

# Ethical and Clinical Deliberations on Protecting Community Mental Health Outreach Workers from Second Hand Smoke

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## ABSTRACT

In the Province of Ontario the right to work in a smoke-free work place was granted when the Smoke-Free Ontario Act was enacted May 31st, 2006 (Ontario Ministry of Health Promotion, 2007). Home health care workers have the right to ask a person not to smoke in their presence and can leave without providing further services, unless doing so would present an immediate, serious danger to the health of any person. While the Act may seem clear, employer guidelines informing home health care workers on how to provide a reasonable level of care to vulnerable and at risk clients in this new safety-focused culture are not. This paper analyzes a case study in which client and staff rights and responsibilities within the context of this legislation are reviewed. A real-life organizational solution triggered by the ethical dilemmas in the case scenario is presented.

**Key Words:** *second hand smoke policies, community mental health*

## Background

If you are a community mental health outreach worker, you most certainly serve clients who smoke and likely encounter second hand smoke on a daily basis. Chronic exposure to second hand smoke may cause you some worry about the long-term effects on your health. However, there are no universal policies or procedures that definitively protect community outreach clinicians from second hand smoke. In the Province of Ontario the right to work in a smoke free work place was granted when the Smoke-Free Ontario Act was enacted May 31st, 2006 (Ontario Ministry of

Health Promotion, 2007). In spite of this, mental health outreach workers still accept exposure to second hand smoke as an expected workplace hazard in the community. The Ontario government assumes that there are no safe levels of exposure. We have learned that more than 1,000 non-smokers are expected to die each year in Canada due to second hand smoke. This includes over 300 lung cancer deaths and at least 700 deaths from coronary heart disease (Makomaski-Illing and Kaiserman, 1999; De Groh and Morrison, 2002). As mental health professionals we are excellent at minimizing risk, creating safety plans and advocating for the rights of others. By extension, we also need to address the issue of exposure to second hand smoke in our community work settings and clearly outline the rights and responsibilities of outreach workers and their employers.

The Smoke-Free Ontario Act addresses the right to protection from second hand smoke in community or home settings as follows, "Home health care workers have the right to ask a person not to smoke in their presence while they are providing health care services. If anyone refuses the request, the home health care worker can leave without providing further services-unless doing so would present an immediate, serious danger to the health of any person." The Act also states, "Employers of home health care workers are advised to familiarize themselves with the rights and responsibilities of a worker who chooses to leave a client's home because someone refuses the worker's request to not smoke in their presence." Furthermore, "... the home health care worker must follow any guidelines provided by the employer that are reasonably aimed at ensuring the person to whom the health care services were being provided or were to be provided is kept safe and provided with a reasonable level of care." The responsibility of enforcing the Act is awarded to Local Public Health Units. It is the law that home health care workers must be protected from second hand smoke while at work, and this law is enforceable (Ontario Ministry of Health Promotion, 2006, pp.1-2).

While the Act may seem clear on the surface, employer guidelines informing home health care workers on how to provide a reasonable level of care in this new safety-focused culture are not. Most outreach programs lack policies and procedures to guide decision-making regarding this issue. Clearly this is an ethically charged debate; one that balances the rights of clinicians and the rights of clients to determine what they do in their own homes. Additionally, community mental health practitioners have a special obligation to care for clients who are often particularly vulnerable. Simply ending a visit because of second hand smoke exposure and abandoning a client in crisis, or at risk of harm, is not an option.

## Case Study: Ben

Ben (a pseudonym) is a 43-year-old man who lives in a self-contained apartment, subsidized by a supportive housing agency governed by the Ontario Landlord and Tenant Act. He is served by an Assertive Community Treatment (ACT) Team, a homemaker who visits twice per week, housing staff from the supportive housing agency, and family members. Ben has a severe and persistent mental illness, and has very little insight about his illness and the need for treatment. Ben's mother is heavily involved with his care and she serves as the substitute decision maker for treatment decisions. She does not feel that the ACT team is providing sufficient care.

Ben is a very heavy smoker. His brother also smokes and visits Ben regularly while ACT Team members are present. Visiting him in his home has become increasingly difficult due to the high levels of second hand smoke that are a constant presence in his home. All the home health care workers are complaining of not being able to breathe in his apartment, being exposed to harmful toxins, and feeling ill when they visit him. In an effort to reduce the second hand smoke in Ben's apartment, the ACT team purchased an air purifier for his home, with funds provided by Ben's Public Guardian and Trustee. Ben also agreed to open his solitary window and not smoke when workers are present. Regardless of these efforts the team members complain that the apartment remains smoke filled.

Ben requires daily visits from ACT staff due to being on a Community Treatment Order (CTO). These visits ensure that he takes his oral medication. Without such treatment in the past his mental health status deteriorated quickly, resulting in numerous hospitalizations. Ben has voiced many times that he does not like his CTO, nor his daily visits and medications. Ben's workers often have to be quite assertive to gain entry to his home.

Daily entry to Ben's apartment has been very important in order to conduct risk assessments of his home environment. Ben's behaviours continue to pose a fire risk despite ongoing attempts to coach him regarding potential fire hazards. Ben often splices cords and wires with a kitchen knife. Tissues and paper towels cover Ben's countertop, where he smokes and keeps his ashtray. He does not remember to empty his ashtray and has to be prompted to do this daily. Also on the countertop is a hot plate that he frequently forgets to turn off or drapes with cords and plugs. He disassembled his fire alarm to prevent the continual annoyance of its sound.

In addition to these risks, Ben must be assisted in proper food handling procedures. He continually forgets to put food back in the fridge and it spoils. On occasion Ben has eaten the spoiled food and became ill. Food left out also attracts pests into Ben's apartment, and he is at risk of his apartment becoming infested. Ben must be assisted each day to throw out garbage that is scattered across the countertops in his kitchen and on top of his hot plate.

Ben's behaviours have been difficult to change; he is clearly an individual who is at high risk and requires intensive support. However, outreach workers are chronically exposed to high levels of second hand smoke which is at odds with their right not be exposed to second hand smoke in the workplace.

## Process for Case Study Analysis

This case study was recently presented for discussion at an Ontario conference for ACT team clinicians. (Ontario ACCT Conference, Niagara Falls, 2008). Approximately 50 mental health clinicians attending the workshop were asked to analyze this case study and make recommendations for new organizational policies and procedures which could guide ACT clinicians on how to protect themselves from second hand smoke while providing a reasonable level of care. Participants were asked to analyze the case scenario using a number of different perspectives. They were also asked to brainstorm regarding ideas for practical program policies and procedures that would integrate the following:

1. Rights and responsibilities afforded to home health care workers within the Smoke-Free Ontario Act legislation.
2. The perspectives of various stakeholders, including the client, the family, the ACT team, and manager ("employer"). Where differences of opinion occurred, alternative dispute resolution or negotiation processes were recommended to attempt to craft outcomes to serve mutual interests.
3. Ethical principles that guide and govern health care provision (Garrett, Baillie and Garrett, 1993). Principles suggested included:
  - a) Autonomy, focusing on the rights of individuals to self determination and rooted in society's respect for individuals' ability to make informed decisions about personal matters,
  - b) Beneficence & Non-maleficence, focusing on the concepts 'Do good and Do no harm'. This involves making the best decision for the client from a professional perspective, while not harming him.
  - c) Justice. This includes ensuring that policies and procedures are morally and ethically justifiable and conscionable.
  - d) Duty to Care, focusing on the ACT team's professional obligation to provide care with watchfulness, attention, caution, and prudence, lest it be considered negligent.
  - e) Duty to Protect, that is, protecting the client from the possible precipitation of harm despite the fact this may disrupt therapeutic alliance.

**TABLE 1 BRAINSTORMING RESPONSES GENERATED AT ACT FORUM**

<b>Client's Perspective</b>	
<b>Insights Regarding the Dilemmas</b>	<b>Possible Solutions/Ideas for new Procedures</b>
<ul style="list-style-type: none"> <li>• This is my house, my rules, my autonomy and my right to smoke!</li> <li>• Smoking is my way of dealing with stress</li> <li>• Smoking helps with the symptoms of my illness</li> <li>• You're trying to control me by asking me not to smoke</li> <li>• All of my peers smoke, it's my social outlet</li> <li>• I have smoked a long time!</li> <li>• I've quit drinking. I've quit street drugs. Do I have to give up smoking too?</li> <li>• Smoking is all I have left in the world</li> <li>• Some of my community mental health workers smoke with me; some say they don't mind the second hand smoke</li> <li>• Some of my workers buy the cheap cigarettes for me, because I can't get them</li> <li>• My community mental health workers bring me cigarettes when I'm in hospital</li> </ul>	<ul style="list-style-type: none"> <li>• Wear a mask when you come to see me</li> <li>• We'll go out on the porch</li> <li>• I won't smoke when you are here, or I'll only smoke for five minutes</li> <li>• I'll open up the window/turn on the fan</li> <li>• Only send staff to visit me who don't care if I smoke</li> <li>• Take me out for a coffee if I don't smoke</li> </ul>
<b>The Family Perspective</b>	
<ul style="list-style-type: none"> <li>• You're abandoning my son (when advised that team members may leave the apartment if it is too smoke filled)</li> <li>• It's your job/you get paid to go in his apartment</li> <li>• Are you singling my son out?</li> <li>• You must see him because he is on a CTO</li> <li>• I'm his substitute decision maker, he doesn't fully understand that his smoking is putting people at risk</li> </ul>	<ul style="list-style-type: none"> <li>• Meet my son outside of his apartment to get away from the smoke</li> <li>• Only meet my son at the door (although a risk assessment of his home environment can not be conducted using this alternative)</li> <li>• Family members can agree not to smoke during home visits, and encourage Ben not to smoke during visits as well</li> <li>• Put my son in the hospital/long term care-he is in too great a risk at his apartment</li> </ul>
<b>The ACT Team Perspective</b>	
<ul style="list-style-type: none"> <li>• Team members have the right not to be exposed to second hand smoke but do have a duty to care</li> <li>• Team members have a responsibility to educate clients about the dangers of second hand smoke</li> <li>• Team members feel the dilemma of wanting to respect the client's choice, while balancing health needs of team members, and protecting health status of clients</li> <li>• Team members may have different views on second hand smoke</li> <li>• Is the client competent to make decisions about healthy life choices? Recognizing that while Ben is incompetent for general treatment decisions, the competence required to know smoking is harmful for self and others is relatively low – are there other angles we should address?</li> <li>• Do we have a duty to protect those who live around Ben in the same apartment complex from second hand smoke as well?</li> <li>• Is this the right kind of housing for the client?</li> <li>• Clients' homes in the community are definitely a work setting, but are they a true "workplace" as outlined in the Smoke-Free Ontario Act?</li> <li>• How much should we favour client-centered autonomy over a health centered-approach (beneficence) in order to preserve the fragile alliance with a low-insight client?</li> <li>• How do we define "risks"? Is second hand smoke generally considered a chronic (non-acute) risk and therefore a weak argument for withdrawing service?</li> </ul>	<ul style="list-style-type: none"> <li>• A team must have a consistent approach with each client, even if particular team members have different views about second hand smoke, the policies and procedures have to apply universally</li> <li>• A flexible case by case plan to reduce exposure to second hand smoke must be created</li> <li>• Fostering strong relationships with clients is key- if there is mutual respect, clients will respect our right to not be exposed to second hand smoke</li> <li>• Services may need to be provided in an alternative way that satisfies, if not completely, all concerned (e.g. take it outside or to other environments, reduce length of visits, etc.)</li> <li>• "Risks" may need to be hierarchically ordered for a more coherent and meaningful discussion and to help staff make judgment calls</li> </ul>
<b>The Manager ("Employer") Perspective</b>	
<ul style="list-style-type: none"> <li>• How do I know the employee has followed obligations to provide care before terminating the home visit?</li> <li>• Are employees able to deny service when a client lives in a high risk situation?</li> <li>• Has an alternate plan for service been arranged if a staff member ends a visit early due to second hand smoke exposure?</li> <li>• Can some workers who don't mind smoke do the visits with clients who smoke?</li> <li>• Are workers able to refuse to do visits?</li> <li>• Can we change the hiring process and only hire smokers who don't mind the exposure to second hand smoke?</li> </ul>	<ul style="list-style-type: none"> <li>• Manager should consult legal counsel and seek the advice of an ethicist</li> <li>• Must consider if the individual is living in an environment that provides enough support as this could reduce the need for frequent outreach visits into smoky environments</li> <li>• Can ask Fire Marshall to attend client's home and enforce rules</li> <li>• Must foster sense of responsibility within the client to take ownership over this problem</li> <li>• We need to ensure a fair process where clients who smoke are not unduly punished due to counter-transference from clinicians</li> <li>• Advocacy may need to occur at the housing policy level to ensure safe environments</li> <li>• Is there a protective mask that staff can wear during high risk situations?</li> </ul>

## Discussion Outcomes

Many responses were generated in the brainstorming session. Participants proposed a range of hypothetical objections, opinions and other comments from each stakeholder perspective. This brainstorming assisted participants in developing new insights into the complexities of the dilemma and stirred creativity in finding solutions to guide policy and procedure development for outreach teams. Overall, empathy was expressed for the client's need for autonomy and control over his life, the need to preserve a positive therapeutic relationship with the client, and the importance of negotiation and "thinking outside the box" to address the safety needs of staff. Responses are listed in Table 1.

## A Real-Life Organizational Solution Triggered by the Case Study

The case study of Ben represents a very typical scenario faced regularly by outreach workers in the St. Michael's Hospital Community Mental Health Service in Toronto. The Community Mental Health Service (CMHS) encompasses several outreach programs, including ACT, intensive case management (ICM) and early intervention (EI) for psychosis. The clients served by the CMHS experience serious mental illnesses, concurrent substance use issues, homelessness, complex medical conditions and legal issues. The teams routinely do outreach to shelters, boarding homes, private apartments and homes. Since the enactment of the Smoke-Free Ontario Act the teams have struggled with many issues already outlined in this discussion paper. The majority of their clients smoke, many are difficult to engage in service, and adherence to service plans can be sporadic. Many of the dilemmas and insights revealed at the ACT forum had already been identified and debated in staff meetings, clinical case conferences, etc.

In order to develop better guidelines on how to protect outreach clinicians from second hand smoke while providing a reasonable level of care, it was decided that a task force, with representatives from the different outreach teams, chaired by the Clinical Leader Manager of the service, should be developed to tackle the problem. The task force began its meetings in the fall of 2006.

## Task Force Steps

### *Step One: Completing an Internal Scan*

The first step was to identify the extent of the second hand smoke problem across the CMHS outreach programs. Clinicians agreed that unlike the younger, "first episode of psychosis" population, the older, longer term clients were more likely to smoke heavily. They were also more likely to have moved into their own apartments over time, due to receiving housing help from the teams. This resulted in living situations with greater autonomy for the clients, but also meant that these clients needed more daily support regarding routine activities of daily living, were less likely to have smoking rules imposed on them (as is the case in boarding homes or other joint living situations, for example), and there was greater chance for exposure to second hand smoke by staff.

The clinicians also agreed that most clients were agreeable to not smoking in the presence of staff or moving outdoors as necessary, although a small percentage (approximately 5%) of the clients found it very difficult to make changes, resulting in increased risk to staff. The story of Ben was one such example, although the circumstances described have been changed somewhat to protect the identity of the client.

### *Step Two: Completing an External Scan*

During the spring of 2007 task force members called several community mental health and other community-based health services in the Greater Toronto Area to determine if any other agencies had developed practical guidelines regarding the issues being explored. At that time, no such policies or procedures were identified. The Clinical Leader Manager also raised the issue amongst Greater Toronto Area ACT teams and on an e-forum for provincial ACT teams and similarly found no work had been done in this area. Most ACT team leaders had not yet considered the implications of the Smoke-Free Ontario Act on their outreach workers.

A literature search was also completed by the team. Overall, there was very little literature related to protecting community workers from second hand smoke and how to develop guidelines to balance staff and client rights and responsibilities. Useful information was, however, received from British sources where nurses and city councils have begun work to protect community workers from second hand smoke (Royal College of Nursing, 2006; Dundee City Council, 2005; Dimond, 2003). A common theme in these resources was the use of decision trees to provide direction regarding the responsibilities of the staff and employers. The decision trees provided guidance in educating clients, informing clients of new smoke-free policies, assessing risk in community settings, and determining when it is appropriate for a community worker to leave a community setting due to second hand smoke.

### *Step Three: Consulting an Occupational Hygienist*

The possibility of using safety equipment, safety masks in particular, had been raised on several occasions by staff. Some team members were familiar with the use of N95 masks during the SARS crisis in 2003 and were wondering if such masks could be worn when working in smoke-filled environments. A St. Michael's Hospital occupational hygienist was asked to serve as a consultant to the task force. Our occupational hygienist informed us that N95 masks were not sufficient and that large, cumbersome, expensive masks with filters would need to be worn to safely filter out the toxic elements of second hand smoke. Each mask would have to be fit-tested to individual staff members, filters would need to be replaced frequently, and staff would need to be screened for pregnancy, heart disease or claustrophobia before being cleared to wear the masks. Clearly these masks were not without their own risk. Furthermore they were flatly rejected by the task force due to the fact that they would interfere with the therapeutic relationship with clients.

### *Step Four: Consulting the Hospital Bioethicist*

Most helpful in the task force process was the consultation provided by the hospital's bioethicist. After carefully reviewing the list of dilemmas faced by the outreach teams, the advice to the

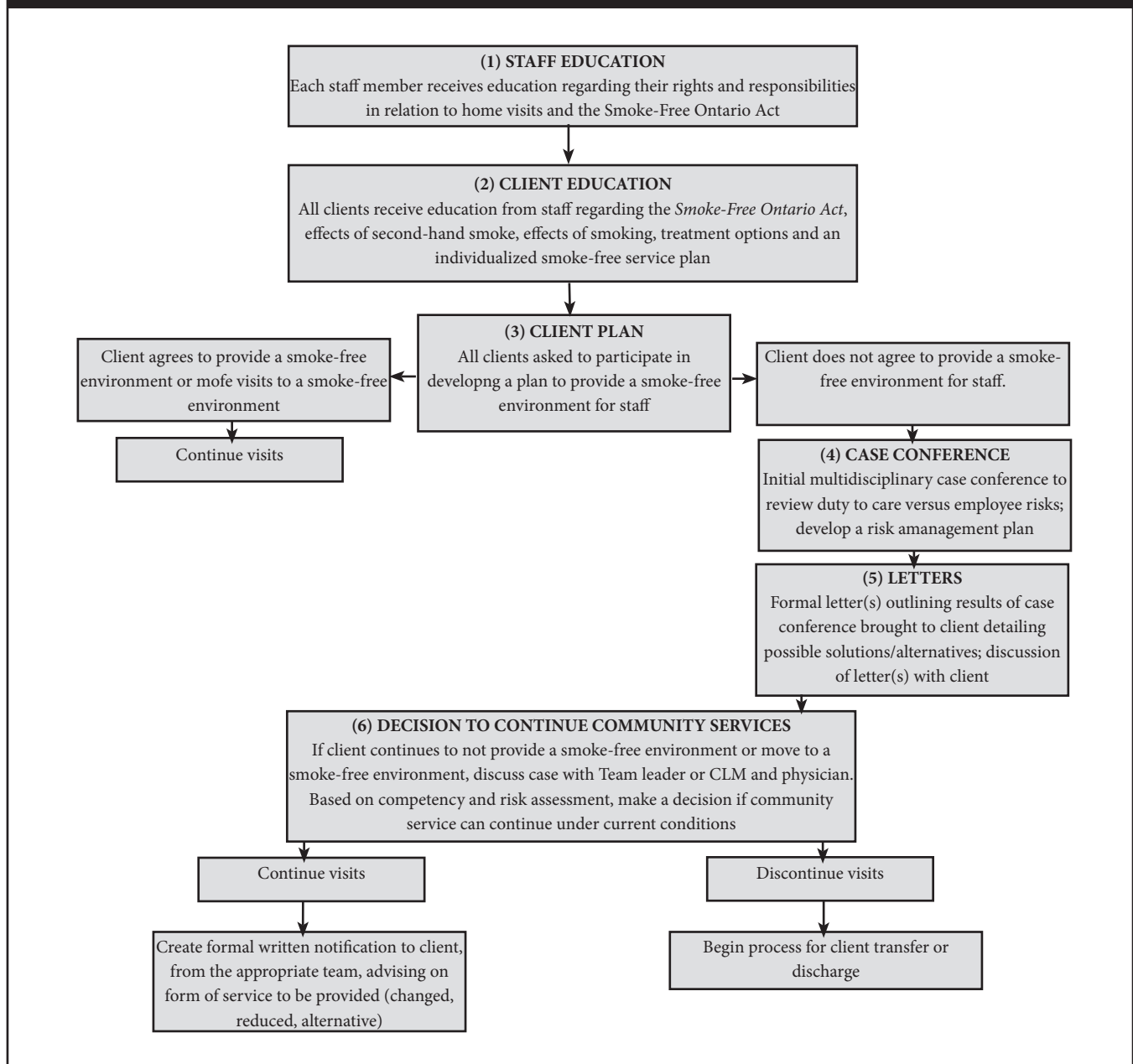
task force was:

1. To use a fair, open, inclusive and transparent process when establishing guidelines for the teams. This should include reviewing all the stakeholder perspectives.
2. To establish guidelines, which are practical, clear, fair and rationally justifiable. The guidelines should consider all the stakeholders' rights and responsibilities, the legislative requirements, human rights, professional standards of practice, duty to care, and duty to protect.
3. To ensure that our most vulnerable clients are not simply abandoned because we now have the right to refuse to be in a dwelling when clients continue to smoke, especially when

we know or ought to have known, that a risk of serious harms might befall them in the absence of our interventions.

4. To first exhaust all lesser intrusive/invasive means of managing the situation and reconciling what might appear to be competing rights and interests. This includes an emphasis on negotiation, especially when one has a reasonable therapeutic alliance with the client.
5. To use creative and innovative techniques in navigating "risky" situations with discretion and good judgment.
6. To use team-driven versus individually-driven processes to assist with decisions and judgment calls. These processes should be clear and coherent.

**FIGURE 1: SECOND HAND SMOKE EXPOSURE: DECISION TREE FOR HOME VISIT SERVICE PROVISION PLANS**



**Step Five: Developing New Guidelines for Staff**

Using the aforementioned suggestions, the task force then took on the job of developing a policy and procedure document to offer clear guidelines for staff. Procedures identified by the task force focused mainly on:

1. An education campaign to ensure that all outreach workers are clear about their rights and responsibilities in relation to the Smoke-Free Ontario Act.
2. An education campaign for clients receiving CMHS services. This involved developing an information package to be reviewed with each client.
3. Developing individualized client plans to facilitate a smoke free environment for visiting staff. Client engagement and creativity were encouraged to negotiate strategies, such as use of alternative visit sites, asking family members not to smoke, ventilating the apartment prior to a visit, use of nicotine replacement therapies, etc.
4. Initiating case conferences to develop plans for clients who do not provide a smoke-free environment for staff. This includes a multidisciplinary team discussion to ensure that all factors, including general competence, level of risk, client concerns, etc. are considered in the plan. All attempts should be made to individualize the plan and brainstorm regarding creative solutions. The policy advises that only after several attempts have been made to negotiate with a non-adherent client, and only if he is low risk and competent, could a team decision

be made to withdraw service due to the risks of second hand smoke. In such a scenario, alternative services may need to be arranged for the client (e.g. clinic visits where staff members do not enter the private home).

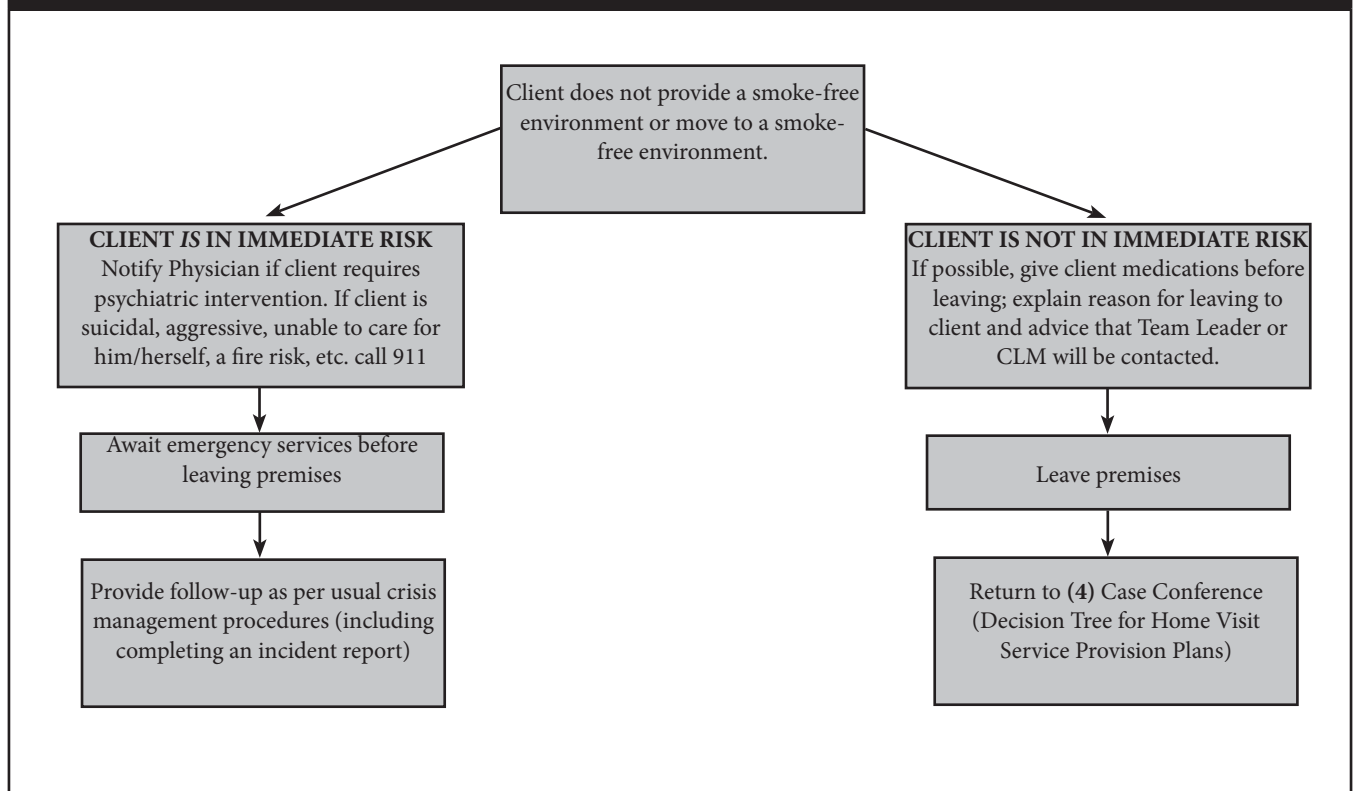
5. Developing decision trees to clearly guide decisions in managing home visits for clients who do not provide a smoke-free environment. These decision trees were designed to help navigate situations in which clients are not in immediate risk and in immediate risk. Samples of the decision trees are provided in Figures 1 and 2.

**Step Six: Developing a Smoking Cessation Program for Clients**

Lastly, the task force believed it was the responsibility of the CMHS to provide support and treatment options to clients who want help with reducing or quitting their smoking. Clients were provided with information on the effects of smoking and second hand smoke. People were offered information and free access to nicotine replacement therapy, and other smoking cessation aids.

Individuals were given information on how to contact the Smoker's Helpline, the Nicotine Dependence Clinic at the Centre for Addiction and Mental Health in Toronto, and other local community smoking cessation groups. A smoking cessation group was also created and facilitated by CMHS staff. This group provides counseling, assistance, education and support for clients who wish to reduce or quit smoking.

**FIGURE 2 SECOND HAND SMOKE EXPOSURE: DECISION TREE FOR TERMINATING HOME VISITS**



## The Real-Life Case Outcome

As per the policy of Ben's supportive housing agency, his apartment was inspected bi-annually by the Fire Marshall. Upon the Fire Marshall's last visit Ben was issued a warning to keep his fire alarm connected, or he could face eviction. Six months later when the Fire Marshall visited again he found that Ben had in fact disabled his fire alarm. Ben was issued an eviction notice from the Fire Marshall, and the ACT team moved him into a boarding home. Ben has been successful in adapting his smoking behavior so that he now smokes outside, as is the policy at his new residence.

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## EDITOR'S NOTE:

Smoking clearly is an important issue for consumers of mental health services as well as mental health practitioners and service providers. There are significant social, political, cultural and health effects associated with smoking and, most critically, ethical considerations. JEMH invites readers from around the world to comment or submit their views, experiences and perspectives on these important tobacco issues.