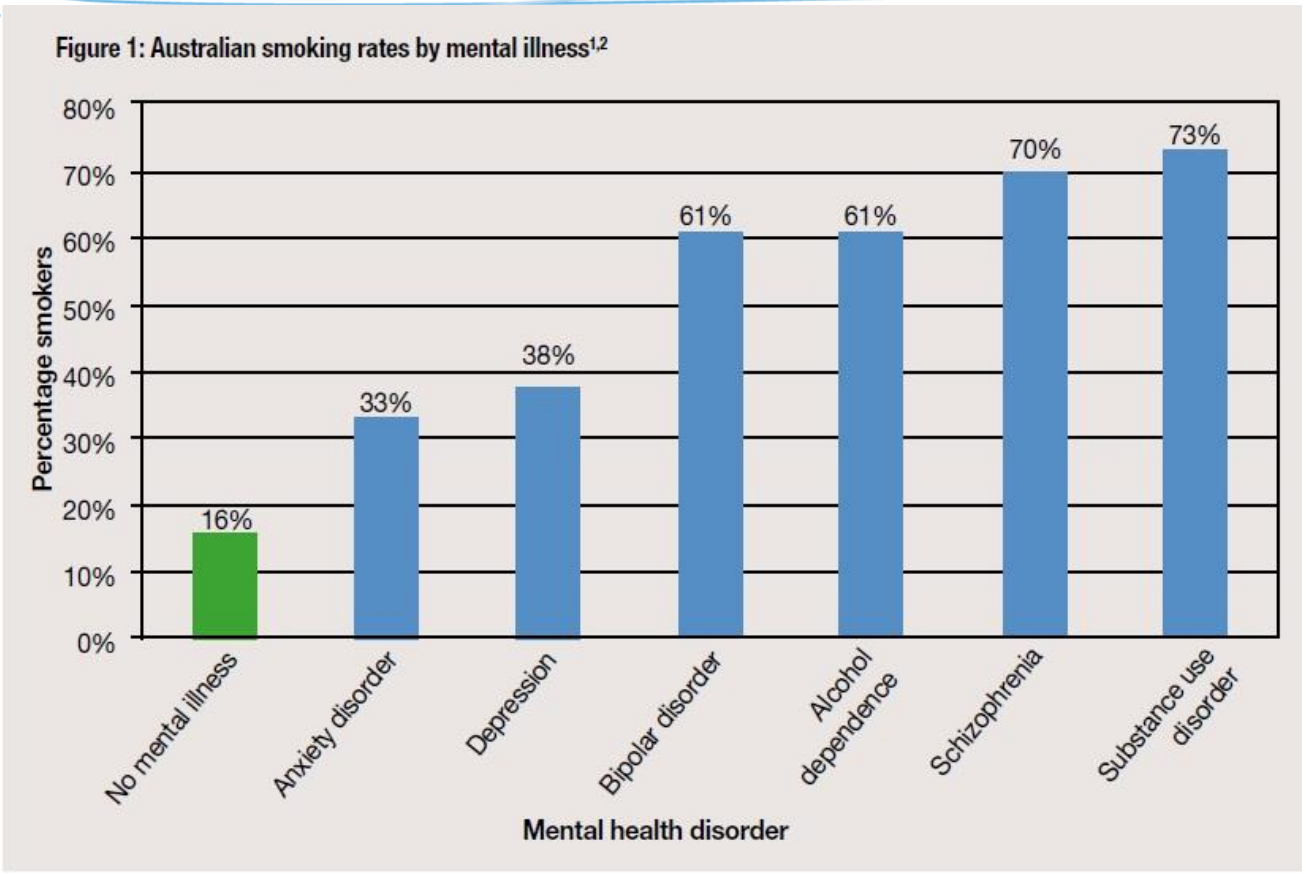
Road to recovery – enablers and barriers to tackling tobacco in mental health services

19 May 2016

Disproportionately high smoking rates



Australian Doctor, How to Treat, *Helping smokers with mental illness*, 2 October 2015

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Physical health and smoking

- Smoking is the most significant contributor to poor physical health in people with mental illness

- Lower life expectancy - Australian men with mental illness live 16 years less and women live 12 years less

People with mental illness or a lived experience of mental illness are more likely to die from smoking-related diseases than as a result of their mental illness

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Mental health and smoking

- Smoking increases the risk of mental illness
- Nicotine-dependent smokers have twice the risk of attempting suicide compared to non-smokers
- Smoking increases the required dose of some medications, e.g. benzodiazapines, clozapine, fluvoxamine
- The stress paradox – smoking **increases** stress

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…and increases social and financial inequities

- Denormalisation of smoking in the general population means smokers are increasingly experiencing social stigma
- A cigarette addiction is expensive ($,000s per annum)
  - “every disability support pension payment is predominantly spent on cigarettes” (report from mental health service staff)
- Households with smokers are 3x more likely to experience severe financial stress and report going without meals or being unable to heat the home

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Common quitting/mental health myths

Myth 1: PMI are not interested in quitting

→ **Fact**: just as motivated to quit and attempt to quit as frequently

Myth 2: Smoking is the “least of their problems”

→ **Fact**: Smoking increases health, financial and social disparities

Myth 3: PMI just cannot quit

→ **Fact**: PMI can quit, and stay quit, with the right support

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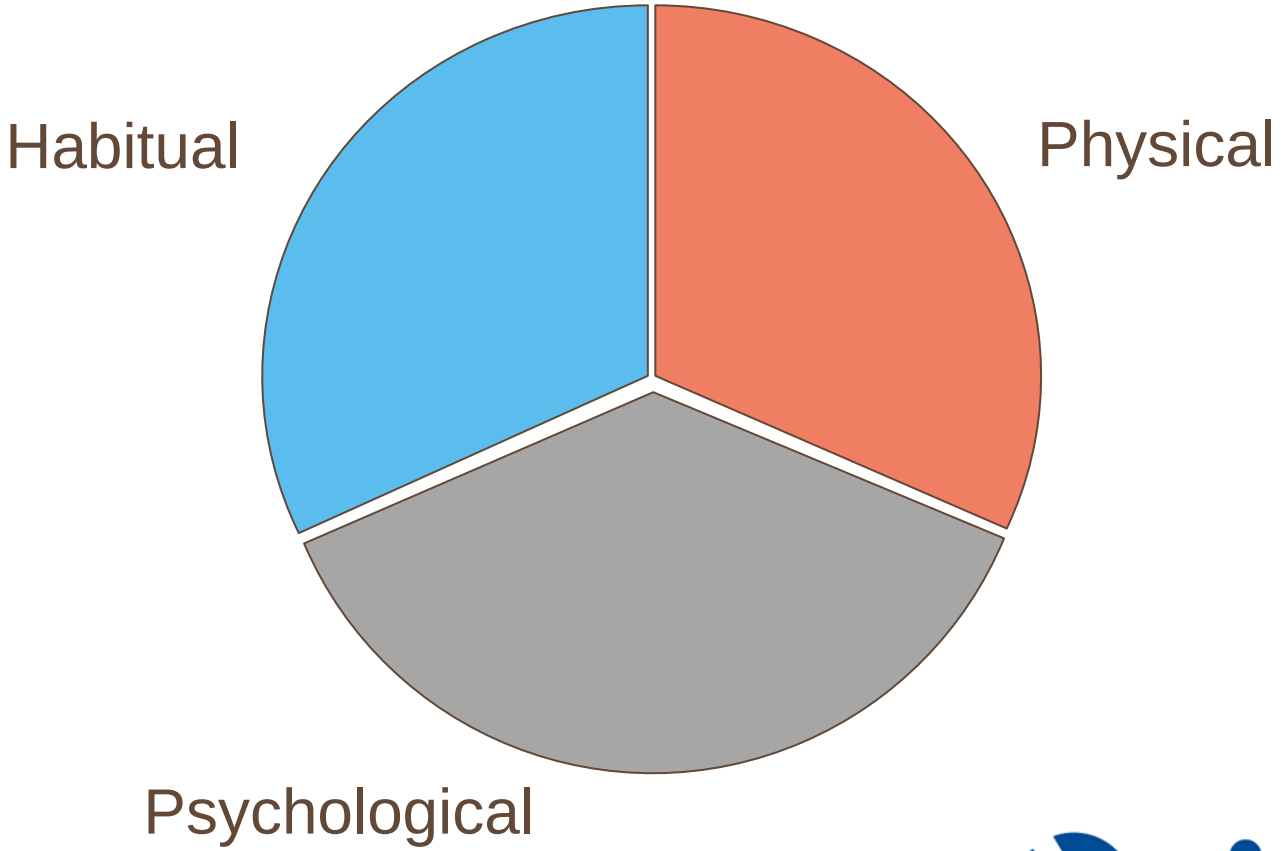
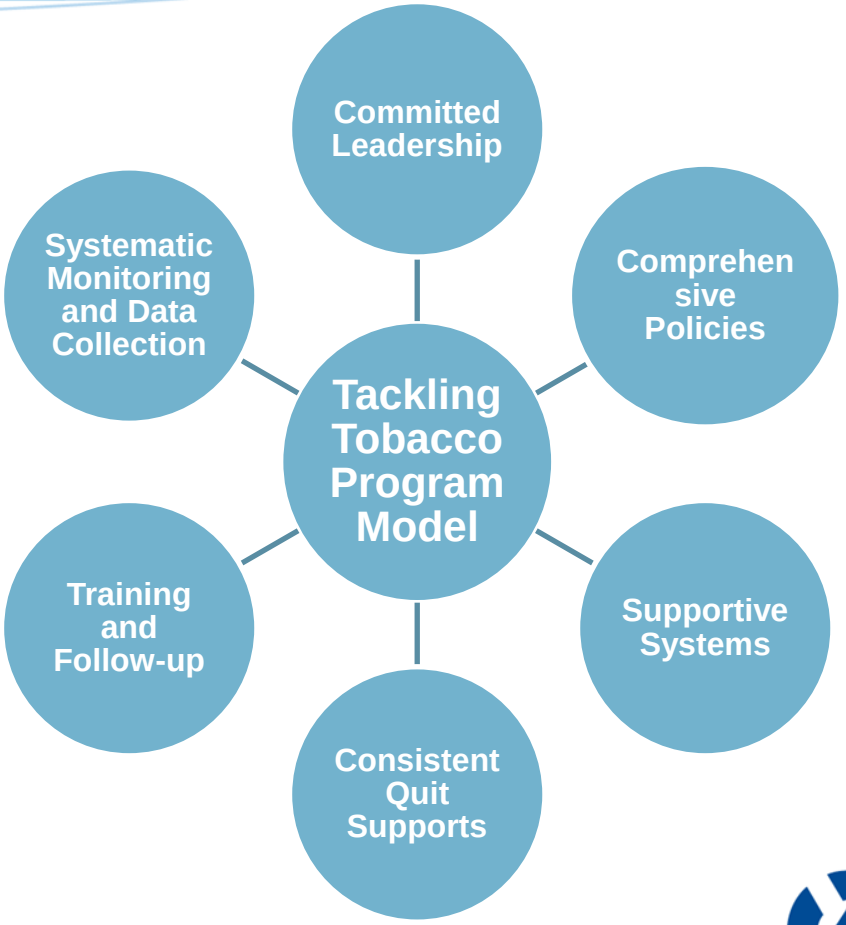
What is a smoking addiction?



The Tackling Tobacco Framework



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The ideal model

(based on theTackling Tobacco Framework)

1. Committed leadership

- Committed executive enabling and/or facilitating the model
- Committed and active champions at the frontline
- Committed peer leaders?

2. Comprehensive policies

- Smokefree policies
- Screening policies
- Referral policies
- Care pathways

3. Supportive systems

- Physical system – environment, signage, games
- Cultural systems – rewarding staff, reducing social aspects of smoking
- Processes – for example, the inclusion of smoking cessation information on induction

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The ideal model
(based on theTackling Tobacco Framework)

4. Training and follow up

- Staff with confidence, attitude and knowledge to promote quitting and offer effective support
- Tailored resources to support staff, carers, families and consumers

5. Consistent quit supports

- Every smoker has a documented care pathway
- Consumers are encouraged by staff, peer mentors and the physical environment to be tobacco-free
- Referral to Quitline or other cessation services, and prescription of NRT, is standard care

6. Systematic monitoring and data collection

- Data on smoking status, quit attempts, cigarettes consumed, smoking intentions and therapeutic interventions are routinely captured

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The Tackling Tobacco Pilot in Victoria
Project phases

Phase 1 – **Consultations**

- Explore the enablers, barriers and requirements and develop site-specific workplans

Phase 2 – **Piloting**

- Pilot model over an 18 month to 2 year period

Phase 3 - **Modifications and continual improvement**

- Monitoring to determine whether changes are embedded into routine practice

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Phase 1 – Consultations

- Three mental health services will pilot the model across multiple sites
  - Eastern Access Community Health (EACH)
  - Orygen Youth Health
  - Melbourne Health (CCU Broadmeadows, NAMHS Community Team North Epping, SECU Sunshine)

- Results of the consultations are in and workplans are being developed

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What the consultations have shown

1. Committed leadership	• Committed executive but not all yet enabling or facilitating • Passionate front-line staff but limited training and resources
2. Comprehensive smoking policies	• Inconsistency in promotion and enforcement of smokefree, screening and referral policies • Different sites/programs have different approaches to screening and referral • Few agreed care pathways
3. Supportive systems	• Apart from ‘No smoking’ signage, little in the physical system is supportive of a tobacco-free environment • Cultural systems support continued smoking • Very few processes appear to support quitting

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What the consultations have shown (cont.)

4. Training and follow up

- Training in brief interventions and NRT required
- Lack of resources to support staff delivering interventions
- No tailored information for staff, families, carers or consumers

5. Consistent quit supports

- Consumers infrequently/inconsistently asked about their smoking and offered help to quit
- No standard referrals to Quitline/other cessation services
- No system for clients to access pharmacotherapies

6. Systematic monitoring and data collection

- Inconsistent data collection and evaluation of how smoking is addressed
- No established systems to routinely monitor if consumers are offered smoking care or whether they succeed

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Next Steps

- **Complete co-designed workplans**
  - These workplans will set out how to address each of the framework's elements within the context of each site/organisation

- **Training and resources**
  - Co-develop training and other resources for staff to support their work
  - Co-develop information for staff, carers, families and consumers that uses a recovery-oriented approach and that sets out the benefits of quitting

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Beyond the pilot

- **Sharing tools and learnings**
  - Online community of practice group open to sites not in the pilot?
  - Email newsletter (project updates, new publications, new tools) for all interested people?

Conclusion

1. People living with mental illness want to stop smoking and they do attempt to quit
2. It is likely they are not getting the support – from the people and environments around them – that they need to succeed in their quit attempts
3. Barriers to organisational changes that will support quit attempts are known and can be overcome

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THANK YOU!

Any Questions?

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