Taking Texas Tobacco Free: A Step-by-Step Guide to Implementing a Multi-Component Tobacco Free Workplace Program within Behavioral Health Settings

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Introduction to the Taking Texas Tobacco Free Program

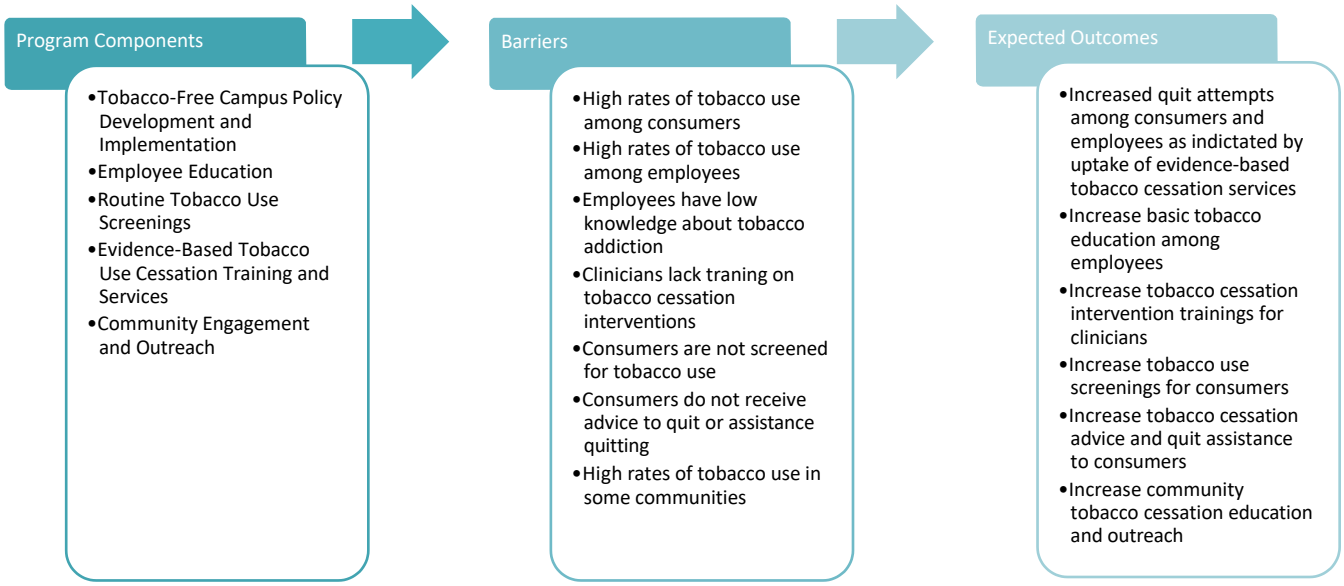
Taking Texas Tobacco Free (TTTF) is an evidence-based organizational-level intervention funded by the Cancer Prevention & Research Institute of Texas that provides practical advice, technical assistance, consultation, education, training, and treatment resources to behavioral health centers throughout the state of Texas. TTTF assisted centers to implement a multi-component tobacco-free workplace program that included: 1) tobacco-free campus policies; 2) education to all staff; 3) the integration of tobacco use assessments (TUAs; e.g., tobacco use screenings) into routine practice; 4) training of clinicians on evidence-based tobacco use cessation services and their provision to staff and consumers; and 5) a community engagement and outreach component.

The focus on organizations treating individuals with mental and behavioral health needs is critically important to cancer prevention because these individuals: 1) comprise 21% of the population but represent approximately 44.3% of the tobacco market[1]; 2) account for as many as 50% of annual smoking-related premature deaths[2]; 3) experience cancer incidence that is 70% higher than the general population predominately due to tobacco use [3-6]; and 4) despite the existence of effective treatments and overall decline in tobacco use among the general population, have smoking rates that have remained relatively static over time, suggesting that they benefit less from existing tobacco control interventions than other tobacco users.[7-9] Organizational-level interventions are necessary to affect tobacco use rates among subgroups experiencing tobacco-related disparities because they yield greater reach with enhanced cost-effectiveness relative to individual-level treatments.[10,11] Therefore, evidence-based tobacco-free workplace programs like TTTF have the potential to make a significant impact on the prevention of tobacco-related cancers among individuals with mental or behavioral health needs and those that serve them.

Comprehensive tobacco-free workplace programs are multi-component programs that include a tobacco-free workplace policy as well as attention to the identification and treatment of tobacco users through provider training/education and the implementation of regular screening and treatment/referral policies/procedures. Tobacco-free workplace policies that completely prohibit the use of tobacco and other nicotine delivery products on worksite property alone are an effective means in reducing tobacco use and dependence.[12] For example, smokers employed in workplaces with complete smoking bans are more likely to consider quitting and quit at higher rates than those employed at workplaces with partial or no bans.[13] The implementation of tobacco-free workplaces, particularly when coupled with the provision of tobacco use cessation resources, may also reduce smoking rates among those who continue to smoke.[13] Additional benefits include reduced absenteeism, reduction in smoking-related fires, increases in staff productivity, averted medical costs,[14] sustenance of cessation through the elimination of tobacco cues, and a reduction in exposure to environmental tobacco smoke (ETS) among non-smokers.[12,13]

TTTF was adapted from a comprehensive tobacco-free workplace program previously implemented within Integral Care, one of the 39 Local Mental Health Authorities (LMHAs) serving individuals with behavioral health needs in Texas, and was guided by recommendations for comprehensive tobacco control programming.[15-17] TTTF was specifically designed to increase the capacity for and the provision of evidence-based interventions for tobacco use in LMHAs because the delivery of evidence-based interventions is known to increase quit attempts and cessation.[16] TTTF program components were designed to address consumer-level, center-level, and community-level barriers and thereby meet the need for evidence-based service provision within the targeted LMHAs. Primary program components entailed tobacco-free campus policy implementation and enforcement (organization-level); staff education about tobacco use hazards (staff-level); provider training to regularly screen for and address tobacco dependence via intervention (provider-level); and community outreach to address and prevent tobacco use more broadly (community-level). These are further explicated in the figure below. To maximize buy-in at the targeted settings, we used a toolkit-based approach to facilitate organizational, staff and provider, and community-level changes in how tobacco use was being addressed, which allowed stakeholders in these settings to identify their needs at each level and select evidence-based strategies for best addressing them within their context.

Figure 1. Major Components of TTTF and how they address barriers at behavioral health centers



Implementation Components of Taking Texas Tobacco Free

TTTF's success was largely evaluated based on increasing over baseline the percentage of educated/trained staff and the percent increase in the provision of TUAs and cessation interventions, as opposed to individual-level consumer data on quit attempts. All centers involved in the program implemented enforceable ***tobacco-free campus policies*** that included electronic nicotine delivery systems (ENDS) through the use of technical consultation and a detailed tobacco-free timeline. In combination with the other program components, this led to a considerable amount of uptake of evidence-based tobacco cessation interventions. ***Employee education*** was addressed by reaching every staff at participating LMHAs with education about tobacco use/hazards and the benefits of tobacco-free workplace policies, with significant knowledge gains noted. Specifically, we provided 100 staff trainings that 2272 non-provider staff attended in our initial 3-year funding period. This reach suggested a high acceptability of the educational components of the program among participating centers.

Qualitatively, ***the routine provision of tobacco use screenings*** was addressed by assisting LMHAs implement TUAs into clinical practice through training, template sharing, and the provision of technical assistance. At the time this guide was written, over 118,000 tobacco use screenings had been administered due to TTTF, with treatment or referrals provided as applicable and indicated. This represents a significant increase in screenings, advice to quit, and assistance in quitting provided to LMHA consumers. Qualitatively, capacity building for ***evidence-based tobacco use cessation training*** was addressed through embedding knowledge and expertise to treat tobacco use throughout the LMHAs. Specifically, we provided 126 trainings focused on treatment tobacco dependence that 2326 providers attended, 2 specialized trainings about psychopharmacology for nicotine dependence that more than 60 prescribers attended, 10 trainings on Motivational Interviewing to facilitate behavior change that over 200 providers attended, and Certified Tobacco Treatment Specialist (CTTS) trainings where 62 providers were trained to become clinic champions for the TTTF program. LMHA provider attendance at these trainings suggests great interest in continuing education in this topic area which can be applied in work with their consumers. Moreover, providers reported a significant increase in their use of these tobacco cessation counseling interventions, including the provision of advice and behavioral assistance with quitting.

Capacity building for ***evidence-based tobacco use cessation services*** was also addressed through the provision of Nicotine Replacement Therapy (NRT) to LMHAs, sharing successful strategies for building monies into annual budgets for additional NRT, and providing application templates directed at external funders to obtain additional funding for the continuation of free NRT provision to staff and consumers. At the time this guide was written, over 10,000 boxes of NRT had been dispensed to consumers and over 1,000 boxes have been dispensed to LMHA staff, a significant proportion of which was supported by LMHA-generated funds. These data suggest a high prevalence of quit attempts being undertaken among both consumers and staff. Because NRT is an efficacious method of addressing tobacco use that leads to quit attempts and cessation, the use of NRT represents an evidence-based practice that helps decrease tobacco use prevalence in this setting.[18-20]

Finally, ***community engagement and outreach*** was addressed through education to local community agencies about the benefits of adopting tobacco-free workplace policies (e.g., homeless shelters); the creation and distribution of tobacco cessation dissemination materials to participating LMHAs and community partners; a Facebook page; a website; local newspaper announcements promoting tobacco-free LMHA anniversaries to promote tobacco-free norms in the surrounding communities; carbon monoxide (CO) screening provision at dozens of health fairs; and guidance to LMHAs about reaching out to local community agencies to assist them in developing and implementing their own tobacco-free workplace policies. At the time this guide was written, TTTF had reached over 100,000 Texans via these social media and community outreach efforts.

The purpose of this *Implementation Guide* is to share the TTTF program with the broader public and centers outside of Texas, and to offer step-by-step guidance for its implementation in other settings. On the following pages, the reader will find our recommendations, experience, and wisdom garnered through our work in disseminating and implementing the TTTF program across Texas. We have organized the guide roughly by each component of the multi-component program, but it is important to acknowledge that each component is implemented concurrently, as opposed to in a sequential manner. All components are important, and attending to each will facilitate the impact that your center can have on addressing tobacco use and preventing cancer among your consumers. We are exceedingly pleased to share our experiences with you, and are available to your center should questions arise during your tobacco-free journey.

Sincerely,

The TTTF team

Tobacco-Free Campus (TFC) Policy Development and Implementation

Tobacco-Free Campus (TFC) Policy Processes

There is ample evidence showing that exposure to environmental tobacco smoke (ETS) causes death and disease among non-smokers and the Surgeon General has determined there is no safe level of exposure. The Surgeon General's report cited numerous studies that found "an association between workplace smoking policies, particularly more restrictive policies, and decreases in the number of cigarettes smoked per day, increases in attempts to stop smoking, and increases in smoking cessation rates." [21]

Implementing a TFC policy can lead to more quit attempts and greater quit rates among consumers and staff alike. This is important because behavioral health staff often smoke at rates higher than the national or state average. For example, some studies suggest that smoking rates among staff at behavioral health and substance use treatment facilities are between 20% [22-24] and 40%. [25-27] If not proactively addressed, these high rates of smoking among staff can lead to a reluctance to address tobacco use among consumers. [28] Overall, this results in a missed opportunity to contribute to the lifelong health of consumers and staff through proactively addressing tobacco use and dependence in these settings. [Please note that when we refer to tobacco use herein, we refer to the use of all tobacco products and include electronic nicotine delivery systems (ENDS) in our conceptualization.] Therefore, the implementation of a TFC policy can facilitate a "teachable moment" to address these issues among all organizational stakeholders for the betterment of their health and welfare. Implementing TFC policies at behavioral health centers are critical interventions to creating an environment that is healthy, welcoming and conducive to supporting people who are trying to quit using tobacco products.

Development and enforcement of TFC policies, including all smokeless tobacco and electronic nicotine delivery systems (ENDS) and covering all buildings and grounds, are an effective population-based intervention. These policies have the effect of changing the culture and norms of previously accepted behavior. In many cases, a TFC policy directly supports the center's mission of promoting a healthy place to receive health care.

Tobacco-free policies protect all people from exposure to harmful ETS, support people who are making a quit attempt, discourage continued tobacco use while prompting people to try to quit, and makes using tobacco less accessible and convenient. [29]

Policy development and implementation

- A work group should be convened to develop and implement a strong tobacco-free campus policy that applies to all consumers, staff, visitors and vendors, includes all smokeless and electronic tobacco products and covers all sites
- Decide on a TFC policy start date 6-9 months in advance and communicate it clearly verbally and visibly through signs to prepare staff and consumers for transition
- All staff should receive ongoing training in intervention and communication skills on how to respectfully address tobacco use violations
- Post-implementation, conduct routine surveillance checks to ensure enforcement of policy and implement improvement plan if violations discovered

Tobacco Work Group Development and Composition

In developing and implementing a 100% TFC policy, the executive management team should convene, as staffing allows, one or more work groups tasked to facilitate the following procedures and protocols: 1) integrate tobacco use assessments into routine clinical practice; 2) provide tobacco treatment resources to consumers and staff; 3) develop sustainable tobacco cessation training resources for all staff; 4) disseminate information about the policy; and 5) provide general education about the harms of tobacco use and the benefits of quitting - to staff, consumers, visitors and the community at large.

When possible, the work group/s should be composed of a wide range of center staff including a project leader to coordinate all activities. Members of the work group/s may include program directors and/or managers and training coordinators as well as representatives from information technology (IT), human resources, facilities, medical records, quality improvement/assurance, public relations/communications, pharmacy (if applicable), nursing, and community outreach. The inclusion of consumers and/or peer counselors may be considered as well. Members of the work group/s should serve as champions of the tobacco-free program and process, and membership should not be limited to non-tobacco users.

The work of implementing a TFC at a behavioral health center may be most efficiently accomplished by dividing the labor into two main parts: 1) responsibility for developing and implementing the tobacco-free campus policy; and 2) responsibility for developing policies and procedures to screen for tobacco use and provide treatment services to consumers and staff. The work groups will develop communication plans to inform staff, consumers and the community-at-large of the tobacco-free program.

Spindletop Center, a community behavioral health center, in Beaumont, Texas developed effective work groups comprised of staff and consumers. A case study article on the formation and the accomplishments of the work group is currently under journal review for publication. If you would like access to the case study, please contact the Taking Texas Tobacco Free team through our website and a team member will share the case study with you.

Crafting a Tobacco-Free Campus (TFC) Policy

The first step in crafting a TFC policy is for the Chief Executive Officer/Executive Director to decide that the organization is going to execute the policy. Once this decision has been made, a work group will be charged with identifying sample policies, collaborating with key stakeholders to create a draft policy, and presenting the policy to the governing board or executive management team for approval. Understanding and approving the policy by the board and executive management is vital to the success of the program implementation.

A strong TFC policy:

- Applies to all staff, consumers, contractors, vendors, and visitors;
- Includes all tobacco products, without exception of ENDS; and
- Applies to all sites (owned and leased), including housing units owned and/or operated by the organization, parking lots, and official vehicles.

The most restrictive policy is the most effective and easiest policy to implement and enforce. Eliminate loopholes and exemptions that allow people to use tobacco products in certain areas or at certain times. We do not recommend the use of designated smoking areas – it is best to bring the entire campus tobacco free at once, as this presents the clearest direction about expectations and because having designated smoking areas may only deter the effectiveness of the policy in engendering quit attempts.

Appendix A: Betty Hardwick Center tobacco-free campus policy, Heart of Texas tobacco-free policy, Denton County MHMR tobacco-free policy

It is important to set a date for the TFC policy implementation as soon as possible, even before a policy has been crafted. The benefits of identifying a tobacco-free date early provides the work group/s with a deadline to work toward, and allows the organization enough time to announce their intentions and prepare staff and consumers for the changes to come. This allows opportunities for dialogue (e.g., town hall meetings) and the development of materials and signage. Ample permanent signage placed on the grounds and inside all buildings will serve as both notification and reminder of the policy to staff, consumers, contractors, vendors, and visitors.

When identifying a TFC policy implementation date, allow the organization and its constituents about 6 to 9 months to plan and prepare before the policy takes effect. Setting a date too soon may not allow sufficient preparation time for staff and consumers to process and/or be informed about the change. Setting a date too far in advance draws out the process and contributes to a loss of urgency and may lead to complacency within the work group/s and may convey messaging to staff and consumers that the change is not important. Our website provides a comprehensive timeline with tasks that should be accomplished to implement a 100% TFC policy and to implement tobacco treatment services into clinical operations under the TOOLS tab, click Implementation Resources: https://www.takingtexastobaccofree.com/toolkit, then click on the View 6-month Policy Development Timeline hyperlink. The timeline is available in excel format.

Details for staff training and enforcement of the policy should be included in the TFC policy. This will include informing and training all new staff on the policy and its associated rationale, resources for quitting tobacco, and how to approach others on campus who may be violating the policy. Language should also include a plan regarding disciplinary actions for staff who violate the TFC policy.

TFC Policy Communication Plan

Communication with staff and consumers at all stages of the TFC policy development is imperative. There is no single right way to communicate information on the TFC policy, but a lack of communication will provide fertile ground for rumors, mistrust, confusion, resistance, and anxiety for staff and consumers alike.

Information should be communicated as early as possible and on a regular and consistent basis. As soon as executive management has set a date to become 100% tobacco-free, this information should be communicated to all staff. In this communication, a general overview of the policy should be included along with an explanation of what this will mean to staff and consumers. Information should be provided regarding opportunities for staff to share their concerns through town hall meetings, staff meetings and online/email avenues. All thoughts should be welcomed as they reduce staff and consumer anxiety and create a venue to share new ideas. The meetings are not a place to debate if the policy should take effect; rather, the meetings should focus on how to make the transition as smooth as possible. An intranet site or similar resource to share information should be created and staff should be directed to this site.

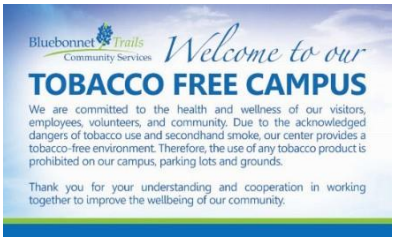
For example, the Heart of Texas Region MHMR center in Waco, Texas held three town hall forums in which staff and consumers were able to ask questions, express their concerns, and provide feedback on the upcoming policy. The forums took place about 3 months prior to the implementation of the TFC policy. Turnout to the forums was low and the majority of the participants were tobacco users who did not agree with the new policy, but they were appreciative of having the opportunity to share their thoughts. The CEO of Heart of Texas Region MHMR center facilitated 2 of the 3 forums.

Appendix B: Spindletop Center and Metrocare Center notification emails

Signage and other mechanisms should be developed to inform and educate consumers about the TFC policy and provide opportunities and venues for them to express their concerns and have their questions answered. However, town hall discussions with consumers should be separate from meetings with staff.

Appendix C: Tobacco-free campus signage notifications

Business card-size information/education cards are a great and inexpensive way to supplement permanent campus signage about the new policy. These can be created for staff to give to people who violate the policy. Typically, one side of the card includes information on the policy and the other side includes information on tobacco treatment resources that are available through the organization.



As details of the policy are developed and the implementation date approaches, notifications should be forwarded to all contractors and vendors. In some cases, contracts may have to be rewritten or language added to reflect the new policy and a statement of agreement from the contractor. Training opportunities can be included in the notifications.

Appendix D: Betty Hardwick Center letter to medical providers/partners

Hiring announcements should include a statement that the organization is, or will become, a 100% tobacco-free organization.

As the implementation date nears, frequent communications should be emailed to staff. The use of multiple communication channels is recommended, including electronic newsletters, communication from CEO/ED, posters/flyers, screensavers on computers and digital kiosks in lobbies. In addition, human resources and insurance updates should be used to relay important information to staff, consumers, and visitors.

The public relations/communications department should create a series of press releases for the local media to promote the policy and educate the community of the impending policy change. A press release should be sent to all media outlets the day before the policy goes into effect and again on the first day the TFC becomes effective.

Appendix E: Integral Care tobacco-free campus press release

TFC Policy Implementation Day

Although leadership and employees may fear the worst when the implementation day arrives, the day typically begins and ends with little to no disruption in daily services. The advanced communication, the town hall meetings, the transparent discussions, and availability of tobacco treatment resources has paid off and the implementation goes relatively smooth. This has been the repeated experience of many behavioral health centers that have effectively implemented a tobacco-free campus policy, including those participating in the TTTF program.

It is essential that all permanent signage be in place on the implementation date and that all ashtrays, smoking buckets, and cigarette receptacles be removed from the grounds. All smoking gazebos and smoking areas should be cleaned and refreshed, perhaps repurposed as a place to get shade and enjoy fresh air. This may be a great time to begin a new norm of utilizing a former smoking gazebo as a space to hold a group, a staff meeting, or to have lunch. All permanent signage should be in place on the implementation day as a reminder that smoking and tobacco use is not allowed on any of the grounds.

Appendix F: Tobacco-free campus permanent signage examples

There will be consumers and staff who violate the TFC policy, either accidently or intentionally. It is very important that these early violations are addressed immediately in a polite, respectful and empathetic manner. Staff should have an ample supply of quit cards to distribute to people and the cards should be placed in waiting rooms, lobbies, and other common areas.

How to Effectively Communicate the Tobacco-free Campus Policy:

- Be polite and respectful at all times;
- Express empathy and understanding – listen to their story and concerns;
- Do not take criticism of the policy personally- you are doing your job to ensure the health and safety of everyone;
- Understand the dynamics of nicotine withdrawal and using tobacco as a coping skill; understand people are reverting to an engrained and previously acceptable behavior;
- Share the importance of compliance with the policy and what we would like to see happen in the future; and
- Share information on tobacco treatment resources and encourage them to talk to their case manager or provider at any time to get more information.

Consider the TFC policy implementation day a time to celebrate and perhaps plan a tobacco-free kick-off event to thank the work group/s for their time and effort in the process. If your organization is doing a tobacco-free kickoff, invite the local press to be part of the event. The general public, contractors and vendors, and community partners should also be invited.

Emails should be sent to all staff requesting their compliance with the policy and encouraging all staff to address violations as they occur.

Ideally, an organization is not implementing a TFC policy in isolation. Many other initiatives are taking place to screen people who use tobacco and offer tobacco treatment services (see next section).

Post-Implementation Surveillance

It is important to be vigilant about addressing violations at all times. Centers will find that over time, people begin to gravitate to certain areas on the grounds to smoke or use tobacco. Clinic managers cannot be complacent and satisfied because people are no longer smoking by the front door or next to windows. Consistent enforcement of the policy is essential and ongoing. All staff should have the expectation that the TFC policy will require continuous reinforcement.

Clinic managers should conduct quarterly surveillance checks by walking the grounds looking for piles of cigarette butts. Finding places with tobacco butts may indicate a good area to place a new permanent sign about the policy. Managers should talk to consumers about the policy, provide continued training and improvement plans for staff, and contact facilities if any signage has been removed or vandalized or if additional signage is needed.

Appendix G: Tobacco-free campus surveillance checklist

Based on the surveillance check, an improvement plan should be developed. All staff should be provided a copy of the surveillance check and tasked with ways to address the issues over the next three months. If improvements are not seen over time, ongoing staff training on effectively talking with consumers who violate the policy may be needed.

Some clinics may have a harder time managing violations than others and monthly surveillance should be required for these clinics.

Staff Education

Education about Tobacco Use among Behavioral Health Consumers

An essential component of TTTF was the provision of education and training to all staff and providers. Reaching every staff in this process was considered crucial in generating support for TTTF and facilitating new norms about tobacco use. Both groups received training on how tobacco use and ETS affects the body; tobacco use among individuals with behavioral health needs; the tobacco-free workplace policy/program; how to assist others with maintaining compliance with the policy; and basic information about tobacco dependence treatment and effectiveness. This 1-hour interactive training was provided in person at each clinic (or at a central clinic, as scheduled). The providers' training (e.g., case managers, social workers) was 2 hours in duration and included the aforementioned components with more in-depth training on the delivery of individual and group interventions and referral sources. The content for these presentations was informed by recommendations for best practices in tobacco control,[15] the expertise of team members, and prior tobacco- free workplace implementation work.[28] Knowledge within each group was assessed before and after the training and knowledge gains were subsequently shared with LMHA leadership. In TTTF, over 200 on site trainings reached over 4500 staff and providers with sizeable pre/post-knowledge gains (up to 63%) observed. Sample didactic slides for these presentations are available on the TTTF website: www.takingtexastobaccofree.com

Education about the Tobacco-Free Campus Policy

All staff should be provided basic intervention and communication skills to address tobacco use violations on a consistent basis. Addressing violations is the responsibility of all staff and this expectation should be consistently reinforced through staff meetings, all-staff emails, and educational opportunities.

Some staff may be fearful of addressing people who are violating the policy and some will choose to ignore the violators because they do not agree with the policy. It is important to address these reservations and provide opportunities for staff to learn from one another. One example of this is to have a staff shadow another staff who feels comfortable addressing people violating the policy. Staff training will increase comfort levels and confidence through the provision of organizational support for "community enforcement." *It is important to stress that the policy is in place for the health and safety of all people and that everyone plays a role in making it successful.*

In order to reach all staff, educational sessions should be scheduled or provided during staff meetings on an ongoing basis. Program managers are ultimately responsible for the education of their staff and enforcement of the TFC policy at their clinic. Staff should be provided with scripts on how to address violations and educational opportunities should allow time for staff to role play having these difficult conversations in small groups with one another. To view a role-play of a staff member having a conversation with a person who is using tobacco on the grounds, please visit www.takingtexastobaccofree.com.

Staff should be encouraged to share their experiences of addressing violations and discuss how to handle repeated violations at their clinic. Over time, consumers and visitors will begin to identify specific areas to use tobacco products, which may be away from people or entrances, but still be on the center's grounds. It is important to anticipate these behaviors and plan to address these violations just as more blatant ones would be handled.

A TFC policy acknowledgement form should be completed by new staff documenting that they have read and understand the TFC policy, agree to abide by the policy, understand the course of possible discipline for violating the policy, and agree to actively address any violations of the TFC policy.

Appendix H: Employee tobacco-free acknowledgement

Education to all staff

- Education and training of all staff and providers is essential in the areas of:
  - The tobacco-free policy/program
  - How to assist in the compliance/enforcement of the policy
  - The physical effects of tobacco and electronic nicotine delivery systems (ENDS)
  - Tobacco use among people with behavioral health needs
  - Tobacco dependence treatment and effectiveness
  - To ensure program sustainability, this training should be embedded within New Employee Orientation

Ongoing Training

Behavioral health centers historically have a high staff turnover rate and keeping knowledge current and appreciation for the purpose behind the tobacco-free campus is essential to its sustainability. Therefore, it is important to focus on adequately training all new staff and this can be accomplished by embedding this training within New Employee Orientation.

New staff should also receive training on addressing people who choose to break the TFC policy. Business cards violation/treatment resource cards, role playing, and scripts should be provided to new staff during this training. New staff can also shadow current staff to become familiar with the processes and procedures.

Routine Tobacco Use Screenings

Implementing the tobacco-free campus policy is an important step in addressing tobacco use and creating a healthy and safe environment for all people, but in isolation it will have limited impact in reducing tobacco use. Protocols and procedures should be created to screen consumers for tobacco use and provide resources to help consumers quit using tobacco. Recommendations for screening consumers at behavioral health centers takes on added importance due to the systemic failure to consistently screen consumers for tobacco use and a hesitancy among clinicians to provide treatment services.[30]

Clinicians' comfort regarding the routine screening for tobacco use among consumers may be directly connected with the accuracy of their knowledge about the process. Some staff may believe that it is impossible for consumers to quit using tobacco. Others may believe that quitting tobacco may make a consumer's mental health symptoms worse or jeopardizes their recovery plan. However, scientific evidence shows that consumers can become tobacco-free when provided support from staff and utilize proven treatment medications and that there are generally no adverse impacts on their mental health or recovery.[31] We address these, and other, assumptions about tobacco use among individuals with mental health issues in a handout called "Myths and Facts" that can be found in Appendix J (noted later in this document).

Reluctance to engage in regular tobacco use screenings is generally decreased as accuracy of clinicians' knowledge about tobacco use and the benefits of quitting for individuals with behavioral health needs increases.

The Clinical Practice Guideline *Treating Tobacco Use and Dependence: 2008 Update* outlines evidence-based guidelines to provide tobacco treatment services to consumers that all health care providers can use. Some of these behavioral counseling techniques are outlined further in the evidence-based tobacco use cessation training and services section. Meta-analytic studies show that screening for tobacco use leads to a 2.5 times greater likelihood of being tobacco-free for 5 or more months compared to not screening.[16]

Development and Implementation of a Tobacco Use Assessment (TUA)

A work group should be established to develop and implement the processes, procedures, and protocols to routinely screen for tobacco dependence and establish a protocol for referral to treatment, provision of educational materials, etc. As with the TFC policy work group, the composition of the TUA work group should include a range of stakeholders from the organization. Practice managers from all departments and level of care, information technology (IT), quality improvement/assurance, billing/coding, nursing, and pharmacy are examples of professionals that might be included in the work group.

One of the first steps in developing an organization's TUA is to collect sample TUAs and consider the questions and information that the organization would like to ask. At a minimum, a TUA should be able to collect the following information:

- Current tobacco use status including type of tobacco used, for how long, and how much
- Past quit attempts, longest period of abstinence, and methods used in prior quit attempts
- Exposure to environmental tobacco smoke (e.g., living with a person who smokes)
- Readiness to quit (usually assessed along a continuum)
- Treatment plan and referral options

Appendix I: Tobacco use assessment examples

The Contemplation Ladder can be used to assess readiness to quit along a continuum.[32] The ladder has a consumer rate on a scale of 0 to 10 where they are at the present time in thinking about quitting smoking where several of the numbers have text anchors, such as "I have no thoughts about quitting smoking," "I think I need to consider quitting smoking someday," "I think I should quit smoking but I am not quite ready," "I am starting to think about how to reduce the number of cigarettes I smoke a day," and "I am taking action to quit smoking." A consumer's readiness to quit can dictate next steps in intervention (e.g., focus on building motivation and resolving ambivalence about making an attempt, assisting practically with the attempt using cognitive-behavioral counseling and medications, or appropriately direct a referral if the screener is not a treatment-providing clinician).

TUAs should be kept relatively short with consideration of the wide range of staff members who will administer the TUA. The TUA should ask about all tobacco products (including ENDS) and not be limited to conventional cigarette smoking. Keep in mind that the TUA can be combined with evidence-based tobacco interventions – particularly the brief public health intervention approaches detailed in the evidence-based tobacco use training and services section of this guide (e.g., the 5A's and 5 R's).

Discussions in the workgroup should include how the TUA will be administered, by whom, how often, and where the TUA should be placed in the electronic health record (EHR) system or if it will be collected on paper charts.

All new consumers should be administered a TUA during the intake interview. To ensure that all consumers are being screened for tobacco use, a hard stop should be added to the EHR or mandated for staff using paper charts. By utilizing a hard stop, a clinician will be prohibited from moving forward in the EHR until a TUA is completed.

If an organization chooses not to screen consumers at every visit, the organization should consider the following options for screening frequency:

- All new consumers at intake;
- Quarterly for all tobacco users, and monthly screening for tobacco users actively trying to quit; and
- Annually for non-tobacco users.

TUAs can coincide with other assessments and should be updated as other assessments are updated. Notifications or "flags" may be included in the EHR to alert staff that a TUA is due. If a center utilizes paper charts, TUA's should be integrated into the annual assessment processes.

Information technology (IT) staff can provide valuable expertise on the technical capabilities of the EHR system and how to integrate the TUA into the system. Their input will be critical on the formatting of the questions and how the data can be reported. Quality Improvement/Assurance staff should also be included in the decisions about compiling and reporting data, quality assurance, and compliance. All members of the work group should provide input into where the TUA should be placed in EHR to make it easy, convenient and intuitive for staff to complete.

Integrating screening for Tobacco Use into routine practice

- Establishment of a tobacco use assessment (TUA) task force to develop and implement processes, procedures and protocols for routinely screening for tobacco use that are essential to motivate consumers to quit and provide them with the resources to do so
- TUAs should cover:
- Current tobacco use (i.e. type, for how long, and how much)
- Past quit attempts
- Exposure to environmental tobacco
- Readiness to quit (usually assessed along a continuum, e.g. the Contemplation Ladder
- Treatment plan and referral options
- Integration of the TUA in the electronic health record (EHR) or collection on paper charts
- TUA task force should assess availability of within agency evidence-based tobacco treatment resources to all consumers and staff and provide referrals if needed

Tobacco Treatment Availability: Planning and Resources

Because part of the TUA includes a referral for treatment or a treatment plan, the TUA task force will also assess what within-agency tobacco intervention resources are already offered. The design and implementation of tobacco treatment programming vary depending on the resources available at a particular health care setting as well as the population being served. Desirable counseling services may include within-agency individual or group sessions, cessation groups offered in the community, or services received pursuant to calling a QuitLine. Medication availability is also important. If a department or unit does offer tobacco treatment resources, the task force will want to assure that the intervention is evidence-based and consider training as many staff as possible to replicate the service. Tobacco treatment services should be made available to all consumers across all levels of service (e.g., outpatient, inpatient, residential).

When tobacco treatment services are available, it is important to outline the processes and procedures regarding how consumers will access these resources. All staff members should be able to refer a consumer to receive tobacco treatment services, but one person should be responsible for coordinating and following up with the consumer regarding their quit attempt. There must be a way for staff to document treatment goals, progress toward the goals, use of treatment medications, and attendance at individual or group sessions.

If no cessation services are being offered, the TUA task force will need to explore existing programs at other mental health organizations and attempt to replicate the services at their organization. For example, there are several best practice examples provided at the Taking Texas Tobacco Free website (www.takingtexastobaccofree.com) and at the National Behavioral Network for Tobacco and Cancer Control (www.bhthechange.org). As each organization is unique, existing programs may need to be tailored to the individual needs and context of each organization.

We recommend that every center provide behavioral counseling and medication (e.g., NRT) for tobacco cessation to both consumers and staff. However, some centers may not have the resources to do this among both consumers *and* staff. At a minimum, staff should refer tobacco using staff who want to quit to their state QuitLine. State QuitLines offer free telephone coaching and possibly free NRT. Exact services vary from state to state. A task force member will want to investigate what services are offered by the state's QuitLine. Quitlines can be accessed by phone at 1-800-QUIT-NOW (1-800-784-8669). Additional information about their services can be found online at http://www.naquitline.org/. In Texas and some other states, QuitLine services are provided in Spanish. For services in Spanish, people should call 1-855- DEJELO-YA (1-855-335-3569) or access http://espanol.smokefree.gov. QuitLines also have services in at least 15 additional languages through a third party. Most QuitLines offer an online and/or text message programs. Online and fax referrals may be options that will ensure the consumer receives a contact call from the QuitLine. If possible, an electronic referral to the QuitLine should be integrated into the EHR to make the referral process very quick and convenient for clinicians.

As within-agency programs are being developed, the TUA task force should explore the tobacco treatment resources that exist within their communities and develop support groups for staff and/or referral processes to groups outside the agency. Local hospital(s), FQHC, non-profit agencies, county health departments, or community foundations may offer programs. Additionally, non-profit agencies like the American Heart Association, American Cancer Society or the American Lung Association may offer tobacco cessation programs or training for staff to become a group facilitator.

In addition, other resources may be available to the general public, including smoking cessation apps and online programs that are evidence based. Although there are many examples of these resources, one illustrative resource is the Quitter's Circle: https://www.quitterscircle.com/.

Evidence-Based Tobacco Use Cessation Training and Services

As indicated by the Clinical Practice Guidelines, approved and recommended treatments for tobacco dependence include behavioral counseling and pharmacotherapy (e.g., medications).[16] The combination of counseling and medication is more effective than either alone.[33] Staff should encourage all consumers making a quit attempt to use both counseling and medication. It is important for consumers and for staff to know that evidence-based tobacco treatments are effective and can lead to concurrent reductions in stress, anxiety, and depression, while increasing psychological quality of life and positive affect.[34] Below, we describe brief interventions, behavioral counseling options, and common medications used to address tobacco dependence, including Nicotine Replacement Therapies and prescription medications. In general, the more cessation sessions a consumer attends, the increased effectiveness of the "intervention."

Brief Public Health Interventions for Tobacco Use

According to the Clinical Practice Guidelines, the interventions for tobacco cessation can be brief (i.e., no more than 10 minutes per clinical encounter) or intensive (i.e., 10 or more minutes per clinical encounter).[16] Brief interventions are characterized by short and practical counseling encounters that can be used by a variety of providers in both outpatient and inpatient healthcare settings. The focus of these interventions will depend on the consumer's readiness quit tobacco.

Many tobacco users may not want to quit tobacco within the upcoming 30 days. Indeed, motivation to quit tobacco use may change from day to day, and perhaps even hour to hour based on situational cues. If a consumer indicates that they do not wish to quit smoking within the next 30 days, clinicians may use the "5 R's." The "5 R's" are used to increase motivation to make a quit attempt, and entail the following steps: 1) ask consumers for some **R**easons why quitting may be personally relevant or beneficial to them (1 minute); 2) ask consumers about what they perceive as the short-term, long-term, and environmental **R**isks of continued smoking (1 minute); 3) ask consumers about what they perceive as the perceived benefits or **R**ewards of quitting (1 minute); 4) ask consumers about the barriers or **R**oadblocks to quitting (3 minutes); and 5) **R**epeat these steps each encounter to facilitate motivation to make a quit attempt.

Appendix J: Myths and facts handout

On the other hand, some consumers may be interested in quitting tobacco use within the next 30 days. For these consumers, the "5 A's" of treating tobacco dependence (Ask, Assess, Advise, Assist, and Arrange) are recommended as a brief intervention and a quick and easy way for clinicians to begin conversations about tobacco use and – if the consumer is amenable - determine a further course of treatment. Below is a table describing the "5 A's" of treating tobacco dependence. Our website also offers a video illustrating this screening procedure: www.takingtexastobaccofree.com.

5 A's of Tobacco Treatment	
	Ask – every consumer, at every visit, about their tobacco use (e.g., "Do you use any tobacco use products, even every once in a while?")
	Assess – their desire to quit using tobacco (e.g. "Do you want to quit using tobacco in the next 30 days?")
	Advise – them to quit using tobacco (e.g., "Quitting tobacco is one of the most important things you can do to improve your overall health.")
	Assist – those who have a desire to quit to access treatment resources (e.g., "I am very happy you want to quit. Would you like to hear about the options to help you quit tobacco?")
	Arrange – a follow-up session to check in on their progress (e.g., "I would like to meet with you again in two weeks to discuss your progress.")

Source: Treating Tobacco Use and Dependence: 2008 Update (Available from: https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html)

Administration of the "5 A's" is not solely the responsibility of one staff member: It is most effective when multiple staff are consistently engaging consumers with the 5A's.

Behavioral Counseling

Any health care setting with trained personnel and time allocated for counseling could incorporate more intensive behavioral interventions which are particularly beneficial to individuals with greater tobacco dependence and with co-morbid physical or mental health conditions. Based on the consumer's willingness in quitting, intensive interventions could focus on Motivational Interviewing (MI), [35,36] a more in-depth exploration of the "5A's" detailed above, or on cognitive behavioral and problem solving/skills treatment.

When consumers are not ready to change their tobacco use, provider's lectures and exhortations to modify their behavior are very unlikely to promote behavior change compared to when consumers express their own concerns and reasons for a change. MI is a goal-oriented, patient-centered counseling intervention that aims to strengthen personal motivation for and commitment to achieve a goal[35]; as such, it is especially appropriate for consumers who are not ready to change their tobacco use at a particular moment in time. MI is used to explore the individual's beliefs, feelings and values regarding tobacco use, identify any ambivalence about the use and stimulate motivation for behavior change. By using MI, the provider pays attention to expressions of any desire, ability, reasons, and need to stop tobacco use, as well as verbalizations of commitment to quit and any steps toward change. Health care professionals using an MI approach basically use a "guiding" communication style, by creating a balance between asking consumers about their tobacco use and intentions to quit, listening nonjudgmentally to their reasons to change or not the tobacco use, and informing them about the benefits of quitting and the resources available.[36] Given that motivation for change can fluctuate during the quitting process, MI can be integrated at any time with other therapeutic models, especially with cognitive-behavioral/problem solving approaches.[37] In the TTTF program, we provided 8 hour introductory MI trainings to our LMHA stakeholders and recommended that clinicians obtain further training and ongoing coaching to become comfortable with using this approach with their tobacco using consumers. Many resources for additional training can be found on the MI website: www.motivationalinterviewing.org

When consumers are ready to quit, they are likely to need a more practical focus in counseling. As mentioned earlier, this can entail expanding on the "5 A's" to better understand high risk situations, make individualized recommendations for coping methods, etc. The *Guidelines* describe many cognitive-behavioral strategies for addressing tobacco use among various population groups,[16] and there are several treatment handbooks available as well.[38] These approaches are discussed during Certified Tobacco Treatment Specialists (CTTS) training, which we recommend for clinicians providing intense interventions for tobacco users. In the TTTF program, we sent clinicians to CTTS training to embed this specialized knowledge within centers, and recommended that these new CTTS champions organize further trainings within their centers upon their return to spread the specialized knowledge further within the agency. Additional details on the format, procedures and treatment content of intensive cessation programs for specific population groups (e.g., Latino tobacco users) also exist and can be found in the literature.[39]

Behavioral Counseling Considerations

Behavioral counseling can be offered in individual or group formats. There is no single model for offering individual or group sessions. The most important criteria is that the staff are adequately trained and comfortable helping a person quit using tobacco. Ideally, staff members should be Certified Tobacco Treatment Specialists (CTTS) or have received training to facilitate a specific curriculum (e.g., American Cancer Society's *Quit for Life* program). Like many other group offerings, the work group will need to consider whether to utilize:

- Open groups (new attendees admitted throughout) versus closed groups (no new attendees admitted once group begins)
- An abstinence-focus (quitting completely is the goal) versus non-commitment focus (allow attendees to determine their own goals)
- A fixed number of sessions (curriculum-based group) versus an open-ended structure (no set number of sessions)

The manual *Learning About Healthy Living: Tobacco and You*[40] provides guidance on facilitating fixed, curriculum-based groups, available at rutgers.edu.

Organizations have used certified peer specialists, navigators, wellness specialists, and case managers and therapists to facilitate tobacco treatment groups. It is important to identify staff who have experience with groups and have received advanced tobacco treatment training.

Medications for Tobacco Use Cessation

There are three nicotine replacement therapies (NRTs) available over the counter, as indicated below:

- Nicotine patch
- Nicotine gum
- Nicotine lozenge

There are additional medications available by prescriptions as indicated below:

- Nicotine nasal spray
- Nicotine inhaler
- Buproprion SR (brand name: Wellbutrin or Zyban) – contains no nicotine
- Varenicline (brand name: Chantix) – contains no nicotine

These medications have been shown to be effective and safe with mild, if any, side effects for most people who use them. Prescription medications, such as varenicline, buproprion, and nicotine nasal spray and inhalers will need a physician's prescription and likely need to be dispensed in a controlled location such as an on-site pharmacy, through an integrated health program pharmacy, or at a retail pharmacy.

Some clinicians and prescribers may be hesitant to prescribe varenicline (Chantix) due to reports of significant side effects impacting mental health status and a black box warning related to these reports. A large scale multi-national study (EAGLE) found no statistically significant difference in reported side effects between people with no history of mental health diagnosis and people who have had a mental health diagnosis.[19] On December 16, 2016, the FDA *removed* the black box warning for varenicline and buproprion due to research showing that there is no relative increase in risk of side effects for people with a mental health diagnosis compared to the general population of tobacco users.

Some pertinent information about these over the counter and prescription tobacco use cessation medications is available on the following link - Some pertinent information about these over the counter and prescription tobacco use cessation medications is available on the following link - https://smokingcessationleadership.ucsf.edu/sites/smokingcessationleadership.ucsf.edu/files/Documents/FactSheets/Pharmacologic-Product-Guide_October%202017.pdf Additionally, to learn more about the proper use of tobacco cessation medications and possible side effects of the medications, visit www.takingtexastobaccofree.com.

Pharmacologic Product Guide: FDA-Approved Medications for Smoking Cessation

Rx for Change

	Nicotine Replacement Therapy (NRT) Formulations					Bupropion SR	Varenicline
	Gum	Lozenge	Transdermal Patch	Nasal Spray	Oral Inhaler		
Product	**Nicorette**[1], **ZONNIC**[2], **Generic** OTC 2 mg, 4 mg original, cinnamon, fruit, mint	**Nicorette Lozenge,**[1] **Nicorette Mini Lozenge,**[1] **Generic** OTC 2 mg, 4 mg; cherry, mint	**NicoDerm CQ**[1], **Generic** OTC (NicoDerm CQ; generic) Rx (generic) 7 mg, 14 mg, 21 mg (24-hr release)	**Nicotrol NS**[3] Rx Metered spray 10 mg/mL aqueous solution	**Nicotrol Inhaler**[3] Rx 10 mg cartridge delivers 4 mg inhaled vapor	**Zyban**[3], **Generic** Rx 150 mg sustained-release tablet	**Chantix**[3] 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[4] and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Pregnancy[4] and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Pregnancy[4] (Rx formulations, category D) 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[4] (category D) and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Bronchospastic disease ▪ Pregnancy[4] (category D) and breastfeeding ▪ Adolescents (<18 years)	▪ Concomitant therapy with medications/conditions known to lower the seizure threshold ▪ Hepatic impairment ▪ Pregnancy[4] (category C) and breastfeeding ▪ Adolescents (<18 years) **Warning:** ▪ Black-boxed warning for neuropsychiatric symptoms[5] **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 (e.g., linezolid, methylene blue)	▪ Severe renal impairment (dosage adjustment is necessary) ▪ Pregnancy[4] (category C) and breastfeeding ▪ Adolescents (<18 years) **Warning:** ▪ Black-boxed warning for neuropsychiatric symptoms[5]
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 for standard; 10 minutes for mini) ▪ 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	*≥10 cigarettes/day:* 21 mg/day x 4–6 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks *≤10 cigarettes/day:* 14 mg/day x 6 weeks 7 mg/day x 2 weeks ▪ 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: 3–6 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

	Nicotine Replacement Therapy (NRT) Formulations					Bupropion SR	Varenicline
	Gum	Lozenge	Transdermal Patch	Nasal Spray	Oral Inhaler		
Adverse Effects	▪ Mouth/jaw soreness ▪ Hiccups ▪ Dyspepsia ▪ Hypersalivation ▪ Effects associated with incorrect chewing technique: – Lightheadedness – Nausea/vomiting – Throat and mouth irritation	▪ Nausea ▪ Hiccups ▪ Cough ▪ Heartburn ▪ Headache ▪ Flatulence ▪ Insomnia	▪ Local skin reactions (erythema, pruritus, burning) ▪ Headache ▪ Sleep disturbances (insomnia, abnormal/vivid dreams); associated with nocturnal nicotine absorption	▪ Nasal and/or throat irritation (hot, peppery, or burning sensation) ▪ Rhinitis ▪ Tearing ▪ Sneezing ▪ Cough ▪ Headache	▪ Mouth and/or throat irritation ▪ Cough ▪ Headache ▪ Rhinitis ▪ Dyspepsia ▪ Hiccups	▪ Insomnia ▪ Dry mouth ▪ Nervousness/difficulty concentrating ▪ Nausea ▪ Dizziness ▪ Constipation ▪ Rash ▪ Seizures (risk is 0.1%) ▪ Neuropsychiatric symptoms (rare; see Precautions)	▪ Nausea ▪ Sleep disturbances (insomnia, abnormal/vivid dreams) ▪ Constipation ▪ Flatulence ▪ Vomiting ▪ 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	▪ 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	▪ 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	▪ 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	▪ 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
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	▪ Need for frequent dosing can compromise adherence ▪ Cartridges might be less effective in cold environments (≤60°F)	▪ Seizure risk is increased ▪ Several contraindications and precautions preclude use in some patients (see Precautions) ▪ Patients should be monitored for potential neuropsychiatric symptoms[5] (see Precautions)	▪ Should be taken with food or a full glass of water to reduce the incidence of nausea ▪ Patients should be monitored for potential neuropsychiatric symptoms[5] (see Precautions)
Cost/Day[6]	2 mg or 4 mg: $1.90–$3.70 (9 pieces)	2 mg or 4 mg: $2.66–$4.10 (9 pieces)	$1.52–$3.48 (1 patch)	$5.57 (8 doses)	$9.47 (6 cartridges)	$2.58–$6.84 (2 tablets)	$10.14 (2 tablets)

[1] Marketed by GlaxoSmithKline.
[2] Marketed by Niconovum USA (a subsidiary of Reynolds American, Inc.)
[3] Marketed by Pfizer.
[4] 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.
[5] 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.
[6] Wholesale acquisition cost from Red Book Online. Thomson Reuters. September 2015.

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.

Source: University of California, San Francisco Schools of Pharmacy and Medicine. Rx for change curricula (http://rxforchange.ucsf.edu/)

Clinicians dispensing medications for tobacco cessation must also be familiar with the ways in which they interact with other drugs. In addition, they need to understand the ways in which quitting or reducing tobacco use effects the potency off common psychiatric medications, as well as other substances, such as caffeine. Clinical training should cover these topics to enhance this understanding which is important to ensuring a successful quit attempt and the safety of the consumers we treat.

Appendix K: Medication interaction document

Within the EHR, distribution and ongoing use of tobacco treatment medications should be documented and updated at every follow up visit. Clinicians should document the type of education materials provided to consumers, current level of tobacco treatment medication being used, and prescribers should review documentation to make any necessary changes in psychotropic medication levels should a consumer quit using tobacco. Each facility will determine what process works the best for them and which clinicians/titles are responsible for the dispensation of medications to consumers.

Tobacco Treatment Medication Availability

Breaking the dependence on tobacco is very difficult; only 3-5% of people are able to quit without any assistance.[41] It is important that processes and procedures be developed to provide convenient and inexpensive access to tobacco treatment medications. These medications should be made available to consumers in conjunction with the tobacco-free campus implementation date. The availability of the medications will likely reduce anxiety and fear among consumers (and staff), provide a valuable incentive to make a quit attempt, and show that the organization wants to support tobacco users to quit rather than punish them for using tobacco.

Many behavioral health centers are concerned about how to pay for tobacco treatment medications for consumers. The majority of consumers receiving services do not have private insurance, and if they do, NRT and other medications may not be covered.

One way to offset the cost of providing medications is to utilize the Patient Assistant Program (PAP). PAP provides free or very low cost medications to people who meet financial need requirements. Varenicline (Chantix) and buproprion (Wellbutrin/Zyban) are typically available to through PAP formulary.

Centers can also bill for reimbursement for tobacco treatment services (see Billing/Reimbursement section). Revenue generated from the billing will likely not cover the costs for the service, but it could be used to defer some of the cost to purchase NRT or other medications.

To further reduce the cost burden of purchasing NRT, non-profit organizations may be able to access NicoDerm CQ™ patches and Nicorette™ gum and mini lozenges manufactured by GlaxoSmithKline Consumer Healthcare through their NRT - Direct Purchase Program (DPP). DPP provides NRT to organizations at a significantly discounted rate. For more information on the NRT DPP Program, please contact:

Michael Conahan
908-625-8731
michael.c.conahan@gsk.com
National Account Manager - Wellness Partnerships
GlaxoSmithKline Consumer Healthcare

Some other options to cover the cost for tobacco treatment medications include collaborating with the agency's development/fund raising staff to solicit funds. Members of a work group can also explore local or regional community foundations, community donations, or local, regional or state grants. CVS Pharmacy has community grants available to organizations who provide tobacco treatment services. Visit their Community Grants website to learn more: https://cvshealth.com/social-responsibility/our-giving/corporate-giving/community-grants

Tobacco treatment medications should also be made available to all staff members. The work group will want to review their insurance coverage and determine:

- What tobacco treatment medications are covered;
- How long can a staff member access the medication;
- Any applicable co-pays and/or pre-authorization requirements; and
- Whether cessation groups and/or individual counseling charges are covered.

Coverage benefits should be communicated to all staff in advance of the tobacco-free campus policy implementation and staff should be reminded of the benefits on a regular basis before and after the tobacco-free campus policy becomes effective. Implementing organizational screensavers with this information and/or including it on within-organization media may be helpful to enhance communication.

The Affordable Care Act has mandated that compliant insurance carriers include tobacco cessation services among their coverage. If your organization's insurance plan has limited or no coverage for tobacco treatment services, the Human Resources department should inquire about implementing this required benefit. If medications are not covered under the insurance plan, it becomes critical for the organization to provide tobacco treatment medications to interested staff. For instance, the organization should consider adding tobacco treatment medication expenses as a line item in the general budget. For example, an organization serving approximately 20,000 consumers that employs approximately 1,000 staff should expect to budget between $50,000 and $80,000 annually for NRT.

Storage, Tracking & Distribution of Nicotine Replacement Therapies (NRT)

Procedures will need to be developed for the storage, tracking and distribution of NRTs. For storage and distribution, many factors will need to be considered including:

- number of facilities within the center and number of people served at each facility;
- storage capacity at various facilities; and
- medication dispensing regulations and requirements for various facilities.

Based on these factors, some facilities may not be able to store or dispense the NRT. As facilities are ruled out, procedures should be developed to accommodate NRT availability to all consumers at all locations. This may involve couriers, staff pickup, etc.

Nicotine patches, gum, and lozenges are over the counter medications and should be stored in a locked cabinet, accessible to a limited number of clinicians, and kept at room temperature. Distribution of NRT products to consumers should be noted in their electronic health record or paper chart.

Remember to be aware that NRT products expire – like all medications – and so time until expiration date should guide product distribution to consumers and staff. When a new product arrives it should be placed behind the older product so the older product is used first. Staff should follow established protocols to monitor expiration dates and dispose of expired products.

Tracking NRT allocation and distribution across multiple facilities will take some planning and coordination. NRT-related procedures should include how the NRT inventory tracking and reordering of additional NRT will occur as supplies are reduced. It may take time to determine the appropriate amount of NRT needed at each facility. Inpatient facilities and other residential settings will likely need a larger inventory than outpatient facilities.

Over the counter NRT can be dispensed by a variety of clinical staff and at a range of facilities. These processes are highly individualized to specific centers and there is no recommended "model practice." When developing procedures and protocols for the distribution of NRT, it is important to take the following into consideration in addition to inventory tracking and charting of dispensed NRT.

Which clinics will be providing NRT to consumers?

- Which staff can distribute NRT to consumers?
- If consumers are receiving services at a clinic that has no NRT available, how do consumers get NRT?
- Will NRT be provided at extended observation units, respite housing, and crisis services?
- Do consumers need to attend individual or group sessions to receive NRT?

Identifying staff members who will dispense the NRT is essential to the processes and procedures for its distribution. As NRT is an over the counter medication a wide array of staff may dispense the nicotine replacement therapy. Staff ranging from case managers, counselors, pharmacy staff, nurses and doctors can all be involved in the distribution of nicotine replacement therapy. Ideally, the Chief Medical Officer will sign a standing order so that any appropriate staff members may dispense NRT to consumers. Additionally, a procedure should be in place to ensure that a consumer's primary prescriber is aware that consumers that they are treating are receiving NRT from the agency.

Appendix L: Denton County & Betty Hardwick Center NRT storage and distribution procedures

Centers should have adequate controls in place to ensure responsible and ethical dissemination of NRT. Centers should avoid allowing clinicians to have a supply of NRT in a desk drawer to be distributed or placing boxes of NRT in common areas for consumers to take with little or no supervision or follow up. NRT is commonly diverted for sale on the street if there is not a well thought out strategy for dispensing NRT to only those consumers involved in cessation services. As such, NRT should be provided only to people who have a desire to quit using tobacco.

The work group will want to decide for how long consumers can receive NRT though their program. Research indicates that it takes a person with a mental health diagnosis longer to quit using tobacco than other people, so an extended period of NRT use should be considered and accounted for with these consumers. Determining how much and how long a consumer may receive NRT will likely depend on the center's available budget to purchase NRT and the processes of disseminating NRT.

Printed materials on how to properly use NRT should be provided to consumers along with information on nicotine withdrawal, craving, and resources to support their quit attempt (within the center, in the community, online, text messaging programs, etc.). There are also videos that may be helpful to consumers that are available on our website: www.TakingTexasTobaccoFree.com.

Monitoring Tobacco Use Intervention and Quality Improvement Plans

Once the work group has developed tobacco use screening procedures and staff training curriculums, and has identified procedures to store, track and dispense tobacco treatment medications, the program should be implemented. It is likely that the clinical staff will have similar reactions and feelings about providing tobacco treatment services as all staff may have about the organization becoming 100% tobacco-free. Clinical staff may feel unprepared, unsure of their skills, skeptical about consumers' willingness to attempt to quit using tobacco, and may even question whether it is a good idea for consumers to quit using tobacco.

Due to these concerns, early and ongoing monitoring and auditing of clinical charts is very important. Through these audits, staff and specific units that are not following the prescribed procedures and protocols can be identified and improvement plans can be developed to address individual or units as a whole.

The audit tool should evaluate the following:

- Number of TUAs completed vs. number of consumer visits
- Educational materials provided for treatment and reducing exposure to secondhand smoke
- Referrals to internal and/or external treatment resources
- Treatment plan updates and notes on NRT or medication use/progress
- Prescriber consulted about impact on medications during quit attempt

Integral Care Clinical Staff Tobacco Treatment Credentialing Program

To offer best services to individuals served by the agency, Integral Care developed specialized trainings and a reporting and monitoring system specific to tobacco treatment services. This includes a credentialing training as well as chart audits and NRT distribution monitoring.

The specialized tobacco cessation training was developed to provide staff with more in depth understanding of tobacco use, how it relates to individuals with mental illness and ways to help an individual quit using tobacco. After completion of the training and passing a competency exam, the staff member receives a credential to become the front lines of the process of distributing NRT. While the nicotine replacement voucher is ultimately approved by a prescriber, the credentialed staff member has the knowledge to have a meaningful conversation with individuals served by Integral Care regarding their tobacco use. The four hour training covers topics including: *Health Effects of Tobacco Use, Tobacco Use and Mental Illness, Assessing for Nicotine Dependence, Tobacco Cessation Aids, Helping an Individual Quit Using Tobacco,* and *Appropriate Documentation of Tobacco-Related Services*. The credential plays an important role in program development to ensure staff members are confident and competent in delivering tobacco cessation services.

To ensure best services are being provided, Integral Care has developed a comprehensive reporting and monitoring system for tobacco cessation services. This system is comprised of two parts: 1) auditing of individual charts to ensure that policies and procedures are being followed and documented and 2) monitoring the distribution of nicotine replacement therapy. Integral Care developed a comprehensive audit tool and schedule to properly monitor staff member's behavior in regards to tobacco cessation services. The schedule calls for the audit of random staff members from various units monthly. The audit measures documenting tobacco use assessments, person centered care plans, and progress notes. The results are shared with the unit's program manager and individualized training is provided as needed. The auditor can also recognize trends within a unit or across the agency to identify areas of need for tobacco training.

Integral Care also monitors the distribution of NRT to its consumers. A report is generated to see the amount of nicotine replacement therapy distributed to individuals as well as the duration and regularity of its use. This information can be used to identify individuals that may be over using NRT. It also allows staff to identify consumers that would be good candidates for referrals to more intensive tobacco cessation services, either working directly with a certified tobacco treatment specialist or by being referred to wellness groups. Individuals recognized as either over using NRT or sporadically using nicotine replacement therapy should be referred to a certified tobacco treatment specialist.

By consistently offering trainings for staff and being able to monitor tobacco cessation services and NRT distribution, Integral Care ensures that its staff feel competent and confident when offering tobacco cessation services.

Please click on this link to view a sample tobacco use assessment audit tool: www.takingtexastobaccofree.com.

- An improvement plan should address the following:
- Identify the problem (e.g., low percentage of consumers are being administered tobacco use assessment);
- State the desired goal (e.g., 100% of consumers who have not had a tobacco use assessment administered in the 12 months will be administered a tobacco use assessment);
- State the action required to achieve the goal (e.g., staff will administer the tobacco use assessment to all consumers who have not had one completed in the past 12 months); and
- Outline improvement timeline (e.g., a report will be run at the end of next month to gauge improvement on assessing all consumers for tobacco use).

Quality improvement plans (QIPS's) may require additional training or guidance on how to accomplish the task required. It may involve communicating expectations or providing accurate information to the entire unit so everyone knows what is expected of them.

It is natural that there is a drift in the quality and consistency of services over time if processes are not monitored and evaluated. A monitoring system should be an ongoing activity and information obtained should be used to make necessary changes to clinical processes, as applicable. Staff should evaluate all aspects of existing practices and be willing to change those that have experienced any unintended drift from the original protocol or that have proven to be unhelpful. Screening for tobacco use and providing cessation treatment should be considered an evolving - not a static - service. A treatment program developed today likely will not have the exact same processes in place three years later, and centers will always want to be focused on looking for ways to improve the quality of consumer services.

Provision of evidence-based tobacco use cessation training and services

- Combining behavioral counseling and pharmacotherapy (i.e. medications) has proven most effective in quitting tobacco
- For tobacco users not ready to quit, clinicians should consider the 5 R's (**r**easons, **r**isks, **r**ewards, **r**oadblocks and **r**epetition) as well as Motivational Interviewing techniques to explore and resolve ambivalence
- The 5 A's regarding tobacco use (**a**sk, **a**ssess, **a**dvise, **a**ssist and **a**rrange) are a brief and effective intervention to address tobacco use that can be supplemented with other cognitive-behavioral strategies to facilitate quit attempts and sustain abstinence
- Over-the-counter (OTC) nicotine replacement therapy (NRT; i.e., gum, lozenges, patches) and prescription medications (nicotine inhaler, nicotine nasal spray, buproprion, varenicline) are an important part of an effective and safe treatment plan to quit tobacco
- The Patient Assistant Program (PAP) can help to offset the costs of NRTs and tobacco medications that may not be covered by medical insurance plans
- Ongoing monitoring and quality improvement plans for tobacco intervention services are essential to ensure sustained success of the program
- As ongoing clinician training is essential, the TUA task force should provide continuing tobacco treatment training for clinicians and provide periodic advanced training for nurses and providers and send staff to become Certified Tobacco Treatment Specialists (CTTS)

Reimbursement, Billing, and Coding

During the process of implementing tobacco treatment services it will be necessary to identify how the services will be documented. Tobacco treatment service codes should be created for the various services offered at the center. Tobacco treatment group and individual service codes will allow the center to track services provided and to identify areas of strength and areas in need of improvement. This information can be used to identify units and individual staff which are having success in implementing tobacco treatment services as well as identify units and staff that may need more training.

The question of billing and reimbursement is often asked in regards to offering tobacco cessation services. In most cases, offering strictly tobacco cessation services is a non-billable service. For example, in the state of Texas, only Licensed Clinical Social Workers may bill for tobacco cessation services. One can bill for tobacco cessation services when they tie tobacco cessation into billable services already offered by the agency. An example of this would be to tie tobacco cessation services into supportive housing services. To bill under supportive housing services, the staff member must ensure that they are providing the services that meet the requirements to document for the other service.

Ethical Considerations in Tobacco Use Cessation Treatment

Addressing tobacco use within behavioral health settings may give rise to ethical issues. Some of the ethical issues we have discussed with clinicians implementing TTTF include the following:

- In centers with limited resources, how ethical is it to offer cessation resources if it comes at the cost of reducing the provision of other services?
- For how long should a clinician promote cessation services to a consumer who is uninterested?
- How long should a clinician use Motivational Interviewing and other motivational techniques to try to encourage a quit attempt versus devoting time to the presenting problem?

- Is harm reduction (e.g., reducing the number of cigarettes consumed) an appropriate treatment goal if the consumer is unwilling to consider complete abstinence?
- Should consumers be triaged to receive cessation medications and other clinical services based on their readiness to quit?
- If a medication or treatment is not covered by the consumer's medical insurance coverage, is it ethical to mention it to them?
- Is it ethical to offer cessation-focused medications to a consumer who is already overburdened by medications?
- When it is okay to suggest that a consumer go on a "treatment holiday" for tobacco use cessation? How do you know when to pick cessation treatment back up again?

It is important that clinicians reflect on these ethical questions, as these are situations that can easily arise in the context of tobacco use intervention provision in behavioral health settings. Professional codes of ethics and consultation with other clinicians may be helpful for working through dilemmas after - and potentially even before - they arise. In our experience with the clinicians we have worked with over the years, the general consensus is that it is highly ethical to routinely address tobacco use among consumers given that it is in concert with the broader wellness mission of the organization and because tobacco users are more likely to die from the consequences of tobacco use than from their psychiatric presenting problem. We believe that it is important to engage consumers about tobacco use cessation routinely, as motivation and readiness to quit can waiver day by day or even potentially moment to moment.[37] Clinicians can make a big difference in helping to resolve ambivalence about tobacco use and facilitating quit attempts among their consumers. Quitting tobacco use is extremely difficult and consumers may need a great deal of support to maintain abstinence as nicotine dependence is truly a chronic disease – cravings can arise even years after quitting in the presence of certain prompts. Behavioral health clinicians are well-placed to provide the support that consumers need to quit. Yet, many clinicians also agree that a treatment holiday may also be used on occasion for individuals who have made serious efforts at quitting but seem "stuck." However, they stress that maintaining a close therapeutic relationship is important in offering a holiday, and that the decision about taking one should be well-considered, mutual, and with a clear plan for re-visiting the issue with a fresh outlook after a prescribed period of time. It is recommended that clinicians addressing tobacco use among consumers regularly meet to discuss ethical issues that arise in their practice to benefit from each other's experiences and viewpoints.

Ongoing Training: Maintaining Tobacco Treatment Competency

It is essential that as many clinicians as possible are provided a high level of tobacco treatment training and that the training is ongoing and sustainable. A significant barrier preventing clinicians from addressing tobacco use is a lack of training, knowledge, and skills to adequately assist a person with a quit attempt. A robust training program will provide the foundation for a competent and highly skilled clinical staff and ensure that all staff have a consistent level of knowledge. The more staff who have a higher levels of tobacco treatment training, the more likely consumers are going to be screened, referred for treatment, provided resources for quitting, and followed up.

The TUA work group should incorporate ongoing tobacco treatment training as refresher courses and webinars for current clinicians, provide periodic advanced level training (e.g. Treating Tobacco Dependence in Mental Health Settings – Dr. Jill Williams) for nurses and providers, and commit to send staff to become Certified Tobacco Treatment Specialists (CTTS). The CTTS trained staff can assist with the development of training programs and provide valuable clinic level expertise. Ideally, before providing tobacco treatment services to a consumer, a training program should be developed for credentialing clinicians. Without a consistent training program, untrained staff are less likely to talk with consumers about their tobacco use or may provide incorrect and/or potentially harmful information to a consumer.

Centers should encourage clinicians to take advantage of high-quality free online resources and webinars. Some examples include:

- Smoking Cessation Leadership Center (http://smokingcessationleadership.ucsf.edu/webinars) –
- National Behavioral Health Network For Tobacco & Cancer Control (http://www.bhthechange.org/events/)

As a way to embed expert knowledge within a setting, it is recommended that centers send staff to become a certified tobacco treatment specialist. Although there are costs associated with this commitment, it represents a way to sustain local expertise and facilitate future staff training. There are many CTTS programs available across the country. Below is a list of some programs:

- Mayo Clinic Nicotine Dependence Education Program: http://www.mayo.edu/research/centers-programs/nicotine-dependence-center/education-program/overview
- University of Massachusetts Medical School: http://www.umassmed.edu/tobacco/
- Rutgers University Tobacco Dependence Program: http://www.tobaccoprogram.org/
- Florida State University College of Medicine: http://med.fsu.edu/index.cfm?page=ahec.tobaccoTreatment
- University of Mississippi Medical Center: Act Center for Tobacco Treatment, Education and Research: http://www.act2quit.org/education/
- University of Colorado School of Medicine: RMTTS-C Program: https://www.bhwellness.org/programs/rmtts

Community Engagement and Outreach

An important and often overlooked component of a comprehensive tobacco-free workplace program is engaging the community. Behavioral health centers do not exist in a vacuum, but are an overall important piece of the safety net services in their community. The development of a comprehensive tobacco program will have direct and indirect impacts on many people and organizations within the broader community.

As mentioned earlier, a center's intentions to adopt a 100% tobacco-free campus policy should be communicated with all partner agencies, contractors, governmental agencies, and other key stakeholders. This communication may take the form of written letters, emails, disclosures at community coalitions or other meetings, town hall meetings, press releases to the media, announcements in local newspapers, and social media announcements. In all announcements, the communication should focus on what the center intends to do, why the change is taking place, and the anticipated benefits to the community as a result of the change.

Behavioral health centers have collaborative relationships with other organizations in their communities – other behavioral health providers, FQHC's, alcohol and drug treatment programs, hospitals, housing authorities, emergency services, community health centers, homeless shelters, and food banks to name a few. Each of these agencies should be notified of your upcoming TFC policy and opportunities to help people break their addiction to tobacco products and improve their health.

Communications among organizations may lead to further collaborations and shared resources. Your center may serve as a referral source or vice versa. Some consumers may be discharged from the hospital or an extended observation stay during which they were not permitted to use tobacco and have achieved abstinence from tobacco. In these cases, a direct referral to a tobacco treatment program will support their ongoing abstinence.

Some community partners may have considered adopting a TFC policy, but were hesitant to make the transition. Your center can provide guidance and experience to assist partners to make the transition as smooth as possible. It is important to have partners become tobacco-free to support your consumer's quit attempts. For instance, imagine how discouraging it could be for a recent former smoker, who is struggling to maintain abstinence, to leave a tobacco-free campus where they receive their mental health care only to have to walk through clouds of smoke to visit their primary care provider.

Appendix M: Celebrating tobacco-free policy anniversary

Centers may fear community backlash or a decrease in people coming in for services. However, safety net populations typically have nowhere else to receive services so are not inclined to abandon services. The consumers most upset by the change are those most in need of cessation services and therefore present a wonderful opportunity for staff. It is important to remember that tobacco-free campus does not imply that consumers are obligated to quit, they just can no longer smoke on center property while receiving services. It is very valuable that your center shares the successes and challenges with the community. For example, celebrating the TFC policy one year anniversary, writing a letter to your local newspaper editor highlighting your changes, or sharing stories of people who have successfully quit using tobacco because of your policy and the services provided by your center. All of these communication opportunities will increase community support for your efforts and increase the number of partners who will follow your actions.

Community engagement and outreach

- The success of a comprehensive tobacco cessation program requires the engagement of the larger community
- It is essential to communicate the adoption of a 100% tobacco-free campus policy to all partner agencies, governmental agencies, contractors and other key stakeholders through town hall meetings, emails, written letters, and press releases to the media and local newspapers, and social media
- Communications may also lead to further collaborations, shared resources and referrals, partnerships and providing guidance in tobacco cessation to other community organizations

Frequently Asked Questions

The following are some of the more commonly asked questions or concerns of behavioral health centers implementing the TTTF program:

Do staff have to quit using tobacco once the TFC policy is implemented?

No. Typically a tobacco-free campus policy prohibits the use of tobacco products while on the grounds. Policies may extend to any official work business, whether on or off campus, and may include parking lots, in company and private vehicles, and/or when meeting with a consumer. A staff can use tobacco products before or after work hours and not be in violation of the policy.

Encouraging consumers to quit using tobacco will jeopardize their treatment and recovery. Isn't it non-therapeutic to take tobacco away from them?

Many studies have shown that assisting consumers to quit tobacco does not jeopardize their treatment or increase psychiatric symptoms in the long term. In fact, research shows that helping people with a mental illness to quit tobacco may decrease depression, anxiety, and stress and decrease relapse rates in substance abusers. It could be said that it is counter-therapeutic to refrain from assisting consumers to quit tobacco when research shows that 1 out of every 2 people with a mental illness will likely die from a tobacco-related illness.

Our center passed a smoke-free/tobacco-free policy already but people still use on the grounds all the time. Can these policies be effectively enforced?

Yes, the policies can be enforced. Effective enforcement includes visible, permanent tobacco-free campus signage prominently displayed inside and outside buildings. Early and often communication with staff and consumers about the policy and training all staff, including new staff, on how to talk with a person who is violating the policy is also crucial. Most importantly, it is the responsibility of ***all*** staff to talk with people who are violating the policy. If only a few people address violations, the policy will not be effective. The enforcement must be shared by all staff.

A center may have to "reboot" and update their existing tobacco-free policy and start from scratch. This implementation guide provides examples to help you implement a sustainable tobacco-free campus policy.

It is a right to smoke. Isn't it against the law to prohibit people from smoking?

Everybody was born a non-tobacco user and people who use tobacco products are not a protected class. There is no constitutional right to use tobacco and therefore prohibiting the use of tobacco products is legal. No one is preventing consumers from smoking; the policy only places legal limitations on where smoking can occur…it can no longer occur on center property.

Will consumers and staff be at risk of being hit by vehicles because they will need to go in the street or across the street to use tobacco?

This concern has been voiced by a surprisingly high number of behavioral health centers. There is no evidence showing an increase of people being struck by a vehicle when leaving campus grounds to use a tobacco product.

Won't consumers become violent, combative or aggressive if they cannot smoke on the grounds?

Overall, with an effective communication strategy the vast majority of people accept and understand the TFC policy. After all, it follows what they are used to in other settings (e.g., government buildings, movie theaters). However, there may be instances when a person gets irritated about not being able to use tobacco on the grounds and in these situations staff usually have no trouble reminding consumers of the new policy that does not allow smoking on campus. This is also a wonderful opportunity to provide information on treatment services or encourage them to talk to a staff member about resources available to help them quit using tobacco.

Will neighboring businesses and homeowners complain because tobacco users will go to their property to use tobacco?

This is a realistic concern and one that needs to be discussed months before the implementation of the TFC policy. All neighboring businesses, homeowners, and other possibly impacted parties should be notified of the impending TFC policy and be invited to a town hall meeting or another scheduled meeting. Your plan for education and enforcement should be shared and all attendees should be provided with information on who they should call at your center if consumers are found using tobacco products on their property.

Why should we encourage people to use nicotine replacement therapy? Doesn't nicotine cause cancer and heart attacks?

It is true that tobacco products and NRT (patches, gum, lozenges, inhaler, and nasal spray) contain nicotine. When a person uses NRT, they are getting one chemical into their body – nicotine, which does not cause cancer or heart attacks. When a person uses a tobacco product, they are inhaling or ingesting thousands of chemicals – many which cause cancer and cause heart attacks. The Surgeon General's 2014 report, *The Health Consequences of Smoking – 50 Years of Progress,* provides a detailed explanation of the hundreds of health complications as a result of smoking. http://www.surgeongeneral.gov/library/reports/50-years-of-progress/exec-summary.pdf [16]–

It is the thousands of chemicals, and combinations of the chemicals, that make tobacco products so deadly. The goal of NRT is to deliver nicotine, or the addictive drug that gets people hooked quickly and makes quitting hard, in the safest way – through NRT products. This makes the process of quitting easier, and the NRT products can be tapered down over time. Indeed, for the majority of people, using NRT will have no negative health consequences – tobacco users are already getting nicotine through their tobacco products, and NRT products are designed to give the consumer a smaller, steadier dose over time than they are already used to.

Does prohibiting consumers from using tobacco on the grounds negatively impact treatment outcomes?

No. Actually, the opposite is true. Research has shown that people who have a mental illness see a decrease in depression, anxiety, and stress levels after they quit using tobacco. Associated improvements have shown to have a greater than or equal effect as antidepressants for depressive and anxiety disorders.[34] For people receiving services for chemical dependency, quitting smoking increases the likelihood of long-term abstinence by 25%.[42] However, it is important to recognize that symptoms of withdrawal from nicotine often mimic those of psychological disorders (e.g., increased agitation, anxiety, restlessness) and can be confused as exacerbating psychological conditions. Consumers should be educated that these are temporary nicotine withdrawal symptoms that will resolve within 2-4 weeks if they abstain from tobacco use. NRT or combination NRT therapies can help to address some of these withdrawal symptoms, and should be used as long as needed to make this critical period easier for the consumer.

Won't people stop coming for services?

No, adopting a tobacco-free campus policy does not lead to a significant increase in people choosing not to receive mental health services.[34]

You recommend that tobacco-free campus policies include e-cigarettes. Is the aerosol from the electronic cigarettes/vape pens harmful?

The 2016 Surgeon General's report on *E-Cigarette Use Among Youth and Young Adults* summarizes, "E-cigarette aerosol is not harmless 'water vapor,' although it generally contains fewer toxicants than combustible tobacco products." The aerosol created by e-cigarettes can contain ingredients that are harmful and potentially harmful to the public's health, including: nicotine; ultrafine particles; flavorings such as diacetyl, a chemical linked to serious lung disease; volatile organic compounds such as benzene, which is found in car exhaust; and heavy metals, such as nickel, tin, and lead.[43]

Are electronic cigarettes or vape pens an effective nicotine replacement therapy?

Electronic cigarettes or vape pens are not regulated or approved by the Food and Drug Administration (FDA) as nicotine replacement therapies. For this reason, we do not recommend their use in this manner.

Is it legal for residential housing complexes to adopt tobacco-free policies?

Yes. This applies to tobacco use inside private residence, common areas (e.g. courtyards, patios, play areas, pools, laundry facilities, etc.), and other outside areas.

On November 30, 2016, the U.S. Department of Housing and Urban Development (HUD) announced that public housing developments in the U.S. will now be required to provide a smoke-free environment for their residents within the next 18 months. More about this recent decision can be found at:

https://www.hud.gov/program_offices/healthy_homes/smokefree2

I am not hurting other people if I smoke within my apartment.

Unfortunately, this belief is not true. Tobacco smoke seeps between adjoining units and throughout all areas of buildings through light fixtures, ceiling crawl spaces, cracks in walls, plumbing, shared ventilation, and doorways. The Center for Energy and the Environment found that up to 65 percent of air within a unit can be lost through leakage to another unit, hallway, or exterior.[44]

The 2006 U.S. Surgeon General's report on secondhand smoke also supported the adoption of smoke-free policies in multi-unit housing as the only way to protect residents against involuntary exposure and that "there is no risk-free level of exposure to secondhand smoke."[21]

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APPENDICES

Appendix A

- (1) Betty Hardwick Center tobacco-free campus policy
- (2) Heart of Texas Region MHMR tobacco-free campus policy
- (3) Denton County MHMR tobacco-free campus policy

Appendix B

- Spindletop Center email notification
- Metrocare Services email notification

Appendix C

- Tobacco-free campus signage notifications

Appendix D

- Betty Hardwick Center letter to community providers/partners

Appendix E

- Integral Care tobacco-free campus press release

Appendix F

- Tobacco-free campus permanent signage

Appendix G

- Tobacco-free campus surveillance checklist

Appendix H

- Employee tobacco-free policy acknowledgement

Appendix I

- (1) Betty Hardwick Center tobacco use assessments
- (2) Heart of Texas Region MHMR tobacco use assessments
- (3) Denton County MHMR tobacco use assessments

Appendix J

- Myths & facts handout

Appendix K

- Medication interaction document

Appendix L

- NRT storage and distribution procedures

Appendix M

- Celebrating tobacco-free policy anniversary

Appendix A

BETTY HARDWICK CENTER [BACK] PAGES: 1 of 2 COI # 3-6.3a

SUBJECT: TOBACCO FREE WORKPLACE

Authorized/Reviewed By: Adopted: 9/1/2014
Effective 11/20/14

INTRODUCTION:
Betty Hardwick Center 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 community and does not promote a healthy environment for our patients or employees. Encouraging and assisting our employees, our patients and our visitors to be tobacco free is consistent with our mission to improve the health of the communities we serve.

SCOPE: This Policy applies to all patients, visitors, contractors, physicians, volunteers and employees of Betty Hardwick Center. 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.

PROCEDURES:

(1) Smoking and the use or possession of tobacco products (cigarettes, cigars, chewing tobacco, snuff, pipes, any form of electronic devices, etc.) is prohibited in or on all Betty Hardwick Center owned or leased buildings, grounds, parking lots or vehicles.
(2) Smoking in private vehicles on BHC owned or leased properties is also not allowed.
(3) This policy applies to facilities leased by BHC whether or not the owner or other tenants follow similar guidelines. No exceptions to this policy will be granted.
(4) Employees will not be allowed to smoke or use any tobacco products during their paid work time (including breaks) and are encouraged not to use tobacco products during their unpaid work time (lunch).
(5) Smoke odors at any time are not allowed. (Cross reference: Human Resources Dress Code Policy)
(6) Employees are prohibited from using tobacco products on the Betty Hardwick Center campus and contiguous property anytime during their work shift.
(7) BHC 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 BHC 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 Handbook, pre-admission materials, etc. will include notice regarding BHC 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) Full compliance with this policy is expected. Employees who violate this policy will be subject to disciplinary procedures according to policy.
(14) BHC will adopt clinical practices that provide client education and training on health related topics, including the health hazards of tobacco

Heart of Texas Region MHMR

I. Purpose

As a local authority and healthcare provider of behavioral and developmental health services, **Heart of TX Region MHMR Center** is committed to maintaining healthy and safe environments that promote and foster positive and healthy lifestyle choices.

Accordingly, **HOTRMHMR** is designated as a Tobacco Free Campus for the benefit of the overall health of its clients, employees, contractors, volunteers and visitors. **HOTRMHMR** prohibits all forms of tobacco use on all campuses and facility grounds owned, leased, or operated by **HOTRMHMR**, effective September 1, 2014.

II. Definitions

Tobacco

Any product containing tobacco including, but not limited to: cigarettes, cigarette facsimiles (such as e-cigarettes), cigars, pipes, chewing tobacco, and snuff. This procedure does not apply to the use of smoking cessation products such as nicotine patches or chewing gum.

Facilities

All property owned, leased or operated by **HOTRMHMR** for the purpose of conducting its business, including but not limited to:
Indoor and outdoor spaces and common areas;
Parking lots and driveways (including inside vehicles while on agency premises);
Vehicles owned or leased by **HOTRMHMR**; and
Sidewalks, curbs and gutters adjacent to property owned or leased by **HOTRMHMR**.

Employee

For purposes of this procedure only, **HOTRMHMR** employees, volunteers, and students.

Consumer

Any individuals receiving services from **HOTRMHMR**.

Third Party Contractor

Any non-Employee who is a party to a contract with **HOTRMHMR**.

Visitor

Any person using or present at any of the **HOTRMHMR** facilities who is not an Employee or Client or Consumer.

III. Procedure

1. Tobacco Free Facilities

No Tobacco shall be used at or on any of **HOTRMHMR**'s Facilities. All **HOTRMHMR** Facilities will have a prominent "No-Tobacco" sign that informs persons at or on the Facility that Tobacco is not permitted at that Facility. Regardless of location (on or off **HOTRMHMR** premises), In the course of business, employees may not use tobacco products while in the presence of consumers/clients.

2. Employees

Employees will comply with the "Center Employee Code of Conduct" in implementing this policy, including reporting of violations of this procedure.

3. Visitors

Employees who witness Visitors violating this procedure should not become confrontational but should explain this procedure and respectfully ask them to comply.

4. Consumers

All Clients/Consumers will be given information regarding this procedure at intake. If an Employee observes a Consumer using tobacco at any **HOTRMHMR** Facility or campus, the Employee should not be confrontational with the Client, but instead engage the Client by respectfully asking him/her to comply with this procedure.

Note: *This procedure does not apply to clients who use tobacco products while in their **HOTRMHMR** group homes.*

5. Third Party Contractors
All **HOTRMHMR** contracts with Third Party Contractors and vendors shall contain language enforcing **HOTRMHMR**'s Tobacco-Free Campus procedure. Any Employee who observes a Third Party Contractor violating this procedure must inform him/her that **HOTRMHMR** does not allow Tobacco in its Facilities or campus.

6. Applicants for Employment
All applicants for employment will be informed about the Tobacco Free Campus Policy.

Denton County MHMR

Section No. 7.704 PAGE 1 of 2

POLICY: HUMAN RESOURCES
SUBJECT: TOBACCO, VAPOR AND SMOKE FREE WORKPLACE

Approved by:

_____
Administrator of HR

Concurred:

_____
Chief Executive Officer

Effective Date: 06/01/15

Revised Date:

I. PURPOSE: Denton County MHMR Center (DCMHMRC) is committed to maintaining healthy and safe environments that promote and foster positive and healthy lifestyle choices.

II. POLICY: It is the policy of the Board of Trustees to ensure DCMHMRC is designated as a Tobacco, Smoke and Vapor Free facility for the benefit of the overall health of its employees, clients, visitors, volunteers, vendors, and physicians. DCMHMR prohibits all forms of tobacco use on all center property and facility grounds owned, leased, or operated by DCMHMRC, effective September 1, 2015.

III. SCOPE: This procedure applies to all applicants, employees, clients, third party contractors, and/or visitors of DCMHMR to provide a safe and healthy environment for employees to work that has established a tobacco free workplace procedure. Smoking, or any other use of tobacco or tobacco products, is prohibited anywhere within Denton County MHMR facilities, on facility grounds or parking lots. This applies to any individual on Denton County MHMR Center properties.

IV. DEFINITIONS:

1. Tobacco: Any product containing tobacco including, but not limited to: cigarettes, cigarette facsimiles (such as e-cigarettes), cigars, pipes, chewing tobacco, and snuff. This procedure does not apply to the use of smoking cessation products such as nicotine patches or chewing gum.
2. Facilities: All property owned, leased or operated by DCMHMRC for the purpose of conducting its business, including but not limited to:
    i. Indoor and outdoor spaces and common areas;
    ii. Parking lots and driveways (including inside vehicles while on agency premises);
    iii. Vehicles owned or leased by DCMHMRC; and
    iv. Sidewalks, curbs and gutters adjacent to property owned or leased by DCMHMRC.
3. Employee: For purposes of this procedure only, DCMHMRC employees, volunteers, and students.
4. Consumer: Any individuals receiving services from DCMHMR.
5. Third Party Contractor(s): Any non-employee who is a party to a contract with DCMHMR.
6. Visitor: Any person using or present at any of the DCMHMR facilities who is not an employee, client, or consumer.

V. PROCEDURE

a. Tobacco Free Facilities: Smoking or other tobacco use will not be permitted anywhere on facility grounds, within facilities, center vehicles or any vehicle parked on Center property. Signs will be posted at all entrances, within the facilities, and in parking lots advising of the Tobacco-Free policy. Regardless of location (on or off DCMHMR premises), in the course of business, employees may not use tobacco products while in the presence of consumers/clients.

b. Employees: Employees, at all levels, are responsible for monitoring compliance and assisting with enforcing the provisions of this policy. Employees are expected to be good neighbors and refrain from using tobacco products on the properties of nearby businesses and residences. Employees who violate the provisions of this policy are subject to appropriate and progressive disciplinary action.

c. Visitors: Employees who witness Visitors violating this procedure should not become confrontational but should explain this procedure and respectfully ask them to comply.

d. Clients: All clients will be given information regarding this procedure at intake. If an employee observes a client using tobacco at any DCMHMRC facility, the employee should not be confrontational with the client, but instead engage the client by respectfully asking him/her to comply with this procedure.

Note: This procedure does not apply to clients who use tobacco products while in their DCMHMRC group home.

e. Third Party Contractors: All DCMHMRC contracts with Third Party Contractors and vendors shall contain language enforcing DCMHMRC's Tobacco-Free Campus procedure. Any Employee who observes a Third Party Contractor violating this procedure must inform him/her that DCMHMR does not allow tobacco in its facilities or campus.

f. Applicants for Employment: All applicants for employment will be informed about the Tobacco Free Policy.

Appendix B

Metrocare is Helping Take Texas Tobacco Free – October 2014 Insider Newsletter

Beginning January 1, 2015, Metrocare will become a tobacco-free campus. Tobacco use is the single most preventable cause of disease, disability, and death in the United States. Metrocare is dedicated to improving the health of our consumers, employees, and community by taking the entire campus tobacco free.

Who does this apply to?

- All full-time and part-time Metrocare employees
- Clients
- Contractors
- Visitors
- Volunteers
- Students

Essentially, everyone who steps foot on Metrocare property will be expected to comply with the tobacco-free policy.

What tobacco products are included in this policy?

- Cigarettes
- Electronic smoking devices
- Chewing tobacco
- Cigars
- Pipes
- Snuff

What areas must be tobacco free?
All Metrocare campuses and contiguous property including and not limited to:

- Leased and owned buildings
- Grounds
- Driveways
- Walkways
- Parking lots
- Vehicles, including employee-owned vehicles used to conduct Metrocare business during paid time

Nicotine replacement therapy (NRT) products will be made available by Metrocare for employees and clients who are interested in quitting tobacco and need assistance. These include nicotine patches, gum and lozenges, and they are allowed on Metrocare property. More information will be provided on how to access these products in future communications.

Moving forward, employees will receive more information about the campaign through signage, email communications, and through publications, like The Insider.

Going tobacco-free has become the standard for many healthcare institutions and companies. Organizations that are already completely tobacco-free include Blue Cross Blue Shield, Texas Health Resources, and hundreds of businesses and organizations across the region and nation.

As a leader in our community, Metrocare is committed to improving the lives and health of our employees and consumers. Making a difference in the community begins with making positive changes right here in our own agency.

If you have questions or suggestions about the tobacco-free campaign, please contact the People Department at peopledept@metrocareservices.org.

From: Sally Broussard
Sent: Tuesday, June 24, 2014 5:01 PM
To: CENTER
Subject: Spindletop Center will be a Tobacco Free Campus soon!

Beginning in 2015, DSHS will be requiring all of its contractors to become Tobacco Free campuses. DADS is sure to follow suit quickly. We are looking forward to having a healthier workforce and consumers by assisting all users of tobacco products to become tobacco free.

Spindletop applied for, and has been selected to receive assistance with this process from Taking Texas Tobacco Free. So, we will be getting assistance from the very best experts at MD Anderson hospital and the Cancer Prevention and Research Institute of Texas. Many other organizations have been through this transition successfully ahead of us, so we will have the benefit of their experience and expertise.

There will be MUCH more information coming soon, and I know you have many questions! We have set a tentative Spindletop Center Quit date to become a completely tobacco free campus for January 1, 2015. Our consultants will be here to visit our facility the week of July 14th to give us more information about how we can make this program a success. They will have lots of tips for reducing our anxiety about implementing this process!

Right now, here are some things that will be happening as soon as we prepare for a Tobacco Free campus:

- You will each be receiving an anonymous survey with just 14 questions about your own tobacco use. This will be online and very easy to complete. It will help us determine how many of our staff are currently using tobacco, smokeless tobacco and electronic cigarettes. We urge you to be completely honest so that we will have an accurate baseline to help us get started.
- We will be asking your help to assist us with a similar survey for our consumers.
- We will be creating a Tobacco Free Campus Policy.
- We will be developing tobacco cessation information and resources for our staff and consumers. There will be funding available through our grant to assist with this.

Even though you have questions, please be patient as we await our consultants to arrive to guide us with some very specific implementation timelines. I certainly do not have all the answers yet! I will keep you all posted as we progress and will be sending out more information very soon,

Thanks,
Sally

Sally Broussard, MA, LMFT

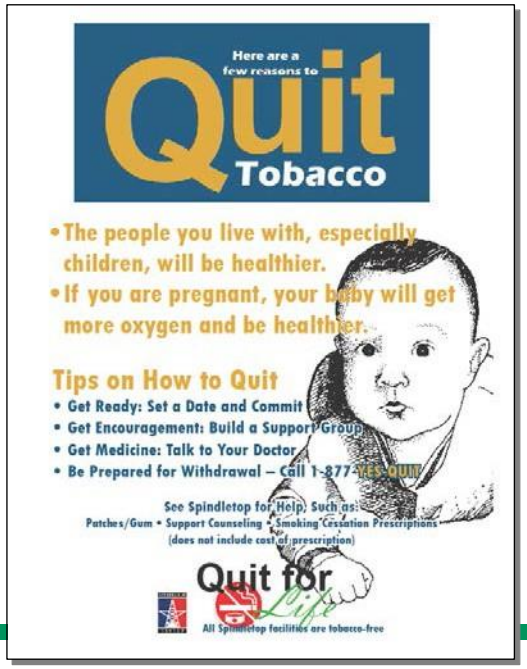
Appendix C


BORDER REGION
BEHAVIORAL HEALTH CENTER
IS PROUD TO ANNOUNCE THAT
EFFECTIVE SEPTEMBER 1, 2015
WE WILL BECOME A TOBACCO-FREE CAMPUS
3
Healthy is the way to be...
Tobacco Free at BRBHC!


Effective January 1, 2015
METROCARE
IS GOING
TOBACCO
FREE
WITHIN 20 MINUTES OF QUITTING SMOKING...
20 MINS
Your heart rate drops.
48 HOURS
Your sense of taste starts to come back.
6 MONTHS
Your lung capacity is greatly improved.
8 HOURS
Your complexion dramatically improves.
6 WEEKS
Your energy levels are much higher than before.
1 YEAR
Your risk of heart attack is now half the risk of a smoker's.
To maintain good health and a healing environment, all Metrocare campuses are tobacco free.
ASK METROCARE FOR INFORMATION, GUIDANCE AND SUPPORT.
Metrocare SERVICES


Did you know...
Betty Hardwick Center,
its entire campus, grounds,
parking lots, off-campus
facilities and properties become
Tobacco Free
November 20th, 2014


Here are a few reasons to
Quit
Tobacco
You will have more money to spend on things other than cigarettes!
Tips on How to Quit
• Get Ready: Set a Date and Commit
• Get Encouragement: Build a Support Group
• Get Medicine: Talk to Your Doctor
• Be Prepared for Withdrawal – Call 1-877-YES-QUIT
Ask Spindletop For Help, Such as:
Patches/Gum • Support Counseling • Smoking Cessation Prescriptions
(does not include cost of prescription)
Quit for Life


Here are a few reasons to
Quit
Tobacco
• The people you live with, especially children, will be healthier.
• If you are pregnant, your baby will get more oxygen and be healthier.
Tips on How to Quit
• Get Ready: Set a Date and Commit
• Get Encouragement: Build a Support Group
• Get Medicine: Talk to Your Doctor
• Be Prepared for Withdrawal – Call 1-877-YES-QUIT
See Spindletop for Help, Such as:
Patches/Gum • Support Counseling • Smoking Cessation Prescriptions
(does not include cost of prescription)
Quit for Life
All Spindletop facilities are tobacco-free

Appendix D

October 6, 2014

Subject: _____

(insert client name)

Dear Medical Provider/Partner:

Betty Hardwick Center will become a Tobacco Free Campus effective November 20, 2014. The Center is participating in the Taking Texas Tobacco Free project in partnership with Integral Care and the University of Houston. As a result of that partnership, the Center has the ability to pass along free nicotine replacement therapy (NRT) products to our clients to assist them in tobacco cessation efforts. However, Texas Medicaid already covers Nicoderm Patches, Nicorette Gum, Chantix and Zyban as approved smoking cessation aids.

The client named above is one of your patients who has expressed an interest in smoking cessation and who currently has Medicaid coverage.

The tobacco free campus policy will be in effect even in our residential homes and day programs. As you know, as a condition of the Home and Community Based Services Program where they reside, our program must have written orders for even over the counter medications (such as the gum/patch NRT).

As the treating physician for this client, please consider whether or not you would advise the patient's use of NRT.

If you are agreeable to their participating, please send orders to…

Sincerely,

Appendix E

Austin Travis County Integral Care
Behavioral Health & Developmental Disabilities Services

***Integral Care* Announces New Tobacco Free Workplace Policies** *(Austin) –Integral Care* today announced plans to implement a new tobacco-free policy at all facilities, effective *DATE.* Hospital leaders say the new policy reflects the health system's mission: "We are eliminating tobacco-use on our properties to provide a healthy and safe environment for employees, consumers and visitors and to promote positive health behaviors," said *Mr. David Evans,* chief executive officer at *Integral Care.*

The new policy bans the use of all tobacco products, including cigarettes, cigars, pipes and smokeless tobacco, within all properties owned, leased, or occupied by *Integral Care.* This includes parking lots, hospital vehicles, and employees' personal vehicles parked on the premises. Employees are prohibited from using tobacco products during working hours.

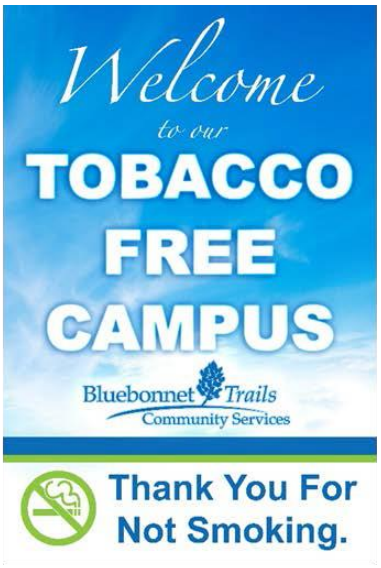
The US Surgeon General's Office in 1964 declared that smoking is hazardous to health. Yet smoking remains the number one cause of preventable death and disability, according to the Centers for Disease Control & Prevention.

Integral Care views tobacco-use as a quality concern: "We can no longer turn a blind eye to on-campus smoking when we know that continued tobacco use can cause problems for a consumers," said Director of Tobacco cessation program, *Dr. Singh.*" 30 minutes exposure to smoke increases the risk of blood clots, slow blood flow to Coronary Arteries, Injures blood vessels and interferes with their repairs, and also kills more than AIDS, cocaine, heroin, alcohol, car accidents, fire and homicide COMBINED"

Furthermore, three-fourths of all tobacco-users say they want to quit. But the *Integral Care* medical director recognizes the challenges of breaking the addiction to nicotine and respects an individual's quitting process. "We are not telling anyone, 'you must quit smoking.'" said *Dr. Van Norman, Director of Medical Services* "We are saying, 'Don't use tobacco at our campuses.' While you are a consumer or visitor at this center, we can suggest ways to ease nicotine withdrawal symptoms. And if you are ready to quit, we have trained professionals and community partners who can help you."

Integral Care hopes center employees will help inform visitors and patients about the new policy, said Mr. Evans, CEO. "This will not be easy," he said, "but it's central to our continuing efforts to make an excellent place to work and to receive health care." In implementing the new tobacco ban, the hospital plans to offer symptom relief or tobacco-cessation treatment to interested staff, visitors and consumers.

Appendix F


Welcome
to our
TOBACCO
FREE
CAMPUS
Bluebonnet Trails
Community Services
Thank You For
Not Smoking.


TOBACCO FREE
YOUR COOPERATION IS APPRECIATED
Behavioral Health Center
of Nueces County


TOBACCO
FREE
PROPERTY
Texas Panhandle
CENTERS
Behavioral & Developmental Health
Making Lives Better


TOBACCO FREE
CAMPUS
CAMPUS LIBRE DE TABACO


TOBACCO FREE
CAMPUS
CAMPUS LIBRE DE TABACO
FOR BETTER HEALTH, USE OF TOBACCO
PRODUCTS IS PROHIBITED IN ALL AREAS
OF OUR PROPERTY.
PARA MEJORAR SU SALUD, EL USO DE
PRODUCTOS DE TABACO ESTA PROHIBIDO
EN TODAS PARTES DE NUESTRA PROPRIEDAD.
betty
hardwick
center

Appendix G

Tobacco-free Campus Surveillance Checklist

Reviewer: Please walk the grounds and note people (staff, security, visitors, consumers) who may be actively using tobacco and cigarette butts on ground – note areas with high concentration of litter; take notice of signage or lack thereof. Please take the time to talk with staff about enforcing the tobacco-free policy and assessing and offering cessation services to consumers.

Date of scan:_____ Name of reviewer: _____

Time scan took place: _____

Address and name of facility: _____

Tobacco Use on Premise

Were people using tobacco products on grounds at time of visit? □ Yes □ No

If yes, indicate who was using (or who you believe they may be):

□ Integral Care staff □ Security staff □ Consumer □ Visitor □ 3rd party vendor

Are informational cards readily available to provide to people who are using tobacco products on the grounds?

□ Yes □ No

Are cigarette butts found lying on the ground? □ Yes □ No

If yes, list the locations (take photos of litter):

Tobacco-free Signage

Are tobacco-free signs visibly displayed outside on the grounds? □ Yes □ No

Are tobacco-free signs damaged or vandalized in any manner? □ Yes □ No

If Yes, list extent of damage (take photo of damage):

Are tobacco-free signs visibly displayed inside building(s) □ Yes □ No

Staff Interactions (talk to two or three staff at facility)

Do employees comply with tobacco-free campus policy all the time? □ Yes □ No

If no, how often do staff not comply? □ Sometimes □ Often □ All the time

Are employee's supervisors notified when an employee violates policy? □ Yes □ No

Do consumers comply with tobacco-free campus policy all the time? □ Yes □ No

If no, how often do consumers not comply? □ Sometimes □ Often □ All the time

Are consumers educated on the policy and respectfully asked to comply with policy? □ Yes □ No

Are consumers provided an educational card when observed using tobacco? □ Yes □ No

Are contracted vendors educated on the policy and respectfully asked to comply with policy? □ Yes □ No

Are contracted vendors provided an educational card when observed using tobacco? □ Yes □ No

Tobacco Cessation

Are consumers provided information on tobacco-free campus policy during Intake? □ Yes □ No

Are employees familiar with Integral Care's Tobacco Cessation Plan on the Internet? □ Yes □ No

Can employees describe the process in which consumers can obtain NRT? □ Yes □ No

Are employees familiar with the process in which employees can obtain NRT to quit? □ Yes □ No

Are tobacco cessation materials available to: employees? □ Yes □ No

consumers? □ Yes □ No

Appendix H

Employee Tobacco-free Policy Acknowledgement

Made effective by the date of acknowledgement, I have received an electronic copy of the Drug, Alcohol and Tobacco Free Workplace Policies. I also acknowledge that the provisions of these Policies are part of the terms and conditions of my employment with Integral Care and that I agree to abide by them.

3.12 BOARD OF TRUSTEES POLICY

Title: Tobacco Free Work Place Policy

Section: Internal Management

Cross Reference: OP 03.26

PURPOSE

The purpose of this policy is to make Integral Care facilities tobacco free for the benefit of the overall health of its consumers, employees, contractors, volunteers and visitors. This includes all tobacco products as well electronic nicotine delivery devices.

As the local authority and provider of behavioral health and developmental disability services, Integral Care is committed to healthy and safe environments that promote positive, healthy behaviors.

POLICY

It is Integral Care's policy to enforce tobacco free initiatives for the health and well-being of its consumers, employees, contractors, volunteers and visitors at Integral Care facilities and establish the means to do so. These initiatives include, but are not limited to the following:

* The development and implementation of appropriate Integral Care procedures relating to these initiatives;

* Providing assistance for Integral Care consumers and staff to become tobacco free through tobacco cessation education, American Public Health Service approved treatment(s) and support;

* Increasing Integral Care's involvement in treating nicotine addiction; and

* Coordinating and cooperating with local government in the development and execution of a Tobacco Free Workplace Plan.

Effective Date: July 29, 2010

Revised Date: January 30, 2014

Approved: Matt Snapp

Signature: _____

Appendix I

Name [redacted] Case#: 820719 Page: 1 of 2
Type: Tobacco Use Assessment Date: 10/06/2014
Printed on 10/06/2014 at 01:37 PM (Draft)

Betty Hardwick Center

Tobacco Use Assessment

Client Age: O Age 13 or older O Age 12 or under

Cigarette smoking status:

O Current every day smoker

O Current some days smoker

O Former smoker

O Never smoker

O Smoker, current status unknown

O Unknown if ever smoked

O Do you live with tobacco user(s)? O Yes O No

Any tobacco use status:

☐ Current user ☐ Past user ☐ Never used ☐ Currently use cigarettes ☐ Currently use pipe

☐ Currently use cigars ☐ Currently use smokeless ☐ Currently use other-e-cig/vap, etc.

☐ Previously used cigarettes ☐ Previously used pipe ☐ Previously used cigars

☐ Previously used smokeless ☐ Previously used other-e-cg/vap, etc.

If other, please specify:

How many years?

Type/amount of tobacco used per day:

Have you ever attempted to quit? O Yes O No Approximate Date of last quit attempt:

How many times have you attempted to quit tobacco?

Methods used in previous quit attempts: ☐ Acupuncture ☐ Counseling ☐ Cognitive Behavioral Therapy
☐ Hypnotherapy ☐ Over the Counter Medication
☐ Prescription Medication ☐ Without Assistance (aka Cold Turkey)
☐ N/A ☐ If other, please specify:

Have you ever used BHC supplied Nicotine Replacement Therapy products? O Yes O No

Readiness to quit:

O Not interested in quitting O Thinking about quitting within next 30 days O Ready to quit

O Referred to: BHC Tobacco Cessation O Referred to: Quit Line O Other Referral

O No Referral O Provided Quitline Card O Provided Quit Smoking Brochure

O Provided Secondhand Smoke Brochure O Nothing Provided

O Other: Please Specify:

Past Users Only:

Approximate quit date:

I attest that a Tobacco Use Assessment was completed for this person face-to-face.

Heart of Texas Region MHMR
Tobacco Use Assessment

Name _____ **ID #** _____ **Date of Birth** _____ **Assessment Date** _____

Do you live with a tobacco user? ☐ Yes ☐ No

Have you ever used tobacco? ☐ Yes ☐ No If No, survey is complete.

Do you currently use tobacco? ☐ Yes ☐ No If No, date last used _____

Complete the following only if a current tobacco user

	None	Daily	Weekly	Monthly	Occasionly	Length of Use	Years	Months
Cigarette use	☐	☐	☐	☐	☐	_____	☐	☐
Pipe use	☐	☐	☐	☐	☐	_____	☐	☐
Cigar use	☐	☐	☐	☐	☐	_____	☐	☐
Smokeless tobacco use	☐	☐	☐	☐	☐	_____	☐	☐
E-cigarettes, vap. use	☐	☐	☐	☐	☐	_____	☐	☐

Have you ever attempted to quit? ☐ Yes ☐ No Approximate date of last attempt _____

How many times have you attempted to quit tobacco? _____

Methods Used to Quit in Previous Attempts

- ☐ Not Applicable
- ☐ Counseling
- ☐ Hypnotherapy
- ☐ Prescription medication
- ☐ Other (please specify)
- ☐ Acupuncture
- ☐ Cognitive Behavioral Therapy
- ☐ Over-the-counter medication
- ☐ Without assistance (aka Cold Turkey)
- ☐ Nicotine Replacement Therapy

If other, please specify: _____

Have you tried HOTRMHMR Tobacco Cessation? ☐ Yes ☐ No

Are you ready to quit? ☐ Not interested in quitting ☐ Thinking about quitting within next 30 days ☐ Ready to quit

Referred to

- ☐ No referral
- ☐ Quit Line
- ☐ Other referral (please specify)
- ☐ HOTRMHMR Tobacco Cessation
- ☐ Scott & White "Enuff of the Puff"

If other, please specify: _____

Materials Provided

- ☐ No materials provided
- ☐ Quit Smoking Brochure
- ☐ Other material (please specify)
- ☐ Quitline Card
- ☐ Secondhand Smoke Brochure

If other, please specify: _____

Denton County MHMR Center

TOBACCO CESSASTION QUESTIONAIRE

Cigarette smoking status:
0 Current every day smoker
0 Current some days smoker
0 Former smoker
0 Never smoker
0 Smoker, current status unknown
0 Unknown if every smoked

Do you live with tobacco user(s)?
0 Yes 0 No

Do you butt out and relight?
0 Yes 0 No

If so, how many times per day? _____

Any tobacco use status:
0 Current user 0 Past User 0 Never used

0 Currently use cigarettes
0 Currently use pipe
0 Currently use cigars
0 Currently use smokeless
0 Currently use other-e-cig/vape, etc.

0 Previously used cigarettes
0 Previously used pipe
0 Previously used cigars
0 Previously used smokeless
0 Previously used other-e-cig/vape, etc.

If other please specify: _____

Fagerström Test:

1) How soon after you wake up do you smoke your first cigarette?
   a) Within 5 minutes (3 points)
   b) 6-30 minutes (2 points)
   c) 31-60 minutes (1 point)
   d) After 60 minutes (0 points)
2) Do you find it difficult to refrain from smoking in places where it is forbidden?
   a) Yes (1 point)
   b) No (0 points)
3) Which cigarette would you hate most to give up?
   a) The first one in the morning (1 point)
   b) All others (0 points)
4) How many cigarettes per day do you smoke?
   a) 10 or fewer (0 points)
   b) 11-20 (1 point)
   c) 21-30 (2 points)
   d) 31 or more (3 points)
5) Do you smoke more frequently during the first hours after waking than during the rest of the day?
   a) Yes (1point)
   b) No (0 points)
6) Do you smoke if you are so ill that you are in bed most of the day?
   a) Yes (1 point)
   b) No (0 points)

Proposed Scoring Cut Offs:
0-2 very low
3-4 Low
5 Medium
6-7 High (Heavy)
8-10 Very High

How many years have you been using tobacco products? _____

Type/amount of tobacco used per day: _____

Have you ever attempted to quit? 0 Yes 0 No **Approximate Date of last quit attempt**: _____

How many times have you attempted to quit tobacco? _____

Methods used in previous quit attempts:
0 Acupuncture 0 Counseling 0 Cognitive Behavioral Therapy 0 Hypnotherapy
0 Over the Counter Medication 0 Prescription Medication 0 Without Assistance (aka Cold Turkey)
0 If Other, please specify:_____

Have you ever used Nicotine Replacement Therapy products? 0 Yes 0 No

If yes, what products: _____

Readiness to quit: 0 Not interested in quitting 0 Thinking about quitting within next 30 days
0 Ready to quit
Quit Date (if ready to quit): _____

Referrals: 0 Denton County Tobacco Cessation 0 Provided Quit Smoking Brochure(s)
0 Quitline (1-877-YES-QUIT) 0 No Referral
0 If Other, please specify:

Signature line indicates last line of report

Staff Name	ID#	_____	_____
Staff Name, Credentials	Staff ID	Signature	Date

Report Run On: _____

Appendix J

Myths & Facts About Quitting Tobacco

Myth #1: "Tobacco helps me deal with my anxiety and stress. If I quit smoking, they will get worse!"
This is probably the most common myth about smoking! Smoking cigarettes is very harmful to our bodies and can actually make anxiety much worse. And while it's true that smoking a cigarette might give you the feeling of temporary relief from anxiety, it's not a long-term way to deal with anxiety.

Of course, it's natural to feel anxious when it comes to quitting tobacco and anxiety is the most common symptom of nicotine withdrawal. Nicotine replacement therapy helps reduce anxiety caused by nicotine withdrawal. When you quit tobacco, talk to your health care professional about nicotine replacement therapy and other healthy ways to cope with anxiety, like exercising or deep breathing.

Myth #2: "I'm too old to quit. I've already done too much damage to my body so there's no use to quitting now."

You are never too old to quit smoking and it's never too late to quit. Remember, there are many health benefits to quitting smoking. You'll even start to notice health benefits within a day of smoking your last cigarette, like lower blood pressure and lower levels of carbon monoxide in your bloodstream. Be sure to watch the video on "Benefits of Quitting" to learn more about the many benefits of quitting smoking.

Myth #3: "I am trying to recover from drug or alcohol abuse. I shouldn't quit smoking now, it might make my recovery harder to achieve."

We know how much hard work it takes to recover from substance addition. Did you know that quitting smoking actually increases your chances for long term sobriety by 25%? Continuing to smoke can act as a trigger or temptation for other substance use and can make your recovery harder. So, quitting smoking at the same time you're recovering from substance addiction can actually make recovery easier.

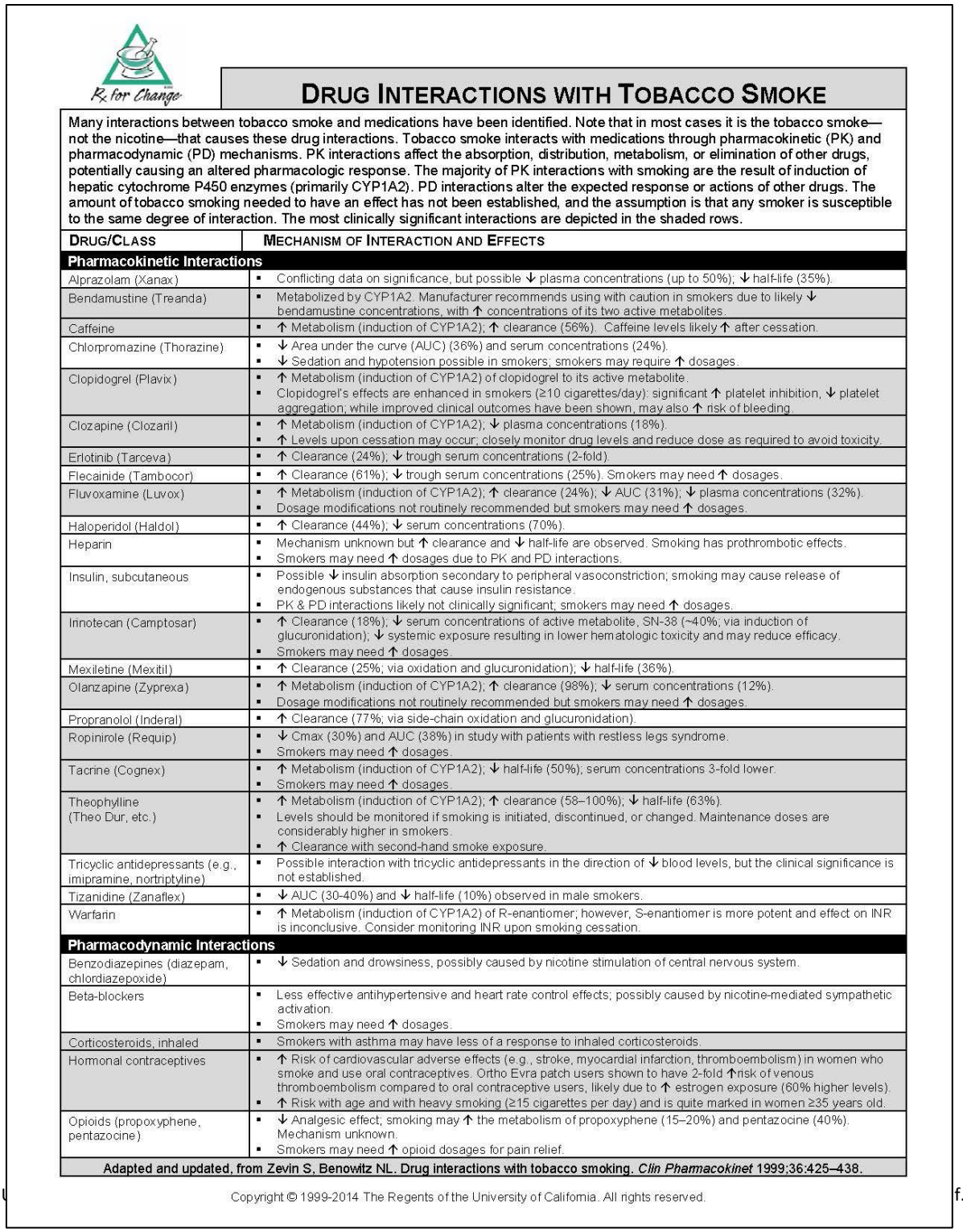
Myth #4: "If nicotine is in tobacco products, why would I use medication that has nicotine in it? Won't that give me cancer too?"

The nicotine in tobacco causes addiction. Other than being addictive, nicotine has few negative health effects. It may raise your heart rate and blood pressure a little, but other than that, it doesn't really harm your body. Nicotine does not cause cancer. The thousands of other chemicals found in tobacco are what's harmful to your health.

Nicotine replacement therapy helps reduce withdrawal symptoms, which makes it easier to quit. There's only a small chance someone will become addicted to nicotine replacement therapy.

We know quitting tobacco is hard and may feel overwhelming. But with the right resources and support, you can do it. For more resources, please visit our website at takingtexastobaccofree.com.

Appendix K



Rx for Change

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 through pharmacokinetic (PK) and pharmacodynamic (PD) mechanisms. PK interactions affect the absorption, distribution, metabolism, or elimination of other drugs, potentially causing an altered pharmacologic response. The majority of PK interactions with smoking are the result of induction of hepatic cytochrome P450 enzymes (primarily CYP1A2). PD interactions alter the expected response or actions of other drugs. The amount of tobacco smoking needed to have an effect has not been established, and the assumption is that any smoker is susceptible to the same degree of interaction. The most clinically significant interactions are depicted in the shaded rows.

DRUG/CLASS	MECHANISM OF INTERACTION AND EFFECTS
Pharmacokinetic Interactions	
Alprazolam (Xanax)	▪ Conflicting data on significance, but possible ↓ plasma concentrations (up to 50%); ↓ half-life (35%).
Bendamustine (Treanda)	▪ Metabolized by CYP1A2. Manufacturer recommends using with caution in smokers due to likely ↓ bendamustine concentrations, with ↑ concentrations of its two active metabolites.
Caffeine	▪ ↑ Metabolism (induction of CYP1A2); ↑ clearance (56%). Caffeine levels likely ↑ after cessation.
Chlorpromazine (Thorazine)	▪ ↓ Area under the curve (AUC) (36%) and serum concentrations (24%). ▪ ↓ 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; while improved clinical outcomes have been shown, may also ↑ risk of bleeding.
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%).
Olanzapine (Zyprexa)	▪ ↑ Metabolism (induction of CYP1A2); ↑ clearance (98%); ↓ serum concentrations (12%). ▪ Dosage modifications not routinely recommended but smokers may need ↑ dosages.
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.

Source: U f.edu/)

Appendix L

Betty Hardwick Center

A Community Resource

Behavioral Health/Intellectual & Developmental Disabilities

Tobacco Cessation Policy

Adopted: October 16, 2014

Approved By: _____

Dr. Patrick Young, Medical Director **Jenny Goode, CEO**

Introduction:

Betty Hardwick Center has adopted a tobacco free campus policy that is effective November 20, 2014. The Center is participating in the Taking Texas Tobacco Free project in partnership with MD Anderson, the University of Houston and Austin Travis County Integral Care. Included in that partnership is opportunity to provide staff and clients with training and education related to tobacco usage, to provide Nicotine Replacement Therapy, and to provide support in terms of eliminating the use of tobacco.

Staff Training:

Betty Hardwick Center staff have been offered training and will continue to receive ongoing education and training related to tobacco usage, cessation and supporting clients in cessation. The Center has adopted Tobacco Assessments to be completed with clients and documented Cessation Education efforts. Printed materials will be made available on the Center's intranet and for client distribution on an ongoing basis.

Nicotine Replacement Therapy Storage:

A. Nicotine Replacement Therapy will be maintained in secured locations in the Human Resources office, the Clinic, the HCS Medical Clinic and on site in HCS homes and the Formosa Respite House.
B. Nicotine Replacement Therapy will be inspected to ensure no outdated products are handed out to clients/staff.
C. All NRT will be stored away from disinfectants and cleaning agents.
D. If NRT products are recalled by the FDA or other agency, such NRT stock will be collected and returned to the manufacturer or disposed of in accordance with instructions provided. Center staff would provide notice to clients or staff affected by the recall or discontinuation.

Client Assessment:

1. Clients may be assessed at intake, with a nursing assessment in or outside of the clinic or by a case manager/services coordinator at any time.
2. Staff will record the assessment in Anasazi on the Tobacco Assessment Form.
    a. Assess current tobacco use status, tobacco products utilized, frequency of tobacco usage, desire to quit, history of quit attempts.
3. BHC clinician will educate client on tobacco cessation services at agency and provide them with a quit line card.
    a. If consumer is ready to quit, and they are indigent, they can be referred to the Clinic, where Clinic staff will verify the Tobacco Assessment was complete and that the client demonstrates readiness to quit.
    b. If a consumer is ready to quit, and they have Medicaid, they can be referred to their medical doctor, to discuss smoking cessation aids (Texas Medicaid covers smoking cessation including Chantix, Zyban, Nicorette and Nicoderm.) Clients of our Psychiatric Clinic may receive prescriptions from our clinic providers for NRT covered by their insurance/Medicaid.
    c. If the patient receives Psychiatric Clinic services, the Clinic staff will initiate the Tobacco Cessation Education form and insert the treating Physicians signature so they will receive notification on their home page. Clients who are not participants in Psychiatric Clinic will not require the Tobacco Cessation Education Form.
    d. The Intake worker/CM/SC/Nurse who initiated the discussion shall include the quit plan/attempt in person centered care plan.
    e. All indigent Clients who receive free NRT from the Center must sign the Client Participation Acknowledgement in the electronic record prior to receiving NRT.
    f. If consumer is not ready to quit, engage in motivational interviewing.
        i. Notate consumer's decision to not quit/refusal of services in appropriate notes.
4. Case manager refers client to tobacco cessation counselor, quit line, community resources (nicotine anonymous, etc.)
    a. Case manager continually assesses consumer's tobacco use and quit attempts.
    b. Completes formal TUA annually
5. When NRTs are provided, the Consumer advised on possible side effects and told to contact pharmacist or medical provider if any side effects occur.
6. Clients are advised that they can return to Clinic to obtain more NRT.

Nicotine Replacement Therapy Supply Distribution:

FOR STAFF Betty Hardwick Center will supply the following –

- 2 weeks supply of Nicoderm CQ patches and Nicorette Gum, for up to 12 weeks in a year, and
- A one-time copay ($30) to primary care physician to cover an appointment for prescription to assist with smoking cessation. Present receipt for co-pay and copy of prescription in HR.

Staff in HR will have pre-bagged sets of NRT materials. Each bag will be numbered. Staff who will distribute the NRT will have responsibility to identify the bag number on the log, will identify who received the bag, the date that occurred and will sign their name. Each month, the log will be submitted to the CEO's office for collection and reporting.

HR staff will distribute the bag to employees with instructions that they should review all material in the package and consult with their physician prior to using if they have any concerns based upon the Directions on the box.

FOR CLIENTS Betty Hardwick Center staff must first complete the Tobacco Assessment in Anasazi.

Clients with Medicaid should be referred to their medical doctor to inquire about assistance with tobacco cessation. Texas Medicaid currently covers Nicoderm, Nicorette, Zyban and Chantix. Medicaid Clients who are seen in our Psychiatric Clinic may discuss prescriptions for tobacco cessation with our providers. Indigent Clients who indicate interest in quitting will be provided with a Voucher to present to the Clinic. Betty Hardwick Center will supply the following for indigent clients who are motivated to quit –

- 2 weeks supply of Nicoderm CQ patches and Nicorette Gum, for up to 12 weeks a calendar year, and
- Upon completion of training, Betty Hardwick Center clinic providers may elect to prescribe additional prescription drugs to assist with cessation.

Staff in Clinic will have pre-bagged sets of NRT materials. Each bag will be numbered. Staff who will distribute the NRT will have responsibility to identify the bag number on the log, will identify who received the bag, will verify the Medicaid status of the client, that the assessment was completed with them, the date that occurred and will sign their name. Each month, the log will be submitted to the CEO's office for collection and reporting.

Additional supplies of NRT will be located at Formosa Respite for clients who are admitted to respite who smoke, and who need NRT relief. Respite staff will provide NRT patches one day at a time, based upon the request of the Client.

Clients at CAC and in the HCS Residential program are expected to follow the same Assessment and Voucher system identified above.

Denton County MHMR

Section No: 3.14.02	Page 64 of 2
Policy: CONSUMER SERVICES SYSTEM Subject: NICOTINE REPLACEMENT THERAPY STORAGE AND ALLOCATION	APPROVED BY: _____ Medical Director _____ Administrator of Human Resources CONCURRED: _____ Chief Executive Officer
Effective Date: 06/01/2015 Revised Date:	

I. PURPOSE: Purpose of this procedure is to help guide tobacco use assessment, distribution, and storage of NRT and staff training.

II. SCOPE: As a CPRIT grant recipient, provide staff and clients with training and education related to tobacco use, provide NRT and provide support in terms of eliminating use of tobacco.

III. PROCEDURE: The Center's continued efforts to provide a benefit of a healthy work environment for employees, clients, visitors, volunteers and vendors, and in compliance with the Tobacco Free Workplace Policy, has established a Tobacco Free workplace procedure.

IV. GLOSSARY:

1. **DCMHMRC:** Denton County MHMR Center
2. **HR:** Human Resources
3. **NRT:** Nicotine Replacement Therapy
4. **Clients:** Active clients registered in care or active in center's 1115 programs
5. **Staff:** Employee of the DCMHMRC
6. **TCQ:** Tobacco Cessation Questionnaire

V. DCMHMRC STAFF TRAINING:

Center staff will be offered training and will continue to receive ongoing education and training related to tobacco cessation questionnaires, cessation and supporting clients in cessation of tobacco use. Printed material will be available for client's distribution and education. Record of this training will be documented in and monitored by HR.

VI. NRT STORAGE:

a. The stock supply of NRT will be stored and monitored by methods to ensure safety and security.
b. All NRT will be kept under lock in the designated storage area of the center facilities.
c. Only designated staff will have access to the locked storage area.

NRT will be inspected and counted monthly by designated nursing staff to ensure those outdated or deteriorated products are removed from the stock. NRT in need of disposal will be disposed of as per center medication disposal policy. Monthly audit report will be submitted to HR.

d. If NRT products are recalled by FDA or other agency, such NRT stock will be collected and returned to the manufacturer or disposed of in accordance with instructions provided. Center staff would provide notice to consumers or staff affected by the recall or discontinuation.
e. NRT will be kept separate from disinfectants and cleaning products.

VII. TOBACCO USE ASSESSMENT:

a. Initial screening for desire to quit may be done at intake, with a nursing assessment or by case manager
b. Clients may receive TCQ by a case manager at any time in or outside of the clinic.
c. TCQ is completed annually to keep track of tobacco use and quit attempt.
d. If a client is not interested in quitting, note and document client's decision, assess client's desire to quit on an ongoing bases.
e. Children assessed for smoking in home. If caregiver is using tobacco products, offer education of dangers of second hand smoke and offer smoking cessation resources available in the community to care givers.
f. No TCQ will be administered to any minors.

VIII. NRT ALLOCATION:

a. In order to receive the over the counter NRT, the client must meet with the designated program or clinic staff and complete the TQA and determine the amount of NRT. Staff must meet with the designated HR staff and complete the TQA to receive a two week supply of NRT.
b. Once the client's amount is determined, only a two (2) week supply will be provided at one time. If the client decides to continue NRT, they will need to meet with the designated staff prior to receiving next two (2) week allocation. The client's treating clinician will be informed when the client receives NRT supply.
c. Allocation of NRT will be documented accordingly and for clients will become part of their permanent record, for staff documentation will be maintained by HR.
d. Clients can receive up to 12 weeks of NRT per calendar year. Staff can receive two (2) week supply of NRT after which staff will be provided referral to available resources.
e. Crisis Residential Unit, Psychiatric Triage, and Intake will receive a supply of NRT gum to provide to clients as a temporary alternative to using tobacco products while on Center property.
f. Individuals will be provided written notification of the side effects associated with NRT.
g. Individuals will be notified and will sign acknowledging that they are aware of the following:
    i. NRT is an over the counter product
    ii. NRT is not being prescribed by staff at DCMHMRC.
    iii. Medical oversight is not being provided.
h. If a client has Medicaid or other insurance, the client may receive tobacco cessation aids (such as Zyban, Chantix, Nicoderm, Nicorette) if covered by their insurance and deemed clinically appropriate by treating clinician.
i. No NRT will be allocated to minors.
j. Should the center run out of NRT, clients will be given referral sources to assist them in continuing with their tobacco cessation.

Appendix M


betty hardwick center


CONGRATULATIONS
Pecan Valley Centers for Behavioral and Developmental Healthcare
for your one year anniversary of becoming a 100% tobacco-free organization to protect all people from the harmful effects of secondhand smoke exposure on your properties and for assisting the people you serve to quit using tobacco products.
WANT TO QUIT TOBACCO? VISIT YESQUIT.ORG OR 1-877-YES-QUIT
(937-7848)
PECAN VALLEY CENTERS
TAKING TEXAS TOBACCO FREE
CANCER PREVENTION & RESEARCH INSTITUTE OF TEXAS


LET'S CELEBRATE!!!
Join Spindletop's Tobacco-Free Committee as we say a very big THANK YOU to all our staff and clients for a job well done in making the transition to becoming a Smoke Free Campus. We invite you to join us for a special Celebration:
• BEAUMONT IDD NORTH CAMPUS: Friday, March 27 during IDD Fun Day @ 9 a.m.
• SOUTH COUNTY CAMPUS: Tuesday, April 7, 3 p.m. - 4:30 p.m. @ the Multipurpose Room
• ORANGE OUTPATIENT CLINIC: Wednesday, April 8, 10 a.m. - 12 p.m. @ the Main Group Room in the S/A Unit
• SOUTH CAMPUS IN BEAUMONT: Thursday, April 9, 11 a.m. - 1 p.m. @ the Basketball Court behind Building C
Enjoy cake and listen as former smokers share their testimonials and journeys on becoming smoke free.
For more information, call 409-839-1046.
SPINDLETOP CENTER
Quit for Life


CONGRATULATIONS
Pecan Valley Centers for Behavioral and Developmental Healthcare
for your one year anniversary of becoming a 100% tobacco-free organization to protect all people from the harmful effects of secondhand smoke exposure on your properties and for assisting the people you serve to quit using tobacco products.
WANT TO QUIT TOBACCO? VISIT YESQUIT.ORG OR 1-877-YES-QUIT
(937-7848)
PECAN VALLEY CENTERS
TAKING TEXAS TOBACCO FREE
CANCER PREVENTION & RESEARCH INSTITUTE OF TEXAS


Lets Celebrate !!!
Quit for Life