BEA

Bringing *Everyone* Along

RESOURCE GUIDE

FOR HEALTH PROFESSIONALS
PROVIDING TOBACCO CESSATION SERVICES FOR
PEOPLE WITH MENTAL ILLNESS
AND SUBSTANCE USE DISORDERS

January 2008

A project of the Tobacco Cessation Leadership Network

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INTRODUCTION

The *Bringing Everyone Along Resource Guide* has been developed to assist an array of health professionals including tobacco dependence treatment program directors and treatment specialists, mental health and substance use treatment program directors and treatment specialists, and primary care providers to adapt tobacco cessation services to the unique needs of tobacco users with mental illness and substance use disorders. The Guide aims to be a practical resource based on existing research, insights and advice obtained through key informant surveys of professionals, and the interpretation and recommendations of an Expert Advisory Committee.

The Resource Guide provides recommendations for adapting all types of tobacco dependence treatment services as well as specific advice for professionals adapting services in four settings: 1) tobacco dependence treatment programs available in the community, 2) tobacco quitlines, 3) mental health treatment programs, and 4) substance use treatment programs. We have also included general recommendations for primary care providers.

There is a spectrum of mental illness and substance use disorders (MI/SUD) that varies considerably by severity. All are overrepresented among tobacco users. Compared to a 20.6% smoking prevalence in the general population[1] it is estimated that prevalence is 35% for people with panic disorders smoke, 49% for people with depression, 80% for people with alcohol dependence, and 88% for people with schizophrenia and bipolar disorder.[2] For these reasons, professionals in every treatment setting will and regularly do encounter tobacco users with MI/SUD. All smokers with MI/SUD are likely to have difficulty quitting and need more assistance. In many cases, tobacco dependence treatment services are either limited in their capacity to help these tobacco users or are lacking entirely. It is our hope that the *Bringing Everyone Along Resource Guide* will help tobacco treatment professionals begin to fill the gap between the services available and the services needed.

ABOUT TERMS

Information for the Resource Guide has been synthesized from multiple professional disciplines. Each professional group uses somewhat different terms in its practice. To help streamline the writing of sections 1 and 2 of the Guide, the term "client" has been used to identify patients of medical providers, consumers of mental health services, and clients of quitlines, tobacco treatment programs and substance use programs. The specific terms are used again in Section 3. The terms "mental illness and substance use disorders" (MI/SUD) are used together to include the spectrum of diagnoses. The term "serious mental illness," as defined by the National Alliance on Mental Illness, includes major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.

INTRODUCTION

Tobacco use is the chief preventable cause of death in the United States.[3] Smoking is a known cause of cancer, heart disease, stroke, and chronic obstructive pulmonary disease.[4] While a reduction in tobacco use has occurred in the general population and effective smoking cessation treatments are becoming integrated into mainstream medical care, not everyone has benefited equally. Smoking prevalence and daily cigarette consumption remains significantly higher among individuals with mental illness and substance use disorders.[5] It has been estimated that just under half of all cigarettes smoked in the United States are smoked by people who have had a mental illness or substance use disorder (MI/SUD) in the past month.[5]

The number of smokers who have MI/SUD is substantial. Many of these smokers lack basic information about the harm of smoking and benefits of quitting, are unaware of existing cessation services that can help them, and may have limited access to services that meet their unique needs. As more smokers with MI/SUD seek and are offered help, current treatment services will need to be adapted, and additional services added and promoted in order to better assist these smokers to quit.

FACTORS IN HIGHER SMOKING RATES

Researchers believe that genetic/familial and psychological factors play a role in higher smoking rates among people with MI/SUD. There are data that show a strong genetic influence on the initiation of smoking, maintenance of smoking, and the pattern of smoking. These associations are especially strong between depressive symptoms and smoking.[6] There are also data to show that prenatal exposure to maternal smoking is correlated with higher risk of smoking in offspring.[7] Smoked nicotine can normalize some psychiatric symptoms (e.g. sensory gating for those with schizophrenia)[8] and reduce other symptoms (e.g. anxiety, boredom, and poor concentration).[6] Because smoked nicotine provides an immediate coping mechanism for modulating mood, it can be effective for blunting some effects of past or current traumatic events or life stressors.[9,10] Social factors also play a role since smoking is part of the normal culture in most mental health treatment facilities and among persons with substance use disorders. Smoking continues to be part of the normal culture for these clients after they are discharged from treatment facilities and as they continue in their recovery.[11]

SMOKING AND DEPRESSION

The relationship between smoking and depression is particularly strong. In an American study of adults, about 70% of men and 80% of women with a history of major depression were current or past smokers, (compared to about 50% of the general population) and 25% to 40% of psychiatric patients seeking smoking cessation treatment had a past history of major depression.[11, 12] Researchers believe that a possible explanation is that continued smoking elicits changes in the hippocampus that protect people from experiencing depressive symptoms. It follows, that people with depression might use tobacco to manage their symptoms and to subsequently experience episodes of depression when they stop. In one study, depressed smokers were more likely to report "self medication" processes.[13] In another, patients with a history of depression were more likely to experience depressive episodes after being treated for tobacco dependence than were smokers without such a history. [14]

SMOKING WORSENS MENTAL ILLNESS

In addition to the physical health consequences of smoking that have been documented for the population as a whole,[4] there is evidence that smoking contributes to a worsening of mental illness. Tobacco use is strongly associated with abuse of and dependence on alcohol, cannabis,

and other substances.[15] Tobacco smoking has been shown to be a predictor of greater problem severity and poorer treatment responses in patients undergoing outpatient substance use treatment.[16, 17] Smokers with the diagnosis of schizophrenia are generally more psychotic and have a greater number of hospitalizations than nonsmokers with the disorder.[18] Smoking is associated with a higher risk for suicide and attempted suicide.[19, 20, 21] Regular smokers with panic disorder report more severe and intense anxiety symptoms when compared to nonsmokers with panic disorder.[22] Heavy smokers have more severe psychiatric symptoms, poorer overall general well-being, and greater functional impairment when compared to nonsmokers and light smokers.[23]

SMOKING AND THE DEVELOPMENT OF MI/SUD

Among young people, cigarette smoking is a strong predictor of the development of depressive symptoms.[20,24] In study of nearly 2,000 youths, tobacco smoking predicted an increase in the risk of a subsequent onset of depressed mood, but depressed mood did not predict initiation of cigarette smoking. This supports a possible causal link from tobacco smoking to later depressed mood during childhood and early adolescence but not vice versa. [25] Persistent smoking appears to be the strongest predictor of depressive symptoms.[26] Depression is also related to the initiation of other substances linked to smoking. In a report from the National Survey on Drug Use and Health, young adults (age 18-25) with a past year history of a major depressive episode (MDE) were a third more likely to initiate alcohol use than those without a MDE and twice as likely to initiate illicit drug use.[27]

Smoking has also been linked to the development of anxiety disorders. In a four year prospective study of adolescents and young adults, smoking was associated with an increase for subsequent development of panic disorder.[28] And, in an analysis of data from the National Comorbidity Survey, daily smoking was linked to the development of panic disorder and agoraphobia.[29]

MI/SUD AND TOBACCO CONTROL ENVIRONMENT

PRICE INCREASES AND PROGRAMS

Tobacco control strategies have not had the same effect on tobacco users with MI/SUD as they have in the general population of smokers. As described above, while overall smoking rates have declined, the proportion of MI/SUD among current smokers has increased.[30] Cigarette price increases, a widely used and promoted intervention to reduce tobacco use, may not now have the effect on reducing tobacco use as was seen in earlier reports. Low-income smokers in particular, many of whom suffer from MI/SUD, appear to be relatively unaffected by price increases.[31] There is also evidence that smokers with mental health problems feel excluded from mainstream cessation programs.[32]

SMOKE-FREE POLICIES

Smoke-free and tobacco-free policies are a tobacco control strategy that has been helping to stimulate more reduction and quitting in these populations, especially as they are increasingly adopted in mental health and substance use treatment facilities. In a recent survey of state psychiatric hospitals, reported by the Association of State Mental Health Program Directors Research Institute, 41% did not permit smoking for patients, 12% planned to eliminate smoking within the next year, and another 17% planned to change their smoking policy in the future.[33] Despite initial resistance by facility staff members, smoke free policies can be successfully adopted, help change the MI/SUD culture around smoking, and help more clients, and staff, to quit.

CASE EXAMPLES

In 2003, a tobacco free policy was implemented in Capitol Health in Nova Scotia. The staff members of the program were concerned that the smoke-free policy would negatively impact their services and clients both in terms of admission rates and length of stay. Further, staff believed that the new policy would result in behavior problems among clients and preclude effective treatment of other addictions. When qualitative data was analyzed, it showed improvements to treatment services and outcomes, and enhanced overall client and staff health as a result of implementation of the policy.[34]

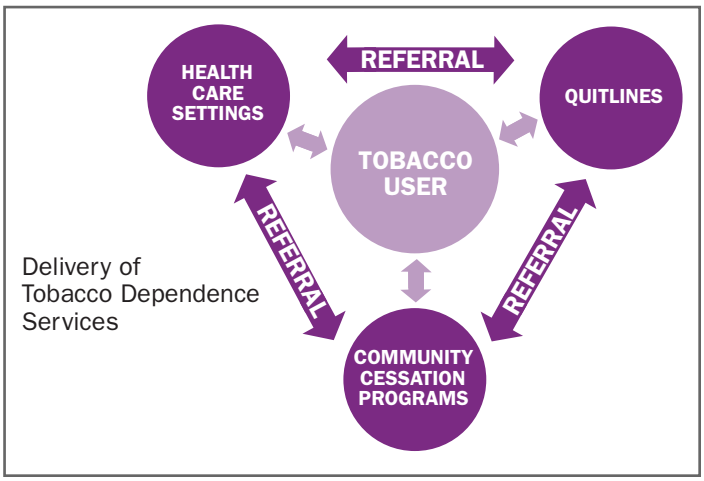
In 2001, New Jersey implemented a licensure standard for all residential addiction treatment programs. The new standard required treatment programs to be completely tobacco free (including grounds) and to assess and treat tobacco dependence for their clients who smoked. At 1-year follow-up, all 30 residential programs surveyed provided some tobacco dependence treatment and 50% had tobacco-free grounds. Eighty-five percent of the programs accepted the state's offer to provide free NRT for their clients, reaching more than 2,326 smokers. Seventy-seven percent of all clients were smokers, and 65% of the smokers reported they wanted to stop or cut down tobacco use. Forty-one percent of the smokers reported that they did not use any tobacco during their entire residential stay. There was no increase in irregular discharges, or reduction in proportion of smokers among those entering residential treatment, compared with prior years. When surveyed, program directors reported that they recognized the benefits of treating tobacco in addictions treatment and of creating a supportive environment. The new requirement worked as a catalyst for organizational and cultural change in New Jersey treatment facilities.[35,36]

INTRODUCTION

The BEA Expert Advisory Group reviewed the existing literature and survey data collected from professionals who provide tobacco dependence treatment to people with MI/SUD (see Section 5). The Advisory Group interpreted this information and developed the following key findings and general recommendations for adapting tobacco dependence treatment for people with MI/SUD.

KEY FINDING: SERVICES FOR TOBACCO USERS WITH MENTAL ILLNESS AND SUBSTANCE USE DISORDERS ARE COMPLEX.

Currently, tobacco dependence treatment is generally delivered in conjunction with other health care at health care facilities, medical clinics/offices, and hospitals; through programs and services that tobacco users seek out (quitlines and community cessation programs); and sometimes through referrals between these programs and services (e.g. health care to quitlines; quitlines to community cessation programs).



The types of tobacco dependence treatment provided in these settings vary by intensity. Services range from brief treatment, including simple advice to quit, prescriptions for medications and, referral to quitlines by primary care providers, to intensive treatment offered by trained tobacco treatment specialists.

BRIEF TREATMENT

Brief treatment, designed especially for busy primary care providers, is the most widely recommended and commonly used form of tobacco dependence treatment in medical settings. Most tobacco users, if they receive any treatment, are likely to receive brief treatment. The Public Health Service (PHS) Clinical Practice Guideline recommends that routine screening for tobacco use be included for all clinic visits and all tobacco users receive at least brief treatment (3 minutes or less) from their primary healthcare providers.[37]

INTENSIVE TREATMENT

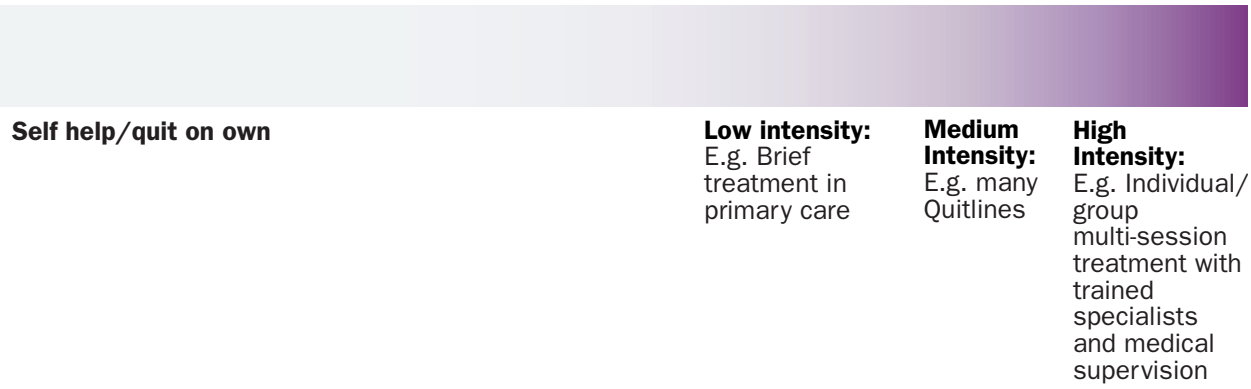
Intensive treatment is more complex, requiring specialized training and more time to provide. Intensive treatments that include coaching/counseling by trained professionals over several weeks or months coupled with appropriate cessation pharmacotherapies and follow-up consistently lead to better abstinence rates than brief treatment. Although reimbursement for and availability of intensive treatment is limited, the Guideline recommends that intensive treatment be offered to any tobacco user who is willing to participate. [37]

QUITLINES

Quitlines are another resource. Treatment through tobacco quitlines is available in all 50 states and is helping to reach more tobacco users. Tobacco quitlines vary considerably in the services they provide. Most provide more than brief treatment and some provide fairly intensive treatment. [38]

Figure 1 illustrates the range of tobacco dependence treatments by intensity and a broad estimate of their availability.

Figure 1: Estimate of tobacco treatment services available by treatment intensity



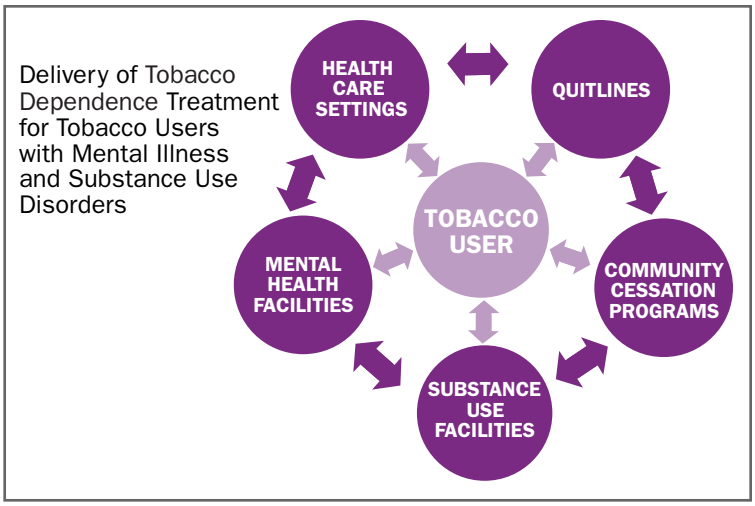
TREATMENT SERVICES NEEDED FOR TOBACCO USERS WITH MENTAL ILLNESS AND SUBSTANCE USE DISORDERS.

Tobacco users with serious and persistent MI and/or with SUD have very high rates of smoking,[39] the highest average consumption of cigarettes,[5] and have the most difficulty quitting. These smokers are more likely to be receiving care through mental health and substance use treatment facilities and some may also receive care from a primary care provider.[40] These smokers need to have tobacco dependence treatment integrated directly into their mental health or substance use care and, if needed, coordinated with primary care providers.

Compared to individuals with serious mental illness, a large proportion of tobacco users with MI/SUD are less functionally impaired, and are likely to receive their care in routine health care settings. These tobacco users will benefit from more tailored tobacco dependence treatment integrated with their usual health care. Like tobacco users in treatment facilities, these clients also have more difficulty quitting than those without MI/SUD and will need more intensive care than the brief treatment more common in routine health care[41] (see Figure 2). Health professionals who routinely work with these tobacco users advise that services in routine healthcare will need to include more intensive follow-up, more medical management of both tobacco use and MI/SUD, and more monitoring of medications, to help these clients successfully quit.

Figure 2: Difficulty quitting for all tobacco users

The need for more intensive services, coordination of care, and follow-up for tobacco users with MI/SUD creates the need for a more extensive and multi-disciplinary referral network. This type of network, including partnerships between programs and other services, is driven by the need to integrate treatment for mental health or substance use, tobacco use, and overall health care.

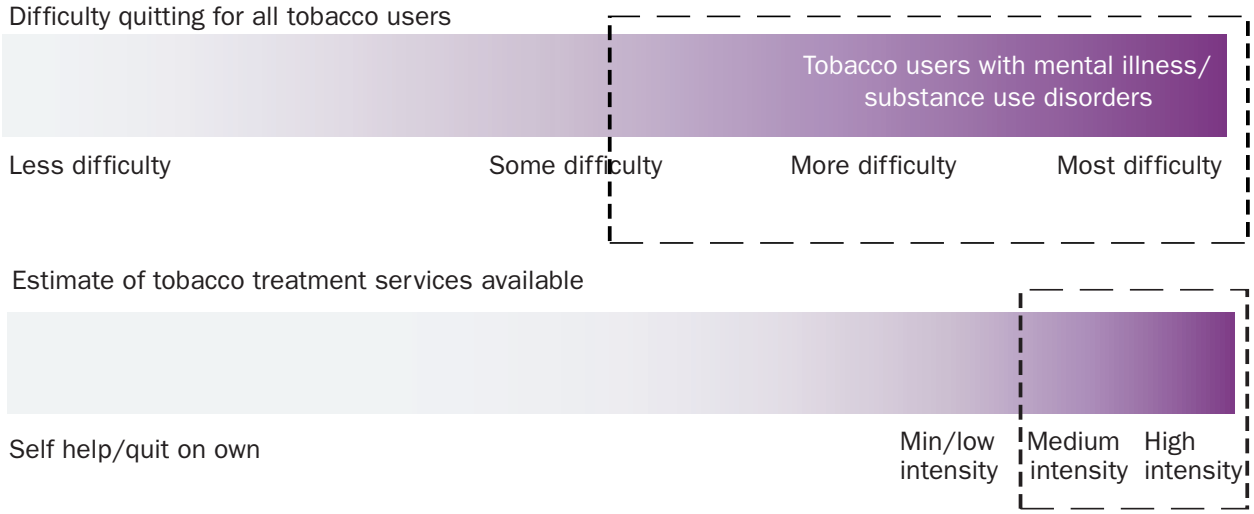


KEY FINDING: THERE IS A SIGNIFICANT GAP IN SERVICES.

Few tobacco dependence treatment programs have been adapted for clients with MI/SUD and the number of tobacco treatment specialists trained to deliver more complex interventions is limited (see competencies for Tobacco Treatment Specialists at www.attud.org). Many MI/SUD treatment providers do not regularly offer even brief treatment for tobacco users seen in treatment facilities. In some cases, when tobacco use is assessed, MI/SUD treatment providers may advise clients to quit but rarely assist them in making a quit attempt or follow up and help manage a quit attempt. [42,43,44] In addition, few MI/SUD treatment programs have trained staff to deliver tobacco cessation services for clients, and few referral networks exist.

In order to improve treatment for tobacco users with MI/SUD, the gap between treatment services needed and treatment services available needs to be closed. To begin to close this gap, the BEA Expert Advisory Committee recommends that existing tobacco cessation services be tailored for each treatment setting and then additional services be created where they do not exist.

Figure 3: Gaps in Services



SIX RECOMMENDATIONS FOR ADAPTING TREATMENT PROGRAMS.

RECOMMENDATION 1: CHANGE EXISTING BELIEFS

Many providers and clients still believe that tobacco users with serious MI/SUD don't want to or can't quit. These beliefs are outdated and serve as barriers, even preventing treatment from being offered. There is ample evidence that they both want to and can quit.[45-49]

In a recent study of over 300 depressed smokers and their readiness to quit, 79% reported an intention to quit and 24% were ready to quit in the next 30 days. [50] In a 2006 study of smokers with psychiatric disorders, those who were treated and followed for 12 months were three times more likely to be abstinent than those who were not treated.[51] In a study of smokers in a substance abuse facility, 75% accepted an offer for smoking cessation treatments. [52]

Another recent study of clients with substance use disorders shows that many want to participate in treatment and many have tried to quit repeatedly including the year leading up to treatment for substance use. [53] In a 2004 review of clinical trials, 50% to 77% of clients in substance abuse treatment expressed interest in quitting smoking. [54]

Surveys have shown that the majority of smokers (around 70 percent) want to stop smoking yet quit rates remain very low.[55] Among persons with mental illness and addictions there is evidence of a desire or motivation to quit smoking. But the cessation rates among these individuals are particularly low and they have many of the same concerns as other smokers (e.g. not being ready yet to quit).[56]

RECOMMENDATION 2: PROVIDE TAILORED TREATMENT SERVICES

Tobacco users with serious MI/SUD respond to the same evidence-based treatment approaches as other tobacco users. However, programs and services do need to be tailored both behaviorally and pharmacologically to the specific needs of the client, their functionality, and usual treatment setting. Coordination among the key care providers is necessary so that tobacco cessation treatment can be integrated into ongoing treatment for MI/SUD. The availability of a referral network and/or partnerships between primary care providers, quitlines, tobacco treatment specialists, and mental health and substance use professionals is important to address the more complex needs of these tobacco users. With greater training and expertise of professionals within a specific program, there is less need to refer out for additional services.

RECOMMENDATION 3: USE RESULTS FROM A COMPREHENSIVE ASSESSMENT TO HELP TAILOR SERVICES

Determining how to tailor treatment services and what referrals/partnerships are needed for each client should be based on an initial individualized, detailed assessment. Professionals completing the assessment and treatment planning need to have adequate training to be prepared to complete the assessment questions and make appropriate treatment and referral decisions.

ASSESSMENT FOR TOBACCO TREATMENT PROFESSIONALS

The intake assessment should include questions regarding the client's mental health and substance use history. The emphasis for these questions is not to determine a diagnosis, but to assess current functional status and relative functional stability during previous quit attempts, and to identify potential referral needs. An assessment of current level of functioning and functioning at the time of any previous quit attempts can be a more informative guide for tailoring treatment than a diagnosis (See Section 4 for sample assessment questions.).

What is stable functioning?

Stable functioning of a client is defined by our Expert Advisory Committee as the absence of current acute major life or medication changes. In addition, the client is motivated and has support from care providers and others to quit. Stable functioning may be present while the client is recovering from other substance dependence, and such recovery should not delay attempts to quit smoking. Functional stability during a previous quit attempt means determining how well the client handled withdrawal, if there were any significant health or medication changes, any significant change in psychiatric symptoms or substance use, and the circumstances surrounding relapse.

Clients are more likely to be successful and need less program tailoring if they are:

- Currently functioning adequately.
- Able to participate in treatment.
- Have a history of adequate functioning during previous quit attempts.
- Motivated.
- Ready to quit.
- Stable on any medications.

Those whose current level of functioning requires substantial support or who became less functional during a previous quit attempt may need more tailored and coordinated treatment management. These individuals may require additional monitoring by personnel with the clinical skills to assess levels of functioning and to monitor medications.

ASSESSMENT FOR MENTAL HEALTH AND SUBSTANCE USE TREATMENT PROFESSIONALS

The intake assessment should include questions about present and past tobacco use, assessment of nicotine dependence, and an assessment of readiness to quit. Tobacco users with mental illness and substance use disorders may not know how to quit or have little prior quitting experience to draw upon. Assessing readiness to quit (questions usually included in typical tobacco intake assessments) is also important in tailoring tobacco treatment within MI/SUD services. Several toolkits that include appropriate assessment questions have been recently developed to assist MI/SUD professionals develop tobacco cessation treatment interventions within MI/SUD settings. Sample intake assessments and links to these toolkits can be found in Section 4.

RECOMMENDATION 4: PROVIDE CESSATION PHARMACOTHERAPY AND MONITOR PSYCHIATRIC MEDICATIONS CONCURRENTLY

Clients with MI/SUD are more highly nicotine dependent and will most often need cessation medications to manage withdrawal. Choice of medication should support any existing medication regimens and take the following into consideration: current/past MI/SUD history, client preference, previous levels of withdrawal when attempting abstinence from tobacco, the specific treatment environment, the treatment specialist's familiarity with cessation medications, availability of the medication to the client and the relative risk/benefit.

CESSATION PHARMACOTHERAPY

Dose level and duration of drug treatment will need to be tailored to individual needs. As recommended by the PHS Guideline, more dependent smokers, including those with psychiatric and substance abuse co-morbidities, may need higher doses of cessation medications, combination medications (e.g. nicotine patch + fast acting NRT such as nicotine gum or inhaler, NRT + bupropion) and for longer duration of treatment.[37] While increasing dose, combining medications, and lengthening treatment maybe clinically indicated, this has not been FDA approved. Clients should first discuss medication treatment options with their providers.

There are several other important considerations when treating clients with MI/SUD using bupropion or varenicline. History of bipolar symptoms should be assessed since bupropion can cause the onset of manic symptoms and is contraindicated. Experts have noted that tobacco users with alcoholism, eating disorders and substance use disorders have experienced difficulties such as agitation and seizures using burpropion and, while it is not contraindicated, it is not recommended. Smokers with HIV/AIDS on highly active antiretroviral therapy (HAART) do not receive the beneficial effects of the drugs due to smoking. Also, bupropion interferes with efficacy of protease inhibitors and other medications used by people with HIV/AIDS. Nicotine nasal spray is not recommended for people who abuse drugs intranasally. The safety of varenicline, the newest tobacco cessation medication, has not been well established for persons with mental illness. While our experts reported positive initial results with varenicline, there have been two recent reports suggesting a psychotic exacerbation in a person with schizophrenia and in a person with bipolar disorder who were taking varenicline.[57,58] Additionally, post marketing adverse behavior and mood changes have been reported, but no casual links have yet been established.[59] A warning has been added to the varenicline package insert to monitor for psychiatric symptoms and report any symptoms to a healthcare provider. See chart in Section 4 for prescribing information.

PSYCHIATRIC MEDICATIONS

Psychiatric medications will need to be monitored and potentially adjusted for clients who significantly reduce or stop smoking. The tars in tobacco smoke can change the metabolism of a

variety of medications including some psychotropic medications. When tobacco users initially quit, their blood levels of these medications can rise, increasing the risk of adverse events seen with higher doses, even if dose levels remain constant.[60, 61]

Medications that Have Their Levels Affected by Smoking and Smoking Cessation [62]		
ANTIPSYCHOTICS	Chlorpromazine (Thorazine)	Olanzapine (Zyprexa)
	Clozapine (Clozaril)	Thiothixene (Navane)
	Fluphenazine (Permitil)	Trifluoperazine (Stelazine)
	Haloperidol (Haldol)	Ziprasidone (Geodon)
	Mesoridazine (Serentil)	
ANTIDEPRESSANTS	Amitriptyline (Elavil)	Fluvoxamine (Luvox)
	Clomimpramine (Anafranil)	Imipramine (Tofranil)
	Desipramine (Norpramin)	Mirtazapine (Remeron)
	Doxepin (Sinequan)	Nortriptyline (Pamelor)
	Duloxetine (Cymbalta)	Trazodone (Desyrel)
MOOD STABLIZERS	Carbamazepine (Tegretol)	
ANXIOLYTICS	Alprazolam (Xanax)	Lorazepam (Ativan)
	Diazepam (Valium)	Oxazepam (Serax)
OTHERS	Acetaminophen	Riluzole (Rilutek)
	Caffeine	Ropinirole (Requip)
	Heparin	Tacrine
	Insulin	Warfarin
	Rasagiline (Azilect)	

RECOMMENDATION 5: TAILOR BEHAVIORAL TREATMENT

TREATMENT INTENSITY

More intensive behavioral treatment is often necessary to help clients with MI/SUD quit. More intensive treatment usually means more and sometimes longer sessions, particularly for higher functioning clients. For lower functioning clients, more sessions are often needed, but the sessions may need to be shorter and the content more focused and concrete. Compared to tobacco users in the general population, clients with MI/SUD may also need a longer preparation time prior to quitting. Preparation techniques such as discussing the pros and cons of reducing daily smoking and delaying the time between cigarettes may be needed before clients are ready to attempt significant reduction of smoking and quitting. This process could take a number of weeks or months before the client is ready to progress towards abstinence.

TREATMENT FLEXIBILITY

Behavioral treatment needs to be flexible enough to allow changes in the content of treatment and the schedule of appointments or meetings. Predetermined quit dates and follow-up schedules are often too limiting for this population. Clients may need more time to learn about tobacco use and to master adequate coping and quitting skills. Many tobacco dependence treatment services for a general population are based on the assumption that most clients who attend are ready to attempt total abstinence from tobacco in the first week or two. Lower functioning clients may have sufficient motivation to quit but lack confidence, self-efficacy, and the skills needed to quit on the same schedule.

TREATMENT APPROACHES

Motivational interviewing and skill development is currently a widely used approach to counseling for addictive behavior. Some of the aspects of motivational interviewing can also be helpful when working with these clients, especially those with substance use disorders. But, other aspects may be too open-ended for some clients with cognitive impairments. These clients may need a more concrete and directive approach with shorter, more specific steps. At the same time, many clients with serious mental illness are accustomed to learning and using an array of specific, personal behavioral survival skills to function in the broader community or in the treatment setting.

These can include such skills as:

- Basic self-care
- Social skills
- Time management
- Use of stress reduction techniques
- Enlisting support persons
- Knowing the importance of attending regular appointments
- Using medications faithfully
- Anger management
- Cognitive skills to envision life beyond smoking.

These same skills can also help clients develop greater self-efficacy for quitting and more hope about their eventual success. Learning, practicing, and internalizing concrete behavioral skills for quitting can be a natural extension of the skills acquisition process they have already developed and honed.

Clients with MI/SUD may participate in tobacco dependence treatment group programs geared to a broader population, but they may feel less welcome and/or feel misunderstood by other group members who do not share these disorders. Before recommending a group program, professionals may first need to assess whether clients are functionally able to benefit (e.g. able to participate in a group process for 1-2 hours). Additional attention by the group facilitator as well as an option for some one-to-one sessions outside the group time may be needed. On the other hand, tobacco users with experience in substance use disorders treatment programs and/or 12 Step recovery programs (e.g. Alcoholics Anonymous or Narcotics Anonymous) may be assets to the overall functioning of a tobacco treatment group since they are often familiar and comfortable with group treatment settings, group dynamics, and group process. They have also developed skills in making one life change that they can apply to becoming a non-smoker.

RECOMMENDATION 6: INCREASE TRAINING AND SUPERVISION FOR COUNSELING STAFF

Clinical training for tobacco treatment specialists is important. Any professional providing treatment for these populations will need to make treatment decisions, have more contact with healthcare providers, participate in case management, make referrals and help clients make connections between the different treatment services. In our survey, the approach to treatment loosely followed the type of background and professional discipline of the provider. The professionals interviewed who had little or no training in MI/SUD were more careful on the intake assessment when asking about symptoms and functioning. They were also more concerned about sensitivity issues and more likely to believe that asking questions about mental illness and substance use would be intrusive or offensive to their clients.

Professionals with more training and background in mental health and substance use were more comfortable in assessing symptoms and previous history. They were also careful to adhere

to the specific professional standards under their license, which helps protect the professional and helps ensure appropriate and ethical care for clients.

Professionals who had more clinical training reported that their clients were well aware of their problems and understood the need to have them discussed as part of the treatment plan. They added that when these issues are not discussed during the assessment, clients are not well served and the work to help them quit maybe undone. Further, not addressing these issues directly may inadvertently communicate that MI/SUD disorders should remain hidden. This, in turn, can have the unfortunate effect of reinforcing the stigma surrounding MI/SUD.

Increased and ongoing training and supervision is important for building skills and confidence for effectively addressing these issues and for improving treatment.

INTRODUCTION

The following section presents information from a key informant survey with health professionals who treat tobacco users with MI/SUD (A list of survey respondents may be found in Section 5). The advice in each section is based on the experience of these professionals as they apply evidence-based best practices in their respective settings. The advice provided by these professionals has not been separately evaluated. As more research and evaluation becomes available, this advice will likely need to be updated.

Four tobacco cessation treatment settings were identified as part of the survey:

- Programs in community settings;
- Tobacco quitlines;
- Services in mental health treatment settings;
- Services in substance abuse treatment settings.

A fifth setting, primary care clinics, was identified but a database of primary care providers was not available for the survey. A set of general recommendations for primary care providers is included based on the PHS Guideline[37] and advice from other health professionals.

Each set of recommendations is in four parts: 1) Intake assessment; 2) Treatment planning; 3) Treatment approach and follow-up; and 4) Summary advice.

TOBACCO DEPENDENCE PROGRAMS IN COMMUNITY SETTINGS

INTAKE ASSESSMENT

A thorough assessment is strongly advised to structure an effective treatment plan that takes into account co-morbidities and concurrent treatments/providers. Assessment questions are divided into several categories: 1) demographic characteristics, 2) tobacco use history, 3) current quit attempts, 4) social support, 5) current life situation, 6) current health history, and 7) screening for mental health or substance use disorders. See Section 4 for a description of tobacco dependence assessment questions and sample assessments.

MENTAL HEALTH AND SUBSTANCE USE ASSESSMENT ISSUES

Tobacco cessation professionals not trained in MI/SUD were concerned that clients seeking cessation services may be sensitive about sharing any MI/SUD history. These professionals preferred getting this information indirectly. There was also a concern about professional responsibility/liability for action if a client seeking cessation treatment disclosed a MI/SUD problem in a non-mental health/substance abuse setting. These concerns were not shared among professionals who had more training in MI/SUD. Instead, they recommended asking direct questions about MI/SUD in order to establish the most effective treatment plan possible.

The following outlines advice for both direct (recommended) and indirect approaches to obtaining client information on history of MI/SUD.

DIRECT APPROACHES

Programs with trained mental health professionals use a set of direct questions to determine any MI/SUD history. They assess whether a client has ever received counseling, treatment, diagnosis or medications for mental health, emotional or behavioral problems and ask separate questions about a history of substance abuse or dependence. Many of these programs obtain extensive information from clients on past and current mental health and medical conditions. They will often include standardized assessment instruments to better characterize current symptoms or level of functioning (e.g., Beck Depression Inventory[63], K6[64]).

For substance use it was recommended that staff ask questions in a way that "normalizes" use, e.g.: asking, "How much do you drink?" rather than "Do you drink?" Standardized assessment questions can be used to help determine a general level of problem drinking and the potential need for referral (e.g.: CAGE test[65] C- "Ever Cut down on drinking?" A- "Ever get Annoyed when people ask about drinking?" G- "Ever feel Guilty about drinking?" E- "Ever have an Eye opener or morning drink?").

Some tobacco dependence treatment programs receive client referrals from a mental health agency or a primary care provider. In this case the client should have signed a release of information, making them aware that any MI/SUD information will be shared. When both the client and the tobacco treatemnt professional understand that this information is shared, MI/SUD issues are more likely to be addressed directly rather than indirectly.

INDIRECT APPROACHES

Programs with staff not trained in MI/SUD, often approached assessment in a more conversational way. In this approach, the tobacco treatment professional works to establish rapport with the client through an interview tailored to the particular client. Most tobacco treatment programs ask at the intake assessment whether a client is currently taking any medications. If a client reports taking any psychotropic medications, the presence of a mental illness is assumed. Follow-up questions are asked during the interview as well as questions about any current or previous history in behavioral counseling, and about a counseling relationship with a MI/SUD provider, if disclosed. From there, follow-up questions help determine whether the client is presently working with a behavioral health care provider. If so, the client is reminded that tobacco abstinence could be disruptive to their day-to-day life and can alter the effects of any psychiatric medications they may be taking. These clients are referred to their primary provider to monitor any psychiatric symptoms and to make any necessary adjustments in medications dosages.

Additional questions can also be asked about whether any family members have a history of mental illness or substance use. Clients may be willing to discuss problems with family members more than their own problems. If there is a positive family history, the client may have similar problems. Through the interview process, the presence of MI/SUD use may be revealed by spontaneous report or become evident by observation of behavior. Appropriate referrals (if necessary and available) can then be made.

See Section 4 for a sample of both direct and indirect ways of asking clients mental health and substance use questions.

TREATMENT PLANNING

Our experts recommended that treatment planning be tailored based on the stability of a client's MI/SUD or stability of their recovery process.

Clients who are not stable (e.g. active substance use, current depression, anxiety disorders) should be counseled to seek treatment from their primary care and/or mental health provider before or concurrently with pursuing quitting tobacco. If a client refuses to follow through on a referral, tobacco dependence treatment would not be withheld. But, ongoing encouragement and referrals for treatment should continue if the client is unable to maintain focus in quitting smoking due to these pre-existing conditions. An exception is when there are concerns about harm to self or others. In this case, any tobacco treatment is bypassed and an immediate referral to a hospital emergency room and/or the client's primary provider (or 911) should occur immediately.

tobacco cessation pharmacotherapy is essential. Benefit coverage (e.g. Medicaid, Medicare) and easy and inexpensive access for cessation medications and client management while on drug treatment need to be addressed as part of the treatment plan.

If possible, tobacco treatment professionals will need to have access to prescribers or be able to make referrals to specific primary care providers familiar with mental health/substance abuse treatment and tobacco cessation treatment. Knowledge of health plan reimbursement policies is important for coordinating care, since many clients are enrolled in health plans. Referrals to quitlines that provide medications as part of their services can also help.

Programs without good access to prescribers will need to coordinate with the client's primary care provider or psychiatrist in the development of a tobacco treatment plan so that the tobacco treatment professional can help monitor symptoms and assist with follow-up as needed. Closer provider coordination improves the likelihood that management, monitoring, and adjustment of any concomitant medications during the client's quit attempt will occur.

APPROACHES TO TREATMENT AND FOLLOW-UP

Clients with less functional impairment can participate in a typical, structured treatment approach (e.g. specific quit day). Clients who are functionally impaired will need a less structured and more flexible treatment approach that links the quit date to client readiness. Flexibility with the quit date will require some adjustments to other components of a cessation program as well.

There are several reasons for the need for flexibility. Clients with MI/SUD are likely to be more nicotine dependent, making it more difficult to quit. Clients with MI/SUD may have little previous or positive quitting experience and may need to do more preparation before they have sufficient confidence and skills to try. One survey respondent stated that everyone in her groups was encouraged to set a quit date, but that timelines varied. Another said that treatment was approached gradually—learning not to smoke in specific situations and waiting to set a quit date until later.

Expert Advisory Committee Caveat

It is important to be cautious about doing too much planning, or delaying a quit date more than necessary. While it is important to help match the pace of treatment to the needs of the client, it is also possible to inadvertently provide a reason to continue to postpone quitting. This is a difficult balance for any client, but particularly important for those with mental illness and substance use disorders.

Some clients may need to follow incremental steps that can be more easily accomplished. Breaking down the quitting process into smaller, more concrete pieces can help clients build skills and reduce the risk of failure in a given quit attempt. Flexibility in the duration of treatment is also important. Tobacco treatment professionals reported that there is often a need to reevaluate and increase the duration of cessation treatment compared to smokers without MI/SUD. Some programs also reported that clients continue to attend group sessions for ongoing support long after "formal" treatment ends. At the same time, many clients will have developed behavioral skills to cope with symptoms of MI/SUD and can use these same steps to successfully develop behavioral skills to stop smoking. Many also have long histories of participation in therapeutic and support groups, so they are knowledgeable and practiced in group dynamics.

SUMMARY OF PROFESSIONAL ADVICE

- Use a supportive, open, and flexible approach (e.g. flexible quit date), tailored to the individual.
- The more treatment options, such as group, individual, or combinations, the better.
- More treatment sessions are better and long-term follow-up is useful for relapse prevention.

- Pharmacotherapy is essential: work with client's prescriber to monitor medications and health status.
- Provide specific education to clients (and staff) about nicotine addiction and tobacco cessation medications. For example, some people have concluded that because they know smoking is harmful, it is nicotine that causes cancer.
- For group programs, clients who have been treated for addictions or been part of recovery support programs can be an asset in any group treatment setting. They can help solidify a group and make it more effective for those members who have little experience in therapeutic or support group settings. Clients with serious mental illness may do better in a group together. They may be more likely to find greater acceptance and understanding of their disorders as they attempt to quit smoking. However, programs need to provide enough flexibility so that clients could opt to be in general population groups, if they chose to.
- Supplementing group experiences with individual counseling time for additional support and skill development may improve client satisfaction and reduce anxiety.
- Level and type of training for professionals providing cessation services to this population is important to outcomes. A background in addiction, behavioral health (including group dynamics) in addition to tobacco dependence training can help professionals feel more competent and comfortable when working with these clients.
- The availability of a physician, medical director, or other health care provider embedded in the treatment team is an advantage. Most clients will have co-morbid medical conditions and a medical provider can help provide direct input into the cessation treatment plan.

TOBACCO QUITLINES

INTRODUCTION

Quitlines are mostly state funded, telephone-based services that provide counseling and support by trained professionals for tobacco users who want to quit. Quitlines represent the public health model of tobacco dependence treatment – low-cost effective interventions to a potentially large population of tobacco users. The general approach to quitline services is to first complete an initial screening for all callers to determine client needs and appropriate educational materials that can be mailed. Callers interested in quitting are then connected to a trained counselor. The trained counselor develops a quit plan, and then (depending on the resources of the quitline) may offer medications (e.g. nicotine patches) and provide several, proactive follow-up calls scheduled at specific times. Quitline services vary by state. Each state contracts with a quitline vendor and negotiates the protocol.

Some quitline counselors are professionally trained mental health or substance use specialists, although most are not. Some have had continuing education in this area and others have received training as part of their quitline training. The quitlines who responded to our survey all receive a significant number of calls from clients affected by a range of MI/SUD.

Some quitlines have modified their basic format to accommodate callers with MI/SUD. All quitlines agreed that they better serve clients who have less functional impairment than those with serious MI or callers in treatment for SUD. Three variations in services were identified from our survey: 1) Adding mental health and substance use questions to the initial assessment. Clients are then referred for adjunct treatment in the community if necessary; 2) Developing a proactive/ interactive network with mental health and substance use providers to link clients seen in either setting and sharing information about clients' tobacco dependence treatment; and

3) Staffing the quitline with certified state-credentialed addictions counselors, a full-time counselor with a dual license in mental health and addictions and a medical director for case management. This type of treatment team can focus on a more comprehensive strategy through an integrated constellation of providers and services within the quitline itself.

The following sections summarizes the combined advice from these different approaches.

INTAKE ASSESSMENTS

Quitline intake assessments are similar to assessments used in community tobacco treatment programs (see Section 4). Most quitlines have also adopted the Minimum Data Set, a standardized set of assessment questions. The core questions, developed through the North American Quitline Consortium, currently do not have questions on mental health or substance use.[66]

Quitlines, like other treatment programs, vary in how they ask MI/SUD questions. Some use a direct questioning approach and others a more indirect, conversational approach.

DIRECT APPROACH

Quitlines using a direct approach include MI/SUD questions as part of the standard intake process for all clients. Examples are: "Do you have any physical and/or emotional disabilities?" and "Do you have any mental health or emotional issues that might impact quitting?" These broad questions are intended to cover both clients with known histories of mental health or substance use disorders as well as those who might have an undiagnosed disorder.

While these questions do not directly address substance use/abuse, they provide the counselor with a vehicle to follow-up on these issues during the initial counseling sessions. Follow-up questions can include asking about current problems with alcohol, substance abuse, depression or anxiety, current medications (including psychiatric medications), and any care received from a psychiatrist, social worker, counselor or other mental health professional.

In one program, the American Society of Addiction Medicine (ASAM) assessment[67] is completed during the intake assessment. The counselor assigns a low, medium or high rating to each dimension of the assessment and recommends a level of care in a three-step care model. Level 1 is basic triage by a client service specialist. Level 2 is handled by a counselor and addresses co-occurring conditions including alcohol or substance abuse, depression, and anxiety. The Level 2 counselor provides treatment information on medications, relapse prevention, withdrawal symptoms and managing triggers and cues. Level 2 is usually one time with follow up at 7 and 13 months. Level 3 care is comprehensive, intense and individualized treatment with multiple preparation calls and a schedule of follow-up calls timed to help prevent relapse.

INDIRECT APPROACH

The quitline using an indirect approach did not ask mental health or substance use questions during the intake assessment. Rather, the potential presence of these conditions was indirectly assessed during the counseling phase of treatment. The counselor discussed medications, alcohol use, and asked the client about any history of professional support or recovery programs. Counselors were also trained to listen for cues such as cognitive disorganization, slower processing, or accelerated speech which might indicate the presence of serious MI/SUD. Based on the history information, the self-reported information and observed cues, individual treatment plans were developed on a case-by-case basis. The counselors from this quitline were trained to generally adapt their tobacco treatment protocol to individual quitters, but did not necessarily have a background in mental health or substance abuse treatment.

QUITLINE ISSUES

A concern raised by some quitlines regarding assessing for mental health and substance use disorders was the potential legal and ethical obligation to refer to the primary prescriber to assess the client's condition before continuing to treat for tobacco dependence. Quitlines not in a position to collaborate in treatment with a client's primary prescriber (due to resources or program format) are in a more difficult position than quitlines who can. These quitlines may opt not to assess MI/SUD. A counter concern was that by not assessing MI/SUD before initiating tobacco dependence treatment, clients could become unstable resulting in greater liability. A suggested solution was to recommend that the client check in with their primary prescriber before the next scheduled quitline appointment to continue treatment.

Another concern was that since quitlines are based on a public health delivery model rather than a clinical treatment model, there is a strong need to clearly establish with all clients the scope of services that can be provided. Specifically, quitlines need to establish that the cessation counselor is **not** functioning as a mental health provider, even if their counselors have those credentials. Clients without access to a mental health or a primary care provider, but in need of such services, would need to be referred. For example, the California Smokers Helpline uses a set of crisis line numbers with referral information of all kinds and community mental health access numbers, all organized by county of the caller.

Using 211 to find resources.

2-1-1 is an easy to remember telephone number that, where available, connects people with important community services and volunteer opportunities. The implementation of 2-1-1 is being spearheaded by United Way and comprehensive and specialized information and referral agencies in states and local communities. For more information, visit www.211.org.

WORKING AS A TEAM

If the client does have a primary care or mental health provider, these quitlines advised encouraging clients to inform their providers about their plans to quit. One program does this proactively, asking for a signed release so counselors can directly contact a client's mental health provider. This approach, whenever possible, is strongly encouraged by our expert advisors.

Some quitlines receive referrals for cessation services through partnerships with mental health counseling centers in the community. In these cases, the mental health assessment is done by the referring program prior to contact with the quitline. Under this system, release of personal health information has been obtained from the client to be shared with the quitline so that the respective providers can communicate about a client's care.

Ongoing training, supervision, and case review with trained professionals is strongly recommended to help increase skills and confidence in handling callers with a broad range of mental illness and substance use disorders.

TREATMENT PLANNING

Quitline treatment plans followed standard protocols with modifications for clients who reported MI/SUD. Again, an important modification was that clients were encouraged to contact their primary care or mental health provider and inform them of their decision to quit smoking before continuing. Adding this extra step was intended to help ensure that the client is being followed for their mental health or substance use disorder, and that their level of functioning is adequate and stable before proceeding.

TREATMENT APPROACHES AND FOLLOW-UP

Treatment approaches for callers with MI/SUD who were stable and without functional impairment were the same as for other callers. The best advice for lower functioning callers was to make the treatment approach supportive and flexible, keeping the content more concrete and

focused, as opposed to facilitative and insight-oriented. Increased time for cognitive processing is needed, necessitating assignment of smaller tasks and less reading. Likewise, calls could be split into several, shorter calls rather than fewer, longer calls.

Characteristics of the therapeutic relationship, important for any client, are especially important for clients with MI/SUD. These include trust, message consistency, compassion, being non-judgmental, expressing confidence in the ability to quit, and help increasing support.

Clients were encouraged to use pharmacotherapy and referred to their primary prescriber for prescriptions. The possible need for dose adjustments of any psychiatric medications was also discussed. Some quitlines provide medications, primarily nicotine replacement therapy, and some advise clients to purchase cessation medications on their own.

SUMMARY OF PROFESSIONAL ADVICE

- Assess current participation in MI/SUD treatment and treatment compliance.
- Assess current level of functioning.
- Determine level of functioning for previous quit attempts.
- Encourage contact with current prescriber prior to and during the quitting process.
- Keep the approach brief, focused and concrete, especially for lower functioning clients with MI/SUD. More repetition may be necessary.
- Pay close attention to a client's cognitive processing. Calls may need to be shorter and not move too quickly.
- For lower functioning clients, limit the use of abstract or open-ended questions.
- Limit the use of written materials. Lower functioning clients may have difficulty processing much written information.
- Provide clients with mental health referrals in their local area, if needed.
- Provide ongoing training and supervision for quitline staff.

MENTAL HEALTH TREATMENT PROGRAMS

INTRODUCTION

The culture of mental health treatment facilities and services plays an important part in the success of tobacco dependence treatment for consumers. Because staff members help establish and support the social norms of the facility, when they smoke themselves and/or believe that smoking is an important part of treatment for consumers, tobacco dependence treatment programs can be undermined. Education outreach to staff members is needed to increase awareness about the harms of smoking and benefits of quitting, help reduce barriers to quitting, for promoting quitting among staff, and for ensuring more routine screening and treatment for tobacco use.

INTAKE ASSESSMENT

The initial mental health assessment conducted by a counselor, social worker, nurse, psychologist, or other psychotherapist, should include a standard set of questions to screen for tobacco use. The tobacco screening questions identify and assess a tobacco use status by asking about current use (what product, how much, how often, when), history of use, previous quit attempts, level of dependence (using Fagerström Test for Nicotine Dependence scale[69]) and interest in trying to quit (see Section 4 for examples). Mental health providers need to then act on the assessment information and offer treatment tailored to the consumer's needs. Consumers will need to continue to be screened and their tobacco use monitored throughout their treatment. Since

"vital signs" are not routine in the delivery of mental health care, chart reminders will need to be devised to facilitate ongoing screening. With the growth of policies restricting smoking in mental health facilities, smoking cessation is increasingly mandatory for these consumers and medications to manage withdrawal are often necessary. However, enrollment in tobacco treatment programs should continue to be voluntary.

TREATMENT PLANNING

After identifying an interest in tobacco treatment and assessing adequate stability of mental illness, treatment planning begins with an evaluation of a consumer's readiness to quit during an individual counseling session. The categories used to gauge readiness to quit are: 1) not thinking about quitting, 2) not prepared to quit now but thinking about quitting sometime in the next 6 months, 3) thinking about quitting in the next month. From there, consumers are helped to develop a treatment plan tailored to their specific needs and stage of readiness to quit. The treatment plan needs to consider the consumer's mental health status and treatment and level of functioning now and during any previous quit attempts along with corresponding sequelae.

Part of the initial counseling should include consumer education about the effects of smoking and quitting on other drugs they might be taking (e.g. psychiatric medications, see page 12). Quitting smoking may require a *reduced* dose of some medications. A potential positive bi-product of reducing psychiatric medication doses is a reduction in dose-related side effects. For some consumers, the potential of reducing side effects may increase motivation to try to quit.

Treatment plans could include a series of individual sessions with a case manager (if available), enrollment in a cognitive-behavioral group cessation program, a wellness program, or a combination of group program and individual counseling. Consumers should be encouraged to participate in groups when possible, but be permitted to opt out if they are uncomfortable. Most of the mental health professionals interviewed completed individual consultations with consumers then made decisions about whether a one-to-one setting, a group setting, or a combination of settings would be most appropriate.

CESSATION PHARMACOTHERAPY

Prescription buproprion, varenicline or non-prescription nicotine replacement therapy (NRT) is commonly recommended for consumers based on their diagnosis, existing medication regimen, and potential need to reduce risk. Different medications have been shown to be effective in consumers with different diagnoses. Bupropion has been shown to be most effective in consumers with depression, but relapse is high when treatment is discontinued.[69,70] Bupropion has also been effective in treating consumers with post traumatic stress disorder (PTSD)[71] but has adverse effects in consumers with bipolar disorder and eating disorders.[72] Programs using the nicotine patch have been moderately successful in consumers with schizophrenia.[73] Nicotine replacement therapy has been successfully used in consumers with PTSD.[74] Varenicline has been effective for many smokers but has not yet been tested in persons with mental illness. There have been two recent reports of psychotic exacerbations on varenicline,[56,57] and, post marketing adverse behavior and mood changes have been reported. No casual links have yet been established, but consumers and providers are warned to closely monitor psychiatric symptoms when quitting smoking.[59] For a more complete discussion of prescribing cessation medications for clients with mental illness, see Smoking Cessation for Persons with Mental Illness" [75] and "Tobacco-Free Living in Psychiatric Settings" [30].

TREATMENT APPROACHES AND FOLLOW-UP

A flexible approach using cognitive behavioral therapy is recommended. A group program format is about 8-10 people for 7-12 weeks. Typical content includes:[75]

- Introduction to tobacco history and prevalence of use.
- Education about the properties of nicotine, health effects of nicotine and tobacco use, and addictive nature of nicotine.
- Review of the reasons why people smoke.
- Education about how to quit smoking, use of medications, and developing a quit plan.

Consumers new to quitting will likely have fewer skills. These consumers may need to begin with a program focused less on setting a specific quit date and more on how to overcome obstacles to quitting. Peer support in the groups can help clients address common problems and be reassured that they are not alone in their efforts.

The University Medical and Dental School of New Jersey (UMDNJ) has developed a specific program called "Learning about Healthy Living" for low motivated smokers in mental health settings.[77] This program has a manual used with 20-week group sessions, carbon monoxide monitoring, information on medications and availability of treatment. The purpose of this program is to stimulate enough motivation in smokers to subsequently enter an eight to ten week treatment program.

INCREMENTAL STEPS

Consumers who are ready to quit will benefit from programs that are structured in incremental steps that are more easily accomplished. Breaking down the quitting process into smaller, more concrete pieces can help consumers build skills and reduce the risk of failure in a given quit attempt.

LONGER FOLLOW-UP

Program follow-up may be lengthy since consumers often maintain contact with case managers for an extended period of time. The extended follow-up is important for some consumers and will help them to reach complete cessation and prevent relapse. The ongoing follow-up also permits a smoother coordination of medications. It is not unusual for consumers to want to continue attending groups and remain on medications long after quitting for extra support.

Increasing motivation to quit

Motivation to quit and to remain abstinent can be improved through community outreach. An example is a program that does quarterly presentations on tobacco education at a mental health day treatment center so consumers who smoke can get information in a comfortable, low demand environment. This approach also provides opportunities for mental health consumers who have already quit to talk about their experiences and to encourage others to move toward quitting.

SMOKE-FREE POLICIES

Treatment is facilitated by the adoption of smoke-free policies, which prohibit smoking in or around the facility by both consumers and staff. Since staff and consumers have previously smoked side-by-side supporting one another in their nicotine dependence, smoke-free policies can significantly improve quitting support for everyone. Tobacco has also been used as a reward for good behavior in many mental health facilities. As more and more mental health facilities become smoke-free, both staff and consumers will benefit by supporting one another in quitting.

SUMMARY OF PROFESSIONAL ADVICE

- Ideally, a consumer's mental health provider and/or primary care provider should be involved in tobacco dependence treatment planning and medication management.
- Treatment plans need to be tailored to individual circumstances. A combination of cognitive-behavioral therapy with nicotine replacement therapy (NRT) or other medication (such as bupropion or varenicline) is important to cessation outcomes.

- Quitting may be a struggle for consumers and they will likely need more time to work towards their goals. The issue may not be *motivation* to quit but *confidence* that it can be done. Any reduction in cigarettes smoked in a day needs to be recognized as progress. For these reasons, quit dates need to be flexible and goals need to be frequently reevaluated.
- Group sessions can work very well. Consumers support one another in their quit attempts in the group and socially outside the group.
- Support for quitting is improved when the agency has smoke-free policies. Overall support by staff is invaluable to consumers, as is creating a social environment where nonsmoking consumers do not feel marginalized.
- To be successful, the staff in mental health facilities need to be educated, involved, and also helped to quit.

SUBSTANCE USE TREATMENT PROGRAMS

INTRODUCTION: THE SUBSTANCE USE TREATMENT CULTURE

Tobacco dependence is classified as an addiction and is the most common substance use disorder.[77] Even so, tobacco dependence is commonly ignored in substance use treatment programs.[78] Explanations for why this is the case are related to the ways in which the culture of recovery programs has developed and to the attitudes, skills, and knowledge of the staff.[78] The culture of substance use treatment programs typically supports tobacco use and can undermine tobacco dependence treatment. About 30 to 40% of staff in community-based treatment programs are tobacco dependent.[79] Many treatment program staff strongly believe that tobacco is not a "real" drug, that it is not as harmful as other drugs of abuse, and that quitting smoking is too stressful and would jeopardize recovery from other substances.[78]

Increasingly the data are showing otherwise. In a 10-year prospective study of graduates from an inpatient substance use treatment center, tobacco related illnesses caused significantly more deaths than alcohol related causes.[80] The death rate among narcotic addicts who received treatment was fourfold higher among smokers compared to non-smokers.[81] There is also evidence that smoking cessation may help clients already in recovery programs and may protect against relapse to the illicit drug of choice.[82] Alcoholics who quit smoking are more likely to succeed in treatment.[83] Smokers relapse back to alcohol and illicit drugs more often, more frequently and sooner than nonsmokers.[84]

Although the culture of treatment programs and treatment staff are slow to change, they are changing. Addiction treatment specialists are recognizing the importance of addressing mental illness and tobacco use during substance use recovery programs. And, treatment programs are recognizing the importance of assisting their staff members who use tobacco to quit. More training and ongoing supervision of staff is also helping to reinforce the importance of quitting, to address problems, and to build capacity and skills within treatment programs.

The substance use treatment programs that were included in our survey had undergone the cultural change from programs that supported tobacco use to programs that treat tobacco dependence. They all emphasized the importance of directly addressing the cultural and staff issues in order to better integrate effective tobacco dependence treatment into substance use treatment.

INTAKE ASSESSMENT

Tobacco use questions need to be incorporated into the standard substance use intake assessment and follow-up care, whether it is done in person or over the phone. Intake questions for tobacco use follow the same format as questions about other substances: frequency of use, his-

tory of use, current use, time of use, quit attempts, and symptoms of withdrawal. Programs can also use the Fagerström test[68] and take a carbon monoxide reading[1] (with client permission) in their assessment to establish level of dependence.

Readiness to quit needs to be assessed since many clients may not have tried to quit before and may not be prepared to quit now. The categories used to gauge readiness to quit are: 1) not thinking about quitting, 2) not prepared to quit now but thinking about quitting sometime in the next 6 months, 3) thinking about quitting in the next month. From there, the counselor helps the client develop a treatment plan tailored to the client's specific needs and stage of readiness to quit. Some clients may have tried to quit before and will have more experience. These clients may be more ready and prepared to quit when they enter treatment. Many clients will not have tried to quit before and will need more education and preparation before they are ready to quit. See Section 4 for example intake questions and assessments. Clients with substance use disorders and mental illness may need even more time to prepare before attempting to quit.

TREATMENT PLANNING

Clients who use tobacco should be offered tobacco treatment services if they are interested and ready to quit. In smoke-free residential programs, the decision to be abstinent has already been made and tobacco dependence treatment is part of the overall treatment protocol. Including tobacco dependence treatment in the overall treatment plan and providing NRT or other pharmacotherapy to these clients when they first enter treatment is essential.

In outpatient settings, clients make their own decision. If they are interested, tobacco dependence treatment can be integrated into their ongoing treatment plan. Tobacco users can be offered assistance (information, resources, medication, quitline information) depending on their readiness to quit, and encouraged to take advantage of the resources available to them in the community. Treatment providers need to have good knowledge of the free and low-cost resources available in the community and any benefits available through their clients' health plan coverage. Clients who are in recovery, especially those with less functional impairment, will benefit from services offered through tobacco quitlines.

Initial treatment planning needs to cover:

- Education and explanation about tobacco use and dependence.
- Education on specific health and psychosocial implications for smokers with current/past history of substance use disorders (risks of continued smoking, benefits of quitting) to support motivation to quit and increase awareness in committed smokers.
- Withdrawal symptoms that can be anticipated.
- Treatment options (NRT's, prescription medications, cost, availability, and any benefit coverage).
- General health and wellness.
- Identification of support systems (physicians, therapists, friends, family, peers).

If clients are ready to quit tobacco permanently, tobacco treatment is provided concurrent with other treatments. If they are not ready to quit, motivational interviewing can be used to help move clients along the continuum from smoker to ex-smoker.

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[1] The level of toxic carbon monoxide (CO) inhaled from tobacco smoke can be read using a CO monitor. As part of a tobacco cessation program, measurements of carbon monoxide (CO) in expired air may be useful in showing smokers both their exposure to CO and their rapid return to normal CO levels when they stop smoking. [85]

TREATMENT APPROACHES AND FOLLOW-UP

A treatment approach using cognitive behavioral therapy with cessation medications is recommended. Treatment content typically includes:

- Education on tobacco use and dependence (many clients will not be familiar with the harm associated with tobacco use, the benefits of quitting, and nicotine addiction).
- Use of pharmacotherapies to quit.
- Individual counseling to help develop coping skills (other than using substances) for controlling cravings, recognizing triggers, and developing motivation and confidence.
- Group sessions for establishing a network of social support.

For clients with functional impairment, treatment may need to be more flexible with the content provided in smaller steps that can be more easily accomplished. For clients new to quitting and who may have fewer skills, the treatment may need to focus less on setting a specific quit date and more on how to overcome obstacles to quitting. Peer support in groups, important to substance use recovery, can also help clients address common problems in recovery from tobacco dependence and be reassured that they are not alone in their efforts.

Follow-up during recovery helps maintain abstinence. Clients in recovery may continue to attend support groups for longer periods of time than those from a more general population.

CESSATION PHARMACOTHERAPY

Use of pharmacotherapy is strongly recommended for these clients. Medication may be used alone (varenicline or bupropion) and is often used in combination (especially NRT) to suppress withdrawal symptoms. Many of the substance use professionals interviewed recommended higher doses of NRT and regularly used combination medications.

There are a few recommendations for cessation medications for clients recovering from substance use. Bupropion is contraindicated with a history of alcohol abuse. Agitation is a potential side effect of bupropion that substance use treatment providers report can remind clients of the effects of their drug of choice. Some clients may want to avoid use of bupropion to eliminate this potential side effect. For similar reasons some substance use treatment programs avoid recommending nicotine nasal spray for clients recovering from cocaine addiction.

THE ROLE OF SMOKE FREE POLICIES

Smoke-free policies are a significant catalyst for changing the culture of substance use treatment programs and for integrating tobacco dependence treatment. Treatment staff members often are in recovery themselves, and many are still smokers. Smoke-free policies provide support for clients and staff trying to quit and emphasize the important benefits of quitting.

EDUCATIONAL MATERIALS

Educational materials are used in recovery programs more often than in treatment for mental illness. Tobacco users in recovery, often unfamiliar with tobacco use and dependence and how to quit, benefit from learning more about quitting. Because these clients may have previously learned about the mechanism and effects of alcohol and other substances in their recovery program, this background can be readily applied to tobacco.

Many standard tobacco treatment materials are used, depending on the reading level and functional status of the client. Free materials can be obtained from the Centers for Disease Control and Prevention, Office on Smoking and Health. (See Section 4.)

SUMMARY OF PROFESSIONAL ADVICE

- Education is an important first step in motivating clients to consider quitting. Motivational interviewing helps move them through the stages of readiness.
- Many of these clients need more intensive treatment than a quitline can provide.
- It is important that substance use providers believe that their clients can quit smoking and that it is worth the time and resources to take clients from one step to the next.
- A focus on learning coping skills and developing confidence to quit is needed. These clients may lack experience and self-confidence to undertake cessation.
- Aggressive use of medications is often necessary and may be used over a longer period of time. Medications need to be provided at low or no cost, especially for clients without health care benefits.
- Adoption of smoke-free policy at treatment centers helps support cessation together with participation in smoke-free recovery support groups.
- Clients with experience in recovery settings do well in groups.

PRIMARY CARE PROVIDERS

INTRODUCTION

Primary care providers, because they see many patients and care for them over longer periods of time, are on the "front line" of tobacco dependence treatment. Brief treatment (3 minutes or less), outlined in the PHS Clinical Practice Guideline, is designed especially for primary care providers who have limited time. Because it is relatively easy and can reach many tobacco users, the Guideline recommends that all tobacco users receive at least brief treatment from their primary healthcare professionals.[86]

The introduction of tobacco quitlines in all 50 states has helped streamline the delivery of brief treatment into three steps:

- Ask: screen for tobacco use as part of vital signs at each clinic visit.
- Advise: all tobacco users to quit and prescribe/recommend stop smoking medications for those who are ready to set a quit date.
- Refer: tobacco users to a tobacco quitline for follow-up.

Clinical Monitoring Recommendations for Patients with MI/SUD[1,2]

1. Patients should be seen 1-3 days after initiating smoking cessation.

2. Patients should be monitored weekly for the first four weeks for signs of psychotic relapse, onset of depression or depressive symptoms, and the need to change medication levels.

3. After the first month, patients should be reviewed monthly for six months.

4. The primary care provider and the mental health provider should communicate at the beginning of tobacco dependence treatment and then during the cessation period if any psychiatric complications occur.

1 Strasser, K., Moeller-Saxone, K., Hocking, B., Stanton, J., & Kee, P (2002). Smoking cessation in schizophrenia. General practice guidelines. Australian Family Physician, [31, 21-24].

2 Provincial Health Services.(2006). Tobacco reduction in the context of mental illness and addictions: A review of the evidence. Centre for Addiction Research of British Columbia.

PATIENTS WITH MI/SUD

Compared to other tobacco users, tobacco dependence treatment for patients with MI/SUD is more complex. These patients:

- Need more intensive behavioral therapy. More person-to-person contact yields better outcomes.

- May require more assistance with motivation and encouragement to try.
- Need to have psychosocial issues addressed that can undermine cessation.
- Have unique medication and pharmacokentic issues. Cessation may produce rapid, significant increases in medication blood levels (see page 12).
- Need individualized treatment plans based on diagnoses and assessment of stability and functionality (see page 10). If non-compliance is related to instability, it may not be the right time to quit.
- May need a longer preparation time before quitting. These patients may not have tried to quit before and may need more time to practice not smoking in a variety of circumstances to learn coping skills and how to adjust their personal and social environment. They may also need to start cessation medications before they quit completely and wean off smoking more gradually.

Patients who have been assessed, are currently stable, ready to quit, and are not functionally impaired will be able to participate in tobacco treatment programs offered to the general public. Patients who are ready to quit but have more functional impairment will need more individualized management and follow-up. Patients who not stable may need to wait to quit until their MI/SUD is stabilized.

CESSATION PHARMACOTHERAPY

Use of pharmacotherapy is strongly recommended for these patients. Dose level and duration of drug treatment need to be individually tailored. More dependent smokers, including those with psychiatric and substance abuse co-morbidities, may need higher doses of NRT, combination medications (e.g. nicotine patch + fast acting NRT such as nicotine gum or inhaler, NRT + bupropion) and for longer duration of treatment.[37] (While increasing dose and combining medications are often clinically indicated, this has not been FDA approved.)

Different medications have been shown to be effective in patients with different diagnoses. Programs using the nicotine patch have been used with some success in patients with schizophrenia.[73] Nicotine replacement therapy has also been successfully used in patients with PTSD.[74] Bupropion has been shown to be most effective in patients with depression, but relapse is high when treatment is discontinued.[69,70] Bupropion has also been effective in treating patients with post traumatic stress disorder (PTSD)[71] but has adverse effects in patients with bipolar disorder and eating disorders.[72] Bupropion is contraindicated with a history of alcohol abuse. Agitation is a potential side effect of bupropion that substance use treatment providers report can remind clients of the effects of their drug of choice. Some patients may want to avoid use of bupropion to eliminate this potential side effect. For similar reasons, nicotine nasal spray is not recommended for people who abuse drugs intranasally. Bupropion interferes with efficacy of protease inhibitors and other medications used by people with HIV/AIDS. Varenicline has been effective for many patients, include patients with MI/SUD but has not yet been tested in patients with mental illness. There have been two recent reports suggesting a psychotic exacerbation in a person with schizophrenia and in a person with bipolar disorder who were taking varenicline.[57, 58] Additionally, post marketing adverse behavior and mood changes have been reported. Although no casual links have yet been established, patients and providers are warned to closely monitor the psychiatric symptoms of all patients who are quitting smoking.[59] For a more complete discussion of prescribing cessation medications for patients with mental illness, see Smoking Cessation for Persons with Mental Illness"[75] and "Tobacco-Free Living in Psychiatric Settings"[30].

Advice for Tailoring Serivces in Primary Care		
CLINIC VISIT STEPS	PATIENTS WITHOUT MI/SUD	PATIENTS WITH MI/SUD
Vital signs	Expand vital signs to screen all patients for tobacco use at every visit.	Expand vital signs to screen all patients for tobacco use at every visit. Update MI/SUD questions in medical history.
Review of systems	In a clear, strong, and personalized manner, urge every tobacco user to quit. Determine willingness/readiness to quit now (e.g. in next 30 days).	In a clear, strong, and personalized manner, urge every tobacco user to quit. Determine current ***interest*** in quitting. **If interested, review:** • Tobacco use history and any previous experience in quitting (how prepared is the patient?) • Stability of MI/SUD and current psychosocial issues that can impact cessation. • Functional impairment that can impact cessation efforts. • Level of tobacco use and nicotine dependence. **If not interested:** • Discuss reasons for not being interested. • Discuss pros and cons of quitting and identifying reasons to consider quitting. • Encourage trying later and offer to help.
Treatment plan	1) If ready to quit, • Set a quit date (ideally within 2 weeks). • Recommend/prescribe stop smoking medications. • Refer to national tobacco quitline or other program for follow-up. • Follow-up at next clinic visit. 2) If not ready to quit: • Discuss reasons for not being ready. • Discuss pros and cons. • Encourage quitting later when ready and offer to help. • Give national quitline information and number.	**If interested;** Determine ***readiness*** to quit. If ready: • Discuss patient preferences. • Discuss a quit date (be flexible) and begin preparation steps (e.g. cutting down and delaying cigarettes; not smoking in home or car.) • Recommend/prescribe cessation medications (may need higher NRT doses or combination doses). • Address psychosocial needs that might undermine cessation. • Refer to tobacco quitline (if no functional impairment) or other program for more person-to-person contact. • When quit, schedule return visit in 1-3 days, then weekly for the first month to monitor symptoms and medication levels. Monthly thereafter for six months. • Communicate with mental health provider (if appropriate) initially and then during cessation process if complications occur.

NATIONAL QUITLINE: 1-800-QUIT NOW OR 1-800–784-8669

Advice for Tailoring Services by Treatment Setting: At-A-Glance Summary*				
Program area	Tobacco Dependence Treatment Programs	Tobacco Quitlines	Mental Health Treatment Programs	Substance Use Treatment Programs
Intake and Assess-ment*	• Presence of MI/SUD assessed indirectly through assessment of meds and observation of behavior. • Normalize use of substances in intake process to increase comfort in disclosing (not "if" but "how much.") • Direct questions recommended; more possible with training.	• Can assess MI/SUD indirectly through verbal cues or med use. • Direct questions recommended • Training on MI/SUD is needed. • Need to establish that quitline is not mental health provider.	• Add tobacco use and dependence questions to existing intake process. • Determine readiness to quit or next step– many not ready to quit.	• Add tobacco use and dependence questions to existing intake process. • Determine readiness to quit or next step – many not ready to quit. • Normalize use of substances in intake process to increase comfort in disclosing (not "if" but "how much").
Developing Treatment Plan	• Need multiple formats to help tailor to client. • Need to coordinate with PCP or mental health provider for medication management. • Cessation pharmacotherapy essential.	• Important to determine MI/SUD stability before proceeding. • Important to link client with current provider for medication management. • Cessation pharmacotherapy essential.	• Treatment plan is tailored to include tobacco at stage of readiness. • Treatment may need to begin with information and preparation. • Education about metabolic effects of quitting on medications needs to be included. • Cessation pharmacotherapy essential.	• Outpatients programs: services offered; interest/acceptance – based on readiness to quit. Can provide concurrently with SUD treatment. • Provide Motivational Interviewing to move to next step if not yet interested. • Add tobacco dependence treatment to residential treatment if smoke-free. • Provide education on nicotine dependence – new info and counter to conventional SUD treatment (may leave out tobacco) and help identify support.
Treatment Approach and Follow-up	• More sessions help; longer follow-up. • Option for flexible quit date – may need more preparation. • Content more flexible. • Build confidence with smaller steps. • Supplement group time with individual sessions for more support.	• Treatment plan needs to be more concrete and focused if clients are functionally impaired. • Open-ended facilitative questions (often used with Motivational Interviewing) are less helpful for lower functioning clients. • May need more, shorter and more frequent follow-up calls.	• Treatment from case manager or refer to tobacco specialist – individual or group program; also wellness groups. • Need more than quitline services. • First priority is MH stability. • More extensive preparation needed (incremental steps) – based on readiness. • Reduced smoking more common than abstinence. • Smoke-free policies support cessation and reduction. • More support and longer follow-up.	• Provide individual counseling + group support. • Need more than quitline services. • Aggressive cessation pharmacotherapy may be needed. • Long-term support is important for some. • Smoke free policies in treatment facilities help support cessation.
Written Materials	• May not be very helpful to clients, are infrequently used. • If used, must be simple and concrete.	• Infrequently used by clients, value to them is uncertain. • Therapeutic relationship more important than materials.	• Sometimes used to help with learning. • Need to be appropriate to level of functioning.	• All types of materials widely used, except those produced from the tobacco industry. • Need range of language and literacy needs. • Include family (likely also smokers).
Training and Super-vision	• Additional training is important. • Background in addiction or behavioral health improves comfort of treatment specialist and outcomes.	• Additional training is very important. • Supervision and expertise for case review also important.	• Special training on tobacco treatment and help to quit for staff is important. • Belief in benefit of quitting is very important.	• Additional training and continuing ed in tobacco dependence important. • Belief in benefit of quitting important. • Clinical supervision + team meetings and case review.

MH-mental health; SUD – substance use disorder; PCP – primary care provider

*See full Resource Guide for details at www.tcln.org/bea

SECTION FOUR **RESOURCES FOR PROGRAM DEVELOPMENT**

CONTENTS:

General intake assessment questions

New Jersey, Massachusetts client assessments

Sample counseling questions, California Smokers' Helpline

Tobacco cessation medication prescribing guide

Online resources:

- Toolkits
- Presentations
- Consumer information
- Websites
- Video

GENERAL INTAKE ASSESSMENT QUESTIONS

DEMOGRAPHIC CHARACTERISTICS:

Name, address, age, gender, marital/partner status, number of other smokers in household.

PERSONAL TOBACCO USE HISTORY:

Average number of cigarettes smoked per day (last 30 days); time to first cigarette smoked each day; Fagerström Test for Nicotine Dependence (FTND) score[48]; previous purposeful quit attempts (at least 48 hours, excluding illness or hospitalization); experience with nicotine replacement therapy (NRT) and other smoking cessation medications; potential reasons for relapse or failure to attain abstinence; how smoking affects mood and severity of withdrawal symptoms.

FAMILY TOBACCO USE HISTORY:

Whether or not parents, siblings, other household members smoke, how important smoking is to the family culture, whether family smoking is a trigger for client smoking.

CURRENT QUIT ATTEMPT:

Readiness to quit; self-efficacy for smoking cessation; barriers and support for quitting; reasons for quitting, client concerns and goals about quitting.

SOCIAL SUPPORT:

Client's support system (how family, friends, peers feel about smoking/quitting), current living situation (e.g., in group home or residential treatment programs with other smokers.)

CURRENT LIFE SITUATION:

Current stresses, e.g., divorce, new baby, personal/family illness, financial hardships, loss of job, death of loved one etc. May consider adding other assessments such as the Beck Depression Inventory.[48]

CURRENT HEALTH HISTORY:

Current medications and potential contraindications to stop smoking medications, e.g.: seizure risk of bupropion, skin sensitivity for nicotine patches.

SCREENING FOR MENTAL HEALTH OR SUBSTANCE USE DISORDERS:

The Expert Advisory Committee strongly recommends using direct assessment questions that address MI/SUD in smokers seeking treatment. Such information is needed to help design an effective treatment plan, since the presence of MI/SUD can undermine any quit attempt. Examples are: "Have you ever received counseling, treatment, or medication for a mental health, emotional, or behavioral problem?" "Have you ever received counseling, treatment or medication for alcohol or other drug problems?"

Site/Client ID	City	County
Initial Assessment Date	Initial Target Quit Date	

For Office Use Only

QUITCENTER CLIENT INFORMATION QUESTIONNAIRE

Please put a check mark (✓) next to your answer. Add additional information where needed.

2a. What is your birth date?	Month _____ Date _____ Year _____	
2b. How old are you?		
2c. Have you ever attended this Quitcenter before?	YES	
	NO	
3. What is your gender?	Male	
	Female	
4. Which of the following best describes your current relationship status?	Never Married	
	Married	
	Divorced	
	Widowed	
	Separated	
	Member of an Unmarried Couple	
5a. Do you have any children?	YES / NO	
5b. If yes, how many children do you have?		
5c. How many children are under 19?		
5d. How many children live with you?		
6a. What race/ethnicity best describes you?	Caucasian/White	
	African American/Black	
	Hispanic/Latino	
	Asian	
	American Indian/Alaskan Native	
	Native Hawaiian or Pacific Island	
	Other please indicate:	
6b. Please list specific culture:	example: Hispanic/Latino -Puerto Rican	
6c. What language is primarily spoken at home?	English	
	Spanish	
	Both English and Spanish	
	Other please indicate:	

7. What is the highest level of education that you have achieved?	Less than High School Diploma	
	High School Diploma or GED	
	Some College/Technical School	
	College Degree	
	Graduate Degree	
8a. Which of these best describes your current employment status?	Full-time employment	
	Part-time employment	
	A full-time homemaker	
	A full-time student	
	Part-time student	
	Retired	
	Unemployed	
	Permanently sick or disabled	
8b. What is your occupation (if applicable)?		
9. Is your household annual income from all sources:	Less than $10,000	
	$10,000 - $14,999	
	$15,000 - $19,999	
	$20,000 - $24,999	
	$25,000 - $34,999	
	$35,000 - $49,999	
	$50,000 - $74,999	
	$75,000 - $99,999	
	$100,000 or more	
10a. What type of insurance do you have?	Medicare	
	Medicaid	
	Both Medicare & Medicaid	
	Other Health Insurance	
	No Insurance	
10b. What is the name of your insurance provider?		
11. Does your health insurance cover smoking cessation counseling?	YES	
	NO	
	Don't Know	
12. Does your health insurance cover any smoking cessation medications?	YES	
	NO	
	Don't Know	

13. How did you find out about this clinic?		
	Family/Friend	
	Newspaper Magazine	
	Health Care Provider please *indicate*	
	Doctor ❑ Nurse ❑ Dentist ❑	
	Pharmacist/Drugstore	
	Television	
	Radio	
	NJ Quitnet (Internet)	
	Internet site other than Quitnet	
	NJ Quitline	
	ALA or ACS	
	Brochure/Pamphlet	
	Local Partnership Against Tobacco	
	Employer	
	Insurance Company	
	Library	
	School	
	Other please indicate	

TOBACCO SPECIFIC INFORMATION		TOBACCO USE HISTORY	
14. Please check appropriate box for each type of tobacco:			
a.	CIGARETTES	Cigarettes–Never Used Cigarettes–Used in Past Cigarettes–Currently Use	
b.	PIPE	Pipe–Never Used Pipe–Used in Past Pipe–Currently Use	
c.	CIGARS	Cigars–Never Used Cigars–Used in Past Cigars–Currently Use	
d.	CHEWING /SMOKELESS TOBACCO	Chewing Tobacco–Never Used Chewing Tobacco–Used in Past Chewing Tobacco –Currently Use	

15. What age were you when you first used or tried tobacco?		
16a. What age were you when you started using tobacco on a regular basis?		
16b. How many years have you used tobacco?		
17. How many cigarettes do you smoke each day?		
18. Give the full details of your main current cigarettes (full brand and name, size etc)		
19. How many minutes after you wake up do you smoke your 1st cigarette?		
20a. Do you sometimes awaken at night to have a cigarette or use tobacco?	YES	
20b. If yes, how many nights per week do you typically awaken to smoke?	NO	
21. How many times have you tried to quit smoking?		

22. Is/was your current usual brand of cigarette a "light" ("low tar") brand?	YES	
	NO	
23. Is/was your current usual brand of cigarette a menthol brand?	YES	
	NO	
24. In the last six months, have you received any mail addressed to you from any tobacco company?	YES	
	NO	

CURRENT QUIT ATTEMPT

25. How important is it to you to stop tobacco use now?
Please check one box.

1	2	3	4	5	6	7	8	9	10

Not at all Important — Average Importance — Extremely

26. How confident are you that you will succeed in stopping your tobacco use now?
Please check one box.

1	2	3	4	5	6	7	8	9	10

Not At All Confident — Somewhat Confident — Extremely

27. A lot of my friends or family smoke.
Please check one box.

1	2	3	4	5	6	7	8	9	10

Not true at all. — Somewhat true of me. — Extremely true of me.

28. I'm around smokers much of the time.
Please check one box.

1	2	3	4	5	6	7	8	9	10

Not true at all. — Somewhat true of me. — Extremely true of me.

29. Which statement best describes smoking inside your home?

a. Smoking is not allowed anywhere inside the home.

b. Smoking is allowed in some places or sometimes.

c. Smoking is allowed anywhere inside the home

d. Other please indicate

30. Please check (s) next to the one statement that best describes your current situation:

a. I am interested in quitting smoking/tobacco use in the next month, and I would be interested in any assistance I could get.

b. I am interested in drastically reducing the number of cigarettes I currently smoke (reduce by 50%or more), but am not interested in quitting totally.

c. I am seriously considering quitting in the next 6 months, but not in the next 30 days.

d. I currently smoke/use tobacco and am certain that I do not want to quit in the next 6 months.

e. I have recently stopped smoking/using tobacco, and I need to work at not slipping back to using.

f. I have not smoked/used tobacco products for over 6 months.

31. Do people smoke outside the entrance to your work place?	YES	
	NO	

CURRENT HEALTH AND MEDICAL HISTORY

32. Currently, do you have any symptoms or a disease that you believe is caused or made worse by your tobacco use?	YES NO	
33. Have you ever received counseling, treatment or medication for a mental health,emotional or behavioral problem?	YES NO	
34. Have you ever received counseling, treatment or medication for alcohol or other drug problems?	YES NO	
35. Are you pregnant or is there a chance that you could be pregnant at this time?	YES NO	

36. The following questions ask about how you have been feeling during the past 4 weeks. For each question, please circle the number that best describes how often you had this feeling.

In the last 4 weeks, about how often did you feel…	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a …so sad that nothing could cheer you up?	4	3	2	1	0
b. …nervous?	4	3	2	1	0
c. …restless or fidgety?	4	3	2	1	0
d. …hopeless?	4	3	2	1	0
e. …everything was an effort?	4	3	2	1	0
f. …worthless?	4	3	2	1	0

In the **last 4 weeks**, how many times have you seen a health professional about these feelings?
Number of visits _____

Comments _____

_____

	Condition:	Past	Currently treated
37. Please check if you have a	Heart Disease (coronary disease, heart attack)		
	High Blood Pressure		
	Diabetes		
	High Cholesterol		
	Stroke		
	Cancer type:		
	Lung Disease (asthma, emphysema, COPD)		
	Depression		
	Anxiety		
	Schizophrenia		
	Bipolar Disorder		
	Alcohol Problems		
	Drug Problems		

38. Would you say that, in general, your health is:	Excellent
	Good
	Fair
	Poor

THANK YOU FOR COMPLETING THIS FORM.
PLEASE BE SURE TO BRING IT WITH YOU TO YOUR NEXT SCHEDULED APPOINTMENT.

For Office Use Only

Measurement of Expired Carbon-monoxide _____p.p.m On site: _____ Off-Site: _____

Body weight: _____pounds

MASSACHUSETTS BRIEF INTERVENTION/ASSESSMENT PROTOCOL

ASK – Systematically identify all tobacco uses at every visit

SMOKING STATUS: [check one]

❑ NEVER SMOKED	➪ ➪ ➪	Encourage continued abstinence
❑ RECOVERING SMOKER	➪ ➪ ➪	Do you need any further help at this time?

❑ SMOKER ❑ OTHER TOBACCO USE (snuff, chew, etc…)

Average number of cigarettes smoked per day? _____

How soon after waking do you smoke your 1st cigarette? _____

ADVISE – Strongly urge all tobacco users to quit

❑ This program is an addictions treatment program that cares about all aspects of your health and addictions, including nicotine addiction, especially because there are special risks for smokers with histories of alcohol and other drug abuse. I encourage you to consider quitting either now or in the future.

ASSESS – Determine willingness and readiness to make a quit attempt

MOTIVATION & CONFIDENCE IN QUITTING

❑ On a scale of 1-10, with 1 being not at all important and 10 being extremely important, how important would you say it is for you to quit smoking?
Not at all 1…3…5…7…10 Extremely important

❑ On the same scale, how interested are you in quitting?
Not at all 1…3…5…7…10 Extremely interested

If uninterested, ask: What would make you more interested? _____

❑ If you decided to try and quit smoking, on a scale of 1-10, how confident are you that you could successfully do it? Not at all 1…3…5…7…10 Extremely confident

If unconfident, ask: How could the program help you become more confident?

_____

❑ If you were to quit, what would be some reasons? _____

STAGE OF CHANGE

❑ Pre-contemplation (Not considering quitting) ❑ Action (Off tobacco 1 day to 6 months)
❑ Contemplation (Thinking about quitting) ❑ Maintenance (Off tobacco 6 months or more)
❑ Preparation (Ready to quit in next 30 days)

If in preparation, ask: What steps have you taken to prepare for your quit attempt?

_____

ASSIST – Aid the client in quitting or planning for the future

❑ Evaluate past quitting experience: How many times have you tried to quit smoking? ____

What kinds of pharmacotherapy (NRT) have you tried? (gum,patches,inhaler,Zyban/Wellbutrin)

_____

❑ Discuss what program offers: ❑ Individual counseling and pharmacotherapy on-site ❑ Referral to local tobacco treatment specialist off-site ❑ Support for tapering ❑ Support for going 'cold turkey' ü Self-help materials ❑ Nicotine Anonymous information

Give materials; encourage support & use of telephone counseling @ Tobacco-Free Helpline 1-800 TRYTOSTOP or website www.trytostop.org

ARRANGE – Schedule follow-up contact

❑ Offered referral for on-site tobacco treatment: Client would like to be referred: _____
Client does not want to be referred: ____

❑ Will follow-up as part of regular treatment planning

INDIRECT ASSESSMENT QUESTIONS
SCREENING FOR MENTAL ILLNESS OR SUBSTANCE USE DISORDERS

Sample questions provided from California Smokers' Helpline counseling protocol.

Note: Callers to the California Smokers' Helpline are asked first about their needs. Callers interested in quitting and who want to speak to a counselor are either transferred to an available counselor or scheduled for a call back by the counselor. The counselor then completes a series of assessment questions including a tobacco use history. Callers are also asked about medication use and professional support. For those taking any psychotropic medications or participating in any type of professional support, the following series of questions are asked to help screen for potential issues around mental illness and substance use and to establish an appropriate quit plan.

Medications

1. Are you taking medication for any reason?

   If yes (and taking psychotropic medication),

   a) How is it working for you?

   b) How long have you been taking the medication(s)?

   c) Does a psychiatrist or another doctor prescribe it for you?

   d) How often do you see you doctor?

   e) Have you spoken with him or her about quitting?

Professional Support

2. Do you attend any meetings or counseling of any kind?

   If yes,

   a) How is that going?

   b) How long have you been going?

   c) How often do you attend?

   d) Will you be able to get support for quitting there?

If Yes to either 1 or 2:

Assess Psychiatric Health (Stability)

1. Are you having any symptoms (related to diagnosis) currently?
2. Are you currently in treatment?
3. How regularly do you attend treatment (compliance with medication)?
4. How is the treatment working for you?
5. What, if anything, has your health care provider said to you about quitting smoking?
6. If client is not presently seeing a health care professional, explore how client can seek care in their area prior to next scheduled call.

Assess previous quitting history & symptoms

1. When you quit before, what did you notice about your symptoms?
2. If you noticed a change when you quit before, what did you do?
3. If on medications, did you notice any change in how your mediation(s) worked after quitting?

Tobacco Cessation Pharmacology 2007: Nicotine Replacement Therapy (NRT) and Non-Nicotine Therapies

Nicotine Replacement Therapies

General NRT recommendations: 1) Use sufficient amount to control withdrawal (overdosing is very unlikely; under-dosing is common; 2) Use one patch daily or flexible dosing NRT every few hours to maintain steady state; 3) Combination therapy (nicotine patches + flexible dose NRT) may be necessary for heavier, dependent smokers to control withdrawal. NRT may be less effective for women than for men

Therapy Efficacy	TRANSDERMAL PATCH (OR = 1.9)*[1] Nicoderm CQ®, Generic	GUM (OR = 1.5)*[1] Nicorette®, Generic	LOZENGE (OR = 1.95 (2 mg); 2.76 (4mg)*)[2] Commit®	INHALER (OR = 2.5)*[1] Nicotrol® Inhaler	NASAL SPRAY (OR = 2.7)*[1] Nicotrol® NS
Length of Treatment	8-10 weeks	Up to 12 weeks	12 weeks	3-6 months	3-6 months
Dosing	•**More than 10 cigs/day** start on 21 mg. patch. •**Less than 10 cigs/day,** start on 14 mg. patch. •Apply once daily in am on hairless skin on upper body. Rotate sites. •Peak level in 2-8 hr. •21 mg. x 4-6 wks. 14 mg. x 2 wks. (or 4-6 wks. if starting dose). •7 mg. x 2 wks.	•**25 or more cigs/day** = 4 mg. •**Less than 25 cigs/day** = 2 mg. •1 every 1-2 hrs. x 6 wks. •1 every 2-4 hrs. x 3wks. •1 every 4-8 hrs. x 3 wks.. •Peak level in 15-20 min. •Use "chew and park" technique; rotate to different sites in mouth. •**Use enough** to control symptoms, up to 24 per day.	•**1st cig less than 30 min after waking** = 4 mg. •**1st cig more than 30 min after waking** = 2mg. •1 every 1-2 hrs. x 6 wks. •1 every 2-4 hrs. x 3 wks. •1 every 4-8 hrs. x 3 wks. •Peak level in 15-20 min. •Dissolve slowly, rotate sites in mouth, DO NOT CHEW. •**Use enough** to control symptoms, < to 5 in 6 hrs. up to 20 per day.	•6-16 cartridges per day/individualized dosing; **start at least six per day initially. Use enough** to control symptoms. •Peak level in 15-20 min. •Puff continuously for 20 minutes. •Inhale into back of throat or puff in short breaths; DO NOT inhale into lungs. •Can use part of cartridge and save rest for later (within 24 hours).	•Dose = one squirt to each nostril. •Peak level in 11-13 min. •Dose 1-2 times each hour as needed. **Use enough** to control symptoms. •Min dose = 8/day. •Max = 40/day. •Use correctly. DO NOT sniff, swallow, or inhale.
Precautions	•Severe uncontrolled eczema or psoriasis. •Recent (< 2 wks) MI. •Serious underlying arrhythmias. •Serious or worsening angina. •Pregnancy (Category D). •Remove at night for sleep disturbances.	•Recent (< 2 wks) MI. •Serious underlying arrhythmias. •Serious or worsening angina. •TMJ •Pregnancy (Category D). •Do not eat or drink 15 min. prior to use. •May stick to and damage dental work.	•Recent (< 2 wks) MI. •Serious underlying arrhythmias. •Serious or worsening angina. •Pregnancy (Category D). •Do not use more than one at a time or one after the other. •Do not eat or drink 15 min. prior to use.	•Recent (< 2 wks) MI. •Serious underlying arrhythmias. •Serious or worsening angina. •Severe reactive airway disease. •Pregnancy (Category D).	•Recent (< 2 wks) MI. •Serious underlying arrhythmias. •Serious or worsening angina. •Pregnancy (Category D). •Severe reactive airway disease).
Pros	•Easy to use; better compliance. •Steady dose (even when sleeping). •Can combine with flexible dosing NRT.	•Flexible dosing. •Helps with predictable urges (e.g. after meals). •Keeps mouth busy. •Use in combination with patch and for relapse prevention.	•Flexible dosing. •Helps with predictable urges (e.g. after meals). •Keeps mouth busy. •Use in combination with patch and for relapse prevention.	•Flexible dosing. •Helps with predictable urges (e.g. after meals.) •Keeps hands and mouth busy. •Use in combination with patch and for relapse prevention.	•Flexible dosing. •Helps with predictable urges (e.g. after meals). •Use in combination with patch and for relapse prevention.
Cons	•May irritate skin. •May disturb sleep. •Can't adjust dose.	•Need to use correctly – "chew and park." •May cause nausea, hiccups, coughing, heartburn, headache and flatulence.	•May cause insomnia. •May cause some nausea, hiccups, heartburn, coughing, headache and flatulence.	•May irritate mouth and throat (improves with use). •Does not work well below 40 degrees.	•Need to use correctly (DO NOT INHALE). •Nasal irritation is common. •May cause dependence. •May want to avoid with clients re-covering from cocaine addiction.
Availability	Over-the-counter	Over-the-counter (regular, mint, orange)	Over-the-counter (regular, cherry, mint)	Prescription	Prescription
Cost per day Average wholesale	$2.50 - $3.50	$4.00 - $4.50	$4.00	$5.70= 6 cartridges	$3.70 = 8 doses

* Odds ratio (OR) = odds of remaining abstinent after 6 months compared to placebo

OHSU Smoking Cessation Center October 2007

Tobacco Cessation Pharmacology 2007: Non-Nicotine Medications

Therapy Efficacy	BUPROPION SR 150 mg. (OR = 2.1)*[1] Zyban®/Wellbutrin®	VARNEICLINE (OR = 3.68)*[3, 4] Chantix®	For all medications
Length of Treatment	• 7-12 weeks. • May take up to 6 months of total therapy to prevent relapse.	• 12 weeks. • If quit at 12 weeks may take for additional 12 weeks to prevent relapse.	•Patients should continue on medications even if not successfully quit at first. Research shows that up to 8 weeks may be needed to fully quit. •Symptoms or history of substance use and/or depression reduce success in quitting. Recommend treating these conditions first whenever possible before beginning tobacco dependence treatment. •Clients on psychiatric medications should be monitored for potential increase in medication side effects after reducing or quitting smoking. •Clients with a history of depression should be monitored more closely for symptoms of depression following smoking cessation. •Women metabolize nicotine more rapidly than men especially when pregnant women and on birth control. NRT, if used, may need to be adjusted.[5,6] •For complete prescribing instructions, please refer to the manufacturers' package inserts.
Dosing	•7-day up titration prior to quitting. •Days 1-3; 150 mg tablet each am. •Days 4-end; 150 mg tablet am and pm. •Doses should be > 8 hours apart. •Dose not adjusted by # cigs smoked per day. •May be combined with NRT. •May be combined with NRT to improve efficacy.	•7-day up titration prior to quitting. •Days 1-3; .5 mg. white tablet per day. •Days 4-7; .5 mg. white tablet twice per day, am and pm. •Days 8 to end of treatment; 1.0 mg light blue tablet twice per day. •Take after eating with full glass of water. •Doses should be > 8 hrs apart. •Dose not adjusted by # cigs smoked per day.	
Precautions	•Immediate release form of Wellbutrin® increases seizure risk compared to Sustained Release (SR) or Extended Release (XL) forms. •Do not use with seizure disorder, heavy drinking, eating disorders, or while on monoamine oxidase inhibitor. •Can increase suicidal thoughts in children and adolescents. •Can cause agitation. •Not recommended for clients with bipolar disorder.	•Doseage adjustment is recommended for patients with severe renal impairment. •Not recommended for combination therapy with NRT. •Not tested in children or pregnant women. •Can cause sleep disturbances and abnormal dreams. (Take second dose earlier in day.) •Can cause nausea – up to 30% of patients. (Dose can be reduced to .5 mg twice per day if nausea cannot be tolerated.) •Client psychiatric symptoms should be monitored after quitting.	
Pros	•Easy to use •Reduces urge to smoke	•Easy to use. •Reduces urge to smoke + satisfaction from smoking.	
Cons	•May disturb sleep •May cause dry mouth	•Nausea or sleep disturbances can be a problem for some. Dose can be adjusted (0.5 mg twice daily) to reduce symptoms.	
Availability	Prescription Available as generic: bupropion SR 150mg.	Prescription	
Cost per day Average wholesale	$4.33	$4.00	

* Odds ratio (OR) = odds of remaining abstinent after 6 months compared to placebo

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ONLINE RESOURCES

TOOLKITS

Smoking Cessation for Persons with Mental Illness: A Toolkit for Mental Health Providers (2007). A 42-page binder developed by the University of Colorado at Denver and Health Sciences Center and funded by the Tobacco Disparities Initiatives of the State Tobacco Education and Prevention Partnership (STEPP), Colorado Department of Public Health and the Environment that educates mental health care professionals about specific guidelines and strategies to use to reduce the burden of tobacco among persons with mental illnesses. To order copies of this toolkit and additional materials, visit www.steppitems.com

Tobacco-Free Living in Psychiatric Settings: A Best-Practices Toolkit Promoting Wellness and Recovery (July 2007). Developed by the National Association of State Mental Health Program Directors (NASMHPD). Provides practical tips for converting facilities to smoke-free status. Available at: www.nasmhpd.org/general_files/publications/NASMHPD.toolkit.FINAL.pdf

PROFESSIONAL PRESENTATIONS

BEA Expert Advisory Committee Members (found at www.tcln.org/bea/resources.html)

Bringing Everyone Along: Survey Results. Presented at the BEA Expert Advisory Committee held June 28-29, 2007 in Portland, Oregon.

Setting the Stage: Conducting Tobacco Treatment with clients with Substance Use Disorders. Janet Smeltz, M.Ed., LADC-I, CTTS-M, Director, T.A.P.E. Project, Institute for Health and Recovery. Presented at the Expert Advisory Committee held June 28-29, 2007 in Portland, Oregon.

Tobacco Use in Special Populations: Psychiatric and Substance Use Disorders. Eric Heiligenstein, M.D., Clinical Director, Psychiatry Service University Health Services Associate, CTRI, University of Wisconsin-Madison. Presented at the Expert Advisory Committee held June 28-29, 2007 in Portland, Oregon.

From the Front Lines: One Wisconsin Program's Experience Treating Nicotine Addiction in an Integrated Alcohol, Drug and Tobacco Program. Sheila Weix MSN, RN, CARN, David Macmaster, CSAC, TTS. Presented at the Wisconsin Tobacco Prevention & Control Conference held May 1-2, 2007 in Madison, Wisconsin. Available at: www.smokefreewi.org/conference07/documents/FromtheFrontLines.pdf

New Initiatives for Reaching Smokers with Mental Illness. TCLN Roundtable Discussion held on March 20, 2007. Speaker materials available at: www.tcln.org/schedule/index.html

Smoking Cessation in People with Serious Mental Illness. New York State Cessation Centers Collaborative Conference Call held on March 07, 2007. Conference audio and speaker materials available at: www.nysmokefree.com/newweb/showcalls.aspx?p=552010

CONSUMER INFORMATION

Quitting for Good. An informative article published by www.schizophreniadigest.com. Available at: www.njchoices.org/smokingforschizophreindigest.pdf

Facts about Smoking and Mental Health Disorders (2007). Tobacco Cessation Leadership Network. Available at: www.tcln.org.

Smoking and mental illness (2006). Fact sheet developed by SANE. SANE Australia is a national charity working for a better life for people affected by mental illness – through campaigning, education and research. Available at: www.sane.org/information/factsheets/smoking_and_mental_illness.html

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Key Assistance Report, Focus on Smoking Cessation (Date Posted: March 27, 2007). National Mental Health Consumers' Self-Help Clearinghouse. The Clearinghouse is supported by a grant from the U.S. Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration, and the Center for Mental Health Services. Available to download from the Clearinghouse website at: www.mhselfhelp.org.

You CAN Quit: Tips for Preparing to Quit (2007). A brochure that educates persons with mental illnesses about the dangers of smoking. Developed by the University of Colorado at Denver and Health Sciences Center and funded by the Tobacco Disparities Initiatives of the State Tobacco Education and Prevention Partnership (STEPP), Colorado Department of Public Health and the Environment. Available at: www.steppitems.com.

You CAN Quit (2007). A poster that educates persons with mental illnesses about the dangers of smoking. Developed by the University of Colorado at Denver and Health Sciences Center and funded by the Tobacco Disparities Initiatives of the State Tobacco Education and Prevention Partnership (STEPP), Colorado Department of Public Health and the Environment. Available at: www.steppitems.com.

WEBSITES

Centers for Disease Control and Prevention, Office on Smoking and Health. The CDC Office on Smoking and Health website has many free tobacco use prevention and cessation resources for professionals and clients, including posters, videos/DVD's, and pamphlets. Many materials are available in Spanish. www.cdc.gov/tobacco

Consumers Helping Others Improve their Condition by Ending Smoking (CHOICES). The goal of this consumer driven organization is to increase awareness of the importance of addressing tobacco use and to create a strong peer support network that encourages mental health consumers to make a positive healthy lifestyle change by addressing smoking and tobacco use. www.njchoices.org/index.htm

Program for Research in Smokers with Mental Illness (PRISM). This research program is directed towards understanding reasons for the high rates of tobacco use among individuals with major psychiatric disorders. Website: http://prism.yale.edu/

Smoking Cessation Leadership Center (SCLC). The SCLC website provides a list of mental health resources. To view these resources and learn about the SLC's ***Mental Health Partnership for Wellness and Smoking Cessation***, go to: http://smokingcessationleadership.ucsf.edu/

New York State Tobacco Dependence Resource Center aims to provide New York's chemical dependency service providers, policy makers, and researchers with cutting-edge scientific resources and support on integrating tobacco dependence interventions into chemical dependency treatment. You will first have to register to obtain these resources. Website: www.tobaccodependence.org/

North American Quitline Consortium (NAQC). The NAQC website provides information about quitline services available in all 50 states, the District of Columbia, Canada, and Mexico. www.naquitline.org.

UMDNJ Tobacco Dependence Program (TDP) The tobacco dependence program is dedicated to reducing the harm to health caused by tobacco use. The TDP particularly aims to provide expertise on quitting smoking for those who need it most and has several resources for tobacco users with mental illness and substance use disorders. Website: www.tobaccoprogram.org.

VIDEO

Smoke Alarm: The Truth About Smoking and Mental Illness (2007): The New York State Department of Health funded a project conducted by the Clubhouse of Suffolk, Inc., a private not-for-profit psychiatric rehab agency to tailor intervention for patients who struggled with tobacco addiction. The outcomes of the project are documented in the video. Contact Lindsey von Busch at 732-288-0629 to obtain a copy.

This Guide is based on insights and advice obtained through a survey of professionals who have been providing cessation services for these patients/clients, existing literature, and interpretation and recommendations from an Expert Advisory Committee. The following describes the survey project, the background literature used, the members of the Expert Advisory Committee, and the survey participants.

BEA SURVEY PROJECT

The survey project was staged in two phases. Briefly, Phase One consisted of an online survey to collect broad program information and, in Phase Two, in-depth telephone interviews were conducted to collect detailed program information and expert opinions. Our goal was to ask experienced professionals across multiple programs to identify common trends that have been effective for treating their patients/clients in the "real world".

The interview survey addressed five program areas related to treatment of tobacco dependence: 1) Patient/client intake assessment; 2) Treatment planning; 3) Treatment approach and follow-up; 4) Materials used and; 5) Staff training and supervision. A sixth area was a global assessment of professional opinions about what worked best for their patients/clients.

One hundred and four online surveys were completed, followed by 28 in-depth phone interviews. The professional leaders who completed the interview surveys and contributed their expertise are listed on pages 51-55. The Tobacco Cessation Leadership Network provided the primary database for contacting professional leaders. The North American Quitline Consortium (NAQC) and the Association for Treatment of Tobacco Use and Dependence (ATTUD) provided assistance by contacting their members to complete the survey. A complete summary report from these surveys can be found at www.tcln.org/bringingeveryonealong.

The invitation to participate in these surveys was directed to tobacco treatment specialists and tobacco treatment programs. However, respondents were more diverse, likely due to the heterogeneous composition of the member databases and the cross disciplinary characteristics of tobacco cessation programs. The professionals responding to these surveys fell into four broad categories: 1) Tobacco treatment programs that include specialized services for clients with mental illness and substance use disorders; 2) Tobacco quitlines; 3) Mental health programs that include tobacco dependence treatment in client treatment plans; and 4) Substance use programs that include tobacco dependence treatment in client treatment plans.

The Expert Advisory Committee identified a fifth category of primary care providers. But because we did not have access to a database of primary care providers, we were unable to collect survey information from this group. Instead, we have provided a summary for primary care providers based on the Public Health Service Clinical Practice Guideline 5A's and advice from our experts.

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PARTICIPATING ORGANIZATIONS

TOBACCO CESSATION LEADERSHIP NETWORK

The mission of the Network is to help increase the capacity in every state to establish effective, sustainable, and affordable cessation services to help tobacco users quit and stay quit. We seek to do this by linking state and national cessation leaders together to share information, resources and strategies, thereby enabling programs in each state to become more comprehensive and successful. www.tcln.org.

ASSOCIATION FOR TREATMENT OF TOBACCO USE AND DEPENDENCE (ATTUD)

ATTUD is an organization of providers dedicated to the promotion of and increased access to evidence-based tobacco treatment for the tobacco user. www.attud.org.

NORTH AMERICAN QUIT LINE CONSORTIUM

The North American Quitline Consortium (NAQC) seeks to unite health departments, quitline service providers, researchers and national organizations in the United States and Canada to enable these quitline professionals to learn from each other and to improve quitline services. www.naquitline.org.

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