Addressing Barriers to Delivering Tobacco Dependence Interventions Across Mental Health Settings

February 10, 2010

Daryl Sharp, PhD, APRN-BC
Susan Blaakman, MS, APRN-BC

Objectives

- To apply principles from leadership, organization and health behavior change sciences to the challenges inherent in disseminating tobacco dependence (TD) treatment across mental health settings
- To brainstorm & strategize with webinar participants regarding strategies to facilitate TD implementation effectiveness

Historical perspectives

- Scope of the problem acknowledged widely
- Many educational/training materials available
- Various care delivery models described
- Moving to wider scale dissemination

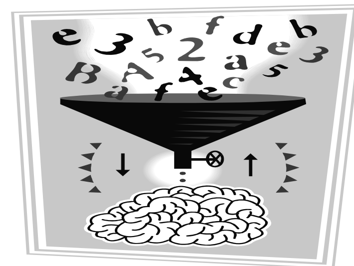
Diffusion of Innovation = Widespread implementation of tobacco dependence treatment

Opens a literature that may help us strategize about how to effectively disseminate tobacco dependence treatment across mental health settings

Goal/Rationale

- To reduce the morbidity and mortality burden of tobacco dependence for the mentally ill
- High prevalence leads to more stigmatization & marginalization in an already vulnerable population
- Tobacco dependence interferes with recovery; ability of many to lead healthy, productive lives

We know what we need to do

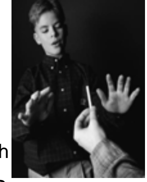


We know what we need to do

- Enforceable smoke free policies
- Staff training: brief and intensive interventions
- Standardized assessments of smoking status & interest in stopping smoking
- Inclusion of Nicotine Dependence & Withdrawal on Axis I diagnosis list & treatment plan
- Protocols for & access to pharmacotherapy
- Treatment for staff who smoke
- Support for consumer-based models

(Prochaska, 2009; Ziedonis, 2007)

We know what we need to do



- Denormalize tobacco use
- Facilitate culture change
  - "Person to person spread of smoking cessation"
  - Marginalization of smokers but not too much
- Advocate for public health strategies
  - Taxes
  - Countermarketing
  - Smoke-free policies (e.g. work places; health care facilities; restaurants & bars)

(Christakis & Fowler, 2008; Schroeder, 2008; Schroeder & Morris, 2010)

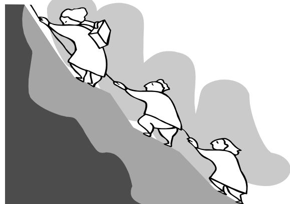
Implementation Models

- In-patient treatment
- Out-patient treatment
  - Integrated
    - All MH clinicians expected to deliver brief & intensive interventions
  - Co-location of services
    - Intensive tobacco dependence service easily accessible (along with all MH clinicians expected to deliver brief interventions)
  - MH-PCP collaborative interventions
- Consumer-delivered interventions
- Community-based treatment

So what's our challenge?

- A significant proportion of MH providers lack interest in addressing tobacco dependence
- A significant proportion of our treatment settings struggle to provide patients with adequate treatment

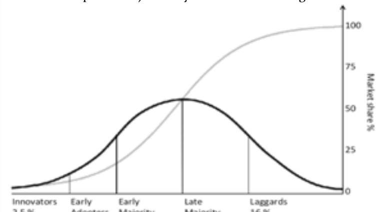
For many care delivery settings, significant practice change is needed



Leadership, organization science & behavior change literature can provide helpful guidance

Innovation-Diffusion Model

Describes the process by which an innovation is accepted or rejected by an individual or organization



Rogers, E.M. (1962; 2003). Image: http://en.wikipedia.org/wiki/Diffusion_of_innovations

Clinical innovation implementation

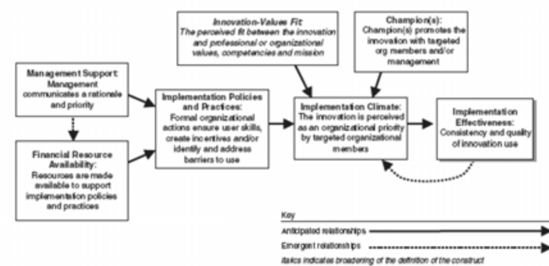
- *Change and innovation fail not because the goals or new strategies are inappropriate but because organizations are unable to successfully implement them* (Caldwell et al., 2008)

- *Like individuals who work to stop smoking, effective practice change requires clinicians to change their behavior*

Innovation use is related to:

- ***Management support***
  - ***Management communicates rationale & priority***
- Financial resource availability
  - Resources made available to support implementation policies & practices
- Implementation polices & practices
- ***Implementation climate***
  - ***Innovation perceived as work priority by members***

(Helfrich et al., 2007; Klein, Conn & Sorra, 2001)



(Helfrich et al., 2007, p. 282)

Management Support

- The public policy arm of an organization's "tobacco control program"
- Responsible for providing the structural supports through policies and procedures that support denormalization & the cultural shift toward tobacco free recovery
- Accountable for defining the vision, staying connected with the body, dealing effectively with sabotage

(Friedman, 1991)

Leadership Matters

A significant failure of leadership is at the heart of health care organizations that do not provide adequate patient-centered evidence-based treatments for the leading preventable cause of death and disease worldwide.

Differentiation and Leadership

"The key to successful leadership has more to do with the capacity for self-definition than with the ability to motivate others."

Friedman (1985, p. 221)

Differentiation defined

- Refers to taking responsibility for defining positions on matters of importance
- Consistent with one's own values and goals
- Holding onto such positions in the face of reactivity from others

(Friedman, 1985; 1991)

Essential leadership components

- **The leader needs to define his or her position:**
  - Take non-reactive, clearly conceived and well defined positions
- **The leader needs to stay in touch/connected with the body**
- **The leader needs to have a capacity to deal with the inevitable sabotage**

(Friedman, 1985; 1991)

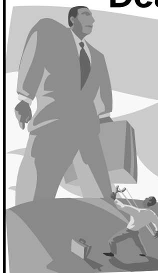
Component I
Defining the vision

- Communicates TD as organizational priority
  - Articulates risks & benefits, rationale, fit with professional & organizational values/mission
- Discerns organization's strengths and weaknesses with respect to TD intervention delivery
- Sets and enforces policies
- Thoughtfully identifies & recruits potential champions

Component II
Staying in touch

- Is visible and personally involved with TD champions
- Works with champions who take lead in implementing policy, conducting training, collaborating with staff
- Allocates resources (e.g. information systems support/ system prompts, staffing)
- Uses variety of venues to keep issue central (e.g. presentations, print media, employee treatment)
- Recognizes staff efforts to deliver high quality TD interventions

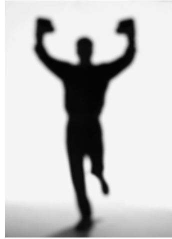
Component III
Dealing with sabotage



- Exploring vs. defending against nay-sayers
- Responding to policy violators (vs. looking the other way)
- Managing the triangles
  - Not the responsibility of management to persuade employees to value TD interventions
  - Is the responsibility to expect employees to follow policies and to do no harm
- Engaging employees in problem solving

Innovation Implementation

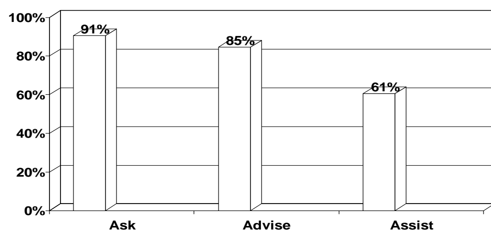
Management support including:
- Financial resource availability
- Champions
- Innovation-values fit
- Implementation policies & practices



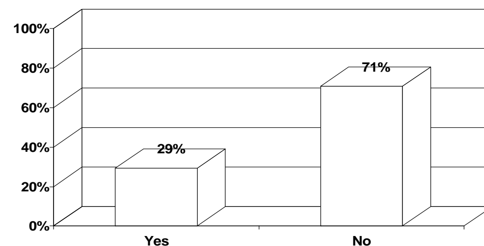
Implementation Climate

- Employees' shared perceptions of the importance of innovation implementation within the organization
  - Strong climate when employees perceive innovation implementation as a major organizational priority as evidenced by promotion, support and reward (Helfrich et al., 2008, p. 283)

Brief Interventions by APNA Nurses



Intensive Interventions by APNA Nurses



Findings/Implications

- Nurses reported relatively high knowledge (re: meds, counseling, resources) but lacked confidence in ability to help & in clients' abilities to reduce/quit smoking
- Nurses asked & advised but did not consistently refer or provide intensive interventions
- Nurses less likely to intervene if not confident

(Sharp, Blaakman et al., 2009)

Findings/Implications

- Education including strategies to **enhance motivation** needed to **build nurses' efficacy/confidence** in delivering tobacco dependence interventions
- Respondents more likely interested in topic but ¼ did not rate it as a work priority
- **Workplace values impact nurses**
- Increasing value of tobacco dependence interventions is vital to support wellness/recovery & denormalization efforts

(Sharp, Blaakman et al., 2009)

In addition to holding leaders and managers accountable, how can we strengthen implementation climates in MH treatment settings?

How do we foster health care team norms that support effective implementation of TD interventions?

What strategies can we use?

Team norms that support change

A commitment to behave in ways to implement interventions:

- Group is willing to tolerate mistakes
- Work effectively as a team
  - Awareness & conviction
  - Knowledge & skills
  - Use of data to achieve results
  - Clear mutual perceptions of task/objectives
  - Inclusive in decision-making
  - Authority to manage work
  - Support one another when new things are tried

(Caldwell et al., 2008; Lukas, Mohr, & Meterko, 2008)

Strategy: Think parallel process

- Meet people where they are
- Strive to understand staff perspective
- Wherever possible, offer options
- Roll with resistance non-reactively
- Avoid willfulness
- Support staff initiatives for change
- Partner with staff to tailor interventions for their practice context

(Miller & Rollnick, 2001; Williams et al., 2006)

Strategy: Acknowledge reality

- Providers usually work at a busy pace
- Staffing patterns tend to be relatively lean
- There is little time to keep on top of the literature across multiple legitimate competing interests
- Adopting new practice strategies often involves adaptation of the innovation and the organization

(Weiner et al., 2007)

Strategy: Consultation & supervision

- Education/training is necessary but not sufficient to facilitate behavior change
- Explore values fit with intervention delivery
- Problem-solving/skills building with treatment staff equally important
- Mobilizes social support
- Supports integration of TD treatment (often perceived as external regulation) into clinical practice

(Williams et al., 2006)

Strategy: Measure progress

- Decide how you will know if you are making progress
  - Abstinence rates
  - # of CPD
  - # of serious quit attempts
  - # & type of interventions delivered (ask-advise-refer; intensive)
  - Staff knowledge, efficacy, motivation

- Use data to revise program as needed

Case Study #1

- Recently established outpatient MH clinic targeting Rx refractory clients
- ***On site champions***: Facility Medical Director, Clinic Medical Director & Social Worker
  - ***Developed vision; strong advocate for TD interventions; allocated financial resources for training & consultation; setting expectations that treating TD is essential part of recovery-focused patient-centered care***

Case Study #1

- Model ***choice***: Co-located intensive TD intervention program piloted in another agency
  - All staff to deliver brief interventions
  - Intensive interventions delivered by those self-identified

  Supporting staff initiatives for change
- ***Training staff including champions***
- ***Access to ongoing consultation & supervision***
- ***Monitoring outcomes***

Case Study #2

- Research intensive hospital
- Senior medical & nursing management advocates ***champions at executive level thoughtfully identify mid-level champions***
- Working with nursing practice to pilot interventions on CV unit—***supporting staff initiatives for change***
- Studying practice flow and feasibility from key informants (NPs who will play a pivotal role in implementation) ***striving to understand staff perspective; meeting them where they are***

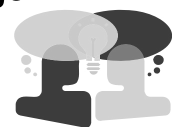
Case Study #2

- Risks of continued ineffectiveness & potential benefits of evidence-based Rx ***exploring values fit***
- Initial response doubtful of feasibility ***rolling with resistance; striving to understand perspective***
  - Reframed expectation from "the NPs have to deliver this intensive intervention to…the NPs have a crucial role to play but perhaps can partner with the nurses to deliver the full intervention" ***tailoring to practice context***
- ***Training champions***
- ***Providing ongoing consultation & supervision***
- ***Monitoring referrals & outcomes***

Our Challenge

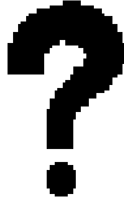
- ***Tobacco dependence treatment needs to be designed and implemented in ways that are acceptable to:***
  - Patients
  - Families
  - Clinicians
  - Health care systems
  - Community stakeholders

Our challenge



- We know what we need to do
- We know what our leaders need to do
- If it's not working well where you practice, it is important to strategize with your colleagues and leaders about how to improve delivery of TD interventions
  - Many of the tools we encourage our clients to use to stop smoking can help ***us*** find solutions to more effectively deliver TD interventions across care settings.

Questions/Thoughts



Acknowledgements

Smoking Cessation Leadership Center:
http://smokingcessationleadership.ucsf.edu/

Substance Abuse & Mental Health Services Administration:
http://www.samhsa.gov/

American Psychiatric Nurses Association:
http://www.apna.org/

And thank you, too, for your attention!

References

Caldwell, D.F., Chatman, J., O'Reilly, C.A., Ormiston, M., & Lapiz, M. (2008). Implementing startegic change: The importance of leadership and change readiness. Health Care Management Review, 33, 124-133.

Christakis, N. A., & Fowler, J. H. (2008). The collective dynamics of smoking in a large social network. *The New England Journal of Medicine, 358*, 2249-2258.

Friedman, E. H. (1985). *Generation to generation.* NY: The Guilford Press.

Friedman, E. H. (1991). Bowen theory and therapy. In A.S. Gurman, D.P. Kniskern (Eds.). *Handbook of family therapy,* Vol. 2. NY: Brunner/Mazel., pp. 134-170.

References

Helfrich, C.D., Weiner, B.J., McKinney, M.M., & Minasian, L. (2007). Determinants of implementation effectiveness: Adapting a framework for complex innovations. *Medical Care Research and Review, 64*, 279-303.

Klein, K.J., Conn, A.B., & Sorra, J.S. (2001). Implementing computerized technology: An organizational analysis. *Journal of Applied Psychology, 86*, 811-824.

Lukas, C.V., Mohr, D.C., & Meterko, M. (2009). Team effectiveness and organizational context in the implementation of a clinical innovation. *Quality Management in Health Care, 18*, 25-39.

Miller, W.R. & Rollnick, S. (2001). *Motivational interviewing: Preparing people for change,* 2nd ed. New York: The Guilford Press.

References

Prochaska, J. (2009). Ten critical reasons for treating tobacco dependence in inpatient psychiatry. *Journal of the American Psychiatric Nurses Association, 15*, 404-409.

Rogers, E.M. (1962). *Diffusion of Innovations.* NY: Free Press.

Rogers, E.M. (2003). *Diffusion of Innovations (5th ed.).* NY: Free Press.

Schroeder, S. (2008). Stranded in the periphery - the increasing marginalization of smokers. *New England Journal of Medicine, 358*, 2249-2258.

Schroeder, S. A. & Morris, C.A. (2010). Confronting a neglected epidemic: Tobacco cessation for persons with mental illness and substance abuse problems. *Annual Review of Public Health, 31*, 16.1-16.8, doi: 10.1146/annurev.publhealth.012809.103701.

References

Sharp, D.S., Blaakman, S.W., Cole, R.E., & Evinger, J.F. (2009). Report from a national tobacco dependence survey of psychiatric nurses. *Journal of the American Psychiatric Nurses Association, 15*, 172-181.

Weiner, B.J., Helfrich, C.D., Savitz, L.A., & Swiger, K.D. (2007). Adoption and implementation of strategies for diabetes management in primary care practices. *American Journal of Preventive Medicine, 33*, S35-S49.

Williams, G. C., McGregor, H. A. Sharp, D., Levesque, C., Kouides, R. W., Ryan, R. M., & Deci, E. L. (2006). Testing a self-determination theory intervention for motivating tobacco cessation: Supporting autonomy and competence in a clinical trial. *Health Psychology, 25,* 91-101.

Ziedonis, D.M., Zammarelli, L., Seward, G., Oliver, K., Guydish, J., Hobart, M., & Meltzer, B. (2007). Addressing tobacco use through organizational change: A case study of an addiction treatment organization. *Journal of Psychoactive Drugs, 39*, 451-459.