Gac Sanit. 2016;30(5):389–392

Special article

Deconstructing myths, building alliances: a networking model to enhance tobacco control in hospital mental health settings

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ARTICLE INFO

Article history:
Received 2 March 2016
Accepted 25 April 2016
Available online 17 June 2016

Keywords:
Smoking
Tobacco
Hospitals
Mental health services
Psychiatry
Public health

ABSTRACT

Life expectancy for people with severe mental disorders is up to 25 years less in comparison to the general population, mainly due to diseases caused or worsened by smoking. However, smoking is usually a neglected issue in mental healthcare settings. The aim of this article is to describe a strategy to improve tobacco control in the hospital mental healthcare services of Catalonia (Spain). To bridge this gap, the Catalan Network of Smoke-free Hospitals launched a nationwide bottom-up strategy in Catalonia in 2007. The strategy relied on the creation of a working group of key professionals from various hospitals —the early adopters— based on Rogers' theory of the Diffusion of Innovations. In 2016, the working group is composed of professionals from 17 hospitals (70.8% of all hospitals in the region with mental health inpatient units). Since 2007, tobacco control has improved in different areas such as increasing mental health professionals' awareness of smoking, training professionals on smoking cessation interventions and achieving good compliance with the national smoking ban. The working group has produced and disseminated various materials, including clinical practice and best practice guidelines, implemented smoking cessation programmes and organised seminars and training sessions on smoking cessation measures in patients with mental illnesses. The next challenge is to ensure effective follow-up for smoking cessation after discharge. While some areas of tobacco control within these services still require significant improvement, the aforementioned initiative promotes successful tobacco control in these settings.

Desmontando mitos, construyendo alianzas: un modelo en red para mejorar el control del tabaquismo en el ámbito de la salud mental hospitalaria

Palabras clave:
Hábito de fumar
Tabaco
Hospitales
Servicios de salud mental
Psiquiatría
Salud pública

RESUMEN

La esperanza de vida para las personas con trastornos mentales graves se reduce hasta 25 años en comparación con la población general, principalmente debido a enfermedades causadas o agravadas por el tabaco. Sin embargo, el tabaco es un tema a menudo descuidado en el ámbito de la salud mental. El objetivo de este artículo es describir una estrategia dirigida a mejorar el control del tabaco en servicios de salud mental hospitalarios de Cataluña (España). Por este motivo, la Red Catalana de Hospitales sin Humo puso en marcha en 2007 un grupo de trabajo de profesionales clave, los *early adopters*, según la teoría de la difusión de las innovaciones de Rogers. En la actualidad, el Grupo de Trabajo, con un enfoque de abajo arriba, está integrado por profesionales de 17 hospitales (el 70,8% de todos los hospitales de la región con unidades de hospitalización de salud mental). Desde 2007, el control del tabaco ha mejorado en diferentes áreas, tales como el aumento de la sensibilización de los profesionales, la formación de profesionales en intervención para dejar de fumar y el cumplimiento de la prohibición de fumar en las

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http://dx.doi.org/10.1016/j.gaceta.2016.04.017

salas de ingreso. El Grupo ha elaborado y difundido materiales como guías de práctica clínica y de buenas prácticas, ha implementado programas para dejar de fumar, y ha organizado jornadas y sesiones formativas sobre intervención en tabaquismo en personas con trastornos mentales, entre otras actividades. Los siguientes pasos se centrarán en garantizar un seguimiento eficaz de la cesación tabáquica después del alta hospitalaria. Aunque aún queda mucho trabajo en algunas áreas del control del tabaquismo dentro de estos servicios, este enfoque descrito promueve con éxito mejoras en este ámbito.

Introduction

The prevalence of smoking in people with mental disorders is higher than in the general population.[1] However, smoking is viewed as a normal habit in the culture of mental health settings. The aim of this article is to describe a strategy to overcome this neglected situation in Catalonia (Spain).

Smoking in mental health-care settings: denying the problem

Smoking is the biggest avoidable cause of death and disability in developed countries. Although the prevalence of smoking in these countries has declined in recent years, certain populations, such as people with mental illness, are not following this trend.[2] This difference may reflect a failure of public health and clinical services to address the needs of this population.

Smoking prevalence and the number of cigarettes per day rises as the severity of the mental disorder and the number of mental health disorders in life increase.[1] Consequently, the prevalence of smoking is dramatically higher in psychiatric inpatients, with prevalence rates up to 80%,[3] while the prevalence of smoking in the general population of Catalonia is 25.9%. For example, the prevalence in patients with schizophrenia is 60% in outpatients and up to 80% in inpatients, 60% in patients with bipolar disorders and 70-90% in patients with other substance use disorders. Thus, life expectancy for people with severe mental disorders may decrease by up to 25 years[4] mainly due to diseases caused or worsened by smoking.[5] However, smoking has usually been neglected in mental health care settings.

Patients with mental illness are less likely to receive advice to quit smoking than patients without mental illness.[6] Additionally, mental health professionals and systems have been reluctant to implement total smoking bans in mental health-care units. While smoke-free policies in workplaces and public places have been implemented in many countries, mental health wards are usually exempt.

A proposal of change through specific strategies

There is a need to increase the priority of tobacco control in the mental health agenda. Changing priorities and professional motivation requires time and a well-defined strategy.

In Catalonia, a nation located in the north-eastern part of Spain with more than 7.5 million inhabitants, the Catalan Network of Smoke-free Policies ("the Network") was established in 1999 to promote tobacco-control strategies in hospitals[7] (www.xchsf.cat). The Network is supported and funded by the Catalan Government through its Public Health Agency. The Network currently (2015) consists of 75 hospitals, 90% of all hospitals that offer public services in Catalonia.

Tobacco control has been thoroughly improved in Catalan hospitals in recent decades; however, the impact of the Network on mental health settings has been minor or lacking. Thus, the Network designed a specific strategy in November 2007 to target hospital mental health settings including both inpatient and outpatient units. This strategy required low-intensity institutional support; a low economic burden was also necessary in accordance with the Spanish financial crisis.

Strategy development and outcomes

Creating a framework to introduce changes: recruiting early adopters

The Network began a new strategy to enhance tobacco control in hospital mental health settings via a bottom-up approach that works from the grassroots through people working together, resulting in decisions that arise from collaboration. The strategy relied on the creation of a working group of key professionals identified as motivated and experienced in the topic of smoking in patients with mental disorders: the early adopters.

The Network based its strategy on Rogers' theory of the Diffusion of Innovations,[8] which explains the process that occurs when people adopt a new idea, practice, intervention, etc. This theory has been applied broadly in health-care settings.[9] According to this theory, individuals are categorized by the degree to which they adopt a new idea earlier than other members of a social system. The Network sought early adopters of tobacco control in mental health hospitals to serve as opinion leaders; early adopters are the first to adopt new strategies and to diffuse them to the majority through social channels.[8] This approach was intended to help speed the diffusion process and to broaden and strengthen the influence of professionals on their settings by having them act as a group.

Rogers[8] described five qualities that cause some new procedures or strategies to spread more rapidly and successfully than others: perceived benefit of the change, compatibility with existing beliefs and practices, complexity of the proposed change, trialability, and observable results of the adoption of the change by others. In our case, the first steps consisted of contacting key mental health professionals and explaining the purpose of the working group (the Tobacco and Mental Health Group). Over time, more professionals from other hospitals joined the working group. The group held a maximum of three meetings per year and worked mainly over the Internet. Participation in the working group was not economically rewarded, and funding from private companies was never involved.

The working group began in 2007 with 11 professionals from six hospitals who had been directly identified and invited by the Network. Afterwards, the Network contacted the head of the mental health service in every hospital with mental health inpatients units in order to identify potential participants. In 2016, the working group consisted of 29 professionals from 17 hospitals (12 doctors, 11 psychologists, 6 nurses). The working group comprises 70.8% (n = 17) of all Catalan hospitals with acute mental health inpatient units (n = 24). Professionals from the remaining 29.2% of hospitals (n = 7) rejected the offer to participate in the working group after one invitation. We could not identify a common characteristic between the hospitals that rejected the offer, although all of these hospitals had a low-low/medium tobacco control strategies rating in the periodic evaluations of the Catalan Network.

Through consensus, the working group established a variety of objectives described below. Outcomes from the working group are