Tobacco-Free Living in Psychiatric Settings

A Best-Practices Toolkit Promoting Wellness and Recovery

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To Smoke or Not to Smoke

By Bill Newbold

To smoke or not to smoke there is no question about it whether it is lung cancer or a long life the choice to choose is obvious.
Life is good, life is great, life is hard but much harder when I smoked.
When I smoked I had no time to be in life so smoking is not to be and is not nobler too.
What a cigarette does hurts not only myself but the others about.
There are no more places left to smoke in my life or even in the world at large.
I have decided to ban smoking in my apartment and so far that has happened. No one for over two weeks has smoked here.
I can feel the fresh air keeping me healthy.
Once there was money to smoke and time to waste but now the days are shorter and my life too.
I can not waste my time and money doing something to hurt myself.
I love me and who I am becoming.
I think therefore I know not to smoke.
I know not to smoke so I am an ex-smoker.
I am an ex-smoker therefore I have become free of the addiction.
I am free of the addiction and now it is time to help others free themselves from the smoking.

Published with permission of the author and Choices, (Consumers Helping Others Improve their Condition by Ending Smoking,) a consumer-driven program for addressing tobacco use and addiction.
www.njchoices.org

Introduction

Silently and insidiously, tobacco sales and 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 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.

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.

Studies spanning more than four decades illustrate again and again how smoking devastates the health of the smoker as well as those who passively breathe in the deadly toxins. In psychiatric facilities, the accepted use of tobacco not only causes disease and death, it harms 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 percent of public mental health facilities allow smoking. If we share the goal of recovery with consumers and physicians, and view health and wellness as integral to recovery, the issue of tobacco use in our facilities cannot be ignored.

Tobacco companies systematically target vulnerable populations—children, people of color, the homeless, the LGBT (lesbian, gay, bisexual and transgender) community,—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 22 percent of the general population. Nearly half of all cigarettes consumed in the United States are by individuals 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. (Appendix A.) This toolkit is part of that initiative.

Tobacco 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 tobacco use 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 to quit and learn new ways to live longer, healthier lives.

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.

As individuals committed to supporting health, wellness and recovery, and entrusted with the care and treatment of consumers in our facilities, 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 and clinicians, 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.[i]

As administrators, we will commit the leadership and resources necessary to create tobacco-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.

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.

How to use this toolkit

The charts, checklists, policies, and resources in this toolkit are practical tools to create a tobacco-free psychiatric setting. Regardless of your progress on this initiative for wellness and recovery, we encourage you to make the tools work for you.

The toolkit is organized sequentially into three chapters with relevant appendices:

- Getting Ready
- Implementing
- Sustaining the Effort

Adapt the tools and the sequence to fit *your* goals, process, workplace, and community.

Though state psychiatric hospital superintendents are the primary audience, the toolkit is meant to be shared. Pass along all or part of it to champions both within and outside your facility to help create a tobacco-free setting and community for people with mental illness. Clinical staff will be interested in sections about treatment protocols and curricula. Human resources managers can use guidelines and sample policies to review and revise your employee policies, procedures, and benefit design. Core team members may read through the entire toolkit as they craft plans for smoke-free psychiatric settings.

Share the tools outside of your facility, particularly with clinicians, case managers, community mental health centers, acute care hospitals, residential facilities, tobacco quit lines and consumer-operated services. While each milieu has particular challenges during this transformation, if we work together and view tobacco use within the context of wellness and recovery, we can overcome these challenges to better help consumers and staff make and sustain healthy choices.

The toolkit is designed to address all types of tobacco use, including cigarettes, cigars, and chewing tobacco. Effective tobacco-free policies recognize the health impacts and addictive nature of nicotine in its various forms. Cessation treatment is essentially the same, whether a consumer smokes or chews tobacco.

Finally, the toolkit is based on what we know today to be best-practices for 'Tobacco-Free Living in a Psychiatric Setting.' As we work with and learn from new research and partner experience, we will add to our knowledge and change our tools. Our goal, however, is steadfast: to improve the wellness and recovery of people with mental illness.

If you have suggestions or items that could help colleagues through this transition, please send them to Bob.Glover@nasmhpd.org

Questions and Answers

As you eliminate tobacco use to foster wellness and recovery, engage staff, consumers, family members, and people in your community in discussion. Listen. Address concerns. Collaborate with partners. 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 for a lifetime. What we will do is have a safe environment where consumers or staff members can learn how smoking impacts their lives and find 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 tobacco use here, we actually become *more* like treatment and health care facilities on 'the outside.' We've known for more than 40 years that smoking is hazardous to our health. Workplaces all over our community have banned tobacco use. 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 and those around 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 tobacco-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 want to quit, 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 and consumers 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 consumers and staff 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. We don't refuse treatment for other addictions, even when we believe the client is not motivated to remain abstinent. We give everyone the opportunity to detoxify while in treatment with the hope that they will choose a substance-free life. Quitting is hard, especially in environments where tobacco use is acceptable. By incorporating tobacco cessation in our recovery philosophy, we can 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 tobacco use to open new doors to wellness and recovery.

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 will reduce uncomfortable nicotine withdrawal symptoms by appropriately using nicotine replacement therapy and other medications. 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 tobacco-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 tobacco-free 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 will create and post signs to remind consumers, staff, and visitors that our hospital is a sanctuary from smoke. We will expand drug formularies to include more options for nicotine dependence treatment. And we need to create new forms with reminders that keep tobacco use on the front burner in our treatment 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; less fire danger, and the knowledge that we are achieving excellence by providing people with mental illness with the healthy, therapeutic environment they deserve.

Getting Ready

Launching a successful tobacco-free initiative as part of broader recovery can take months—but it is the greatest investment you can make for health and wellness. Depending upon the laws that govern smoking in your community, it can take up to a year and a half. It likely will take less time if your facility is in a smoke-free jurisdiction.[ii]

LEAD

During the initial months, you will encounter adamant opposition and resounding support. As a leader, you will need to remain visible, respect the concerns of opponents, develop a clear process that engages consumers, staff and community leaders, and work to develop a shared vision of wellness and recovery.

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.

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.

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.**[iii]
- **Smokers with schizophrenia spend more than one-quarter of their total income on cigarettes.**[iv]
- **Tobacco use interferes with psychiatric medications.**[v]
- **Although more than two-thirds of smokers want to quit, only 3 percent are able to quit on their own. They are far more successful with the kind of help we will be offering.**[vi]
- **Even highly addicted smokers with mental illness *can* quit and are more likely to succeed with a combination of medications and behavioral therapy.**[vii]

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 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.

Staff Champs Lead the Way

When Summit Behavioral Healthcare in Cincinnati went smoke-free in 2004, supportive smoke-free champions from within the staff helped prepare staff and patients on units, including their own, for going smoke-free. The champions, who readily identified themselves, attended weekly patient and staff meetings to explain the initiative, discuss the issues, and hand out flyers and data.

"Having these employees take a leading role," said Malcolm King, nurse executive at Summit Behavioral, "helped give the initiative a grassroots feel, rather than one … being dumped on everyone from above. This active involvement was immensely helpful in our eventual success."

REACH KEY AUDIENCES

Removing tobacco from mental hospitals is a transformational change that frightens some, expands opportunities for others, and improves the overall health and safety 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.[viii]

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.[ix] Consider the perspectives of key audiences:

- **Clinical 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. Offer support for smokers on staff who want to quit.[x]
- **Union leaders:** Discuss how staff who work in psychiatric hospitals smoke at higher rates than the general population (30 percent to 40 percent, compared with 22 percent)[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.

> **"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*
> Sacramento, CA, , *1999*
> Dept. of Health Services, 2002

- **Medical and quality improvement staff:** Emphasize how tobacco cessation is relevant to patients and essential in integrating mental health and physical healthcare.[xii] [xiii] Consider ways to align and measure medical tobacco cessation 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-tobacco policies when they come to visit. Offer support or share community resources for family members who wish to quit tobacco.

- **Human resources personnel:** Design new benefits, programs, and policies to eliminate tobacco use at work and support smokers to quit.
- **Law enforcement and security staff:** Explain how the new tobacco-free 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 tobacco 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 serve them.[xv]

Maine Hospital Wins Legal Battle

In the 1970s, like many who worked in mental hospitals, David Proffitt rewarded patients with cigarette breaks if they attended groups. That memory, jarred by the alarming 2006 NASMHPD report, prompted him to "right some wrongs" in the Augusta, Maine hospital he heads. In 2007, Riverview Psychiatric Center adopted a tobacco-free campus that systematically treats peers for the addiction. The effort is essential to recovery, says Mr. Profitt: "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 tobacco-free initiative, lawyers for mental health system clients filed a legal complaint that the policy would violate a client's ability to refuse treatment. Banning smoking, they claimed, "forced" clients into cessation treatment. The hospital prevailed in court, then carefully prepared for the changes.

Getting Ready: During the four months prior to going tobacco-free, the hospital held frequent meetings. Staff presented information to the hospital advisory board, consumers, the National Alliance on Mental Illness, and others, posting the information, policy, and starting date on websites. Smoking was banned campus-wide, including in vehicles.

Implementation: The hospital gradually reduced smoking breaks. Treatment staff assessed all consumers for tobacco use and readiness to quit, then informed them of options. Staff and clients interested in quitting received nicotine replacement, attended classes, and participated in support groups. Clinical systems for intake, treatment, and discharge were altered to address tobacco addiction.

Results: There has been no increase in behavioral problems or incidents of seclusion and restraint and no increase in client grievances. Within a month of implementing the policy, one-third of the staff that smoked had quit. Consumers and staff who have quit are proud of their abstinence. The hospital celebrates consumers and staff who are doing well in the quitting process.

SPEARHEAD TEAM TO 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 tobacco 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 cessation.[xvi]

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.

Externally, 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 the community about your efforts, debunking myths about mental illness. Emphasize the connections between physical and mental health. Lead the community in demanding smoking cessation services. Share how your new initiative increases fire safety. Tell your story in professional journals, blogs, websites, and speeches.

Smoking Prevalence among People with Mental Illnesses

Major depression	**50 to 60 %**
Anxiety disorder	**45 to 60 %**
Bipolar disorder	**55 to 70 %**
Schizophrenia*	**65 to 85 %**

*20 % of those with schizophrenia started smoking at college age and many began smoking in mental health settings, receiving cigarettes for good behavior.

Source: Presentation at NASMPD Medical Directors Council Technical Report Meeting on Smoking Policy and Treatment at State Operated Psychiatric Hospitals, April 20-21, 2006. San Francisco, California. DeLeone et al., in press.

PLAN

Adequate planning and broad engagement can mitigate potential problems, 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]

In looking at the lives of consumers, consider changes you will need to make within your psychiatric setting as well as in community settings. Collaborate with partners to support consumers to make healthy choices and maintain tobacco abstinence after they are discharged.

Within the Facility

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

- ☐ Create a plan with an implementation timetable.
- ☐ Include social, clinical, and system changes in your plan.
- ☐ Incorporate communications strategies in every aspect 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. Take into consideration other major institutional events.
- ☐ Choose a fair-weather start date for your initiative if you are replacing smoke breaks with ‘fresh air’ breaks or other outdoor activities.

In the Community

As you plan to transform your facility, consider ways to help consumers make healthy choices after they leave. This will involve collaborative efforts:

- ☐ Raise awareness among new partners about disparate smoking rates 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.
- ☐ Use tools that provide people with mental illness a way to assess their own progress, including standard tobacco-use assessments and carbon monoxide monitors.
- ☐ Partner with follow-up agencies and resources, including outpatient programs, case managers, consumer-operated services, private psychiatric facilities, state tobacco programs and quit lines to broaden efforts to help people with mental illness sustain abstinence from tobacco use.

ADOPT SYSTEMS TO ADDRESS TOBACCO USE

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

Clinical Systems Changes

- ☐ Train staff in the clinical and psychosocial elements of smoking or chewing tobacco, encouraging them to earn CME or CEU credits for learning about tobacco cessation.
- ☐ Assess tobacco use for all patients, entering tobacco use disorder as an official diagnosis.
- ☐ Assess other wellness measures, including body mass index, to monitor impact of tobacco cessation on weight.
- ☐ Devise clinical protocols with a reminder system to advise all tobacco users to quit and assess motivations to quit at least three times a year.
- ☐ Assure that a specific mental health practitioner is responsible for each person's mental health needs and coordinates all services, including tobacco cessation.
- ☐ Include tobacco cessation in treatment plan.
- ☐ Provide all tobacco users who are motivated to quit with interventions.
- ☐ Incorporate tobacco cessation into individual and group therapies.
- ☐ Include both prescription and over-the-counter 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 in patient charts.
- ☐ 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 in discharge plan tobacco cessation or relapse prevention with support.

Other Systems Changes

- ☐ Provide free or low-cost tobacco cessation treatment for employees, through benefits, wellness programs, and employee assistance programs.
- ☐ Bill insurance for client and employee tobacco cessation treatment.
- ☐ 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.
- ☐ Work with families on how they can support consumers in their efforts to become tobacco-free.
- ☐ Collect data about consumer and staff tobacco use, including use of evidence-based methods 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 consumer's insurance coverage, public or private insurers may cover at least some aspects of tobacco cessation treatment. Such treatment is generally considered a medical benefit, 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, 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 midwifes, 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 where 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

If you adequately prepare staff, consumers, and community members for your transition to a tobacco-free environment, you will find partners eager to help you implement your new policies. Build systems that support consumers with integrated care, highly trained staff, healthy activities, and consistent help for breaking their nicotine addiction as part of wellness and overall recovery. Knowledge and understanding of nicotine addiction and treatment will help you design the treatments and protocols that encourage consumer wellness and recovery.

Tobacco-Free Campus

Secondhand tobacco smoke poses a real health risk to everyone exposed to it.[xxi] As more and more communities and workplaces become smoke-free, tobacco companies increasingly push smokeless products that also are addictive and cause health problems. 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 ban use of all tobacco products.

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

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

A smoke-free environment also provides economic benefits for consumers. A recent study found that smokers with schizophrenia spend more than one-quarter of their total income on cigarettes—a persuasive reason for quitting.[xxii]

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

Nevertheless, fewer than half of our state psychiatric 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 tobacco-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 medicine doses based on tobacco use.

With tobacco-free grounds as the ultimate goal, some facilities move smoking outdoors as a first step.[xxv] Others ban tobacco use completely. Some consumers argue for the right to use tobacco in 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 tobacco-free as part of a larger recovery initiative, clients and staff may use cigarettes as contraband, substitute smoking for unhealthy eating, or switch to smokeless tobacco.

Tobacco-Free Campus

Define your terms:

- Include all tobacco products
- Define physical boundaries of campus
- Consider exceptions, including ceremonial use or medical orders
- Create a contraband policy
- Include enforcement policies with consumers, staff, and visitors

Experts recommend that in creating a tobacco-free campus, hospitals should:[xxvi]

- ☐ Implement tobacco-use 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.
- ☐ Include in the policy information about off-site use, including home visitations.
- ☐ Exempt from the policy traditional Native American spiritual or cultural ceremonies.

See Appendix B for an example of a tobacco-free campus policy and a contraband policy. Other hospital policies and resources can be found at the website of Americans for Non-Smokers Rights, http://www.no-smoke.org/

41 percent of State Psychiatric Facilities are Smoke-Free.

NASMHPD Research Institute, Inc. (2006). Survey on Smoking Policies and Practices for Psychiatric Facilities. Presented by Joe Parks, M.D. at the NASMHPD Medical Directors Council Technical Report Meeting on Smoking Policy and Treatment at State Operated Psychiatric Hospitals

TRAIN STAFF IN GOLD-STANDARD CARE

Smoking often is a chronic, relapsing condition—an addiction that can be very difficult to break. 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 process for treating tobacco use, the 'gold standard of preventive care,' uses a protocol known as the 5A's.[xxvii]

- **A**sk about smoking
- **A**dvise quitting
- **A**ssess readiness to quit
- **A**ssist quit attempt
- **A**rrange for follow-up

Clinicians increasingly use an abbreviated protocol: **A**sk, **A**dvise & **R**efer.[xxviii] This approach can improve whole-person care by linking medical and behavioral health professionals as they help clients quit smoking.

- **A**sk about smoking
- **A**dvise quitting
- **R**efer to help

The first three A's—Ask, Advise and Assess—begin the tobacco conversation. When a person is ready to quit, you can best help them with assistance that includes social support and both psychosocial treatment and cessation medications. Resources to train treatment staff in tobacco cessation may be found in Appendix H.

Tool engages consumers, informs providers[xxxvi]

Consumers can visually understand how smoking harms them through a carbon monoxide meter. Providers can point to results to help motivate a smoker to quit or show how cutting down or quitting improves health:

— 50 ppm: air pollution emergency
— 35 ppm: legal limit for 8-hours work
— 28 ppm: significant loss of oxygen-carrying blood capability

The price of monitors ranges from $600 to $1,500.

TREATMENT

From intake to discharge, a consumer who smokes may quit and relapse multiple times. With clinical systems in place, individuals in psychiatric facilities can repeatedly engage in quitting. With each attempt, they can gain understanding and skills for wellness and recovery. You can effectively help them in your facility through an integrated care model that includes both psychosocial treatment and cessation medications delivered by a single provider or a team.[xxix]

ASSESS CLIENTS

When you assess tobacco use as part of your intake process, you can begin a dialogue with consumers, establish nicotine addiction as a diagnosis, and determine suitable treatment. The right assessment tool also can help monitor the effectiveness and impact of treatment and create an appropriate discharge plan.

The assessment below, developed by licensed clinical psychologist and renowned tobacco-cessation researcher Karl Fagerstrom, is used by many to gauge nicotine addiction.

ITEMS AND SCORING FOR THE FAGERSTROM TEST FOR NICOTINE DEPENDENCE*			
	QUESTIONS	**ANSWERS**	**POINTS**
1.	How soon after you wake up do you smoke your first cigarette?	Within 5 minutes	**3**
		6-30 minutes	**2**
		31-60 minutes	**1**
		After 60 minutes	**0**
2.	Do you find it difficult to refrain from smoking in places where it is forbidden (in church, at the library, in the movies, etc.)?	Yes	**1**
		No	**0**
3.	Which cigarette would you hate most to give up?	The first one in the morning	**1**
		All others	**0**
4.	How many cigarettes per day do you smoke?	31 or more	**3**
		21-30	**2**
		11-20	**1**
		10 or less	**0**
5.	Do you smoke more frequently during the first hours after waking than during the rest of the day?	Yes	**1**
		No	**0**
6.	Do you smoke if you are so ill that you are in bed most of the day?	Yes	**1**
		No	**0**
		TOTAL	

SCORING:	**0-2 points**	**Mild nicotine dependence**	**SOURCE:** Fagerstrom KO: Measuring degree of physical dependence to tobacco smoking with reference to individualization of treatment, Addictive Behavior 3: 235-241, 1978.
	3-6 points	**Moderate nicotine Dependence**	
	7-10 points	**Heavy nicotine dependence**	

Appendix F shows an assessment tool, adapted from New Jersey QuitCenters, that also measures tobacco-use history and readiness to quit. It can be found at www.tobaccoprogram.org/questionaire.htm

PSYCHOSOCIAL TREATMENT

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.

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- cessation outcomes.[xxx xxxi]

> **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 in the next six months.
> **Preparation:** Client is actively considering quitting in the immediate future or within the next month.
> **Action:** Client makes overt attempts to quit and is within the first six months of the process.
> **Maintenance:** Client has quit for longer than six months.

Consumers 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]

A New Jersey-based program called CHOICES (Consumers Helping Others Improve their Condition by Ending Smoking), founded in 2005, trains peer counselors who are paid to educate smokers in the community. Peer counselors have told more than 2,400 consumers that smoking is harmful and treatment works.[xxxiii] www.njchoices.org

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

Three therapeutic approaches are considered best-practices to help smokers quit: intra-treatment social support, extra-treatment social support, and problem-solving.[xxxiv]

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.

Two New Manuals for Conducting Health Groups

Consumers 'Learn About Healthy Living'

Treatment staff can adapt a program designed for tobacco users with all types of mental health problems. Learning About Healthy Living: Tobacco and You is a two-part course offering education and support for healthy choices. The first part, for people with mental illness whether they are ready to quit smoking or not, is structured around 20 topics. It mostly teaches about the impacts of tobacco use, but also educates consumers about healthy diet, activity, and stress management. Those who complete the first series of sessions and want to quit smoking can participate in an eight- to ten-week action-based program to learn to quit. The guide includes goals, objectives, and handouts for each session. http://ubhc.umdnj.edu/nav/LearningAboutHealthyLiving.pdf It was developed with input from consumers and treatment staff through a partnership of the New Jersey Department of Human Services and the University of Medicine and Dentistry of New Jersey. If you use the manual, please share feedback with Dr. Jill Williams, jill.williams@umdnj.edu

Colorado Groups Focus on Education, Skills to Quit Smoking

Another new guide for facilitators was developed by the University of Colorado at Denver Health & Science University. In this program, also aimed at people with mental illness, 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 celebrates the journey. http://www.cdhs.state.co.us/dmh/providers_ebp.htm For more information, contact Dr. Chad Morris, Faculty, Department of Psychiatry, Chad.Morris@UCHSC.edu or (303) 315-9472.

CESSATION MEDICATIONS (APPENDIX D)

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 using tobacco.

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 underscore the importance of offering appropriate pharmaceutical and psychosocial support and communicating about the quitting process with the consumer, families, staff and health care providers.

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

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 makes people addicted to tobacco. Therefore, nicotine replacement therapy is helpful, not harmful in helping smokers quit.[xxxv]

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.[xxxvi]

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, at the time of publication, it was too new for post-market surveillance and had not yet been tested on people with mental illness.[xxxvii]

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.[xxxviii xxxix] 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.[xl]

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.[xli xlii] When smokers initially quit smoking, their blood levels of medication can rise rapidly, increasing the risk of side effects if dosages are not changed.[xliii]

SMOKING CESSATION MAY INCREASE BLOOD LEVELS OF THESE MEDICATIONS		
ANTIPSYCHOTICS	Haloperidol	Olanzapine
	Chlorpromazine	Clozapine
	Fluphenazine	
ANTIDEPRESSANTS	Clomimpramine	Imipramine
	Desipramine	Nortriptyline
	Doxepin	
MOOD STABILIZERS	Carbamazepine	
ANXIOLYTICS	Desmethyldiazepam	
	Oxazepam	
OTHERS	Heparin	Acetaminophen
	Insulin	Caffeine
	Theophylline	Propranolol
	Tacrine	Warfarin

Source: Twin Valley Behavioral Healthcare, Patient Smoking Cessation Guidelines, May 3, 2007.

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, an inhaler or nasal spray.[xliv] Higher doses of NRT may be more effective, since studies indicate higher nicotine levels per cigarette when smoked by people with some disorders like schizophrenia.[xlv xlvi] This also may 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 choice of medications for helping smokers quit.

Depression: Many studies link the effects of smoking to depression and vice versa because some smokers, especially those with a history of depression, may experience depressive symptoms when quitting 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 up to four times more likely to smoke than the general population and are generally more highly addicted to nicotine than other smokers. For some, tobacco use and nicotine may improve cognitive functioning and lessen some positive symptoms of schizophrenia. However, the effects are generally not major and people with schizophrenia *can* stop smoking without significant psychiatric consequences. Overall quit rates for people with schizophrenia are about half those of the general population of smokers.[l] [li] People with schizophrenia 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 risperidone, 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 schizoaffective disorder and may modestly improve some selected aspects of cognitive functioning in people with schizophrenia.[liii] [liv]

Relapse Prevention

Nicotine addiction is like a chronic disease. It often takes many tries for a tobacco user to quit.

However, relapsed smokers often fail to adequately plan their quit, do not use medications, or use them incorrectly. Generally speaking, those attempting to quit tobacco significantly under-dose or stop using pharmacotherapy too soon.[lv]

Regardless of the reason, each relapse can provide insights for a particular consumer. A relapse is a slip, not a failure. When treatment staff understand this, they can communicate this with consumers and encourage them to learn from prior experiences during their quitting process.

Appendix E suggests ways clinicians can use the Ask, Advise, Refer model to help relapsed tobacco users improve their quitting success.

PROVIDING HEALTHY ACTIVITIES [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 responsibility to promote healthy behaviors and include this role in job descriptions and performance evaluations.
- ☐ Provide alternate recreation and social outlets for consumers and staff.
- ☐ 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 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, landmarks 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 Ms. 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 gets measured, gets done." 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.

Understand the extent of the problem, set achievable goals, and use meaningful measures to improve wellness by reducing tobacco use. Consult with others from community, state, and national groups on ways to adopt consistent measures that can be used to improve continuity of care for consumers and leverage broader health improvements at the state and national levels.

As a facility, here are some items you may wish to measure:

- Tobacco use by consumers
- Tobacco use by staff
- Quit attempts, including use of evidence-based treatments
- Quit rates, at three months, six months, and one year

Incorporate measures about consumer tobacco use into clinical systems, including intake and treatment information.

Outside vendors can use health risk appraisals to measure staff tobacco use and other health behaviors. Organizations may offer financial incentives, including cash bonuses or reduced health insurance premiums, for staff participation in such appraisals, which are designed to reduce health risks.

In addition, collect information about staff training on tobacco cessation and the extent staff uses the training to help consumers quit.

Information about consumers and staff can be aggregated and measured over time to assess progress on your smoke-free initiative, improve efforts, and celebrate significant benchmarks.

At the state and national levels, fuel the interest of partners in public and private health to gather data about the health behaviors, morbidity, and mortality of people with serious mental illness. Together, we can use the data to improve the wellness and recovery of people with mental illness nationwide.

At least seven national data systems, if adapted, could be used to improve the wellness and recovery of people with mental illness. These studies address co-morbidities, mortality, and insurance coverage, health care and health behaviors.[lvii]

Employee Benefits and Services

Staff members who smoke often are most resistant to facility efforts to curb tobacco use. They are more likely to oppose the tobacco-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 using tobacco. [lviii]

Employers recognize the value of investing in a tobacco-free workforce: [lix]

- 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, cessation medications and social support. Structure your tobacco-cessation benefits and services, including your employee assistance program, to:[lx]

- 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 prescription and over-the-counter niocotine-replacement medication, bupropion, and varenicline.

Show tobacco users you understand the chronic nature of tobacco dependence by designing a benefit that makes it easier for them to succeed: [lxi]

- 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.
- Offer a variety of options for psychosocial treatment and medications.

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 subtracting years to their 'real age' so they will live longer, healthier lives.

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

CONTINUITY OF CARE

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 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 quitting. The level of service, including hours of operation, varies from state to state. The website www.1800quitnowcancer.gov can show you services in your state, including hours and languages spoken.

These and other resources are listed in Appendix H.

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

Celebrating

Some things are worth celebrating: health, safety, clean air. New insights that wrinkle your brow, but propel you to create a better world. New systems that lead to excellence. New partners that improve health. A person's first day without tobacco.

Pioneers in tobacco-free psychiatric settings incorporate celebration in their work. Hospitals in Ohio recognize consumers who remain abstinent from smoking for seven months. The University of Colorado at Denver Health & Science University awards certificates to those who show up to all 10 sessions of the tobacco-cessation group.

Consider how celebration can shift the culture in your facility from insidiously promoting smoking to one that honors the people who do battle with the gripping addiction. Contests ending with celebration and mementos can reinforce healthy choices. Laud a consumer or staff member for a tobacco-free day with a special crown or a congratulatory note.

Give T-shirts to those who attend healthy living groups. Throw a facility-wide party to mark reduced smoking rates by staff and consumers. Bring together consumers
and staff to plan healthy choice parties, providing consumers with opportunities to build the kinds of 'normalized' relationships they once associated exclusively with smoking.

Finally, celebrate your decision to create a tobacco-free setting. Bill Newboll, a consumer who quit smoking through the CHOICE program, muses about his success:
"I love me and who I am becoming." This, indeed, is worthy of celebration…one day at a time and year after year.

APPENDICES

Appendix A	NASMHPD Position Statement on Smoking Policy and Treatment at State Operated Psychiatric Hospitals
Appendix B	(1) Tobacco-free Policy, Northcoast Behavioral Healthcare System State of Ohio Department of Mental Health (2) Contraband Policy, Northcoast Behavioral Healthcare System State of Ohio Department of Mental Health
Appendix C	Relationship-Centered Interviewing
Appendix D	FDA-Approved Medications
Appendix E	Relapse Protocols
Appendix F	Sample Tobacco-use Assessment Questions
Appendix G	Twin Rivers Behavioral Health Smoke-Free Guidelines: Clinical Guidelines for Cognitive and Behavioral Interventions, Post-Discharge Guidelines, Implementation
Appendix H	Resources

Appendix A

NASMHPD POSITION STATEMENT ON SMOKING POLICY AND TREATMENT AT STATE OPERATED PSYCHIATRIC HOSPITALS

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 has 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 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.

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.

As partners in the recovery process, we will work with individuals, national organizations and decision makers, public and private service providers, and other support systems to ensure that those who want to be tobacco free have access to continued cessation treatment and support in the community. Health and wellness is a shared responsibility. NASMHPD is committed to doing their part to assist individuals in improving their quality of life by going tobacco free and will continue to advocate for those with mental illness in their right and hope to be well in recovery.

Approved by the NASMHPD Membership on July 10, 2006

Appendix B

Northcoast Behavioral Healthcare System
State of Ohio Department of Mental Health

Policy and Procedure Manual

Section: **05 - General Administrative Policies**

Policy: **05.07 – Smoke-Free Environment**

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's 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 the case manager, 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.

Reference Authority

Policy Owner: **Smith, Douglas**

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

Policy and Procedure Manual

Section: **05 - General Administrative Policies**

Policy: **05.08 - Handling of Contraband After Confiscation**

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 storage with the patient's 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

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 D

Pharmacologic Product Guide: FDA-Approved Medications

	NICOTINE REPLACEMENT THERAPY (NRT) FORMULATIONS						*BUPROPION SR*	*VARENICLINE*
	GUM	LOZENGE	TRANSDERMAL PREPARATIONS[1]		NASAL SPRAY	ORAL INHALER		
	Nicorette[2], Generic OTC 2 mg, 4 mg; original, FreshMint[2], Fruit Chill[2], mint, orange[2]	**Commit[2], Generic** OTC 2 mg, 4 mg mint	**Nicoderm CQ[2]** OTC 24-hour release 7 mg, 14 mg, 21 mg	**Generic Patch** OTC/Rx (formerly Habitrol) 24-hour release 7 mg, 14 mg, 21 mg	**Nicotrol NS[3]** Rx Metered spray 0.5 mg nicotine in 50 µL aqueous nicotine solution	**Nicotrol Inhaler[3]** Rx 10 mg cartridge delivers 4 mg inhaled nicotine vapor	***Zyban[2], Generic*** Rx 150 mg sustained-release tablet	***Chantix[3]*** Rx 0.5 mg, 1 mg tablet
	▪ Pregnancy (Category D) ▪ Recent (=2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Temporomandibular joint disease	▪ Pregnancy (Category D) ▪ Recent (=2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris	▪ Pregnancy (Category D) ▪ Recent (=2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris		▪ Pregnancy (Category D) ▪ Recent (=2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Underlying chronic nasal disorders (rhinitis, nasal polyps, sinusitis) ▪ Severe reactive airway disease	▪ Pregnancy (Category D) ▪ Recent (=2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Bronchospastic disease	▪ Pregnancy (Category C) ▪ Concomitant therapy with medications or medical conditions known to lower the seizure threshold ▪ Severe hepatic cirrhosis **Contraindications:** ▪ Seizure disorder ▪ Concomitant bupropion (e.g., Wellbutrin) therapy ▪ Current or prior diagnosis of bulimia or anorexia nervosa ▪ Simultaneous abrupt discontinuation of alcohol or sedatives (including benzodiazepines) ▪ MAO inhibitor therapy in previous 14 days	▪ Pregnancy (Category C) ▪ Severe renal impairment (dosage adjustment is necessary)

	³25 cigarettes/day: 4 mg *<25 cigarettes/day:* 2 mg Week 1–6: 1 piece q 1–2 hours Week 7–9: 1 piece q 2–4 hours Week 10–12: 1 piece q 4–8 hours ■ Maximum, 24 pieces/day ■ Chew each piece slowly ■ Park between cheek and gum when peppery or tingling sensation appears (~15–30 chews) ■ Resume chewing when taste or tingle fades ■ Repeat chew/park steps until most of the nicotine is gone (taste or tingle does not return; generally 30 min) ■ Park in different areas of mouth ■ No food or beverages 15 min before or during use ■ Duration: up to 12 weeks	*1st cigarette =30 minutes after waking:* 4 mg *1st cigarette >30 minutes after waking:* 2 mg Week 1–6: 1 lozenge q 1–2 hours Week 7–9: 1 lozenge q 2–4 hours Week 10–12: 1 lozenge q 4–8 hours ■ Maximum, 20 lozenges/day ■ Allow to dissolve slowly (20-30 minutes) ■ Nicotine release may cause a warm, tingling sensation ■ Do not chew or swallow ■ Occasionally rotate to different areas of the mouth ■ No food or beverages 15 minutes before or during use ■ Duration: up to 12 weeks	*>10 cigarettes/day:* 21 mg/day x 6 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks *£10 cigarettes/day:* 14 mg/day x 6 weeks 7 mg/day x 2 weeks ■ May wear patch for 16 hours if patient experiences sleep disturbances (remove at bedtime) ■ Duration: 8–10 weeks	*>10 cigarettes/day:* 21 mg/day x 4 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks *£10 cigarettes/day:* 14 mg/day x 6 weeks 7 mg/day x 2 weeks ■ May wear patch for 16 hours if patient experiences sleep disturbances (remove at bedtime) ■ Duration: 8 weeks	1–2 doses/hour (8–40 doses/day) One dose = 2 sprays (one in **each** nostril); each spray delivers 0.5 mg of nicotine to the nasal mucosa ■ Maximum – 5 doses/hour – 40 doses/day ■ For best results, initially use at least 8 doses/day ■ Patients should not sniff, swallow, or inhale through the nose as the spray is being administered ■ Duration: 3–6 months	6–16 cartridges/day; individualized dosing ■ Initially, use at least 6 cartridges/day ■ Best effects with continuous puffing for 20 minutes ■ Nicotine in cartridge is depleted after 20 minutes of active puffing ■ Patient should inhale into back of throat or puff in short breaths ■ Do NOT inhale into the lungs (like a cigarette) but "puff" as if lighting a pipe ■ Open cartridge retains potency for 24 hours ■ Duration: up to 6 months	150 mg po q AM x 3 days, then increase to 150 mg po bid ■ Do not exceed 300 mg/day ■ Treatment should be initiated while patient is still smoking ■ Set quit date 1–2 weeks **after** initiation of therapy ■ Allow at least 8 hours between doses ■ Avoid bedtime dosing to minimize insomnia ■ Dose tapering is not necessary ■ Can be used safely with NRT ■ Duration: 7–12 weeks, with maintenance up to 6 months in selected patients	Days 1–3: 0.5 mg po q AM Days 4–7: 0.5 mg po bid Weeks 2–12: 1 mg po bid ■ Patients should begin therapy 1 week prior to quit date ■ Take dose after eating with a full glass of water ■ Dose tapering is not necessary ■ Nausea and insomnia are side effects that are usually temporary ■ Duration: 12 weeks; an additional 12 week course may be used in selected patients

	Nicotine Replacement Therapy (NRT) Formulations						Bupropion SR	Varenicline
	Gum	Lozenge	*Transdermal Preparations*		Nasal Spray	Oral Inhaler		
			Nicoderm CQ	*Generic Patch*				
Adverse Effects	▪ Mouth/jaw soreness ▪ Hiccups ▪ Dyspepsia ▪ Hypersalivation ▪ Effects associated with incorrect chewing technique: – Lightheadedness – Nausea/vomiting – Throat and mouth irritation	▪ Nausea ▪ Hiccups ▪ Cough ▪ Heartburn ▪ Headache ▪ Flatulence ▪ Insomnia	▪ Local skin reactions (erythema, pruritus, burning) ▪ Headache ▪ Sleep disturbances (insomnia) or abnormal/vivid dreams (associated with nocturnal nicotine absorption)		▪ Nasal and/or throat irritation (hot, peppery, or burning sensation) ▪ Rhinitis ▪ Tearing ▪ Sneezing ▪ Cough ▪ Headache	▪ Mouth and/or throat irritation ▪ Unpleasant taste ▪ Cough ▪ Rhinitis ▪ Dyspepsia ▪ Hiccups ▪ Headache	▪ Insomnia ▪ Dry mouth ▪ Nervousness/difficulty concentrating ▪ Rash ▪ Constipation ▪ Seizures (risk is 1/1,000 [0.1%])	▪ Nausea ▪ Sleep disturbances (insomnia, abnormal dreams) ▪ Constipation ▪ Flatulence ▪ Vomiting
	▪ Gum use might satisfy oral cravings ▪ Gum use may delay weight gain ▪ Patients can titrate therapy to manage withdrawal symptoms	▪ Lozenge use might satisfy oral cravings ▪ Patients can titrate therapy to manage withdrawal symptoms	▪ Provides consistent nicotine levels over 24 hours ▪ Easy to use and conceal ▪ Once-a-day dosing associated with fewer compliance problems		▪ Patients can titrate therapy to manage withdrawal symptoms	▪ Patients can titrate therapy to manage withdrawal symptoms ▪ Mimics hand-to-mouth ritual of smoking	▪ Easy to use; oral formulation might be associated with fewer compliance problems ▪ Can be used with NRT ▪ Might be beneficial in patients with depression	▪ Easy to use; oral formulation might be associated with fewer compliance problems ▪ Offers a new mechanism of action for patients who have failed other agents
	▪ Gum chewing may not be socially acceptable ▪ Gum is difficult to use with dentures ▪ Patients must use proper chewing technique to minimize adverse effects	▪ Gastrointestinal side effects (nausea, hiccups, heartburn) might be bothersome	▪ Patients cannot titrate the dose ▪ Allergic reactions to adhesive might occur ▪ Patients with dermatologic conditions should not use the patch		▪ Nasal/throat irritation may be bothersome ▪ Dependence can result ▪ Patients must wait 5 minutes before driving or operating heavy machinery ▪ Patients with chronic nasal disorders or severe reactive airway disease should not use the spray	▪ Initial throat or mouth irritation can be bothersome ▪ Cartridges should not be stored in very warm conditions or used in very cold conditions ▪ Patients with underlying bronchospastic disease must use the inhaler with caution	▪ Seizure risk is increased ▪ Several contraindications and precautions preclude use (see Precautions, above)	▪ May induce nausea in up to one third of patients ▪ Post-marketing surveillance data not yet available
	www.nicorette.com	www.commitlozenge.com	www.nicodermcq.com	www.habitrol.com	www.nicotrol.com	www.nicotrol.com	- - - -	www.chantix.com
Cost/Day[4]	2 mg: $2.65–$5.16 (9 pieces) 4 mg: $3.18–$5.81 (9 pieces)	2 mg: $4.92 (9 pieces) 4 mg: $5.26 (9 pieces)	$3.35–$3.91 (1 patch)	$2.10–$2.94 (1 patch)	$3.67 (8 doses)	$5.25–$6.07 (6 cartridges)	$3.62–$5.73 (2 tablets)	$4.00–$4.22 (2 tablets)

[1] Transdermal patch formulations previously marketed, but no longer available: Nicotrol 5 mg, 10 mg, 15 mg delivered over 16 hours (Pfizer) and generic patch (formerly Prostep) 11 mg and 22 mg delivered over 24 hours.
[2] Marketed by GlaxoSmithKline.
[3] Marketed by Pfizer.
[4] Average wholesale price from 2006 Drug Topics Redbook. Montvale, NJ: Medical Economics Company, Inc., December 2006.

Abbreviations: Hx, history; MAO, monoamine oxidase; NRT, nicotine replacement therapy; OTC, (over-the-counter) non-prescription product; Rx, prescription product.

For complete prescribing information, please refer to the manufacturers' package inserts.

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Appendix E

Relapsed Smokers Who Are Ready to Try Again: What to Do?

A 3-STEP PROTOCOL FOR CLINICIANS

Many smokers who relapse do so because they fail to plan. Often, patients think that they can simply "make" themselves quit and do not avail themselves of the many proven behavior change programs provided by various sources. Furthermore, most smokers do not use a cessation medication or, if they do, they use it incorrectly. Generally speaking, patients significantly under-dose or stop pharmacologic therapy too soon.

You can help relapsed smokers regain abstinence by encouraging them to learn from their prior experiences rather than use those experiences as proof that they cannot quit. To underscore this perspective, inform patients that the best way to quit smoking is to combine a behavior change program with a cessation medication. The following **3-step protocol** will help you provide this information in an efficient, effective manner for patients who are ready to try again:

STEP 1: ASK

- "TELL ME ABOUT YOUR LAST QUIT ATTEMPT(S)."
- "DID YOU USE A SMOKING-CESSATION MEDICATION?"
  - If yes: "EXPLAIN HOW YOU USED YOUR MEDICATION."
    – Reinforce proper usage/ rectify incorrect usage or dosage
  - If no: "WHAT WAS YOUR REASONING FOR NOT USING A MEDICATION?"
- "DID YOU RECEIVE ANY PROFESSIONAL ADVICE OR ENROLL IN A BEHAVIOR CHANGE PROGRAM?"
  - If yes: "TELL ME WHAT YOU LIKED, OR DIDN'T LIKE ABOUT THE ASSISTANCE YOU RECEIVED."
  - If no: "WHAT WAS YOUR REASONING FOR NOT SEEKING ADVICE OR ENROLLING IN A PROGRAM?"

STEP 2: ADVISE

- "ACCORDING TO THE MOST CURRENT RESEARCH AND THE SURGEON GENERAL, THE BEST WAY TO QUIT IS TO COMBINE A SMOKING CESSATION MEDICATION WITH A BEHAVIORAL PROGRAM."

  NOTE: Examples of behavior change programs are listed on the reverse side, under the "Refer" section of the protocol.
- "LET'S DISCUSS WHICH MEDICATION(S) WOULD BE BEST FOR YOU."
- Review current level of tobacco use, past usage of medications, personal preference, precautions/ contraindications, etc. to determine best product for current quit attempt.

  NOTE: Refer to attached ***Pharmacologic Product Guide*** for dosing instructions, etc. for FDA-approved smoking cessation medications.
- If patient has failed a serious quit attempt using monotherapy, consider the following options:
  - If prior medication was used correctly, was well tolerated, and appeared to have been effective, consider repeating the same medication regimen in conjunction with an enhanced behavioral program.
  - If prior medication was used incorrectly, carefully review usage instructions.
  - If prior medication was used correctly but did not control urges/withdrawal, or if patient prefers something new, review other medication options, including both single and combination therapy:

Combination therapy currently is off-label for all cessation medications, but is supported by multiple clinical trials and the *Clinical Practice Guideline for Treating Tobacco Use and Dependence.*

– *Safe:* Most smokers are highly tolerant to nicotine from years of smoking. Side effects are rare and easily mitigated by reducing or stopping use.

– *Effective:* Especially in those who failed with one medication. Also useful in patients who are heavily

dependent (2 or more packs/day).

Suggested combinations:

–Nicotine patch as base therapy + gum, lozenge, or inhaler as needed for breakthrough urges.

Sustained-release bupropion (Zyban) has been examined in combination with nicotine replacement therapies, but their combined effectiveness is not well established.

Currently, varenicline (Chantix) is not recommended for combination therapy.

STEP 3: REFER

The amount of counseling that patients receive is linearly related to their success in quitting. More counseling contacts yield higher quit rates. If you do not have the time or expertise to assist patients with quitting and to provide follow-up counseling, refer patients to other resources:

- To a behavior change program:

  "HERE ARE SOME SUGGESTIONS. WHICH DO YOU THINK WOULD WORK BEST FOR YOU?"

  - 1 800 QUIT NOW, the national toll-free telephone quit line
  - All products are accompanied by a free behavior change program: Refer to usage instructions for enrollment procedures
  - Hospital-based or other local resources
  - www.quitnet.com, an on-line tobacco cessation support program
  - smokefree.gov, an on-line guide for quitting
  - American Lung Association, American Cancer Society, or American Heart Association web-sites or cessation programs (e.g., American Lung Association's *Freedom From Smoking* group cessation program)
  - Local pharmacist, physician, or therapist specializing in cessation
- To a community pharmacist:
  - "WHEN YOU PURCHASE YOUR SMOKING CESSATION MEDICATION, PLEASE TAKE A FEW MINUTES TO DISCUSS PROPER USAGE WITH THE PHARMACIST, EVEN IF IT IS A PRODUCT YOU HAVE USED IN THE PAST. PROPER USAGE WILL GIVE YOU THE BEST CHANCE OF SUCCESS."
- To other staff:
  - If you have dedicated cessation staff within your clinic or health-care organization, refer patient to these resources for follow-up counseling.

For more information, see Fiore MC, Bailey WC, Cohen SJ, et al. (2000). *Treating Tobacco Use and Dependence. Clinical Practice Guideline.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service. Available at: www.surgeongeneral.gov/tobacco.

For complete prescribing information, please refer to the manufacturers' package inserts.

Appendix F

Sample Tobacco Assessment Questions
Adapted from New Jersey QuitCenters

Initial Assessment Date	Initial Target Quit Date

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?		
How many times have you tried to quit smoking?		
Is/was your current usual brand of cigarette a “light” (“low tar”) brand?	YES	
	NO	
Is/was your current usual brand of cigarette a menthol brand?	YES	
	NO	
In the last six months, have you received any mail addressed to you from any tobacco company?	YES	
	NO	

CURRENT QUIT ATTEMPT

24. How **important** is it to you to stop tobacco use now?
    Please check one box.

1	2	3	4	5	6	7	8	9	10

Not at all — Average Importance — Extremely Important

25. How **confident** are you that you will succeed in stopping your tobacco use now?
    Please check one box.

1	2	3	4	5	6	7	8	9	10

Not At All — Somewhat Confident — Extremely Confident

26. A lot of my friends or family smoke.
    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.

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 *please indicate*	

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 *type:*		
	Lung Disease (asthma, emphysema, COPD)		
	Depression		
	Anxiety		
	Schizophrenia		
	Bipolar Disorder		
	Alcohol Problems		
	Drug Problems		

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

Question	Response	
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	

For Office Use Only	
Measurement of Expired Carbon-monoxide ________p.p.m	On site: Off-Site:
	Height _________ Body weight: _____________pounds
	Body Mass Index:_____________

Appendix G

TWIN VALLEY BEHAVIORAL HEALTHCARE
CLINICAL GUIDELINES FOR MANAGEMENT OF SMOKING CESSATION

PHASE OF MANAGEMENT	ACTIONS	PERSON(S) RESPONSIBLE	TIME FRAME
NOTIFICATION	All patients will be advised on admission that : 1. Twin Valley is a smoke-free facility and the use of all tobacco products is prohibited AND 2. The admitting physician will discuss treatment options that could help minimize any discomfort that they may experience from nicotine withdrawal.	Admissions Clerk, Nursing Supervisor, or Intake Social Worker	On Admission
ASSESSMENT	The patient will be assessed for Nicotine Dependence and need for nicotine replacement therapy and other pharmacological or behavioral interventions. A diagnosis of Nicotine Dependence will be entered into the patient's record, and if appropriate and desired, treatment interventions will be implemented. Options for assessment: 1. Number of cigarettes smoked/day AND /OR: 2. Standardized tool (Fagerstrom Scale) The impact of smoking cessation on medication metabolism should also be considered	Admitting Physician	On Admission
INITIAL EDUCATION AND SUPPORT	Patients will be provided information regarding the effects of smoking, what can be expected with smoking cessation/nicotine withdrawal, and what could be of help. Verbal support will be provided and questions answered.	Unit Nurse	At Time of Nursing Assessment
TREATMENT PLANNING	After initial assessment, patients will receive appropriate individualized treatment for their nicotine addiction and interventions will be entered in the treatment plan.	Unit Treatment Teams	At Treatment Team Meeting

<table>
<tr><th colspan="4">TWIN VALLEY BEHAVIORAL HEALTHCARE
COGNITIVE AND BEHAVIORAL INTERVENTIONS</th></tr>
<tr><td>BASIC CHARACTERISTICS</td><td>Staff will continue to provide verbal support, encouragement and other treatment throughout the hospitalization:

1. All tobacco users will be offered at least a minimal intervention. Even brief interventions lasting 3 minutes or less increase abstinence rates.
2. Intensive interventions are more effective than less-intensive interventions and should be used if possible.
3. Four or more sessions of persons-to-person treatment, with a session length of at least 10 minutes and a total contact time of 31-90 minutes appears especially effective in increasing abstinence rates.
4. Treatment delivered by a variety of clinician types (e.g., physician, psychologist, nurse, dentist) increases abstinence rates so all clinicians should be prepared to provide smoking cessation interventions.
5. Interventions should be tailored to the patient’s individual circumstance and level of motivation.</td><td rowspan="3">All Clinical Staff:

RNS
TPWS
Social Worker
Psychologist
AT
Psychiatrist
Clinic Physician
Dentist
SAMI Staff</td><td rowspan="3">Throughout the hospitalization</td></tr>
<tr><td>TREATMENT FORMAT</td><td>The following interventions are effective and can be used for smoking cessation:

1. Proactive counseling
2. Group counseling
3. Individual counseling
Interventions that are delivered in multiple formats increase abstinence rates.</td></tr>
<tr><td>TREATMENT MODALITIES</td><td>ADVICE: Physicians and other clinicians should strongly advise every patient who smokes to quit. Physician advice to quit increases abstinence rates and advice from other clinicians is also likely to be effective.</td></tr>
</table>

TWIN VALLEY BEHAVIORAL HEALTHCARE COGNITIVE AND BEHAVIORAL INTERVENTIONS			
TREATMENT MODALITIES (Continued)	**PRACTICAL COUNSELING AND SUPPORT:** including problem solving training, coping skills training and relapse prevention, such as: 1. Encouraging the patient in the quit attempt 2. Communicating concern and caring 3. Encouraging the patient to talk about the quitting process 4. Providing basic information about smoking and quitting. 5. Identifying high-risk situations that increase the risk of smoking. 6. Developing and practicing coping skills. 7. Training and encouraging the patient to seek and utilize social supports. **OTHER CLINICAL INTERVENTIONS:** Referral to individual therapy and group therapy dependent on patient's individual issues and symptoms (e.g., Anger management, leisure recreation, SAMI Basics, etc)	All Clinical Staff: RNS TPWS Social Worker Psychologist AT Psychiatrist Clinic Physician SAMI Staff	Throughout the Hospitalization

POST-DISCHARGE GUIDELINES	
PATIENT STATUS	**SUGGESTED ACTIONS**
Patients who have expressed a desire to remain tobacco abstinent	• Encourage them in their continued efforts to remain tobacco-free. • Suggest that they consider remaining on nicotine replacement (NRT) under the direction of their outpatient doctor after discharge. • If they wish to continue on NRT after leaving the hospital, provide a prescription for the nicotine replacement system they received while here. Although patches, gum and lozenges are over-the-counter, Medicaid will reimburse for them if the patient has a written prescription. • Offer phone numbers of support organizations (Tobacco Quit Line, American Lung Association, American Cancer Society, etc.). • Emphasize that they should use the product as directed only and that they should not smoke within *two hours* of wearing the patch, taking a lozenge, or chewing nicotine gum to minimize the risk of nicotine toxicity. If they are tempted to smoke, they should seek support to avoid doing so. • If they do smoke, they should not be discouraged, but try again to quit in the future.
Patients who are ambivalent about remaining tobacco abstinent	• Encourage them to *try* to remain tobacco-free after discharge. Point out the benefits they may see. • Suggest that if they do return to smoking after discharge, they should reconsider quitting in the future. • If after your discussion, they decide to try to remain abstinent after discharge, suggest that they consider remaining on nicotine replacement under the direction of their outpatient doctor. • If they wish to continue on NRT after leaving the hospital, provide a prescription for the nicotine replacement system they received while here. • Offer phone numbers of support organizations (Tobacco Quit Line, American Lung Association, American Cancer Society, etc.). • Emphasize that they should use the product as directed only and that they should not smoke within *two hours* of wearing the patch, taking a lozenge, or chewing nicotine gum to minimize the risk of nicotine toxicity. If they are tempted to smoke, they should seek support to avoid doing so. • If they do smoke, they should not be discouraged, but try again to quit in the future.
Patients who have firmly decided to return to smoking	• Encourage them to reconsider. Point out the benefits they may see. • Offer phone numbers of support organizations (Tobacco Quit Line, American Lung Association, American Cancer Society, etc.) to access if they change their mind. • If they continue to insist that they will smoke after discharge, stop all nicotine replacement on the day of discharge, at least *two hours* before leaving the hospital to minimize the risk of nicotine toxicity.

IMPLEMENTATION

Reviewed and adopted by the Medical Staff Executive Committee on: ___________________________________

Reviewed and adopted by the Administrative Executive Committee on: _____________________________________

These guidelines shall remain in effect until revised or rescinded by the Office of the Chief Executive and/or Chair of MSO.

___________________________	______________________________
Chief Executive Officer	Chair of MSO

Appendix H

Resources

Tobacco Dependence Training Resources

ACT Center for Tobacco Treatment, Education, and Research, University of Mississippi
A program of the School of Dentistry provides training, education, treatment and research, including a comprehensive tobacco treatment specialist program. http://actcenter.umc.edu/

Addiction Technology Transfer Center of New England
An online course on tobacco of cessation, funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.
www.attc-ne.org/education/courses/ann262.html

Association for the Treatment of Tobacco Use and Dependence
An association of tobacco treatment specialists that promotes greater access to evidence-based tobacco treatment. Association has developed competency standards for tobacco treatment specialists. www.attud.org

Mayo Clinic Nicotine Dependence Center Education Program
An intensive five-day course focusing on tobacco dependence treatment skills.
http://mayoresearch.mayo.edu/mayo/research/ndc_education/tts_certification.cfm

The Tobacco Cessation Resource Center
An online training for pharmacists on a basic cessation protocol that can be used in any practice situation http://www.ashp.org/stop_smoking/index.cfm?cfid=17002563&CFToken=47266449

University of California School of Pharmacy
Rx for Change: Clinician-Assisted Tobacco Cessation teaches health professionals about tobacco cessation. A six-hour course available at no cost for non-commercial research or teaching.
http://rxforchange.ucsf.edu/

University of Colorado at Denver Health & Science University
Facilitator's guide for structured 10-session program for people with mental illness interested in quitting tobacco. http://www.cdhs.state.co.us/dmh/providers_ebp.htm

University of Massachusetts Medical School, Center for Tobacco Prevention and Control
Center engages in a range of tobacco-related research, clinical treatment, technical assistance and professional education. www.umassmed.edu/behavmed/tobacco

University of Medicine and Dentistry of New Jersey, Tobacco Dependence Program
Provides training on tobacco dependence, program consultation, technical assistance, research and clinical service. www.tobaccoprogram.org Publishes facilitators guide for 20-session Learning about Healthy Living group program for people with mental illness.
http://ubhc.umdnj.edu/nav/LearningAboutHealthyLiving.pdf

University of Wisconsin Medical School, Center for Tobacco Research and Intervention
Provides extensive training and technical assistance to put tobacco cessation research into practice. www.ctri.wisc.edu and an online program www.medscape.com/viewprogram/3607

Quitting Resources for Consumers, Staff, or Families

1-800-QUIT-NOW
www.1800quitnow.cancer.gov

American Cancer Society
1-800-ACS-2345
www.cancer.org

American Heart Association
1 800-242-1793 (call center) or 800-242-1793
www.amhrt.org

American Legacy Foundation QuitNet
http://www3.quitnet.com/

American Lung Association
1 800-586-4872 or 212-315-8700
www.lungusa.org

CHOICES (Consumers Help Others Improve their Condition by Ending Smoking)
www.njchoices.org

Clubhouse of Suffolk
30-minute educational and motivational video
Tobacco and Mental Health Training Project
939 Johnson Avenue
P.O. Box 373
Ronkonkoma, NY 11779.

Healthiest State in the Nation
On-line wellness tools, including quit-tobacco tracker
www.healthieststate.net

National Cancer Institute
Cancer Information Service
1-800-4-CANCER or 800-422-6237
www.cancer.gov

Office on Smoking & Health, Centers for Disease Control & Prevention
770-448-5705
www.cdc.gov/tobacco

National Tobacco QuitLine, includes links to state services
1-800-QUIT NOW
1800quitnow.cancer.gov

Nicotine Anonymous
1-877-TRY-NICA (1-877-879-6422)
www.nicotine-anonymous.org

Smokefree.gov
Online materials, including info on state Quitlines
www.smokefree.gov

Tobacco-Free Workplace Resources

Americans for Non-Smokers Rights
A section on workplace efforts to become tobacco-free includes information for health facilities, a national list of hospitals that have become tobacco-free, information, sample policies, and relevant news stories. http://www.no-smoke.org/goingsmokefree.php?id=449

Joint Commission on Accreditation of Health Care Organizations
New interactive site where registered members can add information and links to relevant materials. Topics include Smoking Cessation and Smoke-Free Hospital Campus.
https://exchange.ucsf.edu/exchweb/bin/redir.asp?URL=http://wikihealthcare.jointcommission.org/

North Carolina Healthy Hospital Initiative
A state initiative that helps hospitals become tobacco-free. A program of North Carolina Prevention Partners, the website includes sample tobacco-free policies, a model timeline, and news releases. http://www.ncpreventionpartners.org/

Office on Smoking and Health, Centers for Disease Control & Prevention
Site includes information about second-hand smoke, smokeless tobacco, fact sheets and other resources. http://www.cdc.gov/tobacco

"Save Lives, Save Money"
The Centers for Disease Control & Prevention in June 2006 published a booklet that makes the case for making a business tobacco-free and outlines options and steps.
http://www.cdc.gov/tobacco/research_data/SecondhandSmoke/Workplace_Policy.pdf

University of Michigan Health System
This hospital system developed a Smoke-Free Hospital Implementation CD with practical tools and information, including a checklist for action, legal issues, signage examples, news releases, and information about inpatient/outpatient cessation programs. You can order a free copy of the CD from: http://www.med.umich.edu/mfit/tobacco/requestSFE.htm

U.S. Department of Health & Human Services, 2006 Surgeon General's Report
The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Includes science, policies, and resources to support creation of a smoke-free workplace. http://www.surgeongeneral.gov/library/secondhandsmoke/

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