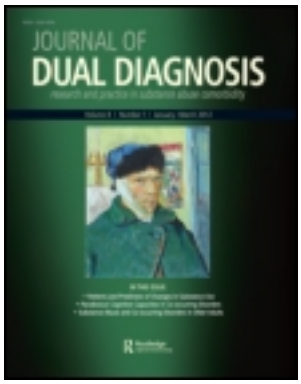

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Implementing Tobacco Education and Cessation Services at a Large Community Mental Health Center: Lessons Learned

Hillary A. Gleason BA [a b], Marie Hobart MD [a b], Michael Jellison BA, CTTS [a], Greg Seward MSHCA, LADC-I, CTTS-M [b c] & Leah Bradley LCSW [a]

[a] Community Healthlink, Worcester, Massachusetts, USA

[b] Department of Psychiatry, University of Massachusetts Medical School, Worcester, Massachusetts, USA

[c] Tobacco Consultation Service, and Addiction and Comorbidity Treatment Services, UMass Memorial Medical Center, Worcester, Massachusetts, USA

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Implementing Tobacco Education and Cessation Services at a Large Community Mental Health Center: Lessons Learned

Hillary A. Gleason, BA,[1,2] Marie Hobart, MD,[1,2] Michael Jellison, BA, CTTS,[1]
Greg Seward, MSHCA, LADC-I, CTTS-M,[2,3] and Leah Bradley, LCSW[1]

High rates of early morbidity and mortality in populations with chronic mental illness and addiction, along with the psychosocial risks tobacco use may pose, call for a need to systematically address tobacco in behavioral health settings. While smoke-free policies and other tobacco-related initiatives have faced a variety of barriers, implementing tobacco-free environments remains a vital step in tackling the health discrepancies between persons with chronic mental illness and the general population. This article examines the course of one community mental health center going tobacco-free, along with the challenges facing the initiative and lessons learned in the process. Consistent assessment and treatment of tobacco use, along with an emphasis on overall wellness, were major achievements of the tobacco-free initiative. Despite barriers to policy enforcement and resource integration, the initiative continues to enhance access to person-centered services and promulgate information about tobacco cessation. More direction is needed to address the lapses in tobacco cessation treatment that persist in the behavioral health system. (*Journal of Dual Diagnosis*, 8:140–147, 2012)

Keywords *tobacco, policy, smoke-free, community mental health center, mental illness, addiction*

The field of behavioral health has made great strides in addressing co-occurring mental health and substance abuse disorders in the past years, but such a systemic integration has not necessarily been extended to tobacco. Despite increasing efforts to address tobacco use in behavioral health facilities, a gap around tobacco treatment and policies persists (Stuyt, Order-Connors, & Ziedonis, 2003; Ziedonis, Parks, Zimmermann, & McCabe, 2007). Long-held beliefs about the therapeutic effects of tobacco endure among many behavioral health clinicians, stymieing efforts to debunk the remnants of a smoking culture that persist in the behavioral health field (Johnson, Moffat, & Malchy, 2010).

Although smoke-free initiatives and tobacco-related policies have reduced the number of Americans smoking from around 40% in 1964 (Department of Health Education and Welfare, 1964) to around 18.3% currently (McClave, McKnight-Elly, Davis, & Dube, 2010), smoking prevalence among persons with mental illness and addiction remains high. People with a chronic mental illness are two to three times more likely to be nicotine-dependent than the general population, and they consume 44.3% of the cigarettes sold in the United States (Lasser et al., 2000). However, patients with mental illness and addiction receive minimal amounts of tobacco cessation counseling; a 2001 study by Thorndike, Stafford, and Rigotti found that only 38% of primary care visits and 12% of psychiatric visits included cessation counseling for persons with chronic mental illness. In addition, there is a considerable lack of knowledge among behavioral health care professionals about tobacco dependence, treatment, and its relationship to mental illness and addiction (Ratschen, Britton, Doody, Leonardi-Bee, & McNeill, 2009).

With the growing number of federal and local policies, as well as the increase of public establishments implementing smoke-free grounds, the need to extend this attention to tobacco in behavioral health settings is becoming all the more evident. Organizations such as the National Association of Alcohol and Drug Abuse Counselors and the Substance Abuse and Mental Health Services Administration (SAMHSA) have begun urging tobacco to be addressed on par with alcohol and other drugs in behavioral health settings (Ziedonis, Parks et al., 2007). Finally closing the tobacco use gap between behavioral health consumers and the general population will require interventions at both the individual level, through tailored counseling and treatment, and the organizational level, through implementation of smoke-free policies in settings frequented by individuals with mental illness and addiction.

Research shows that many behavioral health consumers are already concerned about their tobacco use and the environmental hazards it poses. Studies show that that 70% to 80% of smokers with mental illness or addiction want to quit or reduce tobacco use, and most generally understand the detrimental health effects of secondhand smoke (Joseph, Willenbring, Nugent, & Nelson, 2004; Prochaska et al., 2004). While there seems to be sizeable resistance against the implementation of

[1]Community Healthlink, Worcester, Massachusetts, USA
[2]Department of Psychiatry, University of Massachusetts Medical School, Worcester, Massachusetts, USA
[3]Tobacco Consultation Service, and Addiction and Comorbidity Treatment Services, UMass Memorial Medical Center, Worcester, Massachusetts, USA
Address correspondence to Hillary A. Gleason, Community Healthlink OPD, 72 Jaques Ave., Worcester, MA 01610, USA. E-mail: hillary.gleason@umassmed.edu

smoke-free grounds before policies are enacted, these negative responses have been proven time and time again to subside (El-Guebaly, Cathcart, Currie, Brown, & Gloster, 2002; Lawn & Pols, 2005; McNally et al., 2006). Therefore, the aims of this descriptive report are to outline the process of a large community health center going tobacco-free and to discuss the current status of this initiative in terms of successes and remaining challenges. Furthermore, practices for overcoming these challenges in general behavioral health settings will be considered.

ADDRESSING TOBACCO IN BEHAVIORAL HEALTH SETTINGS

Individuals with chronic mental illness and addiction die 25 years earlier than those in the general population (National Association of State Mental Health Program Directors Medical Directors Council, 2006). Tobacco use contributes significantly to this early morbidity and mortality, given the population's higher likelihood for heavy tobacco use (consuming more than 24 cigarettes per day; Lasser et al., 2000). For individuals with histories of substance use disorders, ongoing tobacco use may also be associated with worse abstinence outcomes (Prochaska, Delucchi, & Hall, 2004). Given the important role tobacco plays in the health and recovery of persons with chronic mental illness and addiction, behavioral health facilities are an ideal setting for tackling tobacco consumption.

In both substance abuse and psychiatric residential treatment programs, tobacco cessation efforts can greatly improve the quality of the therapeutic milieu. After implementing tobacco-free policies in several inpatient psychiatric hospitals, instances of coercion and restraint were reduced by 31% and 29%, respectively (National Association of State Mental Health Program Directors, 2006). For ex-smokers entering residential treatment, being in a tobacco-free setting eliminates the lure of tobacco breaks and the socialization it affords and therefore lowers the triggers that may lead an individual back into smoking. Furthermore, being in a tobacco-free setting reduces and eliminates exposure to secondhand smoke, a Class A carcinogen.

Nonetheless, it is difficult to implement tobacco-free policies without a cohesive plan and careful attention to broad organizational infrastructure. Without appropriate implementation, tobacco-free initiatives may have little to no effect on consumers' smoking cessation (El-Guebaly et al., 2002). Successfully implementing complex, evidence-based interventions requires the consideration of an organization's unique social and environmental factors while utilizing effective tools for implementing, assessing, and sustaining change at system and practitioner levels (Lehman, Simpson, Knight, & Flynn, 2011). Community Healthlink, a large community mental health center that values change and flexibility, enacted such an intervention using an organizational to system-level change approach called Addressing Tobacco Through Organizational Change (ATTOC), developed and implemented by Ziedonis et al. (2007).

CASE STUDY: COMMUNITY HEALTHLINK

Community Healthlink, a member of UMass Memorial Healthcare, is a large community mental health center based in Worcester, Massachusetts, with services and facilities spanning the entirety of central Massachusetts. Since its inception in 1977, Community Healthlink has been providing mental health, substance use, rehabilitation, and homelessness services to individuals and families. Community Healthlink has outpatient clinics at five locations throughout the state and includes over 80 treatment programs. More than 19,000 adults and children receive services from Community Healthlink each year.

Community Healthlink's primary location in Worcester provides services to more than 5,500 individuals annually. The main site includes an outpatient clinic, inpatient programs, and administrative offices. Of the individuals these programs serve, 37.2% are female; 73.5% are Caucasian, 17.1% are Hispanic, 5.3% are African American, 1.5% are Asian, and 2.4% fall under a different race category. In terms of age, 4.5% are aged 0 to 17, 36.5% are aged 18 to 34, 54.2% are aged 35 to 64, and 4.7% are 65 years or older.

Planning and Implementation

Community Healthlink's primary site in Worcester went tobacco-free in September 2008. Employing the ATTOC approach, the initiative was further informed by the recent experiences of UMass Memorial Medical Center and the University of Massachusetts Medical School adopting a tobacco-free campus policy earlier in the year. Within Community Healthlink's overall goal of a tobacco-free campus and buildings, they focused on improving tobacco treatment for consumers, as well as staff training and recovery as their target goal. As members of UMass Memorial Health Care, Community Healthlink used the resources made available to them from UMass Memorial Medical Center in order to guide their champions and leadership team. These resources included the revised and implemented clinical practice guidelines, the tobacco-free policy of UMass, as well as the trainings, presentation, and communication packages from UMass's director of the tobacco-free initiative.

The ATTOC approach integrates organizational and cultural change efforts across environmental, staff, and consumer goal areas. Through telephonic, electronic, and on-site consultations and trainings the implementation is carried out with the use of six core strategies. These include (1) preparing for the intervention, (2) identifying on-site tobacco treatment specialists, (3) choosing ATTOC leaders, often called "champions," (4) forming work groups to carry out the 12-step ATTOC approach in goal areas, (5) scheduling ongoing phone and

electronic consultations for expertise and advice, and (6) offering in-person consultation and supervision. Many of the same aspects and goals of the ATTOC approach used in the UMass systems programs were used with Community Healthlink, given the progress UMass had made adopting the tobacco-free policy in goal areas over the course of the prior year. These included staff training and recovery, better assessments and treatments for consumers, and tobacco-free buildings and campus. A more detailed description of ATTOC is provided in this issue's article by Ziedonis et al. (2012).

Strategies were formed in response to, and in anticipation of, the challenges the initiative would face, which made for a flexible, interpersonal approach for curbing tobacco use of both staff and consumers. In anticipation of staff and consumer resistance, the implementation team provided ample opportunities for input and training and firmly established the health-related goals of the policy.

Several months prior to the implementation of the new tobacco policies, groups of both staff and consumers were formed to discuss and prepare for the impending ban. These steering groups included smokers and nonsmokers and were drawn from different levels and programs in the agency. While each area of Community Healthlink had its own representative to spearhead the tobacco initiative, roles for the implementation team were left largely indefinite to allow for more flexibility. An agency-wide tobacco champion was chosen with the CEO's clear support, and the policy's enforcement and ongoing development were chiefly allotted to the agency's compliance manager, Safety Committee chair, and department managers. Department Managers were also designated to orient new employees on the tobacco policy. The Safety Committee was charged with periodically updating agency leadership on compliance and enforcement of the policy.

The steering groups focused on known barriers—such as staff resistance and policy violation—and evidence-based strategies to overcome them. They reflected on other change successes they had in the past. They arranged the optimal placement for tobacco-free signs, informational sessions and trainings, and compliance management. The groups made plans to enhance services for staff and consumers who wanted to quit and also to cope with those who were not ready to quit or reduce their tobacco use. In spite of modest funding, members of the steering groups were able to procure resources through other local initiatives, state and national resources, and their existing connection to the tobacco cessation resources and tobacco-free initiative at the University of Massachusetts Medical School and UMass Memorial Medical Center.

During the months preceding the ban's enactment, information was disseminated about the policy, along with the hazards posed by tobacco use and secondhand smoke. Smoking cessation counseling and nicotine replacement therapy (including the patch, gum, and lozenge) were made available to both consumers and staff prior to the enforcement of the ban and continued after the policy's enactment. Although the steering groups were primarily interested in tobacco cessation efforts, other areas of wellness—such as nutrition and stress reduction—were woven into the initiative from the very beginning, effectively underscoring the need for the ban. While some staff and consumers reacted negatively to news of the policy, this widespread information about the need to ensure a healthy, tobacco-free environment met most concerns.

Through the steering groups, the tobacco policy was defined and its goals set. The entire grounds would be tobacco-free. The tobacco ban was framed in terms of the agency's responsibility to the health of its consumers and staff:

> Community Healthlink recognizes its responsibility to provide a safe and healthy environment for consumers, visitors, and employees. As a provider of health services, Community Healthlink is a tobacco-free workplace. . . . This policy is designed to promote health, reduce the risk of fire hazards and protect consumers, patients, employees, visitors and others from the environmental hazards of second-hand tobacco smoke.

Carbon monoxide meters, payroll messages, signage, and initial supplies of nicotine replacement therapy were provided by the University of Massachusetts Medical School and UMass Memorial Medical Center's tobacco-free initiative. Training and presentations were made available to Community Healthlink staff and were carried out by staff from the University of Massachusetts Medical School and UMass Memorial Medical Center. Scholarships to a basic skills training for tobacco use cessation were offered on a limited basis to Community Healthlink staff as well. A Nicotine Anonymous group was started on-site, and consumers interested in quitting were set up with QuitWorks—a Massachusetts-based tobacco cessation program that provides free telephone counseling and nicotine patches to smokers residing in Massachusetts. Several peer specialists—consumers who have undergone training for providing support to peers—were also coached on how to engage consumers in conversation about tobacco cessation and to direct consumers to other resources when needed. Additionally, carbon monoxide meters were used with staff and consumers to give personalized feedback about smoking and to initiate conversation about the effects of smoking on the body. Carbon monoxide meters measure the amounts of carbon monoxide in the body and serve as effective tools for teaching and monitoring tobacco use (Bittoun, 2008). This strategy was particularly useful in prompting consumers with low motivation to consider quitting (Williams et al., 2010).

Years after the ban's enactment, keeping up the initial steam of the project has proven to be a challenge. A Community Healthlink nurse reflected on this, "For a while you wouldn't see anyone [smoking], but now I'll see a few during the week. And no one will say anything to them—they avoid confrontation. Of course, I'll say something!" To combat the unresponsiveness, information regarding the health effects of tobacco, reasoning for the policy, and best practices for enforcing the policy continue to be delivered. Periodic training occurs with staff members, and tobacco cessation pamphlets are left in

waiting areas and hallways. Although the tobacco steering groups no longer meet, the agency's Safety Committee periodically discusses the policy.

Despite the lack of reimbursement for tobacco-related services, Community Healthlink has utilized other resources to provide for them. Clinicians incorporate tobacco cessation services into broader behavioral health visits and may refer consumers to peer supports or the on-site chapter of Nicotine Anonymous. Instead of purchasing nicotine replacement therapy, staff can refer consumers to QuitWorks, prescribers can provide varenicline or bupropion, or consumers may tap into their health insurance's nicotine replacement therapy coverage. MassHealth (the state agency managing Medicaid, which is held by a large portion of Community Healthlink consumers), for example, covers 90 days of nicotine replacement therapy annually as well as counseling to help people quit tobacco use.

Many Community Healthlink programs utilize cost-free resources, such as QuitWorks, to support their tobacco services, as well as insurance coverage for nicotine replacement therapy. Others tap into funding from the Bureau of Substance Abuse Services or other government grants and agencies to help afford additional nicotine replacement therapy, tobacco specialists, or other resources. Ongoing efforts to identify and offer support to staff working in tobacco-free programs such as the Council to End Nicotine Addiction in Recovery are made. Furthermore, staff members have ongoing access to the UMass Memorial Hospital's employee assistance program, which provides counseling and support for employees who want to quit or reduce their tobacco use.

Gains Made

Since the implementation of the policy, the grounds at Community Healthlink are no longer littered with cigarette butts, and those entering the building no longer walk through a cloud of smoke. One Community Healthlink employee noted:

> Our policy reflects what we value—our consumers' health, our staff's health. And I think our consumers know that, even if they don't agree with [the tobacco ban]. . . . Sure, there are still staff and consumers at the ends of the street smoking, or the occasional rule-breaker. But we've come a long way from where we were. And we even created another paid position for a peer to collect the butts at the edges of campus. So we're trying.

Consistent screening and treatment have been vital to the success of the tobacco-free initiative. Outpatient clinicians attempt to incorporate tobacco cessation into their regular treatment plans. In several of the residential programs, consumers are assessed on intake for tobacco use and dependence. Following the "5 A's" (ask, advise, assess, assist, arrange follow-up), consumers are advised to quit tobacco and are connected with resources and nicotine replacement therapy, if desired (Dixon et al., 2009). Some programs offer informational sessions and groups, and cessation packets are distributed. When a consumer wishes to cease treatment in an inpatient program because of the tobacco policy, interventions are held. These interventions are modeled after those used for voluntary treatment termination due to cravings for alcohol and other drugs. After inpatient treatment, consumers receiving tobacco services are referred to other community resources. Those who signed up for QuitWorks also have their progress monitored.

As reflected in the policy statement, Community Healthlink's impetus for addressing tobacco stems from the desire to improve both the physical and behavioral health of their staff and consumers. This wellness approach can help introduce the topic of tobacco cessation, as it underscores the concern for consumers' overall health and well-being. As consumers' motivations to quit are explored, staff find they are oftentimes rooted in health issues. Consumers may have family or friends suffering from the direct health effects of tobacco use, they themselves may have a condition exacerbated by tobacco use, or they may be concerned for the secondhand smoke intake of family members and pets. Carbon monoxide meters can be a powerful tool in depicting the immediate effects of tobacco use on the body and emphasize its impact on overall wellness.

Consumers in certain programs at Community Healthlink can be connected with nurse care managers and peer specialists who help with nutrition, physical exercise, stress reduction, and other health concerns in addition to smoking cessation. The importance of smoking cessation is woven throughout each wellness factor, elucidating its effects on exercise, stress, and preexisting illnesses. One nurse care manager explained,

> When we're talking about physical activity, sometimes that's when a consumer realizes [the effects of tobacco use], because they realize they can't take ten steps without being out of breath. . . . I sometimes lead hikes for consumers. They're all smoke-free. . . . And in the end, many of our smokers feel proud of themselves. They realize, "Wow, I just quit for 2 or 3 hours!" You know, they realize, "That wasn't so bad!"

While staff may advise consumers to quit, meeting a person "where they are" in terms of their tobacco use and motivation to quit is an effective and encouraging way to address tobacco. The nurse added, "Baby steps, you know? We're planting seeds." Whereas consumers may not be apt to attend groups or individual counseling focused solely on tobacco cessation, groups and visits centered on general health and wellness can successfully integrate the topic of smoking cessation into the larger framework. Moreover, by framing tobacco cessation as "tobacco education," consumers with lower readiness to change can be encouraged to make an "informed decision" in regard to tobacco without feeling obliged to quit.

Community Healthlink's outpatient clinic is also a part of a nationwide SAMHSA-funded initiative to integrate primary care into behavioral health settings. Here, the effects of tobacco on a consumers' wellness are all the more salient. A clinician noted, "If they're hearing it from us, and hearing it from their

primary care down the hall too, they start to see the whole picture [of tobacco use]."

Challenges

Despite the tobacco ban's overall success, some degree of ambivalence around the policy persists. One employee mentioned, "I just wish everyone would take it seriously. Tobacco is killing our consumers at a much greater rate than the direct effects of their mental illness or addiction, but not everyone sees it as a problem." Some of the staff and consumers continue to view tobacco as a low concern on the "health hierarchy"—a comparison of health risks and the behaviors that may lead to them (Solway, 2011)—largely because its effects do not result in immediate problems or crises. While this attitude did not generally emerge as outright resistance to the policy, it reflects a sort of apathy around tobacco use. At one informational session on tobacco for individuals with addiction, a consumer echoed this lack of concern about tobacco by protesting, "One thing at a time. We're trying to focus on the important stuff."

The difficulty that many programs face is the brevity of patients' stay and visits. Consumers in detoxification, respite, crisis stabilization, and several other programs all have stays under 1 month, and thus treatment is often condensed. In this context, it can be challenging to provide comprehensive treatment for tobacco. Similarly, outpatient visits may also provide insufficient time for treating tobacco—particularly with psychiatrists and prescribing nurses, whose visits rarely allot over 20 minutes. While relatively brief tobacco interventions can be effective motivational tools (McIlvain & Bobo, 1999; Steinberg, Ziedonis, Krejci, & Brandon, 2004), it may be difficult to wedge in tobacco treatment with the numerous other issues a clinician attends to in one visit.

Given the multitude of programs that Community Healthlink offers, tobacco services and resources can be fragmented. There is limited systematic connection of tobacco resources between certain programs, and in spite of efforts to facilitate linking a consumer's tobacco resources from one program to another, the transition is not always complete. One staff person noted,

> We have tobacco resources. We have specialists and meetings and peer support and informational materials. . . . But instead of looking within the agency, there's a lot of duplication of efforts. . . . I'm sure there are some funding issues preventing the free flow of resources, but there could at least be more agency-wide pow-wows, sharing of ideas.

Large behavioral health centers like Community Healthlink might benefit from a more structured and visible network of tobacco resources, including an agency-wide tobacco cessation coordinator.

As with other tobacco bans, some Community Healthlink staff remain at a loss for how to enforce the policy. While they may ask consumers to leave the grounds when smoking, there remains a problem addressing those who continue to smoke on the grounds, particularly for those in residential treatment. Several of the staff expressed how difficult it may be to ask a consumer to move off the grounds; one clinician explained, "You just feel bad. It's raining and it's cold out, and all they want is a quick cigarette." By stressing Community Healthlink's goal of overall wellness, along with the need to ensure a healthy environment, enforcement of the policy may appear less like reprimand and more like a genuine concern for consumers' health.

Future Directions

Community Healthlink plans to expand the tobacco ban to more sites in the future. They are also considering their supported housing programs and even aspire to make one residential site for persons with mental illness—in which only 25% of the consumers smoke—tobacco-free. Given the upcoming imperative for meaningful use of electronic health records, Community Healthlink also hopes to develop their electronic health record to systematically call for an assessment of consumers' smoking status. Requiring this brief assessment would remind staff at all levels to address tobacco, at least initially—which in itself raises an individuals' chance of quitting (Dixon et al., 2009; McIlvain & Bobo, 1999; Steinberg et al., 2004).

Community Healthlink continues to enhance access to tobacco cessation services and hopes to improve communication and support for tobacco treatment among its various programs. Tailoring tobacco treatment to address individuals with different levels of motivation continues to be an important step in encouraging those who are still smoking to quit. Community Healthlink plans to educate more staff on the issue of tobacco—specifically aiming to increase the number of employees trained as certified tobacco treatment specialists. Furthermore, Community Healthlink hopes to educate more peer specialists in tobacco cessation in order to provide support and information to consumers attempting to quit or reduce their tobacco consumption.

By incorporating tobacco education into existing wellness and behavioral health groups, the issue of tobacco may become more regularly and successfully addressed throughout the agency. Although the traces of a smoking culture persist at Community Healthlink, it continues to fade as the demand for wellness strengthens. One staff person, a smoker, reflected on this shift, "We all smoke outside now, on the corner in plain view. . . . And you can't help but feel ashamed! Everyone sees you and thinks, 'Why is she still smoking?'"

DISCUSSION

Tobacco education and cessation efforts are necessary in behavioral health settings to address the high rates of tobacco use and related illnesses in behavioral health consumers. While

tobacco treatment is increasingly being incorporated into routine behavioral health, there remains a serious lack of knowledge and action around tobacco in behavioral health settings (Ratschen, Britton, Doody, Leonardi-Bee, & McNeill, 2009). While tobacco education and cessation efforts have made some headway in the behavioral health system, a gap persists between tobacco use in this population versus the general public (McClave et al., 2010).

Community Healthlink, a large community mental health center serving central Massachusetts, encountered similar problems as other behavioral health facilities when it transitioned to a tobacco-free center in 2008. The 3 years following initiation of the ban have included challenges in terms of staff members' attitudes, reluctance to enforce penalties, brevity of stays, funding, and an expansive infrastructure. However, the initiative continues to meet these challenges, responding with new trainings, wellness resources, and informational materials to suit the unique populations that the multitude of programs serves.

While being too lenient on policy enforcement can cause a ban to become ineffectual (Sharp, Shwartz, Nightingale, & Novak, 2003), the case of Community Healthlink suggests that flexibility in meeting individuals where they are, along with the provision of wellness resources, can be generally effective in addressing tobacco use. Community Healthlink's tobacco policy demonstrates the agency's concern for the overall health of its consumers and staff and underscores the importance of informed decision making when it comes to tobacco use. By providing information on the social, financial, and health effects of tobacco, consumers are empowered to make their own educated decision about tobacco use.

A holistic wellness model that incorporates tobacco cessation reinforces the reciprocal connection between physical and behavioral health and serves as a response to the population's high risk of morbidity and mortality. Using this approach, clinicians who may not feel confident confronting an individual about tobacco may be more comfortable broaching the subject in terms of general wellness, and consumers may be more responsive to the message (Ratschen, Britton, Doody, & McNeill, 2009). This emphasis on wellness and a healthy environment may also reduce the need to impose penalties, because clear reasoning for tobacco bans may contribute to the policy's overall success (Backer & Grant, 1982).

Given the long and entrenched history of tobacco use in behavioral health settings, along with beliefs about its therapeutic effects, efforts to address tobacco in populations with mental illness and addiction have been stymied. While the behavioral health system has come a long way, smoking bans still precipitate concerns about a breakdown of the therapeutic milieu in treatment settings (Johnson et al., 2010). Some behavioral health staff may view tobacco bans with ambivalence, believing that policy enforcement should be someone else's role. Engaging clinical, clerical, and housekeeping staff in the smoke-free policy should include sufficient and ongoing opportunities for input, personal support, and education on both cessation practices and reasoning for the ban (Johnson et al., 2010; Ratschen, Britton, Doody, & McNeill, 2009).

Enforcing smoking bans can result in a standstill when it comes time to impose penalties such as fines or program discharge. Thus, efforts to enforce smoking bans may be ineffective and ultimately result in a relaxation of the policy (Johnson et al., 2010). Nonetheless, consistent application of tobacco policies is shown to be more successful than selective bans or policies that allow case-by-case exemptions (Ratschen, Britton, Doody, & McNeill, 2009). A "zero tolerance" approach to tobacco seems to work better than the "three strikes" system (Sharp et al., 2003). So long as the message being delivered to consumers is consistent, the need to enforce penalties seems to diminish. Particularly when regularized policy application is complemented by cessation counseling and education, tobacco policies can be the most effective and meaningful.

More education about tobacco use and cessation is needed among behavioral health staff. Many behavioral health staff are still uninformed or misinformed about effective tobacco treatment, as well as the repercussions of tobacco use on therapy and medication (Ratschen, Britton, Doody, Leonardi-Bee, & McNeill, 2009). Tailoring treatment to fit an individuals' readiness to change, learning needs, and attitudes is an important aspect of effectually treating tobacco use (Johnson et al., 2010).

Behavioral health facilities adopting or maintaining tobacco bans may benefit from these and other strategies. More system-level reminders, such as prompts in the electronic health record, will aid in regular tobacco assessment and treatment. A systematic continuity of tobacco care—both between programs and between the agency and community—may help prevent tobacco relapse. Providing information on local resources, such as Nicotine Anonymous chapters, phone meetings, and Internet meetings, as well as programs similar to QuitWorks, may assist with these transitions. Personalized feedback and goals—such as carbon monoxide meter readings or quitting for a designated number of hours—may also help motivate consumers to reduce or quit tobacco (Ziedonis et al., 2008).

Organizational change and person-centered tobacco counseling in behavioral health settings are important factors in solving the health disparities between behavioral health consumers and the general population. More direction is needed to tackle the lapse in tobacco treatment in the behavioral health system as well as to attend to the increasingly visible need to integrate other physical health concerns into behavioral health treatment. Addressing primary health concerns along with the behavioral is an important step in establishing a more comprehensive understanding of an individual and facilitating complete recovery.

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