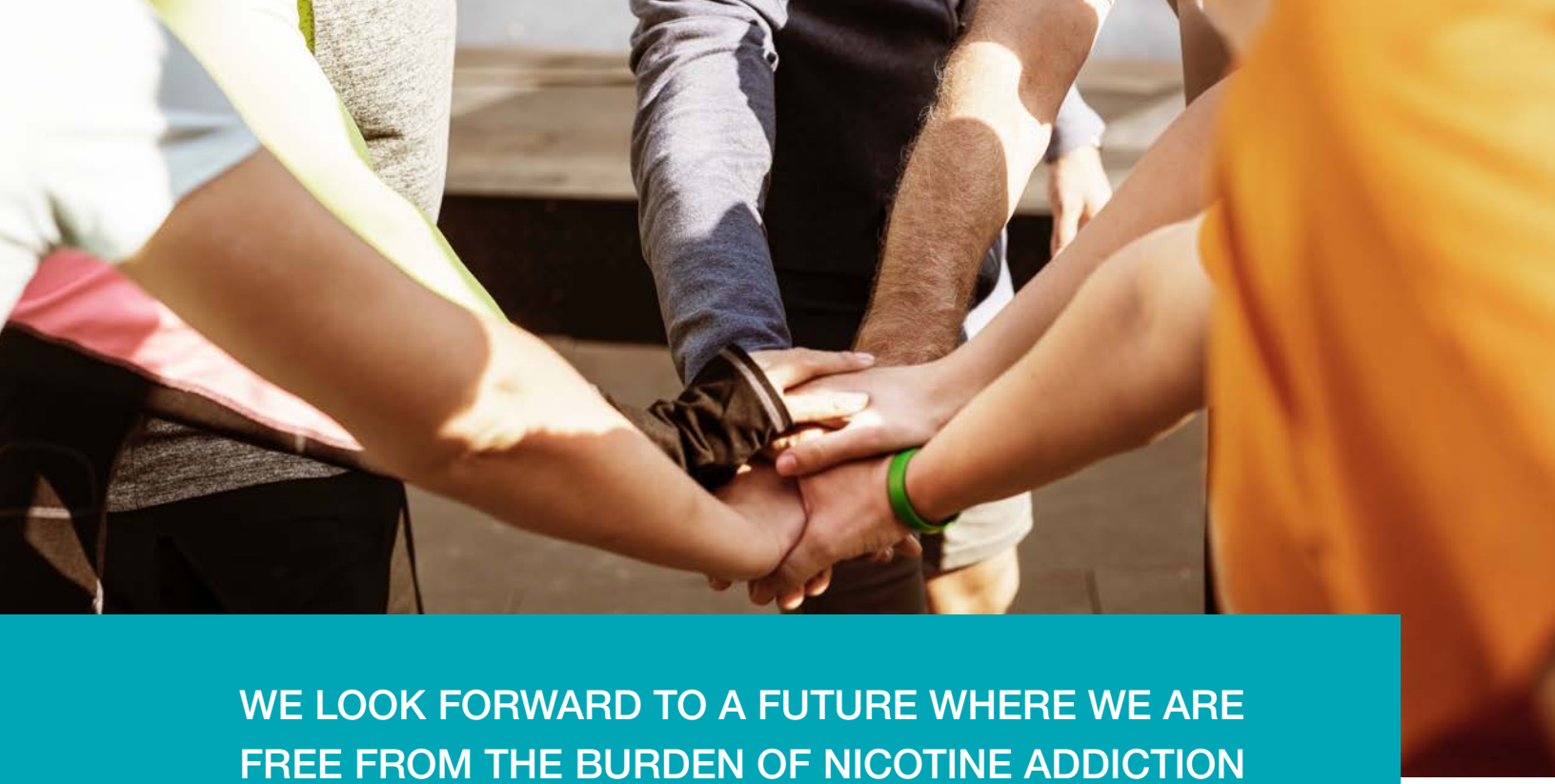
California
Behavioral Health
& Wellness Initiative

Tobacco-free Toolkit
for Behavioral Health Agencies

Smoking Cessation Leadership Center

UCSF

University of California
San Francisco



WE LOOK FORWARD TO A FUTURE WHERE WE ARE FREE FROM THE BURDEN OF NICOTINE ADDICTION AMONG THE BEHAVIORAL HEALTH POPULATION...

Dear Behavioral Health Agency,

We have dedicated ourselves to improving the health and wellness of the behavioral health population in California. As you know, real strides can be made in assisting these clients lead healthy, productive lives in smoke free environments.

A crucial component of health and wellness is living free from the burden of nicotine addiction. Smoking is one of the leading causes of premature, preventable death among adults in the United States. In the behavioral health population, the toll is even greater. This population smokes at a rate that is 2-3 times that of the general population. As a result, they are far more likely to die of smoking-related diseases than from causes related to their mental illness or substance use disorder.

Smoking cessation during treatment is crucial to the physical health of the client and can improve treatment outcomes for their behavioral health disorders. Behavioral health agencies have a unique opportunity to improve the health and wellness of their clients by creating a smoke-free environment where combustible and other tobacco use is prohibited, and cessation treatment is promoted and well supported.

This toolkit serves as a resource and guide for behavioral health agencies adopting a tobacco-free 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 the overall health of those you serve.

We look forward to a future where we are free from the burden of nicotine addiction among the behavioral health population, and we are happy to be partners with you in making that future a reality.

Sincerely,

Smoking Cessation Leadership Center at the University of California, San Francisco

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"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."

CESSATION ADVICE FROM PEER EX-SMOKERS

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

> *"When I was being treated for alcohol in a residential program the staff did not care about my tobacco addiction. I had to have my family bring me nicotine patches and I was able to quit even though almost everyone else was smoking. It was hard but I was able to do it in spite of the lack of support. It shouldn't be that way! Quitting tobacco is one of the best things I have done to support my recovery and mental wellness."*
>
> ~ **Heather, peer ex-smoker**

The purpose of this toolkit is to provide guidance for Behavioral Health Agencies adopting tobacco-free policies and implementing cessation services as part of treatment plans in its facilities.

Tobacco use remains one of the leading causes of death among Americans and Californians. 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.

THIS TOOLKIT PROVIDES:

- General information on tobacco addiction and how to quit
- 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 AND/OR SUBSTANCE USE DISORDERS)?

While smoking rates in the general population have decreased over the last decade, this is not the case for persons with behavioral health conditions[1]. In spite of measures that have greatly reduced smoking in the general population – smoke-free air laws, high cigarette taxes, anti-tobacco media campaigns – this population continues to smoke at very high rates, putting them at increased risk of tobacco-related disease and death.

The Substance Abuse and Mental Health Service 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://www.samhsa.gov/wellness-initiative.

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

SOME IMPORTANT STATISTICS:

2-3x

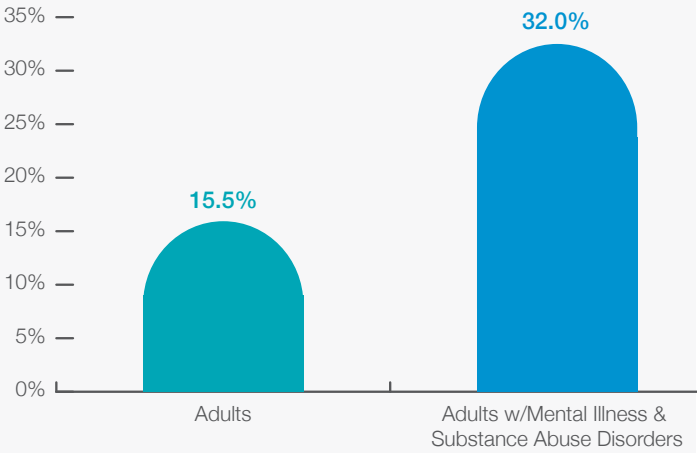
Persons with behavioral health conditions smoke at rates that are 2-3 times higher than the general population.[2]

40%

They represent a surprising 40% of the U.S. tobacco market.[2]

- Those who smoke – SMOKE MORE: individuals with behavioral health conditions smoke more cigarettes daily and smoke them down to the filter more than other smokers.[3]
- People with behavioral health conditions die 5+ years earlier than those without these disorders[4]; many of these deaths are caused by smoking cigarettes.[5,6]

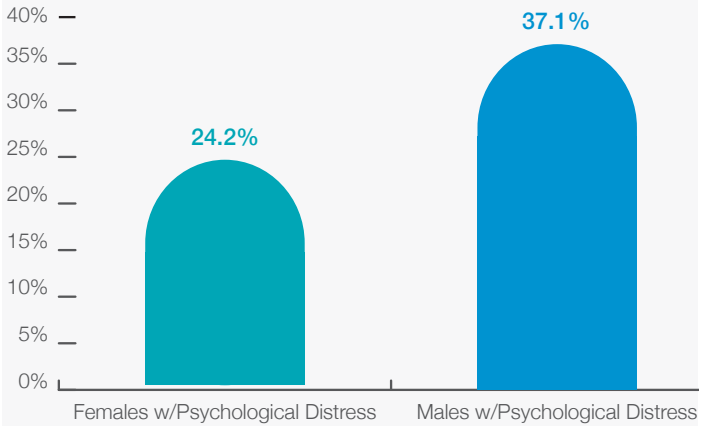
Smoking Rates, U.S. Adults and U.S. Adults with Mental Illness & Substance Abuse Disorders, 2016



Source: Centers for Disease Control and Prevention, (https://www.cdc.gov/tobacco/disparities/mental-illness-substance-use/index.htm), Data taken from the National Survey on Drug Use and Health, 2016, and refer to adults aged 18 years and older self-reporting any mental illness in the past year, excluding serious mental illness.

In California, the adult smoking rate is 11.4%, well below the national rate. This is in large part due to the state's groundbreaking and comprehensive approach to tobacco control (a link for a list of California State tobacco laws can be found in the **Resources** section, page 29). However, adults identifying as having psychological distress (29.8%) still smoke at rates far higher than others; males with psychological distress (37.1%) smoke at more than 3 times the statewide rate.

Smoking Rates among California Adults with Psychological Distress, 2018

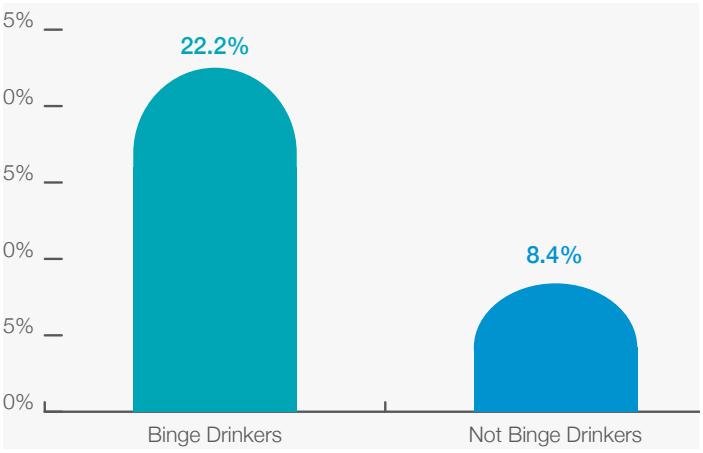


Source: California Department of Public Health, California Tobacco Control Program. California Tobacco Facts and Figures 2018. Sacramento, CA: California Department of Public Health; 2018.

Smoking is also more common among those who have substance use disorders. In California, those who report binge drinking smoke at nearly 3 times the rate of those who do not binge drink.

In addition to smoking rates, rates of addressing tobacco use are lacking in behavioral health treatment settings. In substance use treatment facilities, CA is ranked 9th lowest in the nation for tobacco use screening, 18th lowest in providing cessation counseling, 10th lowest in utilization of nicotine replacement therapy (NRT), and 4th lowest in percent of smoke-free campuses.[7]

Smoking Rates among California Adults who are Binge Drinkers and Not Binge Drinkers, 2016

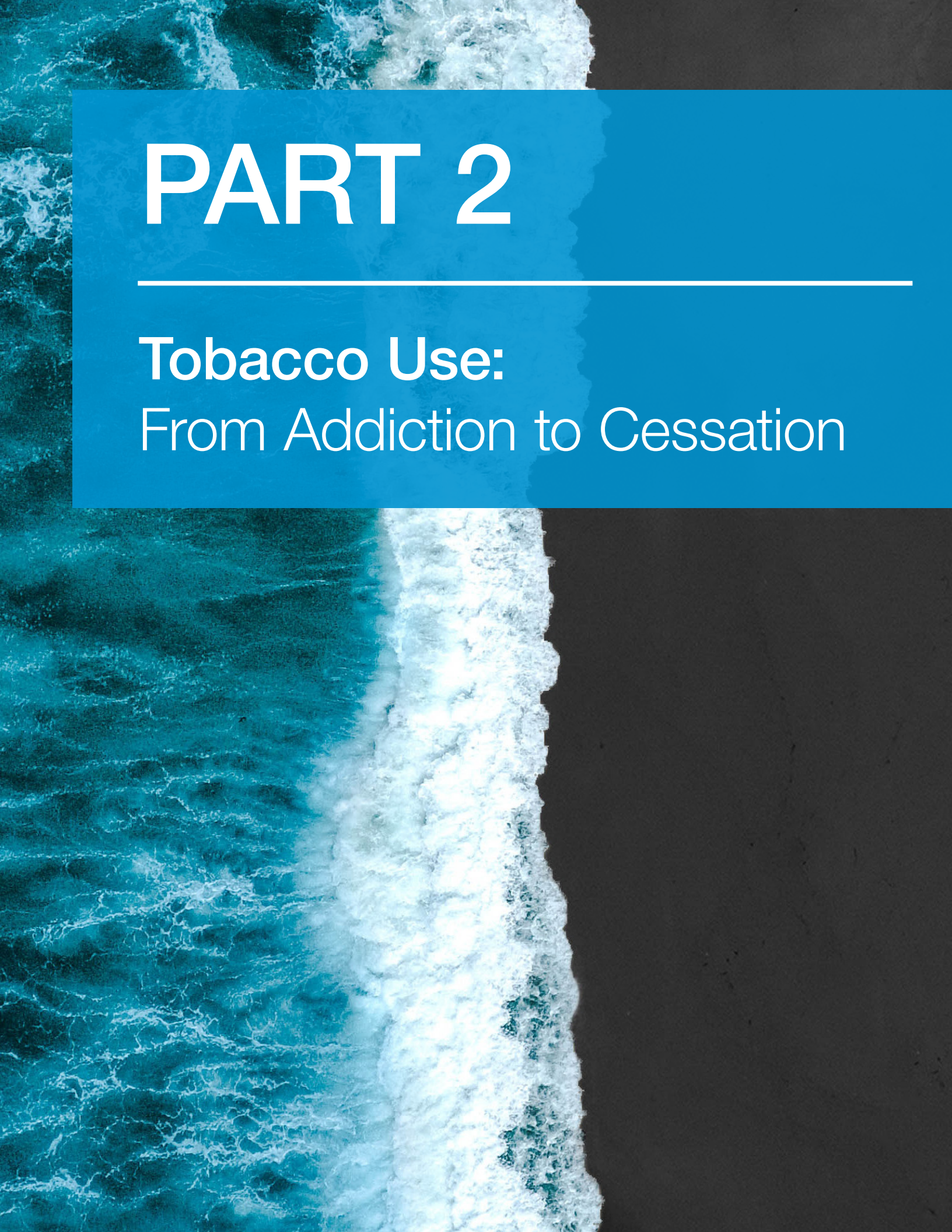


Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance Survey, 2016. Accessed from the BRFSS Web Enable Analysis Tool, https://nccd.cdc.gov/weat/index.html#/.

CA GENERAL PREVALENCE IS 11.4%, BUT INDIVIDUALS WITH BEHAVIORAL HEALTH CONDITIONS SMOKE AT MORE THAN 3X STATEWIDE RATE.

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 health. 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

Tobacco Use:
From Addiction to Cessation

TOBACCO IS VERY ADDICTIVE

- Tobacco products contain nicotine, an addictive substance. Most smokers become addicted to nicotine.[8]
- 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.[9]
- Research suggests that nicotine may be as addictive as heroin, cocaine, or alcohol.[8,10]
- More people in the United States are addicted to nicotine than to any other drug.[11]

IT ISN'T JUST THE SMOKING THAT IS 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.[12]
- Thirdhand smoke is residual nicotine and other chemicals left on indoor surfaces by tobacco smoke.[13]

TOBACCO COMPANIES TARGET "VULNERABLE POPULATIONS"

- Tobacco companies have a long history of targeting youth.[14]
- Tobacco companies have also targeted those of lower socioeconomic status through point of sale advertisements as well as more billboards in poorer areas.[15]
- 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.[16]
- 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).[17,18]

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 that cause cancer and other diseases. These disease-causing chemicals include: arsenic, benzene, and many others.

See Appendix A: Drug Interactions with Tobacco Smoke, Page 31;
Pharmacologic Product Guide: FDA-Approved Medications for Smoking Cessation, Page 33

QUITTING TOBACCO IS A CHALLENGE, BUT IT CAN BE DONE

Considering that tobacco addiction is a chronic, relapsing illness, 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 – rather than hired workers with clever techniques – in their battle against smoking.[19] 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, page 35

IMPROVED MENTAL HEALTH WITH QUITTING SMOKING

Table 1: Effect of smoking cessation on mental health. Sensitivity analysis after removal of studies of low quality (medium-Newcastle-Ottawa scale). Meta-analysis of 26 studies.

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, 2014

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)

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

It may take up to 30 quit attempts to quit successfully.[20]

Smokers who use medications and counseling to quit are twice as likely to be successful than those quitting "cold turkey."[21]

Free Services for smokers who want to quit is available from the California Smokers' Helpline, at www.nobutts.org and 1-800-NO-BUTTS.

WHAT'S THE DEAL WITH E-CIGARETTES?

- E-cigarettes are not FDA-approved cessation devices. 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" is an increasingly popular e-cigarette that is shaped like a USB flash drive. Sales of this product increased seven-fold between 2016-2017 and holds the greatest share of the e-cigarette market. Of concern is that this product is especially popular among young people.

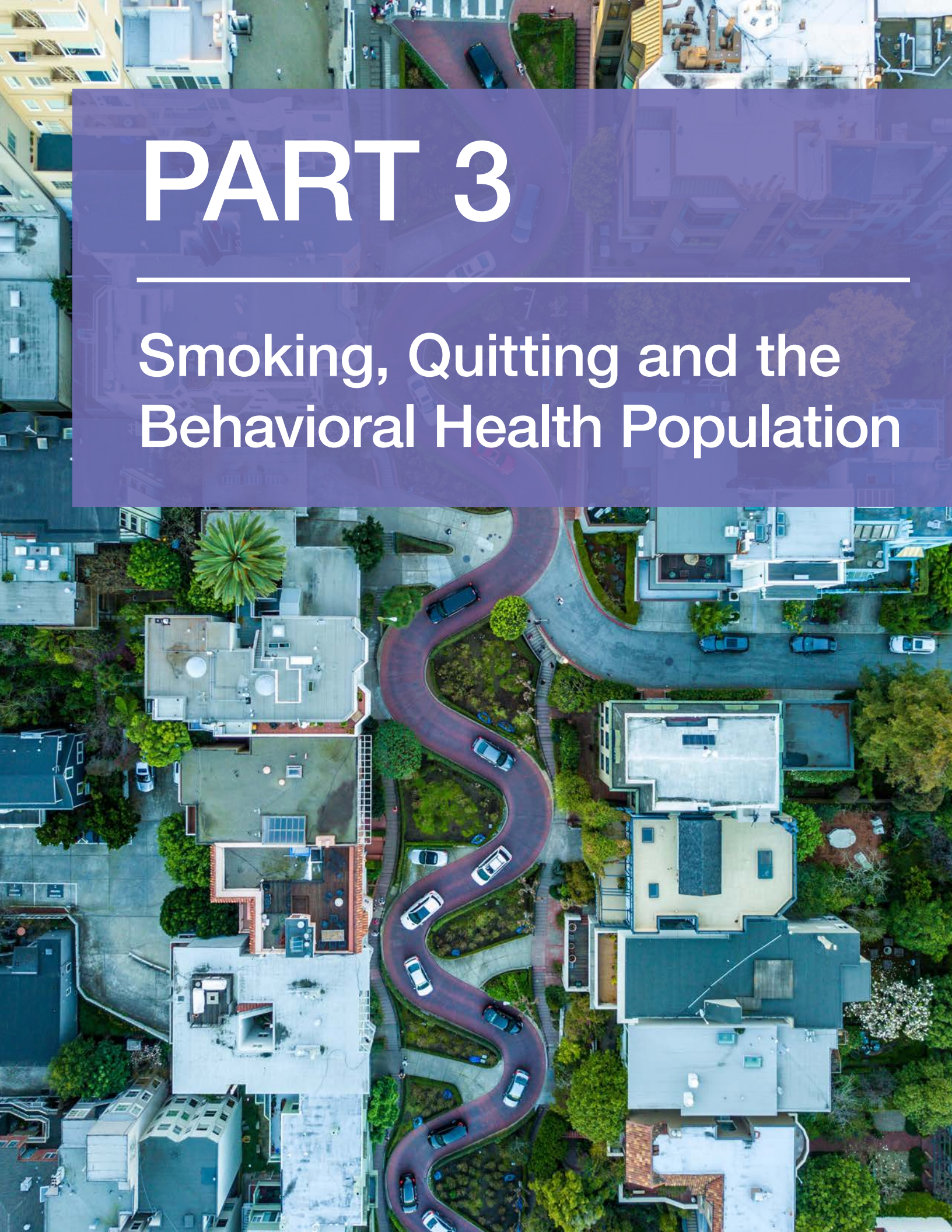
E-CIGARETTES ARE STILL FAIRLY NEW, AND SCIENTISTS ARE STILL LEARNING ABOUT THEIR LONG-TERM HEALTH EFFECTS. HERE IS WHAT WE KNOW NOW:

- 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.

Source: **https://www.cdc.gov/tobacco/basic_information/e-cigarettes/about-e-cigarettes.html**

If asked about using e-cigarettes for cessation, clinicians can stress again that the main goal is to stop or reduce the use of combustibles — and to 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 inform patients, however, that e-cigarette use can only help improve their health if it helps them reduce and eventually stop combustibles entirely.[22]

To learn more about e-cigarettes and behavioral health, visit https://smokingcessationleadership.ucsf.edu/webinars/archive for the webinar, "Vaping and E-cigs among Behavioral Health Populations: Research Evidence and Research Needs."



PART 3

Smoking, Quitting and the Behavioral Health Population

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 because of their tobacco use:

- Individuals with behavioral health conditions smoke at far higher rates than those without these disorders (32.5% vs. 15.5% rate of general population).[23]
- 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.[24]
- Individuals with a mental illness have a higher rate of fatality due to cancer.[25]
- 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.[26]
- Despite high rates of smoking among those with substance use disorders, less than half of substance abuse treatment centers offer cessation services, 44.6%.[27]
- 85% of those in treatment for opioid addiction smoke.[28]

Contrary to popular beliefs, persons with behavioral health conditions 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 addicts, 50% of alcoholics, and 42% of heroin addicts were interested in quitting smoking at the time they started treatment for their other addictions.[29] However, smokers with other substance use, psychiatric disorders, and strong nicotine dependence are less likely to succeed in a quit attempt.[30]

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

For more information on the clinical practice guideline for treating tobacco use and dependence, click on this link,
https://www.ncbi.nlm.nih.gov/books/NBK63952

THE MYTHS:

- They are not interested in quitting.
- They cannot quit.
- Quitting interferes with recovery from mental illness or addictions.
- Tobacco is not as harmful as other substances.
- Tobacco is necessary for self-medication, and tobacco cessation would be too stressful.
- Tobacco cessation efforts might prevent treatment of other addictions.

See Appendix C: "The Tobacco Epidemic Among People with Behavioral Health Disorders, page 38

THE TRUTH:

- The most common causes of death among people with mental illness are heart disease, cancer, and lung disease, which can all be caused by smoking.[31]
- With careful monitoring, delivering smoking cessation interventions does not interfere with treatments for mental illness and can actually be part of the treatment.[32]
- 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.[33]
- 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.[34]

PART 4

Preparing to Go Tobacco-Free

Having a tobacco-free policy is an important step in creating an environment for clients that supports their overall health. When considering tobacco-free policies, it is important to assess your organization's readiness to change.[35]

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

BASED ON YOUR ORGANIZATIONAL READINESS, THE BELOW ACTIONS MAY BE HELPFUL:

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, as well as working to provide a healthy workplace.
- 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 written policy based on feedback provided through meetings and focus groups.
- Consider how to deal with 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 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.

PART 5

Going Tobacco-free in California

Implementing a tobacco-free policy that includes all tobacco products, including electronic devices, 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.

BELOW IS A 10-STEP PROCESS FOR IMPLEMENTATION OF A COMPREHENSIVE TOBACCO-FREE POLICY.

Step 1: Convene a Tobacco-Free Committee
Step 2: Create a Timeline
Step 3: Craft the Message
Step 4: Draft the Policy
Step 5: Clearly Communicate your Intentions
Step 6: Educate Staff and Clients
Step 7: Provide Tobacco Cessation Services
Step 8: Build Community Support
Step 9: Launch the Policy
Step 10: Monitor the Policy and Respond to Challenges

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:

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

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 D: Model Tobacco-Free Policy Timeline, page 40

3 **Step 3: Craft the Message.** Explain why you want to address tobacco-use in your facility, and what you want to accomplish.[36]

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 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 E: Model Tobacco-Free Policies, page 41

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

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.

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 F: Sample Announcement, page 48
See Appendix G: Sample Letter to Clients, page 49

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. Remember to maintain your focus on wellness and recovery.

See Appendix H: NASMHPD Toolkit FAQ, page 50

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.[37]

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.

Elicit, 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
- 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

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 I: Sample Letter to Neighbors, page 52

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:

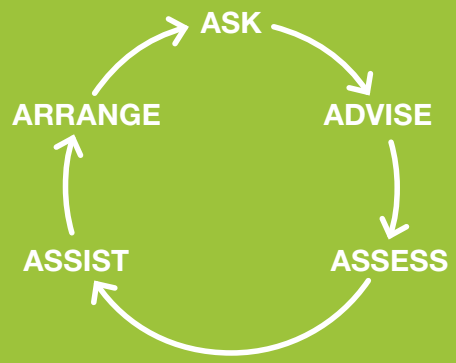
- Mental health and addictions agencies
- Primary care clinics
- Criminal justice settings (e.g., community corrections)
- Public health/county agencies
- School systems
- The Mayor's Office
- Insurance companies
- The state Medicaid office
- Homeless shelters

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:

6

- 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 opportunities.



IF YOU HAVE LIMITED TIME:

ASK → ADVISE → REFER

Free Services for smokers who want to quit is available from the California Smokers' Helpline, at www.nobutts.org and 1-800-NO-BUTTS.

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). 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 tobacco cessation medication and counseling opportunities 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.[19] 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 J: Tobacco Use Assessment (TUA), page 53

TOBACCO CESSATION MEDICATIONS

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

- Nicotine replacement therapies (NRT) include patches, gum, and lozenges (over-the-counter medications). Inhalers and nasal spray are also 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.

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.[38, 39] 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.[40, 41]

Individual or group treatment should include practical counseling (e.g., problem solving, skills training), and social support.[16] 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.

A general rule regarding smoking cessation efforts is that more is better, and the behavioral health population are case in point. More intensive treatment frequency and longer duration of treatment improve quit rates. In addition, multiple types of providers are effective in delivering tobacco treatment, and involving more than one type leads to greater success.[16]

QUITLINES

Quitllines are a tobacco cessation resource with demonstrated effectiveness that community organizations should readily utilize.[42, 43] These telephonic services are widely available to all tobacco users in the U.S. and Canada, and generally offer some combination of counseling and cessation medications. California Smokers' Helpline can be reached at **www.nobutts.org** and 800-NO-BUTTS. The helpline offers 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

1-800-622-8887

CALIFORNIA SMOKERS' HELPLINE
1-800-NO-BUTTS

The California Smokers' Helpline has a number of free materials available for organizations, including cards that can be given out to clients, visitors and staff.

Materials can be ordered at www.nobutts-catalog.org

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.[44, 45] Nicotine Anonymous is an example of a peer-to-peer support group.

More information can be found at **www.nicotine-anonymous.org** and the CDC's Tips from Former Smokers campaign, **cdc.gov/tobacco/campaign/tips/index.html**

"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 health and a role model for my children."

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 on **http://rxforchange.ucsf.edu** where registered users are free to 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. **http://www.njchoices.org/**

The Peer-to-Peer Tobacco Recovery Program. This program provides existing or emerging peer specialists 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

Additional information regarding this program is available from the University of Colorado Denver Behavioral Health & Wellness Program at **http://www.bhwellness.org**

FUNDING TOBACCO CESSATION SERVICES.

There are several potential ways of funding tobacco cessation services for both employees and clients. Some private health plans cover tobacco dependence counseling or medications; 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] Medicaid, known as Medi-Cal in California, covers all FDA-approved tobacco cessation medications.

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 Medicare CPT 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.

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

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**
- World No Tobacco Day on May 31st each year: **http://www.who.int/tobacco/wntd/en/**

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 tend to congregate to smoke. Signage should also be in the different languages representing your clients. 9

See Appendix K: Sample Signage, page 54

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.

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. 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.[47] 10

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 (such as 1-800-NO-BUTTS cards), 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.

POTENTIAL CHALLENGE	RECOMMENDATION
Overcoming resistance of staff	■ Education surrounding tobacco and tobacco-free environments often works to ease resistance to policy implementation
Managing residences and businesses within the catchment area	■ Involve neighboring businesses and homes throughout the implementation process ■ Have a representative speak at a homeowner's association meeting and talk with local business owners ■ Opening the lines of communication early on in the process is crucial to maintaining 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 ■ 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 ■ 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

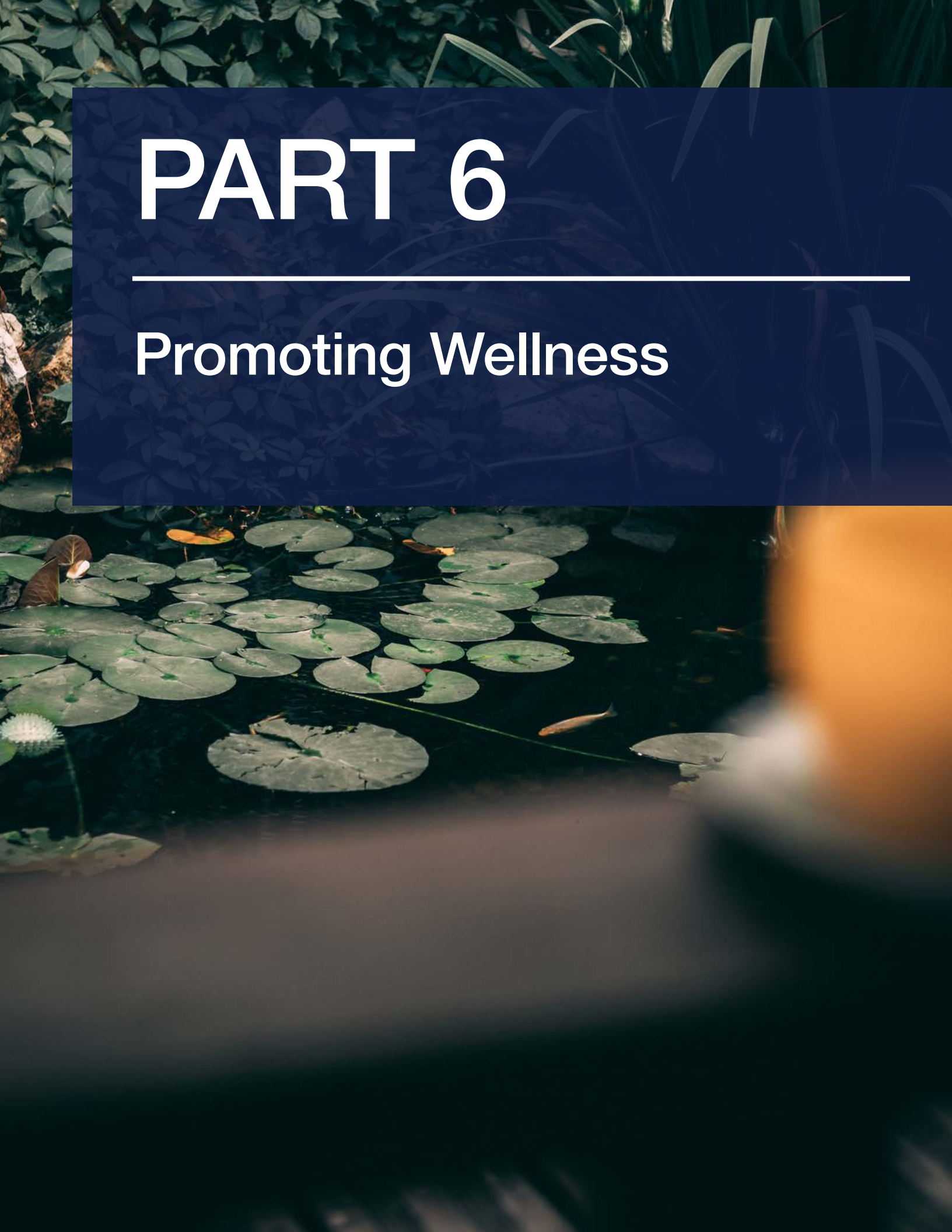
Staff members who violate the tobacco-free policy should be subject to disciplinary action, up to and including termination. The tobacco-free policy, employee handbook, hiring paperwork, and new employee orientation can all clearly refer to progressive disciplinary actions.

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.

Links to best practices and case studies are available in the Resources section of this document on page 29



PART 6

Promoting Wellness

Wellness means overall well-being. It includes the mental, emotional, physical, occupational, intellectual, and spiritual aspects of a person's life.[48] 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.

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.

See Appendix L: Relapsed Smokers Who Are Ready to Try Again: What to Do? A 3-Step Protocol for Clinicians, page 55

Clean Air Break

Smokers often look forward to smoke breaks as time to not only smoke but to take time for themselves, away from work. Clean air breaks can replace this and allow the quitter to walk around the block or campus. 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.[49]

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.[50]

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. Medications to help control mental illness symptoms can increase appetite and lead to weight gain. 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.[51]

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.[52]

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 meal. 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[53], kidney diseases, non-alcoholic liver disease[54], tooth decay and cavities[55]. 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.

Active Living

Regular physical activity helps improve overall health and fitness, and reduces risk for many chronic diseases.[56] 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.[57] 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

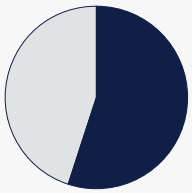
WEEKLY WEIGHT TRAINING:

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

Gambling Disorder is a progressive disorder characterized by a continuous or periodic loss of control over gambling; a preoccupation with gambling and with obtaining money with which to gamble; irrational thinking; and a continuation of the behavior despite adverse consequences.[58]



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.[59]

While many people gamble responsibly, individuals already diagnosed with addictions may be at-risk for problem gambling. Providing gambling related activities within a facility 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:[58]

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. Call 1-800-GAMBLER
Use these items to guide in providing a healthy environment for disordered gamblers and those who are at-risk of developing a problem:[60]

- 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 healthy free-time free 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 movie 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

RESOURCES

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

California's Tobacco Control Laws

Tobacco Laws Affecting California, 2018

ChangeLab Solutions

https://www.changelabsolutions.org/sites/default/files/2018_CA_Law_Booklet_FINAL_20180627.pdf

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

State of California Tobacco Control Data

https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CTCB/Pages/FactsandFigures.aspx

Smoking Cessation Leadership Center

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.

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.

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.

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.

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.

Partnership for Prevention

http://www.prevent.org

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

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."

New York State Tobacco Dependence Resource Center

http://www.TobaccoDependence.org

This center hosts a collection of resources and a large virtual community of people interested in integrating tobacco dependence interventions into chemical dependence programs.

Tobacco Recovery Resource Exchange

http://www.tobaccorecovery.org

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.

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%). • ↓ Sedation and hypotension possible in smokers; smokers may require ↑ dosages.
Clopidogrel (Plavix)	• ↑ Metabolism (induction of CYP1A2) of clopidogrel to its active metabolite. • 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%). • ↑ 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%); ↓ plasma concentrations (32%). • Dosage modifications not routinely recommended but smokers may need ↑ dosages.
Haloperidol (Haldol)	• ↑ Clearance (44%); ↓ serum concentrations (70%).
Heparin	• Mechanism unknown but ↑ clearance and ↓ half-life are observed. Smoking has prothrombotic effects. • 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. • 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. • Smokers may need ↑ dosages.
Mexiletine (Mexitil)	• ↑ Clearance (25%; via oxidation and glucuronidation); ↓ half-life (36%).

(continued)

Drug/Class	Mechanism of Interaction and Effects
Nintedanib (OFEV®)	• Decreased exposure (21%) in smokers. • No dose adjustment recommended; however, patients should not smoke during use.
Olanzapine (Zyprexa)	• ↑ Metabolism (induction of CYP1A2); ↑ clearance (98%); ↓ serum concentrations (12%). • Dosage modifications not routinely recommended but smokers may need ↑ dosages.
Pirfenidone (Esbriet®)	• ↑ Metabolism (induction of CYP1A2); ↓ AUC (46%) and ↓ Cmax (68%). • Decreased exposure in smokers might alter efficacy profile.
Propranolol (Inderal)	• ↑ Clearance (77%; via side-chain oxidation and glucuronidation).
Ropinirole (Requip)	• ↓ Cmax (30%) and AUC (38%) in study with patients with restless legs syndrome. • Smokers may need ↑ dosages.
Tacrine (Cognex)	• ↑ Metabolism (induction of CYP1A2); ↓ half-life (50%); serum concentrations 3-fold lower. • Smokers may need ↑ dosages.
Theophylline (Theo Dur, etc.)	• ↑ Metabolism (induction of CYP1A2); ↑ clearance (58–100%); ↓ half-life (63%). • Levels should be monitored if smoking is initiated, discontinued, or changed. Maintenance doses are considerably higher in smokers. • ↑ 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. • 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). • ↑ Risk with age and with heavy smoking (≥15 cigarettes per day) and is quite marked in women ≥35 years old.
Opioids (propoxyphene, pentazocine)	• ↓ Analgesic effect; smoking may ↑ the metabolism of propoxyphene (15–20%) and pentazocine (40%). Mechanism unknown. • Smokers may need ↑ opioid dosages for pain relief.

Adapted and updated, from Zevin S, Benowitz NL. Drug interactions with tobacco smoking. Clin Pharmacokinet 1999;36:425–438.

Rx for Change

Smoking Cessation Leadership Center
UCSF
University of California San Francisco

Smoking Cessation Leadership Center
UCSF
University of California San Francisco

Pharmacologic Product Guide: FDA-Approved Medications for Smoking Cessation

	Nicotine Replacement Therapy (NRT) Formulations					Bupropion SR	Varenicline
	Gum	Lozenge	Transdermal Patch	Nasal Spray	Oral Inhaler		
Product	**Nicorette[1], Generic** OTC 2 mg, 4 mg original, cinnamon, fruit, mint	**Nicorette[1], Generic** **Nicorette[1] Mini** OTC 2 mg, 4 mg; cherry, mint	**NicoDerm CQ[1], Generic** OTC (NicoDerm CQ, generic) 7 mg, 14 mg, 21 mg (24-hr release)	**Nicotrol NS[2]** Rx Metered spray 10 mg/mL nicotine solution	**Nicotrol Inhaler[2]** Rx 10 mg cartridge delivers 4 mg inhaled vapor	**Zyban[1], Generic** Rx 150 mg sustained-release tablet	**Chantix[2]** Rx 0.5 mg, 1 mg tablet
Precautions	■ Recent (≤ 2 weeks) myocardial infarction ■ Serious underlying arrhythmias ■ Serious or worsening angina pectoris ■ Temporomandibular joint disease ■ Pregnancy[3] and breastfeeding ■ Adolescents (<18 years)	■ Recent (≤ 2 weeks) myocardial infarction ■ Serious underlying arrhythmias ■ Serious or worsening angina pectoris ■ Pregnancy[3] and breastfeeding ■ Adolescents (<18 years)	■ Recent (≤ 2 weeks) myocardial infarction ■ Serious underlying arrhythmias ■ Serious or worsening angina pectoris ■ Pregnancy[3] and breastfeeding ■ Adolescents (<18 years)	■ Recent (≤ 2 weeks) myocardial infarction ■ Serious underlying arrhythmias ■ Serious or worsening angina pectoris ■ Underlying chronic nasal disorders (rhinitis, nasal polyps, sinusitis) ■ Severe reactive airway disease ■ Pregnancy[3] and breastfeeding ■ Adolescents (<18 years)	■ Recent (≤ 2 weeks) myocardial infarction ■ Serious underlying arrhythmias ■ Serious or worsening angina pectoris ■ Bronchospastic disease ■ Pregnancy[3] and breastfeeding ■ Adolescents (<18 years)	■ Concomitant therapy with medications/conditions known to lower the seizure threshold ■ Hepatic impairment ■ Pregnancy3 and breastfeeding ■ Adolescents (<18 years) ■ Treatment-emergent neuropsychiatric symptoms[4] Boxed warning removed 12/2016 **Contraindications:** ■ Seizure disorder ■ Concomitant bupropion (e.g., Wellbutrin) therapy ■ Current or prior diagnosis of bulimia or anorexia nervosa ■ Simultaneous abrupt discontinuation of alcohol or sedatives/benzodiazepines ■ MAO inhibitors in preceding 14 days; concurrent use of reversible MAO inhibitors	■ Severe renal impairment (dosage adjustment is necessary) ■ Pregnancy[3] and breastfeeding ■ Adolescents (<18 years) ■ Treatment-emergent neuropsychiatric symptoms[4] Boxed warning removed 12/2016
Dosing	*1st cigarette ≤30 minutes after waking: 4 mg* *1st cigarette >30 minutes after waking: 2 mg* Weeks 1–6: 1 piece q 1–2 hours Weeks 7–9: 1 piece q 2–4 hours Weeks 10–12: 1 piece q 4–8 hours ■ Maximum, 24 pieces/day ■ Chew each piece slowly ■ Park between cheek and gum when peppery or tingling sensation appears (~15–30 chews) ■ Resume chewing when tingle fades ■ Repeat chew/park steps until most of the nicotine is gone (tingle does not return; generally 30 min) ■ Park in different areas of mouth ■ No food or beverages 15 minutes before or during use ■ Duration: up to 12 weeks	*1st cigarette ≤30 minutes after waking: 4 mg* *1st cigarette >30 minutes after waking: 2 mg* Weeks 1–6: 1 lozenge q 1–2 hours Weeks 7–9: 1 lozenge q 2–4 hours Weeks 10–12: 1 lozenge q 4–8 hours ■ Maximum, 20 lozenges/day ■ Allow to dissolve slowly (20–30 minutes) ■ Nicotine release may cause a warm, tingling sensation ■ Do not chew or swallow ■ Occasionally rotate to different areas of the mouth ■ No food or beverages 15 minutes before or during use ■ Duration: up to 12 weeks	<u>≥10 cigarettes/day:</u> 21 mg/day x 4–6 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks <u>≤10 cigarettes/day:</u> 14 mg/day x 6 weeks 7 mg/day x 2 weeks ■ Rotate patch application site daily; do not apply a new patch to the same skin site for at least one week ■ May wear patch for 16 hours if patient experiences sleep disturbances (remove at bedtime) ■ Duration: 8–10 weeks	1–2 doses/hour (8–40 doses/day) One dose = 2 sprays (one in each nostril); each spray delivers 0.5 mg of nicotine to the nasal mucosa ■ Maximum - 5 doses/hour or - 40 doses/day ■ For best results, initially use at least 8 doses/day ■ Do not sniff, swallow, or inhale through the nose as the spray is being administered ■ Duration: 3 months	6–16 cartridges/day Individualize dosing; initially use 1 cartridge q 1–2 hours ■ Best effects with continuous puffing for 20 minutes ■ Initially use at least 6 cartridges/day ■ Nicotine in cartridge is depleted after 20 minutes of active puffing ■ Inhale into back of throat or puff in short breaths ■ Do NOT inhale into the lungs (like a cigarette) but "puff" as if lighting a pipe ■ Open cartridge retains potency for 24 hours ■ No food or beverages 15 minutes before or during use ■ Duration: 3–6 months	150 mg po q AM x 3 days, then 150 mg po bid ■ Do not exceed 300 mg/day ■ Begin therapy 1–2 weeks prior to quit date ■ Allow at least 8 hours between doses ■ Avoid bedtime dosing to minimize insomnia ■ Dose tapering is not necessary ■ Duration: 7–12 weeks, with maintenance up to 6 months in selected patients	Days 1–3: 0.5 mg po q AM Days 4–7: 0.5 mg po bid Weeks 2–12: 1 mg po bid ■ Begin therapy 1 week prior to quit date ■ Take dose after eating and with a full glass of water ■ Dose tapering is not necessary ■ Dosing adjustment is necessary for patients with severe renal impairment ■ Duration: 12 weeks; an additional 12-week course may be used in selected patients ■ May initiate up to 35 days before target quit date OR may reduce smoking over a 12-week period of treatment prior to quitting and continue treatment for an additional 12 weeks

	Nicotine Replacement Therapy (NRT) Formulations					Bupropion SR	Varenicline
	Gum	Lozenge	Transdermal Patch	Nasal Spray	Oral Inhaler		
Adverse Effects	■ Mouth and throat irritation ■ Jaw muscle soreness ■ Hiccups ■ GI complaints (dyspepsia, nausea) ■ May stick to dental work ■ Adverse effects more commonly experienced when chewing the lozenge or using incorrect gum chewing technique (due to rapid nicotine release): - Lightheadedness/dizziness - Nausea/vomiting - Hiccups - Mouth and throat irritation	■ Mouth and throat irritation ■ Hiccups ■ GI complaints (dyspepsia, nausea)	■ Local skin reactions (erythema, pruritus, burning) ■ Sleep disturbances (abnormal or vivid dreams, insomnia); associated with nocturnal nicotine absorption	■ Nasal and/or throat irritation (hot, peppery, or burning sensation) ■ Ocular irritation/tearing ■ Sneezing ■ Cough	■ Mouth and/or throat irritation ■ Cough ■ Hiccups ■ GI complaints (dyspepsia, nausea)	■ Insomnia ■ Dry mouth ■ Nausea ■ Anxiety/difficulty concentrating ■ Constipation ■ Tremor ■ Rash ■ Seizures (risk is 0.1%) ■ Neuropsychiatric symptoms (rare; see Precautions)	■ Nausea ■ Sleep disturbances (insomnia, abnormal/vivid dreams) ■ Headache ■ Flatulence ■ Constipation ■ Taste alteration ■ Neuropsychiatric symptoms (rare; see Precautions)
Advantages	■ Might serve as an oral substitute for tobacco ■ Might delay weight gain ■ Can be titrated to manage withdrawal symptoms ■ Can be used in combination with other agents to manage situational urges ■ Relatively inexpensive	■ Might serve as an oral substitute for tobacco ■ Might delay weight gain ■ Can be titrated to manage withdrawal symptoms ■ Can be used in combination with other agents to manage situational urges ■ Relatively inexpensive	■ Once-daily dosing associated with fewer adherence problems ■ Of all NRT products, its use is least obvious to others ■ Can be used in combination with other agents; delivers consistent nicotine levels over 24 hours ■ Relatively inexpensive	■ Can be titrated to rapidly manage withdrawal symptoms ■ Can be used in combination with other agents to manage situational urges	■ Might serve as an oral substitute for tobacco ■ Can be titrated to manage withdrawal symptoms ■ Mimics hand-to-mouth ritual of smoking ■ Can be used in combination with other agents to manage situational urges	■ Twice-daily oral dosing is simple and associated with fewer adherence problems ■ Might delay weight gain ■ Might be beneficial in patients with depression ■ Can be used in combination with NRT agents ■ Relatively inexpensive (generic formulations)	■ Twice-daily oral dosing is simple and associated with fewer adherence problems ■ Offers a different mechanism of action for patients who have failed other agents ■ Most effective cessation agent when used as monotherapy
Disadvantages	■ Need for frequent dosing can compromise adherence ■ Might be problematic for patients with significant dental work ■ Proper chewing technique is necessary for effectiveness and to minimize adverse effects ■ Gum chewing might not be acceptable or desirable for some patients	■ Need for frequent dosing can compromise adherence ■ Gastrointestinal side effects (nausea, hiccups, heartburn) might be bothersome	■ When used as monotherapy, cannot be titrated to acutely manage withdrawal symptoms ■ Not recommended for use by patients with dermatologic conditions (e.g., psoriasis, eczema, atopic dermatitis)	■ Need for frequent dosing can compromise adherence ■ Nasal administration might not be acceptable or desirable for some patients; nasal irritation often problematic ■ Not recommended for use by patients with chronic nasal disorders or severe reactive airway disease ■ Cost of treatment	■ Need for frequent dosing can compromise adherence ■ Cartridges might be less effective in cold environments (≤60°F) ■ Cost of treatment	■ Seizure risk is increased ■ Several contraindications and precautions preclude use in some patients (see Precautions) ■ Patients should be monitored for potential neuropsychiatric symptoms[4] (see Precautions)	■ Patients should be monitored for potential neuropsychiatric symptoms[4] (see Precautions) ■ Cost of treatment
Cost/day[5]	2 mg or 4 mg: $1.90–$5.49 (9 pieces)	2 mg or 4 mg: $3.33–$4.23 (9 pieces)	$1.52–$3.49 (1 patch)	$8.75 (8 doses)	$14.95 (6 cartridges)	$2.58–$8.25 (2 tablets)	$15.90 (2 tablets)

[1] Marketed by GlaxoSmithKline.

[2] Marketed by Pfizer.

[3] The U.S. Clinical Practice Guideline states that pregnant smokers should be encouraged to quit without medication based on insufficient evidence of effectiveness and theoretical concerns with safety. Pregnant smokers should be offered behavioral counseling interventions that exceed minimal advice to quit.

[4] In July 2009, the FDA mandated that the prescribing information for all bupropion- and varenicline-containing products include a black-boxed warning highlighting the risk of serious neuropsychiatric symptoms, including changes in behavior, hostility, agitation, depressed mood, suicidal thoughts and behavior, and attempted suicide. Clinicians should advise patients to stop taking varenicline or bupropion SR and contact a health care provider immediately if they experience agitation, depressed mood, or any changes in behavior that are not typical of nicotine withdrawal, or if they experience suicidal thoughts or behavior. If treatment is stopped due to neuropsychiatric symptoms, patients should be monitored until the symptoms resolve. Based on results of a mandated clinical trial, the FDA removed this boxed warning in December 2016.

[5] Approximate cost based on the recommended initial dosing for each agent and the wholesale acquisition cost from Red Book Online. Thomson Reuters, January 2019.

Rx for Change

Abbreviations: MAO, monoamine oxidase; NRT, nicotine replacement therapy; OTC, over-the-counter (nonprescription product); Rx, prescription product.

For complete prescribing information and a comprehensive listing of warnings and precautions, please refer to the manufacturers' package inserts.

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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

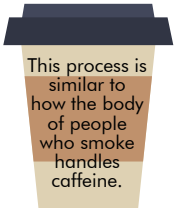
"Approximately **25%** of adults in the U.S. have some form of mental illness or substance use disorder*, and these adults consume almost **40%** of all cigarettes smoked by adults."
(Centers for Disease Control and Prevention)

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.



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

He also smokes. Recently, he successfully quit smoking.

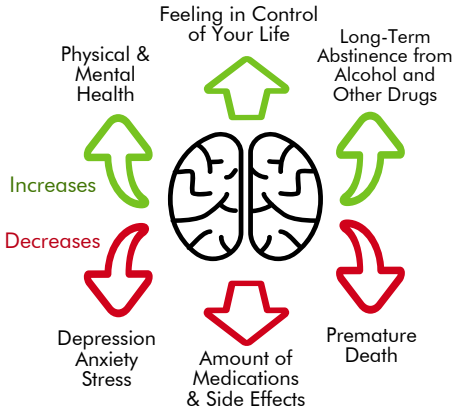
After quitting smoking, Joe still drank a lot of coffee.

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

If you are interested in quitting smoking talk with:

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

You can also call:
California Smokers' Helpline
1-800-NO-BUTTS

Or

Nicotine Anonymous
1-877-879-6422 toll free

Or phone meetings
605-475-6230
Enter Pin # 4567891

Or

Go Online to:
Becomeanex.org
Quitnet.com

Or Call These People

_____

_____

_____

_____

Benefits of Quitting Tobacco – over time - for People in Mental Health Recovery

Health

- It is easier to breathe when walking upstairs or running for a bus.
- People have less coughs, colds, and flu.
- 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.

Relationships and Socializing

- At first it may seem like quitting is interfering with your personal relationships. Over time things 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 hug and kiss 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.

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

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

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 CA Smokers' Helpline.
- 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 activites–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

Facts About Tobacco & Mental Illness and Substance Abuse

- 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.**

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
- Health usually improves and people feel better.
- 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 2015, the percentage of adults aged 18 and over who were current cigarette smokers was 15.1%.[3]
- It is estimated that secondhand smoke caused nearly 34,000 heart disease deaths and 7,300 each year during 2005–2009 among adult nonsmokers in the United States.[2]
- People with mental illness and/or substance use disorders smoke 40% of all cigarettes produced in the U.S., with 30.9% of all cigarettes smoked only by those with a mental illness.[4, 6]
- Almost half (200,000) of annual deaths from smoking are among people with mental illness and/or substance use disorders.[5]
- Nearly 1 in 3 adults (31.6%) with mental illness smoke cigarettes, compared with around 1 in 5 adults (18.7%).[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.[7]
- Persons with mental illness and/or substance use disorders die, on average, about 5 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]
- About 1 in 3 mental health centers offer cessation services, 32.6%.[10]
- 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 were not current cigarette smokers.[11]
- Current cigarette smokers 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.[11]
- Individuals with drug problems who also smoke are four times more likely to die prematurely relative to individuals with drug problems who do not use tobacco.[12]
- Less than half of substance abuse treatment centers offer cessation services, 44.6%.[13]
- 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 addicts, 50% of alcoholics, and 42% of heroin addicts were interested in quitting smoking at the time they started treatment for their other addictions.[14]
- Treating tobacco use during additions treatment increases likelihood of abstinence from alcohol and illicit drugs by 25%.[15]
- More than 50% of patients with terminal cancer have at least one psychiatric disorder.[16]
- 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.[17]
- Individuals with a mental illness have a higher rate of fatality due to cancer.[18]

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.

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APPENDIX D: 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 E: 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

Tobacco or Nicotine Delivery Products – Cigarettes, pipes, pipe tobacco, tobacco substitutes (e.g., clove cigarettes), chewing tobacco, cigars, e-cigarettes.

Tobacco Paraphernalia – combustible material is contraband unless authorized (see Policy #32.12, Declaration of Contraband).

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.

II. 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.

III. 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) employees and other employees who work on the (name) campus will be advised of the provisions of this policy during New Employee Orientation.
4. (name) will post this policy in employee common areas and in the (name) New Employee Orientation Handbook.

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 excluding breaks. 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 (or Patients)

1. Inpatients and outpatients 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 except in the individual's locked personal vehicle.
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. Smoking outside on property and refuses to comply with policy. Smoking in personal vehicle on campus. *Excessive absences from the workplace during assigned shift (extra breaks, longer lunch breaks, etc.). *Employee's clothing smells strongly of tobacco smoke.	The supervisor must have verifiable reports of the infractions and/ or have witnessed the infraction directly. 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. 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. 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. 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.

Signatures: _____

BOILER PLATE TOBACCO POLICY

INTRODUCTION:

_____agency is dedicated to improving the health of our patients and communities we serve. The health hazards of smoking and tobacco use are well known. Tobacco use is the number one cause of preventable illness and death across the nation. Allowing the use of tobacco products in and around our campus does not support the image of our Center as a health care leader in the behavioral health/SUD community and does not promote a healthy environment for our patients' employees and other stakeholders. In keeping with our image of being a health care leader we are encouraging our employees, patients and visitors to be tobacco –free consistent with our mission of [insert agency mission here] _____

_____

_____

SCOPE: This Policy is effective as of _____ and applies to all patients, visitors, contractors, physicians, volunteers and employees of _____agency. It is applicable at all campuses, facilities, vehicles and programs.

This prohibition includes but is not limited to cigarettes, cigars, snuff, pipes, chewing tobacco, and any form of electronic smoking devices. (1)

PROCEDURES:

1. Smoking and the use or possession of tobacco products (cigarettes, cigars, chewing tobacco, snuff, pipes, etc.) is prohibited in or on all _____agency owned or leased buildings, grounds, parking lots or vehicles.
2. Smoking in private vehicles on _____ agency owned or leased properties is also not allowed.
3. This policy applies to facilities leased by _____agency whether or not the owner or other tenants follow similar guidelines. No exceptions to this policy will be granted.
4. We will be implementing tobacco-free workdays (no tobacco use at work) to protect staff, clients and visitors from 2nd and 3rd hand smoke.
5. Smoke odors at any time are not allowed. (Cross reference: Human Resources Dress Code Policy or other appropriate policy)
6. Employees are prohibited from using tobacco products on the _____agency campus and contiguous property anytime during their work shift.
7. _____wishes to maintain good relationships with its neighbors, so loitering on or littering (including cigarette butts) on, smoking on, or the use of tobacco products on neighboring property is not permitted.
8. Human resources will post on all job postings, inform all candidates through the hiring process, and inform all new hires at orientation that the organization is a tobacco-free workplace.
9. Signs will be posted at strategic locations around _____agency campuses to notify staff, visitors, contractors, volunteers and patients of this policy.
10. Patients will be informed of the tobacco-free policy during the admission and/or pre-admission process. Patient information, such as the Patient handouts, pre-admission materials, brochures etc. will include notice regarding _____agency tobacco-free policies. Patient alternatives to smoking will be offered.
11. All employees are authorized to communicate this policy with courtesy and diplomacy to other employees, contractors, volunteers, patients and visitors.

12. Use of tobacco products is prohibited in all company vehicles.
13. As with other agency policies, employees who violate this policy will be subject to our usual disciplinary procedures.
14. _____agency will adopt clinical practices that include routinely completing Tobacco Use Assessment (TUA) and provide client education and training on health related topics as part of psycho education, including the health hazards and behavioral health recovery hazards of tobacco use and the benefits of being tobacco-free as well as information and resources to assist with tobacco dependence treatment (cessation).
15. _____Agency will periodically monitor compliance and assess rate of completed TUA in client's charts.

(1) This policy includes any tobacco product yet to be invented except products specifically tested for safety and efficacy and approved by the FDA (Federal Drug Administration) for treatment of tobacco use disorder/tobacco dependence.

Adapted from Betty Hardwick Center from the

Taking Texas Tobacco-free Archives

TOBACCO-FREE POLICY SAMPLE: THUNDER ROAD TREATMENT FACILITY

Nicotine is an addictive substance in tobacco. Tobacco use is the cause of numerous diseases and health problems, both for the intentional user and for bystanders. Tobacco is a gateway drug that is statistically linked to the use by teenagers of alcohol and other drugs. Tobacco use has been shown to correlate with higher relapse rates for persons in recovery from alcohol and other drugs. (Stuyt, 1997; Frosch, 2000; Prochaska 2004)

Thunder Road is a tobacco-free program. Thunder Road will endeavor to assist all clients to become or remain tobacco-free. Our program and policies regarding tobacco comprehensively address tobacco use and dependence as well as the issues of pollution inherent in a smoking environment. Clients are provided with education, cessation, and counseling services to assist them during the residential phase of treatment and to support them in a tobacco-free lifestyle thereafter. In addition, staff are encouraged to become free of tobacco dependence and required to have no evidence of tobacco use at work as of August 1, 1999.

Tobacco-Free Program.

1. Client Services. The following basic clinical services address client tobacco use:

   - Evidence. Clients and families will be expected to have no evidence of tobacco use at Thunder Road as of August 1, 1999.
   - Assessment. Tobacco use is included as a part of the detailed histories and assessments conducted by staff members as a part of the admissions process.
   - Counseling. Clinical staff members in all Thunder Road programs are expected to routinely incorporate tobacco dependence treatment in treatment planning, counseling, and other clinical activities at Thunder Road. They are also required to assist tobacco-dependent family members to address their own tobacco use or dependence issues.
   - Therapeutic Community Management. Staff involved in monitoring and guiding the therapeutic community aspects of the program 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.
   - 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.
   - Medical Interventions. In appropriate circumstances, medical staff may make appropriate prescription therapies or other medical interventions available to clients who are experiencing withdrawal from tobacco addiction.
   - Prohibition of Tobacco Products. Clients, families, staff, and visitors are prohibited from having or using tobacco products or paraphernalia (lighters, rolling papers, promotional clothing, and other tobacco brand-specific items) at Thunder Road. Clients failing to comply will receive consequences appropriate under the circumstances of each case.
   - Continuing Care. Tobacco dependence treatment support will continue throughout the continuing care phase of treatment with appropriate treatment planning and education.
   - Client/Family Compliance. Violation of this policy by clients or their families will be addressed as a treatment issue first, and as a disciplinary issue if violations persist. Repeated violations may result in a variety of consequences up to and including termination from the program and a treatment meeting will be scheduled with members of the multidisciplinary team.
   - Visitor Compliance. Visitors will be informed of the policy and asked to comply. A visitor who persists in violating this policy will be asked to leave.

2. Staff Training and Standards of Conduct Relating to Tobacco. Staff members are required to meet the following standards in connection with the tobacco-free program.

- Tobacco-Free Facility and Grounds. No tobacco use is allowed within the facility, on the Thunder Road grounds, or in sight of Thunder Road by any persons, including clients, staff, or parents. Visitors will be encouraged not to use tobacco products in the vicinity of the program. Visitors will be required to not use tobacco products at Thunder Road or while participating in activities sanctioned by Thunder Road. There is to be no smoking in any facility vehicle or during any Thunder Road activity offsite.

- Avoiding Staff Reinforcement of Tobacco Use. Staff are to refrain from discussing smoking habits or pleasures, and adhere to the August 1, 1999, guideline of "no evidence of tobacco use at work," including no smell of tobacco.

- Support of Nicotine Dependence Treatment. Staff will support the nicotine-free program by giving a uniform message to the clients regarding the hazards of smoking, the risks of addiction, the desirability of staying tobacco-free, and the need for inclusion of tobacco in basic clinical interventions. Staff will not display any pro-tobacco logos or messages on their clothing or in other products or materials displayed during working hours.

- Staff Tobacco Dependence Training. 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.
  - Tobacco use in teenagers
  - Relapse prevention in teenagers.
  - The integration of tobacco dependence treatment into the treatment of alcohol and drug addictions.

All other staff members will participate in an in-service training on tobacco and this policy as a part of the regular new staff orientation program.

Staff Tobacco Dependence. As of August 1, 1999, all staff have been prohibited from using tobacco products during work hours, including but not limited to displaying evidence of tobacco use, visibly carrying either tobacco products or paraphernalia, or smelling of tobacco. Since October 1, 1998, new hires have been expected to be tobacco -free, neither visibly carrying tobacco products or paraphernalia or smell of tobacco. Thunder Road provides a variety of resources to staff members who are interested in discontinuing tobacco use themselves. All of these resources are voluntarily accessed by the individual staff member.

1. *Treatment and Stress Management Resources.* Thunder Road makes available to all staff a written guide to all tobacco treatment and cessation resources in the geographic area, particularly identifying those which are available under the employee health plans used by staff. The guide includes resources that are unrelated to existing employee benefits. The program will develop resources to assist staff to manage stress, with the overall goal of reducing the impetus of smokers or former smokers to smoke.

2. *Management Training.* Managers will receive training on ways they can be supportive to tobacco-dependent staff who have chosen to quit using.

3. *Monitoring.* All employees, clients, volunteers, and visitors are expected to adhere to this policy. All employees are expected to be familiar with it and to monitor compliance. Employees who do not follow this policy will be subject to the same disciplinary procedures used for any performance issue.

4. *Nicotine Replacement Therapy.* Staff, family members, and Continuing Care clients may use nicotine replacement therapy (NRT, i.e., over-the-counter nicotine patches) on site as part of their tobacco dependence treatment.

APPENDIX F: SAMPLE ANNOUNCEMENT

(Adapted from Kaiser Permanente, Northern California)

Smoke-Free Campus

Open Letter to Physicians and Staff

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. The California Smokers' Helpline also offers telephone counseling free of charge at 1-800-NO-BUTTS.

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 G: 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-No-BUTTS, where trained coaches can help you through the quitting process.

Sincerely,

NAME OF CEO/PRESIDENT OF AGENCY

APPENDIX H: 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 I: 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 J: TOBACCO USE ASSESSMENT (TUA)

ACBHCS Tobacco Use Assessment
TUA

Name _____ ID # _____ Date of Birth _____ Assessment 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
- ☐ Hypnosis
- ☐ 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)
- ☐ Clozapine (Clozaril)
- ☐ 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
- ☐ Benefits of quitting in mental health recovery
- ☐ Stop smoking checklist

If other, please specify: _____

APPENDIX K: SAMPLE SIGNAGE

APPENDIX L: RELAPSED SMOKERS WHO ARE READY TO TRY AGAIN: WHAT TO DO?

Smoking Cessation Leadership Center
UCSF
University of California San Francisco

Relapsed Smokers Who Are Ready to Try Again: What to Do?

A 3-Step Protocol for Clinicians

Many smokers who relapse do so because they fail to plan. Often, patients think that they can simply "make" themselves quit and do not avail themselves of the many proven behavior change programs provided by various sources. The average person who quits does so after many unsuccessful attempts—estimated from 10 to as many as 30[1]. Furthermore, most smokers do not use a cessation medication or, if they do, they use it incorrectly. Generally speaking, patients significantly under-dose or stop pharmacologic therapy too soon.

You can help relapsed smokers regain abstinence by encouraging them to learn from their prior experiences rather than use those experiences as proof that they cannot quit. To underscore this perspective, inform patients that the best way to quit smoking is to combine a behavior change program with a cessation medication. The following **3-step protocol** will help you provide this information in an efficient, effective manner for patients who are ready to try again:

Step 1: ASK

- "Tell me about your last quit attempt (s)."
- "Did you use a smoking cessation medicine?"
    - **If yes:** "Please tell me how you used your medicine."
      -Reinforce proper usage/rectify incorrect usage or dosage.
    - **If no:** "What was your reasoning for not using a medicine?"
- "Did you receive any professional advice or enroll in a behavior change program?"
    - **If yes:** "Tell me what you liked or didn't like about the assistance you received."
    - **If no:** "What was your reasoning for not seeking advice or enrolling in a program?"

Step 2: ADVISE

- "According to the most current research, the best way to quit is to combine one or more smoking cessation medicines with a behavioral program."
  Note: examples of behavior change programs are listed on the reverse side, under the "Refer" section of the protocol.
- "Let's discuss which medicine(s) would be best for you."
- Review current level of tobacco use, past usage of medications, personal preference, precautions/contraindications, etc. to determine best product for current quit attempt.
  Note: refer to the Rx for change ***Pharmacologic Product Guide*** for dosing instructions, etc. for FDA-approved smoking cessation medications.
- Consider the following options:
    - If prior medication was used correctly, was well tolerated, and appeared to have been effective, consider repeating the same medication regiment in conjunction with an enhanced behavioral program.
    - If prior medication was used incorrectly, carefully review usage instructions.
    - If prior medication was used correctly but did not control urges/withdrawal, or if patient prefers something new, review other medication options, including both single and combination therapy:

(continued)

Combination therapy is supported by multiple clinical trials and the *Clinical Practice Guideline for Treating Tobacco Use and Dependence* (p. 118):

- *Safe:* Most smokers are highly tolerant to nicotine from years of smoking. Side effects are rare and easily mitigated by reducing or stopping use.
- *Effective:* Can be considered a first-line approach for any patient, but is particularly applicable for those who failed with one medication and those who are heavily dependent (2 or more packs/day).

Suggested combinations:

- Nicotine patch + *ad libitum* gum, lozenge, inhaler, or nasal spray as needed for situational cravings.
- Sustained-release bupropion (Zyban) + nicotine patch.

Currently, there is insufficient evidence to routinely recommend varenicline (Chantix) as part of combination therapy.

Step 3: REFER

The amount of counseling that patients receive linearly related to their success in quitting. More counseling contacts yield higher quit rates. If you do not have the time or expertise to assist patients with quitting and to provide follow-up counseling, refer patients to other resources:

- To a behavior change program:
  "Here are some suggestions. Which do you think would work best for you?"
  - 1 800 QUIT NOW, the national toll-free telephone quit line.
  - All products are accompanied by a free behavior change program: Refer to usage instructions for enrollment procedures.
  - Hospital-based or other local resources (e.g. a group program).
  - BecomeanEx.org, an on-line tobacco cessation support program.
  - Smokefree.gov, an on-line guide for quitting.
  - American Lung Association, American Cancer Society, or American Heart Association web-sites or cessation programs (e.g. American Lung Association's Freedom From Smoking group cessation program).
  - Local pharmacist, physician or other health-care provider specializing in cessation.
- When referring a patient to a community pharmacist, advise the patient:
  - "When you purchase your smoking cessation medicine(s), please take a few minutes to discuss proper usage with the pharmacist, even if it is a product you have used in the past. Proper usage will give you the best chance of success.

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For complete prescribing information, please refer to the manufacturers' package inserts.

Rx for Change

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Tobacco-free Toolkit
for Behavioral Health Agencies

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