



Acknowledgements

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Introduction

Silently and insidiously tobacco sales and tobacco smoking became an accepted way of life not only in our society, but also in our public mental health treatment facilities.

Revenue from the sales of tobacco provides discretionary income for facilities. Smoke breaks for staff and patients have become an ‘entitlement’, deserved and protected, and one of the only times consumers can practice relating to each other and staff in a ‘normalized’ way. When, what, and how much to smoke are often the only choices consumers make as inpatients, reinforcing cigarette use by virtue of the autonomy it appears to allow. More troubling, cigarettes are used as positive/negative reinforcement by staff to control consumer behavior. While taking seriously and treating illicit drug use by those with mental illness for some time, a substance far more deadly and pervasive, and used disproportionately by this population, has largely been ignored.

And now, a few words about tobacco. It Kills. And, it kills those with mental illness disproportionately and earlier, as the leading contributor of disease and early death in this population.

A preponderance of evidence has clearly established the deleterious health effects of tobacco smoking and second-hand or environmental tobacco smoke. Science as well as experiences in mental health facilities have also shown that tobacco smoking leads to negative outcomes for mental health treatment, the treatment milieu, overall wellness and, ultimately, recovery.

Smoking promotes coercion and violence in facilities among patients and between patients and staff. It occupies a surprising amount of staff and patient time that could be better used for more productive activities. It is a poor (and often only) substitute for practice in decision-making and relationship building and is inappropriate as a means to manage behavior within the treatment milieu. And, while smoking can be framed as the one ‘choice’ consumers get to make while inpatients, and a personal ‘choice’ for staff, it is critical to realize that *addiction is not a choice*.

But, quitting smoking is. While smoking has become more socially unacceptable and its prevalence has decreased in the general population, much needs to be done to assist those with mental illness who choose to quit. Currently, 59% of public mental health facilities allow smoking. If we agree that the goal shared by consumers and physicians for mental health is recovery, and that health and wellness is an integral part of that recovery, the issue of tobacco use in our facilities cannot be ignored.

Tobacco companies systematically target vulnerable populations—children, people of color, homosexuals, the homeless—with slick marketing persuading them to smoke products laced with nicotine. More addictive than heroin, the nicotine in cigarettes reaches the brain within seven seconds. The vulnerable become the hooked.

Many in society, educated about smoking’s health impacts and inconvenienced by higher tobacco taxes and laws banning public smoking, have quit. But people in psychiatric hospitals have largely continued. While overall smoking in the United States has decreased, *the proportion*

of smokers with psychiatric diagnoses has increased. Seventy-five percent of individuals with either addictions or mental illness smoke cigarettes, compared with 23 percent of the general population. Nearly half of all cigarettes consumed in the United States are by people with a psychiatric disorder. Researchers offer various explanations for the high prevalence of smoking among those with mental illness: genetics, self-medication, trauma, socio-economics.

In any case, the end result is illness and death. People with serious mental illness, on average, die 25 years younger than the general population—largely from conditions caused or worsened by smoking, according to a 2006 report by NASMHPD.

With knowledge comes responsibility. NASMHPD members, stunned by the shocking statistics, in July 2006 unanimously supported a resolution to reduce the toll of smoking on people with mental illness. This toolkit is part of that initiative.

Smoking cessation is but one step toward recovery. But it is a big one. Smoking is the single most preventable cause of premature death and disability in our country. In the U.S., 440,000 people die each year from tobacco-related causes. More than 8.6 million people are disabled from smoking-related diseases, such as chronic obstructive pulmonary disease and lung cancer.

We can reduce those numbers by transforming the milieu into one that discourages smoking and helps consumers and staff quit. At any given time, approximately 50,000 consumers are housed in the 235 state public psychiatric facilities in the U.S. Roughly 200,000 pass through the facilities each year. With comprehensive programs to curb tobacco use, we have the potential to help them choose quitting and learn new ways to live longer, healthier lives.

As individuals committed to supporting health, wellness and recovery, and entrusted with the care and treatment of consumers and staff in our facilities and of limited public funds, we must act on what we know. Therefore, NASMHPD promotes recovery and will take assertive steps to protect all individuals from the effects of tobacco use in the public mental health system.

As physicians, we commit to educating individuals about the effects of tobacco and facilitating and supporting their ability to manage their own physical wellness. We will practice the 5 A's; ASKING individuals about tobacco use, ADVISING users to quit, ASSESSING their readiness to make a quit attempt, ASSISTING with that attempt and ARRANGING follow-up care.

As administrators, we will commit the leadership and resources necessary to create smoke free systems of care, provide adequate planning, time and training for staff to implement new policies and procedures, and ensure access to adequate and appropriate medical and psychosocial cessation treatment for consumers and staff alike.

Project SCUM

In the mid-1990s, RJ Reynolds developed a marketing campaign to boost sales among San Francisco's gay and homeless populations. The public learned about the campaign, internally dubbed Project SCUM (Sub Culture Urban Marketing), after the master settlement agreement in 1991 required tobacco companies to make internal documents public.

Internal SCUM documents, with notes and scribbles, show how tobacco companies peddle their lethal wares.

<http://www.americanlegacy.org/117.htm>

The once-separate roads to mental and physical health form a single pathway to wellness, recovery, and hope through this initiative. We are forging new alliances. The Smoking Cessation Leadership Center, a program office of the Robert Wood Johnson Foundation, is on the path with us to show people with mental illness they can break their gripping addiction to nicotine and to help health care professionals understand and rise to the challenge. We thank them for their support.

Questions and Answers

As you eliminate smoking to foster wellness and recovery, engage staff, consumers, family members, and people in your community in discussion. Listen. Address concerns. Engage partners in your change process. Remember to maintain your focus on wellness and recovery. Here are some questions you may face:

Q: Smoke breaks are one of the few opportunities we, as consumers, have to relate to staff as peers. Besides, smoking is our only pleasure. How can you take that away?

A: We appreciate that you want to spend time with staff outside of treatment. And we want to create healthy ways to do that. Smoking is an addiction. As a treatment facility, we can no longer support addiction by condoning smoking by consumers *or* staff. Furthermore we will work together, consumers and staff, to create new activity choices and opportunities that are both fun *and* healthy.

Q: People come to psychiatric hospitals in crisis. These are times they most need to smoke. Won't this new policy worsen their crises? Or, worse yet, people won't get help when they need it because they don't want to quit smoking.

A: At a time of crisis, our immediate job is to deal with the crisis, not with smoking. As the person recovers, we will provide a healthy environment that promotes wellness. That means, smoking is not a choice. We will not or cannot *force* someone to quit smoking. What we will do is have a safe environment where consumers or staff members can learn about how smoking impacts their lives and resources and opportunities that will help them choose to quit. Research has not yet determined the best time to help someone quit smoking. We know, however, that the best time to encourage healthy behavior is now.

Q: Here you go again, slamming us with more rules! Why can't you just let us do what we want like people on 'the outside'?

A: As we prohibit smoking here, we actually become *more* like 'the outside.' We've known for more than 40 years that smoking is hazardous to our health. Workplaces all over our community have banned smoking. Why? Because, whether or not you are puffing on a cigarette, smoke is bad for you. It kills. Already it has killed way too many peers. While you are here, you have every right to breathe clean air and every opportunity to make healthy choices. In reality, the challenges will help you later in coping with the smoke-free rules that increasingly govern life on 'the outside.'

Q: Smoking is a personal choice. How can you take that away without some serious collective bargaining?

A: Interesting question. Historically, unions have fought for *safe working conditions*. Internal documents show that tobacco companies have strategically marketed worker messages expounding upon the *right to smoke*. Yet, knowing cigarettes are loaded with toxic chemicals, including 60 known carcinogens, I'd rather we expend our energy working together on safety and health.

Q: How can we expect people to quit smoking, while they're quitting everything else? We are here to deal with "real drugs," not cigarettes. Besides, clients don't want to quit. Even those who do, won't be able to.

A: Cigarettes *are* real drugs. They contribute to more illness and early death than any other drug, legal or illegal. And they are highly addictive—on par with heroin. As we create a healthier environment, we will train staff about smoking, the quitting process, and how smoking impacts other addictions. Evidence suggests that smoking actually harms recovery from the addiction to other drugs because it can trigger the use of those substances. Also, as part of this initiative, we want to work with other community treatment facilities to similarly protect clients and consumers from smoke and help them quit or maintain their abstinence from smoking.

Q: Clients will just start smoking again once they are discharged. Why bother quitting?

A: Many of our clients *will* smoke again. Quitting is hard, especially in environments where smoking is acceptable. We want to use our milieu to help clients learn refusal skills, identify triggers, and regain control if they relapse. We also hope to be leaders, inspiring other mental health facilities in our community to similarly ban smoking to open new doors to wellness and recovery. We hope every person who comes here gains new skills—that don't involve smoking—to cope with stress, depression, and other difficult situations.

Q: Smoking calms down consumers. When they can't smoke, won't we experience complete mayhem?

A: Banning smoking in psychiatric hospitals actually *reduces* mayhem. Facilities that do not allow smoking report fewer incidents of seclusion and restraint and a reduction in coercion and threats among patients and staff. We are carefully planning this effort so the consumers, staff, and visitors here have plenty of time and support to prepare for change. We plan to post a countdown to our <date> launch right here in the foyer. Meanwhile, we invite you to voice your concerns and join our team as we become smoke-free and embrace recovery.

Q: How will we afford to transform our facility so drastically?

A: Certainly, we can expect some up-front costs as we transform our facility through this stop-smoking initiative. We'll need ongoing staff training. We need to add to our health benefits so our employees have extra help to quit smoking. We need to create and post signs to remind consumers, staff, and visitors that our hospital is a sanctuary from smoke. And we need to new forms with reminders that keep tobacco use on the front-burner in our treat of clients as whole persons. These are small investments compared to what we gain: longer, healthier lives for consumers and staff; financial savings through improved employee health and productivity, and knowledge that we are achieving excellence by providing people with mental illness with the healthy, therapeutic environment they deserve.

How to use this toolkit

Getting Ready

Launching a successful stop-smoking initiative as part of broader recovery can take months—but it is the greatest investment you can make for health and wellness. You will be most successful if you allow ample time to discuss proposed changes and expected positive outcomes with a variety of audiences, engaging them in strategic planning, implementation, and continuous quality improvement. Depending upon the laws that govern smoking in your community, it can take about a year and a half. It likely will take less time if you live in a smoke-free jurisdiction.ⁱ

COMMUNICATE

Craft three or four simple messages that explain why you want to address tobacco use in your facility, what you hope to accomplish, and your underlying concern for constituents. Key messages to consumers and staff may include:

- People with serious mental illness die 25 years younger than the general population due largely to conditions caused or worsened by smoking.ⁱⁱ
- Tobacco use interferes with psychiatric medications.ⁱⁱⁱ
- Although more than two-thirds of smokers want to quit, only 3 percent are able to quit on their own.^{iv}
- Even highly addicted smokers with mental illness *can* quit and are more likely to succeed with a combination of medications and behavioral therapy.^v
- Given what we know, we are compelled to improve the overall health, wellness and recovery for those we serve. Helping smokers quit is critical in achieving that goal.^{vi}

As you discuss this initiative, remember that success stories inspire. Weave them into messages. Look for champions within your institution or at other facilities with strong

12 Steps for Addressing Tobacco in Mental Health Services

1. Acknowledge the challenge.
2. Establish a leadership group and commitment to change.
3. Create a change plan and implementation timetable.
4. Start with easy system changes.
5. Assess and document in charts nicotine use, dependence, and prior treatments.
6. Incorporate tobacco issues into patient education curriculum.
7. Provide medications for nicotine dependence treatment and required abstinence.
8. Conduct staff training.
9. Provide treatment and recovery assistance for interested nicotine dependent staff.
10. Integrate motivation-based treatment throughout the system.
11. Develop policies to address tobacco use.
12. Establish ongoing communication with 12-step recovery groups, professional colleagues, and referral sources about systems change.

Source: Stuyt EB, Order-Conners B, and Ziedonis DM. Addressing Tobacco through Program and System Change in Mental Health and Addiction Settings. *Psychiatric Anals.* 33(7): 446-456. 2003.

tobacco cessation programs, highlight staff and consumers who have quit smoking, motivated others to quit, or improved quality of care in the institution and community by addressing the deadly addiction to smoking.

REACH KEY AUDIENCES

Removing tobacco from mental hospitals is a transformational change that frightens some, expands opportunities for others, and improves the overall health of all. Recruit partners, including representatives from treatment staff, unions, patients and patient advocates, to assess how ready your organization is to change. Include smokers, non-smokers and former smokers. You may also wish to invite cancer survivors and local representatives from nonprofit organizations that support smoke-free living to participate in your effort.^{vii}

Hold discussions. Educate individuals, groups, departments, and the public about the addiction to smoking and its impact on health and recovery. Listen. Address concerns and recognize progress, engaging a cross-sector group to help create and implement a sustainable process for the changes you seek.^{viii} Consider the perspectives of key audiences:

- **Line staff, including nurses and substance abuse staff:** Share data about the impact of eliminating tobacco on client behavior. Emphasize the simplicity and brevity of an integrated care model and offer training. Appeal to various motivations: pride in improved performance data and health, increased engagement in treatment by clients who quit smoking, more time to treat clients, including opportunities to engage them in activities that improve recovery.^{ix} Offer support for smokers on staff who want to quit.^x
- **Union leaders:** Discuss how members who work in mental hospitals smoke at higher rates than the general population (30% to 40%, compared with 22%)^{xi} and are regularly exposed to toxins through second-hand smoke. This not only contributes to greater illness and earlier death, but also results in higher health care costs and, consequently, suppressed wages. Work with the union and supportive members to embrace new policies that will improve the health of members. Ask them if they will promote benefits or services that can support members who want to quit smoking.
- **Medical directors and quality assurance personnel:** Emphasize how smoking cessation is relevant to patients and essential in integrating mental health and physical healthcare.^{xii xiii} Consider ways to align and measure stop-smoking medical interventions with mental health treatments. Facilitate cross-disciplinary communications designed to treat the whole person.
- **Consumers:** In multiple conversations and forums, emphasize that eliminating tobacco use on-campus is designed to promote recovery. Discuss the health and financial costs of nicotine addiction. Talk about healthy choices for recovery, including the choice to quit smoking. Offer support for quitting and new, healthy activities that provide choices and normalized relationships with staff.
- **Families:** Share the importance of maintaining a healthy treatment environment. Ask family members to respect new no-smoking policies when they come to visit. Offer support or share community resources for family members who wish to quit smoking.

“The biggest threat to our wages may be the increasing costs of health care and health insurance. How does smoking affect your Health and Welfare fund?”

Researcher, *Costs of Smoking in California, 1999*,
Sacramento, CA, Dept. of Health Services, 2002

- **Human resources personnel:** Design new benefits, programs, and policies to eliminate smoking at work and support smokers to quit.
- **Law enforcement and security staff:** Explain how the new no-smoking policies exist for therapeutic reasons. Establish clear policies designating tobacco as contraband. At the same time, delineate and script appropriate interventions to consistently and compassionately deal with infractions by consumers, staff, and visitors.^{xiv}
- **Lawmakers and state officials:** Emphasize how the new smoking cessation efforts represent a cost-effective investment of state money. This investment not only increases staff availability for therapy, it can pay for itself in reduced health care costs for clients in the mental health system and the staff who serves them.^{xv}

SPEARHEAD A TEAM TO HELP SPREAD THE WORD

Visible support from top administrative and clinical leadership is essential. Chief executive officers and medical directors will find internal and external champions for the smoking cessation initiative as they engage in discussion, encourage broad leadership, and recognize efforts that support the changes. Stay in the loop as committees move on various aspects of smoking cessation.^{xvi}

Help policymakers and the public understand the tremendous toll of tobacco on people with mental illness. Write opinion pieces or letters to editors that educate community members about your efforts, while debunking myths about mental illness. Emphasize the connections between physical and mental health. Lead the community in demanding accessible smoking cessation benefits and services. Tell your story in professional journals, blogs, websites, and speaking engagements.

You can showcase the effort to curb tobacco as an engagement process aimed at recovery—not a top-down mandate. Team presentations and co-authored articles can include the perspectives of clients, family members, clinicians and administrators, while modeling the team approach you seek. Share successes and challenges internally and at professional conferences and meetings. Learn.

PLAN

Adequate planning and broad engagement can mitigate potential negative outcomes, such as the creation of a black market and movement of contraband and housekeeping and maintenance issues associated with surreptitious smoking. New state or community laws prohibiting smoking, if applicable, could help frame your plan.^{xvii}

Here are some tips that can contribute to a smooth transition:

- Create a plan and implementation timetable.
- Include social, clinical, and system changes in your plan.
- Incorporate communications strategies in all aspects of your plan.
- Frequently remind staff, consumers and families of key dates and events.
- Provide a visual countdown so participants can better adjust and comply with changes.
- Do not implement the policy on a holiday or holiday weekend.
- Choose a fair weather start-date for your initiative if you are replacing smoke breaks with ‘fresh air’ breaks or other outdoor activities.

As you transform your facility, catalyze broader change that supports people with mental illness in efforts to quit tobacco:

- Raise awareness among new partners about smoking disparities among people with mental illness
- Develop community-wide goals and measures that will shape and improve strategies for reducing smoking
- Adopt strategies, including broader use of tobacco cessation counseling and medications, to reduce inequitable smoking rates among people with mental illness

ADOPT SYSTEMS TO ADDRESS TOBACCO USE

Create policies and systems that promote healthy choices for patients about tobacco use.

Clinical Systems

- Train staff in the clinical and psychosocial elements of smoking, encouraging them to earn CME or CEU credits for learning more about tobacco cessation.
- Provide free or low-cost tobacco cessation treatment for employees, through benefits and wellness programs and employee assistance programs.
- Assess tobacco use for all patients and include in treatment plan.
- Assess other wellness measures, including body mass index, to monitor impact of tobacco cessation on weight.
- Assure that a specific mental health practitioner is responsible for each person's mental health needs and coordinates all services, including tobacco cessation.
- Incorporate smoking cessation into individual and group therapies.
- Include FDA-approved tobacco dependence treatment medications in your pharmacy formulary.
- Establish a reminder system that prompts clinicians of all sorts to address tobacco use.
- Document changes in client tobacco use and interventions to address them.
- Compile information about community resources, including the National Tobacco Quitline, 1-800-QUIT NOW (1-800-784-8669), and share with consumers and families.
- Include tobacco cessation or relapse prevention as part of the discharge plan.

Other Systems Changes

- Design employee benefits and services, readily available for those who want to quit.
- Bill insurance for client and employee tobacco cessation.
- Replace smoking breaks with "fresh air" breaks.
- Develop clear policies to remove smoking areas from the hospital campus.
- Place no-smoking signs and smoking cessation materials in conspicuous places.
- Add tobacco to your list of contraband.
- Acknowledge clients and staff who quit tobacco or support others to quit.

BILL INSURANCE FOR TOBACCO CESSATION

Reimbursement for treating tobacco dependence for staff or clients, though inconsistent from plan to plan and state to state, is improving. Integrating smoking cessation into routine addiction psychosocial treatment helps the primary addiction and does not require additional billing.^{xviii}

Clinicians can integrate tobacco-dependence treatment within the context of medical/psychiatric management of related problems.^{xix}

In addition, depending upon the client's insurance coverage, public or private insurers may cover at least some aspects of tobacco cessation treatment. Such treatment is generally considered a medical, not a mental health benefit. However, this is changing.

At least 38 states cover some tobacco-dependence treatment (i.e., counseling or medication) for Medicaid recipients in their state, but only Oregon covers all forms recommended in the 2000 Public Health Services Guideline.^{xx} To see what your state covers, go to <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5544a2.htm#tab1>

Medicare covers pharmacotherapy and two four-session series per year for individual smoking-cessation counseling provided by individuals trained in tobacco cessation. Coverage is available only to those "treated with a therapeutic agent whose metabolism or dosing is affected by the use of tobacco" or those with a "disease or adverse health effect caused or complicated by tobacco use." These restrictions are not likely to impact patients with mental health diagnoses.

Services may be provided by psychologists, clinical social workers, physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, clinical physical therapists and occupational therapists as long as the provider is in a Medicare certified facility and is legally authorized to perform services in the states in which they are furnished.

For more information, including billing codes and how to become involved in changing coverage rules, go to <http://www.attud.org/public/faq.php>

Some private health plans also cover tobacco cessation counseling or medications. Others explicitly exclude tobacco-related addiction from coverage. Billing departments will need to inquire directly to private insurance plans to see whether tobacco cessation services are covered and, if so, whether restrictions apply. Reimbursement may be more readily available if the treatment is associated with another medical problem.

Public and private health insurers respond to market demand. As both employers and providers, psychiatric hospitals are in a position to demand, use, and bill for tobacco cessation treatment services. Insurance coverage for tobacco cessation counseling and medications is listed as a best-practice in the Public Health Service Guideline.

Implementing

A smoke-free environment, staff trained in gold-standard care, integrated care, healthy consumer activities, and systems to support the smoke-free initiative will help people with mental illness break their nicotine addiction as part of their wellness and overall recovery.

SMOKE-FREE CAMPUS

Secondhand tobacco smoke poses a real health risk to everyone exposed to it.^{xxi} Consequently, state and local regulations, requirements by the Joint Commission on Accreditation of Healthcare Organizations, and an overall shift in the social norm are spurring hospitals and other organizations to become smoke-free.

In addition to improved health, there are economic benefits of becoming smoke-free. As an employer, you can expect to experience increased employee productivity and reductions in:

- Employee absenteeism
- Life insurance premiums
- Disability claims
- Medical expenditures for workers and retirees

A smoke-free environment also provides economic benefits for consumers. A recent study found that smokers with schizophrenia spent more than one-quarter of their total income on cigarettes.^{xxii}

Finally, because the tar in cigarettes reduces the body's ability to metabolize psychotropic medications, smoking cessation may also decrease the costs for these medications.^{xxiii}

Nevertheless, fewer than half of our state's mental hospitals currently have smoke-free campuses. A recent survey by the National Association of State Mental Health Program Directors Research Institute, however, found state mental hospitals increasingly interested in becoming smoke-free. The survey compares hospitals that permit smoking with those that do not:^{xxiv}

- Hospitals that permit smoking report significantly more tobacco-related incidents of seclusion, restraint, coercion and threats among patients and staff.
- Hospitals that do not permit smoking report fewer tobacco-related health issues.
- Both groups report similar staff training in medication treating and drug interactions, but smoke-free hospitals are significantly more likely to offer medication treatments for tobacco and modify client medicine doses based on tobacco use.

With smoke-free grounds as the ultimate goal, some facilities move smoking outdoors as a first step.^{xxv} Others ban it completely. Some consumers argue for the right to smoke in

smoke•free cam•pus

Define your terms:

Do you include all tobacco products?
Does it extend indoors, outdoors, across the street?

What is the contraband policy?

How do you enforce it with clients? Staff?
Visitors?

what they consider to be “home.” Clinicians counter that facilities should not permit addictive behaviors in a therapeutic environment. There are concerns that, unless facilities take a comprehensive approach to becoming smoke-free as part of a larger recovery initiative, clients and staff may use cigarettes as contraband, substitute smoking for unhealthy eating, or use of smokeless tobacco.

Experts recommend that in creating a smoke-free campus, hospitals should:^{xxvi}

- Implement smoking policies across the board, for staff and patients alike.
- Provide both staff and patients access to cessation assistance, including nicotine replacement therapy.
- View and handle consumer violation of the policy as a treatment issue.
- View and handle staff violation of the policy as a personnel issue.
- Develop a policy for visitor violations.
- Exempt from the policy traditional Indian spiritual or cultural ceremonies in the policy.

Further information about how to implement a smoke-free grounds policy can be found at www.tobaccoprogram.org, the University of Massachusetts or Mayo Clinic.

Northcoast Behavioral Healthcare System in Ohio in its policy clearly states the policy for use or possession of all types of tobacco products. The policy also includes a grid describing rules for violations by staff, consumers, and visitors. Appendix A.

TRAIN STAFF IN GOLD-STANDARD CARE

The most effective tobacco dependence treatment, known as the gold standard of preventive care, uses a protocol known as the 5A's.^{xxvii}

- Ask about smoking
- Advise quitting
- Assess readiness to quit
- Assist quit attempt
- Arrange for follow-up

Clinicians increasingly are using an abbreviated protocol: **Ask, Advise & Refer**.^{xxviii} This approach can improve whole-person care by linking medical and behavioral health professionals as they help clients quit smoking.

- Ask about smoking
- Advise quitting
- **Refer to help**

Resources to train addiction treatment staff in tobacco dependence may be found in Appendix B.

Maine Hospital Wins Legal Battle to Help Smokers Quit

In the late 1970s, like many who worked in mental hospitals, David Proffitt rewarded patients who attended groups with cigarette breaks. That memory, jarred by the alarming 2006 NASMHPD report, prompted him to “right some wrongs” in the Augusta, Maine hospital he heads. In April 2007, Riverview Psychiatric Center adopted a smoke-free campus that systematically treats peers for the addiction. While tackling tobacco takes effort, Mr. Proffitt views it as essential to recovery: “We do not believe we are giving a good caring environment by allowing the practice of a deadly addiction.”

Legal Hurdle: After the hospital announced its intention to become tobacco-free, advocacy lawyers representing mental health system clients, filed a legal complaint that the policy would violate the system’s mental health consent decree ensuring that clients had the right to the least restrictive setting and ability to refuse treatment. They claimed that banning smoking “forced” clients to engage in smoking cessation treatment. The hospital prevailed in court and, over the next four months, worked with staff and peers to create a tobacco-free environment. As long as smoking is an option, hospital staff argued, it is impossible to have meaningful discussions about alternative activities and new social opportunities to enhance recovery.

Getting Ready: During the four months before the policy was implemented, the hospital held two all-client forms and weekly small group meetings. Clients were assessed for tobacco use and readiness to quit and informed about options. Hospital staff presented statistics and health information to the hospital advisory board, consumers, staff, NAMI, and others. Presentations were posted on websites, announcing the starting date and the new policy. Smoking was banned on the entire campus including staff vehicles

Implementation: The hospital reduced one smoking break per week during the five weeks before smoking was banned. Staff and clients who wanted to quit were given the opportunity to receive prescriptions for nicotine replacement, take a classes, and participate in a support groups. Clinical systems, including intake procedures, treatment, and discharge planning, all were altered to address tobacco addiction.

Sustainability: The hospital celebrates patients and staff who are doing well in their quitting. When a consumer breaks the rules to smoke, staff seizes the opportunity to help him or her identify triggers and consider other coping mechanisms.

Results: There has been no increase in behavioral problems or incidents of seclusion and restraint and no increase in client grievances. One-third of the staff has quit smoking. And consumers and staff who have quit are proud of their abstinence. Riverview Psychiatric Center believes that recovery is based on the whole self being able to achieve the highest levels of independence and health and the capacity to perform in self-selected and meaningful roles. Addiction is incompatible with full recovery and it is the responsibility of care providers to ensure that all persons get the opportunity to experience a life free of addiction influences.

PSYCHOSOCIAL TREATMENT

Smoking often is a chronic, relapsing condition. It can take a smoker many tries to ultimately quit. Thus, it is useful to think of tobacco cessation as a process rather than an event.

The most effective stop-smoking treatment includes both psychosocial treatment and cessation medications. People in mental hospitals can benefit from an integrated care model that includes both treatment modes delivered by a single provider or a team.^{xxix}

Evidence shows that person-to-person counseling works best for helping smokers quit. This can be provided individually, in groups, or through a telephone quit line. Less than one-third of the State Mental Health Facilities surveyed reported offering smoking cessation programming at least once a week.^{xxx}

Mental health providers are well suited to integrate nicotine dependence treatment into whole-person care because they:

1. Already have advanced training in behavioral and substance abuse disorders that can be readily applied to nicotine dependence.
2. Can address the dynamic interaction of tobacco use and psychiatric symptoms.
3. Offer treatment sessions of sufficient numbers and duration to obtain optimal success, given the “dose-response” effect between treatment and smoking outcomes.^{xxxi}

Clients work with mental health practitioners to set treatment goals about smoking, based on how ready they are to quit: pre-contemplation, contemplation, preparation, action, and maintenance. Practitioners offer feedback to increase the motivation levels and assist clients through the process of quitting.^{xxxii}

The recommended psychosocial approaches to smoking cessation support broader goals to support consumer wellness and empowerment to improve mental and physical well-being. The elements of relationship-centered interviewing may be found in Appendix C.

Stages of Change for Quitting Tobacco

Pre-contemplation: Client is not considering quitting tobacco use and does not intend to quit in the foreseeable future.

Contemplation: Client is not prepared to quit, but intends to do so

Three therapeutic approaches are considered best-practices to help smokers quit: intra-treatment social support, extra-treatment social support, and problem-solving.^{xxxiii}

Intra-treatment social support encourages the client in quitting efforts, educating about the addiction, empathizing, and engaging the client to talk about quitting.

Extra-treatment social support includes enlisting clients to solicit support from others in quitting efforts.

Problem-solving includes helping clients recognize situations when they are likeliest to smoke and enlisting them to develop and use coping skills.

Colorado Groups Focus on Education, Skills to Quit Smoking

The University of Colorado at Denver Health & Science University recently initiated wellness groups for people with mental illness interested in quitting tobacco. Two facilitators teach problem-solving skills and cognitive-behavioral techniques in a structured 10-session program. Topics include the physical effects of smoking, confidence-building, refusal skills, becoming fit and well, understanding and coping with stress, depression, negative feelings and difficult situations. The final session focuses on celebrating the journey. The program is modeled after one developed by SANE, a non-profit in Australia whose mission is to improve the lives of people with mental illness. www.sane.org A manual to operate a similar group program will be available on-line. For more information, contact Dr. Chad Morris, Faculty, Department of Psychiatry, Chad.Morris@UCHSC.edu or (303) 315-9472.

CESSATION MEDICATIONS

Medications can help clients cope with the physical and emotional challenges of nicotine withdrawal as psychosocial therapies help them learn to live their lives without smoking.

Nicotine withdrawal effects can be similar to medication side-effects or mental illness relapse. Symptoms may include anger, irritability, impatience, restlessness and anxiety; difficulty concentrating and impaired task performance; cravings, hunger and weight gain; sleep disturbances, drowsiness and fatigue. The similarities between nicotine withdrawal, medication side-effects, and mental illness relapse underscore the importance of communicating about the quitting process with the consumer, families, staff and health care providers and offering appropriate pharmaceutical and psychosocial support.

The Food and Drug Administration has approved seven medications to help people quit tobacco. These include the five nicotine replacement therapies (NRTs) and two psychotropic medications.

Tool engages consumers, informs providers^{xxxvii}

Readings from a carbon monoxide meter can provide audio and visual feedback to show consumers the potential harmful effect of smoking:

- 28 ppm: a significant loss of oxygen-carrying capability of blood
- 35 ppm: legal limit for eight hours of work exposure
- 50 ppm: air pollution emergency alert

This knowledge can spur a consumer to quit or provide positive reinforcement for improvement. It also shows a physician whether or not the client is complying with treatment and reducing cigarette use.

Smokers who want to quit and practitioners who help them have expressed wariness about using medications with nicotine to curb the nicotine addiction. It is, however, the smoke, tars and

additives in cigarettes that make people sicken and die. The nicotine addicts people to tobacco. Therefore, nicotine replacement therapy is helpful, not harmful in helping smokers quit.^{xxxiv}

Nicotine Replacement Therapies ^{xxxv xxxvi}				
Medication	Strength	Dosage	Advantages	Disadvantages
Patch	Seven strengths: 5, 7, 10, 14, 15, 21 and 22 mg	16- or 24-hour release 6 to 10 weeks	<ul style="list-style-type: none"> • Consistent nicotine delivery • Easy use and concealment • Good compliance 	<ul style="list-style-type: none"> • Insomnia • Inability to titrate dose • Allergic reaction to patch adhesive • Morning nicotine cravings with 16-hour release
Gum	2-mg and 4-mg	up to 12 weeks	<ul style="list-style-type: none"> • Satisfy oral cravings • Delay weight gain • Can titrate to control withdrawal symptoms 	<ul style="list-style-type: none"> • Not socially acceptable • May adhere to dental fillings or bridges • Must be used properly to be effective
Lozenges	2 and 4 mg	1 lozenge every 1 to 2 hours while awake Up to 12 weeks	<ul style="list-style-type: none"> • Satisfy oral cravings • Delay weight gain • Can titrate to control withdrawal symptoms 	<ul style="list-style-type: none"> • Heavy users may experience hiccups, nausea, dyspepsia, and flatulence
Nasal spray	0.5 mg per spray	1 to 2 doses/hr. Not to exceed 40 doses/day For 3 to 6 months	<ul style="list-style-type: none"> • Rapid absorption • Can titrate for nicotine levels • Similar to smoking act 	<ul style="list-style-type: none"> • Nasal and throat irritation • Risk of dependence • Need to wait 5 minutes before driving because of sneezing
Inhaler	4 mg. per cartridge	Every 1 to 2 hours while awake 6 to 16 cartridges/day Up to 6 months	<ul style="list-style-type: none"> • Can titrate for desired nicotine levels 	<ul style="list-style-type: none"> • Can cause local irritation • Should be used cautiously in patients with bronchospastic disease

The two psychoactive drugs recommended by the FDA for tobacco cessation are bupropion SR and varenicline.

In addition to its use as an antidepressant, bupropion is believed to affect various brain neurotransmitters, including those that release dopamine in the mesolimbic system. Dopamine release levels have been found to reinforce addiction to nicotine and other substances.^{xxxvii}

Varenicline, approved by the FDA in 2006, is a partial nicotine agonist that lessens withdrawal symptoms and inhibits the “buzz” from a smoke. In early trials, it showed some better results than bupropion. However, it is too new for post-market surveillance and has not yet been tested on people with mental illness.^{xxxviii}

Other FDA-Approved Drugs for Tobacco Cessation				
Medication	Strength	Dosage	Advantages	Disadvantages
Bupropion SR	150 mg.	<ul style="list-style-type: none"> • Start 1 week prior to quit date • 150 mg/day for three days, then 150 mg twice a day • 6-12 weeks, but safe for much longer 	<ul style="list-style-type: none"> • Decreases cravings and withdrawal symptoms • Forestalls weight gain • Used to treat depression 	<ul style="list-style-type: none"> • Insomnia • Dry mouth • Small risk of seizures • Not for those with anorexia nervosa or bulimia
Varenicline	0.5 mg.	<ul style="list-style-type: none"> • Start 1 week prior to quit date • 0.5 mg/day for three days, then 0.5 mg 2 times a day for 4 days • Then, 1 mg/day morning and evening for 12 weeks. • Use for 12 more weeks can prevent relapse 	<ul style="list-style-type: none"> • Showed better results than bupropion in early trials 	<ul style="list-style-type: none"> • Untested on people with psychiatric diagnoses • Nausea • Insomnia • Constipation • Flatulence • Vomiting • Too early for post-market surveillance

SELECTING AND DOSING MEDICATIONS

While research on the use of tobacco cessation medications for people with mental illness is limited, clinical experts suggest that the use of NRT and bupropion medications in tobacco dependence is important.^{xxxix xl} Medications should be individualized based on a client’s psychiatric disorder, current medications, how the medications interact with tobacco use, and costs. Decisions also need to reflect the client’s preference, smoking habits, and tolerance of adverse effects, including nicotine withdrawal symptoms.^{xli}

During the quitting process, the dosage of tobacco cessation or other medications may need to be moderated. The tars in tobacco smoke change the metabolism of many antipsychotics, antidepressants, and anxiolytic medications.^{xlii xliii} When smokers initially quit smoking, their blood levels of medication can shift rapidly, increasing the risk side effects if dosages are not changed. Antipsychotic drugs affected by nicotine levels include haldol, prolixin, thorazine, clozapine, and olanzapine.^{xliv}

Medications Affected by Tobacco^{xlv}	
Antipsychotics	Fluphenazine, Haloperidol, Olanzapine, Clozapine, Chlorpromazine
Antidepressants	Amitriptyline, Doxepin, Clomipramine, Desipramine, Imipremine
Others	Caffeine, Theophylline, Warafin, Propanolol, Acetaminophen

The patch may be the preferred nicotine replacement option for people with serious mental illness because of its high compliance rate and ease of use. It is, however, less helpful for immediate cravings. Thus, clinicians frequently couple it with nicotine gum, inhaler, or nasal spray.^{xlvi} Higher doses of NRT are more likely to be effective, but also to produce adverse effects. Increasingly, those with severe nicotine addiction are prescribed a combination of nicotine replacement therapies—a patch plus one of the short-acting forms.^{xlvii}

Research on particular diagnoses could also influence the pharmacologic means of helping smokers quit:

Depression: Many studies link the effects of smoking to depression and vice versa because it is common for smokers to have depression symptoms or develop them while trying to quit smoking.^{xlviii} Bupropion can simultaneously address depression and smoking cessation. It can also effectively assist people without a history of depression or alcoholism in quitting tobacco.^{xlix}

Schizophrenia: People with schizophrenia are four times more likely to smoke than the general population and are generally more highly addicted to nicotine than other smokers. The nicotine may improve psychiatric symptoms or cognitive functioning or prevent worsening of nicotine withdrawal symptoms. However, people with schizophrenia *can* stop smoking, but overall quit rates are about half those of the general population of smokers.^{li} They may require longer duration of integrated treatment. In addition, they may be better assisted in quitting with combined and higher doses of NRT or bupropion and treatment with atypical antipsychotics, including resperadone, clozapine, or olanzepine (atypicals) rather than with the older, typical

antipsychotics.^{lii} The nicotine nasal spray may be a promising approach for smokers with schizophrenia and shizoffective disorder and may modestly improve some selected aspects of cognitive functioning in people with schizophrenia.^{liii liv}

PROVIDING HEALTHY ACTIVITIES^{lv lvi}

Historically, mental health treatment facilities have supported smoking as socially acceptable by rewarding staff and patients with smoking breaks. Here are some ways to transform your hospital's culture to support healthy activities:

- Supplant staff and consumer smoking breaks with fresh-air breaks
- Educate health care staff in its role to promote healthy behaviors
- Provide alternate recreation and social outlets for clients and providers
- Recognize staff for promoting healthy therapeutic and social activities with consumers.

Ohio Consumers, Staff 'Make Tracks'

Curiosity about a pedometer launched a wellness program that has dozens of Ohio consumers and staff tromping "coast to coast" on a virtual journey toward wellness and recovery.

It all started when a consumer noticed a staff member's pedometer and asked for one of his own. This sparked a team of staff and consumers to create a program that tallies the combined number of steps consumers and staff from two facilities take toward a specific "destination."

The first journey took the "travelers" east on Route 66 from Chicago to San Diego. Along the way, they received encouraging E-mail notes with photos of the landmarks from the area. On Route 66, these range from a national park to the largest ketchup bottle in America. When the group collectively reached "San Diego," they held a celebration at the facility, eating a healthy "California" veggie pizza.

Immediately after reaching its first destination, the walking group started a second journey. This time they "hiked the Appalachian Trail" with bottled water and trail mix in hand. Jennifer Schwirian, clinical program director for Athens Behavioral Health, doesn't know what food they'll enjoy when they reach the end of the trail in Georgia. "Maybe peaches," she says. The Snack Committee will consider healthy options and make a decision.

So far, roughly four months into the program, more than 200 people have received pedometers and are tallying steps and taking the wellness journey. The two Ohio facilities involved in the effort both are tobacco-free. Eventually, staff will integrate health measures for body mass index into the program. But for now, they're scrambling to map miles for the popular program: "We've walked a lot further and faster than we had thought," says Schwirian.

Sustaining the Effort

To systematically address tobacco use and addiction, hospitals need measures, clinical systems, and activities that consistently and compassionately address the issue and assist consumers in wellness and recovery.

MEANINGFUL MEASURES

“What we measure, we can change.” National organizations, including NRI/ORYX data and the Joint Commission on the Accreditation of Health Care, in an effort to improve tobacco use treatment measure how hospitals address tobacco use. INCLUDE MEASURES.

Depending upon how you use them, tobacco cessation measures can be more than scorecards. Coupled with internal changes, they can be benchmarks that help build sustainable tobacco cessation treatment that leads to longer, healthier lives for consumers.

EMPLOYEE BENEFITS AND SERVICES

Staff members who smoke often are most resistant to facility efforts to curb smoking. They are more likely to oppose the smoke-free campus and less likely to help clients quit. Show them you understand the personal challenges they face during this transition by providing resources, support and encouragement for them to quit smoking.^{lvii}

Employers recognize the value of investing in a smoke-free workforce:^{lviii}

- Health care costs are 40 percent higher for smokers than nonsmokers
- Employees who smoke spend about 18 days a year on smoke breaks.
- Smokers are absent from work 26 percent more often than non-smokers.
- They cost a company drug plan about twice as much as employees who do not smoke.
- Cost analyses show that tobacco cessation benefits pay for themselves and can save employers money after a few years.

The most effective treatments include psychosocial treatment and cessation medications (See Implementation above). Structure your tobacco-cessation benefits and services, including your employee assistance program, to:^{lix}

- Pay for counseling and medications, together or separately
- Cover counseling services, including telephone, group, and individual counseling
- Offer several counseling sessions over a period of several weeks
- Offer the FDA-approved medications, including both prescription and over-the-counter nicotine-replacement medication and bupropion.

Show tobacco users you understand the chronic nature of tobacco dependence by designing a benefit that makes it easier for them to succeed:^{lx}

- Require employees to pay no more than the standard co-payment. Data show that smokers are much more likely to quit when no co-payment is required.
- Provide at least two courses of treatment per year.

CLINICAL SYSTEMS

Once you set a goal to curb tobacco use and addiction, create a baseline measure, monitor your progress, and partner with others throughout the facility to continuously improve results.

Client assessments offer a strong foundation that can be used to establish nicotine addiction as a diagnosis, leading to treatment that is monitored and maintained until a client is discharged.

Relevant assessment areas include:

- Type of tobacco product used
- Number of years using tobacco
- Severity of addiction
- Quitting history
- Readiness to quit
- Exposure to second-hand smoke
- Mental health and health history
- Height and weight to monitor body mass index
- Insurance coverage

Staff can use the tobacco questions in the tool to monitor and evaluate changes in a client's quitting process and mental health, modifying treatment if indicated.

The University of Medicine and Dentistry of New Jersey uses a comprehensive assessment tool to screen, monitor, and evaluate changes as consumers engage in quitting tobacco at their QuitCenters. The tool is posted at www.tobaccoprogram.org/questionnaire.htm Appendix D shows the tobacco-related questions, modified to include height and weight information.

Clinical protocols can systematically incorporate tobacco cessation monitoring and treatment by:

1. Screening all mental health patients for tobacco use.
2. Entering tobacco use disorder as an official diagnosis.
3. Advising all smokers to quit
4. Asking about their motivations to quit at least three times a year. Devise a reminder system.
5. Providing all smokers who are motivated to quit with interventions.
6. Including in discharge plans tobacco cessation or relapse prevention with community support in client discharge plans.

Visitors and discharged patients, motivated to quit or prevent relapse, will benefit from knowing resources in the community. Two potential resources are Nicotine Anonymous and the Tobacco Quit Line. Nicotine Anonymous, available in almost every state, is a twelve-step cessation and

Staff, consumers 'grow young'

Consumers and staff in one New York hospital engage in 'healthy competition' to see how many 'years' they can add to their collective lives.

Every week, individuals log in to www.realage.com to answer questions about smoking, exercise, diet and other issues impacting their health. The site calculates a corresponding physiological age based on that information and provides specific suggestions for adding years to their 'real age.'

Hospital staff tabulates results weekly for individuals and collectively for consumers and staff. Participants then compete to see which team and individual trims the greatest percentage of years from their 'real age.'

The competition generates interest in healthy choices and cause for weekly celebration.

*Source: John Allen, Director
Bureau of Recipient Affairs
Office of Mental Health, New York*

maintenance program. Information about existing groups or how to start a new group is available at www.nicotine-anonymous.org.

While not rigorously studied for those with mental illness, Quit Lines offer easily accessible information and cessation support. Consumers from any state can call a national telephone number 1-800-QUIT-NOW and can be routed to a state-run quit line for support in quitting. The telephone resource can be a stable source of assistance and support or an adjunct referral resource for consumers or family members engaged in the quitting process. The level of service varies from state to state.

In the longer term and the broader community, mental hospitals can support broader smoke-free workplace laws and efforts by community psychiatric facilities to similarly eliminate tobacco use in helping consumers in wellness and recovery.

CELEBRATIONS

Create opportunities to support and celebrate consumers and staff as they go through the quitting process and make healthy choices. Hospitals in Ohio issue certificates to consumers who have remained abstinent from smoking for seven months. Attendance at all 10 group sessions merits a certificate from the University of Colorado at Denver Health & Science University program. Celebrations can also recognize a tobacco-free day for a particular consumer or group achievement, such as improved measures for reducing tobacco use.

APPENDICES

Appendix A	Tobacco-free Policy, Northcoast Behavioral Healthcare System State of Ohio Department of Mental Health
Appendix B	Contraband Policy, Northcoast Behavioral Healthcare System State of Ohio Department of Mental Health
Appendix C	Tobacco Dependence Training Resources for Addiction Treatment Staff
Appendix D	Relationship Centered Interviewing
Appendix E	Sample Tobacco Assessment Questions

APPENDIX A

Northcoast Behavioral Healthcare System

State of Ohio Department of Mental Health

Policy and Procedure Manual

05 - General Administrative Policies

Section:

05.07 - Smoke Free Environment

Policy:

Date Original: 03/01/1990

Date Effective: 11/16/2005

Date Last Reviewed: 10/19/2005

Purpose

Medical evidence clearly shows that smoking, either mainstream or side-stream (second-hand smoke), is harmful to the health of smokers and nonsmokers. In an effort to comply with the spirit of local clean air ordinances and the need to provide a healthy environment for patients and work associates, this hospital will counsel patients and work associates about the hazards of smoking, offer Smoking Cessation programs for patients and work associates to decrease or stop nicotine intake, and implement a smoke free environment. All patients, work associates, families and visitors are expected to comply with the smoking regulations detailed in this policy. Use of any tobacco product is prohibited on NBH hospital grounds after September 2, 2003.

Education and Notification

1. Each patient and work associate will be informed of the potential harmful effects of smoking and the hospital will offer the opportunity to participate in a smoking cessation program. Resource materials will be provided to unit-based and CSN work associates to assist in smoking education efforts for patients. Those patients and work associates who seek specific treatment for smoking cessation will be supported in this effort. As part of each patient's individual assessment by his/her treating psychiatrist, the various options for helping that patient avoid the distraction and discomfort of smoking cessation will be addressed. This will allow the patient to better focus on the primary psychiatric reason for their hospitalization.
2. Patients and visitors will be informed of this smoke free environment policy and of the corrective action(s) to be implemented upon infringement of the policy.
3. Work associates who violate this smoke free environment policy will be subject to progressive corrective action for Neglect of Duty.

Tobacco Prohibition

1. Use of tobacco products of any type is prohibited anywhere on NBH hospital grounds, including buildings, bathrooms, personal automobiles, parking lots, sidewalks, grassy areas, etc.
2. All unit-based work associates have the responsibility of educating patients to NBH' smoke free policy and providing health information about smoking. Policy information will be presented to the patients as part of an individualized treatment program, and will include advance notice of possible consequences for smoking infractions.
3. The sale of cigarettes, tobacco products and smoking materials is prohibited. All patients will be requested to turn in their smoking materials upon admission; these materials will be returned at discharge. Any smoking materials found on the unit will be confiscated by staff and returned to the patient at discharge.
4. Visitors are not to bring in cigarettes or other tobacco products. Violation may result in termination of visiting privileges.

Smoking and Contraband Violation Grid Process

When each patient is admitted, smoker or non-smoker, he/she should be educated by the Wellness Coordinator (or admitting nurse if Wellness Coordinator not available on admission day) on the no-smoking policy, the basic treatment options, and the patient/selling/visitors violation grids.

During the first treatment team meeting the smoker patient should be offered all available methods of remaining smoke free, and the smoking policy should be reviewed again.

When any new visitor arrives on a unit, the unit RN should review the no-smoking policy with the visitor before he/she/they are allowed to visit with the patient on or off grounds.

When any repeat visitor arrives on a unit, the unit RN should remind them that NBH is a smoke-free campus and to not provide any contraband to the patients.

When any case manager arrives on a unit to take a patient off the grounds for any reason, the unit RN should review the non-smoking policy with them, particularly the fact that they should not allow the patient to bring any contraband back onto the grounds following the level 4 off-grounds pass. In addition, they should understand that the patient has been educated about the value of maintaining abstinence even when away from NBH, but still may choose to smoke when off grounds.

Definition "Restrict patient from all unsupervised on-grounds movement for"

(This appears on the Patients and Selling grids)

It means that the patient may use level 2 movement on grounds, but not level 3, but yet may continue to use levels 4 and 5 if granted by treatment team or court, as required by law. The purpose is to not allow the patient to be on grounds alone or with other patients without staff present. Thus, only level 3 is actually affected. The unit should work out a plan to allow the patient who normally has level 3 work privileges to continue that work, but only with staff present during the restriction days.

Treatment teams will use the following grids when addressing violations of this policy.

Smoking Violation Grid - Patients	Smoking Violation Grid - Selling Contraband	Smoking Violation Grid - Visitors
<p>1st Violation</p> <p>Re-educate patient on smoking policy, including future consequences if policy is violated again. Educate patient about potential health risks, fire hazards, risks of second-hand smoke. Offer smoking cessation classes, treatment options available, and health education. Team meeting with the patient to review the treatment plan for potential changes. If smoking was on the unit, mandatory ward search for contraband. Confiscation of all contraband found during the violation - Any money found in excess of \$30 should be confiscated and placed into the patient's account.</p>	<p>1st Violation</p> <p>Re-educate patient on smoking policy, including future consequences if policy is violated again. Educate patient about potential fire hazards and hazards of second-hand smoke. If patient is a smoker, offer smoking cessation classes, treatment options, and health education. Treatment team to meet with patient and review the treatment plan for potential changes. Mandatory ward search for contraband. Confiscation of all contraband found during the violation - Any money found in excess of \$30 should be confiscated and placed into the patient's account.</p> <p>Restrict patient from all unsupervised on-grounds movement for 7 days.</p>	<p>1st Violation</p> <p>Wellness Coordinator or treatment team member to re-educate visitor(s) on smoking policy.</p> <p>Educate about future consequences to the patient they are visiting <u>and</u> to their ability to visit if policy is violated again.</p> <p>Educate about health risks, potential fire hazards and hazards of second-hand smoke.</p>
<p>2nd Violation</p> <p>Repeat all areas covered in the 1st violation</p> <p>Strongly encourage smoking cessation course (set of classes as defined on that unit) Team meeting with the patient to review the treatment plan for potential changes.</p> <p>Peer counseling by successfully abstinent patient along with Wellness Coordinator.</p>	<p>2nd Violation</p> <p>Repeat all areas covered in the 1st violation.</p> <p>If patient is a smoker, strongly encourage smoking cessation course (set of classes as defined on that unit).</p> <p>Restrict patient from all unsupervised on-grounds movement for 14 days.</p> <p>Consultation with CCO to determine need to further restrict movement beyond the above.</p>	<p>2nd Violation</p> <p>Repeat all areas covered in the 1st violation.</p> <p>Visitor to meet with at least 2 treatment team members to discuss policy before able to visit again.</p> <p>Visitation held for 14 days. Treatment plan to be adjusted accordingly.</p>
<p>3rd Violation</p> <p>Repeat all steps as after the 1st violation.</p> <p>Team meeting with the patient, including unit psychologist, to address behavioral triggers for smoking and to review the treatment plan for potential changes.</p>	<p>3rd Violation</p> <p>Repeat all areas covered in the 1st violation.</p> <p>Restrict patient from all unsupervised on-grounds movement for 30 days.</p> <p>Consultation with CCO to</p>	<p>3rd Violation</p> <p>Repeat all areas covered in the 1st violation.</p> <p>Visitor to meet with highest ranking police officer at that campus to review the smoking policy.</p> <p>Visitation held for 30 days.</p>

Officer and/or Patient on Patrol member to speak with patient regarding smoking safety issues. Restrict patient from all unsupervised on-grounds movement for 7 days.	determine need to further restrict movement beyond the above. Officer and/or Patient on Patrol member to speak with patient regarding smoking safety issues.	Treatment plan to be adjusted accordingly.
4th Violation	4th and beyond Violations	4th Violation
Repeat all steps as after the 1st violation. Restrict patient from all unsupervised on-grounds movement for 14 days. Consultation with CCO to determine need to further restrict movement beyond that above.	Repeat all areas covered in the 1st violation. Restrict patient from all unsupervised on-grounds movement for at least 60 days, until further plan and/or restrictions determined by CCO, which will involve full treatment team meeting with CCO and ANE.	Repeat all areas covered in the 1st violation. Visitation held for 60 days. Treatment plan to be adjusted accordingly. Full treatment team meeting with patient and visitor(s) before visitation allowed again.
5th and beyond Violations		5th and beyond Violations
Repeat all steps as after the 1st violation. Restrict patient from all unsupervised on-grounds movement for 30 days. At least one team meeting with patient to include ANE and CCO to address severity of violations, including any need to further restrict movement.		Repeat all areas covered in the 1st violation. Visitation held for at least 60 days, plus until patient is smoking-free for 14 days. Treatment plan to be adjusted accordingly. Treatment team meeting with patient, visitor(s), ANE, and CCO before visitation allowed again. At this meeting consequences for future violations, ranging up to elimination of all visitation, will be set by the CCO and enforced by team.

This policy shall be formally monitored and modified as necessary to maintain the effectiveness of its implementation.

(DS)

Reference Authority

Policy Owner: **Smith, Douglas**

Administrative Decision (With the role of the Hospital promoting good health)
Joint Commission on Accreditation of Healthcare Organizations

Appendix B

Northcoast Behavioral Healthcare System
State of Ohio Department of Mental Health

Policy and Procedure Manual

05 - General Administrative Policies	Section:	
05.08 - Handling of Contraband After Confiscation	Policy:	
Date Original: 09/01/1980	Date Effective: 04/13/2005	Date Last Reviewed: 04/01/2005

Purpose

To provide an identified and consistent procedure for the handling of found contraband the following is the procedure.

Definition

Contraband - Any item not permitted on NBH property. This includes, but is not limited to:

- A. Any weapon, such as a firearm, knife, pepper spray, stun gun, etc.
- B. Alcoholic Beverages
- C. Illicit substances, such as marijuana, LSD, PCP, cocaine, heroin, mushrooms, amphetamines, etc.
- D. All tobacco products such as snuff, cigarettes, chewing tobacco, cigars, etc.
- E. Lighters or matches or any type.

NOTE: Staff may bring items D and E onto NBH grounds, but shall not make use of these items on grounds and shall not bring such items onto any inpatient unit.

Procedure

A. On NBH or State Property

- 1) In the event suspected marijuana, drugs or other contraband is found in the possession of residents, employees, visitors or on the grounds of NBH, the NBH Police Department is to be notified at once and the

contraband released to the investigating Police Officer. An Incident Report shall be initiated.

2) The use of any tobacco products by patients or staff will result in the initiation of an Incident Report.

3) The NBH Police Department will take custody of all contraband and will turn over same to the Ohio State Highway Patrol (OSHP) for disposal according to the provisions contained in Section 2933.41 of the Ohio Revised code.

4) All confiscated items such as open packs of cigarettes and lighters will be disposed of by the police department. Expensive lighters will be confiscated and kept by the police department until the patient is discharged.

5) All confiscated packs of cigarettes that have not been opened will be placed in the patients property and returned to them upon discharge. Family members will be allowed to pick up unopened packs of cigarettes and expensive lighters.

B. Off grounds or off State property

1) Marijuana, drugs or other contraband found at a CSN site location or other off ground locations are to be reported to the Local Authorities, who will take custody of any contraband.

2) The NBH Police will follow up on the incident through the Incident Report (IR) that must be initiated and submitted by the staff/Supervisor who found the contraband and reported it.

Failure to abide by this procedure will place NBH personnel in violation of State and Federal laws.

Appendix C (To be added: Training Resources from Barriers and Solutions)

Appendix D

Relationship Centered Interviewing

Engagement

- Clinicians may believe that there is not enough time to let a patient tell his or her story, but research has shown that most patients will continue to speak without interruption for only two to three minutes.
- To "engage" a patient, a clinician must establish rapport by joining the patient during the opening minutes of the encounter. The first minutes form strong initial impressions. Communicate warmth by the introduction; be curious about the patient as a person rather than a medical problem. Listen to the language of the patient and adapt to that language. Invite the patient to tell the story of the illness. Find out all the complaints and the patient's goals for the visit and agree on an agenda.

Empathy

- Empathy begins when the clinician expresses understanding of the feelings, values, and experiences of the patient. Fortunately, empathy is not necessarily intrinsic to personality: Empathetic responses can be learned.
- It is important to create a warm setting. Consider using nonverbal language. Do not write and listen at the same time. When listening, look at the patient. Don't permit physical barriers -- typically the chart or desk -- to come between you and the patient.
- Invite the patient to tell you what he is feeling or thinking. Be curious about the experience of the patient as a person. Say, "That must be scary," or "How do you feel about that?"

Education

- Preventive medicine and health promotion are critical to delivery of high quality care.
- Education is not simply giving information, but requires understanding the patient's cognitive, emotional, and value perspectives. The clinician must discover what the patient knows and how the patient is thinking and feeling about whatever knowledge he or she possesses.
- Clinicians should assess the patient's understanding by asking questions and imagining their questions: What has happened to me? Why has it happened to me? What is going to happen to me? Supplement oral patient education with written notes and patient information handouts.

Enlistment

- Enlistment occurs when patients become partners in their own health care. Empowering and motivating them increases the likelihood that they will adhere to treatment and thus the likelihood of greater patient satisfaction. This is good for the health plan too, because office visits are actually reduced, quality and efficiency of care are improved, and ultimately the patient's loyalty to the plan and doctor is increased.
- There are two important steps in enlistment: agreeing on diagnosis, and agreeing on a treatment plan.
- Because most patients make a self-diagnosis, it is extremely helpful to elicit and acknowledge it early in the interview. Discuss any discrepancies between your conclusions and those of the patient.

John Butler, M.D., is consultant for clinician-patient communication for physician services at Health-Partners in Minneapolis. Vaughn Keller, Ed.D., is associate director of the Bayer Institute for Health Care Communication, and co-developed the E4 communication concept described in the text with Gregory Carroll, Ph.D., the institute's director.

Appendix E

Sample Tobacco Assessment Questions
Adapted from New Jersey QuitCenters

Initial Assessment Date	Initial Target Quit Date
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For Office Use Only

TOBACCO SPECIFIC INFORMATION

TOBACCO USE HISTORY

Please check appropriate box for each type of tobacco:

a.	CIGARETTES	Cigarettes – Never Used	
		Cigarettes – Used in Past	
		Cigarettes – Currently Use	
b.	PIPE	Pipe – Never Used	
		Pipe – Used in Past	
		Pipe – Currently Use	
c.	CIGARS	Cigars – Never Used	
		Cigars – Used in Past	
		Cigars – Currently Use	
d.	CHEWING /SMOKELESS TOBACCO	Chewing Tobacco – Never Used	
		Chewing Tobacco – Used in Past	
		Chewing Tobacco – Currently Use	

What age were you when you first used or tried tobacco?

What age were you when you started using tobacco on a regular basis?

How many years have you used tobacco?

How many cigarettes do you smoke each day?

Give the full details of your main current cigarettes
(full brand and name, size etc)

How many minutes after you wake up do you smoke your first cigarette?

Do you sometimes awaken at night to have a cigarette or use tobacco?

YES

NO

If yes, how many nights per week do you typically awaken to smoke?

8

9

10

Not true at all.

Somewhat true of me.

Extremely true of me.

27. I'm around smokers much of the time.
Please check one box.

1

2

3

4

5

6

7

8

9

10

Not true at all.

Somewhat true of me.

Extremely true of me.

28. Which statement best describes smoking inside your home?

a. Smoking is not allowed anywhere inside the home.	
b. Smoking is allowed in some places or sometimes.	
c. Smoking is allowed anywhere inside the home	
d. Other <i>please indicate</i>	

29. Please check (✓) next to the **one statement that best describes** your current situation:

a.	I am interested in quitting smoking/tobacco use in the next month, and I would be interested in any assistance I could get.	
b.	I am interested in drastically reducing the number of cigarettes I currently smoke (reduce by 50% or more), but am not interested in quitting totally.	
c.	I am seriously considering quitting in the next 6 months, but not in the next 30 days.	

d.	I currently smoke/use tobacco and am certain that I do not want to quit in the next 6 months.	
e.	I have recently stopped smoking/using tobacco, and I need to work at not slipping back to using.	
f.	I have not smoked/used tobacco products for over 6 months.	
30. Do people smoke outside the entrance to your work place?		YES
		NO

CURRENT HEALTH and MEDICAL HISTORY

31. Currently, do you have any symptoms or a disease that you believe is caused or made worse by your tobacco use?	YES	
	NO	
32. Have you ever received counseling, treatment or medication for alcohol or other drug problems?	YES	
	NO	
33. Are you pregnant or is there a chance that you could be pregnant at this time?	YES	
	NO	

34. Please check if you have a history of:	Condition:	Past	Currently treated
		Heart Disease (coronary disease, heart attack)	
	High Blood Pressure		
	Diabetes		
	High Cholesterol		
	Stroke		
	Cancer <i>type:</i>		
	Lung Disease (asthma, emphysema, COPD)		
	Depression		
	Anxiety		
	Schizophrenia		
	Bipolar Disorder		
	Alcohol Problems		
	Drug Problems		

38. Would you say that, in general, your health is:	Excellent	
	Good	
	Fair	
	Poor	

Does your health insurance cover smoking cessation counseling?

YES

NO

Don't Know

Does your health insurance cover any smoking cessation medications?

YES

NO

Don't Know

<i>For Office Use Only</i>	
Measurement of Expired Carbon-monoxide _____ p.p.m	On site: _____ Off-Site: _____
	Height _____ Body weight: _____ pounds
	Body Mass Index: _____

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