

Tobacco Free Pilot Programs in State Hospitals

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Rationale

- The original reason for hospitals to become smoke-free was to protect against the harmful effects of second hand smoke.
- Joint Commission standards regarding smoking changed in 1992
- JC currently requires hospitals to develop a written policy prohibiting smoking in all buildings. Exceptions must be defined in writing.
- The Mental Health community has become sensitized to the role that smoking plays in the elevated morbidity and mortality of persons with a serious mental illness.

Lanza, J., G.M., Wright, M.D., et al. (2009, January). Smoking policies and practices in state psychiatric convalesces: Survey results from 2008. Alexandria, VA: NTL.

Scope of the Problem

- Persons with SMI die, on average, 25 years earlier than the general population.
- Most die from tobacco caused diseases.
- Among alcoholics in recovery who die, 51% of mortality is attributed to smoking-related illness.
- Among treated narcotic addicts, the death rate of smokers is 4 times that of non-smokers.

Technical Report on Smoking Policy and Treatment in State Operated Psychiatric Facilities, NASMHPD Medical Directors Council Parks, J and Jewel P October, 2006
 Technical Report on Morbidity and Mortality in People with Serious Mental Illness NASMHPD Medical Directors Council Parks, J, Svendsen, D et al October, 2006

Rationale

- For Mental Health facilities, becoming a smoke-free facility entails decreasing exposure to second-hand smoke and helping individuals served achieve a healthier lifestyle.
- Additional Motivating Factors:
 - Tobacco use should be characterized as an addiction and not merely as a habit.
 - The desire to go on a smoking break often supersedes efforts to engage individuals in diagnostic or therapeutic activities and can be the source of conflict.
 - Purchasing cigarettes is a significant financial burden to clients who have limited incomes.

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Barriers

Barriers to implementation of a smoke-free policy among 25 psychiatric hospitals that did not plan to implement the policy in the next 12 months

| Barrier | N | % |
|---|----|----|
| Overall staff resistance | 17 | 68 |
| Resistance from clients who smoke | 13 | 52 |
| Advocates or family members | 13 | 52 |
| Unions or labor organizations | 9 | 36 |
| State policy | 7 | 28 |
| Other | 3 | 12 |
| Financial costs | 2 | 8 |
| Exempt from "no smoking in a public building" | 2 | 8 |
| Outside hospital management | 1 | 4 |
| Not a priority | 1 | 4 |
| Limited capacity or untrained staff | 1 | 4 |

Psychiatric Services, September 2010, Vol. 61, No. 9, p. 901

Barriers

- Staff resistance - often cite smoking as a means to establish a therapeutic relationship with patients or to reward desired behavior

Challenges-SMI

Treatment complexities

- Nicotinic cholinergic system may play a role in the pathophysiology of schizophrenia and make it more difficult to stop smoking.
- Smoking interacts with psychoactive drug metabolism.
- Quit attempts, if not well managed, can be thwarted by symptom emergence or drug interactions.
- Failure rate for persons with SMI utilizing mainstream programs is about double the general population.

Mink, G.A. and Dixon, L. Half Full or Half Empty. Psychiatric Services 2015; 61(9): 852

Challenges - SA

- Best time to introduce tobacco treatment for substance users remains unclear
- Treating tobacco use improved alcohol and other drug outcomes by an average of 25%.
Pechenko et al., 2006, Journal of Consulting and Clinical Psychology
- One study found that drinking outcomes were worse with concurrent tobacco treatment
Joseph, A., Wilensberg, M., Nugent, S., & Nelson, D. (2004). A randomized trial of concurrent versus delayed smoking intervention for patients in alcohol dependence treatment. Journal of Studies on Alcohol, 65(3), 681-691.
- A recent review concluded that even though the research is not yet conclusive, tobacco treatment should be provided to clients at the same time as their alcohol treatment whenever clients request tobacco treatment.
Koel, M., Fu, S., & Joseph, A.M. (2009). Tobacco cessation treatment for alcohol-dependent smokers: When is the best time? Alcohol Research and Health, 32 (2) 203-207.

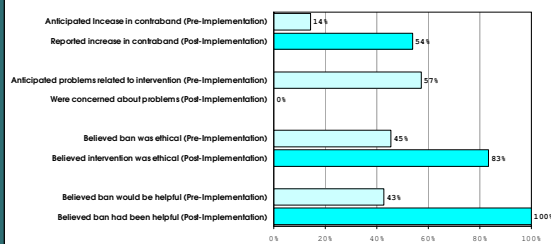
The Reality

- Studies show that smoking bans do not increase aggression, use of seclusion, discharge against medical advice, or the use of as-needed medications.
- Persons with MI and SA can successfully quit smoking and benefit from smoking cessation interventions.
- The state facility environment is a secure, supportive environment that is ideal for smoking cessation.
This was found in NC in a pilot at Dorothea Dix Hospital.

Dix Pilot

In 2002, Dorothea Dix Hospital conducted a pilot of a tobacco-free environment on its adult admissions units.

Smoking Cessation Survey



Dorothea Dix Pilot

No significant difference in:

- Rates of seclusion and restraints
- SIB and Assaults
- Instances of contraband
- Staff Call-outs

Dorothea Dix Pilot

Conclusions:

- The assumption that a smoking ban on an inpatient unit will increase aggression in psychiatric patients is not supported by data.
- Staff Education and participation in outcomes research positively affect staff perceptions and support of controversial hospital policy decisions.
- A smoking ban may increase contraband, which must be considered prior to implementing a ban.

Matthews, L.S., Diaz, B. et al. Implementing a Smoking Ban in an Acute Psychiatric Admissions Unit. *Journal of Psychosocial Nursing*. 43(11) pp.33-36.

Broughton and WBJ Pilots

In 2009, Broughton Hospital and Walter B Jones ADATC embarked on pilot projects to develop a tobacco free campus.

Broughton Hospital

- State-run Psychiatric Hospital
- Capacity : 278
- Services include:
 - General Adult, Adult extended care
 - Geriatrics
 - Adolescent
 - Deaf (Psych and Substance Abuse)
 - Medical services.

Walter B Jones ADATC

- State-run Alcohol and Drug treatment Center
- Capacity : 80 beds
- Services include:
 - 56 beds acute rehab
 - 24 beds acute care (detox-locked unit)
 - Perinatal Services (Up to 5 infants)

Components of Pilots

- Both facilities formed committees to develop a plan that included as key elements:
 - Background and Rationale
 - Financial Assessment
 - Implementation Timeline
 - Patient Tobacco Cessation Treatment Plan

Components of Pilots

- Employee Tobacco Cessation Plan
- Patient Survey – Pre-Ban
- Employee Survey – Pre-Ban
- Employee Resources
- Assessment of Outcomes

Implementation Strategies

- Use a broad group of disciplines in planning for implementation.
- Communication with key stakeholders particularly with individuals that were already in inpatient treatment programs and their families.
- Input was solicited from patients through both the pre-ban survey and also through patient councils.

Implementation Strategies

- Train staff as Facilitators through the “Quit Now” program.
- Develop nicotine assessment tools.
- Develop interventions for delivery in multiple settings
 - Individual providers
 - Nursing
 - Programming in the psychosocial rehabilitation setting

Key Concepts

- Policies are communicated early in the admission process
- Treatment is offered to all smokers.
- Participation in programming is voluntary
- Treatment decisions are individualized and based on consumer preferences

Outcomes Assessments

- Patients:
 - Behavioral Outcomes
 - Seclusion
 - Restraint
 - Assaults
 - Elopements
 - Contraband

Outcomes Assessments

- Attitudes
 - Pre-ban questionnaire
 - Post-ban questionnaire

Outcomes Assessments

- Employees:
 - Staff call-outs
 - Attitudes
 - Pre-ban questionnaire
 - Post-ban questionnaire
 - Rates of completion of smoking cessation program
 - Rates of smoking cessation

Pilot Program

- Broughton Hospital became tobacco free on October 1, 2010
- Walter B Jones ADATC became tobacco free on April 1, 2010