SAMHSA
National Center of Excellence
for Tobacco-Free Recovery

# Tobacco-free Toolkit
## for Behavioral Health Agencies

Smoking Cessation Leadership Center

UCSF
University of California
San Francisco

tobaccofreerecovery.org

# SMOKING CESSATION DURING TREATMENT IS CRUCIAL TO THE PHYSICAL HEALTH OF THE CLIENT AND CAN IMPROVE TREATMENT OUTCOMES FOR THEIR BEHAVIORAL HEALTH DISORDERS

**Dear Behavioral Health Agency,**

Thank you for picking up this toolkit! In your role, you have a unique opportunity to improve the health and wellness of a population that suffers from multiple burdens and barriers to health equity. We at the Smoking Cessation Leadership Center are committed to helping you succeed.

Smoking is one of the leading causes of premature, preventable death among adults in the United States, and the behavioral health population smokes at a rate that is 2-3 times that of the general population.[1] **As a result, individuals with a behavioral health condition are far more likely to die of smoking-related diseases than from causes related to their mental illness or substance use disorder.**

Why is smoking prevalence higher in this population? Individuals with behavioral health conditions have been:

- victimized by the tobacco industry's target marketing
- exposed to various forms of trauma, increasing the risk of developing addictions
- suffered from delays in accessing care and less access to quality care
- subjected to stigma and provider bias

In short, tobacco dependency is not a question of "What's wrong with you," but rather "What's happened to you?"

Addressing smoking is central to creating health equity. Smoking prevalence is highest among those with behavioral health conditions, and behavioral health conditions - both mental illness and illicit drug use - are highest among American Indian and Alaskan Native populations, individuals reporting as multiracial and individuals responding as Lesbian, Gay or Bisexual.[1]

Tobacco cessation can also improve treatment outcomes for the client's behavioral health disorders and concurrent cessation treatment can increase the likelihood of longterm sobriety by 25%.[2] Cessation also improves an individual's mood as much as an anti-depressant can.[3]

This toolkit serves as a resource and guide for behavioral health agencies adopting a tobacco-free wellness policy for their facilities and campuses. It provides information on tobacco use among the behavioral health population, as well as a step-by-step guide to becoming a tobacco-free facility and treating tobacco use in clients and staff. It also suggests ways of incorporating a larger program of wellness that not only supports smoking cessation, but improves overall the mental, emotional, physical, occupational, intellectual, and spiritual aspects of one's life.

We look forward to a future in which we have overcome and eliminated the added burden of nicotine addiction among the behavioral health population, and we are pleased to partner with you in making that future a reality.

Sincerely,

Smoking Cessation Leadership Center at the University of California, San Francisco Substance Abuse and Mental Health Services Administration's (SAMHSA)

National Center of Excellence for Tobacco-Free Recovery

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## CESSATION ADVICE FROM PEER EX-SMOKERS

*Sources: Prochaska, Reyes, Schroeder, et al (2011) Bipolar Disorders; BACR peers, Marin County, CA; and Kaiser Permanente*

*"Smoking not only destroys your health, it creates an addiction, which can complicate emotional stability."*

*"Avoid alcohol at all costs."*

*"I never realized until I quit that the nicotine was what made me anxious and the addiction kept me feeling like it was the only way to cope."*

*"Give yourself the gift of being smoke-free – it lasts a lifetime."*

*"Keep a quit journal."*

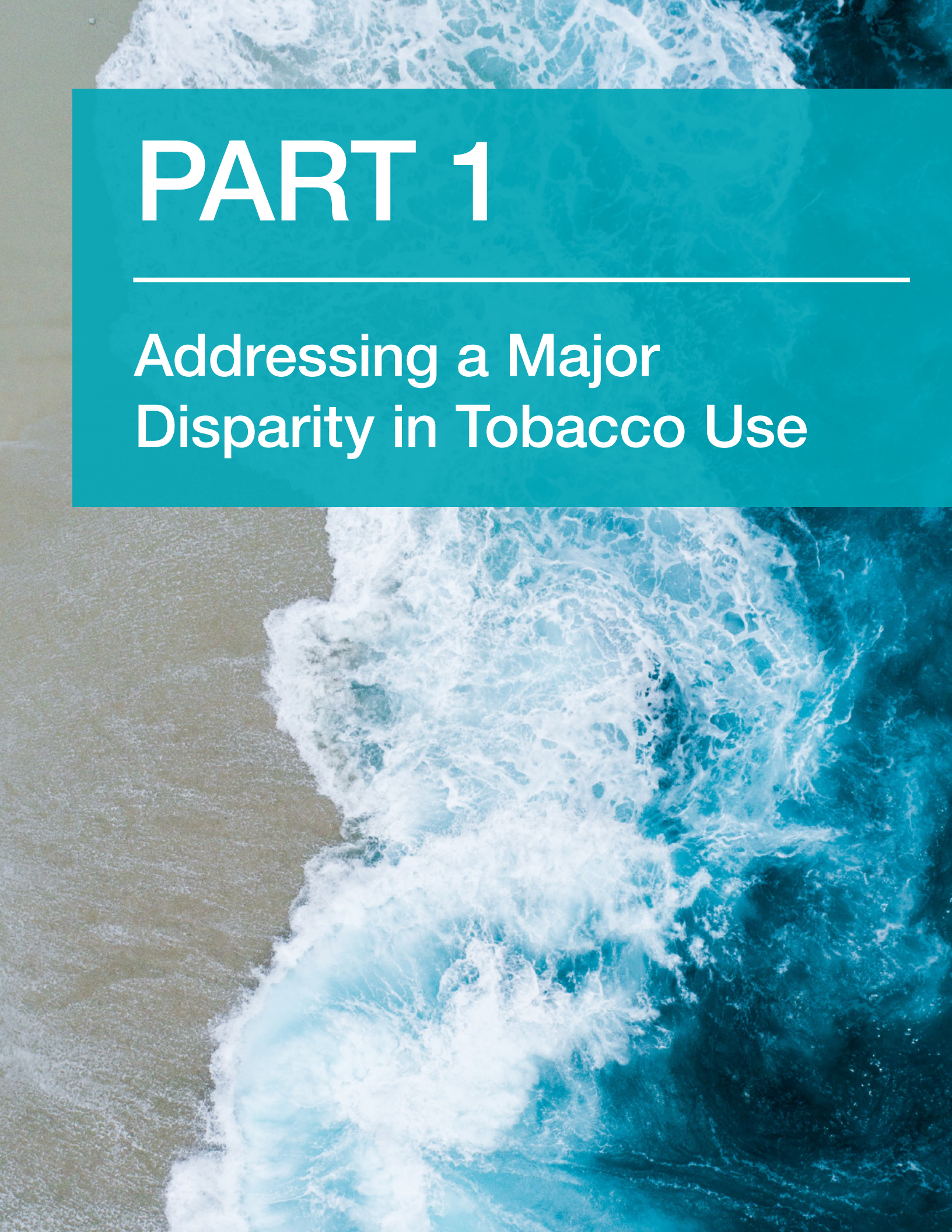
*"The best thing I ever did was to make it to recovery. The next best thing was to quit smoking."*

*"A routine benefits a person with mental illness who wants to quit smoking."*

*"Don't think of it as losing a friend, think of it as gaining your freedom."*

*"Whatever your reasons for quitting tobacco, never give up, never give in, and take it one second, one minute at a time every day."*

*"Even though I quit during all my pregnancies, I always went back to cigarettes. Until one day I decided I just didn't want to be dependent on anything – not alcohol, drugs or tobacco. I wanted to be healthy and a role model for my children."*



# PART 1

## Addressing a Major Disparity in Tobacco Use

*"The best thing I ever did was to make it to recovery. The next best thing was to quit smoking."*

**~ The quotes, like this one, that you will see throughout this document are pieces of cessation advice from peer ex smokers  real words from actual people who have been in your clients' shoes.[2]**

The purpose of this toolkit is to provide guidance for substance abuse and mental health treatment facilities adopting tobacco-free policies and implementing cessation services as part of treatment plans.

Tobacco use remains one of the leading causes of death among Americans. Tobacco use causes a number of devastating and debilitating diseases, including stroke, emphysema and many kinds of cancers.

The single most important thing smokers can do to improve their health is to quit smoking; tobacco-free policies are important components of creating an environment that is conducive to quitting. This work is an integral part of a larger strategy to promote wellness among the behavioral health population. Whether your facility is a shelter, a residential recovery home, an outpatient clubhouse, community center or clinic, the guidance contained in this document will assist your organization with planning, rolling out and sustaining tobacco policies.

## THIS TOOLKIT PROVIDES:

- General information on tobacco addiction and how to provide cessation services
- How tobacco impacts the behavioral health population
- Step-by-step guidance on how to prepare for and implement a tobacco-free policy in your facility
- Ways of incorporating additional wellness activities and strategies

## WHY FOCUS ON THOSE WITH BEHAVIORAL HEALTH CONDITIONS (PEOPLE WITH MENTAL ILLNESS(ES) AND/OR SUBSTANCE USE DISORDERS)?

In spite of measures that have greatly reduced smoking in the general population – smoke-free air laws, high cigarette taxes, and effective media campaigns – this population continues to smoke at higher rates, putting it at increased risk of tobacco-related disease and death[4].

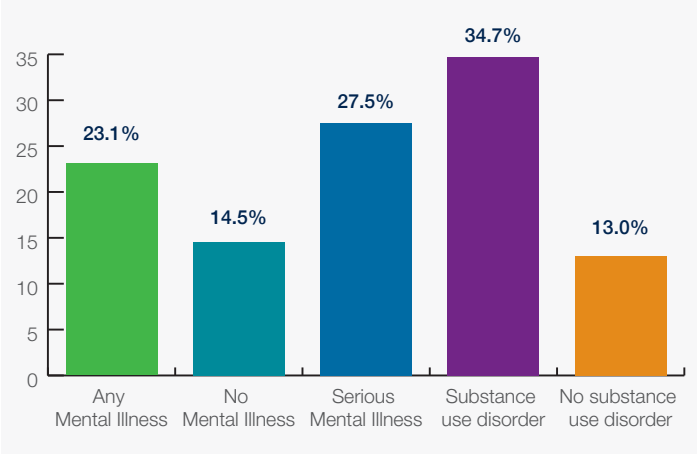
The Substance Abuse and Mental Health Services Administration (SAMHSA) outlines 8 dimensions of wellness:

1. Emotional—Coping effectively with life and creating satisfying relationships
2. Environmental—Good health by occupying pleasant, stimulating environments that support well-being
3. Financial—Satisfaction with current and future financial situations
4. Intellectual—Recognizing creative abilities and finding ways to expand knowledge and skills
5. Occupational—Personal satisfaction and enrichment from one's work
6. Physical—Recognizing the need for physical activity, healthy foods, and sleep
7. Social—Developing a sense of connection, belonging, and a well-developed support system
8. Spiritual—Expanding a sense of purpose and meaning in life

**SAMHSA's** wellness initiative is available at **https://store.samhsa.gov/system/files/sma16-4958.pdf.**

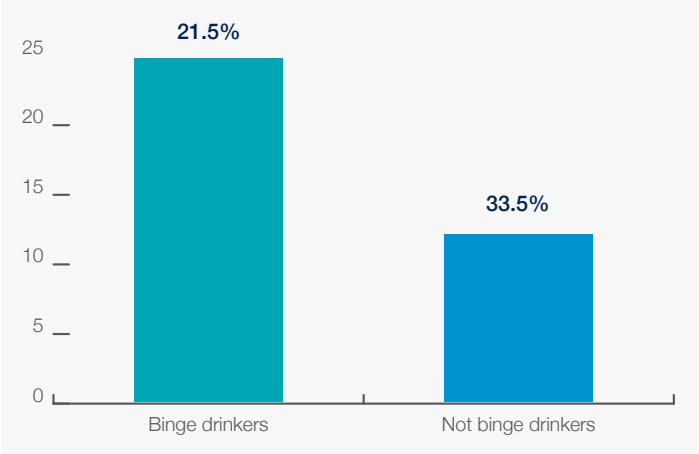
**Creating a tobacco-free environment and supporting cessation are crucial for both the Environmental and Physical aspects of wellness.**

### Smoking Prevalence among U.S. Adults with Past Year Any Mental Illness, No Mental Illness, Serious Mental Illness, Substance Use Disorder, and No Substance Use Disorder, 2020




Source: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2021). National Survey on Drug Use and Health 2020 (NSDUH-2020-DS0001). Retrieved/analyzed from **https://datafiles.samhsa.gov**

### Smoking Prevalence Among U.S. Adults who Binge Drink vs. No Binge Drinking, 2020



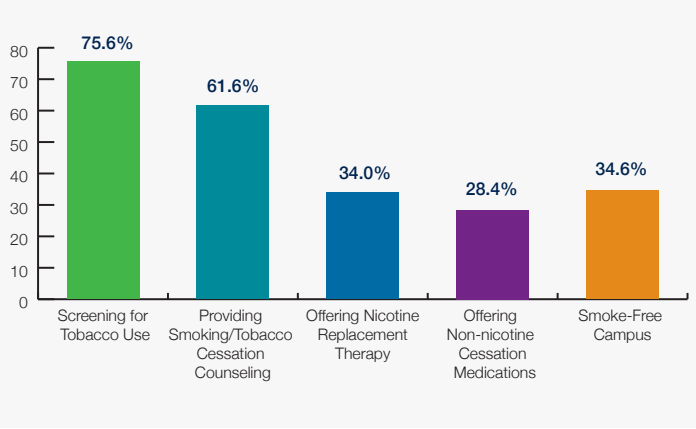

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance Survey, 2020. Accessed from the BRFSS Web Enable Analysis Tool, **https://nccd.cdc.gov/weat/index.html**

In the United States, the adult cigarette smoking rate is 12.5%.[5] For those states and jurisdictions with smoking rates below the national rate, many have a comprehensive approach to tobacco control. However, adults with any mental illness still smoke at rates (23.1%) higher than those without mental illness (14.5%); adults with a past year substance use disorder (34.7%) smoke at more than 2 times the rate among those without a past year SUD.[6]

In addition to smoking rates, rates of addressing tobacco use are low in behavioral health treatment settings. In 2021, among mental health facilities, 63% screened patients for tobacco use, 48% offered tobacco cessation counseling, and 54% had smoke-free campuses;[7] corresponding estimates for substance abuse facilities were 76%, 62%, and 35%, respectively.[8] About one in three behavioral health treatment facilities offered nicotine replacement therapy; one in five offered non-nicotine cessation medications.

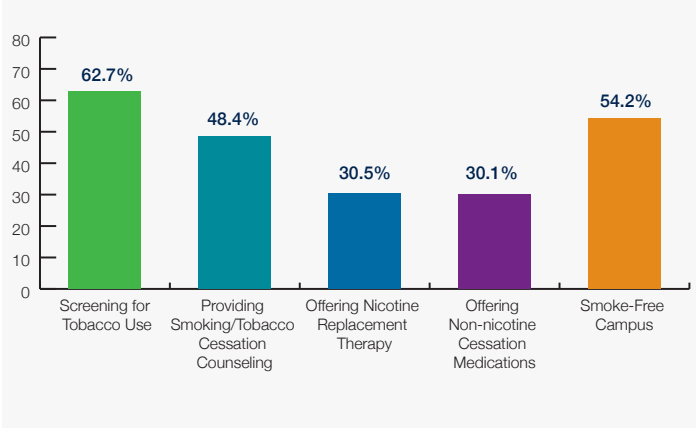
*Please see the instructions for using the SAMHSA Behavioral Health Services Locator at **http://tinyurl.com/ywn7r9yr** to learn how you can download and analyze smoke free facilities and level of cessation intervention in your area!*

**Tobacco Cessation Interventions and Smoke-Free Policies in SUD Treatment Facilities – United States (N=14,173), 2021**




Source: Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS): 2020. Data on Substance Abuse Treatment Facilities. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2021.

**Tobacco Cessation Interventions and Smoke-Free Policies in MH Treatment Facilities – United States (N=10,456), 2021**

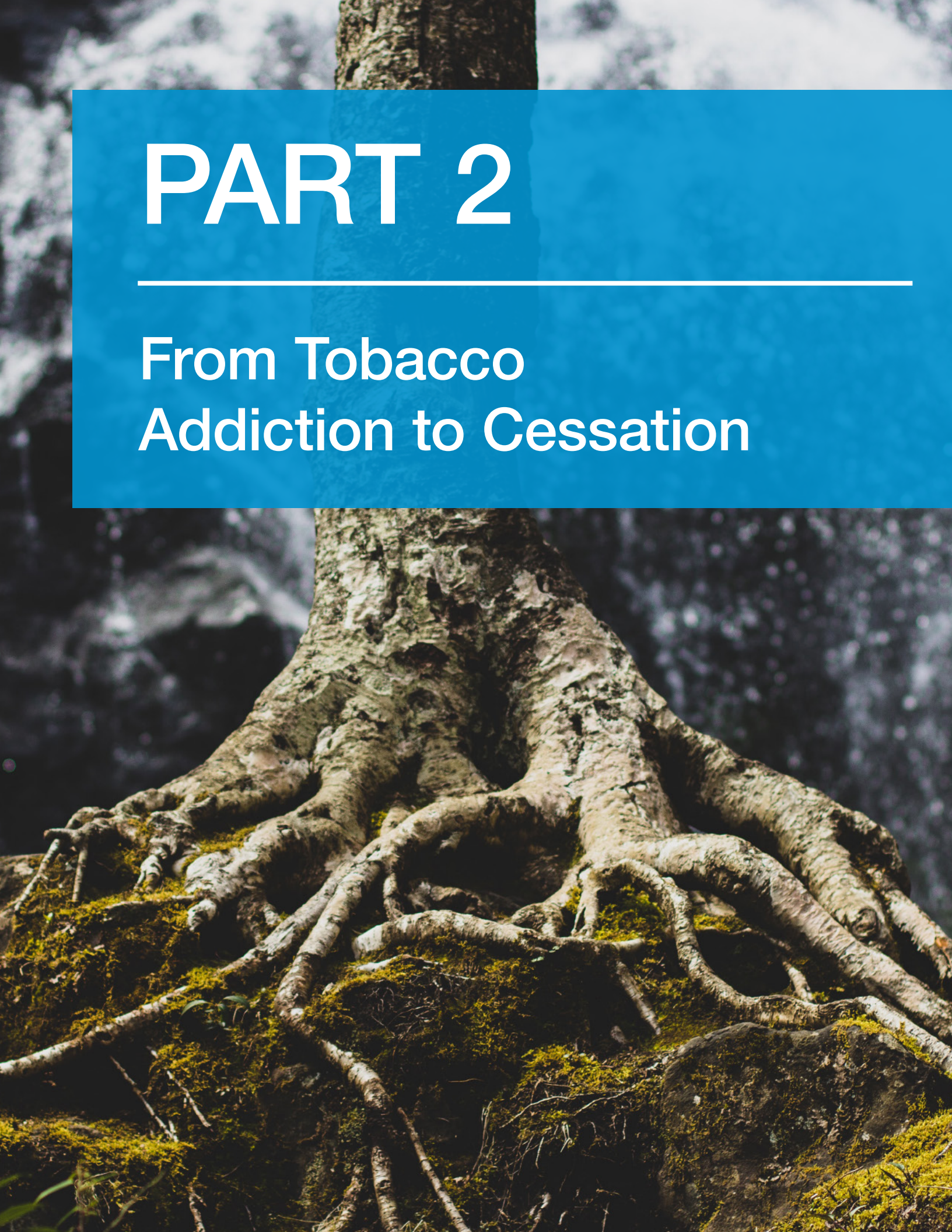



Source: Substance Abuse and Mental Health Services Administration, National Mental Health Services Survey (N-MHSS): 2020. Data on Mental Health Treatment Facilities. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2021.

**INDIVIDUALS WITH BEHAVIORAL HEALTH CONDITIONS SMOKE AT MORE THAN 2X THE RATE OF THOSE WITHOUT BEHAVIORAL HEALTH CONDITIONS.[4]**

## THE IMPORTANCE OF SMOKE-FREE ENVIRONMENTS

To assist people with behavioral health conditions in living healthy, meaningful lives, healthcare and social services agencies need to promote behaviors that lead to improved health and overall wellness. Creating a tobacco-free environment is one of the primary ways that a community healthcare agency can create a safer and healthier environment for clients, staff, and visitors. It is an integral part of promoting and supporting wellness for both clients and staff at your facility.



# PART 2

## From Tobacco Addiction to Cessation

## TOBACCO IS HIGHLY ADDICTIVE

- Tobacco products contain nicotine, an addictive substance. Most smokers become addicted to nicotine.[9]
- The nicotine in any tobacco product is absorbed into the blood when a person uses it, immediately stimulating the adrenal glands to release the hormone epinephrine (adrenaline). Epinephrine stimulates the central nervous system and increases blood pressure, breathing, and heart rate. Like cocaine and heroin, nicotine activates the brain's reward circuits and increases levels of the chemical messenger dopamine, which reinforces rewarding behaviors.[10]
- Research suggests that nicotine may be as addictive as heroin, cocaine, or alcohol.[11]
- More people in the United States are addicted to nicotine than to any other drug.[12]

## SECONDHAND & THIRDHAND SMOKE IS ALSO HARMFUL

Secondhand smoke (smoke from burning tobacco products, such as cigarettes, cigars, or pipes, and/or exhaled by person smoking) contributes to around 41,000 deaths among nonsmoking adults and 400 deaths in infants each year.[13]

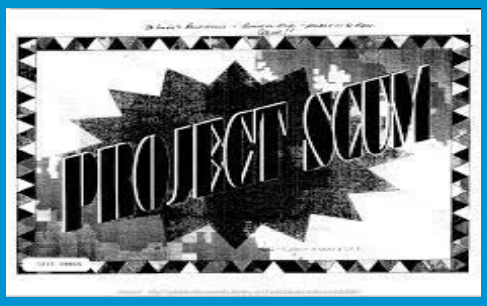
Thirdhand smoke is residual nicotine and toxic chemicals left on indoor surfaces by tobacco smoke.[14] Not only can these dangerous chemicals cling to walls, carpets, car interiors, clothing and hair, they cannot be removed with common cleaning methods and actually become more toxic over time. Breathing, ingesting or touching materials contaminated with this residue can damage DNA and increases the risk for short- and long-term health problems, including heart disease, stroke, cancer and other smoking-related diseases.[15]

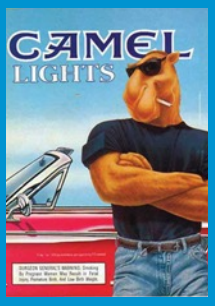
Thirdhand smoke is especially hazardous for infants and children, which is of particular significance for family members visiting loved ones in residential treatment facilities. Babies and small children are particularly vulnerable because they are often held close to hair, clothes and skin or allowed to crawl on the floor. They can then ingest tobacco residue by putting their hands in their mouths after touching contaminated surfaces. Infants exposed to these harmful chemicals are more likely to die from Sudden Infant Death Syndrome (SIDS).[16]

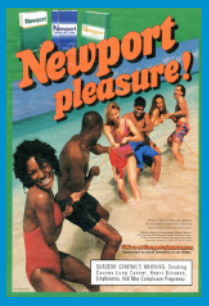
## TOBACCO COMPANIES TARGET VULNERABLE POPULATIONS

The tobacco industry has a long, troubling history of targeting youth, people living in areas with fewer resources and communities of color. These practices are a key part of how systemic racism has led to poorer outcomes to the people and the communities who are impacted.  Promoting smoke-free areas and tobacco cessation is an important part of health equity efforts.

- Tobacco companies have a long history of targeting youth.[17]
- Tobacco companies have also targeted those of lower socioeconomic status through point-of-sale advertisements and increased billboard placement in poorer areas.[18]
- For many years, the tobacco industry specifically targeted behavioral healthcare facilities and persons with behavioral health conditions through the use of promotional giveaways and charitable donations, including providing free cigarettes to psychiatric facilities.[19] In addition, many tobacco advertising campaigns falsely depict smokers experiencing stress relief and mood elevation from smoking.
- The tobacco industry has funded research to foster the myth that cessation would be too stressful, because persons with mental illness use nicotine to alleviate negative mood (i.e., self-medicate).[20, 21]








Project SCUM" – project subculture urban marketing, for example, was an intitiative designed to appeal to the LGBT community in San Francisco. The Tobacco Industry also sponsored pride events and gave money to HIV/AIDS causes.[22]

*"Whatever your reasons for quitting tobacco, never give up, never give in, and take it one second, one minute at a time every day."*

## QUITTING TOBACCO IS A CHALLENGE, BUT IT CAN BE DONE

Considering that tobacco addiction is a chronic, relapsing disease, it is important that clients feel empowered to reduce consumption and/or quit again should any single effort fail. They are more likely to do so when they consider their caregivers as true partners in their battle against smoking.[23] Quitting smoking is challenging, so it is important that smokers realize it will likely take multiple quit attempts until they have stopped smoking for good. People who quit often start smoking again because of stress, cravings, weight gain, and being around other smokers. Smokers should not be discouraged by relapse – they can try to quit again and should be encouraged to do so with positive messages that highlight the benefits of quitting (health, money savings, healthy environment for family, etc.) and treat each quit attempt as a win. Stay mindful of how difficult it often is to stop smoking; use this knowledge to maintain a compassionate perspective.

*See Appendix B: How Quitting Tobacco Can Improve Your Mental Health*

**Many smokers quit "cold turkey," but there are evidence-based methods to help a smoker quit, including:**

- Nicotine replacement therapy (patches, gum, lozenges) and prescription medications such as varenicline (brand name Chantix) and bupropion (brand name Zyban)
- Brief counseling from a healthcare provider, including asking about smoking status, advising to quit, and offering assistance with quitting and/or referring to resources
- Counseling sessions (individual or group, either brief or longer in length, in person or by phone, text or online)

**CASE STUDY:** Oklahoma Changes Systems for Assessing and Addressing Tobacco Use

In 2011, the Oklahoma Tobacco Settlement Endowment Trust (TSET) brought together partners to develop a plan to address tobacco use among behavioral health clients and providers. After this meeting, TSET awarded grants to health system partners to help put the plan in place. This effort which emphasizes the importance of peer support, appears to be making an impact: Oklahoma has the highest proportion of mental health treatment facilities offering cessation counseling, offering non-nicotine cessation medications, and providing smoke-free campuses in the U.S.

Learn more at **https://www.cdc.gov/tobacco/disparities/promising-policies-and-practices/pdfs/osh-behavioral-health-promising-practices-20160709-p.pdf**

## IF AT FIRST YOU DON'T SUCCEED... QUIT, QUIT AGAIN

It may take up to 30 quit attempts to quit successfully.[24]

Smokers who use medications and counseling to quit are twice as likely to be successful than those quitting "cold turkey. [25]

Free Services for smokers who want to quit is available at SMOKEFREE.GOV and 1 800 QUIT NOW (1 800 784 8669).

Please refer to **Smokefree.gov at https://smokefree.gov/** or learn more about quitlines at **https://www.cdc.gov/tobacco/quit smoking/cessation/faq-about-1-800-quit-now/index.html**

You can also watch a video on what it s like to make that first call to a quitline here **https://youtu.be/vqLroNoGTrc**

## WHAT ABOUT ELECTRONIC CIGARETTES?

- With the exception of VUSE (authorized for marketing by the FDA Center for Tobacco Products in October 2021),[26] most electronic cigarettes are not FDA-approved to be marketed as tobacco products. While e-cigarettes have the potential to benefit some people and harm others, scientists still have a lot to learn about whether e-cigarettes are effective for quitting smoking.
- Because there are so many e-cigarette products entering the market, it is impossible to know the actual content of the aerosol that is inhaled.
- JUUL, holds the greatest share of the e-cigarette market. Sales of this product increased seven-fold between 2016-2017.[27] Of concern is that it is especially popular among young people and has the potential to create nicotine dependence among this generation. At the time this toolkit was last updated in 2021, the FDA had delayed its decision about whether to approve JUUL for market distribution.
- Clinical practice guideline authors have recommended a harm reduction approach to the use of e-cigarettes as cessation devices. Specifically, if patients ask about e-cigarettes during a discussion of cigarette substitutes, clinicians can take the opportunity to stress that the main goal is to stop or reduce the use of combustibles. They should also note that effects of long-term e-cigarette use are not known, but these devices are probably much safer than combustible tobacco products. Clinicians could tell patients, however, that if they use e-cigarettes, their health will only improve if their use helps them significantly reduce their use of combustible products and eventually stop combustible use entirely.

## SCIENTISTS ARE STILL STUDYING THE LONG-TERM HEALTH EFFECTS OF E-CIGARETTES. HERE IS WHAT WE KNOW NOW:

- Most e-cigarettes contain nicotine, which has known health effects, including being addictive and highly toxic to developing fetuses and harmful to adolescent brain development.
- Besides nicotine, e-cigarette aerosol can contain substances that harm the body.
- E-cigarettes can cause unintended injuries. Defective e-cigarette batteries have caused fires and explosions, some of which have resulted in serious injuries. In 2019, many vaping products found on the black market that contain nicotine or THC caused an increasing number of lung injury cases – the use of these products has been linked to severe breathing problems and lung injury.

Learn the latest from the CDC about e-cigarettes and vaping by visiting:
**https://www.cdc.gov/tobacco/basic_information/e-cigarettes/about-e-cigarettes.html**

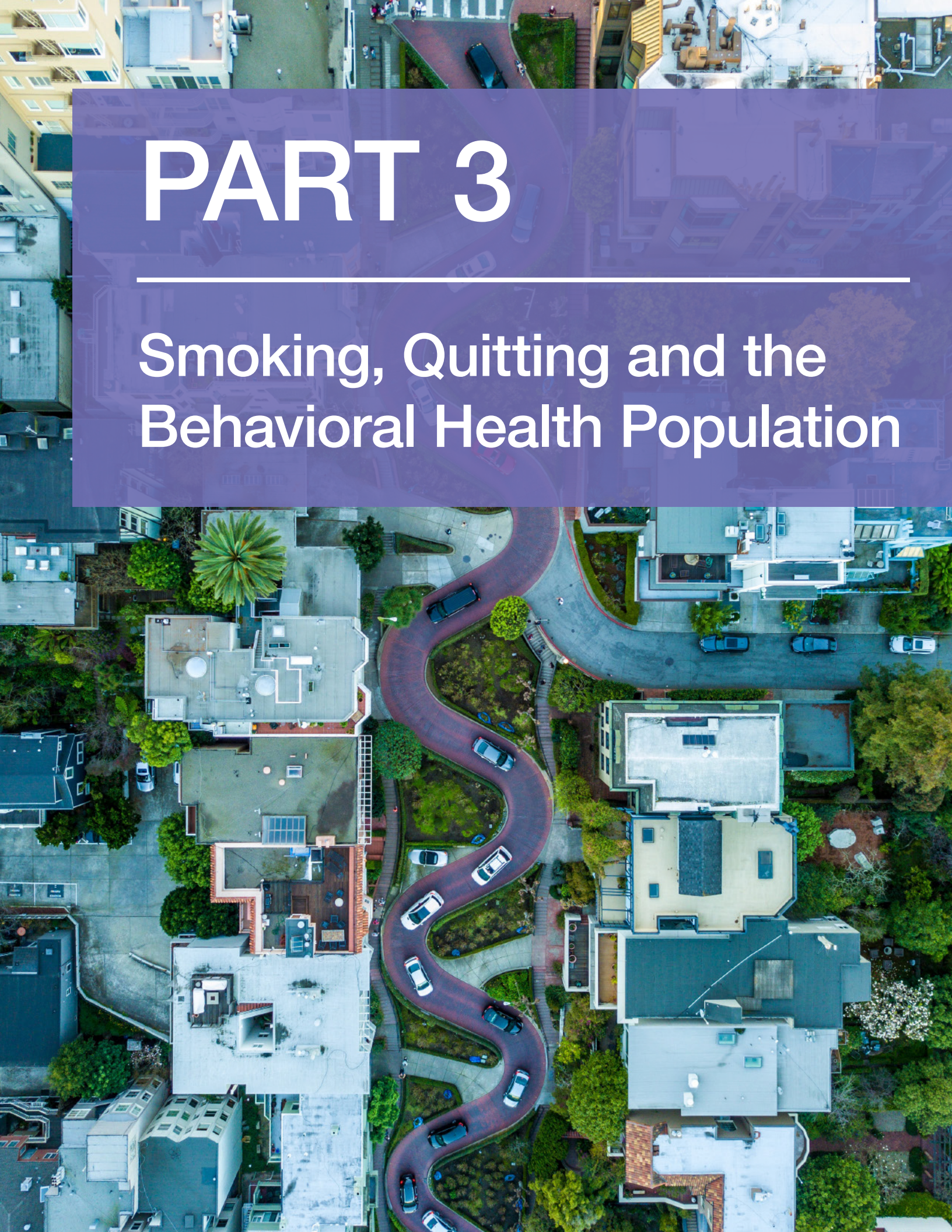
## NICOTINE VS. SMOKING
## IT'S THE TOBACCO THAT IS HARMFUL, NOT THE NICOTINE

While nicotine is the addictive substance in tobacco products, medications proven to help smokers quit may contain nicotine. Nicotine patches, gum, lozenges and other FDA-approved products are effective in safely helping a smoker quit, and smokers should be encouraged to use them.

**Cigarettes and other tobacco products do contain many harmful chemicals (about 7,000 different compounds) that cause cancer and other diseases. These disease causing chemicals include: arsenic, benzene, and many others.**

**These chemicals also interfere with psychiatric medications such as antipsychotics, antidepressants, hypnotics, and anxiolytics by decreasing the drug s concentration in the blood and thereby reducing the medication s effectiveness. Reduction in efficacy can then lead to unnecessarily higher dosages. Meanwhile, some nonpsychiatric medications such as insulin, warfarin, and caffeine require higher dosages to reach appropriate efficacy with smokers.**

*See Appendix A: Drug Interactions with Tobacco Smoke*



# PART 3

## Smoking, Quitting and the Behavioral Health Population

*"Even though I quit during all my pregnancies, I always went back to cigarettes. Until one day I decided I just didn't want to be dependent on anything – not alcohol, drugs or tobacco. I wanted to be healthy and a role model for my children."*

## Many people in recovery or receiving treatment for mental health disorders smoke tobacco. Tobacco cessation should be offered as a part of recovery and treatment, as those in this population are more likely to suffer due to their tobacco use:

- Individuals with behavioral health conditions smoke at far higher rates than those without these disorders (25.5% vs. 12.5% rate of adults without a behavioral health condition).[28]
- Individuals with a mental illness may develop cancer at a 2.6 times higher rate on account of late stage diagnosis and inadequate treatment and screenings.[29]
- Individuals with a mental illness have a higher rate of fatality due to cancer.[30]
- Individuals with substance use disorders who also smoke are four times more likely to die prematurely relative to individuals with drug problems who do not use tobacco.[31]
- Despite high rates of smoking among those with substance use disorders, fewer than two-thirds of substance abuse treatment centers offer cessation services, 61.6%.
- 85% of those in treatment for opioid addiction smoke.[32]

## ADVERSE HEALTH EFFECTS OF TOBACCO USE

People with mental illness or substance use disorders die up to 10 years earlier than those w/o these disorders; many of these deaths are caused by smoking cigarettes.

The most common causes of death among people with mental illness are heart disease, cancer, and lung disease, each of which can be caused by smoking.

Drug users who smoke cigarettes are four times more likely to die prematurely than those who do not smoke.

Nicotine has mood-altering effects that can temporarily mask the negative symptoms of mental illness, putting people w/ mental illness at higher risk for cigarette use & nicotine addiction.

Tobacco smoke can interact with and inhibit the effectiveness of certain medications taken by mental health and substance abuse patients.

Sources: CDC. Vital Signs: Current Cigarette Smoking Among Adults Aged ≥18 Years With Mental Illness United States, 2009 2011. MMWR 2013;62(05):81 87; Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding Excess Mortality in Persons With Mental Illness: 17 Year Follow Up of a Nationally Representative US Survey. Medical Care 2011;49(6):599 604; CDC. Vital Signs Fact Sheet: Adult Smoking Focusing on People With Mental Illness, February 2013. NCCDPHP, Office on Smoking and Health, 2013; Smoking Cessation Leadership Center. Fact Sheet: The Tobacco Epidemic Among People With Behavioral Health Disorders. San Francisco: SCLC, University of California, 2015; Smoking Cessation Leadership Center. Fact Sheet: Drug Interactions With Tobacco Smoke. San Francisco: SCLC, University of California, 2015.

## GET THE FACTS:

- With careful monitoring, delivering smoking cessation interventions does not interfere with treatments for mental illness and can actually be part of the treatment.[33]
- There is mounting evidence that clients who receive treatment for tobacco use are more likely to reduce their use of alcohol and other drugs, have less psychiatric symptoms, and enjoy better treatment outcomes overall.[34]
- Smoking cessation is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life compared with individuals who continue to smoke. The effect sizes are equal or larger than those of antidepressant treatment for mood and anxiety disorders.[35]

*See Appendix C: "The Tobacco Epidemic Among People with Behavioral Health Disorders*

## IMPROVED MENTAL HEALTH WITH SMOKING CESSATION

| Outcome | No. of studies included | No. of studies excluded | Effect Estimate |
|---|---|---|---|
| Positive affect | 1 | 2 | ↑ 0.68 |
| Psychological quality of life | 4 | 4 | ↑ 0.17 |
| Anxiety | 4 | 0 | ↓ -0.37 |
| Depression | 9 | 1 | ↓ -0.29 |
| Mixed Anxiety and depression | 4 | 1 | ↓ -0.36 |
| Stress | 2 | 1 | ↓ -0.23 |

*Taylor et al, BMJ*

**Contrary to popular beliefs, persons with behavioral health conditions want to quit smoking, want information on cessation services and resources, and most importantly, can successfully quit using tobacco.** One study found that 52% of cocaine addicts, 50% of alcoholics, and 42% of heroin addicts were interested in quitting smoking at the time they started treatment for their other addictions. However, smokers with other substance use, psychiatric disorders, and strong nicotine dependence are less likely to succeed in a quit attempt.

Treating those with behavioral health conditions follows similar clinical guidelines as those for the general population. However, extra care must be taken by the provider to ensure that any medication prescribed for smoking cessation does not interfere with other medications. It is important for anyone treating this population of smokers to understand the clinical guidelines developed for cessation among those with behavioral health conditions. These guidelines can be accessed at the Substance Abuse and Mental Health Services Administration's website: **https://www.integration.samhsa.gov/health-wellness/wellness-strategies/tobacco-cessation-2**

Read more information on the clinical practice guideline for treating tobacco use and dependence or visit: **https://www.ncbi.nlm.nih.gov/books/NBK63952**

**CASE STUDY:** Texas Provides NRT as Part of a Range of Tobacco Cessation Measures in Mental Health Treatment Settings

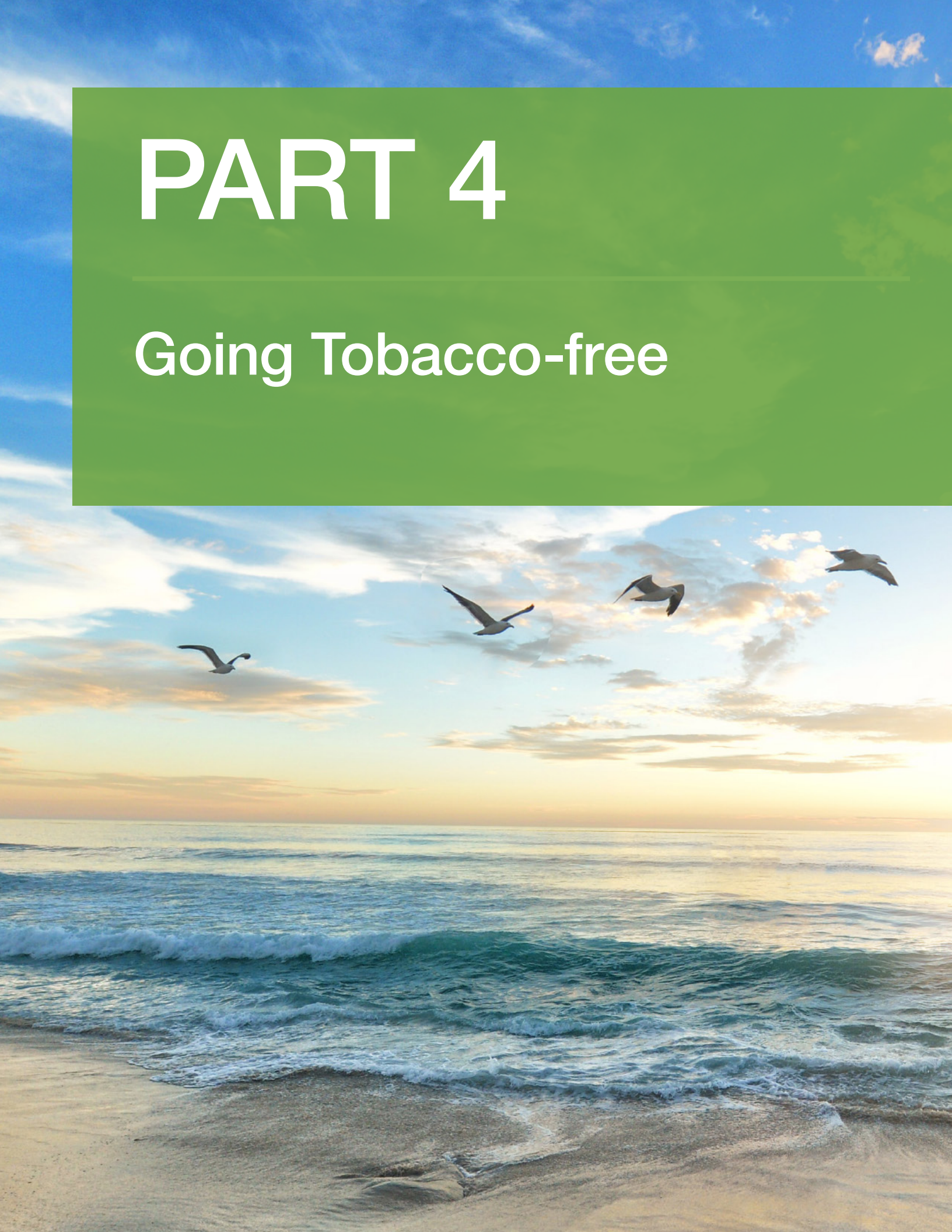
During 2013-2017, the Taking Texas Tobacco Free (TTTF) project put comprehensive and sustainable tobacco-free programs in place in Texas. The goal was to reduce tobacco use and secondhand smoke exposure among employees, clients, and visitors by adopting tobacco-free campus policies, screening employees and clients regularly for tobacco use, and providing counseling and NRT to tobacco users who want to quit.

Learn more at **https://www.cdc.gov/tobacco/disparities/promising-policies-and-practices/pdfs/osh-behavioral-health-promising-practices-20160709-p.pdf**

## NOTES

# PART 4

## Going Tobacco-free



*"I never realized until I quit that the nicotine was what made me anxious and the addiction kept me feeling like it was the only way to cope."*

**Having a tobacco-free policy is an important step in creating an environment for clients that supports their overall health and wellness. When considering tobacco-free policies, it is important to assess your organization's readiness to change.[36]**

## IN WHICH STAGE DOES YOUR ORGANIZATION BELONG?

**Precontemplation** – Organization is not considering policy change

**Contemplation** – 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

## ACTIONS YOU CAN TAKE TO MOVE YOUR ORGANIZATION TOWARD A SMOKE-FREE POLICY:

### Precontemplation

- Allow 6 months to move towards advanced stages of change.
- Create buy-in through education/training to staff, clients, and community change agents.
- Actively convey the message that allowing tobacco use within healthcare facilities is in direct opposition with providing quality healthcare to clients, and a healthy workplace for staff.
- Participate in a forum (local or national) to gather ideas/support on moving the organization forward.

### Contemplation

- Create a tobacco-free committee within the agency.
- Gather information from staff and clients through informal town-hall meetings or more formalized focus groups.

### Preparation

- Create a draft of the written policy based on feedback provided through meetings and focus groups.
- Consider how to address adherence issues among staff and clients.
- Examine what services will be provided to staff and clients to help them get through the day.
- Begin training and educational sessions within the organization.

### Action

- Announce a tobacco-free date.
- Display a countdown to the tobacco-free date.
- Notify staff and clients via various methods and at multiple times (e.g., flyers, meetings, emails).

### Maintenance

- Conduct an evaluation of the policy.
- Amend policy based on findings.
- Continue to educate staff and clients on the importance of maintaining a tobacco-free environment.

**Implementing a tobacco-free policy that includes all tobacco products, (*see FDA legal definition in Appendix G: Model Tobacco-Free Policy*), improves the health and wellness of everyone in your organization. It is crucial that, as you implement the policy, you engage all of those who work in and receive services from the facility, ask for input and communicate the process for implementation clearly. It is also important that smokers, both clients and staff, if they choose to quit smoking, receive support in their quit attempts.**

## THE FOLLOWING IS A 10-STEP PROCESS FOR IMPLEMENTATION OF A COMPREHENSIVE TOBACCO-FREE POLICY:

*"Don't think of quitting as losing a friend, think of it as gaining your freedom."*

## 10 STEPS FOR GOING TOBACCO-FREE

1

**Step 1: Convene a Tobacco-Free Committee.** The committee should be made up of administrators, staff, and consumer/client representative(s) who will be responsible for creating and implementing the tobacco-free policy. Key members of the committee are:

- Human resources director
- Facilities director
- Environmental services representative
- Clinical and/or medical director
- Key employee groups
- Key client groups
- Security representative
- Pharmacy representative
- Health education representative
- Public affairs representative

*Tip: Include those who may be nay-sayers, like a staff member/counselor who smokes and believes it is more important to address a client's alcoholism because "cigarettes are their last feedom". Including these people who feel negatively toward the intitiative in the beginning and giving them a voice on the committee will likely bring an otherwise unheard perspective to the endeavor. It will also show them that their opinion is valued and give them time to, hopefully, come around. Their experience will then be more compelling when they interact with clients.*

2

**Step 2: Create a Timeline.** To adequately prepare your organization for becoming tobacco-free, a 6-12 month planning and implementation timeline is preferable.

*See Appendix E: Model Tobacco-Free Policy Timeline*

3

**Step 3: Craft the Message.** Explain why you want to address tobacco-use in your facility. Talk about what you want to accomplish.[37]

Key messages may include:

- "We are developing this policy to provide a healthy and safe environment for employees, clients, and visitors and to promote positive health behaviors."
- "Persons with behavioral health conditions die up to 25 years younger than the general population due largely to conditions caused or worsened by smoking."
- "Tobacco acts as a cue for other drug use and maintains drug-related coping styles."
- "Policies that discourage smoking can improve health outcomes: Smoking slows wound healing, increases infection rates in surgeries and is the most common cause of poor birth outcomes."
- "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."
- Starting [DATE], we will no longer permit use of tobacco products on our campus.
- [Name of a trusted staff manager/ HR director/ tobacco-free program coordinator] will be responsible for this initiative. Please contact her/him if you have suggestions to improve our process or if you have questions or concerns.

4

**Step 4: Draft the Policy.** An effective tobacco-free policy will provide a clear rationale that cites the documented health risks that tobacco use poses to clients and staff. The tobacco-free wellness policy is most effective when created in consultation with members of staff and clients. It will acknowledge the right of employees to work in a tobacco-free environment and to not subject clients, or anyone else, to second hand smoke.

*See Appendix G: Model Tobacco-Free Policy*

## THERE ARE A NUMBER OF COMMON CONSIDERATIONS WHEN WRITING A TOBACCO-FREE POLICY:

**Understanding your state's tobacco-free policies for mental health and substance use facilities**

As of March 15, 2020, eleven (11) states require tobacco-free grounds for most mental health facilities. Five (5) states require tobacco-free grounds for most substance use facilities. You can find a detailed summary of these laws at: **https://www.publichealthlawcenter.org/sites/default/files/resources/Tobacco-Free-State-Policies-Mental-Health-Substance-Use-Facilities.pdf**

**Determining the reach of tobacco-free areas**
It is recommended that all indoor and outdoor facility areas be tobacco-free, if possible. For those facilities that allow clients to leave the premises, a 100% tobacco-free environment is the healthiest and most easily-enforced policy.

**Revision of human resources policy**
It is recommended that human resources policies are revised to reflect the tobacco-free policy. Dress code (scent of smoke) issues can be included in policy changes. For example, if employees come to work smelling strongly of smoke, they would be considered in violation of the tobacco-free policy.

**Provision of cessation medications**
Sites should offer or facilitate access to nicotine replacement therapy (NRT) or other FDA-approved cessation medications and behavioral counseling to clients and staff members who require assistance refraining from smoking while onsite. This assistance should begin at least one month before the tobacco-free policy goes into effect and last at least 3 months post implementation, if not longer. Your facility's Human Resources department should communicate to staff about cessation medication benefits offered by their health insurance plans. TIP: Using terms that are more familiar to behavioral health clinicians can help encourage tobacco dependence treatment. NRT is similar to MAT (medication-assisted treatment).

5

**Step 5: Clearly Communicate Your Intentions.** Inform employees and clients of the tobacco-free policy timeline as early as possible. Tobacco users will need time to get used to the idea of a tobacco-free campus. Tobacco users who want to quit will also be more successful if they have time to adjust and potentially begin to prepare for this significant life change.

*See Appendix H: Sample Announcement*
*See Appendix I: Sample Letter to Clients*

## ANSWERING QUESTIONS

As you eliminate tobacco use to foster wellness and recovery, engage staff, consumers, family members, and people in your community in discussion. Listen. Address concerns. Collaborate with partners.

*See Appendix J: NASMHPD Internal Memo & FAQ*

**Communication and support will assist in alleviating anxieties. It is vital to reinforce the reason for introducing the policy. Be transparent and consistent in your messaging. It is helpful if agency leadership can provide employees with information about other community health settings, hospitals, and businesses in the area that have successfully gone tobacco-free. Indeed, evidence has shown that becoming a tobacco-free facility does not deter patients from seeking or staying in treatment.**

Staff may raise concerns regarding how agency clients will react, but in practice, staff members often have as much or more difficulty adjusting to tobacco-free policies. The initiative's leaders must be prepared to speak to the most common concerns described in Step 10 below.

Solicit, listen to, and respond to employee concerns. Allow employees and managers time to express concerns and prepare for changes. Hold discussions with individuals, groups, departments and the public, emphasizing how an addiction to tobacco impacts health, safety and recovery from behavioral health conditions. Separate town hall meetings with clients and staff will allow individuals to express themselves and provide an opportunity for leadership to fully describe the rationale for a tobacco-free initiative. During this process, suggestions can be gathered on how to make this transition most effective.

## PRACTICE A "TOBACCO-FREE DAY"

Before the policy goes into effect, have a well-advertised day for clients, staff and visitors to practice being in a tobacco-free environment. Provide information on why a tobacco-free environment is good for everyone and resources for quitting. Incorporate other healthy-living activities like physical activities and cooking classes.

### NO SMOKING ON SHIFTS

*"On our smoke free and tobacco free site, we strive to provide a tobacco free environment for our clients, staff, and visitors. All employees are required to be tobacco free while at work, during any scheduled work shift (including all breaks) whether on or off site."*

## CONSIDER MANY DIFFERENT MEANS FOR GETTING THE MESSAGE OUT, INCLUDING:

- Internet, Intranet
- Pay check messages
- Signage (especially in areas where smokers congregate)
- Letter from CEO, President, or Chief Medical Officer
- Letters to staff
- Pamphlets for staff
- Pamphlets for clients
- Notice boards
- Posters and banners in and outside the building, on shuttles between buildings
- Appointment card announcements
- A prominently displayed countdown to the kick-off day
- With client's case workers

Inform your neighbors. Potential problems with neighbors need to be anticipated. For example, cigarette butts, litter, and loitering have fueled neighborhood ire when organizations go tobacco-free. Reach out to neighborhood residents and businesses before there is a problem. Take the same steps in working with the neighbors as you have with employees: Explain your rationale and provide plenty of notice. Offer a personal contact should neighbors have concerns. You may even want to invite neighbors to the kick-off celebration or award prizes purchased from neighboring businesses.

*See Appendix K: Sample Letter to Neighbors*

Inform Outside Providers, Agencies and county social service referral. Other community providers can be key partners helping reinforce a tobacco-free message. For example, they can be asked to tell prospective clients of your agency's tobacco-use policy.


## HERE IS A LIST OF POTENTIAL AGENCIES TO CONSIDER NOTIFYING:

- Mental health and addictions agencies
- Primary care clinics
- Criminal justice settings (e.g., community corrections)
- Public health/county agencies
- School systems
- Mayor's Office
- Insurance companies
- State or county Medicaid office
- Homeless shelters



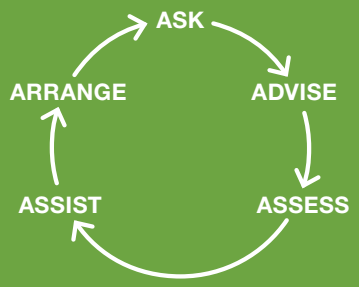
**Step 6: Educate Staff and Clients.** Offer educational events for staff and clients. Staff should be encouraged to learn more about tobacco cessation through continuing education and supervision. Such training should include:

- The association between mental illnesses, substance use and tobacco dependence
- Evidence based pharmacotherapy and counseling for tobacco cessation
- Brief screening and assessment tools
- Practical strategies for inclusion of tobacco cessation into treatment planning
- Community referral resources

There are a number of resources to assist agencies in accomplishing training goals. The Resources section at the end of this toolkit refers to relevant content. We also encourage you to visit the Behavioral Health section of our website at **https://smokingcessationleadership.ucsf.edu/behavioral-health** or call us toll-free at **1-(877)509-3786**.

Tobacco cessation leads to a 25% increase in long-term abstinence[2]

Tobacco cessation equals the positive mood affect of an anti depressant[3]




## IF YOU HAVE LIMITED TIME:

**ASK → ADVISE → REFER**

Free services for smokers who want to quit are available at **SMOKEFREE.GOV** and **1-800-QUIT-NOW (1-800-784-8669).**

Regardless of patients' stage of readiness for cessation attempts, staff should be trained to utilize the "5 A's" (Ask, Advise, Assess, Assist and Arrange). Similar to SBIRT (Screening Brief Intervention and Referral to Treatment), clinicians are encouraged to "Ask" all patients at every visit if they smoke. If they do smoke the clinician should "Advise" them in a personalized manner to quit. Providers are then directed to "Assess" patients' willingness to make quit attempts over the next month, "Assist" in setting quit dates and obtaining services (e.g., Quitline, agency groups), and "Arrange" for follow-up contacts to determine if quit attempts were successful.

For agencies that lack the necessary resources to perform the "5 A's", an abbreviated model may be used which is referred to as "AAR". In this model, providers "Ask" all patients if they use tobacco, "Advise" tobacco users to quit through personalized messages, and then "Refer" tobacco users to appropriate community cessation services (including Quitlines).

7

**Step 7: Provide Tobacco Cessation Services.** Agencies that are going tobacco-free should provide counseling opportunities and tobacco cessation medication to both staff and clients. Nicotine dependence is a chronic, relapsing disorder often requiring multiple attempts before individuals quit for good. Only 4-7% of unaided quit attempts are successful, but proven treatments exist that significantly enhance those odds. Combining counseling and nicotine replacement therapy (NRT) or other FDA-approved smoking cessation medications is the most effective option. Staff and clients will need these cessation aids to prevent or alleviate withdrawal symptoms while at work.

## TOBACCO RAPID IMPROVEMENT ACTIVITIES

Meet to assess strategies for integrating tobacco screening, assessment, treatment, and referral into policies and procedures. Here are common steps that a policy committee or organization can take:

- Include tobacco use and cessation questions on intake and assessment forms
- For medical personnel, add tobacco-use status to vital signs at every visit
- Add chart stickers documenting tobacco usage
- Create a policy that tobacco usage must be included in treatment planning
- Consider wellness incentives for employees and clients

*See Appendix L: Tobacco Use Assessment (TUA)*

## TOBACCO CESSATION COUNSELING

Effective tobacco cessation counseling includes individual, group, and telephone sessions. Regardless of the treatment modality, the Stages of Change Model can be utilized to gauge individuals' readiness for treatment. In this model, motivational interviewing allows providers to tailor interventions to shifting stages of change, and assists patients to become autonomously motivated and competent to make cessation attempts.[38, 39]

Individual or group treatment should include practical counseling (e.g., problem solving, skills training), and social support.[40] Cognitive behavioral therapy (CBT) will also help accomplish reduction and cessation goals by changing the dysfunctional thoughts, emotions, and behaviors that often accompany tobacco dependence.

Be prepared to address and support clients' reasons and motivations for quitting. Have materials to provide to clients that make the case for the importance of cessation.

*See Appendix O for Substance Abuse and Mental Health Services (SAMHSA) flier on Benefits and Tips of Quitting for Good*

**The Financial Benefits of Quitting**
Along with improving physical and mental health, quitting smoking can improve one's financial health. Use the cost calculator link at https://smokefree.gov/quit-smoking/why-you-should-quit/how-much-will-you-save to help clients figure out how much money they can save by quitting.

**Quitting for Good**
A general rule regarding smoking cessation efforts is that more is better, and the behavioral health population is a case in point. More intensive treatment frequency and longer duration of treatment improve quit rates.

## QUITLINES

Quitllines are a tobacco cessation resource with demonstrated effectiveness, doubling a smoker's chances of quitting successfully. These telephonic services are widely available to all tobacco users in the U.S. and Canada, and community organizations should readily utilize them.[41, 42] Quitlines generally offer some combination of counseling and cessation medications. This video on the CDC website (**https://www.youtube.com/watch?v=vqLroNoGTrc**) demonstrates what happens when someone calls a quitline.

**1-800-QUIT-NOW** (also at **https://smokefree.gov**) is a toll-free number operated by the National Cancer Institute (NCI) that will connect you directly to your state's tobacco quitline Some states' helplines offer tailored services for the behavioral health population and offer to providers and clients bi-directional services using clients' electronic health records.

**TAKE CHARGE**

Call for FREE help to quit smoking

**1-800-QUIT-NOW (1-800-784-8669)**

The CDC has a number of free materials available for organizations at: **https://www.cdc.gov/tobacco/quit smoking/cessation/index.htm**

Order free Quit Cards on the SCLC site under Resources at: **https://smokingcessationleadership.ucsf.edu/1-800-quit-now-cards**



## THE POWER OF PEERS

Peer-to-Peer programs have become a central feature of the recovery movement. Over the past several decades, there have been a growing number of programs, incorporating clients as peer specialists and educators. The shared lived experiences among peers and the ability to relate is a very powerful tool in the public treatment community. Peer support has proven to be a part of successful interventions by reducing hospitalizations, diminishing exacerbations of symptoms, as well as increasing treatment compliance and coping skills for persons with behavioral health conditions. Forty-eight states have certification programs and include peers as part of their Medicaid behavioral health network. **Learn more about the role peers can play in recovery treatment on the SAMHSA site** [43, 44]

**Nicotine Anonymous**, a self-described fellowship offering group support, and the CDC's Tips from Former **Smokers campaign**, both make use of the effectiveness of peer support in quitting tobacco.

**CASE STUDY:** Smoking Cessation in Persons with Serious Mental Illnesses: The Experience of Successful Quitters, Baltimore MD

In-depth interviews with 78 people with serious mental illness who had successfully quit tobacco use indicate that persons with serious mental illnesses are able to successfully quit smoking despite extensive histories of heavy smoking. Importantly, former smokers living with mental illnesses indicated a willingness to be involved in helping others quit, and should be utilized in formal smoking cessation efforts aimed at their peers.

Source: Dickerson F, Bennett M, Dixon L, Burke E, Vaughan C, Delahanty J, DiClemente C. Smoking cessation in persons with serious mental illnesses: The experience of successful quitters. *Psychiatric Rehabilitation Journal.* 2011;34:311–316. **http://dx.doi.org/10.2975/34.4.2011.311.316**.

# PEER-TO-PEER TOBACCO DEPENDENCE RESOURCES

**Rx for Change: Tobacco-free for Recovery Peer-to-Peer online training.** This online training provides valuable information on key terms and definitions related to tobacco use, why it is important to quit smoking, the different types of tobacco products and why they are addictive, what helps people to quit smoking, and how to help people quit. The Rx series offers online videos, trigger tapes, and train the trainer facilitator notes. While this online curriculum is tailored to meet the needs of mental health peer counselors, it is a helpful training tool for any provider or advocate interested in learning more about mental health and smoking cessation. Rx for Change and the other Rx online series is available for free via its website (**https://rxforchange.ucsf.edu/**), where registered users can download the curriculum, trigger tapes, handouts, and brief videos.

**CHOICES – Consumers Helping Others Improve their Condition by Ending Smoking.** This curriculum has been in use in mental health treatment facilities since 2004. The treatment approach supports a focus on wellness and recovery within the behavioral health field. **The Learning About Healthy Living (LAHL) manual** is available publically. **https://rwjms.rutgers.edu/images/Departments/Psychiatry/Addiction%20Psychiatry/2012lahl.pdf**

**The DIMENSIONS Peer-to-Peer Tobacco Recovery Program.** This program provides existing or emerging peer specialists with training on how to effectively incorporate tobacco cessation treatment within their scope of practice. The program gives peer specialists the skills necessary to:

- Conduct one on one motivational interviews
- Run tobacco cessation support groups
- Provide internal and external referrals to tobacco cessation services
- Raise awareness through agency and community trainings

The University of Colorado Denver Behavioral Health & Wellness Program website (**https://www.bhwellness.org/**) can provide additional information regarding this program

## TOBACCO CESSATION MEDICATIONS

A variety of medications have been identified as effective in helping people to stop using tobacco. Medications demonstrated to be safe and effective for tobacco dependence treatment and that are Food and Drug Administration (FDA) approved include:

- Nicotine replacement therapies (NRT) include patches, gum, and lozenges (over-the-counter medications). Inhalers and nasal spray are only available by prescription.
- Bupropion SR (Wellbutrin, Zyban) was the first non-nicotine medication shown to be effective for smoking cessation and was approved by the FDA for that use in 1997.
- Varenicline (Chantix) is a medication that blocks nicotine receptors and was approved by the FDA for the treatment of tobacco dependence in 2006.

Recent research supports that combinations of the above are often most effective. For instance, it is common to use the NRT patch combined with nicotine gum to control cravings.

*To learn more about tobacco cessation medications, please see download Pharmacologic Product Guide: FDA-Approved Medications for Smoking Cessation from the SCLC website at* ***http://tinyurl.com/bdht7xy4****.*

*To learn more about* ***Funding/Reimbursement for Tobacco Cessation Services*** *and the* ***Behavioral Health addendum*** *please see Appendices M or download the pdfs at* ***https://www.lung.org/getmedia/08ed3536-6bab-48a6-a4e4-e6dbccaea024/billing-guide-for-tobacco-1.pdf.pdf*** *and* ***https://smokingcessationleadership.ucsf.edu/sites/smokingcessationleadership.ucsf.edu/files/Documents/FactSheets/billing-guide-addendum-for_0.pdf***

8

**Step 8: Build Community Support.** Garner support from local and state health departments and tobacco-free coalitions. They are often able to provide resources, including signage, technical assistance, and educational materials in multiple languages that can be used when engaging the community.

There are a variety of national events that can be used to showcase local initiatives such as:

- The Great American Smoke Out on the 3rd Thursday of every November:
- **https://www.cancer.org/healthy/stay-away-from-tobacco/great-american-smokeout.html**
- Mental Health Awareness (May) **https://www.nami.org/Get-Involved/Awareness-Events/Mental-Health-Awareness-Month**
- No Menthol Sunday in mid-May each year: **https://www.nomentholsunday.org/**
- World No Tobacco Day on May 31st each year: **http://www.who.int/tobacco/wntd/en/**
- National Recovery Month (September) **https://www.samhsa.gov/recovery-month**
- National Addiction Treatment Week (October) **http://treataddictionsavelives.org/**

**Step 9: Launch the Policy.** Before the policy implementation date, ensure that all needed agency and campus signage is posted. Your local and state health department will be an invaluable resource in providing direction. Signage should be placed at building entrances and in key locations around the property perimeter, particularly where staff and clients congregate to smoke. Signage should also be in the different languages representing your clients. 9

*See Appendix N: Sample Signage*

Visitors will need to be informed both directly and indirectly about the new tobacco-free policy. Staff will appreciate cards or brochures they can give to a client, visitor, or co-worker who is violating the tobacco-free policy. These usually include a message about the policy with information about how to quit, including the Quitline phone number. Subtle messages include removal of smoking shelters and cigarette receptacles. These areas can be turned into recreational spaces or serenity gardens.

On the day of the policy implementation, hold a kick-off event to celebrate the tobacco-free policy and your organization's commitment to wellness. Invite community partners and local media to cover the event.

**Step 10: Monitor the Policy and Respond to Challenges.** Anticipate negative reactions by some staff and clients. 10

Staff members may express concerns that the policy will have a negative impact on the organization. Staff may cite smoking as a means to establish a therapeutic relationship with patients or to reward desired behavior. Studies show that smoking bans do not increase aggression, use of seclusion, discharge against medical advice, or use of as-needed medication.

Staff may also report that they do not want to be responsible for "policing" clients, visitors, and co-workers. Agency leadership must make it clear that it is everyone's job to create a healthy work environment, which includes respectfully enforcing the policy. Staff should not be confrontational, but should provide information regarding the policy, and information about how to quit, and then inform the relevant agency personnel or treatment teams if individuals refuse to comply with the policy. If a violation poses a risk, security or police should be notified.

## SAMPLE SCRIPT

**Addressing a visitor:** *Hello, I wanted to let you know that we are a Smoke and Tobacco free campus and I'm going to have to ask you to put out your cigarette or please move off campus to smoke. We appreciate your cooperation.*

**Addressing an employee:** *As a reminder staff must be completely tobacco free during work shifts including breaks. You are not required to quit tobacco use, but quitting is one of the most important steps you can take to improve your health. I have a resource with information on smoking cessation if you're interested in learning more.*

| POTENTIAL CHALLENGE | RECOMMENDATION |
|---|---|
| Overcoming resistance of staff | ■ Offer education surrounding tobacco and tobacco-free environments to ease resistance to policy implementation |
| Managing residences and businesses within the catchment area | ■ Involve neighboring businesses and homes throughout the implementation process<br>■ Have a representative speak at a homeowner's association meeting and talk with local business owners<br>■ Open the lines of communication early on in the process in order to maintain good relations in the community |
| Addressing staff's "right" to smoke | ■ Include staff in the written policy and have representative from Human Resources assist with drafting this section in the policy<br>■ Educate staff on state laws regarding smoking indoors (many states have a Clean Indoor Air Act in effect) |
| Individuals in short and long term residential healthcare facilities argue for the right to use tobacco in what they consider to be "home" | ■ Acknowledge that it is difficult to quit tobacco. At the same time, it is the responsibility of the agency to promote a healthy environment free of environmental tobacco exposure<br>■ Provide access to both cessation counseling and medications |

## CLIENT VIOLATIONS

Clients who continually break agency rules should be subject to consequences, with the ultimate sanction being to no longer receive agency services. However, **it is preferable for the treatment team to first attempt to address infractions as a component of treatment**. Tobacco use can often be tied to other substance abuse and dependence. Tobacco policy infractions are an example of addictive behavior that exemplifies the life consequences individuals will endure to maintain an addiction. Inappropriate responses to the policy may also suggest the need for a client's skill development in the areas of healthy coping strategies and effective communication.

## EMPLOYEE VIOLATIONS

Staff members who violate the tobacco-free policy should be subject to disciplinary action, up to and including termination. The tobacco-free policy, employee handbook, hiring paperwork, and new employee orientation can all clearly refer to progressive disciplinary actions. Offering tobacco cessation services and nicotine replacement therapy before and after the campus policy takes effect can discourage these violations before they happen.

| VIOLATION | ACTION |
|---|---|
| First | Verbal Coaching |
| Second | Written Warning |
| Third | Suspension |
| Fourth | Termination |

## EVALUATE IMPACT

Throughout the first months and/or years of the policy, it is important to keep statistics on violations, complaints, and client and staff quit attempts to evaluate the impact of the policy. If possible, it is recommended that an external, independent evaluator/planner create and execute this data collection and evaluation. This evaluation should also include client and staff feedback about the policy collected through surveys and/or interviews and focus groups.

If hiring an outside evaluator is not an option, consider a series of campus clean-up-type events pre- and post-policy implementation. Groups can collect cigarette butts and compare the number of discarded cigarettes to get a sense of smoking rates before and after policy implementation. There should be fewer butts after the policy has been implemented.

This type of tracking event can also be held in conjunction with Earth Day or another environmental awareness observance since cigarette filters are made from cellulose acetate, a plastic that typically does not biodegrade. There are studies showing that chemicals seeping into aquatic ecosystems from cigarette butts can become toxic to fish and microorganisms.[45]

# PART 5

## Promoting Wellness

Wellness means overall well-being. It includes the mental, emotional, physical, occupational, intellectual, and spiritual aspects of a person's life.[46] Promoting a tobacco-free environment and cessation resources is an opportunity to also focus on the general wellness of clients and staff. Many believe tobacco use relieves stress or helps control weight, and these may be real concerns for those who are smoking but want to quit. Listening and recording, with no judgement, these feelings and concerns can help develop alternate activities and support. These activities will likely add to the overall wellness of all clients and staff. Many clients use smoke breaks as a time to bond with one another and to take a break from the routine and work of their day. Therefore, it is important to provide ample alternative healthy opportunities for clients to connect socially. It is also important to use inclusive and affirming language (language that is inclusive of the experiences of people of differing abilities, genders, sexualities, races and spiritualities) that recognizes the need to take time and care for oneself.

## DE-STRESSING WITHOUT TOBACCO

As mentioned, the nicotine in cigarettes creates a chemical reaction in the brain. For many people who have quit, stress is often a trigger for smoking and a reason for relapse. Techniques to relieve stress can be taught and employed so that quitters have other options for stress management. It IS possible; clients and staff can re-learn how to relax without tobacco.

**Clean Air/Self-Care Break:** Smokers often look forward to smoke breaks as time to not only smoke but to take time for themselves, away from work. Reframing smokebreaks as clean air breaks or self-care breaks can replace this time and allow the quitter to walk around the block or campus, work in the garden, on an art project, or write in their journal,etc. These breaks are a great way to de-stress in a healthy way.

### CLEAN AIR BREAK

Don't forget to have plenty of indoor activities to replace smoke breaks too like mindfulness exercises, stretching or nutrition breaks.

**Yoga:** Yoga combines physical postures, breathing exercises, and meditation. Current research suggests that a carefully adapted set of yoga poses may reduce low-back pain and improve function. Other studies also suggest that practicing yoga (as well as other forms of regular exercise) might improve quality of life; reduce stress; lower heart rate and blood pressure; help relieve anxiety, depression, and insomnia; and improve overall physical fitness, strength, and flexibility.[47]

**Meditation:** Meditation is a mind and body practice that has a long history of use for increasing calmness and physical relaxation. There are many types of meditation, but most have four elements in common: a quiet location with as few distractions as possible; a specific, comfortable posture (sitting, lying down, walking, or in other positions); a focus of attention (a specially chosen word or set of words, an object, or the sensations of the breath); and an open attitude (letting distractions come and go naturally without judging them).
Many studies have been conducted to look at how meditation may be helpful for a variety of conditions, such as high blood pressure, certain psychological disorders, and pain, though evidence about its effectiveness for smoking cessation is at this time uncertain.[48]

**Gardening:** Therapeutic benefits of garden environments have been documented in ongoing research. Gardening can help to lower stress, boost self-confidence, build teamwork, and foster perseverance. Learning to care for living things assists individuals in treatment with creating a renewed sense of purpose and self-worth. Gardening is a healthy outlet that builds patience and offers an opportunity to develop community and interconnectedness.[49] The rewards are both immediate and long term, as one sees the plants and garden develop and change with the seasons. Growing fruits, vegetables and herbs can provide an opportunity to incorporate nutrition education.

**CASE STUDY:** Alcoholism Center for Women Institutes a Tobacco-Free Campus and Gardening Therapy Program in Los Angeles, CA

In 2018, Alcoholism Center For Women (ACW) received a grant to implement the project, "Initiative to Reduce Tobacco-Related Disparities at Residential Behavioral Health Facilities." During a period of 15 months, ACW reduced smoking breaks from 3 to 1, eventually going entirely smoke-free by January 1, 2020. In addition to a Tobacco-Free policy, ACW implemented tobacco-use identification and treatment protocols, invested in Nicotine Replacement Therapy, and expanded wellness policies. Prior to creating a tobacco-free campus, ACW had a nutrition program, trauma-informed yoga classes and music therapy. Garden therapy was recently added and has become an integral component of the program, allowing clients to embrace the importance of nature in their recovery and has helped clients reduce the burden of their tobacco cravings.

## WEIGHT MANAGEMENT

More than 80% of people with serious mental illnesses are overweight or obese — a major factor that helps lead to a death rate 3 times that of the overall population. Factors that contribute to obesity include unhealthy eating habits and lack of physical activity. Adding to these challenges, people with serious mental illnesses may have impairments in memory and mental processes that make it more difficult for them to learn and adopt new weight loss behaviors such as counting calories.[50]

Medications to help control mental illness symptoms can increase appetite and lead to weight gain. On the other hand, the ingredients in tobacco smoke—but not the nicotine—activate liver enzymes that increase the breakdown of many medications used to treat mental illnesses. They also work to shorten the half-life of caffeine. Thus, when people on these medications stop smoking, they can reduce the dose of these drugs, thereby also reducing unwanted medication side effects, including weight gain.

### Healthy Eating

The most effective way to manage weight is through healthy eating:

- Emphasizes fruits, vegetables, whole grains, and fat-free or low-fat milk and milk products
- Includes lean meats, poultry, fish, beans, eggs, and nuts
- Is low in saturated fats, trans fats, cholesterol, salt (sodium), and added sugars
- Stays within your daily calorie needs. Most adults need about 2000 calories per day to maintain their current weight.[51]

One of the best ways of managing the contents of what you eat is to cook your own meals. This can also be a fun and relaxing activity. If the facility has a community garden for clients, gardening and growing food can be incorporated into planning and preparing delicious and nutritious meals. The possibilities for creativity and fun are endless.

To live healthier, longer lives, most people need to get fewer calories from added sugars. Sugar-sweetened beverages (SSBs) or sugary drinks are leading sources of added sugars in the American diet. SSBs include regular soda (not sugar-free), fruit drinks, sports drinks, energy drinks, sweetened waters, and coffee and tea beverages with added sugars. Frequently drinking sugar-sweetened beverages is associated with weight gain/obesity, type 2 diabetes, heart disease[52], kidney diseases, non-alcoholic liver disease[53], tooth decay and cavities[54]. As a part of a healthy eating plan, it is a crucial to limit or eliminate altogether the consumption of SSBs.

It is a good idea to encourage SSBs be replaced with water, and inventive ways of drinking water can be found. For example, adding fruit to water and experimenting with flavor combinations in fruit-infused water is fun and delicious.

For additional resources on the importance of good nutrition in overall health, you may consider investigating the Center for Nutrition Policy and Promotion (CNPP), created within the U.S. Department of Agriculture in 1994. CNPP's mission is to improve the health of Americans by developing and communicating dietary guidance based on scientific research.The staff at CNPP is composed primarily of nutritionists – many of whom are Registered Dieticians. CNPP's Office of Nutrition Marketing and Communications has developed and manages the following websites that may be helpful for you:

**https://www.myplate.gov/** **https://dietaryguidelines.gov/** **https://nesr.usda.gov/**

### Active Living

Regular physical activity helps improve overall health and fitness, and reduces risk for many chronic diseases.[55] Physical activity is also fun and helps relieve stress, anxiety and depression. Exercise is good medicine, and there are plenty of ways to be fit – find physical activity that you love to do.

## ACTIVE LIVING

In order to get important health benefits from exercise, adults should do both aerobic exercise and weight training.[56] Adults need at least:

**WEEKLY AEROBIC EXERCISE:**

| | | | | |
|---|---|---|---|---|
| 2 hours and 30 minutes (150 minutes) of moderate intensity aerobic activity (i.e., brisk walking) | or | 1 hour and 15 minutes (75 minutes) of vigorous intensity aerobic activity (i.e., jogging or running) | or | An equivalent mix of moderate and vigorous-intensity aerobic activity |

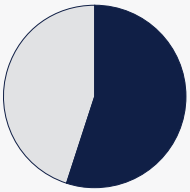
**WEEKLY WEIGHT TRAINING:**

Weight training muscle strengthening activities on 2 or more days a week that work all major muscle groups (legs, hips, back, abdomen, chest, shoulders, and arms).

*Keep in mind, some physical activity is better than none, and adults who participate in any amount of physical activity gain some health benefits.*

## ADDRESSING GAMBLING DISORDER

Studies have shown that prevalence rates of tobacco dependence among problem gamblers are between 41-60%, making tobacco dependence the most common comorbid disorder among problem gamblers.[57] Problem gambling, or Gambling Disorder, like tobacco dependency is an addiction.



**55%**

**55% of clients in gambling treatment programs reported that they SMOKE TOBACCO**

**Gambling Disorder can lead to problems with finances, relationships and work, not to mention potential legal issues. People with gambling disorder often hide their behavior. They may lie to family members and others to cover up their behavior and may turn to others for help with financial problems. Some gamblers are seeking excitement or action in gambling, others are looking more for escape or numbing.[58]**

While many people gamble responsibly, individuals already diagnosed with addictions may be at-risk for problem gambling. Providing gambling related activities within a facility, such as bingo night or raffles, could cause triggers for disordered gamblers, and some individuals have been known to trade addictions (stop drinking, but start gambling).

## SCREEN FOR GAMBLING DISORDER

As with other addictions, steps can be taken to treat the gambler. Therapies for gamblers run the gamut from intensive treatments to group-based recovery, including cognitive behavioral therapy treatment.

**BRIEF Bio Social Gambling Screen:**

**1.** During the past 12 months, have you become restless, irritable or anxious when trying to stop/cut down gambling?

**2**. During the past 12 months, have you tried to keep family or friends from knowing how much you gambled?

**3**. During the past 12 months, did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends or welfare?

A POSITIVE RESPONSE to any of the 3 questions suggest a person may be at risk for problem gambling.

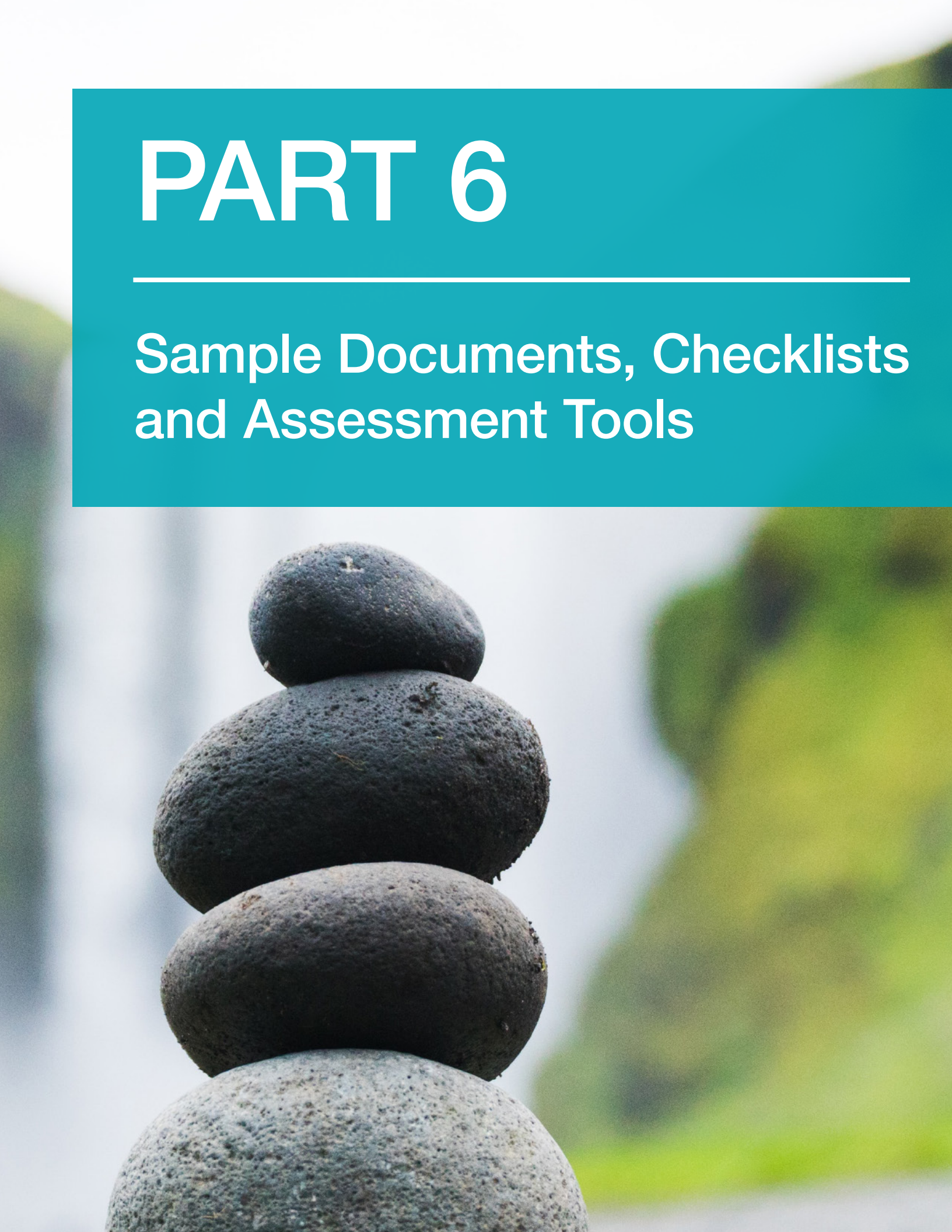
**No cost, confidential help is available 24/7. To access local resources, call the National Problem Gambling Helpline at 1-800-522-4700.**

**Use these items to guide in providing a healthy environment for disordered gamblers and those who are at-risk of developing a problem:**

- Understand what gambling is: prize, chance, consideration
- Refrain from providing lottery tickets or raffle tickets as a prize or an incentive
- Watch for lottery scratchers or tickets in waste baskets
- Promote free, healthy free time activities including exercise, meditation and board games rather than gambling related activities such as: casino or bingo night, gambling venue field trip or sports pools
- Be aware of gambling related materials: poker chips, dice, games or movies that are gambling related
- Listen – when individuals are pre occupied with gambling (free time is filled with trips to casinos, watching gambling related movies, talking about gambling activities) they may be at risk of problem gambling

# PART 6

## Sample Documents, Checklists and Assessment Tools



# RESOURCES

**Smoking Cessation Leadership Center**

**Substance Abuse and Mental Health Services Administration's (SAMHSA)
National Center of Excellence for Tobacco-Free Recovery**

toll-free 1-877-509-3786

http://smokingcessationleadership.ucsf.edu

The Smoking Cessation Leadership Center provides free technical assistance and the latest news and information on tobacco control, as well as links to online webinars and healthcare provider resources for helping patients quit smoking.

**American Cancer Society**

http://www.cancer.org

American Cancer Society provides a comprehensive Guide to Quitting Smoking, which reviews medications available and provides tips for successful quit attempts.

**American Lung Association**

http://www.lungusa.org

In addition to cessation information and education provided on the website, the American Lung Association hosts Freedom from Smoking Online, a web-based cessation program that provides an online support community and expert help.

**Americans for Non-Smokers' Rights**

http://www.no-smoke.org

This website is a great resource for model tobacco-free policy language, and a comprehensive list of smoke-free businesses.

**Behavioral Health and Wellness Program, University of Colorado Denver**

http://www.bhwellness.org

The Behavioral Health and Wellness Program provides training and technical assistance regarding organizational change, policy implementation, and integrating cessation services into behavioral health treatment. Free reports and literature for implementing tobacco-free policies are available.

**Case studies**

Promising Policies And Practices To Address Tobacco Use By Persons With Mental And Substance Use Disorders

https://www.cdc.gov/tobacco/disparities/promising-policies-and-practices/pdfs/osh-behavioral-health-promising-practices-20160709-p.pdf

**Centers for Disease Control and Prevention**

http://www.cdc.gov/tobacco

The Centers for Disease Control and Prevention offers comprehensive smoking cessation materials and links to state and community resources.

**The Center for Tobacco Cessation**

https://www.nobutts.org/free-training

The Center for Tobacco Cessation (CTC) is the training and technical arm of the California Smokers' Helpline. CTC helps organizations throughout California to increase their capacity in tobacco cessation. The Center offers webinars, online courses, toolkits, training and technical assistance.

**Cessation Treatment for the Behavioral Health Population**

The Substance Abuse and Mental Health Services Administration's website:

https://www.integration.samhsa.gov/health-wellness/wellness-strategies/tobacco-cessation-2

**National Association of State Mental Health Program Directors**

http://www.nasmhpd.org

NASMHPD has developed a series of policy and research reports including a toolkit for "Tobacco-Free Living in Psychiatric Settings."

**Partnership for Prevention**

http://www.prevent.org

Resources are available for establishing smoke-free policies in indoor worksites and public places.

**Public Health Law Center**

https://www.publichealthlawcenter.org/

Offers resources on legal and policy issues that health leaders and policymakers can use to control the epidemic of commercial tobacco use.

**Tobacco Recovery Resource Exchange**

https://tobaccorecovery.oasas.ny.gov/

Developed for behavioral health and addiction treatment organizations, the Tobacco Recovery Resource Exchange provides online training, manuals, and toolkits for integrating tobacco treatment and implementing tobacco-free policies.

## APPENDIX A: DRUG INTERACTIONS WITH TOBACCO SMOKE

Smoking Cessation Leadership Center
UCSF
University of California San Francisco

# Drug Interactions with Tobacco Smoke

Many interactions between tobacco smoke and medications have been identified. Note that in most cases it is the tobacco smoke—not the nicotine—that causes these drug interactions. Tobacco smoke interacts with medications by influencing the absorption, distribution, metabolism, or elimination of other drugs, potentially causing an altered pharmacologic response. Because of these interactions, smokers may require higher doses of medications. Upon cessation, dose reductions might be needed. The most clinically significant interactions are depicted in the shaded rows.

| Drug/Class | Mechanism of Interaction and Effects |
|---|---|
| **Pharmacokinetic Interactions** | |
| Alprazolam (Xanax) | • Conflicting data on significance, but possible ↓ plasma concentrations (up to 50%); ↓ half-life (35%). |
| Bendamustine (Treanda) | • Metabolized by CYP1A2. Manufacturer recommends using with caution in smokers due to likely ↓ bendamustine concentrations, with ↑ concentrations of its two active metabolites. |
| Caffeine | • Metabolism (induction of CYP1A2); ↑ clearance (56%). Caffeine levels likely ↑ after cessation. |
| Chlorpromazine (Thorazine) | • ↓ Area under the curve (AUC) (36%) and serum concentrations (24%).<br>• ↓ Sedation and hypotension possible in smokers; smokers may require ↑ dosages. |
| Clopidogrel (Plavix) | • ↑ Metabolism (induction of CYP1A2) of clopidogrel to its active metabolite.<br>• Clopidogrel's effects are enhanced in smokers (≥10 cigarettes/day): significant ↑ platelet inhibition, ↓ platelet aggregation; improved clinical outcomes have been shown (smokers' paradox; may be dependent on CYP1A2 genotype); tobacco cessation should still be recommended in at-risk populations needing clopidogrel. |
| Clozapine (Clozaril) | • ↑ Metabolism (induction of CYP1A2); ↓ plasma concentrations (18%).<br>• ↑ Levels upon cessation may occur; closely monitor drug levels and reduce dose as required to avoid toxicity. |
| Erlotinib (Tarceva) | • ↑ Clearance (24%); ↓ trough serum concentrations (2-fold). |
| Flecainide (Tambocor) | • ↑ Clearance (61%); ↓ trough serum concentrations (25%). Smokers may need ↑ dosages. |
| Fluvoxamine (Luvox) | • ↑ Metabolism (induction of CYP1A2); ↑ clearance (24%); ↓ AUC (31%); ↓ Cmax (32%); ↓ Css (39%).<br>• Dosage modifications not routinely recommended but smokers may need ↑ dosages. |
| Haloperidol (Haldol) | • ↑ Clearance (44%); ↓ serum concentrations (70%); data are inconsistent therefore clinical significance is unclear. |
| Heparin | • Mechanism unknown but ↑ clearance and ↓ half-life are observed. Smoking has prothrombotic effects.<br>• Smokers may need ↑ dosages due to PK and PD interactions. |
| Insulin, subcutaneous | • Possible ↓ insulin absorption secondary to peripheral vasoconstriction; smoking may cause release of endogenous substances that cause insulin resistance.<br>• PK & PD interactions likely not clinically significant; smokers may need ↑ dosages. |
| Irinotecan (Camptosar) | • ↑ Clearance (18%); ↓ serum concentrations of active metabolite, SN-38 (~40%; via induction of glucuronidation); ↓ systemic exposure resulting in lower hematologic toxicity and may reduce efficacy.<br>• Smokers may need ↑ dosages. |

(continued)

| Drug/Class | Mechanism of Interaction and Effects |
|---|---|
| Methadone | • Possible ↑ metabolism (induction of CYP1A2, a minor pathway for methadone).<br>• Carefully monitor response upon cessation. |
| Mexiletine (Mexitil) | • ↑ Clearance (25%; via oxidation and glucuronidation); ↓ half-life (36%). |
| Nintedanib (OFEV®) | • Decreased exposure (21%) in smokers.<br>• No dose adjustment recommended; however, patients should not smoke during use. |
| Olanzapine (Zyprexa) | • ↑ Metabolism (induction of CYP1A2); ↑ clearance (98%); ↓ serum concentrations (12%).<br>• Dosage modifications not routinely recommended but smokers may need ↑ dosages. |
| Pirfenidone (Esbriet®) | • ↑ Metabolism (induction of CYP1A2); ↓ AUC (46%) and ↓ Cmax (68%).<br>• Decreased exposure in smokers might alter efficacy profile. |
| Propranolol (Inderal) | • ↑ Clearance (77%; via side-chain oxidation and glucuronidation). |
| Riociguat (Adempas) | • ↓ Plasma concentrations (by 50-60%).<br>• Smokers may require dosages higher than 2.5 mg three times a day; consider dose reduction upon cessation. |
| Ropinirole (Requip) | • ↓ Cmax (30%) and AUC (38%) in study with patients with restless legs syndrome.<br>• Smokers may need ↑ dosages. |
| Tasimelteon (Hetlioz) | • ↑ Metabolism (induction of CYP1A2); ↓ drug exposure (40%).<br>• Smokers may need ↑ dosages. |
| Theophylline (Theo Dur, etc.) | • ↑ Metabolism (induction of CYP1A2); ↑ clearance (58–100%); ↓ half-life (63%).<br>• Levels should be monitored if smoking is initiated, discontinued, or changed. Maintenance doses are considerably higher in smokers.<br>• ↑ Clearance with second-hand smoke exposure. |
| Tricyclic antidepressants (e.g., imipramine, nortriptyline) | • Possible interaction with tricyclic antidepressants in the direction of ↓ blood levels, but the clinical significance is not established. |
| Tizanidine (Zanaflex) | • ↓ AUC (30-40%) and ↓ half-life (10%) observed in male smokers. |
| Warfarin | • ↑ Metabolism (induction of CYP1A2) of R-enantiomer; however, S-enantiomer is more potent and effect on INR is inconclusive. Consider monitoring INR upon smoking cessation. |
| **Pharmacodynamic Interactions** | |
| Benzodiazepines (diazepam, chlordiazepoxide) | • ↓ Sedation and drowsiness, possibly caused by nicotine stimulation of central nervous system. |
| Beta-blockers | • Less effective antihypertensive and heart rate control effects; possibly caused by nicotine-mediated sympathetic activation.<br>• Smokers may need ↑ dosages. |
| Corticosteroids, inhaled | • Smokers with asthma may have less of a response to inhaled corticosteroids. |
| Hormonal contraceptives | • ↑ Risk of cardiovascular adverse effects (e.g., stroke, myocardial infarction, thromboembolism) in women who smoke and use oral contraceptives. Ortho Evra patch users shown to have 2-fold ↑ risk of venous thromboembolism compared to oral contraceptive users, likely due to ↑ estrogen exposure (60% higher levels).<br>• ↑ Risk with age and with heavy smoking (≥15 cigarettes per day) and is quite marked in women ≥35 years old. |
| Serotonin 5-$HT_1$ receptor agonists (triptans) | This class of drugs may cause coronary vasospasm; caution for use in smokers due to possible unrecognized CAD. |

Adapted and updated, from Zevin S, Benowitz NL. Drug interactions with tobacco smoking. Clin Pharmacokinet 1999;36:425–438, and Kroon LA. Drug interactions with smoking. *Am J Health-Syst Pharm* 2007;64:1917-21



Rx for Change

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## APPENDIX B: HOW QUITTING TOBACCO CAN IMPROVE YOUR MENTAL HEALTH

# How Quitting Tobacco Can Improve Your Mental Health

BREATHE CALIFORNIA
Golden Gate Public Health Partnership

"Approximately **25%** of adults in the U.S. have some form of mental illness or substance use disorder*, and these adults consume almost **40%** of all cigarettes smoked by adults."
(Centers for Disease Control and Prevention)

## 1. Common Myths

- MYTH: "People with mental illnesses and substance use disorders aren't interested in quitting smoking and can't quit."
- FACT: Behavioral health consumers are interested in quitting smoking and can quit successfully.
- MYTH: "Quitting smoking interferes with other treatments for mental illnesses and substance use disorders."
- FACT: Quitting smoking can actually improve mental health and substance recovery.
- MYTH: "Smoking is less harmful than other addictive substances."
- FACT: Heart disease, lung disease, and cancer, all of which can be caused by smoking, are the biggest killers of people with mental health issues.

## 2. How Smoking Can Affect Medications

Chemicals in cigarette smoke can drive psychotropic** medications to leave the body faster.

This process is similar to how the body of people who smoke handles caffeine.

Meet Joe.
Joe drinks coffee to keep going throughout his day.

He also smokes. Recently, he successfully quit smoking.

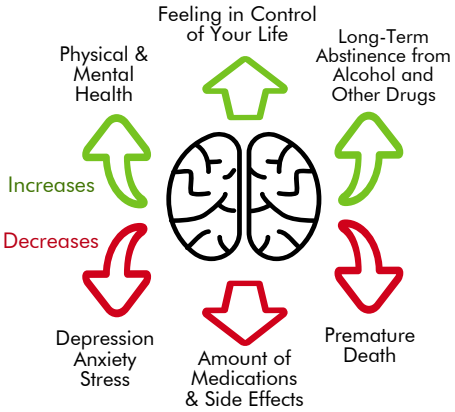
After quitting smoking, Joe still drank a lot of coffee.

He started having headaches and trouble sleeping.
He decided to drink less coffee.

1. Joe's headaches went away and he slept better.
2. He had the same energy, but with less coffee.
3. His health improved from quitting smoking, and he saved more money from having less cofffee.

A similar process can happen with some mental health medications.


## 3. Benefits of Quitting




## 4. If at first you don't succeed, quit, quit again!

- Permanently quitting smoking can take several attempts
- Every attempt increases the chance of successfully quitting smoking
- Use of certain quit-tobacco medications and counseling have been found to be effective
- Behavioral health consumers may have unique challenges when quitting smoking and often benefit from more tailored quit smoking plans

**Tell your healthcare provider if you smoke**

*Mental illness is any diagnosable mental, behavioral, or emotional disorder. Substance use disorder is a dependence on, or abuse of alcohol or illicit drugs. (Substance Abuse and Mental Health Services Administration)

**Psychotropic medications are any medication capable of affecting the mind, emotions, and/or behavior. (MedicineNet)

Breathe California, Golden Gate Public Health Partnership
1 Sutter Street, Suite 225, San Francisco, CA 94104
(650) 994-5868
www.ggbreathe.org

Smoking Cessation Leadership Center

UCSF

University of California San Francisco

# Benefits of Quitting Tobacco for People in Mental Health Recovery

If you are interested in quitting smoking talk with:

Your case manager
Your doctor
A non-smoking friend or sponsor

You can also call:
1800QuitNow

Or

Nicotine Anonymous
1-877-879-6422 toll free

Or

Go Online to:
Becomeanex.org
Smokefree.gov

Or Call These People

## Health

- It is easier to breathe when walking upstairs or running for a bus.
- People have less coughs, colds, and flu. Less risk of severe illness from COVID.
- Skin looks younger.
- Exercising will be easier. When people exercise the brain releases endorphins that make people feel good.
- Health improves. People have fewer symptoms and lower risk of chronic diseases, such as: asthma, heart disease, high blood pressure, Chronic Obstructive Pulmonary Disease (COPD), diabetes and cancer.

## Facts About Tobacco & Mental Illness and Substance Abuse

- The positive mental health impact of quitting tobacco use can be as effective as an anti-depressant.
- Quitting tobacco use can improve the likelihood of long term sobriety from alcohol and other drugs by 25% if addressed at same time as alcohol/drug recovery.
- Tobacco-related diseases are the number 1 cause of death for people with mental illness.
- Tobacco use can trigger cravings and urges to drink and use drugs.
- Tobacco use mimics addiction to other drugs and alcohol. Quitting tobacco is likely to help you stay clean and sober.
- Tobacco/nicotine is as addictive as heroin and cocaine.
- **Smoking interferes with dosage levels of some psychotropic medications requiring higher doses. When you quit you will probably find you'll need less of these medications.**

## Relationships and Socializing

- At first it may seem like quitting is interfering with your personal relationships. Over time that may change.
- Relationships are often better – People are often more available because they are not focused on the next cigarette.
- Clothes and hair and body smell better – Family and friends are more likely to be comfortable around you.
- Friends, family members and pets will not be exposed to harmful secondhand smoke. They are likely to spend more time with you.
- Many people feel less isolated.
- People no longer are held back from socializing in places where smoking isn't allowed. They might even feel like they fit right in.

## My Plan to Quit Smoking–Consider these–add your own Activities

- I'll cut down--set a quit date.
- I'll ask my provider to support me.
- I'll call 1800quitnow.
- I'll get nicotine patches and/or gum.
- I'll get rid of smoking stuff around the house.
- I'll ask non-smoking friends for support.
- I'll go to a group or get counseling.
- I'll change my routines and plan alternative activities–esp. going to places where I can't smoke.
- I'll reduce stress-get more exercise.

## Add your own ideas here:

## LIST Your Reasons for Quitting Smoking

## LIST Triggers to Avoid

## Self Esteem

- People usually feel better about themselves because they have conquered something very challenging in the recovery process.
- People generally feel proud that they were able to quit.
- Friends and family often offer lots of praise for quitting which is heartwarming.
- Health usually improves and people feel better.

## Employment and Housing

- Quitting smoking may increase job opportunities. Many employers don't want to hire people who take breaks often to smoke or smell of smoke.
- Landlords are more likely to rent to non-smokers. Non-smokers tend to be less risk in terms of fire hazard, smoke smell damaging curtains and carpeting, nicotine staining walls. Landlords don't have to worry about drifting secondhand smoke annoying other tenants.
- Non-smokers have an advantage in jobs and housing.

## Finances

- People will have more money to pay bills and buy things such as healthy food, new clothing, a car or electronics.
- And you will have more money for fun, such as going out to movies, gym, restaurants and more.

## Relapse Prevention Once You've Quit Smoking

- Protect yourself from triggers: people, places and things. Avoid falling into old patterns.
- Watch your thoughts and moods. If you are getting negative thoughts, reach out and talk to someone.
- Avoid getting too Hungry, too Angry, too Lonely too Tired, or Bored. (HALT –plus B).
- Carry nicotine gum or lozenges at all times in case of a crisis. Also carry other oral soothers, like regular gum, mints, cinnamon sticks, or suger-free candy.
- Choose a non-smoking sponsor if you're in 12-Step Programs. Choose non-smoking friends to hang out with. Go to places where you can't smoke.
- Check out Nicotine Anonymous if you need more support or have 2-3 non-smoking buddies to call when you're tempted to smoke.

## Healthy Living Activities

- Can help you quit and stay quit.
- Do something physically active every day.
- Follow a healthy food plan.
- Drink plenty of water.
- Breathe deeply.
- Meditate and pray.
- Use coping skills to manage stress.
- Get support from friends and family.
- Be grateful and reward yourself.

# APPENDIX C: THE TOBACCO EPIDEMIC AMONG PEOPLE WITH BEHAVIORAL HEALTH DISORDERS

Smoking Cessation Leadership Center
UCSF
University of California San Francisco

## The Tobacco Epidemic Among People with Behavioral Health Disorders

### Facts and Resources

### Compelling Statistics

- Cigarette smoking is responsible for more than 540,000 deaths per year in the United States[1], including an estimated 41,000 deaths resulting from secondhand smoke exposure.[2]
- In 2020, the percentage of adults aged 18 and over who currently smoke cigarettes was 12.5%.[3]
- It is estimated that secondhand smoke causes 7,333 annual deaths from lung cancer and 33,951 annual deaths from heart disease.[2]
- People with mental illness and/or substance use disorders smoke 40% of all cigarettes produced in the U.S., with over 21% of all cigarettes smoked only by those with a mental illness.[4]
- Almost half (200,000) of annual deaths from smoking are among people with mental illness and/or substance use disorders.[5]
- Nearly 1 in 4 adults (23.1%) diagnosed with any mental illness smoke cigarettes, compared with less than 1 in 5 adults without any mental illness (14.5%).[6]
- In addition to the high prevalence of smoking among those with mental illness, those persons also smoke more cigarettes per month and are less likely to stop smoking than those without mental illness.[5]
- Persons with mental illness and/or substance use disorders can die, on average, up to about 10 years earlier than persons without these disorders.[7]
- Up to 75% of individuals with serious mental illnesses and/or substance use disorders smoke cigarettes.[8] And, 30–35% of treatment staff smoke.[8]
- Less than half of mental health treatment centers in the U.S. offer cessation counseling services, 48.4%.[9]
- According to SAMHSA data, use of illicit drugs and alcohol was more common among current cigarette smokers than among nonsmokers in 2011, as in prior years since 2002. Among persons aged 12 or older, 26.1% of past month cigarette smokers reported current use of an illicit drug compared with 5% of persons who did not currently smoke cigarettes.[10]
- Adults who smoked cigarettes in the past month were more likely than those who were not nicotine dependent to have engaged in alcohol use (65.2% vs. 48.7%), binge alcohol use (42.9% vs. 17.5%) and heavy alcohol use (15.7% vs. 3.8%) in the past month.[10]
- Adults receiving both mental health and substance abuse treatment had close to double the odds of dying from a tobacco-related disease compared to the general population.[11]
- Despite popular opinion, persons with mental illness and/or substance use disorders want to quit smoking, want information on cessation services and resources, and most importantly they can successfully quit using tobacco. One study found that 52% of cocaine users, 50% of alcohol-dependent individuals, and 42% of heroin users were interested in quitting smoking at the time they started treatment for their other addictions.[12]
- Treating tobacco use during additions treatment increases likelihood of abstinence from alcohol and illicit drugs by 25%.[13]
- More than 50% of patients with terminal cancer have at least one psychiatric disorder.[14]
- Individuals with a mental illness may develop cancer at a 2.6 times higher rate on account of late stage diagnosis and inadequate treatment and screenings.[15]
- Individuals with a mental illness have a higher rate of fatality due to cancer.[16]

### Tobacco Treatment is Part of Recovery

Asking, advising, and referring a client to smoking cessation resources can take as little as 30 seconds.

1. **Ask** all clients whether they smoke.
2. If they smoke, **advise** them to quit.
3. **Refer** them to resources for help, such as the national quitline, **1-800-QUIT-NOW**, BecomeanEx.org, Smokefree.gov, or a local **Nicotine Anonymous**, www.nicotine-anonymous.org meeting

### Resources

The Smoking Cessation Leadership Center (SCLC) offers a variety of webinars by national experts.
All live webinars and select recorded webinars offer CME/CE credit.
Visit smokingcessationleadership.ucsf.edu/webinars/cme for the list of webinars with CME/CE credit.

**National Behavioral Health Network for Tobacco and Cancer Control—www.bhthechange.org**
The National Council for Behavioral Health, in collaboration with SCLC, the Behavioral Health and Wellness Program, and Centerstone Research Institute, has launched a program to provide organizations with information to help individuals with mental illness and addictions quit smoking.

***Free tobacco cessation training***

**Clinician-Assisted Tobacco Cessation Curriculum—www.rxforchange.ucsf.edu**
This online comprehensive tobacco cessation education tool provides the knowledge and skills necessary to offer tobacco cessation counseling to consumers who use tobacco.

The following versions are available:

- The 5 A's curriculum
- Ask-Advise-Refer curriculum
- Psychiatry curriculum
- Cardiology provider curriculum
- Mental Health peer counselor curriculum
- Respiratory care curriculum
- Surgical provider curriculum

***Free guides and toolkits***

- **The following are available at http://smokingcessationleadership.ucsf.edu**
  - **DIMENSIONS: Tobacco Free Toolkit for Healthcare Providers, with Behavioral Health Supplement**
  - **Tobacco Treatment for Persons with Substance Use Disorders**: A toolkit for Substance Abuse Treatment Providers
  - **Tobacco Free Living in Psychiatric Settings, National Association of State Mental Health Program Directors**
  - **Tobacco Free Toolkit: For Community Health Facilities**
- **2008 U.S. Public Health Service Guideline—Treating Tobacco Use and Dependence**: visit http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html

***Consumer-run programs***

- **Behavioral Health and Wellness Program: DIMENSIONS: Tobacco Free Program**, https://www.bhwellness.org/programs/tobaccofree/
- **Choices,** www.njchoices.org: Consumer-driven program for smokers with mental illness

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***Visit http://smokingcessationleadership.ucsf.edu or call (877) 509-3786 for free technical assistance.***

Smoking Cessation Leadership Center

UCSF
University of California San Francisco

Revised 05/2022

## APPENDIX E: MODEL TOBACCO-FREE POLICY 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 | | ■ | ■ | | | |
| Revise current human resource policies to cover use of tobacco while on duty | | ■ | ■ | | | |
| 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 the new policy | | | | ■ | | |
| Post signage | | | | | ■ | |
| Launch date and kick-off event | | | | | | ■ |

## APPENDIX F: BEHAVIORAL HEALTH TOBACCO POLICY CHECKLIST

As your organization drafts its tobacco-free policy, utilize this checklist to ensure that each area below is appropriately addressed in your written policy.

**Tobacco-Free Environment (for Clients, Staff and Visitors)**

- ❑ Program Buildings (indoors)
- ❑ Program campus/grounds
- ❑ Vehicles
- ❑ Program Sponsored events
- ❑ Specifically prohibits staff and clients from smoking together

**Enforcement (for clients, Staff and Visitors)**

- ❑ General enforcement
- ❑ Identifies specific enforcement consequences
- ❑ Mention of cessation and/or education
- ❑ Establishes designated individual(s) for enforcement

**Screening, Education and Treatment Services**

- ❑ Screening for tobacco use at intake
- ❑ Removes tobacco products from client possession at intake
- ❑ Client education curriculum mentioned (e.g. format, hours, frequency)
- ❑ Staff training mentioned (e.g. format, hours, frequency)
- ❑ General cessation mentioned
- ❑ Referral to outside cessation services mentioned
- ❑ Onsite cessation program mentioned
- ❑ Specific behavioral treatment services mentioned
- ❑ Specific pharmacotherapy treatment services mentioned

**Policy Organization**

- ❑ Communication of the policy
- ❑ Printed Materials
- ❑ Signage
- ❑ Rationale given for health or environmental consequences
- ❑ Policy indicates all tobacco products, including e-cigarettes, preferably using the state definition of tobacco products
- ❑ Applicable enforcement/adoption date
- ❑ Individual(s) identified to review and/or update the policy

## APPENDIX G: MODEL TOBACCO-FREE POLICY

*POLICY MANUAL SECTION – ENVIRONMENT OF CARE*

**Effective Date:**

**TITLE: TOBACCO-FREE ENVIRONMENT**
**This is a new policy in the (organization name) Policy and Procedure Manual.**

**PLEASE NOTE: This policy supersedes all agency policies referencing tobacco or smoking.**

I. PURPOSE

It is the policy of (name) to prohibit smoking or the use or sale of any tobacco products on the (name) campus.

As a health care provider committed to the health and safety of staff, patients, physicians, visitors, and business associates, (name) is taking a leadership role on the major public health issue of tobacco use. To promote (name) commitment to public health and safety and to reduce the health and safety risks to those served and employed at the workplace, all (name) facilities, campuses, state vehicles, and properties are tobacco-free environments as of (date). No smoking of cigarettes, cigars, or pipes or use of chewing tobacco or e-cigarettes in any form or other tobacco product will be permitted in facilities or on properties of (name) on or after that date.

This policy is applicable to all staff on the (name) campus whether they are employees of (name) or other agencies, to medical staff, visitors, students, volunteers, vendors, lessees and contractors. This policy is applicable to all inpatients and outpatients.

A ban on tobacco does not take away an individual's rights as there is no "right to smoke" in (state). (name) does not require staff, patients or visitors to stop using tobacco; however, it is required that people do not smoke or use other tobacco products on this [or on all] organization physical sites campus or during work time.

The purpose of this policy is to describe how the tobacco-free workplace requirements will be implemented.

**DEFINITIONS**

**Smoking** means inhaling, exhaling, burning, or carrying any lighted or heated cigar, cigarette, or pipe, or any other lighted or heated tobacco or plant product intended for inhalation, whether natural or synthetic, in any manner or in any form. Smoking includes the use of an electronic smoking device that creates an aerosol or a vapor, in any manner or in any form, or the use of any oral smoking device for the purpose of circumventing the prohibition of smoking. California Business and Professions Code Section 22950.5(c).

**Tobacco Product** means

(A) A product containing, made from, or derived from tobacco or nicotine that is intended for human consumption, whether smoked, heated, chewed, absorbed, dissolved, inhaled, snorted, sniffed, or ingested by any other means, including, but not limited to, cigarettes, cigars, little cigars, chewing tobacco, pipe tobacco, or snuff.

(B) An electronic device that delivers nicotine or other vaporized liquids to the person inhaling from the device, including, but not limited to, an electronic cigarette, cigar, pipe, or hookah.

(C) Any component, part, or accessory of a tobacco product, whether or not sold separately.

Tobacco Products do not include products approved by the U.S. Food and Drug Administration for sale as a tobacco cessation product or for other therapeutic purposes where the product is marketed and sold solely for such an approved purpose.

**Nicotine Replacement Products** – e.g., gum, patches, lozenges, inhalers

**Workplace** – workplace means facilities or properties including but not limited to patient care buildings,

clinics, facilities, office buildings, parking lots, (name)-owned vehicles, or property leased or rented out to other entities. This policy applies regardless of whether a (name) facility or property is owned and whether or not the other tenants follow similar guidelines. Employees and clients at off-site patient activities shall not use tobacco products.

ACCOUNTABILITY

It is the responsibility of all staff members to enforce the organization's tobacco-free environment policy by encouraging their colleagues, clients, visitors and others to comply with the policy. Supervisors are responsible for implementing and enforcing (name) Tobacco-Free Environment policy.

The community, staff, clients and visitors will be informed of the policy through a variety of communication methods.

II. PROCEDURE

*GENERAL POLICY PROVISIONS*

1. No tobacco products or related paraphernalia such as lighters and matches shall be used, sold or bartered anywhere on the (name) campus and may be possessed only in locked personal vehicles.
2. Signs declaring this campus "tobacco-free" shall be posted at the (name) campus entrances and other conspicuous places.
3. (name) will post this policy in employee common areas and in the (name) New Employee Orientation Handbook. All client handouts, pre-admission brochures and website information will be updated to communicate the policy,

*A. Employees, Volunteers, Physicians, Students and Contract Workers*

1. Respectful enforcement of this policy is the responsibility of all (name) employees.
2. Employees, students, medical staff, volunteers, vendors, lessees and contractors are expected to comply with this policy.
3. This policy will be explained to employees during New Employee Orientation.
4. Job announcements for all positions on the (name) campus will display a notice that (name) has a tobacco-free work environment policy.
5. Employees are prohibited from smoking or using other tobacco products during any and all parts of their paid work shift. Employees may not smoke or use other tobacco products in their private vehicles while the vehicle is on (name) grounds.
6. Employees who encounter staff or visitors who are violating the tobacco policy are encouraged to politely explain the policy and report the violation to the person's supervisor, if known.
7. Staff who fail to adhere to this policy or supervisors who fail to hold their employees accountable may be subject to progressive discipline culminating in corrective or disciplinary action as defined in (name) Human Resources and Staff policies.

*B. Clients*

1. Clients are prohibited from smoking or using tobacco on campus.
2. All clients admitted to (name) will be assessed for history of tobacco use and the need for interventions related to tobacco addiction including nicotine replacement and cessation education.
3. Clients may not possess any tobacco-related items on the campus.
4. Employees who encounter clients who are violating the tobacco policy are encouraged to politely explain the policy, and report the violation to the client's treatment team, if known.
5. Violation of this policy by clients is a treatment issue to be addressed by the treatment team.

*C. Visitors*

1. Signs will be posted at campus entrances and in selected locations inside and outside of the facility.
2. Employees who encounter a visitor who is violating the tobacco policy are encouraged to politely explain the policy to the visitor.
3. Visitors who become agitated or unruly or repeatedly refuse to comply when informed of the tobacco-free campus policy may be reported to (name of appropriate department or personnel). (the identified personnel) will respond to the situation as appropriate, according to their professional judgment and need to maintain a safe environment.

*D. Outside Groups*

Outside groups who use (name) facilities for meetings will be advised of this policy. Violation of the policy will result in the rescinding of approval for the group to meet on this campus.

*E. Guidelines for Enforcement*

| **Violation examples** | **First Offense** | **Second Offense** | **Third Offense** | **Fourth Offense** |
|---|---|---|---|---|
| Smoking outside on property but complies with request to stop.<br><br>Smoking outside on property and refuses to comply with policy.<br><br>Smoking in personal vehicle on campus.<br><br>*Excessive absences from the workplace during assigned shift (extra breaks, longer lunch breaks, etc.).<br><br>*Employee's clothing smells strongly of tobacco smoke. | The supervisor must have verifiable reports of the infractions and/or have witnessed the infraction directly.<br><br>Verbal intervention with employee. Review policy and perimeter of the campus, give clear expectation it is not to reoccur. Review the Help Quit education available and possible assistance with nicotine replacement and alternative therapies for difficulties with compliance while at work. | The supervisor must have verifiable reports of the infractions and/or have witnessed the infraction directly.<br><br>Repeat first offense interventions and document all discussion in a supervisory log. Refer also to the first verbal intervention and make the expectation clear in writing. Sign the log and have the employee sign that this was reviewed and discussed with them. Again review the assistance available to comply at work. | The supervisor must have verifiable reports of the infractions and/or have witnessed the infraction directly.<br><br>Present the employee with a Memorandum of Expectation or a Performance Improvement Plan clearly stating the expectation and consequences if the policy is violated again. Clarify that the behavior will affect the performance rating and may result in further corrective or disciplinary action. | The supervisor must have verifiable reports of the infractions and/or have witnessed the infraction directly.<br><br>Document the new infraction and forward with previous documentation to the appointing authority for consideration of a meeting for corrective or disciplinary action that may affect pay, status, or tenure and possible termination. |

Staff who witness infractions of any kind are asked to remind the person of the Tobacco-free campus policy using the scripted phrase on the reminder card. If the offender is a client, please report the offense to the client's treatment team if known. If the offender is staff, please report the offense to the supervisor if known.

*SCREENING, ASSESSMENT AND CESSATION PROTOCOL*

**Tobacco Use Screening and Assessment:** During the admission process into the treatment program at (organization name), each client will be asked about their use of products containing nicotine, their desire and willingness to quit, and whether they would like staff support to quit. The admissions packet will contain a Tobacco Use Assessment form to evaluate the history and nature of the client's addiction. Upon intake, tobacco products brought to campus will be confiscated.

Staff Education and Training: Staff will support the nicotine-free program by delivering a uniform message to the clients regarding the hazards of smoking, the risks of addiction and the desirability of staying tobacco-free. All clinical staff members will be provided with a comprehensive training program addressing:

- Attitudes and beliefs regarding tobacco use
- The disease model of tobacco dependence
- The pharmacology of nicotine
- Assessment and management of tobacco dependence and withdrawal
- The integration of tobacco dependence treatment into the treatment of alcohol and drug addictions

**Cessation Support:**

1.) Brief Intervention – Ask, Advise, Refer (AAR).

a. Ask all clients if they smoke.

b. If they smoke, advise them in a personalized manner to quit.

c. Refer to a quitline, 1-800-QUIT-NOW or to smokefree.gov.

2.) Individual Counseling: Motivational Interviewing techniques will be used to measure clients' readiness for change. In cases where the client wants to stop using nicotine products, the counseling staff will include Smoking Cessation as an item to work on in the client's treatment plan. This topic will become a treatment goal in the same manner as all other substances and counselors will provide support and assignments to help clients to achieve this goal. Clients will be provided additional counseling during the first 14 days following their quit attempt. Each session will allow the client and the counselor to identify goals, action steps and barriers faced, so that the client feels supported.

3.) Group Counseling: Smoking Cessation Groups will be held on a weekly basis and will discuss various topics related to nicotine use, NRT use, emotional and physical dependence, withdrawal and triggers. The Program Director will assist counseling staff in identifying appropriate literature and group topics.

4.) Therapeutic Community Management. Staff involved in monitoring and guiding the therapeutic community aspects of the program should place special emphasis on coping skills and relaxation techniques, because many clients have formed the habit of substituting tobacco or other drug use for these skills.

a. Recreation Alternatives. Staff will provide creative and appealing breaks for clients, such as music, outdoor activities, deep breathing and relaxation techniques, exercise, videos, client performances, magazines, and books.

5.) Nicotine Replacement Therapy: Clients are encouraged to use nicotine replacement therapy (NRT, i.e., over-the-counter nicotine patches) on site as part of their tobacco dependence treatment.

Signatures: _____

## APPENDIX H: SAMPLE ANNOUNCEMENT

(Adapted from Kaiser Permanente, Northern California)

**Smoke-Free Campus**

**Open Letter to Physicians and Staff**

KAISER PERMANENTE®

To all Physicians and Staff,

All of us at Kaiser Permanente know that we are committed to improving the health of our members and staff. We also know that smoking is a health hazard. Therefore, to promote good health, and create a healthy environment for members and staff, our Kaiser Permanente campus will become smoke free on [DATE].

This new policy, known as Smoke-Free Campus, means the existing designated smoking areas will remain in place until [DATE]. After that, there will be no areas where smoking is permitted.

We recognize that giving up smoking is difficult -- and we are committed to helping any employee or physician who needs support in their efforts to quit.

To assist those who want to quit smoking, Kaiser Permanente offers free smoking-cessation courses to all Kaiser members. The classes may include a one-day workshop, a six session workshop and an eight-session workshop. Attendance in the classes provides members and staff with the opportunity to obtain smoking-cessation aids, like the nicotine patch or bupropion SR, for a standard co-payment. The Health Education Department has more information on these classes and other quit-smoking resources. Calling 1-800-QUIT-NOW puts individuals in touch with counselors free of charge.

Over the course of the next several months, look for more information and details about our Smoke-Free Campus in employee and member publications, as well as posters, flyers and other positive activities. If you have any questions about the Smoke-Free Campus policy, please contact _____, Human Resources, at _____.

Signatures of:

Physician-in-Chief

Service Area Manager

Medical Group Administrator

Labor Management Representative

## APPENDIX I: SAMPLE LETTER TO CLIENTS

***Send on Agency practice letterhead***

To Our Clients:

Beginning on *DATE, NAME OF Organization* will adopt a campus-wide, tobacco-free policy. This policy means that clients, visitors, employees and physicians are prohibited from using tobacco products anywhere inside or outside ORGANIZATION.

*ORGANIZATION* has joined behavioral health facilities  across the nation that have become tobacco-free. This policy has been endorsed by numerous health advocacy groups, including *NAMES OF SUPPORTING ORGANIZATIONS*. It is intended to help *ORGANIZATION* maintain the healthiest possible environment for clients, employees and visitors.

Upon your admission to *ORGANIZATION*, please notify the intake staff if you use tobacco. This information will be forwarded to providers who can help you quit, provide tobacco-cessation products, or discuss alternative resources for you.

Thank you for your cooperation with this *ORGANIZATION* policy and for helping maintain a healthier environment for everyone.

If you choose to quit or cut back on tobacco-use, I am always happy to talk with you about it. You may also consider calling the tobacco quit line, 1-800-QUIT-NOW or visiting smokefree.gov, where trained coaches can help you through the quitting process.

Sincerely,

*NAME OF CEO/PRESIDENT OF AGENCY*

## APPENDIX J: NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS SAMPLE INTERNAL MEMO/FAQ

# Questions and Answers

As you eliminate tobacco use to foster wellness and recovery, engage staff, consumers, family members, and people in your community in discussion. Listen. Address concerns. Collaborate with partners. Remember to maintain your focus on wellness and recovery.

Here are some questions you may face:

**Q: Smoke breaks are one of the few opportunities we, as consumers, have to relate to staff as peers. Besides, smoking is our only pleasure. How can you take that away?**

**A:** We appreciate that you want to spend time with staff outside of treatment. And we want to create healthy ways to do that. Smoking is an addiction. As a treatment facility, we can no longer support addiction by condoning smoking by consumers or staff. Furthermore we will work together, consumers and staff, to create new activity choices and opportunities that are both fun *and* healthy.

**Q: People come to psychiatric hospitals in crisis. These are times they most need to smoke. Won't this new policy worsen their crises? Or worse yet, people won't get help when they need it because they don't want to quit smoking.**

**A:** At a time of crisis, our immediate job is to deal with the crisis, not with smoking. As the person recovers, we will provide a healthy environment that promotes wellness. That means smoking is not a choice. We will not or cannot *force* someone to quit smoking for a lifetime. What we will do is have a safe environment where consumers or staff members can learn how smoking impacts their lives and find resources and opportunities that will help them choose to quit. Research has not yet determined the best time to help someone quit smoking. We know, however, that the best time to encourage healthy behavior is now.

**Q: Here you go again, slamming us with more rules! Why can't you just let us do what we want like people on 'the outside'?**

**A:** As we prohibit tobacco use here, we actually become *more* like treatment and health care facilities on "the outside." We've known for more than 40 years that smoking is hazardous to our health. Workplaces all over our community have banned tobacco use. Why? Because, whether or not you are puffing on a cigarette, smoke is bad for you. It kills. Already it has killed way too many peers. While you are here, you and those around you have every right to breathe clean air and every opportunity to make *healthy* choices. In reality, the challenges will help you later in coping with the tobacco-free rules that increasingly govern life on "the outside."

**Q: Smoking is a personal choice. How can you take that away without some serious collective bargaining?**

**A:** Interesting question. Historically, unions have fought for *safe working conditions.* Internal documents show that tobacco companies have strategically marketed worker messages expounding upon the right to smoke. Yet, knowing cigarettes are loaded with toxic chemicals, including 60 known carcinogens, I'd rather we expend our energy working together on safety and health.

**Q: How can we expect people to quit smoking, while they're quitting everything else? We are here to deal with "real drugs," not cigarettes. Besides, clients don't want to quit. Even those who want to quit, won't be able to.**

**A:** Cigarettes *are* real drugs. They contribute to more illness and early death than any other drug, legal or illegal. And they are highly addictive—on par with heroin. As we create a healthier environment, we will train staff and consumers about smoking, the quitting process, and how smoking impacts other addictions. Evidence suggests that smoking actually harms recovery from the addiction to other drugs because it can trigger the use of those substances. Also, as part of this initiative, we want to work with other community treatment facilities to similarly protect consumers and staff from smoke and help them quit or maintain their abstinence from smoking.

**Q: Clients will just start smoking again once they are discharged. Why bother quitting?**

**A:** Many of our clients *will* smoke again. We don't refuse treatment for other addictions, even when we believe the client is not motivated to remain abstinent. We give everyone the opportunity to detoxify while in treatment with the hope that they will choose a substance-free life. Quitting is hard, especially in environments where tobacco use is acceptable. By incorporating tobacco cessation in our recovery philosophy, we can help clients learn refusal skills, identify triggers, and regain control if they relapse. We also hope to be leaders, inspiring other mental health facilities in our community to similarly ban tobacco use to open new doors to wellness and recovery.

**Q: Smoking calms down consumers. When they can't smoke, won't we experience complete mayhem?**

**A:** Banning smoking in psychiatric hospitals actually *reduces* mayhem. Facilities that do not allow smoking report fewer incidents of seclusion and restraint and a reduction in coercion and threats among patients and staff. We are carefully planning this effort so the consumers, staff, and visitors here have plenty of time and support to prepare for change. We will reduce uncomfortable nicotine withdrawal symptoms by appropriately using nicotine replacement therapy and other medications. We plan to post a countdown to our launch date right here in the foyer. Meanwhile, we invite you to voice your concerns and join our team as we become tobacco-free and embrace recovery.

**Q: How will we afford to transform our facility so drastically?**

**A:** Certainly, we can expect some up-front costs as we transform our facility through this tobacco-free initiative. We'll need ongoing staff training. We need to add to our health benefits so our employees have extra help to quit smoking. We will create and post signs to remind consumers, staff, and visitors that our hospital is a sanctuary from smoke. We will expand drug formularies to include more options for nicotine dependence treatment. And we need to create new forms with reminders that keep tobacco use on the front burner in our treatment of clients as whole persons. These are small investments compared to what we gain: longer, healthier lives for consumers and staff; financial savings through improved employee health and productivity; less fire danger, and the knowledge that we are achieving excellence by providing people with mental illness with the healthy, therapeutic environment they deserve.

## APPENDIX K: SAMPLE LETTER TO NEIGHBORS

*DATE*

*NAME*

*TITLE*

*ADDRESS*

*CITY, STATE ZIP CODE*

Dear *NAME*:

Effective *DATE*, *ORGANIZATION* will take a proactive step to implement a tobacco-free policy on all of our campuses. The tobacco ban will apply to all patients, visitors, medical staff members, vendors and employees. This means as of *DATE*, no tobacco-use of any kind will be permitted inside hospital buildings and on parking lots or grounds.

We have talked with employees about possible neighborhood concerns and are confident that most will exercise consideration of you and your property. Though we do not endorse it, we are concerned that some employees may leave the hospital to use tobacco products. If any staff behaviors, whether related to smoking or not, becomes a problem for you (*CHOOSE: OR YOUR EMPLOYEES or THOSE WITH WHOM YOU LIVE)*, please contact me at the number below.

As a health care institute, *ORGANIZATION's* primary mission is to protect the health of those in our community, while promoting a culture of healthier living. We are not asking employees to stop using tobacco. However, we are requiring them to refrain from tobacco-use during work hours. *ORGANIZATION* is developing programs for employees who choose to quit using tobacco products altogether as well as programs to help get them through their designated shifts. Our patients are our first priority. Thus we are working with our physicians as we develop coping and nicotine-treatment strategies.

We appreciate your help and support as we head toward *DATE*.

Sincerely,

*NAME OF ADMINISTRATIVE CHAMPION*

*TITLE NAME OF FACILITY*

*TELEPHONE NUMBER OF FACILITY*

## APPENDIX L: TOBACCO USE ASSESSMENT (TUA)

ACBHCA Tobacco Use Assessment

# Tobacco Use Assessment
## TUA

Date of Assessment

Name _____ ID # _____ Birth _____ Date _____

1. Do you live with a Tobacco user? ☐ Yes ☐ No
2. Have you ever used tobacco? ☐ Yes ☐ No **If No, STOP SURVEY is complete.**
3. Do you currently use Tobacco? ☐ Yes Go to 6. ☐ No If no, go to **4 and 5**

4. Quit > 1 year ago end here
5. Quit < 1 year ago. What help do you need to stay quit? _____

*Complete the following only if a current tobacco user*

| | Amount | None | Daily | Weekly | Monthly | Occasionally | Age of first Use |
|---|---|---|---|---|---|---|---|
| 6. Cigarette use | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| 7. Pipe Use | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| 8. Cigar Use | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| 9. Smokeless tobacco use | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| 10. E-Cigarettes, vap. Use | _____ | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |

10a. Do you smoke menthol? ☐ Yes ☐ No

11. Have you ever attempted to quit? ☐ Yes ☐ No Approximate date of last attempt_____
12. How many times have you attempted to quit tobacco? _____

13.

Which of these ways have you tried in the past to quit tobacco?

- ☐ Nicotine patch
- ☐ Nicotine lozenge
- ☐ Nicotine Gum
- ☐ Nicotine nasal spray or Inhalor
- ☐ Zyban
- ☐ Chantix or varenicline
- ☐ Other_____
- ☐ help from local agency _____
- ☐ Tobacco cessation group
- ☐ Nicotine anonymous
- ☐ Acupuncture
- ☐ CA Smokers 1 800-No-Butts
- ☐ Cold Turkey

14.

Meds with levels decreased by smoking- check those patient takes. May need decrease after 3 weeks quit

- ☐ Amitryptyline (Elavil)
- ☐ Notriptyline (Pamelor)
- ☐ Imipramine
- ☐ Clomipramine (Anafranil)
- ☐ Fluvoxamine (Luvox)
- ☐ Trazodone (Desyrel)
- ☐ Fluphenazine (Prolixin)
- ☐ Haloperidol (Haldol)
- ☐ Olanzipine (Zyprexa)
- ☐ Chlorpromazine (Thorazine)

15. Ready to Quit _____ Thinking about quitting within the next 30 days_____ Not interested in quitting _____

16. Referred to

- ☐ Smokers' Helpline
- ☐ Nicotine Anonymous
- ☐ Other referral (please specify)
- ☐ Tobacco treatment plan
- ☐ No referral

If other, please specify: _____

17. Materials Provided

- ☐ No materials provided
- ☐ Benefits of Quitting
- ☐ Benefits of quitting in recovery
- ☐ Other material (please specify)
- ☐ Quit line Card
- ☐ Secondhand Smoke Flyer
- ☐ Stop smoking checklist
- ☐ Benefits of quitting in mental health recovery

If other, please specify: _____

## APPENDIX M: FUNDING/REIMBURSEMENT FOR TOBACCO CESSATION SERVICES.

There are several ways of funding tobacco cessation services for clients and employees. Many private health plans cover tobacco use disorder counseling and/or medications, including over the counter nicotine replacement therapies (NRTs). Employees and clients should be encouraged to verify specific coverage.

As of August 2010, the Centers for Medicare and Medicaid Services (CMS) began covering tobacco cessation counseling for outpatient and hospitalized Medicare beneficiaries, regardless of whether the patient has signs and symptoms of tobacco-related disease.[46] Find out if Medicaid covers FDA-approved tobacco cessation medications and NRT by going to https://www.cdc.gov/statesystem/factsheets/medicaid/Cessation.html.

The seven FDA-approved products, considered to be first line treatments as defined by Treating Tobacco Use and Dependence: 2008 Update, include 5 NRTs – gum, patch, lozenge, nasal spray, and inhaler. There are also 2 prescription only non-nicotine medications, Bupropion (Zyban or Wellbutrin) and Varenicline (Chantix).

In addition to medications, individual, group, and phone counseling are evidence-based treatments. Using medication or counseling alone can increase someone's chance of successfully quitting, but the combination of both is even more effective.

Medicare providers can bill both for tobacco cessation counseling as the primary reason for the visit (305.1) or secondary, to another medical problem- where an office visit CPT code is utilized rather than a counseling code. Practices often bill CPT codes 99406 (3-10 minute visit) or 99407 (>10 minute visit) when providing face-to-face tobacco cessation counseling by a physician or other qualified healthcare professional. A single counseling session of less than three minutes is considered to be part of a standard evaluation and does not qualify for separate Medicare reimbursement.

Only qualified behavioral health providers are allowed to bill for cessation service using both DMS-5 codes (Diagnostic and Statistical Manual of Mental Disorders, Edition 5) and the ICD-10 diagnosis codes (International Statistical Classification of Diseases and Related Health Problems, 10th Revision).

Tobacco cessation should be seen as a preventive service, which means that all 7 cessation medications and 3 forms of counseling should be covered without cost sharing and/or prior authorization.

Agencies are encouraged to review health plans and ensure that cessation services such as counseling and medications are covered benefits for employees. Agencies might also choose to offer tobacco services through wellness programming or employee assistance programs.

### Additional resources:

https://www.aafp.org/dam/AAFP/documents/patient_care/tobacco/codes-tobacco-cessation-counseling.pdf
https://www.lung.org/assets/documents/tobacco/billing-guide-for-tobacco-1.pdf
https://www.lung.org/assets/documents/tobacco/billing-guide-addendum-for.pdf

### Example:

Background

**Overview of Cessation Coverage**

| Insurance Type | Required coverage | |
|---|---|---|
| Medicare | • 4 sessions of individual counseling<br>• Prescription cessation drugs<br>• Up to 2 quit attempts/year<br>• No cost-sharing for counseling<br>• Annual prevention visit | |
| Standard Medicaid | For Pregnant Women:<br>• Individual, group and phone counseling<br>• All tobacco cessation medications (prescription and OTC)<br>• No cost-sharing For pregnant | Non-Pregnant Enrollees:<br>• All tobacco cessation medications (prescription and OTC)<br>• Coverage of counseling varies by state/plan<br>• Cost-sharing varies by state/plan |
| Medicaid Expansion | Tobacco cessation treatment as a preventive service | |
| Individual Insurance Plans* or exchange plans | Tobacco cessation treatment as a preventive service | |
| Small Group Plans* | • Tobacco cessation treatment as a preventive service (*excludes plans that are "grandfathered", those that were in operation before March 2010 and have not made significant changes and do not have to meet ACA requirements) | |
| Employer Provided Plans (Large Group/Self Insured)* | • Not required to cover the essential health benefits (EHBs)<br>• If EHBs are covered, they must follow the ACA guidelines and cover tobacco cessation treatment as a preventive service | |

AMERICAN LUNG ASSOCIATION.

Billing for Tobacco Cessation

**California Medi-Cal Coverage**

**Medications:**
- NRT Gum
- NRT Patch
- NRT Lozenge
- NRT Inhaler
- NRT Nasal Spray
- Bupropion
- Varenicline

**Counseling:**
- Individual
- Group
- Phone

**Barriers:**
- Annual Limits

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## APPENDIX N: SAMPLE SIGNAGE



# APPENDIX O: BENEFITS AND TIPS OF QUITTING FOR GOOD

## If your last smoke was:

**12 hours ago**
The carbon monoxide level in your blood drops to normal.

**2 weeks to 3 months ago**
Your chance of having a heart attack begins to drop and lung function begins to improve.

**1 to 9 months ago**
The coughing and shortness of breath you've been experiencing decrease.

**1 year ago**
Your added risk of coronary heart disease (because of smoking) has been cut in half.

**2 to 5 years ago**
Your chance of having a stroke is reduced to the same as a nonsmoker.

**10 years ago**
Your chance of dying from lung cancer is just half of what it was when you smoked.

Also, your risk of getting cancers of the mouth, throat, esophagus, bladder, kidney, and pancreas has dropped.

**15 years ago**
Your risk of coronary heart disease is reduced to that of a nonsmoker's.

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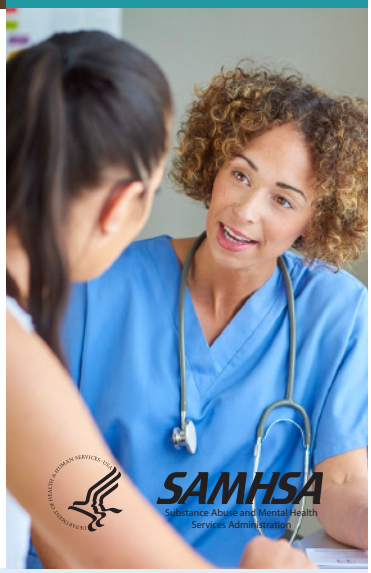
HHS Publication No. SMA18-5069YCQ

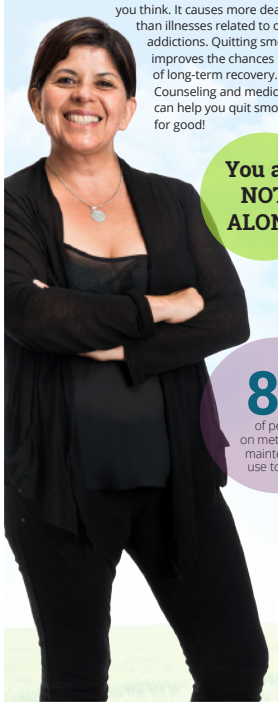
# You Can Quit Tobacco

## Benefits and Tips for Quitting for Good




## WHY IS IT IMPORTANT TO STOP SMOKING?

Many people in recovery smoke tobacco. But smoking can be more harmful than you think. It causes more deaths than illnesses related to other addictions. Quitting smoking improves the chances of long-term recovery. Counseling and medication can help you quit smoking for good!




## WHAT TO EXPECT. YOU CAN QUIT!

You may receive individual, group, or telephone-based sessions to help you quit smoking. You will learn about how tobacco affects your health and tips to help you quit. Then, you and your counselor and doctor will help you come up with a plan. Here are some examples of what you might talk about:

- **Your reasons for quitting.** To get healthy? For your children? To save money?
- **Your goals.** Your counselor and support group can help you set goals to quit smoking. Then, they will help you with each step.
- **Your treatment plan.** Your counselor will help you come up with a plan that works for you. The plan could include medications to help you quit, counseling, or both.

## THE BEST TIME TO QUIT IS NOW

- Quitting smoking while in addiction treatment may help improve your chances of achieving and maintaining recovery from other substances.
- There are several different smoking cessation medications that can help you quit. Taking these medications AND finishing the program make quitting easier.
- You could save thousands of dollars each year by quitting smoking.
- Quitting heals your body and your mind. Studies show that your mood will improve and your anxiety can lessen.

## ASK FOR HELP TODAY!

Ask your doctor or counselor about how they can help you quit smoking for good today! Ask about the medications and counseling they can offer you.

For free help to quit smoking, call 1-800-QUIT-NOW (1-800-784-8669) or visit www.smokefree.gov.

## WHAT WILL YOU DO WHEN YOU QUIT?

Don't let smoking hold you back anymore. Get back to doing what you love. What will you do first?

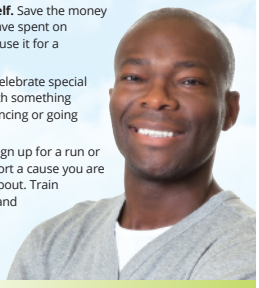
**Play and exercise.** Throw a ball around with your kids/grandkids, go for a walk, or swim.

**Get outside.** Check out your neighborhood. Take the dog for a walk or go to the park.

**Treat yourself.** Save the money you would have spent on cigarettes or use it for a new hobby.

**Celebrate.** Celebrate special occasions with something active like dancing or going for a hike.

**Give back.** Sign up for a run or walk to support a cause you are passionate about. Train with friends and family for an extra boost of support.



## WHAT CLIENTS ARE SAYING

"[Since I stopped smoking] I actually have money saved, my health, [I am] sleeping better, all aspects of my life [have improved]. Breathing better, I got more energy, and the biggest thing, I've saved like $5,000 over the last 2 years. . . . I would be counting money in my car right now for change for cigarettes if I was still smoking, so the group is definitely a lifesaver. . . . The last thing I want to do is have another cigarette."

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