Questions and Responses from Collaborative Conference Call, June 1, 2016

Question: A challenge that has been identified by a patient is that they see health care professional smoking (off-site) sometimes when they are walking to their appointment. If staff can't quit, how will I be able to? The campus is tobacco-free but staff will go off campus to smoke. How should an organization address their staffs' tobacco use as it impacts their patients in a negative way?

Response: Some institutions require staff to abstain from tobacco during work hours, as is common with alcohol use. Some do not. Some institutions do not hire staff who use tobacco. Is this staff member using tobacco in violation of his/her contract? Based on patient reaction as outlined in the question, is it possible for this institution to revisit their policies regarding use of tobacco during work hours?

Dynamics at work can be as complicated as dynamics in a family. My message to the patient (if I were receiving the info of concern from the patient) would be to focus on self struggle to change tobacco use, to be clear that quitting tobacco is hard for everyone, including staff. I'd use motivational interviewing to explore the patient's interest in moving forward with quitting and assist in ways to manage the challenges.

You could also use this as a learning opportunity regarding how addictive tobacco is regardless of whether or not you are staff or a client. But I agree with the points made above that it might be time to revisit your tobacco policy. For instance, if staff are smoking right off campus in view of others including clients, the expectation staff not do this could be inserted into policy. Also, if the choice is made to hire staff who smoke then there is usually also a policy covering smelling of smoke at work. We also highly suggest that agencies provide/support tobacco cessation opportunities for staff as well as clients. For other enforcement tips please see our tobacco free policy toolkit at https://www.bhwellness.org/toolkits/Tobacco-Free-Facilities-Toolkit.pdf

Question: How dangerous are "chipped" cigarettes? Does this increase addiction and/or exposure to more chemicals?

Response: I need clarification on definition of "chipped" cigarettes. I think this question may be about "butting out and relighting"? Chipping is infrequent smoking?

If the question is about butting out and relighting: I see two issues. First is that from topography studies of smokers, we understand that each time a person lights up any piece of a cigarette, inhalation is deeper. So if a person smokes one cigarette in 3 episodes, they are inhaling deeper and more each episode, so that it actually increases exposure and pulls toxins deeper into lungs. Second is that if we are trying to extinguish behaviors, eliminate choice to smoke, we want to count episodes of smoking. Counting cigarette sticks for someone who smokes 10 sticks in 20 episodes would underestimate the task at hand. More triggers and more toxins=more dependence

Question: You briefly mentioned some of the challenges for providers addressing tobacco use with their patients. What would you say are some of the greatest challenges and what are some suggested strategies to address them?

Response: Fostering hope and maintaining motivation. In my practice I see that if people can see progress in money saved or improved breathing, they become hopeful. Groups where some members are succeeding are invaluable since that is often contagious.

One of the greatest challenges we face are social, living, and treatment environments that directly or indirectly condone smoking. To the extent possible, it is critical to help smokers find smoke-free living environments and positive social environments where individuals aren't bonding over a shared addiction. In this regard tobacco cessation treatment often involves more than office visits. Addressing tobacco use also involves supporting a continuity of care with other treatment providers and community service agencies. Also, while we have made much progress, many providers continue to perpetuate historical myths that smoking helps alleviate symptoms and that client don't want to quit and can't quit. All these beliefs continue to be refuted by a growing evidence base but we need to do more to educate interdisciplinary providers on this.

Question: Dr. Morris, can you please provide some examples of using Mindfulness techniques with tobacco users?

Response: We initially focus on awareness in the moment. A common technique for those not ready to set a quit date is for a provider to instruct him/her not to quit but instead pay attention to when cravings occur. What is their mood, environment, time of day etc. As a provider, I am then able to review patterns of use so that we can start exploring substitute behaviors.

Another common technique is to explore values through a card sorting exercise. Identifying core values is instrumental in a personal evaluation of whether or not tobacco use is consistent with these values. This is outlined in our Work and Wellbeing Toolkit at https://www.bhwellness.org/resources/toolkits/physicians While this toolkit was developed for physicians' wellness, many of these exercises apply broadly to any individual trying to make a behavioral change.

Question: I am working with a mental health provider who also treats adults with developmental disabilities on an outpatient basis. They have a tobacco free campus, but their property is on a busy street. The provider allows clients to smoke on one part of the property because they are worried if they strictly enforce the no-smoking rule, their clients might smoke near the street and could get hurt. Can you suggest something they can do instead? Thank you for your assistance.

Response: I don't think it serves people well to give them confused messages about the rules. Are the residents provided with treatment?

Once the agency goes smoke free they can assess if this scenario is playing out. We often find that agencies don't go tobacco free based on "what if's". This typically means that the agency is ambivalent about a tobacco free policy and we use motivational techniques in moving agency leadership toward change. If individuals do end up smoking in dangerous areas, it becomes part of the enforcement effort to educate clients at their developmental level regarding where they can safely smoke off campus and away from roads. Any danger spots, even if officially off-campus, can be written into policy as a clinical issue. For example, with any clients we are encouraging self-efficacy and ownership of behaviors whether they have developmental disabilities or behavioral health disorders. If they have severe developmental disabilities, they probably wouldn't be by a dangerous road unaccompanied regardless of whether they are smokers or not.