Twelfth in a Series of Technical Reports

TECHNICAL REPORT ON SMOKING POLICY AND TREATMENT IN STATE OPERATED PSYCHIATRIC FACILITIES

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REPORT PREPARATION

This report is the 12th in a continuing series of reports initiated by the Medical Directors Council of the National Association of State Mental Health Program Directors (NASMHPD) and developed in collaboration with NASMHPD leadership. The purpose of these reports is to provide information and assistance to State mental health directors on emerging clinical and service systems issues.

"Smoking Policy and Treatment in State Operated Psychiatric Facilities" was developed though expert presentations, discussions and literature distributed prior to and during a Medical Directors' meeting in San Francisco, California, from April 20-21, 2006. A list of meeting participants is included as Appendix A. The purpose of this report is to demonstrate the urgent need for providers and systems of care to lead and support individuals and environments in their efforts to go tobacco and smoke free.

Joe Parks, M.D. and Peggy Jewell, M.D. (Editors) and Maile Burke M.P.A. (Technical Writer) prepared an initial draft of this report which was distributed to all meeting participants for review and comment. The subsequent draft was then returned to the editors for further revision. Final approval for this report is pending. The report does not necessarily reflect the views of the NASMHPD membership.

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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.

THE PREVALENCE OF SMOKING

National Trends

The combination of science and advocacy is powerful. It has changed social norms with regard to tobacco use, affected public policy, and contributed significantly to decreasing smoking prevalence in the United States.

- In 2002, for the first time in the United States, more adults had quit smoking than were still smoking.
- In 2003, the first State in the U.S. (Utah) reached the Healthy People 2010 objective of less than 12 % smoking prevalence.
- In 2005, total cigarette sales declined for the first time ever and deaths due to cancer declined from the previous year, also for the first time ever.

Changing social norms, increased taxes on cigarettes, mass media campaigns educating the public about the dangers of primary and secondary, or environmental, tobacco smoke, and continued passage of smoking bans across the U.S. are directly contributing to these outcomes. States taxes on cigarettes have increased steadily from a year-end average of $.13 in 1980 to $.84 in 2005. Thirty states have local laws that require 100 % smoke free workplaces, bars, and/or restaurants, and twelve have state laws that require 100 % smoke free workplaces and/or restaurants. We have all seen an increasing number of television and print public service announcements with messages warning of the dangers of primary and second hand smoke. As of April 2006, 41% of state mental health treatment facilities are now smoke free, both inside and on their grounds.[1]

Smoking cessation treatment has improved and is more accessible. A 24-hour national telephone line, 1-800-QUIT-NOW, seamlessly links callers in fifty states to local quit lines 365 days a year. Counseling and nicotine replacement products are being covered by an

[1] NASMHPD Research Institute, Inc. (2006). Survey on Smoking Policies and Practices for Psychiatric Facilities, preliminary unofficial summary. 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.

increasing number of state Medicaid programs, from one program in 1994 (Rhode Island, for counseling) to forty programs by 2003, although only two cover all pharmacotherapy and counseling treatments recommended in the Public Health Service's clinical practice guidelines for treating tobacco use and dependence. An additional seven state (non-Medicaid) programs cover all recommended pharmacotherapy and some counseling. Medicare is poised to provide some medication and some counseling coverage in 2006. The American Cancer Society estimates 10% of PPO plans nationwide offer some type of coverage for smoking cessation.

Continued efforts are necessary. Smoking rates for U.S. women have increased to almost equal those of U.S. men and a link between exposure to environmental tobacco smoke and breast cancer in young women is currently being studied. Approximately 44.5 million Americans still smoke, and one third to one half of regular smokers who do not quit will die prematurely. Approximately one half of all cancers are due to smoking.

Although 70 % of smokers want to quit, less than 3 % succeed each year. A physician asking their client about tobacco use has shown to impact quit attempts, but only 50 % of smokers report having received smoking cessation advice from their doctors in the past year; 25 % of those sought and received further counseling and assistance. Public health promotion and prevention efforts increase *quit attempts*. Management of the physical and psychological effects of nicotine withdrawal increases *actual quit rates*.

As smoking prevalence falls, the remaining smokers will represent a 'hard core' group for which smoking cessation will be the most difficult. These individuals will have been smokers the longest and will have tried to quit multiple times. Many will have co-occurring mental and/or substance abuse disorders. By improving our knowledge and skills with respect to tobacco addiction and smoking cessation treatment, we can help

individuals positively impact their health and wellness, contributing to their efforts toward recovery.[2]

Smoking Among Persons With Severe Mental Illness and Addiction Disorders

Smoking prevalence is among the highest for people with mental illness. About 75 % of individuals with serious mental illness are tobacco dependent compared to approximately 22% of the general population (APA Substance Abuse Treatment Guidelines, 2006: Grant et al, 2004). In fact, about 44% of all the cigarettes consumed in the United States are by individuals with a mental illness and/or substance use disorder (Lasser et al 2000).

Smoking Prevalence Among People With Mental Illness

Disorder	Percent Smokers
Major depression	50 to 60 %
Anxiety disorder	45 to 60 %
Bipolar disorder	55 to 70 %
Schizophrenia	65 to 85 %

Smoking prevalence is also high among those with addiction disorders. Approximately 60-95% of clients in drug abuse treatment programs smoke (Bernstein & Stoduto 1999: Patten, et al., 1999: Richter, et al., 2004)

[2] Schroeder, Steven (2006) U.S. Tobacco Control and Cessation: A Brief Overview. NASMHPD Medical Directors Council Technical Report Meeting on Smoking Policy and Treatment at State Operated Psychiatric Hospitals.

Smoking Prevalence Among Addiction Patients

Addiction	Percent Smokers
Alcoholic inpatients	85%
Alcoholic outpatients	71-93%
Former problem drinkers	41%
Crack Cocaine	88%
Cocaine outpatients	75%
Cocaine inpatients	85-90%
Methadone maintained	95%

Those with psychiatric disorders tend to smoke more cigarettes per day and are able to obtain more nicotine from smoking the same number of cigarettes than the general population (APA, 2006: Williams et al. in press). Tobacco dependence is a pediatric disease in the sense that most individuals start smoking before the age of 18; however about 20% of smokers with schizophrenia began smoking after that age and many began smoking in mental health settings, receiving cigarettes for good behavior (DeLeon et al., in press).

Smoking Among Treatment Staff

Rates of smoking among treatment staff in mental health and substance abuse facilities and programs appears to be higher than the general population with approximately 30 to 40% of staff smoking versus 22% in the general population (Bernstein & Stoduto 1999: Bobo & Hoffman 1995: Bobo & Davis 1993: Bobo & Gilchrist 1983: Williams et al in press). Some treatment settings such as Methadone Maintenance Programs appear to have even higher rates of smoking. Of note, however, rates of smoking amongst staff do vary by discipline. Physicians, dentists and dental hygienists have very low rates of smoking, at approximately 3-5 %. (Goldstein et al., 1998: Strouse 2004 unpublished). [3]

[3]Guydish, Joseph and Ziedonis, Doug (2006) Prevalence and Impact of Smoking. NASMHPD Medical Directors Council Technical Report Meeting on Smoking Policy and Treatment at State Operated Psychiatric Hospital.

THE IMPACT OF SMOKING

Tobacco Dependence is More Severe In Persons with Severe Mental illness

Once tobacco dependence develops, it appears harder for those with mental illness to quit smoking due to impairments in social and cognitive functioning, problems associated with anxiety and medication side effects, lack of treatment system support, social/peer pressure to continue to smoke, and lack of other coping resources. Individuals appear less successful in their efforts to quit on their own; it is twice as difficult for those suffering from major depression and anxiety disorders (about 25% quit) and only 5-10% of those with schizophrenia are able to do so. Most however, have made attempts to quit and many express an interest in attending tobacco dependence treatment activities.

Morbidity and Mortality In Persons with Severe Mental illness

Concomitantly, this population experiences higher rates of disease and premature death and a reduced quality of life than the general population. Most will die from tobacco caused diseases, with half of all deaths due to smoking experienced by individuals with mental illness. It can be expected that, in an inpatient setting, fellow patients and staff are disproportionately impacted, compared to other environments, by the second hand smoke from these primary smokers.

Those with schizophrenia have a 20% shorter life span than the general population. Tobacco caused diseases that also lead to death are more prominent in those with schizophrenia than the general population. This population experiences higher standardized mortality rates for cardiovascular disease (2.3x), respiratory disease (3.2x) lung cancer and infections than the general population (Brown et. al., 2000). The proportion of smoke related illnesses in the general population and those with schizophrenia are the same, but at rates two to three times higher in those with schizophrenia.

Among treated narcotic addicts, the death rate of smokers is 4 times that of nonsmokers (Hser et.al. 1994). Among alcoholics in recovery who die, 51% of mortality is attributed to

smoking-related illness. At a 20-year follow up, cumulative mortality was 48% versus 19% expected if one had never smoked (Hurt et al., 1996).

Effect of Smoking on the Treatment of Severe Mental Illness

Smoking and Psychiatric Medication

Smoking does have direct effects on some, but not, all medication blood levels. Medications that are metabolized through the 1A2 isoenzyme of the P450 system are effected.

Medications Effected by Tobacco

Antipsychotics	Fluphenazine, Haloperidol, Olanzapine, Clozapine, Chlorpromazine
Antidepressants	Amitriptyline, Doxepin, Clomipramine, Desipramine, Imipremine
Others	Caffeine, Theophylline, Warfarin, Propranolol, Acetominophen

Tobacco smoking increases the metabolism of these medications that results in a need to almost double the regular dose of these medications in smokers (APA 2006). Nicotine replacement therapy does not effect medication blood levels.

Smoking and the Therapeutic Milieu

Results of a survey of non-smokers in state mental health facilities conducted this year by the NASMHPD Research Institute, Inc., concluded that there are multiple negative effects of smoking on the therapeutic milieu. There are approximately 50,000 patients housed at any given time in the 235 state public psychiatric facilities in the U.S. and approximately 200,000 patients pass through them each year. More facilities that still allow smoking on hospital grounds reported that smoking related issues were a precursor to seclusion/restraint events (34% vs. 5%), threats and coercion between patients (49% vs. 18%), and were the

cause of environmental health problems in the milieu (66% vs. 22%). Facilities that still allow smoking on grounds reported significant rates of elopement related to smoke breaks (33%) and fires related to smoking materials (30%). One third of facilities that still allow smoking use it as a behavioral incentive by linking it to privilege status. Three quarters of smoking facilities escort patients to smoke, which becomes a major consideration in unit scheduling and staff time commitment.[4]

A 1999 survey of 199 non-smoking long-term state hospital patients in 9 hospitals in 3 states revealed several negative milieu impacts. 26% of non-smokers saw patients threaten or coerce each other around cigarettes on a daily basis and 21% had seen staff use cigarettes to coerce and manipulate patients on a daily basis. Almost half (48%) of non-smoking patients were bothered by other patients smoking, with 30% of those saying they were too intimidated to ask that the smokers stop. 30% of non-smoking patients were uncomfortable with staff smoking, with 22% of those saying they were uncomfortable with asking staff to stop. 27% of non-smokers indicated that other patients who were smokers encouraged them to start smoking and 6% reported that staff had encouraged them to start smoking.[5]

Data from the California Department of Mental Health's high security forensic facilities show that when violence occurs between patients or between patients and staff it often happens shortly before and shortly after smoke breaks.[6]

Benefits of Going Smoke Free

There are economic benefits to employers and consumers when going smoke free including reduced absenteeism, increased on-the-job productivity, reduced life insurance payouts,

[4] NASMHPD Research Institute, Inc. (2006). Survey on Smoking Policies and Practices for Psychiatric Facilities, preliminary unofficial summary.

[5] Unpublished study conducted by Joe Parks, M.D., (1999) NASMHPD Medical Directors Council

[6] Mayberg, Stephen (2006) Experiences in California's state high security forensic facilities. NASMHPD Medical Directors Council Technical Report Meeting of Smoking Policy and Treatment at State Operated Psychiatric Hospitals.

and reduced medical expenditures for workers and retirees. The estimated benefit to cost ratio is 1:1 by the third year, and 5:1 by the 10th year. Benefits to consumers include saving the portion of their income that is spent on cigarettes. A study in New Jersey found approximately 27% of consumer's total income was spent on cigarettes (Steinberg et al., 2004). These savings can create opportunities for new activities or hobbies; even a change of residence. Further, smoking cessation may decrease the amount of psychotropic medication consumer's need thereby decreasing costs to the consumer (if any direct costs) and to the facility. [7]

It is due to the known dangers of environmental tobacco smoke that 18 states and 2 U.S. Territories have passed laws and local ordinances restricting smoking in the workplace. A list of States and Territories with laws prohibiting smoking in the workplace is provided in Appendix B.

Most importantly are the enormous health benefits from going smoke free. In a matter of minutes to a few days after not smoking, blood pressure is lowered, stamina increases and the ability to smell and taste improves. Within 2-4 weeks, respiratory infections decrease. In a year, the risk of heart attack decreases 50% and within 5-10 years of being tobacco free the risk of heart attack and stroke is equal to that of someone who never smoked. Over time the gains from quitting smoking increase, and morbidity and mortality decrease. At 10 years smoke free, the risk of cancer decreases.

Finally, considering that 33-50% of the 46 million Americans who smoke will die prematurely from their addiction, efforts to increase the current 2.5% cessation rate to 10% would save 2.4 million additional lives in any year. Increasing the quit rate to 15% would save 4 million lives. ***No other health intervention makes such a difference*** (Schroeder 2005).

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[7] Guydish, Joseph and Ziedonis, Doug (2006) Prevalence and Impact of Smoking.

Consumer Autonomy: Choice and Recovery

In many systems of care when, what, and how much to smoke are the only choices individuals are allowed to make. They are told when to rise and when to eat. They are provided a schedule of activities and told where to go and when to show up. Smoke breaks are also, very likely, one of the few regularly scheduled times when they are able to relate to others and staff in an 'equal' or 'normalized' way. These reasons may actually reinforce use of cigarettes or an assertion of a 'right' to smoke by virtue of the 'autonomy' it allows. This type of treatment milieu, often found in long-term stay institutions, also decreases what is key to recovery – the ability to make healthy choices while valuing a belief in oneself with hope of a future.

Most individuals in recovery want to quit smoking, largely due to the cost of cigarettes, and for health reasons as well. However, they fear being forced to quit within a single setting or attempt. Forced treatment and intervention has been a "well intentioned" consequence of public mental health practice and smoking cessation policies can be seen by individuals in recovery as 'more of the same.' They also fear encroachment on what little autonomy they have left and being treated differently than others; they want to enjoy the same rights and privileges as staff and others not institutionalized, and to have access to the same things. The National Alliance on Mental Illness (formerly the National Alliance for the Mentally Ill) policy on smoking supports living tobacco free, but does request accommodations to allow smoking for individuals who cannot stop. A copy of the Alliance's smoking policy included as Appendix C.

These feelings will vary by the type of treatment setting in which the tobacco free policies are implemented. In an acute care setting where individuals stay for a relatively short time, little resistance will likely be encountered; they realize they can't smoke right now, but will be able to again soon. In intermediate settings a mixed response can be expected. Concerns about fairness and being treated equally (the same as staff) with respect to smoking cessation and consequences for violating policy arise in consumers. Allowing staff to smoke 'off campus' but return smelling of smoke triggers cravings in nicotine dependent

consumers and can be considered cruel and unfair, while reinforcing the inequity of a policy purporting to protect health.

In long-term facilities, whether one appreciates it or not, patients are in a place that constitutes ‘home’ and many individuals oppose smoking bans in these facilities. When discussing smoking bans in long-term facilities, consideration was given to whether interventions by mental health professionals should extend into someone’s ‘home.’ Meeting participants were invited to contemplate how far they would go and what they would do to ‘ban smoking’ in their own homes and the homes of extended family members.

The difference is that it is our direct responsibility as providers of care to patients, employers to our staff, and trustees of taxpayer dollars to act on what we know. Multiple reports clearly implicate smoking in creating and maintaining a toxic inpatient milieu that includes violence, threats, sexual favors, coercion and the diversion of limited staff time for treatment to manage smoke breaks and their consequences. This directly interferes with all patients right to a safe, healthy and effective treatment environment. It also directly interferes with staff's right to a safe and healthy work environment.

In our facilities, we accept that individuals can be restricted from the ‘freedoms’ of everyday life and we must ensure that those restrictions are consistent with their treatment needs, their protection and the protection of others. Other ‘legal’ choices, such as consumption of alcohol, are prohibited due to individual health effects and the assumption that their use could not be managed in a manner that would assure the safety of all patients. Although not illegal and therefore potentially seen as a "choice", self-mutilation is prohibited and actively prevented, though unlike smoking it does no harm to others. Overall there is a much greater impingement on personal rights in hospitals that continue to allow smoking than in those that are smoke-free.

So where and how do these seemingly divergent views meet? Around the goal shared by patient and provider – Recovery.

Wellness is a basic and central aspect of achieving recovery.   smoking destroys wellness and therefore is an obstacle to recovery. Early death from smoking-related illnesses is a common and absolute barrier to recovery. A partnership promoting lifestyle change toward wellness and not just implementation of a smoking policy should be the focus of our efforts. The task at hand is to commit to creating environments in which individuals can practice making choices about their lives to improve their decision-making processes and experience more meaningful autonomy.

Consumers should be given individualized treatment and support to choose wellness, including full information about what is in tobacco and it's effects on health and access to adequate medical and behavioral treatment to overcome nicotine addition. Families as well as staff should be offered education and help to support the recipient's choice to be tobacco free with linkages to community resources and natural support systems made with the consumer to prevent recidivism upon their return to the community. In New Jersey, a grant from the Legacy Foundation supported the development of CHOICES, (www.njchoices.org) a consumer advocacy group that provides support for other consumers to learn about treatment options and the benefits of quitting.

We must also provide socialization and recreational activities to replace the 'smoke break' and allow individuals opportunities to build relationships with staff and others in a more positive and normative context.

If we want to have long term impacts on smoking and improved health outcomes we need to change the milieu to increase the focus on an internal locus of control for individuals. Much of our inpatient systems are currently designed to promote and reinforce the expectation that people who receive mental health services require an external locus of control in order to maintain behavior (i.e. rules, staff interventions, scheduling, etc.). Even on issues surrounding restraint and seclusion use, most focus on staff interventions rather than promoting individual responsibility and teaching de-escalation strategies to the patients. This promotion and development of informed decision making capacity, with the opportunity to practice making choices in inpatient settings, will not only have positive

effects with respect to smoking cessation, it will also promote the kinds of behavior and decision-making that will help people be successful when returning to the community.

We must promote decision-making ability and personal responsibility to meet treatment goals, letting consumer's choose with staff and milieu reinforcing behavior. Our current inpatient environments allow individuals to do well where they have almost no decision making opportunities, yet when they are discharged and faced with the enormity of decisions that effect community life, they frequently return to the hospital. To change this outcome, while promoting recovery and sustainable changes with regards to smoking upon discharge, inpatient facilities should review programming, scheduling, and even the times at which individuals go to bed and wake up, to help individuals build and practice positive decision making skills while experiencing the natural consequences (i.e. inability to attend a function if one does not wake on time) in a controlled environment. In few community living situations does an individual have someone to force waking and ADLs. Promoting personal responsibility while an inpatient helps reinforce the necessary skills for sustaining community tenure. It is also very important to develop a transition plan and provide adequate follow up and support.[8]

Regardless of where they are implemented, no smoking policies should be implemented seamlessly; for all persons (staff, visitors and consumers alike) at all times. If it is really medically important, it should be equitably implemented.

Finally, it was agreed by all that continuing to smoke, once addicted, is no more a choice than continuing any other addiction.

GOING SMOKE FREE IN STATE PSYCHIATRIC FACILITIES

[8] Allen, John and Parks, Joe (2006) Hospital Therapeutic Milieu and Treatment Programming. Presentation at the NASMHPD Medical Directors Council Technical Report Meeting on Smoking Policy and Treatment at State Operated Psychiatric Hospitals.

Survey Results on Current Policies and Practices

Between March 6 and April 14, 2006, a survey of 222 state mental health facility's smoking policies and practices was conducted by the NASMHPD Research Institute, Inc. Questionnaires were distributed to Directors/Administrators through electronic mail and collected from them through electronic mail, facsimile and postal mail. Postcard reminders were sent by postal mail on March 21,2006. A total of 158 surveys (71%) were returned. (Preliminary results from this survey were presented at the Technical Report meeting. The final report has since been completed and is enclosed as Appendix D.)

41% of respondents did not permit smoking at their facility including on grounds. Since 2002, on average, one more SMHA hospital goes smoke-free each month. This trend is likely to continue for the foreseeable future.

The average length of operating as a nonsmoking facility was over three years, with a range of less than a year to 15 years. It took most of these facilities an average of 9 months to make the transition from smoking to non-smoking.

The most cited motivators during the transition of their facility from smoking to non-smoking included promotion of healthier lifestyles and a cleaner environment, more time for active treatments and improved group therapy attendance, less incidents of fire danger, and compliance with state law.

These respondents cited the improved health of patients, cleaner grounds/environment, and more time for treatments as advantages to becoming a smoke free facility. Interestingly, they found a *decrease* in behavioral problems related to smoking habits, *less* violence and *increased* staff satisfaction after implementing no smoking policies. While surprising, these outcomes are in fact similar to those found in other facilities that have implemented smoking bans both in the U.S. and abroad.

The difficulties of going tobacco free as cited by non-smoking facilities surveyed included the creation of a black market and increased contraband, more "police work" for staff due to searches, and dealing with new admission nicotine withdrawal.

59% of respondents still allow smoking at their facilities. The motivators to allow smoking include the use of tobacco to decrease agitation in patients, to de-escalate some situations, and as a reward or incentive to comply with staff. (These reasons border on the unethical and highlight staff training needs). However, *almost half of these facilities (45%) are going tobacco free in the future, most within a year*. While not queried about why they plan to go smoke free, assumptions include compliance with state laws, changing public attitudes about smoking, champions who promote smoke free environments, and increased awareness of policy makers across the United States.

Concerns cited by these facilities about going smoke free include resistance and opposition from staff who smoke, staff fear of patients' reactions, fear of advocate's reactions and fear of change, in general. These facilities were most interested in obtaining information about facilities that have made a successful transition from smoking to nonsmoking and about smoking cessation techniques. Of note, *non-smoking facilities also wanted more information about tobacco cessation techniques or treatment*.

Highlighted Facility Experiences

Decreased Violence

A review of findings from 26 international studies that reported on the effectiveness of smoking bans in inpatient psychiatric settings found *staff generally anticipated more smoking-related problems than actually occurred*. There was no increase in aggression, use of seclusion, discharge against medical advice or increased use of as-needed medication following the ban (Lawn & Pols, 2005). A literature review of 22 empirical studies of the impact of total or partial smoking bans suggested that these policies had "no major long-standing untoward effect in terms of behavioral indicators of unrest or compliance." (el-Guebaly et al., 2002).

A study of the effects of a total smoking ban at Vernon State Hospital in Texas found that after implementation of a smoking ban, the number of sick calls, total disruptive behaviors and verbal aggression events declined markedly and significantly. Patients and staff tolerated bans well and staff's pre-ban apprehension dissipated (Hemple et al., 2002). A study comparing patient's verbal and physical aggression before and after implementation of a smoking ban at Wichita Falls State Hospital, also in Texas, saw decreased episodes of physical and verbal aggression and a corresponding decrease in injuries to patients and staff. This study concluded that the *unequal distribution of tobacco was the primary contributor of aggression in their facility* (Quinn et al., 2000).

The facilities under Northcoast Behavioral Healthcare in Ohio also saw a decrease in incidents of aggression after the implementation of their smoking ban.[9]

Staff Preparation and Participation

Both meeting participants and literature speak to the need for "*considerable preparatory work with staff to ensure full compliance*" with smoking bans (Stubbs et al., 2004).

In Texas, opposition from staff at the Wichita Falls State Hospital slowed, but did not stop implementation of a smoking ban. The Wichita Falls State Hospital is a civil psychiatric facility at 100% capacity with270 individuals from children to the aged. It is located in a County with a population of approximately 100,000 and its employees have a 'show me' attitude. Facility employees went directly to the media with complaints about a proposed smoking ban instead of communicating internally with hospital management. As the facility had previously communicated its intentions to go smoke free to the media, this was not terribly effective. Further, while the facility had maintained positive relations with patient rights organizations, these organizations found legislators sympathetic to their 'right to smoke' and tried to block the smoking ban as well. State lawmakers eventually passed legislation prohibiting smoking in public places, however, and state treatment facilities

[9] Smith, Douglas (2006) Northcoast Behavioral Healthcare's implementation of a smoke free environment in Ohio. NASMHPD Medical Directors Council Technical Report Meeting on Smoking Policy and Treatment at State Operated Psychiatric Hospitals.

proceeded to implement their planned policies. In a switch from traditional thinking, the state mental health authority sees a smoke free environment as a recruitment and retention tool, providing a healthy environment for those who do not want to be exposed to second hand smoke. To ensure a better fit between prospective staff and facility, screening up front for a history of smoking and advising of the seriousness of a facilities smoking policy, pre-hire, was suggested.[10]

In consulting with seven other smoke free state mental health facilities (serving adults, youth and women) while developing their own recommendations regarding smoking, the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) found that in general the transition from smoking to non-smoking went smoothly and, that *staff experienced more difficulties than clients*. And while the ODMHSAS was concerned about the potential effects of a smoking ban on recruitment and retention of personnel at their facilities, no significant changes in staffing were seen. [11]

At the Anoka Metro Regional Treatment Center in Minnesota hospital leadership and staff were ambivalent and unclear about the smoking ban they implemented (the ban was implemented in response to state legislation). This set the stage for chaos, with staff unable or unwilling to enforce the ban and families of patients contributing to the development of an underground economy by providing contraband. Once staff got on board, implementation improved with only minor problems experienced and hospital administration felt the facility and grounds improved drastically.[12]

In Pennsylvania, an individual's 'right to smoke' prevailed, with labor unions 'credited' with stopping implementation of a statewide smoking ban. The state's mental health

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[10] Smith, James (2006) Presentation at the NASMHPD's Medical Directors Council Technical Report Meeting Smoking Policy and Treatment at State Operated Psychiatric Hospitals.

[11] Jewell, Peggy (2006) Tobacco Free Policy Development and Implementation in the Oklahoma Department of Mental Health and Substance Abuse Services. NASMHPD Medical Directors Council Technical Report Meeting on Smoking Policy and Treatment at State Operated Psychiatric Hospitals.

[12] Hartford, Dave (2006) Presentation at the NASMHPD Medical Directors Council Technical Report Meeting on Smoking Policy and Treatment at State Operated Psychiatric Hospitals.

authority firmly believed that if employees and consumers had wanted a ban, these unions would have supported it. More preliminary education discussing the health effects of smoking and the benefits to patients and staff of going smoke free would have been useful, possibly leading to successful implementation of no smoking policies in state facilities.[13]

Costs and Benefits

The implementation of no smoking policies has both direct and indirect costs to facilities. The Okalahoma Department of Mental Health and Substance Abuse Services, comprised of seven mental health facilities and four substance abuse facilities, went tobacco free statewide in January 2004. A survey of employees found 41% consumed tobacco products. Tobacco use in consumers varied by facility from 52% in day programs to 92% in their residential substance abuse treatment program. Approximately 15% of ODMHSAS employees were successful at quitting smoking, with support provided by their employer.

Direct costs associated with providing nicotine replacement therapy and counseling include a one-time expenditure of $25,000 to provide nicotine replacement to approximately 3,775 employees (one four-week supply of patches, gum, or lozenges at one time, up to a maximum of 12 weeks or 90-day course, within a nine month period with the 12-week or 90-day course repeated one time with approval from the Medical Director), an ongoing, annual expenditure of $100,000 for approximately 8,864 patients within the system to provide nicotine replacement products as determined by the patient and physician, cessation classes ("Fresh Start" at a minimum), and cessation information materials, and a one-time expenditure of $2,500 for educational signs and posters placed or created by patients within the facilities. No additional funding was provided for training of existing staff or maintenance provided by existing staff, such as electrical and repair work.[14]

The Norman Alcohol and Drug Treatment Center in Okalahoma is a 62-bed residential treatment program under the ODMHSAS. Approximately 92% of the patient population

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[13] Diamond, Mary (2006) Smoking bans in Pennsylvania. NASMHPD's Medical Directors Council Technical Report Meeting on Smoking Policy and Treatment at State Operated Psychiatric Hospitals.

[14] Jewel, Peggy (2006) Presentation at the NASMHPD Medical Directors Council Technical Report Meeting.

smokes. This facility experienced increased costs associated with staff time to police and enforce the ban and staff time (and supply costs) to replace and maintain items such as bed linens damaged due to patients smoking under sheets and burning them, toilets clogged by cigarettes and packaging from surreptitious smoking in bathrooms, outlets and smoke detectors disconnected or broken, ceiling tiles destroyed by patients hiding cigarettes and lighters, and window and door locks damaged by patients trying to avoid detection while smoking. These costs have not been quantified. [15]

Three of the nine state facilities in Ohio went smoke free in 2003. These three facilities comprise Northcoast Behavioral Healthcare**.** Prior to implementation approximately 25% of staff and 70% of consumers were smokers. Costs to implement the smoke free environments included approximately $14,000 to $20,000 lost annually from cigarette sales by AVI vending at Northfield (acute and long-term psychiatric hospital with 180 civil and forensic beds and approximately 400 staff). As this revenue supported a patient "indigent and entertainment" fund, the facility was very motivated to recoup these losses. Though not quantified, considerable time and effort (1 ½ years for planning and implementation) was spent creating a "healthy environment." Health and wellness was the focus of their policy change versus a smoking ban.

This long term planning included committee work, focus groups with staff and consumers, surveys of staff and consumers, and graduated implementation. Staff were educated through paycheck stuffers, posters, meetings and attendance at 'Fresh Start' training offered by the American Cancer Society. Education of consumers and their families was accomplished through posters, written materials, unit meetings and direct mailings. A Wellness Coordinator was designated for each of the 15 inpatient units to serve as patient and staff liaisons to the "Wellness Committee" around implementation of the tobacco-free policy and other health issues.

[15] Ra, Wynema (2006) Initiating A Tobacco Free Environment in a Residential Setting, Norman Alcohol and Drug Treatment Center, Norman, Oklahoma. NASMHPD's Medical Directors Council Technical Report Meeting on Smoking Policy and Treatment at State Operated Psychiatric Hospitals.

A sample Smoke Free Environment policy and grid targeted to curb smoking/tobacco use or sale/provision of contraband was developed for and provided to staff, patients and visitors, with graduated penalties for infractions, and is included as Appendix D. Utilizing a countdown concept, reminders of the benefits of tobacco cessation treatment were provided leading up to and beyond the implementation date of the policy change, with a new flyer containing educational and motivational messages posted and distributed each day for the 30 days before and after the target date.

The facility tried other creative methods, such as purchase and installation of a smoke detector with a voice reminder system, and had to combat contraband and indoor smoking issues. They did not have an increase in fires, and in fact, *realized a decrease in violence.* There was concern that multiple infractions due to violations of the smoking policy would label a consumer a 'rule breaker' in the eyes of the court and unnecessarily decrease chances or rapidity of release back to the community, so work was done with the courts to prevent this rigid interpretation. Change in length of stay was noted among the different treatment facilities related to the tobacco ban. The remaining 6 state hospitals in Ohio are now also smoke free. [16]

Different Treatment Settings and Populations

Within the forensic, high security facilities under the Department of Mental Health in California**,** smoke breaks outdoors are not possible and smoking has been allowed on site. Implementation of no smoking policies have been fraught with difficulties largely associated with staff and union issues and participants wedded to the status quo. Given the data on violence increasing shortly before and after smoke breaks, it is felt that workers would have responded more positively to the smoking ban if violence reduction versus health and wellness was given as the reason for the ban. In retrospect, the Department

[16] Smith, Douglas (2006) Northcoast Behavioral Healthcare's Implementation of a Smoke Fee Environment in Ohio. Presentation at the NASMHPD's Medical Directors Council Technical Report Meeting on Smoking Policy and Treatment at State Operated Psychiatric Hospitals, April 20-21, 2006, San Francisco, California.

believes they should have implemented their smoking ban when the State correctional system went smoke free.

As far as patient compliance with bans, those at the high security, forensic facilities in California are in 'for life'; there is no incentive for them to follow rules, whether as part of facility policy or individual treatment plan. Cigarette smoking is seen as the only 'pleasure' they have left. None of the hospitals are willing to implement smoking bans 'on their own' and actually want to be 'forced' by a policy or policy maker. Hence, the California Department of Mental Health is planning to implement a statewide smoking ban covering all its facilities. Evidence on the health effects of primary and second hand smoke makes a difference and continues to be a compelling reason supporting no smoking policies, as does information about the successful implementation and positive outcomes of smoking bans in facilities in other states.[17]

In Virginia, smoking policies at facilities under the Department of Mental Health, Mental Retardation, and Substance Abuse Services are an artifact of system beliefs about mental health treatment. Facilities and those hired to work there provide acute care and treatment for those with mental illness and support discharge and integration back into the community. Smoking is not permitted in state facilities and restrictions to this 'right' in an acute care setting are considered appropriate and not a deprivation, due to the short term nature of the patient's stay. As smoking in jails is prohibited, jail transfers to mental health facilities should not be expected to smoke. To allow smoking may provide an incentive to seek hospitalization. While Virginia is considered a 'tobacco state', this fact is not felt to be as important to policy as the generally conservative nature of the state. All public mental health facilities in Virginia are planning to be smoke free in the near future.[18]

In Oklahoma, at the Norman Alcohol and Drug Treatment Center, implementation of a smoking ban was more difficult. The 62-bed residential facility has 40 male beds and 22

[17] Mayberg, Stephen (2006) Presentation at the NASMHPD's Medical Directors Council Technical Report Meeting.

[18] Reinhard, James (2006) Smoking policies in facilities under the Department of Mental Health, Mental Retardation, and Substance Abuse. NASMHPD Medical Directors Council Technical Report Meeting on Smoking Policy and Treatment at State Operated Psychiatric Hospitals.

female beds and serves clients who are court-referred, polysubstance-dependent, pregnant, HIV positive, are IV drug users or have co-occurring disorders. Treatment includes gender specific client centered motivational enhancement, 5 stages of change, manual therapy and cognitive behavioral therapy provided in individual, group and family sessions. Almost all clients smoke (92 out of 100) and almost all smoke more than one pack a day (95%). Six percent use smokeless tobacco products.

The facility conducted community meetings and smoking cessation classes, offered nicotine patches and medication (Wellbutrin) upon by prescription from a physician, provided education on the physiological effects of smoking and tobacco use, and upon infraction gave extra duty assignments, letters of counseling, contractual agreements, contingency management, referrals to lower levels of care and occasional discharges.

Punitive and restrictive measures to enforce the smoking ban increased and reinforced anti-social and criminal thinking patterns and behaviors in clients. Negative effects on the physical environment included plumbing problems, smoking inside the facility, improper use of electrical outlets, grass fires and trash can fires, cigarette butts outside, creation of a black market and movement of ‘contraband’, tampering with locking devices on doors and windows, and destruction of ceiling tires. Negative effects on the treatment milieu included creating an ‘us vs. them’ attitude and reinforcing anti-social/criminal thinking patterns and behaviors.

Factors contributing to the difficulties encountered include a short stay; the time in treatment was insufficient for clients to transition through stages of change, and difficulty for staff to make a paradigm shift; their thoughts and beliefs were not sufficiently impacted. The lack of choice in nicotine replacement products (patches only) was also a recognized factor.

What helped by way of solutions included consultant advice and training for all staff, expanding treatment plan elements, redirection and reframing, installing cameras, offering physical fitness opportunities, dealing with infractions as a treatment issue, and having

smokers and nonsmokers attend cessation classes. Remaining challenges include funding and providing more smoking cessation classes and nicotine replacement products.[19]

In Texas, the Vernon State Hospital is the only maximum-security forensic treatment facility in the state. Its population is about 5% over capacity, at 345 patients, all of whom have been declared incompetent, not guilty by reason of insanity or have been civilly committed because of dangerousness. It also houses the state's only adolescent forensic program for youth civilly committed, determined unfit and not responsible for their behavior or as an alternative to jail. The facility strives to provide treatment and move patients into the least restrictive environment. Approximately 35-40% of admissions receive treatment and are released in 30 days. The length of stay for the remaining portion is not much longer, with very few staying a year. Many come into the facility from the county jail, which does not permit non-smoking.

The facility is a major employer in this small rural community of approximately 12,000 residents. People who make up the workforce in Vernon can be characterized as loyal and dependable, with a good work ethic.

Both patients and staff adjusted to the hospital's smoking ban more readily and easier than in the Wichita Falls Hospital. This could be due to staff more readily accepting and supporting their employers decisions as well patients having already adapted to a smoke free environment while in jail and generally short lengths of stay at the facility [20]

Lessons Learned

Public mental health authorities from seven different states representing a total of 39 mental health and substance abuse treatment facilities providing acute, intermediate and long term (including forensic) care shared their experiences in planning and implementing

[19] Ra, Wynema (2006) Initiating A Tobacco Free Environment in a Residential Setting, Norman Alcohol and Drug Treatment Center, Norman, Oklahoma.

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[20] Smith, James (2006) NASMHPD Presentation.

no smoking policies during this Technical Report Meeting. The following points summarize their experiences in the form of suggestions for those initiating change.

- **Articulate a goal of improving overall health, wellness and recovery for those we serve, with tobacco cessation a critical objective in achieving that goal.** Given what we known about the deleterious effects of tobacco, especially in those with mental illness, we cannot promote recovery and ignore a substance and practice that is the leading cause of morbidity and mortality in our patients. Our role must be to educate, facilitate and support decision-making around healthy lifestyle choices, which goes beyond implementation of no smoking policies, but definitely includes it. Facility smoking policies should apply to staff, consumers and visitors alike.

- **Provide Leadership.** It is critical that the state mental health authority believes that helping individuals to stop smoking is important and communicates clearly and unequivocally that policies to support cessation will be implemented. Talking points stating the overall goal, the reasons for going smoke free and the expectations for policy development and implementation should be developed and used consistently during planning and implementation. Include information about the health consequences of smoking and second hand smoke, the state mental health authorities' responsibilities to consumers, staff and taxpayers and the assistance that staff and consumers will receive to help them be tobacco free. Sample talking points are provided in Appendix E.

- **Ensure broad participation in planning and implementation**. An assessment of the "readiness" of the system, program, and participants to change should be conducted with an individualized plan for implementation created (much like a treatment plan for consumers). The State Mental Health Authority and representatives from treatment and other facility staff, unions, patients and patient advocates should be part of the committee(s) formed to conduct this assessment, and develop and implement the resulting plan. Among them should be smokers, non-smokers and former smokers. Local representatives from nonprofit organizations that support smoke free living,

including cancer survivors, can also be invited to participate. Visiting a smoke free facility can be informative and helpful.

Committee representatives should keep their peers informed of ongoing activities, with staff taking responsibility for advising visitors. It is critical to work with communities during all phases of development and implementation, including the media, as public opinion and support does matter.

- **Ensure adequate time to plan and implement new policies**. While most states surveyed averaged 9 months for implementation, a year and a half is recommended. Take time to discuss proposed changes and expected positive outcomes with peers, consumers and their advocates, and staff and their unions. Anticipate and mitigate potential negative outcomes such as the creation of a black market and movement of contraband and housekeeping and maintenance issues associated with surreptitious smoking. Provide frequent reminders about key dates and events in the form of a countdown to day the facility achieves its smoke free goal and provide smoking education and cessation support during the countdown to allow the system and participants to better adjust and comply with changes. Do not implement the policy on a holiday or holiday weekend (i.e. January 1st) or in winter months, if in a cold climate and replacing smoke breaks with 'fresh air' breaks or other outdoor activities. Implementing change in facilities could be 'easier' if occurring in response to passage of state or county laws prohibiting smoking.

- **Improve treatment and the milieu to support the goal of health, wellness and recovery and the objective of being tobacco free**. Provide adequate education and training for physicians and staff on smoking cessation and treatment issues. Provide adequate cessation counseling and nicotine replacement products for both staff and consumers. Check staff and consumer's health plans to maximize available reimbursement for these services. Seek out offers and potential sources of no cost or low cost products, including pharmaceutical purchasing pools.

Increase opportunities for consumers to make and practice lifestyle choices and behaviors. Promote an internal locus of control and responsibility in meeting smoking cessation and other treatment goals by supporting consumers' ability to make personal choices, with staff and the milieu reinforcing behavior. Replace smoke breaks with other activities that allow consumers to continue to interact with staff. To prevent recidivism, advise consumer's support systems about changes in policy and provide them with tobacco prevention education and cessation information as well. Create a transition plan that provides follow up and support for smoking cessation upon discharge.

BEST PRACTICES IN SMOKING CESSATION

A combination of psychosocial support, nicotine replacement and medication will produce the best outcomes for those with mental illness who want to stop smoking. These interventions are affected by state and local laws and ordinances as well as individual facility policies regarding tobacco use.

Implementing Organizational Change

A number of resources are available to assist facilities and programs in addressing tobacco use and going tobacco free.

The New Jersey Tobacco Dependence Program is an expert source for consultation, program and policy development, training, and ongoing clinical and program support in this area. The following steps for addressing tobacco within mental health and addiction services comprise the "12 Steps for Change" used by this program (Stuyt et al., 2003):

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 systems 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 Addressing Tobacco policies.
12. Establish ongoing communication with 12-step recovery groups, professional colleagues, and referral sources about systems change.

Assessment of this programmatic intervention to assess its effectiveness on policy development, staff knowledge, attitudes and practices, and consumer's receipt of nicotine treatment is currently being done by the University of California at San Francisco and the Robert Wood Johnson Medical School with support from a National Institutes of Drug Addiction grant.

A manualized approach to assist facilities and programs to implement smoke free grounds has also been developed with materials available from the New Jersey Tobacco Dependence Program at www.tobaccoprogram.org. Other programs that provide training and consultation include the University of Massachusetts and the MAYO Clinic.

No Smoking Policies

With smoke free grounds as the ultimate goal, a starting point for some facilities may be achieving smoke free facilities, with smoking still allowed outside. In populations with co-occurring disorders graduated changes may be easier, but local factors including state law, employee feelings and labor union positions also need to be taken into account. Note that harm reduction by reducing number of cigarettes or opportunities to smoke may just encourage individuals to smoke more efficiently. If providing NRT indoors, while allowing smoking outside, a short acting NRT should be used. Use carbon monoxide meters to ensure NRT matches nicotine level.

Smoking policies should be implemented across the board, for staff and patients alike. Consumer violation of the smoking policy should be viewed and handled as a treatment issue. Staff violation of the smoking policy should be viewed and handled as a personnel issue. Cessation assistance, including nicotine replacement therapy should be made available for both staff and patients alike.

When implementing smoking policies, a thorough review of inpatient milieu should occur to increase health decision making opportunities for patients while changing the expected locus of control from external (staff, rules and policy) to internal (subject to natural consequences) promoting personal responsibility necessary for living in the community.

Tobacco should be added to a facilities current list of 'contraband' and dealt with in the same way. A sample policy on handling of contraband after confiscation from the Northcoast Behavioral Healthcare System in Ohio is included as Appendix F.

Better education of consumers' visitors to the facility about the no smoking policy can assist in decreasing 'contraband' brought into the facility and development of any underground economy. Smoking cessation efforts should include community-based providers and peer run programs to provide necessary community support to sustain this lifestyle change.
No smoking policies, where applicable, should have an exemption for possession and use of tobacco as part of a traditional Indian spiritual or cultural ceremony.

Prevention

Due to their high-risk status, all non-smoking and former-smoking patients should be offered primary and relapse prevention programming. Hospitals reported improved attendance and participation using a group approach that included all patients - smokers, former-smokers and non-smokers.

Tobacco Dependence Treatment

Less than a third of SMHA facilities reported offering smoking cessation programming at least weekly and a third had not provided any staff training. Available strategies to treat those ready to quit smoking include Nicotine Anonymous and Quit Lines, various forms of psychosocial treatment and six FDA approved medications.

Nicotine Anonymous is a twelve-step cessation and maintenance program available in almost every state. Information about available groups in a given area and assistance in starting a new group is available from www.nicotine-anonymous.org.

While not rigorously studied and probably more effective with the general population (such as facility staff) than those with mental illness, Quit Lines offer easily accessible, no cost, anonymous information and cessation support 24 hours a day, 365 days a year. Accessible from each state by calling 1-800-QUIT-NOW, this service provide a stable source of assistance and support on its own, or as an adjunct referral source

The traditional stepped care model of tobacco dependence treatment assesses and triages a smoker to an intervention of varying levels of intensity. Minimal intensity levels of care include self-change and self-help, including telephone quit lines. Medium intensity levels of care include brief counseling and follow up. A high intensity level of care provides specialized, intensive clinic treatment. It is best to incorporate all available treatment options into all levels of care.

The U.S. Department of Health and Human Service, Public Health Service's Quick Reference Guide for Clinicians Treating Tobacco Use and Dependence summarizes strategies for providing appropriate treatments for every patient:

1. Patients who use tobacco and make the choice to quit should be treated with the "5 A's": Ask, Advise, Assess, Assist and Arrange.

2. Patients who use tobacco but are unwilling to quit at the present time should be treated with the "5 R's": Relevance, Risks, Rewards, Roadblocks, and Repetition.

3. Patients who have recently quit using tobacco should be provided relapse prevention treatment.(Fiore et al., 2000)

Other clinical guidelines include Reducing Tobacco Use: Report of the Surgeon General (2000), the American Psychiatric Association's Nicotine Dependence Treatment Guidelines (1996), and several more from the Agency for Healthcare Research and Quality, the Center for Disease Control and Prevention, the National Cancer Institute, the National Heart, Lung and Blood Institute, the National Institute on Drug Abuse and the University of Wisconsin.

Psychosocial Treatment

More research is needed on the effectiveness of motivational enhancement and cognitive behavioral therapy. Some pay people to not smoke. Adolescent groups enjoy looking through magazines and identifying and discussing manipulative tobacco advertisements.

- Motivational enhancement approaches to therapy include engagement and empathy, matching cessation goals and techniques to five different stages of readiness (precontemplation, contemplation, preparation, action, and maintenance), and matching services to motivational levels.

  Motivational Interviewing with personalized feedback increases motivation to quit at one week and one month; better than providing a brochure and referral to cessation treatment or providing a brochure and education on the health effects of smoking. (Steinberg et al, in press)

  The carbon monoxide meter is also a very powerful tool for engagement, providing audio and visual feedback that increases an individual's appreciation of the health consequences of smoking and understanding of what they must do (or not do – smoke).

It allows good positive reinforcement for consumers and provides confirmation to the physician that their patient is complying with treatment and reducing cigarette use.

- Social/peer support is necessary. With a grant from the American Legacy Foundation, the Robert Wood Johnson Medical School at the University of Medicine and Dentistry of New Jersey, the New Jersey Mental Health Association, and the New Jersey State Mental Health Services Department created a program called "Choices" which provides consumers with information and peer support so they can make real choices about tobacco use (www.njchoices.org).

Medication

Nicotine may modulate cognition, psychiatric symptoms and medication side effects. With a change in smoking status, it is important for physicians, staff, consumers and their families to be aware of possible changes similar to medication side effects and/or relapse to mental illness. Withdrawal effects include anger/irritability, impatience, restlessness, and anxiety, difficulty concentrating and impaired task performance, cravings, hunger and weight gain, and sleep disturbances, drowsiness and fatigue. Caffeine is metabolized through 1A2, such that nicotine withdrawal in coffee drinkers produces caffeine intoxication. Individuals feel more restlessness and more edgy; behaviors that mimic nicotine withdrawal but are not caused by it. When you smoke less, you need less coffee to feel its effects.

Nicotine Replacement Therapy (NRT)

Historically, primary care and a medical model have driven nicotine treatment. 97% of the general public is treated with medication and only 3% get integrated psychosocial treatment and a medication treatment (psychosocial treatment in this model is measured in exposure in minutes). For the Severely Mentally Ill population, almost every study is an integrated study of medication and psychosocial treatments. Schizophrenia and depression have the best evidence based treatment. Bipolar disorders have not been well studied.

There are five FDA approved nicotine replacement treatment medications: patch, gum, spray, lozenge, and inhaler. The fastest to the brain is the spray. The inhaler is a misnomer; it's similar to the gum and lozenge, absorbed in the oral mucosa area. The patch is the longest acting.

Across the board in the general population, 25% will be abstinent at one year if these particular products are used. That rates goes up to 35 % if Zyban in used in conjunction with the patch. This not what the FDA currently suggests, but those who are treating patients actually combine several NRTs, such as a patch for a foundation, a short-term agent on top of that and even a psychotropic medication like Buproprion. (Bupropion is an atypical antidepressant thought to affect levels of dopamine and norepinephrine such that craving for cigarettes and symptoms of nicotine withdrawal decrease). In those with schizophrenia, more NRT is needed in combination with an anti psychotic medication and Buprion or Zyban is often added to decrease anxiety. No better outcomes are shown between high doses and low doses. Don't assume individuals know how to use NRT products. It is important to educate them on proper usage. Using CO meters to monitor CO and Cotinine levels is helpful, providing powerful audio and visual feedback to patients as they blow into the machine. One company selling such monitors in Bedfont Scientific USA (www.bedfontusa.com).

What is known? Inpatients are easier to manage than outpatients who require more engagement and motivation. Medication and behavioral therapy for 10 weeks or more in a row works well. Taking away NRT is a critical time, with the most critical being the first three days of quitting (Ziedonis et al.,2006).

The best way to effectively manage acute withdrawal from tobacco with NRT would be for patients to control and administer their own dose and medication, though this could be problematic in forensic hospitals where possession of gum and plastics may be prohibited for patients.

Ancillary interventions

Addressing medical co-morbidities with smokers is a useful strategy in getting them to quit. For instance, smoking is most recently being linked to increased breast cancer rates in young women. Sharing this information with this growing population of smokers provides important education about the risks of tobacco, allows more informed decision making and may make young women think twice before starting or continuing to smoke. Sharing the rapid benefits of quitting – respiratory, CU, kidney function, impotence – can also provide motivation to quit. Providing individuals with a list of health problems and then asking them to indicate which they experience or are concerned about can be particularly effective, especially when the problems are improved or ameliorated by quitting smoking. Discussing the costs of cigarettes with individuals is another powerful motivator to quit. Program enrichment options provided to replace 'smoke' breaks; i.e. fresh air breaks, stress management classes, weight management classes, and/or exercise programs also have powerful effects on smoking cessation and success in being smoke free.

Again, a combination of psychosocial support, nicotine replacement and medication will produce the best outcomes for those with mental illness who want to stop smoking. Tobacco cessation practice can improve clinically by conducting better screening, assessment and treatment; programmatically, by implementing training and quality improvement measures to ensure program integrity; and system wide, by increasing collaboration and networking to leverage existing and develop new financial resources to support NRT and cessation programs.

BALANCING VALUES - INDIVIDUAL RIGHTS AND PUBLIC HEALTH

Do people have a right to harm themselves? How and why do seat belt or helmet laws get passed? Why have laws prohibiting indoor smoking passed? Generally, the preponderance of evidence shows a particular intervention will decrease mortality and/or morbidity, save lives, and save costs to society as a whole. There can be an expectation of limitation of 'absolute' freedom when others would bear the burden of that freedom. Recall that the suit against "Big Tobacco" was for the cost of care for Medicaid patients who smoked. We are

at a point in time when society and policies are moving from allowing to prohibiting smoking. What is being seen in the U.S. is translating into what we do in our systems of care.

As administrators and employers, our reasons for restricting or eliminating smoking certainly include spending taxpayer's dollars wisely and protecting individuals from second hand smoke. As physicians and partners in the goal of recovery with consumers, however, our concerns go much deeper.

The goal of mental health systems is recovery. Overall health and wellness is part of that recovery. We cannot in good conscience, therefore, ignore a substance and practice that is the leading cause of morbidity and mortality in our patients. Our role in the recovery process is to teach, facilitate and support a consumer's ability to make their own decisions and be responsible for those decisions, and to provide an environment conducive to this process.

Our efforts are focused, therefore, on advising, offering and providing consumers with the individualized treatment they need within a supportive environment to achieve the goal of recovery, and not simply 'ban smoking' in our facilities. In fact, policies to eliminate smoking in facilities should not be implemented without access to adequate treatment and support. It is important that staff employed in our public mental health facilities are held to the same standards and expectations of behavior with regard to smoking and provided the same treatment and support.

In a special issue of *Tobacco Control* dedicated to an examination of the use of 'rights' arguments in tobacco control efforts, editors found experts divided into two camps: those who believe an understanding of rights can shape the way the tobacco control movement operates, and those who believe that this understanding, while not impacting the movement itself, can strengthen tactics that reduce tobacco use and counter the influence of the tobacco industry.

Whether we operate from a stance of viewing ourselves as the ultimate ‘protector’ from the tobacco industry or one of many credible sources providing information about the effects of tobacco for use in personal decision making, we must commit to supporting consumer choice of a lifestyle change in our stand against tobacco use; not just implementation of a no smoking policy. This necessitates work to increase understanding and availability of education on the effects of smoking and prevention and cessation services for all members of society, not just those in public mental health facilities

Addiction is not a real ‘choice.’ Quitting smoking is. The rights we promote, therefore, are the right to know what’s in tobacco, the right to breathe smoke free air, the right to treatment options to support quitting and the right to health, wellness and hope in recovery.

RECOMMENDATIONS FOR KEY STAKEHOLDERS

National Decision Makers (NASMHPD, JCAHO, CMS, Advocacy groups, NACSMHA)

- State Mental Health Authorities' (SMHAs) inpatient facilities should be encouraged and supported in their efforts to provide smoking cessation and prevention and in going smoke-free.

- SMHAs should be assisted in studying and quantifying the long-term benefits to facilities of going smoke free.

- SMHA should cover smoking cessation and prevention, including Nicotine Replacement Therapy (NRT), for the uninsured.

- Medicare Part D plans should cover NRT.

- State Medicaid should cover smoking cessation and prevention including NRT.

- A toolkit, including technical assistance, should be created and offered to SMHA facilities that want to go smoke free.

- A toolkit of best practice curriculum for smoking cessation, relapse prevention and primary prevention for SMHA facilities should be created. It should include recommended best practices for control of contraband and staff training related tobacco issues.

- A toolkit for prescribing NRT, including dosing and offering Continuing Medical Education/Continuing Education credits, should be created for SHMA and public mental health clinicians.

- A minimum acceptable frequency of psychosocial treatment for smoking cessation should be established.

- A second report addressing smoking in community SMHA treatment settings should be produced.

- Tobacco use in the severely mentally ill population in a broader context of morbidity and mortality should be studied.

- Alliances should be built with cancer survivors and those suffering with COPD.

- Support materials to educate families and other collaterals on supporting a recipient's choice to be smoke free should be developed.

- A group should be re-convened in two years to assess outcomes in facilities and communities as a result of this meeting, the NASMHPD Position Statement and the Technical Report.

State Mental Health Commissioners

- SMHA inpatient facilities should be encouraged and supported in their efforts to provide smoking cessation and prevention and in going smoke-free.

- Leadership needs to issue a definitive policy statement about stopping tobacco sales and use. The timeline to implementation is optional; the policy change is not.

- With a goal of reducing the proportion of those with severe mental illness who smoke, emphasize health promotion and 'total' wellness in efforts to go tobacco free.

- Do not implement any smoking ban without cessation support, including NRT.

- Emphasize a consumer's right to wellness, recovery and treatment when advocating for increased accessibility to NRT.

- Support tobacco cessation and offer NRT for staff, as well as consumers.

- Recognize that the process of quitting smoking is more than a facility issue; it is a systems issue. Post-discharge, continued psycho-social interventions need to be made available within the community. Work with the community to ensure tobacco cessation help is available for discharged patients.

- SMHA facilities should not sell tobacco products.

- Use carbon monoxide meters and a full formulary in cessation treatment.

Facility Medical and Nursing Personnel, Superintendents and Staff

- SMHA inpatient facilities should provide smoking cessation and prevention and be smoke-free

- Use a process oriented approach, implementing a no smoking policy over time, rather than issuing an edict for immediate compliance.

- Increase consumer awareness of NRT options and availability.

- Offer "optimized" tobacco cessation treatment:
    - Individualized throughout the continuum of care (inpatient to outpatient)
    - NRT available as needed and, preferably, self-administered
    - Smoking cessation/prevention programming provided regularly and frequently
    - Education of consumer's visitors and support systems about the facilities smoke free environment and availability of smoking cessation and NRT.

- Inquire about the environment the patient will be returning to upon discharge. Do family members, friends or roommates smoke? If possible, advise these individuals of the challenges faced by the patient, provide education and link to cessation resources if they themselves smoke. Encourage smoke free homes.

- Support self-help/self management in going tobacco free for wellness.

Community Service Systems

- Consumer advocacy and support groups and individuals should take training from telephone Quit lines and incorporate lessons learned into peer support lines and peer drop in centers.

- Quit Line and other smoking cessation program/service personnel should be trained to better understand the unique needs of those smokers/former smokers with mental illness.

- Community based mental health service/program provider's understanding of smoking cessation and nicotine withdrawal issues and resources should be increased.

- A toolkit to expand community based services, including self-help/peer support groups as extended support systems for smoking cessation, should be developed.

- "Smokers Anonymous" or a similar 12-step program for former smokers to help prevent recidivism should be developed and offered.

APPENDIX A

LIST OF PARTICIPANTS

NASMHPD's MEDICAL DIRECTORS TECHNICAL REPORT MEETING ON
"SMOKING POLICY AND TREATMENT AT STATE OPERATED PSYCHIATRIC HOSPITALS"
April 20 – 21, 2006
San Francisco, California

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APPENDIX B

U.S. SMOKE FREE WORKPLACE STATES

	Smoke free Offices (all areas of offices)	Smoke free Restaurants (all areas of restaurants)	Smoke free Bars (all areas of bars)	Casinos (all areas of casinos)
California	þ	þ	þ	þ
Delaware	þ	þ	þ	þ
New York	þ	þ	þ	þ
Connecticut	þ	þ	þ	þ
Maine	þ	þ	þ	þ
Massachusetts	þ	þ	þ	þ
Rhode Island	þ	þ	þ	þ
Vermont	þ	þ	þ	þ
Washington	þ	þ	þ	þ
Puerto Rico	þ	þ	þ	þ
New Jersey	þ	þ	þ	¨
Colorado	þ	þ	þ effective July 1, 2006	¨
Montana	þ	þ	þ effective 2009	¨
Utah	þ	þ	þ effective 2009	¨
Florida	þ	þ	¨	¨
Idaho	þ	þ	¨	¨
Hawaii	þ	þ	¨	¨
North Dakota	þ	þ	¨	¨
Maryland	þ	¨	¨	¨
Guam	¨	þ	¨	¨

Cherner, Joe. “Joe Cherner Announcement” Joe @smokefree.org

APPENDIX C

NAMI PUBLIC POLICY PLATFORM
REVISED, EIGHTH EDITION, JULY 2006.

7.3 Smoking

NAMI recognizes that cigarette smoking creates significant health problems for people with brain disorders. Research shows that people with brain disorders are twice as likely to smoke as the general population and that people with schizophrenia are three to four times as likely to smoke as the general population. The negative effects of cigarette smoking on personal health are well documented, including increasing risks of respiratory problems, heart disease, and certain forms of cancer. The negative effects of exposure to "second hand" smoke for those who don't smoke are also well documented. Thus, NAMI recognizes the importance of creating smoke free environments within psychiatric treatment facilities.

At the same time, NAMI recognizes that requiring consumers to stop smoking when hospitalized can exacerbate psychiatric symptoms. Nicotine withdrawal is difficult for the general population – it is particularly difficult for individuals experiencing a psychiatric crisis. Research suggests that smoking may have a therapeutic effect in reducing depression, anxiety and the negative symptoms of schizophrenia. Smoking may also help relieve the Parkinsonian symptoms associated with antipsychotic medications, particularly the older medications. Nicotine has been shown to decrease the blood level of antipsychotic medications, therefore causing smokers to require higher doses of anti-psychotic medications than non-smokers.

Thus, NAMI calls upon physicians and health providers generally (in community as well as inpatient settings) to implement educational and smoking cessation programs to help consumers reduce and stop smoking. NAMI asserts that psychiatric treatment facilities instituting smoke free policies must provide supports and accommodations to consumers who are smokers, including:

(1) Smoking cessation strategies and ongoing supports for consumers who wish to reduce or stop smoking;

(2) Nicotine substitute products for individuals with long-term nicotine dependence, such as the patch, nicotine gum or other alternatives to smoking;

(3) Socialization, recreational and other structured activities for consumers who frequently have few activity options in psychiatric treatment facilities other than smoking;

(4) Counseling and other therapeutic supports designed to assist consumers in reducing nicotine dependence; and

(5) Accommodations to allow smoking for individuals who cannot stop smoking. In some jurisdictions, this would involve changing state law. There is also research evidence that smoking cessation may produce physiological and behavioral changes that, for some, may appear similar to the symptoms of mental illnesses. And, because smoking affects metabolism, smoking cessation may result in increased concentrations of psychiatric medications in the bloodstream, a potentially dangerous complication. Thus, physicians must be fully aware of the smoking histories of their patients and carefully assess and monitor the physiological and functional effects of smoking cessation. Adjustments to medication regimens should be made as appropriate.

NAMI advocates for research and services in response to major illnesses that affect the brain, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder.

APPENDIX D

A Comparative Analysis of Smoking Policies and Practices among State Psychiatric Hospitals

By Kathleen M. Monihan, M.S, Lucille M. Schacht, Ph.D.

Executive Summary
The health and environmental effects of smoking are being reflected in the smoking policies and practices of state psychiatric hospitals. A recent survey of these hospitals found that 41% do not permit smoking for patients, 12% plan to eliminate smoking within the next year, and another 17% plan to change their smoking policy in the future. Substantially more of the hospitals that permit smoking experienced environmental/safety issues related to smoking and tobacco as compared to the group of hospitals that do not permit smoking. Over 90% of all hospitals offered multiple forms of treatments to their patients that smoke, while some differences in practices were found between hospitals that permit smoking compared to hospitals that do not permit smoking. Most hospitals that do not permit smoking reported the transition period was a year or less and that the health of patients has improved and that more time is available for active treatment.

Introduction
Recent attention to the health and environmental effects of smoking has prompted new actions in a number of states that restrict areas where smoking is permitted. The Surgeon General's office has produced a multitude of reports over the past two decades focusing on the affects of smoking, both in terms of physical health and mental health. In addition to health conditions caused or exasperated by smoking, a clear economic burden for medical care and lost productivity is attributable to smoking practices[1]. The Surgeon General's report also indicates that the states spend an estimated $12 billion on "treating smoking attributable diseases",[1] representing a large economic burden to public institutions. Compounded with the existing financial strain for treating these diseases, persons with mental illness are noted to be twice as likely to smoke tobacco as the general population and to smoke more heavily.[2]

State mental health agencies and state medical directors are interested in the status of their state psychiatric hospitals in the general movement toward non-smoking environments. Their interests reflect awareness of the costs of smoking and the treatment implications for persons residing in hospitals. In May 2005, they enlisted the support of the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute (NRI) to conduct a brief survey on the policies regarding smoking for staff and patients in state psychiatric hospitals. This survey was comprised of seven questions to collect basic information on current smoking policies such as location of areas where smoking is permitted, number of smoke breaks, and policy change towards smoke-free environment.

The results of this initial survey indicated wide variation in policies and practices among the responding hospitals.[3] The results reflect only 55% of all state psychiatric hospitals. Of the hospitals that responded to the initial survey, 20% stated that smoking was not permitted entirely on hospital grounds. Most hospitals offered cessation treatments and/or programs. Of those hospitals that allowed smoking, some hospitals appear to allow smoking on units, and while the average number of smoke breaks a day was six, some hospitals indicated unlimited access.

This early survey offered limited information on the smoking policies of state psychiatric hospitals. When attempting to interpret the results, a number of important follow-up questions were identified. One major area of concern was definition. The survey tool did not include a definition of terms which lead some hospitals to indicate smoking was not permitted on hospital grounds but that there were organized smoke breaks for patients. Including policy related to either staff or patients in the tool may have also contributed to apparent inconsistencies. The second major area of concern was provision of treatments. While a majority of hospitals indicated that nicotine replacement treatment medications were on formulary and patient cessation groups were conducted, the survey did not ascertain the actual utilization of these services. The final area of concern was understanding the motivators and obstacles for change. As indicated by the initial survey results, many hospitals plan to implement changes in smoking policies and become smoke-free environments. The lessons and experiences from hospitals that have successfully transitioned to non-smoking could prove helpful to hospitals beginning the process to become smoke-free.

To address the foregoing concerns and to serve the interests of the state psychiatric hospitals who are also enrolled in NRI's Behavioral Healthcare Performance Measurement System™ (BHPMS), the NRI created a second survey to investigate and provide hospitals with information and resources on moving towards a smoke-free establishment. The results would also be available to the medical directors for their technical report on the same issue. The focus of this most recent survey was to probe more deeply into the current and planned policies and practices regarding smoking for patients.

Methods

All state psychiatric hospitals were targeted to receive the survey. "Smoking" was defined as any lighted tobacco product (e.g. cigarettes, cigars, etc.). "Smoking on premises" was defined as any area where the facility has governance, including any buildings, balconies, patios, courtyards, areas adjacent to exit doors, parking areas, and lawn expanses. Hospitals were defined into two groups: hospitals that permit smoking on premises and those that do not. Separate survey tools were developed for each of the stated groups. Hospitals were instructed to complete only the one survey tools that aligned with their current practices. The surveys contained a common set of questions for comparative purposes, as well as specific questions for the particular group of hospitals. The survey for hospitals that permit smoking contained 20 questions, whereas the survey for hospitals that did not permit smoking contained 14 questions. Some questions included multiple parts to delineate difference aspects of an issue, and there

was a mix of qualitative and quantitative items. Common questions addressed policy, environmental issues, staff training, prescribing practices and treatments. Questions specific to hospitals that permit smoking addressed prevalence, access to smoking areas, and issues of changing to non-smoking. Questions specific to hospitals that do not permit smoking addressed several aspects of the change process. Both surveys also included an open-ended item to elicit specific areas where hospitals desired additional information in order to support a non-smoking environment.

Surveys were distributed via email to directors and administrators of state psychiatric hospitals with an introductory message from NRI and Joseph Parks, MD as the NASMHPD medical directors' liaison. A total of 222 surveys were distributed via email, followed by a postcard reminder after two weeks, and an email reminder after four weeks. The survey tools were also posted on the web for convenient access. The data collection period spanned between March 6 and April 27, 2006. A total of 181 surveys were completed and returned (82% response rate). Forty-four states (88%) were represented in responses. Survey results were analyzed using general descriptive statistics, correlations among questions, and t-tests between groups. Statistical significance was evaluated with an alpha level of 0.05 through all tests.

Findings

Surveys were returned from 82% of all state psychiatric hospitals. Among responding hospitals 41% are non-smoking and 59% permit smoking by patients on hospital premises. Nearly all hospitals have written smoking/non-smoking policies. More than half the hospitals that do not permit smoking and almost two-thirds of the hospitals that do permit smoking have a designated committee on issues related to smoking. The presence of a designate committee could reflect forthcoming changes in policy. However, among hospitals that permit smoking, hospitals that are not planning changes were just as likely as those that are planning changes to have such a committee.

Overall Comparison

Three specific environmental/safety issues in relation to smoking and tobacco use were identified on the survey. In all cases, significantly more hospitals that permit smoking experienced these issues than those that do not permit smoking. One of the many concerns of facility staff is the relationship between smoking and aggression. Many of hospitals that permit smoking expressed concern that patient agitation would increase if smoking was no longer allowed. However, as shown in Figure 1, significantly fewer hospitals that do not permit smoking experienced aggression issues related to smoking or tobacco use compared to hospitals that permit smoking.

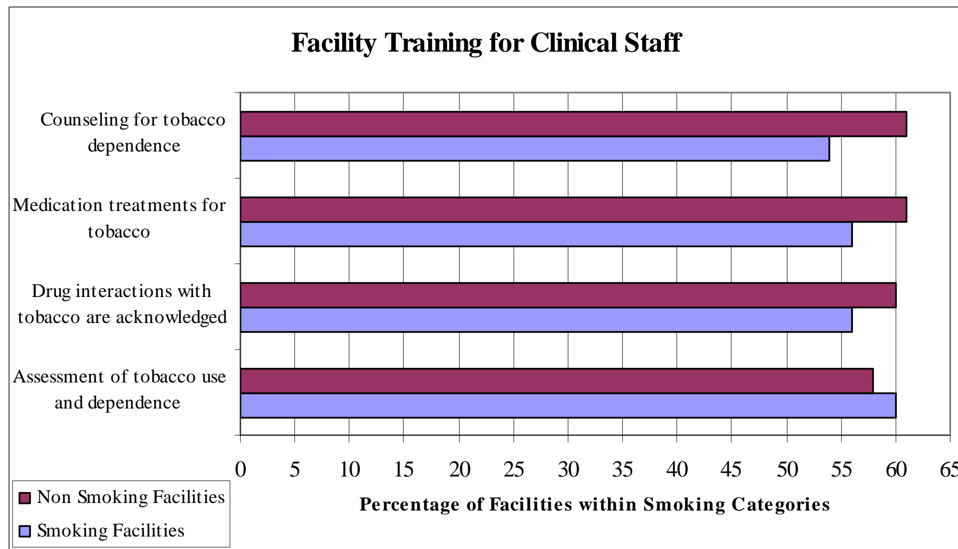
Figure 1: Environmental/safety issues related to smoking and tobacco

Issue:	Smoking Not Permitted (%)	Smoking Permitted (%)
Smoking/tobacco as precursor to seclusion/restraint	5	34
Smoking/tobacco users and coercion/threats among patients and staff	18	49
Smoking/tobacco related to other health conditions	22	66
No environmental/safety issues	**61**	**47**

Although 22% of hospitals that do not permit smoking experienced health conditions in relation to smoking or tobacco use, a much greater proportion of hospitals that permit smoking (66%) experienced those same issues. Finally, almost seven times as many hospitals that permit smoking experienced issues of smoking/tobacco as a precursor to seclusion or restraint as compared to hospitals that do not permit smoking.

About 70% of all hospitals provide training for clinical staff in assessing and treating patients who smoke. Four specific components of training are shown in Figure 2. There were no significant differences between the hospital groups on these four components. Many hospitals are cognizant of smoking issues when training clinical staff to provide appropriate services to their patients who smoke. Many hospitals provide training in all four areas (34%).

Figure 2: Components of clinical staff training that addresses smoking issues of patients



While there was no difference between the hospital groups in terms of clinical training in medication treatment and drug interactions, there was a significant difference between these groups in prescribing practices. Sixty-six percent of hospitals that do not permit smoking indicated prescribing practices are modified for patients who smoke compared to 49% of hospitals that permit smoking. This difference may be a reflection of the more immediate needs of patients who smoke when entering a non-smoking hospital.

Over 90% of hospitals in both smoking and non-smoking environments offered multiple forms of treatments to their patients. Forms of treatment included nicotine replacement therapies (NRT) such as the patch, gum, lozenges, sprays, and/or inhalers; antidepressant medications specifically used for cessation; acupuncture; hypnosis; and smoking cessation sessions. A similar proportion of hospitals that permit smoking and those that do not permit smoking reported using NRTs (94%). However, there was a significant difference in the prescribing of antidepressants for purposes of smoking cessation. Fifty-three percent of hospitals that permit smoking stated they used antidepressant for smoking cessation, compared with 36% of hospitals that do not permit smoking. Less

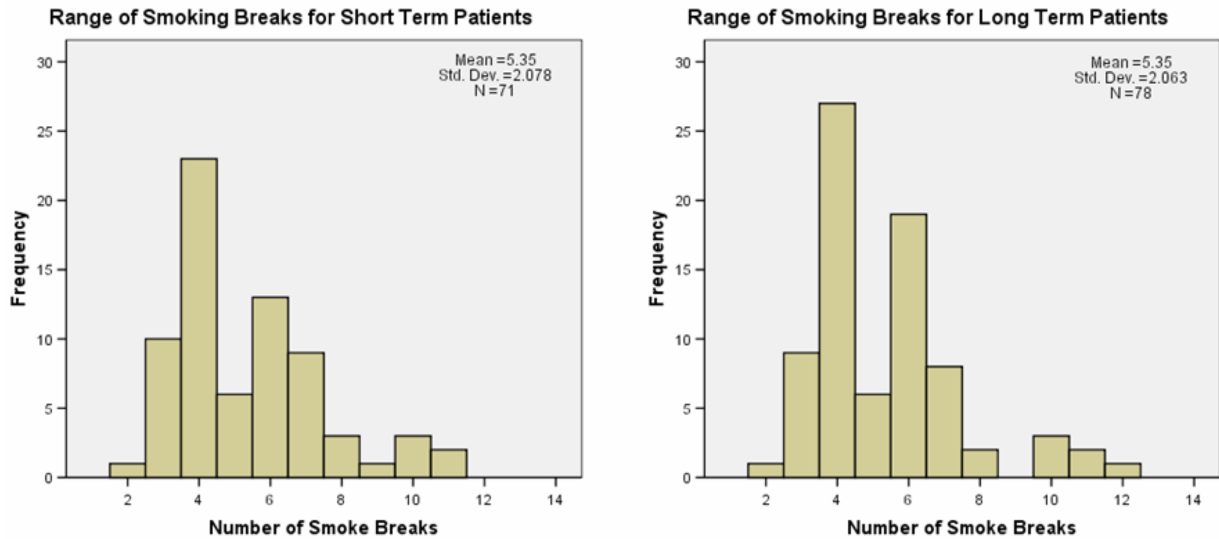
than 30% of hospitals offer regularly scheduled smoking cessation sessions at least weekly and most of these hospitals reported low to moderate attendance.

Hospitals that permit smoking

Hospitals that permit smoking typically have constructs or protocols by which they allow patients to smoke. The vast majority of hospitals do not allow smoking inside the buildings. Notably, less than 2% of hospitals permit smoking on living units. Established smoking times, designated smoking areas, and patient escort to smoking areas were overwhelmingly implemented. In fact, 44% of hospitals that permit smoking implemented all three of these controls. Smoking permissions based on privilege status was also indicated widely (34% of hospitals). Many hospitals stated that gaining access or permission to smoke was a motivator for patients to comply with staff.

Figure 3 illustrates the distribution of smoke breaks given to patients across hospitals reporting a defined number of breaks. There was no significant difference in these patterns between short term and long term patients. In addition, 6% of hospitals reported unrestricted access to smoking areas and 25% of hospitals reported no defined breaks. Approximately 10 hospitals provide less than four smoke breaks per day for either short term or long term patients. On average, hospitals provide five smoke breaks per day; possibly fostering a pattern of tobacco dependence.

Figure 3: Number of smoke breaks provided for patients

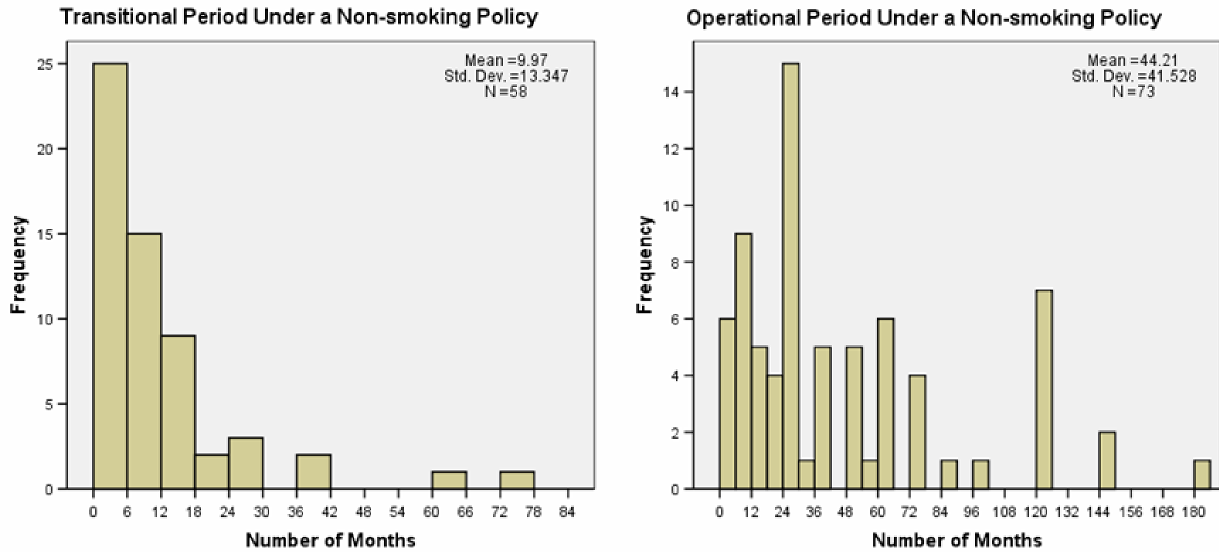


Of those hospitals that permit smoking, more than half stated that they intended to change or modify their smoking policy sometime in the future. The most common change was an intent to prohibiting smoking for patients altogether (34%), followed by a plan to move towards smoke-free grounds (29%), reduce smoking areas (14%), and reduce number of smoke breaks (8%). Only 10% of these hospitals indicated that more than one aspect of the policy was expected to change. Among hospitals expecting to change, 71% indicated the change would occur within the year. Seemingly, much of the focus is to move toward a smoke-free environment for patients in the near future.

Hospitals that do not permit smoking
Of all the responses, 41% of hospitals state that smoking is not permitted on the premises or grounds. On average, these hospitals have been operating as non-smoking establishments for almost 4 years. The average transition time to implement non-smoking policies was 10 months.

As shown in Figure 4, most hospitals (84%) were able to transition to smoke-free environments in a year or less, and the most common transitional period was less than 6 months. Within the past 6 years, 83% of hospitals that now do not permit smoking made the change from smoking establishments. A number of hospitals have been operating as non-smoking establishments for over 10 years. Some hospitals were not able to reported transitional periods (23%), several indicating they have been operating under a non-smoking policy since opening.

Figure 4: Transitional and operating periods for non-smoking hospitals (Note: Scales are different between graphs.)



Discussion

The survey of state psychiatric hospitals suggests a nationwide movement towards adopting a non-smoking policy for patients. Over one-third of hospitals that permit smoking have reduced the number of smoke breaks over the past two years. Interestingly, there was no relationship between the recent reduction in the number of smoke breaks and whether hospitals were planning additional changes to policy. Of the 32 hospitals that are planning to adopt a non-smoking policy for patients or smoke-free grounds, 21 of these hospitals intend to change within the year. Potentially, 52% of all state psychiatric hospitals could be smoke-free within a year. When the projection includes hospitals that anticipate changing in more than a year, more than 70% of state psychiatric hospitals could be non-smoking within the next few years.

There are environmental consequences for permitting smoking on the hospital's premises which places additional strain on those hospitals. Financial and staff resources are taxed

to accommodate patients who smoke, in terms of health care and active treatment time. Hospitals that permit smoking report a high prevalence of smokers among their patient population, reflective of the Surgeon General's findings. Specifically, more than half of the hospitals that permit smoking report that more than 60% of their patient population smokes. Since most hospitals do not permit smoking inside buildings, staff resources are allocated to chaperoning patients to smoking areas. More than half of the hospitals that permit smoking also indicated that tobacco products are sold legally on hospital premises. For these hospitals, an obstacle to change may well include a financial impact for this lost resource. Finally, more of the hospitals that permit smoking maintain a designated committee on issues related to smoking, limiting staff resources for other treatment issues. Many hospitals that do not permit smoking stated that, since the hospital adopted a non-smoking policy, the health of patients has improved and that more time is available for active treatments.

Awareness of the impact of smoking on general health and psychiatric treatment is evident in the practices being adopting by many hospitals in each group. There are wide variations in the choices among the treatment models. While the training of clinical staff in a majority of hospitals addresses smoking issues, the training is not universal. In addition, more hospitals offer NRTs and antidepressants than regularly scheduled smoking cessation sessions. A substantial proportion of hospitals indicate using antidepressants for cessation purposes as well as NRTs, both of which require the attention of physicians.

It was observed that almost seven times as many hospitals that permit smoking experienced issues of smoking/tobacco as a precursor to seclusion or restraint as compared to hospitals that do not permit smoking. Given the Surgeon General's report, it can be assumed that the prevalence of smoking among psychiatric hospital patients would be independent of the hospital's policy on smoking. Contrary to concerns of hospitals that permit smoking, hospitals that do not permit smoking indicated that they experienced a decrease in behavior problems related to smoking, What appears as a potential obstacle to change was not experienced by some hospitals that were successful at changing to non-smoking establishments.

On the survey, hospitals were also asked a series of open-ended questions to explain motivations and obstacles about adopting a smoke-free policy or retaining a smoking environment. A follow up report on these areas will be available at a later date.

References

1. U.S. Department of Health and Human Services. The Health Consequences of Smoking: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

2. Lasser K, Boyd W, Woolhandler S, et al: Smoking and mental illness: a population-based prevalence study. JAMA 284: 2606-2610, 2000.

3. Schacht LM, Monihan K: Smoking Policies in State Psychiatric Hospitals. Alexandria, Virginia: National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) 2005.

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APPENDIX E

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' smoke free policy and providing health information about smoking. Policy information will be presented to the patients as part of an individualized treatment program, and will include advance notice of possible consequences for smoking infractions.

3. The sale of cigarettes, tobacco products and smoking materials is prohibited. All patients will be requested to turn in their smoking materials upon admission; these materials will be returned at discharge. Any smoking materials found on the unit will be confiscated by staff and returned to the patient at discharge.

4. Visitors are not to bring in cigarettes or other tobacco products. Violation may result in termination of visiting privileges.

Smoking and Contraband Violation Grid Process

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

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

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

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

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

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

(This appears on the Patients and Selling grids)

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

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

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

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

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

(DS)

Reference Authority

Policy Owner: **Smith, Douglas**

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

APPENDIX F

TALKING POINTS FOR SEPTEMBER 2, 2003 FRESH AIR
Northcoast Behavioral Healthcare (NBH)

1. NBH is now focusing on overall Wellness. The elimination of smoking on grounds for staff and patients, beginning September 2, 2003, is part of that endeavor.

2. NBH recognizes that the change to a non-smoking environment will be difficult for some patients and staff.

3. NBH will be offering a wide range of support, nicotine replacement, and alternatives to smoking to assist in this adjustment.

4. NBH is committed to protecting all individuals on our grounds from second hand smoke, a severe health threat.

5. There is a Wellness Coordinator on each unit. These individual staff members have had training from the American Cancer Society and will be running smoking cessation programs and groups for patients and staff.

6. The Wellness Committee members are also available to help assist in the transition from a smoking to a non-smoking hospital setting.

7. Smoke breaks are being replaced with healthy breaks, outdoors when possible. Breaks are not to be eliminated.

8. All tobacco products will be considered contraband after September 2, 2003. All lighters, matches, etc. will be considered contraband after September 2, 2003. Staff, but not patients, may bring these items onto NBH grounds, but shall not make use of these items on grounds and shall not bring such items onto any inpatient unit.

9. Staff are expected to follow the non-smoking policies after September 2, 2003. This includes not smoking anywhere on grounds, including in personal vehicles.

10. An incident report should be written by any staff member who observes any staff or patient violating the non-smoking policy anywhere on NBH grounds.

THINK HEALTHY!!

APPENDIX G

Northcoast Behavioral Healthcare System
State of Ohio Department of Mental Health

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 the patients property and returned to them upon discharge. Family members will be allowed to pick up unopened packs of cigarettes and expensive lighters.

B. Off grounds or off State property

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

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

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

REFERENCE LIST

American Psychiatric Association. Practice Guidelines for the Treatment of Patients With Substance Use Disorders. American Psychiatric Press Inc. Washington, DC. 20006

American Psychiatric Association Nicotine Dependence Treatment Guidelines. American Psychiatric Press Inc. Washington, D.C. 1996.

Bernstein, S.M. & Stoduto, G. (1999). Adding a Choice-Based Program for Tobacco Smoking to an Abstinence-Based Addiction Treatment Program. *Journal of Substance Abuse Treatment, 17*, 167-173.

Bobo, J.K., & Gilchrist, L. (1983). Urging the alcoholic client to quit smoking cigarettes. *Addictive Behaviors, 8*, 297-305.

Bobo, J.K. & Davis, C.M. (1993). Recovering staff and smoking in chemical dependency programs in rural Nebraska. *Journal of Substance Abuse Treatment*, *10*, 221-227.

Bobo, J.K., Slade, J. & Hoffman, A.L. (1995). Nicotine addiction counseling for chemically dependent patients. *Psychiatric Services, 46*, 945-947.

Brown, S., Inskip H., Barraclough, B. (2000) Causes of excess mortality of schizophrenia. ***Br J Psychiatry, 177:***212-217.

Cherner, Joe. Joe Cherner Announcement. Joe @smokefree.org.

de Leon, J., Diaz, F.J. (2005) A meta-analysis of worldwide studies demonstrates an association between schizophrenia and tobacco smoking behaviors. *Schizophr Res, July 15; 76 (*2-3*):*135-57.

Department of Veterans Affairs, Public Health Strategic Health Care Group. VA in the Vanguard: Building on Success in Smoking Cessation. *Conference proceedings; September 21, 2004, San Francisco, CA.*

D'Mello, D.A., Bandlamudi, R.G., & Colenda C.C. (2001). Nicotine Replacement Methods on a Psychiatric Unit. *American Journal of Drug and Alcohol Abuse, 27(3),*525-529.

el-Guebaly, N., et.al. (2002). Public Health and Therapeutic Aspects of Smoking Bans in Mental Health and Addiction Settings. *Psychiatric Services, Vol. 53, No. 12,* 1617-1622.

Fiore MC, Bailey WC, Cohen SJ, et.al. *Treating Tobacco Use and Dependence.* Quick Reference Guide for Clinicians. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. October 2000.

Fogg, B. & Borody, J.(2001). *The Impact of Facility No Smoking Policies and the Promotion of Smoking Cessation on Alcohol and Drug Rehabilitation Program Outcomes, A Review of the Literature.* Canadian Centre on Substance Abuse, Addictions Policy Working Group.

Fox, B.J. & Katz, J.E., eds. (2005) Individual and Human Rights in Tobacco Control: Help of Hindrance? *Tobacco Control, Vol. 14, Supplement II.*

Goldstein, M. G., DePue, J. D., Monroe, A. D., Lessne, C. W., Rakowski, W., Prokhorov, A., Niaura, R., Dube, C. (1998). A population-based survey of physician smoking cessation counseling practices. *Preventive Medicine, 27*:720-729.

Grant B.F.,Hasin D.S., Chou S.P., Stinson F.S., Dawson, D.A. Nicotine Dependence and Psychiatric Disorders in the United States: results from the National Epidemiological Survey on alcohol and related conditions. *Archives of General Psychiatry* 2004;61:1107-1115.

Haller, E., McNiel, D.E., & Binder, R.L. (1996). Impact of a Smoking Ban on a Locked Psychiatric Unit. *J Clin Psychiatry, 57;8.*

Hemple, A.G., et.al. (2002). Effect of a Total Smoking Ban in a Maximum Security Psychiatric Hospital. *Behav. Sci. Law, 20:*507-522.

Hser, Y.I., McCarthy, W.J., et.al. (1994) Tobacco use as a distal predictor of mortality among long-term narcotics addicts." *Prev Med 23(1):61-9.*

Hurt, R.D., Ofird, K.P., Croghan, I.T., Gomez-Dahl, L, Kottke, T.E., Morse, R.M. & Melton, L.J. (1996). Mortality following inpatient addictions treatment: Role of tobacco use in a community based cohort. *JAMA, 275*, 1097-1108

Lasser, K.,Wesley B.J., Woolhandler S.,Himmenstein, D.U., McCormick D. & Bor, D.H. (2000). Smoking and Mental Illness: A population-based prevalence Study. *JAMA* 2000:*284*:2606-2610.

Lawn, S. & Pols, R. (2004). Smoking Bans in Psychiatric Inpatient Settings? A Review of the Research. *Australian and New Zealand Journal of Psychiatry, 39:*866-885.

Minnesota State Operated Services, Department of Human Services. Administrative and Patient Care policy 2040 (Employee Smoking) and 6140 (Prohibition of Smoking).

Monihan, K.M., & Schact, L.M. (2006 A comparative analysis of smoking policies and practices among state psychiatric hospitals. Alexandria, Virginia: National Association of State Mental Health Program Directors Research Institute, Inc. (NRI).

Munafo, M., Rigotti, N., Lancaster, T., & Murphy, M. (2001). Interventions for smoking cessation in hospitalized patients: a systematic review. *Thorax, 1;56:*656-663.

National Alliance on Mental Illness. Policy on Smoking, 7.3, Revised, July 2006.

Ohio State Department of Mental Health, Northcoast Behavioral Healthcare System. Administrative policies 05.08 (Handling of Contraband After Confiscation) and 05.07 (Smoke Free Environment, Smoking and Contraband Violation Grid) and Talking Points for Fresh Air.

Patten, C.A., Martin, J.E., Hofstetter, C.R., Brown, S.A., Kim, N., & Williams, C. (1999). Smoking cessation following treatment in a smoke-free Navy Alcohol Rehabilitation program. *Journal of Substance Abuse Treatment, 16,* 61-69.

Quinn, J., Inman, J.D., & Fadow, P. (2000). Results of the Conversion To a Tobacco-Free Environment in a State Psychiatric Hospital. *Administration and Policy in Mental Health, Vol. 27, No. 6.*

Richter, K.P., Choi, W.S., & Alford, D.P. (2004). Smoking policies in U.S. outpatient drug treatment facilities. *Nicotine & Tobacco Research, 7,* 475-480.

Schroeder, S. A. (2005) What to Do With a Patient Who Smokes. *JAMA, Vol. 294, No. 4.*

Smith, C.M., Pristach, C.A., & Cartagena, M. (January 1999). Obligatory Cessation of Smoking by Psychiatric Inpatients. *Psychiatric Services, Vol. 50, No.1,* 91-94.

Steinberg, M.L., Ziedonis, D.M., Krejci J.A. & Brandon, T.H. Motivational Interviewing With Personalized Feedback: A Brief Intervention for Motivating Smokers With Schizophrenia to Seek Treatment for Tobacco Dependence. *Journal of Consulting & Clinical Psychology, in press.*

Steinberg, M.L., Williams, J.M,. & Ziedonis, D.M. (2004) Financial Implications of Cigarette Smoking Among Individuals With Schizophrenia. *Tobacco Control, 13(2).*

Strouse R., Hall J., Kovac M. (2004) Survey of Health Professionals' Knowledge, Attitudes, Beliefs, and Behavior Regarding Smoking Cessation Assistance and Counseling. Mathematica Policy Research, Inc. submitted to the Robert Wood Johnson Foundation. May 27, 2004. Draft report.

Stubbs, J., Haw, C., & Garner, L. (2004). Survey of Staff Attitudes to Smoking in a Large Psychiatric Hospital. *Psychiatric Bulletin 28:*204-207.

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

U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General.* Atlanta, Georgia: U.S. Department of Health and Human Services,

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health, 2000.

Weinberger, A. H., Sacco, K.A., George, T. P. (2006). Comorbid Tobacco Dependence and Psychiatric Disorders. *Psychiatric Times, Vol. XXV, Issue 1.*

Williams JM, Gandhi KK, Steinberg ML, Foulds J, Ziedonis DM, Benowitz N. Higher Nicotine and Carbon Monoxide Levels in Menthol Cigarette Smokers with and without Schizophrenia. *Nicotine & Tobacco Research* (in press).

Ziedonis, D., Williams JM, Steinberg M., Foulds J., 2006. Addressing Tobacco Addiction in Office-Based Management of Psychiatric Disorders: Practical Considerations. *Primary Psychiatry 13(2)*:51-63.