FLINDERS UNIVERSITY
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Australia: The Healthiest Country by 2020: National Preventative Health Taskforce

Making Smoking History

Submission

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Table of Contents

1. INTRODUCTION..... 3

2. RECENT RESEARCH..... 4

3. GOING SMOKE-FREE..... 7

4. SPECIFIC RESPONSES TO NATIONAL PREVENTATIVE HEALTH TASKFORCE QUESTIONS..... 9

5. CONCLUSION..... 11

5. REFERENCES..... 12

1. Introduction

This submission will focus on the issue of smoking within mental health service systems and the consequent need for education and training by staff, support for people with mental illness generally, and support to improve the system's response to this issue. This will also incorporate more general responses to the consultation questions.

Direct causal links between smoking and onset and exacerbation of multiple health problems is well established. The World Health Organization (2006) estimated that tobacco consumption accounted for 5 million deaths worldwide in 2006 and that this figure will double by 2020. In the current climate of growing concern for the harmful effects of cigarette smoking and passive smoking the high prevalence of this activity within psychiatric settings can no longer be ignored. Those with mental health problems smoke significantly more and consequently experience greater smoke-related physical harm than the general population. Many people with mental health problems continue to receive care within health systems that largely condone or actively reinforce their smoking or which continue to place support to quit in the 'too hard basket'. This situation is unacceptable and will only serve to widen the social disparities that already exist for many people with mental health problems. Support for system reform is needed, alongside the many community reforms suggested by the Taskforce. Without one acknowledging the role of the other, little will change for this group regarding quit rates and initiation into smoking.

Globally, tobacco is the leading risk factor for disease burden (Houston & Kaufman, 2000). Of those who smoke regularly, one in two die 15 years early and one in four dies 23 years early (Doll *et al*, 2004). Exposure to environmental tobacco smoke also increases the risk of lung cancer and ischaemic heart disease by up to 25% (Scientific Committee on Tobacco and Health, 2004) with heavy passive smoking associated with a 50- 60% increase in the risk of coronary heart disease (Whincup *et al*, 2004).

Smoking prevalence is among the highest for people with mental illness who are in psychiatric units where up to 70% are smokers and 50% heavy smokers (Jochelson & Majrowski, 2006) with rates of smoking lower for those patients living at home. Smokers with mental health problems are also heavier, more dependent smokers and have smoked longer than smokers in the general population (Kumari & Postma, 2005). The high prevalence of smoking amongst all people with a mental illness is a major public health problem.

Links between smoking and higher premature death rates from all major physical health conditions have been noted for this group when compared to the general population (Brown, Birtwhistle, Roe, & Thompson, 1999; Coglan, Lawrence, Holman & Jablensky, 2001). This has resulted in much greater smoking-related morbidity in those with mental illness with a diagnosis of schizophrenia increasing risk of death from respiratory disease ten times more than for the general population (Joukamaa *et al*, 2001). Since one in two regular smokers dies 15 years prematurely (Doll *et al*, 2004), at least 50% of those with mental illness who persist in regular smoking will die prematurely from smoking related diseases. The increased risk of many smoking related diseases is responsible for a large proportion of the excess natural mortality of those with mental health problems (Brown *et al*, 2000).

As well as impacting on physical health, smoking increases the risk of first developing a mental health problem (Cuijpers et al, 2007). Smoking is associated with an increased prevalence of all mental illness (Farrell et al, 2001) and higher suicide rates (Malone et al, 2003). A clear relationship exists between the amount of tobacco smoked and the number of depressive and anxiety symptoms; however, symptoms reduce after cessation and wellbeing improves, with anxiety reducing as soon as one week after cessation (Campion et al, 2008a).

Despite those with mental illness being about twice as likely to smoke, they are also less able to stop smoking (Lasser et al, 2000) despite half of smokers with mental health problems in the UK expressing a desire to stop smoking (Jochelson & Majrowski, 2006). Smoking cessation medication and other non-pharmacological support such as support and advice from individuals or groups, healthcare professionals or via the telephone/internet, can increase abstinence rates in those with mental health problems to as high as those in the general population (Campion et al, 2008b, Foulds et al, 2006). Smoking also increases the metabolism of a number of medicines, including anti-depressants and anti-psychotics, meaning that larger doses may be required. However, significant reductions in the medication dose may be needed following cessation (Campion et al, 2008b).

The culture of smoking in psychiatric settings is perceived to be an entrenched process that has been central to the history of mental institutions with the development of asylums and their evolution into our current psychiatric inpatient facilities. Tobacco rations were an assumed part of day to day life in many such institutions (Shlomowicz, 1990). The idea of imposing smoking bans in psychiatric settings is thought to be a recent phenomenon though there is clear evidence from a number of 19th Century documents that this is not entirely so (Gellar & Kaye, 1999; Pinta, 1991). The British College of Physicians and US Surgeon General reports of the 1950s and 1960s highlighted the physical harms of smoking and triggered a new wave of concern. These reports eventually influenced and prompted a number of US psychiatric institutions to introduce smoking bans from the late 1980s and early 1990s. Concern about smoking within psychiatric facilities is now an international phenomenon with mental health services in many countries recognising that more needs to be understood about this population. For too long, the mainstream health system and the mental health system has ignored this population. A particular quote from a senior mental health worker who was involved in the ethnographic research I undertook some years ago sums up the overall neglect and the underlying values and forces that have shaped this neglect of this population. This and other views/values continue to pervade the sector from within and from outside the mental health system:

'In my heart of hearts, with patients with schizophrenia, I feel that they haven't got much left for them, so good luck to them. If they want to smoke, let them'

2. Recent Research

People with mental illness can quit smoking but they need consistent support and systems of care that understand this. The introduction of smoke-free policy in psychiatric units is possible but needs to be a carefully planned process involving all parties affected by the bans with consistency, co-ordination, and full clinical and administrative support for smoking bans. In the UK, this has begun with the recent release of the NHS document "Where Do We Go From Here", which discusses management responsibilities, staff responsibilities and setting realistic goals for tobacco control within psychiatric settings (Seymour, 2004). Further UK guidance was developed to support mental health trusts to implement smoke-free policies, working with staff and patients to overcome their concerns (McNeill & Owen, 2005). Other examples are the Canadian Tobacco-Free Living toolkit available from the National Association of State Mental Health Program Directors (NASMHPD, 2007). Systematic guidelines for successful introduction of smoke-free policy based on the Australian experience would be useful.

A previous systematic review of the existing research in this field (Lawn & Pols, 2005) revealed a number of core principles required for successful implementation of smoke-free policy in psychiatric inpatient units. More recently, an independently conducted national audit involving more than 50% of inpatient mental health units (Lawn & Campion, 2008) confirmed the

applicability of these core principles which included the importance of clear and consistent leadership, team cohesion across professional disciplines, effective use of Nicotine Replacement Therapy (NRT) and incorporation of nicotine withdrawal management into routine clinical management, preparation, education and training of staff, and the importance of staff smoking status. This survey also found that smoke-free policy is possible within psychiatric inpatient settings, but that a number of core interlinking features are important for success and ongoing sustainability. The report is intended to provide a framework and context for Australian Guidelines and to further assist those mental health services that are considering becoming smoke-free, both in Australia and elsewhere. The report is provided as an attachment to this submission for further information.

The findings of the report are summarised below for convenience. Their relationship to the taskforce recommendations will be discussed here also.

Summary of Key Report Findings

Planning time:
Increased success in policy implementation was evident in sites that took more than 6 months to plan their smoke-free initiative compared to sites that took less than 6 months. This has implications for resource management and support that may be given to these settings.

Combination NRT provision:
There was improved success of smoke-free initiatives where there was provision of a combination of NRT products to patients and matching it with individual patients' withdrawal needs.

This has implications not only for supply and how hospital pharmacies respond, but also for staff and patient education and for coordinated discharge planning into the community. Further implications exist for community staff, GPs and people with mental illness regarding education, costs, PBS processes, etc.

Leadership:
Clear, consistent and visible leadership was associated with success of smoke-free initiatives.

It is time for these people to lead and have the courage to do so and the support to do so.

Teamwork:
Cohesive teamwork was associated with success of smoke-free initiatives.

Fragmentation caused by uncertainty, staff retention problems, poor skills base and other issues needs attention.

Education/ training:
Education and training was associated with smoking policy status, with smoke-free sites being more likely to have extensive or standard education and training provided to staff, and failed sites or those not considering going smoke-free more likely to had provided none or minimal training to staff.

This is a critical issue for mental health staff, GPs, PHC workers, and all support workers and organisations that support people with mental illness. Staff need to know about NRT with the same level of knowledge that they have about other treatments. For too long they have used tobacco the help clinically manage patients agitation, boredom and distress (Lawn & Pols, 2003). This is true in hospitals and in the community. It has implications for others like GPs and community supports.

Staff smoking rates:
There was a relationship between staff smoking rates and failure of smoke-free initiatives.

Any staff working in health-related fields need support to address their own tobacco use, given their roles as role models to others and their clinical roles in helping people manage their health. This does not only apply to mental health staff. Mental health nurses have had a long history of high rates of smoking and in many settings, have become as institutionalised as the mental health patients they serve (Lawn & Condon, 2006).

Staff NRT provision:
A positive association was found between whether NRT was offered to staff and units' smoke-free status.

Health services generally could do more in this regard to build 'healthy' systems and workforce.

Staff smoking cessation:
Better quality leadership, education and training, and teamwork played an important role in supporting staff to quit smoking.

This strongly supports the notion that ad hoc and isolated measures are not adequate. It's time to have a clear overall plan with all those involved on the same page.

Enforcement:
The presence of enforcement increased success of smoke-free policy.

Linked to this is support for health workers to know and understand how to do this in practice in ways that engage patients effectively whilst also operationalising policy effectively. Token efforts are dangerous for morale and create confusion, distrust and frustration.

Locked/ open status:
No association was found between locked and open status and smoking policy status.

Geographical:
Regional sites may be more successful at implementing smoke-free policy than urban sites.

HDU access:
No association was found between access to High Dependency Unit access and success of smoke-free policy.

When staff were adequately trained to help patients to manage distress and withdrawal they were effective regardless of where they were situated within the system.

3. Going Smoke-free

The following points are provided as a checklist of the most salient lessons to emerge from the above research. Many of these suggestions are important for any change process. Formal smoke-free guidelines are yet to be developed for the Australian context. This checklist provides a starting point.

Preparing for Smoke-free Policy

- Provide leadership that is clear, consistent and routinely visible and accessible to clinical staff and actively role models the desired change.
- Build and maintain team cohesion around the change. Be inclusive of all staff groups and disciplines as part of broad and meaningful consultation.
- Understand the nature of the population served and implications for your service and clinical practice.
- Understand the organisational culture and practices of staff and your service.
- Support as many staff as possible to quit smoking in the months prior to implementation of smoke-free policy. Encourage nursing leaders to lead this process by example. Provide free or subsided NRT to staff smokers as part of their employment.
- Support clinical change champions from within the staff group that will be directly implementing and enforcing smoke-free policy. Recognise the importance of nursing leaders in this process.
- Allow at least 6 months for planning and preparation of the field. Allow at least a further 6 months post implementation support to the unit and understand that ongoing monitoring and support may be needed to sustain the change and check any reversals in progress. Integrate this into service management for the longer term.
- Understand that smoke-free policy is a process not an event.
- Understand and assess the education and training needs of clinical staff. Ask them what they need. Provide all clinical staff with education and training that moves beyond didactic information about the harms of smoking and the broad concerns about smoking for mental health populations. Actively assess what staff know and what they do not know, how they want training to occur and enlist their peers to lead its planning and delivery. Provide on the job training in the ward where staff can practice their skills and receive feedback. Model the skills that you want staff to develop.
- Consider the timing of education and training so that it remains relevant to staff when they need to put it into practice.
- Look at the physical environment of the unit and get advice on how it may be altered to foster non-smoking.

Implementing Smoke-free Policy

- Choose a smoke-free implementation date that will be feasible and minimise adverse impacts for patients and staff. Consider other events, activities and demands to avoid overloading staff. Choose a salubrious time of year.
- Enlist support from consumer groups, consumer consultants who may be working on the unit, and carers/family.
- Recognise the interdependence of smoke-free strategies. Understand the unit's attempts to be smoke-free mirror the individual's attempt to quit smoking. It requires patience, diligence, persistence, consistency, encouragement and support and a range of strategies at

ones disposal. Beware of the 'honeymoon' period and relapse risk if staff are not diligent and work cohesively as a team.
- Address splitting and undermining behaviours by staff individuals without delay. Don't let grievances fester over time.
- Think through the practical aspects of storage of cigarettes and lighters while the patients are on the ward. Sort processes for leave, Develop processes for keeping track of NRT prescription and distribution to patients. Make this part of general medication monitoring and tracking processes. Ask clinical staff involved in completing paperwork and handling NRT what they feel would work best.
- Learn from the National Seclusion and Restraint project. Recognise that the skills and options for this project closely connect to management of nicotine withdrawal. Review the level of diversional activities offered to patients and ask them what they think would help with nicotine withdrawal. Consider cooking and music groups.
- If staff turnover is an issue, ensure that core staff are supported to provide a consistent approach.
- Make monitoring of progress of the policy a routine item for clinical staff in the unit. Encourage them to lead the process of finding solutions to issues as they arise.
- Have a clear layer of response options for staff to implement as part of their interactions with patients who are smokers. Staff need to feel supported by the team; they need to know that any difficulties will be the team's responsibility to resolve and that this will be done consistently and promptly.
- Consider rotating staff between open and locked settings to maximise skill sharing, exposure to learning how to support highly distressed patients, and to promote consistency of approach to patients.
- Provide dedicated staff in the unit to support the staff team for at least 6 months post implementation, acknowledging that staff will need a level of ongoing support to problem-solve issues as they arise beyond delivery of education and training as part of preparation for the policy. Encourage staff to share their learning and to model effective strategies for interacting with agitated patients with their peers. Show them how to respond in collaborative, non-confrontational ways that minimise patient distress.
- Prime community clients, staff and related services. Communicate the policy.

NRT Management

- Consider seeking clearance for nursing staff involved in emergency admission to have capacity to undertake one-off prescribing of NRT to patients to avoid any delays during the admission process.
- Use a combination of NRT tailored to the individual and their experience of nicotine withdrawal.
- Consider patches primarily with other forms of NRT used in conjunction with patches for acutely unwell patients, as needed. In particular, inhalers and lozenges will likely provide more immediate relief and oral comfort for patients awaiting transfer from the emergency department to the ward.
- Use more than one patch if needed and monitor effectiveness routinely with the patient.
- Routinely assess the effectiveness of NRT as part of clinical management support to the person during their stay in hospital. Make this part of clinical management along with other treatments and team decision-making processes.
- Provide dedicated project staff or clear staff change champions who can provide ongoing direct and administrative support for the change process for at least 6 months post implementation of the smoke-free policy.

4. Specific Responses to National Preventative Health Taskforce Questions

The needs of people with mental illness are noted in Technical Report No.2 and many dimensions of the problem of smoking and multifaceted responses are suggested within the report. Clearly, the Taskforce has achieved much in bringing together this important report. Please do not forget the needs of people with mental illness. They are not a mere minority group. In Australia, 40% of smokers have a mental illness (Access Economics, 2007). In the US, 45% of all cigarettes are smoked by people with mental illness (Lasser, et al., 2000). In Australia, this figure is more than 42% for people with mental illness (Access Economics, 2007). Social disadvantage and smoking go hand in hand Jarvis & Wardle, 2005) and this is likely to be an increasing trend as these groups increasingly and disproportionately make up those who continue to smoke, whilst those who are more able will successfully quit. Tobacco control strategies on their own are clearly inadequate and will be increasingly so.

I support all the actions proposed in the report. However, like any action, I ask that a full consideration of the potential negative unintended consequences be made and the necessary further actions be taken to minimise these negative consequences for people with mental illness.

Increasing Tax on Tobacco

A recent editorial discussed a number of issues related to this action; the evidence supporting it but also its potential adverse consequences for people with mental illness (Lawn, 2008). From that editorial:

Chapman (2003) has argued for increased tobacco control, stating that those who see tobacco as a legitimate product and tobacco control as jeopardising the financial benefits gained through tobacco excise are ill-informed regarding its social costs and the ethics of continuing to support its revenue-raising role. However, the price and demand relationship of some commodities may be very elastic for some groups within the population, that is, raising taxes on them will not necessarily lead to reduced demand for those commodities. People in lower socioeconomic groups have previously been found to quit smoking more in response to price rises than those with higher disposable incomes (Chapman, 1995; Townsend, Roderick & Cooper, 1994; Wasserman, et al., 1991). A global report by the World Bank (Jha & Chaloupka, 1999) found that raising taxes on tobacco by 10% would lead to a 4% reduction in demand for cigarettes in high income countries and an 8% reduction in demand in low income countries. In a review of thirty-five years of policy on tobacco consumption, Bardsley and Olekalns (1999) argued that increasing the price of cigarettes has had the greatest impact on consumption declining, with education and reduced advertising having minimal effects. However, their conclusions are strongly challenged by other researchers on methodological grounds (Bardsley & Olekalns, 1999; Borland, 1999). Raising taxes is clearly effective in reducing consumption and is also thought to discourage children and adolescents from commencing smoking, although some researchers have raised questions about the efficacy of this approach with adolescents (Doran, Girgis & Sanson-Fisher, 1998).

Unfortunately, where government taxes on tobacco have increased, research has found that government revenue from those taxes has also been disproportionately high. That is, the expected decline in consumption from the act of raising taxes has not occurred. Increased revenue from increased taxes has been found to be disproportionately more, suggesting that some smokers are slow to respond to price rises. Their smoking behaviour has remained elastic, despite price rises. Smokers with a mental illness may fit this description. The World Bank report (Jha & Chaloupka, 1999) expressed concern that increasing taxes on tobacco would have a disproportionate impact on poorer consumers because taxes consume a higher share of their income than richer consumers. It further suggested that the loss of perceived 'benefits' of smoking to lower income smokers may be comparatively greater than for higher income smokers.

Raising the cost of cigarettes to depress the demand for them has been shown to induce some smokers to quit or cut down their consumption, and to prevent others from commencing smoking (Jha & Chaloupka, 1999; CDCP, 2000). However, a Canadian study looking at disadvantage and low quit rates found that peoples' immediate circumstances were overwhelming motivators to continue smoking as a mechanism for coping with those circumstances, regardless of long-term goals for better health and financial stability (Steward, et al., 1996a; Stewart, et al., 1996b). With this in mind, the impact of price rises on the smoking behaviours of people with mental illness has not been comprehensively studied and, therefore, price increases as sufficient motivators for change cannot be assumed for this group. What we do know is that they spend a great deal on cigarettes as a proportion of their income. A study by Lawn (2001) found that smokers with a mental illness were returning approximately 27.7% of their total income to the government treasury in excise taxes on tobacco. Another Study found that mentally ill smokers elevated the importance of cigarettes, often choosing them over food, security of accommodation and safe interactions with others. Few of these smokers altered their smoking behaviour when the price of cigarettes increased, though most expressing wanting to quit (Lawn, Pols & Barber, 2002). These smokers therefore demonstrated the elasticity of their responses to cigarette price rises.

In the report, additional evidence since 2004 is quoted success of interventions "provided symptoms are well controlled'. The reality for many people with mental illness is that this is a fluid concept, with daily challenges. The consequences of this for maintaining vigilance to stay quit cannot be overstated. My personal experience and my years as a mental health worker tell me that the health system's concept of wellness and the person's concept of this are vastly different. Quitting is hard; staying quit is even harder for people with mental illness. Symptom fluctuations are common, not the exception, and they are a response to the normal ups and downs of life stresses. They impact significantly on the vulnerability to smoking relapse for these populations. Any actions must acknowledge this complexity.

5. Conclusion

The complexity of this issue for people with mental illness means that a multi-layered and systematic clinical response is needed, as part of a holistic response that recognises the need to address social inequality fundamentally. I applaud the actions suggested by the taskforce but reiterate that they are not undertaken without also investing in providing more support for people with mental illness. An important part of this support is building the capacity of the workforce that supports these people and greatly influences there health behaviours either overtly or covertly by currently ignoring their smoking behaviours. Information alone is insufficient to change behaviour. This is so for smokers and health service staff. Investment in modelling and mentoring to show staff how to actually support people in the field is needed. Coordination of follow-up support is one critical component of this support. It encompassed more than just Quitline support and includes GPs, practice nurses, community mental health staff and others.

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