

Smoke Free Behavioral Health Facilities: Opportunities and Lessons Learned

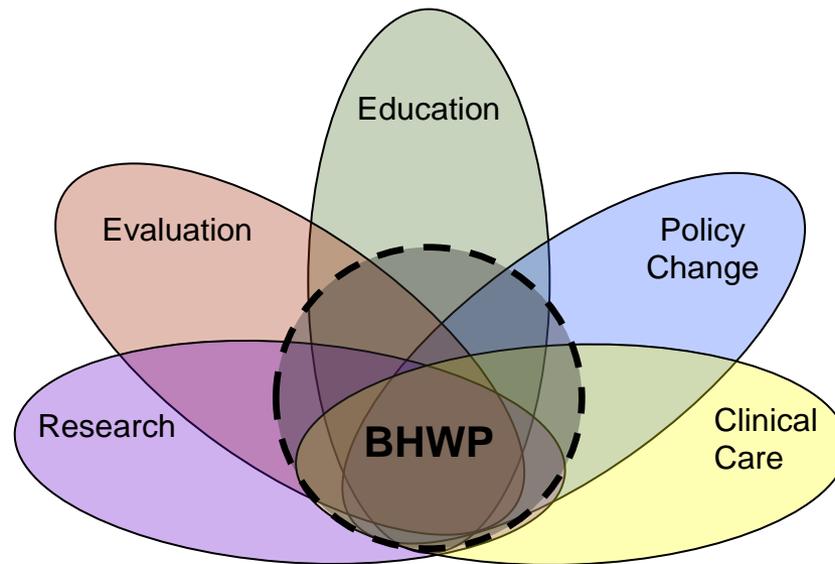
Chad D. Morris, Ph.D.
Generations
April 19, 2011, Noon-5p



Behavioral Health & Wellness Program

Behavioral Health & Wellness Program

www.bhwellness.org



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What is killing the majority of us is not infectious disease, but our chronic and modifiable behaviors



Common Concerns

- “They can’t”
- “It isn’t relevant”
- “They don’t want to”
- “I don’t have time to do this on top of everything else”
- “I’ve always heard smoking helps symptoms. I don’t want to make their symptoms worse.”
- “They will lose their sobriety if they also try to quit smoking or lose weight”
- “It isn’t my job to police smoking”



Cont...

- “Smoke breaks are a time when I build relationships with clients”
- “I don’t have the training necessary”
- “Why spend time on this when there are more important psychiatric, substance abuse, and medical issues?”
- “If we go tobacco-free, behavioral problems will increase”
- “The issues we face are unique”
- “This is one of their last personal freedoms”
- “How are we going to fund this?”



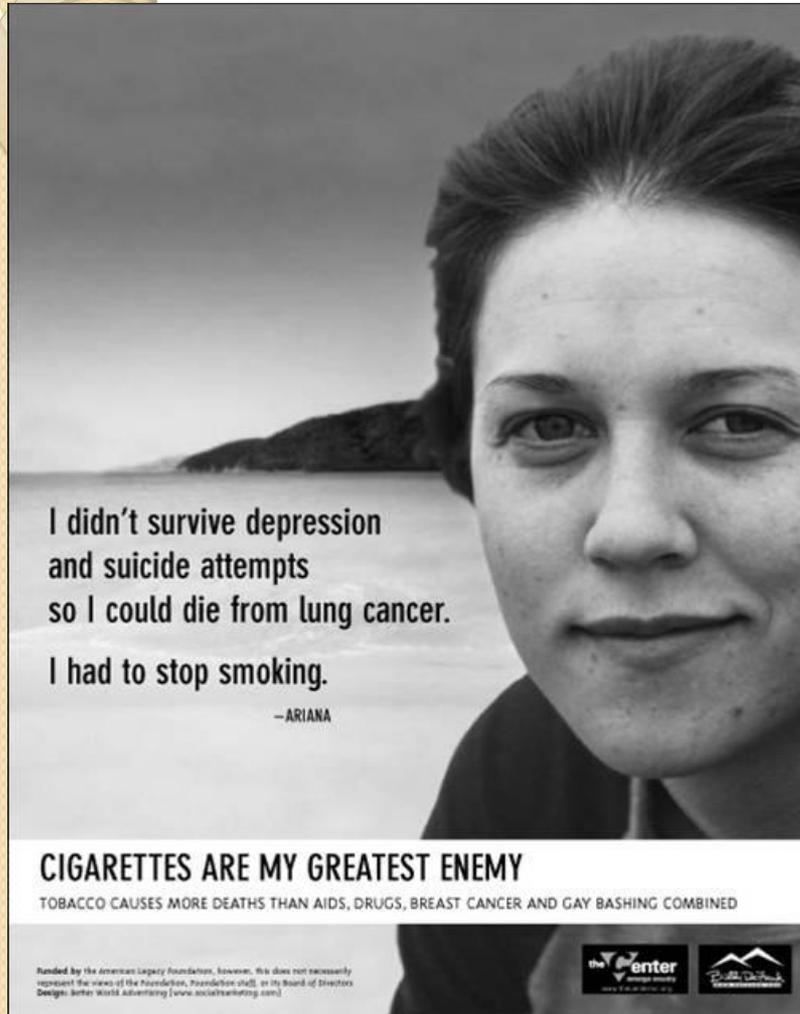
Framing the Day

- **Relevant Facts**
- **Barriers**
- **The Evidence for Intervening**
- **Tobacco Free Policies**
 - **Effectiveness**
 - **10 Steps Toward Success**
 - **State & National Resources**

Dialogue



Wellness



I didn't survive depression
and suicide attempts
so I could die from lung cancer.

I had to stop smoking.

—ARIANA

CIGARETTES ARE MY GREATEST ENEMY
TOBACCO CAUSES MORE DEATHS THAN AIDS, DRUGS, BREAST CANCER AND GAY BASHING COMBINED

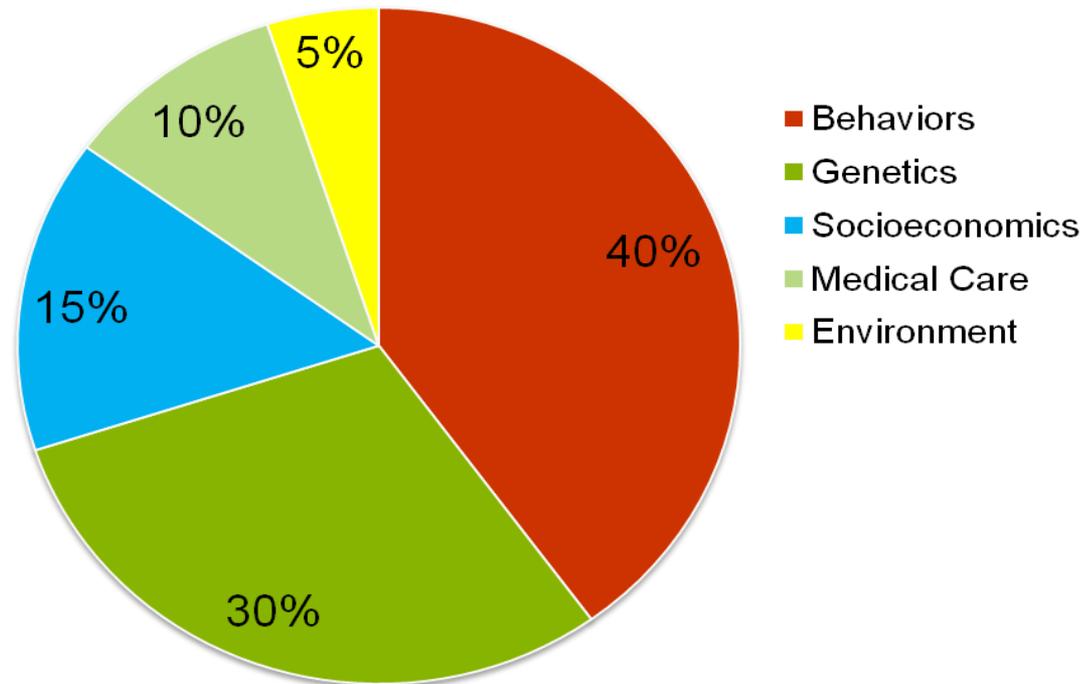
Funded by the American Legacy Foundation, however, this does not necessarily represent the views of the Foundation, Foundation staff, or its Board of Directors
Design: Inter World Advertising [www.socialmarketing.com]



Leading a meaningful and fulfilling life through conscious and self-directed behaviors, focused upon living at one's fullest potential



Where Do We Need to Intervene?



Slide Courtesy of Ben Miller and John Mahalik:

McGinnis JM, Foege WH. Actual Causes of Death in the United States. JAMA 1993;270:2207-12.

Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual Causes of Death in the United States, 2000.

JAMA 2004;291:1230-1245.



Why The Behavioral Health Sector?

- Experts in behavioral change
- Access to the highest risk population
- Duration of treatment and ability to monitor
- Therapeutic alliances
- Reassurance of other treatment systems
- Integrated and co-occurring philosophies and models
- Increased treatment effectiveness
- Integration with wellness programs and initiatives

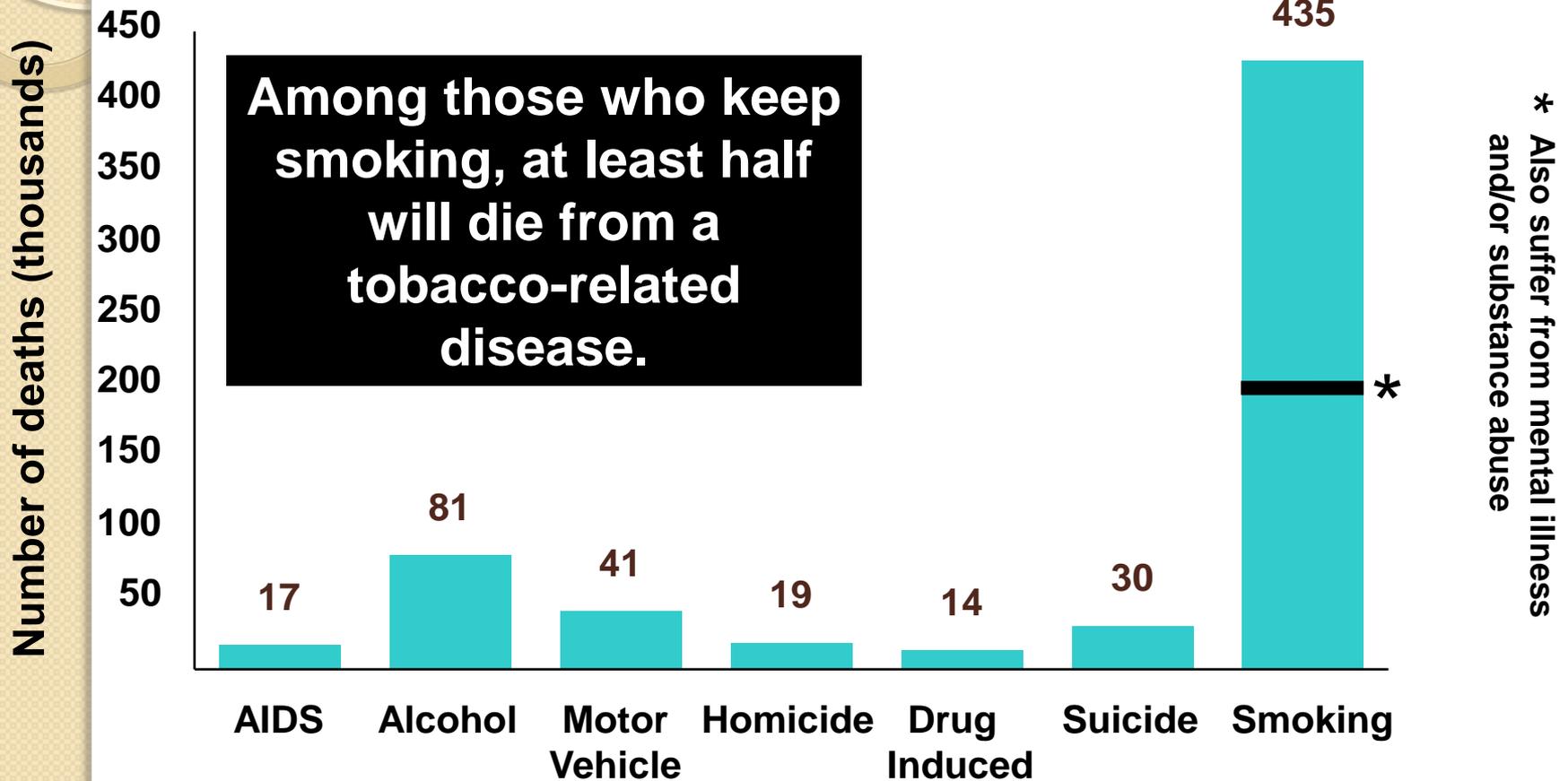


Facts & Figures



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Comparative Causes of Annual Deaths in the U.S.

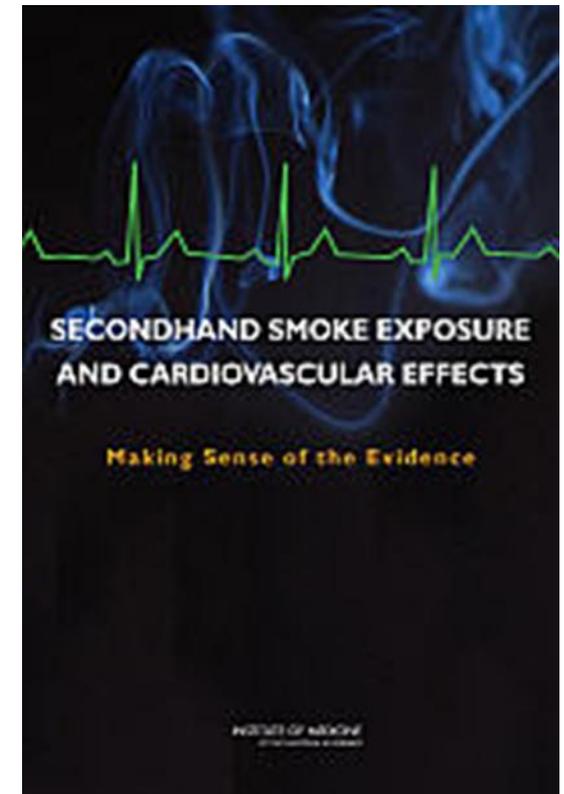


Mokdad et al. (2004). *JAMA* 291:1238–1245.
Flegal et al., (2005). *JAMA* 293:1861–1867.



Secondhand Smoke

- Third leading preventable cause of disability and early death (IOM, 2009).
- Nonsmoker heart disease risk increased by 25–30% and risk of lung cancer increased by 20–30% (IOM, 2009).



Prevalence

Utah Adult smoking rate of 9.5% (BRFSS 2009)

Persons with Addictions & Mental Illnesses are:

- Nicotine dependent at rates **2-3 times** higher
- Represent over **44%** of the U.S. tobacco market
- Consume over **34%** of all cigarettes smoked

(Lasser K et al: JAMA 284:2606-10, 2000)



Tobacco Use by Diagnosis

Schizophrenia	62-90%
Bipolar disorder	51-70%
Major depression	36-80%
Anxiety disorders	32-60%
Post-traumatic stress disorder	45-60%
Attention deficit/ hyperactivity disorder	38-42%
Alcohol abuse	34-80%
Other addictions	49-98%

(Beckham et al., 1995; De Leon et al., 1995; Farnam 1999; Grant et al., 2004; Hughes et al., 1996; Lasser et al., 2000; Morris et al., 2006; Pomerleau et al., 1995; Stark & Campbell, 1993; Ziedonis et al., 1994)



Youth Tobacco Use

- As many as 80% of tobacco users start smoking before they are age 18
- Adolescent smokers are more likely to report heightened levels of stress, depression, and anxiety
- An over twofold risk for suicide attempts for adolescents who smoke >15 cigarettes per day

(Brown et al., 1996; Chassin et al., 1984; Escobedo et al., 1998; Koval et al., 2000; Patton et al., 1996; Pederson et al., 2000; Riala et al., 2007; Sonntag et al., 2000; Stein et al., 1996)



What Works?



Proven Effectiveness

- Workplace bans lead to a 72% reduction in exposure to environmental smoke (Task Force on Community Preventive Services, 2005)
- There is significant evidence demonstrating that smoking cessation strategies are very effective (US DHHS, 2010; Fiore et al., 2008)
- Persons with mental illnesses and addictions can successfully quit using tobacco (Evins et al., 2005; George et al., 2002)



Cessation Concurrent with Mental Health or Addictions Treatment

Smoking cessation has no negative impact on psychiatric symptoms and smoking cessation may even lead to better mental health and overall functioning

(Baker et al., 2006; Lawn & Pols, 2005; Morris et al., Unpublished data; Prochaska et al., 2008)



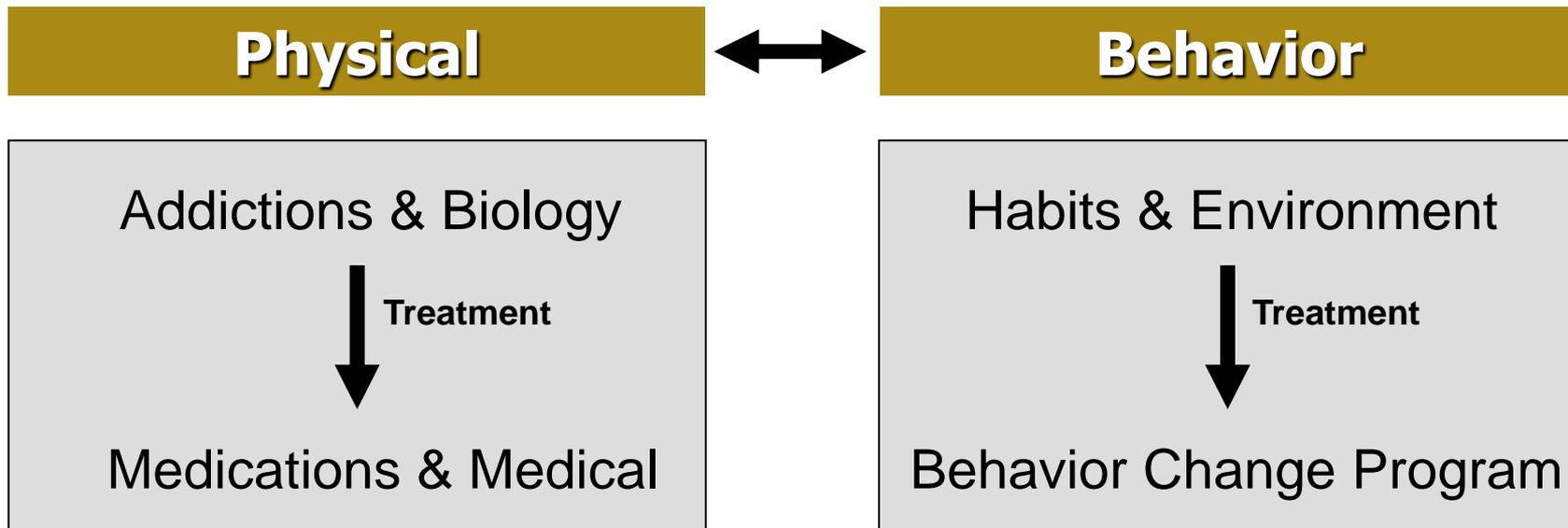
Cessation Concurrent with Mental Health or Addictions Treatment

Participation in smoking cessation efforts while engaged in other substance abuse treatment has been associated with a 25% greater likelihood of long-term abstinence from alcohol and other drugs.

(Bobo et al., 1995; Burling et al., 2001; Hughes, 1996; Hughes et al., 2003; Hurt et al., 1993; Pletcher, 1993; Prochaska et al., 2004; Rustin, 1998; Saxon, 2003; Taylor et al., 2000)



Intervening



Tobacco Cessation Works

- 70% of smokers say they want to quit, 40% of smokers attempt to quit
- Quitting tobacco is difficult but absolutely feasible if assistance is provided
 - Quit rates with willpower alone – 4%
 - Pharmacotherapy (NRT) alone – 22%
 - Quitline counseling plus NRT – 36%
 - Chantix – 44%
- Smokers are more than twice as likely to quit with coverage



Smoking Cessation Results for Mental Illnesses

Most combine meds & psycho-education
+/- CBT

Schizophrenia: 8 studies (n= 9-70)

Quit rates 35-56% post-treatment,
12% at 6-months

Depression: 8 studies (n= 29-615)

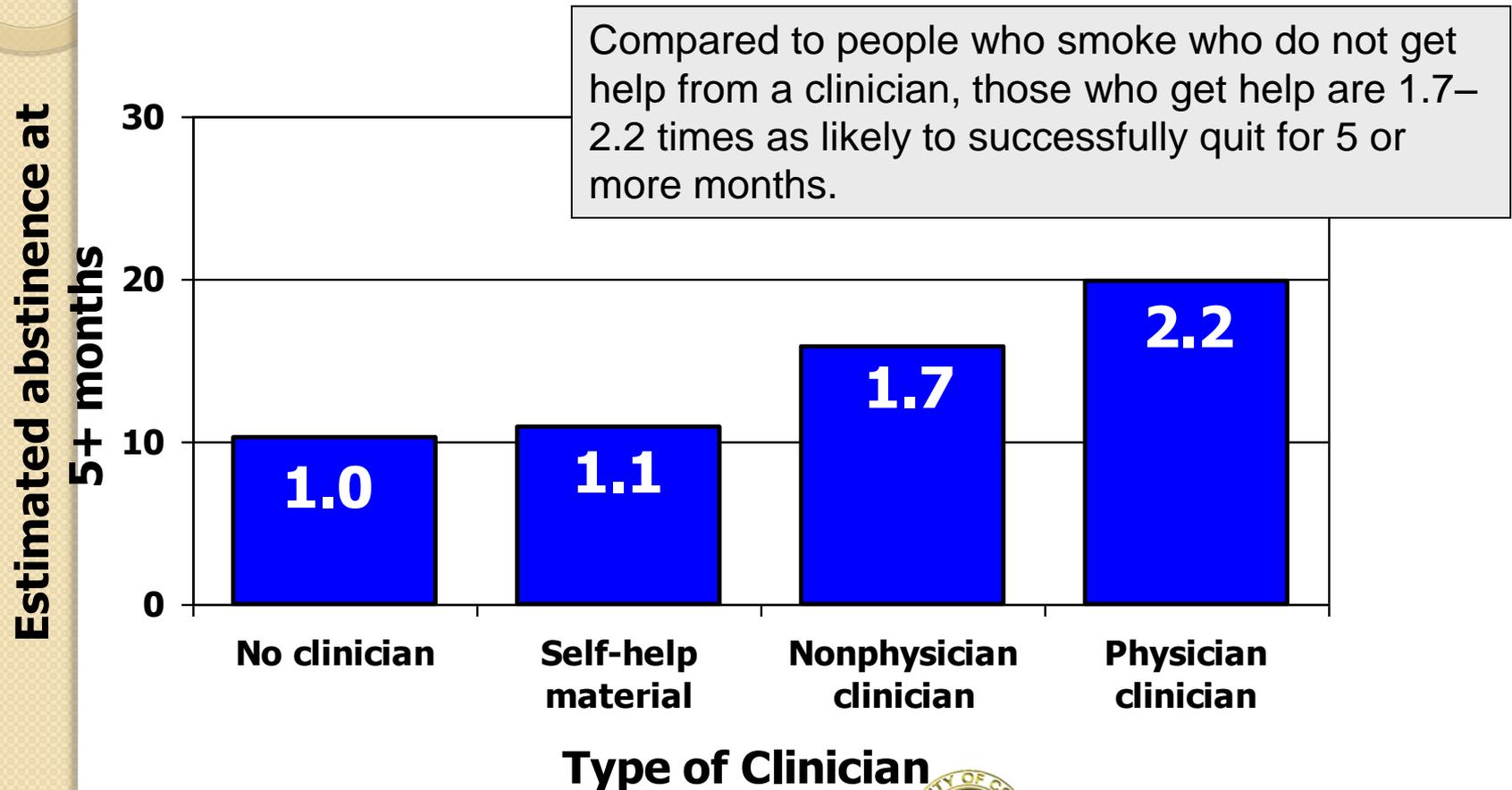
Quit rates 31-72% post-treatment,
12-46% at 12 months

(el-Guebaly et al., 2002)



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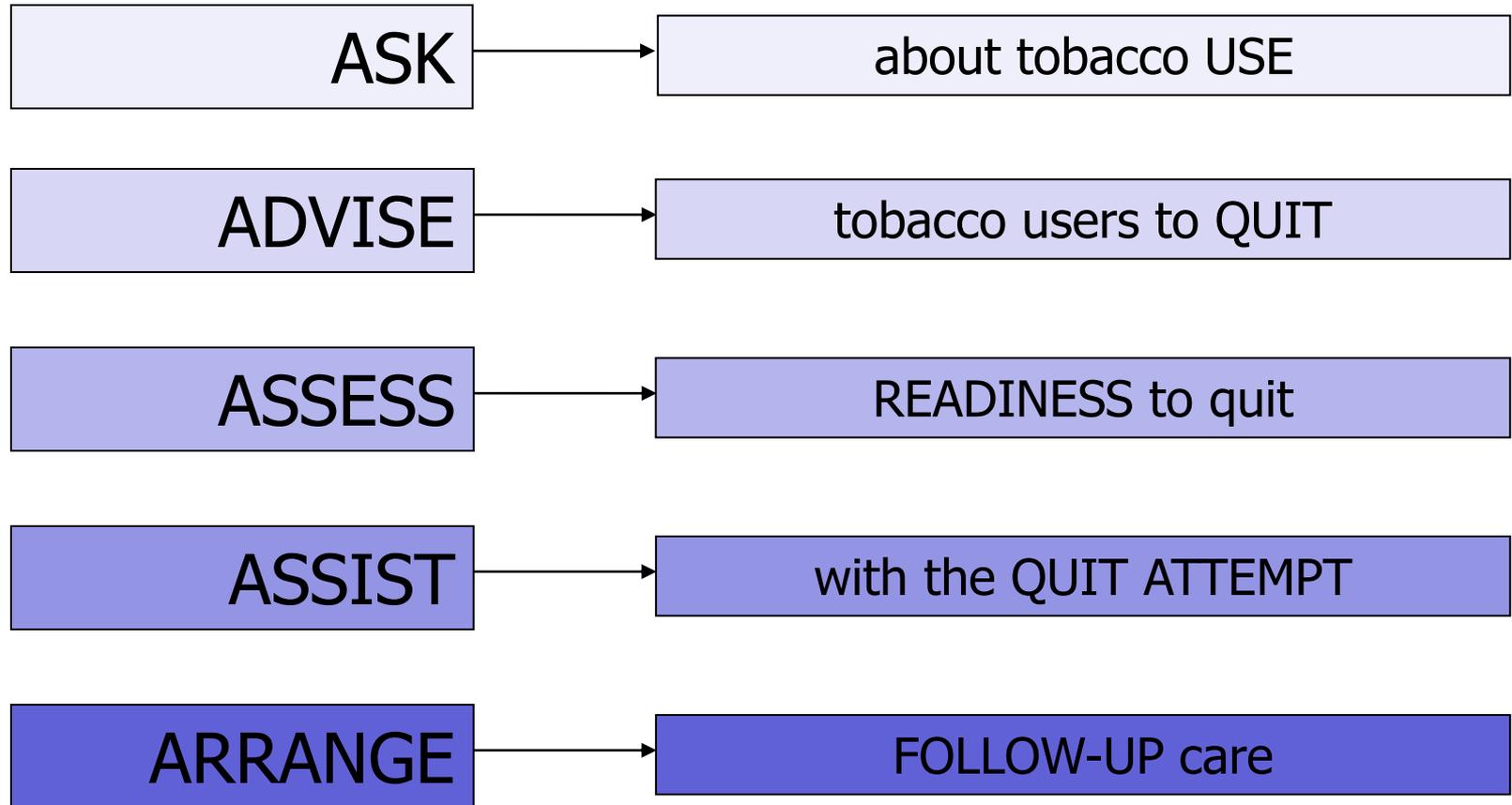
Advice Can Improve Chances of Quitting



Fiore et al. (2008). *Treating Tobacco Use and Dependence: 2008 Update*. Rockville, MD: USDHHS, PHS.



Assessment and the 5A's



2 A's and R Model

- **ASK:** Determine tobacco use status
- **ADVISE:** “Quitting is very important to improving your health. I can refer you to people who can help you”
- **REFER:**
 - To a Quitline (1-800-Quit-Now)
 - To Cessation and/or Wellness Group
 - To Peer Support Group



Tobacco dependence is a 2-part problem.

Physical

The addiction to nicotine



Treatment

Medications for cessation



Behavior

The habit of using tobacco



Treatment

Behavior change program

Treatment should address both the addiction **and** the habit.

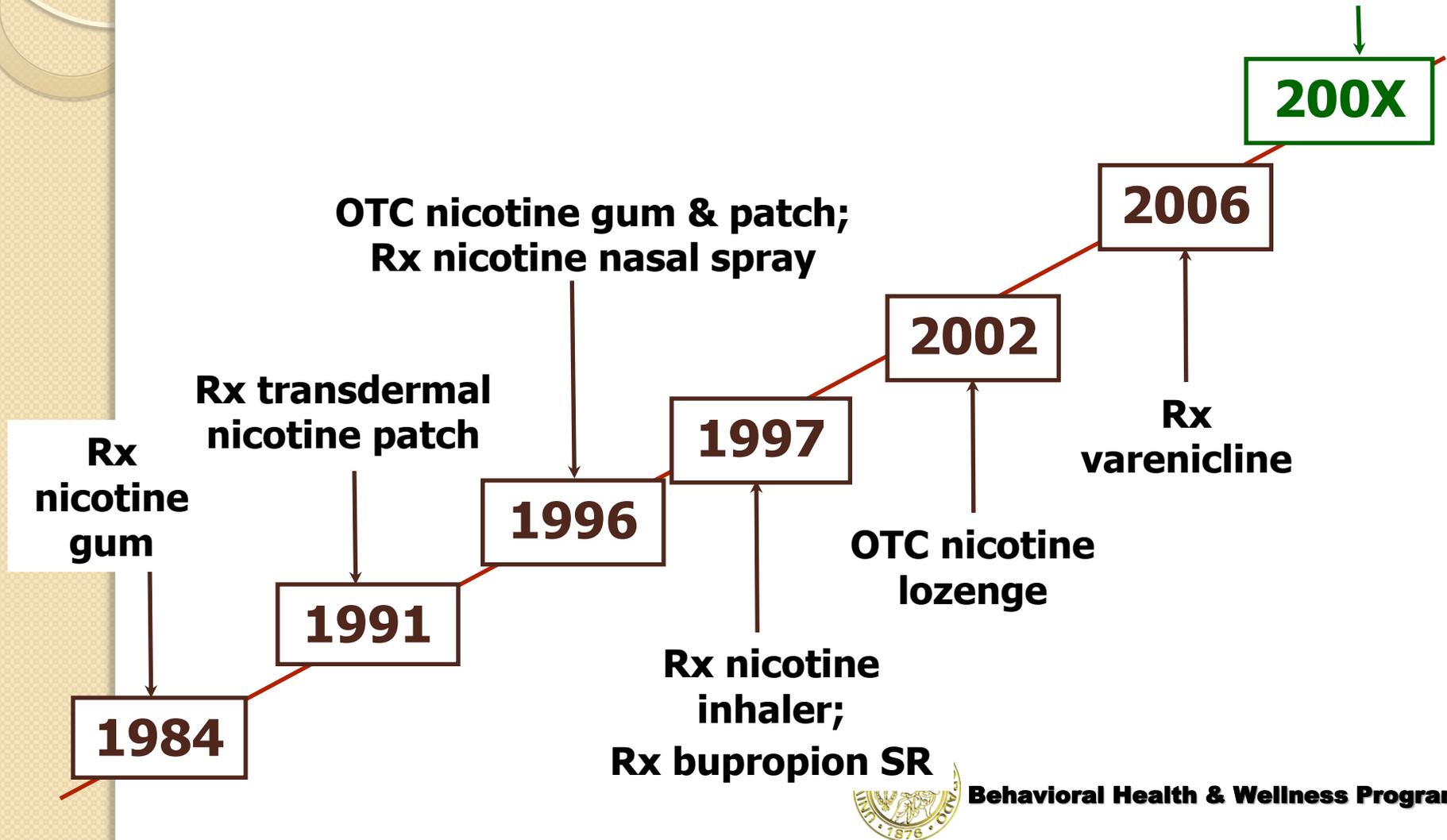
NRT for Tobacco Dependence

- Decreases nicotine withdrawal symptoms
- Lessens negative mood states in early abstinence
- No interactions with psychiatric medications
- Safe with concomitant smoking
- May be used long-term (6 months+)



FDA Approvals for Smoking Cessation

*Drugs in Development:
rimonabant, nicotine
vaccine, etc.*



Combination Therapy

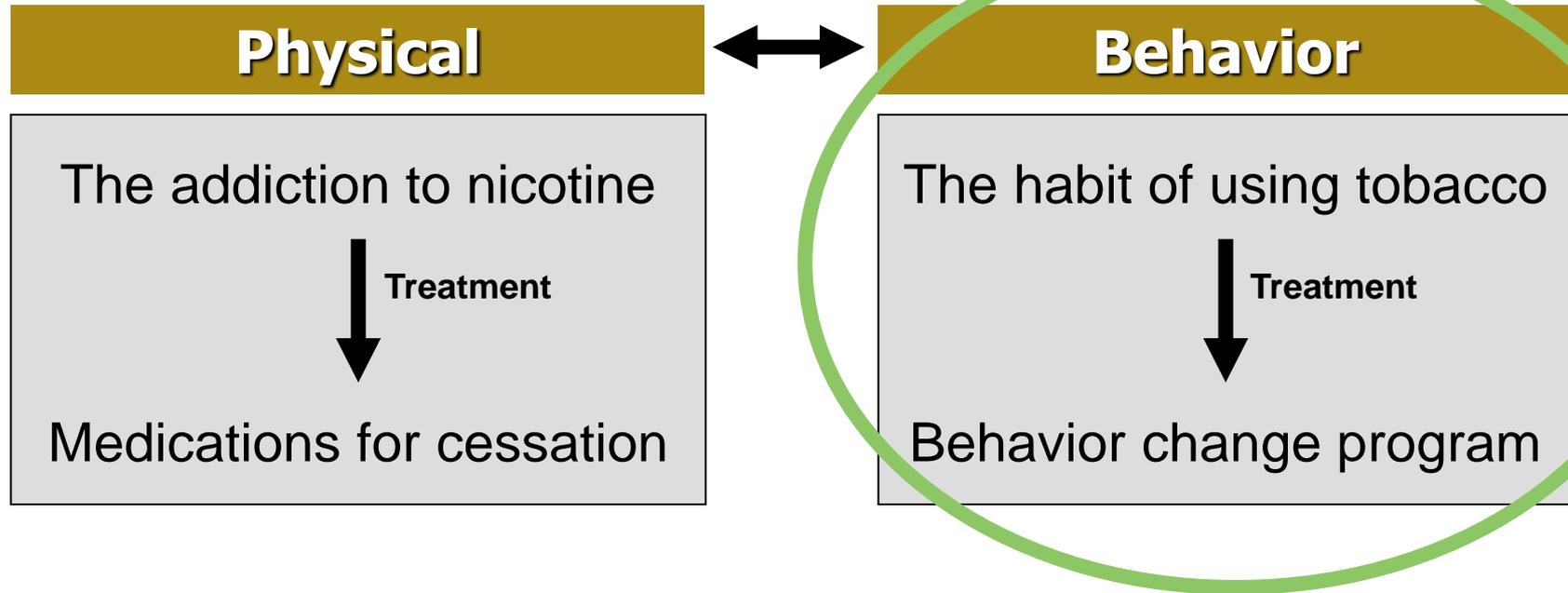
Long-acting formulation (patch), which produces relatively constant levels of nicotine

PLUS

Short-acting formulation (gum, lozenge, inhaler, nasal spray), which permits acute dose titration as needed for withdrawal symptoms



Tobacco dependence is a 2-part problem.



Treatment should address both the addiction **and** the habit.

Courtesy of the University of California,
San Francisco



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Wellness Resources & Tools

- Cognitive-Behavioral Therapy
- Motivational enhancement
- Individual counseling
- Groups meeting
- Family based strategies
- Peer-to-peer support
- Referrals (e.g., Quitline, Quitnet)
- Other media (e.g., web-based, texting)



Motivational Intervention

- 30 minute session
- Motivate smokers to seek tobacco dependence treatment
- Provides brief, personalized feedback about impact of tobacco use
 - Carbon Monoxide (CO)
 - Money spent on tobacco



Utah Cessation Services

Quitline

- 1-888-567-TRUTH
- <http://www.tobaccofreeutah.org/quitline.htm>

Quitnet

- <http://utah.quitnet.com/qnhomepage.aspx>



The Power of Peer-Driven Services

Adjuncts to formal treatment, involvement in self-help groups, and social opportunities in community and institutional settings foster empowerment and self-efficacy

(Davidson, Chinman, Sells, & Rowe, 2006, Knight, 2006)

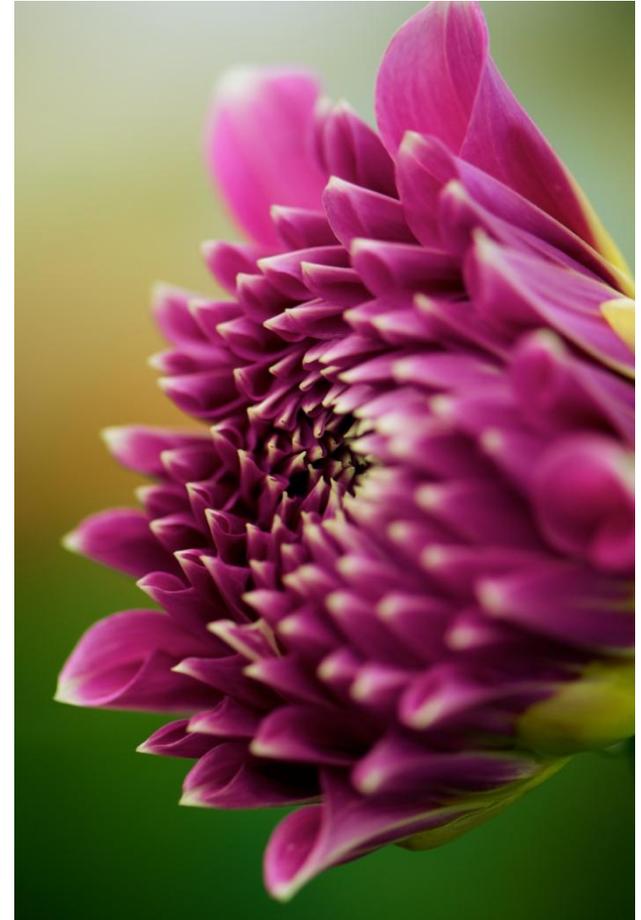


Tobacco-Free Policies



Return on Investment

- **For Facilities:**
 - Reduced maintenance and cleaning costs
 - Decreased accidents and fires
 - Decreased health insurance costs
 - Decreased worker's compensation payments



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Return on Investment

- **For Staff:**

- Decreased hospital admissions
- Decreased absenteeism
- Increased staff productivity
- Increased staff satisfaction

- **For Clients:**

- Decreased disease and death
- Decreased hospital admissions
- Increased quality of life



Psychiatric Hospital Outcomes

- Improved health of patients,
- Cleaner grounds/environment,
- Reduced seclusion and restraint,
- Decreased coercion and threats among patients and staff,
- Increased availability of tobacco cessation medication,
- Increased staff satisfaction

(NASMHPD, 2007)



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Considerations



Organizational Readiness

Stage of readiness drives effective action:

- **Precontemplation** – The organization is not considering change
- **Contemplation** – The organization plans to implement a tobacco-free plan over the next 6 months
- **Preparation** – A tobacco-free plan will be implemented over the next month
- **Action** – A tobacco-free plan has been implemented but has not been in effect for more than 6 months
- **Maintenance** – A tobacco-free plan has been in effect for 6 months or longer



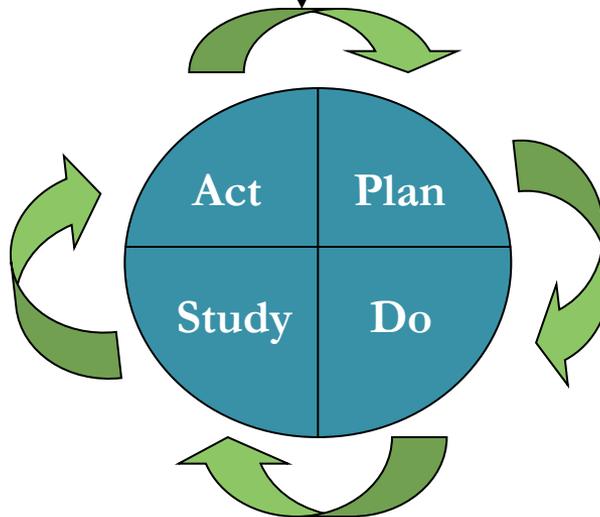
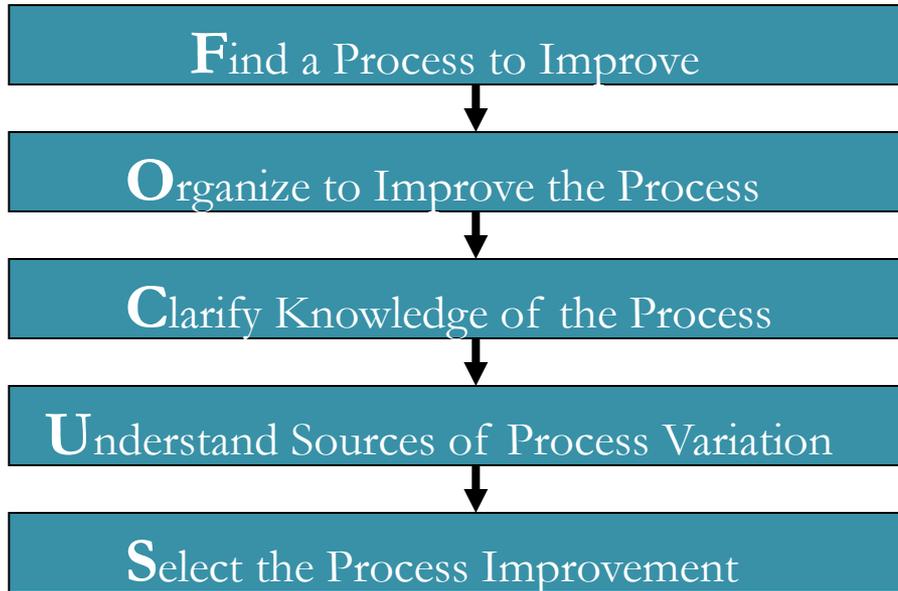
Intersecting Cultures

- The **clinical world** asks “What care is called for?” and “Is it high quality?” ,
- The **operational world** asks “What will it take to accomplish such care?” and “Is it well executed?” .
- The **financial world** in turn asks “Is it a good value?”

(Miller, Mendenhall, & Malik, 2008)



Rapid Improvement Projects



Ten Steps Toward Success

- **Step 1. Convene a tobacco-free committee**
- **Step 2. Create a timeline**
- **Step 3. Craft the message**
- **Step 4. Draft the policy**
- **Step 5. Clearly communicate your intentions**
- **Step 6. Educate staff and clients**
- **Step 7. Provide tobacco cessation services**
- **Step 8. Build community support**
- **Step 9. Launch the policy**
- **Step 10. Monitor the policy & respond to challenges**



Step 1. Convene a Tobacco-Free Committee

- **Key members of the committee are:**
 - **The human resources director**
 - **Facilities director**
 - **Environmental services**
 - **The clinical and/or medical director**
 - **Key employee groups**
 - **Key client groups**
 - **Security**
 - **Pharmacy**
 - **Health education**
 - **Public affairs**



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Step 2. Create a Timeline

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
Establish a tobacco-free committee						
Create buy-in with top-level administrators and clinical staff						
Develop and secure a budget						
Develop an implementation timetable						
Host focus groups with staff and clients						
Draft policy and garner feedback from clients and staff						
Revision of current human resource policies to cover use of tobacco while on duty						



Step 2. Create a Timeline

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6
Announce plans of policy implementation						
Start countdown to launch date						
Educate employees, clients, visitors, community, and neighbors						
Provision of cessation services						
Train all employees on new policy						
Post signage						
Launch date						



Step 3. Craft the Message

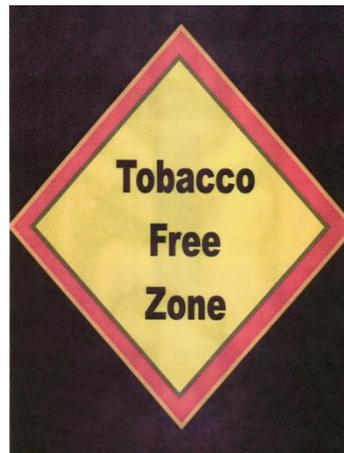
“We are developing this policy to provide a healthy and safe environment for employees, clients, and visitors and to promote positive health behaviors.”

“Tobacco acts as a cue for other drug use and maintains a drug-related coping style.”



Step 3. Craft the Message

We are not saying you must quit smoking. But we are saying you cannot use tobacco while you are at work. If you are ready to quit, we want to support your efforts.”



Step 4. Draft the Policy

- Provide a clear rationale that cites the documented health risks that tobacco use poses to clients and staff.
- Create in consultation with staff and clients.
- Acknowledge the right of employees to work in a tobacco-free environment.



A Parallel Process

- Client, visitor, and staff policy
- Client and staff resources
 - Facilities
 - Incentives
 - Medications
 - Peer support



Step 5. Clearly Communicate Your Intentions

- Internet, Intranet
- Pay check messages
- Signage
- Letter from CEO, president, or Chief Medical Officer
- Letters to staff
- Pamphlets for staff
- Pamphlets for residents
- Notice boards
- Posters and/or banners in and outside the building
- Appointment card announcements
- A prominently displayed countdown to the kick-off day



Step 5. Clearly Communicate Your Intentions

- Inform Outside Providers and Agencies
 - Mental health and addictions providers
 - Primary care clinics
 - Criminal justice
 - Public health
 - School systems
 - Mayor's office
 - HMOs
 - Medicaid office
 - Homeless shelters



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Step 6. Educate Staff & Clients

- The association between mental illnesses, addictions and tobacco dependence,
- Evidence based pharmacotherapy and counseling,
- Scope of work changes,
- Brief screening and assessment tools,
- Treatment planning & discharge planning,
- Referral



Clinic Checklist: Staff Resources and Knowledge

- Have staff been assigned clear roles and responsibilities for interventions?*
- Are clinicians knowledgeable in discussing risks, benefits of quitting, physiological & emotional processes during quit attempts?*
- Are clinicians familiar with setting realistic goals for quitting (cessation & harm reduction)?*
- Are staff & clinicians aware of internal & external resources?*
- Are staff & clinicians familiar with referral process to cessation programs?*

From: Health Care Provider's Tool Kit for Delivering Smoking Cessation Services: California Tobacco Control Alliance

www.tobaccofreealliance.org



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Step 7. Provide Tobacco Cessation Services

- Counseling
- Quitline & Quitnet
- Peers
- Nicotine replacement therapies (NRT)
- Bupropion SR (Wellbutrin, Zyban)
- Varenicline (Chantix)



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Integration into Standard Practice

- Assess tobacco as part of normal assessment & screening procedures
- Add tobacco to treatment plan with goals and objectives specific to tobacco
- Provide educational materials related to tobacco
- Address tobacco use in individual and group sessions



Clinic Checklist: Material Resources

- Do intake forms include charting smoking status or is there another mechanism for charting smoking status?*
- Are tobacco use assessments included in client visits?*
- Does the intake form provide space for updating information during subsequent patient visits?*
- Is there a current copy of specific resources/ referrals available to all staff?*
- Are there patient educational materials readily available (& in non-English languages)?*
- Are prescribing guidelines for cessation available to clinicians?*

From: Health Care Provider's Tool Kit for Delivering Smoking Cessation
Services: California Tobacco Control Alliance

www.tobaccofreealliance.org



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Vitals

Brief Strategy A1. Ask—Systematically identify all tobacco users at every visit

Action	Strategies for implementation
<p>Implement an office-wide system that ensures that, for EVERY patient at EVERY clinic visit, tobacco-use status is queried and documented.^a</p>	<p>Expand the vital signs to include tobacco use or use an alternative universal identification system.^b</p> <div style="border: 1px solid black; padding: 10px; margin: 10px 0;"> <p style="text-align: center;">VITAL SIGNS</p> <p>Blood Pressure: _____</p> <p>Pulse: _____ Weight: _____</p> <p>Temperature: _____</p> <p>Respiratory Rate: _____</p> <p>Tobacco Use: Current Former Never (circle one)</p> </div> <p>^b Alternatives to expanding the vital signs are to place tobacco-use status stickers on all patient charts or to indicate tobacco use status using electronic medical records or computer reminder systems.</p>

^a Repeated assessment is *not* necessary in the case of the adult who has never used tobacco or has not used tobacco for many years, and for whom this information is clearly documented in the medical record.



Tobacco-Free Pledge

Smoke-Free BPC Pledge Form

I support Smoke-Free BPC:

- I *WILL* be Smoke-Free
(I will make a commitment to quit smoking)
- Smoke-Free BPC
(I will support a smoke-free environment)
- I *QUIT!*
(I am a former smoker who will support others to quit)

Signature _____ Date: _____

Please print name here



Funding

- Private health plans
- State Medicaid
- Centers for Medicare and Medicaid Services (CMS)
- Employee health plans
- Employee wellness programs



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Step 8. Build Community Support

- Local and state health departments
- Tobacco-free coalitions
- Telephonic and web-based forums.
- National events
 - Great American Smoke Out the third Thursday of every November
 - World No Tobacco Day on May 31st each year



Step 9. Launch the Policy

- Insure signage is in place
- Inform visitors directly and indirectly
- Throw a kick-off celebration

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Anschutz Medical Campus is a



TOBACCO-FREE

Campus



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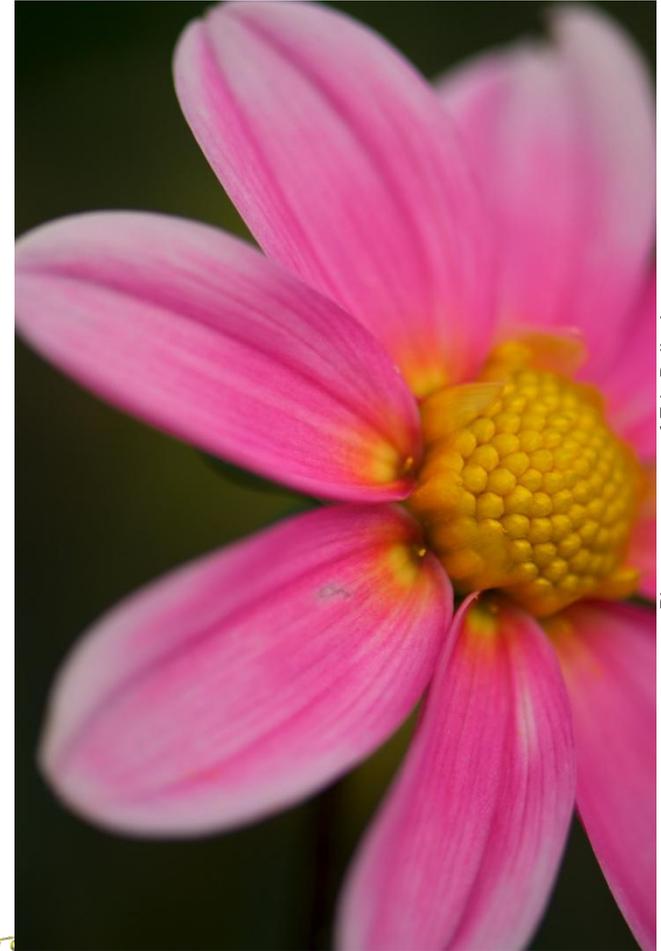
Step 10. Monitor the Policy & Respond to Challenges

- The addictive nature of tobacco emerges with policy change
 - Tie to bad life choices
- Staff need to address it when they see it-
 - This is the treatment- addressing it where it is happening
- Could increase searches
- After the honeymoon phase...



Step 10. Monitor the Policy & Respond to Challenges

- Client, visitor, and employee violations
- Work with relapse, but the needs of the agency will outweigh the disruptions of any one client, visitor or employee



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Utah Policy

<http://www.tobaccofreeutah.org/>

http://www.dsamh.utah.gov/recovery_plus_tobacco_project.html



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National Resources

Smoking Cessation Leadership Center

<http://smokingcessationleadership.ucsf.edu>

Behavioral Health and Wellness Program

<http://www.bhwellness.org>

Americans for Non-Smokers' Rights

<http://www.no-smoke.org>

Partnership for Prevention

<http://www.prevent.org>

National Association of State Mental Health Program Directors

<http://www.nasmhpd.org>

Tobacco Recovery Resource Exchange

<http://www.tobaccorecovery.org>

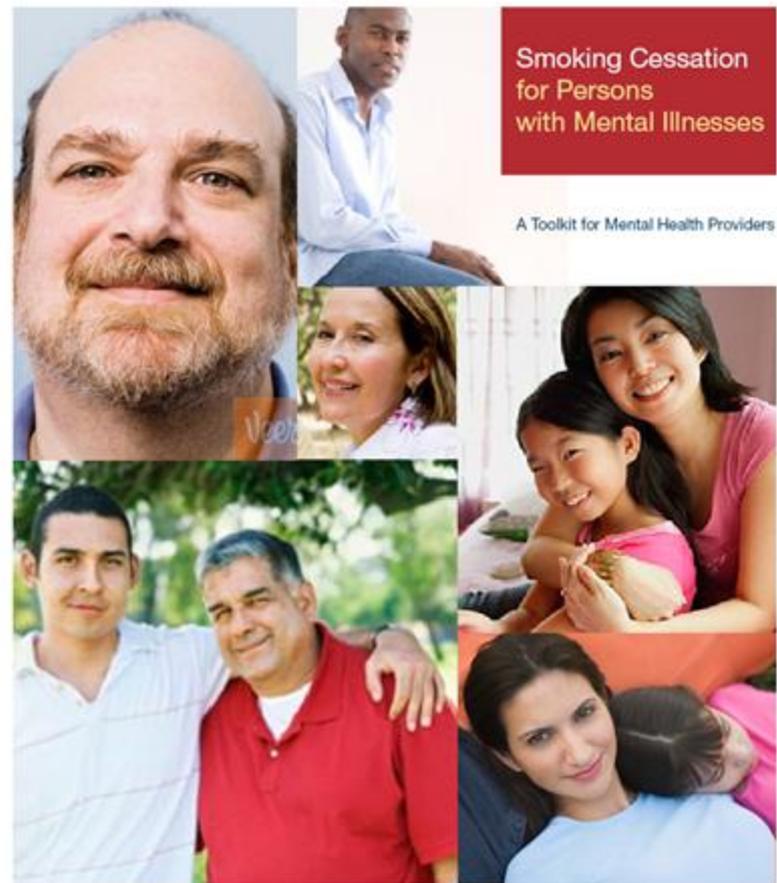


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Smoking Cessation for Persons with Mental Illnesses
A Toolkit for Mental Health Providers



For free copies go to - http://smokingcessationleadership.ucsf.edu/Downloads/MH/Toolkit/Quit_MHToolkit.pdf



Behavioral Health & Wellness Program

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