient

2. Consistency

- a. Clear and agreed understanding of a service's definition of 'Smokefree'
- b. Organisational preparedness for Smokefree
- c. Clear consistent information and training for staff
- d. Training includes psychiatrists and registrars
- e. Information widely available for stakeholders

3. Therapeutic engagement and support is available in inpatient units

- a. Recovery plans for managing dependence
- b. Smoking cessation support groups
- c. Support and therapeutic engagement available at weekends and in the evenings

Yours faithfully



Te Wera Kotua & Fiona Clapham Howard
Co-Chairs

On behalf of NAMHSCA members present at the May 2010 meeting in Wellington

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on Mental Health Inpatient Units becoming “Smokefree”

The members of NAMHSCA¹ acknowledge the negative impact that smoking has on physical health. We also acknowledge the disproportionate burden of smoking on people with mental illness².

We note that the revised health targets announced last year by the Minister of Health include ensuring that hospitalised smokers receive help and advice to quit.

As District Health Boards (DHBs) move to meet these targets, most are also moving to implement Smokefree mental health inpatient units, so that the hospitals can be entirely Smokefree. NAMHSCA acknowledges the work done so far in DHBs to prepare for this transition, and in some cases, to implement it already.

However, in choosing to dispense with the exemptions for mental health inpatient units under the Smokefree legislation, a number of concerns arise which NAMHSCA wishes to highlight, and potentially mitigate with a series of recommendations.

One such concern is the lack of choice in going Smokefree for the many service users who are detained in inpatient units under the Mental Health Act. We note, therefore, the risk that inpatients in the most restricted situations (for example, in locked units, or without leave) will bear the brunt of Smokefree initiatives.

While smoking has not been proven to be an inviolable human right, the practice of not permitting involuntary patients to smoke does extend the debate into the arena of human rights and tino rangatiratanga.

¹ NAMHSCA members are individuals/‘lead consumer advisor(s)’ who are directly employed by or contracted to a DHB to provide a consumer perspective to the Mental Health Service, provider arm. Membership also recognises the Maori and Pacific Island ‘lead’ advisors’.

NAMHSCA. (2007). *Terms of Reference*. Wellington, New Zealand: Author

² A high proportion of people with mental illness smoke. Studies estimate at least one-third of tobacco products sold in New Zealand are sold to people with a diagnosis of mental illness.

Tobias M, Templeton R, Collins S. 2008. How much do mental disorders contribute to New Zealand’s tobacco epidemic? *Tobacco Control*. Published online 31 July 2008.

<http://tobaccocontrol.bmj.com/cgi/rapidpdf/tc.2008.026005v1> Accessed 15 September 2008.

This aspect of lack of choice regarding one's 'home' is acknowledged and addressed in the Smokefree legislation, with patients in hospital care institutions, residential disability care institutions, and rest homes permitted to smoke in "dedicated smoking rooms"³. Even prisoners are permitted to smoke in their cells under this legislation as it currently stands.

We are supportive of the elimination of exposure to second-hand smoke for staff and non-smoking service users, and do not advocate for indoor smoking rooms. However, we struggle with the implications of DHBs' insistence on completely Smokefree premises and grounds: patients under the Mental Health Act will have nowhere to go to smoke, while voluntary patients can choose to continue their habit by leaving the grounds to smoke.

Furthermore, because of a widely held perception that Nicotine Replacement Therapy (NRT) is only available for those who are quitting, a very real possible outcome for many people – already in considerable distress – is that they will also be forced to reduce their intake of a highly addictive substance on which they depend.

We believe that receiving advice and help regarding quitting smoking, while important, is not the most important priority when a person in acute mental distress has been admitted to a mental health inpatient unit.

Another area of concern is the difficulty inherent in defining what is meant by 'Smokefree mental health inpatient units'. Already, some of the DHBs whose inpatient units have become 'Smokefree' are reporting different approaches across their services to tobacco products, lighters, matches and enabling service users to smoke, depending on which unit a person is admitted to, and under which circumstances (e.g. voluntary or involuntary status). This creates ambiguity for staff, service users and families and undermines the overall Smokefree intention.⁴

In the absence of any prescriptive leadership from the Ministry of Health regarding DHB mental health services going Smokefree, each district is approaching the matter differently in terms of time frame and definition of 'Smokefree'. This ad hoc approach is confusing for staff, managers, service users and their families and whanau.

Accordingly, NAMHSCA offers the recommendations below as a Consumer Advisor perspective on best practice:

- to assist DHBs to implement Smokefree services, and
- to help ensure that mental health service users receive consistent, humane management of their nicotine dependence.

The recommendations are congruent with the Ministry of Health's target for offering hospitalised smokers advice and support to quit.

³ Smoke-free Environments Amendment Act, 127 Stat. N.Z. § 5-6A (2003). Retrieved online 24 November 2009. <http://www.legislation.govt.nz/act/public/2003/0127/latest/DLM234940.html>

⁴ Flinders University, 2008. *Smokefree Initiatives in Psychiatric Inpatient Units: a National Survey of Australian Sites*. Adelaide: Author.

Recommendations:

1. Smokefree begins in outpatient / community settings

- a. **Assessments routinely include nicotine dependence.** Substance dependence is already required to be part of a standard mental health or addiction assessment, but services have historically turned something of a blind eye to cigarettes. We recommend that assessment for nicotine dependence becomes routine practice for all outpatient / community mental health service users as part of a comprehensive mental health assessment.
- b. **Support and assistance is offered for quitting.** Following assessment, those service users who are identified as having a nicotine dependence and wanting to quit, are offered information, advice, support and encouragement to do so. This can include NRT, and can also form part of the goals of the service user's recovery plan.
- c. **Advance Directives are made to cope with Smokefree as an inpatient.** Service users who smoke and don't want to quit are assisted by community staff to make an Advance Directive detailing the kind of NRT and other supports they will need if they have to go into a Smokefree inpatient unit in the future.

[See also 3.a. below – Recovery plans for managing dependence.]

2. Consistency

- a. **Clear and agreed understanding of a service's definition of 'Smokefree'.** This should include whether service users who don't wish to quit permanently but cannot leave the premises:
 - i. will have their nicotine dependence managed with NRT, or
 - ii. will be facilitated to continue smoking. For example, will staff escort service users off-site for smoking?

Whatever a service decides it means by 'Smokefree', that decision and its implications need to be discussed and agreed by all involved, including staff, management, service users, family, whanau and other agencies that interface with the inpatient units.

This may also mean addressing the approach to management of tobacco products, lighters, and matches to ensure it is congruent with other items of risk and/or value within mental health inpatient units, and across services.

- b. **Organisational preparedness for Smokefree.** Policies, procedures, protocols, systems and structures are in place to ensure staff and management can effectively and humanely implement and maintain the agreed definition of 'Smokefree'. Non-punitive approaches towards service user 'breaches' are strongly recommended.

An acknowledged transition period is also recommended as staff, service users and visitors all adjust to the new culture; staff 'breaches' during this time should also be managed with non-punitive approaches.

All staff are trained around policies, procedures, protocols etc before Smokefree is implemented. Regular updates or refreshers could be considered as part of ongoing mandatory staff training, and for orientation of new staff.

- c. **Clear consistent information and training for staff.** Staff, particularly in inpatient settings but also in community teams, have access to information about NRT and quitting smoking that is consistent across units, divisions and DHBs. Information and training needs to include:
 - iii. The range of NRT options available
 - iv. The methods of using different NRT options e.g. nicotine replacement gum requires a particular chewing technique to be effective; lozenges should be sucked then "parked" in the cheek, not chewed; etc
 - v. How to administer NRT for people who are not yet quitting but who are in distress and experiencing enforced withdrawal ('temporary cessation')
 - vi. The effect of nicotine on psychotropic medication and mental distress e.g. some cessation treatments such as Champix may increase depression symptoms; therapeutic dosage of some psychotropics such as Clozapine can decrease when nicotine is reduced or eliminated
- d. **Training includes psychiatrists and registrars.** Doctors receive the same information and training around NRT as the rest of the multi-disciplinary team (MDT), and preferably at the same time; MDTs are in agreement about delivering the organisation's overall approach to NRT.
- e. **Information widely available for stakeholders.** Service users and their families, whanau, supporters and other agencies have access to appropriately worded information that is consistent both with the organisation's overall approach and units' delivery of this in practice.

3. Therapeutic engagement and support is available in inpatient units.

- a. **Recovery plans for managing dependence.** All nicotine-dependent individuals have a recovery plan that includes support for managing their dependence whilst in a Smokefree unit. Support can include one-to-one coaching, groups and/or peer support as well as NRT.

[See also 1.c. above - Advance Directives made to cope with Smokefree as an inpatient.]

- b. **Smoking cessation support groups.** Groups are run for inpatients offering advice on quitting, information and support options. Staff who wish to quit smoking may participate also.

- c. **Support and therapeutic engagement available at weekends and in the evenings.** Groups and other supports are not just provided from Monday to Friday. A range of meaningful activities is provided to help distract from and replace nicotine dependence.