Implementation of a tobacco-free workplace program at a local mental health authority

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Abstract

Tobacco-free workplace policies that incorporate evidence-based practices can increase the reach and effectiveness of tobacco dependence treatment among underserved populations but may be underutilized due to limited knowledge about implementation processes. This paper describes the implementation of a comprehensive tobacco-free workplace program at a behavioral healthcare community center in Texas. The center participated in a tobacco-free workplace program implementation project that provided guidance and resources and allowed center autonomy in implementation. Six employee-based subcommittees guided implementation of program components including consumer and staff surveys, policy development, signage, tobacco use assessments, communication, and nicotine replacement distribution. Timeline development, successes, challenges, lessons learned, and sustainability initiatives are delineated. Concerns about the tobacco-free workplace policy from the center's staff and consumers were gradually replaced by strong support for the initiative. Program success was enabled by consistent support from the center's leadership, publicity of program efforts, and educational campaigns. The center surpassed the program expectations when it adopted a tobacco-free hiring policy, which was not an initial program goal. This center's path to a tobacco-free workplace provides an implementation and sustainability model for other behavioral health community centers and other organizations to become tobacco free.

Keywords

Tobacco-free workplace, Community-academic partnership, Tobacco-free hiring, Behavioral health community center

INTRODUCTION

Smoking prevalence remains disproportionately high among people with behavioral health disorders (BHD), which include psychiatric and substance abuse disorders [1–5]. Consumption rates of other tobacco products are higher among individuals with serious psychological distress [6], which is also associated with increased health risks [7]. Quitting tobacco

Implications

Policy: Contractual agreements requiring behavioral healthcare settings to be tobacco-free are critical first steps in support of tobacco-free environments for patients and staff; however, additional policies need to be implemented and enforced that address integration of tobacco dependence treatment into behavioral healthcare settings as core components of tobacco control and health promotion.

Research: Research is needed to examine specific system- and provider-level factors (e.g., organizational readiness, provider training, administrative support, etc.) that may predict better adoption of tobacco-free workplace policies and improvement in the patient's health outcomes.

Practice: Behavioral healthcare providers should strive to integrate evidence-based tobacco dependence interventions into the psychiatric treatment of their patients as these interventions have proven safe, effective, and beneficial for this population.

use reduces chronic disease risk [8]; thus, interventions aiming to promote cessation among individuals with BHD are necessary. Moreover, individuals with BHD are motivated and able to quit and can benefit from tobacco cessation [9–15].

System-level policies, such as tobacco-free workplace (TFW) regulations, promote health-related initiatives by prohibiting the use of any form of tobacco on worksite premises. These regulations protect all individuals from environmental tobacco smoke and help current and former tobacco users to achieve and maintain abstinence by eliminating environmental temptations [16–18]. Unfortunately, these regulations and provider-level interventions, like tobacco use assessments (TUAs) and empirically based cessation treatments, have only been haphazardly provided to

tobacco users with BHD [19–22]. Adding TUAs to a healthcare setting's electronic health record (EHR) has been shown to increase the identification and treatment of tobacco users [23]. Providing cessation interventions to tobacco users attempting to quit in response to TFW policies maximizes the positive impact of these regulations on cessation outcomes [24, 25].

Despite the benefits of comprehensive TFW programs for the individuals' health, behavioral health centers have fallen behind in the adoption of such programs. Reasons for this include the misconception that quitting tobacco among individuals with BHD would interfere with their psychiatric treatment, the high rate of tobacco use among behavioral health employees, and lack of specialized training among providers [19, 26, 27]. Moreover, there is limited awareness and dissemination of existing models of effective implementation as well as programs that provide practical assistance to translate scientific evidence into the successful adoption of comprehensive TFW.

Taking Texas Tobacco Free (TTTF) is an academic-community partnership aimed at assisting selected Local Mental Health Authorities (LMHAs) across Texas to adopt comprehensive, evidence-based, and multi-component TFW programs that are sustainable beyond the funding period [28]. LMHAs are administrative entities that oversee and provide behavioral health services to specific geographic areas of the state [29]. Capitalizing on the contractual requirement that LMHAs had to adopt a TFW policy by January 2016, TTTF focused on implementation of the program in 18 of the 39 LMHAs, encompassing over 250 clinics. To complement and facilitate the TFW program, TTTF's specific goals were to (1) increase basic tobacco education among the LMHAs' staff, (2) decrease tobacco use among the LMHAs' staff, (3) increase tobacco cessation intervention training for the LMHAs' providers, (4) increase TUAs among the LMHAs' consumers, (5) increase tobacco cessation advice to the LMHAs' consumers, (6) increase tobacco cessation assistance (e.g., nicotine replacement therapy (NRT), counseling) to the LMHAs' consumers, and (7) increase community tobacco cessation education and outreach. To evaluate the goals' achievement, TTTF administered surveys pre- and post-program implementation and requested reports from LMHAs. Aiming to provide a model for similar settings [30], the purpose of this paper is to describe the implementation of the TFW program at Spindletop Center, one of the LMHAs participating in TTTF [28].

OVERVIEW OF SPINDLETOP CENTER

Spindletop Center (hereafter Spindletop) is the LMHA for the four-county catchment area of Southeast Texas (<http://spindletopcenter.org>). It provides diverse psychosocial and behavioral healthcare services to individuals with mental illness, intellectual and developmental disabilities, and substance use disorders. Its mission is to “help people help themselves by providing resources and support.” Spindletop

employs more than 450 full-time staff and manages outpatient clinics in a service area spanning approximately 3200 mi². In fiscal year 2015, they served 8865 children, youth, and adults. Spindletop also manages housing for some of their consumers.

PARTNERSHIP WITH THE TTTF PROGRAM

Spindletop participated in the TTTF program, which provided LMHAs with guidance and resources that facilitated program implementation while promoting the individual clinics' autonomy in program adoption. TTTF major components were (a) TFW policy development, implementation, and enforcement; (b) staff education about the health risks of tobacco use and benefits of quitting; (c) provider training to increase the provision of evidence-based tobacco cessation services; and (d) community outreach. Spindletop capitalized in the multi-component program offered by TTTF and tailored it to fit their needs and resources. The extent to which Spindletop implemented these components with fidelity was an indicator of program success.

SPINDLETOP'S STEPS TOWARD THE IMPLEMENTATION OF A TOBACCO-FREE WORKPLACE

Building a tobacco control team

An executive officer from Spindletop's leadership was appointed as a program leader/“tobacco champion.” This person attended initial meetings and trainings offered by TTTF and completed a certified tobacco treatment specialist (CTTS) training. The tobacco champion created and oversaw an employee-based workgroup that guided the implementation of the TTTF program according to a suggested timeline. The workgroup, comprising 15 volunteers from different programs in the center (smokers and non-smokers), met regularly for 6 months before the center's tobacco-free date (i.e., starting date when tobacco and e-cigarette use was prohibited on the center's premises). Six subcommittees were formed: consumer and staff surveys, policy development, signage, communication, TUAs, and NRT distribution. These subcommittees facilitated a sense of ownership and teamwork among the employees. Table 1 summarizes their timeline.

Gathering baseline data

The *staff and consumer survey subcommittee* distributed internal surveys to gather baseline data about their tobacco use. The surveys included questions about past and current tobacco use, type/s of tobacco products consumed, quit attempts, and interest in quitting. The questionnaires were distributed center-wide by e-mail. Results revealed that among respondents ($N=306$), consumer tobacco use rate was 42% (35% cigarette smoking specifically). Among current tobacco users, 56% wanted to quit. Spindletop's internal staff survey results were unable to be released, but

Table 1 | Summary of tobacco-free workplace timeline

	Tasks	Six months	Four months	Two month	One month	Two weeks	Quit Date	One week	One month	Three months	Six months	One Year
DATE	POLICY DEVELOPMENT											
	Select employee lead for TFW project and develop workgroup											
	Reference samples of TFW policies											
	Draft TFW policy (including surveillance, monitoring, HR, etc.) and request leadership approval											
	ORGANIZATIONAL PREPARATION											
	Create survey to distribute to staff and consumers to gather baseline information about tobacco use											
	Communicate the new policy to all employees, community partners, consumers, and other vested groups and outline upcoming process to become a TFW											
	Create publicity (graphics, language, venues) on TFW policy adoption and center's quit date											
	Explore NRT/medications covered under health benefits and, consider providing coverage for cessation aids not covered by insurance											
	Integrate tobacco use assessment, coding, and billing for tobacco cessation services into EHR											
	Determine procedures to provide NRT to consumers and employees											
	Create, produce and install signage informing all of new TFW policy for waiting areas, break rooms, etc.											
	Design and order promotional materials for education and policy implementation (water bottles, sticky notes, hand sanitizers, etc.)											
	Release results from baseline survey to all staff and consumers											
	Continue to communicate TFW policy internally as well as community partners, vendors and other vested groups											
	Select and order new trash receptacles, if needed											

estimates from the TTTF pre-implementation surveys ($N=226$) revealed that their tobacco use rate was 24% ($n=54$). Baseline information helped tailor the program components to Spindletop's needs.

Component A: tobacco-free workplace policy

The cornerstone of TTTF was that LMHAs developed and implemented a TFW policy that included selection of a "center's tobacco-free date" as well as the installation of permanent policy-related signage. Before TTTF implementation, Spindletop did not have any tobacco-related policy in place and the use of tobacco products was allowed on the center's "grounds" and properties. To implement this component, three subcommittees worked together.

The *policy development subcommittee* developed a concrete TFW policy and enforcement plan. TTTF provided sample policies for adoption consideration. The policy specified that use of tobacco products would be prohibited on property owned, leased, operated, or adjacent to Spindletop by the center's tobacco-free

date. The *signage subcommittee* focused on the creation and display of tobacco-free signage for the property. Signage was particularly important in places where tobacco users had routinely congregated to use tobacco. TTTF provided recommendations and examples of the other behavioral health centers' signage as well as a monetary contribution (i.e., US\$1100) to support signage purchases. This subcommittee also created handout cards with information about the upcoming tobacco-free date, resources offered, and estimated costs of cigarette consumption per year.

The *communication subcommittee* developed and maintained channels of communication with consumers and staff regarding the new tobacco-free policy and its implementation and enforcement procedures. Tasks undertaken by this subcommittee included distributing handouts, notices, and cards; sending letters to vendors and stakeholders (e.g., contractors); and announcing the policy prior to enactment via a center-wide e-mail campaign. A section of "frequently asked questions" was included in Spindletop's intranet. The subcommittee enlisted the assistance of the

	Tasks	Six months	Four months	Two months	One month	Two weeks	Quit Date	One week	One month	Three months	Six months	One Year
	Create website (internal and external) with information on policy and cessation resources											
	TUA integrated in EHR											
	Educate various units/teams on TFW policy, tobacco use documentation in EHR, and cessation resources											
	Solicit concerns about policy and post Q & A on website/emails											
	Create employee TFW policy acknowledgment statement (have all current and new employees sign statement)											
	Begin to install permanent signage outside – ensure signage is in place prior to implementation date											
	Remove all cigarette receptacles and ashtrays from property											
	POLICY IMPLEMENTATION											
	Create publicity on TFW policy adoption and quit date; celebrate implementation											
	Celebrate successful quit stories											
	Bring employee violations to supervisors attention, and address with employee											
	Ensure trash receptacles and signage are in place at all sites											
	Distribute NRT to all consumers interested in quitting											
	Assess consumers for tobacco use											
	MONITORING & EVALUATION											
	Ensure supervisors are enforcing TFW policy											
	Continue to inform employees on TFW policy, compliance concerns and updates, highlight cessation opportunities and successful quit efforts											
	Conduct chart audits to ensure TUA is being completed											
	Conduct chart audit for cessation referral documentation and NRT/medication assistance											
	Conduct environmental scan of grounds and have conversations with employees about TFW policy and compliance issues											
	Follow-up survey for employees and consumers											

HR human resources, *NRT* nicotine replacement therapy, *EHR* electronic health record, *TUA* tobacco use assessment

housekeeping team (e.g., eliminating ashtrays, cleaning gazebos) to remind tobacco users about the tobacco-free policy at areas where users regularly gathered to smoke.

The policy has been in effect since January 1, 2015. Despite the initial and expected challenges, its implementation has been well received and effective.

Component B: basic tobacco education

The multi-component program entailed the provision of onsite education to all staff about the health effects of tobacco use and the disproportionate burden of the consequences of tobacco use experienced by consumers with BHD. Before partnering with TTTF, Spindletop had not provided tobacco education to their staff. In preparation for the TFW, the TTTF team conducted

training for staff educating them about the hazards of tobacco use and benefits of quitting, emphasizing the relationship between tobacco use and behavioral health. Meeting goal no. 1, 247 staff received this education. This shared knowledge about tobacco facilitated communication among staff and possibly increased motivation to quit among tobacco users [31].

Offering tobacco-related education in the workplace can increase acceptability of TFW policies and motivate employees to quit tobacco [25]. Estimates from the TTTF-administered surveys indicated that among respondents ($N = 223$), staff smoking rate was 17%. Out of 37 smokers, 46% made a quit attempt since the implementation of the TFW and attributed their reduction of cigarette consumption partially or completely to the TFW. Therefore, Spindletop met program goal no. 2.

Component C: specialized tobacco cessation training for providers

Following established guidelines [15, 32], TTTF facilitated and conducted training on evidence-based practices for tobacco dependence for clinical providers. These trainings provided knowledge and skill building in regard to the TUAs and their integration into health records, delivery of motivational interviewing (MI) interventions for behavior change [33], 5A model (i.e., Ask-Advise-Assess-Assist-Arrange), and recommendations of FDA-approved medications [32]. Evaluation of this program component was measured by both the amount of training received by providers and their engagement in evidence-based practices.

Prior to partnering with TTTF, Spindletop had not provided any training to their providers regarding tobacco dependence treatment. Out of 29 providers, less than 20% reported having received training related to tobacco use or its treatment in the last 12 months. To fulfill this program component, the TTTF team provided education on evidence-based practices to 115 providers. In addition, 14 providers attended more specialized trainings about the treatment of tobacco dependence [i.e., 2-day training focused on considerations of tobacco use and cessation in behavioral healthcare settings, including the role of pharmacotherapy [34]; CTTS training; and an 8-h MI training offered by the TTTF team]. Also, Spindletop provided in-house MI trainings so staff could continue using this intervention with consumers attempting to quit. Meeting program goal no. 3, more providers reported being trained on evidence-based practices for tobacco cessation (Table 2).

The training was expected to increase the providers' evidence-based practices. With regard to TUAs before partnering with TTTF, Spindletop had included one question about tobacco use as part of their intake screening (i.e., "Do you smoke?"); however, there was no standard procedure to provide treatment to those who acknowledged being a tobacco user. The majority of providers admitted that they did not typically provide treatment or referrals for tobacco users. Following recommendations from TTTF, the TUA subcommittee developed and implemented an 11-item TUA that was integrated into the consumer's EHR.

The TUA assessed a consumer's history of tobacco use, exposure to environmental smoke, motivation to quit, quit attempts, and use of NRT. Hence, Spindletop's consumers were asked about their tobacco use every time they came to see a provider and were given assistance (e.g., brief counseling, NRT, or a connection with a tobacco counselor). Within 24 months after the TUA integration into the EHR, Spindletop staff completed 5519 TUAs (among youth and adults), meeting program goal no. 4. Anecdotally, a psychiatrist noticed that patients added smoking to their chief complaint once they had been asked about tobacco use during the intake interview.

NRT is an evidence-based treatment for tobacco dependence [32, 35], and its effectiveness and safety among behavioral health consumers have been demonstrated [19]. TTTF provided Spindletop a supply (total value of US\$15,365) of NRTs (14 and 21 mg nicotine patches and 4 mg nicotine gum) to be distributed among consumers and staff. The NRT subcommittee communicated with TTTF personnel about the provision of NRTs and coordinated the storage and distribution of these products. This committee developed and implemented an electronic system to keep track of the NRTs distributed. They also identified ongoing sources and means of obtaining additional NRTs. Free NRT was widely used at Spindletop cf. [36], and their tracking system had proven feasible and efficient in the distribution of NRT. A total of 3449 boxes of NRT were distributed among consumers and 88 among staff in a 2-year period.

Besides the provision of NRT, additional evidence-based strategies were used and adopted by Spindletop as a result of the training provided. Prescribers increased their recommendation of FDA-approved non-nicotine medications such as varenicline and bupropion (from zero to four providers in year 1), and more providers reported using the 5As in their clinical encounters with tobacco users during the past month (Table 3), including referring people to the Quitline for continued treatment. Additionally, Spindletop's peer support specialists facilitated groups using the CHOICES curriculum, especially developed for smokers with BHD [37]. According to the information provided previously and Tables 2 and 3, Spindletop met program goals no. 5 and no. 6.

Table 2 | Tobacco training among providers before and after TFW program implementation

In the last 12 months, have you received any training on	Pre-implementation (N = 29)	Post-implementation (N = 57)
assessing consumers for tobacco use?	4 (13.7%)	46 (80.7%)
the use of pharmacotherapy to treat tobacco use?	3 (10.3%)	45 (78.9%)
the effects of nicotine on psychiatric medication?	5 (17.2%)	42 (73.7%)
the effect of psychiatric medication on tobacco use?	4 (13.7%)	42 (73.7%)
the use of counseling/behavioral therapy to treat tobacco use?	4 (13.7%)	38 (66.7%)
hazards of smoking and benefits of quitting that are specific to individuals with BHD?	6 (20.7%)	43 (75.4%)

Data were obtained in aggregated form and authors were unable to identify or obtain data from all same subjects. Hence, statistical significance tests are not reported

TFW tobacco-free workplace, BHD behavioral health disorder

Table 3 | Practice of 5As among providers before and after TFW program implementation

	Among cigarette users		Among other tobacco users	
	Pre-implementation (N = 23)	Post-implementation (N = 40)	Pre-implementation (N = 10)	Post-implementation (N = 28)
Ask ^a	18 (62.1%) ^a	39 (68.4%) ^a	12 (41.4%) ^a	33 (57.9%) ^a
Advise	13 (44.8%)	33 (57.9%)	9 (31.0%)	25 (43.9%)
Assess	15 (51.7%)	31 (54.4%)	7 (24.1%)	25 (43.9%)
Assist	8 (27.6%)	26 (45.6%)	4 (13.8%)	21 (36.8%)
Arrange	7 (24.1%)	20 (35.1%)	5 (17.2%)	16 (28.1%)

N indicates the number of providers who report seeing a cigarette/tobacco user during the last month. Frequencies indicate the number of providers who report the respective practice (i.e., 5A) during the last month with some or all consumers who were smokers. Data were obtained in aggregated form and authors were unable to identify or obtain data from all same subjects. Hence, statistical significance tests are not reported

^a The “Ask” question was inquired separately from the others. For this question, the sample pre-implementation was 29 and post-implementation 57

Component D: community and outreach component

The community and outreach component of TTTF encouraged the engagement in activities that contribute to the sustainability and expansion of Spindletop's TFW efforts. Prior to partnering with TTTF, Spindletop did not engage on a regular basis in community or outreach activities related to tobacco control. Perhaps the most significant outreach activity carried out by Spindletop was the provision of free NRT to the consumers' relatives (e.g., the parents/caretakers of non-tobacco using youth). This approach was unique to Spindletop's adoption of the multi-component TTTF program and benefitted hundreds of community members. Other forms of outreach included display of brochures and posters, distribution of informational cards, and inclusion of tobacco-related material on their website. As such, Spindletop met program goal no. 7.

CHALLENGES, UNINTENDED CONSEQUENCES, AND ALTERNATIVES

Overcoming initial concerns and anxiety of the staff—Similar to previous reports [38], some of Spindletop's staff expressed concerns about the implementation of a TFW, particularly regarding the fear that consumers would be agitated and stable patients would psychiatrically decompensate if they were not allowed to use tobacco. To address these concerns, education was provided that emphasized recent research demonstrating that TFW policies are not significantly associated with an increase in behavioral problems among consumers [39] and that psychiatric symptomatology may be reduced after quitting smoking [9], especially if offered adequate treatment. The Spindletop's leadership widely publicized the upcoming changes far in advance to their tobacco-free date, facilitated timely training, and gradually rolled out the implementation process. Hence, the staff were increasingly exposed to different elements of the tobacco-free program to increase preparedness, which, in turn, reduced distress levels. Reflective of this, a provider expressed, “I have been very impressed with the outcome. It was good that everyone kept going despite that I was not [initially] on board with this.”

Smoking inside of the housing facility—Right after the tobacco-free date, smokers living in Spindletop's housing facility started smoking inside their rooms, setting off the smoke alarms. In response, staff attempted to enroll all resident smokers in a cessation program and offered them free NRTs. Given that consumers varied in their level of motivation and readiness to quit smoking, the staff constantly reminded them about the opportunity to join the cessation program. Additionally, a tobacco-free policy was added to the resident's lease agreement. It stated that residents were not allowed to use tobacco on the property or in their units and that it was a lease violation if they were found using tobacco cf. [40]. In a caring and supportive way, Spindletop's staff utilized tobacco-related violations to a resident's lease as an opportunity to work with the consumer to facilitate a quit attempt. Using a non-judgmental approach and a personalized message [32], providers encouraged consumers to consider cessation as another step in the direction of achieving more independent living.

Motivating providers that were long-term smokers or recovering non-nicotine substance users—As previously reported [27], it is common that the behavioral health centers' staff and peer counselors who were recovering substance abusers and/or current smokers exhibited reluctance to provide support for their consumers to quit smoking. This was the case at Spindletop where some employees were still smoking by the time the workplace tobacco-free date arrived. This hesitation to counsel recovering substance users to quit smoking was partially due to the perception that consumers were “trying to quit too many substances at once” and fear that the consumer would relapse to non-nicotine substance use if they attempted to quit smoking [27]. Alternatively, the tobacco control team identified and provided information to disprove this supposition [15]. In a non-judgmental way, they acknowledged the staff's concerns and still encouraged them to promote cessation. Peer counselors were encouraged to be role models in stopping tobacco use as they had done with regard to other substances.

Reframing the smoking breaks—The TFW prohibited the use of tobacco products in buildings as well as on adjacent outdoor areas or grounds. During the first weeks of the policy implementation, as many as 40 people (both consumers and staff) gathered in the streets in front of

homes to smoke and littered the street with cigarette butts. This created an unintended inconvenience to neighbors who threatened to call the media. Although this was an ongoing challenge, Spindletop's leadership encouraged and worked with the staff to consider the use of NRTs (e.g., nicotine gum) even if it was just for the break and to motivate their consumers to also do so. Employee breaks were reframed as NRT use breaks rather than smoking breaks [41].

Enough provision of NRT—Spindletop distributed all the NRTs provided by TTTF in 5 weeks. Although a good outcome associated with many individuals making quit attempts, it was unanticipated that the NRTs would be dispensed so quickly. Staff and consumers wanted to share the NRTs with their relatives increasing the demand for the product. To address this need, Spindletop's leadership started buying the NRTs at a local pharmacy; then negotiated a governmental contract with a pharmaceutical company that sold the NRTs at a more reasonable rate. Spindletop re-evaluated their expenses and managed to reduce costs in other areas to budget for the continued and long-term provision of free NRTs.

BEYOND TTTF: SUSTAINABILITY AND ADOPTION OF A TOBACCO-FREE HIRING POLICY

TTTF sustainability model refers to procedures and strategies that help a center maintain a TFW in the absence of continued grant funding. Spindletop successfully implemented program components that helped sustain their tobacco control efforts (e.g., tobacco-free signage, inclusion of tobacco champions, incorporation of TUAs in EHR, etc.). Additional sustainability strategies included tobacco education for new staff, free/low-cost booster training for staff (e.g., internet-based trainings), and budgeting to offer on-site cessation aids (i.e., NRT).

One year after the implementation of the TFW program, Spindletop adopted a tobacco-free hiring policy, becoming a pioneer in this regard among Texas' LMHAs and surpassing program expectations. Similar to the development of the TFW regulation, Spindletop ensured the dissemination of information related to the new policy. They included a statement on the job application regarding the tobacco-free hiring policy, announced it in their Web page, and told job candidates during the interview process. The policy applied to new hires (including former employees wanting to be re-hired) not current employees (details of the policy can be obtained by request). Spindletop's leadership reported an overall impression that this policy had positively contributed to further address tobacco use among consumers and staff and to create a healthier environment.

Conclusions

Comprehensive TFW programs that integrate evidence-based practices can increase the reach and

effectiveness of tobacco dependence treatment among individuals with BHD. Unfortunately, these programs are underused in behavioral healthcare settings [10] due to limited knowledge about their benefits and implementation processes. Academic-community partnerships are an ideal means to facilitate the translation of scientific findings and evidence-based practices for tobacco dependence treatment into real-world scenarios. Spindletop, an LMHA in Texas, capitalized on a multi-component TFW program [28] to adopt and implement a TFW policy on all its premises. Spindletop exceeded program expectations by also adopting a tobacco-free hiring policy.

Spindletop's experience in implementing tobacco-free related policies demonstrate the fundamental role of organizational leaders and healthcare providers to prioritize tobacco use treatment in behavioral healthcare facilities. The academic partners' support and guidance through the process were certainly valued. Additional key elements of the implementation process included a structured and detailed action plan, a goal-oriented and multi-disciplinary team comprised of smokers and non-smokers, division of labor/tasks, development of and accountability of implementation via a designated timeline, provision of tobacco-related education to all employees, and open and consistent communication regarding system-level changes. Importantly, a problem solving approach as well as an empathetic and non-judgmental attitude toward the tobacco user with BHD seemed crucial for the "buy-in" and enforcement of tobacco-free policies. Furthermore, the main lessons learned included the need to budget from the outset for the ongoing demand of NRTs and to include the consumers' voices early in the planning process.

The integration of system- and provider-level changes show promise for the successful implementation of TFW policies in behavioral health settings. The accomplishments of a large community behavioral health center validate that addressing tobacco use in behavioral health scenarios is not only feasible but a core component of tobacco control and health promotion. Spindletop's path to a tobacco-free workplace may serve as model for other behavioral healthcare centers to become tobacco-free.

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